Socio-ecological resilience and parental mental illness: Child and parent perspectives of service delivery

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A thesis submitted for the degree of Doctor of Philosophy at the University of Otago Dunedin Aotearoa/New Zealand

October 2018
IN MEMORY

To the families from the Caroline Reid Family Support Service who have experienced the loss of family members during the time I have been working on this thesis, I wish to acknowledge your loved ones who have passed away and the continued grief for you all.

Maria S, a grandmother as parent

Mark F, a father

Krystal T, at 16 years

Jack S, at 14 years
ABSTRACT

Service delivery for children of parents with mental illness (COPMI) and their families is considered essential in many countries for the prevention of mental illness and addiction in children, and their future resilience. Although types of interventions are well researched, and some risk factors can be identified for children, service delivery for families living with severe and chronic parental mental illness has not been sufficiently distinguished or advanced, and the perspectives of this group of service users have not been well captured. This thesis explores child and parent perspectives on service delivery for COPMI and their families in Aotearoa/New Zealand (A/NZ) who have increased needs due to severe and chronic parental mental illness. Socio–ecological perspectives on resilience are utilised to understand these needs. This perspective moves beyond the level of individual or family understandings of COPMI and resilience, locating their needs for support in the broader ecological context of society and culture.

Socio–ecological perspectives on resilience contribute to discourses of support for this group by providing an alternative rationale to the usual risk discourse for service delivery. Such perspectives enable wider factors which affect these families as much as mental illnesses to be uncovered, and pathways of resilience–focused practice to be identified. Socio–ecological resilience theories are further used to locate COPMI and other NGO service delivery in the socio–political sphere of A/NZ.

A long–term COPMI service, the Caroline Reid Family Support Service (CRFSS) which supports whole families for up to eight years, was studied using a primarily qualitative methodology. Convenience sampling was employed to gather data about service–user perceptions of service delivery. The data consisted of interviews of a maximum variation sample of 10 child or youth service–users; four age–differentiated child or youth service–user focus groups (24 participants); and 32 adult service–user, mixed method surveys. Findings
were analysed by thematic analysis and descriptive statistics and compared to CRFSS service goals.

The importance of relationships between service users and workers emerged as the primary theme. The most important elements of this theme were trust, open communication, care of the whole–person, and continuity. Other primary themes included comprehensive family practice, experiences of stigma, peer support, and recreational activities as a conduit for respite and developmental gains. These findings have implications for staff training, support and retention, and support findings from contextually relevant resilience studies in A/NZ and Australia (Bottrell, 2009b), (Munford & Sanders, 2016). Interrelatedness between components of service delivery revealed the scaffolding and probable value–added effects of worker to service–user relationships, and child and youth peer relationships, which raises questions for programme theorisation, delivery, funding and evaluation. Connections in findings add to knowledge of socio–ecological resilience for these families: experiences of stigma and the destigmatising effects of COPMI peer support; and worker to service–user, and child and youth peer relationships, to the enhancement of respite and possibility of developmental gains during recreational activities. The primacy of worker–client relationships within the context of comprehensive family practice contributes to understanding how holistic needs across a family system may be coordinated and enhanced.

Analysis revealed that the long–term, relational and comprehensive nature of the service delivery preferred by service users lacks feasibility in A/NZ and other similar socio–political climates. This is due to the influence of neoliberal ideologies and policies that prevent and resist such service delivery, feed stigma, thwart third sector resilience and capacity, and alter the sector’s values and practices. Strategies which would enable NGOs to resist organisational hybridity and become more resilient are proposed (Walker & Shannon, 2011).
ACKNOWLEDGEMENTS

The title of a holiday, crime–fiction read reminded me of Leonard Cohen’s song ‘Anthem’ (Cohen, 1992): that everything is an ‘imperfect offering’, and the ubiquitous cracks in all not only exist but allow the light to emerge (Penny, 2013). I am at great risk of sounding corny, but nevertheless, I will say it anyway. At the end of this thesis, this song resonates with my own PhD story, and the participants of this study.

I begin by acknowledging the families impacted by parental mental illness at the Caroline Reid Family Support Service (CRFSS) who participated in this research. Thank you for your contributions. Many of you are seen by society as ‘cracked’. I hope this thesis ‘rings some bells’ by highlighting your perspectives on what is helpful for service delivery and the reality of what you face. I further wish to acknowledge Graeme and Caroline Reid and their family. It was their personal story which inspired the CRFSS.

I wish to thank the many people who have supported me throughout this thesis:

- My family for your constant support and encouragement especially when I have wavered, particularly Ken, Rebekah and Phil, Lydia and Henny. Thank you, friends – you know who you are – who have not been put off by my absence and distraction, for continuing to include me, and for lending houses to write.

- Dr Emily Keddell, Dr Peter Walker and Dr Lynne Briggs, thank you for your supervision. Emily, you have guided me from beginning to end; thanks for your patience, honesty, theoretical challenges, and helping me hold the story in mind throughout. Thanks Peter for coaching me through socio–political and organisational theory, taking the time to discuss ideas with me, for the wisdom imparted from your experience with PhD students, and for knowing exactly the right thing to say when needed. Lynne, I have appreciated your quantitative advice, and your professional input over the years, particularly in the clinical social work masters’ papers.

- Thank you also to the University of Otago for the scholarship which enabled me to focus solely on this project.

- My colleagues at the CRFSS and Stepping Stone Trust (SST), who supported this project, believed in me, provided advice, and enabled child participants to attend focus groups and interviews – Matt Barus, Jess Brown, Yano Scalia and Fiona Welles. Two social work students assisted with data collection: Michaela Helem and Mary Harema.

- Michael Moxham for proofreading.
• Murray Winn, for enabling me to be well.

• Reference group members who gave excellent advice during the early stages of the project, I especially acknowledge two members: Cynthia Spittal for your extensive support and mentoring, and Lottie Boardman for your continued interest and wonderful socio–political discussions.

• Dr Anne Scott, for your apt advice when I was in need of it. Thank you to my other friends and fellow researchers at the Child Custody Project. You have influenced me in more ways than you realise.

• To members of the Prato International Research Collaborative for Change in Parent & Child Mental Health, for your welcome inclusion. I have learned so much from you.

• Dr Debbie Wilson, for sharing the interested in COPMI and pointing me in the direction of professionals as secondary attachment figures.

• Dr Bronwyn Dunnachie of the Werry Centre and the National ‘Supporting Parents, Healthy Children’ mental health initiative, for your interest and the opportunities you have given me.

• The Christchurch COPMIA Liaison Group which I have maintained some links with. Thanks for continuing to connect and keeping me up to date with what is happening in the city.
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<td>A/NZ</td>
<td>Aotearoa/New Zealand</td>
</tr>
<tr>
<td>COPMI</td>
<td>Children of parents with mental illness</td>
</tr>
<tr>
<td>COPMIA</td>
<td>Children of parents with mental illness and/or addiction</td>
</tr>
<tr>
<td>CRFSS</td>
<td>Caroline Reid Family Support Service</td>
</tr>
<tr>
<td>MM</td>
<td>Mixed–method or mixed–methodology</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSD</td>
<td>Ministry of Social Development</td>
</tr>
<tr>
<td>NGO</td>
<td>Non–government organisation</td>
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CHAPTER 1 – INTRODUCTION

One way of observing changing discourses in the COPMI\(^1\) field is via themes and descriptors of international COPMI conferences over the last decade. These themes have included: “Keeping children and families in mind”, “Addressing the needs of the whole family”, and “Transgenerational mental health”\(^2\). The conference in 2019 in Oslo, Norway, hints at another progression. Entitled, “It Takes a Village”, the conference:

... explores the ways that we strengthen and support families where a family member has a mental illness, a physical illness or substance use issue ... strengthen the awareness and capacity of ‘the village’ ... about the need and the opportunities of these families to create a better future.

This emphasis may be due to several factors, one of which could be the different approach Scandinavians have concerning support and social welfare (Keddell, 2015a; Khoo, Nygren, & Hyvonen, 2006). I could not help but wonder if such a conference was held in Aotearoa/New Zealand (A/NZ), would it have such a theme? The idea of a village of support approach promoted for adults with severe, chronic and complex mental illness, their children and families, seems almost utopian in this neo-liberal socio-political context.

In this study of service-user perceptions of a COPMIA\(^3\) service in A/NZ, the notion of a village of support is relevant to service delivery. In locating service delivery in this A/NZ context, this thesis considers layers of support for COPMIA and their families. Support is understood as ranging from in-the-home and the wider circle of family and friends; to neighbourhood and local services; and

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\(^1\) COPMI is the internationally recognised acronym for ‘children of parents with mental illness’.

\(^2\) These themes are from conference materials obtained when attending in 2009 (Adelaide), 2014 (San Francisco) and 2016 (Basel).

\(^3\) COPMIA is a more recent A/NZ acronym for ‘children of parents with mental illness and/or addiction’. It will be used when referring to A/NZ service delivery and policy context. However, when not referring to the A/NZ social service context, COPMI will be used. To add to the confusion, at the time of data collection, the service studied was still using the acronym COPMI, as COPMIA was adopted later; hence all ethics committee documentation uses this.
cultural and political ideologies which translate into policies, funding and everyday attitudes. A strong argument made in this thesis will be that a village of support does not exist locally or nationally, physically or psychologically, for most COPMIA and their families facing serious, chronic and complex illness in A/NZ, and this has significant ramifications for service delivery. In addition, the wider influences of the socio–political environment have diminished support to and between NGOs (non–government organisations) to provide services which meet diverse needs.

When the mental health consumer movement was consulted about the A/NZ government’s COPMIA guidelines for adult mental health services, they sent an important message in rejecting the COPMIA acronym in favour of “Supporting Parents, Healthy Children”; suggestive of a similar view to “It takes a Village” (MOH, 2015). However, this does not diminish the specific needs COPMI have, and in this study, child and adolescent service–users also express their needs for support. This service evaluation represents needs for support voiced by all family members, and it is in this broader socio–ecological context these will be positioned.

Explanatory lenses framing this thesis require the capacity to consider the layers of influence in the lives of individuals and services. Ecological theory, as understood by social work usage in Australasia, offers a structure to do this, based on the work of Bronfenbrenner (Coady, 2001; Connolly & Harms, 2012; Nash, Munford, & O’Donoghue, 2005; O’Donoghue & Maidment, 2005). A further overarching theory is required to understand principles of practice for service delivery. When considering service delivery for COPMI, an important focus is prevention of ill health, addiction, and/or adversity via supporting and strengthening COPMI in a way which might counteract any adverse effects. This not only applies to COPMI, but their parents and family systems as, ecologically speaking, their wellness cannot be separated from each other. The most appropriate theory for this is resiliency theory, with a socio–ecological lens. The study of patterns of adaptation in the face of adversity, this theory identifies
what elements are necessary and need resourcing, and therefore where priorities should lie (Bottrell, 2009b; Munford et al., 2013; Ungar, 2012b).

A further premise of the thesis is that as social work research, it has a ‘beyond knowledge’ purpose. The use of socio–ecological, theoretical lenses in this study enables the thesis to “reveal the structures and mechanisms that generate and maintain inequality” for COPMIA and their families in A/NZ, the Caroline Reid Family Support Service (CRFSS), its parent organisation Stepping Stone Trust (SST), and other NGOs (D’Cruz & Jones, 2004, p3; Everitt, Hardiker, Littlewood, & Mullender, 1992).

This introductory chapter outlines the research aims and methodology used and describes the research setting. The chapter then moves on to describe the research question and pertinent issues, contributions this thesis makes, and finishes with an outline of the thesis.

THESIS AIMS AND SCOPE

The CRFSS began as a small, independent, community social service for 7 to 16−year−old COPMIA and their families in 2004, originally called the Caroline Reid Charitable Foundation, and located in Ōtautahi/Christchurch. When this research project started late February 2011, the service had been absorbed, renamed and managed by Stepping Stone Trust (SST)4 for a year. Although the need for evaluation had been considered pre−SST, it became more essential post−amalgamation. Challenges to the CRFSS service model were issued by SST senior management, due to difficulty securing long term funding for CRFSS, and lack of data and theory to make a case to the state health funding body. As no additional funding for evaluation research was available and human resources were already stretched, a form of evaluatory study for a thesis seemed a feasible solution. This thesis began as part of a Master of Social Work degree.

4 Stepping Stone Trust is the largest not−for−profit, community mental health organisation in this city of Ōtautahi/Christchurch, A/NZ. It provides respite, community and residential services to adolescents and adults, and short and long term COPMIA services (https://www.stepstone.org.nz/).
Post-data analysis, in recognition of the large amount of original data, the university initiated an upgrade to PhD. Official upgrade was April 2014.

The third paradigm of pragmatism affected the scope of the thesis. Resource limitations meant data collection sources had to be prioritised. As the service delivery was long term and continuous, it was not possible to utilise pre- and post-testing. Although it would have been useful to include data from staff, referrers and other professionals, capturing the service-user voice seemed essential for understanding what was important about service delivery, what could be improved, and to provide indicators for future evaluation. Additionally, the perspectives of children and adolescents in this domain were rarely portrayed. Thus, a primarily qualitative methodology was employed to gather data about service-user perceptions of service delivery: interviews of a maximum variation sample of 10 child service-users; four age-differentiated child service-user focus groups (24 participants); and 32 adult service-users were surveyed using a mixed method questionnaire.

Thesis aims were expanded during the project. It became apparent as my understanding of evaluation and organisational practice grew that staff and management needed to more fully understood the model of practice, thus a further was to provide a theoretical framework for service delivery. The location of research findings in the wider socio-political environment arose due to a realisation that what service-users felt was important was difficult to provide in A/NZ. Undertaking an organisational analysis emerged from this broader enquiry, as it seemed important to understand why the intra- and inter-organisational conflict occurred.

In this thesis, the term child service-users will include the entire period in which young people are with the service, that is, from 7 to 16 years of age. Child participants refers to all child and adolescent participants in the project, ranging in age from 7 to 18 years.
This section considers the socio-ecological context of CRFSS and SST, detailing the history of the service and amalgamation with SST. Information for this section, where not referenced, was obtained from personal experience of living in Ōtautahi/Christchurch, insider experience of employment with CRFSS and SST, and conversations with CRFSS and SST staff during this research project.

It is important to disclose that I was an employee of CRFSS from mid-2009 until March 2014, which incorporated the period of research design, ethical consent, data collection and initial analysis. As an internal evaluator, I was also a clinical family social worker, working with adult family members of service-user children. In March 2014 I left CRFSS to focus on this study. The debate, ethical issues, and strengths and limitations surrounding the insider-outsider continuum are discussed in Chapter Four—Methodology.

ŌTAUTAHI/CHRISTCHURCH, AOTEAROA/NEW ZEALAND

Ōtautahi/Christchurch is the third largest city in A/NZ, with a population of approximately 350,000. Its original name, Ōtautahi, was given by the A/NZ Māori tribes who were the areas first inhabitants from early in the 13th Century. Although a treaty was signed between the British Crown and A/NZ Māori in 1840, the Tiriti o Waitangi (Treaty of Waitangi), which Māori believed protected their status, rights, governance and self-determination, this has not been upheld. Māori experienced similar treatment to other indigenous cultures worldwide: land was taken, and laws introduced which systematically subjugated their rights and culture. Thus, the effects of colonisation have been largely detrimental (Consedine & Consedine, 2005; Orange, 2015; Ruwhiu, 2001; Walker, Eketone, & Gibbs, 2006; Wilson, 2016). Today, Māori are disproportionally represented in negative statistics, including: physical and mental illness, infant mortality, and lower life expectancy; crime and imprisonment; secondary and tertiary underachievement; low wages, unemployment, welfare benefit use and poverty (Marriott & Sim, 2014; Walker et al., 2006).
A/NZ Māori are otherwise known as tangata whenua. Te Reo Māori is the language of our tangata whenua and became an official A/NZ language in 1997 (NZ Māori Language Act 1997). Definitions of Te Reo Māori words will be provided in footnotes, from the English translation of the Māori dictionary (http://Māoridictionary.co.nz/). In this thesis, tangata whenua will be referred to as Māori.

Ōtautahi was renamed Christchurch by early English settlers in 1856. It is officially the oldest established city in A/NZ, situated in the second of the larger A/NZ islands, Te Wai Pounamu, the South Island. Population ethnicity of the greater Ōtautahi/Christchurch area reflects European settlement, with ethnic makeup of 85.9% ‘A/NZ European’; 8.2% Māori; 7.9% one or more minority groups; and 2.6% one or more Pacific people’s groups. In 2013 population figures for A/NZ revealed 15% Māori, 74% A/NZ European, 12% Asian, 7% Pacific Peoples, and 1% Middle Eastern/Latin American/African. (Consedine & Consedine, 2005; Orange, 2015; Statistics New Zealand, 2013; Statistics New Zealand, 2015).

Since the severe earthquakes in Ōtautahi/Christchurch from September 2010 and throughout 2011, the socio-ecology has changed. About 90% of the central business district was demolished; large tracts of housing alongside rivers on the eastern side were red zoned; significant damage occurred to roads, water and sewage systems in large parts of the city; and many homes were demolished or required significant repair. Numerous people had to move to other suburbs. A further disruption for families was the effect of the state education department, the Ministry of Education (MOE) closing many primary and intermediate schools in areas with lower populations (Mutch, 2017). Consequently, large numbers

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5 Tangata whenua – (noun) local people, hosts, indigenous people, people born of the whenua, ie, of the placenta and of the land where the people’s ancestors have lived and where their placenta are buried.

6 This term is understood as referring to A/NZ Māori, excluding Cook Island Māori. Cook Island Māori are included in Pacific Peoples statistics.

7 Data from the 2018 census will not be available until late 2019.
of people, including families, experienced dislocation of their communities. Demand for mental health services has increased exponentially (The Health Committee, 2015/16).

**A/NZ MENTAL HEALTH SERVICES**

CRFSS is placed in the context of a post-deinstitutionalisation era in A/NZ mental health service provision, in which all but the most serious and complex 1–3% of mental health services are provided by NGOs and primary health providers. Most receive majority funding from the state health department, the Ministry of Health (MOH). MOH funding is primarily linked to an individual’s national health index number (NHI) and requires a physical or psychiatric diagnosis.

As COPMIA are largely without psychiatric diagnoses, service provision, until the effects of a 2015 state health initiative, has been funded in a more indirect manner via MOH–contracted funding for their parents who are mental health consumers; or private grants and/or small amounts of government funding from a different purse, usually the Ministry of Social Development (MSD). Until this COPMIA–MOH initiative in 2015, the state was not proactive about meeting the needs of COPMIA (MOH, 2015). Although many NGOs and a few state child and adolescent mental health services have been pursuing the needs of COPMIA, in typical fashion it has taken a national initiative to enable policies and processes, and training and intervention to become implemented (MOH, 2015; State of Victoria, 2014; Reedtz, Lauritzen, & Van Doesum, 2012; Solantaus & Toikka, 2006; Tchernegovski, Maybery, & Reupert, 2017).

Support from mental health services and other social service groups is noted to influence supportive outcomes for families, and these vary across countries (Falkov et al., 2015; Foster et al., 2016; Lauritzen, 2014; Reupert & Maybery, 2016). Maybery and Reupert (2009) found in countries such as Australia, mental health clinicians rarely talk to parents about their children or provide parenting support, due to deficits in practitioner skills and knowledge of working with parents and children, and practitioners’ stigma concerning parental
capacity. Hosman et al. (2009) describe similar issues in the Netherlands. These deficits have fuelled the international drive for family-focused, mental health practice training for adult mental health clinicians, and A/NZ is in the midst of this process (Falkov et al., 2015; Foster, 2015; Foster et al., 2016; Foster, O’Brien, & Korhonen, 2012a; Goodyear et al., 2015; Maybery, Goodyear, O’Hanlon, Cuff, & Reupert, 2014; Reupert, Maybery, & Morgan, 2015).

At present, the prevalence of severe and chronic parental mental illness in A/NZ is difficult to ascertain. About 20% per annum of adults will experience a diagnosable mental illness, however these figures do not specify severity or chronicity of illness, nor which adults are parents (Mental Health Foundation, 2010; MOH, 2015). Between one and three percent of adults with mental illness meet the criteria to access statutory mental health services, constituting ‘severe’ illness. However, not all adults with severe and/or chronic mental illness attend such services. No figures exist in A/NZ indicating how many COPMIA exist, nor how many have parents with severe and chronic mental illness. International data reveal some information about how many adults with mental illness and/or addiction are parents, but again, minimal data exists specifying numbers of parents who have severe and chronic conditions. One estimate is that 1.3% of Australian children live in families with parents who have severe and chronic mental illness (Maybery et al., 2009; Steer, Reupert, & Maybery, 2011).

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**COPMI SERVICE DELIVERY**

COPMI service delivery is commonly categorised into three type of programmes: for children and adolescents, for parents with mental illness, and

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8 International prevalence figures of parents who have mental illness are variable due to methodological issues (Maybery, Nicholson, & Reupert, 2015), with one well-known study showing 68% of women and 54% of men meeting criteria for mental illness were parents (Nicholson, Biebel, Katz-Leavy, & Williams, 2004); and another estimating 38% of women with serious mental illness were mothers, and 23% of men were fathers (Luciano, Nicholson, & Meara, 2014). (Reupert & Maybery, 2016). Data from the Netherlands note about 9.7% of the whole population (under the age of 22 years) has a parent with mental illness, 56% of whom are below 12 years of age (Hosman et al., 2009). (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009), using a combination of methodologies to reduce variance, estimate 23.3% of Australian children have a parent with a mental illness (Maybery et al., 2015).
for whole families (Hinden, Biebel, Nicholson, Henry, & Katz-Leavy, 2006; Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007; Reupert, Maybery, Nicholson, Gopfert, & Seeman, 2015; Reupert et al., 2009). Programmes for school aged children and adolescent often focus on peer support and incorporate aspects of respite, mental health education, coping skill training and recreation (Grové, Melrose, Reupert, Maybery, & Morgan, 2015; Foster, Lewis, & McCloughen, 2014; Reupert et al., 2009; van Santvoort, Hosman, van Doesum, & Janssens, 2013). Parent programmes may be group or individual, or a combination of both, and often incorporate individual support by way of home visiting or case management, and parent training (Hinden et al., 2006; Nicholson et al., 2007; Reupert et al., 2009). Family programmes vary depending on the ages of children represented in the families, often incorporating families with younger as well as older children (Nicholson et al., 2007). Components may include separate support programmes for children and parents which incorporate features of separate programmes outlined above, interventions to enhance child development and prevent developmental delays, and parent–child therapy (Hinden et al., 2006; Nicholson et al., 2007; Reupert et al., 2009).

Gaps in service delivery include a lack of programmes for fathers; indigenous, migrant and refugee communities; people living in rural communities; and COPMI with behavioural and psychiatric issues (Hinden et al., 2006; Reupert, Maybery, Nicholson, et al., 2015; Reupert et al., 2009). Many programmes are time limited, ranging from a few weeks to several years (Hinden et al., 2006; Nicholson et al., 2007; Reupert, Maybery, Nicholson, et al., 2015; Reupert et al., 2009).

THE CAROLINE REID FAMILY SUPPORT SERVICE⁹

The CRFSS was begun in 2004 by Graeme Reid, husband of Caroline Reid. Caroline developed serious mental illness in 1973 following the birth of her second child (Reid, 2017). Graeme describes the time:

⁹ Information drawn on for this section comes from unpublished CRFSS and Caroline Reid Charitable Foundation documents, Graeme Reid’s memoirs, personal communication with staff during this project, and insider knowledge from working for the service.
...the nightmare that mental health problems bring to the family environment (p3), (Caroline Reid Charitable Foundation, 2009).

It was a dream of both Graeme and Caroline to begin a service which supports COPMIA and their families. From their own experiences and those observed from other families in the mental health community, they felt that long term and continuous relational support, comprehensive and flexible service delivery to cater for variations in need over time, and regular recreation for children and adolescents to provide respite and build positive memories were all important. Graeme refers to COPMIA as “the silent sufferers”. Unfortunately, Caroline died from cancer in 2002 and did not see this dream realised (Caroline Reid Charitable Foundation, 2009; Reid, 2017).

With the support of local professionals concerned about COPMIA who met under the name ‘Holding it Together’, and local specialist child and adolescent mental health services, the Caroline Reid Charitable Foundation was instituted in 2003, and service began in 2004. The service was set up to provide programmes for COPMI who had parents/caregivers with mental illness, and their families. The mission statement reads:

...aiming to honour and strengthen families by supporting children and adolescents from 7−15 years, living in an environment where the mental illness of a family member has impaired the family’s quality of life (Caroline Reid Charitable Foundation, 2009).

Funding was provided predominantly via private grants and individual donations. Initial service delivery included long term and continuous recreational programmes, camps and one-to-one support to child service-users aged 7−16 years; and home visits, parent education and aspects of family case management and other support for parents/caregivers and other family members. CRFSS has since developed other areas of service provision including a short-term service, but it is this long-term service which is the focus of this thesis, and it remains much the same as when it began.
At the time of data collection, CRFSS employed one family social worker (0.6 FTE, full time equivalent) and two children’s workers (0.6FTE each). CRFSS provided a comprehensive service to 40 COPMIA, representing 25 families. At least one adult family member for each child service–user was required to engage with the service, and of the 25 families, 48 adults were service–users. At least one adult service–user from each family received regular service delivery. The majority of parents were separated, and the service was not resourced to visit all parents each month. Therefore, monthly visits were prioritised for parents/caregivers who provided significant caregiving, were willing to engage with the service, and were available during working hours.

Adult service–users were parents, step–parents and grandparents. Of the 48 adult service–users, 70.8% were female and 29.1% male. Ethnicity was 75% NZ European and 8.33% Māori.
TABLE 1.1 - FREQUENCY DISTRIBUTION OF ADULT SERVICE-USER DEMOGRAPHICS IN 2011 (N=48)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>29.17</td>
</tr>
<tr>
<td>Female</td>
<td>34</td>
<td>70.83</td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31−35 years</td>
<td>5</td>
<td>10.42</td>
</tr>
<tr>
<td>36−40 years</td>
<td>14</td>
<td>29.17</td>
</tr>
<tr>
<td>41−45 years</td>
<td>14</td>
<td>29.17</td>
</tr>
<tr>
<td>46−50 years</td>
<td>6</td>
<td>12.50</td>
</tr>
<tr>
<td>50−55 years</td>
<td>4</td>
<td>8.33</td>
</tr>
<tr>
<td>56−60 years</td>
<td>3</td>
<td>6.25</td>
</tr>
<tr>
<td>61−65 years</td>
<td>1</td>
<td>2.08</td>
</tr>
<tr>
<td>Mode</td>
<td>36,40, 41−45</td>
<td></td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European</td>
<td>36</td>
<td>75.00</td>
</tr>
<tr>
<td>NZ European and Māori</td>
<td>1</td>
<td>2.08</td>
</tr>
<tr>
<td>NZ European and Zimbabwean</td>
<td>1</td>
<td>2.08</td>
</tr>
<tr>
<td>Indian</td>
<td>2</td>
<td>4.17</td>
</tr>
<tr>
<td>European</td>
<td>1</td>
<td>2.08</td>
</tr>
<tr>
<td>Māori</td>
<td>4</td>
<td>8.33</td>
</tr>
<tr>
<td>Japanese</td>
<td>1</td>
<td>2.08</td>
</tr>
<tr>
<td>NZ European/Dutch</td>
<td>1</td>
<td>2.08</td>
</tr>
<tr>
<td>New Zealander</td>
<td>1</td>
<td>2.08</td>
</tr>
</tbody>
</table>

Child service–user demographics for the whole service were not recorded. The reason for this was because child service–user data collection occurred over a two–year period, therefore due to client throughput and fluctuating client numbers depending on how many children each family had (25 families), there was not one set of demographics which accurately reflected child service–users. In hindsight, it may have been useful to have snap-shot demographics of the same time adult service–user demographics were recorded. Unfortunately, in the change from paper records to electronic records, the service was not able to provide this information without considerable effort, therefore it is not available in this thesis.
However, some general demographic information is available. Child service–users were aged between seven and 16 years of age, with no one age group more strongly dominant than others as the intake process usually resulted in four or five child service–users in each age group. Sometimes there were more males or females of a certain age, but overall approximately half were male and half female. Their ethnicity was reflective of adult service–users. Demographics of child participants were gathered and are summarised under the description of the sample in this chapter, and fully outlined in Chapter 3: Methodology. Some child participants were no longer service–users at the time of data collection.

Criteria for referral were two–fold: parental mental illness of a chronic and severe nature accompanied by complex psychosocial issues, and child service–users experiencing adverse effects attributed to this. Referrals were made from statutory and community agencies. Although addiction was sometimes a factor for adult service–users, it was secondary to the presence of mental illness for intake and service focus. The service recognised the specialist knowledge required for working with addiction, emphasising the need to ensure service–users were connected and supported with agencies who were better equipped. Therefore, this thesis recognises the common comorbidity between mental illness and addiction, but does not include literature specific to addiction, even though the term COPMIA will be used to denote A/NZ service delivery.

Although the service catered for child service–users until they turned 16 years of age, because of the relational focus, intake occurred when children were at primary school (Years 3 – 6). Discharge was shortly after the end of Year 11 of schooling\(^{10}\). The discharge process allowed child service–users to finish that year, and they usually graduated at the beginning of the following year after attending a camp. Throughput was dependent on the size of the cohort of 16–year–old child service–users; typically three to five per year.

\(^{10}\) Most A/NZ adolescents turn 16 years of age during Year 11.
Exclusion criteria for child service–users was mental illness which affected their ability to manage group events, for example, ADD, ADHD, conduct or oppositional defiant disorders, and psychosis. Some child service–users developed mental illness while they were service–users of the service: typically, adjustment disorders, anxiety and/or dysthymia/depression. If a child’s symptoms did not adversely impact other children in the service, they were free to continue attending group outings\textsuperscript{11}.

One male and one female children’s worker provided one–to–one mentoring support to child service–users. In addition, they planned and implemented age–differentiated recreation days (monthly for under–13 and over 13 years), two annual age–differentiated camps (under–13 and over 13 years), mental health education at some recreation days and at camps, and 3–4 day, formal mental health education programmes. Where appropriate, agency liaison and attendance at meetings was also part of this role.

Recreation days were generally held on a Saturday and began as early as 8.30 am when several vans began collecting child service–users from their homes. This could take at least 1.5 hours per van. There was no charge for transport, and meals were provided. Children’s workers were assisted by screened volunteers at recreation days and camps. Sometimes recreation days had a creative theme and games, food and activities would be based around that theme. At other times the days focused more on an actual activity, for example, a tobogganing trip, or kayaking, or walking to an area for a picnic and games. The older group of child service–users had more input into the types of activities they engaged in (13+). Further information on types of activities at recreation days and camps is in Appendix P.

\textsuperscript{11} To my knowledge no child clients were excluded from group events for this reason.
Formal mental education programmes were still being implemented when data for this project were collected. The only group to have completed the CUMI\textsuperscript{12} course (Children Understanding Mental Illness), an educational and therapeutic COPMIA programme running over three to four days, were the 7–13–year–old child service–users (Year 3 – 8). The intention was for child service–users to complete an age–appropriate version of the course twice while at CRFSS.

Family workers were responsible for intake and assessment, monthly home visits and regular telephone calls to a nominated adult family member, and two to three visits per year and telephone contact to other parents/caregivers. The role incorporated multiple aspects of comprehensive family practice, as reflected in the service goals outlined further below, including: parenting support and education; monitoring of the mental health and general health of family members; assessing gaps in support and referral, and advocacy and liaison with other agencies; discussion of family mental health care plans; general psycho education; and planning and implementation of a monthly parent support group.

CRFSS staff met weekly to update each other on matters relating to their separate roles, any concerns they had about service–users, and to discuss future interventions. Sometimes family and children’s workers visited families together.

\textsuperscript{12} The CUMI programme was developed by Bernadette Berry, clinical psychologist, Dunedin, for Supporting Families Otago. Bernadette was contracted by SST to train CRFSS workers in this programme.
# TABLE 1.2 – COMPONENTS OF CRFSS SERVICE DELIVERY

<table>
<thead>
<tr>
<th>Service Components</th>
<th>Parents/caregivers</th>
<th>Child service-users Year 3–8</th>
<th>Child service-users Year 9–11</th>
<th>Staff responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake and assessment of service-user families</td>
<td></td>
<td></td>
<td></td>
<td>Family workers</td>
</tr>
<tr>
<td>Home visiting</td>
<td>Monthly</td>
<td></td>
<td></td>
<td>Family workers</td>
</tr>
<tr>
<td>Telephone calls</td>
<td>As needed</td>
<td>As needed</td>
<td>As needed</td>
<td>All workers</td>
</tr>
<tr>
<td>Liaison with professionals</td>
<td>As needed</td>
<td>As needed</td>
<td>As needed</td>
<td>All workers</td>
</tr>
<tr>
<td>Support at meetings with professionals</td>
<td>As needed</td>
<td>As needed</td>
<td>As needed</td>
<td>All workers</td>
</tr>
<tr>
<td>One–to–one informal visits (or small group visits)</td>
<td>At least bi–monthly</td>
<td>At least bi–monthly</td>
<td></td>
<td>Children’s workers</td>
</tr>
<tr>
<td>Transport to and from group recreational activities</td>
<td>Monthly</td>
<td>Monthly</td>
<td></td>
<td>Children’s workers</td>
</tr>
<tr>
<td>Group recreational activities</td>
<td>Monthly</td>
<td>Monthly</td>
<td></td>
<td>Children’s workers</td>
</tr>
<tr>
<td>Camps</td>
<td>Annually</td>
<td>Annually</td>
<td></td>
<td>Children’s workers</td>
</tr>
<tr>
<td>CUMI course (Children understanding mental illness)</td>
<td>One family night after the course</td>
<td>Once</td>
<td>Once</td>
<td>Children’s workers</td>
</tr>
<tr>
<td>Whole family social events</td>
<td>At least one per year</td>
<td>At least one per year</td>
<td>At least one per year</td>
<td>All workers</td>
</tr>
<tr>
<td>Whole family meetings</td>
<td>As needed</td>
<td>As needed</td>
<td>As needed</td>
<td>All workers</td>
</tr>
<tr>
<td>Parent Support Group</td>
<td>Monthly</td>
<td></td>
<td></td>
<td>Family workers</td>
</tr>
</tbody>
</table>
AMALGAMATION WITH STEPPING STONE TRUST

Prior to beginning the service, Graeme Reid founded several other community services. The most notable was Stepping Stone Trust (SST). In March 2010, due to the imminent retirement of Graeme Reid and in anticipation of future funding difficulties for small NGOs, the Caroline Reid Charitable Foundation Board disbanded, and the foundation became CRFSS, under the management of SST.

This thesis is concerned with funding issues. The Caroline Reid Charitable Foundation Board were aware of the socio-political context in A/NZ and its impact on state-NGO contracts. The state and other significant private funders were moving towards funding large organisations, but small community agencies were increasingly ignored. SST could use state health funding attached to adult service-user NHIs to fund CRFSS staff salaries and continued with private funding for child service-user activities and resources. However, this did not prove to be straightforward. SST senior management experienced pressure from the state funding and planning team about on-going funding of CRFSS in its current form, as the model did not fit with state sanctioned brief, prescribed interventions.

For this reason, in response to pressure from SST management, in 2013 the CRFSS team began a short-term service in addition to the long-term service, with no extra resources. The short-term service consisted of a three-month intervention period for service-user families with less severe and complex needs. Parents/caregivers received assessment and brief family work interventions, often involving referral to other services. Child service-users attended a CUMI course. At the time this represented an intake of approximately 12 new families per year.

Fortunately for all parties, changes occurred in the COPMIA landscape in A/NZ. A new Director of Mental Health who was familiar with the COPMI work in Australia lobbied from the top. The result was that in 2014, CRFSS staff funding for both long and short-term services was recognised under a COPMIA contract. Since then the MOH have introduced guidelines for COPMIA work in adult
mental health, and the entire mental health field has become more intentional in considering the needs of COPMI. CRFSS has attracted more state funding. Although children’s worker positions remain at 0.6 FTE each, they have been relieved of most short-term work because the service has gone from one 0.6FTE family worker to two FTE family workers. One family worker works in the long-term service, and the other coordinates and delivers most of the short-term service.

For now, the CRFSS long term model is safe, however as will be discussed in Chapters Two and Six, this may not always be the case due to risks within SST when changes of senior staff occur, and from outside SST, due to the influence of the socio-political environment.

**THE SERVICE NARRATIVE**

This sub-section describes aspects of the CRFSS service narrative at the time of data collection. This is relevant as twelve service goals developed from this narrative were incorporated into the initial version of the research question (Appendix A). These goals were worded to reflect the original vision and mission statements of the service, and actual service delivery, and were as follows:

1. To assist service-user children to have more diverse childhood experiences;
2. To assist service-user children to feel less stigmatised;
3. To develop a mentoring relationship with each child service-user;
4. To provide opportunity for children to play and be children;
5. To enhance child service-user’s knowledge of mental illness;
6. To assess child service-users’ (and siblings where pertinent) health and wellbeing;
7. To improve social inclusion in service-user families;
8. To assist service-user families to access services;
9. To assist service-user families to develop a care plan around mental illness;
10. To educate adult service-users about the impact of mental illness on parenting;

11. To assist adult service-users to enhance their parenting capacity;

12. To assess and educate adult service-users regarding mental illness.

Goals relate to known difficulties which some COPMI and their parents/caregivers experience, particularly those who have parents/caregivers with serious and chronic mental illness and complex psychosocial issues. The literature relating to these is explained in Chapter Two in relation to what informs service delivery and principles of practice for this service-user group. As this sub-section explains the service narrative, references to the literature are omitted.

Sometimes parental mental illness and its accompanying social adversity affects children’s opportunities to attend extra-curricular events, special school outings and socialising with friends, and the family may rarely venture from home. Therefore, goals concerning providing opportunities for child service-users to ‘play and be children’ and have new experiences, reflect this (Goals One and Four). At times, COPMIA are required to perform significant caring and/or household tasks in the home when a parent is unwell, and/or are experiencing anxiety, and/or live in a stressful environment, and this is also a motivation for Goal Four. A common deficit is children’s lack of knowledge about parental mental illness, and therefore the service, with parent/caregiver knowledge and consent, seeks to ameliorate this in age-appropriate ways (Goal Five). Social isolation and stigma are common in this service-user group, and thus goals concerning the provision of mentoring and a destigmatising environment are intended to fill these gaps (Goals Two and Three). Goal Six reflects the preventive nature of the service in its aim to strengthen and support child service-users and reduce risks. Thus, through normal service delivery, workers actively notice child service-users and/or have conversations with parents/caregivers about their children, to ensure they receive necessary support in a timely manner.
Goal Seven reflects the social isolation that adults with mental illness and their families often experience, and Goal Eight, the difficulties and stigma associated with accessing support. Supporting parents/caregivers to be ‘as well as possible’, for their own sake and that of their families, is the rationale behind Goal 12. Many of the CRFSS adult service-users were disengaged with mental health services and/or required further treatment which had gone unnoticed by other professionals at intake. Often time had not been taken to explain and explore diagnoses and experiences of mental illness to the adult with mental illness and/or other adult family members. Goals Nine and 10 concern raising awareness for parents/caregivers with mental illness of the possible effects their illness may have on their children, so support may be provided, and crisis plans made. Closely aligned is Goal 11, as helping parents to gain a full range of parenting skills and knowledge results in a strengthened family system.

DEFINITIONS

This sub-section continues to provide context by outlining definitions of childhood, adolescence, parenting and family life in the A/NZ research setting, primarily from Māori and A/NZ European (Pākehā 13) perspectives.

The dominant social discourse in A/NZ has emerged from the influence of English colonists and is therefore eurocentric (Orange, 2015; Ruwhiu, 2001; Walker et al., 2006). Although Māori perspectives have re-emerged, are enshrined in law, and helping professionals are bound by bicultural codes of practice, unless the organisation works from a kaupapa Māori14 framework, these perspectives remain on the margins (ANZASW, 1993; Hayward, 2004; Te Puni Kōkiri [Ministry of Māori Development], 2002; Waitangi Tribunal, 2016; Walker et al., 2006).

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13 Pākehā – (noun) New Zealander of European descent, probably originally applied to English-speaking Europeans living in A/NZ.

14 Kaupapa Māori – Māori approach, Māori topic, Māori customary practice, Māori institution, Māori agenda, Māori principles, Māori ideology – a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society.
The terms *childhood* and *adolescence* are new from an historical perspective in the Western world. During the last 200 years, Western society has gradually moved to the current state, in which children and adolescents in A/NZ and many countries are given special status via an international charter and national laws exist concerning child labour, child education, and child protection (Feldman, 2012; Pollock, 2011; Santrock, 2013; UNICEF, 2014; Walrond, 2011). Today, the state in A/NZ provides financial support to families on low incomes and/or without employment to ensure basic needs of children and adolescents are met. In this Western context, childhood is understood as the period between birth and puberty, and adolescence as the stage from childhood to adulthood (Feldman, 2012; Fowler & Fowler, 1995; Santrock, 2013). In A/NZ culture, adolescence is considered to begin at age 13 years and end at 19 years, regardless of the onset of puberty (Feldman, 2012; Santrock, 2013; Walrond, 2011).

The construction of families has changed over recent centuries from the extended family to the nuclear model, and since then to the current situation of diverse arrangements of adults and children, many of whom live separately and often disconnectedly from their extended family. Adults who are caregiving may or may not be related by birth to children, and adult relationships in the household may be heterogenic, homogenic, or non-intimate. However, the discourse around family construction in A/NZ has not kept up with actual changes, and ranges from open rejection to wholehearted acceptance.

Defining family thus differs across the social and cultural milieu of A/NZ. When Pākehā and non-Pacific cultures use the term, they are usually referring to their immediate family of parents/caregivers and children. When Māori and many Pacific cultures use the term, they are usually referring to the wider, extended network (Metge & Kinloch, 1978). This affects how the parent–child term is viewed (Metge & Kinloch, 1978). In A/NZ European (Pākehā) culture, ‘parent–child’ usually refers to a son or daughter by birth, adoption or foster care arrangement, and although times are changing, and a child may have two mothers or two fathers in homogenic situations, or step-parents in blended
families, primarily a child is considered to have only one mother and one father, and these ‘parents’:

... see the relationship as exclusive, with both the rights and responsibilities of parenthood focused almost entirely on ‘father’ and ‘mother’, so that others hesitate to intervene even when things go obviously wrong (p35) (Metge & Kinloch, 1978).

In Māori culture, and Samoan and other Pacific cultures, no distinction is usually made between lineal and collateral family. The term ‘parents’ is less exclusive and applied to aunts, uncles, grandparents and others who take a parental role and share rights and responsibilities for the children’s welfare (Metge & Kinloch, 1978). This understanding is reflected in the Māori word whānau\textsuperscript{15}. The term whāngai\textsuperscript{16} is also reflective of the Māori concept of whānau.

Unfortunately, the discourse relating to how family is defined in much mainstream psychological theory and its applications is still largely Eurocentric (Keddell, 2017; Keller, 2013; Keller, 2005a; Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000; Solomon, 2002; Szapocznik & Kurtines, 1993). Consequently, the predominant discourse in A/NZ views the task of childhood and adolescence as the development of the child into adulthood with the goal of them reaching their full potential, developing increasing independence and autonomy. Responsibilities and work, whether remunerated or not, are gradually introduced at age-appropriate stages, with minor variations dependent on one’s cultural and familial circumstances (Jose & Schurer, 2010; Kagitcibasi, 2012; Keller, 2013; Langford, Ritchie, & Ritchie, 1998; Rothbaum et al., 2000; Szabo et al., 2017).

Changes in parenting philosophy have followed (Feldman, 2012; Forehand & Kotchick, 2016; Kagitcibasi, 2005; Keller, 2013; Rothbaum et al., 2000; Santrock, 2017).

\textsuperscript{15} Whānau – (noun) extended family, family group, a familiar term of address to a number of people – the primary economic unit of traditional Māori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members.

\textsuperscript{16} Whāngai – (noun) foster child, adopted child – this is a customary practice. Often a couple’s first child was brought up by grandparents or adopted by one of the brothers or sisters of a parent, but almost always the foster child was a blood relation, usually a close relation. Foster children always knew who their natural parents were.
For parents/caregivers this means today in this A/NZ context, parents with and without mental illness, regardless of culture, are expected by A/NZ society to support their children according to mainstream psychological theory and resultant parenting philosophies.

The difference between Eurocentric idiocentrism and Majority World allocentrism lies at the heart of definitions of parenting and family. Idiocentrism is the primarily Western focus on individualism, and allocentrism refers to a collectivist philosophy (Forehand & Kotchick, 2016; Greenfield, Keller, Fuligni, & Maynard, 2003; Jose & Schurer, 2010; Kagitcibasi, 2005; Keller, 2013; Keller et al., 2004; Keller, 2003; Tamis-LeMonda, Hughes, Yoshikawa, Kahana, & Niwa, 2007; Vansteenkiste, Zhou, Lens, & Soenens, 2005). As will be seen in Chapter 2, these bi-polar perspectives cast very different shadows on developmental psychology and interventions for children and families. One pertinent example is the domain of child welfare, in which there is a contrast between child focused and child protectionist perspectives common in A/NZ, and the combined family support and child welfare orientation common in Scandinavian countries, reflective of a more allocentric approach to the needs of children and parents/caregivers (Gilbert, 2012; Healy & Darlington, 2009; Keddell, 2017; Khoo et al., 2006; Solomon, 2002).

In this thesis, the term *family* is understood as including a variety of constructions. Unless specifically referring to whānau, it is intended *family* refers to this broad range of family types. *Parents* represents the range of adults responsible for the care of a child or adolescent. These may include birth, adopted or foster parents, step-parents, whāngai parents, aunts and uncles, and grandparents. When reference is made to development theory and parenting practices, philosophies, interventions and assessments, it will be noted whether these are mainstream or inclusive of the views of the Majority world.

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17 A term coined by Cigdem Kagitcibasi referring to ‘the majority of’ the world’s population residing in developing countries – the non-Western world.
THE RESEARCH QUESTION

In seeking service-user perceptions of the CRFSS in relation to the service narrative and its goals, the research question pursued a qualitative evaluation of service-user perspectives which were compared to the goals of CRFSS. The implications of these findings for service delivery in A/NZ were then explored. Thus, the research enquiry is expressed by three questions:

1. What are service-user perspectives of the CRFSS service, and how do these compare to the CRFSS narrative, as reflected in its goals?

2. How are these findings about service delivery for COPMI and their families positioned within the broader socio-political discourse of NGO service delivery in A/NZ?

3. What steps can be taken to enable NGOs to provide service delivery congruent with these service-user perspectives?

THE SAMPLE

A brief description of the sample is provided in this sub-section, and a full description is outlined in Chapter 3: Methodology.

The maximum variation sample of child interviewees consisted of five males and five females aged between 10 and 16 years. Ethnicity in the sample consisted of two Māori, and eight of A/NZ European descent.

The 24 focus group participants of a possible sample of 45 were aged between eight and 18 years, with a mean age of 14 years; 58.3% were female and 41.6% male; 83.3% A/NZ European and 8.3% Māori. The mean length of time that child participants had been service-users of CRFSS was 4.7 years; the range was 0.4 to 8 years. Reasons for non-participation were that parents declined their children’s participation (one set of parents, affecting two siblings), not interested, forgot to attend, had already completed an interview, and had moved out of the city after the earthquakes.
Adult participants were 32 of a possible 45 adult family members who received service from CRFSS. Their relationships to child participants were 90.6% parents, 6.2% grandparents and 3.1% step-parents. The most common age group was 41–45 years; age groups ranged from 31–35 years to 61–65 years. The sample had significantly more females than males, with only 31.2% male. Ethnicity consisted of 9.3% Māori, 68.7% A/NZ European; the remainder were minority groups including Indian, European and Zimbabwean. Reasons for non-participation were that some eligible participants were not interested in the project, some preferred not to participate in research, some had limited involvement with the service, and one family had moved to another country and did not respond to emails.

Of the adult sample, 40% of participants were living in partnered relationships at the time of data collection. Employment statistics revealed 37.5% were in paid employment; 15.6% were working part-time and on a partial welfare benefit, and the remainder were on full government welfare benefits. In relation to accommodation, 50% lived in their own homes; the remainder in rented accommodation, half of which were state owned.

Mental health data reflect differing groups of adult participants: 65.6% of participants had at least one diagnosed mental illness; 76.1% of which was an unspecified anxiety disorder and 71.4% a mood disorder. Of this group, 52.3% had more than one diagnosis. Of the sample, 56.2% stated that their children’s other parent had mental illness, with similar percentages of anxiety, mood disorder; 38.8% of this sample had more than one diagnosis. A group of 37.5% of adult participants were raised in a family in which a parent/caregiver had mental illness, only one of whom did not develop a diagnosable mental illness. Alcohol and/or other drug consumption data were sought using a Likert scale which offered a range from ‘not at all’ to ‘a lot’. One participant selected ‘a lot’ in relation to personal intake of alcohol, and three participants selected ‘a lot’ in relation to the alcohol use of other family members (Appendix F: Questionnaire).
CONTRIBUTIONS

This thesis makes contributions to research in several areas beyond its evaluatory value to CRFSS and SST:

- Expanding service–user perspectives on COPMIA service delivery;
- Advances the academic understanding of relationship–based practice and its scaffolding effects in COPMIA service delivery, and other family support work with children and adolescents who face significant risks;
- The addition of a macro–micro analysis and strategic plan for NGOs supporting families in A/NZ and other similar contexts;
- A broadening of socio–ecological resiliency theory to consider macro–meso resilience.

SERVICE–USER PERCEPTIONS OF SERVICE DELIVERY

The provision of service–user perceptions about service delivery at CRFSS adds to the minimal data which exist in A/NZ. That perspectives of the whole family system were captured, and views of a group of COPMIA with chronic, severe and complex needs, expands international COPMI knowledge. Service–user views of the nature of support, both relationship–based and with interconnected programme components for the whole family system, is relevant to many contexts other than A/NZ and/or COPMI.

RELATIONSHIP–BASED PRACTICE

Theoretical understanding of relationship–based practice is further expanded in this study through use of the adult–youth mentoring literature, recognition theory, and both mainstream and socio–ecological resilience theory. Further, understanding how relationship–based practice scaffolds other areas of service delivery for this service–user group is enhanced.

STIGMA FOR COPMI AND THE ROLE OF PEER SUPPORT

Much is written in the COPMI literature about the need for peer support programmes, but the emphasis on their destigmatising effect highlighted by
service–user views in this study is not strong, and neither are the links between stigma theory and resilience theory made, which this thesis offers.

**MICRO–MESO ANALYSIS AND STRATEGIES**

Attention to the broader socio–political system and its influence on service delivery as well as at a micro–level is rare in any service evaluation and appears to be non–existent in the COPMI field; thus, in this regard, the study is distinctive. Inclusion of macro–meso analysis in the discourse extends understanding of COPMIA service delivery in A/NZ to other NGOs supporting families and service users facing social adversity (Aimers & Walker, 2016; Walker & Shannon, 2011). Further, other countries operating in similar socio–political environments may benefit from this analysis and strategies.

**SOCIO–ECOLOGICAL RESILIENCY THEORY**

This study advances understanding of resilience theory by re–engaging in the socio–ecological. Theorisation of principles of social–ecological, resilience–focused practice for service delivery, and expanding the discussion to include resilience across macro and meso levels, broadens our understanding of resilience theory (Munford & Sanders, 2016; Ungar, 2008). Of note is the consideration given to understanding resilience factors for organisations in this socio–political environment (Walker & Shannon, 2011).

In relation to the COPMI literature, these principles of socio–ecological, resilience–focused practice provide a framework for understanding the needs of COPMI and their families in which severe, chronic and complex mental illness occurs. Some threads exist in the COPMI literature, but this study assists to identify and further theorise them. The application of the A/NZ ‘Pathways to Resilience’ study to this service–user group and study is a substantial gain to COPMIA service delivery in this country (Sanders et al., 2013; Munford et al., 2013).
The section outlines the structure of the thesis by providing a synopsis of each chapter.

Chapter 2, the literature review, introduces theoretical frameworks of ecological theory and socio-ecological resilience theory, reviewing what is important for service delivery for COPMI and their families through these lenses as they intersect with the COPMI literature. This chapter then deliberates on several aspects of service delivery relating to resilience-focused practice: relationship-based practice, comprehensive family practice, peer support as an anti-stigma strategy, and scaffolded recreational activities. The wider socio-political environment and how this enables or prevents socio-ecological, resilience-focused service delivery in A/NZ is then reviewed, utilising the work of Bourdieu to understand social change, institutional logics as defined by Thornton to consider differences between organisations and sectors, the Hybridity Lens developed by Aimers and Walker to typify organisational changes, and the Walker and Shannon Ideal Strategic Model for methods to enable change ((Aimers & Walker, 2016; Bourdieu, 1997; Thornton & Ocasio, 2008; Walker & Shannon, 2011).

Chapter 3 outlines methodology used and the rationale for choices made, and details research methods employed. Ethical issues related to engaging in research with perceived vulnerable populations are considered. The sample is described, the analysis process is explained, and issues concerned with the insider—outsider continuum addressed.

Chapter 4 reveals results from the study, utilising the current best practice, mixed-method format of integrating quantitative and qualitative data according to primary research findings (Bryman, 2012; Creswell & Tashakkori, 2007). The chapter addresses the twelve goals of the initial research question, making conclusions about service-user perceptions in relation to this service narrative.
Chapter 5 is the micro–analysis of predominant themes from the data, structured according to themes of relationship—based practice, comprehensive and interconnected family practice, de–stigmatising peer support, and scaffolded recreation as a conduit for relationship formation, respite and developmental enhancement. The chapter concludes with implications for practice and recommendations from this discussion.

Chapter 6 applies macro–analysis tools to service delivery, with an analysis of CRFSS and SST in the socio–political environment of A/NZ. Comparisons are made between the discourse of the state, the SST and CRFSS narratives, and CRFSS service–user perspectives. The Ideal Strategic Model is applied, and resultant implications for practice are noted and recommendations made (Walker & Shannon, 2011).

Chapter 7, the final chapter of the thesis, reiterates predominant findings, addresses strengths and limitations of this thesis, and notes implications for future research.
CHAPTER 2 – RE–ENGAGING WITH THE SOCIO–ECOLOGICAL IN COPMI SERVICE DELIVERY

To fully appreciate service–user perceptions of the Caroline Reid Family Support Service (CRFSS), an understanding of the wider context of service–user needs and service delivery is required. The field of children of parents with mental illness (COPMI) is predominantly influenced by traditional psychological perspectives. My goal is to broaden the COPMI discourse by re–engaging with socio–ecological perspectives. I will argue that for this group of CRFSS service–user families, most struggles and therefore service delivery needs cannot be understood through a narrow lens, and for this group of service–users, a socio–ecological approach is essential. Utilising the socio–ecological branch of resilience theory, I will show that service delivery grounded in this perspective guides how this group of COPMI and their families, and other marginalised service–user groups in Aotearoa/New Zealand (A/NZ) and similar locations, can be supported.

The usual rationale for service delivery for COPMI and their families draws heavily on risk discourse. I do not deny serious risks exist, particularly for the CRFSS service–user group, and these will be outlined. Historically, risk discourse has been necessary to lend weight to the rationale for COPMI service delivery. I will argue that support discourse equally contributes to this rationale and deserves equal weighting at this stage in the COPMI research.

Support discourse is emphasised in this study in several ways. As outlined, the methodology’s prioritisation of service–user perspectives on what the CRFSS village of support could be contributes to our understanding of support for this service–user group. The emphasis on socio–ecological resilience theory also fuels the argument for the efficacy of support, as the intent of resilience research is to identify mediators and tensions of resilience, so these may be
addressed, not just identify risk factors. Further, a focus on contextually relevant findings from the *Pathways to Resilience Study (New Zealand)* also contributes by providing local knowledge of supportive service delivery for marginalised A/NZ youth with similar risks to this service-user group (Munford et al., 2013; Sanders et al., 2013). Finally, the roles stigma and poverty play in undermining support for COPMI and their families in A/NZ will be elucidated, thus revealing barriers to support discourse. It will be emphasised that support discourse enables the emergence of an alternative discourse from that promoted by the neoliberal environment in which this study is positioned (Beddoe & Keddell, 2016; Garratt, 2010; Larner & Craig, 2002).

This thesis widens the socio–ecological perspective further to consider the socio–political environment in which non–government organisations (NGOs) which deliver services to COPMI and their families in A/NZ are situated. An additional argument of this thesis is that these macro factors constrain service delivery and resist and prevent socio–ecological, resilience–focused practice.

The chapter is divided into four sections. Section 1 introduces the overarching theoretical frameworks of the thesis: ecological theory, and socio–ecological resiliency theory (incorporating mainstream resiliency theory). Section 2 applies these theories to the context of CRFSS service–users. The third section considers a socio–ecological, resilience–focused approach to service delivery for this group of COPMI and their families, narrowing to focus on four aspects:

- Relationship–based practice;
- Comprehensive family practice;
- COPMI peer support as an intervention for stigma;
- Scaffolded recreational activities for COPMI supporting relationship formation, respite and developmental enhancement.

These aspects encompass the essence of CRFSS service delivery and I will argue they facilitate the navigation and negotiation of the seven tensions of resilience for this service–user group, enabling application of suggested principles of practice from socio–ecological resilience theory.
The final section examines the resilience of the NGO sector. I will outline how the macrosystem determines the extent to which CRFSS and Stepping Stone Trust (SST) can align service delivery with service–user perceptions, and its influence on the institutional logics of NGOs. A precis of competing logics in the A/NZ state–NGO partnership environment will be given, with an analysis of implications at micro, meso and macro levels. The three theoretical lenses used are:

- Organisational hybridity theory (Aimers & Walker, 2016);
- Institutional logics (Thornton & Ocasio, 2008);
- Bourdieu’s theory of social relationships (Bourdieu, 2011).

Section 4 concludes with suggested strategies from A/NZ research which would enable NGOs to be more resilient (Walker & Shannon, 2011).

SECTION 1: THEORETICAL FRAMEWORKS

Ecological theory of human development will be utilised to provide a theory of interrelated needs, concerns and priorities of service delivery for COPMI. A further theory is required to explain what occurs when an individual’s environment does not support his or her full development. This is important because the intent of COPMI social service delivery is to reduce the risk of mental illness in COPMI, by strengthening and supporting them and their families. Socio–ecological resilience theory will be used to understand adversity associated with parental mental illness during childhood and adolescence, and to explain why some people adapt and others do not. Further, if parents/caregivers have experienced adversity, this theory explains resilience needs for adults and family systems. Socio–ecological resiliency theory will be employed as a guide to best practice service delivery for this service–user group (Munford et al., 2013; Ungar, 2012b).
Ecological theory, as understood in social work in Australasia, is employed in this thesis as a metatheory, utilising its general principles (Coady, 2001; Connolly & Harms, 2012; Nash et al., 2005; O’Donoghue & Maidment, 2005).

Bronfenbrenner (1993) theorised the development of an individual, from birth to death, was influenced by five environmental systems (Feldman, 2012; Santrock, 2013). These are: The microsystem (individual setting);

- Mesosystem (relationships between microsystems);
- Exosystem (links between microsystem and another social setting);
- Macrosystem (overall culture);
- Chronosystem (sociohistorical context and changes over the life course) (Bronfenbrenner, 1993; Feldman, 2012; Santrock, 2013).

What Bronfenbrenner, a prominent ecological theorist, emphasises is that people do not grow in isolation: they are products of their environments as well as their biology, and this concept will be applied to this enquiry. Children, for example, are impacted by the everyday environment in which they live — the microsystem, which includes relationships with parents/caregivers, siblings, extended family, other caregivers, friends and teachers — and children, in turn, also actively impact these relationships (Bronfenbrenner, 1993; Feldman, 2012; Santrock, 2013). The child and these relationships are also shaped by wider influences, the exo and macro systems, which include other institutions such as the local community and government, schools, other groups, the media, the socio–political environment, and the whole culture. Each aspect may have an immediate and major impact. The chronosystem acknowledges the contributions of past events and contexts. (Bronfenbrenner, 1993; Feldman, 2012; Santrock, 2013).

Bronfenbrenner (1993) notes that what most scaffolds a child’s development is external to outside of the child. The wider environment impacts positively or negatively on the child and their parents and wider family system. As will be seen, adverse social factors in the wider environment often accompany mental illness, especially for this service–user group.
A central question of ecological theory debate is: Should people adapt to systems, or should systems change (Payne, 2014)? In this thesis, it is understood sometimes both are necessary, but the emphasis will be on the need for systemic change in A/NZ (Ungar, 2002).

A peculiarity exists in the terminology of ecological theory in A/NZ social work practice. Although based on Bronfenbrenner’s work, the simplified, three–level approach used by several American authors is commonly used in A/NZ when speaking generally about a socio–ecological approach (Connolly & Harms, 2012). That is, Bronfenbrenner’s environmental systems have been simplified from five to three: the micro, meso and macro. The micro and macro systems remain the same; however, the New Zealand social work understanding of ‘meso’ is the intermediate layer between the microsystem and macrosystem, incorporating the interactions between the two, and in this context, the organisations and groups which are placed between both. In this thesis, these definitions of micro, meso and macro are used to structure the discussion.

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**Socio–Ecological Resiliency Theory**

In this section, socio–ecological resilience theory will be examined. Mediators of resilience from mainstream study will also be presented, together with debate and subsequent caveats resulting from the socio–ecological stance noted.

Two branches of resiliency theory have developed over five decades of research. Mainstream resilience research began by focusing on individual resilience. These studies emerged from questions about why only some children adapted in adverse or precarious situations (Garmezy, 1974; Masten, 2001; Rutter & Quinton, 1984)). More recent socio–ecological resilience research is concerned about wider issues which affect resilience, and problems with mainstream resilience research such its Eurocentrism and intra–individualistic approach (Bottrell, 2009b; Garrett, 2015; Ungar, 2012b). This thesis aligns with latter socio–ecological studies as they enable a full explanation...
of the environment of this service-user group and therefore which resilience-enhancing interventions should be prioritised.

DEFINITIONS

The differences between the two branches of resilience research is clearly shown in how each defines resilience. Socio-ecological theorists define resilience broadly (Bottrell, 2009b; Garrett, 2015; Munford, 2013; Unger, 2011). They argue that consideration be given to social and cultural factors such as socioeconomic status and social adversity. This is relevant to the discussion of resilience for COPMI and their families, as socio-ecological factors may be protective or, conversely, increase risk (Hosman et al., 2009; Nicholson, Kathleen, Beth, Alexis, & Lawrence, 2001; Reupert & Maybery, 2007a; Reupert, Maybery, Nicholson, et al., 2015; Rutter, 1987; Tebes, Kaufman, Adnopoz, & Racusin, 2001). Rutter (1987), in his studies of social adversity accompanying major mental illness, went so far as to argue social adversity factors were more detrimental than the direct effects of mental illness on children.

Socio-ecological approaches emphasise the combination of factors which determine resilience in the face of adversity: The actions of the individual interacting with the capacity of the environment, aligning resilience theory with complexity theory (Munford et al., 2013; Sanders, Munford, & Liebenberg, 2012). Either the environment “makes good or fails on its promise to a child” (Ungar, 2011, p10) and (Munford et al., 2013). As will be seen, the environment in A/NZ fails COPMI and their families in many areas.

The socio-ecological definition of resilience is, according to a lead scholar in the field, Ungar (2008):

In the context of exposure to adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual’s family, community and culture to provide these health resources and experiences in culturally meaningful ways (p225).
Munford and Sanders (2016), A/NZ resiliency theorists, see risk and resilience as multi-dimensional and interactional concepts that unfold over time; no single variable making a difference, rather a whole range of factors within the context of a person’s life.

This wider perspective is noted in part, although much less emphasised, in mainstream research (Garrett, 2015; Luthar, Cicchetti, & Becker, 2000; Luthar, 2006; Masten, 2007; Masten, 2012a; Rutter, 2012b; Werner & Smith, 1982). In mainstream resilience literature, ‘resilience’ is defined as:

...a broad conceptual umbrella, covering many aspects related to positive patterns of adaption in the context of adversity (Masten & Obradović, 2006), (p14).

Ungar (2008), paraphrasing the work of Kirby and Fraser (1997), define mainstream resilience theory as:

(1) A constellation of characteristics children have when, despite being born and raised in disadvantaged circumstances, they grow up successfully.

(2) Competence when under stress. Resilient children may show competence dealing with threats to their well-being.

(3) Positive functioning indicating recovery from trauma (p220), (Ungar, 2008).

SOCIO–ECOLOGICAL RESILIENCY THEORY

Rather than emphasising an individual’s coping ability under stress, socio–ecological resilience theory:

...purposely decenters individuals to avoid blaming them for not flourishing when there are few opportunities to access resources (Ungar, 2013), (p256).

Although predictors and correlators of resilience claimed by mainstream theory may be consistent variations exist in emphasis and patterns, as found by Ungar in a culturally diverse, mixed methods study of 1500 youth from 14 communities, across four continents (Luthar et al., 2000; Masten & Obradović, 2006; Ungar, Lee, Callaghan, & Boothroyd, 2005; Ungar & Liebenberg, 2005).
Many global aspects of resilience were found, but four propositions emerged which encompass cultural differences. These are:

1. Resilience has global as well as culturally and contextually specific aspects.
2. Aspects of resilience exert differing amounts of influence on a child’s life depending on the specific culture and context in which resilience is realized.
3. Aspects of children’s lives that contribute to resilience are related to one another in patterns that reflect a child’s culture and context.
4. How tensions between individuals and their cultures and contexts are resolved will affect the way aspects of resilience group together (Ungar, 2008), (p226–231).

In relation to proposition 1, sometimes aspects of resilience were common to all youth but expressed differently depending on context (heterogeneity), for example, how independence or dependence were valued and expressed. At other times aspects of resilience were entirely cultural manifestations (homogeneity), such as strategies young people employed to survive in some violent communities (Ungar, 2008). As A/NZ is a bicultural country, it follows that both heterogenic and homogenic aspects of resilience will be present between and within Māori and Pakeha service−user groups.

Proposition 2 states that because context affects how much influence different mediators of resilience have, achieving construct equivalence in resilience measurements is almost impossible (Ungar, 2008). Examples given include the dependence—Independence dichotomy, parenting style (authoritarian, authoritative or permissive), and religious beliefs and practices. As discussed, Māori and Pakeha cultures operate from different worldviews, including having differing notions of childhood, parenting and family, and how and where health and wellbeing are defined and located (Boulton, Tamehana, & Brannelly, 2013; Metge & Kinloch, 1978; Rochford, 2004).

Resilience patterns highlighted in proposition 3 revealed aspects of resilience related thematically, rather than fitting into individual, relational, community
and cultural domains. For example, Western boys and girls each showed similar patterns, as did Majority world girls; but Majority world boys fitted into two groups, depending on how social cohesion and common purpose were valued in their cultural settings (Ungar, 2008). Consequently, in A/NZ it cannot be presumed that the resilience patterning of Pakeha individuals and families is the same for Māori individuals and families, or the influence of differing tensions is the same.

The final proposition revealed seven tensions between individuals and their cultures which affect how aspects of resilience group together. The tensions were found in each context, but the degree of influence each had was dependent on the context. These are show in Table 2.1 (p231, Table 3), (Ungar, 2008). These tensions are described further in Section 2 in relation to the socio–ecology of COPMI and their families.

**TABLE 2.1 – SEVEN TENSIONS OF SOCIO–ECOLOGICAL RESILIENCE, FROUNGAR, 2008 (TABLE 3, P231)**

<table>
<thead>
<tr>
<th>No</th>
<th>Tension</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access to material</td>
<td>Availability of financial, educational, medical and employment assistance and/or opportunities, as well as access to food, clothing and shelter</td>
</tr>
<tr>
<td>2</td>
<td>Relationships</td>
<td>Relationships with significant others, peers and adults within one’s family and community</td>
</tr>
<tr>
<td>3</td>
<td>Identity</td>
<td>Personal and collective sense of purpose, self–appraisal of strengths and weaknesses, aspirations, beliefs and values, spiritual and religious identification</td>
</tr>
<tr>
<td>4</td>
<td>Power and control</td>
<td>Experiences of caring for one’s self and others; the ability to effect change in one’s social and physical environment in order to access health resources</td>
</tr>
<tr>
<td>5</td>
<td>Cultural adherence</td>
<td>Adherence to one’s local and/or global cultural practices, values and beliefs</td>
</tr>
<tr>
<td>6</td>
<td>Social justice</td>
<td>Experiences related to finding a meaningful role in community and social equality</td>
</tr>
<tr>
<td>7</td>
<td>Cohesion</td>
<td>Balancing one’s personal interests with a sense of responsibility to the greater good; feeling a part of something larger than one’s self socially and spiritually</td>
</tr>
</tbody>
</table>
Four principles guide how these seven tensions are resolved:

1. *Children can only select from the health resources they have available (the principle of navigation).*

2. *They will choose health resources from those that are available and most likely to influence positively health and physical–health related outcomes as determined by their culture and context (the principle of negotiation).*

3. *The way they relate one aspect of resilience to another will reflect convergence in how children behave across cultures (the principle of homogeneity).*


The purpose of identifying the tensions is to enable these aspects to be supported and strengthened by individuals, families, communities, social services and governments.

A contextually relevant study for this thesis which highlights how these principles were resolved for at risk youth in this context, including both Māori and Pakeha in the sample, is the ‘Pathways to Resilience Project New Zealand’ (Munford et al., 2013; Munford & Sanders, 2016; Sanders et al., 2013):

> The purpose of the study was to identify the factors that were related to the achievement of positive outcomes for youth who were users of multiple services. These were very vulnerable young people who faced a complex mix of challenges in navigating safe pathways through adolescence and into adulthood … The study had a particular interest in explaining the ways in which the risks confronted by these youth, their resilience and wider social ecologies, combined with supportive and remedial services to create different patterns in outcomes (Sanders et al., 2013), (p3).

The components of this study were: a survey of the at risk youth aged between 12–17 years (N=605), and a survey of a comparison group of youth (N=872); a survey of adults nominated by the ‘at risk’ youth (N=448); qualitative interviews with a subsample of youth (N=109) and their nominated adults (N=76); and case file reviews from organisations who worked with this subsample of youth (Sanders et al., 2013).
The project built upon the Canadian Pathways to Resilience study\(^\text{19}\), with participants from six sites covering the majority of A/NZ. Although participants were adolescents, the CRFSS parents with mental illness were once such young people who faced very similar challenges. I argue these findings are equally relevant to this group. This work, and that of other socio–ecological theorists Ungar and Bottrell and others, will be utilised to explore principles of socio–ecological, resilience–focused service delivery further in the chapter.

The COPMI literature, having emerged primarily from traditional psychology and in Western contexts, adheres more strongly to mainstream resiliency theory. However, this does not mean COPMI research does not address socio–ecological factors. Many COPMI scholars note the role of factors from the macrosystem, including (Hosman et al., 2009; Leinonen, Solantaus, & Punamaki, 2003b; Leinonen, Solantaus, & Punamäki, 2002; Reupert, Maybery, Nicholson, et al., 2015; Solantaus, Leinonen, & Punamäki, 2004). Nevertheless, the important point to note is that the emphasis has historically been traditional and Eurocentric, with few COPMI scholars challenging the dominant discourse (Gladstone, Boydell, & McKeever, 2006).

THE DEBATE SURROUNDING MAINSTREAM RESILIENCY RESEARCH

Socio–ecological resiliency theorists have challenged the dominant resiliency discourse in two areas. The first, its “Eurocentric epistemology” and until relatively recently, few Majority world validation of findings or rigorous studies have occurred (Ungar, 2008, (p222), and (Bottrell, 2009a; Garrett, 2015; Luthar et al., 2000). The second concern is the tendency for mainstream resilience dialogue to focus on intra–individual personal traits which determine whether a person is resilient or not.

In relation to intra–individual traits, although not specified on the mainstream resiliency theory ‘short list’ in this way (Table 2), they are commonly interpreted

\(^{19}\) http://resilienceproject.org/
as such due to links with personality traits, such as intelligence, emotional regulation, and planfulness. The intra–individualistic stance suggests these inherent personal traits either advantage or disadvantage the individual (Fergusson & Horwood, 2003). Socio–ecological theorists argue that although biological and genetic factors may predispose children to react in certain ways, they do not determine outcomes, as child development is “highly plastic” (Munford et al., 2013, p9) and (Clarke & Clark, 2003; Sroufe & Rutter, 1984; Ungar, 2013). Rather, these scholars argue that the mediators may affect the threshold at which adversity impacts, or individual behaviour or choices, which in turn have either a positive or negative effect on outcomes (Munford et al., 2013). Munford et al. (2013) argue intra–individual factors may account for some variation in outcomes for at–risk youth, but do not sufficiently explain improvements in outcomes for this group, citing growing evidence for the “person–in–environment exchange” for resilience (Lipsitt & Demick, 2012, p10).

Ann Masten’s term ordinary magic, coined to explain the ordinary and common resources and processes that support resilience, may add to an individualistic understanding (Masten, 2015; 2001). Although the author makes an important point about the nature of resilience mediators, for CRFSS families these resources and processes are often ‘extraordinary’. Socio–ecological theorists emphasise this point, stating that not only does consideration need to be given to how resilience and adaptation are defined, but the inherent unfairness in society must also be acknowledged and addressed in social policies (Garratt, 2010; Seccombe, 2002; Ungar, 2012b).

The importance of this debate is stressed by Garrett (2015, p1909), who describes a “thematic affinity which unites ‘resilience’ with the more encompassing politics of neo–liberalism”. Bottrell (2009a) shares these views, stating mainstream resilience theory can easily be incorporated into the neoliberal rhetoric used by policy makers because of a shared language:

...emphasis on an individual responsibility for coping, competence and success, largely defined in terms of enterprise... (p334).
As will be reviewed later in the chapter, after more than three decades in A/NZ of radical neoliberalism, with resultant detrimental effects on the CRFSS service–user group and the NGO sector, these socio–ecological considerations must be present when resilience and child adaptation are discussed (Bottrell, 2007; Munford & Sanders, 2016; Ungar, 2013). As will be seen, neoliberal policies have increased poverty, altered the way state social service management operates, thus reducing inter–sectorial collaboration, and changed the face of NGO service delivery through state–NGO contracts which focus on short term and narrow interventions (ComVoices, 2016a; Larner & Craig, 2002). Keddell et al (2016) summarise the worst effects in their editorial:

Within the persuasive and normalised worldview promoted by neoliberalism, those who fail to obtain wealth, health and independence from the state are viewed as personally responsible for their own perceived shortcomings. Accordingly, the role of social work is conceived as managing and responsibilising those who cannot or will not become self–reliant (p1).

Munford et al. (2013) note many factors in the short list cannot be directly altered by children and young people: they require adults to intervene. Similarly, the effects of stigma, social isolation and poverty on capacity to navigate and negotiate resilience reduce the capacity of many parents with severe and chronic mental illness to alter these mediators without support, as discussed below (Beddoe & Keddell, 2016; Corrigan, Bink, Schmidt, Jones, & Rüschi, 2016; Corrigan, Markowitz, & Watson, 2004).

Sanders et al (2012, p15) suggest caution in seeking “single solutions or explanations” that is, cause and effect, advocating for:

.. building a subtle understanding of the complicated ways in which interactional processes help children develop in many contexts.

The second area of debate, Eurocentricity, arises because of the underpinning of traditional psychology in mainstream research. The four propositions arising from intercultural resilience research found that variations exist between and within cultures and contexts as to which developmental milestones are
emphasised, and in what order they develop (Ungar, 2008). In the A/NZ helping professions, traditional psychological theories are strictly adhered to when working with non-Māori service-users, informing most assessment and intervention concerning child health and wellbeing, and parent education and support. Although Māori service-users can increasingly access kaupapa Māori assessment and intervention, this does not always occur, and as the wider system is still so Eurocentric, Māori service-users are still affected by Eurocentric assessments (Boulton, 2013 #1335; Rochford, 2004). Even though child developmental theory is Eurocentric in its emphasis on stages rather than pathways and processes and what is prioritised to flourish in a Western environment, intercultural theorists recognise that developmental milestones are still important if viewed contextually (Feldman, 2012; Keller, 2013; Keller, 2003; Robinson, 2007; Rothbaum et al., 2000; Santrock, 2013; Smith, Cameron, & Reimer, 2017).

The most prominent theory from traditional psychology pertinent to this review, one which is dominant in the parental mental illness and COPMI area, is attachment theory (Bowlby, 1988; Holmes, 1993). Although strongly adhered to in the helping professions in the Western world to the point of becoming what Smith et al. (2017) coined a master theory, its criticisms mean it does not meet the criteria for the socio-ecological approach of this thesis. These critics argue that the theory’s roots in Western, middle class, traditional norms continue to be held up as ideal. Summarising differences between Eurocentric views on attachment and cultural differences across the Majority world, Keller (2013, pp 182–187) cites variations in understandings of parenting and expectations of infant and child behaviour which affect how attachment is defined and organised.

- Multiple caregiving arrangements, the norm for human populations versus the Western dyadic notion, citing (Van IJzendoorn & Sagi-Schwartz, 2008);
- Stranger anxiety, although universally present, is differently enacted depend on context;
• Differing views of the self which has consequences for how attachment is defined, citing (Duranti, 2008; Everett, 2009; Ochs, 1988; Taylor, 1989);

• The way security is experienced reflects the underlying values of the culture – individualised psychological bonds versus communal, hierarchically organised, relational patterns (Keller, 2013; Keller, 2007).

These critics argue that the underlying constructs of attachment theory, and therefore how attachment status is assessed, do not reflect contextual variations in many non-Western and rural eco-social situations (Keller, 2013; Rothbaum et al., 2000; Yeo, 2003). These Western conceptions of attachment results in the infant only seen as adaptive:

...where material and social resources are plentiful so that families can afford the caregiver–child exclusivity without neglecting other tasks (Keller, 2013, p180).

The reason this is such a problem for this thesis is because attachment theory is used so extensively: In mainstream resilience theory to explain the predominant mediators of resilience; to explain causes of mental illness and predict future mental illness; and to determine how parents with psychiatric illness will perform as parents (Bowlby, 1988; Bronfenbrenner, 1993; Holmes, 1993, 2001; Keddell, 2017; Keller, 2013; Masten, 2001, 2015; Rothbaum et al., 2000; Solomon, 2002). These factors all contribute to COPMI assessment and intervention. Additionally, in the A/NZ setting, attachment theory is utilised haphazardly in child welfare social work and related areas in which the CRFSS service–user group often feature, to make decisions about where children should live and how much contact they should have with parents with mental illness (Gilbert, 2012; Keddell, 2017; Solomon, 2002).

Critics note the need for an intercultural understanding of the measures and interventions of attachment, particularly in relation to the competence hypothesis and emphasis on exploration (Keller, 2013; Rothbaum et al., 2000). The existence of the attachment relationship or importance of the parents—child relationship is not disputed by these critics, and neither are the negative outcomes for children if they do not have at least one loving, responsive, and
safe adult caregiver, or the need for children to interact with their worlds in developmentally appropriate ways (Keller, 2013; Rothbaum et al., 2000). The notion of collective, secure relationships as the centre of all development is more important in the Majority world, not less (Keller, 2013; Rothbaum et al., 2000). In these essentials it appears common ground exists between Western and Majority world views.

With this in mind, Smith et al. (2017) suggest that in replacing the word attachment with relationship, the essential meaning is not diminished, and this seems the appropriate approach for this thesis (Smith et al., 2017). Thus, in this thesis, attachment system will be replaced with relational system, and attachment with relationship, unless referring to the theory itself.

In relation to parenting arrangements, I take the stance that variations of parenting arrangements exist, and caregiving may be provided by one parent or several, as is the practice in 95% of the world (Keller, 2013). In terms of intergenerational transmission of relational patterns, the constructs of attachment are understood as generally reliable in the A/NZ cultural context, informing knowledge of possible future problems and required supportive interventions. However, I do not support rigid adherence to the prediction and irreversibility claimed in mainstream attachment theory, given what has been discussed. Bowlby acknowledged his ideas about a critical period for attachment had been overstated, and confirmation of reversibility via Rutter’s studies of adopted Romanian orphans who mostly recovered from early relational deprivation when given warm, loving care and stimulation has been made. (Keller, 2013; Kreppner et al., 2007; Rothbaum et al., 2000; Rutter et al., 2007; Smith et al., 2017; Tizard, 2009). I therefore take a cautious approach in this regard.

Where this thesis takes issue is the unchallenged use of attachment theory to indiscriminately make decisions about where children should live, rather than

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20 As outlined, the use of the term parent in this thesis represents the range of adults responsible for the care of a child/adolescent. These may include birth, adopted or foster parents, step–parents, whangai parents, aunts and uncles, and grandparents.
provide support and resources needed to ameliorate gaps for parents and families, especially the CRFSS service−user group (Gilbert, 2012; Keddell, 2017; Solomon, 2002; Smith et al., 2017). As will be seen, CRFSS families and many others like them lack this supportive environment and the resources to navigate their way towards resilience.

**MAINSTREAM RESILIENCE THEORY**

These criticisms do not discount mainstream resilience theory, rather reposition it in a broader framework which determines how it is used and the discourse around resilience. As stated, predictors and correlators of resilience are consistent across diverse situations (Masten & Obradović, 2006). Mainstream theorists argue mainstream resilience research possesses “substantial potential for augmenting the understanding of processes affecting at–risk individuals despite criticisms” (Luthar et al., 2000, p543). Mainstream theory adds value to understanding how Ungar’s ‘tensions’ might operate and cluster in A/NZ, as it is embedded in the culture which CRFSS service−users negotiate and navigate towards resilience, and as noted, homogeneity in resilience patterning within Western culture was found (Ungar, 2008).

Bearing this in mind, the section now turns to mainstream resilience research and what it offers for this study. During decades of resiliency research, a short list of possible assets and protective factors associated with child resilience emerged from mainstream research (Garmezy, 1974; Masten, 2015; Masten, 2006; Masten & Obradović, 2006; Rutter, 1979; Werner & Smith, 1982). See Table 2.2. Some words have been added to this table which do not appear in the original version. These words are in bold and italics.
Direct predictors of good outcomes are assets or resources (Masten, 2006). If predictors play a role in high-risk, high-adversity situations, they are protective factors (Masten, 2006; Zimmerman, Bingenheimer, & Notaro, 2002). Protective factors modify the effect of risk in a positive direction; however, a vulnerability factor, is not necessarily the opposite of a protective factor (Luthar, Sawyer, & Brown, 2006). These terms are understood in relation to what is known as risk factors, which are predictors of undesired outcomes (Masten, 2006). Examples of risk factors are genetic factors such as a parent with major mental illness; adversity such as maltreatment, abuse, neglect, war, divorce; and status indicators such as premature birth, low socio-economic status, low maternal education, and unwed teenage parents (Masten, 2006; Masten, 2015). These

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**TABLE 2.2 – THE ‘SHORT LIST’ OF WIDELY REPORTED FACTORS ASSOCIATED WITH RESILIENCE IN YOUNG PEOPLE AND IMPLICATED ADAPTIVE SYSTEMS (MASTEN, 2015, P148, TABLE 6.1)**

<table>
<thead>
<tr>
<th>Resilience Factors</th>
<th>Adaptive systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective caregiving and parenting quality</td>
<td>Primary Relationship/Attachment; family</td>
</tr>
<tr>
<td>Close relationships with other capable adults</td>
<td>Secondary Relationship/Attachment; social networks</td>
</tr>
<tr>
<td>Close friends and romantic partner</td>
<td>Tertiary Relationship/Attachment; peer and family systems</td>
</tr>
<tr>
<td>Intelligence and problem-solving skills</td>
<td>Learning and thinking systems of the CNS*</td>
</tr>
<tr>
<td>Self-control; emotional regulation; planfulness</td>
<td>Self-regulation systems of the CNS</td>
</tr>
<tr>
<td>Motivation to succeed</td>
<td>Mastery motivation and related reward systems</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>Mastery motivation</td>
</tr>
<tr>
<td>Faith, hope, belief life has meaning</td>
<td>Spiritual and cultural beliefs</td>
</tr>
<tr>
<td>Effective schools</td>
<td>Education systems</td>
</tr>
<tr>
<td>Effective neighborhoods; collective efficacy</td>
<td>Communities</td>
</tr>
</tbody>
</table>

*CNS, central nervous system
often co–occur, hence researchers’ studies of the impact of cumulative risk or risk gradients, where risk rises in positive correlation with the number of problems (Masten, 2006; Masten, 2001). Many are associated in the literature with parental mental illness (Hosman et al., 2009; Reupert & Maybery, 2007a; Reupert & Maybery, 2016).

Mainstream theory states the greatest dangers to children are those which damage or disable their protective systems, thus preventing normal development (Masten & Obradović, 2006). These systems may also be damaged or disabled by other adversity, for example, the self–regulation system, by early neglect or maltreatment; or the mastery motivation by an unresponsive environment such as that which may be experienced by a neglected infant. Such circumstances would heighten a child’s vulnerability to other adversity, and ill equip them for the developmental tasks ahead (Masten, 2006; Masten, 2001).

The primary relational system impact other systems which mediate resilience in a manner which is known as the cascading effect (Fergusson & Horwood, 2003; Masten, 2006; Munford et al., 2013; Werner, 1989). Anything which disrupts, severs, or hampers the parent–child relationship increases risk and decreases resilience, including child maltreatment, parental loss and separation, and parental mental illness (Cicchetti, 2013; Holmes, 1993; Munford et al., 2013; Kendall-Tackett, Williams, & Finkelhor, 1993; Supkoff, Puig, & Sroufe, 2012). Clearly if there are multiple, supportive parental figures, these effects are lessened.

The short list includes secondary and peer relational systems which also protect from harm and risk, bolster coping, mitigate the effects of other family adversity, and are strongly predictive of general resilience (Munford et al., 2013; Masten & Narayan, 2012). Other adult relationships are found to become more important as a child grows older, especially if primary relationships are weak (Howe, 1995; Munford et al., 2013; Walsh, 2012; Werner, 1989). A sense of belonging to a peer group was also shown to be an essential element of
resilience in socio–ecological resilience theory (Bottrell, 2009b; Munford & Sanders, 2016; Sanders, Munford, Liebenberg, & Ungar, 2014).

That many mediators develop over the life span, such as the self–regulation system and mastery motivation, and that the phenomenon of ‘late bloomers’, in which the trajectory of one resilience can change dramatically in the transition from adolescence to adulthood, contribute to the argument for the efficacy of support (Masten, Obradovic, & Burt, 2006; Masten, 2001, 2015; Luthar, 2006).

Developments in the related field of neuroscience reveal the human brain is not necessarily prone to irreversible damage from psycho–social experiences as was once believed, and that beneficial early interventions enrich neural networks damaged by harsh environments, reducing vulnerability to future mental illness (Cicchetti & Curtis, 2006; Curtis & Nelson, 2003; Gunnar & Fisher, 2006; Luthar & Brown, 2007; Wastell & White, 2012). The physical, psychological and contextual changes which occur as children grow provide turning points for either resilience or maladaptation during at least the first year of a child’s life, early childhood, and adolescence, and adversity– and resilience–enhancing processes have stronger effects during these periods (Bonnano & Mancini, 2008; Cicchetti & Tucker, 1994, 2013; Egeland, Carlson, & Sroufe, 1993; Gunnar & Fisher, 2006; Kim-Cohen, 2007; Kreppner et al., 2007; Luthar & Brown, 2007; Masten, 2015; Post & Leverich, 2006; Romer & Walker, 2007; Rutter, 1985; Rutter, 1987; Van Ijzendoorn & Juffer, 2006).

SECTION 1 SUMMARY

This section has outlined theoretical frameworks for this thesis. Ecological theory is used to structure the thesis discussion, contextualise service delivery for COPMI and their families in A/NZ, and clarify interactions between systems. Socio–ecological resiliency theory explains how and what enables individuals to navigate towards and negotiate resilience, focusing mostly on the impact of intercultural environmental factors on the individual and families. A socio–ecological approach to resiliency argues that interactions between mediators
and tensions must be viewed as complex, nuanced and variable between and within cultures, and be guided by the principles of navigation, negotiation, homogeneity and heterogeneity. The implication for bicultural practice in A/NZ was noted.

Mainstream resilience theory has been positioned within this socio-ecological lens, with caveats noted in relation to its Eurocentric and intra-individualistic discourse. Its use is advocated in this thesis if understood from a socio-ecological perspective. The undergirding of traditional psychology in mainstream resilience theory was noted and was considered important material for this context if viewed less rigidly regarding developmental milestones and predictions.

Due to intercultural limitations of attachment theory, the pure form of the theory was rejected. However, the essence of secure, supportive primary relationships which enable culturally appropriate development was advocated. The term attachment in this thesis is replaced by relational or relationship. The use of attachment theory in Western psychiatry to predict psychiatric illness and determine what interventions should occur was considered generally relevant, although a cautious approach was taken to rigidity in assessment and prediction. It was noted that this theory’s views on primary relationships should be extended to more than the usual dyadic norm, and concerns were voiced about its use to make decisions about child custody in A/NZ.

It was argued that both branches of resilience theory contribute to the support discourse by identifying what enables resilience across cultures and where support needs lie. That many mediators of resilience develop over the lifespan, sensitive periods exist, and the phenomenon of late bloomers all contribute to this discourse, supported by neuroscience advances in understanding brain plasticity.
SECTION 2: SOCIO–ECOLOGICAL RESILIENCE AND FAMILIES WITH PARENTAL MENTAL ILLNESS

The socio–ecological context for CRFSS families in A/NZ is outlined in this section. The possibility of strengths associated with parental mental illness begins the section, general risks are summarised and the socio–ecology of CRFSS service–users reviewed. Consideration is given as to how the tensions and mediators of resilience may be affected by parental mental illness.

My aim is to equally emphasise the discourse of support. This poses some difficulty due to the prominence of material relating to risk. There is no denying risks exist, especially when clustered as they are for CRFSS families. Parental mental illness\textsuperscript{21} is noted to affect many aspects of daily life for parents and children, including relationships, roles, stressors, resources and supports, affecting how COPMI and their families navigate and negotiate the tensions and mediators of resilience. Significantly, serious risks exist in the wider environment which have more influence than mental health factors.

To my knowledge, no published research on the experiences of COPMI and their families in A/NZ is currently available.

STRENGTHS AND RESILIENCE EMERGING FROM PARENTAL MENTAL ILLNESS

Very little is written acknowledging the resilience and strengths arising in a child or adolescent with a parent who has mental illness. One comparative study of COPMI living in Scotland were:

\[\ldots\text{less likely to convey stigmatizing views of people with MHPs [mental health problems], largely due to their personal experience...}\ (\text{Cogan, Riddell, & Mayes, 2005, p}47).\]

Similarly, the phenomenon of post–traumatic growth is acknowledged in general psychological literature, although is barely present in the COPMI

\textsuperscript{21} As noted, addiction is considered a comorbid adjunct to mental illness in this thesis, therefore literature specific to support needs for parents with addiction and their families is excluded.
literature (Foster, L O'Brien, & T Korhonen, 2012b). White measured and found aspects of psychological growth in COPMI (White, 2014). This growth was facilitated initially by COPMI finding support from other adults, which enabled a growing sense of autonomy and self-regard, eventually leading to a stronger sense of identity and healthier relationships with their parent with mental illness.

