AOTEAROA NEW ZEALAND
SOCIAL WORK

VOLUME 36 • NUMBER 2 • 2024

ISSN: 2463-4131 (Online)

Qualitative research

Quantitative research

Qualitative research

Theoretical research

Highlighting Aotearoa New Zealand research and scholarship: What we were reading in 2023

In 2023, we published four issues of volume 35 of our journal, including an issue of *Te Mau* and a special issue on reproductive justice (See Beddoe et al., 2023). These issues included 27 original articles, three viewpoints, two practice notes, and 16 book reviews. Following on from previous editorials that analysed "What we're reading" in a particular year, we offer below another analysis of the top 15 most-read articles for 2023.

Perhaps we shouldn't be surprised that the most-read article published in 2023 was a special editorial on Justice for Palestine included in issue four (Ballantyne et al., 2023). This was a statement by editorial collective members on the situation in Palestine. In the context of the genocide, we were all witnessing on our television screens and the silence of the IFSW on this matter, we felt compelled to comment. Since that editorial was published in December 2023, the horrifying death toll has not stopped climbing, and despite the statements made by the International Criminal Court to halt the ground invasion of Rafah, Israel continues its assault on Gaza and the West Bank unabated. The editorial collective continues to express our utmost solidarity with the Palestinian people and our deep concern for the future prospects of an international rules-based order that respects all peoples' human rights, including the right to self-determination. As we stated in the editorial , "If social work can't advocate for a just settlement, if it can't name the abuse of power and self-interest that perpetuates the suffering of the Palestinian people, the global profession is morally bankrupt and simply part of the problem" (p. 14).

The editorial sections of academic journals are usually formal and conventional in style and serve to do little more than introduce the contents of each issue. For that reason, they are usually the least read part of a journal. However, since three of our editorials made it into the top 15 most widely read in 2023, our journal seems to be an exception to the rule. It may be because we use full titles instead of the standard editorial epithet. Our editors also tend to use the opportunity to add topical material that does more than introduce the content. However, we suspect that, in the case of the editorial by Beddoe (2023), it was the newsworthy nature of the editorial that caught the attention of our readers. Liz announced that our mahi on the journal had been formally recognised by the Aotearoa New Zealand Social Work Association by the awarding the editorial collective the Social Work Research or Education Award and the John Fry Memorial Supreme Award in the 2023 ANZASW Social Work Awards. In the editorial, Liz noted that the journal continues to make a significant and well-respected contribution to scholarship in Aotearoa and internationally, with 47,000 users accessing journal articles in 2023, 20% of whom are visitors from outside Aotearoa New Zealand.

Our journal is committed to enabling new voices, and we actively encourage master's students, with the support of supervisors and others, to craft their work into articles for publication. The value of that process is evident in the article by Renau et al. (2023). This article was based on a study completed for the MA (Social Policy) at Massey University and featured in our top 15 most widely read articles. The article explored how practice standardisation and

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 1–9.

the culture of compliance associated with neoliberal managerialism impacted the ability of social workers to provide support and advocacy for marginalised people. The social workers who participated in the study described limitations on their actions that seemed clearly related to managerialism, "All the participants recognised that management and contract requirements had negatively affected their ability to advocate for their clients" (p. 52). Yet, the authors identify what they refer to as a "neoliberal blindness paradox" (p. 53) in that the social worker participants seemed unable to reflect critically on the neoliberal context, emphasising instead a micro-level practice focussing on personal empowerment and individual solutions. This work suggests the need for further research exploring the impact of the neoliberal political imaginary on social work practice and promoting alternative visions of critical social work, including alternative organisational settings such as social work cooperatives and collectivist forms of service delivery. How, for example, is neoliberalism understood through a colonial lens in an iwi-based social work organisation?

Documents are often overlooked as rich sources of data in social research or considered mere carriers of textual themes. However, as Atkinson and Coffey (2011) argue, "Documents are not neutral, transparent reflections of organisational or occupational life. They actively construct the very organisations they purport to describe" (p. 77). This is especially true of government policy documents and reviews of organisational practice. We welcome the work of researchers willing to undertake the detailed, close reading necessary to offer a thorough content analysis. Fitzmaurice-Brown's (2023) reading of the six separate reviews of Oranga Tamariki in 2019 offers valuable insights into their common areas of concern and the tension between reformist solutions and more radical transformational perspectives. As the author argues, "There is a clear need to take a more structural approach to child-protection reform, interrogating the underlying causes of poor outcomes rather than assuming those outcomes can be improved within current policy paradigms" (p. 17). We are not surprised that this article is one of the most widely read of 2023, and we suspect it will remain a valuable source for practitioners and policy researchers for several years to come.

The *Aotearoa New Zealand Social Work Journal* editorial collective was delighted to publish an issue of *Tu Mau* in June 2023. Unsurprisingly this has been a very popular issue with the comprehensive editorial and three articles featuring in the top 15 most-read articles for 2023. In a comprehensive editorial, that does so much more than introduce the issue, Crichton-Hill et al. (2023) discuss two significant themes to foreground the scholarship to come. The first theme is the impact of Covid-19 on Pasifika people and social work. Citing a rich range of research from various disciplines they start by noting the way the pandemic highlighted existing inequalities, noting the severity of job losses, illness, family stresses and mental distress experienced in Pasifika families. In addition, the restrictions on social gatherings of the lockdown period including the outright bans and limiting number impacted on families' ability to come together for funerals and other milestone events.

The second theme related to the experiences of Pasifika social workers. In particular the Auckland August lockdown in 2012 exacted an "emotional, physical, spiritual, and social toll on many workers. Pacific social workers experienced an increase in their workload, were asked to support new Covid response initiatives (Dalhousie, 2023) contributing to public health measures and addressing family hardship whilst "simultaneously facing increased responsibilities on the home front with caregiving responsibilities" (Crichton-Hill, 2023, p. 2). Changes in work focus, the increase in electronic communication in practice created new challenges for practitioners who value the strength of relationship created in face-to-face practice.

In one of the top-15 *Tu Mau* articles, Cleverley (2023) reports on a qualitative study that explored culturally informed understandings of wellbeing for I-Kiribati people. Kiribati is a small nation in Te Moana-nui-a-Kiwa, where climate change is already having a profound effect and where the "cascading effects of increased global temperatures have impacted small island nations, contributing to displacement" (Crichton-Hill, 2023, p. 5)—including the driving of increased migration of I-Kiribati to Aotearoa New Zealand. Cleverley identifies four key findings from her research: I-Kiribati perspectives of wellbeing; family and home as central to I-Kiribati wellbeing; the importance of the preservation and maintenance of cultural practices; and the centrality of community connection in wellbeing. Maintaining cultural heritage and practices is even more crucial in the event of displacement from island homelands.

Cleverley (2023) makes several recommendations based on her research: to increase the diversity of the Pacific workforce and to reduce some of the barriers that prevent I-Kiribati from accessing health and social services. Secondly, to ensure that more Pacific workers are contributing to management and decision-making to ensure engagement in policy making. Finally, Cleverley argues for increased involvement and collaboration between service providers and Pacific minority communities to build positive relationships important for working with smaller communities such as I-Kiribati.

An article by West explores how social workers engage Pasifika children with disability, and their families. Acknowledging that, for Pasifika families, accessing disability services in Aotearoa New Zealand is a complex undertaking. Disability support systems in Aotearoa New Zealand are challenging to access and Pasifika families face dual systemic barriers due to racism and ableism. West's findings highlight the structural, cultural and personal oppressions experienced by Pasifika families that need to be addressed for social workers to successfully practise with Pacific families. An important finding is that Pasifika families value all children as gifts and may not experience that grief that may occur in response to disability in other families. "Understanding this in practice was crucial, with participants discussing the hurt caused by practitioners who insist on working through the grief process they felt families *should* be experiencing" (West, 2023, p. 17). West's article is a good example of how small-scale research can generate important insights to improve practice and cultural understanding.

In a shift in focus to consider social work education in Te Moana-nui-a-Kiwa, Waqa et al. (2023) share the reflections of students, graduates and junior staff from the University of the South Pacific (USP) from a talanoa on "Culturally relevant social work in Oceania". This top-15 article notes the greater inclusion of Indigenous social work knowledge and theory. The authors conclude that social work education has an over-reliance on Western knowledge and practice frameworks and argue for the development of Pacific specific social work education that maintains Pacific cultural identity; includes Pacific Indigenous knowledge; uses Pacific languages; addresses issues relevant to Pacific nations and communities; and uses culturally inclusive and responsive assessment practices. Climate change loomed again as an issue of significance emphasising the importance of including aspects of cultural identity, traditional knowledge and Indigenous resilience: "This is important specifically as global economic crises are looming in addition to climate change issues experienced by "Small Island States" [which] can lead to displacement of population groups and loss of identity, culture and ways of being" (Waqa et al., 2023, p. 36). The talanoa reported in this article was very positive about future developments for social work in Oceania, advocating for development of higher education in social work and the promotion of social work scholarship and research. The launch of a book at the event where the talanoa took place highlighted the growing Pacific scholarship in the region (Ravulo et al., 2019).

In a time of great upheaval and significant concerns about the relationship between government and Iwi, Lewis et al.'s (2023) article is timely and has emerged as one of the top 15 most read in 2023. The authors' starting premise is that community-based Māta Waka (pan-tribal) organisations which provide a range of services to tamariki, rangatahi and whānau Māori who are not mana whenua are frequently overlooked in discussions of Crown–Māori partnerships. Lewis et al. reported on a Kaupapa Māori study designed to examine the expectations that kaimahi working for a Māta Waka Kaupapa Māori service provider have of other organisations that: partner with tamariki, rangatahi and whānau Māori; and partner with Māta Waka.

In a rich and engaging article, Lewis et al. (2023) draw on findings from wānanga with kaimahi, to illuminate the principles and values that guide their practice, using these as a foundation for exploring the complexities, challenges, and opportunities inherent in building effective partnerships with statutory child protection services on behalf of tamariki, rangatahi and whānau Māori across differences in mandate, power, world views, and guiding frameworks or tikanga Māori. The study findings have implications for current Crown–Māori partnership efforts and, by extension, for the wellbeing of tamariki, rangatahi, and whānau Māori. The authors make the case for significant change to the "top-down, performance-focused, Westerncentric contracting models to investments … which in ways both subtle and forthright, disrespect and devalue Māori ways of being, knowing, relating, and doing" (p. 16).

Two of the top-read articles in 2023 were by Deverick and Mooney (2023a, 2023b) and, taken together, provide a rich resource for budding bicultural researchers in Aotearoa New Zealand. The authors report on a study that was a bicultural collaboration between a Pākehā researcher (a tauira, student) and a Māori social work research supervisor. The first article (2023a) describes the methods they used to conduct the study, and presents a reflective account of the process, in an effort to use a decolonising lens. Deverick and Mooney argue that this reflective process helps acknowledge and take account of the wider social, political and historical contexts in which we practise and research social work. This article will undoubtedly already have proved useful to Pākehā keen to engage in bicultural research processes in studies that engage with Māori participants and in teaching research methods. It describes wider issues of accountability, relationships and supervision, as well as interpersonal aspects such as interviewing processes. The authors provide a realistic account of the tensions inherent in this kind of research and explore how cultural humility can inform the application of these concepts and practices in interview settings. Questions such as "Do all Māori researchers/social workers feel confident with karakia? If not, what might be alternatives when the process is recognised as tikanga" (p. 21) are posed for future exploration.

In the second article, Deverick and Mooney (2023b) explore the personal bicultural practice journeys of four social workers. The complexities of colonisation in social work practice and education are outlined through the presented findings highlighting the importance of shared understandings of te Ao Māori and differing, diverse journeys. A key recommendation presented by Deverick and Mooney, through the voices and experiences of participants, is a need to bridge the gap between policy and practice. This article has no doubt found a readership amongst Pākeha and other tangata tiriti social work students as they navigate the challenges and committments of bi-cultural practice. The authors note that "courageous conversations for bicultural partnerships to succeed and flourish" are needed in social work (p. 45). Alignment with social work values requires working "within discomfort" to support others to do the same: "collaboration, tātaihono, means undertaking this mahi together; only this will keep the fire burning bright well into the future" (p. 45).

Dyer and Chisnell's (2023) inquiry into trauma-informed practice and care for social workers in care and protection roles was another popular reading in 2023. Trauma-informed practice continues to attract a considerable following, and this study adopted a qualitative methodology to explore the perspectives and experiences of care and protection workers. The study asked practitioners questions about their knowledge and training and the support they receive when working with trauma-affected clients. The study found that, although practitioners had a good understanding of trauma and its effects, the implementation of trauma-informed practice was less clear. As the authors argue, "Understanding trauma is not enough, trauma work needs to be capitalised on with an ecological model that incorporates micro, macro, and meso levels" (p. 85). Concerning support and supervision, the study found that "Practitioners seem reluctant to engage in reflective supervision with their supervisors due to concerns about how it may impact their work" and that—in common with the findings of many other studies—"supervision is consistently being prioritised for case management, and time restraints impact the ability for discussions around self-care and emotional resilience" (p. 87). The authors end with a series of recommendations, including that social workers should be trained in the implementation of trauma-informed practice and that there should be trauma-informed supervision training for social work supervisors.

In another exploration of the emotional impact of social work practice on practitioners, Gallagher and Cooper (2023) interview social workers working in end-of-life (EOL) care to discover their views on methods of self-care. The authors find that each one of their participants had personal experiences of death and dying and "they all stated that they had drawn on those experiences throughout their work" (p. 97). They also found that their participants had developed reasonably "robust personal self-care strategies that were practised regularly" (p. 97), including healthy eating, taking time to relax, and ensuring quality sleep patterns. Regarding professional self-care strategies, debriefings and access to regular individual and peer supervision were also valued by each participant. Whilst all participants had experienced some job-specific training for working in EOL care, employers did not always prioritise this, and participants expressed a need for further training related to their specific job roles. Participants also "believed that embedding self-care promotion into training would be beneficial for social workers" (p. 98). The authors conclude by urging education providers to offer further training and development opportunities in EOL care.

In an increasingly diverse Aotearoa with a growing refugee and migrant population, studies that attend to issues for these socially stigmatised population groups are critical. In their popular article, Ayallo and Kelly (2023) pay close attention to the operation of the victim-survivor family violence visa (VFV) by interviewing a sample of both ethnic victim-survivors and supporting non-medical practitioners. They find that victim-survivors' access to this visa was often challenged by cultural factors preventing them from providing the evidence required. These factors included that the most prevalent form of violence was psychological and hard to prove, that violence was often perpetrated by more than one family member, and that the history of family violence often occurred transnationally, including the country of origin. The study also found issues created by a lack of information about the operation of the VFV amongst both migrant women and their supporting practitioners: “Therefore, a great deal of community-based education is required within ethnic communities about partnership visas, the VFV policy, and the availability of social and legal aid programmes for ethnic communities” (p. 110). Concerning social stigma, the authors note that “Honour and shame are central concepts in most ethnic communities” (p. 111), with family breakdown often leading to family and employment exclusion. In this context, “the VFV visa is also a form of proof to their families that the relationship breakdown was not their fault, a form of evidence to prevent such exclusion” (p. 111). The authors conclude by arguing for a “more humanitarian and compassionate approach” to the VFV visa policy (p. 112) including allowing access to work permits, healthcare, education and work and income benefits while any visa application is being processed: “Such critical provisions provide sustainability, prevent further abuse due to financial dependency, allow the victim-survivors to establish themselves and give them more time to consider their immigration options” (p. 112). Scoping reviews provide a useful resource for future researchers and for those in practice who want access to a synthesis of relevant research.

In another top-read article Jackson et al. (2023) explore the existing research on Aotearoa New Zealand women’s experiences of substance use, alcohol and drug services. Although substance abuse and its adverse effects have been widely researched, the experiences of women, particularly mothers who access services, are often absent. Undertaken to inform the development and delivery of a new residential addiction-treatment parenting programme for mothers and children under the age of 3, the authors drew conclusions relating to how substance use, alcohol and drug services can be more responsive to the needs of this client group. Key learnings from the review included recognising the influence of male partners as well as the role of stigma and cultural context in shaping women’s engagement with substance use, alcohol, and drug services. The authors further identify missing voices within research relating to older women, sexual minorities, wahine Māori, and other ethnic minorities. The article concludes with some suggestions for social practice including the importance of education for social workers and the maintaining of a non-judgemental attitude and open-mindedness towards women engaging with these services.

In this issue

The Covid-19 pandemic continues to be a topic of interest in social work research. This issue includes three articles that explore different aspects of the pandemic in Aotearoa New Zealand. In “I am more me”: Post-traumatic growth for New Zealand healthcare social workers during Covid-19”, Christine Becker, Ksenija Napan and Shirley Julich contribute to this evolving research reporting a qualitative study that explored the experience of transformational growth for social workers who worked in healthcare in Aotearoa New Zealand during Covid-19. Using the lens of posttraumatic growth theory, their analysis develops a reading of how social workers responded to the significant professional stress that came with frontline work during Covid-19, and deep caring for their patients. Participants demonstrated a shared a strong self-identification with social work professional values and identity, which might have increased their likelihood of experiencing posttraumatic growth.

Addressing the impact of Covid-19 on supervision, Kieran O’ Donoghue and Yuen Han Kitty Mo report results from a quantitative study in “Cyber-supervision during the Covid-19 pandemic: An exploratory international survey.” With the aim of establishing a baseline of these experiences data were collected from

195 respondents. O'Donoghue and Mo's results showed that both supervisees and supervisors shared similar views about online supervision, which became necessary during Covid-19 lockdowns. A constructive view of online supervision correlated positively with overall satisfaction with supervision, while items less favourable of online supervision correlated negatively with overall satisfaction and evaluation.

O'Donoghue and Mo recommend that supervisors discuss their attitudes and cultural perspectives about online supervision early in the relationship where online supervision is planned.

In the third Covid-19 focused article, Hagyun Kim, Young Han and Donghyun Lee report on "The narratives of Asians amidst the Covid-19 pandemic in Aotearoa New Zealand: Navigating a virtual realm in the context with of anti-Asian racism." Kim et al. explore Asians' pandemic experiences and their impact on their quality of life in Aotearoa New Zealand. Their study is grounded in symbolic interactionism, examining the stories of 26 Asians representing Chinese, Indian, Filipino and Korean communities. Covid-19 created significant disruption to participants' lives, inducing anxiety and uncertainty. Online communication was essential to maintaining connections to family and friends. Participants reported heavy reliance on ethnic communities for support due to barriers to formal support systems. Echoing the findings reported by Park et al. (2023), North-east Asian participants reported distressing racism which targeted individuals with a Chinese appearance during the initial stages of Covid-19, resulting in reduced self-esteem and weakened societal belonging.

An ever-growing, rich body of scholarship of child welfare systems and practices is joined by a new article by Kerri Cleaver (Kāi Tahu, Kāti Māmoe, Waitaha). Building on her previous article (Cleaver, 2023), where she explored Wāhine Māori reproductive justice in the child protection system, Kerri Cleaver extends her analysis in "He Whare Takata: Are wāhine Māori visible in Oranga Tamariki practice guidance?" In her previous literature analysis article, Cleaver provided a detailed description of pre- and post-colonial herstory. Cleaver's work is grounded in a mana wāhine foundational position "that asserts the rakatirataka (leadership and self-determination) of wāhine and the inherent rights of wāhine as 'he whare takata', the house of humanity". This second article examines the Oranga Tamariki practice and evidence centres, specifically auditing content produced following a high-profile child protection case, for evidence of a shift of practice that incorporates wāhine knowing, being and doing holding to the foundation of 'he whare takata'. Cleaver's conclusion is that a refocusing "on wāhine as the holders of future ancestors needs to be included alongside the rhetoric of whānau-centred practice, understanding that mana wāhine is inclusive of a paramountcy of the child position".

In this journal edition, we have two linked articles by Jo Appleby, Barbara Staniforth, Susan Kemp, and Helene Connor (Te Atiawa and Ngāti Ruanui, Ngāti Rahiri and Ngāti Te Whiti), both exploring the intersection between Oranga Tamariki care-experience and mental health services. The first article "What interventions can CAMHS provide for young people involved with Oranga Tamariki? A review of literature" looks at the landscape of provisions and interventions for young people who have contact with our child protection system, Oranga Tamariki. The research reviews existing therapies while applying an analysis of cultural and intersectional needs, including what is available from a Māori positioning.

The findings and recommendations set a foundation for the second article "How should CAMHS work with young people who are involved with Oranga Tamariki? A literature review of the principles for working with care-experienced young people". In this article, Appleby, Staniforth, Kemp and Connor provide guidance on working in mental health services with young people who come with care experience. They identify practice approaches, developing the initial scope of research on interventions with a specific focus on principles for engaging and supporting young people with a care experience. This group of service users are identified as requiring practice that engages holistically with the trauma that a foster system journey might include. Both articles fill an important gap in Aotearoa literature and practice analysis highlighting the complexity of needs when working across stigma, trauma, and mental health. The findings reinforce the importance of the key social work principles of relationality, rights, and collegial collaboration while challenging system barriers, including organisational and structural. A rich resource of practice information for social workers and health professionals working with Oranga Tamariki young people both in the system or after their transition into communities.

Delivering health and disability services in contemporary Aotearoa New Zealand and other like nations is a growing challenge, with ever-decreasing resources and changing populations. Urgent solutions are needed as we approach the future with aging and growing populations. In response, a review of the health and disability sector conducted in 2020 called for significant reform in Aotearoa and the report *Hidden in Plain Sight* (HiPS) was commissioned by the Allied Health Sector, which includes social workers, to recommend how it might address issues raised in the review. The article, "Hidden in plain sight: A critique", contributed by Mary James, Isabel Jamieson and Kate Reid offers a critique of this report, considering the extent to which the recommendations can be implemented from a social work practice perspective.

The principles of collaborative and interprofessional practice have long been mainstays of social work, particularly in the health sector, and the authors appreciate how these principles are put forward in this report to improve the efficiency and equity of service. The authors appreciate the report's recognition of the value of allied health professionals, the diversity and significant size of the workforce and its potential to radically change the way health and disability services are experienced by people across the lifespan.

Despite the acknowledgement of the potential of interprofessional practice and allied health in general, James et al. express disappointment with the report. In their view, the historic challenges of interprofessional practice are not addressed view. Solutions are not offered for the continuing problems associated with the devalued role of social work within the traditionally hierarchical health service environment. Social work in the health setting continues to be relegated to a support status, rather than a primary role in patient-centred care. There is continued need for the role of social workers and their allied health colleagues to be better understood and for the health system to be restructured to make better use of their strengths. The authors also feel that funding issues and the complex challenges within the current contractual environment to devolve services to iwi and the community have not been adequately addressed in the HiPS report.

There is a sense of impatience in this article for a lack of attention to established practice and research to inform ways forward. The authors emphasise that good interprofessional models of care exist in the health system, within iwi services for example, or in the palliative care field, and recommend these be examined for increased understanding of their realities. The authors cite recent research in Aotearoa that evidences good interprofessional practice, its benefits and necessary conditions, including a high level of trust and ability to manage power dynamics. There is no shortage of this knowledge or of opportunity to vastly improve health and disability services in Aotearoa New Zealand.

This issue contains four book reviews. First is a review of *Whāia te Ara Ora: Understanding* *and healing the impact of historical trauma and sexual violence for Māori* by Leonie Pihama, Ngaropi Cameron, Mereana Pitman and Rihi Te Nana, reviewed by Kendra Cox. Darren Renau reviews *The Sage handbook of decision making, assessment and risk in social work* edited by Brian J. Taylor, John D. Fluke, J. Christopher Graham, Emily Keddell, Campbell Killick, Aron Shlonsky, and Andrew Whittaker. Amy Hogan reviews *Defining the boundaries of disability critical perspectives* edited by Licia Carlson and Matthew C. Murray. *Social work practice during times of disaster: A transformative green social work model for theory, education and practice in disaster interventions* by Lena Dominelli is reviewed by Lynsey Ellis.

Neil Ballantyne and Liz Beddoe

References

Atkinson, P., & Coffey, A. (2011). Analysing documentary realities. In D. Silverman (Ed.), *Qualitative research: Issues of theory, method and practice* (pp. 77–92). SAGE Publications.

Ayallo, I., & Kelly, T. (2023). Challenges to the proof of violence, and social stigma for ethnic migrant women in the current Victims of Family Violence (VFV) visa policy in Aotearoa New Zealand. *Aotearoa New Zealand Social Work*, *35*(3), 101–114. https://doi.org/10.11157/anzswj-vol35iss3id1049

Ballantyne, N., Beddoe, L., Cleaver, K., Crichton-Hill, Y., Hyslop, I., Joy, E., Keddell, E., Stanfield, D., & Walker, S. (2023). Justice for Palestine. *Aotearoa New Zealand Social Work, 35*(4), 13-15. https://anzswjournal.nz/anzsw/article/view/1143

Beddoe, L. (2023). Recognition of the role of our journal Aotearoa New Zealand Social Work. *Aotearoa New Zealand Social Work*, *35*(3), 1–4. https://doi.org/10.11157/anzswj-vol35iss3id1118

Beddoe, L., Joy, E., Meadows, L., Cleaver, K., & Crichton-Hill, Y. (2023). Reproductive justice: Holding the line and pushing forward. *Aotearoa New Zealand Social Work*, *35*(4), 1–12. https://anzswjournal.nz/anzsw/article/view/1142

Cleaver, K. (2023). He Whare Takata: Wāhine Māori reproductive justice in the child protection system. *Aotearoa New Zealand Social Work*, *35*(4), 16–30. https://anzswjournal.nz/anzsw/article/view/1135

Cleverley, L. (2023). Understanding I-Kiribati wellbeing and its implications for health and social services. *Aotearoa New Zealand Social Work, 35*(2), 22–33. https://doi.org/10.11157/anzswj-vol35iss2id807

Crichton-Hill, Y., Mafile'o, T., & Veukiso-Ulugia, A. (2023). Resistance, reclaiming and reframing: Relationship-based Pacific social work practice. *Aotearoa New Zealand Social Work, 35*(2), 1–7. https://doi.org/10.11157/anzswj-vol35iss2id1064

Dalhousie, S. (2023). The Fono's "Alert Level 4" Story. *Aotearoa New Zealand Social Work, 35*(2), 41–46. https://doi.org/10.11157/anzswj-vol35iss2id786

Deverick, K., & Mooney, H. (2023a). āpiti hono, tātai hono: A collaborative bicultural social work research approach. *Aotearoa New Zealand Social Work, 35*(1), 21–33. https://anzswjournal.nz/anzsw/article/view/964

Deverick, K., & Mooney, H. (2023b). āpiti hono, tātai hono: Collaborative bicultural social work practice—A selection of findings. *Aotearoa New Zealand Social Work, 35*(1), 34–47. https://anzswjournal.nz/anzsw/article/view/965

Dyer, R., & Chisnell, C. (2023). An inquiry into trauma-informed practice and care for social workers in care and protection roles in Aotearoa New Zealand. *Aotearoa New Zealand Social Work, 35*(3), 76–88. https://doi.org/10.11157/anzswj-vol35iss3id982

Fitzmaurice-Brown, L. (2023). Revisiting the 2019 Oranga Tamariki inquiries: What did we learn, and what might that mean for the future of child protection in Aotearoa? *Aotearoa New Zealand Social Work, 35*(3), 5–18. https://doi.org/10.11157/anzswj-vol35iss3id1032

Gallagher, S., & Cooper, L. (2023). Self-care methods of social workers working in end-of-life care. *Aotearoa New Zealand Social Work, 35*(3), 89–100. https://doi.org/10.11157/anzswj-vol35iss3id1059

Jackson, S. C., Chubb, L., & de Haan, I. (2023). A scoping review of Aotearoa New Zealand women's experiences of substance use, alcohol and drug services. *Aotearoa New Zealand Social Work*, *35*(3), 58–75. https://anzswjournal.nz/anzsw/article/view/1060

Lewis, L., Walker, S., King, P. T., Mackay, H. T. U., Talamaivao, N., Anderson, D., & Kemp, S. P. (2023). Ka mua, ka muri—Walking backwards into the future: Partnering with mainstream child protection services as a community-based Māta Waka organisation. *Aotearoa New Zealand Social Work, 35*(1), 5–20. https://doi.org/10.11157/anzswj-vol35iss1id1016

Park, L., Jaung, R., Park, J., & Song, C. (2023). Asian communities' well-being in Aotearoa during the Covid-19: The mitigating role of sense of belonging in the relationship between racism and life satisfaction. *Aotearoa New Zealand Social Work*, *35*(1), 95–112. https://doi.org/10.11157/anzswj-vol35iss1id1027

Ravulo, J., Mafile'o, T., & Yeates, B. D. (2019). *Pacific social work: Navigating practice, policy and research*. Routledge.

Renau, D., Stanley-Clarke, N., & Mafile'o, T. (2023). Social workers and their understanding of neoliberalism, advocacy, and othering. *Aotearoa New Zealand Social Work*, *35*(3), 44–57. https://doi.org/10.11157/anzswj-vol35iss3id997

Waqa, M., Meo-Sewabu, L., & Nein, M. (2023). Culturally relevant social work in Oceania: Reflections and perceptions. *Aotearoa New Zealand Social Work, 35*(2), 34–40. https://doi.org/10.11157/anzswj-vol35iss2id785

West, D. (2023). "Pasifika families aren't accessing specialist services as much because those services require a really one-eyed view of the child": How social workers engage Pasifika children with disability and their families. *Aotearoa New Zealand Social Work, 35*(2), 8–21. https://doi.org/10.11157/anzswj-vol35iss2id784

"I am more me": Post-traumatic growth for New Zealand healthcare social workers during Covid-19

Christine Becker[1], **Ksenija Napan**[2] and **Shirley Jülich**[2]

[1] Whatu Ora New Zealand Health New Zealand

[2] Massey University, School of Social Work

ABSTRACT

INTRODUCTION: The Covid-19 pandemic posed major challenges to healthcare workers working on the front line. Their risk for negative mental health outcomes is well established, and a high volume of research has been directed at the causes, as well as measures to increase workers' coping and resilience. Further, holistic and salutogenesis-oriented research is emerging directed at the origins of wellness and opportunities to grow after experiencing adversity. We contribute to this evolving research by qualitatively exploring the experience of transformational growth for social workers who worked in healthcare in Aotearoa New Zealand during Covid-19.

METHODS: We conducted semi-structured, online interviews with a sample of six social workers. Their accounts were analysed using an explorative semantic and interpretative form of reflexive thematic analysis, and five main themes were identified. The lens for analysis was Tedeschi and Calhoun's post-traumatic growth (PTG) theory.

FINDINGS: Participants identified PTG in the form of an increased sense of self and self-identity. They reported significant vocational stresses and deep caring for their patients. They shared a strong occupational self-identification with the social work profession, which might have increased their likelihood of experiencing PTG. Most identified a transformational shift toward paying attention to their own needs.

CONCLUSION: These findings contribute to a new and more holistic perspective for our future pandemic response strategies. Further investigation is suggested to explore the identified shift in the balance between care for others and self-care within the profession.

Keywords: Post-traumatic growth; social worker; healthcare; Covid-19; pandemic; qualitative

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 10–23.

CORRESPONDENCE TO:
Christine Becker
ces.becker@gmail.com

On 5 May 2023, the World Health Organisation (WHO) declared an end to Covid-19 as a global health emergency, more than three years after they had declared it a pandemic on 11 March 2020 (WHO, 2023). Covid-19 is the illness caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). It was first identified in Wuhan, China in December 2019, and, from there, evolved into a global pandemic and the biggest health crisis of our time.

Aotearoa New Zealand was one of the most successful countries in controlling the spread of Covid-19 and minimising the loss of health and lives. Its success was attributed to the elimination strategy *Going Hard and Going Early* (Ministry of Health, 2020), which involved entry controls at the border and a four-level national alert system including lockdowns. Healthcare workers, including social workers, were considered essential workers. This meant that they were expected to report for work as usual at all national alert levels including lockdown, following the approach, *we are here if you need us*. On 30 April 2021, a vaccination mandate for healthcare workers came into force in Aotearoa New Zealand (COVID-19 Public Health Response (Vaccinations) Order 2021).

The Covid-19 pandemic posed major global challenges for healthcare systems, particularly the healthcare workforce working at the front line. During the pandemic, healthcare workers faced an increased risk of morbidity and mortality, mental health issues, moral injury, and the fear of disease transmission to loved ones. Specifically, healthcare workers' risk for negative mental health outcomes has been well established and includes exhaustion, depression and anxiety, insomnia, alcohol and drug misuse, burnout, vicarious trauma, and PTSD (Koontalay et al., 2021; Stuijfzand et al., 2020).

The 2020 fast-evolving global Covid-19 crisis led to equally fast-evolving research published over the course of the pandemic. A substantial part of this research focused on workers' risk for negative mental health consequences and on individual and organisational measures to mitigate this risk (Croghan et al., 2021; Sun et al., 2021). While this research is important, another type of research is gaining credence: research that applies a salutogenic perspective and is interested in what the pandemic can teach us (Rajkumar, 2021). Salutogenesis, as opposed to pathogenesis, focuses on the origins of health and well-being instead of the causes of disease (Antonovsky, 1987). While this research is gaining momentum, there is still little research from a qualitative perspective about the rewarding and transformational outcomes for healthcare workers during Covid-19. This study aimed to address this gap. It is a qualitative study with the objective to explore social workers' post-traumatic growth (PTG) experiences from working in physical healthcare settings in Aotearoa New Zealand during the Covid-19 pandemic and its related lockdowns.

The theoretical lens for analysis in this study was post-traumatic growth (PTG) theory (Tedeschi et al., 2018). The theory defines PTG as "positive psychological changes experienced as a result of the struggle with traumatic or highly challenging life circumstances" (p. 13). It is based on the concept that we construct core beliefs about ourselves, and the world we live in, based on our personal experiences, life stories, and frames of reference. It defines trauma not as an external event but as an internal response to an event or to highly distressing circumstances over time. A traumatic experience involves, at least in part, the destruction of our core beliefs and the construction of new core beliefs thereafter. If the new core beliefs are more nurturing of potential and sophisticated than the old ones, we will see PTG, which can be observed in five domains: personal strength; relating to others; new possibilities; appreciation of life; and spiritual and existential change.

PTG theory recognises that the transformative process of growing involves the interaction of emotional, behavioural, social, spiritual, and environmental components. However, PTG theory identifies that the main activity leading to PTG is deliberate rumination following a traumatic experience.

Quantitative investigations into the experience of PTG for healthcare workers during Covid-19 suggest that PTG was common in this population, however, at differing levels. According to PTG scores, measured with the PTG Inventory (PTGI) and the PTG Inventory Short Form (PTGI-SF), the identified PTG levels ranged from *low* for nurses in

New South Wales (NSW), Australia from September to November 2020 (Aggar et al., 2022), to *moderate* for nurses in China in June 2020 (Zhang et al., 2021), to *high* for nurses in Hubei Province, China from February to April 2020 (Mo et al., 2022). A study by Feingold et al. (2022) during the Covid-19 spring peak in 2020 and six months thereafter found that four out of five healthcare workers at a hospital in New York City, USA experienced moderate to high levels of PTG. However, there remains a need for more qualitative research to better understand the trajectory of PTG as a lived experience and provide the depth and richness of knowledge that is needed to efficiently foster PTG in the healthcare workforce.

Overall, this study aims to contribute to a shift in perspective, away from a deficit-oriented and medicalised model of the human experience, toward a holistic and salutogenic-oriented model. It also aims to inform future occupational health measures that move beyond essentially helping workers to cope and bounce back, toward helping them grow and bounce forward. This shift provides the space for rethinking the nature of the crisis and how we conceive our response to it and offers chances for adaptation and growth to our future healthcare systems.

Methods

Participants

A purposive study sample of six registered social workers who worked in physical healthcare settings in Aotearoa New Zealand during Covid-19 was recruited over four months, from 1 March 2022 to 30 June 2022. The recruitment was conducted via the Aotearoa New Zealand Association of Social Workers (ANZASW) and the researchers' professional networks. Social workers who were currently receiving psychiatric treatment for an acute mental health crisis were not part of the sample. An anonymous demographic form was completed by all six participants. The qualifying diversity data was obtained to describe the cultural space that the participants occupied. The demographic data are depicted in Table 1.

Table 1. Demographic Data

DEMOGRAPHIC DATA	
Age range	The participating social workers report their age range as either between 51-60 years of age or 31-40 years of age, with the majority belonging to the higher age group.
Gender	All six participants identify as female.
Professional Experience	Most participants present with many years of professional experience, with about half of the participants having 21-plus years of experience.
Ethnicity	All six participants identify their ethnicity as European, either as Pakeha (New Zealand European) or Other European (from an English-speaking country overseas). One participant also identifies as having connections to iwi.
Relationship Status	The majority of the participants report being partnered or married. One participant reports being single.
Parental Status	The majority of the participants report having children. One participant reports having no children.
Social Work Role and Responsibilities	All six participating social workers are working in health. Two participants had front-line management responsibilities during COVID-19.
Previous Trauma	A question about earlier traumatic experiences in life was answered positively by most participants, with two participants being unsure.

Data generation

We used the methodological design of a reflexive thematic analysis (Braun & Clarke, 2022), and the method of individual online interviews with a semi-structured interview guide. The guide focussed on three subject areas: an exploration of whether there might have been particularly distressing or traumatic experiences during Covid -19; a reflection about whether something 'good' and transformative might have come out of it for the participant; and a critical reflection about what might have facilitated one's growth experiences. The interview style was participant-centred and empathic to enable a free flow of exploration led by the participants. The interviews took about an hour and participants were offered a choice of pseudonyms, which some of them did. Interviews were conducted from April to August 2022.

Positioning the authors

The interviewing researcher was employed as a senior social worker with Te Whatu Ora, New Zealand Health, during the pandemic and, as such, had insider researcher status. The research team used reflexivity to be transparent about the researcher's personal perceptions and how these could influence the research. At the time of this study, the researcher was in the second year of her master's degree in social work. The other two authors are doctorial supervisors.

Analysis

We chose the combination of an explorative and inductive semantic focus and an interpretive focus of analysis (Braun & Clarke, 2022). That is, we stayed close to the participants' language and concepts while using the lens of PTG theory to identify implicit meanings. This enabled us to obtain authentic contextual accounts and let them speak for themselves within an interpretive thematic framework. The software program NVivo 20 was used to support the analytic process.

Ethics

This research project was granted full human ethics approval by the Massey University Human Ethics Northern Committee in Auckland, New Zealand, on 6 December 2021: NOR 21/70.

The participants were informed about the risk for discomfort and distress that can arise from any conversation about potentially traumatic experiences and a list of support sources was provided.