The prominence of the risk discourse may be influencing documentation of strengths and resilience arising from having parents with mental illness or being a parent with mental illness. Gladstone argues this discourse “obscures important questions about the indices of good functioning” for COPMI (, 2015, p85). Problems with researcher bias and study design may also contribute to documentation. Ungar (2013) speaks of ontogenic instability, borrowing the term from Wright, Fopma-Loy, and Fischer (2005) when it comes to identifying who is and who is not resilient. Citing a study of mothers who experienced childhood sexual abuse (Wright et al., 2005), Ungar summarises:

> Which women were found to be resilient had, therefore, much to do with the subjectivity of the criteria used to assess them ... By focusing on both flourishing and languishing as separate dimensions of mental health ... we are, however, better able to identify resilience when it is otherwise obscured by overt symptoms associated with dysfunction (2013, p256).

Bottrell (2009b) questions how risk and adaptation are understood from her studies of adolescent girls in a low socio-economic housing estate in Sydney, Australia. The girls were truanting from school due to stigma and rejection by their peers. From a mainstream perspective this would be labelled risky behaviour; however, Bottrell argues that in seeking a different group of peers who were also truants, their behaviour was adaptive, as they were prioritising their resilience need for peer support (Bottrell, 2009b, 2007, 2009a). The support discourse is also likely to be influenced by such judgements, thus

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22 Dr White presented these findings from her thesis at a meeting of the Prato International Research Collaborative for Change in Parent & Child Mental Health I attended in 2015 in Prato, Italy. To my knowledge, these findings from her thesis have not yet been published.
diminishing knowledge about the capacity of individuals and which supports are needed.

GENERAL RISKS ASSOCIATED WITH PARENTAL MENTAL ILLNESS

COPMI are at higher risk of developing mental illness and experiencing other adversity than children of parents who do not have mental illness, and these factors undermine resilience (Beardslee, Keller, Lavori, Staley, & Sacks, 1993; Goodman, Adamson, Riniti, & Cole, 1994; Hosman et al., 2009; Nicholson, Sweeney, & Geller, 1998; Orvaschel, Walsh-Allis, & Ye, 1988; Reupert & Maybery, 2016; Rutter & Quinton, 1984; Weissman, Wickramaratne, Warner, John, & Prusoff, 1987). Not all COPMI will develop psychiatric illness, however, with figures ranging from 41% to 77% in various contexts (Diaz-Caneja & Johnson, 2004; Foster et al., 2012b; Hosman et al., 2009; Rasic, Hajek, Alda, & Uher, 2014). This elevated risk is across the whole diagnostic range of illnesses, including substance abuse.

If both parents have mental illness, risks are amplified (Bijl, Cuijpers, & Smit, 2002; Hosman et al., 2009). Parents who have mental illness and/or substance abuse comorbidity, that is, more than one disorder, have increased risk of negative impact on their children and (Clark, Cornelius, Wood, & Vanyukov, 2004; Goodman, 2007; Hosman et al., 2009; Kim-Cohen, Caspi, Rutter, Tomas, & Moffitt, 2006; van Santvoort et al., 2012). Hosman et al. (2009, p254) encapsulate risk factors from parental illness factors:

...chronicity of the disorder, parental age of onset, timing in the developmental stages of the child, family history of psychopathology, comorbidity and psychopathology in both parents ... children exposed to recurrent and chronic parental disorders are especially at risk.

For adult CRFSS service-users with mental illness, most of these risk factors apply. The results for COPMI can be substantially adverse, as summarised by Reupert and Maybery (2007a, pp 362–363):
... at a significantly greater risk of having lower social, psychological, and physical health than children in families not affected by mental illness ... a higher rate of behavioural, developmental, and emotional problems in such children compared with those in the general community ... with long-term effects including social and occupational dysfunction.

It is not difficult to see how these risks affect the capacity for many COPMI to navigate towards and negotiate resilience.

Risks also exist for parents with mental illness. Significant numbers of parents with mental illness lose custody of their children, from 28% to 60% of parents with mental illness; an experience which has “profound life-long impact” (Nicholson & Henry, 2003, p123), and (Busch & Redclich, 2007; Nicholson, Sweeney, & Geller, 1998a; Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001; Reupert & Maybery, 2009a). Mothers with mental illness have higher risks of:

- Emotional, behavioural and developmental difficulties (Nicholson et al., 2001; Nicholson & Henry, 2003);
- Reproductive loss (Coverdale, McCullough, Chervenak, Bayer, & Weeks, 1997; Nicholson & Henry, 2003; Ritsher, Coursey, & Farrell, 1997);
- Childhood and adult victimisation (Goodman, Rosenberg, Mueser, & Drake, 1997; Harris & Landis, 1997; Nicholson & Henry, 2003);

Less is written about risks to fathers with mental illness (Biebel & Alikhan, 2016; Nicholson et al., 2004; Reupert & Maybery, 2009a). The phenomenon of postnatal depression (PND) in fathers is becoming more acknowledged, with the range of prevalence (4–25%) similar for fathers and mothers (Andling, Rohrie, Grieshop, Schucking, & Christiansen, 2015; Biebel & Alikhan, 2016; Kim & Swain, 2007; Ramchandani, Stein, Evans, & O’Connor, 2005; Solantaus & Salo, 2005). Paternal PND is strongly associated with maternal PND (50% of men with PND). Other stressors are similar for men and women (Biebel & Alikhan, 2016; Reupert
Some risks are noted for men with mental illness. An older study by Link, Struening, Rahav, Phelan, and Nuttbrock (1997) emphasised men’s experiences of stigma, and the Luciano et al (2014) study, comorbid addiction, lack of tertiary education, and poor to fair physical health. Reupert and Maybery (2009a, p61) found parenthood was important to fathers’ self–image, and the combination of stigma and fear of losing access to their children curbed fathers’ capacity to express concerns, thus they “suffered in silence”.

In relation to risks for Māori in A/NZ, as they are overly represented in mental health statistics, risks for poor outcomes for parents with mental illness and their children are higher than those of the non–Māori population (Marriott & Sim, 2014; Rochford, 2004; Walker et al., 2006).

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**SOCIO–ECOLOGICAL RESILIENCE AND PARENTAL MENTAL ILLNESS**

This section considers the capacity for the wider environment to provide health resources and experiences needed by COPMI and their families, and the effects of parental mental illness on the capacity for COPMI and their families to navigate towards wellbeing and health–sustaining resources (Ungar, 2008). Environmental factors discussed are stigma and poverty, and these factors alone will be shown to severely diminish the village of support. Individual and family capacity is positioned within the effects of these environmental aspects. The impact of serious and chronic mental illness on daily life is also addressed.

**STIGMA**

Social isolation and exclusion are associated with serious mental illness and the primary cause is the stigma associated with mental illness and (Minde, 1991; Nicholson, Sweeney, & Geller, 1998b; Parrott, Jacobs, & Roberts, 2008; Rogosch, Mowbray, & Bogat, 1992; Reupert, Maybery, & Kowalenko, 2012; Tebes et al., 2001). Stigma is strongly associated with mental illness across most cultures, affecting every area of social and economic existence (Corrigan et al., 2016, 2008, 2004; Link, Yang, Phelan, & Collins, 2004; Erving Goffman, 1963, 1961; Hasson-Ohayon, Levy, Kravetz, Vollanski-Narkis, & Roe, 2011; Östman &
Kjellin, 2002; Reupert & Maybery, 2015; Seeman, 2015; Thoits, 2011; Yang et al., 2007). The COPMI literature acknowledges stigma for COPMI and their families (Gladstone, Boydell, Seeman, & McKeever, 2011; Grove, Reupert, & Maybery, 2015; Hosman et al., 2009; Lee, 2006 #1087; Nicholson et al., 1998a; Orel, P A Groves, & L Shannon, 2003; Reupert et al., 2012).

Goffman (1963, p3) defines stigma as “an attribute that is deeply discrediting”, resulting in the individual seen as ‘tainted’ or ‘unworthy’ (Yang et al., 2007); and marked in some way as deviant, flawed, spoiled (Jones, 1984; Crocker, Major, & Steele, 1998). Link and Phelan (2001) note five components: labelling, stereotyping, cognitive separation, emotional reactions, and status loss and discrimination (including structural discrimination). The fifth component highlights the influence of the macro–system in terms of social, economic and politic power which enables stigma to occur in terms of policies and laws (Reupert & Maybery, 2015; Yang et al., 2007). Yang et al. (2007) acknowledges the degree of assault to the self and adds an additional perspective – the stigmatiser:

...stigma as an essentially moral issue in which stigmatized conditions threaten ... what is most at stake for actors in a local social world ... A new interpretative lens by which to understand the behaviors of both the stigmatized and the stigmatizers, for it allows an examination of both as living with regard to what really matters and what is threatened (abstract).

Stigma is socially constructed and relational (Das, Kleinman, Lock, Ramphele, & Reynolds, 2001; Link & Phelan, 2001; Parker & Aggleton, 2003; Yang et al., 2007). Definitions, attributes and degrees of stigma therefore vary within societies, groups and cultures, and between genders (Abdullah & Brown, 2011; Crocker et al., 1998; Goffman, 1961; Hocking, 2003; Jones, 1984; Price-Robertson, 2015; Rashed, 2013; Reupert & Maybery, 2015; Yang et al., 2007). Reupert and Maybery (2015, p53–55) summarise the three ‘phenomena’ of stigma: public, self and associative:
Public stigma – members of the public endorse stereotypes and, on this basis, discriminate or generally devalue (Corrigan, 2000; Feldman & Crandall, 2007; Mullick, Miller, & Jacobsen, 2001).

Self–stigma – individuals who are stigmatized endorse and then internalize a certain stereotype about themselves, leading to automatic thoughts and negative emotional reactions (Corrigan, 2000; Larson & Corrigan, 2008; (SANE Australia, 2013).

Associative stigma – sometimes known as ‘courtesy’ stigma, defined as the prejudice and discrimination associated with stigma extended to family members because they are somehow linked to the person with a stigmatized mark (Corrigan & Miller, 2004; Goffman, 1963; Mehta & Farina, 1988).

The resultant social isolation is detrimental and adds to the risk of psychiatric illness, physical illness, and shortened lifespan (House, 2001; Hutchinson & Haasen, 2004). In describing the seven tensions of resilience, Ungar et al. (2007) explain it was relationships which enabled young people to cope with other aspects of life, and which had positive or negative cascading effects on other tensions such as identity, cohesion, power and control, cultural adherence and social justice. Mainstream resilience theory concurs with this view (Masten, 2001).

The impact of stigma on relationships has further effects. In relation to childhood and adolescence, stigma limits growth and development, as it is through socialisation that much physical, socio–emotional and cognitive learning occurs (Feldman, 2012; Robinson, 2007; Parten, 1933, 1932; Santrock, 2013). The adult mental health recovery literature states that ‘recovery’, that is, living well in the presence of mental illness, is reliant on supportive relationships (Price-Robertson, Obradovic, & Morgan, 2016). As many parents with mental illness are sole parents (the majority of CRFSS families), social supports are even more important (Ackerson, 2003; Nicholson et al., 2001). With limited family and friendship circles, and feeling stigmatised in the community, this leaves few people available for support.
The devastation of stigma extends further via internalisation of messages which destroys many aspects of resilience, including identity (Masten, 2001), (Ungar, 2008). A common result is the ‘why try’ phenomenon, in which self–respect is lost, and the future seems futile, thus degrading hope, self–efficacy, power and control, and therefore the capacity to negotiate resilience (Corrigan et al., 2016; Masten, 2001; Ungar, 2008).

Reupert and Maybery (2016, (p102) summarising the work of Larson and Corrigan (2008), describe the labelling, status loss and discrimination experienced by COPMI and their families:

...the stigma related to mental illness means that parents with a mental illness may be seen as incompetent or violent and children as contaminated or pitiful, which in turn may lead to discrimination regarding child custody arrangements, housing or employment opportunities.

This quotation alludes to the stigma some professionals show towards parents with mental illness and their children (Beddoe & Keddell, 2016; Bassett, Lampe, & Lloyd, 1999; Nicholson et al., 1998; Nicholson & Henry, 2003; Seeman, 2015).

In the A/NZ ‘Pathways to Resilience’ study, most youth participants lacked parents and extended family who could provide a secure primary relationship for them, many were or had been in foster care, and most experienced stigma (Sanders et al., 2013; Munford et al., 2013). These scholars found:

Relational deprivation and the absence of trusting adults were common experiences … (Munford & Sanders, 2016, p236).

Interestingly, the role of professionals was pivotal in ameliorating relational deprivation: It was positive and continuous relationships with professionals which provided the first step of a pathway to resilience for these young people:

It was not until the young people could build a relationship with a trusted adult who could “stand for them” … that things started to change and that they could imagine different pathways (Munford & Sanders, 2016, p236).

The participants described relationships which helped: workers were respectful, believed in them, sought to understand them, helped them locate opportunities
and learn new skills. These facets enabled them to find a new, more positive direction (Munford & Sanders, 2016). A sense of agency was enacted through these relationships in three ways: “making sense of the world; having a voice, and acting on the world” (Munford & Sanders, 2015b, p.616). These safe connections also supported positive identity development in youth (Munford & Sanders, 2015a).

Hope emerged from this relationship between workers and young people (Munford & Sanders, 2016, pp.236, 237):

*Adults who made a difference created possibilities for positive change for these young people by becoming an enduring presence. This in turn enabled young people to find different pathways where they could realise their dreams and aspirations ... This involved practitioners holding the dreams of youth who, given their life experiences, had difficulty believing that their circumstances could be transformed...*

These findings suggest the adaptive resilience system of spiritual and cultural beliefs failed these A/NZ young people (Masten, 2001). It was only when the young people felt safe with a trusted adult that hope began to grow; they became connected with a different spiritual or cultural system (Munford & Sanders, 2016).

School should be a place of respite and positive socialisation, but although some COPMI find this occurs, many report experiencing negative treatment and bullying from peers, and friendships are commonly limited due to reluctance to socialise with friends at home (Hosman et al., 2009; Gladstone et al., 2011; Reupert & Maybery, 2007b). For the group of COPMI who face challenges to their primary and secondary relational systems such as the CRFSS service-users, stigma from peers is a fatal blow to navigating and negotiating many of the tensions of resilience. A sense of belonging with peers has been found to be crucial for at-risk young people in socio-ecological resilience studies. As mentioned above, Bottrell (2009) revealed the importance of peer support in her study. The young people in the A/NZ resilience study also experienced stigma and rejection at the hands of the mainstream peer group, and instead
found solace, acceptance, belonging, and support from other at-risk young people (Munford & Sanders, 2016; Munford et al., 2013; Sanders et al., 2014).

While exposure to anti-social peer behaviour is noted to increase risk in the general population, for at-risk young people who lack relational systems across many domains, this was not found to hold true (Masten, 2006; Werner, 1989). The social withdrawal strategy of the most at-risk youth restricting association with antisocial peers did not lower behavioural risk, as these young people did not have adequate adult or other social supports (Sanders et al., 2014). On the contrary, withdrawal from antisocial peers heightened mental health concerns, therefore increasing risk. Until a sense of belonging was established, the cascading effects of other aspects of resilience-focused practice could not occur (Masten, 2006; Sanders et al., 2014).

Similarly, in the face of stigma, parents with mental illness and other adult family members also require peer support. Consequently, mental health peer support organisations and services supporting family members affected by mental illness have emerged (Davidson, Amy, Guy, & Miller, 2012; Repper & Carter, 2011). Such organisations not only enable relationships to form based on commonality, they facilitate a collective sense of purpose and identity, the ability to effect change, that is, power and control, and cultural adherence, social justice and cohesion (Ungar et al., 2007).

Stigma is anti-resilience. In limiting supports, undermining identity and destroying hope, it operates detrimentally across the range of mediators and tensions of resilience. Stigma by professionals may contribute to further anti-resilience phenomena by way of child custody decisions, welfare benefit assistance, and opportunities for employment and safe housing, as outlined above. These phenomena work together, contributing to the following environmental factor associated with serious mental illness: poverty.

**THE ‘DOUBLE BLOW’ OF POVERTY**

In A/NZ society, poverty is shameful, fuelled by neoliberal ideology (Beddoe & Keddell, 2016; Gray, 2017; Hyslop, 2018; O’Brien, 2016; Hackell, 2016; Parton,
2016; Sawyers, 2016). Although A/NZ has no official poverty line, consensus based on level of income reveals about one in seven households lives in poverty; 14% of the A/NZ population in 2013 (NZCCSS, 2017). The two-thirds of adult participants on welfare benefits in this sample indicates poverty. Often referred to as the double blow, the status loss associated with poverty increases stigma for CRFSS service-users.

Adult and child COPMI research reveals struggles to obtain and access material resources are a problem (Bassett et al., 1999; Gladstone et al., 2011; Maybery, Ling, Szakacs, & Reupert, 2005; Nicholson & Henry, 2003). Access to materials was noted by Ungar et al. (2007, P296) to be a key tension of resilience across cultures. This study found resources must be available and accessible, and individuals need “personal resources to avail him– or herself of those resources.

Poverty is also anti–resilience. It not only increases stigma, which in itself attacks resilience, but is associated with further factors which decrease resilience: child maltreatment, family and community stress, increased pathology in children, poorer quality of schooling, high crime rates, overcrowding, poorer diet and medical care, and limited opportunities to participate in school and community activities (Bleuler, 1974a; Cicchetti & Lynch, 1993, 2013; Masten, 2015; Mordoch & Hall, 2002; Parrott et al., 2008; Sedlak et al., 2010). Unfortunately, this information when used without consideration of other contextual factors and the accumulation of stressors, may be used to blame parents, such as the CRFSS service–user group, rather than to increase support (Ministry of Social Development, 2012; Ministry of Social Development, 2012a; Misa, 2012).

Mainstream resilience research records the detrimental impact of poverty on aspects of resilience (Masten, 2015; Masten, 2001; Shonkoff, 2011; Shonkoff & Phillips, 2000). Childhood and adolescent cognitive and socio–emotional development is adversely affected (Masten, 2001; 2015). Masten (2015) emphasises resilience requires “a human brain in good working order” rather than high intelligence per se, and factors such as:
Cognitive development is promoted and protected by good nutrition and health care, secure attachment, access to good education, and safe neighborhoods ... Poverty, discrimination and war can all threaten brain development and cognitive development in many ways that can influence the development and application of intellectual skills (p156).

One aspect of the self-regulation system, executive function, a cognitive control process which develops rapidly in the preschool years and progressively improves until adulthood, is also affected by poverty (Diamond & Lee, 2011; Masten, 2015, 2001; Moffitt et al., 2011; Raver et al., 2011; Rothbaum et al., 2000; Zelazo & Carlson, 2012). The neural networks which enable executive function are similarly sensitive to risks connected with poverty, in addition to adversity, trauma, toxins, and neglect (Masten, 2015, 2001; Shonkoff, 2011).

These effects of poverty clearly influence an individual’s capacity to negotiate and navigate towards resilience. What this indicates is the extreme need to support parents with mental illness in comprehensive ways, from the early stages of pregnancy.

**DAILY LIFE**

When supports and resources are limited, families are forced to cope. Parents have to function despite impairments they may experience due to mental illness and medication; sometimes they cannot manage, and their children are removed from their care (Bassett et al., 1999; Foster et al., 2012b; Nicholson & Henry, 2003; Nicholson et al., 1998a, 1998b; Nicholson, 1994; Reupert & Maybery, 2016; Reupert & Maybery, 2007a; Risley-Curtiss, Stromwall, Truett Hunt, & Teska, 2004).

Additional challenges for parents with mental illness include multiple appointments for mental health treatment, and when other psychosocial factors are present, as they are for CRFSS families, this adds further social service agency involvement (Nicholson et al., 1998a, 1998b; Seeman, 2015).
Parents with mental illness commonly experience difficulties with mental health treatment, including lack of: continuity of care from mental health staff, supportive partnerships with professionals, choice in mental health treatment, and acknowledgement of their strengths (Bassett et al., 1999; Nicholson & Henry, 2003). How well they manage these challenges and how much support they receive is likely to mediate their sense of purpose and self-appraisal, thus affecting identity; and the ability or inability to adequately care for self and others and effect change in one’s home environment may impact the tension of power and control (Ungar et al., 2007).

Sometimes COPMI take on caring roles when their parents have mental illness. COPMI may monitor their parents for unwellness and care for their parent when unwell, often engaging in extra household and sibling responsibilities at such times (Aldridge, 2006; Bleuler, 1974b; Charles, Stainton, & Marshall, 2008, 2009, 2012; Gladstone et al., 2011; Maybery et al., 2005; Mordoch & Hall, 2002; Pakenham, Bursnall, Chiu, Cannon, & Okochi, 2006; Reupert & Maybery, 2016). The literature notes that ‘children as carers’ may or may not be detrimental. As some responsibility is valuable for development, levels of child responsibility vary across cultures, and debate exists regarding definitions of what is resilient and what is adaptive, which caring may be, the need for careful, context-specific assessment seems wise (Bartlett, 1994; Bottrell, 2009b; Charles et al., 2009; Feldman, 2012; Mordoch & Hall, 2002; Reupert & Maybery, 2016; Santrock, 2013; Werner & Smith, 1992). Nevertheless, if caring responsibilities become onerous or significant caring is prolonged, within the cultural context, it will adversely impact a child’s ability to play, socialise, complete culturally appropriate developmental tasks, and to experience a variety of necessary activities, thus degrading capacity to navigate and negotiate resilience (Charles et al., 2009; Cresswell, 2017; Feldman, 2012; Reupert & Maybery, 2016; Santrock, 2013).

Parental mental illness may negatively impact how family relationships are experienced, as sometimes symptoms of mental illness influence aspects of
parent behaviour\(^{23}\) (Gladstone et al., 2011; Hosman et al., 2009; Nicholson et al., 1998a, 1998b; Reupert & Maybery, 2016, 2007a). As with other aspects of parenting, these effects are ameliorated or increased depending on the involvement of other parents (Ackerson, 2003; Nicholson et al., 2001; Hosman et al., 2009; Reupert & Maybery, 2016). If these relationships are supportive, children are more easily able to navigate and negotiate other tensions (Hosman et al., 2009). If another parent\(^{24}\) is abusive, unsupportive and/or also has mental illness, this exacerbates risk, thus creating additional support needs (Hosman et al., 2009; Reupert & Maybery, 2016, 2007a). The most vulnerable period is the child’s first few years (Cicchetti, 2013; Masten, 2001; Masten & Gewirtz, 2006; Munford et al., 2013; Kendall-Tackett et al., 1993; Reupert & Maybery, 2007a; Supkoff et al., 2012).

The notion of reciprocal impact, the interrelationship between parent and child, is one reason why children and adolescents are negatively affected. This means what is occurring for a parent with mental illness affects a child. The opposite is also true; children’s traits and behaviours may also affect a parent (Falkov, 2012; Nicholson et al., 2001; Reupert & Maybery, 2016).

Relational difficulties between children and parents with mental illness may continue as children age (Crittenden, Landini, & Kozlowska, 2015; Gladstone et al., 2011; Van Loon, Van de Ven, Van Doesum, Hosman, & Witteman, 2015). As noted, diminishing of the secondary and tertiary relationship systems reduces the capacity for additional opportunities to strengthen the resilience of COPMI and their families without the support of professionals (Gladstone et al., 2011;

\(^{23}\) Depending on the age of the child, some situations and/or interactions may be frightening, confusing, hurtful, neglectful, impoverished, and at times, unsafe (Bee, Berzins, Calam, & et al, 2013; Brockington et al., 2011; Goodman & Gotlib, 1999; Goodman et al., 1994; Goodman & Brumley, 1990; Jacobsen & Miller, 1998; Reupert & Maybery, 2007; Reupert & Maybery, 2016; Reupert, Maybery, et al., 2012; Reupert & Maybery, 2007a; Seeman, 2015).

\(^{24}\) Scholars note that family discord, trauma, domestic violence, low cohesion and poor communication are associated with parental mental illness in this context, as often seen in the CRFSS client community (Ackerson, 2003; Hosman et al., 2009; Mordoch & Hall, 2002; Reupert & Maybery, 2016; Warner, Mufson, & Weissman, 1994).
Due to the combined stressors of stigma, poverty and parental mental illness, a further impact on the daily life of COPMI is uneven development. The COPMI literature notes that these children may miss out on aspects of development and cohort experiences (Gladstone et al., 2011). Similarly, in the A/NZ resilience study, many at risk young people were found to be adept in their current situations but lacked skills to operate in a different pathway (Munford & Sanders, 2016).

*Given their life experiences these young people had been denied the opportunities that their peers, who had access to resources and support, took for granted (p236).*

*The young people were highly skilled in dealing with the challenges they faced; however, their strategies did not always generate opportunities for participation in the same activities of their better–resourced peers (p237).*

The second quotation exemplifies the uneven nature of resilience noted by Ungar (2008, 2013); individuals may flourish in some areas and languish in others. These A/NZ young people felt overwhelmed by everyday challenges and found it difficult to navigate towards the supports and resources they needed. The young people had missed out on many “ordinary activities” – important milestones and developmental experiences (Munford & Sanders, 2016, p238).

**CRISES**

Mental health crises are especially challenging times and may decrease the resilience of adults and children if not adequately addressed. In the case of hospitalisation of a parent with mental illness, there is much to manage. Service users note multiple layers of trauma associated with hospitalisation, including: frightening experiences for the parent admitted; not knowing who will look after your children; children and other family members witnessing the intimidating admission process, difficulty in accessing hospital visits, feeling unsafe when visiting, feeling abandoned when a parent is in hospital, not understanding what is occurring for the parent, and being separated from
siblings (Bassett et al., 1999; Cowling, 1999; Fudge & Mason, 2004; Gladstone et al., 2011; Maybery et al., 2005).

**COPING SKILLS**
The challenges outlined above require COPMI and their families to have coping skills, which many are not resourced or supported with. COPMI may be disadvantaged by modelling of behaviours and coping styles which may occur when parents have mental illness (Hosman et al., 2009; Reupert & Maybery, 2016; Kroll, 2004). Further, in coping with situations noted above, COPMI highlight several concerns, including:

- Spending time and energy trying to fix situations at home (Gladstone et al., 2011);
- Making comparisons as a way of managing (Gladstone et al., 2011);
- Balancing parents’ needs with their own (Gladstone et al., 2011);
- Withdrawal, parentification and normalising (Maybery et al., 2005);
- Distraction from school work due to worry and tiredness, and problems due to having missed school work (Gladstone et al., 2011);
- Emotional ups and downs due to parental mental illness (Gladstone et al., 2011; Maybery et al., 2005);
- Fear of developing a mental illness, and/or being ‘contaminated’ by the mental illness (Gladstone et al., 2011);
- Worries about keeping the family together (Gladstone et al., 2011).

Many concerns are exacerbated due to lack of information and opportunities to process experiences and learn alternate coping skills (Bilsborrow, 2015; Corrigan et al., 2004; Cowling, 1999; Fudge & Mason, 2004; Gladstone et al., 2011; Grove, Reupert, & Maybery, 2013; Hosman et al., 2009; Knutsson-Medin, Edlund, & Ramklint, 2007; Peay, Hooker, Kassem, & Biesecker, 2009; Reupert & Maybery, 2016; Reupert, Cuff, & Maybery, 2015; Reupert, Goodyear, & Maybery, 2012; Seeman, 2015). Developmentally, children are unable to accurately make sense of mental illness behaviours if unexplained, tending to misinterpret and self-blame; and as children age, although their capacity
improves, without explanation they still tend to misinterpret (Garley, Gallop, Johnston, & Pipitone, 1997; Reupert, Cuff, et al., 2015). Parents, other adult family members and professionals struggle to have these conversations (Maybery et al., 2014; Maybery & Reupert, 2009; Reupert, Cuff, et al., 2015; Reupert, Maybery, & Morgan, 2015). Gaining perspective through mental health education could be understood as enabling negotiation of resilience through providing a more accurate picture of positive health outcomes (Ungar, 2008).

The chronosystems of parents with serious and chronic mental illness commonly reveal experiences of the same risk factors which exist for their children, and they also lack opportunities to develop coping skills (Hosman et al., 2009). Added to this, parents with mental illness report having to cope with fear their children will develop mental illness, and the pressure of feeling they must prove themselves as parents (Bassett et al., 1999; Nicholson et al., 1998). These negatively impact on their own resilience.

The combination of family, environmental and societal factors outlined form a picture of increased stress for many COPMI and their families (Garmezy, 1985; Goodman & Gotlib, 1999; Grunebaum, Weiss, Cohler, Hartman, & Gallant, 1982; Hosman et al., 2009; Minde, 1991; Rutter & Quinton, 1984; Tebes et al., 2001). Prolonged stress increases risk for physical and mental illnesses, including drug addiction, beyond risks already discussed (Meaney, 2001). In terms of interventions, it is not excessive to conclude that early intervention support to the primary relational system is the place to begin.

Deficits related to the combination of stigma, poverty, and the stressors of coping with everyday realities, were similarly noted in the A/NZ resilience study of at risk youth. Numerous youth participants were adept in their current situations but lacked coping skills to operate in a different pathway (Munford et al., 2013). To move towards a more resilience–focused pathway, they needed support and practical assistance. To support alternative, more resilient pathways, some of these gaps need to be filled, by means of emotional and
practical support (Munford et al., 2013; Sanders, Munford, Liebenberg, & Ungar, 2014; Ungar, 2008).

The primary method of compensating for gaps was by trusted adults supporting young people to seek out opportunities, to exercise their own agency, to learn coping strategies, to draw on the strengths they already possessed to learn new ways of operating. The emphasis was on this occurring in a supportive environment (Munford & Sanders, 2016; Sanders et al., 2014).

These needs and coping skills suggest that service delivery for COPMI and their families, who have many of these support needs and stressors, requires comprehensiveness and flexibility. As outlined, context determines which resilience tensions are prioritised and clustered, and thus what supports are required to access resources differs between individuals (Bottrell, 2009b; Ungar, 2008). Consequently, services must privilege local knowledge about aspects of resilience (Ungar, 2008). My argument is that local knowledge is available for this context from the A/NZ resilience study and via findings from CRFSS service-user perspectives gathered in this study.

A prominent mediating factor for coping in the A/NZ resilience study was how accessible services were for young people. Young people reported having to wait a long time to access services, that promised interventions and resources did not eventuate, and services were available episodically during times of crisis, but then young people were discharged before other supports could be put in place (Munford & Sanders, 2016). Other concerns were feeling overwhelmed by the number of services involved, finding it difficult to engage with services, support not available for long enough periods to enable them to sustain positive change, and not receiving support until their behaviour escalated (Munford & Sanders, 2016; Sanders et al., 2014).

*Their stories suggest there were many missed opportunities for intervention while they were growing up (Munford & Sanders, 2016, p238).*
However, some services worked well because they provided immediate support and created opportunities for young people to find resources and work towards longer term goals (Munford & Sanders, 2016).

**MĀORI, SOCIO–ECOLOGICAL RESILIENCE AND PARENTAL MENTAL ILLNESS**

The over-representation of Māori in negative statistics, including mental and poverty, has been noted (Marriott & Sim, 2014; Walker et al., 2006). These factors along with other cumulative effects relating to colonisation, contribute to a degradation of socio-ecological resilience for tangata whenua (Consedine & Consedine, 2005; Orange, 2015; Ruwhiu, 2001; Walker et al., 2006; Wilson, 2016). All that has been discussed in this section regarding stigma associated with mental illness, poverty, and the impact of parental mental illness on life, is situated within this context for Māori service-users.

**PRINCIPLES OF PRACTICE**

Four principles of socio–ecological, resilience–focused practice for marginalised service–user groups which address the challenges associated with stigma, poverty, and severe and chronic parental mental illness, are now suggested from the work outlined above (Bottrell, 2009b; Munford & Sanders, 2016; Ungar, 2008):

1. Service delivery which supports the professional–service–user and peer relational systems enables resilience to cascade to other domains;
2. Service delivery which is readily available and responsive to need;
3. Service delivery which is flexible enough to respond to individual context and choice;
4. Service delivery which is comprehensive and addresses a wide range of gaps.

In relation to bicultural principles of practice for resilience–focused service delivery, as a Pakeha researcher I do not feel it is appropriate to make suggestions for Maori, nor diminish from the right of Māori to kaupapa services. However, as many participants in the NZ Resilience Study were Māori, and the socio–ecological construct of these principles appears to have congruence with Māori models of health and service delivery, these principles should support the
socio–ecological resilience of service–users in mainstream services (Boulton et al., 2013; Kara et al., 2011; Moore, 2014; Munford & Sanders, 2016; Rochford, 2004). Both support the need for holistic, relationally based, flexible and contextually responsive support.

SECTION 2 SUMMARY

This section sought to understand the socio–ecological environment in which CRFSS service–users in A/NZ are situated. Attempts were made to review strengths and resilience arising from parental mental illness, but little data were found, most probably due to the influence of the risk discourse. That which was located revealed COPMI may experience post–traumatic growth and increased acceptance of difference in others.

It was revealed that stigma and poverty are serious threats to the resilience of CRFSS families, significantly reducing their villages of support. The most significant damage was to capacity for supportive relationships for all family members, thus damaging possibilities of resilient pathways. Comprehensive and varying needs were noted, relating to parental mental illness and its effects on daily lives, coping skills and during crisis situations. For CRFSS service–users, particularly for Māori families, it was noted that the wider environment in A/NZ does not readily provide the health resources and experiences they need to be resilient, neither does it support navigation towards wellbeing. Although the effects of parental mental illness were shown to impact how CRFSS service–users could navigate their way towards resilience, the impact of stigma and poverty on navigation seemed greater still.

The A/NZ resilience study provided insight into challenges of at risk youth facing similar challenges of stigma, poverty, relational deprivation, poor coping skills, lack of support, and uneven development, giving unique insight into how such families maybe supported. Four principles of socio–ecological, resilience–focused practice for marginalised service–users were suggested from socio–ecological theory. Although resilience studies have largely focused on children and adolescents, they also apply to the resilience of adults and family
systems. For many parents with mental illness, childhood adversity and emergence of illness has degraded the mediators and tensions of resilience, and they too have significant resilience needs. Hence, for this group of families facing serious and chronic mental illness, it is argued these principles of socio-ecological, resilience-focused service delivery be applied across the entire service-user family system.

The question which emerges from the socio-ecological, resilience lens for this research enquiry is what could the CRFSS environment do to provide culturally meaningful, health-sustaining resources and experiences for families adversely affected by serious and chronic parental mental illness, and how might they support the capacity of individuals and families to navigate towards these?

SECTION 3: SOCIO–ECOLOGICAL, RESILIENCE–FOCUSED SERVICE DELIVERY FOR COPMI AND THEIR FAMILIES

With these questions and suggested principles of socio-ecological, resilience focused practice in mind for the whole family system, this section provides further context to the research question by analysing service delivery. This will be achieved by reviewing issues for COPMI service delivery, then closely examining four aspects of resilience-focused service delivery pertinent to the needs of marginalised COPMI and their families, and this social service context:

- Relationship-based practice;
- Comprehensive family practice;
- Peer support as an anti-stigma intervention;
- Scaffolded recreation for COPMI as a strategy for respite and developmental enhancement.

Many other domains of literature could have been explored such as child developmental theory, principles of practice across the helping professionals, mental health family case management, and specific modalities of family practice, however the constraints of a thesis required limiting the review of theory to the suggested principles of practice from socio-ecological resilience theory as they apply to this social service context (see page 69).
The section closes by taking a brief look at measures of resilience.

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**THE SOCIO–ECOLOGY OF COPMI SERVICE DELIVERY**

COPMI service delivery varies across the world. ‘Bottom up’ advocacy from NGOs and individual mental health services for COPMI service delivery has occurred in many countries; however, only a few have had ‘top–down’ state support for decades, including Australia, the Netherlands, and some Scandinavian countries (Falkov et al., 2015; Hosman et al., 2009; Solantaus & Toikka, 2006; Tchernegovski et al., 2017). As outlined, state support is required for systemic change across mental health services (Falkov et al., 2015; Tchernegovski et al., 2017). Early identification of COPMI is a noted priority for prevention, as is making provision for children in adult mental health inpatient and outpatient treatment and ensuring adult mental health clinicians are family-focused (Foster et al., 2016; Hosman et al., 2009; Maybery et al., 2014; Nicholson et al., 2001; Parrott et al., 2008; Reupert, Maybery, Nicholson, et al., 2015).

Research into the efficacy of interventions for families living with parental mental illness is emerging (Nicholson, 2009; Reupert & Maybery, 2016). What has been gathered concerning the efficacy of supportive interventions is said to be compelling (Reupert & Maybery, 2016). Examples include the work of Beardslee et al. (2013), Foster et al. (2014), Maybery et al. (2006), Nicholson et al. (2009), Reupert et al. (2012), and Van Doesum et al. (2015). In an often–cited systematic review and meta–analysis of 13 randomised control trials, which included 1490 COPMI, Siegenthaler et al. (2012) conclude that interventions may reduce the likelihood of developing mental illness by up to 40%. The COPMI programmes reviewed in this study incorporated a wide range of mental illness including substance abuse, and types of interventions for various members of the family.

Despite these studies, Nicholson (2009, p222), states that few interventions for families with parental mental illness “have rigorous research evidence to demonstrate effectiveness”. In a systematic review of 19 community
interventions for COPMI (parents with serious mental illness) in the United Kingdom for “clinical effectiveness, cost-effectiveness and acceptability”, Penny Bee (2015, p1) concluded that significant quantitative research is needed to establish evidence. Part of the reason for this, argues Nicholson (2009), may be difficulty in capturing the complexity of families’ lives when affected by parental mental illness with current intervention methods and approaches.

Although gaps in knowledge of the efficacy of service delivery exist, degree of risk is largely known and able to be predicted (Hosman et al., 2009; van Santvoort et al., 2015). Hosman et al. (2009, p258) advocate for thorough, socio–ecological assessment of need, as risks vary:

_The multicausality of the risk in the children stresses the need to assess carefully the accumulation of risk factors within and across domains, and the interactions between risk factors and protective factors .... Both risk and protective factors are located in the child, the parents, the social network and the wider social environment._

As argued by Steer et al. (2011), COPMI are not a homogenous group and service delivery should reflect this.

For the CRFSS service–users, most risk factors apply, resulting in support needs across multiple domains. Some programme development work has occurred which supports this group of service–users. A few whole family COPMI programmes have been established which cater for the comprehensive needs associated with severe and chronic parental mental illness, and offer flexibility and multidisciplinary support over a period of up to three years (Hinden et al., 2006; Nicholson et al., 2007; Reupert et al., 2009). Unfortunately, in many countries, differentiation of needs in COPMI service delivery according to known risks does not occur, and families with complex needs may only be offered limited interventions (Steer et al., 2011). To add further complexity to service delivery, the needs of families change as children grow, and each stage requires differing skills and intensity (Reupert, Maybery, Nicholson, et al., 2015; Reupert & Maybery, 2016). The challenge for service delivery is how to cater
for differential family needs and adjust to developmental changes in children and families.

In relation to triaging according to need, the Netherlands has used knowledge about risk and protective factors to identify and guide programme development and prevention policy (Hosman et al., 2009). Van Santvoort et al. (2015, p296) advocate risk screening to determine the “type and intensity of support” for COPMI, based on findings that some COPMI and their families are at much higher risk than others. Additionally, van Santvoort et al. (2015) suggest that interventions should target common and disorder–specific factors, and Hosman et al. (2009, p253) conclude that these factors should be addressed as part of “a comprehensive approach” for COPMI.

Falkov’s continuum of need (2014), associated with ‘The Family Model’ (2012), is a useful triage tool designed for the clinical workforce to identify, assess and match Australian service delivery to individual COPMI and family needs, and offers possibilities for wider use. Falkov suggests five categories (p2):

1. **Children not known to services:** who are well and supported; who are not known but should be, such as infants, and children with hidden needs such as those in culturally and linguistically diverse groups.

2. **Resilient children in need of support:** including many young carers, and those with parents not requiring specialist care but children would benefit from information.

3. **Children who are vulnerable and in need of services,** including: whose parents are known to adult mental health services and children’s services; whose parents are being treated in primary care settings; of refuge and minority community parents experiencing mental illness.

4. **Children who are vulnerable and in need of services and protection,** including: children whose parents struggle to meet their needs, including safety, despite best efforts and the provision of supports; parents most likely to have co–morbidty, including substance abuse and/or personality disorders.

5. **Children at risk of imminent harm:** a small subgroup in which children experience severe maltreatment; in rare cases fatalities occur.
Combining the work of Hosman et al. (2009) and van Santvoort et al. (2015) with that of Falkov (2014) above would enable guidelines for decision-making on need and service delivery to be made.

The service-users of CRFSS fit into Category Four, as per Falkov’s continuum of need (2014). They exhibit most risk factors listed above and limited protective factors. A pertinent question arises: If resilience theory informs the need for and efficacy of addressing risks in a timely manner, with improvements in resilience of up to 40%, and it can be predicted which children and families require more support than others, does it not follow that service delivery should take this into account (Hosman et al., 2009; Siegenthaler et al., 2012)?

SERVICE DELIVERY FOR FAMILIES IN WHICH PARENTS HAVE SEVERE AND CHRONIC MENTAL ILLNESS

From previous discussion and suggested principles of resilience-focused practice (page 69) it can be concluded that if service delivery is to meet the needs of service-users such as those in this study, it needs to enable worker-service-user relational formation and be comprehensive and flexible enough to cater for individual and family developmental needs. Thus, this section reviews four aspects of service delivery which I suggest are reflective of these socio-ecological, resilience-focused principles of practice. As explained, these principles were developed from contextually relevant studies in Australia and A/NZ, and international resilience studies. The areas discussed also relate to types of COPMI service delivery. They are: relationship-based practice, comprehensive family practice, COPMI peer support as an intervention for stigma, and scaffolded recreational activities.

RELATIONSHIP-BASED PRACTICE (RBP)

The term relationship-based practice (RBP) emerged from social work and is defined as professionals working with the relationship between professional and service-user as the cornerstone of intervention (McMillen, 1992; Ruch, Turney, & Ward, 2010; Trevithick, 2012; Turney, 2012a). As noted, it was relationships with professionals which were the first step on a pathway to
resilience for A/NZ at risk young people (Munford & Sanders, 2016). From the outset, CRFSS intentionally focused on the development of sustained worker–client relationships with the children, youth, parents and caregivers, and wider family members it served.

To understand RBP, several lenses will be utilised. In relation to the CRFSS family worker–adult service–user relationships, social work RBP will be the primary lens. Social work RBP contributes, as social work has long been the profession to focus on family work, especially when competing needs for children and adolescents emerge, and it best describes the role of the family worker. Although mainstream attachment theory is largely excluded, its application to professional case management relationships with adult mental health service–users is pertinent, given the context and some similarities between case management roles and the work of the CRFSS family workers.

To understand CRFSS children’s worker relationships with child service–users, social work RBP has some application, but two additional lenses provide insight: the adult–youth mentoring domain; and recognition theory, applied from the work of Honneth (1997), (Smith et al., 2017; Turney, 2012b). Adult–youth mentoring adds an important perspective on appropriate interventions for marginalised populations of young people such as COPMI, describing the necessity for multicomponent, multipronged service delivery which has significant congruence with the CRFSS service model and is in line with recommendations with the COPMI literature (Hosman et al., 2009; van Santvoort et al., 2015).

**SOCIAL WORK RELATIONSHIP–BASED PRACTICE (RBP)**

O’Leary, Tsui, and Ruch (2013, p143) explain social work RBP:

> ...we place the social worker and the client at the centre of a set of boundaries that promote connection and the use of self, rather than separation and professional distance.

It is the quality of relationship between social worker and service–user which this theory argues is the strongest predictor of positive outcomes, regardless of
the specific model of practice (Coady, 1993; Howe, 1998; Lee & Ayon, 2004; O’Leary et al., 2013). O’Leary et al. do not dismiss the need for professional boundaries; rather, questions how these same boundaries are derived and their fit with the ethos of social work practice. A salient social work domain is child protection, as parents with mental illness have high rates of children in care, it has been found that these parents are reluctant to seek help due to fear of losing custody, and child protection social workers have been found to show stigma towards parents with mental illness (Ackerson, 2003; Busch & Redclich, 2007; Hearle, Plant, Jenner, Barkla, & McGrath, 1999; Larson & Corrigan, 2008; Jones, Macias, Gold, Barreira, & Fisher, 2008; Nicholson et al., 2001; Park, Solomon, & Mandell, 2006; Reupert & Maybery, 2016; Sheehan & Levine, 2005). Many scholars have found the quality of relationship between professional and parent in child–welfare settings has a significantly positive impact on decision making and the effectiveness of help given (De Boer & Coady, 2007; Drake, 1994; Howe, 2010b; Howe, 2008; Lee & Ayon, 2004; Munro, 2011; Ruch, 2005; Turnell, 2004; Turnell, 2006; Turney, 2012a).

Research with service users in similar child protection contexts as A/NZ found parents are more likely to disclose full information and cooperate if child protection workers build good relationships with them, resulting in better protection for their children (Drake, 1994; Gilbert, 2012; Healy & Darlington, 2009; Lee & Ayon, 2004; Keddell, 2017; Khoo et al., 2006; Solomon, 2002). Similarly, a study cited by De Boer and Coady (2007) showed significant correlation between positive worker–service–user relationship, and

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25 This explanation of RBP was made in response to changes in social work practice over recent decades. The profession moved away from RBP during the 1980s/1990s when it was influenced by “more overtly political approaches to practice (p150)”, Turney (2012a). Many social work scholars felt the pendulum had swung too far, with consequences for social work RBP (De Boer & Coady, 2007; Featherstone, White, & Morris, 2014b; Healy & Darlington, 2009; Keddell et al., 2016; O’Leary et al., 2013; Maidment, 2006; Munro, 2011).
improvements in children’s physical care, discipline and emotional care, and parental coping — aspects a parent with mental illness may struggle with.

Sudbery (2002) describes a social worker–service–user relationship which is therapeutic, empowering and developmental; and grounded in the psychodynamic practice of paying attention to transference, counter-transference, and the punitive super-ego. De Boer and Coady (2007) summarise other components: mutual liking, emotional depth, closeness, and strong bonds (De Boer & Coady, 2007); aspects of friendship (Drake, 1994; Ribner & Knei-Paz, 2002); the use of small talk (Drake, 1994); having an informal, conversational style (Ribner & Knei-Paz, 2002); comfortableness (De Boer & Coady, 2007); and reciprocity, love and touch (Maidment, 2006). Worker traits from the child welfare literature are relevant also, as CRFSS workers are similarly required to hold in mind the competing needs of children, parents and families. A “soft, mindful and judicious use of power”, and a “humanistic attitude and style that stretches traditional professional ways–of–being” were found to facilitate service user participation (De Boer & Coady, 2007, p35).

Pitfalls do exist in RBP with parents, as sometimes adverse events occur, workers are misled or compromised, and children are injured, abused or even die (Turney, 2012a; Munro, 2011; Howe, 2010a; Turnell, 2004; Turnell, 2004). This highlights the complexity of such work and the need for support and in-depth supervision for those working in this manner (Cousins, 2004; Ruch et al., 2010; Howe, 2010a; Sudbery, 2002). It also serves as a reminder of the importance of the contextual backdrop to relationship: RBP is both healthy scepticism and relationship. Cooper likens RBP to medicine’s stoical stance, where intensive relational work with parents at risk of losing their children is coupled with difficult conversations (2015, p1):

...they can sustain trusting relationships with families through a blend of compassion, directness and therapeutic ability ... their experience suggests these families welcome these respectful but clear engagements, because they know they are in real difficulty, and also know the consequences of failing to engage and change.
Tchernegovski et al’s (2018) study of adult mental health clinicians working with parents who have mental illness found some clinicians managed the struggle of competing needs well when they maintained a dual focus which considered the needs and experiences of both parents and children at the same time.

A holistic aspect of RBP is raised by Sudbery (2002, 159): The role of assistance in relationship development by meeting basic needs. Sudbery sees this as “acting responsibly in terms of agency function – providing information, providing practical assistance as appropriate, acting as advocate or liaison”. Sudbery (2002, 159) argues this may have restorative significance; an element of reparenting – “undoing of the after effects of disparaging parental figures” when undertaken by a non-threatening, respectful, supportive and encouraging authority figure.

Certainly in the longer term it is precisely these interactions in an enduring relationship which have the potential to lead to a developmental and therapeutic outcome.

**ADULT MENTAL HEALTH CARE**

Goodwin’s (2003) review into the relevance of attachment theory to adult mental health care concludes with its salience. Mental health workers may serve as ‘temporary attachment figures’ by providing a secure base through: sensitive and appropriate responses to distress; emotional containment; consistency and continuity through a reliable, ongoing relationship with the same person; support for as long as the service-user felt the need; and a safe environment (Adshead, 1998; Goodwin, 2003; Goodwin, Holmes, Cochrane, & Mason, 2003b).

Gilburt, Rose, and Slade (2008) found relationships formed with clinicians in an inpatient setting were at the core of mental health patient experiences, both good and bad. Those relationships with effective communication, cultural sensitivity and the absence of coercion were based on a sense of trust. Barriers to service delivery were also relational: ineffective and negative communication with clinicians, lack of trust in clinicians, a lack of safety in terms of staff preventing violence and/or being perpetrators of violence and use of coercion.
Shattell, Starr, and Thomas (2007, p274) summarise similar findings from an outpatient study:

*A therapeutic relationship for persons with mental illness requires in-depth personal knowledge, which is only acquired with time, understanding and skill. Knowing the whole person, rather than knowing the person only as a service recipient, is key for … enhancing the therapeutic potential of relationships.*

The phrase *continuity of care* is often used in the adult mental health domain to describe a best practice model of care which facilitates RBP (Belling et al., 2011; Burns et al., 2009; Cook, Render, & Woods, 2000; Crawford, de Jonge, Freeman, & Weaver, 2004; Freeman, Shepperd, Robinson, Ehrich, & Richards, 2000; Sweeney et al., 2016). Goodwin (2003, p146) goes as far to say that in not providing continuity of care:

*...services may be actively harming, rather than helping, by perpetuating or repeating experiences of insecure, damaging attachments.*

Ware, Tugenberg, Dickey, and McHorney (1999, p399) note the skills required to practice continuity of care are “well within the capabilities of trained clinicians”. However, in practice, the reality is somewhat different, due to the current adult community psychiatric care context of high staff turnover, large caseloads and an emphasis on throughput (Belling et al., 2011; Cook et al., 2000; Crawford et al., 2004).

**RECOGNITION THEORY**

Recognition theory, developed by Honneth, was an alternate conceptualisation of child care relationships, and offers a framework within which to consider relational needs (Honneth & Farrell, 1997; Smith et al., 2017). Recognition theory extends (Smith et al., 2017, p1607):

*...the human requirement for rewarding relationships beyond the individual to encompass social, political and community contexts as sites of human development.*
Consequently, recognition theory is readily applicable to relationship–based practice, as argued by Turney (2012b). The core concepts of recognition theory are (Honneth & Farrell, 1997; Smith et al., 2017; Turney, 2012a):

- Recognition of love;
- Legal recognition – respect;
- Solidarity/social appreciation – recognition of reciprocity, mutuality, the give and take of relationship.

Recognition of love refers to a strong emotional attachment in which each party shares emotions and thoughts, approval and encouragement (Smith et al., 2017). It is from this type of relationship that individuals are ‘recognised’, thus enabling a sense of self and the formation of identity (Turney, 2012b).

Legal recognition, or respect, is described as when “one becomes a bearer of rights if one is socially appreciated” (Smith et al., 2017, p1616). The development of self is extended from the immediate family to respect from the wider environment, thus enabling self–respect (Smith et al., 2017; Turney, 2012a). Respect means both parties contribute to decision–making (Smith et al., 2017). Conversely, the withdrawal of recognition or misrecognition, are understood as disrespect, thus resulting in “shame, anger or indignation” (Honneth, 2007, p72; Turney, 2012b).

Solidarity, that is, social appreciation, or reciprocity, is the key concept of recognition theory. This means interactions with others exist within the reciprocal expectation that each will ‘recognise’ the other as a moral person, that is, respect the other (Honneth, 2007; Turney, 2012b). Mutual esteem, shared values, and “social acknowledgement of the individual’s achievements and abilities” are essential (Smith et al., 2017; Turney, 2012b, P152).

Application of this theory to social work RBP has been criticised mainly due to the theory’s lack of attention to macro influences on recognition and misrecognition (Garrett, 2010; Turney, 2012b). However, in agreement with Turney (2012b), I acknowledge the usefulness of this theory in understanding the micro encounters which occur in worker–service–user relationships.
Although Turney used this theory in relation to adult involuntary service-users, social work RBP is sufficient for understanding worker–adult relationships in this thesis. However, recognition theory illuminates aspects of worker and child service-user relationships and this is how it will be applied.

**THE ADULT–YOUTH MENTORING RELATIONSHIP**

Although the adult–youth mentoring material pertains to mentors as volunteers not paid professionals, this genre offers unique insight into secondary relational systems, and the relationships formed between adult workers and child or youth service-users of the CRFSS. Mentoring of child service-users is a goal of the service.

The term *mentor* is defined as “an experienced and trusted adviser” (Thompson, Fowler, & Fowler, 1995). Mentoring relationships may be formal or informal (natural). Informal mentors develop naturally from the pool of nonparental adults who care and provide support and guidance (DuBois & Silverthorn, 2005b; Rhodes, Spencer, Keller, Liang, & Noam, 2006; Schwartz, Chan, Rhodes, & Scales, 2013; Theokas & Lerner, 2006). Formal mentors relate to mentees via a third party. In the context of CRFSS, the third party is omitted, as mentoring is part of service delivery.

Schwartz et al. (2013) argue adolescence is a developmental stage which is particularly conducive to changes in one’s working models, and adolescents are more likely to listen to the advice and guidance of mentors than parents during this period. The authors locate mentoring research under the umbrella of several theories:

- Attachment theory – mentors as secondary attachment figures (Bowlby, 1988);
- Psychosocial theory – mentors as role models and contributors towards mentees’ sense of self (Erikson, 1968; Markus & Nurius, 1986);
- Social learning theory – mentors as a ‘social mirror’, providing adolescents’ with different viewpoints and guidance on life (Allen & Land, 1999; Keller & Pryce, 2010).
Mentoring is not a strong focus in the COPMI literature although the need for other supportive adults is a clear message. In terms of interventions for COPMI, only a few specified mentors or personal coaches (Orel et al., 2003; Foster et al., 2014). The resilience literature specifies mentoring when referring to the need for a strong secondary relational system for resilience, noting both informal and formal mentors and the presence of mentoring type relationships in adolescents on a resilient trajectory (Hauser, Allen, & Golden, 2006; Masten, 2015, 2001).

In their study about the contribution of non–familial adults to the wellbeing of young people, Schwartz (2013) found having a mentor helped youth develop prosocial values and increase links with community assets. Youth activities alone were insufficient for a reduction in risk: While activities contributed to thriving, it was close mentoring relationships which correlated with risk reduction. Risks were defined using a Risk Pattern Index developed by Leffert et al. (1998): use of alcohol, tobacco and other drugs; sexual intercourse; depression or suicide; antisocial behaviour; school problems; drink driving; and gambling — all of which are known risk factors for COPMI.

Other authors found significant associations between youth mentoring and positive youth developmental outcomes (DuBois & Karcher, 2005; Rhodes & DuBois, 2006, 2002; Zimmerman et al., 2002). Citing results from a National Longitudinal Study of Adolescent Health, DuBois and Silverthorn (2005b) highlight that those who experienced a mentoring relationship from the age of 14 exhibited better outcomes within the domains of education and work, mental health, problem behaviour and health.

Adult–youth mentoring relationships were most likely to produce positive outcomes and avoid harm when they shared a core of common characteristics, similar to relationships formed with professionals in the A/NZ resilience study: mutual trust, and feeling liked, understood and respected (Munford & Sanders, 2016; Rhodes & DuBois, 2006). Mediating factors, as summarised by Rhodes and DuBois (2006), were: mentor empathy and authenticity, as found in a
therapeutic relationship (Spencer, 2006); experiencing fun activities together and enjoying each other’s company (Spencer & Rhodes, 2005); and compatibility in personality, interests, expectations and relationship goals (Bernier & Larose, 2005; Madia & Lutz, 2004).

Emotional closeness in the mentor–youth mentee relationship is linked with favourable psychological outcomes DuBois and Silverthorn (2005a). These authors found mentoring relationship predicted favourable outcomes in all domains except psychological; however, the greater reported closeness was predictive of more favourable mentee psychological well-being. This research is apt given the additional risk of mental illness in the child sample of this project.

A study by Hurd and Zimmerman (2014) produced similar findings regarding emotional closeness when extended duration and/or frequent contact between mentor and mentee were also part of the picture. Other similar findings exist: Hussong (2000) and Newman, Newman, Griffen, O’Conner, and Spas (2007) on the correlation between social support, emotional closeness and positive mental health outcomes among youth and adults; and Newman et al. (2007) and Peirce, Frone, Russell, Cooper, and Mudar (2000) and Hurd & Zimmerman (2014) regarding inverse associations between social support and depression.

Rhodes and DuBois (2006) found frequency of contact an important mediator. Regular contact was linked with positive youth outcomes indirectly as it allowed other processes to take root in the relationship, such as opportunities to engage in beneficial activities (Parra, DuBois, Neville, Pugh-Lilly, & Povinelli, 2002); emotional and instrumental support (Herrera, Sipe, & McClanahan, 2000); deeper integration of the adult into the youth’s social network (DuBois, Neville, Parra, & Pugh-Lilly, 2002); and enhanced feelings of security and attachment in interpersonal relationships (Rhodes, 2005; Keller, 2005b).

Benefits of duration accrued over time (Grossman & Rhodes, 2002; Rhodes & DuBois, 2006). Greatest benefits were for mentoring relationships longer than one year (DuBois & Silverthorn, 2005a; McLearn, Colasanto, & Schoen, 1998;
Klaw, Fitzgerald, & Rhodes, 2003; Rhodes & DuBois, 2006). Volunteer mentor attrition was found to limit the success in efforts of various programmes to establish and sustain close, consistent and enduring mentoring relationships with youth (Hurd & Zimmerman, 2014; Rhodes & DuBois, 2006). DuBois and Silverthorn (2005b, p5) conclude:

...relationships may be especially beneficial when they remain part of the youth’s life for multiple years and thus have the opportunity to facilitate adaptation throughout significant portions of their development.

The processes by which mentors influence developmental outcomes for youth mentees has been studied. The conceptual model developed by Rhodes et al. (2006) proposes three interrelated processes which align with the tensions and mediators of resilience. As outlined, many COPMI have deficits in these areas. These are (Rhodes et al., 2006, p692):

1. By enhancing youth’s social relationships and emotional well-being (2006, 2005, 2002);
2. By improving their cognitive skills through instruction and conversation (2006);
3. By promoting positive identity development through serving as role models and advocates (2006; Markus & Nurius, 1986).

Rhodes et al. (2006, p692) suggest:

...the effectiveness of these three processes is likely to be governed, at least in part, by the quality and longevity of the relationships established between young people and their mentors.

 Particularly pertinent to the CRFSS service delivery model is the literature relating to the wider context in which positive mentoring relationships are situated. According to Rhodes and DuBois (2006), DuBois, Holloway, Valentine, and Cooper (2002) and Hirsch (2005), these include: the benefits of mentoring in a group context that includes multiple peers and multiple adults who collaborate with each other (Hirsch, 2005); and the gains mentoring can
facilitate in relationships youth have with parents, peers and other adults such as teachers (Karcher et al., 2006a; Tierney, Grossman, & Resch, 1995). Rhodes and DuBois (2006, p5) conclude:

...it appears that when a mentor develops linkages with key persons in the youth’s social network, such as parents or peers, effectiveness is enhanced.

Moderating factors were found. These include: premature termination of the relationship by mentor, incompatibility of personality and/or interests of the mentor and mentee; irregular or infrequent contact; lack of emotional connection; deficiency in mentor skills and abilities; limited knowledge of developmental needs of the mentee; and gaps in the mentee’s social network (Rhodes et al., 2006; Whitney, Hendricker, & Offutt, 2011).

For children and youth with risk factors, the positive effects of mentoring alone were not enough to offset the negative effects associated with individual or environmental risk factors, such as those which exist for CRFSS service–users (Rhodes & DuBois, 2006). DuBois and Silverthorn (2005a) note that despite some methodological issues associated with the findings, mentoring was not predictive of benefits in several areas such as substance use, mental or physical health, citing (DuBois & Karcher, 2005; Sanchez, Reyes, & Singh, 2006b; Werner, 1995). The mentoring literature surrounding individual risk factors, such as academic failure, teenage pregnancy, maltreatment or juvenile delinquency, is less clear (Britner, Balcazar, Blechman, Blinn-Pike, & Larose, 2006; DuBois, Holloway, et al., 2002; Rhodes, 2002). DuBois, Holloway, et al. (2002) note that if programmes which target individual risk do not follow desirable programme practice, then the results may be harmful.

If mentoring alone is insufficient for vulnerable children and young people, what does the adult–youth mentoring literature recommend? DuBois and Silverthorn (2005b, p518) conclude:

...mentoring relationships alone are not enough to meet the needs of at–risk youths and therefore should be incorporated into more comprehensive interventions.
COMPREHENSIVE FAMILY PRACTICE

Comprehensive family practice, the notion of holistic, interconnected and whole family service delivery, has been implied by the socio-ecological resilience literature, noted in the COPMI literature, hinted at in social work RBP, and advocated for by the adult-youth mentoring field. Sometimes comprehensiveness is understood as many services providing multiple aspects of service delivery, such as the WrapAround system — of — care, case coordination model for families in which children have complex mental health needs (Winters & Metz, 2009). Although such models meet important needs they do not describe comprehensive family practice from a socio-ecological, resilience-focused perspective. Thus, comprehensive family practice is defined in this thesis as one service providing multiple (but not necessarily all), wide-ranging aspects of service delivery to the whole family system, as an extension of RBP.

The problem with multiple agencies supporting a single family is noted in a paper by Scott (2005) which examines inter-agency collaboration and family-centred practice. The author notes the limitations to this common model for families and that major restructuring is occurring in some locations to form ‘integrative family service centres’. Such strategies are intended “to reduce the number of organisations involved in a case by increasing the functions an organisation can perform and having a single entry point into family services in each district” (Scott, 2005, p133).

Comprehensive interventions are described in adult-youth mentoring as a “multi-component youth development and prevention programme”, with “value added” benefits of mentoring (Rhodes & DuBois, 2006, p8). Rhodes and DuBois (2006, p8), referring to the work of Kuperminc et al. (2005), argue that best results occurred when mentoring is integrated into broader service delivery:

...as a vehicle for delivering or brokering access to other services rather than simply being an ‘add on’ and hence having little or no connection to other program components.
For the child service-users of CRFSS service who are facing environmental and individual risks, this is pertinent and confirming.

Although Rhodes and DuBois (2006) do not specify working with the whole family system, this is implied, given the author’s comments about the enhancement to mentoring when parents and their wider social network are included. Returning to the framework of ecological theory is a reminder of the interactions between systems surrounding children and youth. They are influenced by what is happening daily with their siblings, parents and others in their families in addition to wider areas of influence (Bronfenbrenner, 1993; Feldman, 2012; Santrock, 2013). To include the whole family system seems logical, particularly for this service-user group.

Comprehensive family practice is expressed in other relevant areas also, such as by the Organisation for Economic Co-operation and Development (OECD) in relation to supporting families with complex needs (OECD Ministerial Meeting for Social Policy, 2011, p2):

> Multiple risks require multiple interventions; and these are most effectively delivered through integrated or co-located services ...

A contextually relevant perspective on service delivery for families with complex needs appeared in the New Zealand Productivity Commission’s (NZPC) findings from their 2014–2015 enquiry into social services in A/NZ (New Zealand Productivity Commission, 2015a). The Commission concluded that the disjointed, brief and narrow style of current social service delivery in A/NZ does

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26 The mission of the Organisation for Economic Co-operation and Development (OECD) is to promote policies that will improve the economic and social well-being of people around the world. For further information, see http://www.oecd.org/about/.

27 The New Zealand Productivity Commission (Te Komihana Whai Hua o Aotearoa) is an independent Crown entity bound and guided by the New Zealand Productivity Commission Act 2010. The Commission is instructed by the Crown to complete in-depth ‘productivity-related’ inquiries on topics selected by the Government. For further information, see www.productivity.govt.nz.
not work for this service–user group and an entirely different style of service delivery is required to meet comprehensive needs.

Socio–ecological resilience theory supports comprehensive family practice for those who are marginalised. Ungar (2011) advocates for a holistic, systemic perspective on supporting resilience by attending to a wide range of changes in a person’s life which have the potential to influence outcomes, at the same time (Bierman et al., 2004; Munford et al., 2013; Ungar, 2012a). Munford and colleagues (2013, p19) integrate the work of many including (Cicchetti & Garmezy (1993), Luthar & Cicchetti (2000) and Schoon (2012), when they conclude:

_There is an emerging consensus that factors at a range of levels in interaction with each other make the largest contribution to modifying the impact of stressful environments on children’s development (p19)._

Citing a large randomised control study of kindergarten students in high–risk neighbourhoods in North America who experienced a 10–year “Fast Track” intervention (Bierman et al., 2004), Ungar (2012b, p16) summarises:

_Notably, it was the combination of long term developmentally appropriate services that focus on children’s cognitive skills, peer relationships, parenting practices and the quality of the school climate that accounted for changes in expected child functioning._

Ungar (2012a) emphasises the difference between service delivery for at–risk children and youth which focuses on increasing assets, and service delivery which focuses on increasing resilience, arguing wellbeing is more than absence of disorder and addition of strengths. Using the Fast Track intervention above as an example, Ungar (2012a, p17) argues long term programmes such as this change “social structures and provide assets that interact with levels of disorder to change developmental pathways”; the adapted socio–ecology being the locus of change. What Ungar (2012a, p18) is describing is comprehensiveness in the length of service intervention, not just breadth; long–term service
delivery becoming the environment which “potentiates the long–term positive development among children who are at–risk”.

COPMI PEER SUPPORT AS AN INTERVENTION FOR STIGMA

This section considers the equally crucial tertiary relational system and the positive impact a sense of belonging with peers has on at–risk youth, as outlined (Bottrell, 2009b; Masten, 2015; Munford & Sanders, 2016; Sanders et al., 2014).

Stigma theory has been considered and will be revisited in this section in relation to COPMI. The literature surrounding stigma for COPMI and peer support programmes as an intervention which may have a de–stigmatising effect, in addition to other benefits, will be explored. This is relevant as CRFSS purposely provides situations in which COPMI mix with their peers in a variety of settings over a prolonged period of their lives, and the service narrative, reflected in its goals, values provision of a destigmatising environment for child service–users. One context of scaffolded experience arising from peer support and the resulting destigmatising environment is mental health education, and space will be given to linking these concepts.

STIGMA FOR COPMI

There are three types of stigma, and all negatively affect COPMI. Public, or institutional stigma, has the most influence as it affects all other systems of society, creating the conditions in which people stigmatise others and internalise stigma (Campbell & Deacon, 2006; Corrigan, Watson, & Barr, 2006; Corrigan et al., 2016; Harris & McElrath, 2012; Reupert & Maybery, 2015).

Stigma by association is noted in the general mental health literature (Corrigan & Miller, 2004; Hasson-Ohayon et al., 2011; Östman & Kjellin, 2002). Although the COPMI literature comments that this area is not well researched, its existence is reflected by scholars (Gladstone et al., 2011; Hinshaw, 2005; Larson & Corrigan, 2008; Leahy, 2015; Link et al., 2004; Östman & Kjellin, 2002; Mordoch & Hall, 2002; Marsh & Dickens, 1997; Nicholson et al., 1998a; Reupert & Maybery, 2015; Seeman, 2015). Consequences of stigma by association found include COPMI:
• Being viewed as: “contaminated or pitiful” and (Corrigan & Miller, 2004; Gladstone, 2014; Larson & Corrigan, 2008; Reupert & Maybery, 2016, p102);
• Seen as having “negative personal characteristics when people believe that the parent’s mental illness is caused by genetic or hereditary factors and the child’s risk of developing the same disorder is high” (Koschade & Lynn-Stevenson, 2011; Reupert, Maybery, Nicholson, et al., 2015, p55);
• Avoided or teased (Reupert & Maybery, 2015);
• Parents blamed if COPMI have any problems, therefore children may avoid being seen with their parent and parents reluctant to discuss any concerns they have about their children (Reupert & Maybery, 2015);
• Shamed into avoiding social contact and spending energy on hiding the secret (Larson & Corrigan, 2008; Reupert & Maybery, 2015).

Hence, parents, families and children are unlikely to seek help (Corrigan, Druss, & Perlick, 2014; Hocking, 2003; Reupert, Maybery, Nicholson, et al., 2015).

Lefley (1992) and Hasson-Ohayon et al., (2011) found that two possible sources of self–stigma for relatives are the perception that family members were an extension of deviation from normal, and that the illness may have been caused by family members. Livingstone and Boyd (2010) noted that self–stigma is negatively associated with hope, self–esteem and empowerment, and Patrick W Corrigan et al. (2016), diminished self–respect and the ‘why try?’ phenomenon. Yang et al. (2007, p1526) summarise, predominantly from the work of Major and O'Brien (2005):

...stigma predisposes individuals to poor outcomes by threatening self–esteem, academic achievement, and mental or physical health.

Reupert and Maybery (2015) suggest empowerment is a strategy to counter stigma, particularly self–stigma, via peer support, a strengths approach, building competence, and valuing the perspectives of children and youth.

**PEER SUPPORT FOR COPMI**

In recognition of the stigma and social isolation many COPMI face, peer support programmes have become common preventive interventions in many countries.
Variations exist in the form, criteria, management, length, and components of peer support programmes (Drost & Schippers, 2015; Foster et al., 2014; Grove et al., 2015; Hargreaves, Bond, O’Brien, Forer, & Davies, 2008; Isobel, Pretty, & Meehan, 2016; Orel et al., 2003; Reupert & Maybery, 2009; Santvoort, 2013). Criteria for access also varies. The age of the child or youth may be a determining factor, with few services available for those under eight years, and fewer services for adolescents. Accessibility may also impact, for example, rural areas have few programmes Reupert and Maybery (2009). COPMI with significant behavioural problems and mental illness diagnoses are often excluded (Orel et al., 2003; Reupert & Maybery, 2009). If the programme is an adjunct to adult mental health service users, it is usually only available if the parent is engaged with the service at the time (Isobel et al., 2016).

Peer support groups share common features and frameworks. Features include: activities which enable socialisation, fun, increasing coping skills, other skills and team building; and mental health education. Some specify crisis planning, and a few provide one–to–one mentoring or coaching (Foster et al., 2014; Grove et al., 2015; Orel, Groves, & Shannon, 2003; Yu, 2011). In a review of 26 Australian services for COPMI, Reupert and Maybery (2009b)) found common frameworks and goals: “a strength–based approach, aiming to develop participants’ understanding of mental health and illness, peer support network, and life and coping skills”, as summarised by Foster et al. (2014, p61).

Evidence surrounding the efficacy of peer support programmes is emerging (Foster et al., 2014; Reupert & Maybery, 2009). Foster et al (2014) note most evaluation has focused on child outcomes using psychometrics, with few studies capturing stakeholders’ experiences. Reupert and Maybery (2009, p131) add most evaluation reviewed was simplistic and “lacked the rigor of standard
evidence procedures”, noting lack of funding for training and evaluation. Despite variation in methodology, themes were similar, and generally aligned to service delivery. Those summarised by Foster (2014) from psychometrics were:

- Learning about mental illness,
- Having fun,
- Learning to manage feelings,
- Playing games in a group,
- Realising not alone,
- Making new friends,
- Learning new skills such as problem solving
- Learning it is helpful to talk to other COPMI.

Qualitative and/or mixed method stakeholder data add further insight. Foster’s (2014) evaluation of the ON FIRE programme measured views of child participants. Primary findings were:

- I’m not alone – opportunity to connect with peers,
- Feel braver and stronger – developed personal strengths,
- I can support others (no longer helpless, can now be helpful).

In addition to these, from a mixed method study of camps for 8– to 17–year–old COPMI, Grove et al. (2015) add:

- Positive changes in COPMI’s perceptions of the parent with mental illness,
- Peer support camps were a place of respite from caring.

The themes from a study by Isobel et al. (2016) of peer support groups offered as an adjunct to adult mental health care also agreed. Two further insights were:

- Participants identified respite as ‘escapism’,
- Unexpected comfort of connection and fun in safe relationships.
Isobel et al. (2016, p1) makes an important point. As noted, the context was children of parents attending a statutory adult mental health service, denoting more serious illness:

*This program creates a non-intrusive mechanism within which AMH [adult mental health] services can engage notoriously difficult to access families and deliver early intervention and prevention services...*

As stated, the COPMI literature rarely applies itself to COPMI from families with complex, chronic mental illness. Isobel et al. (2016) suggest this context. Of note, workers maximised access to the programme by providing transport — a recognition of the extra challenges some families face.

Hargreaves et al. (2008) and Olsson, Boyce, Toumbourou, & Sawyer (2005) note possible risks associated with peer support programmes for COPMI, based on theoretical risks identified for a peer support programme for adolescents with chronic physical illness. Bearing in mind (to the writer’s knowledge) no actual research has revealed these risks in COPMI peer support programmes, they are: the risk associated with receiving disturbing information about mental illness; the reduction in external peer networks because of attending the COPMI peer group; and the group developing a subculture in which they feel different from normal adolescents (Hargreaves et al., 2008; Olsson et al., 2005). Both authors note these are easily ameliorated. In relation to the latter two concerns, I argue stigma and isolation are the norm for many COPMI, this subculture already exists, and they have few external networks, therefore a reduction in peer networks is not an issue. Consequently, peer support programmes are important for youth who experience stigma due to the mental illness of family members (Bottrell, 2009b; Sanders et al., 2014). In relation to mental health education, this is addressed in the following sub-section.

Reupert and Maybery (2009) highlight gaps in peer support service provision. Many programmes do not gather intake data on parental mental health diagnoses and other socio-cultural information, and the authors argue this hampers service delivery for COPMI given differential needs and risks shown by
the literature. They note the lack of service provision for the sub-group of COPMI with behavioural problems and/or mental health diagnoses. Themes from providers in this review were also valuable, such as the need for comprehensive family support in addition to COPMI peer support; longer programme delivery to better engage children; more consumer driven programmes which may aid family engagement; expanding age groups to include younger and older COPMI; and providing a range of programmes, short and long term, including transition programmes and ongoing support.

**MENTAL HEALTH EDUCATION**

This sub-section explores the way mental health education may be scaffolded by the tertiary relational system.

As noted, best practice advises mental health education begins within the family system, however the peer environment also supports learning about mental illness (Masten, 2015; Munford & Sanders, 2016). It does this in several ways. The first, by providing “proactive engagement within a safe space” (Isobel et al., 2016, p2), referring to the work of Reupert and Maybery (2010). It seems important to emphasise the safe space in relation to the concern noted by Hargreaves et al. (2008) about risks associated with learning about mental illness. Secondly, through provision of an environment which is free from the stigma of having a parent with mental illness, something which may prevent COPMI from fitting in with their peers (Bottrell, 2009; Munford & Sanders, 2016). When each participant has a parent with mental illness and parents have approved the young person’s attendance, a sense of permission occurs (Cooklin, 2006; Reupert, Maybery, Nicholson, et al., 2015). I argue that this sub-culture, which some theorise as a risk, is a strength, and has the potential for many aspects of resilience to cascade from its support.

One advantage of peer support programmes for mental health education is the opportunity to share experiences. In a study of strategies for reducing family self-stigma in the context of parental mental illness, Hasson-Ohayon et al. (2014), referring to the research of Larson and Corrigan (2008), core useful
elements were the sharing of personal stories of hardship associated with mental illness (*narrative enhancement*); and presentations of coping strategies used by consumers and family members to deal with these hardships. It is precisely in the contact of peer support programmes that this may occur for COPMI.

**SCAFFOLDED RECREATIONAL ACTIVITIES**

This section explores a common area of service delivery for children and youth which occurs in many domains, including COPMI programmes: recreational activities. From a socio-ecological resilience perspective, how recreational activities might support resilience in marginalised children and youth is considered. Recreation is defined as “the process or means of refreshing or entertaining oneself; a pleasurable activity”; the origins of the word are derived from a Latin word meaning “create again, renew” (Thompson et al., 1995, p1149). How recreation builds relationship, and its scaffolding effects, begins the section. Peer relationships were noted as essential for resilience, and this section makes a case for recreational activities aiding such relationship formation for COPMI who experience rejection from mainstream peers. Further, recreation as a form of respite is considered through fun and escapism in addition to being away from the stressors and responsibilities of home. As noted, respite is sometimes required for COPMI.

A further aspect of recreation is considered. As outlined, uneven development occurs for some COPMI such as the CRFSS child service-users and other marginalised children and youth, therefore filling developmental gaps is an essential aspect of the pathway to resilience and should be considered in service delivery (Munford & Sanders, 2016). *Development* is understood as normal expectations of physical, socio-emotional and cognitive growth, as appropriate for the cultural context. In this section the role of recreation in strengthening uneven development is explored.

The term *scaffolding* is understood as a support or platform for development unable to be achieved alone (Feldman, 2012; Santrock, 2013; Vygotsky, 1978).
Derived from the work of cognitive theorist Vygotsky, the notion of scaffolding has been generalised to other developmental domains. In the language of resilience theory, the relational systems would be said to scaffold other areas of development (Vygotsky, 1962).

**RECREATION SUPPORTING RELATIONSHIP FORMATION**

It is not surprising that to understand recreation from a developmental perspective requires reviewing the theory of play. Developmentally, children move from solitary play to social play, then to constructive, then on to playing games. Play encompasses social–emotional, physical and cognitive development, and a large part of this occurs socially; recreation which is interesting and fun via collaborate activity is what commonly establishes friendship relationships during childhood and adolescence (Feldman, 2012; Gottman & Parker, 1987; Hart & Damon, 1988; Parten, 1933; Robinson, 2007; Santrock, 2013). Although not delineated in the same manner, the adult–youth mentoring literature found fun and recreation to be mediators of positive mentor—mentee relationships (Spencer & Rhodes, 2005). The COPMI literature does not emphasise the importance of recreation for peer relationship formation, rather this appears to be presumed.

**RECREATION AS RESPITE**

This section considers how recreational activities provide respite through having fun. As outlined, COPMI may benefit by having respite from caring roles and/or stressful home situations (Cresswell, 2017; Charles et al., 2009, 2012; Hosman et al., 2009; Mordoch & Hall, 2002; Reupert & Maybery, 2016).

The definition of *respite* is rest or relief from obligations and cares (Thompson et al., 1995). The definition of *recreation* implies renewal and refreshment through doing something enjoyable, as does the notion of play. It could be argued that engaging in recreation is respite from other aspects of life. Respite is important because the Western notion of childhood and adolescence presumes a level of freedom from adult responsibility and minimisation of stress for healthy development (Cicchetti & Curtis, 2006; Curtis & Nelson, 2003;

For COPMI, respite may occur by physically being away from the pressures of home. Respite may also occur via engaging in fun activities. If these experiences are scaffolded by an environment in which COPMI feel safe with workers and their peers, how enhanced might respite be?

The existentialist notion of existential joy may be useful in understanding recreation as respite, although the complexities of this perspective are beyond the scope of this thesis (Dick-Niederhauser, 2009; Kast, 1991; Popovic, 2002. With the notion of fun and joy in mind alongside the context of play or recreation, Popovic’s hypothesis that existential joy transcends “so called ‘existential anxiety’” may apply (2002, p32). Although the definition of existential joy and anxiety is different from ordinary joy and anxiety, in the context of therapy, Popovic (2002) argued these ordinary moments offer a prospect of recovery. It is possible that moments of ordinary joy for COPMI through recreation could provide fleeting moments of a different life; seeds of hope, thus strengthening resilience.

**RECREATION AS A MEANS OF ‘FILLING THE GAPS’**

To understand the notion of scaffolded recreation as a conduit for supporting full, holistic development requires linking several groups of literature: the cascading effects of the primary relational system on other areas of development (Masten, 2001, 2015); the notion of sensitive periods during childhood and adolescence and the phenomenon of late bloomers, (Cicchetti, 2013; Luthar & Brown, 2007; Masten, 2015); and the principles of socio-ecological, resilience-focused practice of ‘filling the gaps’ when supported by worker–service–user relationships (Munford & Sanders, 2016). I suggest that when COPMI feel a sense of belonging in relationship with workers or peers, recreational activities are likely to be enhanced and therefore the possibility of developmental gains is heightened and the potential for resilience is increased.
As noted by Masten (2015, pp8,9), opportunities exist to intervene in relation to resilience, and recreation may be one such opportunity:

It turns out that many of the most strategic ways to prevent and ameliorate problems in development may be to promote competence and success ...

As stated, it is through age and culturally appropriate play and recreation that most physical, cognitive and socio–emotional childhood and adolescent development occurs, including a sense of competency: ‘I can do this’ (Feldman, 2012; Robinson, 2007; Santrock, 2013).

Literature linking the concepts of secure relationships scaffolding recreation, following by recreation as a deliberate strategy for developmental gains, was unable to be located. The closest were findings from the A/NZ resilience study (Munford & Sanders, 2016). Munford and Sanders (2012, 2016) link this process with Bolzan and Gale’s notion of ‘interrupted spaces’ which promotes adults scaffolding youth by supporting them to find positive opportunities to exercise their own agency and coping (Halvorsen, 2009; Van Breda, 2014).

The COPMI literature does not appear to link the concepts, although it does comment on the importance of mastery, competence and agency to counter stigma and general risk, and for COPMI who require extensive support due to complex parental illness factors (Gladstone, 2015; Reupert & Maybery, 2015; van Santvoort et al., 2012). One peer support programme with an added personal coaching component was identified which had a goal of assisting COPMI to gain a “sense of mastery and purpose ... and autonomy” (Foster et al., 2014, p62; Yu, 2011).

Reviews of physical activity programmes for at risk children and youth offer some context for this topic as these are purposeful physical activities designed for holistic benefits in addition to physical gains. Three broad classifications are noted in the literature, two of which are relevant to this context Lubans, Plotnikoff, and Lubans (2012, pp1–2):
• Outdoor adventure programmes – experiential learning; range of activities such as canoeing, rock climbing, camping trips away.

• Sport and skill–based programmes – organised sport offering team and individual competition; skill–based usually for younger children targeting motor skills.

Despite anecdotal evidence that these activities are beneficial, reviews noted limited evidence from empirical studies and/or methodological problems in all classifications (Lubans et al., 2012; West & Crompton, 2001). However, Lubans et al. (2012, p9) conclude that all have benefits. Regarding outdoor adventure programmes, the authors summarise:

...it appears that outdoor adventure programmes have the potential to improve resilience and self–concept in at–risk youth.

The context of an ‘unfamiliar environment’ in which “calculated risk taking”, mastering difficult tasks and support from peers and instructors is noted by Lubans et al. (2012, p9) citing the work of Gass (1993) as possibly the most important part of these programmes.

The review of organised sport programmes lists positive child–adult relationships, physical exertion, and the development of prosocial behaviours via interaction with others and achieving mastery of certain skills (Lubans et al., 2012), reviewing the work of Robinson, Rudisill, and Goodway (2009) and Sandford, Armour, and Warmington (2006). Lubans et al. (2012) query the large gains in self–esteem in child and youth participants in a Singaporean sports challenge programme as most probably due to the minimum three years of follow up mentoring provided (Tester, Watkins, & Rouse, 1999). As expected, reviews of skill–based programmes show improvements in targeted areas of physical competence (Gass, 1993; Lubans et al., 2012; Robinson et al., 2009; Sandford et al., 2006; Tester et al., 1999). Despite methodological concerns and the need for further research, this literature suggests physical recreational activities may result in developmental enhancement.
Two final points need to be stressed. First, the obvious need for scaffolded recreation to be both age and stage appropriate and adapted to individual and cultural needs; as emphasised, marginalised youth often have uneven development, flourishing in some areas but languishing in others (Munford & Sanders, 2016). Secondly, mainstream resilience theory notes reignition of mastery motivation is an important indicator of change (Masten & Obradović, 2006). Masten and Obradović (2006) emphasised the significance of social context and interaction in the rekindling of mastery motivation. Masten (2015, p165) summarises:

...there may well be complex interplay among the processes of motivation, relationships, opportunities, and goal formation that converge for positive change in late bloomers.

Other people can support this process, as like the self-regulation system, the motivation system continues to develop and adapt over the lifespan, and who better to do this than a supportive peer group. In the context of late bloomers, as were the young people in the A/NZ resilience study, it was mastery motivation which was one of the first indicators of change (Masten & Obradović, 2006; Munford & Sanders, 2016; Munford & Sanders, 2015b).

Two important points are relevant to rekindling the mastery motivation system: opportunities for stepped, age-appropriate mastery experiences; and providing a social context in which this may flourish (Masten, 2015, pp161-162):

...there is something profoundly social about the development of the mastery motivation in human children. This system emerges in the context of social interaction in the family, with peers, and with teachers, and the joy of mastery appears to be enhanced in the context of positive attachment relationships.

An environment scaffolded by safe worker and peer relationships such as at the CRFSS recreational days or those commonly offered by COPMI peer support programmes seems an ideal opportunity for this to occur.
MEASURING RESILIENCE IN SERVICE DELIVERY

In an environment in which NGOs are expected to provide evidence of the efficacy of their service delivery, socio–ecological resiliency theory offers a different perspective on measurements of resilience and effective service delivery.

Early mainstream theory promoted standardised, objective measures, with the individual as the locus of change, the main idea being individuals exercise personal agency to access opportunities for self–efficacy, sense of coherence, self–esteem and prosociality (Ungar, 2012b). Although mainstream theory has moved on from this to a degree, Ungar (2012a) argues the underlying individualistic approach to measurement embraced by Western psychological sciences has not.

The contextualised approach of socio–ecological resilience theory lends itself to measurements which reflect (Ungar, 2012b, pp14,15):

- Interactional, environmental and culturally pluralistic perspectives;
- Complexity in reciprocal person–environmental interactions;
- Outcomes negotiated with research participant to ensure contextual relevance;
- The social and physical environment as the locus of resources for personal growth.

An important facet is ‘meaning’. Meaning is understood as the factors which determine how people decide which resources are valued and they will access (if their environment allows this), and the “relative power of each individual in the social discourse to influence the definition of what resilience looks like” (Ungar, 2012b, p23). This equates to the valuing of local knowledge in service design and evaluation, as outlined.

Socio–ecologically informed measures of resilience have been developed. Two examples are the Child and Youth Resilience Measure (CYRM–28), developed by an international team of investigators, which measures resilience across
cultures; and a multi-dimensional resilience assessment tool for diagnosing childhood resilience which is sensitive to systemic factors (diagnosing is understood as assessing wellbeing under stress) (Ungar & Liebenberg, 2011; Ungar, 2015). The broader context of evidence-based practice in the A/NZ NGO sector is discussed in Section 4 of this chapter.

SECTION 3 SUMMARY

In this third chapter section, socio-ecological, resilience-focused service delivery for COPMI and their families has been explored, with an emphasis on families with parents who have severe and chronic mental illness.

The socio-ecology of COPMI service delivery revealed variations in how COPMI service delivery is supported. Efficacy of COPMI service delivery looks promising from one large systematic review; other scholars urge more quantitative evidence. Little differentiation occurs in COPMI service delivery for variances in family needs and risks. It was argued that as risks are now able to be predicted, service delivery should match differential risks, and Falkov’s ‘Continuum of Need’ was suggested as a triage tool, in combination with the work from the Netherlands on using risk and protective factors as a guide to programme delivery.

Four aspects of service delivery were explored which were argued to meet the relational, comprehensive and individually contextual needs of CRFSS service-user families: relationship-based practice (RBP), comprehensive family practice, COPMI peer support as an anti-stigma intervention, and scaffolded recreation.

RBP, the notion of professionals as secondary relational figures, was investigated from four genres of literature: social work RBP and adult mental health case management in relation to worker–adult service–user relationships; and recognition theory and adult–youth mentoring for worker–child service–user relationships. The adult–youth mentoring material linked seamlessly with comprehensive family practice, as it revealed that for children
and youth facing risk across several domains, mentoring itself was insufficient and comprehensive, multi-pronged, whole family service delivery was essential. Comprehensive family practice for marginalised service-user groups was reviewed from other perspectives, the most important being socio-ecological resiliency theory. COPMI peer groups as an intervention to counter stigma experienced by COPMI was considered in relation to how supportive peer relationships could ameliorate this. Various forms of peer support service were summarised, and arguments made for the scaffolding effect of peer support in mental health education for COPMI. The final aspect focused on the recreational aspect of CRFSS service delivery for child and youth service-users. Recreation was contended to not only aid the formation of worker and peer relationships, but these relationships were argued to scaffold recreational experiences, thus enhancing experiences of respite and enabling possibilities for developmental gains.

The issue of measurement was considered, as a socio-ecological resilience-focused perspective is entirely different from current use of mainstream resilience informed measures based on early phases of theory development. Alternate measurements and assessments were located, grounded in the principle of the theory.

To conclude, I argue that these four aspects of practice, offered in a sustained fashion to the whole family system, have the potential to create a different socio-ecology: an environment which enables service-user families to locate culturally meaningful, health-sustaining resources and experiences and be supported to negotiate and navigate towards these. Such service delivery supports all relational systems, thus enabling resilience to cascade. That it is sustained and comprehensive allows for responsiveness, flexibility and contextually appropriate interventions which enable other tensions and mediators of resilience to be strengthened.
SECTION 4: THE SOCIO–ECOLOGY OF NGO SERVICE DELIVERY IN AOTEAROA NEW ZEALAND

Individual resilience occurs when there is an opportunity structure (an environment that facilitates access to resources) and a willingness by those who control resources to provide what individuals need in ways that are congruent with their culture (Ungar, 2013, p256).

This section examines what influences the control of resources for individuals and services in A/NZ. I will argue that the opportunity structure for individual resilience does not exist for CRFSS families and other marginalised groups, and the state is unwilling to provide what is needed for the negotiation and navigation of resilience. The focus of this section will be the socio–ecology of NGOs in A/NZ, barriers to the resilience of the sector, and what might enable them to be more resilient and therefore able to meet the resilience needs of their service–users.

As outlined, Munford and Sanders (2016) found social services in A/NZ could be an added risk for vulnerable young people due to waitlists, criteria for access, changes of workers, brief interventions, and inflexible and narrow service delivery. This section discusses theory relevant to socio–political influences on NGO social service delivery in A/NZ, so research findings may be positioned and analysed in this wider context.

Thus far this chapter has highlighted the significant impact of social and cultural factors such as poverty and stigma on the resilience of COPMI and their families, criticising “aspects of developmental and individual–level analyses in the resilience literature” (Bottrell, 2009b, p321; Garrett, 2015; Sanders et al., 2013; Ungar, 2011). This section argues that the macro context exerts the most influence as this is where the predominant power lies. Indeed, all aspects of the health and wellbeing of a country and its people are impacted through macro factors such as economic systems, employment, health, education, and social service policy and delivery (Aimers & Walker, 2016; Larner & Craig, 2002, 2005; Walker & Shannon, 2011).
Socio–ecological, resilience—focused practice is also impacted by macro factors. The broad socio–political sphere in which social service delivery occurs either enables or opposes these principles of practice, and it is argued in the A/NZ context, working in a resilience–focused manner is threatened, if not actively opposed, by two sources in the socio–political sector. The first, state logic based on neoliberal ideology and its resultant impact on social service structures, policy, delivery and funding, sits in opposition to socio–ecological perspectives of resilience (Larner & Craig, 2002, 2005; Garratt, 2010. The second arises from the first: the necessary funding partnerships between NGOs and the state (Aimers & Walker, 2011, 2015, 2016; Walker & Shannon, 2011; Larner & Craig, 2002, 2005). This ‘marriage’ has occurred for the most pragmatic of reasons — survival.