Analysis and discussion

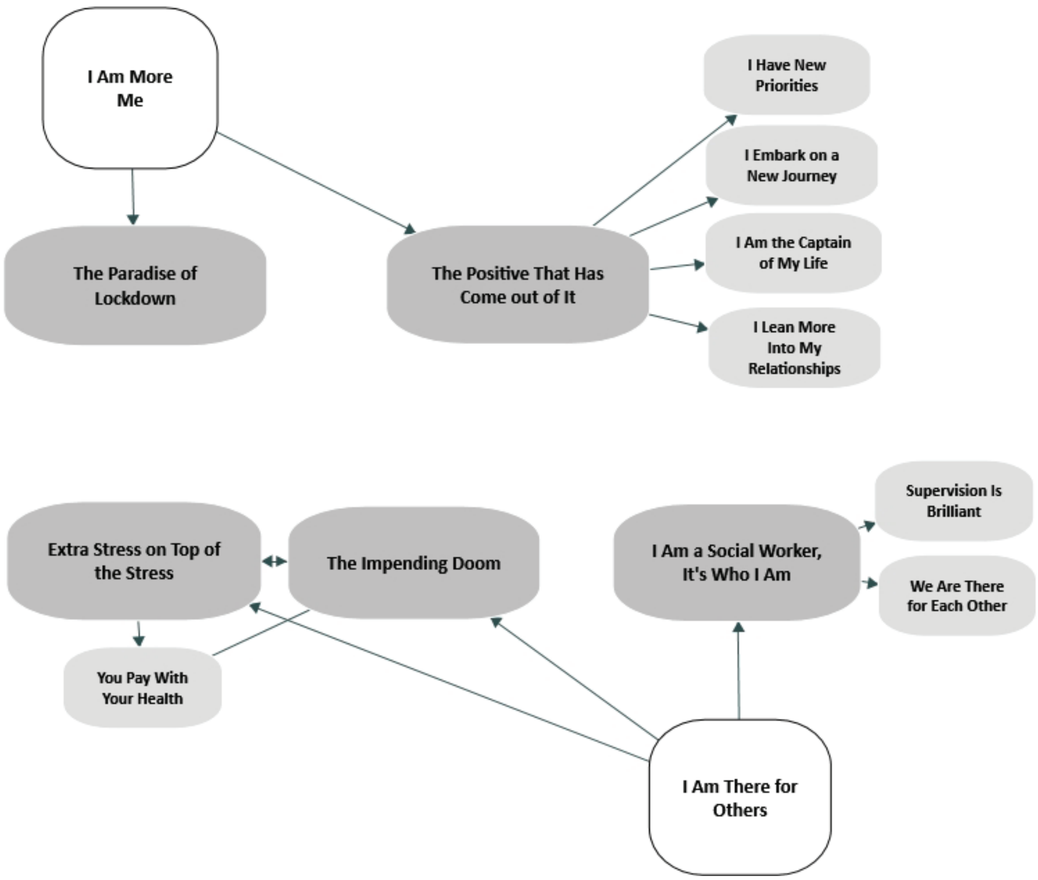
The analysis of this study identified a hierarchical thematic structure comprised of five themes, seven sub-themes, and two overarching themes. The themes were named: *I Am A Social Worker, It's Who I Am; The Impending Doom; Extra Stress on Top of the Stress; The Paradise of Lockdown*; and *The Positive That Has Come Out of It.* The two overarching themes were *I Am There for Others* and *I Am More Me.* These group the themes of this study into two main clusters. A map of this thematic structure is depicted in Figure 1.

Theme 1: I am a social worker, it's who I am

The theme, *I Am a Social Worker, It's Who I Am,* captured the construction of a strong and positive identification with the social work profession that was present across the dataset. For example: "It's intrinsically who I am, I'm a social worker because it's an extension of my value base. It's who I am. I don't know how to be anything else" (Camia). Nuances included placing social work within the bigger concept of a life purpose: "I think I identify as a healer, you know, as a social worker" (Angelica), and recognising tension:

> I do not have a love-hate relationship, but it can be very draining and you often get little reward from it, but I keep coming back to doing it, and whenever I consider doing anything else, I always come back to social work. (Poppy)

Figure 1. Thematic Structure



Key: Themes Are Depicted as Rounded Rectangles; Subthemes as Smaller Rounded Rectangles; Overarching Themes as Rounded Squares. A Single-Directional Arrow Indicates a Hierarchical Relationship Between Themes; a Bi-Directional Arrow a Lateral Relationship Between Themes; a Simple Line an Associative Relationship Between a Theme and a Subtheme of Another Theme.

This identification was accompanied by many declarations of love: “I love my job” (Nadine), “I love my role as a social worker” (Angelica), and even passion: “You cannot not be passionate when you’re putting yourself [in danger] … it reinforces the passion for the field of social work, but also, for me, for families with children … the clients that I’m working with” (Poppy).

Poppy’s comment reveals another consistently identified dimension: deeply caring for patients. For example: “I’ve struggled with that mentally, what was happening to some of those clients out there” (Jenny). For a few participants, their caring involved the stretching of professional boundaries during a lockdown: “I found myself doing grocery shopping for her [a patient] on the Saturday morning because I was worried about her” (Angelica) and “There's a lot of emotion in my voice [during phone consults] … there’s fewer boundaries between me and patients” (Rebecca). These comments reflect a bigger construction: putting the needs of others at the centre of one’s (vocational) attention. It was captured in the overarching theme, *I Am There for Others*, which is one of two overarching themes in this research.

Participants' identification with social work seems to offer favourable properties for the experience of PTG. One is occupational self-identification itself (Mo et al., 2022). Another is the knowledge of social work theoretical models to inform thinking (Cui et al., 2021), including models of meaning-making (Feingold et al., 2022) and trauma (Moreno-Jiménez et al., 2021). For example: "Carl Jung … the work he did was so powerful. We all need to take personal responsibility for our own shadow-self and work on our own, you know, pain and trauma" (Angelica). For several participants, a personal trauma history seemed to deepen their theoretical understanding: "I feel like, I've sort of worked through a lot of major traumas" (Rebecca) and "You think: 'Oh my God, nothing like this has ever happened to me in my life', but actually, to some degree or other, different events of traumas [have similarities]" (Nadine).

Inherent to social work seems to be a belief in the possibility of positive transformation, the key tenet of PTG:

> Social work, it's like Covid, it's often unpredictable, it's often really hard work, and you can't see the light at the end of the tunnel, but you just keep going because you know at some point you'll see the light or there'll be some change or shift or breakthrough … and with social work, you know, often there is. (Poppy)

The participants' identification with social work encompassed its characteristic values and principles: "As a social worker, my truth and integrity are far more important to me [than pleasing others]" (Angelica). A specific area of traumatic tension arose for some from a perceived incompatibility between their commitment to the right of autonomy and the vaccination mandate for healthcare workers: "We don't have that sovereignty over our bodies … we've essentially lost that human right and that was the biggest thing I felt, and still do to a degree, grief over" (Nadine) and "The most difficult thing for me, over this two-year period, has basically been feeling silenced as a social worker. And being seriously concerned about our lack of choice" (Angelica).

Expertise in the area of self-care was identified by many participants as a means of their resistance during the pandemic: "I had developed a self-care training that we could do at team meetings, even on Zoom" (Camia), "It's about being in tune with yourself" (Camia), "I'm a pretty mindful person … when you wake up in the morning, what do you hear first? The birds, you know, the tui" (Rebecca), and "If we're angry, it's not the other person or the government, what's the point, I have to look after myself … it's part of my self-care" (Angelica).

Sub-theme: We are there for each other

The sub-theme *We Are There for Each Other* is one of two sub-themes to the theme *I Am a Social Worker, It's Who I Am*. It captures the idea of camaraderie between colleagues, which was present in every data item. Between peers: "My team were super supportive on an emotional level for me" (Nadine); "We also got a support group sort of going between us … and that side of things was good" (Jenny); "She and I kind of banded together in the crucible of life … and so we kind of had this gluing together" (Camia); "A lot of our Zoom meetings about planning ended up actually being more a collegial support group … that was a huge support" (Poppy).

And, between workers and management: "My boss is very nice … and she's understanding if I don't get work done" (Rebecca) and "My manager stepped up to the plate, and they were very good because I needed quite a bit of time off" (Nadine).

Social support and subjective social support were identified as correlates of PTG by studies into the healthcare workforce during Covid-19 (Zhang et al., 2021).

Sub-theme: Supervision is brilliant

The sub-theme *Supervision Is Brilliant* is the second sub-theme to the theme *I Am a Social Worker, It's Who I Am*. It captures the construction of a nurturing mentorship that was endorsed by every participant. For example: "I regularly had supervision, each month, and it was great. I found that brilliant" (Jenny) and:

> I have a supervisor … she was great. She was so good. I can't thank her enough for how supportive she was and how she did try to help me look at things from a different perspective … she was fantastic. (Nadine)

> My supervisor is a good listener. She's got a really positive style. She hears me out with whatever I'm feeling. She helps me focus on what's important to me. It's been really valuable. (Rebecca)

> Very empathetic, very empowering, just quality supervision, where it's productive, you're sort of getting to the core of what the issues are … I think that my supervisor could really side and guide. (Poppy)

Studies on PTG experiences for healthcare workers suggest supervision to be a PTG-fostering measure during the pandemic (Veronese et al., 2022).

Theme 2: The impending doom

The theme *The Impending Doom* captured the construction of an intense sensation that something tragic and life-threatening was about to happen that was identified across the dataset. For example: "Our biggest problem was the mental emotional impact and fatigue of the impending doom" (Camia); "I can remember the news of Covid and lockdown, and just one doctor and I looking at each other and thinking: 'What is this year going to look like? ... What have we got ahead of us?'" (Angelica); "Sitting on the edge of our seats for two and a half years waiting for it to hit, that's been the hardest bit. And that bit has kind of been like a roller coaster" (Camia), and:

> We didn't know what Covid was, what the impact of Covid would be, and so it was just very airy, like an apocalyptic type feeling driving to work in the mists with no cars, just me … I can slightly feel it in my body now. It's like an internal shaking feeling, it's like on the outside you seem fine, but on the inside, your core, it feels very primal … maybe that is fear. Yeah, just the unknown, going into the unknown when everybody else in society was not doing it. (Poppy)

The described sensation, that something threatening was about to occur seems to be partly linked to fear of the unknown: "That first lockdown, it was stressful, it was, you know, the unknown" (Angelica); and "The first lockdown was probably the worst experience, and probably because it was all so new" (Nadine). Other fears included the fear of infection and transmission of the disease and the fear of war-like frontline combat. These align with fears identified in the literature including fear of self-sacrifice from workers' morality of duty (Fontanini et al., 2021; Liu et al., 2020).

The language used in some studies was analogous to military language, evoking a sense of uniting as a front-line defence to fight a common enemy. Similar analogies were present in this study: "Me working from home, I'm not on the front line with them trying to figure this out" (Camia); and "Like in war, it's a survival thing, you're just doing whatever you can to help as many people as you can to get through" (Poppy).

Several participants described the fear of infection and transmission: "A lot of it was worry and: 'are we going to get infected?'" (Jenny); and "My worry was that I would go to work and bring home this supposedly deadly virus to my children and that would be disastrous" (Poppy).

An additional fear was the elimination of healthcare workers' rights associated with a possible healthcare emergency: "There were times when I have felt calm and safe, and times when that's the last thing I felt, like not knowing whether my rights and freedom would be taken away" (Angelica).

Participants continued their work despite their fears. An inner conflict became visible in several reflections: "Everything in my body's internal warning system was going: 'You shouldn't be going to work'" (Poppy), "I'm not one for running away, so we just kind of cracked on. But it made me feel like it was a big melee" (Camia); and "I felt a huge sense of responsibility to be brave and show up for work" (Poppy).

This indicates a commitment to patients at a level of putting oneself at risk and resonates with the overarching theme *I Am There for Others.*

Theme 3: Extra stress on top of the stress

The theme *Extra Stress on Top of the Stress* captured the idea of an agglomeration of stress, chronic vocational stress, and acute Covid-19-related stress that was detectable almost in every data item. For example: "The roles are generally very busy anyway, so the extra layer of Covid just pushes people over to breaking point" (Poppy); "It's a slightly impossible space even without a pandemic" (Camia); "Our services are full to the brim … we're always at the max" (Rebecca); "We're all just about burned out, we're all hanging on by our fingernails" (Nadine); and "It was, like: 'The whole place is on fire'" (Camia).

This aligns with the finding of Magnavita et al. (2021) that "the Covid-19 pandemic presents a sort of perfect storm regarding the intersection of chronic workplace stress resulting in high rates of healthcare workers' burnout and acute traumatic stress imposed by the pandemic" (p. 3).

The identified agglomeration of stress encompassed different types of stress. These included the double burden of stress at work and in private: "My mother had an anxiety episode. That was all going on simultaneously. It was pretty messy. And I was messy" (Nadine) and "It was the thought of, if I needed to be able to go overseas [to help older parents], I couldn't go, that I struggled with" (Jenny). These stresses also included heat stress from using personal protective equipment (PPE) at home visits: "I'm wearing the 95 mask, the goggles or the visor, the gloves, the full apron, the whole works, and it's so warm, especially on a hot sunny day" (Jenny) and "It's uncomfortable wearing the 95 mask because you really can't breathe very well" (Rebecca).

Also included was stress from trying to stay informed: "The other stress at the time was a huge communication all the time, on a daily, almost hourly, basis" (Angelica); and "It felt, like, four times a day we were getting different information from further up the chain because everyone was building their comms as they were thinking about them" (Camia).

Acute traumatic stress for some was caused by the vaccination mandate. This stress seemed not to relate to the vaccination itself, but to the fact that it was mandated for the healthcare workforce: "You know, it [the mandate] changed my worldview. I don't trust the government, and I don't know what the future is going to look like" (Angelica), "It [the mandate] left me with little respect for the service, or for the government, for everything" (Nadine); and "I was so angry at the management, at the government, I've never been so angry in my life" (Nadine).

Several participants resisted by prioritising the needs of others: "You keep yourself together because you have to, because other people are falling apart around you. Yeah, that sense of needing to not fall apart because you want to be there for other people" (Poppy); and "The option of just curling up under a rock and having a complete mental breakdown myself, that luxury wasn't an option" (Nadine). This, again, resonates with the overarching theme *I Am There for Others.*

From the perspective of PTG theory, the theme *Extra Stress on Top of the Stress* is closely linked with the theme *The Impending Doom.* Both themes capture the types of stresses and fears that have the potential to impact a person's core beliefs – the prerequisite for posttraumatic growth.

Sub-theme: You pay with your health

The sub-theme *You Pay with Your Health* is a sub-theme of the theme *Extra Stress on Top of the Stress*. It captures the construction that working during Covid-19 had come at a cost to participants' mental health. For example: "I could see Covid was continuing and it was affecting my health, the level of stress" (Poppy), "In my car on the way home, I would've had a few tears, probably more exhaustion than fear" (Poppy); "Yeah, lots of tears, lots of meltdowns" (Nadine); "I was so emotional by that stage, I did get stuff mixed up in my head" (Nadine), and:

> I think you're in a lot of automatic pilot when you're trying to get everything done. But I do think there was a high level of anxiety, like, you started to acclimatise to living at this moderate anxiety level all of the time. And so, then, being moderately anxious all of the time became normal. (Camia)

From the perspective of PTG theory, negative mental health outcomes and PTG often coexist in a person.

Theme 4: The paradise of lockdown

The theme *The Paradise of Lockdown* captured the construction of a more connected state of being during the pause of normal life created by the lockdown. This was revealed in the many positive comments: "I think, less travel during lockdown is okay, there are more birds you can hear" (Rebecca), "People were looking out for each other. Neighbours were communicating and talking and that was cool" (Nadine), and:

> One thing I did find that I did enjoy during lockdown was when we were doing our regular walks with the dog. It took me back to my childhood in lots of ways. We would actually take the backpack and make a coffee or a cup of tea and take a flask with us to go for a walk. (Jenny)

Life during lockdown seemed to evoke a deeper sense of connection to the self, to others and to the environment. This resonates with the second overarching theme, *I Am More Me*.

This experience of a more connected way of being, in the midst of a landscape characterised by extreme Covid-19-related stresses, might have provided a context for the rumination process and thereby the creation of new core beliefs.

Theme 5: The positive that has come out of it

The theme *The Positive That Has Come Out of It* captured the transformational experience of PTG. All six participants, on reflection, identified positive changes to what they perceived to be true about themselves and the lives they lived. Their powerful testimonies were captured in the sub-themes, *I Lean More Into My Relationships*, *I Am the Captain of My Life*, *I Have New Priorities*, and *I Embark Upon a New Journey*. These align with the respective PTG sub-domains, relating to others, personal strength, appreciation of life, and new possibilities.

The essence of the participants' identified growth experiences seems to be an increase in their sense of self and self-identity. This increase was captured in the overarching theme *I Am More Me.* For example: "It's been hard, it's been hard the whole time, and it's been hard in lots of different ways for different reasons, but I feel more myself now than I did two and a half years ago" (Camia);

and “To be more of myself, to listen to me more, rather than always catering to other people’s perspectives and points of views. Yeah, I think, COVID time has helped me to grow” (Rebecca).

Sub-theme: I lean more into my relationships

The sub-theme *I Lean More Into My Relationships* captured the construction of growth in the form of a vitalisation of the participants’ relational connectedness. It was identified by two: “I found a new network of supportive people, which was really, really helpful. That was one of the positive things that came out of the trauma” (Angelica); and “I’m conscious of connecting more with my family … it’s made it more apparent that relationship is needed” (Jenny).

For Jenny, PTG, in the form of a revitalisation of her relationships with loved ones, seems to go hand in hand with a new way of engaging:

> Doing things as a family. Like, I texted my son a couple of nights ago, and we’re both on about going to a movie together … In the past, it may have been a case of talking about doing it, but you never get around to actually arranging to do it. (Jenny)

Sub-theme: I am the captain of my life

The sub-theme *I Am the Captain of My Life* captured the construction of growth in the form of a realisation on the part of many participants of how strong they were and how much agency they had. For example: “For me, I guess, one of the positives is, it has actually shown me how strong I actually am, yeah” (Angelica); “I do very much feel, like, I am now captain of my own ship, both personally and also professionally” (Camia); and “I’m probably more connected to my functional home environment now than I was” (Nadine).

Camia appeared to have discovered that she has what it takes and that she has had this in her all along: “I think I came out understanding more of who I am as a person, who I am as a leader, and the value that I can bring to a space” (Camia), while Nadine seemed to have become aware of her ability to actualise change: “I had to say: ‘Okay … I’ll do whatever it takes’, and I never thought that I would actually do something like that, but that’s been part of the growth too” (Nadine).

Sub-theme: I have new priorities

The sub-theme *I Have New Priorities* captured the construction of growth in the form of a new appreciation of life. Participants talked about a transformational shift toward paying more attention to their own needs. This shift seems to be an essential finding of this study and resonates with the overarching theme *I Am More Me*. For example: “It’s made me more conscious that I definitely do need to look after me as a person.” (Jenny); and “I think Covid, and maybe the extra stresses and the extra things we've had to do under Covid, made me realise, well actually, my well-being is quite important, I need to focus on my own time, for me” (Rebecca).

Poppy seemed to have experienced a pull toward a deeper appreciation of her family life and health: “I think that experience made me reassess my priorities, and I think, actually … my own health and my family's well-being … I wanted to put them first” (Poppy).

While Rebecca appeared to have experienced a deepening of her connection with herself and an appreciation of her worth: “Rather than … carry on that same ‘looking after somebody else all the time’ … I'm honouring a bit more that part of me that needs to do my own things” (Rebecca); and “I’ve been ‘Why do I need a raise, they pay me enough’, but ‘No, actually, Rebecca.’ I’m realising, trying to be more, just a bit more self-focused” (Rebecca).

For Jenny, joyful engagement seems to have become a priority:

> For instance, I joined some dancing classes online … In the past, if I was running late home from work … I would have probably said: 'Oh, I won't go tonight'…whereas now, it's probably made me more aware of: 'No, I actually need to go, it's good for me to go, and I get a lot out of going'. So, I'll make more of a conscious effort of trying to plan my days accordingly. (Jenny)

Sub-theme: I embark upon a new journey

The sub-theme *I Embark Upon a New Journey* captured the construction of growth in the form of liberation and self-actualisation. Angelica seemed to have found new motivation to pursue long-desired career opportunities:

> I've worked in the system for a long time, and I have felt constrained within it. So, the silver lining might be that I might finally go out into private practice. And I'm not sure whether that will be as a registered social worker, or whether it will be a more alternative health kind of work or some kind of counselling. (Angelica)

It seemed that the whole experience was transformative for participants albeit it manifested in unique ways for each participant.

Summary of findings

Analysing the accounts of six social workers who worked in health settings in Aotearoa New Zealand during the Covid-19 crisis, this study identified six strands of stories about personal transformational growth woven into a powerful narrative; a narrative that was told about the experience of PTG (Tedeschi et al., 2018) during pandemic times.

This narrative can be divided into three segments. The first segment, the beginning, is set in the participants' normal healthcare occupational environment, which many described as thinly stretched, even at the best times. The participants strongly identified with their social work profession and described a deep caring for their patients. Their identification with social work and its culture, values, and theoretical concepts, might have increased the likelihood for the sample to experience PTG. This aligns with the findings that a higher occupational self-identification (Mo et al., 2022), psychoeducation (Moreno-Jiménez et al., 2021), and meaning-making (Feingold et al., 2022) increase the likelihood of experiencing PTG.

The second segment is set in the unknown world of the virus. It begins when the Covid-19 pandemic reaches the shores of Aotearoa New Zealand, and the country goes into lockdown. All six participating social workers provided accounts that they accepted the call to duty when the pandemic started. Two participants recognised a moment of hesitation at the point of entry into the never-before-experienced environment of Covid-19. This hesitation is illustrated in one participant's comment about her travel to work on the first day of lockdown: "I go through quite a few roundabouts, and it was very tempting to just go right around the roundabout and head back home" (Poppy).

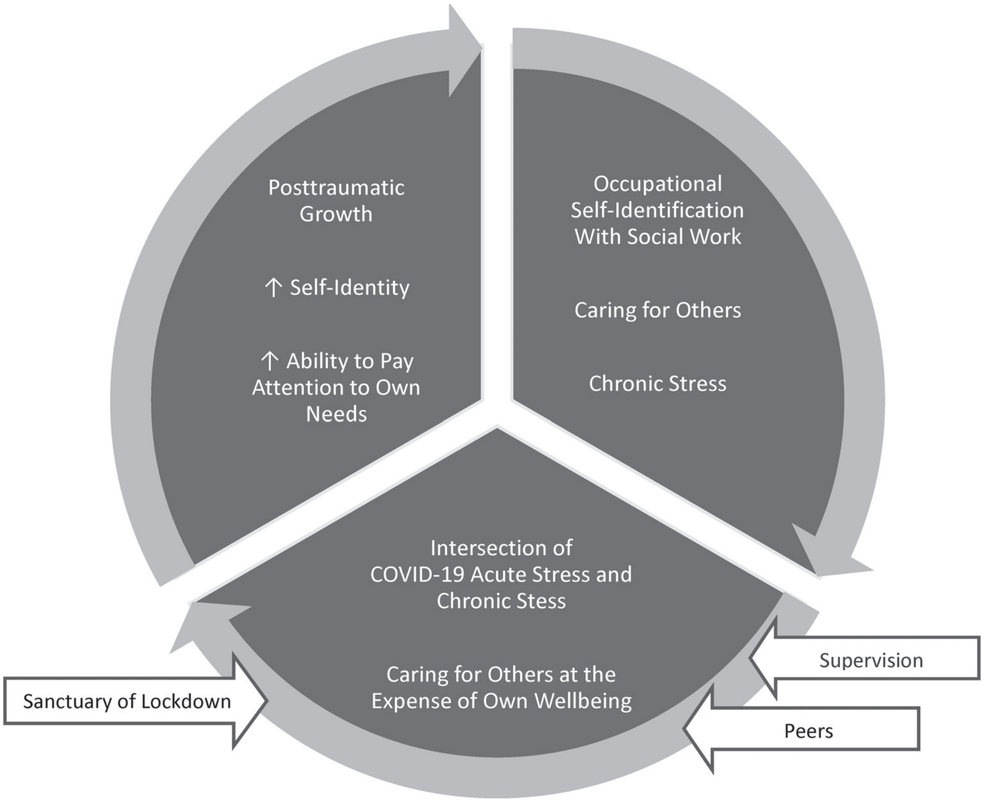
The participants in this study identified that, once they found themselves in the special environment of Covid-19, they benefitted from bonding with their colleagues and attending supervision, while they adapted to the confusing rules of the pandemic, including those of how and when to use PPE. The participants' ability to engage in collegial support might have further increased the likelihood of them experiencing PTG (Mo et al., 2022); as might have their ability to engage in critical reflection during supervision (Veronese et al., 2022).

Journeys continued in the special world of the virus, with participants reporting they experienced extreme pandemic-related stresses, deep and novice fears, a sense of impending doom, loss of their human rights, and trauma. Their stresses aligned with the vocational stresses identified in the literature (Magnavita et al., 2021); as did their fears. They talked about negative health and mental health consequences from their work, including heat stress, exhaustion, and anxiety, which fall in with the negative consequences established in the literature; and they talked about their resistance, using the coping strategies they knew, including self-care. A key feature identified across the dataset is deep caring for others and commitment to the duty of care for patients, even at the expense of one's own well-being.

The third segment began as the pandemic finally ceased. The experience of returning to a normal working life is captured in one of the participants' comments: "It's been a crazy couple of years, it's been a crazy couple of years, yeah, we survived" (Camia). The participating social workers reflected on their return as being alive, however, positively transformed. On reflection, all six identified PTG experiences in at least one of the PTG sub-domains, relating to others, personal strength, appreciation of life, and new possibilities. These included experiences in the form of a realisation of how strong they were, how much agency they had, and what they could achieve; in the form of a coming to life of their relationships with loved ones; in the form of seizing new and long-desired career opportunities; and, in the form of a shift in their priorities in life. For some participants, their experience of PTG also included a realisation that they must have had these potentials in them all along.

The participating social workers identified different PTG experiences. However, the most significant finding

Figure 2. Key Findings



of this study was that most participants experienced PTG in the form of an increased sense of self and self-identity and a shift toward being able to pay attention to their own needs versus the needs of others. These key findings respond to the study objective by drawing attention to a shared phenomenon of growth that warrants further investigation in the healthcare population.

A surprise finding of this study was the positive comments participants made about the special quality of life they experienced outside work in the afternoons and on the weekends during a lockdown. Their comments portrayed life during the lockdown as a sanctuary, almost in the midst of the Covid-19 stresses, with references to a peaceful environment with birdsong and fresh air and a sense of togetherness. The key findings of this study are depicted in Figure 2.

The findings speak to the promotion of a shift in our approach to occupational health, a shift away from an exclusively medicalised model of the human experience toward a salutogenic and holistic model. Introducing a post-traumatic growth focus into the reflexive process during supervision can be suggested as one of the promising occupational health measures in this context.

Conclusion

This study identified deeply personal and meaningful transformational growth experiences for social workers from their work in healthcare during the Covid-19 pandemic in Aotearoa New Zealand. This finding holds merit in relation to the development of future pandemic response strategies that go beyond the preservation of healthcare workers' functioning and coping at adverse times, toward new occupational health approaches with an emphasis on transformation and growth.

A consistent finding in this study was post-traumatic growth in the form of an increased sense of self and self-identity and a shift toward being able to pay attention to one's own needs. This key finding calls for further investigation for the benefit of the social work profession. Overall, social work might possess favourable properties to facilitate PTG experiences in its workers. These include the importance of professional supervision emphasised by the participants in this study.

Acknowledgements

We would like to thank the participating social workers in this study for their willingness to share their reflections and inner processes with us.

Declaration of conflicting interests

No conflicts of interest were declared.

Funding

No financial support was received by the authors.

Received: 28 August 2023

Accepted: 24 February 2024

Published: 15 June 2024

References

Aggar, C., Samios, C., Penman, O., Whiteing, N., Massey, D., Rafferty, R., Bowen, K., & Stephens, A. (2022). The impact of COVID-19 pandemic-related stress experienced by Australian nurses. *International Journal of Mental Health Nursing, 31*(1), 91–103. https://doi.org/10.1111/inm.12938

Antonovsky, A. (1987). *Unravelling the mystery of health: How people manage stress and stay well*. Jossey-Bass.

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

COVID-19 Public Health Response (Vaccinations) Order 2021, (LI 2021/94) – New Zealand Legislation. http://www.legislation.govt.nz

Croghan, I. T., Chesak, S. S., Adusumalli, J., Fischer, K. M., Beck, E. W., Patel, S. R., Ghosh, K., Schroeder, D. R., & Bhagra, A. (2021). Stress, resilience, and coping of healthcare workers during the COVID-19 pandemic.

Journal of Primary Care & Community Health, 12, 1–9. https://doi.org/10.1177/21501327211008448

Cui, P. P., Wang, P. P., Wang, K., Ping, Z., Wang, P., & Chen, C. (2021). Post-traumatic growth and influencing factors among frontline nurses fighting against COVID-19. *Occupational and Environmental Medicine, 78*(2), 129–135. https://doi.org/10.1136/oemed-2020-106540

Feingold, J. H., Hurtado, A., Feder, A., Peccoralo, L., Southwick, S. M., Ripp, J., & Pietrzak, R. H. (2022). Posttraumatic growth among healthcare workers on the frontlines of the COVID-19 pandemic. *Journal of Affective Disorders, 296*, 35–40. https://doi.org/10.1016/j.jad.2021.09.032

Fontanini, R., Visintini, E., Rossettini, G., Caruzzo, D., Longhini, J., & Palese, A. (2021). Italian nurses' experiences during the COVID-19 pandemic: A qualitative analysis of internet posts. *International Nursing Review, 68*(2), 238–247. https://doi.org/10.1111/inr.12669

Koontalay, A., Suksatan, W., Prabsangob, K., & Sadang, J. M. (2021). Healthcare workers' burdens during the COVID-19 pandemic: A qualitative systematic review. *Journal of Multidisciplinary Healthcare, 14*, 3015–3025. https://doi.org/10.2147/JMDH.S330041

Liu, Q., Luo, D., Haase, J. E., Guo, Q., Wang, X. Q., Liu, S., Xia, L., Liu, Z., Yang, J., & Yang, B. X. (2020). The experiences of health-care providers during the COVID-19 crisis in China: A qualitative study. *The Lancet Global Health, 8*(6), 790–798. https://doi.org/10.1016/S2214-109X(20)30204-7

Magnavita, N., Chirico, F., Garbarino, S., Bragazzi, N. L., Santacroce, E., & Zaffina, S. (2021). Sars/mers/sars-cov-2 outbreaks and burnout syndrome among healthcare workers. An umbrella systematic review. *International Journal of Environmental Research and Public Health, 18*(8). https://doi.org/10.3390/ijerph18084361

Ministry of Health (2020) COVID-19 health and disability system response plan. Wellington, Ministry of Health. Retrieved 26 November 2020. Available at https://www.health.govt.nz/publication/covid-19-health-and-disability-system-response-plan

Ministry of Health. (2021). *Health and Independence Report 2020: The Director-General of Health's annual report on the state of public health*. Health and Independence Report 2020 | Ministry of Health NZ

Mo, Y., Tao, P., Liu, G., Chen, L., Li, G., Lu, S., Zhang, G., Liang, R., & Huang, H. (2022). Post-traumatic growth of nurses who faced the COVID-19 epidemic and its correlation with professional self-identity and social support. *Frontiers in Psychiatry, 12*. https://doi.org/10.3389/fpsyt.2021.562938

Moreno-Jiménez, J. E., Blanco-Donoso, L. M., Demerouti, E., Hofheinz, S. B., Chico-Fernández, M., Moreno-Jiménez, B., & Garrosa, E. (2021). The role of healthcare professionals' passion in predicting secondary traumatic stress and posttraumatic growth in the face of COVID-19: A longitudinal approach. *International Journal of Environmental Research and Public Health, 18*(9). https://doi.org/10.3390/ijerph18094453

Rajkumar, R. P. (2021). Suffering and salutogenesis: A conceptual analysis of lessons for psychiatry from existential positive psychology (PP2.0) in the setting of the COVID-19 pandemic. *Frontiers in Psychology, 12*. https://doi.org/10.3389/fpsyg.2021.646334

Stuijfzand, S., Deforges, C., Sandoz, V., Sajin, C. T., Jaques, C., Elmers, J., & Horsch, A. (2020). Psychological impact of an epidemic/pandemic on the mental health of healthcare professionals: A rapid review. *BMC Public Health, 20*(1). https://doi.org/10.1186/s12889-020-09322-z

Sun, P., Wang, M., Song, T., Wu, Y., Luo, J., Chen, L., & Yan, L. (2021). The psychological impact of COVID-19 pandemic on health care workers: A systematic review and meta-analysis. *Frontiers in Psychology, 12*. https://doi.org/10.3389/fpsyg.2021.626547

Tedeschi, R. G., Shakespeare-Finch, J., Taku, K., & Calhoun, L. G. (2018). *Posttraumatic growth: Theory, research, and applications*. Routledge.

Veronese, G., Mahamid, F. A., & Bdier, D. (2022). Subjective well-being, sense of coherence, and posttraumatic growth mediate the association between COVID-19 stress, trauma, and burnout among Palestinian health-care providers. *American Journal of Orthopsychiatry*. https://doi.org/doi:10.1037/ort0000606

World Health Organisation. (2023). WHO Coronavirus Disease (COVID-19) Dashboard. https://covid19.who.int/

Zhang, X. T., Shi, S. S., Ren, Y. Q., & Wang, L. (2021). The traumatic experience of clinical nurses during the COVID-19 pandemic: Which factors are related to post-traumatic growth? *Risk Management and Healthcare Policy, 14*, 2145–2151. https://doaj.org/article/91e66ae3ade84aa4b5140d497b5f8f1b

Cyber-supervision during the Covid-19 pandemic: An exploratory international survey

Kieran O'Donoghue[1] and **Yuen Han Kitty Mo**[2]

[1] School of Social Work
Massey University
New Zealand

[2] Hong Kong Shue Yan University China

ABSTRACT

INTRODUCTION: This article presents the findings of an exploratory international survey on supervisees' and supervisors' experiences of cyber-supervision during the Covid-19 pandemic. The survey aimed to establish a baseline of these experiences.

METHODS: An online survey of 195 respondents was conducted. Demographic data and the supervisees' and supervisors' views were analysed descriptively. Spearman's Rho correlations were undertaken using IBM SPSS 28 to examine the associations between supervisees' and supervisors' ratings of their situation, views and experiences of cyber-supervision, and overall satisfaction and evaluation.

FINDINGS: The results showed that the respondents' supervision changed to online supervision, with video conferencing as the primary method. The supervisees and supervisors shared similar views about online supervision. Items that indicated a constructive view of online supervision correlated positively with overall satisfaction and evaluation. In contrast, items less favourable of online supervision correlated negatively with overall satisfaction and evaluation. Overall, it was found that the attitudes and perspectives of supervisees and supervisors about online supervision were related to their overall satisfaction and evaluation.

CONCLUSION: The practice implications for supervisees and supervisors using online supervision are that they discuss their attitudes and cultural perspectives about online supervision early in the relationship, particularly if they plan to use this medium regularly or in conjunction with face-to-face supervision. Further research is recommended on the influence and impact of supervisee and supervisor attitudes and cultural perspectives on online supervision.

Keywords: Supervision; ICT; Covid-19; survey; supervisees; supervisors

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 24–38.

CORRESPONDENCE TO:
Kieran O'Donoghue
K.B.ODonoghue@massey.ac.nz

The Covid-19 pandemic had an unprecedented effect, with many countries in the early stages of the pandemic locking down and implementing restrictions such as physical distancing and mask-wearing (Fronek et al., 2023). Social workers shifted from in-person, face-to-face practice to information and computer technologies (ICT) (Lombardi et al. 2002; Sewell et al. 2022). Social work supervision sessions changed from in-person meetings to cyber-supervision, particularly when face-to-face meetings were a risk to social workers, their supervisors, and their organisation's ability to deliver services (Mo, 2021a). Cyber-supervision involves using ICT to facilitate supervision sessions (Mo & Chan, 2023).

Literature review

The Aotearoa New Zealand literature about online supervision consists of two papers (King & Hirst, 2011; Rushton et al., 2017). King and Hirst (2011) discussed their experiences of shifting to cyber-supervision. They found that, because they had face-to-face relationships, they could adapt, learn together and work through the ethical and technological challenges of using Skype. Their paper led to the addition of a practice note on electronic supervision to the Aotearoa New Zealand Association of Social Workers (ANZASW) Supervision Policy (ANZASW, 2011). King and Hirst (2011) also discussed the importance of whanaungatanga and kanohi ki te kanohi and recommend face-to-face meetings in person initially before engaging in online supervision. Rushton et al. (2017) shared their experiences of an online peer supervision group using Zoom. They discussed the challenges and learning the non-Māori members had to negotiate concerning Te Tiriti o Waitangi-led practice, bicultural responsiveness and responding to diversity within their group. They noted the importance of Ko wai au (who am I) discussions and how knowing each other assisted them in navigating differences and diversity. Rushton et al. (2017) also commented that some of the group had met in person in different circumstances before establishing the group, which helped establish their supervision relationship. Currently, the only specific local professional guidance on online supervision is the Social Workers Registration Board's (SWRB) Code of Conduct, which states in Principle 10 that social workers are expected to "follow the standards that would be applied in a face-to-face supervisory relationship when using or providing supervision by technological means" (SWRB, 2016, p. 26). The recently released ANZASW Supervision Strategy 2023-2033 does not directly mention the medium of online supervision apart from a footnote reference on page 25, which relates to supervision training and equates face-to-face learning with synchronous online video conferencing learning (ANZASW, 2024).

International studies since 2020 discuss cyber-supervision in specific countries (Mo, 2021a). A Chinese study found that the cyber-supervision relationship mirrored in-person supervision in structure, content, and process (Mo & Chan, 2023). The study also noted that, within the cyber-supervision relationship, the immediacy of the responses, the overall trust in the virtual environment, clear advice, support, and a people orientation from the supervisor resulted in higher satisfaction amongst the supervisees. Another Chinese study found that, for supervisees to feel comfortable with the cyber-supervision process, they needed a supportive supervision context that attended to cultural differences (Mo, 2021b). Supervisees also needed a responsive supervisory relationship, a written contract between committed parties, and an understanding of the strengths and limitations of cyber-supervision. Selem (2021) found that, in implementing electronic group supervision in Oman during the pandemic, training in electronic supervision for supervisees, supervisor competence and technical support were important. Yuliani (2021) proposed an e-supervision model in Indonesia that incorporated a data-base system with knowledge management, training and social network management systems. In this system, the supervisees and supervisors interacted via electronic messaging and social media. Sewell et al. (2021) found increased discussions of ICT use in supervision among Canadian social workers where organisational policy provided clear direction on ICT use. For some participants, the supervisor's qualities and availability influenced their decisions to discuss their use of ICT. They also called for further research on the content and quality of ICT use in supervision and supervision discussions. Connell (2023) explored the change to online supervision during the Covid-19 pandemic in London Local Authority Children's Services. Connell (2023) found that, in general, the participants had a positive experience of online supervision, while some elements of face-to-face, in-person supervision were missed. An established supervisory relationship and good connectivity were identified as important. Future research was also called for that explored a wider range of social work settings and drew from larger and more geographically dispersed samples (Connell, 2023). From this review, it is apparent that little is known internationally about the views and experiences of supervisees and supervisors of cyber-supervision during the Covid-19 pandemic. The study reported here aims to establish a baseline of the views and experiences of supervisees and supervisors of cyber-supervision internationally during the Covid-19 pandemic.

Method

A survey instrument was developed from a review of supervision research (O'Donoghue & Engelbrecht, 2021). Demographic information was gathered from multiple-choice questions. Five-point Likert-type scales were used to measure the respondents' experiences, views, satisfaction, and evaluation of their cyber-supervision. The Hong Kong Caritas Institute of Higher Education Research and Ethics Committee approved the ethics application HRE210107. The questionnaire was in English and distributed via an advert, which included the Survey Monkey link. The International Federation of Social Workers (IFSW) agreed to distribute the advertisement to national organisations and social media. The respondents gave their informed consent by completing and submitting the questionnaire. The survey was open from April 2021 to September 2021; the responses were slow across the first three months, with only 50 responses. We contacted several national organisations, including the Aotearoa New Zealand Social Work Association, the Australian Association of Social Workers and the British Association of Social Workers, directly and applied for their approval to advertise the survey, which increased the number of responses. The 195 responses were analysed using IBM SPSS 28 (IBM Corp, 2021). Descriptive analysis was undertaken for the demographic background questions. The Likert scale data was non-parametric, and this, together with the small supervisee sample size and differences in samples between supervisees and supervisors, meant that non-parametric analysis was undertaken. This involved percentages and counts for the scales. Bivariate Spearman *Rho* correlations were applied to respondents' views and experiences of online supervision and overall satisfaction and evaluation. Cohen's (1988) guidelines concerning the strength of the relationship were used. Missing data was addressed by leaving the cells blank and reporting the number of respondents throughout the article (Pallant, 2016).

Respondents characteristics

The 189 respondents who identified their region were from four IFSW regions. Two-thirds were from Europe (67.19%, *n* = 127), 29.63% (*n* = 56) from the Asia-Pacific region, 2.65% (n = 5) from Africa, and one participant was from North America. Over three-quarters of 194 respondents were female (77.84%, *n* = 151), 21.13% (*n* = 41) were male, and one per cent (n = 2) were gender diverse. Over half were aged between 41 and 60 years (55.9%, *n* = 109), just over a quarter were aged 61 years or more (26.15%, *n* = 51), with 17.95% (*n* = 35) being aged between 20 and 40 years. Among 138 respondents who identified the service area that they worked for almost a third (32.61%, *n* = 45) worked for a health service, 15.22% (*n* = 21) were in children's services, another 15.22% (*n* = 21) worked for community services, 14.49% (n=20) worked for a family service, 13.04 % (*n* = 18) worked with youth, 7.25% (*n* = 10) were in rehabilitation services, and the remaining 2.17% (*n* = 3) worked for elderly services. Most of the 190 respondents who indicated their role were supervisors (82.63%, *n* = 157), with 17.37% (*n* = 33) being supervisees. Nine respondents answered both the supervisee and supervisor experiences questions and identified their role as supervisors.

Supervisees' and supervisors' experiences and views

The supervisee results are presented and commented on first in the following sections, followed by the supervisors' results.

Current situation

The respondents rated their level of agreement (ranging from strongly disagree (SD), disagree (D), neutral (NE), agree (A), and strongly agree (SA)) with four statements about their current supervision situation (See Tables 1 and 2). The supervisees' results show that most supervisees' supervision changed during Covid-19 and almost two-thirds enjoyed using the technical tools available for online supervision. The results concerning whether the shift to online was mutually agreed upon indicate that it was perhaps imposed rather than negotiated or discussed for some. The supervisors' results show that most changed their supervision to incorporate digital devices and technology. For most, the shift was done by mutual agreement. The supervisors had mixed feelings about how much they enjoyed the online tools and the disruption to their usual supervision practice during Covid-19.

Frequency of use

The respondents indicated the frequency (ranging from *never*, *rarely*, *sometimes*, *often* and *always*) of their use of online supervision via different formats during Covid-19 (See Tables 3 and 4). For the supervisees, video-conferencing tools were the most common format, with most using them regularly. A third used chat and messaging tools and email with a degree of regularity. The least common online supervision format was social media sites. Most supervisors frequently used video-conferencing tools. All other online formats were either rarely or never used by a majority of the supervisors. The least used was social media sites, with most supervisors never or rarely using this format in their supervision. These results show that video-conferencing tools were the most common format used during Covid-19 for both the supervisees and supervisors.

Table 1. Supervisees' Current Situation of Supervision

Statement	N	% A + SA	% SD + D +NE
Digital devices and technologies are incorporated into my supervision practice during COVID19	41	85.37	14.63
My usual experience of supervision practice changed greatly during COVID19	41	70.73	29.27
I enjoy using technological tools available to me on online supervision during COVID19	41	65.86	34.14
We mutually agreed to shift to online supervision	41	56.1	43.9

Table 2. Current Situation of the Supervision Provided as a Supervisor

Statement	N	% A + SA	% SD + D +NE
I incorporate digital devices and technologies into my supervision practice during COVID-19	161	90.06	9.94
Both supervisee and supervisor have a mutually agreement to shift to online supervision	160	75.01	24.99
I enjoy using technological tools available to me on online supervision during COVID-19	159	59.12	40.88
My usual supervision practice has been disrupted greatly during COVID-19	160	56.88	43.12

Table 3. Supervisees' Frequency of Use of Online Supervision Format

	N	% Sometimes, Often, and Always	% Never and rarely
Video conferencing tools such as Skype, Zoom, Zoho, Webinar	42	78.57	21.43
Chat and messaging tools such as Slack, Microsoft Teams, Google Hangouts	42	33.33	66.67
E-mail such as Gmail, Yahoo, Outlook	42	33.33	66.67
Messaging apps on smartphones such as WhatsApp, WeChat, Signal, Line	42	14.28	85.72
Others	40	17.50	82.50
Internet Chatrooms	41	9.76	90.24
Social media sites such as Twitter, Facebook, LinkedIn	42	4.76	95.24

Table 4. Supervisors' Frequency of Use of Online Supervision Format

Statement	N	% Sometimes, Often, and Always	% Never and rarely
Video conferencing tools such as Skype, Zoom, Zoho, Webinar	160	93.14	6.86
E-mail such as Gmail, Yahoo, Outlook	153	43.14	56.86
Chat and messaging tools such as Slack, Microsoft Teams, Google Hangouts	156	40.39	59.61
Messaging apps on smartphones such as WhatsApp, WeChat, Signal, Line	153	26.80	73.20
Others	113	22.12	77.88
Internet Chatrooms	145	15.18	84.82
Social media sites such as Twitter, Facebook, LinkedIn	152	13.16	86.84

Views about the use of technological tools

The respondents indicated their level of agreement with each of 11 statements concerning their views about using technological tools (See Tables 5 and 6). For the supervisees, the highest levels of agreement were for the statements concerning the importance of confidentiality and privacy, knowing how to use technological tools to participate in online supervision, having a mutually agreed contract and that an online relationship can be kept despite using different tools. The lowest levels of agreement were for participation in online supervision prior to Covid-19, that it was easy to build a strong working alliance with their supervisor using online tools, that some technological tools affected the boundaries of the supervisory relationship and that there were a wide range of topics during online supervision via different types of technological tools. The majority of the supervisees' views about the use of technological tools were in agreement with the statements and indicated a familiarity with and degree of comfort with using technological tools. For the supervisors, the highest levels of agreement, i.e., greater than two-thirds of the supervisors, were for the protection of confidentiality and data privacy, a mutually agreed contract before implementation of online supervision, knowing how to use different technological tools to participate in online supervision, that an online supervision relationship can be maintained regardless of the tools used and that a range of tools was suitable for online supervision. There were mixed levels of agreement for the other items, with the majority agreeing and at least a third of the supervisors disagreeing. Nearly two-thirds disagreed with the statement concerning participation in online supervision through one or more online tools prior to Covid-19. In short, the supervisees and supervisors shared high levels of agreement about most items.

Table 5. Supervisees' Views Regarding the Use of Technological Tools

Statement	N	% A + SA	% SD + D +NE
The protection of confidentiality and data privacy are important despite using any type of tool	42	97.62	2.38
I know how to use different technological tools to participate in online supervision	42	90.48	9.52
Both the supervisee and supervisor should have a mutually agreed contract before the implementation of online supervision	42	85.71	14.29
An online relationship can still be kept despite using different types of technological tools	41	87.81	12.19
I am comfortable with using different types of technological tools	42	78.57	21.43
I communicate easily with my supervisor by means of online technological tools	42	71.43	28.57
Online supervision does not interfere with work-life balance	41	70.73	29.27
A wide range of topics during online supervision via different types of technological tools	41	53.66	46.34
Some technological tools affect the boundaries of the supervisory relationship	42	59.52	40.48
It is easy to build a strong working alliance with my supervisor via different types of technological tools	42	54.76	45.24
I have participated in online supervision through one or more technological tools before COVID19	42	50	50

Table 6. Supervisors' Views Regarding the Use of Technological Tools

Statement	N	% A + SA	% SD + D +NE
The protection of confidentiality and data privacy are important despite using any type of tool	162	93.21	6.79
Both the supervisee and supervisor should have a mutually agreed contract before the implementation of online supervision	162	91.36	8.64
I know how to use different technological tools to participate in online supervision	160	77.5	22.5
An online supervisory relationship can still be kept despite using different types of technological tools	160	71.26	28.74
I always consider a range of tools that are suitable for online supervision	158	67.09	32.91
I am comfortable with using different types of technological tools	159	62.26	37.74
We discuss a wide range of topics during online supervision via different types of technological tools	158	59.5	40.5
Some technological tools will affect the boundaries of the supervisory relationship	158	56.33	43.67
Online supervision does not interfere with work-life balance	161	50.31	49.69
It is easy to build a strong supervisory working alliance via different types of technological tools	161	54.66	45.34
I have participated in online supervision through one or more technological tools before COVID19	161	36.64	63.36

General views about online supervision

The respondents rated their agreement level with six statements covering general views about online supervision (See Tables 7 and 8). The supervisees' general views acknowledge the strengths of online supervision for supervision at a distance and its value when mixed with face-to-face supervision. The supervisees' views were divided about limiting online supervision as an adjunct to face-to-face and only using it in a lockdown when you cannot meet in person. For most supervisees, online supervision was not their preferred medium, and they disagreed that all supervision should be face-to-face. Over two-thirds of the supervisors agreed that online supervision is the best form of supervision at a distance and is best when mixed with face-to-face in-person supervision.

There were mixed views amongst the supervisors concerning the statement that online supervision should only be used as an adjunct to face-to-face supervision, with a small majority being neutral, disagreeing, and strongly disagreeing. A larger majority held the same neutral or disagreeing views about only using online supervision when we cannot meet in person due to the Covid-19 lockdown. More than three-quarters of the supervisors disagreed or held neutral views about all supervision being face-to-face and in person, whereas most disagreed or held neutral views about the statement that online supervision was their preferred medium for supervision. Both the supervisees' and supervisors' general views of online supervision show that for most, online supervision had a place as a supervision medium alongside face-to-face supervision and was the best form of supervision at a distance.

Table 7. Supervisees' General Views About Online Supervision

Statement	N	% A + SA	% SD + D +NE
Online supervision is the best form for supervision at a distance	41	75.61	24.39
Online supervision is best when mixed with face to face in person supervision	41	73.17	26.83
Online supervision should only be used as an adjunct to face to face supervision	40	52.50	47.50
Online supervision should only be used when you cannot meet in person due to COVID 19 lock down	41	41.46	58.54
Online supervision is my preferred medium for supervision	41	17.08	82.92
All supervision should be face to face and in person	41	17.07	82.93

Table 8. Supervisors' General Views About Online Supervision

Statement	N	% A + SA	% SD + D +NE
Online supervision is the best form for supervision at a distance	160	68.75	31.25
Online supervision is best when mixed with face to face in person supervision	160	69.38	30.62
Online supervision should only be used as an adjunct to face to face supervision	160	48.13	51.87
Online supervision should only be used when you cannot meet in person due to COVID 19 lock down	162	36.42	63.58
All supervision should be face to face and in person	162	20.98	79.02
Online supervision is my preferred medium for supervision	162	10.49	89.51

What was best for supervisees

The supervisees indicated their agreement level with eight statements about what was best about their online supervision. Table 9 shows the statements about the frequency of online supervision and the supervisor's ability to listen and understand had the highest levels of agreement. In contrast, the statements about the supervisor's availability, the user-friendliness of the technology and the online supervision tools used had the lowest levels of agreement.

The majority of the supervisees' views (over two-thirds) agreed that the frequency of supervision, supervisors' listening skills, support, help, and responsiveness were best in their online supervision.

Improvements for supervisees

The supervisees rated their level of agreement for 11 statements concerning how their experience of online supervision could be improved. Table 10 shows that over half of the respondents agreed that a more structured process and training could improve their experience of online supervision. Whereas over a third of respondents agreed that their experience of online supervision could be improved by better privacy and confidentiality settings, better technology, being better prepared, more frequent supervision and training on online supervision. The items with less than one-third of respondents agreeing concerned their supervisors' interactions with them.

Table 9. What is Best About the Supervisees' Online Supervision

Statement	N	% A + SA	% SD + D +NE
The frequency of our online supervision	40	67.50	32.50
My supervisor's ability to listen and understand	41	68.30	31.70
The support from my supervisor	41	65.85	34.15
The help my supervisor provides in regard to my work	41	63.42	36.58
The responsiveness of my supervisor	41	68.29	31.71
The availability of my supervisor	41	63.41	36.59
The user-friendliness of the technology and supervision experience	41	63.41	36.59
The online supervision tools that we use	39	43.59	56.41

Table 10. How the Supervisee's Experience of Online Supervision Could be Improved

Statement	N	% A + SA	% SD + D +NE
By a more structured process in sessions	41	51.22	48.78
By training in online supervision	41	56.10	43.90
By better privacy and confidentiality settings	41	46.34	53.66
By better technology	41	46.34	53.66
By me being better prepared	41	36.59	63.41
By more frequent supervision	41	39.03	60.97
By training on online technology	41	43.91	56.09
By more support from my supervisor	41	31.70	68.30
By my supervisor listening to me better	41	31.71	68.29
By my supervisor being more available	41	24.39	75.61
By my supervisor being better prepared	41	21.95	78.05

Overall satisfaction

The respondents rated their overall satisfaction with their online supervision as, (dissatisfied, somewhat dissatisfied, neither satisfied nor dissatisfied, somewhat satisfied, and satisfied). Among the supervisees ($n = 41$), 70.73% ($n = 29$) were satisfied or somewhat satisfied, 9.76% ($n = 4$) were neither satisfied nor dissatisfied, and 19.52% ($n = 8$) were dissatisfied or somewhat dissatisfied with their experiences of online supervision. Bivariate two-tailed Spearman *Rho* correlations were applied to analyse the associations between supervisees' views and experiences of online supervision and their overall satisfaction. Table 11 details the relationships between the respective items and overall satisfaction with online supervision. The items with a strong positive relationship (i.e., *Rho* >0.5) with the supervisees' overall satisfaction indicated two views. The first was reflective of supervisees being positive about their online supervision regarding ease of use as their preferred medium, enjoying it, and feeling comfortable in their ability to use it. The second concerns the support, constructive relationship, interactional strengths of their supervisors, and frequency of supervision. In contrast, the items with

Table 11. Supervisee Item Correlations with Overall Satisfaction

Item	Rho	Sig (2 tailed)	N
It is easy to build a strong working alliance with my supervisor via different types of technological tools	.818	<.001	41
I communicate easily with my supervisor by means of online technological tools	.799	<.001	41
Online supervision is my preferred medium for supervision	.694	<.001	41
I enjoy using technological tools available to me on online supervision during COVID19	.657	<.001	40
I am comfortable with using different types of technological tools	.653	<.001	41
The frequency of our online supervision	.629	<.001	40
Online supervision is the best form for supervision at a distance	.608	<.001	41
Online supervision does not interfere with work-life balance	.588	<.001	40
The userfriendliness of the technology and supervision experience	.582	<.001	41
My supervisor's ability to listen and understand	.568	<.001	41
I know how to use different technological tools to participate in online supervision	.537	<.001	41
The support from my supervisor	.535	<.001	41
The help my supervisor provides in regard to my work	.533	<.001	41
An online relationship can still be kept despite using different types of technological tools	.506	<.001	40
The responsiveness of my supervisor	.488	.001	41
We mutually agreed to shift to online supervision	.476	.002	40
Digital devices and technologies are incorporated into my supervision practice during COVID19	.462	.003	40
The availability of my supervisor	.412	.007	41
A wide range of topics during online supervision via different types of technological tools	.353	.025	40
By better privacy and confidentiality settings	-.315	.045	41
By my supervisor listening to me better	-.388	.012	41
Online supervision should only be used when you cannot meet in person due to COVID 19 lock down	-.562	<.001	41
All supervision should be face to face and in person	-.606	<.001	41

a strong negative relationship (i.e., *Rho* >-0.5) with overall satisfaction indicated supervisees preferring face-to-face personal supervision and online supervision only being used when you cannot meet in person due to a Covid-19 lockdown had lower overall satisfaction with online supervision. The supervisees' attitude towards online supervision, their comfort in using it, and having a positive supervision experience with their supervisors were related to their overall satisfaction. For the supervisors (*n* = 162), 76.54% (*n* = 124) were satisfied or somewhat satisfied, 14.81% (*n* = 24) were neither satisfied nor dissatisfied, and 8.64% (*n* = 14) were dissatisfied or somewhat dissatisfied with their experiences of online supervision. Table 12 details the relationships between the items and overall satisfaction with online supervision. The items with a strong positive relationship with the supervisors' overall satisfaction included views about enjoying using the technological tools and that it was easy to build a strong supervisory working alliance using different types of tools. The items with a moderate positive relationship (i.e., *Rho* = 0.3 to .49) were statements that showed supervisors were comfortable and willing to incorporate digital devices and

Table 12. Supervisors' Correlations with Overall Satisfaction

Item	Rho	Sig (2 tailed)	N
I enjoy using technological tools available to me on online supervision during COVID-19	.565	<.001	159
I think that it is easy to build a strong supervisory working alliance via different types of technological tools	.552	<.001	161
I always consider a range of tools that are suitable for online supervision	.496	<.001	158
I am comfortable with using different types of technological tools	.478	<.001	159
Online supervision is my preferred medium for supervision	.463	<.001	162
Online supervision will not interfere with work-life balance	.450	<.001	161
Online supervisory relationship can still be kept despite using different types of technological tools	.447	<.001	160
I know how to use different technological tools to promote and facilitate online supervision	.424	<.001	160
We discuss a wide range of topics during online supervision via different types of technological tools	.416	<.001	158
Both supervisee and supervisor have a mutually agreement to shift to online supervision	.377	<.001	160
Online supervision is the best form for supervision at a distance	.344	<.001	160
I incorporate digital devices and technologies into my supervision practice during COVID-19	.300	<.001	161
Video conferencing tools such as skype, zoom, webinar	.284	<.001	160
I have tried to conduct online supervision through one or more technological tools before COVID-19	.269	<.001	161
My usual supervision practice has been disrupted greatly during COVID-19	-.219	.005	160
Some types of technological tools will affect the boundaries of the supervisory relationship	-.232	.003	158
Online supervision should only be used as an adjunct to face to face supervision	-.313	<.001	160
Online supervision should only be used when you cannot meet in person due to COVID 19 lock down	-.376	<.001	162
All supervision should be face to face and in person	-.438	<.001	162

technologies, preferred online supervision, were able to use it with ease and for whom there was mutual agreement to shift to online supervision. They also viewed online supervision as best for supervision at a distance. In general, these results show that when the supervisors have a positive view about the use of technology and are comfortable with the use of technology and online supervision, they had greater overall satisfaction with online supervision.

In contrast, the items with negative moderate relationships (i.e., *Rho* = -0.3 to -0.49) indicated that, where supervisors had a higher level of agreement in respect of all supervision being face-to-face, only using online supervision when you cannot meet in person, and online supervision being only used as an adjunct to face-to-face supervision, they had a lower overall satisfaction rating for their online supervision. This indicates that supervisors who prefer face-to-face supervision over online supervision have lower overall satisfaction with online supervision. In short, the supervisors' attitude towards online supervision and level of comfort with it is related to their overall satisfaction.

Overall evaluation

The respondents rated their overall evaluation of their supervision (as poor, adequate, good, very good and excellent). For the supervisees (*n* = 41), 75.61% (*n* = 31) evaluated their online supervision as excellent, very good or good, whereas 24.39% (*n* = 10) evaluated it as adequate or poor. Table 13 details, in descending order, the correlations between survey items and the supervisees' overall evaluation of their supervision. These results are like those for overall satisfaction, with strong positive correlations between high overall evaluations with items that were positive about online supervision and positive about their supervision and supervisor. The strong negative correlations also indicated the supervisees who had high levels of agreement with their supervision being always face-to-face and with online supervision only used when people cannot meet in person due to Covid-19 lockdown would have a lower overall evaluation of online supervision. For the supervisors (*n* = 161), 77.02% (*n* = 124) evaluated their online supervision as excellent, very good or good, whereas 22.98% (*n* = 37) evaluated it as adequate or poor. Table 14 details the relationships between the items with the supervisors' overall evaluation of their online supervision. The items with strong positive relationships were the same as those for overall satisfaction, namely, that enjoying using technological tools available for online supervision during Covid-19 and that it was easy to build strong supervisory working alliances via different types of tools. Likewise, the items with a moderate positive relationship were statements that showed supervisors were comfortable and willing to incorporate digital devices and technologies, preferred online supervision, were able to use it easily, and for whom there was mutual agreement to shift to online supervision. They also viewed online supervision as best for supervision at a distance.

The results also indicate that, when the supervisors have a positive view about the use of technology and are comfortable with the use of technology and online supervision, they have a more positive evaluation of it. The items with negative moderate relationships indicated that where supervisors had a higher level of agreement in respect of all supervision being face-to-face, only using online supervision when you cannot meet in person, and online supervision being only used as an adjunct to face-to-face supervision, they had a lower overall evaluation of their online supervision. This suggests that a preference for face-to-face supervision is related to a lower overall evaluation of online supervision.

Table 13. Supervisee Item Correlations with Overall Evaluation

Item	Rho	Sig (2 tailed)	N
I communicate easily with my supervisor by means of online technological tools	.803	<.001	41
It is easy to build a strong working alliance with my supervisor via different types of technological tools	.796	<.001	41
I enjoy using technological tools available to me on online supervision during COVID19	.722	<.001	40
I am comfortable with using different types of technological tools	.697	<.001	41
The frequency of our online supervision	.683	<.001	40
Online supervision is the best form for supervision at a distance	.675	<.001	41
The support from my supervisor	.638	<.001	41
My supervisor's ability to listen and understand	.618	<.001	41
I know how to use different technological tools to participate in online Supervision	.587	<.001	41
The userfriendliness of the technology and supervision experience	.559	<.001	41
The help my supervisor provides in regard to my work	.533	<.001	41
Online supervision is my preferred medium for supervision	.532	<.001	41
The responsiveness of my supervisor	.520	<.001	41
Online supervision does not interfere with work-life balance	.490	.001	40
The availability of my supervisor	.490	.001	41
An online relationship can still be kept despite using different types of technological tools	.471	.002	40
Digital devices and technologies are incorporated into my supervision practice during COVID19	.468	.002	40
We mutually agreed to shift to online supervision	.426	.006	40
Video conferencing tools such as Skype, Zoom, Zoho, Webinar	.347	.026	41
By a more structured process in sessions	-.330	.035	41
By more support from my supervisor	-.344	.028	41
Messaging apps on smartphones such as WhatsApp, WeChat, Signal, Line	-.354	.023	41
Internet Chatrooms	-.369	.019	40
By my supervisor listening to me better	-.401	.009	41
By better privacy and confidentiality settings	-.424	.006	41
Online supervision should only be used when you cannot meet in person due to COVID 19 lock down	-.591	<.001	41
All supervision should be face to face and in person	-.652	<.001	41

Table 14. Supervisors' Correlations with Overall Evaluation

Item	Rho	Sig	N
I enjoy using technological tools available to me on online supervision during COVID-19	.587	<.001	158
I think that it is easy to build a strong supervisory working alliance via different types of technological tools	.550	<.001	160
Online supervision is my preferred medium for supervision	.490	<.001	161
I know how to use different technological tools to promote and facilitate online supervision	.489	<.001	160
We discuss a wide range of topics during online supervision via different types of technological tools	.482	<.001	158
I am comfortable with using different types of technological tools	.480	<.001	159
I always consider a range of tools that are suitable for online supervision	.473	<.001	158
Online supervisory relationship can still be kept despite using different types of technological tools	.441	<.001	160
Both supervisee and supervisor have a mutually agreement to shift to online supervision	.410	<.001	159
I incorporate digital devices and technologies into my supervision practice during COVID-19	.398	<.001	160
Video conferencing tools such as skype, zoom, webinar	.389	<.001	159
Online supervision will not interfere with work-life balance	.375	<.001	161
Online supervision is the best form for supervision at a distance	.344	<.001	160
I have tried to conduct online supervision through one or more technological tools before COVID-19	.231	.003	161
My usual supervision practice has been disrupted greatly during COVID-19	-.162	.041	159
Online supervision should only be used as an adjunct to face to face supervision	-.355	<.001	160
Online supervision should only be used when you cannot meet in person due to COVID 19 lockdown	-406	<.001	161
All supervision should be face to face and in person	-454	<.001	161

Discussion

The results show that supervisees' and supervisors' supervision situations changed in response to Covid-19 and video-conferencing was the most frequently used format. The supervisees and supervisors shared similar views about the use of technological tools in supervision, particularly about the protection of privacy and confidentiality, having a mutually agreed contract and the ability to maintain the communication, relational and core aspects of supervision through online supervision. Their general views of online supervision showed that for most, online supervision was a medium they would use alongside face-to-face supervision, and it was the best medium for supervision at a distance. For the supervisees' what was best about their online supervision was the frequency of it, and their supervisors' competence and responsiveness. This finding aligned with Mo and Chan (2021), who found that supervisees appreciated their online supervisors' relational support and responsiveness the most. For the majority of the supervisees, the most agreed improvements to their online supervision were a more structured process in sessions and training in online supervision. The finding about training in online supervision mirrors that of Selem (2021) concerning how training in electronic supervision could improve group electronic supervision. The overall satisfaction and evaluation results showed that supervisees with a positive attitude and approach to online supervision and good supervision with a competent supervisor had higher satisfaction levels and a higher overall evaluation. In contrast, those who strongly preferred face-to-face in-person supervision had lower satisfaction and overall evaluation. One implication of this finding is that there is value in supervisors exploring with supervisees their attitudes to online supervision at the beginning of a supervision relationship to understand how online supervision can be used to meet their needs. In Aotearoa New Zealand, this exploration needs to consider how the Te Tiriti o Waitangi and the profession's pou/values of Rangatiratanga, Manaakitanga, Whanangatanga, Aroha, Kohtahitanga, Mātātoa, and Wairuatanga are embodied and honoured through the online medium (ANZASW, 2019). Turning to supervisors, the results showed that supervisors with a positive attitude about online supervision and the use of technology had a higher level of satisfaction with their online supervision. It is unknown whether this translates into better supervisory practice in the online environment or greater satisfaction of overall evaluation for supervisees. Nonetheless, it highlights the importance of the supervisors' attitude for their overall satisfaction and evaluation in providing online supervision. The survey results align with Connell's (2023) conclusions that online supervision was a positive experience and that the supervision relationship and good connectivity are important. In addition to Connell (2023), who found that some elements of face-to-face in-person supervision were missed, our study found regarding face-to-face and online supervision, that where supervisees and supervisors strongly valued face-to-face supervision, they had lower levels of satisfaction and a less favourable evaluation of online supervision.

The limitations of this study are that the results are not generalisable beyond the respondents. The sample did not represent all international social work regions because the respondents are predominantly from Europe and Asia-Pacific, with only one North American respondent and none from the Latin America and Caribbean regions. Another limitation is that only the supervisees were asked what was best about their online supervision and how it could be improved. The specific limitation of this is that we have no comparable data for the supervisors about their views on what is best and what can be improved in their online supervision and that the correlational analysis for the supervisor differs from that of the supervisees regarding the items analysed.

Conclusion

This article has established a baseline of the views and experiences of supervisees and supervisors of cyber-supervision internationally during the Covid-19 pandemic. The finding that the attitudes and perspectives of supervisees and supervisors about online supervision were related to their overall satisfaction and evaluation has implications for supervision practice and further research. The practice implication concerns supervisees and supervisors who engage in online supervision, exploring and discussing their attitudes, views and cultural perspectives early in their relationship, particularly if they plan to use this medium regularly or in conjunction with face-to-face supervision. The implications for further research are for studies with larger samples focusing on the influence of supervisees' and supervisors' attitudes and cultural perspectives about online supervision on their experiences and outcomes.

Conflict of Interest Statement: The authors have no funding, relationships with companies, individuals or this journal or other declarations of interest to report.

Received: 26 March 2024

Accepted: 6 May 2024

Published: 15 June 2024

References

Aotearoa New Zealand Association of Social Workers. (2011). *ANZASW supervision policy* https://www.anzasw.nz/public/150/files/Publications/Archive/ANZASW-Supervision-Policy-2011.pdf

Aotearoa New Zealand Association of Social Workers. (2019). *Code of ethics.* https://www.anzasw.nz/public/150/files/Publications/Code-of-Ethics-Adopted-30-Aug-2019.pdf

Aotearoa New Zealand Association of Social Workers. (2024). *Supervision strategy 2023- 2033.* https://www.anzasw.nz/public/150/files/Advocacy/240326%20Supervision%20Strategy%20PUBLISHED.pdf

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Lawrence Erlbaum Associates.

Connell, S. (2023). Putting the "Virtual" into supervision during the COVID-19 pandemic and beyond. *Practice*, *35*(4), 335–349. https://doi.org/10.1080/09503153.2023.2212880

Fronek, P., Briggs, L., Rondon-Jackson, R., Hay, K., Maidment, J., & Medina-Martinez, K. (2023). Responding to COVID-19 in social work field education in Australia, New Zealand and the United States. *International Social Work*, *66*(1), 130–143. https://doi.org/10.1177/00208728211048934

IBM Corp. (2021). *IBM SPSS Statistics for Windows, Version 28.0*. IBM Corp

King, L., & Hirst, V. (2011). The supervision matrix-neo seeks Oracle: Online supervision services. In L. Beddoe, & A. Davys (Eds.), (2011). *Common threads – Different patterns: Supervision 2010 Conference proceedings* (pp. 78–85), https://www.researchgate.net/publication/252322913_Common_Threads-_Different_patterns_Supervision_2010_Conference_proceeding

Lombardi, B. M., de Saxe Zerden, L., & Thyberg, C. (2022). Social work answers the (video) call: Tele-behavioral health use during COVID-19. *Journal of the Society for Social Work and Research*, *13*(1), 67–87. https://doi.org/10.1086/715621

Mo, K. Y. H. (2021a). Supervision and information and communication technology (ICT). In K. O'Donoghue & L. Engelbrecht (Eds.), *The Routledge international handbook of social work supervision* (pp. 626–636). Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9780429285943-58/supervision-information-communication-technology-ict-kitty-yuen-han-mo

Mo, K. Y. H. (2021b). In search of a cyber supervision process: From the perspective of social work supervisees in Mainland China. *Journal of Evidence-Based Social Work*, *18*(1), 71–84. https://doi.org/10.1080/26408066.2020.1805383

Mo, K. Y., & Chan, O. (2023). Supervisory relationship in cyber supervision: Implications for social work supervision. *International Social Work, 66*(1), 65–79. https://doi.org/10.1177/0020872821991887

O'Donoghue, K., & Engelbrecht, L. (Eds.). (2021). *The Routledge international handbook of social work supervision.* Routledge. https://doi.org/10.4324/9780429285943

Pallant, J. (2016). *SPSS survival guide* (6th ed.). Allen & Unwin.

Rushton, J., Hutchings, J., Shepherd, K., & Douglas, J. (2017). Zooming in: Social work supervisors using online supervision. *Aotearoa New Zealand Social Work*, *29*(3), 126–130. https://doi.org/10.11157/anzswj-vol29iss3id254

Selem, M. (2021). The effectiveness of electronic supervision for supervisee groups in the school field. *Egyptian Journal of Social Work*, *12*(1), 173–194. https://doi.org/10.21608/ejsw.2021.58386.1124

Sewell, K. M., Mishna, F., Sanders, J. E., Bogo, M., Milne, B., & Greenblatt, A. (2022). Supervision of information communication technologies in social work practice: A mixed methods study. *The British Journal of Social Work*. https://doi.org/10.1093/bjsw/bcac113

Social Workers Registration Board. (2016). *Code of conduct*. https://swrb.govt.nz/download/swrb-code-of-conduct/?tmstv=1713396224

Yuliani, D. (2021). E-Supervision; The future of the social work supervision practice in Indonesia. *Dialogos*, *25*(2), 21–35. https://repository.poltekesos.ac.id/handle/123456789/61

ORIGINAL ARTICLE
QUALITATIVE RESEARCH

The narratives of Asians amidst the Covid-19 pandemic in Aotearoa New Zealand: Navigating a virtual realm in the context of anti-Asian racism

Hagyun Kim[a], **Young Han**[b] and **Donghyun Lee**[c]

[a] Massey University, Auckland, New Zealand.
[b] University of Auckland, Auckland, New Zealand.
[c] Sangmyung University, Seoul, South Korea.

ABSTRACT

INTRODUCTION: The Asian population, the third largest ethnic group in Aotearoa New Zealand, confronts persistent socio-economic exclusion exacerbated during the Covid-19 pandemic amidst rising anti-Asian racism. The study aims to explore Asians' pandemic experiences and their impact on their quality of life in Aotearoa New Zealand, with the goal of contributing to tailored knowledge development for Asians in crisis situations.

METHODS: The study, theoretically grounded in symbolic interactionism, examines stories of 26 Asians representing Chinese, Indian, Filipino and Korean communities. Thematic analysis of semi-structured interviews identifies patterns encapsulating participants' strategies to sustain their lives and challenges faced during the pandemic.

FINDINGS: The Covid-19 pandemic profoundly disrupts participants' lives, evoking anxiety and uncertainty. In response, they turned to virtual realms to maintain daily routines and connections with their home countries. They often relied on ethnic communities for support due to difficulties in accessing formal support systems. Notably, North-east Asians face adversity from racism targeting individuals with a Chinese appearance, resulting in reduced self-esteem and weakened societal belonging.

CONCLUSION: The study sheds light on challenges Asians face amidst escalating anti-Asian racism and highlights the crucial role of ethnic social services during the pandemic. Social workers must engage with ethnic communities, partnering with ethnic social services, to address Asians' needs in times of crisis.

Keywords: Asians; anti-Asian racism; ethnic social services; symbolic interactionism; virtual realm

The Covid-19 pandemic impacted various dimensions of citizens' lives in Aotearoa New Zealand. This sweeping influence extends to both individuals and society at large, fostering heightened uncertainty (Cochrane, 2021). Notably, the pandemic's ramifications have been particularly profound for the Asian community in Aotearoa New Zealand, facing formidable challenges in accessing healthcare and government support due to language barriers and limited social networks, instilling anxiety and confusion (Ministry of Health, 2020).

Furthermore, this already challenging situation is compounded by a rise in Covid-19-related anti-Asian racism (Jaung et al., 2022).

AOTEAROA NEW ZEALAND SOCIAL WORK *36(2)*, 39–56.

CORRESPONDENCE TO:
Hagyun Kim
H.kim2@massey.ac.nz

Amidst mounting anxieties about the spread of Covid-19, there has been a surge in discrimination, physical violence, and harassment against Asians (Gover et al., 2020; Liu et al., 2022). This escalation of discriminatory experiences amidst heightened anxiety and uncertainty poses a pressing challenge for the well-being and health of Asians in Aotearoa New Zealand (Siegert et al., 2023).

This article, theoretically grounded in symbolic interactionism, explores Asians' experiences in Aotearoa New Zealand during the pandemic, highlighting their unique challenges. It reviews Asians' life issues, underlining the research gap on their pandemic circumstances. This is followed by the study's methodology. Findings encapsulate Asians' strategies for sustaining their lives and the challenges they faced throughout the pandemic. The final section discusses the role of ethnic social services in crises for Asians in Aotearoa New Zealand.

Asians in Aotearoa New Zealand

The term *Asians* encompasses an inclusive category, reflecting "differences in geographical, political, cultural, religious, linguistic and socio-economic backgrounds" (Jaung et al., 2022, p. 61). This diversity highlights the multiple dimensions within Asian communities (Ho, 2015), making a comprehensive understanding of Asians as a whole in Aotearoa New Zealand nearly impossible (Kim, 2021). According to the 2018 Census, 707,598 Asians resided in Aotearoa, constituting the third-largest ethnic group, accounting for 15.1% of the total population, after European (70.2%) and Māori (16.5%) (Statistics New Zealand, 2018). Among Asians, the largest sub-ethnic groups were Chinese (247,770), Indian (239,193), Filipino (72,612), and Korean (35,664).

The significant presence of Asians in Aotearoa New Zealand began in the late 1980s when the government abolished racial preferences in immigration policy (Cheyne et al., 2008). Prior to this policy shift, the Asian population was negligible, less than 1% in 1986, with Europeans comprising 87% and Māori 9% (Jackson & McRobie, 2005). Since then, the influx of Asian immigrants has reshaped Aotearoa New Zealand's demographic landscape from primary bicultural to ethnic diverse (Kim & Hocking, 2018). Notably, the majority of Asians residing in Aotearoa New Zealand arrived within the past three decades, despite historical records dating back to the early 1800s (King, 2003).

In response to ethnic diversity in society, efforts have been made to build an inclusive society where citizens fully participate, irrespective of racial and cultural backgrounds, while still maintaining their connection with their cultural origins (Nayar, 2013). Initiatives like the New Zealand Settlement Strategy of 2004, alongside regional settlement strategies, promote mutual respect for diversity (Department of Labour, 2004). The establishment of the Ministry for Ethnic Communities in 2021 further amplifies ethnic voices (Ministry of Ethnic Communities, n.d.). The government's focus has shifted from mere importation to integrating individuals into society while celebrating their traditions as integral components of daily life in Aotearoa New Zealand.

The government recognises the importance of integrating ethnic minority people for social cohesion (Ho et al., 2000), promoting their full participation through measures such as ensuring: 1) they feel welcome and accepted; 2) are suitably employed and housed; 3) understand New Zealand English; 4) have access to information and services; and 5) comprehend Aotearoa New Zealand's way of life (Department of Labour, 2007). Accordingly, settlement services have been established nationwide to address Asians' societal needs, supporting self-help groups (Nash, 2005). For instance, Settlement Support New Zealand, an Immigration New Zealand initiative, offers clear contact points through 18 nationwide offices (Immigration New Zealand, 2014). Local initiatives like Asian Family Services (AFS, www.asianfamilyservices.nz), Chinese New Settlers Services Trust (CNSST, www.cnsst.org.nz) and The Asian Network Inc (TANI, www.asiannetwork.org.nz) provide culturally and linguistically appropriate services, fostering a sense of belonging among Asians with workshops on understanding Aotearoa's practices.