Organisations such as the CRFSS and its umbrella organisation – Stepping Stone Trust (SST) – are examples of the organisational hybridisation process experienced by many NGOs in A/NZ over the past twenty years state (Aimers & Walker, 2011, 2015, 2016; Billis, 2010; Brandsen, Van de Donk, & Putters, 2005; Walker & Shannon, 2011; Larner & Craig, 2002, 2005). Hybridisation refers to the mixture of “types, cultures, coordination mechanisms, rationalities or action logics” (Aimers & Walker, 2016, p2667) which occur in third sector organisations due to these partnerships, and is typically more common in countries “where the state has historically and structurally weaker engagements with issues of social equity and where neoliberal reforms have been most forcibly enacted” – as is the case in A/NZ (Brandsen et al., 2005; Larner & Craig, 2002, p2). These funding mechanisms drive hybridity, and thus, threaten or change actual service delivery (Aimers & Walker, 2016). This is because differing ideological positions of each partner influence how the actors within each partnership think and behave. In the usual partnership of NGO—state, their positions are usually diametrically opposed, particularly during early stages of collaboration. As discussed, these differing ideologies are exampled in the resilience literature itself in terms of which aspects of resilience theory are emphasised by some parties, and which are ignored (Bottrell, 2009b; Ungar, 2012b).
Thus, in this section, concepts and definitions related to *organisational hybridity*, *institutional logics*, and the sociological concept of *social capital* relevant to NGO service delivery in A/NZ will be summarised. This will be followed by an exploration of state logics in A/NZ, noting the contributions of Keynesian welfarism and neoliberalism over the past 40 years, community logics, and the relationship and inevitable clashes between these two positions. The implications of these ideologically informed logics on social service delivery at micro, meso and macro levels will then be examined, with emphasis on the hybridising impact on NGOs partnered with the state and resultant service delivery models. Strategies for enabling NGOs to be more resilient are reviewed from the A/NZ research of Walker and Shannon (2011).

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**ORGANISATIONAL HYBRIDITY**

Organisational hybridity refers to organisations assimilating logics from multiple sectors as they adapt from a pure community organisation for pragmatic reasons — sometimes because of organisational growth, but usually due to the need to seek reliable funding contracts (Aimers & Walker, 2016; Billis, 2010; Brandsen et al., 2005).

The hybridity lens developed by Aimers and Walker (2016, p2668) to facilitate understanding how hybridisation influences organisations that “seemingly resist interference from larger organisations within the third sector or from the state and private sectors” will be used to explain interactions and changes that occur due to state–NGO partnerships. This lens combines Billis’ (2010) typologies to measure hybridity depth (inter–sectorial hybridity), and Brandsen et al’s (2005) analytic types to measure hybridity levels (intra–sectorial hybridity). In both cases, types are best seen as ideals, and most organisations are hybrids of several types to some degree.

Billis’ types of inter–sectorial hybridity are (paraphrased from Aimers & Walker (2016, pp 6–7) and Billis (2010, pp 241–244):
• Pure Organisations – volunteer/member based with a strong sense of collaborative mission and legitimacy, and accountable exclusively to members, may be financially fragile;

• Organic Organisations – lack of clarity about identity within third sector begins to emerge, conflict of interest in mission, accountability, legitimacy and financial survival;

• Organic Shallow Hybrids – significant volunteers but small numbers of paid staff, high degree of overlap in governing, paid worker, volunteer, member and supporter roles. Strong shared mission, however paid staff may influence this;

• Organic Entrenched Hybrids – grown steadily due to state contracts or commercial initiatives, multi-level hierarchy of paid staff, senior staff seen as principle owners, mission drift as power balances shift from volunteers to paid staff;

• Enacted Organisations – hybrids from the outset, often supported or partnered by the state;

• Enacted Shallow Hybrids – established for short-term purposes, may not have any resources independent from the state;

• Enacted Entrenched – established with significant state backing and therefore influence on purpose and governance. Likely to have no volunteers. May include some social enterprise organisations.

Brandsen et al’s (2005) analytical third sector types depict NGOs as ‘caring organisations’ and categorise them depending on how caring is expressed. Aimers & Walker (2016, p2671) summarise:

• Indirect Other – caring for the ‘indirect other’, usually in the political area as well as a practical level;

• Tangible Other – caring for the ‘tangible others, via union–like associations which offer services to members;

• Communities – caring within communities, may originate from families or open or closed communities, tend to be less formal than other types;

• Professional – provide caring services to a range of service–users, may have grown beyond the original organisation.

CRFSS was classified as an organic shallow hybrid from the outset, according to inter-sectorial hybrid. SST began in a similar fashion, but due to state contracts,
hybridity deepened resulting in an organic entrenched typology. Some areas of service delivery could be designated as enacted entrenched due to state initiation and influence. From the perspective of Brandsen’s intra-sectorial hybridity, both CRFSS and SST would be professional organisations (Aimers & Walker, 2016; Brandsen et al., 2005).

Walker and Shannon’s (2011, pii66) model adds another classification for NGOs which categorises organisations according to differing initiation points in state partnerships:

1. **Top–down directed**: state–initiated projects with centrally defined objectives and protocols.
2. **Top–down encouraged**: state establishment of a broad field of funding with relatively indeterminate objectives and protocols.
3. **Bottom–up**: locally initiated but seeking state acknowledgement and support.

Both CRFSS and SST began as bottom–up organisations. SST sits somewhere between top–down encouraged and top–down directed, as although most areas of service delivery are initiated by the organisation, contractual funding ties the organisation to centrally defined objectives and protocols. As outlined, the move from the A/NZ Ministry of Health (MOH) to implement guidelines for COPMI service provision has meant CRFSS has moved to a top–down encouraged service (MOH, 2015). The problem the service faces is that in this contractual funding environment, it is likely that pressure will be placed on it to become top–down directed.

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**INSTITUTIONAL LOGICS**

Organisational types have differing institutional logics (Aimers & Walker, 2016; Brandsen et al., 2005; Billis, 2010). Many authors have contributed to decades of study of institutional logics. This thesis draws on the more recent work of Thornton, Ocasio, and Lounsbury (2012) due to its incorporation of past theory and easy application to the partnership issues relevant to this thesis. The term
Institutional logics is a metatheoretical framework used to denote the broad beliefs, ideologies, and positions held by institutions, which “provide meaning to their daily activity, organize time and space, and reproduce their lives and experiences” (Friedland & Alford, 1991; Little, 2015; Thornton et al., 2012, p2).

The social world incorporates many institutions, sometimes known as interinstitutional systems, institutional orders, or social subsystems (Friedland & Alford, 1991; Thornton et al., 2012; Thornton, 2004). Categories of interinstitutional systems from the work of Thornton (2004) and Thornton and Ocasio (2012) are: the family, the community, religions, the state, the market, the professions and the corporation. Each system has its own source of legitimacy, authority, norms, attention and strategy, and informal control mechanisms and economic systems (Thornton et al., 2012).

Most relevant to this thesis is recent empirical research that considers the pluralistic nature of institutional logics, using the work of Bourdieu as a springboard (Bourdieu, 1977, 2011; Larner & Craig, 2002; Thornton et al., 2012; Thornton & Ocasio, 2008).

Competing institutional logics are at the heart of the story of CRFSS and determine to what extent research results from this investigation are valued and contribute to future practice.

STATE LOGICS

State logics emanate from the system of government in power, and in A/NZ, this includes the standard governmental responsibility for the care and control of citizens but also incorporates ideologies from several developments of neoliberalism. Neoliberalism, in its pure sense, promotes individualism, free choice, self-sufficiency, independence, and contribution to society, along with freedom of the market and reducing or limiting government intervention in the lives of individuals (Cheyne, O'Brien, & Belgrave, 2008; Cummins, 2016; Garratt, 2010; Keddell et al., 2016; Larner & Craig, 2002, 2005).
Neoliberal restructuring in Aotearoa A/NZ has occurred in three distinct phases and has been of significant international interest (Gray, 1998; Larner & Craig, 2002). Larner and Craig note these phases (waves) (2002, 2005):

1. The first wave - 1980s, when the state withdrew from many areas of economic production whilst preserving and extending the welfare and social justice goals associated with social democracy.

2. The second wave - Early 1990s, noted as the more punitive phase, in which the programme of marketisation was extended, and neoconservative and/or authoritarian social policies and programmes were added.

3. The third wave - In the late 1990s the partnering ethos and social investment in economic and social policy emerged, referred to by the authors as the post–neoliberal social governance phase.

These further phases of neoliberalism have incorporated the market provision and solution model across all domains of governance, including social policy and service delivery; and consensus welfarism, otherwise known as ‘the greater good’. Consensus welfarism is a generalist approach which arises in part from the market model, in which the needs of the majority are deemed most important, resulting in dismissal or exclusion of minority voices. (Cheyne et al., 2008; Craig & Porter, 2005; Crossley, 2016; Hackell, 2016; Houston, 2013; Jenkins, 2005; O'Brien, 2016; Larner & Craig, 2002; Shannon & Walker, 2006).

Described by Hackell (2016, p868) as “self–reliant prudentialism” and Jensen (2013) as ‘austerity parenting’, these narratives frame social problems such as parents with mental illness as the moral failure of individuals, and parents whose children are deemed at risk as bad, with good parenting seen as the remedy or removal of the child (Crossley, 2016; Featherstone, White, & Morris, 2014a; Houston, 2013). The role of structural disadvantage is not a factor in this equation (Houston, 2013; Garratt, 2010; Featherstone et al., 2014a). Hackell (2016, p868), citing a term coined by Isin (2004), frames this as “governing through neurosis”; it lessens the sense of social responsibility the public feel towards the poor, thus minimising citizen anxiety, which they argue is embedded in state neoliberalism.
Ecological contributors are similarly excluded in neoliberal policies which incorporate the ‘language of individual resilience’ and omit wider ecological aspects, as discussed (Bottrell, 2009a; Bottrell, 2013; Garrett, 2015; Ungar 2011, 2012a). This discourse allows an easy and dangerous amalgam. Similarly, the individualistic approach emanating from state logics is evident in the COPMI literature (Gladstone et al., 2006; Price-Robertson et al., 2016).

BOURDIEU AND CAPITAL

The sociological notion of capital originates from the work of Bourdieu (1993a, 1977, 1997) and contributes to the socio–political discussion through providing a conceptual lens to analyse dynamics occurring for individuals within NGOs, and the NGOs in the wider funding world. This section outlines definitions and concepts from Bourdieu’s work relevant to this thesis. Extensive use is made of Roxborough’s recent application of Bourdieu’s writings (2016).

Roxborough (2016) explains that from Bourdieu’s perspective, individuals operate in individual social games and each game can only exist when members choose to be part of it (Bourdieu, 1990a, 1993a). To any individual social game, members bring their habitus, which consist of past and present experiences contributing to an individual’s current state (Bourdieu, 1990a, 1993a, 1997; Roxborough, 2016). Bourdieu’s concepts may also be applied to organisations. They too operate in a variety of social games, and each organisation has its own habitus — separate but interlinked with the habitus of key stakeholders within the organisation, both past and present.

Individual and organisational social games exist within a much wider cultural and societal environment known as the field of power (Bourdieu & Wacquant, 1992; Roxborough, 2016). The logic of the field of power relates to how individual social games are played within it; this logic, as with institutional logics, is ‘uncontested and unconscious truths’ — otherwise known as doxa (Bourdieu, 1990a; Roxborough, 2016). Doxa refers to what seems natural and normal. Bourdieu and Wacquant (1992) argue that as individual players and
organisations are unaware of doxa, its logic can only be uncovered via the application of sociological tools (Roxborough, 2016).

It is the skills gained from operating in differing games during the process of habitus that Bourdieu labels capital (Bourdieu, 1990a; Roxborough, 2016). Bourdieu (1977) states capital presents itself in three fundamental guises: economic capital, cultural capital, and social capital. These ‘accumulated relational tokens’ define how skills and power are used, and opportunities for domination of others within the social game (Bourdieu & Wacquant, 1992; Bourdieu, 1993b). Roxborough (2016, p12) summarises Bourdieu (1993b):

...those with the capital that best matches the requirements for playing the game, take a position of high status or power in the field called the dominant. Those, for whom the match of capital is not so good, or non-existent, take a position of low status in the field called the dominated.

‘To dominate or be dominated’ also applies to organisations. Thus, each organisation has high or low status in the field, depending on whether they have the right type of capital, as do individuals within the organisational field of power. Success in social games is about how well the capital of an individual or organisation aligns with the capital privileged by the field (Bourdieu, 1990a, 1990b; Roxborough, 2016), implying what is most important is being aware of what capital is valued, and ensuring one’s capital aligns with what is required. Bourdieu calls this “a feel for the game”.

The term social struggle is used by Bourdieu to describe the “necessary struggle between dominated and dominators (p15)” (Roxborough, 2016). This power play is one of the rules of the game. Both parties are necessary for the game’s survival: the dominators fight to maintain their position by ensuring the capital they possess and utilise is privileged; and the dominated, although in a more passive position, experience suffering. This struggle sometimes results in the dominated (Bourdieu, 1993b), in (Roxborough, 2016):

...seeking to alter or rewrite the field parameters, albeit in vain, to attempt to bring a change in their position (p15).
What does this mean for NGOs operating in a field of power in which the state is the dominant player? Is the struggle hopeless? One of the difficulties with these power dynamics is their unconscious and uncontested nature, as stated above. The beauty of Bourdieu’s work is that it provides a thinking tool by which to make explicit and analyse the habitus, doxa, positioning and power play of those operating in the field; in this context, the state and NGOs (1992).

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COMMUNITY LOGICS

Where state logics are reflective of the ideology of the ruling government party and able to be clearly articulated, community logics differ as they represent the diverse needs of those living in communities. Community logics are pluralistic, inclusive, non-universalist and tend to be drawn from the bottom-up. Importantly, they incorporate the needs of individuals as well as the group (Larner & Craig, 2002; Thornton et al., 2012). Larner and Craig (2002, p12) conclude, citing (The Community and Voluntary Sector Working Party, 2001):

*The ‘inclusive’ community is now understood as intrinsically pluralist, the parts of which cannot be summed into total sets of interests such as class, ethnicity or gender … A single body will not be able to act as the voice of the community and voluntary sector, hence an ongoing need to work with diversity or pluralism.*

The ideology of the community is derived from its meaning: Shared location, facilities, relationships, and interests (Thompson et al., 1995). Craig (2007) provides three basic meanings: a geographic community; a community of identity; and an issue-based community. Regardless of differing types, Thornton et al. (2012) notes the community’s legitimacy arises from a sense of unity of will, a shared belief in trust and reciprocity. Authority arises from shared commitment to community values and ideology, people obtain community identity from their relationships with others in the community, and norms arise from the group members.

Community organisations therefore reflect these ideologies, particularly the pure organisation using Billis’ typology, otherwise known as a community
development organisation (Aimers & Walker, 2015; Billis, 2010). As would be expected, community organisations differ from each other, thus reflecting the multiplicity of this kind of institution (Aimers & Walker, 2016).

A type of pure organisation unique to the A/NZ context is based on kaupapa Māori ideology. As noted by Aimers and Walker (2015, p3), this genre of organisation existed pre-colonisation, and values a society which is “communal, holistic and with a sacred relationship with the natural world”, therefore, congruent with community logics. It is a requirement for all social policy and social service delivery in A/NZ — including the state — to uphold and honour bi-cultural practice in accordance with Te Tiriti o Waitangi (the Treaty of Waitangi) (Aimers & Walker, 2015; Durie, 2005; Eketone, 2013; Eketone & Shannon, 2006). The implications are that all aspects of social policy and service delivery should reflect kaupapa Māori values, regardless of state logics. Implicit also in community logic is the consumer voice of those who receive services from organisations: in this context, the voice of mental health service users in research.

Although CRFSS and SST began as faith-based initiatives, as did many NGOs throughout A/NZ, the logics of religion are less relevant, given the independent nature of both organisations from the outset. What was retained from their beginnings is congruent with community logics.

IMPLICATIONS

These differing logics affect all areas of life, particularly for those who need social services such as the service-user group in this research context, and the organisations such as CRFSS and SST who provide them. This section considers these implications across the macro, meso and micro systems of A/NZ.

28 Kaupapa Māori – Māori approach, Māori topic, Māori customary practice, Māori institution, Māori agenda, Māori principles, Māori ideology – a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society.
The results of state logics at a macro level in A/NZ are numerous. More stringent social policies have developed for those most affected by the “withdrawal of the social and economic protections of earlier times” (Keddell et al., 2016, p1), summarising the work of Harvey (2005) and Wacquant (2009). The resultant approach to economic growth shows itself in many ways, including increasing disparity between rich and poor, a less stable job market, higher unemployment, a more punitive approach to crime and imprisonment, and failing systems of education, health and housing (Cummins, 2016; Gray, Dean, Agilias, Howard, & Schubert, 2015; Garratt, 2010; Keddell et al., 2016). Larner and Craig (2002, p12) adds this is:

...cross cut by new patterns of territorialized, gendered and racial inequality).

For parents with mental illness and their families — already socially disadvantaged and marginalised — these effects add to their burden. Similar impacts are noted internationally in both the Western and Majority worlds (Craig & Porter, 2005; Larner & Craig, 2005; Muchacha, Dziro, & Mtetwa, 2016). Although it is not the intention of this section to discuss the intricacies of neoliberalism in A/NZ, some aspects which are relevant to understanding the effects on state–NGO partnerships and social service delivery will be outlined.

The influence of Keynesian welfarism on social governance and resulting partnerships with NGOs is noted in the literature, particularly the change from governance as a broad understanding of all areas of government, to governance by official agencies, each in separate silos (Cheyne, O’Brien, & Belgrave, 2000, 2008; Larner & Craig, 2002; New Zealand Productivity Commission, 2015a). Larner and Craig (2002) argue that the retention of this siloing by each wave of neoliberalism is not conducive to the state–NGO partnership model.

Furthermore, the inclusion of the social domain (the intermediate sector) into the state domain with its economic focus, has significantly reduced the role and influence of NGOs in the formation of policy and provision of services (Dalley, 1998; Hawke, 1985; Larner & Craig, 2002; McClure, 1998). Moreover, sectoral
specialists who determined direction, hierarchical structures, separate silos, and an institutional logic that supports consensus welfarism, have dominated the sector (Dalley, 1998; Hawke, 1985; Larner & Craig, 2002; McClure, 1998). This has resulted in both distancing from the needs of individuals, and from professionals and organisations outside of the public sector (Larner & Craig, 2002; New Zealand Productivity Commission, 2015a). Larner and Craig (2002) argue that it is important to understand this pre–neoliberalism history, as it explains politically how the country was set up for what we are now experiencing: Overarching national frameworks (welfare state consensus) which are segmented rather than pluralised and contested, and the marginalisation of groups such as women, Māori and non–European migrants.

Although the community logic voice was heard during this period in terms of protesting the consensus model of welfare, state–NGO partnerships were not promoted or even an option, as from the community’s perspective, the state was the enemy (Larner & Craig, 2002). However, the third wave of neoliberalism did contain the seeds of partnership; as the ‘new public management’ gave rise to central steering, with monitored and accountable subordinates including local organisations, the increased power of treasury produced a strong emphasis on auditing and contracting of services (Larner & Craig, 2002, 2005). “Competition, accountability and consumer demand” have become as important as other welfare expertise (Larner & Craig, 2002, p8; Rose, 1993; Powers, 1997; Yeatman, 1995). This new focus on core business and outputs resulted in the appointment of managers with generalist skills in the upper hierarchies, and expertise in specific domains was contracted out, thus opening the doors to state–NGO partnership — now the source of specialist knowledge and experience (Cheyne et al., 2000; Larner & Craig, 2002).

This third wave of neoliberalism recognised that earlier forms were not working, and social problems could not be solved by a market model or top–down approach (Aimers & Walker, 2008; Chatterjee et al., 1999; Craig & Porter, 2005; Jenkins, 2005; Larner & Craig, 2002, 2005). Consequently, there was a move to
inclusivity, partially influenced by Māori and their push for *tino rangatiratanga*\(^{29}\) (Larner & Craig, 2002). This broader context was posited as *post–neoliberalist* by some, and Larner and Craig (2002) argue it produced a different form of social governance again, termed the ‘social investment approach’, and marketed in A/NZ as the ‘Community Investment Strategy’ (Jenson, 2010; Ministry of Social Development, 2015, 2016; Sawyers, 2016; Tolley, 2015; Perkins, Smyth, & Nelms, 2004; Van Kersbergen & Hemerijck, 2012). Proponents believe a social investment approach is “a return to more inclusive aspirations of social democracy” (Larner & Craig, 2002, p11).

This is strongly disputed. Larner and Craig (2002), joined by Aimers & Walker (2008, 2015), Craig & Porter (2005), O’Brien (2016) and Sawyers (2016) argue the social investment approach has underlying logics which subordinate the social to the economic, and considers the collective but ignores pluralistic perspectives and needs.

What all parties did agree upon was the need to return to a whole government approach (Larner & Craig, 2002, pp12-13):

> ...for co-ordinated responses involving multiple agencies and ‘circuit breaker teams’ to develop solutions to apparently intractable social problems. The need for increased interaction with local institutions and community organisations, by adapting and building on successful models of local coordination, is also emphasised.

Although this whole government approach has not occurred, the stage was set for partnerships with local initiatives who represent local needs, the voice of experience and technical expertise (Larner & Craig, 2002; New Zealand Productivity Commission, 2015a; The Advisory Group on the Review of the Centre, 2002).

Many scholars argue the social investment approach employed in recent changes to the child welfare system and legislation in A/NZ is a narrow

\(^{29}\) (noun) self-determination, sovereignty, autonomy, self-government, domination, rule, control, power.
interpretation derived from neoliberal values (Garratt, 2010; Keddell, 2016; Hackell, 2016; Houston, 2013; O’Brien, 2016; Parton, 2016; Sawyers, 2016; Webster & McNabb, 2016). In a comparison between the White Paper for Vulnerable Children and the Munro Report into the United Kingdom child protection system, Hyslop (2013, p643) states the A/NZ government has chosen to ignore a key finding of the Munro review; “the alliance of scientism and managerialism” of child protection social work, to the detriment of relationship–based practice. Instead, Hyslop (2013, p4) argues that the White Paper for Vulnerable Children is:

...underpinned by neoliberal conceptions of individuated responsibility which conflict with the socially situated and relational understandings which are native to the theory and practice of social work.

**MESO**

Social policy and service delivery implications at a meso level are experienced by the intermediary layer of the community and voluntary sector. These implications affect the staff they employ, service delivery, administration of the organisation, the type of organisation they become, the overall survival of the organisation, and intra– and inter–organisational and inter–sectorial relationships.

As outlined, the state and NGO sector hold differing logics. These logics compete, and who wins the competition depends on who holds the power. As noted by Walker and Shannon (2011), power is determined by where decisions are made. Walker and Shannon apply the civil service management strategies identified by Kickert, Klijn, and Koppenjan (1997) in terms of types of decision–making: instrumental, interactive and institutional. Instrumental being a decision–making approach in which a few have the control; interactive is an open, mutually engaged and inclusive form of decision–making; and institutional decision–making is an organisational approach which gradually builds more variety into networks through use of social capital (Bourdieu, 2011; Walker & Shannon, 2011).
Using this frame, it is clear power is held differently in each approach. In the instrumental strategy, power is held by the main player — in this context, the state who controls the funding contracts. The interactive approach aligns with pure organisations and a community development approach. The institutional strategy is significant as it implies a way forward for organisations who feel powerless, particularly in the context of hybrid relationships (Walker & Shannon, 2011).

Recent evidence of the outworking of state policies and practices is exemplified in the ‘2016 State of the Sector Survey’ by ComVoices, a network of national organisations representing tangata whenua, and the community and voluntary sector (ComVoices, 2016a). Data confirmed the trend of contracts towards narrowed service delivery and less holistic and flexible family practice. Aimers and Walker (2016) found the current ‘one size fits all’ mentality emitting from state funding and support systems in A/NZ does not reflect the organisational multiplicity present within the sector. Findings also revealed greater demands for service combined with increased complexity of need — in the context of less funding from government (ComVoices, 2016a, 2016b; Radio New Zealand, 2016). Further concerns were extra resourcing required to meet compliance, for example, changes to health and safety legislation, charities reporting, and data requirements from the state (ComVoices, 2016a).

The 2014 – 2015 New Zealand Productivity Commission (NZPC) inquiry into more effective social services in A/NZ revealed these reporting requirements were onerous and detrimental to productivity and innovation (NZPC, 2015a). It found an element of hypocrisy on the state’s part, as it was shown that in–house services provided by government agencies faced “too little testing of whether they achieve high standards and value for money (p8)” (NZPC, 2015a, p8).

The issues surrounding evidence–based practice do not dismiss the need for it, but rather question the methods and resources required. As noted by the NZPC inquiry (2015a), many social services are not currently evaluated, or the evaluations undertaken are poor quality and do not feed back into improved
service delivery and planning. In addition, government agencies were found to be ignorant of the efficacy of differing services and interventions, and of the reasons why this occurs. It follows that stewardship of resources requires accountability, but who decides the nature of the evaluation, what determines these decisions, how this is gathered and resourced, and who holds the data, are all questions raised in the literature (ComVoices, 2016a; Webster & McNabb, 2016).

The NZPC inquiry appears to take a balanced view on many of these concerns. The inquiry supports the Ministry of Social Development Investment Approach which gauges effectiveness of different services, yet found the current prescriptive contracting environment is not working and unsuited to all services and service−user groups and makes recommendations for change (NZPC, 2015a. The Commission notes the two ‘system architectures’ for social services funding and governance (2015a, p9):

- **Top−down control** – means that decision making power primarily sits with the relevant minister or chief executive of the agency.
- **Devolution** – transfers substantial decision−making powers and responsibilities to autonomous or semi–autonomous organisations with separate governance.

The inquiry found top−down control, although common, was a good match for some services, but for others it hindered innovation, reduced inter−agency coordination, and limited the much−needed capacity to tailor services to meet service−users’ needs and local circumstances (NZPC, 2015a). Differing types of service users were categorised into four groups, shown in Table 2.3 (NZPC, 2015a, Figure 0.1, pp2,3).
Types of service users

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Description</th>
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<tbody>
<tr>
<td>Quadrant A</td>
<td>Cross-referral – clients with straightforward needs who are competent to make best choices regarding these needs.</td>
</tr>
<tr>
<td>Quadrant B</td>
<td>Self-referral – clients who are competent to self-refer to a service for a particular need.</td>
</tr>
<tr>
<td>Quadrant C</td>
<td>Client as integrator – clients with multiple and complex needs but who are capable of choosing and directing a package of services to meet these needs.</td>
</tr>
<tr>
<td>Quadrant D</td>
<td>Navigator as integrator – clients with high complexity of need and low capacity to coordinate services, requiring someone to navigate these.</td>
</tr>
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</table>

Although these typologies do not specify service-users who are mandated to seek treatment or attend social services, as the different quadrants reflect individual capacity to navigate services and level of support needs, mandated service-users could fit into whichever quadrant best reflects their situations and motivation.

Despite the overall shortcomings of the social service system in A/NZ, the inquiry found it was working ‘reasonably well’ for most A/NZ people, that is, those in Quadrants A and B, as they could navigate the system to find services they required (NZPC, 2015a, p7), however for those in Quadrants C and D:

...the system badly lets down those in society with complex needs that span the silos, and who lack the capacity to extract what they need for support and to help turn their lives around (particularly those in Quadrant D).

Top-down control was found to be a poor option for Quadrants C and D, and a devolution system of funding recommended. The results would be (NZPC, 2015a, p10):
• Decision makers close to the community or culture of clients will have greater ability to tailor services based on local knowledge;
• Well-designed organisations at arm’s length from ministers should face less political pressure towards risk aversion and micro-management;
• Pushing decisions down can mobilise and empower local resources; and
• Devolution produces diverse approaches across locations, which can enable valuable comparison and learning.

The Commission recommends a devolutionary style would improve social services for Quadrants C and D, if well thought out and complemented with other measures such as national standards, regulation and data collection (NZPC, 2015a, 2015b). This does raise the question of different measures for different quadrants. The same denigration by the Commission of ‘one size fits all’ in service delivery could equally be applied to service evaluation.

It is significant, therefore, that findings from the NZPC inquiry echo many of the meso concerns discussed. The inquiry recommended a complete overhaul of the system to better consider differing quadrants of service-users and different types of contracts and partnerships with NGOs reflective of these service-user needs. In addition, the Commission noted the government agency practice of paying less than the full cost of expected service provision to NGO contractors was considered unreasonable; and concerns were raised about the system’s failure to address the needs of individuals and families with multiple, interconnected and complex needs, and the agencies which work with them. No evidence exists to date as to whether the state is heeding this advice. Instead the Community Investment Strategy and child welfare reforms continue to be implemented without amendment.

Scholars note the incongruity of neoliberal state behaviour: On the one hand granting greater freedom to the market to operate without restriction, yet on the other imposing restrictions on service delivery. What was sold as more
inclusive governance is suggested to be an instrumental partnership in disguise (Hajer & Wagenaar, 2003; Schram, 2012; Walker & Shannon, 2011). Consequently, if NGOs wish to keep receiving funding from the state, they must change to align themselves with government priorities (Aimers & Walker, 2016; Billis, 2010; Brandsen et al., 2005; Walker & Shannon, 2011). Power is held by a select few, and community efforts can easily be undermined, and/or a different approach chosen by the state (Larner & Craig, 2002; Walker & Shannon, 2011; Weir, 2009).

Changes to organisational logics were found in the ComVoices 2016 survey (2016a). In a radio interview entitled ‘Community Services under Pressure’, the survey convener, Casey, noted erosion of the independence and values of the sector (ComVoices, 2016a; Radio New Zealand, 2016). Also highlighted was the silencing of the sector (ComVoices, 2016a, p1):

*Partly this is due to social service providers not wanting to ‘rock the boat’ and jeopardise their chances of securing future funding.*

This silencing is a result of the power imbalance between parties (Aimers & Walker, 2016; Bourdieu, 2011; Walker & Shannon, 2011).

Not all actors within the sector have changed their views: Many are still reading from the script of community logics, and this leads to intra–organisational conflict which has been further compounded in many instances by the merging of community organisations during this state–NGO partnership period, such as in this research context (Aimers & Walker, 2016).

**MICRO**

The final layer of implications is the micro level of society, the world of individual citizens and families. It was noted earlier for a group of A/NZ people, life has become more difficult. They have become poorer, less healthy, have had to wait longer to access social services, and/or received narrower, shorter, more fragmented and less holistic service delivery. Smaller community services may have closed (ComVoices, 2016a; Larner & Craig, 2002, 2005; NZPC, 2015a). As
discussed, stigma and poverty which accompany severe and chronic mental illness in A/NZ positions this group of people to be more affected by the macro effects of neoliberalism than most.

This disadvantaged proportion of A/NZ people not only face more difficult circumstances but are labelled differently because of state ideology. As stated, they are viewed as ‘bad’ parents, and poor managers of their resources – responsible for their ‘fate’ (Beddoe & Keddell, 2016; Cleaver, 2016; Featherstone et al., 2014a; Harding, 2014). State logics which support individualisation and responsibilisation mean for anyone who falls into this category, the onus for their situation rests solely on their own shoulders. Although couched in the language of empowerment, that is, each person has the capacity and strength to lead their own lives, this doxa ignores the insidiousness of structural inequality and is an evasion of responsibility for the state and the general population (Beddoe & Keddell, 2016; Hackell, 2016; Houston, 2013; Hyslop, 2018; Jensen, 2013; Keddell et al., 2016). Parents with mental illness and addiction and their families are indeed ‘the dominated’ (Bourdieu, 1997, 1992).

As noted by the NZPC (2015a, p1), consensus welfarism does not meet the needs of this quadrant, and the health economics of ignoring their needs are untenable:

...a different approach is needed to support them to improve their lives. To not change would condemn them and their children to a continuing poor quality of life and continue to inflict large costs on the rest of society through both negative impacts on others and the high costs of government services that “pick up the pieces”.

These layers of disadvantage combined with the doxa of state logic supports the everyday prejudice against these parents with mental illness and addiction and their families expressed by the average A/NZ person, thus reducing wider community support and understanding (Cleaver, 2016; Hackell, 2016; Isin, 2004).
Implications for the NGO helping profession, whether voluntary or paid, are enormous and multi-layered. Helping professionals are burning out, stressed, frustrated, and morale is at an all-time low (ComVoices, 2016a). The silencing of the sector also applies to practitioners. Do they raise objections about pay rates and workload if they know it will affect service delivery, or the renewal of their contract?

An ethical conflict for helping professionals is the individualised, psychological emphasis for human problems to the exclusion of ecological and structure factors, particularly evident in the individualistic approach often taken to resilience theory and child welfare reform (Bottrell, 2013; Cooper, 2015; Featherstone et al., 2014a; Garrett, 2015; Hyslop, 2013; O’Brien, 2016; Parton, 2016; Sawyers, 2016; Ungar, 2012a; Webster & McNabb, 2016).

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**STRATEGIES**

The government holds the purse strings; the question is, do the NGO sector and the actors within hold any power? Strategies for third sector organisations to manage and resist compromises associated with hybridity are virtually non-existent in the literature beyond the work of three authors from Dunedin, A/NZ (Aimers & Walker, 2017; Walker & Shannon, 2011). From a contextual perspective, their work is highly relevant. This research has its roots in Bourdieu’s theory, although developed further and from an organisational perspective.

Case examples from the research of Walker, Aimers and Shannon elicit hopeful options if organisations are ready and willing (Aimers & Walker, 2017; Walker & Shannon, 2011). The first strategy is awareness. Aimers and Walker (2016, p3) note, citing the work of Brandsen et al. (2005):

*...there are cultural and political risks for organisations that embrace hybridity ... that by understanding such risks organisations can make conscious choices about how they balance multi-sectorial logics and governance forms.*
Walker and Shannon (2011) emphasise empowering community agencies to create leverage by building and deploying capital. Power is understood by Foucault as “productive process and achievement” and from Weber, as a resource (Walker & Shannon, 2011, pi65), referring to Foucault (1980) and Heiskala, (2001). The power resources possessed by social actors are referred to as capital: financial, human, natural, and importantly, ‘social and cultural’ in this context (Bourdieu, 2011; Walker & Shannon, 2011).

The notion of institutional capital, coined by Healey (1998), distinguishes between three forms of capital: intellectual (knowledge resources); social (trust and social understanding which builds through face–to–face encounters); and political (the capacity to act collectively for developing local networks and capture external attention and resources) (Healey, De Magalhaes, & Madanipour, 1999; Healey, De Magalhaes, Madanipour, & Pendlebury, 2003; Innes & Booher, 19991). Processes to build institutional capital, termed ‘institutional capacity–building’, may be analysed in terms of (Healey et al., 2003, p65; Walker & Shannon, 2011, pii65):

Knowledge resources: the range of accessible resources; the frames of reference that shape conceptions of issues, problems, opportunities and interventions; the extent to which these are shared and integrated into different spheres and actions; the capacity to absorb and learn from new ideas (openness and learning).

Relational resources: the range of stakeholders involved; the morphology of their social networks; the extent of integration of the various networks; the location of the power to act, the power relations between actors, and the interaction with wider authoritative, allocative and ideological forces.

Mobilisational capacity – the opportunity structure; the institutional arenas used and developed by stakeholders: the repertoire of mobilization techniques used to develop and sustain momentum; the presence, or absence, of critical change agents at different stages.
Adding to this, Walker and Shannon (2011) adopt the Scottish *Achieving Better Community Development (ABCD)* framework (Barr & Hashagen, 2000), which identifies power processes within community organisations according to inputs, process, outputs and outcomes. In an environment in which outputs and outcomes are the focus, Walker and Shannon (2011, pii66) note the importance of investigation of the process, as the process “distinguishes between the obvious tangible ‘outputs’ and the longer term and more substantial outcomes”.

Using this ABCD process, Walker and Shannon (2011) analysed local and regional community—state partnerships, finding leverage from ‘below’ was possible, and in some cases, encompassed more than the partnerships. The authors made sense of their findings using Lukes’ (1974) ‘dimensions of power’ (Walker & Shannon, 2011, pii69):

- Decision—level: the lowest level where decisions are taken;
- Agenda level: where the agenda for options to be considered at the decision—level are set;
- Structural level: the background conditions governing the agenda level.

In this research context, decision—level is state—NGO partnership level, agenda level refers to central government agencies, and structural level is overall government policy. Walker and Shannon found (2011, ppii70-71):

*...while the inputs and power from inside the community were initially weaker in resource terms, they were, in three of the five cases, based upon a strongly unified vision at local/decision level and thus were able to create changes at the agenda level …. The tentative conclusion from these cases is that one pole of the stakeholder triad, if strongly developed, can have significant influence but the resource on which it is based is dependent both upon process and the development of power relationships with other stakeholders and the persistence, nurturing and retention of its resource base).*

The beginnings of a strategic model of practice were born out of this research, and while in the early stages of development and testing, have much to offer
for the A/NZ third sector in partnership with the state. Walker and Shannon (2011, pii79) note:

> If civil servants do not or cannot heed the advice for empowering practice, and there is considerable evidence both within A/NZ and overseas that they often do not, the community can make them conform.

A key asset is noted by Larner and Craig (2005, pp10-11):

> Thus a crucial consequence of neo–liberalism was the emergence of community activists both as highly skilled and articulate organisational leaders and lobbyists...

What is being suggested is that social movements may now be placed within and amongst organisations. The determining factor, according to Aimers and Walker (2015, p1), is whether practitioners and organisations have “strong enough convictions about their practice to carry them through lean funding periods”.

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**SECTION 4 SUMMARY**

Section 4 of the chapter has extended the socio–ecological, resilience–focused framework to consider the resilience of the NGO sector in A/NZ. In exploring the capacity for the sector to provide resilience–focused practice as described, significant barriers were discovered. These barriers were found to emanate from the neoliberal philosophy of governance in A/NZ over more than three decades. The ripple effects of this ideology were noted to affect state social service structure, policy and service delivery, and the state—NGO contracting environment.

The literature has shown that unless NGOs collaborate and act, employing the strategies suggested by Walker & Shannon (2011) and others, resilience–focused practice will never be secure or truly possible, the mission of NGOs will inevitably drift towards state values, and they will remain in a dominated position. The government’s own organisation, the New Zealand Productivity Commission, acknowledged the disparity for Quadrant C and D A/NZ people, the service–user group of this research setting, and found the same concerns as the
NGO about how services are contracted, managed and delivered to these groups of people. The goal of the strategic process is to achieve the type of governance recommended by the Commission: a devolutionary style of funding for NGOs working with these service–users, in which control is returned to the community sector, thus enabling the sector’s experience to tailor service delivery to individual needs, value diverse approaches, and mobilise local resources (Walker & Shannon, 2011).

CHAPTER SUMMARY

This literature review has painted a picture of COPMI service delivery in A/NZ so that the research question’s comparison between service–user perceptions sought in this study and the service narrative, or goals, might be placed in context. This has been achieved through outlining the theoretical frameworks of the ecological model and socio–ecological resiliency theory, incorporating mainstream research, and using these structures to explore the socio–ecological resilience of CRSSS service–users in A/NZ, COPMI service delivery, and the A/NZ NGO sector.

A socio–ecological perspective has resulted in a repositioning of traditional psychological theories, including mainstream resilience research, as it was argued they do not enable full understanding of the issues for this service–user group, such as stigma and poverty, nor contextual or cultural variations. Additionally, the support discourse is emphasised as an equally valid rationale for service delivery, and contributing to a different, less stigmatising discourse.

Suggested principles of practice from socio–ecological resilience theory were noted which were argued to address the relational, comprehensive, flexibility and tailoring needs of this service–user group. Contextually relevant findings from the ‘Pathways to Resilience Study (New Zealand)’ were drawn on heavily. Four areas of service delivery were explored which were contended to enable such practice to occur for the CRFSS service–users, facilitating the negotiation and navigation of resilience: relationship–based practice, comprehensive family
practice, peer support as an intervention for stigma, and scaffold recreational activities.

The final section of the chapter explored the socio– ecological resilience of the NGO sector, arguing the current state–NGO partnership phase of neoliberalism and the imposed Community Investment Strategy do not enable services to meet the needs of most service–users. The increasing hybridisation of NGOs was considered detrimental to the sector and its service–users. Recommendations were made to apply the Hybridity Lens and Strategic Process developed by A/NZ academics to reposition power relations with the state.
This chapter outlines the methodological framework and research methods of this study. The first section explores the methodology relevant to the project, including assumptions about reality and their influence on methodological choices and data analysis, the strengths and limitations of methods associated with the project, and ethical considerations. The second section addresses research methods, including how ethical issues were negotiated in the project, sampling and data collection, demographics, and analysis procedures.

Data collection took three forms: 10 child service−user interviews, four age−differentiated child service−user focus groups (N=24), and 32 mixed−method adult service−user surveys. Therefore, the study is predominantly a qualitative evaluation, however it has features of quasi mixed method design not only due to the mixed method questionnaire, but also the inclusion of other positivist features commonly associated with pragmatism and mixed methodology.

Several theoretical lenses guided the selection of research methods. A strong influence was the profession of social work and its ethical and political perspectives on research, including being participatory, anti−oppressive and partnered with service users; its ‘beyond knowledge’ purpose, with the additional goals of social justice and improvement; and incorporating the researcher’s use of critical thinking, inclusive of reflection and reflexivity (D'Cruz & Jones, 2004; Everitt et al., 1992; Fook, 1996, 2016).

The second major influence was the ‘third paradigm’ of pragmatism. Pragmatism is a method which emphasises the provision of useful data by selecting methods fitting the practical problems which arise (common in evaluation studies) (Teddlie & Tashakkori, 2009). Thus in this paradigm the methodological stance is eclectic (Flick, 2018; Greene, 1994; Patton & Patton, 2002, 2008; Teddlie & Tashakkori, 2009). Pragmatism aligns with
utilisation–focused evaluation, relevant to this study as it is a form of programme evaluation in which methods are chosen for practical reasons, that is, so that the data gathered suits the intended use and intended users of the data (Patton, 2003). Pragmatism is associated with mixed–methodology, as methodology influenced by pragmatism usually involves use of both qualitative and quantitative research methods such as in this study (Teddlie & Tashakkori, 2009).

Consequently, a pragmatic approach to research requires the disparate cosmological, ontological, epistemological and ethical positions associated with qualitative and quantitative methodology to be melded (D’Cruz & Jones, 2004), (Teddlie & Tashakkori, 2009). Despite the debate in the literature concerning incommensurability of mixed methods, social work researchers D’Cruz and Jones (2004, p57) argue, supported by many scholars, that mixing of methods is possible and sometimes desirable, paradigms and methods are in relationship, and therefore the researcher must:

“make explicit his or her intellectual and ethical assumptions in justifying the methods as a way of demonstrating methodological rigour”.

METHODOLOGY

This section outlines the literature relevant to the methodology for this study, beginning with principles of social work research and an outline of pertinent evaluation literature. An explanation of the cosmology, ontology, epistemology and ethics of quantitative and qualitative paradigms is given, and what occurs when mixed methodology is introduced. In relation to these concepts, the worldview of the researcher and its interaction with the project and the insider–outsider continuum discussed. The section then outlines literature relevant to qualitative and quantitative research trustworthiness and methods. Ethical issues associated with human research participants are explored.
The dilemmas of social service research demonstrated in various debates between differing paradigms, the pros and cons of evidence–based practice for social service delivery, the push for consumer–led research, and the promotion of indigenous perspectives have all affected the social work research domain (D’Cruz & Jones, 2004). What has arisen is the need for the social work researcher to consider their positioning, participants, service delivery, theoretical frameworks and research paradigms in their socio–cultural and socio–political contexts.

Social work scholars argue that research is an aspect of social work practice (D’Cruz & Jones, 2004; Everitt et al., 1992; Shaw, 2007). Consequently, social work research must not only align with general ethical research principles, but also with the ethics, values and principles of social work practice. In the Aotearoa New Zealand Association of Social Workers (ANZASW, 1993, S8.4) Code of Ethics relating to research, for example, ethical research procedures such as informed consent, obtaining ethical approval, taking steps to prevent “discomfort, harm or danger”, and accuracy in reporting, are emphasised.

The values of social work affect the profession’s research agenda. As stated by D’Cruz & Jones (2004, pp30-31), social research cannot be seen solely:

...as a pursuit of knowledge but has a political and ethical purpose in keeping with social work objectives to achieve social justice and improve the social conditions of individuals, groups and communities (p30).

...responsibility to give legitimacy to knowledge that has been ‘subjugated’ by dominant views ... more than a technical exercise – it has ethical and political dimensions as well (p31).

These values are captured in the notion of research–mindedness, as defined by Everitt et al. (1992, pviii), noting three principles of social work research (D’Cruz & Jones, 2004):
1. Participatory/developmental model of social work;
2. Anti-oppressive values;
3. Genuine partnership between practitioners and those whom they serve; valuing perspectives gained from lived experience.

In this A/NZ setting, social work research-mindedness necessitates a commitment to biculturalism, based on the Treaty of Waitangi (1840) and expounded in the ANZASW Code of Ethics (1993).

To be a social work researcher requires critical thinking and reflexivity which incorporates traditional scientific thinking, but also recognises and deconstructs assumptions about underlying paradigms, beliefs and behaviours, the influence of the socio-political environment, and the researcher’s positioning (D'Cruz & Jones, 2004; Riessman, 1994a; Trinder, 2000a). Translating this into the practice of social work research means an openness to and inclusivity of varying methods and approaches while also using established ways of working (D'Cruz and Jones, 2004; Fook, 2000, 2002; Ife, 2002). As concluded by D'Cruz and Jones (2004), the selection of methods should not be ad hoc but governed by two factors: assumptions about reality and how this may be known and understood, and pragmatism. These aspects are explored further in the section.

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EVALUATION
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Four differentiations are made between types of evaluation (D'Cruz & Jones, 2004). Practice evaluation occurs when evaluations focus on the activities of practitioners, and programme evaluation when the focus is on a specific programme or activity. Additionally, what occurs between a practitioner and others may be evaluated (process or formative evaluation), or the consequences of this engagement may be evaluated (outcome or summative evaluation). Designs for process evaluations are usually exploratory and descriptive, using either qualitative or quantitative methods, whereas outcome evaluations use explanatory designs to make causal links and associations, and are quantitative (D'Cruz & Jones, 2004). This project evaluates both the practice
and programme of the Caroline Reid Family Support Service (CRFSS), but it is formative rather than summative, as the intent was to explore and describe service delivery from the perspective of service-users, rather than explain the effectiveness of outcomes. (Bryson, Patton, & Bowman, 2011; D'Cruz & Jones, 2004; Patton, 2008).

Developmental, or service evaluation describes evaluation in which goals are emerging and changing and therefore has some application to formative evaluation (Patton, 1996, 2008). From this perspective, it is not just about improving the programme, but changing the programme model to reflect changed conditions and understandings. It does not make overall judgements about effectiveness as a summative evaluation would, because the end-product is not fixed.

As noted, utilisation-focused evaluation emphasises intended methods for intended use (Patton, 2008). Therefore, as with social work research, what is most appropriate is what is important. In utilisation-focused evaluation, methods are situationally responsive and should be decided by a collaborative process with users (D'Cruz & Jones, 2004).

Patton (2008) raises similar questions to D'Cruz & Jones (2004) about the social service sector’s over-emphasis on evaluation, or evidence-based practice. Patton (2008) criticises the politicisation and distortion of findings, noting evaluation methods used are often an ill fit and are expected to deliver what they are not designed to. D'Cruz & Jones (2004, p8) question feasibility issues, criticising the “privileging of certain kinds of evidence”, the ignoring of the consumer voice, and the common disregarding of research findings in “practice, policy and decision making”. Citing the work of Trinder (2000a), D'Cruz & Jones (2004, p8) conclude:

...definition of evidence should be broadened, and claims of evidence based practice should be narrowed.
Nonetheless, evaluation can contribute much to organisational and professional behaviour if it occurs in a developmental manner and is in keeping with social work practice values.

**COPMI PROGRAMME EVALUATION METHODOLOGY**

COPMI programme evaluation is primarily quantitative. Most methods use either pre– and post–psychometric testing or randomised control trials (Bee, 2015; Grove et al., 2015; Reupert & Maybery, 2009; Siegenthaler et al., 2012). Consequently, COPMI voices are largely absent in evaluation and in descriptions of experiences of parental mental illness (Gladstone et al., 2011; Grove et al., 2015; Foster et al., 2014). Conversely, Bee (2015) conclude that more quantitative evaluation is required to establish efficacy.

Many NGOs do not evaluate their programmes and COPMI services are among this group (Reupert & Maybery, 2009). Those that do evaluate are criticised on several grounds, including: insufficient or no background information on participants such as parent and child demographics, diagnoses, and support levels which might indicate differentiation of need and service delivery; inability to articulate the theory of practice; and lack of rigour in research methods (Bee, 2015; Fraser, James, Anderson, Lloyd, & Judd, 2006; Reupert & Maybery, 2009; Siegenthaler et al., 2012).

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**ASSUMPTIONS ABOUT REALITY**

Theories about ways of knowing are understood by the concepts of cosmology, ontology, epistemology and ethics (Bryman, 2012; D'Cruz & Jones, 2004; Teddlie & Tashakkori, 2009). This section defines these terms, making explicit their influence on this study and my positioning as researcher. The literature concerning mixed–methods and pragmatism is also reviewed in relation to assumptions about reality, and matters relating to the insider–outsider continuum discussed. Social work research was noted to support the integration of research from both paradigms, with the proviso that this is undertaken critically and reflexively, and the researcher’s assumptions about reality made explicit.
THE WORLD VIEW OF THE RESEARCHER

The term cosmology is defined as one’s universal worldview. The cosmology of positivism, associated with quantitative research, understands the world as “predictable, knowable and measurable” and reality may be identified and “understood as separate parts” (D’Cruz & Jones, 2004, p51). An interpretivist perspective, associated with qualitative research, assumes the contextualisation of knowledge and socially constructed and that phenomena can be explained and understood only when their context is uncovered (Bryman, 2012; D’Cruz & Jones, 2004; Teddlie & Tashakkori, 2009).

Ontology refers to how reality is understood and consequently, how it will be researched, theorised and explained (Bryman, 2012; D’Cruz & Jones, 2004; Teddlie & Tashakkori, 2009). The ontology of positivism assumes behaviour is mechanistic and can be explained in ways which are causal and deterministic, and that people can be manipulated and controlled (D’Cruz & Jones, 2004). Whereas, interpretivism considers behaviour to be “intentional and creative … can be explained but is not predictable” and that people can shape their own reality (D’Cruz & Jones, 2004, p51).

A person’s epistemology is their theory of knowledge; their assumptions about how it is possible to gain knowledge of reality (Bryman, 2012; D’Cruz & Jones, 2004; Teddlie & Tashakkori, 2009). In relation to positivism, knowledge can be gained from experiments and observations as reality may be known through what is experienced solely by the five senses. Universal truths may be arrived at (Bryman, 2012; (D’Cruz & Jones, 2004; Teddlie & Tashakkori, 2009). Interpretivism understands knowledge as arising from interpretation and insight, assisted by empathic communication between the researcher and participants, and gained from qualitative methods of data collection (D’Cruz & Jones, 2004).

Positivist ethical assumptions distinguish between knowledge and values. According to D’Cruz and Jones (2004, p52), “Science produces knowledge. How it is used is a value, ethical or moral question outside the concern of science”,

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whereas an interpretivist approach considers values to be a subject to research and adheres to moral and ethical relativism.

**PRAGMATISM AND MIXED METHODOLOGY**

As stated, pragmatism refers to practicality shaping the decision-making in research and is a term commonly used in mixed methods (MM) literature. (Teddlie & Tashakkori, 2009, p73) also argue that compatibility exists between qualitative and quantitative methodology, qualifying pragmatism by adding *dialectical* to it:

> *This title emphasizes that pragmatism for MM always takes QUAL and QUAN seriously but then develops a synthesis for each research study.*

Pragmatism rejects “either–or choices from the constructivism–positivism debate”, offering a third paradigm that (Teddlie & Tashakkori, 2009, p73):

> ...embraces superordinate ideas gleaned through consideration of perspectives from both sides of the paradigms debate in interaction with the research question and real–world circumstances.

This study does not meet the four–strand criteria for mixed methods research typified by Teddlie and Tashakkori (2009). Pure mixed method research should employ methods from qualitative and quantitative paradigms to study the same problem, so that biases from each methodology may be ameliorated (Bryman, 2012; D'Cruz & Jones, 2004; Greene, 1994; Flick, 2018; Teddlie & Tashakkori, 2009). The most common method is the mixed method questionnaire (Flick, 2018). According to Teddlie and Tashakkori (2009, p142), to be a true mixed method design, a study must “integrate approaches across the stages of the study”. Inclusion of both quantitative and qualitative questions to study the same phenomenon allows corroboration of data (within–methods triangulation); one set of questions provides accuracy and context; the other, richer and fuller meaning. (Bryman, 2012; D'Cruz & Jones, 2004; Denzin, 1989; Flick, 2018; Teddlie & Tashakkori, 2009) The positivist camp considers data triangulation to increase the validity of a study. However, the stance taken in this thesis is from the latter work of Denzin, and argued by Flick, that *strong*
between—methods triangulation is used to increase knowledge about the issue in question (D'Cruz & Jones, 2004; Denzin, 1989; Flick, 2018).

As this study prioritises qualitative methods and quantitative data were not sought to separately study the same phenomenon, to reduce the bias of qualitative methods, or gathered in a different phase of the study, it is typified differently. It meets the criteria for quasi–mixed design as both types of data were gathered within a primarily qualitative study, and no true integration of data sets occurred (Teddlie & Tashakkori, 2009).

Despite the qualitative emphasis, positivist elements exist. The research question is a mix of interpretivism (service–user perceptions) and positivism (how well the service met its goals). The research strategy was untypically structured for a qualitative study, although this is common for evaluations (Bryman, 2012; D'Cruz, 2004; Teddlie & Tashakkori, 2009). Although my relationships with participants were ‘insider’ or ‘close’, aligning with interpretivism, attempts were made to distance myself, with aspects of the researcher as outsider valued (detailed further in the chapter). The views of participants were accepted as real insights into their lives and experiences of the service (a nuance of positivism commonly used in evaluations), and theory applied in order to understand their meanings, thus contributing to the organisational narrative (Bryman, 2012; D'Cruz & Jones, 2004; Teddlie & Tashakkori, 2009). This does not mean subjectively was not valued. At the same time, a qualitative approach to analysis was employed to understand and gain insight from findings, and the socio–ecological framework employed acknowledges the social construction of knowledge and was utilised to locate findings in their context (Bryman, 2012).

Therefore, the methodology of the project is best explained as qualitative positivism (Bryman, 2012; Prasad, 2018). This is when researchers (Prasad, 2018, p2):
...employ qualitative methods with conventional positivist assumptions about the nature of social reality and the production of knowledge .... Relatively commonsensical and realist approach to ontological and epistemological issues.

It follows that quantitative and qualitative projects rely on different logic to understand data. Quantitative analysis employs deductive logic which means the researcher, on the basis of previous knowledge, deduces a hypothesis (Bryman, 2012). Whereas qualitative research utilises inductive logic, referring to the process by which knowledge is induced from data. In mixed method and evaluatory studies, both types of logic are commonly used (Bryman, 2012; Chen, 1997; Teddlie & Tashakkori, 2009). Teddlie and Tashakkori (2009, p26) describe this as the inductive–deductive research cycle.

... research at any given point in time occurs somewhere within this cycle ... induction could come first, or deduction could come first, depending on where one is in studying the phenomenon of interest.

Teddlie & Tashakkori (2009) note that it is the research question which drives this cycle. How inductive–deductive research cycle occurred in this study is described in the second half of the chapter.

Scholars note eclecticism is a common feature of qualitative analysis (Braun & Clarke, 2012; Teddlie & Tashakkori, 2009). The deductive approach to thematic coding and analysis is referred to as a top–down approach in which the researcher brings codes and interpretations to the data (Braun & Clarke, 2012). In contrast, the inductive approach is when coding and analysis is derived from the content of the data, a bottom–up approach (Braun & Clarke, 2012; Bryman, 2012; Elo et al., 2014; Lincoln & Guba, 1985; Teddlie & Tashakkori, 2009). In a qualitative positivist study such as this, both approaches are utilised.

THE INFLUENCES ON MY PERSONAL WORLDVIEW

This section acknowledges aspects of my personal worldview which are important to disclose for methodological rigour (D'Cruz & Jones, 2004).

My ethnicity is A/NZ European, with descendants largely from the United Kingdom emigrating to A/NZ several generations ago. Since then, both sides of
my family have been primarily A/NZ European ethnicity. Growing up in the lower half of the South Island resulted in limited interactions with Māori or Pacifica cultures, or other non-European groups. Most family members have been employed and had sufficient money to provide basic needs. I live in my own home and have never had to worry about access to food or shelter. Although at the end of the baby-boom cohort, tertiary education was not expected for a female in small town A/NZ. Thus, I emerged from a place of multiple privilege and narrow perspective.

Family trauma in my late adolescence and early adulthood in the form of the sudden death of several family members, combined with emerging knowledge of a sibling’s early trauma and the ongoing effects of this, also influenced my worldview. Although my formal knowledge remained somewhat narrow and privileged, experiences of suffering during what were still formative years resulted in increased empathy for self and others, decreasing dualism, and an emerging sense of social justice.

My undergraduate social work training when I was in my thirties was the first formal educational challenge to my privileged, Eurocentric perspective. My social work career has had mixed influences in this regard. On the one hand, Western psychological theory and child development have dominated my social work studies and workplaces, thus I have tended to accept the efficacy and presume the universality of these theories and perspectives. On the other hand, social work’s ‘broader-than-medical-model’ and ‘person-in-environment’ lenses have nudged me towards inclusion of socio-ecological factors. Added to this have been experiences of working in two long-term relational services with parents facing known risk factors such as social deprivation, stigma, multiple service engagement, and often child protective service involvement. There I saw the interconnections between multiple aspects of hardship and structural inequality for the whole family system. Despite the focus on traditional psychology, the year I spent working in the Canterbury District Health Board (CDHB) Mothers and Babies Service Inpatient Unit, in which mothers from a wide range of socio-economic positions were admitted with their infants,
revealed the role of social–ecological factors in determining outcomes, and the contrast in differing maternal childhood experiences on adult health and family support.

Added to this, the research project itself has had significant effects on the shaping of my worldview. When I began this thesis, I remained largely uncritical of the dominant, Eurocentric discourse of psychology in A/NZ. As I explored the socio–ecological perspective I became aware of the limitations of traditional psychological theories, finally arriving at a position of critique. A further influence which has broadened my perspective has been the interaction with researchers from other disciplines in a local research collaborative which included mental health consumers, sociologists, anthropologists and other critical thinkers.

At this time in my life, my assumptions about reality can best be described by social constructionism. However, in relation to research, I align with the social work stance described by D’Cruz and Jones (2004) which acknowledge the value of both paradigms.

**INSIDER–OUTSIDER POSITIONING**

A significant influence on my worldview in relation to the study was my insider status. As noted, I worked for CRFSS as a clinical social worker with adult service–users during research design, ethical consent, data collection and initial data analysis. This section explores the literature concerning insider–outsider positioning and my reflections on its role in the project. Features of both insider and outsider are common in projects with mixed methodology such as this (D’Cruz & Jones, 2004).

Historically, insider–outsider positioning refers to the (Gair, 2012, p137):

> ...degree to which a researcher is located either within or outside a group being researched, because of his either common lived experience or status as a member of the group.

The fluidity between insider and outsider status is emphasised by some; the notion of researcher in the middle, that to some degree all qualitative
researchers are insiders as they are human beings, no neutrality exists, and they occupy the space between these two positions (Boulton, 2000; Burns, Fenwick, Schmied, & Sheehan, 2012; D'Cruz & Jones, 2004; Dwyer & Buckle, 2009; Mercer, 2007). This means insider–outsider status is more complex. When the researcher starts asking “critical questions about what is normally assumed” the shift to outsider occurs; it is not merely a straightforward matter of membership (D’Cruz & Jones, 2004; Gair, 2012, p138).

Advantages and disadvantages are noted for both positions (Boulton, 2000; Burns et al., 2012; D’Cruz & Jones, 2004; Dwyer & Buckle, 2009; Gair, 2012; Mercer, 2007). Insider status usually enables easier access to participants, early rapport building, enhanced credibility and empathy, and an understanding of the dynamics of a research context. However, insider familiarity may mean power relations are not considered, sampling processes are not ethnically sound, over–identification with participants, role confusion, and intrusiveness in the researcher’s life. Researcher bias may influence questioning, reporting of results and analysis. The consequence of this myopia may be a reduction in the noticing of ordinary, everyday aspects of the research setting. However, if sound research processes and procedures occur, and the researcher discloses and reflects on her positioning, then I argue, along with Mercer (2007, p3):

...what is lost on the swings is more than compensated on the roundabouts.

Although I was technically an insider for the first half of this project, and an outsider for the second, my positioning was more nuanced. A more accurate assessment was that I remained an insider after I left the service due to other factors (related in the section above on researcher positioning), which meant it took me some time to truly critique the service. To add more complexity, while I was employed by the service, at times I was forced into outsider status as I had to ‘hold’ the data separately from other CRFSS staff and my own service–user work. The challenge appears to be in seeking a middle ground along the insider–outsider continuum, the qualitative researcher must draw on self and maintain
a degree of distancing (Boulton, 2000; Burns et al., 2012; D'Cruz & Jones, 2004; Dwyer & Buckle, 2009).

Further tensions associated with insider–outsider role duality occurred during analysis when I could ascertain discrepancies between some questionnaire responses and my insider knowledge of adult service–users (I was still working at CRFSS during analysis). Research and clinical supervision were utilised to manage these challenges.

There were benefits of having insider status: the depth of understanding I had of the CRFSS model, SST culture, and setting of participants; the rapport and trust with colleagues and management; and access to participants who are difficult to include in research. These benefits aided the participants through the provision of wrap–around support by CRFSS during data collection, as well as benefiting the research project.

Common limitations include service–users feeling obliged to consent; however, as discussed below, the number who chose not to participate suggests that the process was sound. The use of a social work student to manage data collection with my adult service–users also reduced some limitations. In relation to bias, the structured nature of data collection and emphasis on open–ended questions protected bias in questioning to some extent. It is hoped that bias in analysis was partly reduced through transparency of the data analysis process with my primary supervisor, use of reference group members in early analysis, reporting of negative cases, congruence in themes between participants, and feedback from supervisors during the writing of the discussion.

QUALITATIVE RESEARCH

This section considers the strengths, limitations and trustworthiness of this paradigm. The use of interviews and focus groups to gather qualitative data, and principles of analysis, are discussed.

Significant debate exists regarding how qualitative research might be trustworthy, if criteria of trustworthiness exist, and if so, what they are (Barusch,
Gringeri, & George, 2011). Some scholars argue that in the context of relativism, there is no need for fixed criteria (Norman K Denzin, 2002; Seale, 1999). However, criteria do exist in the qualitative school, attributed to the seminal work of Lincoln and Guba (1995), and as this thesis aligns with qualitative positivism, these are relevant (D'Cruz & Jones, 2004; Seale, 1999). They are: credibility, transferability, dependability, confirmability and relational authenticity.

Credibility is the notion that data appropriately represents the perspectives of research participants (Barusch et al., 2011; D'Cruz & Jones, 2004; Guba & Lincoln, 1982, 1995). Credibility may be strengthened through ensuring research “is carried out according to the canons of good practice”, triangulation, member checking (respondent validation), and peer debriefing (Bryson et al., 2011, p390, D'Cruz & Jones, 2004; Lincoln, 1995).

Triangulation is the combining and comparing of (Teddlie & Tashakkori, 2009, p27):

...multiple data sources, data collection and analysis procedures, research methods, investigators, and inferences that occur at the end of the study.

Data triangulation occurs when more than one source of data are used to bring variety to the study. Investigator triangulation refers to using more than one researcher in a study, and theory, or analyst, triangulation is the application of multiple theoretical perspectives to a data set (Bryman, 2012; Flick, 2018; Teddlie & Tashakkori, 2009).

Methods triangulation is the most relevant to this study. Methods triangulation takes two forms: between−methods and within−methods. The use of different qualitative methods to investigate the same phenomenon is between−methods triangulation (Flick, 2018). Within−methods triangulation is when both quantitative and qualitative methods are used in the same source of data collection, for example, a MM questionnaire (Flick, 2018). Methods triangulation can be weak or strong (Flick, 2018). Weak triangulation is when
the additional method of data collection is used only to assess if findings disagree or agree. Strong triangulation is when data from the additional method is used to enable convergence of themes and add depth to the study (Denzin, 1989; Fielding & Fielding, 1986; Flick, 2018).

Transferability is different from the quantitative notion of generalisation. The term refers to the possibility of knowledge generated from a study having relevance to another context if similar features in the other context exist (D'Cruz & Jones, 2004). One technique suggested is a thick description, that is, a detailed account of the context and processes of the research, which would enable other researchers to have sufficient information, so they could ascertain if findings could be transferred to additional contexts (D'Cruz & Jones, 2004; Lincoln, 1995).

Dependability of qualitative research is the alternative to quantitative reliability, the notion that findings can be replicated under the same circumstances (Bryman, 2012). Although reliability is not possible in qualitative research, dependability is said to be enhanced through external audits (D'Cruz & Jones, 2004; Lincoln, 1995).

Confirmability of qualitative research is different from the notion of objectivity in positivist research. Leaving aside the debate about whether objectivity in human research exists, in qualitative research in which subjectivity is valued, confirmability increases trustworthiness (D'Cruz & Jones, 2004; Lincoln, 1995). Confirmability is said to be increased through use of an audit trail, and reflexivity of the researcher (Lincoln, 1995). Researcher reflexivity is the researcher’s reflection on her own positioning in the research and what influence this may have had on the study, particularly when the research has insider status, and should include (D'Cruz & Jones, 2004, p76):

An overt expression of values and assumptions (positioning) informing the choice of question, design, data collection and analysis and conclusions.
An audit trail is another method of strengthening confirmability, that is, the documentation of the steps taken from the beginning of a research project to the development and reporting of findings, and record of the researcher’s reflections (D'Cruz & Jones, 2004; Lincoln, 1995).

The fifth criterion, authenticity, is recognised as “quality decisions that are made ‘locally’ within the context and paradigm of the research project itself” (Barusch et al., 2011, p18; Lincoln, 1995). Prasad (2018) argues that authenticity is reminiscent of utilisation-focused evaluation, as qualitative researchers need to show they can craft their project decisions to suit what is needed. With this in mind, Barusch et al. (2011) emphasise the need for methodological awareness rather than universal criteria. Creswell and Miller (2000) argue that validity procedures exist for qualitative inquiries which seem congruent with the notion of authenticity. That is, the researcher makes explicit the lens used which includes her positioning and the use of reflexivity, in addition to employing member checking and peer reviews.

One method recommended for increasing qualitative trustworthiness in evaluation is use of an Expert Advisory Group (EAG) or Reference Group (Birt, Scott, Cavers, Campbell, & Walter, 2016; Johnston-Goodstar, 2012; VeLure Roholt & Baizerman, 2012). Members of EAGs should represent the diversity of the community studied, and provide a forum for discussing needs and concerns related to the research (Johnston-Goodstar, 2012). An EAG enables the researcher to understand the history of the research locality and world-views of evaluation participants and stakeholders, thus ensuring appropriate strategies and skills are employed (Johnston-Goodstar, 2012). An EAG was utilised in this project during the design, data collection and early analysis phases. This is further outlined in the second half of the chapter.

**QUALITATIVE DATA COLLECTION**

This section outlines sampling, methods of relevant qualitative data collection and important features of these methods. Methods discussed are interviews, focus groups and questionnaires. The details of what occurred are outlined in
the second half of the chapter. Ethical concerns exist in relation to research with children and youth, and these are discussed further in this section.

Sampling for qualitative research is non-probability (purposive) (Bryman, 2012; D'Cruz & Jones, 2004). The goal of the sample is to gain participants who can contribute to the subject studied. This does not mean it is not representative of a range of views and variations in participants; such a range is ideal. The importance of the researcher’s disclosure of their aims in sampling is noted (D'Cruz & Jones, 2004).

Many types of qualitative sampling exist. The two relevant to this project are convenience and maximum variation sampling. A convenience sample is one which is available to the researcher due to accessibility (Bryman, 2012). Convenience is necessary in a qualitative programme evaluation. A maximum variation sample occurs when the researcher selects participants to produce a sample that reflects “a population in terms of the relative proportions of people in different categories such as gender, ethnicity, age groups, socio-economic groups and region of residence” (Bryman, 2012, p203).

Interviews are the most common method of qualitative data collection. Principles for interviews, whether structured or not, include the need for flexibility; not leading the interviewee, yet still seek their world view, catering for interruptions and adverse responses, and ensuring recording occurs (Bryman, 2012; D'Cruz & Jones, 2004; Scott, 2000). Principles also exist for semi-structured interview guides, including ensuring that questions are clear, primarily open-ended, meaningful to participants’ experiences, and consider the age, understanding and tendencies of respondents (Bryman, 2012; Scott, 2000).

Interviews are useful for child participants as they can be readily adapted to cater for differing developmental stages and offer the immediate flexibility required (Scott, 2000). A potential concern when interviewing children is their motivation “to give careful and truthful answers” (Scott, 2000, p98). In relation to this, Scott argues rapport is necessary for children to be forthcoming and to
trust in the confidentiality of their responses; although rapport is necessary with all age groups, it is essential that it is optimal for child participants (2000). Lincoln and Guba’s (1989) arguments for qualitative methodology support the needs of child and adolescent participants. They argue the paradigm supports loci of control, informed decision-making and agency, minimises deception, and protects from harm.

Focus groups are another common qualitative method. The purpose is not just efficiency of data collection, but to enable members to discuss questions topics as a group (Bryman, 2012; D'Cruz & Jones, 2004; Horner, 2000; Kitzinger, 2006; MacDougall & Baum, 1997; Scott, 2000). Focus groups can be useful for discussing sensitive topics as participants may provide mutual support through expressing shared experiences and feelings, and the participation of more confident members can enable shyer participants to contribute (Kitzinger, 2006). Another useful phenomenon is their capacity to generate the expression of critical comments and different solutions, noted to be important for improving service delivery (Kitzinger, 2006). Recording and transcribing can be complex and requires significant planning. Ethical issues relating to focus groups are similar to interviews, although confidentiality is more complex due to multiple participants. Principles for focus groups include the need for flexibility and facilitation of discussion, consideration of possible loss of control and unwanted group effects such as group-think, and safety of group members (Bryman, 2012; D'Cruz & Jones, 2004; Kitzinger, 2006; MacDougall & Baum, 1997). Group-think, a potential pitfall of focus groups, is when participants views are censored or conformed by those of other members (MacDougall & Baum, 1997).

Questionnaires are a self-reporting tool for data collection, and commonly include both quantitative and qualitative questions. Rules apply to questions from either paradigm, and include (D'Cruz & Jones, 2004):
Ensure questions are short, clear and focused;
Ascertain early if a participant is a member of the group you are asking questions about;
Phrase questions with sensitivity and respectfully, taking diversity into account;
Keep questions neutral;
Use simple language with everyday words.

For qualitative questioning, both closed and open-ended questions are incorporated, often in conjunction with each other (Bryman, 2012; Teddlie & Tashakkori, 2009). For example, a yes/no response, then an open-ended question requesting an explanation for the choice given.

**QUALITATIVE ANALYSIS**

Qualitative analysis is recognised as a complex process, with two main approaches used: content analysis or analytical induction (D'Cruz & Jones, 2004). This thesis used content analysis, which means that the researcher seeks patterns and meanings from the data (Bryman, 2012; D'Cruz & Jones, 2004). In content analysis themes can be small or large, and as analysis proceeds these themes are commonly collapsed into different sub-themes.

The type of content analysis used in this project was **thematic analysis**, based on the work of Braun and Clarke (2012). This method was chosen as it aligns with the core interpretivist approach of the project, that is, the desire to understand service-user perceptions of the service. Thematic analysis enables meaning and insight to be drawn from qualitative findings. Braun and Clarke (2012, p57) define thematic analysis (TA) as:

... a method for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set. Through focusing on meaning across a data set, TA [thematic analysis] allows the researcher to see and make sense of collective or shared meanings and experience.

Braun and Clarke’s developed a six-phase approach to thematic analysis which is utilised in this thesis (Braun & Clarke, 2012, pp60-69):
1. *Familiarising yourself with the data*;
2. *Generating initial codes*;
3. *Searching for themes*;
4. *Reviewing potential themes*;
5. *Defining and naming themes*;
6. *Producing the report*.

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**QUANTITATIVE RESEARCH**

Criterion for trustworthiness in quantitative research are reliability, internal validity, generalisability, and objectivity (Bryman, 2012; D'Cruz & Jones, 2004; Teddlie & Tashakkori, 2009). Quantitative methodology is relevant to the MM adult questionnaire used in this thesis.

Reliability is demonstrated by the capacity of quantitative questions to produce similar outcomes in a different situation. Closed questions and fixed answers increase reliability, as does format, and variations in conditions for data collection also affect reliability. The only aspect of internal validity relevant to the questionnaire is content, or face, validity, which means questions asked are directly related to the objectives of the study, that is, the research question. As this was a qualitative project, no claims are made regarding generalisation. In relation to objectivity, the notion that research can be conducted in a value–free manner, this does not apply either (Bryman, 2012; D'Cruz & Jones, 2004; Teddlie & Tashakkori, 2009).

**QUANTITATIVE DATA COLLECTION**

Pure quantitative research does not use purposive sampling. As stated, it is experimental and employs empirical research practices (Bryman, 2012; D'Cruz, 2004). The favoured method is probability sampling which enables statistically derived generalisations to be made.

The completion of questionnaires may be supervised or self–directed. General rules for questionnaires have already been outlined. Recommendations exist for the format of quantitative questions, with a vertical format preferable. (Bryman, 2012 #62).
QUANTITATIVE ANALYSIS

Quantitative analysis methods vary, depending on the scope of the project and types of variables (Bryman, 2012). Descriptive statistical analysis was used in the project. This is the most elementary form of quantitative analysis, appropriate for small samples in which frequency, proportional distribution, measures of central tendency, and measures of dispersion are the predominant areas of inquiry (D'Cruz & Jones, 2004). Quantitative analysis typically occurs through use of statistical software (Bryman, 2012; D'Cruz & Jones, 2004; Teddlie & Tashakkori, 2009). Data are coded and entered into a database which then performs calculations and produces the required tables and charts.

ETHICAL ISSUES

Many ethical issues require consideration when completing research with human participants. This section discusses ethical issues noted in the literature which relate to collecting data from children and youth, and from adults with mental illness – all perceived as vulnerable populations. Such ethical issues are relevant to all research participants, regardless of age, and the ethical consent process is designed to ensure these are considered. Details about the steps taken to ensure the safety of research participants are outlined in the second half of the chapter.

CHILDREN AND RESEARCH

A foremost question is: Should children be involved in research, given the well–known ethical issues related to gathering data from children? Ethical issues highlighted in the literature which are discussed in this sub–section are: the right of children to participate in research; capacity to give informed consent; gatekeeping; power imbalance; privacy and confidentiality; and the potential for adverse responses.

CHILDREN’S RIGHTS TO PARTICIPATE

According to the principles of the United Nations Convention on the Rights of the Child (UNCROC), children have a right to “have an opinion and for that opinion to be heard in all contexts” (United Nations General Assembly, 1989).
The convention advocates for children’s rights to be protected from discrimination on any grounds, including age. Further, the Aotearoa New Zealand Association of Social Workers (ANZASW) Code of Ethics (1993, Article 2.3 and 3.2) describes the general responsibility of social workers to prevent and eliminate discrimination against any person or group based on age.

Many scholars advocate for children’s voices to be heard in research, emphasising factors such as children’s social positioning as a minority group, and the history of research about children rather than with children; the need for children’s voices to be audible and their views considered in situations such as foster care; the powerlessness of some groups of children in society; and the competence of children (Greig, Taylor, & MacKay, 2007; Hood, Kelley, & Mayall, 1996; Morrow & Richards, 1996; Scott, 2000). Ideally, children should be involved in all stages of the research process, from design to dissemination (Greig et al., 2007; O’Kane, 2000).

However, concerns exist about children’s capacity to be cognisant of present and future issues relating to participation in research, and these are now addressed.

ACCESS TO PARTICIPANTS

For children to participate in research, parents must provide consent. Despite the existence of legislative frameworks which govern consent for children in research, it remains unclear at what age a child does not require parental consent to participate (Greig et al., 2007). Greig et al. recommend researchers seek the full cooperation of both parents and child participants.

Parents’ frequent refusal to consent to their children participating in research is noted to be due to concerns about protecting their children from possible adverse responses (Christensen & Prout, 2002; Heptinstall, 2000; Thomas & O’Kane, 1998a). Christensen and Prout (2002) suggest that refusing consent for children to participate in a medical or pharmaceutical trial seems responsible, and some historical psychological testing of child participants is now considered indefensible, however emotional discomfort associated with listening to
children’s views is more complex and subjective. In a study of families with parents who had dual diagnosis, Reupert et al (2012) found the gatekeeping behaviour of parents concerning their children’s involvement in the project was significantly overcome by rapport building and the development of trust with the interviewer during the adult data collection phase. The authors emphasise that “parents were not reminded ... or coerced in any way, about involving their children in the study”, and the relationship building “… was not tokenistic but involved regular and meaningful discussions ... far more involved than merely explaining the research process and providing information sheets ...” (2012, p155).

Organisations are also gatekeepers. In their study of foster children, Hood et al. (1996) describe obtaining access to child participants through foster care agencies as slow and time-consuming; professionals were concerned about emotional discomfort and if child participants would benefit. Ethics Committee processes provide additional gatekeeping. Such committees have stringent protocols regarding access to children, and if initial access is gained they require reassurance to ensure adverse responses are minimal, and layers of support exist. It seems that the protection of child participants requires balancing with the right of children’s voices to be heard, especially in evaluations of service delivery which affect them. Unfortunately, sometimes this means (Heptinstall, 2000, p868):

> ...some children may be prevented from taking part in research despite having expressed a personal wish to do so.

**CHILD PARTICIPANT INFORMED CONSENT OR ASSENT**

Morrow and Richards (1996) and Thomas & O’Kane (1998b) describe parental consent for children to participate in research as a passive process, whereas a child’s assent must be active, that is, the child is willing to participate. Gaining assent from the age of seven years on is recommended; prior to this age, parental consent is considered sufficient (Morrow & Richards, 1996). Thomas and O’Kane (1998b) emphasise that the right to withdraw be highlighted as part of the informed consent process.
The consent/assent process is complex, and raises several possible scenarios:

- If a parent consents, would a child feel they can still refuse to participate?
- If a parent refuses but the child wishes to participate, who should make the final decision?
- At what age can a child understand potential adverse responses to the research questions?
- What difference does the position of the researcher on the insider–outsider continuum make to the consent process?

Graham, Powell, and Taylor (2015) suggests awareness of these issues is as important as following procedural ethical processes, and micro–counselling skills and assessment capacity of the researcher are needed to prevent coercion. Thomas and O’Kane (1998a, p337) describes the tension:

> In part the difference is due to children’s understanding and experience of the world being different from that of adults, and in part to the different ways in which they communicate. Above all, it is due to different power relationships.

A separate section below discusses power relationships. This quotation also highlights the differences between child and adult participants which require consideration. Competence to understand and assent is related to the age and stage of the child (Christensen & Prout, 2002; Morrow & Richards, 1996). Despite this, these scholars argue researchers need to have respect for the competencies of children.

**POWER IMBALANCE**

Ethical considerations regarding informed consent are rooted in concerns about the power imbalance between researchers and child participants; between adults and children in society. Hood et al. (1996, p121) explain:

> Children’s ability to refuse to participate took place within their social positioning as inferiors not only to their parents but to us, the researchers.

Morrow and Richards (1996) and Nigel Thomas and O’Kane (1998a) discuss the need for researchers to actively redress the power imbalance so children can
participate on their own terms. Offering choices to child participants regarding the how, when, where and who of research are steps which may assist with this imbalance. Similarly, the need to be mindful of this imbalance is as important as the actual steps taken (Morrow & Richards, 1996; Thomas & O'Kane, 1998a).

**ADVERSE RESPONSES**

This section defines possible adverse responses relevant to this project and discusses distress as an adverse response. As discussed, ethical consent procedures with child participants usually require details about possible adverse responses. This is also noted in the ANZASW Code of Ethics (1993, (S8.2, 8.3), and social work researchers are required to take all possible steps to protect participants from mental discomfort.

Greig et al. (2007, p247) describe the principle of non-maleficence in this regard; “an obligation to do no harm”. Citing the work of Beauchamp and Childress (2008), Greig et al. (2007, p247) discuss the broadness of the term “harm” and need for a firm understanding of what it means to do harm:

> When working with children and adolescents the researcher must take reasonable, sufficient and appropriate steps to avoid causing pain, suffering, incapacitation, offense and death.

It seems more straightforward to identify an adverse physical response; less clear, an adverse psychological response. As noted by Gibson (2007), no guarantees can be made about not causing stress or distress to child participants, however, what is important is for the researcher to make every attempt to minimise distress in participants and to identify, monitor and manage such situations (Heary & Hennessy, 2002; Hennessy & Heary, 2005; Horner, 2000; Smith & Prior, 1995).

**PRIVACY AND CONFIDENTIALITY**

The need to attend to adverse responses may challenges participants’ right to privacy and confidentiality, an overarching tenet of research with human participants. There are, however, limits to confidentiality related to the
principles of non-maleficence (do no harm) and beneficence (acting for the positive benefit of others) (Beauchamp and Childress, 2008; Greig et al., 2007).

Disclosure of certain information may necessitate breaking confidentiality, particularly in relation to child participants (Greig et al., 2007; Styles & Morrow, 1992; Roberts, 2008; Thomas & O’Kane, 1998a, 1998b). The most important point is that limits to confidentiality need to be fully explained to participants before, during and after data collection. In their discussion of the principle of autonomy, Greig et al. (2007) define autonomy in part as fully understanding what will happen to the information gathered about them; not only the ultimate purpose of their information, but also its immediate use. An understanding of children’s differing developmental capacity is therefore necessary in these explanations.

ADULTS WITH MENTAL ILLNESS – A VULNERABLE POPULATION?

These same ethical concerns apply to research with adults. Informed consent, privacy and confidentiality, power relations, and concerns about protecting participants from adverse responses are relevant, and discussed further in the second half of the chapter.

Further ethical concerns are noted when adult participants have severe and chronic mental illness (Nickel, 2006; Wilson & Neville, 2009). Such a group are considered to be a vulnerable population. I have mixed opinions about the term vulnerable, as its use in A/NZ for groups of people has derogatory connotations, thus diminishing perspectives on the capacities of such participants. However, from a research perspective, I acknowledge vulnerability is a relevant term. In an A/NZ paper about culturally safe research with vulnerable populations, Wilson and Neville (2009) suggest Pacquiao’s definition (2008, p190):

...those who are not only particularly sensitive to risk factors but also possess multiple cumulative risk factors. They are more likely than others to develop health problems as a result of exposure to risk or have worse outcomes from those health problems than the rest of the population.
Framed in this way, the adult participants with mental illness in this study are a vulnerable population, as are their children. The main argument of Wilson and Neville (2009) is that research with vulnerable populations is often driven by dominant assumptions about reality and socio-cultural perspectives that exacerbate vulnerability and negate reality. Their challenge to researchers is to consider how their research is constructed and ensure it creates a “culturally safe space” for those who are vulnerable (Wilson & Neville, 2009, p69). The recommended framework is based on partnership, participation, protection, and power, aligning with the notion of social work research-mindedness explained above.

RESEARCH METHODS

This section discusses research methods used in the thesis. It begins by outlining steps taken in response to methodological issues and qualitative–quantitative trustworthiness criteria discussed above. The ethical consent process, use of a reference group, sampling, data collection, ethical issues and thematic analysis are explained.

Although my CRFSS colleagues were not involved in data collection or analysis, I consulted with them on many issues related to the study, particularly research with child participants, including: preparation of research documentation, the process for approaching child participants and obtaining consent; the layers of support needed for an adverse response; and interview guidelines. As child participants were their service-users and at the forefront of their concerns, their input enabled the important differences and capabilities of children to be prominent in my mind. My own experiences of being a parent and working with families who had children of all ages were also drawn on.

METHODOLOGY

Concerns were outlined about COPMI programme evaluation (Gladstone et al., 2011; Grove et al., 2015; Foster et al., 2014; Fraser et al., 2006; Reupert & Maybery, 2009). The first issue noted was the lack of COPMI perspectives in
research, and as stated, their contributions have been prioritised in this study. Through providing a thick description of participants and the service, I have attempted to alleviate concerns about a lack of background information. It is hoped this thesis will enable CRFSS staff to articulate the underlying theory of service delivery — a common problem in services which begin in similar ways. In relation to concerns about research rigour, the remainder of the chapter outlines procedures to ensure my methods were sound.

QUALITATIVE TRUSTWORTHINESS

Five criteria which exist for gauging the trustworthiness of qualitative research were outlined (D’Cruz & Jones, 2004; Lincoln, 1995; Seale, 1999). The steps I took to enhance these are described in this sub-section.

As noted, credibility is enhanced by triangulation. Between–methods triangulation occurred through use of child interviews and focus groups to answer the same questions, and qualitative questions in adult questionnaires included similar questions. The original plan for focus group data was to use it to assess interview data, a form of weak triangulation (Appendix A). However, when the time came, I could not devise a child– and adolescent–friendly way to do this with the range of child participants. After extensive discussion with a member of the reference group and my research supervisor, we decided on an alternate approach. I asked focus group members the same questions as child interviewees and made data comparisons myself. Thus, focus group data were used to check convergence of themes and provide more depth, resulting in stronger triangulation (Flick, 2011; 2018). Within–methods triangulation occurred in the MM questionnaires.

Peer debriefing, considered to increase credibility, was only partially conducted in this thesis. Use of a reference group could be viewed as providing aspects of this, as group members had input into the research design and process, and opportunity to comment on early stages of analysis. As the service–user representative on the reference group chose not to take part in this process, no member checking occurred.
In relation to establishing transferability, I have attempted to provide a thick description throughout the thesis. External audits which support dependability of qualitative research have only occurred through regular research supervision. In the early stages of analysis my primary supervisor was closely involved in checking the accuracy of the process used. It is hoped the discussion chapters increase dependability through consideration of findings in the light of contextual factors and linking findings to what is more stable – the literature. As outlined, confirmability may be increased through an audit trail and researcher reflexivity. All aspects of an audit trail are available for scrutiny for this thesis. An excerpt from the research diary is shown in Appendix R. In relation to reflexivity, disclosure and details of insider status and positioning are outlined below.

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**QUANTITATIVE TRUSTWORTHINESS**

The only aspect of mixed-methods in this project was the adult questionnaire. However, the inclusion of both qualitative and quantitative questions was not to ameliorate biases, but due to pragmatics. Therefore, as per the typologies of Teddlie and Tashakkori (2009), this study is of quasi-mixed design.

The four criteria of quantitative trustworthiness were noted to be reliability, internal validity, generalisability, and objectivity (Bryman, 2012; D'Cruz & Jones, 2004; Teddlie & Tashakkori, 2009). These criteria are discussed in relation to the MM adult questionnaire.

In relation to reliability, some aspects of the questionnaire appear to have increased reliability, whereas others diminished it. Closed questions and fixed answers increased reliability, as did the vertical format (Bryman, 2012). However, in one question, variables were unclearly defined to the extent that data was omitted. In addition, I omitted to obtain data about one important variable, the frequency of contact which adult participants had with CRFSS family workers. Participants were asked to recall past conversations with family workers, and given known problems with retrospective information, this is likely to affect reliability — something I noticed myself during data analysis (D'Cruz &
Jones, 2004). Variations in conditions for data collection also affect reliability; however, these were almost entirely consistent.

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**THE ETHICAL CONSENT PROCESS**

Ethics approval was sought by the Upper South A Regional Ethics Committee who oversee research with health participants, rather than the University of Otago Ethics Committee, as a primary source of funding for CRFSS service–user work was from the Ministry of Health (MOH). The initial application was made on 11 June 2011 (Appendix A). The committee granted provisional approval with minor changes on 27 June 2011. Final approval was gained on 16 August 2011. The committee was approached in early September 2011 to approve minor changes to the children’s documentation. These were approved on 14 September 2011. See Appendix B for ethics approval documents.

The ethical consent process for this project required consideration of how this research was relevant to Māori populations. I was additionally required to gain approval from the *Ngai Tahu* Research consultation committee (Appendix G). As a non-Māori researcher, I sought Māori representation on the reference group formed for this project.

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**EXPERT ADVISORY GROUP**

An EAG was formed from the outset to allow stakeholders and those with experience in evaluation to advise at key points during the research project. The group included:

- Senior clinical social worker from an adult community specialist mental health service;
- Child psychiatrist from the child and adolescent specialist mental health service;
- General Manager of a non–government, early intervention service for new–borns and their families;

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30 *Ngai Tahu* – (personal noun) tribal group of much of the South Island, sometimes called Kāi Tahu by the southern tribes.
I attempted to have stronger Māori representation on the group. One professional was Māori; however, an adult service-user had been invited and although they initially agreed to join the group, they no longer wished to be involved after they left the city (due to the earthquakes).

The reference group met initially in person to discuss the research question, data collection and ethical issues relating to the project. Further contact occurred by group email and meeting with individuals from the group, as requested by members. The adult service-user representative and several other members assisted with the questionnaire design, the COPMIA youth representative assisted with scribing of focus groups, and the clinical social work representative helped with focus group planning. Although it was my intention to involve the reference group more in analysis, as a form of peer debriefing, this did not occur. Having shown them the initial analysis, the four who provided feedback did not wish to be further involved due to time constraints.

I hosted an event to reveal initial findings in 2014; however, only two members could attend. I maintain informal contact with several members of the reference group and intend to send all members a summary of findings and consult them about dissemination of findings.

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**SAMPLING**

As the project was an exploration of service-user perceptions of the service, sampling was purposive. This sub-section outlines steps taken.

**THE INITIAL APPROACH**

After ethics approval was gained in August 2011, a letter was sent to all eligible adult service-users advising of the forthcoming research project. The letter stated they would be approached by a social work student working with the service regarding their own participation in the study and their children’s
participation in focus groups; and that I would approach them regarding child interviews.

**ADULT QUESTIONNAIRES**
The sample included all adult service–users of the service in 2011, that is, those who had been a service–user of the service from the end of 2010 and had some contact with the family support worker of the service during this period. Additional exclusion criterion was active psychosis. This eliminated one person.

The 47 eligible adult service–users with the service were approached by a social work student, or me in a few cases, about interest in completing a mixed–method questionnaire. Thirty–two adult service–users chose to participate in the study.

**CHILD INTERVIEWS**
Ten child service–users were selected from the available 39 children in the service at the end of 2010, for a maximum variation sample (age, gender, ethnicity, length of time in service). Exclusion criterion for the sample was that participants had to have been service–users for one year. This sample method was employed as it was the most prudent method of obtaining a maximum range of interviewees.

Selection of the sample was a staged process. I initially worked on a list based on five school year–groups\(^\text{31}\), selecting a first and second choice male and female child from each group. The two CRFSS children’s workers did the same, then we consulted and arrived at a final list based on weighing up maximum variation alongside the vulnerabilities of the children at the time. Two ‘second choices’ were required as one child participant declined as they found such situations difficult to manage and one parent who initially agreed on their child’s participation, changed their mind and declined without explanation.