The government's shift in response to ethnic diversity, alongside concerted efforts by ethnic social services, has yielded positive outcomes. High Asian life satisfaction levels, including key determinants such as good health, stable employment, income security, and positive family and social relationship (Ministry of Social Development, n.d.), stand at 86.5% (Asian Family Services, 2021), reflecting notable success across various social facets. This success extends to the recent election of Asians to Parliament in 2023. Societal efforts to facilitate Asians' success, coupled with the growing recognition of their contributions to society (Asia New Zealand Foundation, 2021), enhance Asians' participation in the broader societal framework, crucial for promoting diversity in society.

Asians' life issues in Aotearoa

However, concerns persist regarding the exclusion and marginalisation of Asians in Aotearoa New Zealand, despite the positive outcomes of their societal participation. Studies highlight acculturation complexities, exacerbated by barriers like discrimination, racism, and limited social networks (Cheyne et al., 2008; Ho, 2015; Park et al., 2023; Wright-St Clair et al., 2018). Settling in Aotearoa New Zealand poses a stressful transition, influenced by both domestic and societal factors, leading to various acculturative stressors (Lee & Keown, 2018). This includes adapting to new cultural norms, losing their mother language, and re-establishing support systems while preserving heritage connections (Nayar, 2013). From this perspective, settling in Aotearoa New Zealand entails internal and external conflicts, alienation, and grief over losses (Pepworth & Nash, 2009), constraining their societal participation (Kim & Hocking, 2018).

Notably, the experiences of Asians occur within social contexts where they encounter "racism in variegated ways" (Ang et al., 2023, p. 3). Racism manifests as a structured power system where targeted racial groups face persistent denial of belonging and unequal treatment across social domains (Gover et al., 2020). Particularly in Aotearoa, New Zealand "racism is linked to the history of colonisation and ongoing coloniality" (Park et al., 2023, p. 96), necessitating discussion of racism against Asians within this historical framework. Historically, until the 1980s, immigration policy aimed at maintaining a predominantly white population (Bedford et al., 2010), implementing racially motivated immigration policies to uphold British-ness (Spoonley, 1993). This led to a collective culture of whiteness in Aotearoa New Zealand (Chenoweth & McAuliffe, 2021), marginalising Asians as sojourner communities (Kim, 2021). Consequently, Asians, whose appearance and behaviours deviate from dominant white social norms, are often stigmatised as potential threats to social cohesion (Cheyne et al., 2008).

This stigmatisation persists today (Park et al., 2023), with Asians identified as the most discriminated-against group in 2016 (Ministry of Social Development, 2016). Despite a facade of racial harmony (Duncan, 2007), Asians consistently report anti-Asian sentiment involving verbal harassment and physical violence (Chiang, 2021). Furthermore, historically entrenched ethnic inequality perpetuate barriers to full societal participation (Ng, 2017), including a lack of belonging (Butcher & Wieland, 2013), racial income gaps (Anthony, 2015), limited access to public and health services (Peiris-John et al., 2022; Wright-St Clair et al., 2018), and denial of full membership in society (Kale et al., 2018). Troubling statistics indicate that 23% of Asian immigrants seldom socialise with other New Zealanders (Ministry of Business, Innovation and Employment 2015), with 44.4% of Asians exhibiting symptoms of depression, rising to 61.3% among younger Asians (Asian Family Services, 2021).

Asians in Aotearoa New Zealand have historically endured challenges in re-building their lives and negotiating ethnic identities, often confronting societal prejudice. This pervasive inequality was further highlighted during the Covid-19 pandemic, with Asians encountering limited social and psychological resources (Ministry of Health, 2020). Language barriers and constrained social networks hindered their access to healthcare and government support. Simultaneously, many Asians reported Covid-related harassment and racism (Human Rights Commission, 2021; Jaung et al., 2022), amidst what has been described as "the governments' Covid-19 rhetoric and mainstream media's racist sentiment and comments" (Liu et al., 2022, p. 2). Several studies documented incidents of Covid-19-induced anti-Asian racism, particularly through cross-cultural surveys, with many highlighting discriminatory practices against Asians, leading to decreased life satisfaction and weakened belonging (Ang et al., 2023; Jaung et al., 2022; Liu et al., 2022; Park et al., 2023; Siegert et al., 2023).

The Covid-19 pandemic significantly impacts the health and wellbeing of Asians, who often face barriers accessing benefits of an inclusive society, primarily due to their status as Asians in Aotearoa New Zealand (Kim & Hocking, 2018). Questions arise on how Asians navigate daily life amidst heightened uncertainty and anti-Asian sentiments. This study aims to explore Asians' experiences during the pandemic and its impact on their quality of life. By examining their experiences in this context, it seeks to contribute to tailored knowledge development for Asians during crises, informing society on promoting their full participation in Aotearoa New Zealand. Key research questions include:

1. How do Asians maintain daily routines in main social domains; self-care, work, and leisure, during Covid-19?
2. What challenges do Asians face in maintaining daily routines amidst Covid-19?
3. How do Asians respond to Covid-19-induced challenges, including the support they seek or desire?
4. How do Covid-19-related challenges affect the quality of life for Asians in Aotearoa New Zealand?

Methodology

Theoretically grounded in symbolic interactionism, this study posits that individuals' experiences result from social interactions rather than inherent traits (Blumer, 1969). Symbolic interactionism emphasises the process of social interaction in constructing meanings of experiential realities, whereby individuals engage with objects in their environment. This theoretical perspective suggests that meanings are contingent on individuals' interpretation of objects, derived from social interactions (Crotty, 1998), highlighting the existence of diverse meanings within the same phenomena (Braun & Clarke, 2006).

From this viewpoint, Asians construct their reality through interpretive processes. This study explores Asians' reality in the context of the Covid-19 pandemic, examining their experiential narratives within complex social interactions (Corbin & Strauss, 2015). Such an approach aligns with the researchers' positionality as immigrants, offering an insider's view of diverse experiences in integration, and as social work researchers, emphasising the inseparable relationship between individuals and their contexts. This positionality advocates for social change and promotes future research on ambiguously defined problems by disseminating collected narratives. This study received ethical approval by Massey University in 2021 (ref. SOB 21/52).

Participants

The study's participant criteria involved Asians aged 20 years and above, residing in Aotearoa New Zealand for over 5 years, and present during the Covid-19 pandemic. Employing purposive sampling (Victor, 2006), the study recruited individuals meeting these criteria, possessing relevant experiences to address the research questions, and thereby offering valuable insights into Asians' pandemic experiences. Participants included individuals of Chinese, Indian, Filipino, and Korean descent, reflecting their significant presence in Aotearoa's Asian demographic (Statistics New Zealand, n.d.).

Research assistants were enlisted for the Chinese, Indian and Filipino communities and underwent a one-hour introductory session, receiving a comprehensive study overview and consenting to a confidential agreement. Adhering to participant criteria, these assistants circulated study information within their networks, ensuring voluntary participation. Interested individuals received information sheets and consent forms in their preferred languages (Chinese, Hindi, Filipino, Korean, and English), developed in consultation with research assistants and co-researchers, highlighting confidentiality and the right to withdraw at any point. Interview were conducted in participants' preferred languages, with research assistants providing translations as necessary.

Between February and November 2022, 26 participants aged 31-85 were interviewed during the Covid-19 pandemic. The majority were interviewed online, except for those with Korean participants, which were in person. Participants included seven Chinese, six Indian, six Filipino, and seven Korean individuals, all born overseas and residing in Aotearoa for 5-27 years (average 15.2 years). Ten were male, and the rest were female. Geographically, most resided in Auckland, with three exceptions living in Hamilton, the Marlborough District, and Tauranga. Employment varied: one university student, two housewives, two retirees, 18 employed, and three self-employed. Pseudonyms ensured confidentiality. Table 1 presents their demographic characteristics.

Data collection

Semi-structured interviews served as the primary data source, enabling participants to share comprehensive insights while the researcher guided the interview process (Corbin & Strauss, 2015). Using open-ended questions, the study allowed participants to narrate their stories in detail. Interviews were transcribed verbatim and then translated into English for analysis, with assistance from research assistants.

Data analysis

This study employed thematic analysis, a method for identifying patterns within data (Braun & Clarke, 2006). By offering insight into recurring patterns found within the dataset, this approach aims to reveal the meanings participants attribute to their experiences, aligning with symbolic interactionism's view on multiple perspectives on phenomena arising from social interactions (Blumer, 1969). Essentially, thematic analysis facilitates the development of cohesive themes representing meanings participants assign to their experiences (Roberts et al., 2019). The data analysis process followed Braun and Clarke's (2006) six-phase guide: 'familiarisation with data,' 'coding,' 'searching for themes,' 'reviewing theme,' 'defining and naming themes,' and 'writing up'.

Initial data familiarisation involved thoroughly examining participants' narratives. Subsequently, researchers generated initial codes to capture semantic and conceptual nuances in the data, forming the foundation for theme development (Roberts et al., 2019). These codes, along with relevant data excerpts, were aggregated to identify meaningful themes addressing research questions. Themes underwent

Table 1. Participants' Demographic Characteristics

Name	Gender	Age	Marital status	No. Children	Arrival in Aotearoa	Employment status	City of residence
CP1	Female	40	Married	2	1995	Employed	Auckland
CP2	Female	55	Married	1	2010	Student	Auckland
CP3	Female	42	Married	2	2000	Employed	Auckland
CP4	Male	43	Married	2	2002	Employed	Auckland
CP5	Female	45	Married	2	2006	Housewife	Auckland
CP6	Female	41	Married	2	2017	Self-Employed	Auckland
CP7	Female	36	Single	0	2013	Employed	Auckland
IP1	Male	38	Married	0	2008	Employed	Auckland
IP2	Male	40	Married	1	2006	Self-employed	Auckland
IP3	Female	62	Married	3	1998	Housewife	Auckland
IP4	Female	62	Married	1	2002	Employed	Auckland
IP5	Male	40	Married	2	2014	Employed	Marlborough District
IP6	Male	85	Married	0 in care	1999	Retired	Auckland
FP1	Male	32	Single	0	2012	Employed	Auckland
FP2	Female	44	Married	4	2011	Employed	Auckland
FP3	Female	31	Married	1	2016	Employed	Auckland
FP4	Female	34	Single	0	2012	Employed	Auckland
FP5	Male	73	Married	3	2003	Retired	Auckland
FP6	Male	40	Married	1	2011	Employed	Auckland
KP1	Female	47	Single	0	2004	Self-employed	Auckland
KP2	Female	55	Married	2	2010	Employed	Auckland
KP3	Male	50	Married	2	2000	Employed	Auckland
KP4	Male	50	Married	2	2000	Employed	Hamilton
KP5	Female	40	Married	2	2007	Employed	Auckland
KP6	Female	41	Married	1	2009	Employed	Auckland
KP7	Female	64	Married	3	2000	Employed	Tauranga

(CP– Chinese, IP– Indian, FP– Filipino and KP– Korean)

further refinement, considering coherence, relevance, and distinctiveness. Each theme's nature was defined by evaluating relationships between them. During this phase, significant themes were clearly defined, with key attributes identified, and concise and informative names assigned. Lastly, researchers constructed a persuasive narrative by integrating themes with relevant excerpts.

Notably, the six-phase data analysis process is recursive (Braun & Clarke, 2012), with researchers frequently moving back and forth until reaching theoretical saturation, where "additional new data will not add new understanding to the question at hand" (Thai et al., 2012, p. 5). This iterative approach fosters conceptualisation of data, culminating in thematic constructs and their interpretation within research questions (Braun & Clarke, 2006).

Findings

The study's participants disclosed that the onset of Covid-19 pandemic precipitated profound disruptions to their established routines. They also expressed increased anxiety about an uncertain future due to the rise of Covid-19-related anti-Asian racism, particularly targeting individuals of North-east Asian origin, undermining their self-esteem and sense of belonging in Aotearoa New Zealand. Four significant themes emerged: 'turbulence in equilibrium,' 'the normalisation of abnormality', 'navigating a virtual realm' and 'anti-Asian racism targeting individuals with a Chinese appearance.'

According to symbolic interactionism, the meaning of objects stems from social interactions, yet individuals often modify these meanings when encountering phenomena (Blumer, 1969). This implies that "both society and person are abstractions from on-going social interaction" (Stryker, 1980, p. 2), locating themes at micro/meso/macro levels. The micro-level theme, 'the normalisation of abnormality', the meso-level theme, 'navigating a virtual realm', and the macro-level theme, 'anti-Asian racism targeting individuals with a Chinese appearance', collectively depict participants' varied experiences within the broader social context during the Covid-19 pandemic. Use of 'In-vivo codes,' extracted from participants' comments (Corbin & Strauss, 2015), conveyed their perspectives on their lived experiences.

Turbulence in equilibrium

Aotearoa New Zealand is globally renowned for its clean and peaceful environment, a perception that resonates with individuals from overseas, "I thought New Zealand was a peaceful country" (IP4). Many participants in this study shared this positive image before relocating to Aotearoa, harbouring optimistic expectations for their new life, "I was looking for better opportunities for my family" (FP1). However, the immigration process, characterised as transitioning from one social unit into another (Kim & Hocking, 2018), presents a series of acculturative challenges, severely disrupting participants' daily routines and creating hardships.

Upon arrival, many participants faced arduous situations while adjusting to their lives in Aotearoa New Zealand, primarily due to their newly arrival and ethnic minority status. They grappled with challenges related to limited social networks, "Here, we were alone, me and my family" (IP5), language barriers, "English is my second language. There were lots of difficulties in communicating with others" (CP2), unfamiliar culture, "It was a shock when I came here because of the cultural differences" (IP4) and unrecognised life experience and qualifications, "No one recognised my qualification. I had to start a job picking fruit" (KP1), which complicated their adjustment process in Aotearoa New Zealand.

This multifaceted experience often left Asian immigrants facing hardship, "For the first few years, it was emotionally and physically challenging” (KP2), as they grappled with losses related to their accustomed daily routines, roles, and resources, “It was a tough time for me to get a job. Despite all my qualifications, I had to start as a cook” (IP5). Discrimination and racism further compounded their challenges, “People treated us with a different standard” (CP2), making it difficult for them to engage in essential daily activities, leading to financial hardships; “We had to survive with the money we brought from India” (IP5), social isolation, “I didn’t have any connections with local people” (KP1); and acceptance of their minority status in the host society, “As an Asian, I feel left out in this country even though I pay taxes and work hard to feed my family. We are being ignored till today” (IP2).

In response to these challenges, participants exhibited resilience and determination in rebuilding their lives in Aotearoa New Zealand. They were willing to adopt heavy work schedules, “I worked seven days a week” (KP4). Moreover, they employed various coping strategies, such as accepting jobs beneath their qualifications, “I worked at an aged care village despite having 17-years of nursing experience” (CP2); seeking support from ethnic communities, “There are always Indian communities, and you can connect with them” (IP5). In some cases, they deliberately distanced themselves from their ethnic background: “To learn about New Zealand society, I didn’t meet other Koreans” (KP1). In adapting to a new environment, participants employed coping strategies that often resulted in emotional distress, “While distancing myself from my ethnic community, I felt intense loneliness” (KP1), and claimed a physical toll.

> I was a teacher in India. But here I worked picking strawberries and all sorts of that kind. I’m not saying it is bad because every job is important, but I didn’t have a physical work background, so it was hard. (IP4)

Over time, the participants’ persistent efforts allowed them to gradually adapt to their new surroundings. They became familiar with the local community, leading to a growing sense of security in their lives within Aotearoa New Zealand, “After a few years of struggles, my life is now secured. I have a decent job and know the community where I live” (KP3). They achieved a balanced life between their home and host country, “I felt my life is now balanced, I know locals and also people from the Korean community” (KP1). This equilibrium inspired them to integrate into the host society, “I wanted to mingle with local people, so I know how the culture and system in NZ works” (CP2); and set life goals, “My husband has a secure job and I had a plan for myself” (KP2); with increased life satisfaction, “I am thankful to God that we got this opportunity to live in NZ because my family has a good life here” (FP5).

From this perspective, the theme of ‘turbulence in equilibrium’ encapsulates the disruption caused by the pandemic to the balanced lives participants had gradually achieved, “Oh my lord, I thought we were finally settled. I hoped everything would be better from now on but then the Covid outbreak occurred” (KP7). After a period of endurance, many participants began to embrace the benefits of living in Aotearoa New Zealand, “I enjoy living in New Zealand. The environment, air quality and the living standards are much better than my home country” (CP1). However, the onset of the Covid-19 pandemic severely disrupted the equilibrium they had achieved in Aotearoa New Zealand, leading them to an uncertain future again.

> Before Covid, I was happy about my life. People were friendly, casual, and liked to talk to others. I also enjoyed travelling, visiting friends in Queenstown ... However, the pandemic has limited my ability to interact with people, and everything changed. (CP7)

The uncertainty and stringent measures implemented during the Covid-19 pandemic disrupted participants’ daily routines, highlighting the challenges in maintaining pre-pandemic activities, since "Everyone should stay home" (CP1). These restrictive measures served to isolate participants from broader society; "The big challenge I experienced was I couldn't meet people. How dare I visited people when they said no to come" (KP1), underscoring the pronounced social isolation imposed by the pandemic. Furthermore, participants expressed a sense of estrangement from their countries of origin, "I can't visit my family in Philippine because I am stuck in New Zealand" (FP1), indicating the emotional strain resulting from geographical separation.

Specifically, concerns about job security, gained through considerable endeavour, "I had worked in various roles, such as a concierge, farmer, … and recently as a support worker" (FP6), were prevalent among participants. "My husband got lots of stress without work for months" (KP5). Such anxiety was compounded for self-employed individuals, "A lot of Asians had small businesses. They struggled badly because of restrictions" (IP5) and "I witnessed a dramatic decrease in customers to my shop" (KP7). Consequently, the Covid-19 pandemic disrupted the equilibrium participants had gradually achieved in various aspects of their lives, fostering feelings of powerlessness; "There is nothing we can do but just to follow the government rules" (FP4). Heightened stress and anxiety about an uncertain future permeated participants' narratives during the pandemic, "I didn't know how long this pandemic would last. When can I see my parents back home? It made me cry" (KP2). In this sense, the Covid-19 pandemic profoundly disrupted participants' lives in Aotearoa New Zealand, "The pandemic? It broke my lifestyle rather than shaking it" (KP4).

The normalisation of abnormality

The theme of 'the normalisation of abnormality' illustrates how the unprecedented Covid-19 pandemic "It would be a historical event for our next generation" (KP4), transformed what was once considered abnormal into the new normal. In early 2020, the outbreak of Covid-19, with limited knowledge about the virus, "There was not much news. I only knew that once you caught the virus, it could be fatal" (CP7), triggered panic in Aotearoa New Zealand with widespread anxiety, "There was no planning because nobody knew about it" (IP3). Panic buying and stockpiling of essential items became common: "At the beginning, many people rushed to the supermarket and queuing up to stock up on items" (CP2).

With the first confirmed case in Aotearoa New Zealand in January 2020, the government declared a State of National Emergency on May 2020, and implemented various restrictive measures, including mask-wearing, travel restrictions, social distancing, testing, contact tracing, and lockdown, "During the Covid period, all social activities were abandoned and forbidden" (CP1), while still engaging in essential activities. Vaccination and hygiene promotion were also integral to the strategy: "Our normal routine has changed, additional hygiene steps have been added to avoid Covid infection" (FP1), and what was once considered routine in civic society gave way to a new set of norms, "The restriction becomes the new normal as they call it now" (IP3) and the public gradually accepted this abnormality as their new normalcy, "We can't go anywhere without showing vaccination card" (FP5).

Lockdown, in particular, profoundly impacted participants' lives, with most services suddenly closing: "Suddenly everything closed" (IP2). Fear of the virus heightened unease about social interactions, as "People were worried about contact with each other" (CP7). The closure of services further exacerbated the disruption, "In lockdown, I couldn't access treatment or supported services" (CP4). Participants had to relinquish many activities they once enjoyed freely, and now "You cannot do all the normal things that you do before the pandemic" (FP5). While some adapted with discomfort, "It was a little uncomfortable as I had to queue when I shopped" (KP3); others felt frustration and anxiety, "Having no work for months made me worry all the time, questions like; what now, what's going to happen, are we going to be okay?" (FP6), compounded by fear of future uncertainty, "We got worried what will happen next?" (IP4).

While the normalisation of abnormality during the pandemic appeared to impact all Aotearoa New Zealand residents, it posed additional challenges for participants, particularly for those lacking extended family networks, "During the pandemic, only my wife and I lived here. No family support available" (IP5). This was especially pronounced for participants living alone, where the potential fatality of Covid-19 heightened anxiety, "I may die tomorrow because of the virus. In this case, what will happen? I don't have any family here. It triggered my anxiety" (KP1). Moreover, international travel restrictions prevented visits to families in home countries: "There were many travel restrictions. I haven't visited my parents in Hong Kong in the last two years" (CP3). This separation from loved ones carried feelings of guilt and emotional exhaustion: "I felt sorry to my parents in Korea. Am I doing enough for them as a daughter?" (KP2), particularly during times of sickness and death within the family, "During the lockdown, my father-in-law passed away. We couldn't go back to the Philippines and watched the funeral online. It was hard for my husband" (FP2).

The transformation of what was once considered normal into a new reality of restrictions and uncertainty, "I stayed at home all the time, for almost two years" (FP5), resulting in varying degrees of emotional toll. Uncertainty, coupled with feelings of loneliness, was widespread among participants: "My friend lived alone here. She said staying home for 24 hours was very lonely with no one around" (CP2). Moreover, participants experienced a sense of guilt for not being physically present during significant family occasions in their home countries, "Filipinos are known to be family oriented. I felt sorry and sad that I couldn't be present during big occasions" (FP1). This sense of disconnection was further compounded by decreased confidence in living in Aotearoa New Zealand , "Honestly, I lost my confidence in New Zealand. Here you never know what will happen in the future" (CP5), leading to doubts about their post-retirement plans, "The Covid-19 made me rethink where I'll live after retirement, since my future in New Zealand seemed uncertain" (KP2).

Navigating a virtual realm

In the face of strict pandemic-related restrictions curtailing physical interactions and mobility, participants, such as CP5: "I only stayed home. I was cautious about the virus," had to seek alternative means to engage in essential activities. The theme of 'navigating a virtual realm' encapsulated their adaptation to these challenges. In this study, participants predominantly turned to virtual platforms, where they could continue nearly all aspects of their social lives, "I used all possible IT gadgets, such as Zoom and Microsoft teams" (FP1). This reliance extended to communication with the outside world, "Social media was our way to communicate. We updated each other through social media and online chats" (FP2), particularly in maintaining connections with loved ones in their home countries; "I spent most of my day online talking to my parents in South Korea" (KP3).

This extensive online engagement encompassed various activities essential for daily life maintenance, such as shopping, "I mainly did online shopping" (CP1). It also extended to productivity-related pursuits, like "I worked from home and attended

Zoom meetings" (KP2) and transitioning to online learning, "My study switched to online" (CP2). Moreover, these online adaptations included activities of personal significance, such as attending religious services, "We attended church online" (FP6); and leisure activities, "I wouldn't survive without You Tube" (KP4). In this study, participants immersed themselves in the virtual world across almost all aspects of their social lives, while still maintaining a necessary level of physical activity and in-person interactions, "We only went for a walk nearby" (FP2), recognising the limitations of online alternatives. "I'm Chinese. I had to buy some Chinese stuff such as Chinese noodles and rice, which were only available from Chinese grocery shops, not online" (CP1).

However, not all participants readily embraced this digital world for daily life sustenance. As articulated by IP4, "I never ever used Zoom before. Before Covid, I didn't even know Zoom existed." Furthermore, despite their efforts to adapt to the digital world, "I learnt to use those technologies with my family's help" (FP5), participants encountered several limitations associated with no in-person interaction, "Online church services were often disrupted. I turned on Zoom but often did something else" (KP2); and "Meeting classmates online can't replace real presence. I felt a sense of distance from them" (KP5). Additionally, participants for whom English was as a second language found, "Online sessions are much harder to understand" (KP6) than face-to-face interactions.

Significantly, participants with young children faced increased pressure in the domestic sphere, especially due to homeschooling during lockdown, "I have two children. I had to be their teacher and mother, taking on various responsibilities" (CP5). While adults sought ways to occupy their time: "I read books. It helped me spend time and kept my mind busy" (FP5), parents struggled to structure their children's time at home, since "My children were a bit bored because they couldn't go out" (FP2). To manage family time, participants employed various strategies, such as having "A family movie night" (FP6) and "Cooking together" (KP3). However, it seemed to be inevitable that extended periods at home led to domestic conflicts, with KP1 observing, "There was no space for me", exacerbated by increased parental responsibilities, "For me, it was challenging because I worked from home and had to assist my children with their studies … This was an added workload that became too much for me" (FP2).

In line with this parental challenge, female participants faced increased strain, particularly in patriarchal cultures, where traditional gender roles persisted, "It was hard for many Indian ladies, as they faced the male-dominant culture. Women were expected to manage all household chores, while men often didn't do anything" (IP5). While many Asian couples shared domestic duties, "I normally prepared meals because my wife worked from home" (KP4), instances of entrenched patriarchal norms persisted, with women primarily assuming domestic roles, as illustrated by KP5: "My husband did nothing. I had to prepare all meals and play with children. He contributed very little, virtually none ... This made me feel crazy."

As participants navigated virtual realms to sustain their lives during the pandemic, the increased time spent at home necessitated the creation of activities to pass the time. For parents with young children, this posed an additional challenge, "We have a 2-year-old child and a baby. Looking after them made us very exhausted" (CP4). Particularly in patriarchal domestic cultures, female participants shouldered the majority of domestic responsibilities, taking an emotional toll, as shared by CP3:

> Homeschooling was challenging. My son struggled to follow it, so I had to assist him by sitting close and helping him complete his homework … As a mother, this placed a heavy burden on me, and I experienced depression as a result.

Anti-Asian racism targeting individuals with a Chinese appearance

Incidents of anti-Asian racism are regrettably not infrequent in Aotearoa New Zealand, despite its reputation for racial harmony. The prevalence of anti-Asian racism is evident, even before Covid-19, as one participant reported, "People called my husband a yellow monkey at work" (KP5). In this study, participants commonly expressed frustration upon encountering racism, "They ignored me because I am Asian" (KP7), which often manifested covertly.

> In New Zealand, it is hard to report such incidents because they often occur covertly. People may not explicitly state, "you are brown, and I don't want to associate with you" … But many don't even want to have a lunch with me. (IP5)

The Covid-19 pandemic worsened anti-Asian racism in Aotearoa New Zealand. This rise was particularly pronounced among individuals with a Chinese appearance due to the widespread assumption that "Covid originated from China" (CP1). A surge in Covid-19-induced anti-Asian racism occurred during a period marked by public fear and frustration, as "A way to release their pent-up frustration, and I was chosen simply because I am Asian" (KP7). The theme of 'Anti-Asian racism targeting individuals with a Chinese appearance' encapsulates the experiences of racism among Asians during the pandemic, primarily affecting Chinese people, but also extending to individuals from North-east Asia. This is because, "People don't distinguish whether we are Korean or Chinese. We look quite similar" (KP5). Participants with a Chinese appearance reported various forms of anti-Asian racism, including behaviours like social distancing, differential attitudes, and even expressions of racial prejudice that could escalate to life-threatening situations, "I had seen my Chinese friend, especially in the beginning of the pandemic, he was walking, and people were swearing at him" (IP1).

Throughout the pandemic, a substantial volume of unofficial information circulated regarding the virus's origin, often insinuating that "Covid first appeared in China" (CP7). Consequently, the public's responses towards Asians with a Chinese appearance displayed a broad spectrum, characterised by instances of physical distance and discriminatory behaviours. For example, "People stared at us as if we were carriers of the virus" (KP5). Verbal confrontations were not uncommon, instructing participants to keep their distance, such as "When I went for a walk, a woman yelled at me saying to stay away from her" (KP1), or go back to their countries, "People said Chinese brought the virus, so go back to their country. I also saw similar comments on Facebook" (FP3). Additionally, prejudiced attitudes were evident, as described by CP6: "He told me not to be outside. He saw me yellow, and assumed I might have the virus." KP3 recounted a similar experience, citing differential treatment based on his Asian ethnic status:

> A man reproached me for not wearing a mask at the park, despite it not being mandatory at the time. I didn't want to cause any trouble, so I donned a mask. However, in a similar situation later on, he didn't admonish a European passerby.

It is important to emphasise that these incidents do not represent the entirety of Aotearoa's response during the pandemic, where the majority of people were described as "kind and friendly" (CP2). However, it is noteworthy that some individuals expressed their prejudices covertly, while others resorted to verbal abuse, such as instructing Asians with a Chinese appearance to "Go back to China" (KP6) or engaging in racial harassment: "Our shop is next to a Chinese takeaway. I saw several people racially abusing them, telling them to return to China" (IP2). In certain instances, these hostilities escalated to physical threats directed at Asians with a Chinese appearance, as “Someone threw a bottle at one of my Japanese friends and told her to go back to her country” (KP5).

As such, the Covid-19 pandemic has exacerbated various forms of anti-Asian racism, primarily targeting Chinese individuals and extending to people from North-east Asia due to perceived racial similarities. Conversely, individuals from South-east Asia have relatively been exempt from this Covid-19-fueled, anti-Asian racism, “I haven’t experienced any discrimination” (FP3) and “Not in my case” (IP1). This disparity in experiences can be attributed to their differing racial statuses, despite being collectively labelled as Asians in Aotearoa New Zealand. This underscores the reality that individuals from different Asian countries have distinct experiences shaped by their ethnic and social status in society, “I didn’t experience racism during the pandemic because my Filipino features are not Asiatic” (FP1).

The Covid-19 pandemic has brought severe disruptions to citizens’ lives, leading to heightened anxiety, “At the beginning, we were all anxious about the virus” (KP7). These stressful situations were exacerbated when Asians with a Chinese appearance confronted Covid-19-induced, anti-Asian racism, adversely impacting their self-esteem and overall quality of life in Aotearoa New Zealand, “People were not nice to Chinese people … People looked at us differently. I felt weird making eye contact when outside in public, as it made me uncomfortable” (CP7). In response to Covid-specific, anti-Asian racism, most participants opted to ignore or avoid the situation rather than confront it directly, “I tried to keep a low profile … I avoided people because I didn’t want them to point at me and talk about China” (CP2). Particularly among those from North-east Asia, there was a conscious effort to limit public encounters, “I tried not to go outside” (KP5), while ignoring the incidents like this, “When a guy showed me his finger, I didn’t do anything. I didn’t want to ruin my day because of that guy” (KP2). Some participants deliberately disclosed their country of origin to circumvent racism targeting individuals with a Chinese appearance, “We hang the Korean flag at the shop, so people know we are not Chinese” (KP7).

Whether participants consciously concealed their ethnic identity and responded passively to incidents of Covid-19-related, anti-Asian racism, “A lady looked at me, saying ‘don’t touch the vegetables’ … I tried to explain but later apologise and leave the shop” (CP7), with some exceptions of confrontation, “When she said stay away from me, I swore her back” (KP1); the experiences of anti-Asian racism undeniably impacted their quality of life in Aotearoa New Zealand. Some hesitated to reveal their ethnic identity, “At the supermarket, I tried to cover myself, as a Chinese” (CP2), leading to the development of low self-esteem, “I felt intimidated by my Asian status” (KP5), ultimately leading to the realisation of their ethnic minority status in society: “I’ve been here for the last 19 years, and that experience made me realise I am an ethnic minority” (KP1). This study highlights how participants interpret Covid-19-induced, anti-Asian racism depending on their ethnic and social status in society, which, in turn, is closely related to their sense of belonging in Aotearoa New Zealand.

> I am Chinese and married to a Kiwi husband. When I saw my husband’s relatives’ comments on Facebook about Covid-19, I could tell they discriminated against Chinese people … Reading their comments made me feel sad, and I began to wonder who I am here and to them. (CP5)

Discussion

This study examines Asians’ experiences during the Covid-19 pandemic, with a particular emphasis on addressing their specific needs during crises and promoting their participation in Aotearoa New Zealand. Subsequently, the discussion focuses on how Asians respond to Covid-19-induced challenges and the support they seek, aligning with social work objectives of empowerment and societal change (Aotearoa New Zealand Association of Social Workers, 2019).

Since the onset of Covid-19 pandemic, Asians in Aotearoa New Zealand have faced challenges due to limited knowledge, support, and resources (Ministry of Health, 2020), compounded by societal prejudice and anti-Asian racism (Liu et al., 2022). Many Asians encountered difficulties accessing formal support systems and turned to informal networks for assistance, such as family, friends, and religious groups, "My parents couldn't go shopping for groceries. Their friends shopped for them" (CP1). This informal support, like the food bank organised by IP5 through his ethnic church to assist struggling immigrants, proved crucial during the pandemic.

> People reached out to me for help. So, I collaborated with fellow church members to organise a food bank. We delivered food parcels to people in need. I know many immigrants struggled but couldn't get help from the government.

The Covid-19 pandemic induced significant stress and anxiety, with initial uncertainty leading many people to a state of panic, "In the early days, lots of people didn't know what to do and started panicking" (IP1). While many citizens accessed government support, "When I got redundant, I applied for wage subsidy" (FP6), others, particularly Asians, confronted challenges accessing formal support due to limited local knowledge (Koh et al., 2023). Notably, language barriers and the absence of local networks compounded these difficulties, "English is not my first language. I could not fully understand the Covid updates" (CP7). Consequently, they often relied on informal networks for assistance. From this perspective, Asians faced specific risks and consequences owing to their ethnic minority status, which hindered their access to government resources during the pandemic and increased their estrangement from the host society.

Furthermore, during the Covid-19 pandemic, Asians' experiences contained persistent anti-Asian racism, as evidenced by multiple studies (Ang et al., 2023; Jaung et al., 2022; Liu et al., 2022; Park et al., 2023; Siegert et al., 2023), with many Asians reporting incidents of Covid-19-induced harassment and violence (Foon, 2020; Human Rights Commission, 2021). These incidents limited their societal participation, as they continued to face scrutiny based on societal attitudes. For instance, one participant recounted feeling targeted outside during the pandemic, stating, "People were not nice to us … People looked at Chinese people differently" (CP7). Such encounters influenced participants' self-perception, aligning with symbolic interactionism, which posits that individuals' selves are shaped by social interaction (Blumer, 1969), resulting in a heightened awareness of their ethnic minority status in Aotearoa New Zealand: "When a lady yelled at me, saying stay away from her … that experience made me realise I am an ethnic minority" (KP1).

In supporting Asians during the Covid-19 pandemic, this study highlights the pivotal role of ethnic communities, "My Korean friends cooked and left foods in front of our door. I appreciated their support" (KP5). Ethnic social services served as a vital bridge between Asians and the host community. Participants found the utilisation of these services highly effective in accessing essential resources for crisis management, "After I got Covid, Asian Family Services delivered a food parcel, and I found it helpful" (CP4) and "CNSST runs a food bank. They provide substantial support to Asians" (CP2). These services played a significant role during the pandemic, providing necessary support. Particularly for those experiencing anti-Asian racism, ethnic social services served as a platform for Asians to unite, voice collective concern, and develop strategies to address racism: "I joined Asian Family Services' workshop where we shared our experience of racism … We need a place like this, so we raise our concern as a group" (KP1). As such, the role of ethnic social services was crucial in assisting and empowering Asians during the pandemic, highlighting the importance of community-based self-groups and networks.

The wellbeing of the Asian population in Aotearoa New Zealand bears substantial implications for the country' prosperity, where, at the 2018 Census, 15.1% of the population identified as Asian, with a majority having immigrant backgrounds (Ministry of Ethnic Communities, n.d.). Moreover, this demographic is projected to continue growing, with an estimated 42% of Auckland residents identifying as Asian by 2043 (Statistics New Zealand, n.d.). In light of this demographic shift, the government is committed to fostering an inclusive society that nurtures a sense of belonging among all members, irrespective of their racial and cultural backgrounds. This commitment is echoed by the social work practice standards of both ANZASW (2019) and Social Workers Registration Board (2016), which emphasise the inclusive and respectful empowerment of ethnic and cultural groups in society.

Nevertheless, concerns of Asians' social exclusion and marginalisation persist due to historically rooted ethnic inequality (Cheyne et al., 2008; Nayar, 2013), highlighting a disparity between their presence and societal participation (Kale et al., 2018; Lee & Keown, 2018). For many Asians, settling in a foreign country entails a non-normative life transition (Ho, 2015), requiring extensive adaptation. The challenges of this transition are compounded when Asians face anti-Asian racism (Jaung et al., 2022), as affirmed by IP5, "We both have a good job and are financially secure now. But still a lot of time I felt racially discriminated." Experiences of anti-Asian racism in Aotearoa New Zealand often constrain Asians' civic engagement and deny their membership (Ng, 2017; Park et al., 2023), justifying their designation as "a population of interest for social work" (Kim, 2021, p. 4).

In a civic society, equitable treatment and access to opportunities and resources are essential for all members, regardless of social status, particularly during national crises (Chung & Bemak, 2012). Achieving this for Asians requires establishing a transitional bridge that connects their ethnic community with the host society, leveraging social workers' expertise in strengthening community capacities and resources (Viola et al., 2018). The role of social workers in supporting Asians in addressing transitional life challenges and enhancing social participation is crucial. While empowering them at the micro level, it is imperative to emphasise the importance of partnering with ethnic social services to develop resources and strategies at the meso/macro levels, thereby reinforcing the broader impact of these efforts. This mission aligns with the global definition of social work, which emphasises promoting social change, social cohesion, empowerment, and liberation, guided by principles of social justice, human rights, collective responsibility and respect for diversities (IFSW, n.d.).

Study limitations

This interpretive data analysis introduces bias through inferences (Corbin & Strauss, 2015). Despite efforts like back-translation and English validation consultation, differences between the original and translated texts may potentially cause misinterpretation. With only 26 participants from the four largest Asian ethnic groups in metropolitan areas with immigrant backgrounds, findings cannot fully represent all Asians in Aotearoa New Zealand, especially those from other sub-Asian ethnic groups, given the diverse spectrum of the Asian population (Ho, 2015). Future research should replicate this study across various sub-Asian ethnic communities and socio-geographical backgrounds within the Asian community in Aotearoa New Zealand.

Conclusion

Drawing from interviews with 26 Asians in Aotearoa New Zealand, this study unveils their responses to the pandemic's challenges. Participants immersed themselves in virtual realms to maintain routines and connections with home countries. While encountering difficulties in accessing formal support resources due to limited local knowledge, they sought assistance from ethnic communities, highlighting their vital role in times of crisis. This study also highlights challenges faced by Asians, particularly within anti-Asian racism contexts. Amidst Covid-19 stress and anxiety, participants, especially from North-east Asia, experienced racism targeting those with a Chinese appearance, eroding their self-esteem and sense of belonging in the broader community.

This study underscores the need for partnerships with ethnic communities, with a particular emphasis on ethnic social services. These services offer a platform for Asians to access resources and express concerns during crises. It is hoped that this study will raise awareness of the crucial roles of ethnic social services in supporting Asians during crises, contributing to the nation's pandemic responses in the future.