\(^{31}\) Year 4–6, Year 7–8, Year 9–10, Year 11, Year 12+ (inclusive of those who had been discharged from CRFSS)
Although significant criticism exists regarding this type of sampling, especially when it is the sole sample, this was addressed in this study by between-methods triangulation of these findings with those from focus groups.

CHILD FOCUS GROUPS

The convenience sample consisted of all children with the service at the end of 2011, and any new children who joined the service during the period of data collection. It was felt length of time with the service was less important for focus groups. As noted, I intended to have two children’s focus groups following analysis of data from the 10 interviews. All 45 children (who were in the service in 2011) were to be invited (one group 7–12 years, other group 13–17 years). Data gained from interviews were to be presented, feedback requested, and further information gained. Focus groups were to be audio-taped.

However, more focus groups were required as delays in holding the groups resulted in several older child service-users having already left the service. Two focus group were held with child service-users still at CRFSS, and two smaller focus groups were held with those who had been discharged. All children of the service in 2011, 2012 and 2013 were invited to attend focus groups. These were held at the end of 2012 and the beginning of 2013. The delay between interviews and focus groups was due to my original intention to use focus groups as a form of member checking, thus they needed to occur after interview analysis. Further delays occurred due to many earthquake-related issues for the service, service-user families and me. Grouping focus group members according to age groups was in line with what is recommended for child and adolescent participants (Christensen & James, 2008; Gibson, 2007).

The serious earthquakes which affected Christchurch, A/NZ during 2010–2012 affected most people’s personal and professional lives. Practical issues such as commute times to work and around the city increased exponentially. Personal homes required cleaning up after every serious earthquake, as did workplaces. Personal and client homes required repair. Housing became short, and private rents soared, placing significant stress on families such as those at CRFSS. Initially, practical needs were great: clients needed access to water, sanitation, medical supplies, food, support with housing providers, insurers and the earthquake repair authority, and transport as public transport links were altered. As time went on, many clients had to shift to different housing, and mental health in adults and children deteriorated.
Of a possible 45 child service–users, 24 participated. Reasons for not participating were: lack of parental consent (one family only); did not want to participate; forgot about the focus group; and moved out of the city post–earthquakes. Child interviewees were given the choice of attending and some are included in the sample.

Parents of eligible children were approached by the social work student in 2011 as part of her approach regarding adult questionnaires. The student provided and discussed information sheets related to children taking part in focus groups (See Appendix C). Parents were advised focus groups would occur the following year, and children would be required to assent.

I undertook a further consent process for two groups of parents of possible focus group participants myself. The first group were those who did not personally wish to participate in the project and were therefore not further approached by the social work student. The second group were those families who joined the service in 2012; parents or caregivers were ineligible, but child service–users were.

The child assent process for focus groups varied. As the first focus group (Year 3–8 children) was held at a camp, all children whose parents had given consent were given the opportunity to participate. I explained to the children about the focus group and gave them the opportunity to stay and participate or leave. Several left. The remaining children were given the information sheets to read. After explaining further, I gave another opportunity to stay and participate, or leave, and several more left. The remaining group signed the assent forms and we progressed into the focus group itself. See Appendix C and D for information sheets and consent forms.

The other three focus groups were held as stand–alone events. I telephoned the entire sample of adolescents to offer participation and explained the purpose and process. Those who were interested received another telephone call to discuss actual times and dates for the focus groups. I posted information sheets in advance to some participants; however, timeframes did not allow this
with all. For these few participants the content of information sheets was discussed by telephone. Each group began with reading through information sheets, discussing issues, and then signing of assent forms.

DATA COLLECTION

Although focus groups and interviews with adult participants would have been ideal if resources allowed it, this was not possible, and I felt adult participants could more easily manage a questionnaire than child participants if appropriate supports were put in place. Additionally, questionnaires enabled further distancing from my adult service−users.

Data collection occurred over a 19−month period (September 2012 to March 2013). Adult questionnaires and child interviews were completed in the six−month period following ethics consent (2011), but focus groups were delayed until the end of 2012 and the beginning of 2013.

Approved information sheets and consent and assent forms are in Appendices C and D. At the end of Appendix C is an example of the child and youth friendly forms given to participants. These were developed by my CRFSS colleagues and contained the same information.

ADULT QUESTIONNAIRES

Adult questionnaires were self−completion questionnaires. Each adult questionnaire was assigned a number between one and 32 to ensure non−identifiability, and the master list of participants was kept in a secure location. Demographic data do not display demographic information against participant questionnaire numbers to further protect identity. Participant gender is only disclosed in direct quotations. The questionnaire was designed to consider aspects of service delivery for both adult and child service−users of the service and service goals associated with the research question. Although goals were not mentioned, more attention was given to asking adult participants questions related to each goal than for child participants, as this seemed necessary to cover the range of topics in the research question.
Quantitative questions took two forms: closed questions with a vertical format (often with a qualitative response required to explain the answer); and selection from a list of possible answers (Appendix F), (Bryman, 2012).

Prior to ethics application the opportunity arose for a social work student on placement at CRFSS to collect adult data. The student telephoned all eligible adult participants who lived locally, explaining the project and gauging willingness. Those interested were visited to provide further explanations and information sheets. Participants were made aware participation was voluntary and it would not affect the service they received. For those who wished to participate, consent forms were signed.

Most questionnaires were completed with the student present. The social work student who gathered adult data waited while participants answered the questionnaires in all but three cases. Supervision enabled clarification of questions which were not fully understood, almost full completion of questionnaires, and opportunity to check for adverse responses. One participant asked the student to leave the questionnaire to be completed at home, and it was returned by mail (the appointment was during a lunch break). Three eligible adult service−users had left the city due to earthquakes. I approached these service−users myself by telephone and/or email. Two chose to participate. I travelled to visit one family and mailed the questionnaire to the other. Participants were offered a copy of their questionnaires, but no one requested this. Adult data collection was completed by the end of 2011, within four months of Ethics Committee approval.

One adult questionnaire was incomplete in places and some responses were unclear, for example, the participant had ticked all boxes in a closed question. The student discussed with me her attempts to assist the participant to understand. This participant had a psychotic illness but was keen to participate. I felt this participant was not so unwell as to be excluded, and in the spirit of maximising inclusion, I decided to include data that were legible and
understandable and omit data that were unclear. This is acknowledged in the results.

Follow-up telephone calls were made to all participants approached by the social work student. No adverse responses were reported to me. The two who lived away from Christchurch were provided with my contact details. There were no issues to follow up. After all questionnaire data were gathered, unknown to participants, their names were entered into a draw for two $50 supermarket vouchers.

CHILD INTERVIEWS

The interview guide was designed to ensure differing aspects of service provision were covered, using primarily open-ended questions, and questions which were clear, meaningful to child participant experiences, and considered child participants’ ages, understanding, and tendencies, as recommended (Scott, 2000).

I contacted parents or caregivers directly to discuss their child talking part in an interview. If parents or caregivers consented, steps differed depending on the age of the child. Children under 13 years of age were not approached directly, but I telephoned child service-users 13 years and over. For the younger group, parents or caregivers were given the information to discuss with their children. I then contacted older child service-users and parents or caregivers of younger child service-users to establish interest. Those who wished to continue received a home visit to discuss information sheets, answer questions and sign consent and assent forms. Parents or caregivers had to be present for child participants under 13 years. One older child participant lived outside the city at the time of data collection. Conversations took place by telephone and information was sent by mail. I obtained written consent or assent at the time of interview.

Eight of ten interviews took place in the family homes. One interview took place off site. Interviews took place over a six-week period towards the end of 2011.
Average interview length was 30 minutes, with interviews tending to be longer with older participants. Interviews were audio-taped.

All interviewees were contacted the week following their interviews. One adverse response occurred during an interview which is described below. All participants were posted a CD and a typed transcript of their interviews the following year which included a thank you card and a movie voucher. Participants were unaware they would receive a gift.

**CHILD FOCUS GROUPS**

The relatively short responses of focus group members were transcribed *in situ* during each group onto large sheets of paper by an appointed scribe who was not an employee of the service. This method was chosen due to a lack of resources at that time for transcription of audio recordings. As stated, the project began as a Master of Social Work thesis, and was not upgraded to a PhD until after initial data analysis. This decision was made in consultation with the primary research supervisor and a member of the reference group. It was not anticipated that participant responses would be lengthy, and it was felt that such a method of transcription would have the additional benefit of enabling transparency.

Focus Groups 2–4 began with refreshments, during which time I handed around information sheets and discussed their content. Group rules were established; one rule emphasised by all group was ‘the right to pass’, and in all groups, this occurred. After participants signed assent forms, the focus group proceeded. These measures are congruent with what is recommended for successful focus groups with child and adolescent participants (Gibson, 2007).

The average length of focus groups was one hour. Format varied according to the ages of members. The younger group was highly structured, and a variety of methods used to maintain the children’s attention, facilitate participation and reduce group-think, as noted (Gibson, 2007; O’Kane, 2000; Kitzinger, 2006; MacDougall & Baum, 1997). One technique I used extensively was different ‘stations’ around the room for different questions. The stations were words
written on cards, for example: ‘yes’, ‘no’, ‘maybe’. Child participants could stand by the station which best represented their response. After participants had made their choice, we discussed why each group had made that choice. This worked very well as both their bodies and minds were active, and they were well engaged. Sometimes I asked for a show of hands for yes/no/maybe answers. I then had a conversation with each group. For questions in which I felt participants would be overly influenced by peers and more personal questions, they wrote responses on paper notes which were handed to the scribe for adding to the transcript. Another technique used was continuums, with child participants able to stand anywhere along the line they felt represented their viewpoint. Once they made their choice, we talked about where they were placed and their reasons for this. The three focus groups with older participants were smaller in size. I gave them the option of using stations, and they chose to put the station labels on the floor in front of them and raise their hands for each answer. This worked equally well. Writing responses on paper notes was also employed for sensitive questions.

A participant from Focus Group 1 left two-thirds of the way through the group. This child was obviously tired at the end of a camp, and their behaviour had become disruptive.

Participants were asked when they signed consent to agree to notify me if they felt upset about anything discussed. All participants had access to follow-up telephone calls. Those still with the service received ongoing monitoring and support through normal service delivery. Three adverse responses occurred during focus groups and are discussed further in the chapter.

DEMOGRAPHICS OF THE SAMPLE

This section outlines demographics of adult and child participants. The data describe participants and provide some contextual information about their lives. Some child data were obtained through CRFSS records at the time of sampling. Adult data came from questionnaires. Apart from Table 7, all other descriptive statistics were calculated using Excel. Child Interviewees
Given the small sample of child interviewees (INT), ethnicity has not included in Table 3.1 to protect the privacy of participants. Eight were of NZ European ethnicity, and two identified as Māori.

**TABLE 3.1 – FREQUENCY TABLE SHOWING AGE AND GENDER OF CHILD INTERVIEWEES (N=10)**

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Age (years)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT1</td>
<td>15</td>
<td>Male</td>
</tr>
<tr>
<td>INT2</td>
<td>10</td>
<td>Female</td>
</tr>
<tr>
<td>INT3</td>
<td>12</td>
<td>Female</td>
</tr>
<tr>
<td>INT4</td>
<td>16</td>
<td>Female</td>
</tr>
<tr>
<td>INT5</td>
<td>10</td>
<td>Male</td>
</tr>
<tr>
<td>INT6</td>
<td>13</td>
<td>Female</td>
</tr>
<tr>
<td>INT7</td>
<td>12</td>
<td>Male</td>
</tr>
<tr>
<td>INT8</td>
<td>16</td>
<td>Male</td>
</tr>
<tr>
<td>INT9</td>
<td>16</td>
<td>Female</td>
</tr>
<tr>
<td>INT10</td>
<td>14</td>
<td>Male</td>
</tr>
<tr>
<td><strong>Age Range</strong></td>
<td><strong>10 – 16</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mean Age</strong></td>
<td><strong>13.40</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage Male</strong></td>
<td><strong>50%</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage Female</strong></td>
<td><strong>50%</strong></td>
<td></td>
</tr>
</tbody>
</table>

**CHILD FOCUS GROUP PARTICIPANTS**

Table 3.2 shows demographic data for child focus group (FG) participants. Māori were less represented in focus group participants’ ethnicity (8%) than in the child interviews (20%) and the CRFSS child demographics at the time interviews took place (17.5%). This was due to three potential candidates of Māori ethnicity not taking part in focus groups for varying reasons.
<table>
<thead>
<tr>
<th>Focus Group 1 (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
</tbody>
</table>

Mean Age FG1 10.67
Std Deviation FG1 1.41

<table>
<thead>
<tr>
<th>Focus Group 2 (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

Mean Age FG2 18
Std Deviation FG2 0

<table>
<thead>
<tr>
<th>Focus Group 3 (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

Mean Age FG3 16.67
Std Deviation FG3 0.47

<table>
<thead>
<tr>
<th>Focus Group 4 (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

Mean Age FG4 13.60
Std Deviation FG4 1.20

Total Mean Age 14.00
Total Std Dev FGs 3.12
Total Age Range 8 – 18
Total % Female 58.4 (n=14)
Total % Male 41.6 (n=10)
Total % NZ Euro 83.3 (n=20)
Total % Māori 8.3 (n=2)
ADULT PARTICIPANTS

Adult participants consisted of a variety of adults within the child service-users’ family systems who were receiving contact from CRFSS at the time of data collection. Those who were primary adult service-users on referral are known as ‘index’ service-users. An ‘index’ service-user is usually the parent with the major mental illness and/or the most significantly disabled due to mental illness if both parents have psychiatric diagnoses. Table 3.3 shows this data.

Table 3.4 records the relationship of adult participants to child service-users at CRFSS, and the length of time the family had been service-users of the service. The adult sample of 32 had 47 service-user children, hence the increased sample to 47.

TABLE 3.3 – FREQUENCY TABLE SHOWING CRFSS SERVICE-USER INDEX STATUS OF ADULT PARTICIPANTS (N=32)

<table>
<thead>
<tr>
<th>Status</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant an index service-user for CRFSS</td>
<td>19</td>
<td>59.38</td>
</tr>
<tr>
<td>Participant not an index service-user for CRFSS</td>
<td>13</td>
<td>40.62</td>
</tr>
<tr>
<td>TOTAL</td>
<td>32</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Table 3.4 – FREQUENCY TABLE SHOWING RELATIONSHIP OF ADULT PARTICIPANTS TO CRFSS CHILD SERVICE-USERS, AND LENGTH OF TIME WITH SERVICE (N=32)

<table>
<thead>
<tr>
<th>Section 2, Questions 1 and 2</th>
<th>Years</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of time children with CRFSS (N=47)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>4.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>2.27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>0.4 – 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship of participant to children (N=32)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>29</td>
<td>90.62</td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>2</td>
<td>6.25</td>
<td></td>
</tr>
<tr>
<td>Step-parent</td>
<td>1</td>
<td>3.13</td>
<td></td>
</tr>
</tbody>
</table>
Gender, age group, country of birth and ethnicity of the adult sample are shown in Table 3.5. Only 31.2% of the sample were male. The most common age range was 41–45 years.

<table>
<thead>
<tr>
<th>Section 1</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>31.25</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>68.75</td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31–35 years</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>36–40 years</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>41–45 years</td>
<td>10</td>
<td>31.25</td>
</tr>
<tr>
<td>46–50 years</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>50–55 years</td>
<td>3</td>
<td>9.37</td>
</tr>
<tr>
<td>56–60 years</td>
<td>3</td>
<td>9.37</td>
</tr>
<tr>
<td>61–65 years</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Mode</td>
<td>41–45</td>
<td></td>
</tr>
<tr>
<td><strong>Country of Birth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>2</td>
<td>6.24</td>
</tr>
<tr>
<td>India</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>France</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>New Zealand</td>
<td>27</td>
<td>84.37</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European</td>
<td>25</td>
<td>78.11</td>
</tr>
<tr>
<td>NZ European and Māori</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>NZ European and Zimbabwean</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>European</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Māori</td>
<td>2</td>
<td>6.24</td>
</tr>
<tr>
<td>New Zealander</td>
<td>1</td>
<td>3.13</td>
</tr>
</tbody>
</table>

As recorded in Table 3.6, 40.6% of adult participants were living in a partnered relationship at the time of data collection and had a mean of 2.2 children in their care. Of the sample, three were grandparents caring for grandchildren, two of whom were caring for CRFSS service–user children.

Those in paid employment were 37.5% of the sample; the remainder were on a partial or full government benefit. Those in paid employment approximately
represents the sub-group of adult participants who did not have a mental illness. In relation to accommodation, 50% lived in their own homes; the remainder in rented accommodation, half of which were state-owned.

### Table 3.6 – Frequency Table showing Family Living Arrangements, Source of Income, and Housing Type of Adult Participants (N=32)

<table>
<thead>
<tr>
<th>Section 1</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living in a Partnered Relationship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>59.38</td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>40.62</td>
</tr>
<tr>
<td><strong>Children living with</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No children living with</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>Yes children living with</td>
<td>32</td>
<td>100</td>
</tr>
<tr>
<td>Mean number of children per participant</td>
<td>2.2</td>
<td>–</td>
</tr>
<tr>
<td>Mean age of children living with</td>
<td>11.2</td>
<td></td>
</tr>
<tr>
<td>Age range of children living with</td>
<td>2 – 22</td>
<td></td>
</tr>
<tr>
<td><strong>Children not living with</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No children not living with</td>
<td>23</td>
<td>71.88</td>
</tr>
<tr>
<td>Yes children not living with</td>
<td>9</td>
<td>28.12</td>
</tr>
<tr>
<td>Mean age of children not living with</td>
<td>25.7</td>
<td></td>
</tr>
<tr>
<td>Age range of children not living with</td>
<td>11 – 43</td>
<td></td>
</tr>
<tr>
<td><strong>Source of Participants’ Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>14</td>
<td>43.74</td>
</tr>
<tr>
<td>Benefit plus part time work</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Wages</td>
<td>12</td>
<td>37.50</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living in own house</td>
<td>16</td>
<td>50.00</td>
</tr>
<tr>
<td>Living in state rental</td>
<td>8</td>
<td>25.00</td>
</tr>
<tr>
<td>Living in private rental</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>No details re type of rental provided</td>
<td>2</td>
<td>6.25</td>
</tr>
<tr>
<td>Comments re type of rental unclear</td>
<td>2</td>
<td>6.25</td>
</tr>
</tbody>
</table>

**Psychiatric Illness**

To provide a context for this study of parents with serious and chronic mental illness, adult participants were asked questions about their mental health history and that of their children’s other parent(s), and other family members (Section 4, Questions 1–3). These were:
1. Do you have a diagnosed mental illness (including Alcohol and Drug)? Yes/No.

2. Think about the child(ren) from your family who attend Caroline Reid. Does this child(ren)’s other parent have a mental illness? (If you are not a parent, then fill this out for either of the child’s parents.) Yes/No.

3. Is there any other person in your family who has a diagnosed mental illness (include current partner if not child’s parent mentioned above)? Yes/No.

The responses to these questions were combined and analysed. Table 3.7 shows the combination of ‘yes’ and ‘no’ answers, represented as letters ‘Y’ or ‘N’. Two participants responded that neither they, their children’s other parents, nor anyone else in their family had a mental illness diagnosis, despite parental mental illness being the reason for referral to CRFSS (NNN). The table showing the analysis for this is in Appendix I, and as stated, was calculated manually.

<table>
<thead>
<tr>
<th>Yes/No responses to Section 4, Questions 1–3</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NNN</td>
<td>2</td>
<td>6.24</td>
</tr>
<tr>
<td>NNY</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>NYN</td>
<td>7</td>
<td>21.88</td>
</tr>
<tr>
<td>NYY</td>
<td>2</td>
<td>6.24</td>
</tr>
<tr>
<td>YYY</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>YYN</td>
<td>8</td>
<td>25.00</td>
</tr>
<tr>
<td>YNY</td>
<td>7</td>
<td>21.88</td>
</tr>
<tr>
<td>YNN</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>YUY*</td>
<td>1</td>
<td>3.13</td>
</tr>
</tbody>
</table>

* ‘U’ equals ‘unsure’.

Additional questions about psychiatric diagnoses are presented in Table 3.8; 65.6% of the adult sample had a diagnosed mental illness. Of this group, 52.3%
had more than one diagnosis. Further details about psychiatric diagnoses, mental health treatment and history have been excluded due to relevance and are in Appendix I.

TABLE 3.8 – FREQUENCY TABLE SHOWING ADULT PARTICIPANT MENTAL ILLNESS DIAGNOSES (N=21)

<table>
<thead>
<tr>
<th>Section 4, Question 1</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant has diagnosed mental illness</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Participant has mood disorder</td>
<td>15</td>
<td>71.43</td>
</tr>
<tr>
<td>Participant has anxiety disorder</td>
<td>16</td>
<td>76.19</td>
</tr>
<tr>
<td>Participant has psychotic disorder</td>
<td>2</td>
<td>9.52</td>
</tr>
<tr>
<td>Participant has eating disorder</td>
<td>1</td>
<td>4.76</td>
</tr>
<tr>
<td>Participant has drug/alcohol addiction</td>
<td>2</td>
<td>9.52</td>
</tr>
<tr>
<td>Participant has more than one psychiatric diagnosis</td>
<td>11</td>
<td>52.38</td>
</tr>
</tbody>
</table>

In relation to Question 2, 56.2% (N=18) said their children’s ‘other parent’ had mental illness. Table 3.9 contains results about general diagnoses. In addition, it includes the index status of the ‘other parent’, and similarly, excludes treatment and other mental health history data (Appendix I).

TABLE 3.9 – FREQUENCY TABLE SHOWING INDEX STATUS AND PSYCHIATRIC DIAGNOSES OF ‘OTHER PARENT’ (N=18)

<table>
<thead>
<tr>
<th>Section 5, Question 2</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>This parent an index service–user for CRFSS</td>
<td>12</td>
<td>66.67</td>
</tr>
<tr>
<td>This parent not an index service–user for CRFSS</td>
<td>6</td>
<td>33.33</td>
</tr>
<tr>
<td>This parent has diagnosed mental illness</td>
<td>18</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Diagnoses of mental illness

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent has mood disorder</td>
<td>10</td>
<td>55.56</td>
</tr>
<tr>
<td>Parent has anxiety disorder</td>
<td>6</td>
<td>33.33</td>
</tr>
<tr>
<td>Parent has psychotic disorder</td>
<td>3</td>
<td>16.66</td>
</tr>
<tr>
<td>Parent has eating disorder</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Parent has drug/alcohol addiction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Parent has more than one psychiatric diagnosis</td>
<td>7</td>
<td>38.88</td>
</tr>
</tbody>
</table>

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33 As noted, if the adult participant was a grandparent or step–parent, they were asked to answer this question for either parent.
Additional demographic data were gathered about the psychiatric health of ‘other parents’ and ‘other family members’ (Question 3). This information was gathered to provide a full description of the sample and context for the study. However, given the limitations of a thesis, I had to prioritise what was included in the main body of the thesis. Although this demographic data are important background information, as it is very detailed I felt it did not need to be included in the thesis proper, hence its placing in Appendix I. What has been included sufficiently describes the sample for the general reader.

The main points from the data in Appendix I are:

- Twelve adult participants stated they had ‘other family members’ who had mental illness (Question 3);
- 37.5% of adult participants were raised in a family in which a parent had mental illness; only one of whom did not develop a diagnosable mental illness (Section 4, Question 4);
- Section 4: Q6–7, asked questions about current alcohol and drug use: one participant responded, ‘a lot’ (3.1%), five participants responded ‘sometimes’ (15.6%);
- In terms of alcohol and other drug use by other family members, three used ‘a lot’ (9.3%), and seven used ‘sometimes’ (21.8%). The most common substance used was alcohol;
- Adult participants were asked if they experienced significant physical injuries, illnesses and or disabilities, due to the known rates in this population, and the correlation between physical and mental health. Of the sample, seven (21.8%) responded affirmatively (Section 4: Q5).

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ETHICAL ISSUES AND CHILD PARTICIPANTS

This section applies discussion from the literature pertaining to ethical issues to what occurred during this project.

In relation to general principles of research with children, I had little success in involving child participants in the research process, which was recommended (Greig et al., 2007; O’Kane, 2000). My knowledge of ethics relating to child participants grew during the project, I did not fully understand the importance at the beginning and thus did not involve child service−users in the design stage. Although I utilised the knowledge of my colleagues who worked with these child
participants, and I had an older COPMI reference group member, these steps do not remove the need for child participants to be involved from the outset.

Child participants were asked if they wished to be involved in disseminating findings from the project, and participants of the two older focus groups showed strong interest. Opportunity will be given to all child participants to be involved in this.

ACCESS TO PARTICIPANTS

Gaining access to child participants was a smooth process at agency and ethics levels for this project. I had the full support of colleagues at CRFSS and SST management, and the ethics committee were satisfied CRFSS could provide the needed layers of support.

What took more time and effort was the consent process for parents to allow their children to participate, particularly for child interviews. They required time to think about their children taking part, which meant space between contact was necessary. Face-to-face appointments were needed to explain information thoroughly. As the service had good rapport with service-users and given the articulated rationale of allowing their children to have a say, most parents agreed. One avenue of support offered for child participants if an adverse response occurred was follow-up contact from CRFSS children’s workers (with the child’s consent), and parents tended to be reassured by this.

An interesting aspect of gatekeeping occurred when parents who had given consent for a child to be interviewed withdrew consent the following week. At the time they were vague about reasons; however, months later it was discovered that this was due to fear about what their child might reveal. The context was that a care and protection report-of-concern had been made by another agency around that time. Clearly these parents understood the limits to confidentiality explained in the information sheet and consent form.
For this project, consent was obtained for all child participants, regardless of age, as my colleagues and I wished the process to be transparent.

In the same way as parents, allowing adequate ‘time and space’ for child participants to think about information given before they assented, and to change their mind if needed, was important in providing an ethically safe environment. Parents were present at the majority of first appointments with child interview participants, and both parties were encouraged to read and discuss the information together. Child participants were offered choices regarding timing, location and support persons for their interviews.

Several examples of managing the tensions associated with the consent and assent process arose. A 12–year–old male participant whose mother had consented for a child interview and who had told his mother he was interested, was able to say ‘no’ to me when we met. Similarly, when holding Focus Group 1 at the annual camp, children were given two opportunities to opt out of participation and several children did so on both occasions. When contacting older child participants by telephone, several declined to participate. I felt reassured from these experiences about the safety and soundness of the process I was using to obtain consent and assent, and management of issues related to power.

When planning questions for interviews and focus groups I was careful to include open–ended questions which actively sought a negative spin on service delivery. As outlined in the results chapter (Chapter Four), child participants spoke freely about positive and negative aspects of service delivery. That child participants felt free to decline participation is also suggestive that power imbalance concerns were relatively minimal. This reassured me that to a certain extent, the power imbalance had been addressed.

In this project I made use of supervision pathways to discuss this issue: my research supervisor, CRFSS colleagues, and members of the reference group.
My clinical social work supervisor was also a member of the reference group, which enabled me to discuss these concerns during monthly supervision.

**ADVERSE RESPONSE**

The ethics consent form required the recording of anticipated child participant adverse response. These are found in Appendix A, and read:

- (1) *Child distressed by interview questions or focus group discussion*;
- (2) *Child may disclose information which may need to be acted on after interview*;
- (3) *Possible discrepancy between parents’ consent and child’s assent to research*.

Appendix A also outlines the action plans for anticipated adverse responses; the facilities, procedures and personnel available for dealing with emergencies; and arrangements for monitoring and detecting adverse outcomes.

Care was taken to explain to each child participant their right to withdraw from the process at any stage. I also emphasised that in signing consent they were promising if they felt upset in any way they would let me know and we would decide together the best way to get support. At the end of interviews and focus groups this was emphasised again. My work telephone number was given to each of them, along with that of my colleagues. Follow-up telephone calls were made to all children interviewed during the following week.

According to information provided to the ethics committee, three adverse responses of distress occurred during data collection or shortly afterwards: one child participant in an interview; and two child participants in Focus Group 1. Two required additional people to be contacted for support: the interviewee (detailed below) and a focus group member (described in the section regarding privacy/confidentiality). The third child participant spoke to one of the children’s workers immediately following the focus group, thereby gaining support.

During a child interview, a 12–year–old boy becoming increasingly quiet and withdrawn during questions about parental mental illness. I asked him if he
wanted to continue with the interview on several occasions, acknowledging the
sadness and difficulty in talking about the mental illness of a parent. We
continued with the interview at his wish, and at the end I said I needed to obtain
support for him. He said I could speak to his mother. I telephoned her with him
present. I then asked if I could tell the children’s worker who had transported
him to the office for the interview, which he agreed to. When I telephoned his
mother the following day she confirmed her son was safe and settled but an
emotional outburst had occurred towards his father (the parent with the mental
illness) on the day of the interview. She wondered if this was a healthy or
unhealthy response for a child who normally employs denial as a coping
mechanism. Although upsetting at the time, this enabled subsequent
conversations with this family and child service-user.

PRIVACY AND CONFIDENTIALITY
I was aware of the potential for child participants to be concerned about their
parents being given information they provided, as they knew of my working
relationship with them and had often seen me visit their parents at home. The
children may also have wanted to comment on other aspects of the service
which they did not want shared with the children’s workers. For this reason, I
took care to emphasise privacy and confidentiality. The information sheets the
children were given and discussed with them, clearly stated children’s
information was private to them, the researcher, and the supervisor of this
research project, unless a safety issue was raised.

Child participants were reminded of their autonomy regarding their own
information they had given in interviews and focus groups, and the need for
privacy and confidentiality regarding what other children said in focus groups.
All participants were aware I would not tell anyone what they said, apart from
my research supervisor. Children and young people of the ages of my
participants are familiar with these concepts as they are often explained to
them at school and/or in groups they attend. “What’s said in the room stays in
the room” is a frequently used phrase they readily repeat when asked about
rules for a group session, as many of them did.
There were two instances in which confidentiality of participants’ research data required negotiation. During a discussion about experiences of being treated differently due to parental mental health in Focus Group 1, a 12-year-old girl became visibly upset. As we were nearly finished the group and she appeared to compose herself, I continued with the group. We spoke afterwards at length. The questions about stigma and responses of other participants triggered recollections of regular episodes of serious bullying at school. She agreed to accompany me to meet with the CRFSS female children’s worker at the camp and was happy to talk this through with the children’s worker. She gave consent for the children’s worker to contact her parent and the school to follow through on these issues. This led to positive actions taken to improve the situation.

The second incident occurred at the end of a focus group for adolescent child participants. They were given paper and pens to write additional comments about the service to be included in the research. In her note a participant disclosed personal difficulties and wrote her name. I had already been aware of her withdrawn and sad body language during the session. I telephoned her shortly afterwards to advise of my concern and to ask what support she would like. She agreed that I could inform the female children’s worker, and my colleague was able to follow this through.

Consent to disclose information from these child participants enabled the team to discuss the concerns in routine meetings. The matters became part of normal service delivery.

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ETHICAL ISSUES AND ADULT SERVICE–USER PARTICIPANTS
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In relation to serious mental illness affecting participants’ ability to provide consent, the exclusion criterion of active psychosis was the only measure taken. With the support of the social work student, I believed all other adult service–users, including one with illiteracy, who wished to participate should be allowed the opportunity to express their views about the service.
I was nervous about how participants would respond to questions regarding the impact of parental mental illness and stigma by association with their children. The safety plan, as outlined in the ethics application, of questionnaires supervised by the social work student, follow-up telephone calls by the social work student, and ongoing comprehensive service delivery by CRFSS, felt sufficiently supportive to me without being demeaning. To my knowledge, no adverse responses occurred.

In response to the work of Wilson and Neville (2009) and Pacquiao (2008), I argue that in this study, prioritisation of service-user perspectives and adherence to socio-ecological lenses which challenge dominant views and uncover participant realities, although only partially adhering to Wilson and Neville’s framework, are steps in that direction.

THEMATIC ANALYSIS

This section outlines methods used for the transcription and analysis of qualitative data. This section draws on the six-phase approach to thematic analysis developed by Braun and Clarke (2012).

Interviews were transcribed by an outsider, paid for by the University of Otago. Transcripts were not cleaned, and the transcriber deleted all files when the task was completed. As outlined, focus group data were transcribed during these sessions onto large sheets of paper.

The stages of thematic analysis are shown in Figure 1.
Familiarisation of data was facilitated by the first phase of analysis, that is, using broad codes of service delivery and questions, and entering data into simple tables (phases one and two). Thus, the first sweep of data used a deductive process. For example, the table for any question in the interview guide would have 10 variables (the number of interviewees), and the next column would show responses, cut and pasted from transcripts. For questionnaires and focus groups, I entered this data similarly into simple tables using the same format.

When this stage was completed, the second phase of analysis incorporated phases three and four. Data were read and reread, each data set analysed separately to allow inductions to be made without the influence of other data sets. Initial codes were induced from data relating to each question, and between questions in each area of service delivery, and preliminary sub-themes developed. Then data sets were compared, similarities and differences noted, and sub-themes began to be collapsed. This process of induction is described by Braun and Clarke (2012, p59) as “giving voice to experiences and meanings”; in this context, to service users’ views of CRFSS.

The third phase of analysis (phase five) involved a two-part analysis of the data. The first occurred when the sub-themes from the second phase of analysis
were linked to the twelve goals of the CRFSS narrative — an entirely deductive process.

The second part of phase five analysis used a combined deductive–inductive stage to develop overarching themes. I considered the sub–themes from the data from the perspective of the literature, returning to the data constantly to check interpretations and links made.

For example, sub–themes about CRFSS child service–users supporting each other, feeling accepted by each other, feeling as if they understood each other, feeling more like by CRFSS child service–users, were understood as peer support as I read the COPMI literature, and formation of a tertiary relational system as I studied the resilience literature. Questions which elicited these sub–themes also revealed that CRFSS child service–users felt more normal when they were with other CRFSS child service–users, and they could talk to them about their family situations and give advice to others about their family situations. Other data revealed child service–users experienced significant stigma in situations outside of CRFSS and felt that they had to keep parental mental illness a secret, yet this did not occur when at CRFSS. Thus, the themes of peer support and stigma were linked in the findings. Other sub–themes were more strongly deduced. For example, the dominant theme of the importance of CRFSS worker relationships with service–users was understood by how it is conceptualised in the literature — as relationship–based practice.

Although I used theory in the late stages of analysis to collapse, connect and make sense of themes, I approached analysis without any theoretical perspective. It could be argued that theory was derived from data in a similar manner to what occurs when grounded theory is employed (Bryman, 2012).

The sixth phase equates to the process of writing the results chapter of the thesis. In doing so, I am telling the story of findings using predominant themes, leading the reader towards answering the research question.
QUANTITATIVE ANALYSIS

Due to the small sample, and access to and familiarity with Excel, I used this software for all but one set of calculations and to construct tables of descriptive statistics. One set of calculations was calculated manually, in consultation with the university statistics department, as this was the most straightforward method. This data are shown in Table 7 above.

CHAPTER SUMMARY

The chapter began by outlining the methodology of the project, explaining the guiding lenses of social work, utilisation-focused evaluation, and pragmatism. Social work’s views of participation, social justice and subjugating dominant perspectives encouraged eclectic methods, reflexivity, the service–user voice, resulting in what was labelled ‘research-mindedness’. This lens supported the socio–ecological approach taken in the thesis and resulting analysis of micro to macro factors affecting service delivery for this service–user group and the resilience of the NGO sector.

The utilisation–based evaluation genre supported eclectism and service–user participation with its ‘intended use for intended users’ approach, and the developmental notion of evaluation. Aligned with this lens was the paradigm of pragmatism, which enabled a predominantly qualitative methodology and also a structured approach to data collection and initial data analysis, thus providing formative evaluatory data. Pragmatism also made allowances for the limitation of resources and the resulting mixed–method questionnaire.

Reviews of COPMI programme evaluation indicated a lack of COPMI voice due to predominantly quantitative methodology, the absence of background service–user information providing a context for evaluation, lack of methodological rigour, and services which could not articulate their theoretical rationale. It was argued this study addressed many of these concerns.

As this project adhered to qualitative positivism, the five criteria of trustworthiness were deemed applicable. Claims were made for elements of
credibility, transferability, dependability, confirmability and authenticity. The insider–outsider continuum was discussed as fluid, with positives and negatives. Convenience and quota sampling were outlined, and the data collection methods of interviews, focus groups and questionnaires. Content analysis by way of Braun and Clarke’s thematic six–phase analysis process was reviewed.

Quantitative methodology underpinned the mixed–method, supervised, self–completion adult questionnaire, which was discussed as possessing reliability and content validity. The method of analysis was descriptive statistics via Excel spreadsheets.

The ethics of undertaking research with vulnerable populations was explored, with considerable space given to issues relating to children and research. Adults with serious mental illness were considered vulnerable from a research perspective.

The second half of the chapter addressed the details of the project in relation to: methodology outlined, the ethics consent process, use of a reference group, sampling, data collection and analysis. Extensive demographics of the sample were provided. As part of the discussion of steps taken towards qualitative trustworthiness, space was given to details of the researcher’s insider–outsider roles and influences in the project, and steps taken to ameliorate possible negative consequences. Research positioning was disclosed.

In relation to ethical matters, research with adult participants was a straightforward process. Data collection with child participants resulted in several adverse responses; however, it was argued that given that in all cases these responses opened opportunities for further conversations and support, they were only adverse in relation to the ethical consent notion of the word.
CHAPTER 4 – SERVICE–USER
PERSPECTIVES OF THE CAROLINE REID
FAMILY SUPPORT SERVICE

This chapter presents research findings from the study. The research inquiry sought service–user perspectives of the Caroline Reid Family Support Service (CRFSS), and how these compared to the service narrative, reflected in the twelve service goals. Predominant themes from service–user perspectives will form section headings for the chapter, with each theme addressing aspects of the service narrative. These themes were strongly convergent across all data sets. Any divergent and negative findings have been reported. The themes are:

1. The importance of relationships
2. Aspects of comprehensive family practice
3. Experiences of stigma for COPMI
4. Peer support
5. The benefits of recreational activities

These themes align closely with the aspects of socio–ecological, resilience–focused practice outlined in Chapter 2. Although at first glance this might suggest an entirely deductive approach to analysis, this was not what occurred. As discussed in Chapter 3, primary themes emerged from an inductive process, that is, the themes arose from findings, strong convergence in themes occurred across data sets, and literature was only applied to themes in the final stage of analysis. The correlation between themes and the literature is coincidental.

Every attempt has been made to protect the privacy of research participants in the presentation of these data. The four focus groups will be identified by the abbreviations FG1 to FG4. No individuals in focus groups will be uniquely identified, apart from general references to gender and age in a participant’s quoted comment or an explanation in the text. Interviewees will also be
assigned abbreviations; INT1 to INT10. Gender and age of interviewees will be identified in the text where appropriate. Adult participant data will be linked to a questionnaire number; AQ1 to AQ32. When referring to adult participants, unless specified in a quoted comment, gender will be alternately shown as male or female, with no correlation to the gender of the participant. The sample size for focus groups changed from N=24 to N=23 when one participant left Focus Group One during data collection. Where relevant, this is indicated.

Questions used in interviews and focus groups are outlined in the interview guide and will be repeated in the text where appropriate (Appendix E). The adult questionnaire is shown in Appendix F. Adult questionnaire section and question numbers will be provided in the text and in tables; for example, Section 2: Q1.

In line with current mixed−method best practice, quantitative and qualitative data will be thematically interwoven in the chapter (Bryman, 2012), (Creswell & Tashakkori, 2007). When referring to scales used in the adult questionnaire, the relevant words will be shown in single quotation marks. For example, some scales used a range of answers such as: ‘never’, ‘hardly ever’, ‘some of the time’, ‘most of the time’.

Terminology for different groups of research participants will be as follows:

- All research participants – *all participants*;
- Adults – *adult participants*;
- All child and adolescent participants – *child participants*;
- Differentiated groups of child participants – *interviewees or focus group members*.

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**THEME 1 – THE IMPORTANCE OF RELATIONSHIPS**

The importance of relationships between workers and service−users emerged as a predominant theme in all data sets. The only goal which directly relates to this theme is Goal 3: to establish a mentoring relationship with child service−users. However, data also emerged about the family worker
relationship with adult participants, and the importance of relationships also affected other goals of the service.

This theme is divided into two sections: worker relationships with child service–users, and worker relationships with adult service–users.

WORKER RELATIONSHIPS WITH CHILD SERVICE–USERS

Caroline Reid is good because there is always someone around to talk to and can talk to them about anything, and they can help you through things you have been struggling with (FG4).

This section begins with an explanation of data sources — specific questions asked. Child participant material arose from questions about experiences of one–to–one outings with children’s workers, whether child participants felt they could talk to workers about problems, and whether the children’s workers had ever assisted them. Further material arose from general questions about CRFSS activities. These questions were:

- What are the best and worst things about camps?
- What did you like and not like about monthly recreational days?
- Is there anything else you would like to say to add to the research?

General questions to adult participants that provided data contributing to Theme 1 were from Section 2: Q3, 12a, 12b and 13. Specific questions about worker relationships with child service–users are also found in Section 2: Q6, 7, 8 and 11. Section 2: Q6, 7, 10 and 11 have an increased sample size to 47, as adult participants were required to answer for each child with the service. The sample size reduces to 46 for Section 2: Q8 as one participant failed to answer the question. Sample sizes are indicated in the tables. Data from Section 2: Q9, 10 were excluded (Appendix J).

Adult participant perceptions were that their children’s relationships with the CRFSS children’s workers were the most important aspect of service delivery, and time with the workers was enjoyed by their children ‘most of the time’. The majority felt the children’s works were mentors for their children, at least ‘most
of the time’; that their children would talk to the workers if they were troubled at least ‘some of the time’; and that positive changes were observed in nearly three-quarters of their children which were attributed to spending time with the workers. Workers were described as trusted, safe, fun, supportive, and having communication skills. Some children struggled with trust and communication and needed additional support in this area. The main improvements to service delivery suggested by adult participants were more frequent one-to-one visits from the children’s workers and more recreation days. One participant suggested that if CRFSS obtained more funding, more children could be helped by the service.

Themes from child participant data were similar. Similar numbers (80–94%) of participants could talk to workers if troubled. Most participants felt they knew workers well, trusted them, felt supported by them, appreciated advice and assistance given. Continuity of worker relationship was very important for child participants. Children’s worker knowledge of their family situations was recognised as important. Limitations noted related to personal struggles some had with shyness and trust, the working hours of the children’s workers, not understanding the value of talking, and concerns about what might happen if workers became involved. Child participants wanted more frequent one-to-one visits from the children’s workers, and service delivery extended in some form beyond 16 years of age.

**FINDINGS FROM GENERAL QUESTIONS**

When asked if they felt they could talk to the children’s workers if they had a problem, all interviewees and 54.1% of focus groups responded ‘yes’ (Table 4.1).
The role of providing assistance in trust formation and therefore relationship development was queried. Child participants were asked if they could recall an occasion in which the children’s workers had helped them with anything. Eight of 10 interviewees and 66.6% of focus group members could remember occasions in which the children’s workers had assisted them (Table 4.2).

Adult participants’ perceptions of their children’s enjoyment of spending time with the children’s workers revealed that over 90% felt their children enjoyed these visits most of the time (Table 4.3).
TABLE 4.3 – FREQUENCY DISTRIBUTION OF ADULT PARTICIPANTS’ PERCEPTIONS OF THEIR CHILDREN’S ENJOYMENT OF SPENDING TIME WITH THE CRFSS CHILDREN’S WORKERS (N=47)

<table>
<thead>
<tr>
<th>Section 2, Question 6</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the time</td>
<td>43</td>
<td>91.49</td>
</tr>
<tr>
<td>Some of the time</td>
<td>3</td>
<td>6.38</td>
</tr>
<tr>
<td>Hardly ever</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>2.13</td>
</tr>
</tbody>
</table>

In response to being asked which CRFSS activities their children enjoyed, data revealed spending time with the children’s workers rated more highly than any other aspects of CRFSS service delivery they enjoyed (Table 4.4).

TABLE 4.4 – FREQUENCY DISTRIBUTION OF ADULT PARTICIPANTS’ PERSPECTIVES ON THEIR CHILDREN’S ENJOYMENT OF CRFSS ACTIVITIES (N=46)

<table>
<thead>
<tr>
<th>Section 2, Question 12A</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saturday Rec days or 13+ events</td>
<td>34</td>
<td>73.91</td>
</tr>
<tr>
<td>Camps*</td>
<td>35</td>
<td>76.09</td>
</tr>
<tr>
<td>Caroline Reid Magazine</td>
<td>18</td>
<td>39.13</td>
</tr>
<tr>
<td>Small group outings with children’s workers</td>
<td>41</td>
<td>89.13</td>
</tr>
<tr>
<td>1–1 time with children’s workers</td>
<td>42</td>
<td>91.30</td>
</tr>
</tbody>
</table>

*3 participants noted their children had not yet attended a camp

As discussed in Theme 5, adult participants said 92% of their children liked the recreation days ‘most of the time’ and attended most events, yet in response to this question they felt only 73.9% of their children enjoyed monthly recreation days. The most probable explanation, given all data relating to child service–user service delivery, is when offered the opportunity to prioritise aspects of service delivery, they felt individual time and small group outings with the children’s workers rated more highly for their children.

When asked if their child was troubled by something, did they feel they would be able to talk to the CRFSS children’s workers about it, 65.9% of adult participants said their children would talk to the children’s workers ‘most of the time’, and a further 29.7% ‘some of the time’ (Table 4.5).
When adult participants were asked if they viewed the children’s workers as mentors for their children, 86.9% felt they were ‘most of the time’ (Table 4.6).

Adult participants were asked if they had noticed changes in their children which they believed were due to spending time with the CRFSS children’s workers, and 72.3% responded affirmatively (Table 4.7). Changes were noted across the entire age of child service–users.
RELATIONAL THEMES

These are the same workers which give reassurance to kids and that continuity engenders trust.

The predominant findings from the qualitative data were that child participants trusted the children’s workers. This trust was dependent on the length of time child participants were with the service, and staff retention. Sub-themes emerged such as the depth of relationship and felt closeness to the workers; the enjoyment of time spent together; having someone to talk to; the communications skills of the workers; longevity of relationship; support, both emotional and practical; the value of knowing about the wider family situation, and the workers as role models. Adult data revealed changes in child participants which they attributed to these relationships.

TRUST

Trusting the workers was prominent in both adult and child data. When adult participants were asked about children’s workers as mentors, many noted trust:

She loves the children’s workers. They are trusting, safe and they care about the children (AQ25).

In the context of participants speaking of trust, they highlighted other traits such as “caring”, “reassurance” and “safety”. One participant said that because her child trusted the workers, this relationship enabled growth:

Someone they get to know and trust to push them to try new things (AQ20).

When asked if they felt their children would talk to the children’s workers if they had a problem, several adult participants said they would do so because they trust them:

Because she trusts them and feels safe too (AQ26).

Child participants agreed. The older three focus groups (FG2, FG3, FG4) spoke of feeling they could trust the workers and therefore feeling they could talk about problems with them.
... if I was spending time with [male children’s worker] I could tell him about something that was wrong with me, it was quite good (INT10).

Because they talk to you and get to know you. You can trust them (FG2).

Members of focus group one, the youngest child participants, were more reluctant to talk to the workers if they had a problem, but when asked a less direct question about what they enjoyed about the visits, one member said:

Tell them what you like and don’t like about your life and they will keep it a secret – can trust them (FG1).

DEPTH OF RELATIONSHIP AND FELT CLOSENESS

Many comments by adult participants described aspects of a close, positive relationship between the children’s workers and the children. Descriptions such as the children’s workers being “friends” and “family” to their children; and other phrases such as “bonded well”, “identified with”, “comfortable” with, and “enjoys time with (male children’s worker’s name).” Five participants spoke of the children’s workers as ‘fun’.

When asked if her child would talk to the children’s workers if troubled, several participants said their children would do so because of the depth of relationship:

...she has become quite close to the leaders (AQ3).

Another felt this depth of relationship her child had with the children’s workers would help her child to overcome difficulty communicating:

Finds it hard to voice concerns at times but has good relationship with workers so would see them as an option were he able to open up (AQ14).

Child participants expressed similar sentiment, but in a different way.

The workers aren’t scary (FG3).

...have grown up with them (FG4).

When asked about what they enjoyed about one-to-one visits, other comments by child participants alluded to a depth of relationship:
Getting to know workers more (FG3).

Probably just seeing them, like in between the month or two that we’d have the rec day (INT4).


ENJOYMENT

Regarding child attitudes to spending one-to-one time with the children’s workers, adult participants commented:

Always gets excited about having one to one time with children’s worker (AQ6).

Loves the whole process (AQ29).

Child participants noted about one-to-one visits:

He’s always been there for me, so ... I enjoy his company (INT1).

Take us to parks and have fun with us (FG1).

SOMEONE TO TALK WITH

When asked what it was they enjoyed about one-to-one time with the workers, child participants said they provided opportunities to talk with the workers. A cross section of ages and gender were represented in these comments.

Don’t have to worry about the other kids getting in your face – more opportunity to talk and be heard (FG2).

Tell about anything – they are interested and try to understand (FG4).

It feels nice to talk to them (FG1).

When INT9 was asked what she enjoyed about the monthly recreation days, she responded:

Different from socialising with my friends or going to some family event ... different people ... leaders ... they’re really easy to talk to. Not just about going and doing activities but going and actually having decent conversation. Fun, and its people you can trust (INT9)

Adult participants also stated their children valued having the children’s workers to talk to.
Having someone to listen and talk (AQ9).

COMMUNICATION SKILLS
Many adult participants referred to the communication skills of the workers as the main reason their children enjoyed the one-to-one visits, and this was perceived as an important aspect of relationship quality. Words and phrases such as “listen”, “friendly”, “easy to talk to”, “on their level” and “approachable” were mentioned.

Children’s workers’ communication skills were highlighted by one adult participant as the reason his child felt able to talk to them. Two participants referred to workers helping their children see a situation from a different perspective.

They listen well and have great solutions (AQ2).

Some adult participants noted communication skills when referring to the children’s workers as mentors:

They show a genuine interest in the children. Are approachable and listen. They are good examples (AQ14).

LONGEVITY OF THE RELATIONSHIP
Child data very often implied the importance of longevity of relationship. As outlined, at the time of data collection the male children’s worker had been with the service for about eight years; however, it had been difficult to retain staff in the female children’s worker role over the previous three years. Reference to the male children’s worker was made many times by child participants when referring to whom they would talk to if they had problems, with whom they had spoken about mental illness, what they enjoyed about one-to-one visits, monthly recreational days and camps. When asked at the end of the focus group if there was anything else participants wanted to say for the research, this comment was made:

Good that [male children’s worker] has stuck with it – gave everyone someone they knew over a long time (FG2).
Three interviewees (INT1, INT6, and INT10) resonated more strongly with the leader who had been at CRFSS the longest when asked who they would talk to if they had a problem.

Adult data also referred to the longevity of relationship. When asked about children’s workers as mentors, one participant said the ‘continuity’ of the relationship aided the development of trust.

> These are the same workers which give reassurance to kids and that continuity engenders trust (AQ13).

In relation to what they enjoy about one-to-one time:

> He likes [male children’s worker], and continuity with the same person, especially a male role model (AQ13).

When asked what the service did well for their children, the theme of consistency of relationship also arose:

> …providing him with someone who is interested in him – consistency (AQ5).

> Everything – being there and always coming back or making contact (AQ28).

**FEELING SUPPORTED AND VALUED BY THE WORKERS**

Many adult participants described their children feeling supported by the children’s workers in response to questions about one-to-one time with the workers, why their children would talk to the workers about a problem, and the children’s workers as mentors:

> Supporting him through difficult times (AQ5).

> They have been well supported by the worker; am sure they would discuss any issues (AQ9).

INT9, when asked what she enjoyed about spending one-to-one time with the children workers, noted they can provide support and advice because the relationship is different from friends and family members:

> …it’s good to have them to talk to. Because they’re not like friends, but they’re but they don’t know you as a person, and you can talk to your friends, but deep down they’re only
judging you, kind of? You can talk to your family, but really, they’re only concerned about you. But then there’s them, who, they’re like friends but they’re like — they have an older perspective, so they can get support and they can give me advice, but they won’t judge, kind of? ... Whereas [children workers’ names] they kind of have a general idea about what’s happening with the kids. So, they know what they’ve got themselves into! (INT9).

The notion of support through giving advice also arose:

They give you ideas of what to do (FG1).

Support in broader terms was mentioned by child participants. When asked about recollections of times the children’s workers assisted them eight of 10 interviewees and 66.6% of focus group members could recall times when the children’s workers assisted them with practical needs, personal issues, and by supporting their parents. Examples of practical assistance include: provision of transport, helping to access a course (INT1), obtaining a bike (INT10), sponsorship to a camp (INT9), first aid (INT5), and earthquake relief (INT8). Further data are in Appendix K.

Child participants recalled assistance with more personal areas of their lives. One focus group member from FG4 said the workers had assisted him with earthquake related anxiety and a phobia of the dark by referring for counselling and supporting with this process. Participants from two different focus groups (FG2, FG4) could remember assistance with situations of bullying or teasing from other children in which the workers helped them.

Global effects of support were noted by several.

... they helped me to be who I am (FG2).

Another effect of support was noted by one adult participant:

Makes her feel important and worthy (AQ27).

Knowing support was there, even if not needed, was mentioned by two adolescent participants (INT8, INT10):
Yeah definitely .... I could like if I needed to, sort of thing, I feel I could (INT8).

Another group (FG3) described the workers’ “understanding their parents’ mental illness” as something which helped them. FG1 and INT3 felt that when the workers were helping their parents they were also helping them.

*Helped when mum was in a bad situation by giving them an outing and helping with the situation (FG1).*

*Gives my mum a break (FG1).*

**WORKERS AS ROLE MODELS**

The children’s workers as role models was highlighted by several adult participants. One participant’s reason for his children’s enjoyment was the general feeling that the children’s workers were desirable people for his children to spend time with. The second quotation below picks up on the “continuity” of worker as a necessary factor for a role model. Congruent with results outlined above about longevity of worker, adult participants generally mentioned the male children’s workers in this regard.

*Because the workers are generally successful in work/life outside of Caroline Reid as well (AQ30).*

*He likes (male children’s worker), and continuity with the same person, especially a male role model (AQ34).*

*Friendly, fun, big brother feeling (AQ28).*

When asked whether the children’s workers were mentors for their children, many adult participants used the term ‘role models’. Role models were described as people who have the capacity to relate to children on their own level, thus able to provide guidance; being good examples, and male role models. Participants spoke of additional traits which they felt contributed to the workers being role models: consistency; pleasant and friendly; funny; kind; caring; respected; genuine interest in the children; and approachable.

*Because he has very few male role models and they have/are consistent (AQ18).*
He looks up to them and could do with a big brother. Doesn’t get a lot of dad time, he really needs male contact (AQ28).

Role model. They don’t set themselves apart. Join in on the kid’s level and guide (AQ8).

Use of the term ‘role models’ arose also in the question of adult participants about what they felt the service did well for their children. Seven participants used this term.

**WORKERS AS MENTORS**

Adult participants also used the term ‘mentors’ to their children, when describing the role of the children’s workers. When asked what the service did well for their children, seven adult participants noted they did well at providing mentors for them.

The workers are great mentors. They enjoy 1–1 time (AQ14).

**CHANGES IN CHILD PARTICIPANTS**

Question 11 inquired about changes that adult participants may have noticed in their children which they believed were due to spending time with the CRFSS children’s workers. As noted in Table 4.7 above, changes were perceived by 72.3% of adult participants to have occurred in their children across the full age of child service–users. All participants who noted their children had changed as a result of spending time with the children’s workers wrote comments explaining these changes. The changes were all expressed as positive improvements; no negative changes to children were noted. Prominent themes were: an increase in children’s confidence and mood, and improvements to children’s behaviour and capacity to relate to others. Although many variables may have contributed to these changes observed by, adult participants attributed these changes to their children spending time with the children’s workers.

**SELF–CONFIDENCE**

The predominant theme from the adult sample was they felt their children becoming more confident, across the full age range of child participants, due to
spending time with the children’s workers. Comments describe children feeling more confident to try new activities and meet new people, and a sense that this newly found confidence enabled an opening up of their children to realise their potential.

So much out of her shell. Willing to give things a go. Shyness had gone (AQ27).

He has taken on leadership qualities (AQ18).

Seems to not mind meeting new people like he did (AQ21).

**IMPROVEMENTS IN MOOD**
Another predominant theme was participants noticed their children of all ages were happier after spending time with the children’s workers.

**IMPROVEMENTS IN BEHAVIOUR**
Other comments highlighted positive changes in behaviour: more helpful and understanding, improved behaviour, matured, and more talkative at home.

His vocab and behaviour have improved (AQ12).

**INCREASED SOCIAL SKILLS**
There were seven comments by participants which described changes to their children’s ability to get along with others.

More caring and tolerant of others (AQ9).

He has gained confidence and learning to be a team player (AQ18).

**SELF−AWARENESS**
One participant said his child gained a better understanding of self which translated to understanding others also. Another felt her child had recognised leadership qualities in herself.

Better able to understand self, others and his father (AQ23).

**Advice**
One adult participant highlighted the role ‘sound advice’ from the children’s workers has played in their son’s life:
He has received sound advice on a number of instances supporting him to deal with tricky situations (AQ5).

LEARNING TO TRUST

Several comments suggested some child participants were learning to trust:

Bit more outgoing (they appear to trust) (AQ26).

Trusting (male children’s worker), trusting children’s workers, both know other people care about them, not just Mum (AQ6).

MEDIATORS AND LIMITATIONS OF WORKER–SERVICE–USER RELATIONSHIPS

Differences in children’s personalities and the role this has on children’s willingness and capacity to talk to adults was discussed by participants as something which may help or hinder their children from communicating with the children’s workers. Two participants felt the natural talkativeness of their children made a difference. However, eight adult participants said the reason for their children only talking to the CRFSS workers ‘some of the time’ was due to their children having difficulty talking about things which were troubling them. Five of these comments referred to the overall personality of the children being somewhat introverted:

He’s private and not very communicative (AQ13).

Another adult participant implied his daughter lacked assertiveness skills:

She doesn’t stand up for herself and won’t talk (AQ25).

One participant felt gender made a difference:

Boys aren’t as open as girls (AQ23).

Several participants from the ‘some of the time’ and ‘hardly ever’ category felt their children’s cautiousness was due to an underlying difficulty in trusting people:

He keeps things bottled up inside. Trust issues (AQ18).

Too scared to, not comfortable, embarrassed, doesn’t know what to say or how to start (AQ19).
Nine (37.5%) focus group members felt there were some limitations to being able to speak to the children’s workers about problems. Those in the youngest group gave a realistic practical reason:

*Sometimes they are not available – can’t reach them or don’t have money on the phone (FG1).*

An older focus group (FG3) said it depended on the problem, and in some situations a friend may be a better choice.

FG3 said they might not talk to the children’s workers because they were unaware that talking about a problem was useful. The younger focus group alluded to this also when querying the value in talking about a difficult situation when the issue had already been sorted out.

A further limitation was raised by FG1. A member was concerned about the consequences if they disclosed information to the children’s workers:

*It might be scary if they try to fix it (FG1).*

Two focus group participants stated they would not talk to the children’s workers if they had a problem. A member of the younger group (FG1) said they did not trust the children’s workers as much as their own mother. The other who said ‘no’ stated:

*I don’t tell many people stuff – not anybody at all (FG4).*

**Suggestions for Improvements to worker-service-user relationships**

When asked what CRFSS could “do better for your children”, the primary feedback was they wanted more frequent one-to-one visits by the children’s workers (Section 2: Q13).

*Maybe a bit more one-on-one with workers as only see them about 3–4 times per year (AQ26).*

*More time with her alone or in small groups, regular contact even just to say, ‘what’s up, how are you?’(AQ32).*

*Possible more phone calls just to say ‘Hi’, just short ones... (AQ28).*
Child participants were asked if there was anything they did not like about these outings or if there was anything which could be done differently to make these outings better experiences for them. All interviewees and one focus group said there was nothing they did not like about these informal outings.

No ... I like what they do. It makes me feel comfy and makes me want to talk more (INT2).

In terms of suggestions for improvements, interviewees and focus groups all said they would like more regular outings, and three interviewees (INT5, INT6, INT7) felt the outings would be better if the activities were more varied.

Not going always to the same place (INT7).

One child (INT3) felt the outings would be better for her if another child was present as well, due to feelings of shyness. Another (INT9), having stated she would have liked to meet more regularly, qualified this by saying that as she was finishing with the service soon it may not actually be helpful to meet more regularly.

When given the opportunity to make an additional comment for the research at the end of the focus groups, participants from FG2 and FG3 (who had all left the service at the time of data collection) clearly stated that they would like to have seen longer service delivery, more flexible discharge time, and ongoing contact after discharge.

It needs to be longer – till 18 years old; the end of school (depends on maturity levels and what you are doing) (FG3).

Would like ongoing contact even after they leave (FG3).

Should do something for the over 16’s, even if once or twice a year; a camp maybe? (FG2).

Given that the relationships with the children’s workers rated highly for child service–users, it follows that part of the desire for longer service delivery was to have further contact with the children’s workers.
The section outlines research findings about the importance of relationships in relation to CRFSS workers with adult service-users. Although this relationship is primarily the family worker with adult service-users, at times children’s workers are included.

Data for this section arose from both adult and child participants. Adult participant data came from direct and indirect questions (Sections 3 and 4). Child data similarly arose from both types of questioning. In this section, participant data are combined under themes.

Findings were that most adult participants felt safe enough to talk with the family worker if troubled about something ‘some of the time’. Reasons given were due to relationship formation with the worker which was supportive. Confidence was noted in the worker’s knowledge and skills. Child participant data supported this, and some limitations were noted, the main area for improvement being more frequent contact with the family worker.

**MOST OF US FEEL SAFE ENOUGH TO COMMUNICATE WITH THE FAMILY WORKER SOME OF THE TIME**

When asked if they would talk to the family worker if they were troubled by something (Section 4: Q11), 90.6% of the adult sample said they would do so at least ‘some of the time’ (Table 4.8).

<table>
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<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
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<td>Not at all</td>
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<td>3.13</td>
</tr>
<tr>
<td>Very little</td>
<td>1</td>
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<tr>
<td>Sometimes</td>
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</tr>
<tr>
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</tr>
</tbody>
</table>
Major themes were relationship formation with the family worker which enabled conversations, and the skills and knowledge of the family worker. One participant emphasised her own ability to communicate as the primary reason for easy communication with the worker about difficulties.

**RELATIONSHIP FORMATION**

Words such as “rapport”, “continuity”, “gotten to know”, “feel comfortable with”, “trust her a lot” and “bonded well” were used by many adult participants to describe the relationship they had with the family worker in the context of feeling able to talk to the worker if they had a problem.

> Because I have gotten to know the family workers and I feel comfortable with her (AQ24).

> A good rapport and continuity with that person (AQ13).

In a different question about how the family worker had helped, one participant said (Section 4: Q12):

> She has taught/helped me to trust another person ... by being there for me and consistent. Helped me get help for my grandchildren, with my daughters’ mental illness in a big way. I would hate not to have her (AQ18).

**SUPPORT**

In a general question to adult participants asking in what ways the family worker had helped them (Section 4: Q12), data describing a variety of methods of support emerged:

> Being there – listening, non-judgemental (AQ4).

> I know that she is there if I need her. I can confide in her (AQ3).

> Came round to see how I’m getting on with being a solo dad (AQ21).

> By helping my wife – it has taken the weight off my shoulders (AQ24).

Child participants also spoke of the family workers supporting their parents by visiting, talking with, and helping. They highlighted the family workers’ availability in emergency situations.
Someone to talk to, because you know what she’s like, you know what she’s going through... (INT9).

Talk to parents with mental illness and someone else in the house who knows and can help with it (FG1).

One interviewee (INT1) implied his parent trusted the family worker and as a result now had someone to talk with, and another that her grandmother (INT4) could talk to the family worker about issues she could not talk to her family about. This interviewee also noticed the impact of this support on her grandmother:

... talk to her and everything, and she seems a bit happier and stuff from chatting (INT4).

SKILLS AND KNOWLEDGE OF THE FAMILY WORKER

Another prominent theme which adult participants stated enabled them to talk to the family worker if they had a problem, was the perception the family worker was knowledgeable. One participant referred to the worker’s professional background giving a sense of confidence in the advice given. Another said the worker provides her with options from which she is free to choose. This implies the enhancement of self-determination.

Because I trust my worker will discuss it, give me options, and leave the choice to me (AQ18).

Similar data arose from a question asking in what ways had the CRFSS family worker helped them (Section 4: Q12). Prominent themes were providing information, advice, and assisting with problem-solving.

Advice, support, information, and updates on my child’s progress (AQ14).

She has given me more confidence with the girls and their behaviours and has given me advice (AQ3).

Helped me to understand more about myself and my illness. Helped me sort out issues in my home (AQ15).

THE FAMILY WORKER CARES ABOUT MY WHOLE FAMILY

One participant felt the worker’s belief and interest in the wellbeing of his whole family enabled him to communicate with the worker about difficult issues:
I trust them and believe they have a genuine desire to support not only my children but the family as a whole (AQ14).

BARRIERS TO COMMUNICATION

Some adult participants spoke of personal inhibitions, such as feeling frightened to ask for help preventing them from having conversations with the family worker when troubled (one from the ‘very little’ category, and two from the ‘sometimes’ category (Table 8).

I don’t like to ask for help but if they came to see me or rung when I was in a bad patch I would (AQ26).

I tend to hold things close in and work things out with time (AQ20).

One adult participant who responded ‘sometimes’ to this question said a previous negative experience with telling a CRFSS family worker a problem would affect whether he would do so in the future.

Depends on what I feel troubled by. Overreactions by Caroline Reid workers have caused us a great deal more stress and unnecessary trouble (AQ30).

MORE FREQUENT CONTACT

When asked what other ways adult participants would like support from the family worker, the main response was more frequent visits (Section 4: Q13). One parent requested more flexible working hours by the family worker, so he could see her more often.

A child participant also noted ‘more frequent visits’ asked about improvements to service delivery, having noticed the value of the visits to her parent:

Because I know mum always goes like, I talked to (name of family worker removed) the other day about something, and then she goes, oh that was a good talk ... oh I really should have a coffee with (name of family worker removed) ... never gets around to it so you could contact them more, the parents more, the family more (INT3).
SUMMARY – THEME 1

Overwhelming acknowledgement of the value and positive influence of relationships between CRFSS workers and child and adult participants emerged from service–user perceptions in this study. This was the most convergent theme across all data sets. Some of this data emerged from direct questions, but the majority arose from general, open–ended questions about many areas of service delivery. The main feedback for change was for more contact from CRFSS workers with child and adult service–users. The goal of developing a mentoring relationship with child service–users appears to have been met for many service–user children, particularly as they grew older.

Relationship formation occurred between many adult participants and the family workers. Many felt they knew the workers well, trusted them, felt supported, and appreciate the advice and professional perspective. Barriers were noted, primarily relating to adult participant issues with trust. One participant reported an experience in which he felt the family worker overreacted, and which may prevent him from talking to the family worker about problems in the future.

Limitations which arose provide valuable feedback to the service. Some were related to individual differences in relating which require careful consideration, such as difficulties for child and adult participants in trusting others and making allowances for the shyness of a child. Other limitations related to the working hours of the family workers and the need to at least clarify family worker roles with other adult service–users in the family system or have more contact with these adult family members.

THEME 2 – COMPREHENSIVE FAMILY PRACTICE

This theme concerns the broad, multifaceted aspects of whole family service delivery inquired about. I have introduced the notion of comprehensive family practice to these findings and related service goals, as this seems the most appropriate way of grouping such diverse areas of service delivery across the
family system. Comprehensive family practice was discussed as service delivery which considers and attends to broad areas of service–user family life, from psychological health to practical needs. As stated, due to the multiple types of need and uneven development with occurs when people grow up in marginalised and risky environments, comprehensive service delivery which is flexible enough to be tailored to each family’s needs enhances resilience for this CRFSS service–user group.

Service Goals 5–12 apply to this theme. These goals focus on the mental health and wellbeing of adult and child participants and their families, other areas of health and wellbeing, ensuring families have the support they need, and supporting adult service–users in their parenting roles. The format for this theme is different from other themes. Due to the extensive amount of material covered, short summaries are provided at the end of each sub-theme in addition to the summary at the end of the theme. Some data were solicited, and some arose from general questions. Data from all groups of participants contributed.

Most service goals reviewed under this theme required preparatory questions about the topic to be asked of participants before direct questions about service delivery were asked. For example, before questions were asked about child service–user knowledge of mental illness gained while at CRFSS, child participants were asked questions such as how would you define mental illness, do you know who in your family has mental illness, who do you talk to in your family about mental illness, and who do you talk to outside the family about mental illness? They were then questioned about conversations with CRFSS children’s workers about mental illness. The purpose of preparatory questions was to introduce the topic and to establish baseline knowledge. Where relevant, preparatory data are included in the text, otherwise they are in appendices which will be referred to where relevant.
As outlined, data collection under Goal 5 captured predominantly brief or informal service provision\textsuperscript{34}. As noted, sample size for focus groups changed from N=24 to N=23 as one participant left Focus Group 1 during data collection. Where relevant, this is indicated.

In relation to mental health education, 72.7% of child participants could remember learning about mental illness at a CRFSS activity; the remainder were unsure. Four of 10 interviewees and 65.2% of focus group members recalled speaking to a CRFSS worker about mental illness; 21.8% of adult participants felt the service helped their children learn about mental illness ‘a lot’, and 43.7% ‘some of the time’. When asked to rate who other than themselves speaks to their children about mental illness, adult participants rated CRFSS workers higher than other family members, and significantly higher than anyone outside the family.

\textit{CHILD PARTICIPANT PERCEPTIONS}

Child participants were asked if they understood why they attended CRFSS. If they did not know, this was explained to them. They were then asked what they understood by the term ‘mental illness’. For those who could not explain, an age appropriate explanation was given. Other preparatory questions were: who in your family has a mental illness, and have you spoken to anyone in your family about mental illness? Of the 10 interviewees, six had spoken to a family member, and four had not. Fourteen focus group members had spoken to family members, seven were unsure if they had, and three had not. The remainder of this data detailing who in the family system they had spoken to, and data from other preparatory questions to child participants about mental illness, are in Appendix L. As outlined, this material provides important background information, it was felt the level of detail was not needed in the main body of the thesis to describe the sample.

\textsuperscript{34} The only group who had received a dedicated educational and therapeutic programme was Focus Group One. Most members of this group had attended a four–day CUMI course (children understanding mental illness).
One interviewee (INT3) said her mother had tried to explain a little about mental illness, but she felt she learned more at CRFSS:

*Telling me things that mum won’t tell me or none of my family tell me (INT3).*

Questioning then moved to more direct queries about CRFSS service delivery. These results are shown in Table 4.9.

**TABLE 4.9 – FREQUENCY DISTRIBUTION AND OTHER DETAILS FROM CHILD PARTICIPANT DATA REGARDING WHO THEY TALK TO ABOUT MENTAL ILLNESS**

<table>
<thead>
<tr>
<th></th>
<th>Interviews (N=10)</th>
<th>Focus Groups (N=24, N=23)</th>
<th>FG %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Have you talked to anyone outside the family about mental illness?</strong></td>
<td>3 had spoken to someone (2 were CRFSS workers)</td>
<td>18 participants had spoken to someone.</td>
<td>75.00</td>
</tr>
<tr>
<td>2 had in the past, but no longer needed to</td>
<td>4 had not.</td>
<td>16.67</td>
<td></td>
</tr>
<tr>
<td>5 said ‘no one’</td>
<td>2 members were unsure.</td>
<td>8.33</td>
<td></td>
</tr>
<tr>
<td><strong>Who would you talk to if your parent became mentally unwell again?</strong></td>
<td>All could identify someone inside the family, 4 said would talk to family first.</td>
<td>19 would talk to a CRFSS worker.</td>
<td></td>
</tr>
<tr>
<td>Most could identify someone outside the family they trusted.</td>
<td>The three next popular choices were friends, a counsellor and a family member.</td>
<td>82.61</td>
<td></td>
</tr>
<tr>
<td>2 said they would talk to whoever would listen.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Have you talked to a CRFSS worker about mental illness?</strong></td>
<td>4 had spoken to CRFSS workers.</td>
<td>15 had spoken to CRFSS workers.</td>
<td>65.22</td>
</tr>
<tr>
<td>INT10 said no but felt he could have if he had needed to.</td>
<td>6 had not.</td>
<td>26.08</td>
<td></td>
</tr>
<tr>
<td>3 said no, 2 couldn’t recall</td>
<td>2 could not remember.</td>
<td>8.70</td>
<td></td>
</tr>
<tr>
<td><strong>Learn about mental illness at a CRFSS activity?</strong></td>
<td>7 recall learning about mental illness at CRFSS</td>
<td>17 recalled learning about mental illness at CRFSS.</td>
<td>73.91</td>
</tr>
<tr>
<td>3 were unsure</td>
<td>6 were unsure.</td>
<td>26.09</td>
<td></td>
</tr>
</tbody>
</table>
More focus group participants had spoken to someone outside the family (75%) than within (58.3%). Of the five interviewees who said ‘no one’, four had not spoken to a family member either about parental mental illness (INT2, INT5, INT6, and INT7). The fifth, INT4, said she had spoken to various family members over the years but no longer does so as she feels she no longer needs to.

_Because I’ve just moved on from that. Had enough of it in my life really (INT4)._ 

Another participant (INT8) said he does not feel the need to talk to anyone about the situation as it is not a concern for him.

_I don’t feel like I really need to talk to anyone, I mean, I don’t worry about it in the sense that ... I know that they can’t help it, and I don’t need to worry about, like, them having, like, lack of support or anything, because they’ve always had the support (INT8)._

One interviewee spoke of the barriers to talking about her mother’s mental illness:

_INT9: Mm ... no−one. I mean, a few people will ask how mum is, and I was like, she’s fine ... but it’d be, like, anybody from Caroline Reid, like if you ask how mum is, like, well, she’s fine, and it’s like anyone asking from the outside, but then there was, like ... um, she would have her off days, and even if I ask her [if] she’s okay, she’ll just go, I’m tired, and even I don’t understand what’s going on ... so if people ask me how mum is, I fully don’t even understand. And it’s hard to – it’s hard to say how she really is ... so, yeah. It’s kinda hard._

Interviewer: _When you said that you’ve got your two friends that you talk to, do you ever talk to them about what’s going on at home?_

_INT9: ... well they don’t know the deep background stuff with my mum, but they know that I’ve been to boarding school and I’ve been taken out of the house before, but it’s never a very big topic we talk about, it’ll just come up in conversation. I mean, yeah, a lot of my friends have been through the whole custody thing. Especially – one of my friends just ran away from home, went to live with her mum ... But she just doesn’t understand. And she couldn’t understand why my mum couldn’t take custody. And I’m just, like, it’s just the way it is, it just doesn’t happen that way._
Two of seven interviewees who responded they had learned about mental illness at CRFSS activities had difficulty recalling what they had learned. As focus groups could share memories together this probably influenced the ease of recollection and the number of interventions remembered. Interviewees recalled receiving books about mental illness including a “colours book about depression”, group discussions about mental illness, having their questions answered at a panel discussion, and a puppet show. A full account of these findings is in Appendix M.

The themes from focus group member were: what mental illness is; types of mental illnesses; how mental illness relates to their families; treatments for mental illnesses; supports for children; and that they are not alone. A full record of their responses is in Appendix M. The youngest focus group (FG1) had the most to say. This group made 11 comments compared to two other groups (FG2 and FG4) who made one comment each.

*I learned what it actually is – before I came I had no idea what mental illness is* (FG4).

*Learned that both parents have mental illness, not just my mum* (FG1).

*Learned who to talk to if it happens* (FG1).

*You’re not alone* (FG3).

*What they do to try and treat it* (FG1).

The poor recall of some child interviewees is of note. INT5 and INT7 had attended a camp, two weeks prior to data collection, in which a Puppet Show and panel discussion was held about mental illness. INT5 recalled vaguely when prompted; INT7 said he did not remember at all. When queried, he said it was not a topic he liked to discuss.

A member of FG3 said she realised her parent with mental illness still cared about her, even though they might not demonstrate this in an obvious manner.

*They still care even if they do not show it* (FG3).
One child participant (FG1) raised a potential negative effect of educating children about parental mental illness. This child said he now worried he might get a mental illness. The role of denial as a coping mechanism for children living in difficult situations is a matter for further discussion. A further example was INT7 who became visibly distressed when discussing mental illness during the interview.

**ADULT PERCEPTIONS**
Preparatory questions were asked of adult participants concerning what their children knew about their mental illness or the mental illness of the ‘other parent’ or ‘other family members’ (Section 4: Q1–Q3). All adult participants with mental illness (N=24)) said their children knew at least ‘a little’, 70.1% children knew ‘some’, and 29.1% children knew ‘a lot’. Participants said 66.6% of their children had at least some knowledge of the mental illness of the ‘other parents’. Only one child participant was reported to know nothing. Adult participants were asked whether they ever had conversations with their children about mental illness (Section 4: Q16); 71.8% spoke to their children at least ‘sometimes’. These data are in Appendix N.

Participants were then asked if any other people had conversations with their children about mental illness, and if this occurred, they were then asked to choose from a list (Section 4: Q17). Participant selections from the list are in Table 4.10.
TABLE 4.10 – FREQUENCY TABLE SHOWING ADULT PARTICIPANT DATA REGARDING WHO TALKS TO THEIR CHILDREN ABOUT MENTAL ILLNESS (N=32)

<table>
<thead>
<tr>
<th>Section 4, Questions 17 and 18</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others talk to participants’ children (Q17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other parent</td>
<td>14</td>
<td>43.75</td>
</tr>
<tr>
<td>Current partner (if not other parent)</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Family member</td>
<td>11</td>
<td>34.38</td>
</tr>
<tr>
<td>School teacher</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Counsellor</td>
<td>3</td>
<td>9.38</td>
</tr>
<tr>
<td>Family friend</td>
<td>3</td>
<td>9.38</td>
</tr>
<tr>
<td>Caroline Reid children’s worker</td>
<td>19</td>
<td>59.38</td>
</tr>
<tr>
<td>Other mentor</td>
<td>3</td>
<td>9.38</td>
</tr>
<tr>
<td>Child’s friend(s)</td>
<td>2</td>
<td>6.25</td>
</tr>
<tr>
<td>Other – Please state</td>
<td>3</td>
<td>9.38</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>6.25</td>
</tr>
<tr>
<td>No comment</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Marked n/a</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>CRFSS helps child service−users learn about parental mental illness (Q18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>3</td>
<td>9.38</td>
</tr>
<tr>
<td>Very little</td>
<td>2</td>
<td>6.25</td>
</tr>
<tr>
<td>Sometimes</td>
<td>14</td>
<td>43.75</td>
</tr>
<tr>
<td>A lot</td>
<td>7</td>
<td>21.87</td>
</tr>
<tr>
<td>Blank</td>
<td>6</td>
<td>18.75</td>
</tr>
</tbody>
</table>

Adult participants who indicated ‘sometimes’ and ‘a lot’ in response to Question 17 made general remarks about the children’s workers having conversations with their children about mental illness. One adult participant recalled a comic book about mental illness her child was given. Others spoke of the workers being available to have more frequent discussions with their children and support them with problem solving if a parent was particularly unwell or something had changed with a parent with the mental illness.

Some said the workers explained what mental illness is and the impact of illness on different family members. One adult participant said their child learned that other families have mental illness too.

*When my children voice concerns about me they help them to understand what’s going on and what they can do about it (AQ14).*
Explaining to my child about the impact that mental health issues have on the whole family not just the person concerned (AQ19).

Regarding the two adult participants who responded, ‘very little’ to Question 17, one had previously remarked they did not speak to their child about parental mental illness, but their other parent did; the other did not comment.

In a general question to adult participants about what the service did well for their children, one adult participant said the service did well at providing his child with an opportunity to discuss mental illness.

*Gives them … chance to talk about mental illness (AQ32).*

When asked what the service could do better for their children, another participant felt the service could offer more focused interventions about mental illness, implying mental health education was a good thing. This was before the service offered the CUMI course.

*Try to teach kids to interact and talk to each other re the facts. That sharing they are in a similar situation. Have a support group where they can open up (AQ18).*

**SUMMARY**

Findings indicate that participants perceive CRFSS meets this goal for a large group of child participants, with 72.7% (N=33) of child participants acknowledging and articulating learnings about mental illness from CRFSS service delivery; the remainder of child participants could not recall if they had learned about mental illness. Just over half of the child participants recalled direct conversations about mental illness with the CRFSS children’s workers (57.5%). Adult participant findings agreed, with 65.6% of adult participants noting CRFSS workers helped their children learn about mental illness.

Recollection was an issue for some child interviewees; it was noted that focus group participants benefitted from discussing the matter together. The possibility of denial as a coping strategy for COPMI emerged from the findings. However, reluctance to talk about mental illness was not always due to denial. Child data indicated that sometimes parents are reluctant to talk about their
illness; sometimes children feel they have ‘been there, done that’ with talking about mental illness; and sometimes mental illness is sufficiently talked about at home that it is not necessary to talk about with others.

Most participants saw mental health education as a positive experience. Two limitations were noted: a child participant said he now faced the worry he would get a mental illness, and an adult participant commented on the possibility of bullying if her child revealed too many details to other children.

ASSESSING CHILD SERVICE−USERS’ AND SIBLINGS’ HEALTH AND WELLBEING

Assessing the health and wellbeing of child service−users and their siblings, was viewed as an important aspect of comprehensive family practice, and so direct questions were asked of adult participants in this regard. This is reflected in Goal 6. This goal traverses many aspects of CRFSS service delivery, thus findings about all child service delivery and aspects of the family worker role with adult participants are relevant to this goal.

Of note, findings outlined under Theme 1 which arose from a question to adult participants about whether they could talk to the family worker if they had a problem, are pertinent, as problems might be concerning their children. However, findings outlined in this section will be restricted to direct questions to adult participants about aspects of health and wellbeing of their children. No such questions were asked of child participants.

Adult participants were asked paired questions concerning their recollection of conversations with CRFSS workers about different aspects of their children’s mental health and wellbeing (Section 3: Q7, Q19−21). Topics included child development, child mental health, and any other aspects of child health and wellbeing. Some but not all questions requested qualitative responses. Results were that 75% of adult participants recalled talking to CRFSS workers about aspects of their children’s development and health and wellbeing (excluding mental health). Of the 68.7% who had concerns about their children developing mental illness at least ‘sometimes’, talking to a CRFSS rated significantly higher
than anyone else. Of the 59.3% who had noticed concerning mental health symptoms in their children, 47.3% had spoken to a CRFSS worker about these concerns. Other aspects of child health and wellbeing were noted by 81.2% of adult participants to have been discussed at least ‘sometimes’ with a CRFSS worker. (Shown in Tables 4.11 and 4.12.)

<table>
<thead>
<tr>
<th>Section 3, Question 7</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Very little</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Sometimes</td>
<td>17</td>
<td>53.13</td>
</tr>
<tr>
<td>A lot</td>
<td>7</td>
<td>21.87</td>
</tr>
</tbody>
</table>
### TABLE 4.12 – FREQUENCY DISTRIBUTION OF ADULT PARTICIPANT RECOLLECTIONS OF CONVERSATIONS WITH CRFSS WORKERS ABOUT CHILD MENTAL HEALTH (N=32)

<table>
<thead>
<tr>
<th>Section 4, Questions 19 and 20</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Have you ever been concerned about your child(ren) developing a mental illness? (Q19) N=32</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>7</td>
<td>21.87</td>
</tr>
<tr>
<td>Very little</td>
<td>3</td>
<td>9.37</td>
</tr>
<tr>
<td>Sometimes</td>
<td>13</td>
<td>40.63</td>
</tr>
<tr>
<td>A lot</td>
<td>9</td>
<td>28.13</td>
</tr>
<tr>
<td><strong>Who I have spoken to about mental health concerns for my child (Q19) N=25</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family member, excluding other parent</td>
<td>6</td>
<td>24.00</td>
</tr>
<tr>
<td>Partner (if not the other parent)</td>
<td>2</td>
<td>8.00</td>
</tr>
<tr>
<td>Other parent</td>
<td>1</td>
<td>4.00</td>
</tr>
<tr>
<td>Caroline Reid Worker</td>
<td>10</td>
<td>40.00</td>
</tr>
<tr>
<td>GP</td>
<td>6</td>
<td>24.00</td>
</tr>
<tr>
<td>Children’s mental health services</td>
<td>5</td>
<td>20.00</td>
</tr>
<tr>
<td>School teacher</td>
<td>2</td>
<td>8.00</td>
</tr>
<tr>
<td>My counsellor</td>
<td>2</td>
<td>8.00</td>
</tr>
<tr>
<td>Another agency</td>
<td>2</td>
<td>8.00</td>
</tr>
<tr>
<td>No one</td>
<td>5</td>
<td>20.00</td>
</tr>
<tr>
<td>The child</td>
<td>1</td>
<td>4.00</td>
</tr>
<tr>
<td>Blank</td>
<td>7</td>
<td>28.00</td>
</tr>
<tr>
<td><strong>Ever noticed symptoms of mental illness in children you have been concerned about? (Q20a) N=32</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>59.37</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>40.63</td>
</tr>
<tr>
<td><strong>Who I have spoken to about mental health concerns for my child (Q20b) N=19</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family member, excluding other parent</td>
<td>2</td>
<td>10.53</td>
</tr>
<tr>
<td>Partner/other parent</td>
<td>2</td>
<td>10.53</td>
</tr>
<tr>
<td>School counsellor</td>
<td>1</td>
<td>5.26</td>
</tr>
<tr>
<td>Caroline Reid Family Worker</td>
<td>9</td>
<td>47.37</td>
</tr>
<tr>
<td>GP</td>
<td>3</td>
<td>15.79</td>
</tr>
<tr>
<td>Children’s mental health services</td>
<td>3</td>
<td>15.79</td>
</tr>
<tr>
<td>School</td>
<td>2</td>
<td>10.53</td>
</tr>
<tr>
<td>My counsellor</td>
<td>2</td>
<td>10.53</td>
</tr>
<tr>
<td>No one</td>
<td>3</td>
<td>15.79</td>
</tr>
</tbody>
</table>

Question 19 enquired about whether parents had ever been concerned about the possibility of their children developing mental illness, and if so, who parents might have spoken to about these concerns. Question 20 has a different emphasis as it asks if parents had ever noticed symptoms of mental illness in
their children that had concerned them, and if so, who they had spoken to about this.

Sixteen of the 19 adult participants who stated they had noticed symptoms of mental illness in their children they had been concerned about (Question 20a) made comments about the steps taken by workers. The three who did not comment were those who responded ‘no one’ when asked who they had spoken to about their concerns.

Monitoring the situation was mentioned by four adult participants (three CRFSS workers, one GP):

> *Watch quietly to see if it develops or is a learned behaviour (AQ29).*

Six adult participants commented on referrals made to other services: children’s mental health services; a children’s counselling service; a ‘Wise Up’ course (kids’ confidence) run by an NGO; and to a NGO for counselling and family work.

Question 21 inquired about conversations with CRFSS workers regarding other aspects of children’s health and behaviour, including school work and behaviour, and if so, what steps were taken; 81.2% recalled these conversations at least ‘sometimes’ (Table 4.13).

<table>
<thead>
<tr>
<th>Section 4, Question 21</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Very little</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Sometimes</td>
<td>13</td>
<td>40.62</td>
</tr>
<tr>
<td>A lot</td>
<td>13</td>
<td>40.62</td>
</tr>
</tbody>
</table>

Fourteen adult participants said, in response to the second part of Question 21, that the steps taken were: listening, helping to problem solve, making suggestions, and giving advice.
I have a couple of times. Just listened and helped me to work out how to deal with it. Suggested I go and talk to the school (AQ26).

Support for the child was noted by five participants: the children’s workers had spent time supporting their children regarding issues raised by their parents.

Talked things through with daughter on the odd occasion, even popped into school (AQ27).

The final theme was that CRFSS workers liaised with other professionals. Some said workers had provided support in meetings with these services.

Got a referral for counselling for child, suggestions re behaviour, had meetings with school social worker, supported child to go to health camp (AQ18).

**SUMMARY**

This goal appears to be met to a reasonable degree. Between 75% and 81% of the adult sample recalled talking to CRFSS workers about child development and other aspects of their children’s development and health and wellbeing. A smaller number recalled conversations with CRFSS workers about their children’s mental health. Steps taken by CRFSS workers included listening and talking the issues through with adult participants, monitoring the situation, referral to other organisations, and organising a professionals’ meeting.

Also relevant are data from Theme 1, particularly the question to adult participants about whether they could talk to the CRFSS worker if they had problems. As noted, 90.6% of the adult sample said they would do so at least ‘sometimes’ (Table Nine).

**IMPROVING SOCIAL INCLUSION IN SERVICE−USER FAMILIES**

Goal 7, which this sub−theme relates to, reflects an underpinning focus of CRFSS service delivery: to increase support for all service−users (Section 3: Q3−4). The focus of data collection was the social inclusion of adult participants, as a presumption was made that service delivery provided child service−users with improved social inclusion, and so questions were not asked about the service goal of increasing support for child service−users outside the service. In
hindsight, this would have added to the picture of service delivery. Data relating to improved social inclusion because of service delivery for child service−users are located under Themes 3−5.

As will be seen from adult participant comments, improving the quality of social support involves a complex interplay of factors, and 46.8% of the sample noticed at least small changes in the quality of their social support network since being service−users of the service; 25% stated their networks had ‘improved a lot’. Predominant reasons given were attendance at the monthly CRFSS parent group, interventions by the family worker which increased understanding and support from wider family members, and improvements to their mental health. Those who saw no changes mostly attributed this to personal inhibitions in speaking to others, and a sense the service better catered for a partner or their children. Some service−users viewed their social support network as inclusive of the service, that is, improvements to their social support network arose because they now connected with the CRFSS workers.

Preparatory data relating to this goal were collected primarily to refresh the memory of participants about their social supports. Adult participants were asked if they had anyone to confide in and talk things over with when they have problems or difficulties. Most participants had someone to support them at least sometimes; however, two participants said ‘never’ (Table 4.14).

<table>
<thead>
<tr>
<th>Section 3, Question 3a</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, usually</td>
<td>16</td>
<td>50.00</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>14</td>
<td>43.75</td>
</tr>
<tr>
<td>Never</td>
<td>2</td>
<td>6.25</td>
</tr>
</tbody>
</table>

Participants who responded ‘yes’ were asked to identify who this person would be from a checklist; 71.8% could identify a friend with whom they would speak
about difficulties they were facing, and 53.1% selected the CRFSS family worker from the list provided (Table 4.15).

TABLE 4.15 – FREQUENCY DISTRIBUTION OF WHO ADULT PARTICIPANTS TALK TO WHEN THEY HAVE A PROBLEM OR DIFFICULTY (N=32)

<table>
<thead>
<tr>
<th>Section 3, Question 3b</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>8</td>
<td>25.00</td>
</tr>
<tr>
<td>Other family member</td>
<td>9</td>
<td>28.13</td>
</tr>
<tr>
<td>Child</td>
<td>2</td>
<td>6.25</td>
</tr>
<tr>
<td>Friend</td>
<td>23</td>
<td>71.88</td>
</tr>
<tr>
<td>Neighbour</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Counsellor/Therapist</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Community Support Worker</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Mental Health Case Manager</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Minister/Priest/Pastor</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caroline Reid Family Worker</td>
<td>17</td>
<td>53.13</td>
</tr>
<tr>
<td>Early Start Worker*</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Christchurch Resettlement Services=</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Other – friend who is a Minister and a Social Worker</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Blank</td>
<td>1</td>
<td>3.13</td>
</tr>
</tbody>
</table>

*Early Start Project is an early intervention, family support service for parents with 0–5-year-old children, providing home visiting, parent education and support.
= Christchurch Resettlement Services provide social work services and support to refugees and migrants.