Acknowledgements

The authors sincerely thank research assistants, Leah Rodriguez, Yvonne Tang and Vishal Rishi for their invaluable assistance in participant recruitment. Gratitude is also extended to the participants for sharing their experiences during the Covid-19 pandemic.

Funding details

This work was supported by Massey University [RM23813].

Disclosure statement

No competing interests to declare.

Received: 14 November 2023

Accepted: 18 April 2024

Published: 15 June 2024

References

Ang, S., Song, J., & Pan, Q. (2023). Pandemic racism and sexism in Australia: Responses and reflections among Asian women. *Current Sociology*. https://doi.org/10.1177/00113921231159432

Anthony, J. (2015, July 28). *Gender and race discrimination hurting New Zealand financially: Lawyer Mai Chen*. https://www.stuff.co.nz/business/industries/70595477/null

Aotearoa New Zealand Association of Social Workers. (2019). *Code of ethics*. https://anzasw.nz/wp-content/uploads/Code-of-Ethics-Adopted-30-Aug-2019.pdf

Asia New Zealand Foundation. (2021). *New Zealanders' perceptions of Asia and Asian peoples*. https://www.asianz.org.nz/our-resources/reports/new-zealanders-perceptions-of-asia-and-asian-peoples-2022

Asian Family Services. (2021). *New Zealand Asian well-being & mental health report 2021*. https://www.asianfamilyservices.nz/media/rsmi2s4a/asian-family-services-new-zealand-asian-wellbeing-mental-health-report-2021-trace-research.pdf

Bedford, R., Ho, E., & Bedford, C. (2010). Pathways to residence in New Zealand, 2003-2010. In A. Trin, P. Spoonley, & R. Bedford (Eds.), *New Zealand and international migration: A digest and bibliography, number 5* (pp. 1–44). Massey University.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Prentice-Hall.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Braun, V., & Clarke, V. (2012). *Thematic analysis*. American Psychological Association.

Butcher, A., & Wieland, G. (2013). God and golf: Koreans in New Zealand. *New Zealand Journal of Asian Studies*, *15*(2), 57–77.

Chiang, J. (2021, April). *Anti-Asian sentiment in NZ – it's real, it's everywhere*. RNZ. https://www.rnz.co.nz/programmes/the-detail/story/2018790440/anti-asian-sentiment-in-nz-it-s-real-it-s-everywhere

Chenoweth, L., & McAuliffe, D. (2021). *The road to social work and human service practice* (6th ed.). Cengage.

Cheyne, C., O'Brien, M., & Belgrave, M. (2008). *Social policy in Aotearoa New Zealand* (4th ed.). Oxford University Press.

Chung, R., & Bemak, F. P. (2012). *Social justice counselling: The next steps beyond multiculturalism*. Sage.

Cochrane, B. (2021). Seeking asylum in Australia during the COVID-19 Pandemic. *Academia Letters*, Article 241. https://doi.org/10.20935/AL241

Corbin, J., & Strauss, A. (2015). *Basic of qualitative research* (4th ed.). Sage.

Crotty, M. (1998). *The foundations of social research*. Allen & Unwin.

Department of Labour. (2004). *Our future together: New Zealand settlement strategy*.

Department of Labour. (2007). *Settlement national action plan: New Zealand settlement strategy*.

Duncan, G. (2007). *Society and politics: New Zealand social policy* (2nd ed.). Pearson.

Foon, E. (2020). *Spike in racism during pandemic, Human Rights Commission reports*. https://www.rnz.co.nz/news/national/415691/spike-in-racism-during-pandemic-human-rights-commission-reports

Gover, A., Harper, S., & Langton, L. (2020). Anti-Asian hate crime during the Covid-19 pandemic: Exploring the reproduction of inequality. *American Journal of Criminal Justice, 45*, 647–667. https://doi.org/10.1007/s12103-020-09545-1

Ho, E. (2015). The changing face of Asian people in New Zealand. *New Zealand Population Review, 41*, 95–118.

Human Rights Commission. (2021). *Racism and xenophobia experiences in Aotearoa New Zealand during Covid-19: A focus on Chinese and Asian communities*. https://apo.org.au/node/311028

Immigration New Zealand. (2014). *Welcome to settlement support New Zealand (SSNZ).* https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/how-we-support-migrants/settlement-services

International Federation of Social Workers (IFSW). (n.d.). *Global definition of social work.* https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

Jackson, K., & McRobie, A. (2005). *Historical dictionary of New Zealand* (2nd ed.). Scarecrow Press.

Jaung, R., Park, L., Park, J., Mayeda, D., & Song, C. (2022). Asian New Zealanders' experiences of racism during the Covid-19 pandemic and its association with life satisfaction. *New Zealand Medical Journal, 135*(1565), 60–73.

Kale, A., Kindon, S., & Stupples, P. (2018). "I am a New Zealand citizen now – This is my home": Refugee citizenship and belonging in a post-colonising country. *Journal of Refugee Studies, 33*(3), 577–598. https://doi.org/10.1093/jrs/fey060

Kim, H. (2021). Asians in Aotearoa New Zealand: A population of interest for social work. *Aotearoa New Zealand Social Work, 33*(4), 77–81. https://doi.org/10.11157/anzswj-vol33iss4id915

Kim, H., & Hocking, C. (2018). A grounded theory of Korean immigrants' experiences of re-establishing everyday activities in New Zealand. *Journal of Immigrant and Refugee Studies, 16*(3), 255–274. http://dx.doi.org/10.1080/15562948.2016.1272732

King, M. (2003). *History of New Zealand*. The Penguin Group.

Koh, A., Morgan, T., Wiles, J., Williams, L., Xu, J., & Gott, M. (2023). Older Chinese and Korean migrants' experiences of the first Covid-19 lockdown in Aotearoa New Zealand: A qualitative study. *Asia Pacific Viewpoint, 64*(1), 60–71. https://doi.org/10.1111/apv.12364

Lee, B., & Keown, L. J. (2018). Challenges and changes in the parenting experiences of Korean immigrants in New Zealand. *Asian and Pacific Migration Journal, 27*(4), 431–450.

Liu, L., Jia, X., Zhu, A., Ran, G., Siegert, R., French, N., & Johnston, D. (2022). Stigmatising and racializing COVID-19: Asian people's experience in New Zealand. *Journal of Racial and Ethnic Health Disparities.* https://doi.org/10.1007/s40615-022-01448-7

Ministry of Business Innovation and Employment (2015). *Community perception of migrants and immigration*. https://thehub.swa.govt.nz/resources/community-perceptions-of-migrants-and-immigration/

Ministry of Ethnic Communities. (n.d.). *There is strength in diversity.* https://www.ethniccommunities.govt.nz/

Ministry of Health. (2020). *Funding to boost mental health and wellbeing support for Asian community*. https://www.health.govt.nz/news-media/news-items/funding-boost-mental-health-and-wellbeing-support-asian-community

Ministry of Social Development. (n.d.). *Life satisfaction*. https://socialreport.msd.govt.nz/documents/2010/life-satisfaction-social-report-2010.pdf

Ministry of Social Development. (2016). *The social report 2016: Te purongo oranga tangata.* https://www.socialreport.msd.govt.nz/documents/2016/msd-the-social-report-2016.pdf

Nash, M. (2005). Responding to settlement needs: Migrants and refugees and community development. In M. Nash, R. Munford, & K. O'Donoghue (Eds.), *Social work theories in action* (pp. 140–154). Jessica Kingsley Publishers.

Nayar, S. (2013). The Treaty of Waitangi: Framing immigrants' occupational practices in Aotearoa, New Zealand. *Journal of Occupational Science, 20*(4), 382–395. https://doi.org/10.1080/14427591.2013.801102

Ng, K. E. (2017). *Old Asian, new Asian*. Bridget Williams Books.

Park, L., Jaung, R., Park, J., & Song, C. (2023). Asian communities' well-being in Aotearoa during the Covid-19: The mitigating role of sense of belonging in the relationship between racism and life satisfaction. *Aotearoa New Zealand Social Work, 35*(1), 95–112. https://doi.org/10.11157/anzswj-vol35iss1id1027

Peiris-John, R., Bavin, L., Kang, K., Dizon, L., Lewycka, S., Ameratunga, S., Clark, T., & Fleming, T. (2022). Factors predicting forgone healthcare among Asian adolescents in New Zealand: Unmasking variations in aggregate data. *The New Zealand Medical Journal, 135*(1549), 63–80.

Pepworth, J., & Nash, M. (2009). Finding "a safe place to cry": A review of research and evidence informing social work with refugees and new settlers in Aotearoa New Zealand. *Aotearoa New Zealand Social Work, 21*(1/2), 48–59. https://doi.org/10.11157/anzswj-vol21iss1id319

Roberts, K., Dowell, A., & Nie, J. (2019). Attempting rigour and replicability in thematic analysis of qualitative research data: A case study of codebook development. *BMC Medical Research Methodology.* https://doi.org/10.1186/s12874-019-0707-y

Siegert, R. J., Zhu, A., Jia, X., Ran, G. J., French, N., Johnston, D., Lu, J., & Liu, L. S. A. (2023). A cross-sectional online survey of depression symptoms among New Zealand's Asian community in the first 10 months of the COVID-19 pandemic. *Journal of the Royal Society of New Zealand*, 1-15. https://doi.org/10.1080/03036758.2023.2251900

Spoonley, P. (1993). *Racism & ethnicity* (2nd ed.). Oxford University Press.

Statistics New Zealand. (n.d.). Asian ethnic group. https://www.stats.govt.nz/tools/2018-census-ethnic-group-summaries/asian

Statistics New Zealand. (2018). *2018 Census ethnic group summaries*. https://www.stats.govt.nz/tools/2018-census-ethnic-group-summaries/

Stryker, S. (1980). *Symbolic interactionism: A social structural version*. The Blackburn Press.

Thai, M. T., Chong, L. C., & Agrawal, N. M. (2012). Straussian grounded-theory method: An illustration. *Qualitative Report, 17*(26), 1–55. https://doi.org/10.46743/2160-3715/2012.1758

Social Workers Registration Board. (2016). *Code of conduct*.

Victor, J. (2006). *The Sage dictionary of social research methods.* Sage.

Viola, E., Biondo, E., & Mosso, C. (2018). The role of social worker in promoting immigrants' integration. *Social Work in Public Health, 33*(7/8), 483–496. https://doi.org/10.1080/19371918.2018.1546252

Wright-St Clair, V., Nayar, S., Kim, H., Wang, S., Sodhi, S., Chung, A., & Hu, C. (2018). Late-life Asian immigrants managing wellness through contributing to socially embedded networks. *Journal of Occupational Science, 25*(1), 51–64. https://doi.org/10.1080/14427591.2017.1370607

ORIGINAL ARTICLE
QUALITATIVE RESEARCH

He Whare Takata: Are wāhine Māori visible in Oranga Tamariki practice guidance?

Kerri Cleaver (Kāi Tahu, Kāti Māmoe, Waitaha), University of Canterbury, Aotearoa New Zealand

ABSTRACT

INTRODUCTION: The gauge of a society is how it responds to women and children and, in settler colonial nations, how it responds to the Indigenous women and children. This includes how society upholds the rights and responsibilities of women's self-determination of body rights and reproductive Justice. Reproductive justice in the settler colonial environment of Aotearoa[1] is tightly tied to the experiences of wāhine Māori[2] and our lived realities across the colonial project. To give full rights and responsibilities to wāhine as holders of whakapapa, birthing practices, and keepers of knowledge, we must be willing to assess and critique society and hold colonial systems to account.

APPROACH: This article follows on from the companion literature analysis article "He Whare Takata: Wāhine Māori reproductive justice in the child protection system", which provides a detailed description of pre- and post-colonial *her*story, providing the reader with an extensive storying of wāhine as leaders. Both articles accept a mana[3] wāhine foundational position that asserts the rakatirataka (leadership and self-determination) of wāhine and the inherent rights of wāhine as '*he whare takata*[4]', the house of humanity.

CONCLUSIONS: Drawing on the groundwork laid in the companion article, this analysis examines the Oranga Tamariki[5] (OT) practice and evidence centres, specifically auditing content produced following the "Hawkes Bay Uplift"[6] for evidence of a shift of practice that incorporates wāhine knowing, being and doing holding to the foundation of '*he whare takata*'.

Keywords: Mana[7] wāhine; Indigenous; settler colonialism; reproductive justice; child protection

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 57–67.

CORRESPONDENCE TO:
Kerri Cleaver
kerri.cleaver@canterbury.ac.nz

In this article I pose the question "Are wāhine reproductive justice rights as understood as *'he whare takata'* visible in the child protection system in Aotearoa?" This is a question that we would expect Oranga Tamariki to be reflectively asking themselves and actively seeking to address if they are not shifting practice towards social justice equity.

While the companion article, "He whare takata: Wāhine Māori reproductive justice in the child protection system", provides the reader with a full background of the Aotearoa context and wāhine experience as it relates to reproductive justice, a brief outline of key assertions is provided here (Cleaver, 2023). I encourage readers new to this topic area to seek out the full article for the context and explanation of wāhine experiences with the child protection system.

"He whare takata: Wāhine Māori reproductive justice in the child protection system" outlines divergent understandings and approaches to family/ whānau[8] mauriora[9] (wellbeing), the mana wāhine (wāhine knowledges and authority) knowing and a Western colonial narrative (Cleaver, 2023).

Mana Wāhine Knowing and the colonial project

In a mana wāhine knowing, we hold rakatirataka in our whakapapa[10] which connects us to the pūrākau (stories) of Papatūānuku, Hineahuone, Mahuika and Hinetītama to name a few (Ihimaera & Hereaka, 2019; Murphy, 2013). The pūrākau of Hinetītama principally links wāhine to the rights and responsibilities of being *'he whare takata'*, the house of humanity (Mikaere, 2017; Murphy, 2013). This set the way in which wāhine were supported as leaders and rights holders within Māori societies. The infringements on wāhine following non-Māori arrival to our shores were implemented through carefully crafted colonial tools, practised around the world on Indigenous populations in the colonial agenda efforts to take land and power (Blackstock et al., 2020; Blackstock et al., 2023; Krakouer et al., 2023). Indigenous communities, including the Māori experience are effectively brought to submission by subjugating Indigenous women and separating them from traditional systems of gender fluidity, equity, and reproductive rights (Atkinson, 2002).

In Aotearoa New Zealand this was attempted through: ignoring wāhine and pēpi (baby) wellbeing in Māori communities; refusal to allow wāhine participation in any decision-making until the 1970s; denying wāhine access to education and therefore professional roles of care and support; legislation stripping wāhine of responsibilities to land; imposing colonial constructions of family and gender roles; eugenic and assimilation practices, including forced adoption; and a child protection system that starting taking Māori children in bulk until 2019 (Else, 1993; Pihama, 2005; Ramsden, 2002; Richardson, 2004; Smith, 2000; Tikao, 2020; Walter, 2017; Wanhalla, 2015).

In defiance of these tactics, wāhine have remained consistently firm in the rights and responsibilities conferred to us through whakapapa. Examples of this resistance are found in the work of wāhine midwives, Ria Tikini and Mere Harper and more recently Jean Te Huia, Naomi Simmonds, Ngahuia Murphy and Kelly Tikao; the work by Māori Women's Welfare League (MWWL), including Whina Cooper and Aroha Reriti-Crofts; the delivery of Maatua Whāngai, creating Whānau Ora and the creating of hapū and hāpori based kaupapa Māori social services; and in all the unwavering continued work by wāhine who practise mana wāhine through whānau, at hapū level and in our iwi and communities (Else, 1993; Manchester, 2020; Murphy, 2013; Simmonds, 2014, 2017; Tikao, 2020). These wāhine are too many to name but set the path back and forward and prove the failure of the colonial project and that we have nothing to lose that has not already been taken and remain here resistant and in refusal of elimination.

The Hawkes Bay Uplift and following challenges to the state

In 2019, *Newsroom* exposed practice in Oranga Tamariki by filming the attempted uplift of a newborn baby from a young Māori mumma at Hawkes Bay Hospital. The media exposure created a ground swell of support for change across Aotearoa and culminated in a number of key reports critiquing the state and recommending significant changes; *Te Kuku o te Manawa* (Office of the Children's Commissioner); *Ko Te Wā Whakawhiti: It's time for change: A Māori inquiry into Oranga Tamariki* (Whānau ora Commissioning Agency); and *He Pāharakeke, He Rito Whakakīkinga Whāruarua Oranga Tamariki Urgent Inquiry* (The Waitangi Tribunal) (Whānau Ora Commissioning Agency, 2020); The Office of the Children's Commissioner, 2020a, 2020b; The Waitangi Tribunal, 2021).

These reports offer the state and Oranga Tamariki insight into the lived reality of wāhine in forced interaction with Oranga Tamariki. They present many recommendations that include: devolution to Māori, acknowledging that the state has infringed into the kaik[a] (village) for too long; centring wāhine and *'he whare takata'*; and coordinated responses across government that address the foundations of bias and socio-economic harm has led to mokopuna requiring care and protection (Whānau Ora Commissioning Agency, 2020); The Office of the Children's Commissioner, 2020a, 2020b; The Waitangi Tribunal, 2021).

It is connecting across the foundation of childrearing based on *'he whare takata'*, mana wāhine and a Māori world view, the *her*story of lived colonial harm and report recommendations post-2019 that this audit of Oranga Tamariki is situated. My expectation is that Oranga Tamariki quickly accepted the expert evidence presented to them and with a measure of immediacy prioritised practice developments across the practice centre and research priorities in the evidence centre. These should demonstrate growing awareness of mana wāhine, of 'he whare takata' understandings and practice and research that makes visible wāhine. Both the practice and evidence centres should also show a change towards engaging with, and upholding, Kaupapa Māori services as a first step and alongside the key goal of devolution.

Methodology

Epistemologically, Mana Wāhine Theory is the bringing forward of a wāhine analysis, centring our 'complex lived realities' in relationship to our pūrākau creation narratives, intergenerational knowledge transference, the colonial context and wāhine knowing, being and doing (Pihama, 2005, 2020). At an epistemological level, this asserts that wāhine knowledge drawn across the above environments is our foundation of understanding the world. Like many Indigenous ways of knowing, epistemology, ontology, and methodology often overlap or conflate together as the way we see the world and live in the world is not separable to how we understand the world (Wilson, 2020). All of this is true for Mana Wāhine Theory which holds our truths of understanding reality while also how we understand our being and our doing. Mana Wāhine Theory is used across the methodology for the analysis of Oranga Tamariki documents. It centres me as a wāhine and brings with me my tupuna wāhine (ancestors) and their guidance and experiences.

Method

Through a mana wāhine theoretical lens, document reviews, data analysis and content evaluations were completed on Oranga Tamariki (OT) literature and practice documents between 2019 and 2023. Oranga Tamariki is the name of the current child protection system in Aotearoa New Zealand and provides the roles of investigator, interventionist, co-ordinator, caregiver provider and in foster system services. These were analysed for evidence of wāhine visibility, prioritisation, and knowledge across both the OT research and practice centres. A content analysis process was undertaken through a systematic review of all the OT practice centre and evidence centre documents and information. Keywords of *wāhine*, *women*, *woman* and *mother* were chosen to elicit social work focus on wāhine. A meta-analysis was then completed to draw out any practice indicators or themes where wāhine were acknowledged and supported in their roles as *'he whare tangata'*. Once the initial analysis was complete, I needed to go back through the documents when it became clear that *whānau*, *family* and, to a lesser extent, *hapū* and *iwi* were being used in place of wāhine, woman/en or mother. A second analysis was completed to demonstrate the comparison in visibility between the concept of family and/or whānau, hapū and iwi and wāhine Māori.

Critical discourse analysis (CDA) was adopted in the meta-analysis as it foundationally focuses on the role discourse takes in the re(production) of resistance to dominant power and control systems (Van Dijk, 1993). Van Dijk (1993) advocates the use of CDA as an analysis technique to look microscopically at text, talk and communication. A microscopic content analysis was completed on the final documents included in the sample, where text messaging and text were scrutinised for evidence of narratives centring mana wāhine, '*he whare takata*' or wāhine as more than vessels. Mana Wāhine Theory and CDA have a natural alignment in the quest for reconfiguration of power and control and the naturalising of knowledge that sits outside of western 'normal' frames. Intentional use of both Mana Wāhine Theory and CDA seeks to disrupt the reproduction of western hegemonic practice or maintenance of racialised gender inequity. This centres and normalises Māori wāhine knowledge and evaluating OT practice environments against this legitimate pre-colonial and post-colonially constructed norm.

Mana wāhine and 'he whare takata' visibility in Oranga Tamariki practice guidance

This analysis looked for evidence and practice centre resources that encouraged child protection workers to engage, assess and partner with wāhine, whānau and communities in ways that support power sharing, transformation, and the focus on mana wāhine as *'he whare takata'*, wāhine reproductive justice. Without a visible demonstration of wāhine through practice and research, the reinforcement of colonial constructions of wāhine as vessels, lesser, undeserving and to blame are likely reproduced in social work practice. Remembering that this space is contested space, expected to be devolved to Māori, but in the interim, work must be done to reduce harm.

Recognising the rights of wāhine, white supremist colonial herstories, the mana wāhine claim and UNDRIP and te Tiriti rights frameworks as the foundation, the following should be expected of the state child protection system.

1. Oranga Tamariki should be demonstrating internal knowledge of wāhine herstories, mana wāhine foundations.

2. The practice and evidence centre should show narratives and information on intergenerational colonial trauma, *'he whare takata'*, mana wāhine as practice and evidence of practice that seeks to care for wāhine who have been marginalised and oppressed.

3. Visible should be a confirmation of practice shifts towards wāhine continued role in parenting.

4. There should be clear signalling of the path forward to partnering with kaupapa Māori services that hold *'he whare takata'* at the centre of practice. This must include the pathway towards total devolution as the ultimate goal and interim steps to mitigate the continued harm done in the transition period.

Oranga Tamariki evidence and practice centre analysis

Table 1 outlines the initial document and website scan across the practice and evidence

Table 1. Oranga Tamariki Document Analysis

Oranga Tamariki document source.	Included no. Initial Analysis	Final no. analysed	Includes woman/en/ mother in text	Includes wāhine/ whāea or mama in text
Evidence Centre Reports	36	25	13	6
Practice centre whole of site	8	6	4	5

centres of OT. The final documents analysed were 25 on the evidence centre and six webpages on the practice centre.

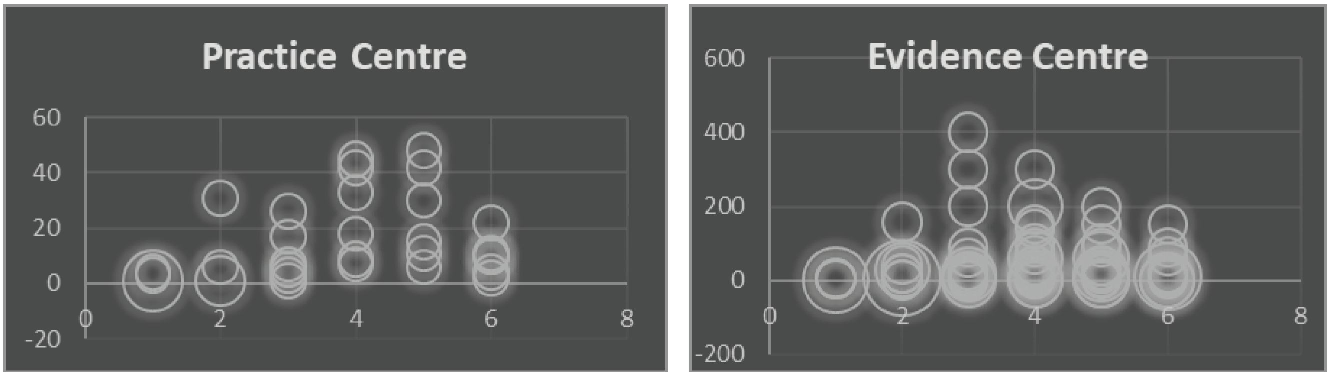
The 25 OT evidence centre reports published between 2019 and June 2023 were analysed based on criteria of relevance to early assessment, entry to care, in care or exit from care. The reports needed to have a focus on parenting or parental relationships. Reports not analysed were discarded due to an emphasis solely on physical needs, mental health services, sexuality or they were community programmes not delivered by OT.

The OT practice centre is the online open access tool utilised for social work practitioners. The centre holds key guidance and information for social workers both inside the organisation and externally. Six practice centre web pages were chosen and analysed based on the inclusion of the keyword wāhine through a keyword search. Nine pages were initially identified and subsequently reduced to five after discarding overlapping evidence centre documents or web domains items. One additional page, *Breastfeeding–caring for and nurturing pēpi,* was added due to its relevance to '*he whare takata*'.

The figures below show the occurrences of words across the documents examined. Wāhine did not feature strongly across either the practice centre or evidence centre in this basic word-occurrence analysis. Parent/s, whānau and family/ies were significantly more visible, demonstrating the clear focus on the concept of a whānau/ family unit across both sites of practice information.

The secondary analysis included a nuanced evaluation of the content of each document and website focusing on interpreting the key story, messaging, and framing of the

Table 2 and Table 3. Practice and Evidence Centres



Notes: Horizontal: Word/s counted. **1.-** Wāhine/ whāea; **2**.- Woman/en/ mother; **3**.- Parent/; **4**.- Whānau; **5**. Family/ies; **6**.- "whānau, hapā and iwi". *Vertical*: Number of word occurrences in each document."
Each circle represents one article or website, while large circles represent more than one document between 2 and 4.

documents and webpages. There was a strong correlation between the occurrence of the words wāhine, women and mother and intentionally preferencing the relationship between wāhine and mokopuna.

One document, "Te Ao Kōhatu" mentioned wāhine a total of five times and woman/en 27 times and conversely utilised whānau 206 times, family/ies 198 times and parents 27 times. "Te Ao Kōhatu" was the clearest document to evidence a te Ao Māori worldview and dedication to challenging the nuclear family model (Dobbs, 2021). In "Te Ao Kōhatu", wāhine were introduced in their relationship to '*he whare takata*' as child bearers, connected to their important role in relation to whakapapa, drawing on the work of Jenkins and Harte (2011) centring a Māori understanding of whānau. This document was the only document that adequately included a Māori concept of wāhine, though wāhine was predominately encompassed into whānau throughout the article.

Three other reports are worth specifically mentioning, evidencing beginning understandings of *'he whare takata'*. The two "Family Violence and Sexual Violence Evidence" briefs reference *'he whare tangata'* in relation to sexual violence, though did not include any depth of understanding (Oranga Tamariki, 2020a). "Understanding Māori Perspectives, Tamariki and rangatahi who are victims of sexual violence or display harmful sexual behaviour" did include an important narrative on the harm impacts for tīpuna (ancestors) and future generations (Oranga Tamariki, 2020a).

The report "Subsequent Children Evidence Brief" (2020), while not including mention of wāhine, was the most comprehensive inclusion of women as mothers and drew on some excellent overseas work by Broadhurst et al. (2017) and national research from Boulton et al. (2018). This report was the only report analysed where woman/en outnumbered whānau, family or parents in keyword mentions. The clear centring on women and mothers resulted in a thorough gender analysis with excellent evidence of positive outcomes when women are provided adequate supports (Allen & Clarke, 2020). Conversely, while conflating of wāhine, women and mother to whānau could be assessed as implicitly including wāhine perspectives, it equally could be argued that encompassing wāhine into whānau or family renders our rights and responsibilities invisible. Encompassment, as an extension of assimilation tools has been well-practised across settler colonial countries as a tool of subjugation and evidenced across the Kāi Tahu experience (Matahaere-Atariki, 1997). The intentional signalling of women evident in "Subsequent children evidence brief" (Allen & Clarke, 2020) directs practice towards engaging with women and a gender analysis.

"Making sense of being in care, adopted, or whāngai: Perspectives of rangatahi, young people and those who are raising them" (Potter & Urbannova, 2021) raised the significance of the intrinsic link between wāhine and mokopuna as '*he whare takata*' with rakatahi and young people talking about their 'mums' in over 100 mentions. There was some alignment in this document with Māori understandings of whāngai, including Māori whānau caregivers being more open to children in care knowing their story and framing a child's relationship to caregivers and their birth parents in terms of growing whānau (Potter & Urbannova, 2021). The visibility of 'mum' as the focus, "why can't I be with mum?" and "mum is unwell" risks wāhine being the sole parent considered responsible for entry into care if not analysed with a focus on embedded paternalism (Potter & Urbannova, 2021, p. 20). This exemplifies the complexities of how research and reports need to ensure the wider understanding of societal impacts and normalised traditional alternative care systems. In doing this, we ensure there is space left for wāhine to move from vessel, blamed mother or broken to practice that upholds both wāhine and mokopuna and the links between.

Of concern was the report, "Factors associated with the disparities experienced by tamariki Māori" (Oranga Tamariki,2020b). The report avoids any analysis of systemic bias, racism, and colonisation, providing statistics and a simplistic analysis connected to rudimentary understandings of poverty. An example is the use of micro whānau experiences or parental income, decile ratings, mental health, correction involvement and reports of concerns as the base of investigating the connection to disparity (Oranga Tamariki, 2020b). This should contain and feature the Māori experience of 183 years of colonisation, the consequential impact across ministerial policies and practices including, but not confined to, the Natives School Act, 1867; The Public Works Act, 1964 and The Marriage Act, 1955 (Smith, 2000; Tinirau et al., 2021; Walter, 2017).

All other reports analysed across the evidence centre lacked any particular focus on wāhine involving no aspects of research prioritisation of wāhine/mokopuna relationships, intergenerational whakapapa trauma or system culpability. The expertise of kaupapa Māori services was also missing across all the reports in any detail or directive that would encourage social workers to seek out expertise external to OT.

The six pages on the practice centre mentioning wāhine ranged from one to four occurrences. These references were in relation to cultural practice, being hapu (pregnant) and gender diversity. The terms *woman/en* were also not well reflected across the practice centre with only four pages picking up minimal mention of women, with the exception of the page on breastfeeding which includes 'mothers' 29 times.

Across the practice centre, *family, whānau, parent/s* are widely and interchangeably used throughout documents. These words appear intentionally chosen while *wāhine, woman, women* or *mother* appear as discarded options. An example of intention can be found on the page '*Strengthening our response to unborn and newborn pēpi'* which mentions wāhine three times, woman once, mother four times but cites family 30 times, parents 26 times, whānau 40 times and hapū 22 times. Other relevant pages, including *Coercively controlling violence* and *Attachments: Tuituia domain,* followed this pattern on minimal inclusion of wāhine or women and high use of the familiar groupings of family, parents, whānau or hapū. The practice centre is the key available resource for OT practitioners, community professionals and the child protection client base as a site of practice information. It is concerning that, across the practice centre, social workers, allied professionals and service users can not see any indication of centring wāhine.

Analysis and findings

Whānau, hapū and iwi were very visible across the practice and evidence centres exhibiting a definite shift towards te Tiriti compliance and attempts to understand a Māori worldview. However, the visibility of wāhine or even women across the practice centre and evidence centre was minimal, even in Māori framed reports. Spivak (1999) identified women positioned as the subaltern, when we are spoken *for*, spoken *about* but rarely allowed voice ourselves. The assessment of evidence and practice centre literature delivers a perfect example of Spivak's (1999) critique of paternal systems that makes women invisible.

The child protection system is not responsible for the axis of subjugation of wāhine that has systematically stripped us of our rakatiratanga and impacted on our wellbeing and ability to hold the responsibilities conferred generationally since Hine-nui-te-po, as *'he whare takata'*. However, it does continue to contribute to the ongoing subjugation and upholds the foundations laid to deny wāhine rights and responsibilities. This is the colonial legacy held by Indigenous women across settler colonial nations and has occurred in a carefully constructed reframing and dehumanising effort over hundreds of years, in Aotearoa over 200 years. The continuation of the status quo and the lack of resistance of state social work to advocate and engage in substantial change processes that shift the oppressive legacy, even when provided multiple templates suggests ongoing complicity and a desire to hold up the broken system.

(Re)producing oppressive practice on wāhine, mokopuna, whānau and the whenua

A key theme across *her*story, the multiple reports on the child protection system and the review of OT completed for this article is systemic reproduction of oppressive practice performed on wāhine, mokopuna, whānau and the whenua. Analysis of the practice and evidence centres did illustrate beginning steps towards a change of focus and bringing forward a Māori world view. However, this did not include pūrākau wāhine, exploring and challenging the power imbalances that underlie and frame wāhine as the problem and centre paternalistic practice. To end the cycle of (re)producing oppressive practice there must be inclusion of *her*story and validation of mana wāhine as a practice methodology. To meet the following challenges, mana wāhine must be the foundation.

Erasure as a colonial tool: Wāhine encompassment into whānau

The latest iteration of erasing wāhine from our own stories as *'he whare takata'* in the child protection system is not surprising but the cleverly oiled machine of white supremacy[11], guarding its nest. Erasing wāhine and replacing this with whānau, at worst, is intentional subjugation and, at best, unthoughtful encompassment. The use of whānau as an inclusive term for wāhine in a Māori world view relies on practitioners understanding our wāhine atua narratives, a *her*story of subjugation and the tools and skills to actively centre *'he whare takata'*. Without this understanding whānau encompasses wāhine narratives and ensures practitioners can choose who they engage, thinking they are whānau centred and upholding the rights of Māori. Without upholding the rights of wāhine and ensuring social work has an intentional focus on reproductive justice, where we connect the macro *her*story to the micro experience, we will continue colonial complicity. Reproductive Justice ensures an equity of opportunity to parent.

Practice centre as a monocultural site- siloing mātauraka Māori

The practice centre exhibits small steps towards embedded mātauraka Māori across practice guidelines and recommendations. The web pages generally relied on the term whānau with minimal to no inclusion of mātauraka Māori, while on the odd Māori-specific pages there is a total focus on Māori ways of knowing, being and doing—but not on wāhine Māori ways of knowing, being and doing. This gives the experience of a fragmented practice centre that siloes the Māori world view and Māori knowledge. The lack of wāhine, except for the repeated short blurb on *'he whare takata'* supports the statement that wāhine have been particularly rendered invisible on the webpages of the practice centre. Balancing the importance of mana wāhine with the risks of essentialising motherhood, resulting in mother blaming requires bringing forth the full *her*story of wāhine Māori from pre- to post-colonial contemporary realities. This practice centre focus on the continuing colonial impacts, Western hegemony and white supremist systems would enable their social workers insights and understandings of the macro issues impacting on the micro lived experiences. The key element is mana wāhine theory and practice which centres wāhine experience, resistance and rakatiratanga, denying and suffocating any leaning towards mother blaming.

Balancing internal and external transformation

The challenge for OT to fund Māori hapū, iwi and hāpori and step aside remains. This is not what Moana Maniapoto-Jackson calls "browning up the workforce" but trusting Māori knowledge and expertise and stepping aside, while Māori are enabled to get on with recovery (personal communication). With a *He Puapua* roadmap (discussed in Cleaver, 2023) that provides a te Tiriti based government partnership approach we should see a reducing state and increasing hapū response (Charters et al., 2019). This would include rethinking what key roles OT should continue to provide and what is beyond their ability to transform. In a measured approach to transformation, I acknowledge the need of OT to develop and grow their staff cultural capacity which requires Māori kaimahi (workers) leading and developing what this looks like. The conflict and tension here is that the reports and evidence state that wāhine are best served and supported by our Kaupapa Māori organisations and that requires our Māori social workers to be available in these spaces—not as trainers to support the renovating of the white supremacist system.

Wāhine, mokopuna, whānau, hapū and iwi

We can all agree that whānau and hapū provide the strength and support and their role in child protection is essential. Whānau, hapū and iwi approaches as understood by the Crown need to incorporate mana wāhine in what is a plus-plus approach. The need to connect child centred practice, whānau, hapū and iwi structures and mana wāhine together is obvious and would ensure a focus on intergenerational wellbeing. This includes positioning our wāhine rakatira across decision making processes and enabled to develop mana wāhine responses. We as wāhine should be at the tables and it is totally time for the patriarchy, including our own, to take a step back.

Recommendations

Practice recommendation: Social workers cannot wait for the state system to catch up and need to lead their own development and build knowledge of mana wāhine and our *her*stories.

Practice recommendation: As social workers, we need to centre wāhine in our practice, while ensuring that we have understood and resist the axis of subjugation that defaults to blaming women.

Practice recommendation: Oranga Tamariki requires expertise to transform the practice and evidence centre research and practice tools. The decision of if this is contrary to Māori needs is a discussion for Māori to lead.

Practice recommendation: Devolution and transformation remains unresolved. Committing to *He Puapua* and te Tiriti o Waitangi, including the Waitangi Tribunal recommendations is a starting point.

Practice recommendation: Policy and practice leaders must bring wāhine leaders into the transformation process and collaborate on supporting the devolution and building of Kaupapa Māori capacity and capability.

Conclusion

Social work practice holds a theoretical framework that includes meso and macro social justice responsibilities if you are practising in the community or for the state. This obligation to address injustice across individual experiences, organisational contexts and policy and practice that is inevitably socially constructed with strong, paternalistic, colonial, systemic foundations is a demonstration of our commitment to two peoples living together.

The reproductive injustice intergenerationally perpetrated on wāhine requires social work to reflect on our complicity and commit to restoring mana wāhine as *'he whare takata'*. Across the child protection system, a re-focus on wāhine as the holders of future ancestors needs to be included alongside the rhetoric of whānau-centred practice, understanding that mana wāhine is inclusive of a paramountcy of the child position. Whānau-centred and mana wāhine are both essential elements of flourishing and thriving communities where mokopuna experience the world as *'taku kuru pounamu'*—our most precious treasures.

To do this we will need the evidence and practice centre to prioritise mana wāhine and *'he whare takata'* with a focus of growing practitioner knowledge. This will need to be connected to a roadmap towards devolution where the end game is no mokopuna Māori in state care.

Received: 15 August 2023

Accepted: 7 May 2024

Published: 15 June 2024

Endnotes

[1] Aotearoa is used as one traditional name for Aotearoa.

[2] Wāhine Māori will be referred to as wāhine from hereon. This term is inclusive of our tākatapui Māori in line with our traditional ways and acknowledged acceptance of gender fluidity and self-identification. Non-Māori wāhine will be referred to as woman/en.

[3] Pere definition of mana "psychic influence, control, prestige, power, vested and acquired authority and influence, being influential or binding over others, and that quality of a person that others know she or he is".

[4] Kāi Tahu dialect is used throughout the document. This replaces 'ng' with a 'k'.

[5] The Aotearoa, New Zealand child protection system.

[6] The Hawkes Bay uplift refers to the media exposure of a Māori baby removal from a wāhine in hospital in 2019.

[7] Pere definition of mana "psychic influence, control, prestige, power, vested and acquired authority and influence, being influential or binding over others, and that quality of a person that others know she or he is".

[8] Whānau, hapū and iwi refer to Māori family and societal structures: Whānau-wide family networks; hapū–a collection of whānau with close shared ancestors; iwi–a wider collection of hapū with shared ancestors.

[9] Mauriora refers to the holistic wellbeing of a person, connected to culture, language, knowledge transmission, healthy environment, and their mental and physical wellbeing.

[10] Whakapapa is defined as our relationships to animate, inanimate, living, and past, to each other and the environment. It includes genealogy that is both human and non-human.