Table 4.16 shows perceptions of changes in the quality of their social support network of friends and family since their time with CRFSS; 46.8% said their networks had improved at least ‘a little’.

TABLE 4.16 – FREQUENCY DISTRIBUTION OF ADULT PARTICIPANT PERSPECTIVES ON CHANGES IN THE QUALITY OF PERSONAL SOCIAL SUPPORT NETWORKS SINCE BECOMING SERVICE-USERS OF CRFSS (N=32)

<table>
<thead>
<tr>
<th>Section 3, Question 4</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worse</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No change</td>
<td>14</td>
<td>43.75</td>
</tr>
<tr>
<td>Improved a little</td>
<td>7</td>
<td>21.87</td>
</tr>
<tr>
<td>Improved a lot</td>
<td>8</td>
<td>25.00</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>6.25</td>
</tr>
</tbody>
</table>
Reasons for changes in their social support networks were noted by some participants. Of the 14 participants who selected ‘no change’ only seven made comments: two said they had no specific reasons, one said he did not know, one said she had not been with the service for long, one said the service was for their son, one noted the service caters more for their wife and children, and one participant felt the reason there was no change was because she finds it difficult to ask for help. It is interesting to note that when adult participants were asked their perspective about what the service could do better for their children, comments were made about increasing socially inclusive activities such as the midwinter family Christmas dinner.

All participants who selected ‘improved a little’ wrote comments. One was not sure why the quality of her networks improved; another felt attending the CRFSS parent group helped. One participant commented the CRFSS’s assistance in educating their partner’s family members had contributed:

_They have helped partner’s family understand our challenges better and encouraged them to help more (AQ30)._ 

Four participants spoke of personal growth in themselves which had contributed to the quality of their social support networks.

_Getting to feel more confident about myself and achieving things (AQ12)._ 

_Because I feel it’s up to me to do things for myself; it’s me that needs to take responsibility, I’ve learned to put myself out there, pushing myself harder (AQ25)._ 

The eight participants who selected ‘improved a lot’ all made comments. Two participants related an improvement in their mental health as a contributor towards an improvement in the quality of their social supports.

_Mental health has improved therefore I am able to communicate with others more easily (AQ14)._ 

_More positive outlook on life, not so dark (AQ27)._ 

Four participants said the support from the service had improved the quality of their social support networks ‘a lot’. Three spoke of the support from the family
worker making a difference. One participant said he felt he had more help; he did not specify if ‘more help’ was the same as better social support networks or if the perception of feeling helped enabled him to have a better quality of social support networks.

Knowing there is support there it helps (AQ24).

The caring and understanding without being judgemental (AQ2).

One participant said her attendance at the CRFSS parent group has assisted in the quality of relationships when she attended other CRFSS events. Another participant commented, in acknowledging that the quality of their social support networks had improved a lot, that he had reconnected with immediate family members, but gave no reason for this.

I spend more time with my father and both my sisters (AQ23).

One participant did not tick any of the choices but chose to comment instead. This participant reflected on having less support but this not necessarily being a bad thing:

I find the question hard to answer as I have less supports but don’t necessarily feel lacking, but it can feel empty – this is due to my journey with recovery (AQ5).

SUMMARY
Nearly half of the adult sample perceived the quality of their social support networks to have improved at least ‘a little’ since being service−users of the service, with one quarter stating these relationships had improved ‘a lot’. Some reasons given were the direct result of service intervention: the parent group; and the family worker’s role in the wider family. However, other reasons cannot be directly attributed to CRFSS interventions. A number cited improvements to their mental health as the predominant reason, and interestingly, one of the reasons for no changes was also due to mental health. It could be argued service interventions to support the health of adult participants indirectly contributed, however no evidence exists beyond that relevant to Goal 12 (further in this section). One service−user highlighted the
difficult mental health recovery journey, noting that supports, presumably formal, have decreased as health improved.

Some adult participants viewed the CRFSS workers as part of their social support network, attributing improvements to the quality of their networks as felt support from workers. These results say something about the value of the service to them.

Possible improvements noted by several participants revealed the varying involvement different adult participants had with the service, but also highlights a gap in service delivery. Some said the service better catered for their partner or their children. When considered with other comments from Theme 1 about wanting visits outside working hours, this implies more flexible service delivery and improved staffing could better support the needs of a group of adult participants.

ASSISTING SERVICE–USER FAMILIES TO ACCESS SERVICES

This sub-theme relates to Goal 8. This goal reflects comprehensive family practice by ensuring service-user families have the supports needed and acknowledging the challenging process for many in finding and engaging with appropriate services. This goal relates to Section 3: Q1–2. Question 1 was preparatory (data are in Appendix O). In Question 2, adult participants were asked if the CRFSS had helped them to access services, and participants were asked to explain either how they were assisted or what help they would have liked. Additional data arose from general questions to both adult and child participants. Data from Goal 6 are also relevant, as referral to other services was noted as one of the steps CRFSS workers took when adult participants had concerns about their children.

Findings were that 62.5% of the adult sample felt the service helped them access services, and three of the four focus groups noted this was one way the family worker assisted their families. Most of those who did not receive help
said it was because they did not need it. One participant noted her working hours prevented getting support.

**CHILD PARTICIPANT FINDINGS**

Minimal data emerged from child participants. One focus group, when asked if they knew what the family worker did, spoke of the worker obtaining help for those in their family who had mental illness:

*Getting in contact with other supports (FG3).*

Child participants spoke of general help and support but did not specify what this was. A member of FG3 said she wished the family worker had referred her father for counselling.

**ADULT PARTICIPANT FINDINGS**

<table>
<thead>
<tr>
<th>Section 3, Question 2</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20</td>
<td>62.50</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>28.12</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>6.25</td>
</tr>
<tr>
<td>Marked N/A</td>
<td>1</td>
<td>3.13</td>
</tr>
</tbody>
</table>

Participants were asked to comment about the assistance of CRFSS or lack of. All those who responded ‘yes’ to this question made comments. They said the workers provided information, made telephone calls on their behalf, made referrals to agencies, advocated for them with services, provided support at appointments, and assisted with problem solving. One participant said she felt the information was given in such a way she felt she had a choice about whether to use it or not.

*Yes, gave information and advice that you can take if you wish to (AQ22).*

Many made comments about general forms of support in accessing services.
Yes, (name of family worker) has helped me with mental health services (AQ6).

Yes, information, support, willing to write letters in support of issues faced (AQ14).

One participant spoke of the service being ‘proactive’ in helping them access services in comparison to other services.

Yes, we knew of them but CR have been the only proactive one (AQ8).

Eight of the nine who responded ‘no’ made comments. The primary theme was they did not need the support of the workers or they had support from their family members. One felt her working hours restricted the amount of support she could receive from the family worker.

No, I would’ve liked support but my work would restrict this due to working hours (AQ24).

Another participant would have liked support but at the time needed there was no family worker at CRFSS.

SUMMARY

CRFSS appears to meet this goal well, with only two adult participants stating they would have liked support to access services but were not able to obtain this due to the limitations of working hours and the service not having a family worker for a period. All others who did not receive support to access services said it was because they did not need it. One child participant noted she wished her father had been referred to counselling.

Support to access services was demonstrated in practical terms by actual referrals, telephone calls, writing letters, organising meetings and support at meetings. It was also described in less tangible ways as advocacy, assistance with problem-solving, advice, choices, and being proactive.

Hints of the difficulties for this service-user group were noted by language such as “helped me with mental health services” and “advocacy”.

233
ASSISTING SERVICE–USER FAMILIES TO DEVELOP MENTAL HEALTH CARE PLANS

As noted, at the time of data collection this goal was a recent intervention, as previously family care planning had occurred informally. Adult participants were asked if they had a family care plan for mental illness (Section 4: Q22), and if the CRFSS workers had ever discussed a family care plan for mental illness with them (Section 4: Q23). No qualitative data were requested (Table 18).

TABLE 4.18 – FREQUENCY DISTRIBUTION OF ADULT PARTICIPANT RECOLLECTIONS OF CRFSS SERVICE DELIVERY IN RELATION TO FAMILY CARE PLANS (N=32)

<table>
<thead>
<tr>
<th>Section 4, Questions 22 and 23</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your family have a family care plan for mental illness (Q22)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>34.37</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>65.63</td>
</tr>
<tr>
<td>Have the CRFSS workers ever discussed a family care plan for mental illness with you? (Q23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>28.13</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>56.24</td>
</tr>
<tr>
<td>Unsure</td>
<td>5</td>
<td>15.63</td>
</tr>
</tbody>
</table>

SUMMARY

Due to the lack of clarity about definitions of family care plans, findings are unclear for this goal; 34.3% of the adult sample stated they had a family care plan, and 28.1% said they had discussed the topic with a CRFSS worker.

ASSESSING AND EDUCATING ADULT SERVICE–USERS REGARDING MENTAL ILLNESS

As with Goal 6, Goal 10 to which this sub–theme is related, also encompasses many aspects of the CRFSS family worker role of working with service–user families in a comprehensive manner. Participants were asked if the CRFSS family worker ever had conversations with them about their mental and physical health and wellbeing (Section 4: Q8); if the CRFSS family worker ever had conversations with them about one of their family member’s health and wellbeing, including mental and physical, (Section 4: Q9); and if the CRFSS family...
worker had helped explain any issues related to mental illness to them (Section 4: Q10). No qualitative data were solicited. Results are shown in Table 4.20. Other data were obtained from child participants when asked general questions about the role of the family worker.

As Questions 8 and 9 did not differentiate between mental and physical health, these findings are inconclusive. Conversations about participant health occurred with 75% of the sample at least ‘sometimes’ (Q8), and conversations about the health of other family members occurred ‘sometimes’ with 65.6% of the sample (Q9) (Table 4.20). Data from Question 10 provide more insight. Of the adult sample, 78.1% said the CRFSS family worker helped explain issues relating to mental illness to them at least ‘sometimes’ (Table 4.19). In addition, child participant findings acknowledged the role of CRFSS workers in assessing and educating about mental illness, and when adult participants were asked how the CRFSS family worker had helped them (Section 4: Q12).
It is unclear whether those who responded, ‘not at all’ and ‘very little’, were referring to the lack of conversation about the topic or the lack of contact with the family worker.

Findings from Section 4: Q12, a general question asking how the CRFSS family worker helped adult participants, revealed insight into service delivery in this area:

*Helped me to understand more about myself and my illness (AQ15).*

*With my last admission they supported me with that and support my son with managing that ... Understanding the impact of my illness and how to minimise that (AQ5).*

*They have helped me through some tough times and have helped me more and made me feel worthwhile (AQ27).*
Child participants acknowledged the role of the family worker in assessing and educating parents about mental illness. Members from the three older focus groups (FG2–4) commented on the value of knowing that the family worker was monitoring how well their parents were doing. One interviewee felt the family worker supporting their parent with the mental illness was the most helpful way to help the family:

...you can help us a lot because there are enough people that are talking to us, but that doesn’t make as much of a difference as you talking to our parents, because our parents are the people with the illness, not us (INT3).

When asked about the role of the family workers, focus group participants said they talk to family members about mental illness. Their comments described talking to the parent with mental illness and parents who do not have mental illness and providing assistance in relation to mental illness.

*Talk to parents with mental illness and someone else in the house who knows and can help with it (FG1).*

*Uncover what is wrong at home and see if you can help lift up the scab and see what’s underneath (FG4).*

**SUMMARY**

In summary, despite difficulties with the findings from Questions 8 and 9, other material from Question 10 and child findings suggest this goal was met for a large group of adult participants. Findings from Theme 1 about relationship formation and support with personal difficulties, Goal 8 with referral to and support with services, and Goal 12 concerning educating about the impact of mental illness on parenting, add to a picture of this occurring as part of service delivery for adult participants. A group of 9.3% did not receive this service delivery in relation to their own mental illness, and 18.7% either felt they did not feel receive this aspect of service delivery in relation to the mental health of family members, or if they did, it was at a minimal level.
ASSISTING ADULT SERVICE–USERS TO ENHANCE THEIR PARENTING CAPACITY

As noted, supporting adults in their parenting role is an appropriate intervention for working with this service–user group in a comprehensive manner. Research findings directly relating to Goal 11 is from Section 3: Q5–10. Findings also arose from general questions to adult and child participants. Data collection attempted to elicit the informal parenting support and coaching from the CRFSS family workers.

As with many of the other goals, it was difficult to differentiate which findings related to each goal, due to the interrelated nature of many aspects of service delivery. For Goal 11, data relating to Goal Six are pertinent, as understanding the health of children is an important aspect of parenting; and Goal 8 of supporting adult participants to access services. Additionally, data relating to Goal 12 below – educating adult service–users about the impact of mental illness on parenting – are relevant, as is supporting adult service–users in their mental health (Goal 10). As these are separate goals, the data are referred to but not included in this section.

Further, the data from child participants about the family worker’s role are also salient. Many spoke of family workers supporting parents in various ways. As reviewed, support is an important aspect of facilitating positive parenting, particularly for parents with mental illness. Some child participant data will be outlined below if not included under other goals. Themes include general support to adult participants by visiting, talking with, helping, being available in emergencies, and helping to access services.

Adult participants who recalled talking to CRFSS workers about parenting issues at least ‘sometimes’ numbered 71.8% of the sample (Q5). The same number (71.8%) reported at least small improvements in their parenting confidence since being with the service (Q6). As noted under Goal 6 above, 75% recalled conversations about child development at least ‘sometimes’ (Q7), and the same percentage felt their knowledge of how to support their children’s development improved at least ‘a little’ since being service–users of the service (Q8). In terms
of conversations about situations of conflict between parents and children, 59.3% recalled these ‘sometimes’ (Q9), and 68.7% felt their ability to deal with situations of parent–child conflict had improved since being with the service (Q10). None of these questions solicited qualitative data. Quantitative results are shown in Table 4.20.

### TABLE 4.20 – FREQUENCY DISTRIBUTION OF ADULT PARTICIPANT PERCEPTIONS OF THE SERVICE ENHANCING THEIR PARENTING CAPACITY (N=32)

<table>
<thead>
<tr>
<th>Section 3, Questions 5–10</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversations with CRFSS workers about parenting issues (Q5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Very little</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Sometimes</td>
<td>17</td>
<td>53.13</td>
</tr>
<tr>
<td>A lot</td>
<td>6</td>
<td>18.74</td>
</tr>
<tr>
<td>Any changes in your confidence in general with parenting since CRFSS attendance (Q6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worse</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No change</td>
<td>9</td>
<td>28.13</td>
</tr>
<tr>
<td>Improved a little</td>
<td>15</td>
<td>46.87</td>
</tr>
<tr>
<td>Improved a lot</td>
<td>8</td>
<td>25.00</td>
</tr>
<tr>
<td>Conversations with CRFSS workers about your child(ren)’s development (Q7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Very little</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Sometimes</td>
<td>17</td>
<td>53.13</td>
</tr>
<tr>
<td>A lot</td>
<td>7</td>
<td>21.87</td>
</tr>
<tr>
<td>Changes in knowledge of how to support child(ren)’s dev since CRFSS attendance (Q8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worse</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>No change</td>
<td>8</td>
<td>25.00</td>
</tr>
<tr>
<td>Improved a little</td>
<td>19</td>
<td>59.37</td>
</tr>
<tr>
<td>Improved a lot</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Conversations with CRFSS workers about parent–child conflict in your family (Q9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>Very little</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>Sometimes</td>
<td>15</td>
<td>46.87</td>
</tr>
<tr>
<td>A lot</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Unclear (ticked all boxes)</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Changes in ability to deal with parent–child conflict since CRFSS attendance (Q10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worse</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>No change</td>
<td>9</td>
<td>28.12</td>
</tr>
<tr>
<td>Improved a little</td>
<td>13</td>
<td>40.62</td>
</tr>
<tr>
<td>Improved a lot</td>
<td>9</td>
<td>28.13</td>
</tr>
</tbody>
</table>
The participant who responded ‘worse’ in response to Question 10 misunderstood the question. She commented that the conflict was between herself and her child’s father over child custody matters.

**CHILD PARTICIPANT DATA**

Child participants, in describing the role of the CRFSS family workers, spoke of family workers visiting their parents, talking with their parents, helping their parents. They also highlighted family workers’ availability in emergency situations, when asked about the assistance given, and conversations with parents about the health and welfare of their children. These areas could all be classed as forms of parenting support. Two focus groups used the term ‘support’.

*There for when parents need support/someone to talk to (FG4).*

Two comments were made from different focus groups about the family workers providing parenting information.

**SUMMARY**

From this material, Goal 11 appears to be met for 60–80% of the adult sample, depending on which aspects was inquired about. However, as no qualitative data was sought, reasons for these improvements are unclear. Other findings provide some clarification: Goal 6 (75% recalled conversations about child development), Goal 8 (62.5% recalled support to access services), and adult participants comments about support from the family workers outlined in Theme 1. As with other goals linked with comprehensive family practice, a group of 20%–40% did not feel they received this aspect of service.

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**EDUCATING ADULT SERVICE-USERS ABOUT THE IMPACT OF MENTAL ILLNESS ON PARENTING**

Closely related to Goal 11 but articulated as a separate goal, Goal 12 relates to Section 3: Q11–12. This goal further elucidates comprehensive practice in a mental health context. Adult participants were asked if they ever had conversations with the CRFSS workers about the impact of mental illness on
parenting (Q11), and if they had noticed any changes in their knowledge or awareness of the effects of mental health on parenting since being a service–user of the service (Q12), (Table 4.21). No qualitative responses were solicited. Of the adult sample, 62.5% recalled these conversations occurring at least ‘sometimes’ (Q11). When asked if they had noticed any changes in their knowledge or awareness of the effects of mental health on parenting (Q12), 68.7% noticed at least small changes.

<table>
<thead>
<tr>
<th>TABLE 4.21 – FREQUENCY DISTRIBUTION OF ADULT DATA ABOUT THE IMPACT OF MENTAL ILLNESS ON PARENTING (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 3, Questions 11 and 12</td>
</tr>
<tr>
<td>Conversations with CR workers about impact of m.i. on parenting (Q11)</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
<tr>
<td>Very little</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>A lot</td>
</tr>
<tr>
<td>Changes in knowledge/awareness of effects of m.i. on parenting (Q12)</td>
</tr>
<tr>
<td>Worse</td>
</tr>
<tr>
<td>No change</td>
</tr>
<tr>
<td>Improved a little</td>
</tr>
<tr>
<td>Improved a lot</td>
</tr>
<tr>
<td>Unclear (ticked all boxes)</td>
</tr>
</tbody>
</table>

**SUMMARY**

The final goal relating to aspects of comprehensive family practice inquired about assisting service–users to improve their knowledge and awareness of the impact of mental illness on parenting. It was noted these findings are best interpreted in combination with Goal 11, to enhance parenting. Goal 12 appears to be met for 68.7% of the adult sample to at least a small degree. As with other goals in this section, a sizeable group either did not receive this aspect of service delivery, or if so, to a minimal degree.
Comprehensive family practice encompasses eight of the twelve goals of the CRFSS service narrative. Findings were:

- **Goal 5** – 72.7% of child service-users recalled receiving mental health education, and 57.5% recalled conversations with CRFSS workers about mental illness; 66.6% of adult participants perceived CRFSS helped their children to learn about mental illness;

- **Goal 6** – 75–81.2% of the adult sample recalled conversations with CRFSS workers about their children’s general health and wellbeing, and of the 59.3% who were concerned about their children’s mental health, 47.3% had spoken to a CRFSS worker about this;

- **Goal 7** – 46.8% of the adult sample felt their social inclusion had improved to at least a small degree since attending CRFSS, with 25% noting it had improved ‘a lot’;

- **Goal 8** – 62.5% of the adult sample said CRFSS helped them access other services; and three of the four focus groups noted this was one way the family worker assisted their families;

- **Goal 9** – was inconclusive due to lack of definitions about family care plans; 34.3% of the adult sample stated they had a family care plan, and 28.1% said they had discussed the topic with a CRFSS worker;

- **Goal 10** – 78.1% of adult participants recalled conversations with CRFSS workers about mental health;

- **Goal 11** – between 71% and 75% of the adult sample noted aspects of service delivery which enhanced their parenting confidence, and knowledge of how to support their children’s development; and between 59.3% and 68.7% felt their knowledge of and ability to manage parent–child conflict had improved;

- **Goal 12** – 68.7% of the adult sample recalled CRFSS workers talking with them about the impact of mental illness on parenting.
Although the service met most of the goals to a reasonable degree, these findings highlight room for improvement. A group of adult participants did not feel they received various aspects of comprehensive family practice. Reasons given vary, and sometimes qualitative data were not sought and so it is unknown why this occurred.

One reason for not receiving service delivery which was noted was, for a few adult participants, they did not have regular contact with the CRFSS family workers due to the limitations of working hours or their partner or the child’s other parent receiving visits, but they did not. All families had regular contact with the CRFSS family workers, but as a high percentage of adult participants were separated, some adults in the family received more contact than others. Unfortunately, adult participants were not asked about the amount of contact they had with the CRFSS family workers. In response to some questions, some adult participants said they did not receive aspects of the service because they did not require the support.

**THEME 3 – STIGMA AND CRFSS SERVICE DELIVERY**

Service–user experiences of stigma were sought to provide context to questions about stigma relating to the research question (Goal 2). Questions about personal experiences of stigma elicited valuable findings. As this material is not directly relevant to the research question it is summarised in this section, however a full account is in Appendix Q.

All focus group members and eight of the 10 interviewees felt there were benefits for mixing with other COPMI at CRFSS. Themes which arose were the service provided a place of normalisation for them, and as a result they felt understood and accepted, and developed a sense of belonging, which enabled sharing about mental illness and mutual peer support. No disadvantages were noted.

When adult participants were asked about the benefits and disadvantages of their children attending a service in which other children are from families with
parental mental illness, data relating to stigma emerged (Q15), and 93.7% felt there were benefits to their children associating with other COPMI. Predominant themes were that the service provided normalising experiences for child service-users, it reduced social isolation, provided a place of belonging and safety, and helped to normalise children’s family situations by mixing with children and youth in similar situations. Disadvantages were noted. Five participants (15.6%) were concerned about the potential negative influence of other ‘more disturbed’ COPMI either at the service or if they associated outside CRFSS activities and became enmeshed in family situations of concern.

EXPERIENCES OF STIGMA

Your mum’s a freak (FG3).

CHILD SERVICE–USERS

In relation to child service-user experiences of stigma, eight of 23 participants present in focus groups when this question was asked stated they were teased or treated differently due to parental mental illness; two were unsure. In terms of interviewees, two recalled incidences of teasing or different treatment. Most interpreted ‘different treatment’ as stigma; a minority reported positive responses as ‘different treatment’. Of adult participants, 34.3% felt their children experienced ‘different treatment’ at least ‘sometimes’ (shown in Table 22).

Child service–users described adverse responses to others seeing their parents or telling others their parents had a mental illness. The most common expression of stigma for child service–users was labelling with demeaning words and feeling discredited in the sight of others, described using terms such as “teased”, “laughed at”, “nasty words” and making fun of their parents. Other themes noted were secret–keeping in relation to parental mental illness, the prolonged nature of stigmatisation, having to experience things others did not such as removal from home, and awkward questions from peers about their parents. Reasons given for not experiencing ‘different treatment’ were that no
one knew about parental mental illness or the parent did not look abnormal. A minority experienced positive responses to parental mental illness.

Themes which arose from the subset of adult participants who noted their children experienced stigma were teasing by peers, social exclusion, additional scrutiny from teachers, their child viewed as contaminated, and their child’s protectiveness of their parent. In contrast, two adult participants viewed their children being ‘treated differently’ in a positive light, noting their children received additional support. This group felt this was because the mental illness was not disclosed or not obvious.

**ADULT PARTICIPANTS**

Adult data regarding personal experiences of stigma were derived from Section 4: Q1–3. Of the adult sample who identified as having a mental illness, 66.6% had experienced ‘different treatment’ by others due to mental illness at least ‘sometimes’ (N=21). The prominent theme was the sense of being judged as less capable or acceptable due to mental illness, resulting in social exclusion. One participant viewed ‘different treatment’ as receiving support.

Of the 18 adult participants who said their child’s ‘other parent’ has a mental illness, 27.7% had personally experienced ‘different treatment’ from others due to this person’s mental illness. Those who had ‘other family members’ with mental illness were asked the same questions: 25% had experienced ‘different treatment’, ‘a lot’. The stigma by association experienced by participants was primarily experienced as blame, social exclusion and pity. One grandparent felt admired for looking after her grandchildren. Lack of contact with the ‘other parent’ or ‘other family member’ with mental illness was the reason given for those who did not experience ‘different treatment’.

For adult participants with mental illness, those who received no ‘different treatment’ gave the same reasons as their children – nobody unnecessary knew.
TABLE 4.22 – FREQUENCY DISTRIBUTION OF ADULT PARTICIPANT PERCEPTIONS OF PERSONAL EXPERIENCES OF STIGMA (N=32)

<table>
<thead>
<tr>
<th>Section 4, Questions 1−3</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult participant treated differently due to their mental illness (Q1) N=21</td>
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<td></td>
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</tr>
<tr>
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<td>4.76</td>
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<tr>
<td>Sometimes</td>
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<td>38.10</td>
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<tr>
<td>A lot</td>
<td>6</td>
<td>28.57</td>
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<tr>
<td>Unclear</td>
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<td>4.76</td>
</tr>
<tr>
<td>Adult participant treated differently due to other parent's mental illness (Q2) N=18</td>
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<td></td>
</tr>
<tr>
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<td>44.4</td>
</tr>
<tr>
<td>Very little</td>
<td>3</td>
<td>16.67</td>
</tr>
<tr>
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<td>16.67</td>
</tr>
<tr>
<td>A lot</td>
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<td>11.11</td>
</tr>
<tr>
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<td>1</td>
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</tr>
<tr>
<td>Blank</td>
<td>1</td>
<td>5.56</td>
</tr>
<tr>
<td>Adult participant treated differently due to other family member's mental illness (Q3) N=12</td>
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<td></td>
</tr>
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<tr>
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<td>Sometimes</td>
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<td>8.33</td>
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<tr>
<td>A lot</td>
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<tr>
<td>Blank</td>
<td>2</td>
<td>16.67</td>
</tr>
</tbody>
</table>

STIGMA AND CRFSS SERVICE DELIVERY

Solidarity, understanding, normalisation, relieves any sense of shame (AQ30).

This section outlines themes relating to benefits and disadvantages of COPMI mixing with other COPMI at CRFSS.

NORMALISATION — FINDING COMMONALITY AMONGST PEERS

The benefit of realising they were not the only child or young person from a family with mental illness was predominant in the data from both adult and child participants. Sometimes this was phrased as “not alone”. It may also be expressed as normalisation – feeling as if what is experienced is normal in a certain group. What the data suggest is that children and young people found a sense of commonality with other children and young people; the realisation
that their families shared something, which they had not experienced before with peers in other situations.

Over 80% of adult participants said one of the main benefits for their children attending activities at CRFSS was the reduced isolation from this sense of commonality for their children.

*A sense of not being alone (AQ5).*

*A sense of understanding and not feeling so singled out when they know other children have parents with mental illness also (AQ14).*

*More beneficial than anything to know other kids have same issues at home (it’s not just them) (AQ26).*

Several adult participants commented that these normalising experiences assisted their children to view their home situations differently.

*She sees she is not alone in this world. Some people are worse off than us but most in the same boat (AQ27).*

*So that she will know that there are other children who have weird parents (AQ10).*

Child participants made similar comments. Some quotations illustrate the normalisation of the setting, and some extrapolate the concept further to show how the setting changed how children and young people saw themselves.

*They treat you like a normal person because everyone has the same experience (FG1).*

*They don’t say that your family is ‘mental’, they don’t call it weird (FG1).*

*It makes me kinda feel like I’m not alone (INT2).*

*You feel like you fit in more ... (INT3).*
You felt kind of normal, and, like, you knew their situation. Like if you were somewhere else and you didn’t really know that their parents had a mental illness it would kind of feel weird, it’d be, like, if you brought it up or something ... I really know their background or what’d happened, so yeah, it was kind of weird. But then Caroline Reid rang me and it was like, you felt all the same, you didn't feel left out, or like you were pushing away or something (INT4).

In contrast, several child participants felt the context of COPMI mixing with other COPMI at CRFSS was irrelevant. They said they did not think of the CRFSS children as COPMI: they just saw them as other children. Several child participants said they had not previously considered that their CRFSS peers were different from other groups of peers:

FEELING UNDERSTOOD

Feeling understood was emphasised. Due to the shared experiences of parental mental illness, many child participants felt their peers understood them.

Many interviewees and all focus groups spoke of the freedom to talk about parental mental illness while at CRFSS, in contrast to comments noted above about adverse experiences when disclosing parental mental illness and the resulting avoidance. Members of one focus group (FG3) felt that this freedom in the CRFSS environment became more meaningful as they became older.

I guess you understand each other more ... you feel like you fit in more, but when you first start it feels weird, because you don’t understand much, when you’re at the end, and then you don’t want to leave... (INT3).

A comment from INT8 highlights that in an environment where one feels understood, often words are not necessary:

It's just fun, like we don’t really need to talk about it too much, I mean we all know that each of our families have been through something, sort of thing, and so we kind of have, I suppose sympathy is kind of the right word to use, for each other... kind of an unspoken thing (INT8).

One interviewee spoke of the sense of comfort he felt in knowing others related to his experiences.
... it makes you feel comforted, I guess, in a way? Knowing that some people there would know what you’re going through … (INT10).

ACCEPTANCE AND BELONGING

As a result, child participants spoke of feeling more accepted; a sense of belonging. All focus group members and eight of ten interviewees felt other children, and leaders, liked them more at CRFSS, other children were less judging of them, and they felt they belonged.

*Can talk about what your mum has – freer at CRFSS than at school (FG1).*

*Feel more liked – if you talk about mental illness they can’t laugh as their parents have it too (FG1).*

*Other people to belong with – others in the same boat (FG3).*

One interviewee (INT9) emphasised the role this environment has in helping her to be herself:

...it’s different, because I know that everyone there has been through something, and they have the experiences that I have ... it is easier knowing that I don’t have to hide anything and I don’t have to act differently. So it’s like when they meet me they meet me. Whereas when you go to high school and stuff people don’t know you, they don’t know your background, they don’t know your family, so you kind of put on an act without putting on an act, because it’s all about first impressions. Whereas there it’s, like, I have a name, and I’m here for the same reason everybody else is here... (INT9).

PEER SUPPORT

Feeling supported by CRFSS peers and providing support to CRFSS peers was a significant theme in the data related to this question. These findings are outlined and discussed in Theme 4.

RISK OF STIGMA FROM COPMI ALSO?

One parent felt her children needed to be careful about what they disclosed at CRFSS, despite the benefit she saw in the sense of normalisation her children gained through attendance. This was the only comment from adult and child data to this effect.
Kids on a whole are mean and tend to hassle each other so never a good idea to let out too much information (AQ21).

SUMMARY – THEME 3

Adult participants reported incidences of personal stigma, stigma by association, and self-stigma at relatively high levels. The most common expression was being viewed as less of a person, resulting in social exclusion. The primary reason for no ‘different treatment’ due to mental illness was that the illness was hidden or “not obvious”. A minority found support from the disclosure of mental illness.

A smaller percentage of child participants felt they were treated differently due to their parents’ mental illness (two interviewees, eight focus group members). Five interviewees said no one knew about their parent’s state, and the remaining three were unsure.

Themes arising from ‘different treatment’ reflected stigma by association and self-stigma, exhibited as demeaning comments, labelling, deriding, secret keeping and social exclusion. As with adult participants, a minority experienced support rather than stigma. Adult participant data relating to their children’s experiences of stigma by association supported child data; however, thematically, adults were aware of the social exclusion but less cognisant of other themes.

Mixing with other children from families with parental mental illness was seen to be beneficial for the majority of child and adult participants. Children felt more normal, liked, accepted, more supported, less judged and less alone, suggestive of changes to their self-stigma. They cited personal benefits from attending, and benefits to their peers by providing support for each other. Adult participants agreed with their children’s views, but also emphasised the benefit of the service providing a domain in which parental mental illness was normalised, their family situations were normalised, and a more equitable social situation for their children than school and other social events. Child participants did not comment on potential disadvantages; however, a few adult
participants felt their children could possibly be negatively influenced by children from more dysfunctional families, particularly if the friendships developed beyond the service events.

It can be concluded that Goal 2 of providing a destigmatising environment for child service-users was well met by CRFSS.

Theme 4 – Peer Support

They know – they have similar stories and try to help (FG4).

The theme of peer support arose from many lines of enquiry beyond questions about the benefits of COPMI mixing with other COPMI at CRFSS noted above. Relevant findings came from the responses of child and adult participants about recreational activities and camps also. Goal 2 also applies to this theme – a destigmatising environment for child service-users – as peer acceptance and support are required for this goal to eventuate. This section begins with findings excluded from Theme 3 on peer support, then outlines findings arising from other general questions about recreational activities and camps.

A high percentage of adult participants mentioned peer support as one of the main benefits of their children mixing with other COPMI at CRFSS: both receiving and giving support to other children. Child data confirmed this. Disadvantages were noted also. A few adult participants were concerned some CRFSS child service-users and their families may be a negative influence on their children. However, others felt this was of benefit.

In the context of questions to adult participants concerning what their children enjoyed about CRFSS recreational activities (Section 2: Q3), and what the service does well for their children, friendship with other CRFSS children was a predominant theme. Similarly, when child participants were asked what they enjoyed about recreational activities and camps, socialising with other children and forming friendships was also a common theme. Other data also supported this. When adult participants were asked what CRFSS did well for their children, social mixing, friendship and socialisation skills were predominant themes.
Relevant limitations to enjoyment of group activities were a young person’s interest in friendships outside the service, and social anxiety and introversion in child service-users.

**COPMI SUPPORTING COPMI**

Child participants felt a benefit of COPMI spending time with other COPMI at CRFSS was that they received personal support from their peers, and equally, they could offer support to their peers.

*Learn new stuff about other parents’ mental illness; they relate to you and give ideas as to how to react; good support (FG1).*

*When you tell them what is happening at home they can give advice because they have experience with that (FG1).*

*It’s just a way we can … help each other in some ways … so I know how … their father can’t read, some kids don’t have parents … and they think their parents are … don’t like them so much, and it’s just like we can comfort them … and assure them that they do (INT1).*

When asked if there was anything else she wanted to say at the end of the interview, INT3 commented:

*I think that Caroline Reid is one of the best things for kids with families that have mental illness, because it helps more and you get to talk with your friends about what they have done, and what their families have gone through, and stuff like that, so it helps you more when you talk to other people, especially to people who understand you more, like, fair enough going and talking to your friends about it, they won’t understand that much, because they don’t know. Talking to someone who’s gone through it is a lot better than just some random (INT3).*

Data from adult participants also described aspects of support: talking with, standing with (solidarity), and mutual caring.

*Other peers to talk with? Someone their age that knows how it feels (AQ28).*

*That they can learn it’s not that uncommon to have a parent with mental illness and they can feel comfortable with kids*
who have same situation and that they are understood and cared about (AQ6).

Adult participants, when asked what CRFSS does well for their children, highlighted the value of the service providing an environment in which their children felt safe, nurtured and cared for. One participant linked the environment with a nurturing of their child’s self-esteem, and another with their child feeling it was acceptable to try new activities.

Provides a safe and caring environment for her (AQ2).

RECREATIONAL ACTIVITIES AND PEER RELATIONSHIPS

CHILD PARTICIPANT PERSPECTIVES

In response to a question about what they enjoyed about CRFSS recreational activities, all focus groups and eight of ten interviewees noted friendship as a primary reason.

Easier to make friends. Because of friends. Having fun. Helped me make friends (INT2).

Don’t argue with people a lot. Different from school and home. I don’t fight with anyone and I’m actually happy and not sad (INT5).

One interviewee noted friendships deepened over the years with service:

Good place to come and hang out with friends. Have a good time in general. Rated 9/10 due to friendship at 13+ but would have rated 5/10 when younger (INT8).

A focus group member made a similar comment about recreation days:

As you got older went for the social side not the activities as much (FG2).

In relation to attending annual camps, six of ten interviewees and all focus groups referred to peer relationships.

The best thing about camp was getting to know people in my cabin … (INT2).

Everyone was together (FG2).
It’s not just a camp, it’s ... more, like, time where you go, you can meet people, you can talk to people, people you can trust, it's not just a camp that you'd normally go on with a school field trip or something, it’s, yeah, more than that (INT9).

CRFSS service-user children did not always get along with each other. A comment from one interviewee about what she did not like about a camp experience, although humourous, illustrates the reality of children’s relationships:

*Having to sleep in a cabin with someone who you don’t really like ... she kept farting and it stunk (INT3).*

**ADULT PARTICIPANT PERSPECTIVES**

When asked about perceptions of their children’s enjoyment of CRFSS recreational activities, adult participants stated friendship was a key reason for their children enjoying these activities (Section 2: Q3).

*Making friends outside usual social group (AQ8).*

*He has made friends in CR (AQ30).*

The theme of friendship arose from other questions to adult participants also. In a question about new experiences for their children when attending CRFSS (Section 2: Q4), one participant said, “making new friends”, was a new experience for her son.

In another general question to adult participants which asked what they believed CRFSS did well for their children (Section 2: Q12), the main theme was that participants believed the service helped their children mix with other children, develop friendships and gain socialisation skills.

*Gives them confidence and helps her to socialise with her peers and interact with them (AQ26).*

*Provides an outlet for her where she can interact with others in a safe environment that nurtures her self-esteem (AQ10).*

*Provides contact with other children, teaches social/manners... (AQ13).*
Adult participants noted some limitations to peer support and friendship at CRFSS. In some cases, as children became adolescents, their relationships outside the service become more important, as noted by one parent:

\textit{Getting to an age where hanging with friends is more important (AQ1).}

Less healthy reasons for difficulty with peer relationships were described by three adult participants. One adult participant felt her son’s introverted personality hampered his enjoyment of social activities at times. Similarly, two participants described their children’s social anxiety about meeting new people and attending social occasions affecting their enjoyment of group activities. In all three cases, these child service–users preferred one–to–one visits with the children’s workers.

\textit{He had difficulty moving to 13+ group due to lack of confidence with building new relationships with peers (AQ14).}

Further data about peer relationships arose from the question to adult participants about benefits and disadvantages to COPMI mixing with other COPMI at CRFSS (Section Four: Q14). Five participants who noted benefits, also described disadvantages.

Other children’s challenging behaviour was highlighted by one parent.

\textit{He sometimes struggles with the other children’s behaviours (AQ5).}

One adult participant felt her child was different from all the other CRFSS children because he was gifted.

\textit{Chance of not bringing out the real competition, talent of the child. No opportunity for child to be challenged, to another extent. Feel group would hold child’s smartness back (AQ16).}

Some felt their children could be negatively impacted by children and their families who were more dysfunctional if the relationship extended beyond CRFSS activities; these participants had also acknowledged benefits.
Only potentially – some kids get pretty messed up when their parents are messed up. I would be concerned if my kids became close friends with them (AQ30).

If others aren’t very stable or are abusive or violent through what they’ve learnt at home (AQ28).

However, two adult participants acknowledged the differences in family situations and felt these were positives.

It’s good for him to have a wide range of friends (AQ23).

SUMMARY – THEME 4

Peer support was a predominant theme in responses from adult and child participants about the benefits of COPMI mixing with other COPMI at CRFSS. Child service−users received and gave support. Adding to this picture, although not expressed as peer support, the theme of friendship and opportunities to develop social skills arose consistently across other areas of questioning to both child and adult participants.

Some difficulties emerged, as noted in the adult data. A few adult participants were concerned that other COPMI could be a negative influence, some felt their children’s individual issues impacted on their ability to tolerate group activities, and one felt the service did not provide adequately for a gifted child.

The data suggest CRFSS group recreational activities meet the relational needs of most child service−users in a positive manner. However, as some individuals benefitted less from these larger group activities, smaller group activities could be an avenue for these child service−users to develop peer support networks.

THEME 5 – BENEFITS ARISING FROM RECREATIONAL ACTIVITIES

Data emerged from all participants about three kinds of benefits resulting from attendance at recreational activities provided by CRFSS. These were:

- Opportunities for relationship building with workers and peers;
- Respite through a different environment and through engaging in fun and play;
- The possibility of developmental enhancement.
These themes form headings for this section. Relevant goals from the research question are Goal 1, to assist service-user children to have more diverse childhood experiences, and Goal 3, to provide opportunities for children to play and be children.

Relationship formation occurred for most child participants with the children’s workers and their peers via recreational activities. Respite from home and through engaging in fun activities was a common theme in the data. In terms of developmental enhancement, participants agreed the service provided new experiences for CRFSS children. Over ninety percent of adult participants said their children had new experiences at CRFSS and that these would be difficult for them to provide. Beyond socialisation, gains from these new experiences were confidence, a willingness to try new things and accept challenges. Some limitations were found in all areas.

Contextual data indicated most child participants attended monthly recreation days ‘most of the time’, with high levels of enjoyment. All child participants had attended camps and enjoyed many aspects of camps.

CONTEXTUAL DATA

Questions about child participant attendance rates at and enjoyment of CRFSS recreational activities provide context for the responses in this section. A summary is given here; the remainder of the data are in Appendix P. Most child participants enjoyed monthly recreation days most of the time. The mean rating out of ten for child interviewees was 8.7/10. The mean focus group rating (omitting Focus Group One as they were not asked this question) was 8.2/10. All interviewees and most focus group participants attended recreation days most of the time. Non-attendance was mainly due to other commitments such as work, family events or sports. Two focus group members who were siblings responded, ‘not many’, because one parent did not allow them to attend very often. Older focus group members mentioned their changing priorities and sometimes wanting to spend time with other friends. Aspects of monthly
recreational days not enjoyed which are relevant are discussed below; the remainder related to childhood preferences and are also in Appendix P.

Child interviewees had all attended annual camps with CRFSS, with eight attending every camp since with the service. Of the 24 focus group participants, all had attended camps. All child participants enjoyed aspects of camps. Most aspects of camps not enjoyed were relatively trivial and typical childhood responses. These are in Appendix P.

Some comments by adult participants provide additional context. Two participants felt the regularity and continuity of the activities contributed to their children’s enjoyment.

- *She loves being included in something that happens regularly – relieves anxiety for her (AQ19).*
- *Continuity and security for him (AQ13).*

**RELATIONSHIP FORMATION**

This section outlines findings which connect recreational activities and relationship formation with peers and workers. The logic of this section is that relationship formation with workers and peers occurred during recreational activities, as these activities were the basis of service delivery for child service-users. Therefore, relevant findings have primarily been outlined in previous themes; these findings will be referred to but not repeated.

**PEER RELATIONSHIPS**

...*helps her to socialise with her peers and interact with them (AQ26).*

Themes 3 (Stigma) and 4 (Peer Support) have reviewed data relating to peer relationships. As noted, child and adult participants felt a primary benefit from attending CRFSS was for their children to form relationships with other COPMI. For many child participants, these relationships felt new and different: they felt more liked, as if they fitted in, were understood and accepted, and could support each other. Friendship formation with peers emerged as a key theme from general and specific questions about other areas of service delivery, as
already outlined above. These relationships could only form during recreational activities.

**WORKER — LEADER RELATIONSHIPS**

*Spending time with leaders, some were pretty cool (FG2).*

In terms of worker and volunteer leader relationships, as noted above (Theme 1), relationship formation occurred during CRFSS recreational activities and one-to-one and small group informal visits. As one-to-one visits were usually based around a recreational activity, particularly when child service-users were younger, these data are relevant to Theme 5. It was only when child service-users were older, and the relationship well established, that the focus shifted away from the activity as a means for communication.

As noted in Theme 1, child participants stated they like attending monthly recreation days because of opportunities to spend time with the leaders. The adult data also confirmed that interaction with the leaders was one of the main reasons their children enjoyed the monthly recreation days.

**SUMMARY**

As recreational activities are the basis for service delivery, and themes above indicate relationships were formed at CRFSS with peers and workers, it may be concluded recreation is a scaffold for relationship formation at CRFSS for most service-user children. The few child participants for whom larger group outings were difficult, as noted in Theme 4, still formed relationships with children’s workers. As suggested, individual and small group recreation with workers may better suit the individual needs of these child service-users.

**RESPITE**

*Gives you something to look forward to (FG3).*

Respite occurred through being away from their regular home situations, and through engaging in fun and play. Goal 4 is relevant to this theme; to provide opportunities for children to play and be children.
Data from child and adult participants mentioned respite from home at monthly recreation days, camps, and informal visits with children’s workers. One interview highlighted the downside to respite from home: while at a camp she worried about her mother.

Respite through fun and play was a common theme from adult and child participants in all aspects of service provision. One thread from these findings highlighted the need for some child participants to have “something to do”. Not all child participants always experienced fun while at CRFSS activities.

A BREAK FROM HOME

In preparatory questions to child participants about mental illness, they were asked why they thought they attended CRFSS. Respite from home was a reason given by interviewees and focus group members.

I just enjoy it in general – time away (INT1).

Time away from family was a good thing (FG2).

When child participants were asked what they enjoyed about monthly recreation days, a predominant theme was respite from home.

Interviewees and focus group members noted one of the best things about camps was an opportunity to have respite from their home situations:

Other than getting away, it’d be mostly the activities (INT1).

... weekend away from home I guess ... Just get away and have fun ... (INT10).

A few child participants felt a benefit from attending CRFSS was the respite they could have from thinking about mental illness.

They’re having a good time – I don’t think about mental illness (FG4).

When asked if there was anything additional they wanted to say for the research, two participants noted:

I like getting away from home; I stop worrying so much when I’m with Caroline Reid (FG4).
I think, like – it’s a good place to go and get away from your family and, like, everything that’s going on at home, or, like, other places, and just kind of, like, relax and just kind of know that you can talk to someone and not be judged about what’s going on and things (INT4).

Adult data agreed. Four adult participants stated the reasons their children enjoy CRFSS activities is because they enjoy respite from home.

They just like to get out of the house (AQ19).

Seven adult participants said one of the benefits of their children attending CRFSS was respite from their home situations. Themes arose such as stress and pressure at home, a break from home for children who spend a lot of time at home or with their own siblings, and respite from adults who were unable to give their child needed attention.

Gives them a chance to do enjoyable things and to get away from the pressures of home (AQ15).

Includes her in activities, company because she spends a lot of time at home ... (AQ19).

Respite from the home and family situation was also highlighted by two adult participants as the primary reason their children enjoy informal visits with children’s workers:

It gets her out and about. This doesn’t happen with me (AQ18).

RESPITE CAN CAUSE WORRIES TOO

One interviewee highlighted a potential downside to respite when talking about attending CRFSS camps.

... I think the hardest thing was having to stay away from mum for so long, because I never went away ... When I did it was for long periods of time, so I wasn’t with her at all, I ... got taken off her ... so going on the camps it kind of got me used to being away from mum ... I always thought, what if I come back and things are worse (INT9).
Fun and Play

She likes getting out of the house doing something that takes her mind off what’s happening at home – the fun with kids her own age (AQ19).

This quotation was made by an adult participant in response to a question about one-to-one visits with the children’s workers.

In preparatory questions to child participants about mental illness, in which they were asked why they think they attend CRFSS, a predominant theme from interviewees and focus group members was the service provided opportunities to have fun. This theme was also found in data relating to monthly recreation days, one-to-one time with the workers, and camps.

When asked what they enjoyed about the monthly recreation days, seven of 10 interviewees mentioned the activities or fun:

Different from sitting around home doing nothing. It is fun (INT1).

It means there’s something to do. The activities (INT6).

Focus group participants made similar comments:

We do lots of fun things (FG1).

Fun at camps was mentioned by four interviewees and all focus groups when asked about the ‘best things’:

Uncontrollable laughter (FG3).

Being silly (FG3).

Child participants were asked to recall memories of recreational activities which they did in an animated fashion, particularly in focus groups when they could reminisce together. When asked about the best things about camps, many mentioned specific activities they really enjoyed. This data, as well as suggestions for other ideas for camps and recreation days, are in Appendix P.
Adult participants were asked what they believed CRFSS did well for their children. About 25% of adult participants felt the service did well at providing their children with fun experiences.

*Gives them time out, helps them enjoy being children ... (AQ22).*

In relation to informal visits with children’s workers, several adult participants referred to their children enjoying the actual activities:

*My son loves to ride the bikes/skateboard with (male children’s worker) (AQ12).*

Many child participants spoke of the relationship between having fun together and relationship formation when asked about informal visits with the children’s workers. Four male interviewees said they liked the outings because they were fun (INT5, INT7, INT8, and INT10). All focus groups spoke of enjoyable activities.

*IT’S NOT ALWAYS FUN*

When asked what he did not like about the monthly recreation days, INT5 responded ‘no’, thought for a minute, then added:

*Sometimes a few people who make fun of me (INT5).*

Other child participants noted aspects of monthly recreation days which they did not enjoy, and that impacted on their capacity to have fun.

*Not if my friend was not there as not so many people to hang out with (INT3).*

*Not getting a good seat in the van; sitting next to people you don’t like (FG2).*

*Being separated from each other if you misbehaved (FG2).*

In relation to camps, participants said:

*Missing home (FG1).*

*Being put in groups with people you didn’t like; not being with your friends (FG2).*
... when we used to go on those camps I'd always get into trouble ... Because of (another child's name) ... And she'd blame like everything on me (INT6).

Having my little brother there (first camp younger brother had attended) ... Because he kept like coming up to me (INT7).

SUMMARY
Respite from home was a theme which emerged from child and adult data across all areas of service delivery. Alongside this came the sense that many CRFSS child participants lacked much to do while at home and did not get out of the house very often for social occasions. Opportunities to have fun was another strong theme in the data, and comments from both child and adult participants linked the notion of respite from home and having fun. Having activities to engage in emerged again in this data.

Some limitations to respite at CRFSS were found. Child participants spoke of worrying about a parent when away at a camp which impacted on her ability to enjoy the camp, and some child participants experienced homesickness at camp, bullying and conflict with peers. Other comments about friendship were typical childhood complaints. Data from Theme 4 about individual needs of some children preventing them from enjoying large group recreational activities were found to also be relevant.

In terms of Goal 3, opportunities to play and be children, data suggest this goal was met well by CRFSS for most children, with the proviso that those who did not enjoy large groups would benefit from more frequent individual and small group visits with workers.

DEVELOPMENTAL ENHANCEMENT
“Loves ... doing activities he normally wouldn’t get to do.”
This theme relates to Goal 1, to assist child service–users to have more diverse childhood experiences. Data relating to questions about new experiences are therefore relevant, as is any material concerning developmental changes in child participants resulting from recreational activities.
Both child and adult participants, when reporting what they liked about the monthly recreation days, spoke of enjoying new experiences. Specific questions were asked about new experiences. The possibility of developmental enhancement was linked with changes in children noticed by their parents (Theme 1), and changes in their capacity to socialise and support their peers at CRFSS (Themes 3 and 4). Data which specifically related to a recreational context were confidence to attempt new things, mastery of new skills, and motivation to try new challenges. Some hindrances were noted.

NEW EXPERIENCES

As noted, when asked general questions about monthly recreation days, the opportunity to have new experiences was a major theme.

Adult participants were asked if any of the recreational activities were new experiences for their children, and if so, what these were, and how difficult it would be for them to provide them (Section 2: Q4–5). All but two adult participants said activities at CRFSS had been new experiences (93.7% of the sample), and the same number said these would be at least ‘somewhat difficult’ for adult participants to provide. In response to Question Five, reasons given by adult participants for difficulty in providing these experiences were money (62.5%), followed by time constraints (21.8%), mental health (18.75%), and transport difficulties (15.6%). These data are in Appendix P.

Places they have not been before (AQ14).

They enjoy getting out with others and trying new things (AQ20).

She enjoys all the outings because we don’t do a lot as a family due to money and mum’s tiredness (AQ28).

When asked in a general question what CRFSS does well for their children, seven adult participants noted the provision of new experiences for them.

Child participants were also asked if they had new experiences while attending CRFSS recreational activities. All interviewees cited new experiences:

Camps, archery, rifle shooting (INT4).
BMX/biking at Bottle Lake Forest (INT7).

The kayaking, the road trip – some new places visited (INT2).

Um, a lot actually. Like I never went to camps a lot ... um ... it'd be like abseiling and rock climbing and all of that at ... the camps I'd never done before. I'd never shot a rifle before going to that camp ... um, yeah. So it's pretty much all those little things, it's like, finally done it ... (INT9)

Full data relating to new experiences for child participants are in Appendix P. Of the 24 focus group participants, 21 (87.5%) had new experiences at CRFSS. Those who had not experienced new activities were from FG1, the youngest group, and had therefore had minimal opportunities for new experiences at the time of data collection. Focus groups described enjoying opportunities to visit new places, try new things, and do something different:

Introducing us to things that our families wouldn’t be able to (FG2).

Up a mountain (on the snow day) (FG1).

Going to the hills for a walk (FG2).

Raft building, sailing, fire station visit, road trips, treasure hunt, snowboarding, Amazing Race (FG3).

Many activities at camps were also new experiences for child participants.

POSSIBLE DEVELOPMENTAL GAINS

Changes in their children because of engaging in these recreational activities were hinted at in the adult data and viewed positively. Due to the interrelated nature of many aspects of service delivery, much other data are relevant. For example, improvements in socialisation through a peer environment of trust, understanding and support; learning to support peers; and feeling able to talk more freely about mental illness, as outlined under Themes 3 and 4, are aspects of socio–emotional development. Further, Theme 1 outlined further nuances of socio–emotional development in the relationship formation with children’s workers which for some child participants were new experiences; some were learning to trust; some were learning to talk with other adults; and adult participants noted many positive changes in their children which they believed
were the result of spending time with the workers, including improvements in self-confidence, mood and behaviour. These may all be viewed as probable developmental gains.

Further traces were found in the data. One adult participant implied her child had made gains at the recreational activities. This participant does not specify if these gains were physical, cognitive and/or socio-emotional.

_The activities are a good learning curve for her (AQ24)._  
Several adult participants mentioned changes in confidence in relation to activities at monthly recreation days:

_Gives them confidence … (AQ26).  
... gives her courage and independence, she can do attitude especially for new experiences (AQ19)._  

When asked what the service does well for their children, one adult participant made links between the CRFSS environment of feeling safe and cared for, and his children’s willingness to attempt new things – suggestive of socio-emotional strengthening:

_Provides a helpful, caring environment and allows them to try things the children may not have otherwise (AQ20)._  

This willingness to try new things is picked up in a comment about monthly recreation days by one adult participant in relation to her son:

_Loves challenging/fun activities (AQ30)._  

**HINDRANCES TO THE BENEFITS OF RECREATIONAL ACTIVITIES**

Participants were asked about improvements to recreational activities provided by CRFSS. A full list of these is in Appendix P. Mentioned in this section are a few comments relevant to this theme.

The main area of complaint by child participants were issues related to transport to, from and during recreational activities. Most of these issues seem unavoidable without more resourcing. One comment is pertinent. A member of FG2 spoke of being forgotten during the pick-ups for recreation days on one
occasion. Other hindrances to maximising benefits to recreational activities were: the organisation of staff (FG3); inconsistency over birthday celebrations (FG1); and not attending “What Now” every year.

Some adult participants felt, with more funding, recreation days could be offered more frequently.

**SUMMARY**

The possibility of developmental gains which were suggested in service–user perceptions are likely to have occurred through new experiences at recreational activities and the forum that recreation provides for learning and growth.

New experiences while attending CRFSS were a common theme from general data. When asked directly about new experiences, 93.7% of adult participants said their children had these while attending CRFSS, and these would be at least ‘somewhat difficult’ for them to provide. Primary constraints to adult participants providing such activities were cost, time, mental health and transport. All interviewees and 21 of 24 focus group members (87.5%) had new experiences at CRFSS.

Links were made with the data from Theme 1 in terms of relationship formation with workers and peers and resultant socio–emotional gains, most of which occurred during recreational activities. Similarly, mention was made of gains in socialisation, peer relating and talking about mental illness from Themes 3 and 4. This section outlined further general remarks related to probable developmental enhancement in recreation: increases in confidence and willingness to try new activities and challenges.

Some hindrances to experiencing the benefits from recreational activities, although only mentioned by a few individuals, were noted and require service attention. One child participant recalled being forgotten to be collected on a monthly recreation day, and several child participants in one focus group felt birthday celebrations were inconsistent. A bullying experience for one child participant occurred. Staff organisation was noted to be poor at times. As
already outlined, the issue for some child participants with being in large groups was a hindrance to developmental gains from these experiences.

SUMMARY – THEME 5

Findings revealed many benefits to recreational activities offered by CRFSS. The context for these findings was high attendance rates at recreational activities, and high enjoyment levels.

A benefit of recreation was that it aided the formation of relationships with peers and workers. However, individual needs are important, and the few child service-users who struggled with large groups require thoughtful provision of smaller group activities to aid relationships with their peers.

Respite was found to be twofold. It occurred when child participants had opportunities to be away from home, and through having fun. Most child participants were attending school, and so respite required something more than just being away from home. The added factor was engaging in fun activities, in age appropriate play. A potential downside to respite was noted by one participant who found longer breaks from home a trigger for past separations and an aggravation to worry about her parent. Experiencing fun at CRFSS activities had some limitations also. Most were normal childhood or adolescent socialisation issues; however, one interviewee experienced some bullying which limited his respite.

Developmental enhancement was considered through opportunities for new experiences that adult participants were unable to provide for varying reasons. The adult data hinted at the benefits of these experiences in building confidence, motivation and mastery. In addition, gains from Themes 1, 3 and 4 were mentioned. Limitations may occur for some child participants who are unable to cope with large group settings in which some of these activities occur.

In terms of meeting relevant goals, Goal 3 of providing situations for child service-users ‘to play and be children’ seems well met, given most of the children experienced relief from whatever pressures they were feeling at home,
and engaged in fun at recreational activities. Goal 1 was also more than adequately met for most child service–users through the new experiences they had while attending CRFSS.

CONCLUSION

This chapter sought to outline primary themes and sub–themes from service–user perceptions of the CRFSS and compare these to the service narrative. Five themes structured the chapter, and within these themes the service goals were addressed.

The majority of adult and child service–users perceived relationships with workers as an important and positive aspect of CRFSS service delivery. In relation to worker–child relationships, adult participants viewed these as more important to their children than other aspects of service delivery. These relationships were described by adult and child participants as safe, trusting, communicative, supportive, and fun. Many adult participants viewed the children’s workers as mentors to their children. Longevity of relationship was highly valued, and staff retention emphasised as important. Adult participants identified positive changes in their children, which they attributed to the influence of these workers. A few adult and child participants noted that difficulty in trusting others affected how easily relationships could be formed with the children’s workers, thus affecting whether child participants would talk to the workers if they were facing difficulties.

In relation to family worker–service–user relationships, similar themes arose for those adult participants who had regular contact with family workers, and similar descriptions of these relationships were given. However, not all adult participants received regular contact from the family workers. The complexity of worker relationships with adult service–users who are parents was noted, and the tension this brings to worker–service–user relations when competing needs arise. Resilience theory informed about the importance of trusted adults as part of a secondary relational system for resilience, and for supporting other
aspects of resilience. For this group of COPMI and their families, these relationships are scarce, and professionals can be part of this system.

The second theme of comprehensive family practice was suggested as a framework for explaining diverse aspects of service delivery across the family system, incorporating mental and physical health and wellbeing, practical needs, mental health education, crisis planning and parenting support. It appears this comprehensive family practice served the needs of child service-users well, and two-thirds to three-quarters of adult service-users who had more regular contact with the service. However, for the remainder of the adult sample who were visited less frequently, aspects of this comprehensive family practice were not experienced as service delivery was directed towards other adult family members. The notion that service delivery which was not only supportive, but which attended to other wider support areas including practical needs, was also suggested as a principle of resilience-focused practice.

Theme 3 considered participant experiences of stigma and the role of CRFSS service delivery in providing a destigmatising environment for child service-users. Public stigma, associative stigma and self-stigma featured in findings from adults and child participants. Reasons given for why some participants did not experience stigma were two-fold: a minority experienced support upon disclosure of mental illness, and others stated it was because no one knew. Child experiences of stigma became more overt when discussing what felt different for them when mixing with other COPMI at CRFSS. Most participants stated it was beneficial for child service-users to mix with other COPMI at CRFSS. Descriptions of what this meant suggested the service provided an environment which was not only appeared to reduce self-stigma, but enabled peer support to emerge. A few adult participants noted potential negative effects for their children mixing with other COPMI at CRFSS. They were concerned about the influence other COPMI may have on their children, one participant noting his son had voiced concerns in this regard. Stigma was argued to be anti-resilience in the literature review, increasing risk, and attempts by
CRFSS to ameliorate this for child service-users while attending service activities are suggestive of resilience-focused practice.

Theme 4, peer support, was closely related to Theme 3, and these links were made in the findings. Child participants not only spoke of feeling supported by their CRFSS peers but feeling they also could offer support. Peer support primarily occurred during recreational activities. Descriptions by child participants of this peer support were in direct contrast to descriptions of stigma. Adult participants concurred with these findings. As discussed in the literature review, the peer relational system is a crucial mediator of resilience, scaffolding many other protective systems.

The final theme, benefits arising from recreation, connected many aspects of service delivery for child participants. Recreational activities were the main avenue for child participants to form relationships with workers and peers, in addition to providing respite and the possibility of developmental gains. Having fun was a predominant sub-theme and viewed as a form of respite in addition to having a break from home. The complexity of respite was highlighted when a child participant noted worrying about parents when away from home. The potential for development enhancement was suggested in findings from other themes, from adult participant perceptions of changes in their children, as well as new experiences at CRFSS. The need for respite was highlighted for COPMI when the impact of parental mental illness was reviewed, and ensuring uneven developmental gaps were filled was viewed as resilience-focused practice. One significant limitation occurred for a few child service-users due to personal difficulties in tolerating group situations, and this was noted as an area for CRFSS to address. Flexibility to adjust service delivery to meet individual needs is an important principle of resilience-focused practice.

Participants suggested improvements to service delivery, and the main feedback was aligned with Theme 1: adult and child participants wanted more frequent contact between the children’s workers and their children, and family workers and adult service-users, and more frequent recreation days and whole
family activities. Focus Groups 2 and 3, all of whom had been discharged from the service prior to data collection, wanted longer service delivery, more graduated discharge, and ongoing contact. Adult participants who infrequently saw the family worker because of work commitments requested more flexible working hours to enable this contact to occur.

Participants’ reported perceptions could be related to all goals of the service, although findings relating to Goal 9 (Theme 2) were unclear due to lack of definition in the question. Participant perceptions showed service goals (Goals 1–6) concerning direct service delivery to child service-users were more consistently reached than service goals (Goals 7–12) concerning direct service delivery to adult service-users. The most probable reason was the variation in service delivery offered to adult participants. As noted, the main area of improvement for child service-users was for the service to ensure the few individuals who could not manage group activities still had their resilience needs met.
This chapter utilises the theoretical framework of socio-ecological resilience theory to discuss themes that emerged from service-user perspectives of the Caroline Reid Family Support Service (CRFSS), and implications for service delivery arising from this analysis. A further intention of this chapter is to contribute towards a theoretical model of practice for CRFSS staff and management. The chapter is divided into two sections: the first section discusses themes, and the second considers implications for practice. The discussion will be framed by socio-ecological resilience theory.

The five primary themes outlined in Chapter Four have been further analysed to reflect connections made in the findings and literature. This was phase five of the thematic analysis processes and used a combined deductive-inductive method to develop overarching themes. Consequently, the five themes have been reduced to three in this chapter, as shown in Table 5.1.
### TABLE 5.1 – PRIMARY THEMES BEFORE AND AFTER FINAL ANALYSIS

<table>
<thead>
<tr>
<th>Themes from research findings, Chapter 4</th>
<th>Themes for discussion, Chapter 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The importance of relationship</strong></td>
<td><strong>Theme 1 – Relationship-based practice (RBP)</strong></td>
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<tr>
<td><strong>Aspects of comprehensive family practice</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Experiences of stigma</strong></td>
<td><strong>Theme 2 – Stigma for COPMI and the importance of peer support</strong></td>
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<tr>
<td><strong>Peer support</strong></td>
<td></td>
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<tr>
<td><strong>The benefits of recreational activities</strong></td>
<td><strong>Theme 3 – Scaffolded recreation and the resultant benefits</strong></td>
</tr>
</tbody>
</table>

The rationale which led to Theme 1, relationship-based practice (RBP), was the first principle of practice (page 69) that was suggested from socio-ecological resiliency theory:

**Principle 1:** Service delivery which supports the professional-client and peer relational systems enables resilience to cascade to other domains (Chapter 2).

Munford and Sanders (2016) noted that for young people in the Aotearoa/New Zealand (A/NZ) resilience study, relationships with professionals enabled hope and scaffolded opportunities for young people to fill developmental gaps. In the same way, it was argued the RBP which formed the centre of CRFSS service delivery enabled comprehensive family practice for adult and child participants. Although comprehensive family practice could stand alone as a theme, in this study it has been theorised as an extension of social work RBP, adult mental health care, and adult-youth mentoring. What this means is that one service operating from a basis of RBP provides comprehensive service delivery, rather than multiple services offering multiple aspects of comprehensive family practice. As argued, this enables services to be more flexible and responsive to individual and family needs, and interconnecting relationships between workers.
and service−users. Principles 2−4 from socio−ecological practice are relevant to this aspect of Theme 1 (page 69):

*Principle 2: Service delivery which is readily available and responsive to need;*

*Principle 3: Service delivery which is flexible enough to respond to individual context and choice;*

*Principle 4: Service delivery which is comprehensive and addresses a wide range of gaps.*

Theme 2 of stigma for COPMI and the importance of peer support also arose from a logical grouping of themes. In this case, this is because each phenomenon affects the other, and links were made in participant perspectives. Theme 2 also relates to Principle 1 of socio−ecological, resilience−focused practice.

Theme 3, scaffolded recreation, was explained as the notion that recreational activities are supported by something else; in this context, relationships. Relationship formation occurred during recreational activities, and in turn, it was argued that these relationships scaffolded recreational activities, thus enabling other processes to occur, in this case, respite and developmental enhancement. Theme 3 aligns with Principle 1 of socio−ecological, resilience−focused practice.

Although at times in this chapter it may seem as though the focus is only on positive feedback about the CRFSS, this has occurred because of the strong convergence of positive themes in service−user perceptions. As stated, I have included all negative feedback about the service in Chapter 4, apart from detailing several minor complaints from child service−users such as who they sat with in the van on a CRFSS trip. All pertinent negative feedback about the service is discussed in this chapter.
SECTION 1: ASPECTS OF RESILIENCE-FOCUSED PRACTICE

This section discusses each theme: relationship-based practice, stigma for COPMI and the importance of peer support, and scaffolded recreation and resulting benefits.

THEME 1 — RELATIONSHIP-BASED PRACTICE (RBP)

Discussion of Theme 1 begins by analysing findings which pertain to service-user perceptions of worker relationships with child participants, then proceeds to analyse findings which relate to worker relationships with adult participants.

RBP WITH CHILD SERVICE-USERS

Findings relevant to RBP can be analysed using theoretical concepts from resilience theory. It was noted that the relational systems are vital for resilience, and professionals may support these systems in various ways (Masten, 2001; Munford & Sanders, 2016). Working with children and adolescents in roles which incorporate mentoring such as the CRFSS children’s workers, is one method of supporting the secondary relational system. This section uses three additional approaches to analyse this theme: adult–youth mentoring; recognition theory; and social work RBP.

Comments by adult and child participants describing child service-users’ trust of the workers and feeling emotionally close to the workers, when viewed from the adult–youth mentoring lens, are suggestive of a positive and successful mentoring relationship and a relationship which provides meaningful support and a springboard for positive change (DuBois & Silverthorn, 2005a; Rhodes & DuBois, 2006; Munford & Sanders, 2016; Spencer, 2006). For example, pertaining to trust: “tell them what you like and don’t like about your life and they will keep it a secret – can trust them”; in relation to emotional closeness: “bonded well”, “friends”, “family”, “have grown up with them”. Emotional closeness was predictive of more favourable psychological wellbeing in
mentees, which may explain parents’ perceptions of changes in their children resulting from spending time with the children’s workers (DuBois & Silverthorn, 2005a). For example, “a lot calmer, happier”, “so much out of her shell ... willing to give things a go”.

These same findings analysed by recognition theory would be explained as ‘recognition of love’, that is, a strong emotional attachment which incorporates the sharing of feelings, thoughts, and acceptance and encouragement, and from which the ‘recognised’ person, the child service–user, forms a sense of self and identity (Honneth & Farrell, 1997; Smith et al., 2017; Turney, 2012b).

It is worth noting that longevity and continuity of relationship with the children’s workers was mentioned by many participants, and these factors were correlated with emotional closeness in the mentoring literature (Hurd & Zimmerman, 2014). As one focus group participant said, “it gave everyone someone they knew over a long time”, and adult participants noted: “he likes ... continuity with the same person, especially a male role model”. These comments also align with those found in the A/NZ resilience study in relation to services increasing resilience for marginalised young people when they were able to remain engaged with them long enough for trust to be established (Munford & Sanders, 2016).

A related and significant limitation for RBP raised by child participants was the issue of staff retention in the children’s worker position. This represents a threat to this service model if CRFSS is unable to maintain some stability in this position. For children and young people with possible insecure relationship systems and social isolation, this moderates the benefits of the service model (Rhodes et al., 2006; Whitney et al., 2011).

A few child participants found it difficult to talk with the children’s workers about problems. For example: “he keeps things bottled up inside ... trust

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35 The term parent represents the range of adults responsible for the care of a child or adolescent in this thesis. Parents may include birth, adopted or foster parents, step–parents, whāngai parents, aunts and uncles, and grandparents.
issues”, and “I don’t tell many people stuff – not anybody at all”. These child service–users had received the same service delivery as others, yet their responses were different. Other factors may play a part: personality style, previous experiences with adults, and levels of anxiety such as demonstrated in child service–users who could not tolerate group activities. It could be these child service–users needed more frequent one–to–one visits to enable trust and emotional closeness to develop than was part of normal service delivery. This is captured in the comment of one adult participant:

*Finds it hard to voice concerns at time but has good relationships with workers so would see them as an option were he able to open up.*

Frequency of contact was a mediator for successful mentoring relationships, and it may be that some child service–users required this (Rhodes & DuBois, 2006). Service capacity to respond to individual context was encapsulated in Principle 3 of socio–ecological resilience–focused practice (Munford & Sanders, 2016). It seems that although the formation of relationships with workers was the most important aspect of service delivery, how this occurred for child service–users differed based on individual factors. Participant feedback about the need for more frequent one–to–one contact between workers and child service–users also highlights the importance of how relationships with workers were perceived by child and adult participants. Frequency must have been adequate for relationship formation to occur for many child participants; however, these comments signify the importance of these visits from the perspectives of both adult and child participants.

Perceptions that child service–users were supported, valued, and able to talk to the children’s workers are further concepts able to be framed by a mentoring relationship, and align with the A/NZ resilience study (Munford & Sanders, 2016). For example: “supporting him through difficult times”, “make her feel important and worthy”, and “tell about anything – they are interested and try to understand”. These traits were found to be additional mediators of positive outcomes for the mentoring relationship (Rhodes & DuBois, 2006).
The notion of legal recognition from recognition theory provides insight into child service−users feeling valued by the children’s workers. Legal recognition was described as social appreciation, or respect, an aspect which enables self−respect in the recipient (Honneth & Farrell, 1997; Smith et al., 2017; Turney, 2012b). In stating the worker−child service−user makes his daughter “feel important and worthy”, this comment suggests the respect shown by the children’s workers resulted in self−respect for this young person.

In relation to talking with the children’s workers, participant perceptions are suggestive of reciprocity in the relationship; a sense of mutuality, for example: “they talk to you and get to know you”, “not just about going and doing activities, but going and actually having decent conversation”. The notion of reciprocity of relationship was noted as fundamental to the formation of functional adult−youth mentoring relationships (Rhodes & DuBois, 2006). Honneth’s concept of solidarity, a key facet of recognition theory, which describes such exchanges as reciprocal interactions in which each person ‘recognises’ the other, also has application to these findings (Honneth & Farrell, 1997; Smith et al., 2017; Turney, 2012b).

Reciprocity was further suggested in other characteristics of mentoring relationships which yielded positive outcomes, such as experiencing fun activities together, enjoying each other’s company, and compatibility in personality and interests, all of which further describe a relationship which was based on a degree of mutuality (Bernier & Larose, 2005; Madia & Lutz, 2004; Spencer & Rhodes, 2005). Similarly, child participants described having fun with the children’s workers, especially during one−to−one visits. In relation to shared interests, one adult participant suggests this when commenting “my son loves to ride the bikes/skateboard with [male children’s worker]”. These descriptions of reciprocity in the children’s worker−child service−user relationships are not usually applied to professional relationships with service−users. It may be that as the findings are from the service−users’ perspectives, this is their way of describing a professional engaging in an age−appropriate way with this group of service−users. However, there is a nuance to the findings which suggest these
descriptions bridge the gap between volunteer mentors and professionals as mentors in a way which is not yet captured in the literature.

Adult–youth mentoring was noted to have its roots in several theoretical fields (Schwartz et al., 2013). The notion of mentors as role models, and mentors contributing to mentees’ sense of self, outworkings of psychosocial theory, may be theorised from this study (Erikson, 1968; Schwartz et al., 2013). The first, role models, was overt in adult participant’s comments. Many used the term to describe workers’ consistent modelling of prosocial behaviour to their children in a manner reminiscent of an older family member. The psychosocial notion of contributing to the mentee’s sense of self could be another lens by which to explain changes in child service-users resulting from spending time with the workers, as many adult participants described an increase in perceptions of their child’s confidence and competence (Markus & Nurius, 1986; Rhodes et al., 2006).

Workers providing good advice was mentioned by adult and child participants: “they listen well and have great solutions”, and “they give you ideas of what to do”. The third theoretical underpinning of adult–youth mentoring, social learning theory, locates these perceptions as the mentor acting as an experienced and trusted advisor, one who provides differing viewpoints and guidance (Allen & Land, 1999; Keller & Pryce, 2010; Schwartz et al., 2013). This may in part explain why child service-users felt their relationships with workers became more important as they grew older; as discussed, adolescence is a developmental stage in which the views of mentors carry more weight than parents (Santrock, 2013; Schwartz et al., 2013).

An aspect of support which emerged for child participants was assistance from the workers, described as helping with practical needs, personal issues and by supporting their parents. Both social work RBP and adult–youth mentoring noted the role of practical aid in assisting the development of trust and secure relationship (Herrera et al., 2000; Sable, 1992; Sudbery, 2002). When child participants described the workers as consistent, reliable, attentive and
supportive, it is surmised that when combined with the data on the children’s workers providing practical assistance, this holistic focus also aided the formation of trusting relationships. Furthermore, these aspects are interrelated. As noted by Munford and Sanders (2016), a trusting relationship with a professional scaffolded practical and other support, thus increasing resilience by enabling other learning and developmental gains to occur.

Comments by child participants that supporting their parents was perceived as a way of assisting them, hints at the value of comprehensive family practice. It seems participants were referring to more active support for their parents by the CRFSS family workers. This aligns with the mentoring literature’s findings in relation to youth with individual and environmental risk factors, such as this COPMI population. Mentoring alone was found to be insufficient and needed to be part of comprehensive family practice (DuBois & Silverthorn, 2005b; Rhodes & DuBois, 2006).

The importance of worker and child participant relationships raises questions about the discharge process. Comments from older child participants suggest that having to leave their relationships with workers was difficult. Interviewee Nine’s description of feeling torn between wanting more one-to-one contact but realising this would make it harder to leave, highlights the tension in this type of service provision. The feedback for change from the focus groups with participants who had left the service about extended contact and graduated discharge adds to the picture of a difficult transition.

Child participant responses raised some limitations for professionals as mentors, which would be less likely to occur in naturally forming mentoring relationships. The first was the lack of availability outside working hours, which meant they were less available if a child participant needed to talk about problems; a challenge for this socially isolated group who have less naturally forming supports (Reupert & Maybery, 2007a; Rutter & Quinton, 1984; Tebes et al., 2001). The second limitation relates to the limits of confidentiality. As stated by one focus group participant in relation to talking to the children’s
workers about problems: “it might be scary if they try to fix it”. One interpretation could be that this child participant recalled a time when the children’s workers or other professionals had “fixed” a problem and the consequences were experienced as frightening. What this comment highlights are the limits to confidentiality when information is disclosed to professionals. For COPMI, disclosures about difficulties may result in professionals scrutinising their parents, and as reviewed, COPMI are often anxious about keeping their families safe and together (Gladstone et al., 2011).

Findings relating to Theme 1 suggest CRFSS service delivery does support the professional–service–user relationships for child participants. This does not mean all aspects of these relationships were straightforward, and that improvements are not needed in some instances. However, in general terms, the emphasis of this theme from both child participants and their parents, suggests the service provided this. Findings also suggest, particularly from adult participants, that these relationships may have enabled a cascading of resilience to other domains for some child participants, particularly when other themes are considered. As reviewed, it was the relationships with workers which enabled vulnerable NZ young people to find a pathway towards resilience (Munford & Sanders, 2016). Further, these secondary relational systems were not only discussed as adding to a child and young person’s sense of security and support but additionally, they mediate some inadequacies in the primary relational systems as children age (Howe & Campling, 1995; Munford et al., 2013; Walsh, 2012). It is unknown if this occurred for these child participants. However, if we trust the large body of mainstream and socio–ecological research, we can surmise that this aspect of CRFSS service delivery is likely to have supported this occurring.

RBP WITH ADULT SERVICE–USERS

The importance of relationships also emerged in relation to workers and adult service–users of the service. Although developmentally their needs are different, resilience theory indicated that relational systems are important, regardless of age. For adult service–users with mental illness who are socially
isolated, often fearful of services, and who may have insecure relationship
patterns, it was argued from the literature that worker–service–user
relationships are the crux of practice (Ruch et al., 2010; Ruch, 2000; Trevithick,
2012; Turney, 2012b). To theorise data in this section, social work RBP will be
applied to findings. An application of mainstream secondary attachment theory
as it has been applied to case manager relationships with adult service–users in
mental health will also be used (Adshead, 1998; Gilburt et al., 2008; Goodwin,
2003, 2003b; Shattell et al., 2007).

As RBP was not a recorded service goal, fewer questions were asked about
worker relationships with adult service–users, therefore less material was
gathered. However, general themes and descriptions in findings were the same
as those expressed about worker relationships with child service–users. What
was different about this data is that for most child service–users, the workers
were truly important people in their lives. This impression exists in the adult
data for some participants, but less so for others, and not at all for the smaller
group who received minimal service delivery.

Descriptors used by some adult participants of their relationships with the
family workers such as trusting, safe, feeling comfortable with, good rapport,
and empathetic, are congruent with descriptors of RBP in the social work
literature RBP (De Boer & Coady, 2007; O’Leary et al., 2013; Ruch, 2005;
Sudbery, 2002; Trevithick, 2012; Turney, 2012b) and in Western adult mental
health care (Adshead, 1998; Gilburt et al., 2008; Goodwin, 2003, 2003b);
Holmes, 1993; Shattell et al., 2007).

A few service–users noted barriers to a trusting, open, supportive relationship
with the family workers. Reasons given included personal struggles with
trusting others or being fearful of or reluctant to ask for help. As with child
service–users, it is likely these service–users required more frequent visits than
the prescribed monthly service delivery to enable trust to be built. There is no
mandate for frequency of contact in the social work RBP literature; however, in
the other relevant field, adult mental health care, professionals would normally
see their service-users more frequently than monthly. It appears frequency was adequate for relationship formation to occur with most service-users, although interestingly, more frequent visits and telephone calls from family workers were the main feedback for service improvement to adult participants. Few participants commented on the matter of duration, although one adult participant emphasised the importance of continuity with the same person. As reviewed, continuity of care was considered essential for secondary attachment to occur in adult mental health care (Burns et al., 2009; Freeman et al., 2000; Goodwin, 2003, 2003b).

One adult participant’s comment about her relationship with the family worker teaching her to trust another person and enabling her to get help, emphasising the worker’s availability and consistency, are reminiscent of Sudbery’s descriptions of social work RBP as having therapeutic, empowering and developmental effects (Sudbery, 2002). Another participant’s comment about feeling he had come know the family workers, and feeling comfortable with them, hint at aspects of mutuality (De Boer & Coady, 2007; Drake, 1994; Maidment, 2006; Ribner & Knei-Paz, 2002). This aligns with descriptions of RBP from adult mental health care of getting to know the “whole person” rather than just as a service recipient (Shattell et al., 2007). The comments of many other participants also suggest this “whole person” interaction, and that conversation was not just about mental illness or parenting. For example: “just being there to talk”, “advice, phone, chats, coffee …”, and “came round to see how I’m getting on …”.

These adult participant perceptions further hint at what social work RBP describes as “a set of boundaries that promote connection and the use of self, rather than separation and professional distance” (Maidment, 2006; O'Leary et al., 2013, p143). The level of relationship and engagement seen in the data seems contrary to what is often reported for parents with serious mental illness. As reviewed, there is a reluctance for this group of service-users to connect with services due to fear of losing custody and the stigma shown by professionals (Larson & Corrigan, 2008; Reupert and Maybery, 2016). It seems
the findings of De Boer et al., (2007) regarding good worker–service–user relationships producing positive outcomes, even in complex child protection settings, also holds true in this situation (Cooper, 2015; Drake, 1994; Ruch et al., 2010; Turnell, 2004).

A good example of the complexity of such relationships occurred in the findings when an adult participant spoke of reservations in speaking to the family worker about future problems. He felt the interference of the family worker made a child welfare situation in his family worse. Despite this, the participant said he would talk to the family worker on some occasions about problems, suggesting the relationship had been affected, but not completely. This is reminiscent of Cooper’s likening of social RBP to medicine’s ‘stoical stance’ in which relational work is coupled with ‘difficult conversations’ (Cooper, 2015). De Boer and Coady (2007, p39) summarise this type of occurrence when describing the ups and downs of relationships in these situations, where difficulties are worked out and “periodic conflict and contention” does not prevent a continuation of a strong working relationships.

This tension is found in other literature. The categorisation of worker traits from De Boer and Coady (2007) which included the ‘soft, mindful and judicious use of power’, and Healy and Darlington’s (2009) participatory principles for service user participation in the child protection arena of respect, appropriateness and transparency, are hinted at in the findings. One participant described her relationship with the family worker:

Bonded well and can be straight up and know I’m not being judged.

This comment suggests elements of the honesty, openness and acceptance required in this arena of work. Another quotation speaks to the use of power:

Because I trust my worker will discuss it, give me options, and leave the choice to me.

Other sub–themes of feeling supported by the family workers, feeling able to talk with the workers about problems, personal mental health, child health and
wellbeing, family issues and parenting, can be explained by social work RBP. The notion that the relationship is the cornerstone by which other interventions are supported all suggest this type of participatory relationship. The quotation above about the worker supporting an adult service-user by giving information, but allowing the service-user to make his own decisions, describes how a service-user’s self-determination may be maximised through collaborative approaches to power (De Boer & Coady, 2007).

Attending to practical needs as an important part of social work RBP was noted in the literature (Sudbery, 2002). Adult participants were not asked direct questions about this; however, questions to child service-users about practical assistance combined with diverse aspects of comprehensive family practice in the findings provided relevant information. For example, child service-users spoke of food parcels, transport, and earthquake relief, and adult service-users revealed family workers proactively referring them to a wide variety of services, organising and attending meetings, advocating, and transporting. As outlined, meeting basic needs, from emotional to practical, were viewed by Sudbery as an enhancement to the therapeutic relationship (Sudbery, 2002). For a service-user group associated with high social deprivation, this is an important aspect of service delivery, and it appears the service design allows this kind of support to occur.

A related concept to comprehensive family practice, an outcome of RBP, is whole family practice. It was interesting that the reason one adult participant gave for feeling she could communicate with the family worker was because she believed the workers “have a genuine desire to support not only my children but the family as a whole”. This comment hints at the tendency in A/NZ and similar countries for social service support and focus to be solely on children’s needs, to the detriment of the support needs of parents and caregivers and the entire family system (Featherstone et al., 2014b; Hackell, 2016; Hyslop, 2013; Kedell, 2015b; Khoo et al., 2006; O’Brien, 2016; Parton, 2016; Sawyers, 2016; Webster & McNabb, 2016). The reasons for this are complex and ideological,
many of which are pursued in the next chapter. Several points are relevant for
discussion here.

The first is the stigmatising message for this group of parents who often have
high support needs, that they should not require additional support, and if they
do, they are not fit to be parents (Crossley, 2016; Featherstone et al., 2014a;
Hackell, 2016; Houston, 2013; Jensen, 2013). I contend that focusing on the
child alone is not resilience-focused practice, neither does it align with social
work RBP, adult–youth mentoring for marginalised children and youth, or
recommendations from the COPMI literature (Falkov, 2012; Munford &
Sanders, 2016; Reupert, Maybery, et al., 2015; Sanders et al., 2012; Ungar,
2008). It is no wonder that parents with mental illness living in such
environments avoid seeking help. As reviewed, social work RBP in child welfare
settings in which parents have been treated humanely and respectfully has
been shown to have positive outcomes for the whole family (De Boer & Coady,
2007; Drake, 1994; Howe, 2010b, 2008; Lee & Ayon, 2004; Munro, 2011; Ruch,
research collaborative have rightly signalled a need to further pursue research
in this area36 (Reupert, Maybery, Nicholson, et al., 2015).

It seems contradictory that the emphasis on Western attachment theory as it
relates to child–centred needs in child welfare settings ignores the primary
relational needs and supports for parents and their wider relational systems
which are emphasised by resiliency theory (Gilbert, 2012; Keddell, 2017;
Solomon, 2002; Smith et al., 2017). I am not suggesting that the attachment
needs of an infant are not essential; they are. Yet it seems that many
attachment arguments lack the benefit of broader theories which consider the
varied needs within a whole family system, and that parents may also have
needs which may be remedied with support. This raises a question about
resiliency theory; do the seven tensions and the short list apply to adults also
(Masten, 2001, 2015; Ungar, 2008)? If so, service delivery might have to

36 Prato International Research Collaborative for Change in Parent & Child Mental Health,
research meeting in Prato, Italy, May 2017.
reconsider how to apply resilience theory to guide support for the whole family system, not just children. The challenge for A/NZ, borrowing the phrase of Khoo et al. (2006), is, ‘Do we just want resilience children, or do we want a resilient society?’

The mandate for whole family practice as part of social work RBP is inherent in the profession’s underpinning of ecological theory (Coady, 2001; Connolly & Harms, 2012; O’Donoghue & Maidment, 2005; Nash et al., 2005). The social worker is trained to consider multiple systems impacting the individual and family, and to act accordingly. The role the social worker is employed to fulfil clearly impacts on their involvement in the outworking of comprehensive, whole family service delivery. However, this thesis argues no matter what tasks a social worker is employed to achieve, to be a social worker requires at least an assessment of these needs.

Consideration of whole family practice leads to the concept of reciprocal impact between parents and children (Falkov, 2012; Reupert, Maybery, et al., 2015). Comments by child participants about how it felt for them to know their parents were supported by the service hint at possible reciprocal impact. If child service–users felt they were helped, supported and reassured by knowing someone was visiting their parents and other family members, talking with them and providing support, how much more impact would improvements in parents’ sense of support from a relationship with a trusted worker have? Reports of small changes perceived to have occurred in broad domains for adult participants, as with changes in child service–users and the possible impact on parents, would be an interesting future study.

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**THEME 2 – STIGMA FOR COPMI AND THE IMPORTANCE OF PEER SUPPORT**

This section explores participants’ experiences of stigma and perceptions of the service providing a destigmatising environment for child service–users. Findings pertaining to adult and child service–user experiences of stigma, when viewed through the lenses of stigma theory, appear to conform to common experiences reported in the literature (Crocker et al., 1998; Goffman, 1963; Jones, 1984; Link
Adults and child service-users described behaviours and comments about them which discredited them, made them feel tainted and unworthy, were an assault on their sense of self, threatened what they held most dear, and categorised them as flawed. Their responses revealed adult and child participants experienced aspects of public, self and associative stigma (Corrigan, 2000; Goffman, 1963; Reupert & Maybery, 2015). Stigmatisation by professionals and the role of structural discrimination are discussed, and peer support is theorised as a strategy to reduce self-stigma for COPMI.

**EXPERIENCES OF STIGMA**

The five co-occurring and interrelated components of stigma are noted in participant responses, as conceptualised by Link and Phelan (2001). Labelling, distinguishing between people and then categorising them, is seen in comments such as “retard”, “loony”, “your mum’s a freak”. Stereotyping, the thought process which links labelled people with negative attributes, was more overt in comments by adult participants, including the sense that people “expect that I am less intelligent and capable” and:

> ...when I disclose I suffer from mental illness a judgement about me is made ... if I say depression they are fine. If I say borderline personality disorder, completely different.

Child participants did not identify stereotyping, rather commenting on its effects. When an adult participant said, “other people don’t want to be near my child in case it’s catchy”, this implies a stereotype of contamination because of parental mental illness (Corrigan & Miller, 2004; Gladstone, 2014; Larson & Corrigan, 2008; Reupert & Maybery, 2015).

The resultant separating between ‘them and us’, conceptualised as cognitive separation, was implied rather than stated in adult and child experiences (Link & Phelan, 2001). One comment by an adult participant – “we don’t fit into other people’s slot” – was the clearest example. Child service-user comments about feeling more normal and liked when attending CRFSS are suggestive of the cognitive separation experienced by peers in other settings.
Labelling, stereotyping and cognitive separation were discussed as providing a rationale for stigmatising behaviours such as devaluing, rejecting and excluding, conceptualised as status loss and discrimination (Link & Phelan, 2001). Themes from child participants revealed their experiences of status loss with peers in several ways — through words such as ‘teasing’ and ‘laughing at’ when parents are encountered, and when child participants told others about their parents’ mental illness. Status loss was also inferred in children’s comments of feeling normal and more liked at CRFSS, and feeling they could talk about their family situations, and in adult participant comments about their children’s exclusion from social events with peers. The degrading in status because of stigma was clearly exemplified in adult experiences. Many described being ignored, shunned, viewed as incompetent, and devalued.

It could be theorised that self−stigma is the ultimate loss of status: a downward movement in one’s own positioning of self in comparison to others. This internalisation of labels, stereotypes and cognitive separation is hinted at in research findings. When one adult participant said, “I feel more comfortable with similar people, feel awkward around ‘normal’ people”, the wording suggests more than status loss: the participant sees himself as abnormal. Child participant comments also hint at self−stigma. Feeling normal at CRFSS implies feeling abnormal in other situations; similarly, feeling more liked at CRFSS infers some child service−users did not evaluate themselves as likeable elsewhere. Interviewee Three’s poignant rhetoric about being treated differently all her life, longing for a normal life and normal parents, suggests entrenched self−stigma. Her comments could be interpreted as an expression of grief and loss over a lifetime of perceived, embedded abnormality. The definition of stigma by Yang et al. (2007) is apt: a moral threat to one’s identity.

Status loss may also be theorised in relation to the cognitive separation of some CRFSS families towards other CRFSS families. Judgements about the status of other service−user families were demonstrated by comments about the disadvantages of COPMI mixing with other COPMI at the service. As noted, they did not want their children to become involved with some CRFSS families.
outside CRFSS activities due to concerns about a negative influence on their children. What is not clear is whether this is stigma, or sensible parent behaviour, as many parents screen their children’s friends for suitability.

Discrimination, the product of the interrelated aspects of stigma, was the most overt component of public and associative stigma in the data. Two reasons are probable: the effects of stigma are what is most prominent in peoples’ experiences, and the research questions focused on the outworking of stigma—“different treatment”. Child and adult participants described explicit examples: “they scrutinise my son more”, “I’ve been in a life that nothing can happen right”, “I get taken less seriously on everything I say”, “not included in activities, lose friends when they find out, not helped with problems”. Child perspectives inferred significant discrimination by peers in their comments describing the contrast between being with peers at CRFSS and peers in other social settings, and through reported behaviours such as awkward questions about their parent with mental illness, not inviting friends home, and keeping parental mental illness a secret. The result of discrimination is clearly seen, as noted above, when one adult participant said, “I feel more comfortable with similar people, feel awkward around ‘normal’ people sometimes.”

These behaviours in response to discrimination may be conceptualised as classic responses to shame (Corrigan & Miller, 2004; Larson & Corrigan, 2008; Reupert & Maybery, 2015). Most child and adult participants who did not experience stigma said it was either because no one knew, or it was not obvious to others. In order to keep mental illness a secret, some child participants choose not to socialise with friends at home. Others were careful not to disclose this information. For some these strategies did not fully work, as other children still asked unwelcome questions concerning the absence of their parents. The result was limitations to social supports. The ‘why try’ phenomenon noted in the literature, a response to ‘stereotype threat’, was not overt in the data, as it was not a subject of enquiry (Corrigan et al., 2016; Link & Phelan, 2001). Holding child service-users’ experiences of stigma from peers in mind with insider
knowledge of the degree of school failure for child service–users, suggests it is likely many CRFSS child service–users experienced this.

Stigma is therefore anti–resilience, as it undermines the primary sense of self, limits secondary and tertiary relational systems and all that cascade from these, destroys hope, and restricts full engagement in resilience enhancing activities, as noted by (Livingston & Boyd, 2010; Major & O'Brien, 2005; Yang et al., 2007).

Inclusion by Yang et al. (2007) of the process which occurs for the stigmatiser as well as the stigmatised is useful when considering the phenomenon in the COPMI literature of stigma from professionals (Reupert & Maybery, 2015; Parkinson, 2016; Seeman, 2015; Taylor et al., 2009). Viewed from this perspective, professionals who show stigma to parents with mental illness are also experiencing a threat to what they consider important. This may explain the increased scrutiny of a child described by one participant when she disclosed to her teachers that she had mental illness. The literature noted COPMI families sometimes feel blamed by professionals for the mental unwellness of a parent, and this also emerged in the findings (Reupert & Maybery, 2015).

Stigma by professionals is a complex matter. For social workers and health professionals working with parents with mental illness, the competing needs of children and adults require judgements to be made, and as discussed, these needs require negotiation. Two issues are relevant to findings: power relations, and the basis of forming judgements (Link & Phelan, 2001; O'Shaughnessy et al., 2015; Reupert & Maybery, 2015; Seeman, 2015; Taylor et al., 2009). As discussed, power is necessary for social stigma to arise and professionals in mental health services and child protection settings have power which parents with mental illness and their families do not (Link & Phelan, 2001). When an adult participant commented about the CRFSS family worker overreacting in a child welfare situation, was this stigma or good practice? That the relationship between family worker and participant was partially preserved suggests the worker’s judgement was not completely unwarranted or a usurping of power.
Were judgements made by the CRFSS family worker in this example based on arbitrary factors, as commonly occurs in parent evaluations which are a snapshot of parenting and often based on white, middle class, Western values (Taylor et al., 2009; Seeman, 2015)? That the setting was relationship-based, continuous and comprehensive family practice provides some reassurance decisions were not based on isolated assessments or according to a formulaic risk assessment tool (Taylor et al., 2009; Seeman, 2015).

Standard CRFSS service delivery involved aspects of scrutiny of child and adult service-users via the assessment process, observations of child service-users during activities, observations of family dynamics during family meetings and home visits, and on-going conversations about parenting and child related matters, yet adult participants did not perceive this as stigmatising. On the contrary, their perceptions discussed in Theme 1 suggest the undergirding of RBP enabled a sense of safety and support for many adult participants which reduced the stigma typically experienced from professionals who scrutinise. From the perspective of resilience theory, this would be explained as a cascade of the secondary relational system, thus revealing the interrelated nature of service delivery. This raises the possibility that RBP could be an anti-stigma strategy for professional-adult service-user relations.

Professional judgements are also influenced by the broader socio-political milieu in which professionals operate. As discussed in the literature review, the ideologies of state values experienced in A/NZ for more than three decades have been absorbed as cultural norms (Hackell, 2016; Isin, 2004). Professionals are also guilty of working from the values of individualism, self-sufficiency and independence. This leads to consideration of structural discrimination.

Structural discrimination affects people with mental illness in a variety of ways, and parents with mental illness and their families were described as receiving double loss of status arising from social adversity factors associated with mental illness (Druss et al., 2000; Link & Phelan, 2001). For the many CRFSS families on welfare benefits, the ‘double blow’ is felt keenly when attending welfare
services, as this is where the stigma about mental illness and being a welfare recipient coincide. Findings hint at the effects of structural discrimination; however, as questions were not asked in this regard, the discussion is more relevant to implications for practice.

PEER SUPPORT AS A STRATEGY TO REDUCE SELF-STIGMA

Consideration is now given to the intersection between research findings and the literature about peer support for COPMI, and what role peer support had in the reduction of self-stigma. As noted, peer support may be a strategy to counter stigma in this service-user group, and socialisation skills and the peer relationship systems are crucial for healthy development (Bottrell, 2009b; Masten, 2001, 2015; Parten, 1933; Sanders et al., 2014; Santrock, 2013). Findings revealed many child service-users lacked opportunities to establish supportive friendships until attending CRFSS due to stigma, and comments by adult participants suggest socialisation skills were lacking in many of their children as a result. Limitations for peer relationships for many COPMI are noted in the literature, due to the social isolation which often accompanies parental mental illness, poverty, caregiving roles, and the effects of stigma (Gladstone et al., 2011; Hosman et al., 2009; Masten, 2001; Reupert & Maybery, 2015).

According to resilience theory and principles of resilience-focused practice from both A/NZ and Australian contexts (p69), peer support is a crucial pathway to resilience for children and young people (Bottrell, 2009b; Masten, 2001, 2015; Munford & Sanders, 2016; Sanders et al., 2014). I argue that the feelings of normalisation, acceptance, belonging and support experienced by child service-users when attending CRFSS reduced self-stigma. This section theorises how this may have occurred, and notes aspects of peer support in the data.

Findings which described child service-users' experiences mixing with other COPMI at CRFSS revealed interactions which appeared to be an antidote to self-stigma. The sub-themes of normalisation, feeling understood, and
acceptance and belonging are the opposite to the labelling, stereotyping and cognitive separation experienced with peers in other situations. When adult participants stated, “a sense of not being alone”, and “a sense of understanding and not feeling so singled out”, and child participants, “they treat you like a normal person because everyone has the same experience”, “you feel like you fit in more”, “you felt like of normal”, these comments illustrate what it is like not to be labelled, stereotyped or cognitively separated. These comments also hint at possible changes in the self-stigma experienced by child participants.

In terms of status, being one of other children and youth in similar situations appears to have resulted in feelings of equal status. As one adult participant said, “She sees she is not alone in the world. Some people are worse off than us but most in the same boat”. Although some childhood issues arose between child service-users, they mostly felt they were not discriminated against while at CRFSS. Child participants describing feeling freer to talk about their family situations, the opposite of the need to manage the stigma by secret keeping. During pickups and drops off for recreation days, and at CRFSS family activities, child service-users saw each other’s parents and housing situations. Despite this, status was maintained; relationships developed, and acceptance occurred. The result was an environment in which they did not feel discriminated against. Interviewee Three described what it felt like: “I don’t have to hide anything and I don’t have to act differently”. Although linked in the COPMI literature, these findings appear to further describe the role of peer support as an intervention to decrease self-stigma, and this may act as a buffer against stigma experienced in other settings. Self-stigma attacks identity, a key mediator of resilience (Ungar, 2008). As the mediators interrelate, a damaged identity is likely to negatively impact on a sense of power and control, relationships, cultural adherence, social justice and cohesion. However, even small improvements to self-stigma are likely to positively affect resilience. The degree to which this occurred in child participants is unknown, however comments such as “I finally felt normal” hint at something significant which had changed within the individual.
An additional benefit of child service-users mixing with other COPMI at CRFSS was the destigmatising effect it had on their perceptions of their families. Although not overt in the child data, it is hinted at in comments such as “everyone has the same experience”, and “if you talk about mental illness they can’t laugh as their parents have it too”, in addition to their comments about feeling more normal. Adult participants raised this more directly, in comments such as those noted above. Just as acceptance arose from normalisation amongst peers when at CRFSS, it is likely that acceptance of family situations may have occurred to a degree via the same process. As reviewed, stigma sometimes occurs within the family system, and these findings suggest that COPMI peer support programmes may reduce this (Reupert & Maybery, 2015).

Child participants noted that they could support each other not only through understanding and empathy, but also by discussing options for dealing with situations and listening to each other’s personal stories. This more active support suggests increased agency and empowerment. That child participants who felt they had to hide the secret of their parents’ mental illness outside of CRFSS, could now talk about it and actively help each other implies that something has changed. As noted by Reupert and Maybery (2015) and Gladstone (2015), valuing the perspectives of children and youth is a strategy to counter stigma. In addition to what the literature says, it appears in this study when child participants were in this safe setting, a group empowerment phenomenon occurred suggestive of a type of collective efficacy.

This initiative emerged from the work of scholars such as Corrigan et al. (2016) and Livingston and Boyd (2010), where it was noted that self-stigma attacked self-esteem, empowerment, hope, and motivation. It is possible that using personal experiences to help others had a role in resisting this dynamic. Perhaps hope emerged from seeing others endure. These nuances may be signs of the cascading of resilience. The lifespan development lens also provides insight. As outlined, adolescence is a developmental stage in which the peer group provides a sense of family (Schwartz et al., 2013; Santrock, 2013). Perhaps what
occurred may be explained by this developmental need to fit in, belong and feel mutually support, as in Bottrell’s study (2007).

Supportive neighbourhoods were noted as a mediator of resilience. There is little one COPMI service can do to change a neighbourhood, but it could be theorised the CRFSS service provided a sense of community for child service–users over a significant period of childhood and adolescence. Theoretical concerns about peer support programmes raised in the literature appear to be balanced by the many benefits this sense of community provided, as outlined in the themes of relationship–based practice, and stigma for COPMI and peer support (Hargreaves et al., 2008; Olsson et al., 2005).

Further insight may be gained from bearing in mind research which indicated that family self–stigma may be reduced through sharing of personal stories and presenting mutual coping strategies, and that adult–youth mentoring was enhanced by relationships between multiple mentees, parents and mentors such as teachers (Hasson-Ohayon, 2011; Larson & Corrigan, 2008; Rhodes et al., 2006; Whitney et al., 2011). Although only supposition, the logic of each genre makes sense particularly when viewed together. Feeling safe in relationship enables other resilience–enhancing processes to emerge within the individual; feeling safe together allows group resilience–enhancing processes to emerge which otherwise might not have.

Continuity and longevity of relationship arose again in this context, this time in relation to sustained peer relationships. Perceptions revealed child participants found the benefits arising from mixing with other COPMI at CRFSS became more important as they become older. The implication of various comments was that it felt strange to begin with but had significance later. This makes sense framed by resilience theory and adolescent developmental theory discussed above.

Returning to the notion of interrelated programme components, I suggest that findings about child service–users’ attendance at CRFSS reduced self–stigma, at least while they attended the service, and increased resilience through
providing regular and on-going opportunities for peer normalisation, acceptance, belonging and support.

MENTAL HEALTH EDUCATION

As discussed in relation to peer support, mental health education for COPMI may be scaffolded by a supportive, de-stigmatising, peer environment, and findings suggest this occurred. However, data also suggest some aspects of learning about mental illness or having conversations about mental illness were difficult or felt unhelpful for some child participants. Other research has shown similar findings (Reupert, Cuff, et al., 2015). Although the benefits of learning about mental illness are clearly stated, it is noted that COPMI have varying responses to this knowledge, including not wanting any discussion, and it is recommended professionals follow the child or young person’s lead in these conversations (Reupert, Cuff, et al., 2015). Examples from findings reveal the complexity of this process, and skill and sensitivity required by professionals to accurately read cues. What follows are several examples illustrating this.

Interviewee Four had been through the eight-year CRFSS programme and was discharged when data was collected. When asked about who she talks with about parental mental illness she said she no longer wanted to do so: “because I’ve moved on from that … had enough of it in my life really”. Considering her age, current levels of support and health, and history of mental health education with peers and workers at the service and within her family system, this participant seems to have sufficient knowledge and have processed enough for her judgement to be trusted.

Interviewee Nine was also older, and due to be discharged from the service at the end of the year of data collection. When asked who she talks to about parental mental illness she said: “…no-one … anybody from Caroline Reid, like of you ask how mum is … well, she’s fine … even if I ask her she’s okay, she’ll just go, I’m tired, and even I don’t understand what’s going on … so if people ask me how mum is, I fully don’t even understand … It’s kinda hard”. It appears the participant is saying she does not know how well or not her mother is because
her mother does not tell her, and she does not know how to interpret her mother’s tiredness or other behaviours. This situation indicates the difficulty in not understanding parental mental illness, and lack of communication within the family. Her lead suggests she would benefit from further information and supported conversations with her mother.

Similar questions asked of three other interviewees raised the possibility of denial as a strategy to cope with parental mental illness. One was overt. Interviewee Three said: “half of me doesn’t really want to know, I don’t want to get into it ... doesn’t register”. The inability of Interviewees Five (aged 10) and Seven (aged 12) to recall anything about a mental health education component of a camp they attended two weeks prior to data collection are suggestive of denial. When significantly prompted, Interviewee Five could vaguely remember a few details; Interviewee Seven could not recall anything. When asked questions about his knowledge of his parent’s mental illness, as discussed, Interviewee Seven became upset and could scarcely answer the questions. This could be understood as a child in which denial worked for him most of the time, and when confronted with reality, this unprocessed information was difficult to cope with. Returning to the work of Reupert, Cuff, et al. (2015), this illustrates the need to follow one set of cues from a child – the underlying cues about difficulty in processing painful material – to recognise the overt cues of resistance for what they are and adjust service delivery to meet the child’s needs.

A final example was from a younger participant in Focus Group One. In the context of learning about mental illness at CRFSS, he said he now worried he might get a mental illness. Resiliency theory comments on the protective role a lack of understanding may have on children in extremely difficult situations such as war or disasters, noting that awareness and knowledge can result in worries which may increase risk of depression (Masten, 2015, 2001). The implication is the need to protect children from too much unnecessary, detailed information. These comments again suggest the need for careful, age-appropriate provision of information by following the child’s lead, talking
with family members, and ensuring follow–up conversations can occur (Reupert, Cuff, et al., 2015).

These interviewees experienced mental health education in a scaffolded context of relationships with workers and peers in which stigma was largely eliminated. Despite this supportive environment, barriers to mental health education occurred, thus suggesting the need for attention to be given to individual needs within peer group education settings.

THEME 3 − SCAFFOLDED RECREATION AND RESULTING BENEFITS

Continuing with the theorisation of findings as interrelated programme components, findings relevant to Theme 3 suggest recreation had an interrelated scaffolding effect in several ways. The first aspect is that recreation was the primary forum for relationship formation between workers and child service–users, and peers. Secondly, adult and child participants noted child service–users’ attendance at CRFSS recreational activities not only provided opportunities to spend time with workers and peers, but this was part of the appeal of attending. As discussed, the adult–youth mentoring literature emphasises the need for fun and enjoyable activities for relationship formation (Spencer & Rhodes, 2005), and developmental theory underscores play and recreation as key pathways for child and adolescent socio–emotional development (Feldman, 2012; Gottman & Parker, 1987; Hart & Damon, 1988; Parten, 1932, 1933; Santrock, 2013). As reviewed, these links appear to be presumed rather than emphasised in the COPMI literature.

This section focuses on reported perceptions of how recreation, scaffolded by relationship formation, provided opportunities for child service–users in two areas: the first, through offering respite; the second, the possibility of developmental gains. Consideration will also be given to what this means for child service–users who could not manage group recreational activities.
The COPMI literature acknowledged the need for COPMI to have respite from various pressures arising in many homes in which parents have mental illness, and some COPMI lack opportunities to engage in play and recreation due to psycho-social factors associated with parental mental illness (Cresswell, 2017; Charles et al., 2009; Hosman et al., 2009; Nicholson et al., 2001; Reupert & Maybery, 2007, 2016; Rutter, 1987). Sometimes parents have limited capacity to support play and recreation when mentally unwell (Foster et al., 2012b; Nicholson & Henry, 2003; Reupert & Maybery, 2016). Findings suggest respite for CRFSS service-users when attending CRFSS recreational activities occurred due to three interrelated factors: the scaffolding effect of feeling safe with peers and workers, physical separation from home, and via engaging in fun recreational activities. The scaffolding combination of secure relationships and a destigmatising environment has already been discussed. This section discusses findings relating to respite from home situations, and through play and recreation.

The literature noted that many COPMI have too many caring responsibilities; however, this did not emerge in the findings, most probably as it was not enquired about. What did emerge was that recreational activities and camps enabled respite from home situations, suggesting that home life weighed heavily for some. Some participants described respite as “getting out of the house”, and “it gets her out and about”, implying respite was provided through a change of environment or a break from social isolation. Another emphasis was on “getting away”, and “time away from family was a good thing”, implying respite occurred due to absence from situations at home. Some child participants specified respite as a psychological break from home: “I don’t think about mental illness”, “I stop worrying so much when I’m with Caroline Reid”. These findings are congruent with possible impacts for COPMI when living with parental mental illness, and the goals of respite for COPMI, as discussed (Charles et al., 2009; Falkov, 2012; Nicholson et al., 2001; Reupert & Maybery, 2016). Child participants who did not attend many group activities could still
experience respite during informal visits with workers; however, this does mean that respite occurred less frequently for them than for those child participants who attended monthly recreation days.

It is unknown if respite occurred for CRFSS child participants at school. However, bearing in mind the anecdotal, insider knowledge of school difficulties and failure for these child participants, the risks noted in the COPMI literature, the stigma many child participants experienced, and the comments from child participants about how they felt when mixing with other COPMI at CRFSS, it is unlikely this degree of respite occurred (Hosman et al., 2009; Reupert & Maybery, 2007a).

The notion of existential joy was reviewed in relation to recreation as respite (Popovic, 2002; Dick-Niederhauser, 2009; Kast, 1991). The argument was that ordinary moments of joy had the potential to offer prospects of a different future (Popovic, 2002). Utilising this concept, the primary theme of fun through recreation in service−user perspectives could be framed as a form of respite. Comments such as “uncontrollable laughter”, “having fun”, and “being silly”, are suggestive of this, and many commented to this effect. These findings appear to add to the notion of what respite could mean for COPMI. Framed in this manner, this is indicative of hope. As discussed, hope is a mediator of resilience (Masten, 2015, 2001). Further, hope emerges from relationship, as occurred in the A/NZ resilience study, which returns the discussion to the interrelated nature of CRFSS programme components (Munford & Sanders, 2016). Could it be that child service−users, feeling safe in relationship, were more fully able to experience these moments of joy, and does the scaffolding of relationships better enable respite to occur? These questions are worth addressing when considering respite for COPMI as a single−component service delivery.

Limitations to fun and recreation existed for a few. Of note, Interviewee Three raised the issue for some COPMI of never fully escaping from concerns about home. Speaking about attending a camp, this participant said the worry was “what if I come back and things are worse?” Although the context of previous
home removal may have added to her fears, it does highlight the interrelationship between parent and child factors, and worries COPMI often experience, as noted in the COPMI literature (Gladstone et al., 2011; Reupert & Maybery, 2016). Perhaps the service could consider sometimes providing whole family activities and camps, thus attending to both sets of respite needs.

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**THE POSSIBILITY OF DEVELOPMENTAL ENHANCEMENT**

Opportunities which exist for children and adolescents to fill developmental gaps, if appropriately scaffolded, were discussed, and principles of resilience-focused practice indicated that to provide a pathway to resilience, service delivery needed to attend to developmental needs by supporting agency and intentionally seeking to fill these gaps (Cicchetti, 2013; Luthar & Brown, 2007; Masten, 2015; Munford & Sanders, 2016).

A service based on relationship-based practice such as the CRFSS should result in developmental gains if understood in the context of the A/NZ resilience research and the notion of ‘filling the gaps’, what has been discussed about the scaffolding nature of the relationship systems, and what has already been reviewed from developmental theory about safety and socialisation (Feldman, 2012; Masten, 2001, Munford & Sanders, 2016; Santrock, 2013). As it was not a subject of enquiry in this study, the topic concerns implications for practice. However, it is relevant to re-emphasise a few findings already discussed. Improvements in socio-emotional development as a result of the establishment of stronger secondary and peer relationship systems did appear to occur for child service-users, as did positive changes noted by parents which suggest developmental strengthening. Speculation about the collective efficacy of the group is also suggestive of increased agency. That these improvements would have a scaffolding effect on recreational activities is highly likely but unsubstantiated. Findings in relation to child service-users having new experiences at the service also increase such possibilities.
SECTION 1 SUMMARY

Discussion of Theme 1 revealed child and adult participant perspectives of the service could be theorised using concepts from relationship-based practice. Adult–youth mentoring and recognition theory explained aspects of children’s worker relationships with most child service–users, and these relationships were framed as positive mentoring relationships. Changes in child service–users were theorised as cascades of resilience and as possible psychological gains arising from emotional closeness in a mentoring relationship. Continuity and longevity of relationships were noted as necessary. Practical assistance was discussed as an important aspect of RBP. The positive impact for child service–users of support given to parents raised discussion of the insufficiency of mentoring alone for this group, and the need for interrelated, comprehensive service delivery. Trust issues for a few child service–users limited the extent of RBP, and more frequent contact was a suggested strategy. Further limitations were noted relating to working hours and limits to confidentiality. The main feedback for change to CRFSS service delivery was to increase the frequency of individual visits to child service–users. A further limitation was discharge at age 16. Staff retention was highlighted as a crucial issue for CRFSS for this model of practice.

Social work RBP proved useful for understanding findings concerning worker relationships with adult service–users. Literature describing secondary attachment relationships in worker–service–user relationships in adult mental health care provided insight. Those service–users who had regular contact with CRFSS workers described similarly trusting relationships to those their children had with workers. Frequency of contact was adequate for most adult service–users however, more frequent visits were the main suggestion for improvement and recommended for service–users who had difficulty with trust. Practical assistance for adult service–users was framed as a necessary component of social work RBP. Similarly, this discussion also led to comprehensive service delivery, which included the relational and support needs of parents as well as their children. Limitations to relationships with adult
service-users were also noted. Some adults struggled with trust, and similarly, more frequent one-to-one visits were suggested. Professional working hours were noted as a restriction for several adult service-users. The competing needs of parents and children were also discussed.

Theme 1 findings were framed as aspects of resilience-focused practice and congruent with important mediators of resilience. It was noted that increased secondary relational systems may mediate impaired primary relationships for child service-users, and scaffold practical and other support to enable other resiliency mediators to develop. Responding to individual contextual needs were noted as supportive of resilience-focused practice.

Child service-user experiences of stigma and how peer support enabled probable decreases in self-stigma was a strong finding in Theme 2. Experiences of adult and child service-users aligned with differing aspects of stigma, responses to stigma, and the five co-occurring processes. Types of stigma were discussed: stigma from professionals; further status loss resulting from poverty; and structural discrimination. Peer support and acceptance at CRFSS for child service-users was framed as an antidote to self-stigma, potentially providing a buffer against stigma in other areas of life. Further benefits were the normalisation of family situations, and hints of increased agency and empowerment via mutual support. Consequently, the need for sustained peer relationships was discussed. These findings were theorised as cascades of resilience from the peer relational system.

Such connections between peer support and self-stigma are an example of the probable interrelated nature of CRFSS programme components. The enhancement of mental health education was discussed as a probable example of this. Although scaffolded by peer relationships, barriers to mental health education existed for some child service-users, indicating attention be given to following the service-user’s lead and to individual factors when providing peer group mental health education.
Discussion of Theme 3 focused on further interrelatedness of service delivery, which was suggested to have occurred at CRFSS recreational activities based on the premise that recreation aided the formation of worker and peer relationships. The resulting relationships were argued to scaffold child service–user experiences of respite, and the possibility of developmental benefits of recreation. Respite occurred for many child service–users via a physical and psychological break from home, decreased social isolation, and through fun and recreation. Limitations occurred for these few child service–users who could not tolerate group activities due to less frequent opportunities to experience respite. Fun and recreation as respite were theorised by existentialism and hope, a mediator of resilience. Some COPMI were prevented from fully experiencing this due to concerns for their parents when away from home.

Scaffolded recreation was considered to have the potential to enable developmental gains. It was suggested this probably occurred for child service–users by increased socialisation skills and richer secondary and peer relational systems. Due to the scaffolding nature of these recreational activities combined with new experiences child service–users had at CRFSS, it was suggested development gains were likely to have occurred in other developmental areas.

SECTION 2: IMPLICATIONS FOR PRACTICE

Section 2 considers implications for practice arising from the discussion of service–user perceptions of CRFSS service delivery. This section explores implications for the CRFSS, other COPMI services, and the research community. Implications for measuring resilience–focused practice are considered, and further issues for the research community.

RELATIONSHIP–BASED PRACTICE

The discussion concerning relationship–based practice has several implications for service delivery. These implications relate to staffing, CRFSS support to
service-users, external social connections for service-users, and comprehensive family practice.

STAFF RETENTION, SUPPORT AND SKILLS

Given the importance of continuity and longevity of relationship for the success of RBP, poor staff retention undermines the model, especially if several staff members leave within a short period of time. Of note was the instability in female children’s worker roles associated with the demographic of young adult women attracted to the position. Most changes in the last decade to this role at CRFSS have been due to female worker pregnancy, thus highlighting gender workforce equality, parental leave and support, and stereotypes of women, which cannot be addressed here.

A further related issue which often influences staff retention is rates of remuneration. It is understood the service is bound by state contract constraints to a large degree, and remuneration rates dictated by contracts do not reflect the nature of the work being asked in CRFSS roles, or the degree of use of self that is required for RBP. As the service has had little trouble attracting high calibre staff, it is possible that remuneration rates do not make a difference to staff retention. It may be that if the position was more highly paid, female children’s workers would be more likely to return to their positions after maternity leave.

Factors other than remuneration may impact staff retention. Ruch (2010) emphasises the need for psychodynamically minded supervision, training and support when working from a RBP perspective. As NGOs experience financial pressure, funding for external clinical supervision and training is often reduced (ComVoices, 2016a). This type of work requires a service structure which attracts skilled staff and supports them beyond contractual provisions. If pay rates cannot match the roles, the service should ensure that levels of support and training do, and that job descriptions and key competencies recognise the extent and demands of these positions.
A frequent model for family work in community services is one worker connecting with different members of the same family. Although benefits exist with this model and it is not to be discouraged, it does not facilitate RBP with both adults and children or enable the degree of comprehensiveness and diversity described below. The CRFSS approach of different workers focusing on different family members requires workers to operate as a team. They must work in a non-hierarchical manner, making decisions and planning interventions together — a model usually reserved for statutory health services in A/NZ. For CRFSS workers, this model requires a level of maturity, respect, humility and openness which also needs to be captured in job descriptions and key performance indicators. For services, this is a way of working differently than from an individualistic approach, and certainly far removed from standardised state contractual models. It is possible the interconnected nature of the CRFSS model compensated somewhat for staff retention issues. Although staff retention is a continuing challenge, family relationships with all CRFSS workers may have provided enough continuity and security for service-users.

The skill set for professionals working as mentors for child and youth service-users in CRFSS is extensive. Participants highlighted aspects such as someone to look up to, a role model, someone viewed as successful, in addition to being dependable and trustworthy (Markus & Nurius, 1986; Rhodes et al., 2006; Schwartz et al., 2013). This could be interpreted as ‘fitness for practice’ for professional competency and registration (ANZASW, 1993). Another characteristic was the capacity to experience fun activities and enjoy each other’s company; a reciprocity which was noted in the findings; perhaps similar to relating to child service-users on their level, noted by adult participants (Honneth & Farrell, 1997; Smith et al., 2017; Spencer & Rhodes, 2005; Turney, 2012b). The professional is required to enjoy child and youth focused activities to the extent they can be fully present in those moments with their young service-users. Further qualities were compatibility in personality, interests, expectations and relationship goals (Bernier & Larose, 2005; Madia & Lutz,
For services, the latter two qualities are straightforward, but compatibility in personality and interests may present more of a challenge in recruitment.

The complexity of managing competing needs and having difficult conversations, as exemplified in research findings, demands an advanced skill set for family workers. Family workers are required to “see double”; to balance family needs, manage their power softly, mindfully and judiciously, and to keep healthy scepticism and relationship in balance (Cooper, 2015; Cousins, 2004; De Boer & Coady, 2007; Tchernegovski et al., 2018). These factors indicate that previous experience in family work, training in working from a strengths–perspective, and high levels of self–awareness and personal maturity are required for these positions, which job descriptions and key performance indicators need to reflect. As found by Tchernegovski et al., (2018), such work requires adequate workplace support such as professional supervision, collegial support and debriefing, and opportunities for team discussions.

SUPPORTING SERVICE–USER RELATIONAL AND OTHER PSYCHOLOGICAL NEEDS

The importance of the relational systems for resilience and reported by CRFSS participants, and the experiences of stigma and social isolation noted by these participants and in the COPMI literature, together indicate that all COPMI service delivery should assess the adequacy of these systems for child, youth and adult service users upon intake (Keller, 2013; Masten, 2001; Ungar, 2008). The information would be invaluable, aiding interventions and referrals to ensure needs are addressed in a timely fashion. It was recommended that assessment of attachment was a task for the experts (Crittenden et al., 2015). With training, support and intercultural understanding, I contend that helping professionals can assess the likelihood for further appraisal and specialised intervention.

Awareness of primary relational needs would enable CRFSS to consider some flexibility of service delivery to service–users who have difficulties and deficits in this area. Such knowledge would affect the frequency of visits and
expectations of the engagement and assessment period. Some child service-users may need more help than others to engage with group activities and others may require more frequent one-to-one contact.

The importance of these relational systems for COPMI and their families has implications for how relational theory is understood, assessed and acted upon. Limits exist due to the Western notion of attachment (Keddell, 2017; Keller, 2013; Smith et al., 2017). If we accept that attachment theory has been excessively stressed, that problems exist with the assessment of attachment status, the constructs of the theory do not have universal application, and this theory can be indiscriminately used to make judgements about parents and children; then considerable ramifications exist for how we understand and support the sub-culture of families in A/NZ with parents who have severe and chronic mental illness (Keddell, 2017; Keller, 2013; Smith et al., 2017). If this group of parents are operating in survival mode and constantly lack resources and support, it is unrealistic and inhumane to expect them to provide the sensitive, focused caregiving that infants require, without significant support. This does not mean I think that infant mental health is not vitally important, nor that I am dismissing the impact of some mental illnesses on parental capacity to provide sensitivity and security for a period. What I am suggesting is that infant mental health be seen in the context of the health needs of the whole family system, and these be addressed and resourced accordingly, and within a broader understanding of how families may be constructed and operate than is the norm in A/NZ.

Another related matter is multiple caregiving. As stated, this is typical for 95% of the world’s population (Keddell, 2017; Keller, 2013; Smith et al., 2017). With this in mind, and the rhetoric about decision-making in child protection areas in A/NZ, and the narrow and indiscriminate use of attachment theory, how might parents with mental illness be better supported? Could the enormous funds used for child removal and foster care placement be channelled differently to fund other adult caregivers who can share parenting responsibilities? I am not suggesting an easy solution, and difficulties exist.
which cannot be addressed in this thesis. What I am concerned about is the
Westernisation of child protection in A/NZ, and left wondering if a broader
perspective on caregiving is needed. If 95% of the world’s population parent
differently, we could learn something from them which might enable parents
with mental illness to be better supported as parents, and enable their children
to have more connection with them.

The need for service flexibility was discussed in relation to meeting the needs of
a few child participants who struggled in large peer groups, thus affecting their
attendance at CRFSS group activities. As emphasised by socio–ecological
resilience theory, responding to individual context is an important pathway to
resilience, and relationships with workers enable other beneficial processes to
occur (Munford & Sanders, 2016; Ungar, 2008). Historically, CRFSS has not
discharged these child service–users, but continued to support them in a
modified fashion. I suggest that the service consider how these decisions might
be challenged by the wider organisation and develop internal policies which
outline a clear rationale for when these situations occur. In the current A/NZ
service delivery climate, these child service–users are at risk of early discharge.
Although a well-considered policy may not prevent organisational changes, it
does indicate that the service is operating from an informed position.

Another area of feedback which has implications for practice is the timing and
process of child service–user discharge. In the light of themes about the
importance of worker–service–user and peer relationships, for these COPMI
who have limited relationship systems, an abrupt finish at age 16 to contact with
children’s workers and organised opportunities to connect with their CRFSS
peers is likely to be detrimental, regardless how well–planned the process is.
The literature reviewed noted that adolescents still rely on these systems until
adulthood (Masten, 2001; Santrock, 2013; Ungar, 2008). Recent extensions to
the connections that A/NZ children in foster care may maintain with foster
parents suggests even the state is cognisant of this, and the Big Brother Big
Sister programme in A/NZ offers mentoring until the end of secondary school,
when adolescents are approximately 18 years of age (Big Brothers Big Sisters of
New Zealand, 2017; Cleaver, 2016). For this reason, it is recommended the service develop an additional programme for 16 to 19-year-olds.

Service delivery would need to be structured differently for this age group, as they have alternative priorities on weekends or have work commitments, and as found in their responses, socialisation needs rated more highly than structured recreation activities. One possibility could be a monthly support group with workers present, supported by telephone contact with workers and a closed social media site for the group. A further benefit of providing extended service delivery is the likelihood that if mental illness is going to emerge, prodromal symptoms are likely to occur during this period. Early intervention mental health care is more likely when professionals who know adolescents well can support them through this process.

The feedback given by some child participants about the limitations to RBP due to the working hours of children’s workers has implications. As boundaries are necessary for professional practice, yet these support systems are so vital, I suggest conversations with CRFSS child service-users occur regularly concerning who could assist outside working hours, and the resources which are required to enable this.

Similarly, the service might consider how it could better meet the needs of the group of adult participants who received less service delivery due to the prioritisation of family worker resources to other adults in the family (as outlined in Chapter 1). At the very least, conversations about expectations are required, and perhaps a wider assessment of other adult family member needs could be included in the initial assessment process to enable appropriate supports. The service could consider clinic-style evenings for such service-users if resources did not allow frequent evening visits for those adults who were working fulltime.

The COPMI literature recognised that insecure primary relational systems were a serious risk factor for COPMI (Hosman et al., 2009; Reupert, Maybery, Nicholson, et al., 2015). A question to consider is whether service delivery
which has been grounded in RBP reduce some of these risks. It seems logical that if the resilience research is trustworthy, such as the knowledge that the secondary relational systems ameliorate some deficits associated with weak primary systems, and resilience cascades from relational systems, it follows that risk factors associated with insecure relational systems could show reductions in the presence of an extended secondary relational system (Hosman et al., 2009; Masten, 2001, 2015; Reupert et al., 2015; Ungar, 2008). This may mean that in such a context, even the smallest reductions in risk factors could be measured as indicators of more resilient pathways, including: behavioural inhibition, negative emotionality, stress reactivity, negative self-esteem, and poor cognitive and social skills (Hosman et al., 2009; Reupert et al., 2015).

SOCIAL CONNECTIONS – THE IMPORTANCE OF RELATIONAL SYSTEMS OUTSIDE CRFSS SERVICE DELIVERY

The research inquiry and predominant themes have steered the discussion to worker–service–user and peer relationships within the service. This does not mean that supporting service–users to extend their relationships outside the service is neither necessary nor essential, given what was discussed about the correlation between social isolation, stigma and this group of service–users, and what is known about the importance of social connections for health and wellbeing.

Improving social inclusion was a service goal. Findings revealed some service strategies increased social inclusion for adult participants, and their perceptions hint at reductions in some barriers to social inclusion through the actions of workers. The whole family social events provided by CRFSS, although socially inclusive events valued by families, do not address wider issues for these families. As noted, supportive neighbourhoods enhance resilience (Masten, 2001, 2015).

For CRFSS child service–users, several barriers exist to them establishing community supports. As stated, stigma and poverty are deterrents. At age 16, these COPMI are not yet engaged in employment or tertiary education and are thus less likely to develop further supports around the time of discharge. These
barriers to widening supports suggests the need to extend service delivery to 19 years of age, a time when these COPMI are more naturally settled into the next stage of their lives. Perhaps individual goal plans which include pursuing external social activities would be a useful addition to such a group.

Supporting adult service-users to have more social connections is also complex for the service. CRFSS could provide more regular, whole family social events, as requested by participants. The value of these is undisputed, but they are difficult to fund and staff regularly. The parent support group is more likely to achieve this, and parenting education groups run by the service may also foster relationship-building. Participant descriptions of CRFSS family workers advocating and mediating within family situations and seeking to strengthen adult service-user mental health through referral, liaison and conversation with service-users may be the most appropriate steps towards social inclusion for the role of the family worker. Extending service delivery further by introducing adult service-users into other groups seems beyond the scope of CRFSS family workers. Perhaps the emphasis for CRFSS workers is to connect adult service-users with local community development initiatives or other local services if they still exist. As reviewed, many smaller community organisations have closed due to the state’s preferences for larger, more programme-oriented funding partners (Larner & Craig, 2002).

COMPREHENSIVE FAMILY PRACTICE

The notion of comprehensive family practice as a framework for understanding much of the CRFSS service delivery and many aspects of research findings, has implications for service delivery. In this section, the interrelated nature of CRFSS programme components suggested in the findings, which occurred because of this model of comprehensive family practice, will be considered. Its role in the delivery of mental health education across the family system, in parent support, and addressing poverty in families, will also be explored. Principles of socio-ecological, resilience-focused practice require such interconnections (Chapter 2), (Munford & Sanders, 2016; Ungar, 2013).
The connections between the different components of service delivery which CRFSS offered service-users have implications for how service delivery is understood and might be measured.

As discussed, these connections were found to be important in adult–youth mentoring research for young people facing individual and environment risk, with mentoring seen as a ‘value-added’ addition to a multifaceted approach of related components of service delivery (Kuperminc et al., 2005; Rhodes & DuBois, 2006). The notion of integrated, comprehensive service delivery for families with complex needs was also recommended by the Organisation for Economic Co-operation and Development (2011), Scott (2005), the New Zealand Productivity Commission (2015a), and resiliency theorists, including Cicchetti & Garmezy (1993), Luthar & Cicchetti (2000), Munford et al. (2013) and Schoon (2012).

One implication for service delivery is this notion of value-added. This means that the interrelationship of components working together offer more value than if they operated individually. Many examples of these value-added interrelationships exist in this study, some of which have already been discussed. One example was the interrelationships between recreational activities enabling worker-service-user and service-user-peer relationships to develop, and these relationships enabling respite and the benefits of recreational activities to be fully experienced. Further examples were the perceived support felt by child service-users when family workers had regular contact with their parents, or by one adult participant when he commented the family worker supportive relationship with his wife has “taken a weight off his shoulders”. Child participants’ experiences of respite were argued to be accentuated by safe relationships with peers and workers. This is important information for staff and management to understand so they may articulate the rationale for these aspects of service delivery, and it has implications for service design and evaluation.
A further aspect of interrelatedness is the simultaneous nature of comprehensive family practice; that is, the capacity to simultaneously attend to a wide range of changes in an individual and family’s life, as noted by Ungar (2011) in relation to several studies (Bierman et al., 2004; Munford et al., 2013; Ungar, 2012b). As Ungar (2012a) concluded, simultaneous service delivery over a long period for marginalised children and youth provides another socio–ecology, from which developmental pathways are changed. If this is true, a question for evaluation of service delivery is how to frame and measure prolonged comprehensive family practice as a different socio–ecology.

An example of the simultaneous and interrelated nature of comprehensive family practice is the service goal of assessing child health and wellbeing. To meet this goal, many interventions contributed to this assessment process, including:

- Family workers talked with parents about their concerns for their children,
- Children’s workers interacted with and observed child service–users at recreation days,
- CRFSS workers met weekly to discuss how families were doing and make plans,
- Family workers liaised with parents and children’s workers liaised with child service–users about possible interventions and referrals,
- Family and children’s workers met with whole families to discuss these matters,
- Family and children’s workers liaised with professionals.

It is possible that these simultaneous and interrelated methods of assessing child health and wellbeing felt supportive for CRFSS adult service–users, rather than the common experiences noted for parents with mental illness of feeling scrutinised and judged by professionals (Bassett et al., 1999; Nicholson et al., 1998; Seeman, 2015).

Mental health education within CRFSS is a further example of the interrelationship between different aspects of service delivery. Due to the
comprehensive and interrelated nature of service delivery, mental health education provided by CRFSS included many components. What is not known is whether this approach made any difference to outcomes for the family. The interrelated aspects of mental health education included:

- Family workers having conversations with parents about how they could talk to their children about mental illness, with the added benefit of family workers having knowledge from the children’s workers of the children’s needs, behaviours and questions.
- Children’s workers talking to child service−users about mental illness, informally and in formal programmes, with the added benefit of having knowledge from the family worker and consent\(^\text{37}\) from parents to discuss specific details of their parents’ mental illness.
- The mental health education provided by CRFSS to child service−users may have been perceived differently by parents because they knew the workers well, and knew the workers understood their whole family situations.

In relation to best practice recommendations of supporting parents to have conversations with their children about mental illness, it may be that offering these simultaneous aspects of mental health education to the whole family maximised this support (Reupert, Cuff, et al., 2015).

A further benefit of interrelated service delivery is that it allows some flexibility which is important for families with parental mental illness, perceived as necessary for some service−users in the research findings, and considered essential for resilience−focused practice (Foster et al., 2012a; Munford & Sanders, 2016; Reupert & Maybery, 2016). As exemplified above, when workers can communicate together and with the family, it is easier to respond to developmental needs, parental health and other psycho−social events.

Although the COPMI literature notes the importance of comprehensiveness, flexibility and tailoring to family needs, little is said about the interrelationship

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\(^{37}\) Child and adult clients are aware of shared information between workers, however standard process for CRFSS was that these conversations are reiterated when needed, and care is taken with what information is shared.
between differing aspects of service delivery within services, or the costs and benefits of one service delivering interrelated and simultaneous components to COPMI and their families (Reupert & Maybery, 2007a; Reupert, Goodyear, et al., 2012). As reviewed, risk may be largely predicted, and models exist for triaging service delivery according to need (Hosman et al., 2009; van Santvoort et al., 2015). It should be possible to determine which families require this type of comprehensive support.

PARENT SUPPORT

Comprehensive family practice has implications for how parents are supported. Individual parent support interventions are offered by many services, but the implications of locating parent support within comprehensive family practice are noteworthy.

One implication is how parenting capacity is assessed. As reviewed, parents with mental illness come under additional scrutiny due to concerns about the impact of mental illness on their ability to appropriately care for their children (Bassett et al., 1999; Nicholson et al., 1998). Seeman’s (2015) argument that parental capacity needs to be assessed over time for parents with serious mental illness, combined with a family case management model, is similar to prolonged, comprehensive family practice. Adlin et al., (2017) make similar arguments in relation to parents with substance abuse disorders. Such a context enables thorough assessment of the types of support that are most useful to individual parents and families, and what methods work best for that family. As noted, resilience-focused practice requires services to respond to individual contexts (Ungar, 2008). Seeman’s (2015) recommendations are in direct contrast to common parent assessments, which tend to focus on one moment in time, rather than over a period, therefore they do not consider changes in mental health and parental capacity. For any parent, such as experience would be stressful; however, for parents with serious mental illness who may have these assessments during periods of acute illness, a one–time assessment seems inhumane and unethical. In A/NZ, some services which
enable prolonged assessment and family case management exist, but these are difficult to access due to waiting lists and narrow criteria.

As noted, positive parenting is a protective factor for COPMI (Hosman et al., 2009; Reupert & Maybery, 2016; Risley-Curtiss et al., 2004; Vostanis et al., 2006). As part of the model of comprehensive family practice, CRFSS might consider how they could be more proactive in providing group parenting support and education for service–users in the long–term programme. This would enable parenting education to occur in a way which considered the needs of this service–user group who sometimes find generic parenting programmes do not suit their needs (Reupert & Maybery, 2011; Thomas & Kalucy, 2002). The addition of CRFSS parenting education into service delivery would also enable an environment for peer support between parents to develop. As noted, many face social isolation and exclusion, and according to resilience theory, this system impacts on other mediators of resilience.

THE DAILY LIFE EFFECTS OF SERIOUS PARENTAL MENTAL ILLNESS, CRISSES AND COPING SKILLS

Comprehensive family practice has implications for attending to the multiple factors associated with serious and complex parental mental illness which, when reviewed, were found to influence aspects of daily life, mental health crises, and the need for coping skills for children and adults (Cowling, 1999; Gladstone et al., 2011; Maybery et al., 2005; Nicholson & Henry, 2003; Nicholson et al., 1998a, 1998b; Reupert & Maybery, 2016; Seeman, 2015). These factors were positioned within the powerful negative influences of stigma and poverty, which are addressed separately, further in the chapter.

As argued, comprehensive family practice aids fair assessment of parent capacity and support needs. Additionally, this practice model enables parent support needs, and those of other members of the family, to be addressed and coordinated, thus reducing the number of agencies involved and providing support for service–users with those agencies which they experience as challenging (Bassett et al., 1999; Nicholson et al., 1998a). Seeman (2015) advocated for such a model for this service–user group for assessment
purposes; she implies this is also beneficial for intervention. I suggest that the service narrative and research findings describe the CRFSS team roles at the CRFSS as a form of family case management, which seems appropriate for the multiple issues for this service−user group. Unfortunately, less and less of this type of service delivery is available in A/NZ for families with complex mental health and other needs.

Such holistic service delivery aligns with the principles of resilience–focused practice suggested. The challenges to daily life, of crisis situations, and the lack of coping skills, were argued to reduce capacity to negotiate the seven tensions of resilience for COPMI and their parents (Ungar et al., 2007). As comprehensive family practice enables the service to respond to the broad and varying needs of families, individual family contexts can be assessed and addressed, and such practice was noted to enable pathways to resilience (Bottrell, 2009b; Ungar, 2008). The noted risks associated with accessibility, longevity and breadth of service delivery for young people in the A/NZ resilience study are reduced with such a model. Unfortunately, the increasing pressure of high caseloads and increasing acuity and complexity of service−users for statutory mental health case managers in A/NZ has resulted in limitations to their ability to provide family case management. Additionally, many of these families no longer received services from statutory mental health in A/NZ. Therefore, community agencies need to take on these roles. The problem is that state contracts rarely allow such broad, multifaceted and continuous practice (Aimers & Walker, 2015; ComVoices, 2016a; Larner & Craig, 2002).

Many of the common effects of serious parental mental illness on daily life, crises events and coping skills of parents, their children and other adults were not explicit in the CRFSS goals. It is suggested that the service considers linking these areas more overtly to service delivery, adjusting goals, or adding sub−goals. This would more accurately demonstrate the extent of service delivery to funders and auditors and provide further aspects of measurement.
Comprehensive family practice has implications for addressing poverty-related issues for families with serious parental mental illness.

As discussed, social adversity components are risk factors for undesired outcomes, often more detrimental than parental illness and stigma, and poverty in childhood alone is associated with higher risk of mental health problems throughout life (Gibson et al., 2017). However, when they co-occur with other factors such as parental mental illness, stigma and adversity, risks are enhanced (Gibson et al., 2017; Masten, 2006). The sustained effects of operating in survival mode pervade all areas of life for children and adults, making it difficult to focus on anything beyond physiological needs (Cicchetti, 2013; Maslow & Lewis, 1987; Masten, 2015; Parrott et al., 2008; Sedlak et al., 2010). Service delivery which seeks to support resilience in COPMI and their families cannot ignore this issue. Findings from this study suggest the comprehensive family practice provided by the service enabled many practical needs to be addressed, for example, providing food, transport, and other aid, and through referral, advocacy, and support at meetings and medical appointments.

However, given the extent of the inequalities experienced by such families, is this sufficient (Garratt, 2010; Garrett, 2015; Gibson et al., 2017; Walsh, 2012)? From socio-ecological resiliency theory, resilience was partly defined as an environment capable of providing the resources and experiences needed for individuals to be resilient (Ungar, 2008). For families with significant parental mental illness, such a resilient environment was found to be usually beyond their reach (Gibson et al., May 2017). In this project, the primary reason adult participants could not provide new experiences for their children was lack of money, welfare benefits were needed by 59.3% of the sample, which equates to about the number of participants with diagnosed mental illness; and 40.6% had used a food bank in the previous year (Appendix O). These statistics are suggestive of the combined income poverty and material hardship experienced by about seven percent of A/NZ children in 2017 (Child Poverty Monitor, 2017; Duncanson et al., 2017; Expert Advisory Group on Solutions to Child Poverty,
As the context for these families is chronic illness, poverty and hardship, these factors are likely to be persistent and thus there is little these families can do to change their situations.

This returns the focus to the impact of the socio-political system not only on families with mental illness, but on the capacity of one service to have a voice. As discussed, services are dominated by the state contracting, competitive environment which has placed them in an unequal, dominated position, preventing them from responding to community needs, and silencing their protests. It is only through collaboration with wider networks that advocacy is possible. Chapter Six considers what the NGO sector might do to more strongly advocate for inequality and to be able to respond to such needs. In the meantime, feedback on such situations could be reported to wider groups who have more power to advocate, such as local NGO networks and mental health provider groups, local COPMIA provider groups, and via professional associations and organisations, for example, the Child Poverty Action Group38.

STIGMA

Findings about peer support as a strategy to decrease self-stigma for COPMI in this setting have implications for service delivery. If many COPMI experience this degree of stigma, this highlights the need for more peer support programmes and consideration of how peer relationships might be sustained if we are serious about their resilience needs. Similarly, adult participants experiencing stigma highlighted implications for services to consider how adult peer support needs might be met for this service-user group — both adults with mental illness, and other adults in the family who may experience stigma by association.

Further implications arise for service delivery from the occurrence of stigma by professionals. The status loss associated with social adversity factors was

38 The Child Poverty Action Group (CPAG) is an independent charity working to eliminate child poverty in Aotearoa/New Zealand through research, education and advocacy. For further information, see https://www.cpag.org.nz/about–us/
discussed as the ‘double blow’ for families such as this service–user group, affecting how service–users are viewed by some professionals, and some professionals were found to contribute to how marginalised service–users accessed state social support such as welfare benefits and state housing (Larson & Corrigan, 2008; Reupert & Maybery, 2016). In addition, the literature noted professional assessments of parenting capacity in this and similar settings were commonly influenced by Western, middle class values (Beddoe & Keddell, 2016; Gray, 2017; Hyslop, 2018; O’Brien, 2016; Hackell, 2016; Parton, 2016; Sawyers, 2016; Seeman, 2015).

The inclusion of the stigmatiser as also threatened by what is held to be personally important is useful in considering what might be occurring for professionals and what this means for service delivery (Yang et al., 2007). One cause of stigmatising responses was noted to be the internalisation of individualistic discourses about why people are poor and/or mentally ill. In contrast, professionals may also bear witness to stigma and respond differently. In relation to social work education, Beddoe & Keddell (2016) suggest two necessary components for tackling the subject: cognitive components, and emotional engagement, not unlike Bourdieu’s strategies of education and experience (Bourdieu, 1993b; Roxborough, 2016). Social workers may advocate by challenging commonly held views and educating about structural inequality, causation and discrimination. Suggestions by Beddoe & Keddell (2016) for social work student education are applicable to professional development in and across professional teams, including the use of complex case studies and service user stories. Professionals have a responsibility to advocate for service–users in wider situations where stigma and discrimination are experienced.

Stigma theory creates ethical questions about the implementation and use of administrative data in predictive tools that assign a risk score in either service distribution or child welfare decision–making (Dare, 2013; Gillingham, 2015; Gillingham & Graham, 2017; Keddell, 2015b). Some proponents of predictive modelling argue that such methods enable families to gain access to supportive services; I do not dispute that this may occur for some families, however,
reported concerns of inaccurate predictions and consequences for families such as the CRFSS service–user group are worrying (Dare, 2013; Gillingham, 2015; Gillingham & Graham, 2017; Keddell, 2015b). It seems that despite some benefits, these methods may contribute to stigma by professionals as the administrative processes reinforce stigmatising labels, stereotypes and cognitive separations. Any method which reduces family needs to a set of labels and risk scores requires the use of caution.

Further research is needed on stigma for COPMI and their families, and it is reassuring to see this being pursued by Prato International Research Collaborative for Change in Parent & Child Mental Health. Child and adolescent experiences of associative stigma and self–stigma due to parental mental illness do not seem to be prominent in the literature. Although peer support programmes are widely used, it would be helpful for theoretical links between peer support and stigma to be made. In addition, the role and function of recreation during peer support programmes, and how respite might be scaffolded to be more effective could be developed. It seems the interrelatedness is not captured in the literature. These connections would lend weight to advocacy and funding applications for extending programmes and provide differing sources of programme efficacy.

SCAFFOLDED RECREATION

Interrelationships between the relationally scaffolded CRFSS recreational programmes, and respite and the potential for developmental gains have implications for COPMI service delivery and for how CRFSS understand and measure these aspects.

RESPITE

It was argued that feeling safe in worker and peer relationships amplified respite experienced by child service–users at CRFSS recreational days (Masten, 2001; Munford & Sanders, 2016; Sanders et al., 2014; Ungar, 2008). The implication for COPMI, and children and adolescents from other marginalised groups is that
isolated camps or programmes without on-going contact with workers and peers are less effective.

Theorisation of recreation as a form of respite, and the importance of this not only for development but for amelioration of stress and caring for children and adolescents such as COPMI, has implications (Cicchetti & Curtis, 2006; Curtis & Nelson, 2003; Feldman, 2012; Gunnar & Fisher, 2006; Meaney, 2001; Luthar & Brown, 2007; Popovic, 2002; Santrock, 2013). As much as anything, it is important for service delivery to be understood for what it constitutes, and for its theoretical rationale to be articulated. The outcomes of this might be subtle in relation to small decisions about how recreational activities are planned and managed. A more overt ramification is how these activities might be framed in service goals, recording and evaluation.

The inability to fully engage in respite due to concerns about parents, as emerged in the findings, indicates that respite for COPMI must occur as part of a process with that child or young person and their family. Consideration should be given to what respite means for COPMI before making referrals, with space made for COPMI to voice concerns and talk with parents about these. Respite for the whole family might also be considered. Professionals may have a role in facilitating this process.

Implications apply to the scenario in which a few CRFSS child service–users could not tolerate group activities due to personal challenges. These may be the very child service–users who need respite the most. More frequent individual visits by the children’s workers are recommended, but the service may not be resourced to provide visits frequently enough to enable the respite needed. These child service–users may benefit from additional mentoring services outside what CRFSS can provide.

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DEVELOPMENTAL GAINS AND MEASURING RESILIENCE

If relationally scaffolded recreational activities could be linked with developmental gains and resilient pathways, this has implications for how we
might understand and measure COPMI service delivery and other programmes for marginalised children and adolescent.

The most important implication in relation to the uneven development of children and adolescents who are marginalised is relational scaffolding. As noted in the A/NZ resilience study, this was the essential feature of the pathway to resilience (Munford & Sanders, 2016). The coping skills required by many COPMI to manage the effects of issues relating to serious and complex parental mental illness have similarity to the A/NZ young people who felt overwhelmed by things which would be taken for granted by peers (Cowling, 1999; Gladstone et al., 2011; Maybery et al., 2005; Munford & Sanders, 2016). Further, as shown in research findings, many had missed out on ordinary A/NZ childhood experiences (Gladstone et al., 2011; Ungar, 2008, 2013). In the A/NZ social service and funding climate, skill−based programmes are prioritised and emphasised; however, without the scaffolding of relationships for marginalised children and adolescents, I contend they may be a waste of resources and have detrimental effects on these groups due to the potential for internalisation of the lack of success.

In contrast, the material viewed on mastery motivation and the notion of late bloomers has hopeful implications for service delivery (Cicchetti, 2013; Luthar & Brown, 2007; Masten, 2001, 2015). As stated by Masten, (2015, p164):

...there may well be complex interplay among the processes of motivation, relationships, opportunities, and goal formation that converge for positive change in late bloomers.

Relationally scaffolded recreational activities and other skill−based activities, including coping skills, are ideal opportunities for marginalised children and young people to develop competency and success, and reignite their mastery motivation, thus taking steps on a different pathway, towards resilience (Bolzan & Gale, 2012; Gass, 1993; Halvorsen, 2009; Lubans et al., 2012; Masten, 2015; Munford & Sanders, 2016; Robinson, 2007; Robinson et al., 2009; Sandford et al., 2006; Ungar, 2008, 2013; Van Breda, 2014).
Implications exist for the CRFSS assessment process and recording of developmental gains. Recreational activities have the potential to be framed as pathways to other mediators of resilience than just socialisation and mentoring relationships, if adequately strategised and documented. This would require little adjustment to group activities provided, but more intentional plans for one-to-one recreational activities for those child service-users who could not tolerate groups. Further, developmental gaps need to be targeted. This appears to already occur informally at CRFSS, however, further aspects need adding to the initial assessment documentation, such as a developmental checklist, and this could be reviewed and updated during the annual review process. In a service delivery climate of onerous reporting, what benefits would be gained by adding to documentation? Firstly, it should be possible for CRFSS to record some aspects suggested with ease and only minor adjustments to current documentation. Secondly, as will be discussed in the next chapter, accumulating an additional set of data builds knowledge capital.

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MEASURING RESILIENCE—FOCUSED PRACTICE

The state–NGO funding climate in A/NZ was noted to focus on evidence-based practice. As discussed, this means the state funds contracts with NGOs but requires evidence to show this is a worthwhile social investment (Aimers & Walker, 2016; Billis, 2010; Brandsen et al., 2005: Walker & Shannon, 2011). This has implications for service delivery.

Due to the discussion about the differences between mainstream and socio-ecological resilience, and inherent within this, limitations associated with solely adhering to traditional psychology, the first implication for service delivery is to decide how and what to measure. Measures relating to early mainstream resiliency theory are still sought by governments and funding bodies, despite changes to the understanding of resilience. The problem with most state sanctioned measures is that they measure the individual as the locus of change; the emphasis is on personal agency to access aspects of resilience (Ungar, 2012b).
Psychometrics which measure resilience exist for children, adolescents and adults, although those designed for use with adults and adolescents appear to have more adequate psychometric properties and research support at the time of writing (Ahern, Kiehl, Lou Sole, & Byers, 2006; The COPMI Initiative, 2018). The Resilience Scale [RS] (Wagnild & Young, 1987) was deemed to have the most credibility to study resilience with adolescents (The COPMI Initiative, 2018). As reviewed, use of psychometrics is common in COPMI programme evaluation, often in pre- and post-service delivery (Bee, 2015; Grove et al., 2015; Reupert & Maybery, 2009; Siegenthaler et al., 2012). For a service such as the CRFSS in which the cohort of children and families may be service-users for up to nine years, this method is not suitable for most aspects of service provision, although it has application to formal mental health education.

Significantly, these measures do not reflect the types of service delivery needed for marginalised service-users as they do not consider the effects of the environment on individual and family resilience, nor the impossibility for many service-users of obtaining these goals without considerable and prolonged support (Beddoe & Keddell, 2016; Corrigan et al., 2016; Corrigan et al., 2004; Munford et al., 2013). In summarising the past 25 years of studies, Nicholson (2009) notes that an ecological systems model which acknowledges the “multiple paths of impact among family members and their characteristics” more accurately represents what should be measured, therefore presenting challenges for researchers.

A further problem exists with measuring resilience. Bottrell’s study of adolescent girls challenged the notion of how risk and adaptation in resilience is designated (Bottrell, 2009b). Bottrell’s arguments that adaptation is nuanced and required closer examination for the motives behind behaviours. One example which challenges commonly sought resilience measures is the educational attendance of CRFSS child service-users. In a similar fashion to the girls in Bottrell’s study, many CRFSS child service-users have low school attendance, yet they attend most CRFSS activities. If school attendance rates for CRFSS are a measure of resilience, then their truancy and suspensions from
school would be considered and potentially measured as non-resilient behaviours. However, if their truancy and suspensions from school were considered as attempts to protect themselves from bullying and stigma and to seek safer situations, then their behaviours might be reframed as resilience-enhancing. Further, if their attendance rates at CRFSS group events are high compared to their attendance rates at school, this might also indicate something about pathways to resilience.

The argument was made for utilising measures which reflect the contextualised approach of socio-ecological resilience theory, and which incorporate local knowledge, and examples of tools were given which were developed by an international team (Ungar, 2012b). These tools require further consideration by the CRFSS for their suitability for the service (Ungar & Liebenberg, 2011; Ungar, 2015).

Any measures CRFSS use face the challenge of capturing the interrelatedness of the differing programme components. As interrelatedness is impossible to capture on such a small scale, I suggest the service documents the individual elements of service delivery, which contribute to the interrelated effects shown in the findings, under the theoretical framework of socio-ecological resilience, allowing the theory to make the connections. I suggest a combination of using the tensions of resilience from Ungar’s work as overall areas of data collection, and within each tension, incorporate relevant aspects and measures from socio-ecological and mainstream resiliency, and noted areas of needed COPMI service delivery. These latter aspects would be valued by funders, and the service reinforces its socio-ecological perspective and gains additional knowledge capital by using the tensions of resilience as the framework for service provision for all members of the family.

It was emphasised that local knowledge and perspectives are essential for tailoring service delivery to meet the socio-ecological resilience needs of families affected by serious and chronic parental mental illness (Bottrell, 2009b; Ungar, 2013). This is further supported by two methodological frameworks
which influenced this project: social work and utilisation-focused evaluation (D'Cruz & Jones, 2004; Everitt et al., 1992; Patton, 2008). Thus, resilience-focused evaluation must, at least in part, seek the perceptions of service-users.

SECTION 2 SUMMARY

Implications for resilience-focused practice emerged from discussion of the predominant themes of the thesis, and these were explored in this second part of the chapter. Implications also arose around how resilience-focused practice might be measured.

As longevity and continuity of relationship are necessary for RBP, matters relating to staff retention and other skills required by staff for this complex work were discussed. It was recommended that these be reflected in job descriptions, key performance indicators, position advertisements and the recruitment process, and that staff be given specialist support and training to work in these roles.

It was argued that all service-user family members should have their relational systems assessed to inform service delivery, and staff be trained to assess possible gaps and needs for further assessment and intervention. This knowledge would inform more tailored and flexible service delivery. A case was made for CRFSS extending service delivery beyond the age of 16 years, to provide for differing but still important secondary and tertiary relational needs of older child service-users. The cascading effect of resilience was considered in terms of how RBP might reduce other risks for COPMI. Questions were posed about the possible reciprocal impact on parents when child service-users’ secondary and tertiary relational systems improved due to attending CRFSS. For child service-users who struggle with group situations, particularly as they grow older and anxiety and mood symptoms may emerge, the adjustments to service delivery usually made by CRFSS need to be formalised to prevent early discharge being imposed. CRFSS also needs to address the group of adult service-users who do not receive regular visits due to their working hours.
The reality of social deprivation and stigma for many parents with major mental illness in A/NZ and the resultant survival mode they are forced to operate in may inhibit the parent–child relational system and should be addressed and resourced. Further, the multiple caregiving approach used by most of the world’s population has validity and could be interpreted in this context as resourcing other family members and paid childcare workers to support parents with mental illness.

Consideration was given as to how CRFSS might support service–users’ other relational systems outside worker–service–user relationships. For child service–users, a sense of community occurred within the service, and if service delivery extended beyond 16 years of age, more naturally forming community supports could occur. CRFSS could enable parent peer relationships through continuation of the parent support group, providing in–house parenting classes, family events, and ensuring other services helped make these connections.

Comprehensive family practice, understood as emerging from a RBP model of care, was discussed from findings in relation to how different programme components interrelate and add value. Parent support, the coordination of daily life issues and crisis events affected by parental mental illness, and poverty for families were considered in relation to how these could be enhanced by comprehensive family practice.

It was noted there is a need for further research to capture COPMI’s experiences of stigma, as well as parents with mental illness. Child participant experiences of stigma, coupled with the way peer support acted against self–stigma at CRFSS, implied a strong need for peer support programmes for COPMI which allow sustained relationships. Additionally, no research appears to exist which considers how this phenomenon might affect mental health education. Stigma by association was highlighted as an issue for adult service–users. Status loss associated with both mental illness and social adversity for this service–user group was considered, and the role professionals might play in either increasing
the stigma or advocating against it. Cautionary comments were made about the potential for predictive modelling to increase stigma from professionals.

The scaffolding of respite for CRFSS child service–users via feeling safe in relationships with workers and peers while engaged in recreational activities implies respite is more effective in this context. It was noted respite needs to be part of a sandwiched family process for COPMI in which conversations occur, worries are discussed, and contingency plans made. Further scaffolding effects were suggested for recreational activities, thus providing opportunities for marginalised COPMI to fill developmental gaps, and services to measure these activities from a different perspective.

Although psychometrics for resilience exist, they do not capture the essence of socio–ecological, resilience–focused practice, nor the subtleties of the adaptive versus risky behaviour debate, or the interrelated nature of programme components. Possible indicators which align with resilience–focused principles of practice were suggested as a starting point, consideration of measures of pathways and outputs rather than outcomes, and mixed methodology recommended to provide depth to future evaluation. It was recommended the more recently developed socio–ecological frameworks for measuring resilience would be more suitable.

**CONCLUSION**

The primary themes from this research project have been discussed in this chapter in relation to the theoretical concepts of socio–ecological resilience theory. Each theme was related to an aspect of socio–ecological, resilience–focused practice. The underpinning of relationship–based practice in CRFSS service delivery was visible in the perceptions of many service–users. Arguments were made from service–user perceptions and the literature about these relationships scaffolding broad aspects of comprehensive family practice and recreational activities for child service–users. The CRFSS appears to operate in a manner with aligns with the principles of socio–ecological, resilience–focused practice for many service–users. However, socio–ecological
resilience theory also requires services to have sufficient flexibility to respond to individual needs, and for some CRFSS participants, further adjustments are needed by CRFSS to enhance their pathways to resilience.

Implications for service delivery arose from each theme. Some implications present challenges to CRFSS, including staff retention, responding to individual needs, and how to measure such interrelated comprehensive family practice. The socio-ecological approach to service delivery for this group of families has implications for COPMI service delivery and research, and other NGOs working with families who are marginalised.

To conclude, despite the above discussion about the relevance of the socio-ecological resiliency framework to service delivery for CRFSS families, one question remains. How realistic are these implications for service delivery in the A/NZ state–NGO funding context?
This chapter deals with the issue of whether, at a meso-macro level, the socio-ecological, resilience-focused service delivery emphasised by study participants is feasible for the Caroline Reid Family Support Service (CRFSS) and its parent organisation, Stepping Stone Trust (SST), and what supports and prevents this type of practice. This chapter considers the impact of the social-political sphere on the ability of CRFSS and SST to provide the relationship-based, comprehensive family practice that supported elements of resilience for the participants of this study. This will be accomplished by applying the organisational theories and tools reviewed to the wider context of service delivery in Aotearoa/New Zealand (A/NZ).

This is a thesis in two parts. It was argued that to ignore the wider implications for practice arising from service-user perceptions about service delivery would do a disservice to the findings. Therefore, this chapter shifts the focus to consider organisation theory, and how the lenses reviewed provide insight into what SST and similar NGOs might do to more readily and securely provide services for COPMI and their families.

The literature reviewed revealed that the current state-NGO contracting environment resists and opposes resilience-focused interventions such as relationship-based practice and interventions which are holistic, flexible and long-term. It is argued that the type of service delivery described by participants in this study and reinforced in the CRFSS narrative is not supported by state social policy, statutory service delivery or funding contracts: The A/NZ government does not acknowledge these principles of socio-ecological, resilience-focused practice for this service-user group. State logics operates from a post-truth stance.
The outworking of this approach was noted to be evident in several areas: the extreme individualistic approach taken by the state to the resilience literature; other efficacious approaches which are appropriate for some groups of service–users expected by the state to meet the needs of all service–users; and the exclusion of ecological approaches from the rhetoric and resulting social service policies. I contend that these outworkings have arisen because the issues do not fit the state’s philosophy or short–to–medium term budget.

In addition, many NGOs are unaware of the extent to which their ideologies have changed, of what they have lost, and what this means for those they work with. Others see what is lost or at risk but feel powerless to seek changes. I argue that services such as the CRFSS will always be difficult to set up and fund, and despite the current situation of relatively stable funding, they continue to be at risk unless a dramatic and sustainable turnaround occurs in the ideology of state social service policy and power relations within state–NGO partnerships.

The first section of the chapter begins the strategic process by employing three analysis tools across the different stages of CRFSS and SST history. These are: institutional logics, Bourdieu’s social practice theory, and the Aimers and Walker’s hybridity lens (Aimers & Walker, 2016; Bourdieu, 1977, 2011; Roxborough, 2016; Thornton et al., 2012). Much can be gleaned from this analysis for the organisations concerned and other NGOs in a similar position. The second section of the chapter extends the discussion by considering strategies which may be employed based on the Walker and Shannon Strategic Model (2011). The chapter finishes with recommendations arising from this strategic process.

This section is informed by several sources: my insider status during research design, data collection and first–stage analysis; my membership of a Christchurch–wide, interagency, COPMIA liaison group; and personal
communication with various members of the research locality during this project. Background information about the research setting is in Chapter One.

SECTION 1: MACRO TO MESO ANALYSIS

Analysis will be provided across four stages of CRFSS and SST history:

1. CRFSS pre-amalgamation with SST;
2. SST pre-CRFSS;
3. Amalgamation of CRFSS into SST;
4. The current situation faced by CRFSS and SST.

CRFSS PRE-AMALGAMATION

Utilising the Aimers and Walker hybridity lens (2016), CRFSS is located as a professional organisation providing caring services to a range of families (Brandsen et al., 2005), and an organic shallow type on the inter-sectorial hybridity spectrum (Billis, 2010). In the six years from conception to amalgamation, this did not change, which is not the usual evolutionary path of similar bottom-up organisations. As discussed, community organisations tend to move towards hybridity as they develop, grow and accept external funding.

This lack of development was due to the service starting differently, as the founder, Graeme Reid, had previous experience in beginning and developing pure organisations. From Bourdieu’s theory, he could be described as bringing significant social and cultural capital to the project (Bourdieu, 2011). Reid was able to begin a service which still retained the best of community logics, but also satisfied the needs of referral agencies.

Community logics were evidenced in several ways. Firstly, by the strong mission shared by paid staff, management (the founder), the board of trustees (some of whom had lived experience) and volunteers, and the easy power-sharing relationships between all groups (Aimers & Walker, 2016; Billis, 2010; Thornton et al., 2012). Secondly, by service values such as flexible, long term and

39 Material in this chapter has been read and approved by those parties concerned.
continuous service delivery, holistic care, comprehensive family work, the roles of staff determined by service–user needs, and an emphasis on relationship–based practice (RBP) that were in response to perceived and actual community needs.

From Bourdieu’s perspective, Graeme Reid’s habitus influenced the service design and overall atmosphere of the organisation. This habitus attracted staff and trustees with similar worldviews; their capital matched what was privileged by the organisation. The result was the evolution of organisational doxa built upon community logics, which incorporated an even organisational structure and shared investment in decision making. In the social game of the CRFSS, power relations would be described as interactive: a reflection of community logics (Kickert et al., 1997; Walker & Shannon, 2011).

The results were many. Staff could and did think for themselves, were accustomed to contributing to what occurred in the organisation, brought qualifications and experience beyond their job descriptions, were personally committed to the work of the organisation and service–users, and learned to negotiate and work together as a team. Larner and Craig (2002) might view these staff members as having the prerequisites for activism, and Bourdieu, as possessing significant cultural and social capital (Bourdieu, 1990a; Bourdieu & Wacquant, 1992).

Service–users of the service could be described as having low status in society due to the stigma surrounding mental illness and the social adversity which accompanied it. They were in every way the dominated (Bourdieu, 1990a; Bourdieu & Wacquant, 1992; Roxborough, 2016). These families fit the picture outlined of the micro impacts of neoliberalism in A/NZ (Garratt, 2010). State emphases on individual responsibility and self–reliance, welfare consensus attitudes, and narrowed, brief social service delivery, have resulted in social inequalities and ensured these families remained at the lowest position in society. The habitus of many of these children is one of trauma, separation, deprivation, and school failure.
In terms of the wider field of power CRFSS operated in, the service was dominant in its service provision for COPMIA in Otautahi/Christchurch, and thus gained respect by referrers. As outlined, seeking funding from private trusts and individual supporters was a normal part of the social game played by many small charitable trusts in A/NZ at the time. As Graeme Reid had capital he was initially successful in this regard. Bourdieu would describe him as a dominator as he had an instinctual feel for the game. This was evidenced by the number of organisations Graeme had successfully began, the survival and growth of CRFSS during these years, and his astuteness at reading the signs, thus instigating the move to disband the Trust and move the organisation under the management of SST.

It was changes in the wider field of power due to successive waves of neoliberalism which began to alter the rules of the game, as described (Larner & Craig, 2002, 2005). The funding scenario was the result of these rule changes: CRFSS’ experiences of fewer private donations, more reliance on the state for funding, and repeated rejections from the Ministry of Social Development (MSD) and the Ministry of Health (MOH) for contracts – despite Graeme Reid’s reputation and the dominant position of the service. In other words, although the state moved to partnering with NGOs, the nature of privileged capital was changing to short term programmes with a quantitative evidence base, and a preference for partnering with larger organisations. Therefore, Graeme Reid and the board of trustees decided to play the game differently by seeking the support of SST.

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**STEPPING STONE TRUST (SST)**

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Within the social game of NGOs, SST would also be a dominator. By the time of amalgamation in 2010, Stepping Stone Trust could be described has having transitioned over a 20–year period from an organic shallow to organic entrenched organisation, according to Billis (2010) and Aimers and Walker. Examples of this transition include funding and power relations within the organisation. SST was initially funded by private grants and donations, and it
had moved to all service provision funded through state–NGO contracts. When SST began, power relations within the organisation were relatively evenly amongst staff, but as it grew larger, its structure became more hierarchical and corporatised. Over time, hybridity deepened further, as seen in pockets of service delivery initiated by the state, and SST moved towards enacted entrenched hybridity (Billis, 2010; Aimers & Walker, 2016).

SST followed the usual pattern of hybridisation described by Billis (2010) and Aimers & Walker (2016); the hierarchy becoming increasingly multi-levelled, with the vision, leadership and decision-making resting with senior staff and management. The habitus moved from most staff with strong community logics, to staff with multiplicity of logics, and a move towards the ideologies of corporations and market (Thornton et al., 2012; Walker & Shannon, 2011). The logics of the community were noted to include cooperative and even decision-making and ensuring service delivery meets the needs of the diverse members of the community, whereas corporate and market logics include a top-down approach to decision making, gaining contracts and ensuring the contract provider’s (the state’s) needs are met, and efficiency in structures and use of resources. This is not to say some staff did not hold elements of community logic, but compromise was required for the state–partnership to be maintained, particularly at senior management level. Clearly the capital of the chief executive officer (CEO) and senior leadership team was a match for that privileged by the state. The CEO could be described as having a feel for the partnership game, and indeed without this multiplicity of logics, the organisation would not have grown and thrived as it has. The social game which took place within SST was one in which those who adhered most strongly to the privileged capital of the organisation rose through the ranks.

In the wider field of power, the state held the dominant position, and NGOs such as SST were in the role of the dominated; the state literally holding the privileged capital through funding contracts. This power gave the state the capacity to dictate the type and length of service delivery, criteria for referral and goals of service delivery, the model of care, and the experience and
qualifications of staff via hourly rates of pay. The resultant model of care, or doxa, of the organisation changed to become more in line with state logics, that is, an individual service-user goal focus accompanied by a discharge as soon as possible philosophy. In no way does this discredit the work of SST staff who were forced to work within the parameters of these contracts. The important point is this contract-initiated model of care was assimilated by the organisation.

The habitus and status of service-users of SST was a different mix from the CRFSS service-users. Although the criterion was referral from specialist mental health services, some SST service-users were recovering from acute rather than chronic episodes, and some lacked the social adversity which often accompanies mental illness.

Two factors also influenced the amalgamation from the perspective of these conceptual lens: the social capital Graeme Reid possessed from his long-term friendship with the SST CEO at the time, and the contribution of the CEO’s professional training as a social worker and knowledge of issues relating to COPMIA. Although these were contributing factors, the CEO’s multiplicity of logics ensured other elements were equally important, such as the dominance of CRFSS in its field, the gap in the market for SST, and the various forms of capital CRFSS brought.

AMALGAMATION

The transition is best described by Thornton’s work on institutional logics. (Thornton et al., 2012). The resultant clash of logics from two different types of organisations began pre-amalgamation. With the conceptual lenses outlined above in mind, the impact of CRFSS staff’s advocacy for the long-term model with the CEO and senior staff, and the resultant change of mind in senior management, could be attributed to several factors:

- The capital CRFSS and its staff possessed;
- The CEOs social work background and knowledge of COPMIA matters;
• The congruence between the holistic focus of CRFSS service delivery and Māori beliefs about ways of working with tamariki (children) and whānau (family) held by the clinical manager;
• The feel for the game of the clinical manager regarding the future growth of COPMIA service provision.

If CRFSS and its staff lacked capital and the ability to be activists, it is likely the long-term service model would have changed, and additionally, if the CEO and senior management had not been receptive and there had been no match in logics. This is a remarkable and unusual outcome, as argued by (Kickert et al., 1997; Walker & Shannon, 2011). Organisations with instrumental decision-making structures rarely engage in interactive decision-making. Therefore, a change in the laws of the social game began from the outset of amalgamation.

This was just the beginning. The intra-organisational conflict continued, and any ground gained by CRFSS staff and the immediate team leader required constant nurturing, reinforcing, and advocacy, particularly as pressure continued to be placed on SST management regarding funding this long-term service (ComVoices, 2016a; Larner & Craig, 2002, 2005). Bourdieu’s theory might view the CRFSS capital as existing on the fringe of privileged capital within the SST social game, but non-existent in the wider field of power.

This intra-organisation conflict, combined with adapting to a different type of organisation operating from with different logics, impacted CRFSS staff on many fronts, in accordance with Bourdieu’s (1999) notion of suffering (Garratt, 2010; Parton, 2016). Staff were already working in an NGO environment in which more was required with less resourcing (ComVoices, 2016a; Larner & Craig, 2005). As emphasised by Garratt (2010), the move towards state contracts resulted in staff having to assimilate extra documentation, statistics recording, auditing requirements, policies and procedures, many of which did not fit service delivery and did not capture the goals and true outcomes of the long-term service. The change in organisational, top-down decision-making arising from corporate logics increased antagonism. However, it was the threats
to the long-term model itself which most upset and drained CRFSS staff members, as it challenged their community and professional logics to the core.

In the face of continual challenges to fund the long-term service, a significant strategy noted to have been employed by staff to appease funders (and to some degree, senior management) was the decision to begin another service stream which offered short term interventions to COPMIA and their families: in addition to their current workload. This could be described as a feel for the game as it was a strategy which staff could tolerate, but the state wholly embraced. Staff were playing the state’s game, while at the same time remaining true to their community logics regarding the CRFSS long-term service delivery. However, the true cost of this strategy was to staff themselves. They were effectively silenced regarding their increased workload, as any complaints would most likely threaten the long-term service.

Luckily for CRFSS and SST, the winds were changing favourably. In the wider field of power, the new dominant player was a COPMIA advocate, as described. As this role carried significant power, the nature of privileged capital began to change from the top. The result of the change to privileged capital was CRFSS began to become dominant again. Consequently, the tremendous capital of CRFSS and SST resulted in earmarked COPMIA contracts, and increased staffing.

THE CURRENT SITUATION

CRFSS has continued to grow, and at present both long and short-term services exist and are well supported by funders, the mental health community and referrers. Reconnections between SST and its original roots – the South West Baptist Church – have the potential for the organisation to return to aspects of community logics again.

Nevertheless, many challenges remain. From within, the challenge of intra-organisational conflict continues as not all members of senior management support the long-term model, and each time changes occur at this level, CRFSS leadership are required to revisit the rationale and reargue the
logic. A particularly risky period occurred at the beginning of 2017 when the immediate service leader resigned. This loss of social and cultural capital and therefore capacity to advocate, had to be rebuilt. Fortunately, the new appointment brought the necessary experience and capabilities.

A further challenge for long-term service delivery is staff retention, and this continues to be a problem, particularly in the female children worker role, which is not ideal for the resilience of this group of COPMI and their families. In the past, changes to the female children’s worker have been partly ameliorated by a male children’s worker who was employed for a 10-year period by the service, as evident in the research findings. However, changes to female children’s worker combined with this male children’s worker’s resignation and changes of family worker, placed the service philosophy at risk for a period.

The third challenge is the on-going risk arising from the conflict of institutional logics between the state and the long-term service design. Although the honeymoon phase of COPMIA service delivery in A/NZ is still in full swing, there will indisputably come a time when state logic will challenge the long-term service again. Therefore, SST, and others who follow a similar path as CRFSS must prepare and act. It is during this honeymoon phase that much work must be done, and the strategies described below employed if the long-term service is to remain secure.

From SST’s perspective, the CRFSS is just one area of the service in which the state dominates. The entire organisation is at the mercy of changes in state social service delivery and contractual requirements, with constant squeezing between the post-truth implementation of state ideology and what professionals and managers know to be best practice.

Steps to enable a process by which power may be regained and influence the state-NGO partnership will be explored in Section 2 of this chapter. These strategies link the wider barriers to resilience-focused practice described above to what service-users of the CRFSS and the service perceived to be important aspects of support.
SECTION 2: TO DOMINATE OR BE DOMINATED – MACRO TO MESO IMPLICATIONS

Utilising the language of Bourdieu (2011) – to dominate or be dominated – the chapter extends the implications of research findings to consider strategies to bring change from a meso to macro level, employing Walker and Shannon’s Strategic Model (2016) discussed. As noted in the 2016 review of the A/NZ third sector (ComVoices, 2016a, p9).

*We need to regain the ‘genius’ of the sector – with its *Tiriti*40/social environmental justice underpinnings and its independence – so we can break away from being the ‘little fingers of the state’ that we have become and stand tall and independent [Edited].*

This chapter will make recommendations relating to the socio-political discussion. These will be applicable to this research locality, other COPMIA programme providers in A/NZ and beyond, NGOs in partnership with the state in A/NZ, and the international COPMI research community. The recommendations may also be applicable to many NGOs facing similar circumstances worldwide, and the professionals working in them.

Several pathways appear to exist for SST and other similar organisations. The first, to continue in the same trajectory towards fully embracing state logics; the second, to continue struggling but without clear plans; and the third, to take stock and then active steps to regain power. This section examines the pros and cons of the first two options, then proceeds to an in-depth analysis of the third using the Walker and Shannon Strategic Model (2011), and Bourdieu’s social practice theory (Roxborough, 2016; Bourdieu, 1977, 1990a, 1990b, 1991, 1992, 1993b, 1997, 2001).

**CONTINUE TO EMBRACE HYBRIDITY**

The first option for SST and others like it is to continue deepening hybridity, eventually casting off all community logics and embracing state and corporative

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40 Tiriti – (noun) treaty.
logics. Accept the inevitable, proponents might say. From a business perspective, this option makes sense: it is easy to fund and evaluate. Adopting the mentality of responsibilisation and individualisation from state ideology, the organisation could happily go forward, providing specialist COPMI short term interventions for all COPMI and their families, including those with chronic and complex parental mental illness. The long-term service could be closed, and all families receive a 3–6–month intervention, with a focus on family assessment, educational and parenting programmes, a family care plan, with all other necessary needs referred out to multiple agencies. These include child and youth mentoring, peer support, family work, recreational activities, and family therapy.

If this approach were taken, some benefits would occur for the organisation. It is a model which many COPMI services utilise, and as discussed, there is efficacy for brief interventions for some groups of COPMI and their families. I could be argued that it is better for service–users and staff if service delivery is securely funded. Other benefits could be a possible lessening of intra–organisational conflict. If SST moved towards more generalist managers, without clinical experience and helping profession qualifications, the service would experience less conflict, as community and professional logics would increasingly decline. In addition, the organisation could further safety–proof itself from intra–organisational conflict by taking advantage of the on–going state contracts which support less qualified staff through low pay rates and employ future staff who lack professional qualifications and community experience.

However, significant and serious costs are also associated with such an approach. Sacrifices would have to be made. To follow this trajectory for COPMIA and their families facing severe and chronic parental mental illness would require the SST senior management and board of trustees to ignore:

- The insight and experience of the CRFSS founders and members of the consumer movement;
- The perspectives of service–users of the service;
- Mainstream resilience theory based on traditional psychology;
• Socio-ecological resilience theory based on resilience across cultures;
• The findings from the NZ Pathways to Resilience study;
• Recommendations from social work relationship-based practice;
• Principles of adult-youth mentoring and from recognition theory;
• Recommendations for worker-service-user relationships in adult mental health care;
• Indications from the COPMI literature about risk factors and prediction, continuums of need, comprehensiveness, and the efficacy of interventions;
• Material from the A/NZ NGO scene indicating gaps in service delivery, increasing complexity of need, and barriers to providing this;
• The report into social service delivery by the NZ Productivity Commission;
• The logics of the community sector.

To continue to hybridise would mean knowingly and willingly moving towards consensus welfarism, individualism and a business model of care – a failed system for this service-user group, according to the New Zealand Productivity Commission inquiry (2015a).

The costs of such an approach would also affect the CRFSS families. If the service could only provide short-term, task-focused service delivery, families would need to be referred to multiple services. As noted, gaps exist in the NGO sector in A/NZ due to the state-NGO partnering environment, resulting in long waiting lists and narrowed service delivery (ComVoices, 2016a). Many CRFSS long term service-users are reluctant to engage in brief interventions due to lack of trust and multiple service fatigue, and similarly, as recreational activities and camps are not scaffolded relationally, many child and youth service-users would not attend.

Short term, goal focused interventions have their place, have efficacy for some service-users, and are better than no interventions. However, the literature, research findings, and discussions of this thesis are clear: They are not suitable for all. Although they may have small benefits for this service-user group,
particularly in terms of child and family education and family care planning, these brief interventions do not address key resilience deficits which would improve the long-term health and wellbeing of these types of families. From a state health economics perspective, they are short sighted and do not make sense (New Zealand Productivity Commission, 2015a).

MAINTAIN THE STATUS QUO

The second option is to maintain the status quo of attempting to juggle the multiplicity of logics. However, it must be emphasised that this is not a passive option. Indeed, the passive option is to follow the trajectory; if nothing changes, hybridity will deepen. To maintain the status quo is therefore like treading water – something active must happen to stay afloat. The organisation must intentionally choose to continue to balance the logics of the community, the professions, and the corporations.

It appears that this is the primary strategy of SST and many other NGOs which has enabled them to survive. However, it is argued this will not be enough to prevent further entrenchment and loss. If the senior management and trustees gain greater awareness of the social game they are playing, their role in the greater field of power, and the risks to their organisation, this will enable them to hold their current position in the short term.

Two problems exist with this option. The first is that it leaves the organisation and the CRFSS vulnerable to any random changes. The only hope for top down change in privileged capital is a strong move to the far left in government. With the current (2019) Labour Party coalition this is unlikely, as historically the Labour government has positioned itself centrally and has been responsible for some waves of neoliberalism.

The second problem is that if awareness is raised at senior management and trustee level, it is a little like leaving the gate in the horse paddock ajar: sooner or later, the horses will bolt. Awareness is powerful, and as discussed from the work of Bourdieu, it is the first step in social change. Awareness is the beginning.
of changing discourse, and this brings disruption within and without the organisation, as people are no longer satisfied with the status quo. Therefore, option two eventually leads to option three. In the medium to long term this leaves SST and other similar organisations with only two choices: the first and the third.

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**REGAIN POWER**

As noted, Brandsen stresses if organisations understand the risks they can make conscious choices about how to balance multi-sectorial logics and forms of governance (Aimers & Walker, 2016). This section seeks to explore these choices through the application of the Walker and Shannon Strategic Model and key concepts from Bourdieu, Thornton and Larner (Bourdieu, 1977, 1997; Larner & Craig, 2005; Thornton et al., 2012; Walker & Shannon, 2011). Each will be examined in relation to the perspective they bring to power processes, agency and capital which may be accessed and built upon to gain leverage further up the decision-making chain.

Drawing from Thornton and Bourdieu, the first step for SST and other similar organisations is to apply Bourdieu’s social practice thinking tool (Bourdieu, 1977, 1997; Roxborough, 2016; Thornton et al., 2012). The beginning of this process has been provided in Section 1 of this chapter.

Much more is required. The SST management and Board of Trustees need to own the process by engaging in it themselves, to experience it (Bourdieu, 1993b; Roxborough, 2016). They need to educate themselves about these lenses, another of Bourdieu’s strategies, to understand the social games the organisation is playing, the competing logics at play, risks to the organisation and CRFSS, what the organisation has lost in the hybridity process, and where the organisation wishes to place itself in the future. Furthermore, Walker and Shannon (2011) agree with Bourdieu, in that raised awareness is insufficient for individuals and organisations to change the nature of privileged capital. SST needs to begin forming strategic alliances with other stakeholders; to start conversations and to renew collaboration and collegiality in an environment.
which has promoted separation and competition. As it is the CRFSS which is the most at risk service at SST, a strategic process could be begun with other COPMIA providers. First in Christchurch, then nationwide. If this group banded together they could approach the Minister of Health with a message about what they feel is best practice for this service–user group. The Walker and Shannon Ideal Strategic Model identifies the strategies which must be employed for privileged capital to be changed.

THE WALKER AND SHANNON IDEAL STRATEGIC MODEL

This model will be utilised to analyse power processes at work upon and within SST and CRFSS, as per the ABCD framework of inputs, process, outputs and outcomes, outlined by Walker & Shannon (2011) (Barr & Hashagen, 2000). According to the strategic model, each power process will be discussed in terms of Luke’s dimensions of power, and Healey’s institutional capacity–building processes (Lukes, 1974; Healey et al., 2003; Walker & Shannon, 2011).

INPUTS

Inputs to community development are resources provided from inside and outside the community (Aimers & Walker, 2008; (Barr & Hashagen, 2000). In this context, the community is the organisation. External funding inputs to the organisation are weak, as SST is primarily in a dominated position within the state partnership. On a positive note, the honeymoon phase of COPMIA service delivery in New Zealand does give SST more power in the COPMIA arena in the short term, and currently SST can influence agenda–level decisions for COPMIA service delivery and evaluation. However, the general organisation is likely to remain dominated in the short to medium term until other strategies can be employed.