[11] White Supremacy is defined in the work by Atawhai o te Ao and incorporates capitalism, the patriarchy and embedded structural systems that normalise and prioritise the knowledge, practice and customs of the Anglo man.

References

Allen & Clarke. (2020). *Subsequent children evidence brief.* Oranga Tamariki—Ministry for Children. https://thehub.swa.govt.nz/sitemap/subsequent-children-evidence-brief/

Atkinson, J. (2002). *Trauma trails, recreating song lines: The transgenerational effects of trauma in Indigenous Australia*. Spinifex Press.

Blackstock, C., Bamblett, M., & Black, C. (2020). Indigenous ontology, international law and the application of the Convention to the over-representation of Indigenous children in out of home care in Canada and Australia. *Child Abuse & Neglect, 110*, https://doi.org/10.1016/j.chiabu.2020.104587

Blackstock, C., Libesman, T., King, J., Mathews, B., & Hermeston, W. (2023). Decolonizing First Peoples child welfare. In C. Cunneen, A Deckert,A Porter, J Tauri & R. Webb, (Eds.). *The Routledge international handbook on decolonizing justice.* (pp.313-323).Routledge.

Boulton, A., Potaka-Osborne, G., Cvitanovic, L., & Williams-Blyth, T. (2018). E tipu E rea: the care and protection of indigenous (Māori) children. *New Zealand Law Journal*, 3(February), 3–7.

Broadhurst, K., Mason, C., Bedston, S., Alrouh, B., Morriss, L., McQuarrie, T., Palmer, M., Shaw, M., Harwin, J., & Kershaw, S. (2017). *Vulnerable birth mothers and recurrent care proceedings*. University of Lancaster.

Charters, C., Kingdon-Bebb, K., Olsen, T., Ormsby, W., Owen, E., Pryor, J., Ruru, J., Solomon, N., & Williams, G. (2019). *He Puapua* (Beehive—New Zealand Parliament, Issue).

Cleaver, K. (2023). He Whare Takata: Wāhine Māori reproductive justice in the child protection system. *Aotearoa New Zealand Social Work, 35*(4), 16–30.

Dobbs, T. (2021). *Te Ao Kōhatu: Principled framing of best practice with mokopuna Māori: A literature review of indigenous theoretical and practice frameworks for mokopuna and whānau wellbeing* (0995149801). Oranga Tamariki Ministry for Children. https://www.orangatamariki.govt.nz/about-us/research/

Else, A. (1993). *Women together: A history of women's organisations in New Zealand: Ngā rōpū wāhine o te motu*. Historical Branch, Department of Internal Affairs.

Ihimaera, W., & Hereaka, W. (2019). *Pūrākau: Māori myths retold by Māori writers.* Penguin Random House.

Jenkins, K., & Harte, H. M. (2011). *Traditional Maori parenting. An historical review of literature of traditional Māori child rearing practices in pre-European times.* Te Kahui Mana Ririki.

Krakouer, J., Nakata, S., Beaufils, J., Hunter, S.-A., Corrales, T., Morris, H., & Skouteris, H. (2023). Resistance to assimilation: Expanding understandings of First Nations cultural connection in child protection and out-of-home care. *Australian Social Work, 76*(3), 343–357.

Manchester, A. (2020). Honouring our pioneer nurses and midwives. *Kai Tiaki: Nursing New Zealand, 26*(3), 26–27.

Matahaere-Atariki, D. (1997). *Interrogating speech in colonial encounters: Native women and voice* [Unpublished master's thesis] Massey University. Interrogating speech in colonial encounters : native women and voice (massey.ac.nz)

Mikaere, A. (2017). *The balance destroyed.* Te Wānanga o Raukawa.

Murphy, N. (2013). *Te awa atua: Menstruation in the pre-colonial Maori world: An examination of stories, ceremonies and practices regarding menstruation in the pre-colonial Māori world.* He Puna Manawa.

Office of the Children's Commissioner. (2020a). Te Kuku o Te Manawa-Moe ararā! Haumanutia ngā tūpuna mō te oranga ngā tamariki (Part 2). Available at: https://www.manamokopuna.org.nz/publications/reports/tktm-report-2/

Office of the Children's Commissioner. (2020b). Te Kuku O Te Manawa – Ka puta te riri, ka momori te ngākau, ka heke ngā roimata mo tōku pEpi. Available at: https://www.manamokopuna.org.nz/publications/reports/te-kuku-o-te-manawa/

Oranga Tamariki. (2020a). *Understanding Māori perspectives: Tamariki and rangatahi victims of sexual violence or display harmful sexual behaviour.* Available at: Understanding-Maori-Perspectives.pdf (orangatamariki.govt.nz)

Oranga Tamariki. (2020b). Factors associated with disparities experienced by Tamariki Māori in the care and protection system. Available at: Factors associated with disparities experienced by tamariki Māori | Oranga Tamariki — Ministry for Children

Pihama, L. (2005). Mana wahine theory: Creating space for Māori women's theories. In L. Pepi (Ed.), *Cultural studies: From theory to action* (pp. 360–374). Blackwell.

Pihama, L. (2020). Mana wahine: Decolonising gender in Aotearoa. *Australian Feminist Studies, 35*(106), 351–365. https://doi.org/10.1080/08164649.2020.1902270

Potter, H., & Urbannova, M. (2021). *Making sense of being in care, adopted, or whāngai: Perspectives of rangatahi, young people, and those who are raising them.* Available at: Making-sense_Qualitative-study.pdf (orangatamariki.govt.nz)

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu.* Victoria University of Wellington.

Richardson, S. (2004). Aotearoa/New Zealand nursing: From eugenics to cultural safety. *Nursing Inquiry, 11*(1), 35–42.

Simmonds, N. B. (2014). *Tū te turuturu nō Hine-te-iwaiwa: Mana wahine geographies of birth in Aotearoa New Zealand.* University of Waikato.

Simmonds, N. B. (2017). Honouring our ancestors: Reclaiming the power of Māori maternities. Available at: Honouring our ancestors: Reclaiming the power of Māori maternities (waikato.ac.nz)

Smith, G. H. (2000). Maori education: Revolution and transformative action. *Canadian Journal of Native Education, 24*(1), 57. https://doi.org/10.14288/cjne.v24i1.195881

Spivak, G. C. (1999). *A critique of postcolonial reason: Toward a history of the vanishing present*. Harvard University Press.

The Waitangi Tribunal. (2021). He Pāharakeke, He Rito WhakakĪkinga Whāruarua Oranga Tamariki Urgent Inquiry. WAI 2915. https://www.orangatamariki.govt.nz/about-us/performance-and-monitoring/reviews-and-inquiries/he-paharakeke-he-rito-whakakikinga-wharuarua-waitangi-tribunal-inquiry-wai-2915/

Tikao, K. W. (2020). *Raro timu raro take–Ngai Tahu birthing traditions*. University of Canterbury.

Tinirau, R., Smith, C., & Haami, M. (2021). *Whakatika, How does racism impact on the health of Black, Indigenous and/or people of colour globally?: An international literature review for the Whakatika Research Project*. Te Atawhai o Te Ao Charitable Trust.

Van Dijk, T. A. (1993). Principles of critical discourse analysis. *Discourse & Society, 4*(2), 249–283.

Walter, I. (2017). *He wahine, he whenua i ngaro ai? Maori women, maori marriage customs and the Native Land Court, 1865-1909.* University of Otago.

Wanhalla, A. (2015). *In/visible sight: The mixed-descent families of Southern New Zealand*. Bridget Williams Books.

Whānau Ora Commissioning Agency. (2020). 'Ko Te Wā Whakawhiti: it's time for change: A Māori inquiry into Oranga Tamariki- Report'. Available at: Whānau Ora | Ko Te Wā Whakawhiti (whanauora.nz)

Wilson, S. (2020). *Research is ceremony: Indigenous research methods.* Fernwood Publishing.

ORIGINAL ARTICLE
THEORETICAL RESEARCH

What interventions can CAMHS provide for young people involved with Oranga Tamariki? A review of the literature

Joanna Appleby, Barbara Staniforth, Susan P. Kemp and **Helene Connor (Te Atiawa** and **Ngāti Ruanui, Ngāti Rahiri** and **Ngāti Te Whiti),** University of Auckland, Aotearoa New Zealand

ABSTRACT

INTRODUCTION: Many care-experienced young people face significant mental health challenges. However, this group is not well served by child and adolescent mental health services. In this first of a two-part series, we present the evidence for effective mental health interventions for care-experienced young people to inform clinical decision-making and improve mental health service delivery. This precedes a second review of principles for working effectively with care-experienced young people.

METHODS: This is a narrative review of the literature regarding mental health interventions for young people involved with child welfare. It is based on international reviews of mental health interventions with the addition of relevant research from Aotearoa New Zealand, especially with Māori young people.

FINDINGS: Appropriate mental health interventions include Trauma-Focused Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Wraparound, and assertive outreach approaches, as well as systemic interventions that work with the whole care system around a young person. Application of each of these interventions to meet the specific needs of care-experienced youth in Aotearoa New Zealand is discussed. The findings are also relevant to other jurisdictions with overrepresentation of Indigenous young people involved with child welfare services.

CONCLUSION: Individual and systemic interventions are recommended that can support holistic mental health care. There is little integration of cultural considerations and anti-discriminatory practice within the existing literature, despite many of these young people coming from marginalised communities. The authors argue that mental health interventions must be culturally appropriate to meet the needs of care-experienced young people.

Keywords: Mental health; child welfare; therapy; adolescents; care-experienced

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 68–83.

CORRESPONDENCE TO:
Joanna Appleby
joanna.appleby@gmail.com

In this article, we present a review of the literature on appropriate mental health interventions for young people involved with Oranga Tamariki, the child protection agency in Aotearoa New Zealand. This review prioritises research with Māori, the Indigenous people of Aotearoa New Zealand. However, the findings may be applicable across jurisdictions, particularly with care-experienced young people from marginalised groups.

In Aotearoa New Zealand, young people involved with Oranga Tamariki face multiple barriers in accessing quality support from child and adolescent mental health services (CAMHS) despite experiencing high levels of mental health difficulties (Oranga Tamariki, 2023). In response to these issues, there has been an interagency commitment to improve mental health services for care-experienced young people (Oranga Tamariki, 2022). To further support this goal of improved CAMHS care for this population, we present the evidence for effective CAMHS interventions for care-experienced young people to answer the research question "What are effective mental health interventions for care-experienced young people?"

This is the first of two literature reviews on CAMHS care. This first article focuses on the range of interventions available for care-experienced young people. The second article focuses on principles that can guide clinical practice with this population, regardless of treatment modality (Appleby et al., 2024). It is our intention that both articles are read together to inform CAMHS clinicians about the *what* and the *how* of effective mental health care for young people involved with Oranga Tamariki or other child welfare systems.

In these articles, we have used a wide definition of "care-experienced" that includes young people who are involved with Oranga Tamariki or other child welfare services. This broad interpretation acknowledges the experience that these young people bring, is shorthand for the more cumbersome phrase "young people who have been involved with Oranga Tamariki", and can be applied in international contexts. We also acknowledge the added layers of trauma for those young people who have been in state care.

Background

Te Hiringa Mahara—the New Zealand Mental Health and Wellbeing Commission (2023)—recently released their report into the wellbeing of young people in Aotearoa New Zealand. The Commission identified that there are decreasing positive mental health outcomes and increasing distress for young people, and their wellbeing is impacted by racism, discrimination, whānau wellbeing, and uncertainty about the future. There has already been recognition that young people in general are underserved by CAMHS in Aotearoa New Zealand, with further lack of responsive service provision for Māori and those involved with Oranga Tamariki (Thabrew et al., 2017). This occurs despite young people involved with Oranga Tamariki being twice as likely to have depressive symptoms and four times as likely to have attempted suicide within the last year compared to the general youth population (Fleming et al., 2021). A recent report into the mental health and wellbeing needs of children and young people involved with Oranga Tamariki (2023) found that these young people are often excluded from CAMHS support. CAMHS teams have not been set up to meet the mental health needs of care-experienced young people, many of whom have experienced trauma.

Rangatahi Māori (Māori young people) are disproportionately represented in the numbers of young people in care, and in mental health need (Oranga Tamariki, 2023). The Human Rights Commission (2022) has recognised the impacts of white supremacy, racism, and colonisation on Māori. The Ministry of Health (2020) developed a Māori Health Action Plan which recognises that Māori mental health is a priority in Aotearoa New Zealand. The Plan aims to reduce health inequities for Māori by valuing and promoting Māori solutions, including Kaupapa Māori (by Māori, for Māori) services (Ministry of Health, 2020).

In their review of Māori models of health, Wilson et al. (2021) discussed how whakapapa (genealogy), whenua (land) and whānau (family) are the foundations of connectedness for Māori and the basis for clinicians engaging in whakawhanaungatanga (the process of connecting with someone) with Māori. They highlighted that a Māori-centred model of relational care must include consideration of the sociopolitical context for Māori. In the *Meihana Model,* clinicians consider ngā hau e whā (the four winds of Tawhirimātea)—how colonisation, racism, migration, and marginalisation impact Māori (Pitama et al., 2017). These four factors are integrated into mental health formulation, alongside individual and whānau factors. Connection is especially important for rangatahi Māori when engaging with clinical services. Hamley et al. (2023) suggested that clinical services consider how to engage with rangatahi Māori creatively and informally outside of usual forms of service engagement. This involves stepping out of dominant views of time, such as individual assessments within a 60-minute appointment time, to a Māori worldview of the interconnectedness of people, places and events within time and whakapapa.

In Aotearoa New Zealand, CAMHS clinicians have seen increased demand for services without commensurate resourcing, and many do not think that CAMHS is still fit-for-purpose (Every-Palmer et al., 2022). Most CAMHS teams are now using the Choice and Partnership Approach (York & Kingsbury, 2009). This model advocates for efficient use of resources while also promoting principles of service user self-determination and participation. However, there is critique that the model commodifies CAMHS delivery, co-opts the language of empowerment to discharge young people from CAMHS, and these "individually based biomedical pathologizing approaches fit well with a neoliberal agenda but fail to engage with the social and political context of people's lives" (Johnstone et al., 2022, p. 224).

Care-experienced young people have complex mental health presentations in the context of traumatic relational disruption in their families and with services. These young people experience high rates of placement disruption and homelessness (Vreeland et al., 2020). They are more likely to be Māori, to have a disability (Oranga Tamariki, 2023), to experience discrimination (Bernard et al., 2021), and to experience difficulties accessing CAMHS (Garcia et al., 2015). Tarren-Sweeney (2021) argued that standard mental health interventions are less effective for these young people due to the high degree of clinical and social complexity they experience, and that they should be identified as a priority group and given treatment tailored to their needs.

Much of the existing literature about mental health interventions for this population is based on interventions for younger children with a focus on parenting interventions. However, the purpose of this review is to explore effective mental health interventions for the older care-experienced adolescents who may not have caregivers actively involved in their mental health care. This article provides an overview of the evidence base for a range of mental health interventions for adolescents, with discussion of how each intervention can be adapted for care-experienced young people.

Structuring the literature

This is a review of the literature on effective mental health interventions for care-experienced young people. It focuses on the adolescent age range of 13-18 years old, which is aligned with the upper age range for CAMHS in Aotearoa New Zealand. For the purposes of this review, the scope of the term care-experienced is wide and includes the full spectrum of involvement with child welfare services, including those who remain with their families, those in family and non-kin placements, and residential and foster care. The interventions that are presented do not comprise an exhaustive list of all mental health interventions for care-experienced young people. Instead, there is a discussion on the application and adaptation in Aotearoa New Zealand of the more commonly cited interventions.

There are two general approaches within the literature about mental health practice with this population. One body of research centres on implementing and assessing clinical interventions, which is the primary focus of this article. Another body of research emphasises the relational and collaborative skills employed by CAMHS clinicians in various interventions with traumatised young people. These skills are the focus of a second review (Appleby et al., 2024).

This article builds on 10 published international reviews of interventions with care-experienced young people. Following identification of the five main intervention types, additional research is presented about the application of these interventions with care-experienced young people, and where available, research from Aotearoa New Zealand is included. It is notable that none of the 10 reviews focused specifically on the adolescent age range, as they included interventions for children, parents, and adolescents. Additionally, none of the published reviews include research with Māori. This article appears to be the first review that is adolescent-specific, presenting the interventions suitable for care-experienced adolescents, while also prioritising local research, particularly with rangatahi Māori.

Method

This is a narrative review of the literature on mental health interventions for care-experienced adolescents. The research question that guided the literature search was "What are effective mental health interventions for care-experienced young people?" A search for relevant articles was conducted through the following databases: the EBSCOhost suite of databases (Child Development and Adolescent Studies, CINAHL Plus, Humanities International Complete and MEDLINE), PsychINFO and Google Scholar. Search terms included synonyms for child welfare (child protection, welfare, looked after children, out of home care, foster care), mental health (wellbeing, psychological health, emotional health, CAMHS), effective (efficacious treatment, successful, positive, enabler, benefit) and interventions (treatment, therapy). The search range covered the years 2005 to 2023 and focused on peer-reviewed articles written in English.

From this search we found 10 reviews that consistently identified several interventions (Bergström et al., 2020; Craven & Lee, 2006; Evans et al., 2023; Hambrick et al., 2016; Landsverk et al., 2009; Lee et al., 2015; Leve et al., 2012; Racusin et al., 2005; Rayment et al., 2014; Tarren-Sweeney, 2021). Five of those publications were systematic reviews (Bergström et al., 2020; Craven & Lee, 2006; Evans et al., 2023; Hambrick et al., 2016; Leve et al., 2012). All the reviews focused on interventions with children and young people involved with child welfare services, and six reviews focused specifically on interventions for children and young people in foster care (Bergström et al., 2020; Craven & Lee, 2006; Hambrick et al., 2016; Landsverk et al., 2009; Leve et al., 2012; Racusin et al., 2005).

We then searched for literature on the application of those interventions with care-experienced young people and marginalised groups, and searched for research conducted in Aotearoa New Zealand, and specifically with Māori. The findings have been presented as a narrative review, prioritising research on implementation with Māori.

Findings

Existing reviews identify Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Dialectical Behavioural Therapy (DBT), Wraparound services, assertive outreach, and systemic interventions as effective CAMHS interventions for care-experienced young people (Bergström et al., 2020; Craven & Lee, 2006; Evans et al., 2023; Hambrick et al., 2016; Landsverk et al., 2009;

Lee et al., 2015; Leve et al., 2012; Racusin et al., 2005; Rayment et al., 2014; Tarren-Sweeney, 2021). Each of these interventions can be used with adolescents in a range of care settings, including where there is placement instability and lack of caregiver involvement. This article summarises each intervention and notes any implementation considerations with care-experienced young people. While the findings are tailored to Aotearoa New Zealand in particular, they are also broadly relevant to other jurisdictions, particularly settler colonial nations with significant overrepresentation of Indigenous children in state care.

Trauma-Focused Cognitive Behavioural Therapy

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is recommended as a first-line treatment for children with post-traumatic stress (Dittmann & Jensen, 2014). In Aotearoa New Zealand, CAMHS are not funded for young people whose needs are solely related to sexual abuse, however the Ministry of Health's (2017) service specifications outline that CAMHS should be available for all young people with psychological difficulties, including emotional and behavioural disturbances, many of whom have experienced trauma.

TF-CBT is based on cognitive and behavioural approaches. Cognitively, there is an emphasis on restructuring unhelpful thoughts following abuse, particularly around self-blame. From a behavioural perspective, TF-CBT posits that classical and operant learning lead to the development of trauma triggers and ensuing avoidance behaviour. Treatment involves psychoeducation about trauma responses, teaching coping skills to replace avoidance, gradual exposure to trauma triggers, and actively talking about the traumatic events (Allen & Kronenberg, 2014).

Young people find the construction of the trauma narrative and cognitive processing necessary in their recovery, despite the inherent challenges in engaging in that therapeutic work (Neelakantan et al., 2019). Many young people have achieved habituation to previous trauma triggers from the exposure work. While initial expectations of therapy were generally not positive, many young people found TF-CBT therapy helpful. Cohen et al. (2011) suggested that TF-CBT can still be used with young people experiencing ongoing trauma, with clinicians focusing on enhancing safety early in the treatment phase, assisting young people to differentiate between real danger and generalised trauma reminders, and effectively engaging parents and caregivers (if available) in their children's treatment.

In Aotearoa New Zealand, Taylor (2019) adapted a manualised TF-CBT protocol for use with maltreated children through the addition of sensory modulation. Children with developmental trauma often have sensory processing difficulties in adolescence and beyond. While the adapted programme was helpful, Taylor (2019) noted significant issues with achieving caregiver involvement in the programme due to frequent placement changes and current experiences of abuse within placements.

Tania Cargo, a Māori Clinical Psychologist, developed the skateboard model of CBT for young people, representing the five-part model in a youth-friendly image (Mathieson et al., 2022). She also developed the waka ama (outrigger canoe) model of CBT for rangatahi Māori (Cargo, 2008). It uses the metaphor of a waka ama instead of a skateboard, with the paddlers representing the role of whānau in helping to steer the waka. While not specifically a TF-CBT model, these adaptations of CBT are helpful to apply when working with Māori care-experienced young people.

While TF-CBT can be helpful, it is most effective when a young person has some stability at home, even if that is just a stable care team (Rayment et al., 2014). There are critiques that CBT can be individualistic and ignores social oppression (Payne, 2014).

Hirini (1997), a Māori clinical psychologist, has also critiqued the cultural bias inherent in CBT assumptions about assertiveness training and what is considered *rational*. Therefore, when providing TF-CBT with care-experienced young people there should be a holistic approach that includes consideration of culture and oppression (Pitama et al., 2017). Clinicians should ensure Māori cultural responsivity with appropriate time for genuine engagement, inclusion of whānau, and use of relevant metaphors (Bennett et al., 2016).

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) was originally developed as a psychological treatment for adults with a diagnosis of Borderline Personality Disorder (BPD) (Linehan, 1993), and has been further developed for use with adolescents with multiple presenting issues (Rathus & Miller, 2013). DBT is based on a biosocial theory of personality, with the premise that emotional dysregulation develops in the context of invalidating environments in childhood, and posits a dialectical world view, where multiple truths exist concurrently (Linehan, 1993).

There is well-documented stigma towards people with a diagnosis of BPD, many of whom have experienced significant trauma (Veysey, 2014). Clinicians may see these people as manipulative, emotionally uncontained, and displaying intentional splitting behaviours, alternating between extreme idealisation and devaluation of clinicians to elicit care and avoid feelings of abandonment (Commons Treloar & Lewis, 2008). However, the DBT approach seeks to understand these difficulties, not as a fixed personality deficit, but as learned behaviours and survival techniques used with the intention of self-preservation and protection (Linehan et al., 2015). This has allowed for the behaviours previously seen as maladaptive to be reframed within a trauma-informed lens as adaptive within their context (Fonagy et al., 2017). This DBT approach can be helpful for CAMHS to understand care-experienced young people.

There has been some promising research into the adaptation of DBT with care-experienced young people in the UK. James et al. (2011) adapted DBT by holding meetings in the community, providing transport and meals, and including a residential ‘outward-bound’ weekend. Andrew et al. (2014) have also implemented a DBT programme for young people leaving care in the UK. For the therapists, adopting a dialectical approach towards the young people they worked with was invaluable. Andrew et al. (2014, p. 510) offered the following dilemmas in working with young people obliged to survive in an adult world as care leavers:

> … apparently competent AND emotionally vulnerable, acceptance of suffering AND recognition of a need for change, adult AND child, independent AND dependent, I get it AND I don’t, this is difficult and change seems impossible AND you must change. While others are drawn into proving the young person does not want to change (“they keep doing this”; “they throw everything away”), and could change if only they wanted to, the dialectical position allows us to accept that all of these positions could be true.

This dialectical understanding of care leavers has been used by DBT therapists to work with the system surrounding the young people. Utilising this systemic support, DBT can be effective even when a young person does not experience placement stability, with the therapists working with the community of professionals surrounding the young person (Rayment et al., 2014).

Andrew et al. (2014) discussed the use of clinician self-disclosure in DBT with care-experienced young people. They suggested that insecure or unsafe care experiences can limit a person’s capacity to understand others' perspectives, or the ways in which their own behaviour affects others. In the DBT programme for care leavers, therapists engage in personal disclosure including about their own families, success, and failures. Andrew et al. (2013) argued that self-disclosure helps to develop the therapeutic relationship, provides modelling of coping with adversity, communicates genuineness, and helps young people to notice the way in which their behaviour affects others.

This aligns with Māori perspectives on whakawhanaungatanga (the process of establishing relationships). CAMHS clinicians can engage in whakawhanaungatanga with whānau Māori (Māori families) to build a trusting relationship (McClintock et al., 2016). This contrasts with the western notion of distanced professionalism that is not often well-received by Māori, with some whānau Māori requiring their CAMHS clinician to share about their own background before they will engage with CAMHS support (McClintock & McClintock, 2018). The result of whakawhanaungatanga processes is that client and practitioner can become whānau (family). From a Māori lens, this form of relational care is culturally and ethically appropriate (Eketone, 2021).

In Aotearoa New Zealand, Morton (2019) provided a DBT programme for young care-experienced boys aged 11-14 years old in a residential community home. Accessibility was enhanced to allow any of the boys in the community home to attend. Two of the three participants were Māori. Morton (2019) found that the programme was helpful, particularly the use of humour, role plays, and aiming skills at an achievable level. For example, learning to use the breath was taught first, before building to the more cognitively complex tasks of staying focused on a task in a social interaction. Morton (2019) noted the significant difficulties with retaining boys in the programme due to frequent placement movements (the programme was delivered within the home) and with high staff turnover. Additionally, Weenink (2019) has evaluated an adaptation of the DBT programme for use in a youth justice residence in Aotearoa New Zealand. The programme was amended for delivery within the constraints of the residence and the original skills manual was adapted to suit the needs of Māori young people, including the use of culturally appropriate art, proverbs, and metaphors. Feedback about the programme from the residential staff was positive, especially for those young people who could be supported by the youth justice staff to practise the DBT skills.

Fuchs et al. (2013) discussed the use of DBT with people from marginalised and underserved backgrounds. They suggested that the therapeutic stance within DBT sees people's experience and expression of distress located within their sociopolitical and historical context. A focus of DBT is to understand this context and validate the distress, before encouraging behavioural change. Fuchs et al. (2013) have suggested that this contextualised approach may be well received from people from marginalised backgrounds, particularly those who mistrust the mental health system. This also aligns with Māori assessment frameworks that emphasise the influence of sociopolitical context on current mental health (Pitama et al., 2017). DBT provides a dialectical framework to validate the lived reality of oppression of marginalised groups while also helping individuals to identify helpful actions that are within their control.

Wraparound

Wraparound is a model for working collaboratively with families where there are multiple problems and several services are involved (Bruns & Walker, 2008). Guiding principles include having family voice, engaging in collaboration, being community-based and culturally competent, providing individualised support, and clinicians making an unconditional commitment to serve young people and their families (Bruns & Walker, 2008). In Aotearoa New Zealand, service specifications exist for CAMHS to provide Wraparound through individually tailored flexible packages of care for young people with complex needs (Ministry of Health, 2017), however it has not been widely used (Shailer et al., 2017). CAMHS teams can use Wraparound specifically with young people who are involved with Oranga Tamariki (Kirkwood, 2014; McNatty, 2017). A team forms around a young person and their family, including CAMHS clinicians and Oranga Tamariki social workers. The programme requires a high degree of collaboration and co-working between CAMHS and child welfare social workers.

The Wraparound process prioritises understanding of a young person's cultural context and ensures that processes are aligned with young people's cultural values and norms. Both Kirkwood (2014) and Tamihere (2015) have written about the close alignment of Wraparound principles with Māori values. Kirkwood (2014), a Māori social worker in CAMHS, has explored the connections between principles of voice and choice with whānau values; natural supports with whānau, hapū (sub-tribe) and iwi (tribe) networks; and the principle of collaboration with the concept of being mana-enhancing (recognising a person's intrinsic value). He has discussed the Wraparound engagement processes with whānau Māori, including whakawhanaungatanga, identifying strengths, instilling hope, and using te reo Māori (Māori language) and Māori metaphors. Tamihere (2015), a Māori clinical psychologist, has also compared Wraparound principles to Māori concepts of mana motuhake (self-determination), aroha (love), tautoko (support) and manaakitanga (care), promoting Wraparound as a culturally appropriate intervention with whānau Māori.

Wraparound programmes require adequate funding to offer flexible and responsive plans that include small caseloads for clinicians (Walter & Petr, 2011). When appropriately funded, Wraparound programmes have been found to contribute to significant improvements in mental health and wellbeing (Bruns & Walker, 2008) and to make a real difference for whānau who face many challenges (Kirkwood, 2014).

Assertive outreach

Assertive outreach is an approach that has been used in adult mental health services for those who struggle to attend clinic-based appointments due to the severity of the mental health and/or social issues they experience. It has been adapted for youth services and involves clinicians having small caseloads of 8-10 clients, meeting clients in their communities instead of clinics, and providing after-hours support (Vijverberg et al., 2017). Assertive outreach includes individual, family, and system interventions (Ryall et al., 2008). Most of the CAMHS assertive outreach research has come from the Australian state of Victoria, where there has been specific funding for CAMHS assertive outreach teams since 1998 (Assan et al., 2008; Ryall et al., 2008). Assan et al. (2008), in their file audit from 2003-2004, found that there was a 100% retention rate of young people in their assertive outreach team, which they attributed to the flexible nature of the approach. Assertive outreach interventions have been found to reduce suicide risk and inpatient hospital admissions (Schley et al., 2008).

Several studies have indicated that assertive outreach is well suited for care-experienced young people. Schley et al. (2008) found that almost half of their assertive outreach clients were also involved with child welfare services in Australia, and that most of the clients had experienced traumatic childhoods. In Aotearoa New Zealand, there are service specifications for intensive clinical support, a mobile assertive outreach approach that also provides training and support with mental health issues for foster parents and other caregivers through Oranga Tamariki (Ministry of Health, 2017). However, there is a dearth of local research on the implementation of any youth assertive outreach approaches.

Systemic interventions

In Aotearoa New Zealand, CAMHS are tasked with promoting inter-sector collaboration for all young people (Ministry of Health, 2017), but this is particularly important for care-experienced young people. Andrew et al. (2014) have detailed the importance of working systemically for young people with complex problems who are involved with multiple services, where often the "well intentioned systems that surround young people ... all too often also serve to reinforce maladaptive behaviours" (p. 511). When those young people feel unable to communicate with services, they may engage in risk behaviours to communicate their distress and influence decisions made about them and their care. Therefore, it is important that the whole system shares a common management plan and formulation of the issues. This helps reduce risky behaviour and provides a sense of containment for a young person where there are multiple services involved.

It is also possible for mental health services to provide support to the system around a young person who is not engaged with the service. Callaghan et al. (2004) presented models of care that incorporate avenues for clinicians to provide guidance to foster carers and child welfare staff without necessarily requiring any direct clinical input with the young person. This avoids the problems of over-assessment of vulnerable young people and recognises the significant impact that a young person's environment has upon their wellbeing. Social workers engaging in early consultancy with CAMHS could even assist with placement decisions and possibly decrease CAMHS referrals (Callaghan et al., 2004).

The THRIVE framework for system change (Wolpert et al., 2019) has been developed in the UK and includes provision for such systemic support. Within this framework are five categories of support for young people: thriving, getting advice and signposting, getting help, getting more help, and getting risk support. This last category is relevant to the discussion of systemic support in the absence of direct clinical work.

Wolpert et al. (2014, p. 9) described the 'getting risk support' category as "perhaps the most contentious aspect" of the model. It is aimed at young people who do not improve with traditional CAMHS input. The THRIVE model recognises that, for a minority of young people, there may not be any effective mental health treatment available, but they remain at risk to themselves or others. These young people tend to be the subject of much discussion between services. They may be understood as 'not ready' for treatment, may routinely go into crisis but are not able to make use of CAMHS support, struggle to attend appointments, and/or CAMHS has not been helpful for them. Within the THRIVE model, the CAMHS team remains involved and joins a multi-agency network to provide support and mental health advice to the system surrounding that young person.

Lidchi and Wiener (2020) and Lobatto (2021) have discussed the use of the THRIVE framework within specialist mental health services for care-experienced young people in the UK. Lobatto (2021) found that the intensive systemic support provided by the service led to increased placement stability for the young people, all of whom had a history of frequent unplanned placement changes. Lobatto (2021) described how the conflict within children's birth families can become replicated in other institutional systems surrounding a young person and explained how the specialist mental health team takes an "appreciative position" (p. 15) to honour all members of the system, creating a healthy community of care surrounding a young person.

There is scarce local research on interagency initiatives, despite agreement that improved collaboration is important (Oranga Tamariki, 2023; Whāraurau, 2021).

Discussion

This review was undertaken to answer the question "What are effective mental health interventions for care-experienced young people?" There is a large evidence base around parenting and family approaches to address mental health issues for younger children. However, for older adolescents, particularly those without consistent carer support, the research base points to TF-CBT, DBT, Wraparound, assertive outreach approaches, and working with the care system surrounding a young person. Interventions should be tailored for care-experienced young people, considering their relational and learning styles and Māori models of connecting that may require adjustments to current CAMHS timeframes.

Care-experienced young people are more likely to be Māori or to belong to cultural minority groups (Oranga Tamariki, 2022) and experience multiple layers of personal and institutional racism, including within mental health services (Bernard et al., 2021). Colonial healthcare systems create barriers for Māori to access mental health services (Latimer et al., 2022), and distrust of government-funded health and welfare systems contributes to lower attempted access to mental health services and deferral of service involvement until the point of crisis. (Elder & Tapsell, 2013). These young people may present at CAMHS with mistrust of clinicians, along with attachment difficulties and communication deficits (Tarren-Sweeney, 2021).

However, care-experienced young people are also survivors and have developed skills to protect themselves from further trauma. A trauma-informed approach is required that sees young people as relational beings in the context of their families, even when in a placement away from them (Bush et al., 2009), is culturally sound and sensitive to their learning styles (Slayter, 2016) and literacy needs (Weenink, 2019). If, as Tarren-Sweeney and Vetere (2014) suggested, the mainstream CAMHS model is not designed to meet the needs of care-experienced young people, it is even less equipped to respond effectively to Māori care-experienced young people. CAMHS need to be attuned to the mental health needs of this group and adapt approaches to respond appropriately.

There is a clear overrepresentation of Māori and other Indigenous young people in state care who also experience mental health difficulties (Oranga Tamariki, 2023). However, there is little discussion in the literature about how mental health interventions for this group adapt to cultural values or experiences of racism and oppression. For example, Fuchs et al. (2013) have discussed DBT approaches to people's institutional mistrust as a result of racism, but those considerations are not evident in the literature on interventions with care-experienced young people. Indigenous mental health research and practice have not been well integrated into the research base about mental health interventions for those young people involved with child welfare.

Effective interventions for care-experienced young people should be available in culturally appropriate and flexible service structures. Tarren-Sweeney and Vetere (2014) proposed a "shift from acute care to preventative, long-term engagement ... a shift from exclusion to active ownership of these client groups" (p. 407). All the interventions presented in this article require funding structures that support flexibility and collaboration. Adapting interventions to suit the learning style, cultural, relational, and attachment needs of care-experienced young people necessitates extended time for therapeutic planning and engagement. Wraparound and assertive outreach programmes depend on clinicians having small caseloads and intensive involvement.

Time is required for clinicians to engage in multi-agency collaboration. The THRIVE model takes this a step further by mental health services investing time into multi-agency discussion for young people who are not 'service users' themselves. This approach offers a new model of care that is appropriate for care-experienced young people. The outcomes of such responsive mental health care could have cascading long-term benefits for young people and whānau wellbeing, relationships, and community contribution.

Limitations

This review summarises the mental health interventions recommended for care-experienced young people and considers application within the Aotearoa New Zealand context. However, there are limitations in the current body of research. Clinical research may exclude care-experienced young people due to their mental health and social complexities. Clinical trials of therapies are less applicable to this population, especially when outcomes are not stratified by special population status (Tarren-Sweeney & Vetere, 2014). There is a significant gap in the literature about culturally appropriate and effective mental health interventions with care-experienced young people, particularly those who experience placement disruption and have no caregiver input into treatment.

Research into effective mental health interventions for care-experienced young people in Aotearoa New Zealand is missing. This should be informed by the care-experienced community. While many of the interventions reviewed in this article have included adaptations for Māori, it would be more helpful for Kaupapa Māori research to explore what is most supportive for the mental health of care-experienced rangatahi Māori.

The scope of this review is limited to general clinical interventions for care-experienced young people, rather than a focus on diagnosis-specific interventions for this population. It is also limited to interventions targeted at a young person, their family and wider support system. It does not include macro-level interventions targeting the social determinants of mental health for this population, such as preventative community work, interventions to reduce societal and institutional discrimination, child protection policies that enhance placement stability and promote wellbeing, and governmental policies aimed at reducing poverty and homelessness.

Implications for practice and policy

Many care-experienced young people have mental health needs that would benefit from clinical service input. Their presentations are often complex, affected by their experiences of abuse and neglect, institutional mistrust, placement instability, and challenging relational styles. Effective CAMHS interventions require innovative and flexible funding structures that allow time for prolonged engagement, intensive involvement, adapted approaches, and multi-agency collaboration. This is particularly evident when considering how CAMHS may be able to support the system around a young person with complex issues. While clinicians may not provide direct clinical input to the young person, the provision of mental health support and advice to child welfare social workers and other professionals could be effective in developing a trauma-informed and developmentally sensitive understanding of a young person. This shared understanding can assist with managing risk and enhancing placement stability, both of which are significant contributors to mental wellbeing for care-experienced young people.

It is important that mental health services are culturally appropriate in both access to services and the interventions offered. For Māori, this includes a holistic approach incorporating whānau and spirituality (Durie, 1994), connections between people, land and time (Hamley et al., 2023), and consideration of how colonisation, racism, migration and marginalisation impact Māori mental health (Pitama et al., 2017). Clinicians should consider how these experiences impact the engagement and intervention processes for young people and create culturally safe pathways into services.

Recommendations

- At a policy level, there should be clarification about the relationship between experiences of trauma and access to CAMHS support. If CAMHS teams will accept referrals for care-experienced young people whose mental health is impacted by trauma, TF-CBT should be made available.
- CAMHS teams to continue to offer DBT. Entry criteria about parental involvement could be more flexible to ensure that care-experienced young people are not excluded from participating.
- Wraparound teams to be established and supported with ringfenced funding to provide a specialist service for care-experienced young people with mental health needs. These teams should be informed by an assertive outreach approach to working with young people. Kirkwood (2014) provided a good description of an effective Wraparound team that operated in the Waitematā district. The findings of this literature review support the re-establishment and development of such teams to provide appropriate support for care-experienced young people.
- CAMHS teams should consider implementation of the THRIVE framework to offer mental health consultation to Oranga Tamariki and other professionals even when not directly clinically working with a young person.
- CAMHS clinicians to be supported to engage in training on: 1) working with whānau Māori; 2) trauma-informed care; and 3) interagency liaison. These trainings to be complemented with reflective discussion on the application with care-experienced young people.