Adding to this weaker picture, inside inputs to CRFSS and SST are in a fragile position, due to loss, in recent years, of long term CRFSS staff members, the immediate service manager, and changes of senior management. Much of the knowledge and relational capital of CRFSS has been diminished, beyond that possessed by one senior staff member. As outlined above, the capital of CRFSS
staff enabled the laws of the SST field to be changed — an achievement, given the different decision-making styles of the two organisations. Given the corporatised structure and deepening hybridity of the organisation, more questions than answers exist in terms of the strength of inside inputs. Any strategies employed are dependent on the re-building of capital in these areas.

The good news is that stronger external inputs exist. The reconnection with the South West Baptist Church in recent years is an important connection, as this Church is dominant in its field, and has considerable status in the Christchurch social service community. It remains to be seen what the trustees hope to achieve here, but it does allow SST to partner with the church and gain significant community knowledge capital, relational capital and mobilisational capacity.

Other groups exist with the potential to be utilised to build capital and gain leverage, some of which already have close local connections with SST. Regional and nationwide networks may offer some support and guidance. Many of these groups, services, and practitioners share the same concerns about the narrowed and restrictive focus of NGO service delivery, the lack of flexibility to attend to real needs, and the focus on the individual rather than the entire family system (ComVoices, 2016a; Houston, 2013; Schram, 2012). As noted by Walker and Shannon (2011), strength is gained from wide ranging, local stakeholder involvement, with the inclusion of as many stakeholders as possible. The challenge for SST is to utilise and work together with these groups and individuals.

A conflict of interest exists for statutory services in this regard, which requires a careful approach and potentially a separate social movement. Employees’ individual input and support could be provided to an SST-initiated network in a less official but equally valuable manner, as private persons joining a network of interest. An outcome of a strategic network may be to support these members in the establishment of other like-minded social movements.
Conflict of interest may also be a problem for NGO stakeholders, given many have felt silenced due to receiving funds from the state. Forming a strategic network offers protection, as if all band together, the state cannot remove funding from all providers. In this sense a network has real power as the state is reliant on them for service provision.

Walker and Shannon stress that as many players as possible need to be engaged, and these players have the capacity to build knowledge resources and further extend the network of players, as exampled above (Walker & Shannon, 2011). There are challenges and crucial factors associated with this that will be discussed in the next sub-section.

PROCESS
The process of strategic engagement with other stakeholders in the social game and wider field of power utilises the recognisable community development process of engagement, relationship–building, intervention and assessment, described by Walker and Shannon (2011) from the work of Barr and Hashagen (2000). Walker and Shannon note the process is the crux of the entire strategic model.

The findings from case studies of community organisations by Walker and Shannon (2011) that a network of local stakeholders who held a strongly unified vision could create changes at agenda level, sometimes above and beyond what was anticipated, are an encouragement; however, organisations and stakeholders must be willing to commit to the process. What this means for SST is an investment of time and personnel.

As a dominator in the field of NGO community mental health and COPMIA interventions, SST is well–placed to begin this process. As noted by Larner and Craig (2002, 2005), NGOs such as SST hold technical and strategic expertise. They not only have professional qualifications and experience, they have developed superior skills negotiating contracts and playing the game. It is within organisations such as this that social movements begin; the question is whether SST is willing to act as a strategic broker.
To gather other stakeholders, it is suggested the strategic broker have a thought-out, preliminary vision statement of what the network might hope to agree on and work towards. This does not limit the important aspects of the process outlined in this model; however, it is argued it is necessary to attract the right stakeholders and ensure the network begins from a certain amount of common ground. What might emerge from the visioning process is the structure of the network: one large group, or several? A network may be centred around the overall issues which reduce power in the partnership with the state, or centred around practice concerns such as working with relationship-based practice, and/or an ecological, resilience focus for families and COPMIA.

Of relevance are Walker and Shannon’s thoughts on Das and Teng’s trust process for partnership relationships (Das & Teng, 1998, 2001; Walker & Shannon, 2011). Aspects of goodwill trust formation may be a challenge for some stakeholders, given the competitive contractual environment they have been operating in (Larner & Craig, 2002). For SST, as a leader in its field, competence trust may be a hurdle. Although all stakeholders are dominated in terms of the state–NGO partnership, as SST is the dominator in the community mental health social game, a strategic network would require SST to value the different forms of capital other stakeholders bring.

A further challenge is sustaining the movement so that capital can be built, and leverage achieved. As noted by the ABCD Model, this involves engagement and relationship building (Barr & Hashagen, 2000). Walker and Shannon (2011) found the crux was often time spent early on developing working relationships with less-established stakeholders, as well as developing the overall group; only then could the group mobilise and affect decisions. If SST were to take on the initial role of strategic broker, the organisation would be committing to initiating and supporting this process.
OUTPUTS

Outputs are the formation and sharing of a vision, and the incremental building of capital which arises during this process (Healey et al., 2003; Walker & Shannon, 2011). The common vision is more than a wish list; it needs to be a comprehensive strategic plan for change. Frameworks and resources for strategic campaigns for social change are readily available from organisations such as the Community Development Alliance Scotland (CDAS) (2017), The Change Agency Education and Training Institute based in Brisbane, Australia (2017), and Community Toolbox, a University of Kansas Community Health and Development work group (2016). The process of working through a strategic plan will elucidate the existing and needed social capital of the network.

Knowledge resources, or intellectual capital, are understood as arising from the visioning process, as the frames of reference that shape how differing stakeholders understand the problems, opportunities and strategies before them are made overt (Walker & Shannon, 2011). This may be a hurdle for SST. The organisation’s hierarchical, instrumental decision-making and dominant positioning is not an easy fit with this process, and SST will be required to operate in a different manner (Kickert et al., 1997; Walker & Shannon, 2011). Nevertheless, knowledge resources will only expand if stakeholders are willing, hence the importance of relationship-building.

The visioning process mirrors Bourdieu’s strategy for social change of bringing doxa to awareness – the first step in the process of changing the nature of privileged capital. If broad-ranging stakeholders who are sufficiently open to each other are included, the visioning process will act as a thinking tool for the group. The group is thereby changing the nature of privileged capital in their social game, which is the outcome they hope to achieve with the state. If done well, there is a satisfying congruence to this process. This is possibly where the true power for change lies.

Gaps in knowledge will also be identified during this process, and so experts from varied domains are needed, for example, experienced clinicians of
differing disciplines, community activists, NGO managers, front-line workers, service users, and researchers. There are several essential areas of knowledge capital needed by the network. One noted by Healey et al. (2003) was the capacity to read and correctly interpret political signs: a ‘political canniness’. These skills were historically the domain of community development activists; however, with the increasing closure of small, pure community organisations, these activists are now difficult to locate.

Another area of knowledge capital is the possession of organisational data relating to service delivery from NGOs. One output to consider is for members of a strategic network to gather individual organisational data, using measures reflective of a broader range of theory than used by the state. Although a longer-term output, capital would incrementally be gained and be of benefit to individual members as well as the group.

These data could be used to create leverage when combined with a third area of essential knowledge capital: a broad, socio-ecological and theoretically grounded understanding of principles of practice, particularly concerning working with children, adolescents and families. Such knowledge informs what data to collect, as well as fuelling the communication strategy to change the nature of privileged capital (Bourdieu & Wacquant, 1992). It follows if knowledge capital is built, relational resources will accumulate. As noted, the density of social networks is important (Healey et al., 2003; Walker & Shannon, 2011).

The issue of power relations was discussed as crucial to relational capital, and implied in these were tension and challenge (Healey et al., 2003; Walker & Shannon, 2011). If the network is unified, the “power to act” (p65) is larger, stronger and therefore fit for the task of interacting with the wider field of power and the dominated within (Healey, 2003 #763, p65; Walker & Shannon, 2011). If power is held by a few, the group becomes self-sabotaging. SSTs management and negotiation of power relations through interactive decision-making would determine the success or otherwise of relational
resources (Lukes, 1974; Walker & Shannon, 2011). For an organisation with hybridity as entrenched as SST, this would be a new approach.

Nonetheless, as seen in the example of the assimilation of the CRFSS into SST, and the more interactive decision-making engaged in with CRFSS early in the amalgamation process, SST is capable of this. Professional and community logics remain within the organisation, and the links with South West Baptist Church by the Board of Trustees are hopeful signs of a willingness to re-engage with community logics. It is surmised the deepening hybridity and corporatisation has largely occurred as a response to the situations faced, without clear knowledge of what could be lost, and this same capacity to play the game could be transferred to the organisation being a fully supportive member of a strategic NGO network.

The third dimension is the mobilisation capacity which arises from the network’s political capital (Healey et al., 2003; Walker & Shannon, 2011). As the accruement of political capital is obtained from knowledge and relational capital gained via inputs and the process, it follows if previous stages of the ABCD framework are successful, the result will be the capacity to mobilise. Likewise, the opposite is true. Healey et al. (2003), along with Walker and Shannon (2011), conclude most problems with the development of political capital arose from inadequate inputs and process completion and maintenance.

Successful negotiating of the output phase through the building of intellectual, relational and political capital results in a strategic network that is poised for the final stage of the strategic model: outcomes.

OUTCOMES
The outcomes, as outlined, are the overall effects of the network — the ultimate results (Barr & Hashagen, 2000; Walker & Shannon, 2011). The primary goal of the network is to create enough leverage to bring about change at least at agenda level.
Utilising Bourdieu’s strategy for changing outcomes requires the network to change “the volume, structure and potentially the type of capital that is privileged”, or in other words, to change the habitus of the dominant players in the same way habitus is formed: through experience and education (Bourdieu, 1990a, p110; Roxborough, 2016). The first step, changing the relative value of tokens of different colours — the volume and structure of different species of capital — affects the network’s positioning and strategic orientation towards the game (Bourdieu & Wacquant, 1992). The key aspect here is to change the relative value between different species of capital, or tokens of differing colours. This implies intentionality and strategy: deliberately accumulating and emphasising some capital to increase the network’s positioning and to change the emphasis on what is important.

The additional steps suggested by Bourdieu to make the strategy more explicit are discreditation of the dominant capital, and valorisation of the species of capital preferred by the network (Bourdieu & Wacquant, 1992). This suggests the need for a communications strategy and associated resources. However, the means must be sufficient to modify the habitus of the dominant players, and to consider the likely resistance from the dominant. Methods need to be credible, sustained and directed at the main audience: the state. They require the dominant players to experience a different form of capital — suggestive of the need for personal stories, and case study upon case study, as well as a bombardment of data over time. The strategy also requires mindfulness of the felt status of the dominant; to play the game in such a way that dominators are as open and accepting as possible. For this to occur a strategic and detailed campaign is required which incorporates different levels and layers of intervention over time. As noted, the community development sector has significant experience in this arena and offers guidelines for activism strategies (Community Development Alliance Scotland, 2017; Community Tool Box, 2016; The Change Agency Education and Training Institute, 2017).
Many recommendations have been made to SST thus far concerning changing the power dynamics in the relationships of NGOs with the state, and protecting and reclaiming the rich knowledge, skills and values these organisations have. It is hoped some of these will be implemented. Most are pertinent to other NGOs in New Zealand and countries with a similar neo-liberally driven, social investment, state–NGO partnership environment.

Beyond these, it is recommended the CRFSS continue to play the state’s game by exploring tools and measures which evaluate both the state’s and the service’s goals for their service–user families using the social investment model to its advantage.

CRFSS staff and those who manage the service need to become well versed in the history and theoretical underpinning of the service, so they may clearly articulate the rationale for the work. This needs to be part of orientation to the service. Goals require reconfiguration to incorporate the findings in this thesis.

SST might consider a flatter management style. In the same way that top–down governance by the state was found to impact the innovation, well–being and productivity of social service agencies, similar effects occur when a larger organisation is too hierarchical (New Zealand Productivity Commission, 2015a). Clearly as the organisation grows it needs to adhere in part to corporative logics for practical reasons, however there should be a limit if the organisation wishes to engage and harness the creative and professional skills of staff. The trend in large, innovative organisations who care about creativity, productivity and staff welfare is towards flatter management structures. These organisations are borrowing some of the genius of the community sector and finding it successful. The NGO sector needs to do this as well.

SST could create a position to lead an organisational review using the conceptual lenses and thinking tools provided: to advise senior management and the Board of Trustees; to keep up to date with research and social service policy and implementation; and to implement the strategies suggested above.
Senior management should begin talking to other NGO managers about their experiences of hybridisation. They also need to be aware of the pressures on CRFSS staff and the immediate service manager. These people are doing incredible and demanding work. They need encouragement, not constant challenge and undermining. It is hoped that in articulating service–user perceptions and the CRFSS service narrative in this thesis, CRFSS staff may no longer have to keep arguing the efficacy of the long–term model within SST.

CHAPTER SUMMARY

This chapter has extended discussion of implications for practice by considering findings in relation to discourses of the state–NGO relationship. A two-part process occurred: the application of macro–theoretical analysis tools, then utilisation of a strategic lens to understand implications for practice.

The application of institutional logics, Bourdieu’s social practice theory, and the Aimers and Walker hybridity lens to four stages of CRFSS and SST history enabled awareness of multiplicity of logics, the hybridisation process, and points of conflict and risk for CRFSS and SST. It was found SST had become increasingly more aligned with state ideology. This caused intra–organisational conflict at amalgamation, and each time new senior staff are employed. Risks to the CRFSS long–term programme from its misfit with state ideology have been temporarily ameliorated due to the honeymoon phase of COPMIA service delivery in A/NZ; however, given the continuation of neoliberal governance and implementation of the Community Investment Model, this will not continue long term. Further, SST itself is dominated by the unequal partnership environment, vulnerable to the whims of the state. Its professional knowledge and expertise is not valued at agenda level.

Section 2 of the chapter considered implications for practice for SST and other NGOs in this and similar environments by exploring possible strategies. An argument was made that SST faces three choices: the first, to continue deepening hybridity; the second, to maintain the status quo, an active but
short-term position; and the third; to regain power using strategies suggested by Walker and Shannon’s Ideal Strategic Model and the work of Bourdieu.

Extensive space has been given to discussing the stages of this recommended third option, and implications and recommendations for SST and other organisations in a similar position. In the current political climate of New Zealand some might consider this model to be idealistic. However, I argue this is not idealism. These ideas have been in existence for many decades, as evidenced in the community development literature and social movements around the world. Indeed, these ideas are an extension of the values and ethics which guide the helping professions.

Furthermore, many NGOs in countries around the world are facing similar limitations, and the neoliberal market approach to social service delivery continues to restrict the capacity for broader evidence-based practice. At the same time, it has been shown the current state–NGO funding model is not working for organisations or service-users, and social deprivation factors are increasing. Yet despite this, the present (2018) A/NZ government coalition continues rolling out the neoliberal diet for social services, evidenced in no changes to the Community Investment Strategy and child welfare reform. NGOs who partner with them have no power.

The good news is that interorganisational collaboration and the formation of strategic and empowering networks have been shown in the literature to be efficacious for leveraging the state, and this new government appears slightly more open to change. Herein lies the power for change. It is up to SST and other similar organisations to decide if it is worth the effort.
CHAPTER 7 – CONCLUSION

In seeking service–user perceptions of this service for children of parents with mental illness and/or addiction (COPMIA) in Ōtautahi/Christchurch, Aotearoa New Zealand (A/NZ), research findings have been compared to the Caroline Reid Family Support Service (CRFSS) narrative in the form of service goals. Themes have arisen about the types of support valued by CRFSS adult and child service–users. The socio–ecological framework of the thesis enabled further analysis of socio–political discourses in which this service–user group and social services such as CRFSS are located, and consequently, the likelihood of these research findings being translated into practice. Thus, analysis and comparison of data and implications from service–user perceptions have been examined at micro, meso and macro levels. This final chapter seeks to reiterate these findings and suggest areas of future study.

REVISITING THE RESEARCH QUESTION

The initial research question arose from the need to gather evaluatory data about CRFSS service delivery. Although wider perspectives on service delivery would have been ideal, due to the restrictions of the project the service–user voice was prioritised. The project has had several aims. The first aim was to compare perspectives of CRFSS service–users to the service narrative, as reflected in its goals, and to consider the implications for the service and other similar services. Further aims were to contribute towards a theoretical framework for the CRFSS, and to analyse the impact of the wider socio–political sphere of A/NZ on CRFSS and its parent organisation, Stepping Stone Trust (SST).

The rationale for the methodology to gather such data was influenced by principles of social work research, a utilisation approach to evaluation, and pragmatism. Therefore, this project had a qualitative core but utilised nuances of positivism. Quantitative data collection was employed in response to resource restrictions. The perspectives of child service–users were sought via
interviews and focus groups, and those of adult service−users, via mixed method questionnaires.

These methods were successful in meeting the aims of the project, in that the findings obtained were able to address the stated goals of the service in most instances. Although some questions lacked clarity and would have benefited from revision, methods were generally successful in answering the research question. Congruency was found between service−user perceptions and the service narrative in most areas for child service−user service delivery. Perceptions of approximately two-thirds of the adult sample aligned with service goals, although the notion of relationship−based practice was captured in perceptions but not in the service goals. The remaining group from the adult sample received minimal service delivery, and thus the CRFSS did not meet its goals regarding these participants.

Theoretical gains from this thesis equip the service to develop in a more informed manner. Recommendations were made for the adjustment of service goals to reflect findings and theory, for further development of service delivery, for the need to respond to individual service−user needs, and to explore how the interconnected nature of comprehensive family practice from a socio−ecological, resilience perspective might be captured in evaluation. Further recommendations were made for SST in relation to the impact of state−NGO funding, and steps which would enable the organisation to regain power.

**STRENGTHS OF THE STUDY**

From a methodological perspective, this study has many strengths. Although a convenience sample of one COPMIA service in Ōtautahi/Christchurch, A/NZ, the degree of thick description, thorough theorisation of themes, and depth of interrogation of the COPMI domain from micro to macro enables findings to be applied well beyond this setting. Sound approaches to qualitative methodology were used which increased trustworthiness, including ensuring ethical processes around vulnerable participants protected the needs of these
participants, enabling participants’ freedom of choice, reporting of both positive and negative aspects of service delivery, and between- and within-methods triangulation. The study was never intended to be a full discussion of service delivery to all COPMI and their families across cultures; however, the depth of the project has enabled this material to have application to similar service-user groups in other settings, and to other NGOs operating in comparable socio-political environments.

Although insider status is associated with bias and requires addressing, from an interpretivist perspective it is also associated with strengths (D’Cruz & Jones, 2004; Mercer, 2007). I suggest that my insider status enabled access to a difficult-to-reach group of COPMI families, thereby allowing their voices to be heard. Potential problems associated with this were approached carefully, and although analysis can often be a problem, involving reference group members early in the analysis process, strong research supervision, late introduction of literature to the analysis process, and the convergence of themes across the data set, are likely to have alleviated bias to some extent.

LIMITATIONS OF THE STUDY

Standard limitations associated with qualitative methodology apply to this study. As this was a study of one COPMIA service in this setting, the findings have direct application solely to this research context. Limitations are associated with the sample. Not all adult and child service-users participated, hence findings cannot be said to represent the views of all service-users.

Limitations are associated with imperfections in the data collection process. On a few occasions a question was inadvertently omitted. That adult service-user questionnaires were not asked to clarify the amount of contact with CRFSS workers and who in their family received contact, limits a full understanding of adult service-user perceptions.
CONTRIBUTIONS AND FURTHER RESEARCH

It was claimed that the thesis makes contributions to research in five areas beyond its benefits for CRFSS and SST. This section revisits each of these, making conclusions and noting areas for future research.

PERSPECTIVES ON COPMI/COPMIA SERVICE DELIVERY

Few dedicated and holistic COPMIA services exist in A/NZ. Those which have operated for several decades are mostly adjuncts to other service delivery, and to my knowledge, none focus solely on serving families with severe and chronic parental mental health. This thesis thus provides multiple insights into what such a service might look like in A/NZ and other similar contexts.

That voices of children, adolescents and various adult family members are captured in this study is new material for the A/NZ COPMIA community, as little exists, and what does exist is not specific to this service–user group. Although service delivery was the focus of inquiry, elements of their experiences are found in the data. The field is young in this country and more work is needed to obtain multiple perspectives of COPMIA and their families in A/NZ concerning their personal experiences and views on service delivery. In addition, as child participant perspectives on service delivery are rare, this findings expand international material. An associated issue may be obtaining access to child participants, which raises the potential need for stronger support of practitioner–led research and altered perceptions of insider research (Greene, 2014; Mercer, 2007; Shaw, 2007; Shaw, 2011).

This thesis began with reference to the notion of a village of support for COPMI and their families: that when parents are supported, children are more likely to be healthy. Although relational, comprehensive support of many CRFSS parents was found, the study also revealed that specific support for child service–users was valued. This was supported in the literature. The Supporting Parents Healthy Children initiative is appropriate for the adult mental health sector of A/NZ; however, I advocate for retaining the COPMIA acronym or a version of it.
in other service domains in A/NZ to ensure the unique needs of COPMIA are not forgotten. Perhaps’ Supporting Parents and Supporting Children’?

This does not mean child and parent needs can be separated. As argued, whole family practice is best practice, particularly when complexity and multiple risks exist. All family members benefit when they all receive support. This knowledge of reciprocal impact, and findings about interconnections between programme components in ways that scaffold and add value to service delivery across the family system require further attention. Intersections between COPMI literature and the adult−youth mentoring genre, which suggests such service delivery, could be developed further.

Findings sent clear messages about what types of support are valued by this group of COPMI and their families, and as argued, the needs of this service−user group are not specified in the COPMI literature, despite what is known about accumulated risk factors for the group. The onus is on the COPMI research community to advance studies which consider differentiated service delivery according to acuity of need, building on such work as Falkov (2014) and Hosman et al. (2009). Locally, the suggestions made for these Quadrant D social service users are apt (New Zealand Productivity Commission, 2015a). I believe this requires urgent attention.

Historically, programme evaluation has not supported service−user perspectives, relying on quantitative methodology, and as outlined, most COPMI and NGO programme evaluation has followed this pattern. The valuable data gained from service−user perceptions in this thesis not only guides future CRFSS evaluation but are a testament to the value of this methodology. There is further work to be done in understanding how utilisation−focused and developmental evaluation might be relevant for any family support service. The context of state sanctioned evidence−based practice is an issue, and these comments need to be borne in mind with strategies suggested in Chapter Six. How to do both is an area which needs further study. Further, as A/NZ is in the early stages of national COPMIA service delivery across sectors, an opportunity
exists to consider broadening the scope of service evaluation to routinely include the service–user voice.

RELATIONSHIP–BASED PRACTICE (RBP)
It was claimed that this thesis advanced the theoretical understanding of relationship–based practice. As argued, RBP has not been applied to COPMI service delivery per se. The use of social work RBP theory to understand family work is not unique; however, its application to COPMI work is. Drawing on adult–youth mentoring scholarly work and recognition theory to understand aspects of longer–term professional work with children, adolescents and COPMI is new ground. Benefits would be gained through further development of both these fields in the COPMI domain.

Further advancement of the RBP literature is also argued through the theoretical links about service delivery made with mainstream and socio–ecological resilience theory. This combination has enhanced understanding of how RBP scaffolds other areas of service delivery. The application of the Pathways to Resilience study findings adds to the knowledge of RBP with youth in A/NZ, and vulnerable youth in other similar settings. All areas require further study. As noted, no theory fully explained the reciprocity and complexity of professional–child/adolescent relationships in this research setting, and the potential exists for a new theoretical model to be developed.

Comprehensive family practice – defined in this thesis as multicomponent, interrelated service delivery for the whole family system, provided largely by one organisation — lacks testing and requires further defining. Cost—benefit analysis work would be useful to understand the pros and cons of this type of practice versus multiple services providing differing aspects. As part of this, the economics of RBP in enabling comprehensiveness and interrelated service delivery over a long period for this service–user group, rather than multiple short–term interventions over the same period, could be explored. This thesis argues in favour of this way of working; however, extensive work is required in this area. For the A/NZ context, this could be considered in relation to the New
Zealand Productivity Commission’s (2015a) recommendations for Quadrant D service users.

Further questions arose about RBP with COPMI families which would benefit from further research:

- Tools and assessment processes for gauging relational deficits and needs for COPMI and parents which are broader than what mainstream attachment theory offers;
- How service delivery might be triaged and adapted to cater for RBP;
- Training and support needs for practitioners to work in this manner;
- Capturing RBP in evaluation;
- The reciprocal impact on children when parents with mental illness have their relational deficits and needs addressed.

STIGMA AND PEER SUPPORT

This study contributes some material to our understanding of COPMI experiences of stigma; however, what was captured was incidental as the primary area of investigation was service delivery. The descriptions of stigma by association and self-stigma in the findings were suggestive of significant stigma for these COPMI. For this group, and for all COPMI, further work is needed to understand expressions of stigma across contexts and cultures.

A possible area for international COPMI collaboration would be the impact of stigma on COPMI’s experiences of mainstream education. In this study participants signalled that stigma from other children was related to whether others knew about parental mental illness or whether mental illnesses were obvious to others. For most child service-users, education was the main forum in which this occurred, and an area in which the majority struggled to find success. It would be helpful to understand more about factors which add to and detract from experiences of stigma for COPMI in general life.

Further theorisation of intersections between stigma theory and socio-ecological resilience theory made in this study would be invaluable. As
argued, stigma undermines most pathways to resilience. How responses to stigma are framed, such as in Bottrell’s study, requires serious work, otherwise we are in danger of further falsely labelling the behaviours of those COPMI or other stigmatised groups who take steps to remove themselves from stigma (Bottrell, 2009b; Sanders et al., 2014; Ungar, 2010).

Both stigma and peer support are separately and jointly acknowledged in the COPMI literature, but links in service delivery between peer support and decreases in self-stigma made in this thesis from findings and theory, advance the knowledge of how peer support counters stigma for this group. As these links are not strong in the literature, this is an important area for further inquiry. Findings in this study which indicated the scaffolding effects of a destigmatising peer environment have ramifications for mental health education, respite, and recreational activities. The nuances of group empowerment which occurred with CRFSS child service-users suggests another related and under-theorised area of study.

Widening the scope of stigma research to consider stigmatising socio-ecological factors which drive attitudes and values not only about mental illness but also socio-economic status, welfare use, and dependency on social services, would be beneficial for this group of COPMIA families. Stigma research needs to include contextual factors such as socio-political ideologies, social policy and practice, and cultural beliefs. As noted by Link and Phelan (2001) in relation to stigma, distal effects are often overlooked in research due to the lack of lived experience in research.

Linked with this is the role professionals might have in either increasing stigma or advocating against it. The definitions from Yang et al. (2007) could form the basis for investigation into what most threatens professionals about COPMI families. It would be useful to identify which factors are of greater concern to them, and what training would be valuable to ameliorate such responses, thus enabling practitioners to differentiate between personal reactions and beliefs, and actual risks.
SOCIO–ECOLOGICAL RESILIENCY THEORY

The introductory chapter argued that this thesis re-engages with the socio-ecological perspective on resiliency theory when applying this framework to COPMI and their families. Previous COPMI research has provided a solid basis for understanding risk and protective factors. However, despite the value of this material it mostly lacks consideration of differences which exist across cultures and socio-political environments. Further, it emphasises micro level resilience interventions and/or does not articulate how broader risk factors affecting COPMI might be addressed. This thesis has challenged the status quo, arguing more research is needed to promote resilience factors affecting COPMI and their families across macro and meso domains, and a broader theoretical framework is required which does not rely solely on mainstream psychology. I am not disputing the value and efficacy of most mainstream psychology, neither do I wish to denigrate in any way those working from this framework. What I am suggesting is its repositioning as a theoretical perspective rather than the theoretical perspective, and acknowledgement of the limitations associated with its Eurocentrism.

Perhaps the COPMI field could consider applying the propositions and tensions posited by Ungar (2008) to studies into how aspects of resilience may be viewed similarly and differently in different contexts and for different groups of COPMI. Such research would enable principles of practice for COPMI service delivery to be developed by the international COPMI research collaborative. The principles of socio-ecological, resilience-focused practice proposed in this thesis have clarified what could be the nature of service delivery aiming to strengthen and support this service-user group in A/NZ, and for service-user families facing similar challenges in other settings. This is just a beginning. These principles require further theorisation and testing. I have argued for the need for more service-user perspectives in evaluation. We need to be asking what COPMI and their families feel are culturally meaningful, health-sustaining resources and experiences, and how service delivery, social policy and the research
community might support the capacity of individuals and families to navigate towards these (Ungar, 2008, 2013).

How resilience is measured was questioned in this thesis. As argued, most psychometric tools reflect outcomes based on mainstream psychology. My proposal is that consideration be given to how pathways to resilience might be measured, not just short-term outcomes. Given all that has been discussed, this is a matter for urgent research. Further, measures which encompass a broader socio-ecological perspective on the adaptation versus risk debate are required.

Considering the resilience of third sector organisations in the wider socio-political environment is a significant expansion of socio-ecological resiliency theory. The analysis and strategies applied expand knowledge of what affects the resiliency of such organisations, and what steps could be taken to lower barriers.

**MACRO-MESO ANALYSIS AND STRATEGIES**

The macro-meso analysis of CRFSS and SST has expanded application of the Aimers and Walker Hybridity Lens, and the Walker and Shannon Ideal Strategic Model to other regions in A/NZ, and to different types of social service organisations (Aimers & Walker, 2016, 2018; Walker & Shannon, 2011). Understanding the impact of multiple logics in intra-organisational conflict has been enhanced by analysis of CRFSS’s amalgamation into SST. Further, the logic of these models has been extended beyond theoretical frameworks to use as organisational analysis tools. Further work is needed to develop their use as analysis tools through applying the model to other settings. Utilising the Ideal Strategic Model in such detail is useful information to other NGO clusters seeking change. If SST went ahead with strategies suggested, documentation of the four-stage process would further enhance the field.

Several gaps in the literature were noted (ComVoices, 2016a; Larner & Craig, 2002, 2005). The experiences of NGOs feeling silenced are largely anecdotal, and research in this area would lend weight to arguments for change. Little has
been written about the impact of neoliberalism on the nature and operation of organisations in A/NZ. This thesis has contributed towards this in relation to one organisation, but further work is needed across similar and different sectors.

As even the state’s Productivity Commission found the CRFSS service–user group required a different type of service delivery, and that funding and governance arrangements needed to change to allow NGOs to respond appropriately, data are required to elucidate this further (New Zealand Productivity Commission, 2015a). If NGO referral and assessment processes gathered data according to what underlies these quadrants, knowledge capital would be built. This is essentially about assessing resilience in service–users: the capacity to navigate towards health–enhancing resources. The Commission’s recommendations about a devolutionary style of governance for social services working with service–users from Quadrants C and D requires further study in relation to: describing types of autonomous governance; protocols and policies which encompass diverse approaches; how these would interact with measures such as national standards, regulation and data collection; and what would be measured. As service–users from these groups require someone else to navigate for them to varying degrees, measurements need to reflect this. This means they need to look more like what was suggested for resilience–focused practice — pathways rather than outcomes.

Further to what has already been outlined regarding contributions of the socio–ecological perspective, the macro–meso discourses and the discussions in the thesis have broadened the possibilities of programme evaluation for the COPMI sector. It was argued that it is necessary to incorporate the macrosystem in evaluation, because to omit it decreases the applicability of findings to other contexts, as programme evaluation would not be fully located in its environment, thereby lessening depth and comparative value. Its provision in this thesis enables findings to have more value to other NGOs in A/NZ and other countries operating in similar socio–political environments.
Further studies into an evaluatory format for COPMI programmes which includes this domain would be useful for the sector.

It was argued that the use of a socio-ecological framework exposes the wider discourse affecting COPMI families, thus enabling studies on barriers to accessing service delivery and to service provision which meet varying needs. An international comparative study of discourse underpinning public health frameworks and national COPMI guidelines would uncover the ideas and values influencing COPMI service delivery in different contexts. COPMI researchers have an opportunity to support COPMI service provision by engaging in this domain. As outlined, service providers are often powerless, and any material which enables this would be valuable.

The Prato International Research Collaborative for Change in Parent & Child Mental Health could employ some of the suggested strategies for organisational change to their own organisation. This group has the potential and capacity to change the nature of privileged capital. However, awareness is needed before strategies can be fully implemented, and the tentacles of neo-liberalism also touch research communities. A challenge for this group is to consider applying Bourdieu’s conceptual lens and analyse the organisation’s habitus and position in the social game and wider field of power.

This group has already identified that it requires stronger cultural diversity in membership. I suggest a further area for broadening perspectives is a greater range of professional disciplines represented: more sociologists, political scientists and social work voices.

CONCLUDING REMARKS

Returning to ecological theory, as defined in Chapter 2, the dilemma of change versus homeostasis was noted. Should individuals and systems change, or should they adapt to the status quo? The final conclusion for this thesis is a definite and resounding yes to systemic change. However, the system which most needs to change has the greatest power and holds the dominant position is the socio-political, not individual service-users and families, as per the
neo-liberal mantra. This sphere is what most determines how resilient COPMI and their families are, and how well social services can provide the support needed.

This thesis has shown that service-user perspectives and the CRFSS narrative are at loggerheads, to some degree, with the SST narrative, and to the utmost degree with state discourses in A/NZ. Strategies have been suggested which could enable services to provide aspects of the village of support requested by service-users of the service. How well SST and other services respond to these strategies will determine the extent to which the findings of this thesis are valued.
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<td>Emily Keddell, Lecturer, Department of Sociology, Gender and Social Work, University of Otago</td>
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6. Co-investigator’s name(s), qualifications and position(s) and, if more than one locality; principal investigator at each locality

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<td>Supervisor’s name</td>
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<td>Declaration: I take responsibility for all ethical aspects of the project</td>
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<th>9.</th>
<th>List locality organisation/s involved, including contact address, and complete the locality assessment in Part 4: Declarations (refer to the Guidelines (NAFG–2009–v1))</th>
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<tr>
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<td>Caroline Reid Family Support Service</td>
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<td>Stepping Stone Trust</td>
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<th>I wish the protocol to be heard in a closed meeting.</th>
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If the answer is yes, please provide a reason why you wish the protocol to be heard in a closed meeting in accordance with the Official Information Act 1982.

Not applicable

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<th>11.</th>
<th>If the study is based, in part or in full, overseas, which countries are involved?</th>
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<th>Has this application been reviewed by another ethics committee in New Zealand or overseas?</th>
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(If yes, advise which country, the name of the committee/s and the decision/s of the committee/s)

Please note a copy of the report/s may be requested.

Not applicable
13. **Human tissue** – Does the project involve collection or use of human tissue? If **yes**, complete Part 5.
   - Yes   No

   - Yes   No

15. **Xenotransplantation** – Does this research involve the transplantation of living biological material from one species to another? If **yes**, complete Part 7.
   - Yes   No

16. **Consent** – Are all participants able to provide consent for themselves? If **no**, complete Part 8.
   - Yes   No

17. **Lay summary** – give a brief lay (non-technical) summary of the study (not more than 200 words) such as you would give as an explanation to participants.

   The aim of this research is to find out what the child and adult clients of CRFSS think of the service. We want to know what key stakeholders think CRFSS does well, and what CRFSS could improve. Previous research recommends several important features of interventions with children of parents with mental illness. We are also interested to know to what extent CRFSS is implementing these.

   The data will be gathered by mixed methods. 10 children (of a possible 39) will be interviewed. After the information from the children’s interviews has been analysed, all the children of Caroline Reid Family Support Service during 2011 (possible 45) will be invited to join a focus group (2 groups: under 13, over 13) where they will be told what we found from the 10 interviews. We want to know if all the children agree with the findings, if there is anything they want changed, and if there is anything new to add.

   We will also be asking all the adults clients of the service to fill out a questionnaire.

18. **Proposed starting date (dd/mm/yy)**
   - August 2011

19. **Proposed finishing date (dd/mm/yy)**
   - November 2012

20. **Duration of project in New Zealand (mm/yy)**
   - 1 year 3 months

21. **Proposed final report date (mm/yy)**
   - November 2012

22. **Has the clinical trial been registered?**
   - Yes   No

   If **yes**, name the register.
   - Not applicable

   If **no**, has registration been applied for?
   - Yes   No

   **Comment**: Not applicable
PART 2: ETHICAL PRINCIPLES

A. Validity of research, (Operational standard paragraphs 53–59). Scientific basis

A1. Aims of the project

A1.1 What is the hypothesis/research question(s) and/or the specific aims of the project? (State briefly.)

The research question is: What are the adult and child clients’ perceptions of the Caroline Reid Family Support Service (CRFSS) ability to accomplish its goals?

Service Goals include: (1) To assist client children to have more diverse childhood experiences (2) To assist client children to feel less stigmatised (3) To develop a mentoring relationship with each child client (4) To improve social inclusion in client families (5) To assist client families to access services (6) To enhancing child client’s knowledge of mental illness (7) To assist client families to develop a care plan around mental illness (8) To educate adult clients about the impact of mental illness on parenting (9) To assist adult clients to enhance their parenting capacity (10) To assess and educate adult clients regarding mental illness (11) To assess child clients’ (and siblings where pertinent) health and wellbeing (12) To provide opportunities for children to play and be children.

This study is a form of programme evaluation. The aim is to evaluate what the key stakeholders of the service think about the service.

A2. Scientific background of the research

A2.1 Has this project been scientifically assessed by independent review?  

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If yes, describe the process, for example, HRC funding assessment process. A copy of the report should also be attached. The researcher’s response may also be included. Not applicable

If no, do you intend to have the project scientifically assessed and by whom? Not applicable

2.2 Describe the scientific basis of the project (300 words maximum). Where this space is inadequate, continue on a separate sheet of paper. Do not delete page breaks or renumber pages.

Qualitative measures (ie semi-structured interviews and focus groups for children):

Qualitative measures were chosen because of the need to glean the views, opinions, and perceptions of the client children. The investigators wished to gain the richness of data obtained through qualitative methods. The “voice of COPMI”, is largely absent in the literature. Qualitative studies have been completed with adult COPMI participants, but few for children. Due to the longitudinal nature of the Caroline Reid Family Support Service (children remain in the service for up to 9 years), it was not feasible to use pre and post testing for this study. The investigators also felt the chosen methodology was better suited to the particular needs of the age group, and more easily adapted to the differing developmental stages in the group.

Quantitative measures (ie aspects of the questionnaire will be structured, and include demographics):

Quantitative measures were chosen for practical reasons. It was not possible to interview adult clients as well as child clients, for a Masters’ thesis. It was felt that the adults would provide valuable data, and some areas of enquiry could only be answered by adult clients. A relatively structured questionnaire was therefore chosen to provide maximum information in a more easily managed format. It seemed important to allow distance between the co-investigator and her clients, and a questionnaire aids this process. While access to a social work student also assists ‘distancing’, a questionnaire is a more easily administered and appropriate method for a student to use than qualitative methods.

A3. Study design

A3.1 Describe the study design. Where this space is inadequate, continue on a separate sheet of paper. Do not delete page breaks or renumber pages.
INTERVIEWS
10 children selected of the available 39 using a maximum variation sample (age, gender, ethnicity, length of time in service). Interviews will be semi-structured and taped. (39 children in service at the end of 2010.)

FOCUS GROUPS
Two children’s focus groups will be arranged following analysis of data from the 10 interviews. All 45 children will be invited. One group 7–12 years, other group 13–17 years. Data gained from the interviews will be presented to the children, feedback requested, and further information will be gained. Sessions will be taped. (45 children in the service during 2011.)

QUESTIONNAIRES
All adult clients of the service (who have received some service from the Family support worker of the service, and been a client of the service from the end of 2010) will be invited to complete a questionnaire.

A4. Participants

A4.1 How many participants do you intend to recruit? (Include details for each locality organisation.)
Interviews: 10 children of the 39 available who were members of the service at the end of 2010, using a maximum variation sample.
Focus Groups: All children who wish to participate from the 45 children who are members of the Caroline Reid Family Support Service during 2011.
Questionnaires: All adult family members of the child clients of the Caroline Reid Family Support Service who were clients of the service at the end of 2010 (who have received some service from the Family support worker of the service) will be invited to participate. Estimate 40–45 adults.

A4.2 Give a justification for the number of research participants proposed, giving the details of power calculations when appropriate.
The initial goal was to interview all clients of the service, however this proved too large for a Masters’ project. My supervisor and I decided to focus interviews on the children of the service, as the service is child focused, and the child’s voice appears to be lacking in the literature regarding COPMI. We chose 10 of the 39, for practical reasons, however wanted all children of the service the opportunity to contribute, hence the number chosen for focus groups is the number of child clients of the service in 2011. It was felt that the children selected needed to be part of the service for a one year period to be able to fully answer questions, hence the cut off for selection of the end of 2010.

Questionnaires will be available to all adult clients applicable (40–45 people).

A4.3 If randomisation is used, explain how this will be done.
Not applicable – purposive sample used because of the nature of the study. All clients of the service are invited to participate.

A5. Statistical method

A5.1 Is the method of analysis quantitative?   x Yes  No
Or qualitative?   x Yes  No

If the method of analysis is wholly qualitative, go to question A5.4.
If the method of analysis is wholly or partly quantitative, complete the following:

A5.2 Describe the statistical method that will be used to analyse the data.
Given the small sample, descriptive statistics will be the only statistics employed.

A5.3 Has specialist statistical advice been obtained about this study?   Yes  x  No

If yes, from whom? (A brief statistical report should be included if appropriate.)
Not applicable
A5.4 If the method of analysis is wholly or partly qualitative, specify the method. Why is this method appropriate? If interviews are to be used, include the general areas around which they will be based and a copy of the interview guide, if one is to be used. Copies of any questionnaires that will be used must be included.

| INTERVIEWS. Semi-structured interviews with 10 selected child clients (age range 8–17 years of age). Interview guide attached. The data analysis will be primarily qualitative. The small amount of quantitative data that will be gathered will be demographic in nature. Qualitative methods suit because the research question is interested in the perceptions of clients regarding the service’s ability to meet its goals, thus opinions, ideas, experiences are sought. Qualitative methodology also lends itself to the age range of the participants, and the size of the sample (given the research question). FOCUS GROUPS. No guide attached. Questions for the focus groups will be developed out of the themes and ideas which arise from the interview material. The questions will therefore cover the same general areas as outlined in the interview guide. Qualitative methodology is the choice again as themes arising from the interview data will be discussed. Two focus groups are planned: a younger (7–12 years) and older (13–17 years) group. New themes may emerge from the comments of these larger groups of children. These cannot be anticipated at this stage. QUESTIONNAIRES. A potential of 45 (approx) adult participants will be invited to complete a questionnaire. Some qualitative data will be gathered using this method. Copy of questionnaire attached. |

A6. Expected outcomes or impacts of research

A6.1 What is the potential significance of this project for improved health outcomes?

It is anticipated that research project will give voice to an often forgotten group in NZ society. Children of parents with mental illness (COPMI) are not officially recognised in NZ. Unlike Australia, NZ does not have a national health framework for COPMI, and there is therefore no funding attached to these children unless they have a physical or mental illness. It is our hope that this project will be a small step in promoting the cause of COPMI, and the need for a national directive for these children. I also hope it attracts more funding the work. The service currently has a two year waitlist for the long term stream. Currently the service is working on developing more through-put by offering shorter term interventions. There is minimal funding available to enable this to develop fully.

A6.2 What is the potential significance of this project for the advancement of knowledge?

- Documentation of the particular model the Caroline Reid Family Support Service uses, and its potential efficacy.
- The voices of COPMI involved in the service will be documented. Most COPMI research appears to be focused on the reflections of adult COPMI, or mothers. Fathers and other adult caregivers of children will also be given the opportunity to participate.

A6.3 What steps will be taken to disseminate the research results?

- Study contributes to a Master of Social Work thesis, a copy of which will be held in the University of Otago library.
- Summarised copies of the results will be sent to all participants.
- Presentation to the wider team of Stepping Stone Trust at a monthly professional development workshop.
- It is intended that findings will be published in available journals, and may be presented at appropriate conferences.

A7. Publication of results

Will any restriction be placed on publication of results?  

Yes  [x]  No

If yes, please supply details.  Not applicable.
A8. Funding

A8.1 How will the project be funded?

Personal cost of the student. Some support may be obtained from Stepping Stone Trust with regard to stationery costs.

A8.2 Does the researcher, the host department, the host institution or the locality organisation has any conflict of interest, eg, financial interest, in the outcome of this research? If yes, please give details.

The co-investigator is employed by the locality organisation.

A9. Incentive payments

A9.1 Have you read and understood the description of incentive payments in the Guidelines?

Note: Details about any payment (in money or kind) or reward made to participants recruited into the project are to be provided in question E10.

A9.2 Does the funding available to the project depend upon the number of participants recruited, eg, is the funding on a per participant basis? If yes, give details of the amount per participant. Where there is a significant difference between these, this incentive to recruit should be declared in the information sheet.

Not applicable

A9.3 Does the funding available to the project include any form of incentive (in money or kind) for the early or complete recruitment of a specified number of participants, eg, bonus payments to the researcher, host department or host institution? If yes, give details.

Not applicable

A9.4 Will all funding available to the project be passed through an audited research account or cost centre? If yes, give details. If no, specify why not.

Not applicable.

B. Minimisation of harm (Operational standard paragraphs 60–68)

B1. How many visits/admissions of participants will this study involve? Clarify what is in addition to standard treatment. Give also an estimate of total time involved for participants.

All research will be in addition to standard treatment.

Adult clients: 1 visits per person; approx 1.5 hours per person.

Child clients: 2 visits per interviewed child (10 children), approx 2 hours per child; 1 focus group per child, approx 1.5 hours per child.

B2. Who will carry out the research procedures?
Adele Parkinson, co–investigator, will organise and carry out the interviews, and organise and be involved with the running of the focus groups. Adele plans to use a social work student on placement with the service to manage the process regarding questionnaires to adult clients (ie make initial approach, visit re consent, distribute and gather questionnaires) in order to distance herself from her adult clients. Some assistance will be required with focus groups; however, this has not yet been decided. Possibilities include other employees of the service, someone from the reference group, and/or the social work student.

B3. What other research studies is the lead investigator currently involved with?

Ms. Keddell is currently involved in a research project, funded by a University of Otago research grant, examining social work decision making in child protection. She is also the lead investigator of an unfunded evaluation of client perceptions of a Family Support Service offered by Anglican Family Care (Dunedin).

B4. Where will the research procedures take place?

Child interviews will take place either in the child’s home, or in an office at Stepping Stone Trust. The child may have the interview at home if he/she wishes, if the family are able to provide a quiet, separate room in which there will be no interruptions.

Focus groups – location not yet decided. A number of suitable rooms are available at Stepping Stone Trust or in the community.

Questionnaires – the social work student will visit adult clients in their own homes.

B5. How do the research procedures differ from standard treatment procedures?

Research procedures are completely separate from the services provided by Caroline Reid Family Support Service.

B6. What are the benefits to research participants of taking part in the project?

Participants have an opportunity to have a say about the service, which may have a direct impact on the quality of service they receive in the future.

They may benefit from the ‘raised profile’ of the service and the particular type of work the service does, through the presentation of findings.

The service may more easily attract future funding as a result of steps taken to evaluate service provision.

B7. Describe any methods for obtaining information. Attach questionnaires and interview guidelines. (If National Health Index (NHI) information is used, see the Guidelines (NAFG–2009–v1).)

Semi structured interviews with children aged 8–17 years.

Children’s focus groups as a form of member checking, and to source new data.

Questionnaire.

Copies of interview guide and questionnaire attached.

B8. Briefly describe the inclusion/exclusion criteria and include the relevant page number(s) of the protocol or investigator’s brochure.

Inclusion criteria: must be a child or adult client of the Caroline Reid Family Support Service in 2011: adult clients must have some contact with the family support worker of the service. Child/family must have been engaged with the service for a 1 year period to participate in interviews or questionnaire. Children can participate in the focus groups if they have been with the service a shorter period than 1 year.

Exclusions criteria: Adult client actively psychotic.

B9. What are the physical or psychological risks or side effects to participants or third parties? Describe what action will be taken to minimise any such risks or side effects.
### Risks to child clients

- (1) child distressed by interview questions or focus group discussion;
- (2) child may disclose information which may need to be acted on after interview;  
- (3) possible discrepancy between parents’ consent and child’s assent to research.

**Action:**
- (1) careful thought/screening of interview and focus groups questions; child has access to children’s workers at CRFSS who could meet with the child relatively quickly after the event, if the child consents, and/or parent(s), if the child consents;  
- (2) clear avenues of referral if child discloses something which needs to be acted on, in conjunction with children’s workers of CRFSS;  
- (3) clear consent/assent processes outlined in information sheet, as discussed in Section E.

See Appendix A for “Risks to adult clients”

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**B10.** What facilities/procedures and personnel are there for dealing with emergencies?

Clear lines of support are already in place should there be any emergency, due to pre–existing relationships between adult and child clients of the service and staff of the service. All clients have contact details for staff for working hours. All clients have other support people available to them external to the agency. This is documented in client files. Emergency contact information is also recorded in client files, as is GP and/or mental health case manager information for adult clients.

These steps will be clearly documented in the information sheet, and also stated verbally at the time of the interviews, focus groups, and when questionnaires are delivered/collected.

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**B11.** What arrangements will be made for monitoring and detecting adverse outcomes?

Current clients of the service will be monitored as part of the normal service provision.

All clients who participate in the interviews or complete questionnaires will receive a follow up telephone call within a week of participation in the research.

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**B12.** If the study is a clinical trial, are participants to be provided with a card confirming their participation, medication and the contact phone number of the principal investigator? Not applicable

- [ ] Yes  
- [ ] No

**B12.1** Do you intend to inform the participant’s GP that their patient is a participant in this study? (If yes, consent from the participant is required.) Not applicable

- [ ] Yes  
- [ ] No

**B12.2** Do you intend to inform the GP of all clinically significant abnormal results obtained during study conduct? Not applicable

- [ ] Yes  
- [ ] No

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**B13.** Is the trial being reviewed by a data and safety monitoring board (DSMB)?

- [ ] Yes  
- [x]  No

If **yes**, who is the funder of the DSMB? Not applicable

- [ ] HRC  
- [ ] Sponsor  
- [ ] Other

If ‘Other’, please specify.

- [ ] Not applicable

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**B14.** What are the criteria for terminating the study?

- Closure of the service.  
- Co–investigator unable to continue for health reasons.  
- Participant chooses to withdraw.  
- Participant becomes actively psychotic over period of time research is undertaken, and is not psychiatrically stable enough to participate during this period.

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**B15.** Will participants be exposed to any potential toxins, mutagens or teratogens?

- [ ] Yes  
- [x]  No

If **yes**, specify and outline the justification for their use.

- [ ] Not applicable
B16. Will any radiation or radioactive substances be used?  
Note: If any form of radiation is being used, please answer B16.1–B16.2.  
If no, go to question B17.

- [ ] Yes  
- [x] No

B16.1 How many x-rays or other procedures are planned for the purposes of this study, i.e., that are not part of standard treatment?  
[Not applicable]

B16.2 Under whose licence is the radiation being used?  
[Not applicable]

B16.3 Has the National Radiation Laboratory (NRL) risk assessment been completed?  
- [ ] Yes  
- [x] No

If yes, please enclose a copy of the risk assessment and a contact name and phone number.  
If no, please explain why not.  
[Not applicable]

B17. Will any medicines be administered for the purposes of this study?  

- [ ] Yes  
- [x] No

B17.1 If yes, is Standing Committee on Therapeutic Trials (SCOTT) approval required?  
[Not applicable]

B17.2 Has SCOTT approval been given?  
(Please attach.)  
[Not applicable]

B18. Does the study involve the use of health care resources?  

- [ ] Yes  
- [x] No

If yes, please specify:  
[Not applicable]

B19. What effect will this use of resources have on waiting list times for patients, that is, for diagnostic tests or for standard treatments?  
[Not applicable]

C. Compensation for harm suffered by participants (Operational standard paragraphs 87–95)

(Refer also to Appendix 3 of the Guidelines (NAFG–2009–v1).)

C1. Will participants be treated by, or at the direction of, a registered health professional as part of the research?  
(Treatment includes screening, diagnosis, for definitions see the Guidelines (NAFG–2009–v1) pages 11–13.)  
If no, go to section D.  If yes, please answer questions C2–C5.4.

- [ ] Yes  
- [x] No

C2. Is the research being carried out principally for the benefit of a manufacturer or distributor of the drug or item in respect of which the research is taking place?  

- [ ] Yes  
- [x] No

C2.1 If the answer to C2 is yes, please complete Statutory Declaration Form B and answer questions C3–C5.4.

C2.2 If the answer to C2 is no, please complete Statutory Declaration Form A and go to section D.

Depending on all the circumstances, the minimum cover that is likely to be acceptable to the ethics committee is that provided under ACC.  In any case, all exclusions to compensation must be clearly and explicitly set out in the participant information sheet including those that may be described in C5.
C3. Is the manufacturer/distributor’s agreement to provide compensation in accordance with the RMI attached? □ Yes □ No

C4. Has the manufacturer or distributor agreed to cover any injury/adverse consequence resulting from participation in this research? □ Yes □ No

C4.1 If no, what qualifications have been specified for cover?
Not applicable

C4.2 Limiting the type of compensation

C4.2.1 Has the manufacturer or distributor excluded any type of compensation, for example, pain and suffering, loss of earnings, loss of earning capacity, funeral costs, dependents’ allowances or any other financial loss or expenses? □ Yes □ No

C4.2.2 If yes, please state what is excluded. (Include in the compensation statement on the information sheet)
Not applicable

C5. Limiting liability – exclusion clauses

C5.1 Has the manufacturer or distributor limited or excluded liability if the injury is attributable to the negligence of someone other than the manufacturer or distributor (such as negligence by the investigator, research staff, the hospital or institution, or the participant)? □ Yes □ No

C5.2 Has the manufacturer or distributor limited or excluded liability if the injury resulted from a significant deviation from the study protocol by someone other than the manufacturer or distributor? □ Yes □ No

C5.3 Is evidence of the following indemnity insurance attached?
Sponsor □ Yes □ No
If yes to either C5.1 or C5.2;
Hospital/institution □ Yes □ No
Investigator □ Yes □ No

C5.4 Is company liability limited in any other way? □ Yes □ No
If yes, please specify.
Not applicable

D. Privacy and confidentiality (Operational standard paragraphs 48–56)

D1. How will potential participants be identified?
Clients of the Caroline Reid Family Support Service at the end of 2010 and/or during 2011.
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>D2. How will participants be recruited (for example, advertisements, notices)?</td>
<td>Potential adult participants will initially be approached by letter, with follow up telephone calls. Parents/guardians will be telephoned first before a telephone approach is made to a child participant. Home visits arranged to further recruitment process.</td>
</tr>
<tr>
<td>D3. Where will potential participants be approached (for example, outpatient clinic)? If appropriate, describe by type (for example, students).</td>
<td>Own homes</td>
</tr>
</tbody>
</table>
| D4. Who will make the initial approach to potential participants? | Child clients: Adele Parkinson  
Adult clients: Social work student will approach adult clients re adult participation in study; Adele Parkinson will approach adult clients re child participation in study. |
| NB: Do not include information on storage and use of tissue samples and related information in the following questions. That is covered separately under Part 5. |
| D5. How will data, including audio– and videotapes, be handled and stored to safeguard confidentiality (both during and after completion of the research project)? | During the research project, electronic data will be held on a secure, password protected computer. Hard copies of data (including tapes) will be kept in a locked filing cabinet. On completion, electronic data will be held on disk only; and the disk and all hard copies will be stored by the lead investigator, Emily Keddell, at the University of Otago. |
| D6. What will be done with the raw data when the study is finished? | It will be stored in a locked cabinet, at the University of Otago; Department of Sociology, Gender and Social Work. |
| D7. How long will the data from the study be kept, and who will be responsible for their safe keeping? (Health information relating to an identifiable individual must be retained for at least 10 years, or in the case of a child, 10 years from the age of 16.) | 10 years; Emily Keddell, University of Otago Department of Sociology, Gender and Social Work. |
| D8. Name those who will have access to the raw data, participant information and/or clinical records during, or after, the study? | During the study: Emily Keddell and Adele Parkinson, all raw data; social work student – individual questionnaires as she collects them only; participant information known by Emily Keddell and Adele Parkinson, social work student will know names of adult participants, children's workers of the service will know names of children interviewed and at focus groups for purpose of providing support to their child clients if needed. After the study: In care of Emily Keddell. |
| D9. Describe any arrangements to make results available to participants, including whether they will be offered their audio– or videotapes. | See A6.3. All participants will be given an age appropriate summarised report of findings; they may borrow a copy of published thesis from co–investigator after completion; interview transcripts will be available to children if they request. This will be clearly outlined in the information sheet. |
E. Informed consent  (Operational standard paragraphs 28–43)

A participant’s informed consent should be obtained in writing, unless the procedures are not experimental and there are good reasons for not requiring written consent. If consent is not to be obtained in writing, the justification should be given and the circumstances under which consent is obtained should be recorded. Attach a copy of the information sheet and consent form provided to participants.

<table>
<thead>
<tr>
<th>E1. By whom, and how, will the project be explained to potential participants?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A letter will be sent to all adult clients and child clients explaining the project, and advising that they will be approached either by Adele Parkinson or the social work student. The letter will be followed up by telephone calls, then introductory visits.</td>
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</table>

<table>
<thead>
<tr>
<th>E2. When and where will the explanation be given?</th>
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<tbody>
<tr>
<td>After the letter is received, adult and child clients will be telephoned at home to discuss if they are interested in participating, and if so, an appointment will be made to visit in the home to further explain, give information sheet, and sign consents.</td>
</tr>
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<tr>
<th>E3. Will a competent interpreter be available, if required?</th>
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<tr>
<td>No</td>
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<tr>
<th>E4. How much time will be allowed for the potential participant to decide about taking part in the project?</th>
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<tr>
<td>Time frame between sending of initial approach letters, telephone calls, and appointments in participants’ homes will be at least 2 weeks.</td>
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<tr>
<th>E5. In what form (written, or oral) will consent be obtained? If oral consent only, state reasons.</th>
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<tr>
<td>Written</td>
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<tr>
<th>E6. If recordings are made, will participants be offered the opportunity to edit the transcripts of the recordings?</th>
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<tr>
<td>Yes</td>
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<tr>
<th>E7. Will data or other information be stored for use in a different study for which ethics committee approval would be required?</th>
</tr>
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<tbody>
<tr>
<td>Not applicable</td>
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<tr>
<th>E7.1 If yes, please explain how.</th>
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<tr>
<td>Yes</td>
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<tr>
<th>E8. Is there any special relationship between the participants and the researchers (for example, doctor/patient, student/teacher)?</th>
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<tbody>
<tr>
<td>Yes – all clients are known to the co-investigator, Adele Parkinson. Relationship to child clients is more distant. Adele’s clients are the adult clients of the service. Her role is the Family Support Worker to adult clients.</td>
</tr>
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<tr>
<th>E9. Will there be any financial cost to the participant, for example, travel and parking costs? If so, will such cost be reimbursed? (Refer to the Guidelines (NAFG–2009–v1).)</th>
</tr>
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<tr>
<td>No</td>
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<tr>
<th>E10. Will any payments be made to participants, or will they gain materially in other ways from participating in this project?</th>
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<tbody>
<tr>
<td>Not applicable</td>
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<th>E10.1 If yes, please supply details.</th>
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<tr>
<td>Yes</td>
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Section F enshrines two fundamental principles. They are:

i. **Culturally safe research practice**: Research involving participants from specific ethnic or socially identified groups (even when small numbers from each group are involved) must involve those participant groups in the research process as full participants. Where a particular ethnic or socially identified group is the principal subject of the research, there must be engagement with appropriate parties, and this process must be outlined in the application.

ii. **If the research is in an area of health inequalities**, then the researcher must demonstrate how the research will contribute to achieving equity of outcomes for those population groups most in need within the public good health system.

**F1.** Have you read the HRC booklet *Guidelines for Researchers on Health Research Involving Māori*?  

Yes ☒ No ☐

**Relevance and responsiveness to Māori**

**F2.** All health research conducted in Aotearoa New Zealand is of relevance to Māori. How relevant is a decision to be made by Māori. The researcher must be able to articulate the context and the relevance of the proposed research to Māori and the possible consequences for Māori health outcomes, and generally, the greater the degree of relevance to Māori, the greater the expectation of participation of Māori and hence consultation expectations.

**F2.1** Given your approach to sampling, what are the anticipated numbers of Māori participants?  

- Child participants – 7
- Adult participants – 4

**F2.2** What is the incidence among Māori of the health issue/disability relevant to the study?  

2006 figures show lifetime prevalence of mental disorder was 50.7% for Māori; NZ population rate was 46.6%, as cited by Oakley Browne, Wells, Scotts (Eds) (2006), *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington:New Zealand.

**F3.** Please explain how this research will contribute to improving Māori health outcomes and reducing health inequalities for Māori.

Given the over-representation of Māori in NZ health statistics, this piece of research should be of particular interest to Māori parents who experience mental illness, Māori children who live in families in which parental mental illness is present, and Māori who have whanau who live with similar challenges.

**F4.** Describe the process by which Māori have been engaged in the conception and design of the proposed research. Please identify the group/s with which consultation has taken place and outline their stated view about the proposed research. Please attach their letter/s of support for this specific research project.

Māori consultation process with Ngai Tahu via Otago University has been completed – copy attached. My clinical manager is Ngati Porou, and will be on the reference group.

**F4.1** Describe any ongoing involvement the group(s) consulted have in the project.

The Reference Group will be involved throughout the entire project via meetings and email. The group will act as an expert advisory body, and will be consulted about all aspects of the research. If they recommend wider consultation with Ngai Tahu at any stage during the project, this process will begin with the Stepping Stone Cultural Liaison Advisor, Sharon Schwalger (Ngai Tahu, Ngati Mamoe).

**F4.2** Describe how information will be disseminated to participants and the group(s) consulted during and at the conclusion of the research project.

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During the project – see F4.1.
Child participants will have information from the 10 child interviews presented to them for discussion at two focus groups. This information, together with further information gained from these focus groups, will be summarised and given to the child participants in appropriate written form at the completion of the project. There will be a note on the written feedback offering access to a summarised copy of all research findings if any of the older children are interested.
Adult participants will be given a summarised copy of all research findings at the completion of the project. They will be able to borrow a full copy of the thesis from CRFSS if they desire.

Responsiveness to ethnic peoples

F5. What other ethnic groups will be participating in this research based on your sampling frame (for example, Pacific peoples or Asian peoples)?

Indian (1 adult, 1 child)
English/Zimbabwean (1 adult, 2 children)
Dutch (1 adult, 2 children)
Japanese (1 adult)
Samoan (1 child)

F5.1 Are there any aspects of the research based on participation or the relevance of the research to specific ethnic groups that might raise specific cultural issues?

If yes, please outline. If no, go to F6.

Some ethnicities do not openly discuss mental illness in families due to significant cultural shame. The issues for families in which parents have mental illness may therefore not be acknowledged or addressed.

F5.2 How can this research contribute to reducing inequalities for ethnic peoples in the New Zealand health system?

All ethnicities in New Zealand are represented in NZ mental health statistics. This project is therefore of interest to all ethnic families cited above in which parental mental illness is a factor, and those supporting these families.

F5.3 Describe what consultation has taken place with specific ethnic group(s) prior to the project’s development and attach evidence of their support.

No specific consultation. Some members of the Reference Group have links with ethnicities beyond Māori/non-Māori. The Reference Group will guide the project in such a manner that consideration is given to the particular needs and values of other ethnicities represented in the study. The co-investigator has professional contacts at Christchurch Resettlement Services, should the need for further consultation arise.

F5.4 Describe any ongoing involvement the group(s) consulted have in the project.

The Reference Group will be involved throughout the entire project via meetings and email. The group will act as an expert advisory body, and will be consulted about all aspects of the research. They will advise if further ethnic consultation is necessary.

F5.5 Describe how you intend to disseminate information to participants and the group(s) consulted at the end of the project.

Child participants will have information from the 10 child interviews presented to them for discussion at two focus groups. This information, together with further information gained from these focus groups, will be summarised and given to the child participants in appropriate written form at the completion of the project. There will be a note on the written feedback offering access to a summarised copy of all research findings if any of the older children are interested.

Adult participants will be given a summarised copy of all research findings at the completion of the project. They will be able to borrow a full copy of the thesis from CRFSS if they desire.

The Reference Group will provide consultation re further distribution at the end of the project.
Responsiveness to other peoples of interest

F6. Are there any aspects of the research based on participation or the relevance of the research to specific peoples of interest that might raise specific issues for such communities (for example, for prisoners, people with disabilities, people with diverse sexual identities)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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If yes, please outline. If no, go to F7.

All participants are “other peoples of interest”. This project will potentially be of interest to parents with mental illness, and children of parents with mental illness, and those who support them.

F6.1 How can this research contribute to reducing inequalities for other peoples of interest in the New Zealand health system?

Research potentially aids perceived efficacy of service, which may attract more awareness of the needs of COPMI and funding to this group in NZ society.

F6.2 Describe what consultation has taken place with specific peoples of interest group(s) prior to the project’s development and attach evidence of their support.

Specific consultation about the particulars of this project will occur at a reference group level. The initial project development has arisen from the co-investigator’s experience of working in the agency, and from an extensive search of the literature. A number of studies exist in different parts of the world in which adult COPMI have reflected on their experiences, growing up in families in which parental mental illness has impacted them adversely. Clear themes have arisen from the literature on what adult COPMI feel would have been helpful/not helpful. The COPMI website (www.copmi.net.au), a national initiative of the Australian government, provides another source of consultation. This organisation leads the way in consumer participation and consultation. Associate researchers provide a solid background in highlighting research and advice on programme evaluation.

Caroline Reid Family Support Service was born out of the consumer movement in 2003. Named after the wife of Graeme Reid, the organisation was started as a result of Graeme and Caroline’s experience as parents with mental illness, and knowledge of the issues for their children and those of the wider mental health community. Caroline died a number of years ago, and Graeme managed the service until March 2010. He continues to have input into the service by way of mentoring the staff as needed. Caroline’s sister, Sue Carswell, remains on the Board of Trustees.

F6.3 Describe any ongoing involvement the group(s) consulted have in the project.

The reference group will be involved in the process from beginning to end. One or two clients of the service will be on this group.

On-going liaison with Graeme Reid will occur throughout the process, although in a less formal fashion than the reference group, due to Graeme’s health and current commitments.

F6.4 Describe how you intend to disseminate information to participants and the group(s) consulted at the end of the project.

See A6.3, as participants are “other peoples of interest”.

F7. Will the study drug/treatment continue to be available to the participant after the study ends?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<td></td>
<td>X</td>
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</table>

F7.1 If yes, will there be a cost, and how will this be met?

Not applicable

F7.2 If no, why not?

Not applicable

F7.3 If there was a placebo arm, what will happen to these participants at the end of the study?

Not applicable

Note: This information needs to be included in the information sheet.
Part 3: General

Describe and discuss any ethical issues arising from this project, other than those already dealt with in your answers above.

When obtaining consent from children there is always concern over ensuring the child is fully aware of the ramifications of the research. There is potential difficulty around parental consent and children's assent, if either party wishes to participate when the other does not. We have endeavoured to be explicit in information sheets, and it is our intention to carefully and mindfully explain all areas. The client group is known to the co-investigator, therefore assessment of consent is likely to be relatively accurate. Clients who are unsure and/or unclear will be given generous timeframes to make decisions (data gathered by the end of 2011).

The issue of the co-investigator's relationship with adult clients is ameliorated through the use of a social work student. We will be very careful to stress the voluntary nature of participation in the project.

Thank you for your assistance in helping us assess your project fully.

Please now complete:

- the declarations (Part 4). If there is more than one site, include a declaration for each site.

If applicable complete:

- a Registered Drug Form
- Form A or B
- Part 5
- Part 6
- Part 7
- Part 8

Attach:

- Checklist to ensure all relevant documents are attached. Incomplete applications will not be reviewed.

Part 4: Declarations

Full project title: ________________________________

*Children of Parents with Mental Illness

1. Declaration by principal investigator

The information supplied in this application is, to the best of my knowledge and belief, accurate. I have considered the ethical issues involved in this research and believe that I have adequately addressed them in this application. I understand that if the protocol for this research changes in any way, I must inform the ethics committee.

Name of Principal Investigator (please print): ________________________________

Signature of Principal Investigator: ________________________________

Date: ________________________________
7. Declaration by Head of Department in which the Principal Investigator is located or appropriate Dean or other Senior Manager

I have read the application, and it is appropriate for this research to be conducted in this department. I give my consent for the application to be forwarded to the ethics committee.

Name (please print): 

Signature: ___________________________  Institution: University of Otago

Date: ___________________________  Designation: ________________

• Where the Head of Department is also one of the investigators, the Head of Department declaration must be signed by the appropriate Dean, or other senior manager.

• If the application is for a student project, the supervisor should sign the Head of Department declaration.

• Submit a declaration by the principal investigator for each site.

3. Locality organisation approval

Locality organisation approval is being sought/is attached from the following locations:

Caroline Reid Family Support Service, Stepping Stone Trust.

Appendix A

Risk to adult clients

Risk to adult: (1) may become distressed by questions in questionnaire; (2) if child requests parent presence at interview, parent may become distressed by child responses

Actions: (1) Adult clients can access support directly from Adele Parkinson (co–investigator), or via social work student (who will report to Adele). Follow up telephone calls within the week after questionnaire completed by social work student. (2) Adele will conduct child interviews, and therefore able to assess adult response. Follow up telephone calls to adults and children, during the week after the interview takes place.
APPENDIX B – ETHICS APPROVAL DOCUMENTS

1: PROVISIONAL ETHICS APPROVAL

27 June 2011

Ms Emily Keddell
Department of Sociology, Gender and Social Work
University of Otago
P O Box 56
Dunedin

Dear Ms Keddell,

Ethics ref: URA/11/06/020 (please quote in all correspondence)
Study title: Adult and Child clients’ views of a COPMI* Family Support service: A mixed methods study
* Children of parents with mental illness
Investigators: Ms E Keddell, Ms A Parkinson

Documents received
- Information sheet to children age approx 8–12 years
- Information sheet to children re interviews and focus groups, age approx 13–17 years
- Information sheet for adult clients re questionnaire
- Information sheet for parents/guardians re children’s interviews
- Consent form for adult participants
- Consent form for child participants
- Consent form for parents/guardians
- Evaluation questionnaire for adult clients
- Semi-structured interview guide for 8–12 year old child clients

The Upper South A Regional Ethics Committee considered your study on 20 June 2011. The following points require attention before ethical approval can be confirmed.

Requests
1. Please provide the supervisor’s signature on page 3 of the application form.
2. Application form B14: Please explain the criteria for terminating a particular person’s participation in the study (ie withdrawing that participant).
3. Is there an interview guide for children aged 13 – 17 years?
4. Please provide a Part 8 declaration.

All information sheets
5. Please explain that this study is part of a Masters study.
6. Include the Advocacy Services information as follows:
   If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.
7. All information sheets and consent forms must be printed on letterhead.
8. The footers of all information sheets and consent forms must include the full study title, a version number and/or date.

**Information sheet for children aged 8 –12**

9. Include further explanation about confidentiality in a focus group. Explain that while participants are strongly urged to protect the privacy of others, confidentiality cannot be guaranteed in a group setting. Suggested text is; “The information obtained during the group discussion will be regarded as confidential and is to remain within the group setting. While every effort will be made to maintain confidentiality, it cannot be guaranteed.”
10. It is felt that the 2nd sentence in the 7th bullet point is too strongly worded, and may discourage some young participants. Please amend or remove this text.

**Information sheet to children aged 13 – 17 years**

11. Please change “consent” to “assent” in the 3rd bullet point.

**Information sheet for parents/guardians re children’s interviews**

12. Please remove the 8th bullet point as this may be seen as an inducement.

**Information sheet for adults re questionnaire**

13. Explain approximately how much time will be required to complete the questionnaire.
14. Using prize draws to reward participants can be seen as a strategy to induce people to take part in a study. Please remove the 9th bullet point.
15. P2 Children’s focus groups, and consent…: As potential participants may be reading this information on a different day to when they consent, please remove the word “today”.

**All consent forms**

16. Include a space at the end of the consent form for the person explaining the project to sign and date.

**Consent form for child participants**

17. Please replace ‘consent’ with ‘assent’.

**Evaluation Questionnaire for adult clients**

18. As the specific ethnicities list could be an identifier within this small population, please use the 2006 Census ethnicity categories.
19. Q10: it is not clear what information is sought about mentors, eg their name, relationship to the child? Please clarify.

**You may not proceed with your study until ethical approval has been given.** In order to obtain ethical approval from the Committee, please forward evidence that the above conditions have been met, with one copy of amended documentation, including:
— a full copy of the amended information sheet/consent form/questionnaire etc with updated version number and date.

Provided the conditions above have been met, final approval for your study will be given by the Chairperson of the Committee. You will receive a letter advising you that final approval has been given, and may then proceed with your study.

Matters of comment, information or advice
The Committee also forwards the following suggestions, which do not affect the application's ethical approval status.

- As ethnicity could be an identifier in this small population, the committee urges caution with reporting on ethnicity in this study.
- As researchers may interview some participants in their homes the committee urges consideration for personal safety. It is suggested to provide the study supervisor with appointment times and locations.

Please don’t hesitate to contact me for further information.

Yours sincerely,

[Signature]

Alleke Dierckx
Administrator
Upper South A Regional Ethics Committee
Uppersoutha_ethicscommittee@moh.govt.nz
16 August 2011

Ms Emily Keddell
Department of Sociology, Gender and Social Work
University of Otago
P O Box 56
Dunedin

Dear Ms Keddell,

Ethics ref: URA/11/06/020 (please quote in all correspondence)
Study title: Adult and Child clients’ views of a COPMI* Family Support service: A mixed methods study
* Children of parents with mental illness
Investigators: Ms E Keddell, Ms A Parkinson

This study was given ethical approval by the Upper South A Regional Ethics Committee. A list of members of the Committee is attached.

Approved Documents
• Information sheet to children age approx 8–12 years dated 29/07/11
• Information sheet to children re interviews and focus groups, age approx 13–17 years dated 29/07/11
• Information sheet for adult clients re questionnaire dated 29/07/11
• Information sheet for parents/guardians re children’s interviews dated 29/07/11
• Consent form for adult participants dated 12/08/11
• Assent form for child participants dated 12/08/11
• Assent form for parents/guardians dated 29/07/11
• Evaluation questionnaire for adult clients
• Semi-structured interview guide for 8–12 year old child clients
• Invitation letter

This approval is valid until 30 November 2012, provided that Annual Progress Reports are submitted (see below).

AMENDMENTS AND PROTOCOL DEVIATIONS

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:
— the researcher responsible for the conduct of the study at a study site
— the addition of an extra study site
— the design or duration of the study
— the method of recruitment
— information sheets and informed consent procedures.
Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports
The first Annual Progress Report for this study is due to the Committee by 31 August 2012. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Statement of compliance
The committee is constituted in accordance with its Terms of Reference. It complies with the Operational Standard for Ethics Committees and the principles of international good clinical practice.

The committee is approved by the Health Research Council’s Ethics Committee for the purposes of section 25(1)(c) of the Health Research Council Act 1990.

We wish you all the best with your study.

Yours sincerely

Alieke Dierckx
Administrator
Upper South A Regional Ethics Committee
Uppersoutha_ethicscommittee@moh.govt.nz
List of members of the Upper Region A Ethics Committee, June 2011

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<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Gender</th>
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<tr>
<td>Liz Richards (Chair)</td>
<td>Consumer Representative Lay member</td>
<td>Female</td>
</tr>
<tr>
<td>Murray Cameron</td>
<td>Health Researcher Health Professional Member</td>
<td>Male</td>
</tr>
<tr>
<td>Angelika Frank–Alexander</td>
<td>Community Representative Lay member</td>
<td>Female</td>
</tr>
<tr>
<td>Allison Franklin</td>
<td>Consumer representative Lay member</td>
<td>Female</td>
</tr>
<tr>
<td>John Horwood</td>
<td>Biostatistician Lay member</td>
<td>Male</td>
</tr>
<tr>
<td>Ellen McCrae</td>
<td>Pharmacist Health Professional member</td>
<td>Female</td>
</tr>
<tr>
<td>Edie Moke</td>
<td>Māori representative Lay member</td>
<td>Female</td>
</tr>
<tr>
<td>Barbara Nicholas</td>
<td>Ethicist Lay member</td>
<td>Female</td>
</tr>
<tr>
<td>Christine Robertson</td>
<td>Health Practitioner Health Professional member</td>
<td>Female</td>
</tr>
<tr>
<td>Russell Scott</td>
<td>Health Practitioner Health Professional member</td>
<td>Male</td>
</tr>
<tr>
<td>Jane Ward</td>
<td>Researcher Health Professional Member</td>
<td>Female</td>
</tr>
</tbody>
</table>

John Horwood, Edie Moke and Russell Scott were not present at the meeting of 20 June 2011.

16 August 2011

Alieke Dierckx (Administrator)
Ms Emily Keddell
Department of Sociology, Gender and Social Work
University of Otago
P O Box 56
Dunedin

Dear Ms Keddell,

Ethics ref: URA/11/06/020 (please quote in all correspondence)
Study title: Adult and Child clients’ views of a COPMI* Family Support service: A mixed methods study
* Children of parents with mental illness

Investigators: Ms E Keddell, Ms A Parkinson

Amended documents

• Assent form for children – focus group, dated 06/09/11
• Assent form for children – interview, dated 06/09/11
• Information sheet for children 8–12yrs – focus group, dated 06/09/11
• Information sheet for children 8–12yrs – interview, dated 06/09/11
• Information sheet for adolescents – focus group, dated 06/09/11
• Information sheet for adolescents – interview, dated 06/09/11

Thank you for submitting the above documents, which have been considered by the Chairperson of the Upper South A Regional Ethics Committee, and approved under delegated authority.

Yours sincerely

Alieke Dierckx
Administrator
Upper South A Regional Ethics Committee
Uppersoutha_ethicscommittee@moh.govt.nz
This research is for a Master of Social Work thesis by Adele Parkinson.

Thank you for being willing to consider taking part in my research project. This information sheet discusses some issues you need to consider before signing consent to take part in the project.

**Some important points ......**

- Taking part is voluntary
- Saying yes or no will in no way affect the service you receive from Caroline Reid Family Support Service
- You need to sign consent to take part
- Michaela will assist you in any way you need to complete the questionnaire. This could take up to 1 hour to complete.
- Whatever you write in the questionnaires will not affect the service you receive from Caroline Reid Family Support Service
- It is really important that you write or give answers that are your opinion not that of your partner and/or other family member, or what you think we want to hear. If you don’t know, just leave it out or you can say “don’t know”
- Michaela will telephone you the week after you completed the questionnaire to see how you are.
• You can withdraw from the project at any time, no questions asked.

**What happens to the information …..**

• The information you provide will not in any way be able to be linked back to you in the research findings. The questionnaires are numbered and only I, Michaela, and my supervisor at Otago University, Emily Keddell, will know who the numbers belong to.

• As soon as Michaela collects the questionnaires she will give them to me. I will store them in a locked cabinet at my home until the project is finished. When the project is finished, the questionnaires will be stored in a locked cabinet by the University of Otago for 10 years, at which point they will be destroyed.

• The information from the questionnaires will be stored electronically for the purpose of collating and analysing the information. This information will be confidential to me and my supervisor. It will be kept secure on a computer with only password access to the research information. At the end of the project this information is put on disk and stored with the other material in a locked cabinet, by the University of Otago, as above. All electronic information on computer will be deleted.

• Only the research findings – the results – can be kept by me and my supervisor. Again, these will in no way be linked to yourself.

• A summary of these findings will be given to you. You may request to borrow a full copy of the thesis, which will include the full results, from the Caroline Reid Family Support Service office at the end of the project.

**What if something goes wrong …..**

What happens if you feel upset as a result of filling out the questionnaire, or if you want to discuss what is in the questionnaire with someone?

This is not likely to happen, but sometimes people can be triggered by a question. You can choose what to do if this happens.

Michaela will ask you when you have finished the questionnaire about how you are feeling, and if you need any support. If you do need support you can choose to:

• Tell her
• Contact me
• Contact another support person

When you consent to complete the questionnaire, I will be asking you to consent to Michaela telling me if she is concerned about you; and Michaela or myself telephoning an appropriate support person if we believe this is necessary. You will be told by either of us if this is going to happen.

I am happy to discuss anything to do with the questionnaire in the normal course of my work with you. We can also talk about what you have written in the questionnaire when we next meet at your request, but I will not be raising any of these issues with you myself – **unless there is a safety issue.** It is important for the research and for our working relationship to keep these matters as separate as possible.

If you are still willing to participate, Michaela will now ask you to sign a consent form for yourself regarding the questionnaire.
Children’s focus groups, and consent ........

Michaela will also be asking you if you are willing to sign consent for your child(ren) to take part in a focus group. This may not happen until early 2012, as I need to complete the 10 interviews with selected children, then sort out and analyse that information into the main ideas (themes) before I can do the focus groups.

I will be sending a letter out to children and parents/caregivers much closer to the time about the details of the focus group. It would be helpful, however, to get your consent for this now. The same rules apply with the information: it is kept private to my supervisor and me. Only the summary of what is said will be available to others, and no children will be identifiable. The children who are at the focus group will know what each other said. They will be asked to respect each other’s privacy and keep what is said confidential – “what’s said in the room, stays in the room”. I may need to get help from my colleagues – Matt Barus and Jess Brown – to run the focus groups, so they may hear what is said, but the same rules will apply to them!

I will audio-tape the focus groups as well as take notes. This tape and these notes will only be viewed by myself and my supervisor and will be stored in the same manner as the questionnaires. The children will be given an age appropriate summary of the research findings (information from the interviews and focus groups) at the end of the project.

Michaela will now ask you to sign parents/caregivers to sign consent for your child(ren) to participate in the focus groups.

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050

Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

Email (NZ wide): advocacy@hdc.org.nz
Thank you for being willing to consider allowing your child to talk to me about Caroline Reid Family Support Service for my research project, which is part of my Master of Social Work study at the University of Otago. This project will take up to two years to complete.

This information sheet discusses some things you need to think about before signing the form agreeing that your child may take part in the project. Please read this carefully before making a decision. If you decide to participate, thank you. If you do not decide to take part there will be no disadvantage to you of any kind, and thank you for considering this request.

As explained in the letter sent to you, we are selecting 10 children to interview about how well the children feel Caroline Reid meets its goals. The interviews will take place at the Stepping Stone office in Lincoln Road, and will take about one hour. Caroline Reid is happy to provide transport to and from the interview.

Some important points ……

- Taking part is voluntary – you and your child can choose!
- Saying yes or no will not affect you or your child being part of Caroline Reid.
- You need to sign a form agreeing for your child to take part (consent).
- Your child also needs to sign a form agreeing to take part (consent).
- Whatever your child says when he/she talks to me (interview) will not affect the way Caroline Reid works with you and your family.
- The information your child gives is his/her opinion. This information remains confidential unless there is a safety issue, at which point confidentiality may need to be broken. If this is necessary, I will advise your child at the time of the interview, and yourself as soon after as is practical.
- Your child can pull out of this research at any time, no questions asked.

What happens to the information ……

- When the research is published, every attempt will be made to protect your child’s anonymity. A copy will be held at the University of Otago library, and at the Caroline Reid Family Support Service offices. You family will be given a summarised copy of the results.
Your child may request a copy of the audio–tape and transcript of the interview.

The data collected will be securely stored in such a way that only my Otago University Supervisor and I will be able to gain access to it. At the end of the project, any personal information will be destroyed immediately except that, as required by the University’s research policy, any raw data on which the results depend will be retained in storage for 10 years. After this time, it will be destroyed.

When I have sorted the information from the 10 interviews into the main ideas, I will ask all the children from Caroline Reid during 2011 to come and meet and talk about the ideas. We call this a focus group. Matt and Jess will probably help me to run this. Your child and I will be the only people who know which ideas his/hers were, unless your child decides to tell others. All the children will decide if they agree with the ideas, or if they have some other ideas about Caroline Reid. As I only have time to interview 10 children, we have a focus group to check if what comes out of the interviews is true of the other 35 children who come to Caroline Reid. The focus groups will probably happen in 2012.

What if something goes wrong ….

What happens if your child feels upset as a result of talking to me about Caroline Reid, or if your child want to talk to someone about some of the questions I asked?

This is not likely to happen, but if it does I will ensure your child gets support. You will be notified as soon as practical.

Any questions ….

If you have any questions about this project, either now or in the future, please feel free to contact either:

- Adele Parkinson, phone 337 6644 ext 729, or 021 577 997, or by email at crfsw@stepstone.org.nz

- Emily Keddell, University of Otago, phone 03 479 5867 or by email at emily.keddell@otago.ac.nz

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050

Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

Email (NZ wide): advocacy@hdc.org.nz
This research project is part of a Master of Social Work thesis by Adele Parkinson.

Here are a few important things for you to know about the research. Remember your parent/caregiver has read lots about this also and has agreed for you to do this if you want to.

- You can choose yourself if you want to participate. Even if your parent says yes, you can say no!
- You can stop and pull out at any time you want.
- You still get to be part of Caroline Reid if you don’t participate. Doing the research has nothing to do with being part of Caroline Reid. It’s extra.
- What you say will be kept safe. Only I and Emily (my supervisor) will know what you said. We won’t tell anyone.
- You can tell other people what you said at the interview, but I can’t. Not unless you tell me something which worries me about you being safe or not. If I am worried, I will talk to you about it at the time, and we will decide together who we need to talk to about the problem.
- The interview will be where you want it to be – it will need to be quiet, and somewhere that no one will interrupt us.
- The interview may take about 1 hour.
- You can have someone with you at the interview for support if you want.
• The interview will be audio taped. This means just our voices will be recorded, but not our faces! You may have a copy of the tape after I have typed it up. You may also have a copy of the typed up version of the tape. All you need to do is ask me for this.

• After I have sorted the information from the 10 interviews into the main ideas, I will invite all the children/young people from Caroline Reid during 2010 to come and meet and talk about the ideas. We call this a focus group. Matt and Jess will probably help me to run this. All the children will decide if they agree with the ideas, or if they have some other ideas about Caroline Reid. As I only have time to interview 10 children, we have focus group to check if what comes out of the interviews is true of the other 35 children who come to Caroline Reid.

• What is discussed at the focus group is confidential (private) and should not be talked about outside of the focus group. Every effort will be made to keep what is said confidential, but this cannot be guaranteed.

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050

Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

Email (NZ wide): advocacy@hdc.org.nz
This research is part of a Master of Social Work thesis by Adele Parkinson.

Thank you for being willing to consider talking to me about Caroline Reid Family Support Service for my research project. This information sheet discusses some things you need to think about before signing the form agreeing to take part in the project.

Some important points ……

- Taking part is voluntary – you can choose!
- Saying yes or no will in no way affect you being part of Caroline Reid.
- You need to sign a form agreeing to take part (assent).
- Your parent/caregiver also needs to sign a form agreeing to you taking part (consent).
- Whatever you say when you talk to me at the interview will not affect the way Caroline Reid works with you and your family.
- It is really important that you talk about what you think, not what your parent/caregiver and/or other family members think, or what you think we want to hear. You can say if you don’t want to answer a certain question, and if you don’t know the answer.
- You can pull out of this research at any time, no questions asked.
- I will telephone you the week after the interview to see how you are.
- If you wish, you may have a copy of the audio tape we make, and a typed copy of what we said.
What happens to the information …..

- When the research is published, no one will be able to work out who you are from what is written up. Only I and my supervisor at Otago University, Emily Keddell, will know what you said.

- Sometime after the interview is finished; I will type up what we both said. This information will be stored on my home computer with a password which only I know. The information I send to my supervisor, Emily, will be protected the same way. The printed out copy (transcript) of your interview will be kept in a locked cabinet at my home, along with the audio tape, until the project is finished. When the project is finished, the printed out copy and the tape will be kept in a locked cabinet by the University of Otago for 10 years, at which point they will be destroyed.

- If you want to tell your parents and other people about what you said, you can do this. I can’t tell anyone except my supervisor UNLESS you say something that causes me to worry that you may not be safe. If I am worried about this I will tell you straightaway, and we will talk about what I need to do next. That would probably be to talk to someone you feel is safe, such as your parent/caregiver, another family member, and/or Matt/Jess. If I needed to talk to them, I would let you know what I said, and we would only talk about the things I was worried about, not anything else you said in the interview.

- When I have sorted the information from the 10 interviews into the main ideas, I will ask all the children from Caroline Reid during 2010 to come and meet and talk about the ideas. We call this a focus group. Matt and Jess will probably help me to run this. You and I will be the only people at the focus group who know who gave which idea. All the children will decide if they agree with the ideas, or if they have some other ideas about Caroline Reid. As I only have time to interview 10 children, we have a focus group to check if what comes out of the interviews is true of the other children who come to Caroline Reid.

- At the end of the project, the typed transcripts stored on computer will be put on disk and kept with the other material in a locked cabinet, by the University of Otago – as explained above. All electronic information on computer will be deleted.

- Only the research findings – the results – can be kept by me and my supervisor. Again, no one will be able to work out who you are from these.

- You will be given a write up of the main ideas which came out of what you said. You may ask to borrow a full copy of the thesis, which will include the full results, from the Caroline Reid Family Support Service office at the end of the project.

What if something goes wrong …..

What happens if you feel upset as a result of talking to me about Caroline Reid, or if you want to talk to someone about some of the questions I asked?

This is not likely to happen, but if it does, you can choose what to do.

I will ask you when we have finished about how you are feeling, and if you need any support. It I see you are upset while we are talking, I will ask you then. If you do need support you can choose to:

- Talk to me
- Talk to your parent/caregiver
- Talk to Matt and/or Jess
- Contact someone else you feel safe with

You will need to tell me what you choose to do, as it is really important that I know you will be OK.
When you give consent to take part in the interview, I will be asking you to agree to tell me if you are upset, and to allow me to contact someone if I feel this is needed. I will tell you what we are going to do.

If you are still willing to take part, I will now ask you to sign a consent form for the interview.

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050

Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

Email (NZ wide): advocacy@hdc.org.nz
Adult and Child Clients’ Views on a COPMI* Family Support Service:
A Mixed Method Study
*COPMI = Children of Parents with Mental Illness

INFORMATION SHEET TO CHILDREN ABOUT
FOCUS GROUPS
(8–12 YEARS APPROX)

This research project is part of a Master of Social Work thesis by Adele Parkinson.

Here are a few important things for you to know about the research. Remember your
parent/caregiver has read lots about this also and has agreed for you to do this if you want to.

- The focus group is to find out what the children who come to Caroline Reid think about the
  Caroline Reid Service. We want to know what you like, and what you think could be done
  better.

- At the focus group we will talk to you about the ideas that came out of the interviews Adele
  has already done with 10 Caroline Reid children. We will talk about the main ideas which
  came out of these interviews to see if you all think the same way, and/or if you have some
  other ideas about Caroline Reid. As Adele only has time to interview 10 children, we have
  the focus group to check if what comes out of the interviews is true of the other children
  who come to Caroline Reid.

- The focus group will take place at .................. (name of place) at ............. (date and
time).

- The focus group may take about 1 hour.

- The focus group will be audio taped. This means just our voices will be recorded, but not
  our faces! You may have a copy of the tape after I have typed it up. You may also have a
  copy of the typed up version of the tape. All you need to do is ask me for this.

- You can choose yourself if you want to participate. Even if your parent says yes, you can
  say no!