Conclusion

Care-experienced young people often present with significant mental health difficulties alongside traumatic histories of abuse and experiences of discrimination. Despite the high mental health need, there has been little research into effective clinical intervention for this group. This is particularly evident for older adolescents without caregiver involvement in their treatment and those who experience frequent placement disruption or homelessness. This review summarises the research base for mental health interventions for care-experienced young people to support the Oranga Tamariki (2022) Action Plan to improve mental health services for this population.

While it is ideal to have caregiver input in mental health interventions, it is still possible for care-experienced young people to participate in TF-CBT or DBT in the absence of caregiver input. These approaches validate the experience of trauma and societal discrimination while also providing young people skills to navigate their emotional responses to difficult environments. Wraparound and assertive outreach are approaches that support individual interventions in a therapeutic context of responsivity, meeting a young person where they are, physically and emotionally. Both approaches recognise that time is required to build a therapeutic relationship with the young person and to work with their surrounding system. There is a focus on flexibility and responsivity to enhance engagement and outcomes. These approaches are differentiated from standard mental health services as they require intensive resourcing, including reduced clinician caseloads.

Systemic interventions are critically important with care-experienced young people, especially those involved with multiple services and engaging in high-risk behaviour. CAMHS can provide systemic approaches in the absence of caregiver involvement, even for young people who are not receiving direct clinical input. Therapeutic readiness does not have to be a prerequisite for mental health service involvement as there is scope for clinicians to provide support to the wider system. The THRIVE model (Wolpert et al., 2019) is an innovative conceptual approach for youth mental health services, offering support to the system surrounding care-experienced young people who have not benefited from traditional mental health services.

There have been challenges for CAMHS teams to provide effective services for care-experienced young people. However, the Oranga Tamariki (2022) Action Plan provides a rationale for CAMHS to improve services for this population. This article outlines some appropriate interventions that can be provided by CAMHS to support the mental health needs of care-experienced young people and work towards more equitable mental health care.

Received: 5 July 2023

Accepted: 2 April 2024

Published: 15 June 2024

References

Allen, B., & Kronenberg, M. (Eds.). (2014). *Treating traumatized children: A casebook of evidence-based therapies*. Guilford Press.

Appleby, J., Staniforth, B., Kemp, S. P., & Connor, H. (2024). How should CAMHS work with young people who are involved with Oranga Tamariki? A literature review of principles for working with care-experienced young people. *Aotearoa New Zealand Social Work,* 36(2) forthcoming.

Andrew, E., Williams, J., & Waters, C. (2014). Dialectical behaviour therapy and attachment: Vehicles for the development of resilience in young people leaving the care system. *Clinical Child Psychology and Psychiatry, 19*(4), 503–515. https://doi.org/10.1177/1359104513508964 ccp.sagepub.com

Assan, B., Burchell, P., Chia, A., Coffey, C., Floreani, S., Weir, J., Wingenfeld Hammond, S., & Woods, B. (2008). The adolescent intensive management team: An intensive outreach mental health service for high-risk adolescents. *Australasian Psychiatry, 16*(1), 423–427. https://doi.org/10.1080/1039856080188602

Bennett, S. T., Flett, R. A., & Babbage, D. R. (2016). Considerations for culturally responsive cognitive-behavioural therapy for Māori with depression. *Journal of Pacific Rim Psychology, 10(8),* 1–11. https://doi.org/10.1017/prp.2016.5

Bergström, M., Cederblad, M., Håkansson, K., Jonsson, A. K., Munthe, C., Vinnerljung, B., Wirtberg, I., Ostlund, P., & Sundell, K. (2020). Interventions in foster family care: A systematic review. *Research on Social Work Practice, 30*(1), 3–18. https://doi.org/10.1177/1049731519832101

Bernard, D. L., Calhoun, C. D., Banks, D. E., Halliday, C. A., Hughes-Halbert, C., & Danielson, C. K. (2021). Making the "C-ACE" for a culturally-informed adverse childhood experiences framework to understand the pervasive mental health impact of racism on black youth. *Journal of Child and Adolescent Trauma, 14*(2), 233–247. https://doi.org/10.1007/s40653-020-00319-9.

Bruns, E., & Walker, J. (2008). *Resource guide to wraparound.* https://nwi.pdx.edu/NWI-book/Chapters/COMPLETE-RG-BOOK.pdf

Bush, A., Chapman, F., Drummond, M., & Fagaloa, T. (2009). Development of a child, adolescent and family mental health service for Pacific young people in Aotearoa/New Zealand. *Pacific Health Dialog, 15*(1), 138–146.

Callaghan, J., Young, B., Pace, F. & Vostanis, P. (2004). Evaluation of a new mental health service for looked after children. *Clinical Child Psychology and Psychiatry, 9*(1), 1359–1045. https://doi.org/10.1177/1359104504039177

Cargo, T. (2008). Hoea a mai tōu waka: Claiming spaces for Māori tamariki and rangatahi in cognitive behaviour therapy. In M. Levy, L. W. Nikora, B. Masters-Awatere, M. Rua, & W. Waitoki (Eds.), *Claiming spaces: Proceedings of the 2007 National Māori and Pacific psychologies symposium* (pp. 97–102). Māori and Psychology Research Unit, University of Waikato.

Cohen, J. A., Mannarino, A. P., & Murray, L. K. (2011). Trauma-focused CBT for youth who experience ongoing traumas. *Child Abuse and Neglect, 35,* 637–646. https://doi.org/10.1016/j.chiabu.2011.05.002

Commons Treloar, A., & Lewis, A. J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality disorder. *Australian and New Zealand Journal of Psychiatry, 42*(7), 578–584.

Craven, P. A., & Lee, R. E. (2006). Therapeutic interventions for foster children: A systematic research synthesis. *Research on Social Work Practice, 16*(3), 287–304. https://doi.org/10.1177/1049731505284863

Dittmann, I., & Jensen, T. K. (2014). Giving a voice to traumatized youth: Experiences with trauma-focused cognitive behavioural therapy. *Child Abuse and Neglect, 38,* 1221–1230. https://doi.org/10.1016/j.chiabu.2013.11.008

Durie, M. (1994). *Whaiora Māori health development.* Oxford University Press.

Eketone, A. (2021). Dual relationships and crossing boundaries in Māori social work practice. *Journal of Indigenous Social Development, 10*(1), 29–49.

Elder, H., & Tapsell, R. (2013). Māori and the Mental Health Act. In J. Dawson & K. Gledhill (Eds.), *New Zealand's Mental Health Act in practice* (pp. 249–167). Victoria University Press.

Evans, R., MacDonald, S., Trubey, R., Noyes, J., Robling, M., Willis, S., Boffey, M., Wooders, C., Vinnicombe, S., & Melendez-Torres, G. J. (2023). Interventions targeting the mental health and wellbeing of care-experienced children and young people in higher-income countries: Evidence map and systematic review. *Systematic Reviews*, *12*(1), 1–33. https://doi.org/10.1186/s13643-023-02260-y

Every-Palmer, S., Grant, M. L. & Thabrew, H. (2022). Young people don't tend to ask for help more than once: Child and adolescent psychiatrists' views on ailing mental health services for young New Zealanders. *Australasian Psychiatry, 30*(6), 684–688. https://doi.org/10.1177/1039856222111562

Fleming, T., Archer, D., King-Finau, T., Ormerod, F., & Clark, T. C. (2021). *Health and wellbeing of young people who have been involved with Oranga Tamariki: Home and housing.* https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Research/Latest-research/Youth19-Rangatahi-Smart-Survey/Youth19_young-people-involved-with-Oranga-Tamaki_mental-physical-health-and-healthcare-access.pdf

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017). What we have changed our minds about: Borderline personality disorder as a limitation of resilience. *Borderline Personality Disorder and Emotional Dysregulation, 4*(11). https://doi.org/10.1186/s40479-017-0061-9

Fuchs, C, Lee, J. K., Roemer, L., & Orsillo, S. M. (2013). Clinical considerations in using acceptance- and mindfulness-based treatments with diverse populations. *Cognitive and Behavioural Practice, 20*(1), 1–12. https://doi.org/10.1016/j.cbpra.2011.12.004

Garcia, A. R., Circo, E., DeNard, C. & Hernandez, N. (2015). Barriers and facilitators to delivering effective mental health practice strategies for youth and families served by the child welfare system. *Children and Youth Services Review, 52*, 110–122. https://doi.org/10.1016/j.childyouth.2015.03.008

Hambrick, E. P., Oppenheim-Weller, S., N'zi, A. M., & Taussig, H. N. (2016). Mental health interventions for children in foster care: A systematic review. *Children and Youth Services Review, 70*, 65–77. https://doi.org/10.1016/j.childyouth.2016.09.002

Hamley, L., Le Grice, J., Greaves, L., Groot, S., Latimer, C. L., Renfrew, L., Parkison, H., Gillon, A., & Clark, T.C. (2023). Te Tapatoru: A model of whanaungatanga to support rangatahi wellbeing. *Kōtuitui: New Zealand Journal of Social Sciences Online, 18*(2), 171–194. https://doi.org/10.1080/1177083X.2022.2109492

Hirini, P. (1997). Counselling Maori clients: He whakawhiti nga whakaaro i te tangata whaiora Maori. *New Zealand Journal of Psychology, 26*(2), 13–17.

Human Rights Commission. (2022). *Maranga Mai!* https://tikatangata.org.nz/our-work/maranga-mai

James, A. C., Winmill, L., Anderson, C., & Alfoadari, K. (2011). A preliminary study of an extension of a community dialectical behaviour therapy (DBT) programme to adolescents in the looked after care system. *Child and Adolescent Mental Health, 16*(1), 9–13. https://doi.org/10.1111/j.1475-3588.2010.00571.x

Johnstone, M., Brown, C., & Ross, N. (2022). The Mcdonaldization of social work: A critical analysis of mental health care services using the Choice and Partnership Approach (CAPA) in Canada. *Journal of Progressive Human Services, 33*(3), 223–243. https://doi.org/10.1080/10428232.2022.2050117

Kirkwood, T. (2014). The engagement phase of wraparound systems of care. *Aotearoa New Zealand Social Work*, *26*(1), 3–9. https://doi.org/10.11157/anzswj-vol26iss1id49.

Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Reutz, J. A. R. (2009). Psychosocial interventions for children and adolescents in foster care: Review of research literature. *Child Welfare, 88*(1), 49–69.

Latimer, C. L., Le Grice, J., Hamley, L., Greaves, L., Gillon, A., Groot, S., Manchi, M., Renfrew, L., & Clark, T. C. (2022). "Why would you give your children to something you don't trust?": Rangatahi health and social services and the pursuit of tino rangatiratanga. *Kōtuitui: New Zealand Journal of Social Sciences Online, 17*(3), 298–312. https://doi.org/10.1080/1177083X.2021.1993938

Lee, T., Fouras, G., & Brown, R. (2015). Practice parameter for the assessment and management of youth involved with the child welfare system. *Journal of the American Academy of Child and Adolescent Psychiatry, 54*(6), 502–517. https://doi.org/10.1016/j.jaac.2015.03.005

Leve, L. D., Harold, G. T., Chamberlain, P., Landsverk, J. A., Fisher, P. A., & Vostanis, P. (2012). Practitioner review: Children in foster care: Vulnerabilities and evidence-based interventions that promote resilience processes. *Journal of Child Psychology and Psychiatry, 53*(12), 1197–1211. https://doi.org/10.1111/j.1469-7610.2012.02594.x

Lidchi, V., & Wiener, A. (2020). How can services be improved to effectively address the mental health of vulnerable children and young people? *Child Abuse & Neglect*, 104648. https://doi.org/10.1016/j.chiabu.2020.104648

Linehan, M. M. (1993). *Diagnosis and treatment of mental disorders: Cognitive-behavioural treatment of borderline personality disorder.* Guilford Press.

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., McDavid, J., Comtois, K. A., & Murray-Gregory, A. M. (2015). Dialectical behaviour therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *JAMA Psychiatry, 72*(5), 475–482. https://doi.org/10.1001/jamapsychiatry.2014.303

Lobatto, W. (2021) Using systemic principles in the design of mental health and wellbeing services for looked after children and young people: Bringing together research, theory and practice. *Journal of Family Therapy, 43*(3), 469–488. https://doi.org/10.1111/1467-6427.12351

Mathieson, F., Bennett, S., Cargo, T., & Froggatt, W. (2022). Cognitive behavioral therapy in Aotearoa/New Zealand. In M. D. Terjesen & K. A. Doyle (Eds.), *Cognitive* *behavioral therapy in a global context*. https://doi.org/10.1007/978-3-030-82555-3_2

McClintock, K., & McClintock, R. (2018). *Tuku iho, tuku iho, culture in Māori health service provision*. https://terauora.com/wp-content/uploads/2019/05/Tuku-Iho-Tuku-Iho.pdf

McClintock, K., Tauroa, R., Mellsop, G., & Frampton, C. (2016). Pilot of Te Tomo Mai, a child and adolescent mental health service evaluation tool for an indigenous rangatahi (youth) population. *International Journal of Adolescence and Youth, 21*(1), 96–103, https://doi.org/10.1080/02673843.2013.813861

McNatty, G. E. D. (2017). *"Becoming the spoke in the wheel": Wraparound and the theory of change: An investigation into what promotes changes within wraparound* [Unpublished doctoral dissertation] Massey University.

Ministry of Health. (2017). *Infant, child, adolescent and youth mental health tier two service specification.* https://www.tewhatuora.govt.nz/our-health-system/nationwide-service-framework-library/about-nationwide-service-specifications/mental-health-and-addiction-service-specifications/infant-child-adolescent-and-youth-mental-health/

Ministry of Health. (2020). *Whakamaua: Māori Health Action Plan.* https://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025

Morton, L. A. (2019). *Piloting a dialectical behavioural therapy-based skills with New Zealand youth in care using three case studies* [Unpublished master's thesis]. Massey University.

Neelakantan, L., Hetrick, S., & Michelson, D. (2019). Users' experiences of trauma-focused cognitive behavioural therapy for children and adolescents: a systematic review and metasynthesis of qualitative research. *European Child and Adolescent Psychiatry, 28*, 877–897. https://doi.org/10.1007/s00787-018-1150-z

Oranga Tamariki. (2022). *Oranga Tamariki Action Plan.* https://orangatamarikiactionplan.govt.nz/assets/Action-Plan/Uploads/Resources/Publications/Oranga-Tamariki-Action-Plan.pdf

Oranga Tamariki. (2023). *Mental health and wellbeing needs of children and young people involved with Oranga Tamariki.* https://www.orangatamarikiactionplan.govt.nz/assets/Action-Plan/Uploads/Understanding-need/Mental-health-and-wellbeing/OT-MW-Needs-Assessment_final-for-publication_Redacted.pdf

Payne, M. (2014). *Modern social work theory* (4th ed). Oxford University Press.

Pitama, S. G., Bennett, S. T., Waitoki, W., Haitana, T. N., Valentine, H., Pahina, J., Taylor, J. E., Tassell-Matamua, N., Rowe, L., Beckert, L., Palmer, S. C., Huria, T. M., Lacey, C. J., & McLachlan, A. (2017). A proposed hauora Māori clinical guide for psychologists using the hui process and meihana model in clinical assessment and formulation. *New Zealand Journal of Psychology, 46*(3), 7–19.

Racusin, R., Maerlender, A. C., Sengupta, A., Isquith, P. K., & Straus, M. B. (2005). Psychosocial treatment of children in foster care: A review. *Community Mental Health Journal, 41*(2), 199–221. https://doi.org/10.1007/s10597-005-2656-7

Rathus, J. H., & Miller, A. L. (2013). *DBT skills manual for adolescents*. Guilford Press.

Rayment, P., Young, C., & Guidolin, M. (2014). Therapeutic interventions for traumatised children in the child protection system in South Australia: Matching the therapy to the child. *Developing Practice: The Child Youth and Family Work Journal,* (38), 34–48.

Ryall, V., Radovini, S., Crothers, L., Schley, C., Fletcher, K., Nudds, S., & Groufsky, C. (2008). Intensive youth outreach in mental health: An integrated framework for understanding and intervention. *Social Work in Mental Health, 1*(3), 153–175. https://doi.org/10.1080/15332980802072512

Schley, C., Ryall, V., Crothers, L., Radovini, S., Fletcher, K., Marriage, K., Nudds, S., Groufsky, C., & Pan Yuen, H. (2008). Early intervention with difficult to engage, "high-risk" youth: Evaluating an intensive outreach approach in youth mental health. *Early Intervention in Psychiatry, 2*, 195–200 https://doi.org/10.1111/j.1751-7893.2008.00079.x

Shailer, J. L., Gammon, R. A., & de Terte, I. (2017). An investigation of the fidelity to a wraparound process in New Zealand. *New Zealand Journal of Psychology, 46*(2), 87–98.

Slayter, E. (2016). Youth with disabilities in the United States child welfare system. *Children and Youth Services Review, 64*, 155–165. https://doi.org/10.1016/j.childyouth.2016.03.012

Tamihere, K. (2015). *"Kōkiritia i roto i te kotahitanga" A process evaluation of a wraparound programme at Te Whānau o Waipareira Trust* [Unpublished doctoral dissertation]. University of Auckland.

Tarren-Sweeney, M., & Vetere, A. (2014). *Mental health services for vulnerable children and young people: Supporting children who are, or have been, in foster care*. Routledge.

Tarren-Sweeney, M. (2021). A narrative review of mental and relational health interventions for children in family-based out-of-home care. *Journal of Family Therapy,* 1–23. https://doi.org/10.1111/1467-6427.12341

Taylor, O. (2019). *Evaluation and update of trauma-focused cognitive behavioural therapy with sensory approaches for the treatment of post-traumatic stress disorder in maltreated children* [Unpublished doctoral dissertation]. Auckland University of Technology.

Te Hiringa Mahara – Mental Health and Wellbeing Commission, (2023). *Young people speak out about wellbeing.* https://www.mhwc.govt.nz/assets/Youth-wellbeing-/Youth-Wellbeing-Insights-Report-Full.pdf

Thabrew, H., Henderson, S., Hazell, P., Moor, S., Kowalenko, N., & Kenn, F. (2017). Is it time for child psychiatry to grow up? *Australian & New Zealand Journal of Psychiatry, 51*(10), 971–973. https://doi.org/10.1177/0004867417718946

Veysey, S. (2014). People with a borderline personality disorder diagnosis describe discriminatory experiences. *Kōtuitui: New Zealand Journal of Social Sciences Online, 9*(1), 20–35. https://doi.org/10.1080/1177083X.2013.871303

Vijverberg, R., Ferdinand, R., Beekman, A., & van Meijel, B. (2017). The effect of youth assertive community treatment: A systematic PRISMA review. *BMC Psychiatry, 17*, 284. https://doi.org/10.1186/s12888-017-1446-4

Vreeland, A., Ebert, J. S., Khun, T. M., Gracey, K. A., Shaffer, A. M., Watson, K. H,. & Compas, B. E. (2020). Predictors of placement disruptions in foster care. *Child Abuse and Neglect, 99.* https://doi.org/10.1016/j.chiabu.2019.104283

Walter, U. M., & Petr, C. G. (2011). Best practices in Wraparound: A multidimensional view of the evidence. *Social Work, 56*, 73–80. https://doi.org/10.1093/sw/56.1.73

Weenink, M. M. M. (2019). *He waka eke noa at Korowai Manaaki: A process evaluation of a dialectical behaviour therapy-informed skills programme for young people in a secure youth justice residence* [Unpublished master's thesis]. Victoria University of Wellington.

Whāraurau. (2021). *2020 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*. https://www.wharaurau.org.nz/all-workstreams/stocktake

Wilson, D., Moloney, E., Parr, J. M. Aspinall, C. & Slark, J. (2021). Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing, 30*(23), 3539–3555. https://doi.org/10.1111/jocn.15859

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., & Munk, S. (2019). *THRIVE-Framework for system change*. www.implementingthrive.org.

Wolpert, M., Harris, R., Jones, M., Hodges, S., Fuggle, P., James, R., Wiener, A., Mckenna, C., Law, D., & Fonagy, P. (2014). *THRIVE: The AFC-Tavistock model for CAMHS.* http://implementingthrive.org/wp-content/uploads/2016/03/Thrive.pdf

York, A., & Kingsbury, S. (2009). *The choice and partnership approach: A guide to CAPA.* CAMHS Network.

How should CAMHS work with young people who are involved with Oranga Tamariki? A literature review of principles for working with care-experienced young people

Joanna Appleby, Barbara Staniforth, Susan P. Kemp and Helene Connor (Te Atiawa and Ngāti Ruanui, Ngāti Rahiri and **Ngāti Te Whiti),** University of Auckland, Aotearoa New Zealand

ABSTRACT

INTRODUCTION: Care-experienced young people tend to have high levels of mental health need which have remained largely unmet by child and adolescent mental health services (CAMHS). This review focuses on how CAMHS clinicians can better support the mental health of care-experienced young people.

METHOD: A narrative review of the current research on principles for working effectively with care-experienced young people is presented. The focus is on principles that can be applied across the full range of mental health interventions, with a focus on Māori perspectives of wellbeing.

FINDINGS: A set of practice principles framed within an ethic of care is presented that includes establishing a trusting and transparent therapeutic relationship, practising flexibly, promoting youth autonomy and choice, providing support to the whole system around the young person, interagency collaboration, and providing extra support during periods of transition. These approaches can be used across a range of mental health interventions and within a philosophy of care that is youth-centred and attuned to the cultural, practical, and developmental needs of care-experienced young people. While Māori youth are the focus of this review, the findings may be applicable for care-experienced young people from other marginalised groups.

CONCLUSION: CAMHS teams should be adequately resourced to enact a responsive ethic of care. Within multi-disciplinary teams, clinical social workers are well placed to promote holistic mental health care. The principles presented in this review can also be applied across other settings to support care-experienced young people to thrive.

Keywords: Child welfare; youth; mental health; ethic of care; CAMHS; care-experienced

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 84–98.

CORRESPONDENCE TO:
Joanna Appleby
joanna.appleby@gmail.com

Following our first literature review on mental health interventions for care-experienced young people (Appleby, Staniforth et al., 2024a), this second review examines the practice principles that can be applied across a range of mental health interventions to support care-experienced young people to thrive. Care-experienced young people are underserved by child and adolescent mental health service (CAMHS) teams in Aotearoa New Zealand (Oranga Tamariki, 2023). This occurs despite young people involved with Oranga Tamariki, the child protection agency in Aotearoa New Zealand, having significantly higher mental distress than the general youth population (Fleming et al., 2021). Care-experienced young people tend to have high mental health needs but only episodic contact with CAMHS, often in crisis, with little longer-term support provided (Munford & Sanders, 2016, Tarren-Sweeney & Vetere, 2014). Internationally, care-experienced young people and CAMHS clinicians have advocated for more responsive mental health support for those involved with child welfare services (Coulter et al., 2022; Golm, 2023). This literature review aims to assist CAMHS clinicians to improve mental health care for this demographic. Practice principles are presented to guide effective clinical practice to meet the needs of this population.

Care-experienced is a term that is usually applied to people who have experience of being in the care of state child welfare services. We have applied a wider scope to this term for this literature review, including all young people who have been involved with Oranga Tamariki, from a referral through to those placed in the care of Oranga Tamariki. This wider definition acknowledges the experience that these young people bring, is shorthand for the more cumbersome phrase "young people who have been involved with Oranga Tamariki" and can be applied in international contexts. However, in using this broader meaning, we are mindful not to diminish the experience of being in state care, and acknowledge how traumatic this can be, as evidenced by the recent Royal Inquiry into Abuse in Care (2021).

The review is designed to support CAMHS teams with principles of how to work with care-experienced young people, recognising the impact of traumatic experiences upon clinical presentations. We present six key principles that CAMHS should consider when working with care-experienced young people, situated within an ethic of care that can be applied across any CAMHS treatment modality. While there is an emphasis on principles for supporting Māori (the Indigenous people of Aotearoa New Zealand), the findings may also be applicable for other Indigenous care-experienced young people who have experienced colonisation and those from other marginalised groups.

In Aotearoa New Zealand, efforts are being made for improved service delivery for care-experienced young people through the interagency Oranga Tamariki (2022) Action Plan. Despite the high level of mental health need and clinical complexity for this population and the plan to improve services, there is little literature about CAMHS best practice with care-experienced young people. This article synthesises the literature on effective mental health practice with care-experienced young people and presents recommendations for how CAMHS teams can best support care-experienced young people.

This is our second literature review about CAMHS care, intended to be read alongside our first review (Appleby et al., 2024a) that examined the range of CAMHS interventions that are appropriate for this group. This second review focuses on the principles that can be applied across all CAMHS interventions. The aim is to provide clinical and practical guidance to CAMHS clinicians working with care-experienced young people, presenting effective practice principles to nurture a therapeutic environment in which young people can thrive.

Focus of this review

There are two general approaches in the research literature on effective mental health practice with this group of young people. One body of research focuses on *what* interventions have been adapted and evaluated for this population. This evaluative research base focuses on specific therapeutic interventions and includes both qualitative and quantitative research approaches. We have synthesised this body of research in our first article (Appleby et al., 2024a). This second article draws implications from the second body of research, which focuses on practice approaches and principles that can be applied across a range of interventions. Our focus in this article is on *how* to work therapeutically with care-experienced young people.

This article is structured into themes identified from this literature review: the importance and nature of the therapeutic relationship; service and clinician flexibility; providing autonomy and choice for young people; providing systemic support; interagency collaboration; and sensitively managing periods of transition. These practices are conceptualised within an ethic of care (Barnes, 2012).

Mental health needs of care-experienced young people

Care-experienced young people have higher rates of mental health issues compared to the general adolescent population (Baker et al., 2017). They often experience intersecting disadvantages, disability, and placement disruption, and have not been well served by health, education, justice, and child protection services (Oranga Tamariki, 2023). Māori young people are over-represented in Oranga Tamariki involvement and mental health need (Oranga Tamariki, 2023), and these young people often experience intergenerational institutional, cultural, and personal racism (Human Rights Commission, 2022). Despite their high levels of mental health need, care-experienced young people often experience barriers in accessing CAMHS support (Oranga Tamariki, 2023). These include the double stigma of being care-experienced and having mental health needs (Garcia et al., 2015), challenges associated with interagency collaboration (Glisson & Green, 2006), and the difficulties of CAMHS access for young people moving between geographical service boundaries (Beck, 2006a). The significant mental health needs for this population have been clearly identified in the literature (Baker et al., 2017; Kerker & Dore, 2006). However, there is little published clinical guidance for how professionals can best work with care-experienced young people.

This review responds to the well-documented difficulties of practice with care-experienced young people and offers practice principles aimed at better addressing their mental health needs. The principles align with social work values, particularly regarding ecological and systemic approaches, the central importance of attending to issues of power and equity, and the incorporation of strengths-based and collaborative practice (International Federation of Social Workers, 2021). Each principle is discussed in turn. However, they are interrelated and are most effective when used holistically within an ethic of care attuned to the needs of care-experienced young people.

Methods

The research question guiding the literature search was “What is effective mental health practice with care-experienced young people?” This is a narrative review of the literature that was conducted as a platform for a qualitative research project with care-experienced young people. The spectrum of involvement covers those who remain with their families, those in whānau (family) and non-whānau placements, and residential and foster care. Much of the existing literature includes multiple developmental periods, such as childhood and early adolescence, and later adolescence and young adulthood. For the purposes of this review, we have focused on principles for working with adolescents.

Relevant articles were searched for on the EBSCOhost suite of databases (Child

Development and Adolescent Studies, CINAHL Plus, Humanities International Complete and MEDLINE), PsychINFO and Google Scholar. Search terms included synonyms for child welfare (child protection, welfare, looked-after children, out-of-home care, foster care, vulnerable youth), mental health (wellbeing, psychological health, emotional health, CAMHS) and effective (efficacious treatment, successful, positive, enabler, benefit). The search range covered the years 2005 to 2023 and focused on peer-reviewed articles written in English.

A narrative review is a synthesis of the major themes identified in the literature via a search strategy with wide inclusion criteria. It is not a systematic review, which typically has a narrower focus, and problematically, may reproduce the western hegemony within academia by privileging certain types of studies through a colonial academic lens (Hapeta et al., 2019). We were particularly interested in qualitative research that included the perspectives of care-experienced young people, and have prioritised inclusion of local research, especially Kaupapa Māori (by Māori, for Māori) research, in recognition of the relevance of this topic for Māori. Using the search process described above to identify the key themes, primarily based on international literature given the lack of local research on this specific topic, each theme was considered for application in Aotearoa New Zealand with supporting literature for how each principle may align with Māori theory and research.

Findings

Our review of the literature identified six key principles when working with care-experienced young people. These include: the importance of a trusting therapeutic relationship; service flexibility; providing choice and promoting youth autonomy; systemic support; and attentiveness during periods of transition. Each principle can be understood within a holistic ethic of care that values responsivity, recognises the mana (self-agency and prestige) of each young person, and values genuine care at the heart of all mental health support. “Care is at the heart of the Māori values system and calls upon humans to be kaitiaki, caretakers of the mauri, the life principle, in each other” (Spiller et al., 2011, p. 155).

The importance of a trusting therapeutic relationship

The quality of the relationship between a young person and their clinician is routinely identified as critical for positive engagement, retention, and outcomes with CAMHS (Munford & Sanders, 2016; Schley et al., 2011). The therapeutic relationship is particularly important for care-experienced young people (Almqvist & Lassinantti, 2018; Butterworth et al., 2017) and can be difficult to establish due to young people’s history of relationship ruptures, difficulties in forming attachments, and mistrust of institutions and services (Andrew et al., 2014). Therefore, clinicians must invest time and effort into establishing a trusting and authentic relationship when working with care-experienced young people.

Specific aspects of the therapeutic relationship that are important for care-experienced young people include trust, genuineness, persistence, and collaboration. Many of these young people have experiences of plans not working out, broken promises, and lack of transparency in decisions made for them (Toros, 2020). It is important for clinicians to do what they say they will, and to be honest about changes in the plan. Once trust has been broken, it is very difficult for care-experienced young people to trust again, and this may result in them choosing to disengage from CAMHS (Butterworth et al., 2017).

Trust is built through the therapeutic relational style, appropriate clinician self-disclosure, and clinician persistence. Many care-experienced young people prefer an informal, authentic relational style that reduces power differentials between them and the clinician (Munford & Sanders, 2016). The literature on relational styles with care-experienced youth and with rangatahi Māori (Māori youth) is aligned. Hamley et al. (2023) discussed the importance of developing genuine connections with rangatahi Māori that occur outside of formal clinic processes. McClintock and McClintock (2018) explained the importance of clinician self-disclosure through whakawhanaungatanga for whānau Māori to engage with CAMHS. *Whakawhanaungatanga* is a term which implies building connections with both kin and non-kin and where clients and clinicians can develop whānau-like relationships. The power differential can be reduced through the clinician acting with humility and the Samoan concept of attending to the vā, the relational space between clinician and young person (Bush et al., 2009).

Due to their histories of relational trauma, many care-experienced young people also behave in ways that put pressure on the therapeutic relationship (Ryall et al., 2008). This can include young people testing the strength of clinician commitment in the early phase by being argumentative or even hostile towards the clinician (Auslander et al., 2017). The young person may test professionals to see if they 'truly' care (Malvaso et al., 2016). Trust is built by the clinician persisting with the young person and seeing the behaviour within the context of their history of relational disruption and mistrust of services. Again, literature on working with rangatahi Māori has similar findings, with the intergenerational effects of white supremacy and colonial healthcare systems (Human Rights Commission, 2022) impacting on how trusting whānau Māori are of mainstream CAMHS (Latimer et al., 2022). Hamley et al. (2023) encouraged clinicians to see these young people in the context of these experiences and provide extra time for engagement in ways that work for the young person, rather than what works for the service.

Flexibility

Another aspect of effective practice is the flexibility of the service and the clinician. Service flexibility includes the potential to meet outside of the clinic and within a young person's community (Schley et al., 2011) and being adaptable with appointment times (Connolly & Joly, 2012). Drop-in clinics may be useful for care-experienced young people to access help when they need it (Almqvist & Lassinantti, 2018). Hamley et al. (2023) developed the *Te Tapatoru* model of service engagement with rangatahi Māori. They challenged CAMHS to step outside standard forms of engagement practices that are rooted in the dominant medical model, to be innovative and creative and meet rangatahi in ways that work best for Māori.

Smith and Appleby (2021) described the dual processes of chronic underfunding of mental health services in Aotearoa New Zealand and the increased focus on standardised clinic-based brief interventions within mental health services to manage service demand, highlighting the inequities this can reproduce for people with complex problems. They suggested that mental health teams should be resourced to have greater flexibility in how services are provided.

In Aotearoa New Zealand, CAMHS service specifications promote the use of flexible appointment venues and times (Ministry of Health, 2017); however, there are many aspects of CAMHS services that are not set up to be user friendly. Services tend to be conditional, with young people expected to keep appointments and be available on certain days or to abide by certain service expectations. CAMHS often have protocols of closing cases after a set number of missed appointments. Almqvist and Lassinantti (2018) argued that this approach is designed to meet the needs of the service, rather than the needs of the young people. The high degree of structure within services is often a mismatch for the unstructured lives of young people in care and those leaving care, many of whom experience frequent placement changes (Malvaso et al., 2016). Edwards (2007) suggested greater tolerance from services about non-attendance, a revision of policies around when cases are closed after non-attendance, and proactive follow-up by CAMHS. Smith and Appleby (2021) advocated for "adequate funding so that mental health services can move from a business model to a recovery model" (p. 64), which could support CAMHS clinicians to practise responsively with care-experienced young people.

Tarren-Sweeney and Vetere (2014) made a strong case for developing CAMHS teams specifically for care-experienced young people, rather than trying to make existing models fit for these young people. Lobatto (2021) described a specialist service in London for care-experienced young people that offers significant flexibility regarding time frames for engagement and meeting with young people in their homes and communities. This approach is similar to the Pasifika CAMHS service established in Porirua (Bush et al., 2009). This service demonstrates a move away from the medical model of discharge after a set number of missed appointments, and instead provides holistic care where clinicians can be agile and responsive to the ever-changing dynamics inherent in this work.

Autonomy and choice

Often, care-experienced young people are not offered choices by CAMHS clinicians (Tatlow-Golden & McElvaney, 2015) or by child welfare social workers (Toros, 2020). Jee et al. (2014) suggested that autonomy was particularly important for care-experienced youth, many of whom felt they had little choice in life and had experiences of child welfare decisions being made *for* them rather than *with* them. Jee et al. (2014) recommended creating opportunities for young people to assert their autonomy and make choices about their involvement with CAMHS.

Young people value autonomy as both part of the therapeutic process, and as an outcome from mental health service input (Lavik et al., 2018). In Aotearoa New Zealand, care-experienced young people have emphasised the importance of services supporting their active participation in decisions that affect them, and challenging services to demonstrate genuine commitment to them through giving time, space, aroha (love) and care to nurture the conditions for full participation (Te Rōpu Arotahi, 2022).

Systemic support

Systemic support is especially important for care-experienced young people (Andrew et al., 2014). Schley et al. (2011) suggested that CAMHS clinicians should provide consultation to the people or services in the environment surrounding a young person, including GPs, school counsellors, caregivers, foster carers, and social workers, a view which is also supported by the Ministry of Health (2017). Caregivers often require CAMHS support to manage the behavioural and emotional issues of young people in their care (Beck, 2006a). These relationships may be complicated by short-term placements and carers having poor mental health knowledge. However, foster carers have reported feeling that CAMHS providers did not listen to them and that they were excluded from treatment plans and interventions (York & Jones, 2017).

Beck (2006b) suggested enhancing placement stability is a key part of the CAMHS role, rather than being silo-ed to the exclusive domain of Oranga Tamariki. Recent studies found that increased CAMHS input, particularly clinicians consulting with child welfare staff and caregivers, resulted in more placement stability for young people which, in turn, contributed to more stable mental health (Lidchi & Wiener, 2020; Lobatto, 2021). Systemic support is also possible in the absence of direct work with a young person. Systemic models are discussed further in our first article about interventions, including the THRIVE model (Wolpert et al., 2019).

From a Māori lens, all things are interconnected, and individual wellbeing is sustained through whānau wellbeing, alongside physical, emotional, and spiritual health (Durie, 1998). This approach encourages practitioners to understand rangatahi Māori within the context of their collective identity within whānau, whakapapa (genealogy), and whenua (land) (Pitama et al., 2017; Wilson et al., 2021). Māori models of relational care are systemic in nature, emphasising whānau-centred practice and holistic care.

Interagency collaboration

Supporting young people who are involved in both CAMHS and Oranga Tamariki requires effective interagency collaboration (Oranga Tamariki, 2023). The literature clearly underscores the need for good working relationships between CAMHS and child welfare systems to improve CAMHS access and contribute to good mental health outcomes for young people (Appleby et al., 2019; Malvaso et al., 2016).

Street and Davies (2002) discussed the philosophical differences that can exist between CAMHS and child welfare professionals. CAMHS clinicians may believe that child welfare staff blame a child for the problems that lie within the care system, while child welfare staff can become frustrated at CAMHS when they require placement stability before intervening. These differences can impact on the care that young people receive and are best mediated through opportunities for services to talk to each other and create shared understandings of young people. In Aotearoa New Zealand, liaison roles between Oranga Tamariki and mental health services have been established to help combat these difficulties (Oranga Tamariki, 2023). Maintaining effective interagency relationships is particularly important for complex cases, where there can be a tendency for the professional community to experience projective identification of a young person’s anxiety and unpredictability (McElvaney & Tatlow-Golden, 2016) and to replicate family patterns of conflict (Lobatto, 2021). Interagency collaboration seems to work best when service leaders encourage collaboration, when collaborative efforts are visible and rewarded within service systems, and when there are many opportunities for services to see each other and share information (He et al., 2015).

Golding (2010) noted that collaboration requires time and is difficult to do well within services with high demand and pressure to move young people through the service. This is particularly problematic when services do not have the means to measure collaboration as activity data. It takes time to build relationships between services and engage in meaningful interagency liaison, so it is important for clinicians and service managers to factor in the time required to collaborate well.

Managing transitions

Periods of transition pose significant challenges for care-experienced young people. These include transitions between placements (Beck, 2006b), in and out of CAMHS care (Munford & Sanders, 2016), and transitioning out of child welfare care (Curry, 2020).

The issue of placement stability can be an area of contention between CAMHS and child welfare services. Placement stability is often a prerequisite for CAMHS involvement (Rayment et al., 2014). However, many young people experience multiple placements, and those who do, tend to have higher mental health needs (Garcia et al., 2015; Munford & Sanders, 2015). This presents a catch-22 for some of the most vulnerable young people. It may be that their untreated mental health issues contribute to placement instability, and yet CAMHS input may not be available until they are in a stable placement (Chambers, 2014). Delays in obtaining CAMHS input while placements are stabilised may also result in deterioration of mental health (McAuley & Young, 2006).