- You can stop and pull out at any time you want.
• You still get to be part of Caroline Reid if you don’t participate. Doing the research has nothing to do with being part of Caroline Reid. It’s extra.

• What you say will be kept safe. Only the people at the focus group (other Caroline Reid children, and any helpers) will know what you said. We won’t tell anyone.

• You can tell other people what you said at the focus group, but we (Adele, and the other leaders) can’t. Not unless you tell us something which worries us about you being safe or not. If we are worried, Adele will talk to you about it at the time, and we will decide together who we need to talk to about the problem.

• What is discussed at the focus group is confidential (private) and should not be talked about outside of the focus group. Every effort will be made to keep what is said confidential, but this cannot be guaranteed.

If you have any questions or concerns about your rights as a participant in this research study, you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050

Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

Email (NZ wide): advocacy@hdc.org.nz
This research is part of a Master of Social Work thesis by Adele Parkinson.

Thank you for being willing to consider talking to me about Caroline Reid Family Support Service for my research project. This information sheet discusses some things you need to think about before signing the form agreeing to take part in the project.

Some important points ……

- The focus group is to find out what the adolescents who come to Caroline Reid think about the Caroline Reid Service. We want to know what you like, and what you think could be done be better.

- At the focus group we will talk to you about the information that came out of the 10 child interviews Adele did over the last few months. We will be asking you all if you agree with the ideas from the interviews, and/or if you have some other ideas about Caroline Reid. As Adele only has time to interview 10 children, we have a focus group to check if what comes out of the interviews is true of the other children/adolescents who come to Caroline Reid.

- The focus group will take place at …………… (name of place) at …………… (date and time).

- The focus group will take about 1 hour.

- The focus group will be audio taped, ie our voices will be recorded, but not our faces! If you wish, you may have a copy of the audio tape we make, and a typed copy of what we said.

- Taking part is voluntary – you can choose!

- Saying yes or no will not affect you being part of Caroline Reid.

- You need to sign a form agreeing to take part (assent).
• Your parent/caregiver also needs to sign a form agreeing to you taking part (consent).

• Whatever you say in the focus group will not affect the way Caroline Reid works with you and your family.

• It is really important that you talk about what you think and not what your parent/caregiver and/or other family members and friends at Caroline Reid think, or what you think we want to hear.

• You can pull out of this research at any time, no questions asked.

• Matt and Jess will help me to run the focus group. Other volunteer Caroline Reid leaders may also be there.

**What happens to the information ......**

• Whoever is at the focus group will know what was said. The only other person who may know what was said is my research supervisor at Otago University, Emily Keddell.

• If you want to tell your parents and other people about what you said in the focus group, you can do this. **No one else at the focus group can tell others what you said unless you say something that causes the leaders or me to worry that you may not be safe.** If we are worried about this we will tell you straightaway, and we will talk about what we need to do next. That would probably be to talk to someone you feel is safe, such as your parent/caregiver and/or another family member. If we needed to talk to them, we would let you know what we said, and we would only talk about the things we were worried about, not anything else you said in the focus group.

• When the research is published, no one will be able to work out who you are from what is written up.

• Sometime after the focus group is finished; I will type up what everyone said. This information will be stored on my home computer with a password which only I know. The information I send to my supervisor, Emily, will be protected the same way. The printed out copy (transcript) of the focus group will be kept in a locked cabinet at my home, along with the audio tape, until the project is finished. When the project is finished, the printed out copy and the tape will be kept in a locked cabinet by the University of Otago for 10 years, at which point they will be destroyed.

• You can talk to other children who were at the focus group about what was said, but you should not tell other people who were not at the focus group about what other children said.

• At the end of the project, the typed transcripts stored on computer will be put on disk and kept with the other material in a locked cabinet, by the University of Otago – as explained above. All electronic information on computer will be deleted.

• Only the research findings – the results – can be kept by me and my supervisor. Again, no one will be able to work out who you are from these.

• You will be given a write up of the main ideas which came out of what you said. You may ask to borrow a full copy of the thesis, which will include the full results, from the Caroline Reid Family Support Service office at the end of the project.

**What if something goes wrong ......**

What happens if you feel upset as a result of something that was said at the focus group, and/or you want to talk to someone about some of the questions that were asked?
This is not likely to happen, but if it does, you can choose what to do.

If Matt, Jess or I see you are upset one of us will come and talk to you to see if you need support. You can come and talk to us also. If you do need support you can choose to:

- Talk to Adele
- Talk to your parent/caregiver
- Talk to Matt and/or Jess
- Contact someone else you feel safe with

You will need to tell us what you choose to do, as it is really important that we know you will be OK.

If you are still willing to take part, Adele will now ask you to sign a consent form for the focus group.
This research project is part of a Master of Social Work thesis by Adele Parkinson.

Here are a few important things for you to know about the research.

Remember your parent/caregiver has read lots about this also, and has agreed for you to do this if you want to.

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050

Free Fax (NZ wide): 0800 2787 7678
(0800 2 SUPPORT)

Email (NZ wide): advocacy@hdc.org.nz

**Information Sheet**

**TO CHILDREN ABOUT INTERVIEWS**

(8-12 YEARS APPROX)
8 - 12 year olds

Information sheet

Info:

☐ You can choose yourself if you want to participate. Even if your parent says yes, you can say no!

☐ You can stop and pull out at any time you want.

☐ You still get to be part of Caroline Reid if you don't participate. Doing the research has nothing to do with being part of Caroline Reid. It's extra.

☐ What you say will be kept safe. Only I and Emily (my supervisor) will know what you said. We won't tell anyone.

☐ You can tell other people what you said at the interview, but I can't. Not unless you tell me something which worries me about you being safe or not. If I am worried, I will talk to you about it at the time, and we will decide together who we need to talk to about the problem.

☐ The interview will be where you want it to be – it will need to be quiet, and somewhere that no one will interrupt us.

☐ The interview may take about 1 hour.

☐ You can have someone with you at the interview for support if you want.

☐ The interview will be audio taped. This means just our voices will be recorded, but not our faces! You may have a copy of the tape after I have typed it up. You may also have a copy of the typed up version of the tape. All you need to do is ask me for this.

☐ After I have sorted the information from the 10 interviews into the main ideas, I will invite all the children/youth people from Caroline Reid during 2010 to come and meet and talk about the ideas. We call this a focus group. Matt and Jess will probably help me to run this. All the children will decide if they agree with the ideas, or if they have some other ideas about Caroline Reid. As I only have time to interview 10 children, we have focus group to check if what comes out of the interviews is true of the other 35 children who come to Caroline Reid.

☐ What is discussed at the focus group is confidential (private) and should not be talked about outside of the focus group. Every effort will be made to keep what is said confidential, but this cannot be guaranteed.
Adult and Child Clients’ Views on a COPMI* Family Support Service:
A Mixed Method Study
*COPMI = Children of Parents with Mental Illness

ASSENT FORM TO TAKE PART IN A FOCUS GROUP
FOR CHILD 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. Adele will audio–tape the focus group so that she can remember what everyone said, but the tape will be destroyed after the study is ended.

4. If I don’t want to answer some of the questions, that’s fine.

5. If I have worries or if I have any other questions, then I can talk about these with Adele.

6. The paper and computer files with my answers will only be seen by Adele and her supervisor, Emily. They will keep whatever I say private.
7. Emily and Adele will write up the results for their University work. The results may also be written up in journals and talked about at conferences. My name will not be on anything Adele and Emily write up about this study.

I agree to take part in the study.

............................................................................................................
Child Signature                                               Date

............................................................................................................
Co–investigator Signature                                    Date

This study has been approved by the Health and Disability Ethics Committee (Upper South A) (ph 03 974 2304) and the University of Otago Human Ethics Committee (ph 03 479 8256). If you have any concerns about the ethical conduct of the research, you may contact the Committee Administrators at the above telephone numbers. Any issues you raise will be treated in confidence and investigated, and you will be informed of the outcome.
Adult and Child Clients’ Views on a COPMI* Family Support Service:
A Mixed Method Study
*COPMI = Children of Parents with Mental Illness

ASSENT FORM TO TAKE PART IN AN INTERVIEW
FOR CHILD 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. Adele will audio-tape me so that she can remember what I say, but the tape will be destroyed after the study is ended.

4. If I don’t want to answer some of the questions, that’s fine.

5. If I have worries or if I have any other questions, then I can talk about these with Adele.

6. The paper and computer files with my answers will only be seen by Adele and her supervisor, Emily. They will keep whatever I say private.
7. Emily and Adele will write up the results for their University work. The results may also be written up in journals and talked about at conferences. My name will not be on anything Adele and Emily write up about this study.

I agree to take part in the study.

..................................................................................................................  ..........................................................  
Child Signature  Date

..................................................................................................................  ..........................................................  
Co–investigator Signature  Date

This study has been approved by the Health and Disability Ethics Committee (Upper South A) (ph 03 974 2304) and the University of Otago Human Ethics Committee (ph 03 479 8256). If you have any concerns about the ethical conduct of the research, you may contact the Committee Administrators at the above telephone numbers. Any issues you raise will be treated in confidence and investigated, and you will be informed of the outcome.
CONSENT FORM FOR ADULT PARTICIPANTS – QUESTIONNAIRES

Adult and Child Clients’ Views on a COPMI* Family Support Service:
A Mixed Method Study
*COPMI = Children of Parents with Mental Illness

CONSENT FORM FOR ADULT PARTICIPANTS

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. Personal identifying information (audio–tapes) 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 10 years, after which they will be destroyed.

4. If I should become upset in any way as a result of completing the questionnaire, I will advise the researcher present, and seek support from that person or according to an agreed plan between myself and the researcher present.

5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand), and in the Stepping Stone Trust Library.
(Christchurch, New Zealand). Every attempt will be made to preserve my anonymity.

I agree to take part in this project.

........................................................................................................................................

Signature of participant
Date

........................................................................................................................................

Signature of co–investigator
Date

This study has been approved by the Health and Disability Ethics Committee (Upper South A) (ph 03 974 2304) and the University of Otago Human Ethics Committee (ph 03 479 8256). If you have any concerns about the ethical conduct of the research, you may contact the Committee Administrators at the above telephone numbers. Any issues you raise will be treated in confidence and investigated, and you will be informed of the outcome.
CONSENT FORM FOR PARENTS/GUARDIANS TO ALLOW CHILDREN TO PARTICIPATE

Adult and Child Clients' Views on a COPMI* Family Support Service:
A Mixed Method Study

*COPMI = Children of Parents with Mental Illness

CONSENT FORM FOR PARENTS/GUARDIANS

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 child’s participation in the project is entirely voluntary.

2. I am free to withdraw my child from the project at any time without any disadvantage.

3. Personal identifying information (audio—tapes) 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 10 years, after which they will be destroyed.

4. If my child should become upset in any way as a result of completing the interview, the researcher present will seek support for my child, and will advise me of this as soon as practical.

5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand), and in the Stepping Stone Trust Library (Christchurch, New Zealand). Every attempt will be made to preserve my child’s anonymity.
I agree for my child to take part in this project.

.............................................................. ..............................................................
Signature of parent/guardian Date

..............................................................
Name of child

.............................................................. ..............................................................
Signature of co-investigator Date

This study has been approved by the Health and Disability Ethics Committee (Upper South A) (ph 03 974 2304) and the University of Otago Human Ethics Committee (ph 03 479 8256). If you have any concerns about the ethical conduct of the research, you may contact the Committee Administrators at the above telephone numbers. Any issues you raise will be treated in confidence and investigated, and you will be informed of the outcome.
APPENDIX E – INTERVIEW GUIDE

CAROLINE REID FAMILY SUPPORT SERVICE:
SEMI–STRUCTURED INTERVIEW GUIDE
FOR CHILD CLIENTS

No:

Age:
Year at School:
Gender:
Ethnicity:
Who lives at your house?

Confidentiality – limits, who can help if upset, audio tape, copies of tape, etc

How long have you been coming to Caroline Reid (CR)?

What kind of activities have you been to with CR? Any favourites? (Take a list to prompt if necessary) Any activities you didn’t like?

Overall, how much do you enjoy coming to CR activities? (How much fun? ..... 10 most fun you can have, 1 really really sucks – take a picture?)

Have you done anything at CR you had never done before? (Example)

How often do you come to the CR monthly Rec days? What stops you from coming?
What do you like about coming to CR Rec days?

What don’t you like about coming to CR Rec days?

Have you got any ideas for Rec days? What else could CR do that would be fun?

What other things do you do in your spare time (outside of school)? (Clubs/Sport/Music/etc)

How long have you been doing these things?

Have you been to a CR camp? (Details – how many times, what they can remember, why not)

If you have, what’s the best thing about camp? The worst thing?

Have you ever been on an outing after school or in the holidays with Matt and Sandy/Katherine/Jess (not a camp or Rec Day)? Tell me about that ……..

What do you like about going out with them?

Is there anything you don’t like about going out with Matt and Jess/Sandy/Katherine?

What could they do differently to make spending time with them better for you?

If you ever had a problem, do you think you could talk to them about it?

Who else could you talk to about your problems?

Have the children’s workers every helped you with anything you have needed? (Details)

Why do you think kids get to come to CR?
Kids come to CR because they have Mums or Dads with a mental illness.

Do you know what a mental illness is? (Explain a little if don't know)

Who in your family has a mental illness?

Has anyone in your family ever talked about mental illness to you? (Who, what, when)

Who do you talk to about your Mum or Dad's mental illness?

Have you ever talked to a Caroline Reid Worker about one of your parent's mental illness?

Have you ever learned anything about mental illness at a Caroline Reid activity? If yes, tell me about this.

If your mum or dad got sick (mentally unwell) again, who would you talk to about it?

Has anyone ever teased you or treated you differently because you've got a mum or dad with a mental illness? If yes, tell me about this.

When you come to CR activities, you get to be with other children who have parents with mental illness. What's it like being with children who have similar experiences to you?

I am the CR family worker. Do you know what my job is?

Do you think I help your family? Please explain this.

Is there anything I could do differently to help your family?

Do you want a CD copy of this interview? If yes, how will you keep it private? Will you be OK if someone else in your family listens to it?
Do you want a typed out copy of the interview? If yes, how will you keep it private? Will you be OK if someone else in your family saw it and read it?

The information from the 10 interviews is going to be collected and sorted out by me. All the children at Caroline Reid will get to hear what the information is, but they won't know who said it. No one else will know what you said except my supervisor, Emily, and me. There are strict rules about keeping this private.

However, you can choose to tell others what you said if you want to.
Appendix F – Questionnaire

Caroline Reid Family Support Service: Evaluation Questionnaire for Adult Clients

No:

Section 1:

Gender: Male ☐ Female ☐


56–60 ☐ 61–65 ☐ 66–70 ☐

Ethnicity:

Which country were you born in?

☐ New Zealand
☐ Australia
☐ England
☐ Scotland
☐ China (People’s Republic of)
☐ South Africa
☐ Samoa
☐ Cook Islands
☐ Māori – Iwi: ____________________
☐ Other – please state the name of the country: ____________________

If you were not born in New Zealand, when did you first arrive to live in New Zealand?

Month ............ Year ............
What ethnic group do you belong to? You may give more than one response:

☐ New Zealand European
☐ Māori – Iwi: _________________
☐ Samoan
☐ Cook Island Māori
☐ Tongan
☐ Niuean
☐ Chinese
☐ Indian
☐ Other – please state: _________________

Household:

People who live in your house: Partner ☐ # of children ☐ Ages of children ☐☐☐☐☐

Other relatives who live with you: ________________________________

Other people who live with you (not relatives): ________________________________

Do you have other children who do not live with you? Yes/No

If Yes, ☐ No. of children ☐ Ages of children ☐☐☐☐☐

Who do these children live with? ________________________________

What is your source of family income? ________________________________

Do you own the house you live in? Yes/No

If No, who owns the house? ________________________________

Section 2:

(1) How long has someone from your family been involved with Caroline Reid? _____ years
(2) What relationship are you to the child/ren from your family who go to Caroline Reid Service?

☐ Parent
☐ Step–parent
☐ Partner of parent
☐ Grandparent
☐ Aunt/Uncle
☐ Other: __________________

(3) Does your child(ren) enjoy attending Caroline Reid Recreation activities? (Answer separately for each child)

Age ☐ Never
☐ Hardly ever
☐ Some of the time
☐ Most of the time

Why is this? _________________________________________________________

Age ☐ Never
☐ Hardly ever
☐ Some of the time
☐ Most of the time

Why is this? _________________________________________________________

Age ☐ Never
☐ Hardly ever
☐ Some of the time
☐ Most of the time

Why is this? _________________________________________________________
(4) Have any of the activities been new experiences for your child/ren? Yes/No

If Yes, what were they? ______________________________________________
_________________________________________________________________

(5) How easy would it be for you to provide these activities for your child/ren?

☐ Difficult
☐ Somewhat difficult
☐ Somewhat easy
☐ Easy
☐ Very Easy

Why is this? __________________________________________________________

(6) Does your child(ren) enjoy spending time with the Caroline Reid children’s workers? (Answer separately for each child)

Age  ☐☐ Never
      ☐☐ Hardly ever
      ☐☐ Some of the time
      ☐☐ Most of the time

Why is this? _________________________________________________________

Age  ☐☐ Never
      ☐☐ Hardly ever
      ☐☐ Some of the time
      ☐☐ Most of the time

Why is this? _________________________________________________________
7. If your child(ren) was troubled by something, do you feel he/she would be able to talk to the Caroline Reid children’s workers about it? (Answer separately for each child)

- Age: □ Never
  □ Hardly ever
  □ Some of the time
  □ Most of the time

Why is this? _____________________________________________________________

- Age: □ Never
  □ Hardly ever
  □ Some of the time
  □ Most of the time

Why is this? _____________________________________________________________

- Age: □ Never
  □ Hardly ever
  □ Some of the time
  □ Most of the time

Why is this? _____________________________________________________________

- Age: □ Never
  □ Hardly ever
  □ Some of the time
  □ Most of the time

Why is this? _____________________________________________________________
(8) A Mentor is someone who is usually older than you, who takes an interest in you, is good for advice, reliable, etc. Do you believe the Caroline Reid children’s workers are mentors for your child(ren)? (Answer separately for each child)

Age □ □ Never
□ Hardly ever
□ Some of the time
□ Most of the time

Why is this? _________________________________________________________

Age □ □ Never
□ Hardly ever
□ Some of the time
□ Most of the time

Why is this? _________________________________________________________

Age □ □ Never
□ Hardly ever
□ Some of the time
□ Most of the time

Why is this? _________________________________________________________

(9) How long do you believe Caroline Reid children’s workers need to be involved with a child in order to be a mentor to the child?

3 months □ 6 months □ 1 year □ 2 years □ 3 years □ 4 years □ 5+ years □

(10) Does your child(ren) have any other mentors? (Answer separately for each child)
Age □ Yes/No

If Yes, for how long have they had this mentor? ___________________

What relationship is the mentor to the child (eg family friend, relation, Big Brother/ Big Sister mentor, neighbour, etc)? ________________________________

Age □ Yes/No

If Yes, for how long have they had this mentor? ___________________

What relationship is the mentor to the child (eg family friend, relation, Big Brother/ Big Sister mentor, neighbour, etc)? ________________________________

Age □ Yes/No

If Yes, for how long have they had this mentor? ___________________

What relationship is the mentor to the child (eg family friend, relation, Big Brother/ Big Sister mentor, neighbour, etc)? ________________________________

(11) Have you noticed any changes in your child which you believe are a result of spending time with the Caroline Reid children’s workers? (Answer separately for each child)

□ Age Yes/No – If Yes, please explain ________________________________

□ Age Yes/No – If Yes, please explain ________________________________

□ Age Yes/No – If Yes, please explain ________________________________
Which Caroline Reid activities does your child enjoy? (You may tick more than one. Answer separately for each child)

Age ☐  ☐ Saturday Rec Day or 13+ events

☐ Annual Camp

☐ Caroline Reid Magazine

☐ Time in small group with children’s workers

☐ Time 1–1 with children’s workers

Please explain: __________________________________________________________

How regularly do they attend? __________________________________________

Age ☐  ☐ Saturday Rec Day or 13+ events

☐ Annual Camp

☐ Caroline Reid Magazine

☐ Time in small group with children’s workers

☐ Time 1–1 with children’s workers

Please explain: __________________________________________________________

How regularly do they attend? __________________________________________

Age ☐  ☐ Saturday Rec Day or 13+ events

☐ Annual Camp

☐ Caroline Reid Magazine

☐ Time in small group with children’s workers

☐ Time 1–1 with children’s workers

Please explain: __________________________________________________________

How regularly do they attend? __________________________________________
(12) What do you believe the Caroline Reid Service does well for your child/ren?

____________________________________________________________________
____________________________________________________________________

(13) What do you believe the Caroline Reid Service could do better for your child/ren?

____________________________________________________________________
____________________________________________________________________

Section 3 – Supports and Parenting:

(1) What services/agencies have you and/or your family members (including children) been involved with over the last year?

☐ GP/Practice Nurse

☐ Mental health sector base (east, west, north, south, rural)

☐ Mothers & Babies Service

☐ Youth Specialty Service

☐ Whakatata House – Child & Family Specialty Service

☐ Needs Assessment

☐ Community Support Worker

☐ Counselling service/counsellor – please state: ____________________________

☐ Parenting service/support – please state: _________________________________

☐ Methodist Mission – parenting support, counselling, Wise Up courses

☐ Presbyterian Support – counselling, family work, parenting

☐ Social Worker in Schools

☐ WINZ

☐ Housing NZ

☐ Earthquake Related Services

☐ Budget Advisory Services – please state which: ________________
☐ Alcohol and Drug Services – please state which: ____________________
☐ Counsellor
☐ Hospital Department – please state which: ____________________
☐ Father & Child Trust
☐ Child Youth & Family Services
☐ Community Corrections Services
☐ Open Home Foundation
☐ Women’s Refuge Service
☐ Food Bank – Please state: ____________________________
☐ Other services – please state: ____________________________________________

(2) Has Caroline Reid Service helped you in any way to get in touch with services if you need them? Yes/No

   If Yes, how did they help you? ___________________________________________
   ______________________________________________________________________

   If No, how would you have liked them to help you?__________________________
   ______________________________________________________________________

(3) When you have problems or difficulties do you have a person whom you can confide in and talk things over with?

   ☐ Yes, usually
   ☐ Yes, sometimes
   ☐ Never
If Yes, who is this person?

- Parent
- Other family member
- Child
- Friend
- Neighbour
- Counsellor/Therapist
- Community Support Worker
- Mental health case manager
- Minister/Priest/Pastor
- Caroline Reid Family Worker
- Other – please explain: ____________________________

Since the time your work with Caroline Reid Service began, have you noticed any change in the quality of your social support network of friends and family?

- Worse
- No change
- Improved a little
- Improved a lot

Why is this? _________________________________________________________

(4) Have you ever had conversations with the Caroline Reid workers about parenting issues?

- Not at all
- Very little
- Sometimes
- A lot

(5) Since the time your work with Caroline Reid Service began, have you noticed any change in how confident you feel in general with parenting?
(6) Have you ever had conversations with the Caroline Reid workers about your child(ren)'s development?

☐ Not at all  
☐ Very little  
☐ Sometimes  
☐ A lot

Since the time your work with Caroline Reid Service began, have you noticed any change in your knowledge of how to support your child(ren)'s development?

☐ Worse  
☐ No change  
☐ Improved a little  
☐ Improved a lot

(7) Have you ever had conversations with the Caroline Reid workers about situations of conflict between parents and children in your family?

☐ Not at all  
☐ Very little  
☐ Sometimes  
☐ A lot

(8) Since the time your work with Caroline Reid Service began, have you noticed any change in your ability to deal with situations of conflict between parents and children in your family?

☐ Worse  
☐ No change  
☐ Improved a little  
☐ Improved a lot
(9) Have you ever had conversations with the Caroline Reid workers about the impact of mental illness on parenting?

- Not at all
- Very little
- Sometimes
- A lot

(10) Since the time your work with Caroline Reid Service began, have you noticed any change in your knowledge and/or awareness of the effects of mental health on parenting?

- Worse
- No change
- Improved a little
- Improved a lot

Section 4 – Health:

(1) Do you have a diagnosed mental illness (including Alcohol and other Drug)? Yes/No

If No, go to Question 2.

If Yes, please state: ___________________________________________________

____________________________________________________

Are you on medication for your mental illness? Yes/No

Are you attending a specialist mental health service? Yes/No

Are you receiving any other form of treatment/therapy for mental illness? Yes/No

  If Yes, please state _____________________________________________

Have you ever been admitted to a psychiatric hospital? Yes/No
If Yes, when was your last admission? ______________________________

How much does your child/ren know about your mental illness?

☐ Nothing
☐ Very little
☐ Some
☐ A lot

Do you believe you are treated any differently by other people because you have a mental illness?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot

Please explain: ____________________________________________________

______________________________________________________________

(2) Think about the child(ren) from your family who attends Caroline Reid – does this child(ren)’s other parent have a mental illness? (If you are not a parent, then fill this out for either of the child’s parents.) Yes/No

If No, go to Question 3.

If Yes, please state diagnosis: ________________________________

______________________________________________________________

Is this person on medication for mental illness? Yes/No

Is this person attending a specialist mental health service? Yes/No
Is this person receiving any other form of treatment/therapy for mental illness? Yes/No

If Yes, please state ________________________________

Has this person ever been admitted to a psychiatric hospital? Yes/No

If Yes, when was his/her last admission? ________________

How much does the child/ren know about their other parent’s mental illness?

☐ Nothing
☐ Very little
☐ Some
☐ A lot

Do you believe you are treated any differently because this person has a mental illness?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot

Please explain: ____________________________________________

______________________________

(3) Is there any other person in your family who has a diagnosed mental illness (include current partner if not child’s parent mentioned above)? Yes/No

If No, go to Question 4.

If Yes, what is your relationship to that person? _______________________

What is that person’s diagnosis? ________________________________________
Is this person on medication for mental illness? Yes/No

Is this person attending a specialist mental health service? Yes/No

Is this person receiving any other form of treatment/therapy for mental illness? Yes/No

If Yes, please state ________________________________

Has this person ever been admitted to a psychiatric hospital? Yes/No

If Yes, when was his/her last admission? __________________

How much does your child/ren know about this person’s mental illness?

☐ Nothing
☐ Very little
☐ Some
☐ A lot

Do you believe you are treated any differently because this person has a mental illness?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot

Please explain: ____________________________________________

__________________________________________________________

(4) Were you raised in a family in which a parent/caregiver had mental illness? Yes/No
(5) Do you or someone in your family have any significant physical injuries, illnesses and/or disabilities? Yes/No

If Yes, please explain: ________________________________

____________________________________________________________________

(6) Do you currently use alcohol and/or other drugs (not prescribed)?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot

Please state what you use, how often and how much: __________________

____________________________________________________________________

Does someone in your family currently use alcohol and/or other drugs (not prescribed)?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot

Please state who, what they use, how often and how much: ________________

____________________________________________________________________

(7) Does your Caroline Reid family worker ever have conversations with you about your health (including mental and physical) and wellbeing?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot
(8) Does your Caroline Reid family worker ever have conversations with you about one of your family member’s health (including mental and physical) and wellbeing?

☐ Not at all  
☐ Very little  
☐ Sometimes  
☐ A lot

(9) Has the Caroline Reid family worker helped explain any issues related to mental illness to you?

☐ Not at all  
☐ Very little  
☐ Sometimes  
☐ A lot

(10) If you were troubled by something, do you feel you would be able to talk to the Caroline Reid family worker about it?

☐ Not at all  
☐ Very little  
☐ Sometimes  
☐ A lot

Why is this? __________________________________________________________
____________________________________________________________________ 

(11) In what ways has the Caroline Reid family worker helped you? _________________
____________________________________________________________________ 

(12) What other ways would you like more support from a Caroline Reid family worker?
____________________________________________________________________ 
____________________________________________________________________
(13) Do you believe your child(ren) is treated any differently because he/she has a parent with a mental illness?

- ☐ Not at all
- ☐ Very little
- ☐ Sometimes
- ☐ A lot

Please explain: _________________________________________________

_________________________________________________________________

(14) When your child comes to Caroline Reid activities, they mix with other children who come from families with a parent with mental illness.

What are the benefits of this? _________________________________

_________________________________________________________________

Are there any disadvantages? Yes/No – Please explain: _________________

_________________________________________________________________

(15) Do you ever have conversations with your child/ren about mental illness?

- ☐ Not at all
- ☐ Very little
- ☐ Sometimes
- ☐ A lot
(16) Do any of these people have conversations with your child/ren about parental mental illness? You can tick more than one.

☐ Other parent
☐ Current partner (if not other parent)
☐ Family member
☐ School teacher
☐ Counsellor
☐ Family friend
☐ Caroline Reid children’s worker
☐ Other mentor
☐ Child’s friend(s)
☐ Other – Please state: ____________________________

(17) Does Caroline Reid Service help your child(ren) to learn about parental mental illness?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot

If you think Caroline Reid does help, please give an example: ______________________

______________________________________________________________________________

(18) Have you ever been concerned about your child/ren developing a mental illness?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot

If you have had concerns, who have you spoken to about this? ______________________

______________________________________________________________________________
(19) Have you ever noticed any symptoms in any of your children which have concerned you that he/she may be developing a mental illness? Yes/No

If Yes, who have you spoken to about these symptoms? _______________________

What steps have they taken? __________________________________________
___________________________________________________________________

(20) Have you ever had conversations with the Caroline Reid workers about other aspects of your children’s health & wellbeing, including school work, behaviour, etc?

☐ Not at all
☐ Very little
☐ Sometimes
☐ A lot

If so, what steps have they taken? ______________________________________
___________________________________________________________________

(21) Does your family have a family care plan for mental illness? Yes/No

(22) Have the Caroline Reid workers ever discussed a family care plan for mental illness with you? Yes/No
APPENDIX G – NGAI TAHU CONSULTATION

Ngāi Tahu Research Consultation Committee
Te Komiti Rakahau ki Kai Tahu

19/04/2011 - 37
Tuesday, 19 April 2011

Ms Keddell
Sociology, Gender and Social Work
Dunedin

Tēnā koe Ms Keddell

Title: Stakeholders’ Views on a Christchurch COPMI* Family Support Service: A Mixed Method Study *COPMI = Children of Parents with Mental Illness

The Ngāi Tahu Research Consultation Committee (The Committee) met on Tuesday, 19 April 2011 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 Rūmāna 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 McGechan:

“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 importance to Māori health.

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 Ministry of Health website

The Ngāi Tahu Research Consultation Committee has membership from:

Te Rūmāna o Ārāirua Incorporated
Kāi Haurangi Rūmāna ki Puketeaki
Te Rūmāna o Moeraki

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NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
Te Komiti Rakahau ki Kai Tahu

Publication, Hauora: Māori Standards of Health IV (200-2005), has its own website, http://www.hauora.māori.nz/. These publications provide information on a range of Māori health issues and will assist in ensuring your research has an appropriate Māori health focus.

The Committee notes the researchers, “May also consult with Stepping Stone Trust Ngāi Tahu Cultural Advisor,” and asks who that person might be.

The Committee suggests dissemination of the research findings to Māori health organisations regarding this study.

We wish you every success in your research and the Committee also requests a copy of the research findings.

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 19 April 2011 to 19 October 2012.

The recommendations and suggestions above are provided on your proposal submitted through the consultation website process. These recommendations and suggestions do not necessarily relate to ethical issues with the research, including methodology. Other committees may also provide feedback in these areas.

Nāhaku noa, nā

Mark Brunton
Kaitskawaenga Rangahau Māori
Facilitator Research Māori
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APPENDIX H – MISCELLANEOUS COMMENTS
FROM CHILD PARTICIPANTS

Child participants were asked at the end of interviews and focus groups if there was anything else they would like to say about the CRFSS which they wished to be included in the research. Some comments have been included in the thesis when relevant to a theme. This appendix provides a fuller account of comments.

General positive comments

Interviews:

“Probably the best thing that has happened to me, other than air cadets.”

“I just really like it.”

“Caroline Reid is fantastic ... And I think it helps me a lot.”

“I’d just say that I quite enjoyed going to Caroline Reid, I mean ... just going out and having fun while we’re doing stuff ... and I quite – overall I quite enjoyed it overall.”

“...it’s kind of more just a big thank you, it's a ‘couldn't have done it without you’ kind of?”

Focus Groups:

“I don’t regret coming to Caroline Reid – it was worth it.”

“I loved it.”

“It’s fun.”

“Amazing.”

“It was the best time of our lives.”

“It’s good; enough said except I like Caroline Reid.”

Has helped me make friends

Interviews:

“I think that Caroline Reid is one of the best things for kids with families that have mental illness, because it helps more and you get to talk with your friends about what they have done, and what their families have gone through, and stuff like that, so it helps you more when you talk to other people, especially to people who understand you more, like, fair enough going and talking to your friends about it, they won’t understand that much, because they don’t know. Talking to someone who’s gone through it is a lot better than just some random.”
Another interviewee said commented on friendship and the fact that since they left the service they still maintain contact with some of the Caroline Reid kids they became close to.

Focus Groups:

“That it’s really great to have CR because you have someone to talk to and learn about your family.”

“More friends out of school.”

“It knew that you weren’t alone.”

It has been good to be with other people who have families with mental illness – destigmatising

Interviews:

“I think that Caroline Reid is one of the best things for kids with families that have mental illness, because it helps more and you get to talk with your friends about what they have done, and what their families have gone through, and stuff like that, so it helps you more when you talk to other people, especially to people who understand you more, like, fair enough going and talking to your friends about it, they won’t understand that much, because they don’t know. Talking to someone who’s gone through it is a lot better than just some random.”

Focus groups:

“Teaches you that everyone out there is similar.”

“It knew that you weren’t alone.”

Provided me with respite from my family situation

Interviews:

“I think, like – it’s a good place to go and get away from your family and, like, everything that's going on at home, or, like, other places, and just kind of, like, relax and just kind of know that you can talk to someone and not be judged about what’s going on and things.”

“... just that I'm glad it’s there, because it’s probably – if it wasn't it wouldn't have been as easy ... because, yeah, it may seem like I have a reasonably happy life, which I do, but it wasn't all happy, it wasn't all fun and games. It was tough, especially considering how young I was, and without Caroline Reid and stuff I don't think it would have been as easy. Without those rec days, just having a break, where I could go out. Because family wouldn't come over and take me somewhere. And at the young age I couldn't go anywhere without mum. So having them was like a way of escape, because with dad being in Australia ... so with how many people they've helped, and I've noticed how many little kids there are, it's ... yeah. They could be going through the same thing, I mean, and by the time they get to my age they'll more understand it. They won't understand what they're doing so young, but they will when they're older, kind of, do you understand?
**Focus groups:**

“I like getting away from home; I stop worrying so much when I’m with Caroline Reid.”

**I want to give back to Caroline Reid by being a leader**

**Interviews:**

“It’s just been a good experience, just … having fun with people I know, so … I’m happy to continue to be a junior leader and give back, sort of thing. I mean they’ve helped us, so, however many years it is now, um, and yeah, we can just help other kids … I always enjoy helping, like, little kids.”

**Caroline Reid supported me through difficult times**

**Interviews:**

“… just that I'm glad it’s there, because it's probably – if it wasn’t it wouldn't have been as easy … because, yeah, it may seem like I have a reasonably happy life, which I do, but it wasn’t all happy, it wasn’t all fun and games. It was tough, especially considering how young I was, and without Caroline Reid and stuff I don't think it would have been as easy. Without those rec days, just having a break, where I could go out. Because family wouldn't come over and take me somewhere. And at the young age I couldn't go anywhere without mum. So having them was like a way of escape, because with dad being in Australia … so with how many people they've helped and I've noticed how many little kids there are, it's … yeah. They could be going through the same thing, I mean, and by the time they get to my age they'll more understand it. They won't understand what they're doing so young, but they will when they're older, kind of, do you understand? … it's kind of more just a big thank you, it's a ‘couldn't have done it without you’ kind of?”

**Focus Groups:**

“Caroline Reid is good because there is always someone around to talk to and can talk to them about anything, and they can help you through things you have been struggling with.”

**I would like to do more fun activities**

**Focus groups:**

“More fun activities like a jet boat and stuff like that.”

**I have learned about mental illness**

**Focus groups:**

“Made mental illness understandable.”

“That it’s not your fault; you can’t do much to help them, but you can help.”
“That it’s really great to have CR because you have someone to talk to and learn about your family.”

I felt accepted at Caroline Reid

Interviews:

“I think, like – it’s a good place to go and get away from your family and, like, everything that's going on at home, or, like, other places, and just kind of, like, relax and just kind of know that you can talk to someone and not be judged about what's going on and things.”

The service should not finish when you turn 16

Focus groups:

The two focus groups with young people who had already left the service over the last two years made comments to this effect.

“It needs to be longer – till 18 years old; the end of school (depends on maturity levels and what you are doing.”

“The finishing time with CR needs to be more flexible.”

There should be follow up support after you leave the service

Focus groups:

“Should do something for the over 16’s, even if once or twice a year; a camp maybe?”

“Would like on-going contact even after they leave.”

Caroline Reid helped my family

Focus Groups:

“Thanks for being there for my family and helping us through tough times.”

“Thanks for being there for my family and helping us.”

Great to have leaders who have been there a long time

Focus groups:

“Good that [male children’s leader] has stuck with it – gave everyone someone they knew over a long time.”
APPENDIX I – EXCLUDED DEMOGRAPHICS

This appendix details excluded mental health demographics from the adult participant questionnaire (Section 4, Q1–3). These data relate to the mental illness history and treatment of participants, and adult participant perceptions of the mental health history and treatment of other parents and other family members. ‘Other treatment’ was left for participants to define: this included counselling/psychotherapy, respite, support meetings, and anxiety treatment.

Table I.0.1 presents data about adult participants from Section 4: Q1.

<table>
<thead>
<tr>
<th>Section 4, Question 1</th>
<th>n</th>
<th>% (N=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication taken for mental illness</td>
<td>18</td>
<td>85.71</td>
</tr>
<tr>
<td>No medication taken for mental illness</td>
<td>3</td>
<td>14.29</td>
</tr>
<tr>
<td>Attends specialist mental health service</td>
<td>8</td>
<td>38.10</td>
</tr>
<tr>
<td>Not attend specialist mental health service</td>
<td>13</td>
<td>61.90</td>
</tr>
<tr>
<td>Other forms of treatment/therapy for mental illness</td>
<td>6</td>
<td>28.57</td>
</tr>
<tr>
<td>Other treatment/therapy – Counselling</td>
<td>3</td>
<td>14.29</td>
</tr>
<tr>
<td>Other treatment/therapy – Meditation</td>
<td>1</td>
<td>4.76</td>
</tr>
<tr>
<td>Other treatment/therapy – Respite</td>
<td>1</td>
<td>4.76</td>
</tr>
<tr>
<td>Other treatment/therapy – Mindsight</td>
<td>1</td>
<td>4.76</td>
</tr>
<tr>
<td>Other treatment/therapy – Bipolar Support Meeting</td>
<td>1</td>
<td>4.76</td>
</tr>
<tr>
<td>Not receive other forms of treatment/therapy</td>
<td>15</td>
<td>71.43</td>
</tr>
<tr>
<td>Has had previous admissions to psychiatric hospital</td>
<td>9</td>
<td>42.86</td>
</tr>
<tr>
<td>Psychiatric hospital admission – within last year</td>
<td>1</td>
<td>4.76</td>
</tr>
<tr>
<td>Psychiatric hospital admission – 3 years ago</td>
<td>3</td>
<td>14.29</td>
</tr>
<tr>
<td>Psychiatric hospital admission – 7 years ago</td>
<td>3</td>
<td>14.29</td>
</tr>
<tr>
<td>Psychiatric hospital admission – many years ago</td>
<td>3</td>
<td>14.29</td>
</tr>
<tr>
<td>Psychiatric hospital admission – no details provided</td>
<td>2</td>
<td>9.52</td>
</tr>
<tr>
<td>No previous admissions to psychiatric hospital</td>
<td>12</td>
<td>57.14</td>
</tr>
</tbody>
</table>

Table I.0.2 presents data from Section 4: Q2 about the children’s ‘other parent’. As noted, if the adult participant was not the child(ren)’s parent, they were asked to answer this question for either of the child(ren)’s parents.
A large percentage of participants and ‘other parents’ diagnosed with a mental illness were using medication, and nearly 40% of each group attending specialist services. A similar percentage of participants with mental illness had been acutely unwell enough to have had previous inpatient hospital admissions. The question was not asked about historical attendance at specialist services. Given that specialist mental health services in A/NZ provide services to the 1–3% of the most severe and/or acutely unwell people with mental illness, this information would have provided further sample description. Anecdotally, all index service-users (the parent with the actual illness) would have been assessed and treated by specialist services in the past. The number of participants attending specialist services reflect the severe and chronic nature of the mental illnesses parents in CRFSS families.

### Table I.0.2 – Frequency Table Showing Adult Participant Perceptions of Mental Health and/or Addiction Treatment for ‘Other Parent’ of Child Service–Users (N=18)

<table>
<thead>
<tr>
<th>Section 4, Question 2</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication taken for mental illness</td>
<td>15</td>
<td>83.33</td>
</tr>
<tr>
<td>No medication taken for mental illness</td>
<td>3</td>
<td>16.67</td>
</tr>
<tr>
<td>Attends specialist mental health service</td>
<td>7</td>
<td>38.89</td>
</tr>
<tr>
<td>Not attend specialist mental health service</td>
<td>11</td>
<td>61.11</td>
</tr>
<tr>
<td>Other forms of treatment/therapy for mental illness</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Not receive other forms of treatment/therapy</td>
<td>18</td>
<td>100.00</td>
</tr>
<tr>
<td>Has had previous admissions to psychiatric hospital</td>
<td>10</td>
<td>55.56</td>
</tr>
<tr>
<td>Psychiatric hospital admission – within last year</td>
<td>3</td>
<td>16.67</td>
</tr>
<tr>
<td>Psychiatric hospital admission – 3 years ago</td>
<td>1</td>
<td>5.56</td>
</tr>
<tr>
<td>Psychiatric hospital admission – 4–5 years ago</td>
<td>2</td>
<td>11.11</td>
</tr>
<tr>
<td>Psychiatric hospital admission – 8 years ago</td>
<td>1</td>
<td>5.56</td>
</tr>
<tr>
<td>Psychiatric hospital admission – 15 years ago</td>
<td>1</td>
<td>5.56</td>
</tr>
<tr>
<td>Psychiatric hospital admission – no details provided</td>
<td>2</td>
<td>11.11</td>
</tr>
<tr>
<td>No previous admissions to psychiatric hospital</td>
<td>8</td>
<td>44.44</td>
</tr>
</tbody>
</table>

Table I.0.3 outlines mental illness treatment details for ‘other family members’ of adult participants, Section 4: Q3.
TABLE 10.3 – FREQUENCY TABLE SHOWING ADULT PARTICIPANT PERCEPTIONS OF MENTAL ILLNESS TREATMENT FOR ‘OTHER FAMILY MEMBERS’ (N=17)

<table>
<thead>
<tr>
<th>Section 4, Question 3</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication taken for mental illness</td>
<td>10</td>
<td>58.82</td>
</tr>
<tr>
<td>No medication taken for mental illness</td>
<td>5</td>
<td>29.41</td>
</tr>
<tr>
<td>Blank — did not state re medication for mental illness</td>
<td>2</td>
<td>11.76</td>
</tr>
<tr>
<td>Attends specialist mental health service</td>
<td>3</td>
<td>17.65</td>
</tr>
<tr>
<td>Not attend specialist mental health service</td>
<td>14</td>
<td>82.35</td>
</tr>
<tr>
<td>Other forms of treatment/therapy for mental illness</td>
<td>2</td>
<td>11.76</td>
</tr>
<tr>
<td>Not receive other forms of treatment/therapy</td>
<td>9</td>
<td>52.94</td>
</tr>
<tr>
<td>Unsure if family member receiving other treatment</td>
<td>4</td>
<td>23.53</td>
</tr>
<tr>
<td>Blank — did not state if family member receiving other treatment</td>
<td>2</td>
<td>11.76</td>
</tr>
<tr>
<td>Has had previous admissions to psychiatric hospital</td>
<td>10</td>
<td>58.82</td>
</tr>
<tr>
<td>Psychiatric hospital admission — within current year</td>
<td>1</td>
<td>5.88</td>
</tr>
<tr>
<td>Psychiatric hospital admission — two years ago</td>
<td>2</td>
<td>11.76</td>
</tr>
<tr>
<td>Psychiatric hospital admission — 15 years ago</td>
<td>1</td>
<td>5.88</td>
</tr>
<tr>
<td>Psychiatric hospital admission — no details provided</td>
<td>6</td>
<td>35.29</td>
</tr>
<tr>
<td>No previous admissions to psychiatric hospital</td>
<td>4</td>
<td>23.53</td>
</tr>
<tr>
<td>Unsure if previous admission to psychiatric hospital</td>
<td>1</td>
<td>5.88</td>
</tr>
<tr>
<td>Blank — did not state if family member admitted to psych. Hospital</td>
<td>2</td>
<td>11.76</td>
</tr>
</tbody>
</table>
APPENDIX J – EXCLUDED QUESTIONNAIRE DATA ABOUT MENTORING

In Section 2: Q10 of the questionnaire, adult participants were asked how long they believed the CRFSS children’s workers needed to be involved with a child to be a mentor for the child. There were 34 participants for this question as two of the 32 questionnaire participants chose to give two responses – one for each of their two children (Table J.0.1). These data have been excluded due to the poor wording of the question. It is unknown if the timeframes chosen by participants reflect how long in total the mentoring relationships should last, or if it reflects how long the workers needed to engage with their children before such a relationship became established.

TABLE J. 0.1 – FREQUENCY TABLE SHOWING ADULT PARTICIPANT PERCEPTIONS ABOUT THE DURATION OF MENTORING RELATIONSHIPS (N=34)

<table>
<thead>
<tr>
<th>Time Periods</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>4</td>
<td>11.76</td>
</tr>
<tr>
<td>6 months</td>
<td>11</td>
<td>32.35</td>
</tr>
<tr>
<td>1 year</td>
<td>5</td>
<td>14.71</td>
</tr>
<tr>
<td>2 years</td>
<td>2</td>
<td>5.88</td>
</tr>
<tr>
<td>3 years</td>
<td>1</td>
<td>2.94</td>
</tr>
<tr>
<td>4 years</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>5+ years</td>
<td>8</td>
<td>23.53</td>
</tr>
<tr>
<td>Blank</td>
<td>1</td>
<td>2.95</td>
</tr>
<tr>
<td>Comment only</td>
<td>2</td>
<td>5.88</td>
</tr>
</tbody>
</table>

Adult participants were asked if their children had other mentors, and if so, who these were. Results are shown in Table J.0.2.
TABLE J.0.2 – FREQUENCY TABLE SHOWING ADULT PARTICIPANT PERSPECTIVES OF ‘OTHER’ MENTORS OF THEIR CHILDREN (N=47)

<table>
<thead>
<tr>
<th>Section 2, Question 10</th>
<th>n</th>
<th>Years</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do children have other mentors? (Q10) N=47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, my child has other mentors</td>
<td>14</td>
<td>29.79</td>
<td></td>
</tr>
<tr>
<td>No, my child does not have other mentors</td>
<td>33</td>
<td>70.21</td>
<td></td>
</tr>
<tr>
<td>Mean – No of years children had other mentors (N=14)</td>
<td>7.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mode – No of years children had other mentors (N=14)</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range – No of years children had other mentors (N=14)</td>
<td>1.5 – 15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Relationship of mentor to child (Q10) N=14                                            |     |       |      |
| Mentor is child’s father                                                                | 2   | 14.29 |      |
| Mentor is child’s older brother                                                         | 3   | 21.43 |      |
| Mentor is child’s older sister                                                          | 2   | 14.29 |      |
| Mentor is child’s youth group leader                                                    | 3   | 21.43 |      |
| Mentor is from Big Brother Big Sister                                                   | 2   | 14.29 |      |
| Mentor is another relative of child                                                    | 1   | 7.14  |      |
| Mentor is child’s step– mother                                                         | 1   | 7.14  |      |
| Mentor is a relative                                                                   | 9   | 64.29 |      |
| Mentor is not a relative                                                               | 5   | 35.71 |      |
| Mean = No of years children had non– relative mentors                                   | 3.2 |       |      |
| Range – # of years children had non– relative mentors                                   | 1 – 8.5 |       |      |
APPENDIX K – EXCLUDED CHILD PARTICIPANT DATA, THEME 1

Child participants were asked if they could recall occasions when the children’s workers had assisted them. Eight of 10 child interviewees and two-thirds of focus group members could remember occasions in which the children’s workers had assisted them. The remaining third of focus group members responded ‘maybe’ to this question; they were unable to recall an occasion but did not discount that it may have occurred. Responses are shown in Table K.0.1.

TABLE K. 0.1 – FREQUENCY TABLE SHOWING FOCUS GROUP MEMBER RECOLLECTIONS OF THE CHILDREN’S WORKERS ASSISTANCE (N=24)

<table>
<thead>
<tr>
<th>Focus Group (N=24)</th>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total number</td>
<td>16</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Total percentage</td>
<td>66.66</td>
<td>0</td>
<td>33.34</td>
</tr>
</tbody>
</table>

Child participants were asked to describe how the children’s workers had assisted them. Their responses are in Tables K.0.2 and K.0.3.
TABLE K. 0.2 – FOCUS GROUP MEMBER RECOLLECTIONS OF ASSISTANCE GIVEN BY THE CHILDREN’S WORKERS (N=16)

<table>
<thead>
<tr>
<th>Focus Group (N=24)</th>
<th>Descriptions of how the children’s workers have assisted them</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Gives my mum a break (and me too).</td>
</tr>
<tr>
<td></td>
<td>Help you to be able to come to Caroline Reid.</td>
</tr>
<tr>
<td></td>
<td>Helped when mum was in bad situation by giving them an outing and helping with the situation (2).</td>
</tr>
<tr>
<td></td>
<td>Helped with transport (2).</td>
</tr>
<tr>
<td>2</td>
<td>Helped me to be who I am.</td>
</tr>
<tr>
<td></td>
<td>If someone teased you.</td>
</tr>
<tr>
<td></td>
<td>Any problem.</td>
</tr>
<tr>
<td>3</td>
<td>Everything.</td>
</tr>
<tr>
<td></td>
<td>Understanding our parents’ mental illness.</td>
</tr>
<tr>
<td></td>
<td>Supporting.</td>
</tr>
<tr>
<td></td>
<td>Knowing you could talk and not be judged.</td>
</tr>
<tr>
<td></td>
<td>Helped with practical things.</td>
</tr>
<tr>
<td>4</td>
<td>Homework.</td>
</tr>
<tr>
<td></td>
<td>Anxiety about earthquakes and the dark.</td>
</tr>
<tr>
<td></td>
<td>Helped me get a counsellor.</td>
</tr>
<tr>
<td></td>
<td>Bullying stuff.</td>
</tr>
</tbody>
</table>

TABLE K. 0.3 – INTERVIEWEE RECOLLECTIONS OF ASSISTANCE GIVEN BY THE CHILDREN’S WORKERS (N=10)

<table>
<thead>
<tr>
<th>Interviews (N=10)</th>
<th>Descriptions of how the children’s workers have assisted them</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Helped get into a forklift course. Brought things home to me from school.</td>
</tr>
<tr>
<td>2</td>
<td>They’ve helped me find my way around playgrounds and with recreation day activities.</td>
</tr>
<tr>
<td>3</td>
<td>The children’s workers and other CRFSS workers have helped my mum, and that’s helping me.</td>
</tr>
<tr>
<td>4</td>
<td>To understand how to have more fun without all the bad and the negative stuff that’s going on at home.</td>
</tr>
<tr>
<td>5</td>
<td>First aid when I fell off my bike at camp.</td>
</tr>
<tr>
<td>6</td>
<td>Couldn't recall anything.</td>
</tr>
<tr>
<td>7</td>
<td>No.</td>
</tr>
<tr>
<td>8</td>
<td>During the earthquake they brought food and coffee.</td>
</tr>
<tr>
<td>9</td>
<td>Got the funding for an Easter camp. They have offered to teach me how to drive a car.</td>
</tr>
<tr>
<td>10</td>
<td>Gave me a bike so I could get to school.</td>
</tr>
</tbody>
</table>
Child were asked preparatory questions in relation to Goal 5: to enhance child service–user’s knowledge of mental illness.

To introduce the notion of mental illness to child participants, they were asked if they knew why they attended CRFSS, to explain what mental illness was, and if they could identify who in their family had a mental illness. They were then asked if they had talked to anyone in their family about mental illness. Responses are in Table L.0.1.

**TABLE L.0.1 – CHILD PARTICIPANT RESPONSES TO PREPARATORY QUESTIONS ABOUT MENTAL ILLNESS**

<table>
<thead>
<tr>
<th></th>
<th>Interviews (N=10)</th>
<th>Focus Groups (N=24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why do you attend CRFSS?</td>
<td>8 – because our parents have a mental illness.</td>
<td>All focus groups said because had a parent with mental illness, also to learn about parental mental illness and meet children from families with similar challenges.</td>
</tr>
<tr>
<td></td>
<td>2 – did not know why, one of whom did not know his/her parent had mental illness (INT5)</td>
<td></td>
</tr>
<tr>
<td>What is mental illness?</td>
<td>8 could explain mental illness</td>
<td>All focus groups could explain.</td>
</tr>
<tr>
<td></td>
<td>2 could not explain mental illness</td>
<td></td>
</tr>
<tr>
<td>Who in your family has a mental illness?</td>
<td>9 identified who has a mental illness</td>
<td>23 focus group participants could identify who had a mental illness.</td>
</tr>
<tr>
<td></td>
<td>1 could not identify (INT5)</td>
<td>1 could not (new to the service, FG1)</td>
</tr>
<tr>
<td>Have you talked to anyone in the family about mental illness?</td>
<td>6 had talked to family members.</td>
<td>14 (58.3%) had talked to family members.</td>
</tr>
<tr>
<td></td>
<td>INT 2, 5, 6, 7 had not.</td>
<td>7 (29.1%) said ‘maybe’ – could not remember if they had or not.</td>
</tr>
</tbody>
</table>

**EXPLANATIONS OF MENTAL ILLNESS**

**Interviewees**

Four participants could name a mental illness – depression. One participant described depression as:
It's when you feel like you're alone … you have no friends – you feel like you've got no friends.

Six participants described mental illness by speaking of the way it affects a person. One participant said it changed the way a person thinks and feels and described his parent taking “happy pills”. Three participants mentioned the brain:

...something that’s mentally wrong with you … it’s in your head.

It's something that happens in the brain that makes your thoughts go ... back, and you think about the worst things.

... mental illness ...which can cause, like, stress and stuff and for you to hurt yourself or cause harm to other people.

... it's kind of like, when ... kind of when your mother's stressing out ... and someone's got to take care of you for a wee while.

One participant said most of her family have mental illness. This participant said they have never had a “big discussion” with their parent about it.

Another participant stated a mental illness cannot be caught from someone the way a physical illness such as a cold can be caught.

Descriptions used were “going crazy” and “disorders”.

One participant said mental illness is caused by things which have happened in the past:

Like someone's – if they've had a bad past or something and it develops into a mental illness.

Focus group members

All groups referred to mental illness as an actual illness.

Sick but not a normal illness, ie depression (suicidal) or schizophrenia (voices in the head). It can come at any time. It is with them for some or the rest of their life.

Can't be caught like a cold.

Physical illness affects the way you walk; mental illness affects the way you think.

A participant from one group ‘normalised’ mental illness:

Not an illness, it is just being different, just the way you are.
One group described mental illness as being “not normal”.

All groups linked mental illness with the mind.

*Their mind is broken.*

*Physical illness affects the way you walk; mental illness affects the way you think.*

*Chemicals in the brain.*

*Don’t think straight.*

The younger group stated it was not the person’s fault. Another group implied this when they spoke of the person not being able to control what was happening to them.

*Not their fault that they can’t play – it is just their illness.*

All focus groups described mental illness by the effects it had on the person with the mental illness.

Group 1:

*Their mind is broken, ie schizophrenia – jumbled.*

*Part of them, and they can’t control it, it just happens.*

*Low energy – can’t play with you.*

*Something that can stop them from doing something (eg playing outside with you).*

Group 2:

*When you hurt yourself on purpose.*

*Different mind–set to most people, view things differently – get more upset and stressed sometimes.*

Group 3:

*A black box.*

*Think, act, do things differently than others.*

*Not connected.*

Group 4:

*Makes them less social and don’t think straight.*

*Plays with their emotions.*
Makes life more hard for people.

Two groups described mental illness by the effects it has on the person’s ability to participate in life.

Low energy – can’t play with you.

Something that can stop them from doing something (eg playing outside with you).

Makes them less social.

SUPPORT FOR PARENTAL MENTAL ILLNESS

Child participants were asked further preparatory questions concerning who they would talk to if their parent with mental illness became unwell. Responses are in Tables L.0.2 and Figure L.1.

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Who would you talk to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Mum (with mental illness), Male CRFSS children’s worker, CRFSS family worker, Maths teacher.</td>
</tr>
<tr>
<td>Two</td>
<td>“I’d probably try and ask mum (with mental illness) what’s wrong... I’d probably ring dad and tell him.”</td>
</tr>
<tr>
<td>Three</td>
<td>“Everyone. Anyone that’d listen to me... Probably talk to (stepdad) and he’d probably talk to help get her to the doctor.”</td>
</tr>
<tr>
<td>Four</td>
<td>“Probably (youth group leader). Or my Nana. That’s probably about it ... or I’d just sort of talk to anyone.”</td>
</tr>
<tr>
<td>Five</td>
<td>Caroline Reid workers; phone Dad, next door neighbours, school teacher.</td>
</tr>
<tr>
<td>Six</td>
<td>Older sisters or family friend.</td>
</tr>
<tr>
<td>Seven</td>
<td>Mum. Social worker at school.</td>
</tr>
<tr>
<td>Eight</td>
<td>“Definitely my dad first, then my – say my auntie, or my friends at school, my best friends at school.”</td>
</tr>
<tr>
<td>Nine</td>
<td>Grandma, CRFSS children’s worker, Dad.</td>
</tr>
<tr>
<td>Ten</td>
<td>A family member first, and then maybe the people at the hospital.</td>
</tr>
</tbody>
</table>
FIGURE L.1 – WHO FOCUS GROUP MEMBERS WOULD TALK TO IF A PARENT WITH MENTAL ILLNESS BECAME UNWELL (N=23)
This appendix provides a fuller account of what child participants learned about mental illness at CRFSS.

**Focus Group members**

Some focus group members said they learned about mental illness in their families.

- *What my parent’s mental illness is.*
- *Found out my parent had a mental illness.*
- *Learned that both parents have mental illness, not just their mum.*
- *Learned that quite a few family members have mental illness.*
- *What it is that is actually wrong.*

Some members from Focus Group 1 said they learned about different types of mental illnesses, different treatments for mental illness, and helpful supports for children who have parents with mental illness.

- *What they try to do to treat it.*
- *What to do if parent becomes unwell.*

Other types of comments were:

- *Not something to be afraid of.*
- *It’s normal.*
- *You’re not alone.*
- *They still care even if they do not show it (parent with mental illness).*

Most of the participants in Focus Group 1 felt it was a good thing to learn about mental illness, but one participant said he now worried that he might be a mental illness.
**Interviewees**

Three participants described methods of teaching about mental illness: a colouring book which taught about depression; a story about mental illness; and a puppet show.

Two interviewees recalled group discussions at CRFSS about mental illness.

*We had to write down about what we knew about mental illness, I didn't know much, and then I learned a whole heap because in our group we had to write stuff down.*

*We used to, like, have little sessions, discussions, about, like, what certain things are, and what a mental illness is, sort of thing. What we thought it was.*

Some interviewees said that their questions about mental illness were answered at CRFSS.
APPENDIX N – EXCLUDED PREPARATORY DATA, THEME 2, MENTAL HEALTH EDUCATION

Preparatory questions were asked of adult participants about what their children knew about their mental illness, the mental illness of the ‘other parent’, and the mental illness of other family members (Section 4, Q1–3). Responses are in Table N.0.1. Of the 21 participants who stated they had a mental illness, two participants answered separately for each of their children, increasing the sample from 21 to 24 (Q1).

### TABLE N.0.1 – FREQUENCY TABLE SHOWING ADULT PARTICIPANT PERSPECTIVES ON HOW MUCH THEIR CHILDREN KNOW ABOUT THE MENTAL ILLNESS OF ADULT PARTICIPANTS, OTHER PARENTS, AND OTHER FAMILY MEMBERS

<table>
<thead>
<tr>
<th>Section 4, Questions 1–3</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What children know about mental illness of adult participants (S4, Q1) N=24</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nothing</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Very little</td>
<td>7</td>
<td>29.17</td>
</tr>
<tr>
<td>Some</td>
<td>10</td>
<td>41.66</td>
</tr>
<tr>
<td>A lot</td>
<td>7</td>
<td>29.17</td>
</tr>
<tr>
<td><strong>What children know about mental illness of other parents (S4, Q2) N=18</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nothing</td>
<td>1</td>
<td>5.56</td>
</tr>
<tr>
<td>Very little</td>
<td>3</td>
<td>16.67</td>
</tr>
<tr>
<td>Some</td>
<td>6</td>
<td>33.33</td>
</tr>
<tr>
<td>A lot</td>
<td>6</td>
<td>33.33</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>11.11</td>
</tr>
<tr>
<td><strong>What children know about mental illness of other family members (S4, Q3) N=12</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nothing</td>
<td>4</td>
<td>33.33</td>
</tr>
<tr>
<td>Very little</td>
<td>3</td>
<td>25.00</td>
</tr>
<tr>
<td>Some</td>
<td>3</td>
<td>25.00</td>
</tr>
<tr>
<td>A lot</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Blank</td>
<td>2</td>
<td>16.67</td>
</tr>
</tbody>
</table>

Adult participants were asked whether they ever had conversations with their children about mental illness (Section 4: Q16). Responses are in Table N.0.2.
TABLE N.0.2 – FREQUENCY TABLE SHOWING HOW MUCH ADULT PARTICIPANTS TALK TO THEIR CHILDREN ABOUT MENTAL ILLNESS (N=32)

<table>
<thead>
<tr>
<th>Participants talk to own children (Q16)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Very little</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Sometimes</td>
<td>19</td>
<td>59.37</td>
</tr>
<tr>
<td>A lot</td>
<td>4</td>
<td>12.50</td>
</tr>
</tbody>
</table>
Adult participants were asked in Section 3: Q1 of the questionnaire what services/agencies they and/or their family members (including children) had been involved with over the previous year. This question was asked to refresh their memories in preparation for Question 2 which related to Goal 8 of assisting service-users to access services.

Participants were asked to tick boxes from a list of service/agencies. See Table O.0.1. Participants were asked to state which hospital departments they had attended. These were:

- Accident and Emergency (A&E), for self-harm or overdose
- Urology
- Thyroid Clinic
- Psychiatric Emergency Services at A&E
- Occupational and physical therapy
- Acute children’s assessment at A&E
- Public hospital (not specified)
- For pneumonia and sleep apnoea
- Children’s outpatients
- Orthopaedics
**TABLE O.0.1 – FREQUENCY TABLE SHOWING ADULT PARTICIPANT PERSPECTIVES ON WHICH SERVICES/AGENCIES THEY AND THEIR FAMILY HAVE BEEN INVOLVED WITH OVER THE PAST YEAR (S3, Q1)**

<table>
<thead>
<tr>
<th>Services/Agencies</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner/Practice Nurse</td>
<td>28</td>
</tr>
<tr>
<td>Mental health sector base (east, west, north south, rural) *</td>
<td>14</td>
</tr>
<tr>
<td>Mothers &amp; Babies Service+</td>
<td>1</td>
</tr>
<tr>
<td>Youth Specialty Service^</td>
<td>3</td>
</tr>
<tr>
<td>Whakatata House – Child &amp; Family Specialty Service~</td>
<td>6</td>
</tr>
<tr>
<td>Needs Assessment</td>
<td>9</td>
</tr>
<tr>
<td>Community Support Worker</td>
<td>10</td>
</tr>
<tr>
<td>Counselling service/counsellor – please state</td>
<td>14</td>
</tr>
<tr>
<td>Parenting Service/support – please state</td>
<td>4</td>
</tr>
<tr>
<td>Methodist Mission – parenting support, counselling, Wise Up Courses</td>
<td>2</td>
</tr>
<tr>
<td>Presbyterian Support Service – counselling, family work, parenting</td>
<td>3</td>
</tr>
<tr>
<td>Social Workers in Schools</td>
<td>5</td>
</tr>
<tr>
<td>Work and Income NZ&lt;</td>
<td>21</td>
</tr>
<tr>
<td>Housing NZ&gt;</td>
<td>11</td>
</tr>
<tr>
<td>Earthquake Related Services</td>
<td>13</td>
</tr>
<tr>
<td>Budget Advisory Service – please state which</td>
<td>3</td>
</tr>
<tr>
<td>Alcohol and Drug Services – please state which</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Department – please state which</td>
<td>11</td>
</tr>
<tr>
<td>Father &amp; Child Trust</td>
<td>0</td>
</tr>
<tr>
<td>Child Youth &amp; Family Services (</td>
<td>5</td>
</tr>
<tr>
<td>Community Corrections Service)</td>
<td>0</td>
</tr>
<tr>
<td>Open Home Foundation/</td>
<td>1</td>
</tr>
<tr>
<td>Women’s Refuge</td>
<td>0</td>
</tr>
<tr>
<td>Food Bank – details not given</td>
<td>12</td>
</tr>
<tr>
<td>Food Bank – Salvation Army</td>
<td>1</td>
</tr>
<tr>
<td>Other services – Police</td>
<td>1</td>
</tr>
<tr>
<td>Other services – Christchurch Resettlement Service=</td>
<td>1</td>
</tr>
<tr>
<td>Other services – Public Health Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Other services – Cholmondeley Children’s Home</td>
<td>1</td>
</tr>
</tbody>
</table>

*Mental Health Sector Base is the adult community specialist mental health teams for Canterbury – divided into five sectors.
+Mothers & Babies Service is the specialist Mothers & Babies psychiatric service (inpatient and outpatient) for the South Island, based in Christchurch.
^Youth Specialty Service is the specialist mental health outpatient service for adolescents.
~Whakatata House is the specialist mental health outpatient service for children (pre-adolescent).
<Work and Income NZ is the Government Department which administers social welfare benefits.
>Housing NZ is the Government Department which provides state housing.
{Child Youth & Family Services is the Government Agency which is responsible for child protection, youth justice and adoption.
} Community Correction Service is the Government Agency responsible for probation and community sentencing of adults convicted of crimes.
=Christchurch Resettlement Services provides social work services and support to refugees and migrants.
/Open Home Foundation is a non–government agency which provides fostering, parent support, and has government contracts for lower level care and protection investigations and social work.
All interviewees said they attended recreation days most of the time. They were also asked what stopped attendance. Responses are shown in Table P.0.1.

**TABLE P. 0.1 – TABLE SHOWING INTERVIEWEE ATTENDANCE RATES AND REASONS FOR NON-ATTENDANCE AT MONTHLY RECREATION DAYS (N=10)**

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>How often attend?</th>
<th>What stops you attending?</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Usually every time</td>
<td>Work</td>
</tr>
<tr>
<td>Two</td>
<td>Usually all the time</td>
<td>Nothing</td>
</tr>
<tr>
<td>Three</td>
<td>Pretty often</td>
<td>Sport — netball</td>
</tr>
<tr>
<td>Four</td>
<td>Pretty much everyone apart from a couple. Became more regular as I got older.</td>
<td>Family, other plans</td>
</tr>
<tr>
<td>Five</td>
<td>All the time. Only missed twice</td>
<td>Something on one time</td>
</tr>
<tr>
<td>Six</td>
<td>Most of the time.</td>
<td>Work</td>
</tr>
<tr>
<td>Seven</td>
<td>Often</td>
<td>Nothing – but would not come if being bullied</td>
</tr>
<tr>
<td>Eight</td>
<td>Every month, pretty much</td>
<td>Special occasion</td>
</tr>
<tr>
<td>Nine</td>
<td>Most of the time, once a month</td>
<td>Paintball (scared of it!). Occasionally something on – usually can work around it.</td>
</tr>
<tr>
<td>Ten</td>
<td>Most of them</td>
<td>No – not unless I have something else planned for the day.</td>
</tr>
</tbody>
</table>

Focus group participants were asked the same questions about attendance at recreation days. Unfortunately, these questions were not asked of Focus Group 3. Sample size is therefore reduced to 19. Responses are in Table P.0.2.
<table>
<thead>
<tr>
<th>Attendance</th>
<th>FG1</th>
<th>FG2</th>
<th>FG4</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Every</td>
<td>0</td>
<td>0.00</td>
<td>4</td>
<td>21.05</td>
</tr>
<tr>
<td>Most</td>
<td>7</td>
<td>36.84</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Some</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Not Many</td>
<td>3</td>
<td>15.79</td>
<td>0</td>
<td>0.00</td>
</tr>
</tbody>
</table>

The two participants who responded, “not many”, were siblings, and said this was because one of their parents did not allow them to attend frequently. Focus Groups 1 and 4 gave reasons for not attending at times. Focus Group 1 noted illness, other commitments, staying with the other parent, sport, and dancing. Focus Group 4 also stated that sports commitments and other activities they want to do including spending time with other friends, were reasons for non-attendance.

Interviewees had all attended annual camps with CRFSS; eight interviewees had attended all annual camps since being service-users of the service. Two interviewees had not attended one camp each. Of the 24 focus group participants, 13 had attended all camps, 10 had not attended some camps, and one participant was unsure about his attendance rate. Reasons for non-attendance were not sought.

Child participants were asked to rate their enjoyment of monthly recreational activities. Unfortunately, this question was not asked of Focus Group 1. Sample size is therefore reduced to 15. Responses are shown in Table P.0.3.
Child participants were asked what they did and did not enjoy about monthly recreation days and camps. Full responses are shown in Tables P.0.4 and P.0.5.

**TABLE P. 0.4 – TABLE SHOWING WHAT INTERVIEWEES DID AND DID NOT ENJOY ABOUT MONTHLY RECREATIONAL ACTIVITIES (N=10)**

<table>
<thead>
<tr>
<th>What we liked about monthly recreation days</th>
<th>What we did not like about monthly recreation days</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMX/biking trip</td>
<td>Walking up a hill.</td>
</tr>
<tr>
<td>Ice-skating</td>
<td>The Amazing Race was boring.</td>
</tr>
<tr>
<td>Kayaking/Canoeing</td>
<td>I got thrown in the water at the beach and I was cold.</td>
</tr>
<tr>
<td>Beach day</td>
<td>Sometimes a few children made fun of me.</td>
</tr>
<tr>
<td>Snow day/mountains</td>
<td></td>
</tr>
<tr>
<td>Pirate day/dress up/boat trip</td>
<td></td>
</tr>
<tr>
<td>QEII pool/hydro slides</td>
<td></td>
</tr>
<tr>
<td>Camps/Road trip</td>
<td></td>
</tr>
<tr>
<td>Craft days</td>
<td></td>
</tr>
<tr>
<td>Graduation</td>
<td></td>
</tr>
<tr>
<td>Heaps.</td>
<td></td>
</tr>
<tr>
<td>All the activities.</td>
<td></td>
</tr>
<tr>
<td>Friendship.</td>
<td></td>
</tr>
<tr>
<td>Decent conversations.</td>
<td></td>
</tr>
<tr>
<td>The activities are fun.</td>
<td></td>
</tr>
<tr>
<td>Having something to do.</td>
<td></td>
</tr>
<tr>
<td>The leaders are easy to talk to.</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE P. 0.3 – FREQUENCY TABLE SHOWING CHILD PARTICIPANTS RATINGS OF RECREATION DAY ENJOYMENT**

<table>
<thead>
<tr>
<th>Interviewee (N=10)</th>
<th>Actual Rating out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>9</td>
</tr>
<tr>
<td>Two</td>
<td>10</td>
</tr>
<tr>
<td>Three</td>
<td>9</td>
</tr>
<tr>
<td>Four</td>
<td>8</td>
</tr>
<tr>
<td>Five</td>
<td>10</td>
</tr>
<tr>
<td>Six</td>
<td>7</td>
</tr>
<tr>
<td>Seven</td>
<td>9</td>
</tr>
<tr>
<td>Eight</td>
<td>9</td>
</tr>
<tr>
<td>Nine</td>
<td>8–9</td>
</tr>
<tr>
<td>Ten</td>
<td>8</td>
</tr>
<tr>
<td>Mean Interviewee Rating</td>
<td>8.75</td>
</tr>
</tbody>
</table>

**Focus Groups (N=15)**

<table>
<thead>
<tr>
<th>Mean Rating out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>Total Mean Focus Group Rating</td>
</tr>
</tbody>
</table>
### TABLE P. 0.5 – TABLE SHOWING FOCUS GROUP MEMBERS RECOLLECTIONS OF WHAT THEY DID AND DID NOT ENJOY ABOUT MONTHLY RECREATION DAYS (N=24)

<table>
<thead>
<tr>
<th>Focus Groups</th>
<th>What we enjoyed about monthly recreation days</th>
<th>What we did not enjoy about monthly recreational days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do lots of fun things.</td>
<td>[Name of volunteer] singing!</td>
</tr>
<tr>
<td></td>
<td>Spend time with friends and each other.</td>
<td>Sometimes they get cancelled.</td>
</tr>
<tr>
<td></td>
<td>Free.</td>
<td>Don’t like What Now – sitting there.</td>
</tr>
<tr>
<td></td>
<td>Make new friends.</td>
<td>Sometimes people don’t get birthday cakes</td>
</tr>
<tr>
<td></td>
<td>Go to new places</td>
<td>because their birthday is not on a Rec Day.</td>
</tr>
<tr>
<td></td>
<td>Go places couldn’t afford otherwise (e.g. jet</td>
<td>Suggested have a monthly (or yearly) birthday</td>
</tr>
<tr>
<td></td>
<td>boating).</td>
<td>celebration for all the birthdays.</td>
</tr>
<tr>
<td></td>
<td>Not boring.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Like getting phoned up.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attending What Now.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Being together.</td>
<td>Order of getting picked up and dropped off.</td>
</tr>
<tr>
<td></td>
<td>Opportunities to do new things.</td>
<td>Not getting a good seat in the van; sitting next</td>
</tr>
<tr>
<td></td>
<td>Spending time with leaders (some were pretty</td>
<td>people you don’t like.</td>
</tr>
<tr>
<td></td>
<td>cool!).</td>
<td>Being separated from each other if you</td>
</tr>
<tr>
<td></td>
<td>Something to do.</td>
<td>misbehaved.</td>
</tr>
<tr>
<td></td>
<td>As you got older went for the social side not</td>
<td>Forgetting to pick you up.</td>
</tr>
<tr>
<td></td>
<td>the activities as much.</td>
<td>Repeating activities (as a result of being there</td>
</tr>
<tr>
<td></td>
<td>Favourite things ... camps, road trips, building</td>
<td>a long time.)</td>
</tr>
<tr>
<td></td>
<td>rafts, hands on activities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More opportunities for us.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introducing us to things that our families</td>
<td></td>
</tr>
<tr>
<td></td>
<td>wouldn’t be able to.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time away from family was a good thing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gives you something to look forward to.</td>
<td>Early starts.</td>
</tr>
<tr>
<td></td>
<td>Eventful.</td>
<td>Waiting a long time (for rides).</td>
</tr>
<tr>
<td></td>
<td>Lots of kids around.</td>
<td>Long, long drives.</td>
</tr>
<tr>
<td></td>
<td>Learning about our parents’ illness.</td>
<td>Staff not being organised.</td>
</tr>
<tr>
<td></td>
<td>Playing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The leaders.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Time away from home.</td>
<td>What Now</td>
</tr>
<tr>
<td></td>
<td>Making friends and catching up with friends.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Getting to do something different.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New Experiences.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Everything.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good to get out in the weekend.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Really enjoyed:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Snow days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Snowball fights</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Making snow cones</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Farm days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Swimming with dolphins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laser Tag</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Biking Days – BMX</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amazing Race</td>
<td></td>
</tr>
</tbody>
</table>

Child participants were asked if they had any ideas about activities for future recreational activities. Responses are listed below.
• Go to the beach more often, e.g. Corsair Bay.
• Sailing.
• Go to different BMX tracks, e.g. Kyle Park in Hornby.
• More Adrenalin Forest trips.
• Go to the Movies.
• Build boats (hands on activities).
• Outdoor activities with Mark.
• Baking biscuits.
• Painting boxes like dolls houses at Caroline Reid – gave us more time with the leaders.
• Craft activities.
• Hiking on the hills with backpack and lunch.
• More organised activities
• Sky diving.
• Queenstown – generally, the luge.
• Glow worm caves at Te Anau.
• Robot fights.
• Deep sea diving.
• Sumo Wrestler suits.
• Paintball with the whole group including the younger children
• Skiing/snowboarding – never been before
• Amazing Race – combination of car rally and orienteering. Activities like the younger children have.

In Section 2: Q4 and Q5, adult participants were asked if their children had new experiences at CRFSS, if so, what these were; and how easy it would be for them to provide these experiences, and the reasons for their responses. Responses are shown in Tables P.0.6, P.0.7 and P.0.8.

| TABLE P.0.6 – FREQUENCY TABLE SHOWING ADULT DATA REGARDING NEW EXPERIENCES AT CRFSS AND DIFFICULTY FOR PARENTS/CAREGIVER TO PROVIDE THESE (N=32) |
|---|---|---|
| Section 2, Questions 4 and 5 | n | %  |
| Have any of the activities been new experiences? (Q4) |  |  |
| Yes | 30 | 93.75 |
| No | 0 | 0.00 |
| Blank | 2 | 6.25 |
| Ease parents could provide these new experiences (Q5) |  |  |
| Difficult | 16 | 50.00 |
| Somewhat difficult | 14 | 43.74 |
| Somewhat easy | 1 | 3.13 |
| Easy | 1 | 3.13 |
| Very easy | 0 | 0 |
### TABLE P.0.7 – FREQUENCY TABLE SHOWING ADULT PARTICIPANT REASONS FOR THEIR INABILITY TO PROVIDE THEIR CHILDREN WITH NEW EXPERIENCES PROVIDED BY CRFSS (N=32)

<table>
<thead>
<tr>
<th>Section 2, Question 5</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money</td>
<td>20</td>
<td>62.50</td>
</tr>
<tr>
<td>Transport</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Time constraints</td>
<td>7</td>
<td>21.88</td>
</tr>
<tr>
<td>Mental health</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>Physical health</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Cannot manage the children</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>New to country</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Lack of confidence</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Energy levels</td>
<td>2</td>
<td>6.25</td>
</tr>
<tr>
<td>Access</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Complicated family issues</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Variables</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>Abseiling</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Camps</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Making new friends/mixing other children their own ages</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Snowboarding</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Road trips</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>What Now</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Snow Day</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Confidence course</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hanmer*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Could do many myself (yes)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Jumping off wharf at Corsair Bay</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Places they have not been before</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Being with other children who have parents with mental illness</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Adrenalin forest</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>All/Everything was a new experience</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Most of the activities</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Paintball</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Doing craft activities</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Biking at Bottle Lake forest</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ninja day</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>A lot of outdoor activities</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Quail Island trip</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Antarctic Centre</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Movies</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ice skating</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Farm day</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>A lot of new experiences</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Blank</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>No new experiences</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Unclear response</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

*An alpine town with hot springs north of Otahuh/Cristchurch*
APPENDIX Q – EXCLUDED PREPARATORY DATA FROM THEME 3, EXPERIENCES OF STIGMA

TABLE Q.0.1 – FREQUENCY DISTRIBUTION OF ADULT PARTICIPANT PERCEPTIONS OF THEIR CHILDREN’S EXPERIENCES OF STIGMA AND THE PROS AND CONS OF MIXING WITH OTHER COPMI WHEN AT CRFSS (N=32)

<table>
<thead>
<tr>
<th>Section 4, Questions 14 and 15</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult participants’ children treated differently due to parental mental illness (Q14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>14</td>
<td>43.75</td>
</tr>
<tr>
<td>Very little</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>Sometimes</td>
<td>7</td>
<td>21.87</td>
</tr>
<tr>
<td>A lot</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Unclear (all boxes ticked)</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Benefits seen for their children mixing with other COPMI at CRFSS (Q15)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits stated</td>
<td>30</td>
<td>93.74</td>
</tr>
<tr>
<td>No Benefits stated</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Blank</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Disadvantages stated</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>No Disadvantages stated</td>
<td>21</td>
<td>65.63</td>
</tr>
<tr>
<td>Blank</td>
<td>6</td>
<td>18.74</td>
</tr>
</tbody>
</table>

EXPERIENCES OF STIGMA

CHILDREN’S EXPERIENCES OF STIGMA – ADULT PARTICIPANT PERSPECTIVE

Two themes emerged from the four adult participants who noted their children experienced stigma by association ‘a lot’: teasing by peers, and social exclusion. Two participants spoke of social exclusion occurring due to an inability to have friends over or to take children to social activities.

They get teased ‘oh your mum’s loony or in loony bin (Hillmorton)\(^\text{41}\) (AQ12).

Not included in things because I can’t take her there, I can’t have conversations with people involved with her activities – birthday parties, sleepovers, etc (AQ19).

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\(^{41}\) Hillmorton Hospital is the Otago/Christchurch state psychiatric hospital, formerly named Sunnyside Hospital.
Because I am at work and my wife struggles to cope with things such as parties, sleepovers, friends phoning. Also because of the state of the house we feel uncomfortable with people coming over. This impacts child because friends can’t come over (AQ24).

Those who felt their children ‘sometimes’ experienced stigma by association provided additional insight. One participant felt when he disclosed his mental illness to the school, the teachers stigmatised the family:

At school – when I state I have a mental illness I think they scrutinise my son more (AQ5).

Social exclusion was raised by this subgroup also, due to the child being viewed as contaminated:

Other people don’t want to be near my child in case it’s catchy (AQ29).

A child’s protectiveness of her parent was noted by one participant, in response to stigmatising comments.

A child feels protective of a parent when others have negative opinions (AQ14).

In contrast, two adult participants viewed being ‘treated differently’ in a positive light. Their children received additional support.

They tend to be attentive and always go the other mile for them (AQ18).

Those who do know are supportive (AQ28).

The group of adult participants who felt their children were not stigmatised, or experienced minimal stigmatisation felt this was because the mental illness was not disclosed or not obvious.

Most people/friends of our children are unaware of our mental illnesses (AQ30).

CHILDREN’S EXPERIENCES OF STIGMA – CHILD PARTICIPANT PERSPECTIVE

The themes from child data echo those of their parents. Of the subgroup of child participants who experienced stigma (8 focus group members, two interviewees), a number described adverse responses to others seeing their parents or telling others their parents had a mental illness. The most common expression of stigma for child service–users was labelling with demeaning words, and feeling discredited in the sight of others, described using terms such as “teased”, “laughed at”, “nasty words” and making fun of their parents.
School photos – mum acted strangely at school and everyone laughed (FG1).

Tried to tell about mum but people just teased and laughed (FG1).

One focus group member described a classic response to stigma arising from shame; secret keeping.

Cover up that mum has a mental illness because people tease and laugh (FG1).

One interviewee described the prolonged nature of stigmatisation in his life. Since attending intermediate school (Grade Seven) he had been taunted (almost four years).

In general, nasty words they say, you know, your mum’s crazy … different. But you learn to just ignore it … Pretty much since about year seven … As you get older it gets easier (INT1).

Being ‘treated differently’ was seen by one interviewee as having to experience things other families do not. To the participant it was not normal to have to speak to lawyers about her family, to be removed from her mother’s care, or for her mother to go to a psychiatric hospital.

Well, I have been treated differently, like … because of things what mum’s done, that made her different, like … when I was little I used to be treated like … I’d been in a life that nothing can happen right. I didn’t like that because … I wanted to be treated like … I would say to mum, when I got upset, I just want to have a normal life, I want to have normal parents. And she’d get really upset about that… INT3).

Three participants spoke of awkward questions about their parents’ behaviours:

Why does your mum not come to parent teacher interviews? (FG3)

Why does your dad do that? (FG3)

One focus group participant said he was never treated differently due to parental mental illness as he kept it a secret. The strategy he employed was:

Don’t ever bring friends home (FG3).

Reasons given for not experiencing ‘different treatment’ were the same as their parents stated: no one knew about parental mental illness or the parent did not look abnormal:

It’s not too obvious (INT10).
A minority experienced positive responses to parental mental illness. One participant who lived with her grandmother due to her mother’s illness, described being asked about her living situation:

…I live with my Nana. She’s like, oh real, why? And I’m like, because my mum has a mental illness, and like, she can’t deal with stress too much, and they’re like, oh cool, and when they come round they’re like, oh, your Nana’s so cool (INT4).

Only one friend did, and she didn’t judge me (FG2).

ADULT EXPERIENCES OF STIGMA

For adult participants with mental illness, those who received no ‘different treatment’ gave the same reasons as their children – nobody unnecessary knew.

Feeling judged as less acceptable or capable was noted by several, with differing degrees of stigma noted for differing diagnoses:

They think what’s wrong with me when I can’t do a certain task or work (AQ12).

I get taken less seriously on everything I say, every view I have, everything I do, as if I’m tainted and only the illness can speak or act (AQ30).

Some are ignorant about mental illness and expect that I am less intelligent and capable of parenting when they know I have one (AQ14).

I believe that when I disclose I suffer from mental illness a judgement about me is made. Especially depending on what degree of diagnosis I tell them. If I say depression, they are fine. If I say borderline personality disorder, completely different (AQ5).

The outcome implied is social exclusion in addition to the demeaning nature of these experiences. One participant overtly stated this:

Not included in activities, lose friends when they find out, not helped with problems (AQ19).

This is also implied in another response relating to the impact of symptoms on what the participant says:

Just the way I can word things – gets me in to trouble (AQ1).

One participant felt social exclusion occurred because people fear mental illness:

Some people are frightened that there may be an episode although never had one outside of family (AQ29).
The result of this is shown in a comment by one participant; an example of self-stigma:

I feel more comfortable with similar people, feel awkward around ‘normal’ people sometimes (AQ6).

As with child service-users, one adult participant saw the benefits of disclosing mental illness. What was meant was unclear.

Sometimes it helps if you have a mental illness (AQ27).

In relation to stigma by association, social exclusion was also noted:

My family (siblings) shun me from my family (AQ18).

Sense get treated differently. Underlying and inexplicable [sic] (AQ16).

We don’t fit other people’s ‘slot’ (AQ24).

Feeling pitied and blamed for the other parents’ mental illness was noted by some:

Sometimes I’m treated as though her mental state is my fault, sometimes I am pitied, sometimes I am blamed for not controlling her behaviour while she is unwell (AQ30).

My mother blames me for my dad’s condition (AQ29).

However, one adult participant who cares for her grandchildren spoke of people complimenting her.

Told I am so strong for doing what I do (AQ18).

Those who did not feel they were ‘treated differently’ by association noted it was due to lack of contact with the person.
APPENDIX R – EXCERPT FROM RESEARCH DIARY

SUPERVISION, 19/10/16

Today we talked about the SWOT analysis I sent, and the socio-political writing I had done so far.

**SWOT Analysis**

P thought this was good. It can be added to and will probably guide the macro discussion in my final chapter. A template to apply theory to at a macro level, ie how do theoretical constructs impact on these factors? (Theoretical constructs being what I put in the literature review.)

Discussed a couple of factors raised in the analysis. How the uncertainty of funding results in staff not feeling they can complain about work pressure as this could jeopardise the service (frozen or limited or threatened funding ... might reduce number of families who can access the service; might mean a discontinuation of the service, might limit the length of intervention). Stressful work anyway, and this adds to stress for staff as they are trapped between their own self-care and their values for the work.

Another stress for staff results from the neoliberal, private sector institutional logic impact on social service delivery contracts and processes raised by Emily in her editorial ... the required technological recording, statistics, and the auditing processes ... become nit-picky ... unbalanced audit processes. That is, really emphasising some factors, but ignoring other really important aspects. Bad audit can result in review of contract with potential for funding to go elsewhere and causes additional pressured on already overworked staff.

Staff retention .... Female children’s workers (and family workers) not remaining with the service for at least 4−5 years undercuts the long term attachment process. Discuss staff retention is often linked to passion and burnout, and funding, however in the CRFSS long term service case, it is to do with the demographic of female workers. The job requires a level of physical fitness older women don’t necessary want. Herein lies two debates: how do you make a worker stay for many years ... how do you make the organisation attractive to them? And the gender debate needs to be mentioned. Is it the environment which makes it hostile to stay? Or is it just a demographic factor. Need to mention the wider debate around parenting, females bearing the brunt of it, men not taking parenting leave or staying home as much, how adaptable is the service for females with young children to return to work. Wider issues about how most social services don’t work with men, and therefore most social workers are female. Men are also treated differently if parenting alone ... an oddity ... affects the psyche of the worker. In this case, it is a demographic issue related to the skill set required for the job (primary teacher type but physical fitness). Question is, how does the employer support return to work? What influence does the Christian ethos of the organisation have ... women more likely to take a certain role? Or the actual job requires values around what is best for children, so mothers more likely to stay home with the child? Also, it is part time, so not enough to support a family if a father stayed home to care? What does this say about flexibility of employment in NZ which would allow both parents to work part time?

Attachment discussion needs to include what happens when staff leave. Protective and vulnerability factors. Is attachment extended to the organisation, at least one long term children’s worker? Attached to the organisation and at least one worker is stable this somehow protects them .... This is the weakest link in the long term service. Staff retention, particularly of the
children’s workers. Longevity of association with workers. Strategies for how you maintain. Are there other frameworks or manifestations? Is the organisation an entity?

What I’ve written so far.

I hadn’t gotten to it yet, but P emphasised I need to write about the internal dialogue within the organisation being a battleground due to the differing logics. Intra-organisational conflict. Conflicting institutional logic. Think about the role and therefore private ethos of the accountant, HR, clinical manager - at different times, different stakeholders/key players come to the fore. Certain power is attached with certain roles, and different key players have differing views of the organisation and try to position the organisation to meet these. Power shifts to the money people at certain times, to HR at others (when new staff required – what skill set?), to clinical manager around auditing. To the CEO when contracts need to be renewed. And once contracts are secured, power may shift back to staff. The tension between staff wishes and theory-driven practice, and the market driven contracts ‘held in mind’ by management. Emphasise the key power roles.

Write about the cultural and political risks for organisations which embrace hybridity. The organisation needs to understand the risks so it can make conscious choices about how they balance multi-sectorial logics and governance forms. Note part if SST – CRFSS – has resisted interference from SST and the state.

Remember the overall thesis format:

- Literature review – hard theory
- Discussion embedding analysis of the data in theory
- Wider issues related to the discussion, particularly the misfit between current best practice and what is being delivered. Need to discuss strategies for this, and debate short term, medium term, long term and other models of service delivery for COPMIA.

The discussion is influenced by my logic. At the beginning, note give a brief synopsis of the key theoretical constructs: micro, meso and macro. Don’t restate them, rather “as discussed, prevention science suggests ....”. The literature review outlines the hard theory. The discussion mentioned the main suggestions related to the discussion.

Key ideas: whether or not the service is effective? Dominant discourses related to this, linking with the research question. And then, the square peg in the round hole issue (macro).

How to frame the whole story .... Could add the macro bits here or there or surround it all from an ecological point of view. An ecological, environmental overall discussion threading through the whole literature review. Within teach theme, talk about micro, meso and macro issues. Eg, Social capital.
REFERENCES


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