Placement stability affects therapy, as a young person's anxiety about their unpredictable living situation makes it difficult for them to reflect on their life experiences. However, Edwards (2007) proposed that there can be other CAMHS interventions for those in unstable placements, such as therapy that focuses on the here and now with an emphasis on learning coping skills. Beck (2006b) also argued that the CAMHS model needs to be adjusted to meet the needs of these young people who move frequently. They suggested that CAMHS interventions should aim to stabilise placements and that CAMHS outreach services are developed that can cross geographical borders, avoiding multiple transfers of care between different CAMHS. Lobatto (2021) described a CAMHS team specifically for care-experienced young people that can follow young people as they move within London, providing mental health service stability despite placement instability.

The period of transition out of care can be very stressful for young people who 'age out' of Oranga Tamariki care (Klodnick & Samuels, 2020). Many of these young people are not well equipped to deal with daily living tasks and may not have family support. Their difficulties may be exacerbated by no longer being eligible for services that may drop off once they turn 17 or 18 years old. This can be a very stressful time for adolescents, particularly those who have been in out-of-home care and may have been looking forward to emancipation for some time. It is often an accelerated and compressed transition into adulthood (Munford & Sanders, 2015).

The reality of being fully independent is often a struggle (Malvaso et al., 2016). It is important for clinicians to be aware of the impact of care transitions on young people's mental health (York & Jones, 2017). Care-leavers have indicated that it would be helpful for CAMHS input to extend beyond the child welfare transition to provide continuity of mental health care at a time when the young person may feel abandoned and isolated (Butterworth et al., 2017). In recognition of this, Oranga Tamariki has extended the upper age limit of their involvement, and the Ministry of Health (2023) is in the process of system transformation to extend upper age limits in recognition of the mental health needs of emerging adults.

Discussion

In reviewing the existing literature, clear themes about effective mental health practice with care-experienced young people can be identified. At the same time, there are significant gaps in the literature around intersectional considerations for this population. Building on these findings, we present a set of practice principles that can be understood within a wider context including intersectional considerations of discrimination and ideological influences on service funding and design. The principles of relationships, flexibility, autonomy and choice, systemic support, interagency collaboration, and managing transitions are based on the foundation of an ethic of care. This approach can be used across any therapeutic intervention or clinical presentation and has applicability in other settings with care-experienced young people.

Ethic of care

The practice approaches and principles described above can be understood within an ethic of care based on the belief that humans are not autonomous and independent, but rather are interdependent, all relying on others for care (Barnes, 2012). Spiller et al. (2010) connected an ethic of care with Māori values of manaaki (care), aroha (love), hau (promoting vitality), kaitiakitanga (guardianship), and hāpai (uplifting others). This embodies the first practice principle of the centrality of the therapeutic relationship, recognising the reciprocity within that relationship, alongside the importance of systemic support and interagency collaboration. An ethic of care is holistic, contextual, need-centred and involves empathy (Botes, 2000). This aligns with the principles on flexibility, promoting choice, and understanding the impact of transitions for those with relational trauma.

Within mental health services, an ethic of care has been compared to an ethic of justice (Barnes, 2012; Botes, 2000). An ethic of justice is focused on universal principles and fairness for all, and is rooted in positivism (Botes, 2000). In the interests of creating fair and equal outcomes, standardised procedures are applied, which Barnes (2012) suggested results in a distanced and impersonal service. In CAMHS, this may look like standardised packages of care for a certain number of treatment sessions, and the service requirement to discharge a young person from CAMHS after a set number of missed appointments. However, an ethic of care in CAMHS practice may involve a prolonged engagement phase with a tailored flexible package of care. An ethic of care has been connected with social work values, with a focus on the process of *being with* people (Collins, 2018). Hay (2019) has suggested that neoliberalism has pushed care to the periphery of social work practice. Social workers who engage in an ethic of care are actively resisting neoliberal organisational ideologies that are not client-centred (Barnes, 2012). This perspective supports the critiques of the Choice and Partnership Approach as a disguise for neoliberalism in CAMHS (Johnstone et al., 2022). Operating within an ethic of care ensures that the young person is kept at the centre of service provision. An ethic of care orients CAMHS clinicians to consider how best to respond to the unique needs of a care-experienced young person, rather than focusing on the limits of standard practice.

Intersectional considerations

Intersectional considerations of racism, poverty, and disability appear to be missing from the literature on mental health support for care-experienced young people. Intersectionality involves an understanding of intersecting inequities (Crenshaw, 1991) and how these impact on mental health service accessibility. For care-experienced young people, this often includes racism, poverty, and disability (Oranga Tamariki, 2023) alongside the stigma associated with being in care and having mental health needs.

In Aotearoa New Zealand, Māori are overrepresented in Oranga Tamariki involvement and mental health need (Oranga Tamariki, 2023). Therefore, it is imperative that cultural considerations are included as part of an intersectional approach to practice. The Māori concept of whakawhanaungatanga aligns with the relational style endorsed in the literature on working with care-experienced youth. This approach involves a genuine connection between clinician and rangatahi. Additionally, it is important that all CAMHS clinicians develop formulations with rangatahi Māori in a way that recognises the impact of colonisation and racism on their clinical presentation (Pitama et al., 2017) while also actively resisting the colonialism inherent in all mainstream CAMHS (Latimer et al., 2022).

The therapeutic relationship should also be attuned to the developmental and cognitive level of the young person, recognising the overrepresentation of young people with disabilities within this population (Oranga Tamariki, 2023). This includes providing services that are physically accessible and using developmentally appropriate language. Service accessibility is also important when considering how best to engage with care-experienced young people who experience poverty, frequent placement changes and homelessness. For Māori care leavers who are experiencing poverty and disability, the lack of financial resources, stable housing, or ability to purchase additional therapeutic support or disability support this likely has a cumulative negative impact.

Intersectional considerations also apply outside of the Aotearoa New Zealand context. The principles may be applied to other Indigenous groups, particularly those who have experienced colonisation, oppression, and marginalisation. Clinicians must be conscious of the intersecting inequities these young people face and offer tailored and sensitive mental health support.

Service-level considerations

Mental health service structures can help or hinder effective practice with this population. Systemic practice is essential with care-experienced young people, requiring time for clinicians to provide support to the system surrounding the young person, including family, carers, and child welfare staff. Collaboration between CAMHS and child welfare is essential and can also be very difficult, requiring investment into building relationships and shared understanding (Appleby et al., 2019). There needs to be CAMHS service-level support for collaborative systemic approaches. It is not feasible for an individual clinician to do this well within rigid service structures that do not account for the time required for interagency liaison.

There is also a challenge for CAMHS service structures to respond to the need for extra support for care-experienced young people during periods of transition. This may mean service reform to respond flexibly for young people moving between geographical areas and aging out of care. This has already been done in some overseas specialty services (Lidchi & Weiner, 2020; Lobatto, 2021). The recent Ministry of Health (2023) *System and Service Framework* outlined plans to increase youth mental health services in Aotearoa New Zealand up to the age of 25, which aligns with the needs of care-experienced young people. These plans require significant support to expand the current workforce beyond just filling the widespread vacancies within CAMHS teams.

Effective mental health services are agile in responding to mental health need, with clinicians able to use discretion and professional judgement in how best to engage and work with young people. This level of responsiveness is resource-intensive, requiring dedicated time to invest in interagency collaboration, and flexibility to extend care beyond traditional age and geographic area limits. However, this service model is not aligned with most current funding models (Tarren-Sweeney & Vetere, 2014).

Influence of political ideology

CAMHS funding structures have developed in the context of neoliberal political ideology with a focus on efficiency (Barnett & Bagshaw, 2020). Neoliberalism has also contributed to the deprofessionalisation of CAMHS clinicians, with less autonomy and discretion available in clinical decision-making (Clark, 2005). When considering Bote’s (2000) discussion about the ethic of care (responsivity) versus the ethic of justice (standardisation), the economic and political context has influenced services to operate primarily within an ethic of justice, with little discretionary funding to apply more individualised and responsive interventions outside of standardised packages of care. Care itself has also developed in the context of neoliberalism, with many services contracted out and young people expected to assume self responsibility the moment they hit 18 years old. This contributes to the experience of poor mental health in and of itself.

Conversely, there has been a stated commitment by the Ministry of Health (2023) to prioritise recovery-oriented approaches that are tailored, located in the community, and responsive to the needs of the community. These are aligned with policies to reduce health disparities for Māori through promoting Kaupapa Māori approaches to mental health and wellbeing. The principles presented in this article are aligned with Māori concepts of relational care (Wilson et al., 2021). However, the Ministry's strategic vision for mental health services is not matched by adequate funding, creating a barrier for CAMHS to adopt an ethic of care.

Clinical social work role

The practice principles align with social work values of anti-discriminatory and systemic practice (International Federation of Social Workers, 2021). Continued social work presence and influence in multidisciplinary CAMHS teams is an important part of enacting these principles in practice. Critical clinical social workers acknowledge the power that they have as clinicians (Brown, 2021) and recognise how social workers have contributed to the problems facing care-experienced young people through racist practice in Oranga Tamariki and removing children from their whānau (Hyslop, 2022). Clinical social workers within CAMHS offer nuanced understanding of trauma-informed care, including the trauma of colonisation, racism, and discrimination (Appleby et al., 2024b).

Ferguson et al. (2020) discussed the concept of a *holding relationship*, a responsive and reliable relationship-based approach where social workers practise ethically with awareness of power and inequalities, persisting and responding empathically to families who may initially be mistrusting and hostile towards services. This approach can be applied to CAMHS practice with care-experienced young people. Social workers are trained to understand young people's mistrust and hostility in the context of relational disruption, experiences of discrimination and limited opportunities to participate meaningful in decision-making affecting them. The theory base for social work practice provides a way of understanding a young person in the context of their social, cultural, and political environment, with awareness of intersectional power and discrimination.

The social work knowledge base is compatible with an ethic of care and with the Ministry of Health's (2023) vision for a recovery model of mental health practice, which offers an alternative to the deficit-based medical model that has not served care-experienced young people well (Oranga Tamariki, 2023; Tarren-Sweeney & Vetere, 2014). Social workers bring specialised understanding of care-experienced young people with potential to positively influence practice at all levels of service planning, funding, and design.

Limitations

This article contributes to the conversation about mental health support for care-experienced young people by presenting principles that can inform CAMHS clinical practice. There are also some cautions to keep in mind in this developing area. While some research with Māori is included in this review, there is a lack of Indigenous-led research on youth mental health, reflecting the dominant monocultural perspective within academic literature. This is a significant limitation given the cultural context of relational practice, especially when considering the over-representation of Indigenous children in state care and facing mental health difficulties (Ralph & Ryan, 2017).

The scope of this review is limited to general approaches to mental health care for care-experienced young people, their family and wider support system. It does not include macro-level interventions targeting the significant contributors to mental health issues for this population, such as preventative community work, interventions to reduce societal and institutional discrimination, child protection policies that enhance placement stability and promote wellbeing, or government policies aimed at reducing poverty and homelessness. Further research into these macro-level interventions could improve knowledge of how governmental policies can influence the mental health and wellbeing of care-experienced young people.

Implications for practice and policy

Care-experienced young people face significant mental health challenges. CAMHS teams have not met these needs well, operating within a medical model that has not taken into consideration the unique needs of this population (Oranga Tamariki, 2023). In this article we have presented practice principles that highlight what CAMHS teams should consider when working with care-experienced youth. Effective practice with care-experienced young people requires significant time investment for engagement, intervention, multi-agency work and transition, which relies on a mental health service structure and leadership that supports this use of clinician time.

From the literature, the following recommendations are made for CAMHS clinicians:

- Actively nurture a therapeutic relationship with care-experienced young people that is authentic and built on foundations of trust and transparency.
- Have a flexible approach to engagement and interventions and be willing to see the young person in community settings, outside of the clinic.
- Offer young people opportunities for decision-making in their treatment.
- Think systemically about a young person and provide support to their wider support system.
- Practise from an ethic of care that is holistic. Mental health care should be tailored to the young person, considering their culture, development, and experiences of trauma and discrimination.

Service-level recommendations to enable CAMHS clinicians to practice from a responsive ethic of care include:

- Adequate funding for CAMHS teams to provide responsive care. Resourcing is required for smaller caseloads, travel time to move from a clinic-based medical model, time for interagency liaison, and resourcing to work with families and caregivers alongside any individual work with young people.
- Consideration of how CAMHS teams may provide continuity of care for young people in periods of transitions, including geographical moves out of service catchment areas. Mental health services that can stay involved throughout these transitions offer continuity of care and can help with placement stabilisation.
- Aligned with the strategic direction of the Ministry of Health (2023), there should also be consideration of extending upper-age limits for CAMHS to support young people aging out of care and facing additional transition-related mental health difficulties.
- Development of specialist teams within CAMHS that work with care-experienced young people to ensure equitable mental health support for this population.

Conclusion

This literature review addresses the disparity between the recognised need for effective mental health support for care-experienced young people, and the limitations of CAMHS practice with this population. Care-experienced young people are more likely to be Māori, to come from underserved communities, and to experience intersecting inequities related to racism, disability, and poverty. Anti-discriminatory practice needs to be a feature of therapeutic work with this population, despite intersectional considerations missing from much of the existing literature.

Principles framed within an ethic of care are presented as an alternative approach for mental health services. CAMHS clinicians can nurture the therapeutic relationship in culturally appropriate ways, practise with flexibility, provide opportunities for young people to make choices, work with the whole system around a young person, provide extra support at periods of transition, and practise from a youth-centred, holistic ethic of care. This practice approach requires philosophical and financial support for the CAMHS sector to rise to the challenge of providing equitable and responsive mental health care.

Received: 5 July 2023

Accepted: 8 May 2024

Published: 15 June 2024

References

Almqvist, A., & Lassinantti, K. (2018). Social work practices for young people with complex needs: an integrative review. *Child and Adolescent Social Work Journal, 35*, 207–219. https://doi.org/10.1007/s10560-017-0522-4

Andrew, E., Williams, J., & Waters, C. (2014). Dialectical behaviour therapy and attachment: Vehicles for the development of resilience in young people leaving the care system. *Clinical Child Psychology and Psychiatry, 19*(4), 503–515. https://doi.org/10.1177/1359104513508964 ccp.sagepub.com

Appleby, J., Staniforth, B., Kemp, S. P., & Connor, H. (2024a). What interventions can CAMHS provide for young people involved with Oranga Tamariki? A review of the literature. *Aotearoa New Zealand Social Work.* 36(2)forthcoming

Appleby, J., Cox, K., Black, K., & Marsh, N. (2024b). Social work formulation: Principles and strategies for mental health social workers in Aotearoa New Zealand. *Aotearoa New Zealand Social Work*, *36*(1), 75–88.

Appleby, J., Shepherd, M., & Staniforth, B. (2019). Speaking the same language: Navigating information-sharing in the youth justice sphere. *Aotearoa New Zealand Social Work, 31*(1), 59–71. https://doi.org/10.11157/anzswj-vol31iss1id537

Auslander, W., McGinnis, H., Tlapek, S., Smith, P., Foster, A., Edmond, T., & Dunn, J. (2017). Adaptation and implementation of a trauma-focused cognitive behavioural intervention for girls in child welfare. *American Journal of Orthopsychiatry, 87*(3), 206–215. https://doi.org/10.1037/ort0000233

Baker, A. J. L., Schneiderman, M., & Licandro, M. (2017). Mental health referrals and treatment in a sample of youth in foster care. *Children and Youth Services Review, 78*, 18–22. https://doi.org/10.1016/j.childyouth.2017.04.020

Barnes, V. (2012). Social work and advocacy with young people: rights and care in practice. *British Journal of Social Work, 42*, 1275–1292. https://doi.org/10.1093/bjsw/bcrl4z

Barnett, P., & Bagshaw, P. (2020). Neoliberalism: What it is, how it affects health and what to do about it. *The New Zealand Medical Journal, 133*(1512), 76–84.

Beck, A. (2006a). Users' views of looked after children's mental health services. *Adoption and Fostering, 30*(2), 53–63.

Beck, A. (2006b). Addressing the mental health needs of looked after children who move placement frequently. *Adoption and Fostering, 30*(3), 60–65.

Botes, A. (2000). A comparison between the ethics of justice and the ethics of care. *Journal of Advanced Nursing, 32*(5), 1071–1075.

Brown, C. (2021). Critical clinical social work and the neoliberal constraints on social justice in mental health. *Research on Social Work Practice, 31*(6), 644–652. https://doi.org/10.1177/1049731520984531

Bush, A., Chapman, F., Drummond, M., & Fagaloa, T. (2009). Development of a child, adolescent and family mental health service for Pacific young people in Aotearoa/New Zealand. *Pacific Health Dialog, 15*(1), 138–146.

Butterworth, S., Singh, S. P., Birchwood, M., Islam, Z., Munro, E. M., Vostanis, P., Paul, M., Khan, A., & Simkiss, D. (2017). Transitioning care-leavers with mental health needs: "They set you up to fail!" *Child and Adolescent Mental Health, 22*(3), 138–147. https://doi.org/10.1111/camh.12171

Chambers, M. (2014). The experience of a CAMHS service for children in care. In A. Vetere & M. Tarren-Sweeney (Eds.), *Mental health services for vulnerable children and young people: Supporting children who are, or have been, in foster care* (pp. 104–159). Routledge.

Clark, C. (2005). The deprofessionalisation thesis, accountability and professional character. *Social Work and Society, 3*(2), 182–190.

Collins, S. (2018). Ethics of care and statutory social work in the UK: Critical perspectives and strengths. *Practice, 30*(1), 3–18. https://doi.org/10.1080/09503153.2017.1339787

Connolly, J. A., & Joly, L. E. (2012). Outreach with street-involved youth: A quantitative and qualitative review of the literature. *Clinical Psychology Review*, *32*(6), 524-534. https://doi.org/https://doi.org/10.1016/j.cpr.2012.05.006

Coulter, S., Mooney, S., MacDonald, M., & Daly, L. (2022). "They shouldn't have to ask": Exploring the need for specialist mental health services for care experienced and adopted children and their families. *Adoption & Fostering 46*(2), 166–183. https://doi.org/10.1177/03085759221094357

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299.

Curry, A. (2020). Envisioning a reflective, relationship-based approach to termination in child welfare: The importance of thinking, feeling, and doing. *Child and Youth Services Review, 117*. https://doi.org/10.1016/j.childyouth.2020.105201

Durie, M. (1998). Whaiora: Maoāri health development (2nd ed.. ed.). Oxford University Press

Edwards, V. (2007). Therapeutic issues in working individually with vulnerable children and young people. In P. Vostanis (Ed.), *Mental health interventions and services for vulnerable children and young people* (pp. 99–109). Jessica Kingsley Publishers.

Ferguson, H., Warwick, L., Disney, T., Leigh, J., Singh Cooner, T., & Beddoe, L. (2020). Relationship-based practice and the creation of therapeutic change in long-term work: social work as a holding relationship. *Social Work Education*. https://doi.org/10.1080/02615479.2020.1837105.

Fleming, T., Archer, D., King-Finau, T., Fenaughty, J., Tiatia-Seath, J., & Clark, T.C., (2021). *Young people who have been involved with Oranga Tamariki: Identity and culture*. https://www.youth19.ac.nz/publications/young-people-involved-with-oranga-tamariki-identity

Garcia, A.R., Circo, E., DeNard, C., & Hernandez, N. (2015). Barriers and facilitators to delivering effective mental health practice strategies for youth and families served by the child welfare system. *Children and Youth Services Review, 52*, 110–122. http://dx.doi.org/10.1016/j.childyouth.2015.03.008

Glisson, C., & Green, P. (2006). The effects of organizational cultural and climate on the access to mental health care in child welfare and juvenile justice systems. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(4), 433–448. https://doi.org/10.1007/s10488-005-0016-0

Golding, K. S. (2010). Multi-agency and specialist working to meet the mental health needs of children in care and adopted. *Clinical Child Psychology and Psychiatry, 15*(4) 573–587. https://doi.org/10.1177/1359104510375933.

Golm, D. (2023). A call to action: The need for routine mental health support for care-experienced children and young people. *Adoption & Fostering, 47*(2), 115–119. https://doi.org/10.1177/03085759231182442

Hamley, L., Le Grice, J., Greaves, L., Groot, S., Latimer, C.L., Renfrew, L., Parkison, H., Gillon, A., & Clark, T.C. (2023). Te Tapatoru: A model of whanaungatanga to support rangatahi wellbeing. *Kōtuitui: New Zealand Journal of Social Sciences Online, 18*(2), 171–194. https://doi.org/10.1080/1177083X.2022.2109492

Hapeta, J., Palmer, F., Kuroda, Y., & Hermansson, G. (2019). A Kaupapa Māori, culturally progressive, narrative review of literature on sport, ethnicity and inclusion. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *14*(2), 209–229. https://doi.org/10.1080/1177083X.2019.1600558

Hay, J. (2019). “Care is not a dirty word!” Enacting an ethic of care in social work practice. *European Journal of Social Work, 22*(3), 365–375. https://doi.org/10.1080/13691457.2017.139925

He, A. S., Lim, C. S., Lecklitner, G., Olson, A., & Traube, D. E. (2015). Interagency collaboration and identifying mental health needs in child welfare: Findings from Los Angeles County. *Children and Youth Services Review, 53*, 39–43. https://doi.org/10.1016/j.childyouth.2015.03.013

Human Rights Commission. (2022). *Maranga Mai!* https://tikatangata.org.nz/our-work/maranga-mai

Hyslop, I. (2022). *A political history of child protection: Lessons for reform from Aotearoa New Zealand.* Bristol University Press.

International Federation of Social Workers. (2021). *Global definition of social work*. https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

Jee, S. H., Conn, A., Toth, S., Szilagyi, M. A., & Chin, N. P. (2014). Mental health treatment experiences and expectations in foster care: A qualitative investigation. *Journal of Public Child Welfare, 8*(5), 539–559. https://doi.org/10.1080/15548732.2014.931831

Johnstone, M., Brown, C., & Ross, N. (2022). The McDonaldization of social work: A critical analysis of mental health care services using the choice and partnership approach (CAPA) in Canada. *Journal of Progressive Human Services, 33*(3), 223–243. https://doi.org/10.1080/10428232.2022.2050117

Kerker, B., & Dore, M. (2006). Mental health needs and treatment of foster youth: Barriers and opportunities. *American Journal of Orthopsychiatry, 76*, 138–147. https://doi.org/10.1037/0002-9432.76.1.138

Klodnick, V. V., & Samuels, G. M. (2020). Building home on a fault line: Aging out of child welfare with a serious mental health diagnosis. *Child & Family Social Work*, *25*(3), 704-713. https://doi.org/https://doi.org/10.1111/cfs.12747

Latimer, C. L., Le Grice, J., Hamley, L., Greaves, L., Gillon, A., Groot, S., Manchi, M., Renfrew, L., & Clark, T. C. (2022). “Why would you give your children to something you don’t trust?” Rangatahi health and social services and the pursuit of tino rangatiratanga. *Kōtuitui: New Zealand Journal of Social Sciences Online, 17*(3), 298–312. https://doi.org/10.1080/1177083X.2021.1993938

Lavik, K. O., Veseth, M., Frøysa, H., Binder, P., & Moltu, C. (2018). What are “good outcomes” for adolescents in public mental health settings? *International Journal of Mental Health Systems, 12*(3), 1–10. https://doi.org/10.1186/s13033-018-0183-5

Lidchi, V., & Wiener, A. (2020). How can services be improved to effectively address the mental health of vulnerable children and young people? *Child Abuse & Neglect*. https://doi.org/10.1016/j.chiabu.2020.104648

Lobatto, W. (2021). Using systemic principles in the design of mental health and wellbeing services for looked after children and young people: Bringing together research, theory and practice. *Journal of Family Therapy,* 1– 20. https://doi.org/10.1111/1467-6427.12351

Malvaso, C., Delfabbro, P., Hackett, L., & Mills, H. (2016). Service approaches to young people with complex needs leaving out-of-home care. *Child Care in Practice, 22*(2), 128–147. https://doi.org/10.1080/13575279.2015.1118016

McAuley, C., & Young, C. (2006). The mental health of looked after children: Challenges for CAMHS provision. *Journal of Social Work Practice, 20*(1), 91–103. https://doi.org/10.1080/02650530600566157

McClintock, K., & McClintock, R. (2018). *Tuku iho, tuku iho, culture in Māori health service provision*. https://terauora.com/wp-content/uploads/2019/05/Tuku-Iho-Tuku-Iho.pdf

McElvaney, R., & Tatlow-Golden, M. (2016). A traumatised and traumatising system: professionals' experiences in meeting the mental health needs of young people in the care and youth justice systems in Ireland. *Children and Youth Services Review, 65*, 62–69. https://doi.org/10.1016/j.childyouth.2016.03.017

Ministry of Health. (2017). *Infant, child, adolescent and youth mental health tier two service specification.* https://www.tewhatuora.govt.nz/our-health-system/nationwide-service-framework-library/about-nationwide-service-specifications/mental-health-and-addiction-service-specifications/infant-child-adolescent-and-youth-mental-health/

Ministry of Health. (2023). *Oranga Hinengaro System and Service Framework*. https://www.health.govt.nz/system/files/documents/publications/oranga-hinengaro-system-and-service-framework-apr23.pdf.

Munford, R., & Sanders, J. (2015). Components of effective social work practice in mental health for young people who are users of multiple services. *Social Work in Mental Health, 13*(5), 415–438. https://doi.org/10.1080/15332985.2014.959239

Munford, R., & Sanders, J. (2016). Understanding service engagement: Young people's experience of service use. *Journal of Social Work, 16*(3), 282–302. https://doi.org/10.1177/1468017315569676

Oranga Tamariki. (2022). *Oranga Tamariki Action Plan.* https://orangatamarikiactionplan.govt.nz/assets/Action-Plan/Uploads/Resources/Publications/Oranga-Tamariki-Action-Plan.pdf

Oranga Tamariki. (2023). *Mental health and wellbeing needs of children and young people involved with Oranga Tamariki.* https://www.orangatamarikiactionplan.govt.nz/assets/Action-Plan/Uploads/Understanding-need/Mental-health-and-wellbeing/OT-MW-Needs-Assessment_final-for-publication_Redacted.pdf

Pitama, S. G., Bennett, S. T., Waitoki, W., Haitana, T. N., Valentine, H., Pahina, J., Taylor, J. E., Tassell-Matamua, N., Rowe, L., Beckert, L., Palmer, S. C., Huria, T. M., Lacey, C. J. & McLachlan, A. (2017). A proposed hauora Māori clinical guide for psychologist using the hui process and meihana model in clinical assessment and formulation. *New Zealand Journal of Psychology, 46*(3), 7–19.

Ralph, S., & Ryan, K. (2017) Addressing the mental health gap in working with indigenous youth: some considerations for non-indigenous psychologists working with indigenous youth. *Australian Psychologist*, *52*(4), 288–298. https://doi.org/10.1111/ap.12287.

Rayment, P., Young, C., & Guidolin, M. (2014). Therapeutic interventions for traumatised children in the child protection system in South Australia: Matching the therapy to the child. *Developing Practice, 38*, 34–48.

Royal Inquiry into Abuse in Care. (2021). *He Purapura ora, he māra tipu*. https://www.abuseincare.org.nz/our-progress/reports/from-redress-to-puretumu/

Ryall, V., Radovini, S., Crothers, L., Schley, C., Fletcher, K., Nudds, S., & Groufsky, C. (2008). Intensive youth outreach in mental health: An integrated framework for understanding and intervention. *Social Work in Mental Health, 1*(3), 153–175. https://doi.org/10.1080/15332980802072512

Schley, C., Radovini, A., Halperin, S., & Fletcher, K. (2011). Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and "high-risk". *Children and Youth Services Review, 33*(9), 1506–1514. https://doi.org/10.1016.j/childyouth.2011.03.013

Smith, G., & Appleby, J. (2021). Social work practice implications of upcoming mental health reforms. *Aotearoa New Zealand Social Work, 33*(2), 61–65. https://doi.org/10.11157/anzswj-vol33iss2id868

Spiller, C., Erakovic, L., Henare, M., & Pio, E. (2011). Relational well-being and wealth: Māori business and an ethic of care. *Journal of Business Ethics, 98*, 153–169. https://doi.org/10.1007/s10551-010-0540-

Street, E., & Davies, M. (2002). Constructing mental health services for looked after children. *Adoption and Fostering, 26*(4), 65–75.

Tarren-Sweeney, M., & Vetere, A. (2014). Establishing the need for mental health services for children and young people in care, and those who are subsequently adopted. In M. Tarren-Sweeney & A. Vetere (Eds.), *Mental health services for vulnerable children and young people: Supporting children who are, or have been, in foster care* (pp. 17-34.) Routledge.

Tatlow-Golden, M., & McElvaney, R. (2015). A bit more understanding: Young adults' views of mental health services in care in Ireland. *Children and Youth Services Review, 51*, 1–9. https://doi.org/10.1016/j.childyouth.2015.01.014

Te Rōpū Arotahi. (2022). *Kia tika, kia pono – honouring truths: An ethical framework for engaging with children and young people who are care experienced*. https://voyce.org.nz/kiatikakiapono

Toros, K. (2021). A systematic review of children's participation in child protection decision-making: Tokenistic presence or not? *Children & Society*, *35*(3), 395–411. https://doi.org/10.1111/chso.12418

Wilson, D., Moloney, E., Parr, J.M. Aspinall, C., & Slark, J. (2021). Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing, 30*(23), 3539–3555. https://doi.org/10.1111/jocn.15859

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., & Munk, S. (2019). *THRIVE-Framework for system change*. www.implementingthrive.org.

York, W., & Jones, J. (2017). Addressing the mental health needs of looked after children in foster care: The experiences of foster carers. *Journal of Psychiatric and Mental Health Nursing, 24*, 143–153. https://doi.org/10.1111/jpn.12362

ORIGINAL ARTICLE
THEORETICAL RESEARCH

Hidden in plain sight: A critique

Mary James, Isabel Jamieson and **Kate Reid** Faculty of Health, University of Canterbury

ABSTRACT

INTRODUCTON: In 2020, the Health and Disability Sector Review (H&DSR) for Aotearoa New Zealand was published (Simpson, 2020). It called for widespread structural change and reform within the health and disability sector. As a response to this report, Allied Health Aotearoa New Zealand (AHANZ) sought advice from the New Zealand Institute of Economic Research (NZIER) as to how their membership could contribute to addressing the issues raised in the H&DSR (Simpson, 2020). The resultant report, *Hidden in plain sight (HiPS)* is the focus of this critique (Hogan, 2021).

APPROACH: An overview of *HiPS* (Hogan, 2021) is presented along with an analysis using a strengths, weaknesses, opportunities and threats (SWOT) framework. Some of the critique offered is from social work literature based on research conducted in Aotearoa New Zealand.

CONCLUSIONS: What becomes evident is: 1) that the proposed change is general practice-centric; and 2) *HiPS* has not considered the wealth of experience of interprofessional collaboration that is already occurring within the sector. What at face value appears a positive response to the proposal of the H&DSR lacks substance when subjected to robust analysis.

Keywords: Allied health, healthcare, interprofessional collaboration, model of practice, social work

Overview of *Hidden in plain sight*

To achieve more equitable health outcomes for all New Zealanders, the Health and Disability Sector Review (H&DSR) was commissioned in 2018 (Simpson, 2020). The review paid specific attention to the needs of Māori, Pacifica, those who have disabilities, and those who live rurally. It highlighted a shift in focus from treatment of illness to health and wellbeing. Following the release of the H&DSR (Simpson, 2020), Allied Health New Zealand (AHANZ) approached the New Zealand Institute of Economic Research (NZIER) seeking advice for members of the allied health professions to contribute to addressing the issues raised. *Hidden in plain sight* (*HiPS*) is the report produced in response to that request (Hogan, 2021).

This critique provides a brief overview of *HiPS* (Hogan, 2021) followed by a critique using a *strengths*, *weaknesses*, *opportunities* and *threats* (SWOT) framework. Hogan (2021) sought to explore how members of the allied health workforce can respond to the way healthcare is delivered in Aotearoa New Zealand. "Equity, effectiveness, efficiency and sustainability" are all key objectives to achieve in the delivery of care (Hogan, 2021, p. 1). Barriers in current models of care are identified, along with the risks that accompany making changes to the models of care. The proposed benefits of what might be possible should changes to the models of care be embraced are articulated. However, the only detail provided regarding current models of care is that of general practitioners (GPs) offering 15-minute consultations who

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 99–110.

CORRESPONDENCE TO:
Mary James
mary.james@pg.canterbury.ac.nz

are unable to provide "person-centred care needed for people with multiple long-term conditions, or even single conditions with complex biopsychosocial contributing factors" (Hogan, 2021, p. 6).

HiPS emphasised the role of GPs as the most prominent primary care providers, highlighting that the shifts occurring within the healthcare system are placing GPs under increasing workload pressure (Hogan, 2021). This pressure comes from a range of systemic sources which include: the devolution of some hospital services back to GPs; a move to more GPs working part time; 15-minute consultations that inhibit GPs' ability to provide holistic care; a lack of ability to refer patients to allied health practitioners where fees for services apply; a lack of ability to pay for GP services; and a lack of opportunity to see a GP which contributes to a lack of continuity of care. A consequence of this pressure is that there are people in the community whose healthcare needs are not being met (Hogan, 2021). Although *HiPS* maintains the central role of GPs as *care coordinators* due to their medical knowledge, it does recommend direct access to allied health professionals thereby reducing "GP control over access to allied health" (Hogan, 2021, p. 7).

After doctors and nurses, the allied health workforce across District Health Boards (now Te Whatu Ora) in Aotearoa New Zealand is described as the country's "second largest clinical workforce" comprising over 30,000 people (Hogan, 2021, p. 3). More than half of these professionals belong to professional bodies that are regulated by the Health Practitioners Competence Assurance Act (2003). The remainder belong to professional bodies that regulate the knowledge and skills of their membership. This regulation is designed to provide a level of protection and assurance for the public that the allied health professionals they work with are competent, fit and proper to provide an expected standard of knowledge and skills pertinent to their professional discipline. In the 2022 workforce survey, 1800 registered social workers identified as working for a government health organisation (Social Workers Registration Board, 2023, p. 16). This number does not include registered social workers working in the not-for-profit sector.

Throughout *HiPS*, an emphasis is given to a move to an interprofessional practice model of care delivery (Hogan, 2021). Interprofessional practice is defined as:

> … a professional behaviour that identifies and engages optimal use of each practitioner's skillset for each patient to provide comprehensive, coordinated, person and whānau-centred care. Interprofessional practice is flexible, adjusting the level of collaboration and the number of practitioners according to the complexity of needs and circumstances of the person receiving care. It requires a clear understanding of roles and team dynamics, and effective leadership and conflict resolution skills. Interprofessional practice works best when practitioners learn from each other and improve their own practice with this acquired knowledge base, creating overlaps in skillsets that reduce fragmentation in professional services. (Hogan, 2021, p. 2)

According to *HiPS* (Hogan, 2021), healthcare services are generally divided into two tiers as determined by the H&DSR (Simpson, 2020). Tier 1 services encompass a broad range of services delivered in the home and community, including marae and schools to meet the needs of most people (Hogan, 2021). Tier 2 services are defined as "health and disability services provided in a hospital setting or by specialists (including outpatient, inpatient, non-community mental health, and hospital based diagnostics)" (Hogan, 2021, p. 2). It is recommended that healthcare provision be integrated and coordinated either vertically or horizontally across providers depending on the needs of each person. The purpose of integrated healthcare services is to ensure people have access to a continuum of healthcare and services across their lifespan (Hogan, 2021).

Together with a growing expectation for targeted, person-centred care specific to each recipient, a move to elevate members of the diverse allied health workforce to work to the full extent of their professional scope of practice is proposed. The purpose of this is to enable health professionals to take a more proactive role in providing healthcare to meet the growing consumer need. To facilitate this, Hogan (2021) recommended assessment and therapeutic intervention by an allied health professional prior to seeing a GP. Benefits include reduced time spent accessing a GP, direct access to an appropriate allied health practitioner, and a reduction in referrals sent to medical specialists.

> According to Hogan:
>
> Current use of allied health is sub-optimal. The solution requires a fundamental shift in the way Tier 1 services are organised and in the behaviours of the Tier 1 workforce. In designing Tier 1 services to support interprofessional practice with increased allied health input, critical design elements include:
>
> - The patient-centred medical home (PCMH)
> - Practice ownership and governance models that support greater community participation and breakdown professional hierarchies
> - Payment models that align with service models
> - Referral processes for direct access to a range of health professionals
> - Cost containment measures
> - Culture shift
> - Empowering with information. (Hogan, 2021, pp. 29–30)

GPs are regarded as key to implementing change in the health and disability sector (Hogan, 2021). They are identified as *gatekeepers* to health services. As many GPs work in private practice with associated business models; their referrals to allied health professionals are dependent on their knowledge and trust in the services provided (Hogan, 2021).

Strengths

The allied health workforce

A strength of *HiPS* is the attention given to identifying the depth and breadth of professions that make up the allied health workforce (Hogan, 2021). This consists of over 30,000 people across 29 professional disciplines who belong to regulatory bodies and/or professional associations. Members of the allied health workforce who belong to a regulatory body and/or a professional association hold a relevant tertiary qualification, have a process for assessing competence to practise, abide by both professional standards of practice and codes of ethics, and have a robust complaints system (Hogan, 2021).

Whilst it is a convenient term to use, a concern when using *allied health* as a generic name for this workforce, is the danger of diluting the specific skills and knowledge these practitioners hold into a bland amorphous group who are unseen and unacknowledged in their practice. Thus, the generic term allied health is also a weakness as it perpetuates medically dominant terminology *othering* highly skilled practitioners of different disciplines. When members of the allied health professions are referred to in a discipline-specific manner, this enhances their visibility, as well as the uniqueness of their skills that are more widely known within the community. It is considered that using the professional title given to the various practitioners provides a context to understand their purpose in being included as a member of the team for the services they deliver to a particular person or population group.

Model of practice

HiPS proposes delivery of care based on the biopsychosocial model of care (Hogan, 2021). A biopsychosocial model of care focuses on empowering people in the community to maintain as much independence as possible, focusing on quality of life, within the constraints of their personal circumstances. A biopsychosocial model of health is proactive and preventative. It enables the members of the allied health workforce to provide healthcare that is specific to the needs of each person. The preference for the model proposed is to "provide better alignment between the health and disability system and the Treasury's Living Standards Framework (Treasury New Zealand, 2019)" (Hogan, 2021, p. 24).

HiPS recommends shifting some work currently undertaken by GPs to their allied health colleagues (Hogan, 2021). In following this practice, GPs are better placed to respond to services that have devolved to their practices from hospital specialists. This move would increase efficiencies in the health sector and give recognition to the role allied health practitioners have in providing preventative health care and education. A challenge to making these types of transitions in healthcare provision is the willingness of GPs to hand over roles they are used to providing (Hogan, 2021). It appears that lower cost of providing allied health services is a key factor driving this recommendation. If cost is the only motivation to transform the delivery of health care services, this reinforces the ongoing status and power disparities between medical and allied health practitioners and is both disingenuous and demeaning. Hence, what at first glance looks like a strength, under further examination becomes a weakness (Hogan, 2021).

While the recommendation for a biopsychosocial model is a strength, it poses risks in implementation as no detail is provided in *HiPS* regarding how this might look for social work (Hogan, 2021). Social workers bring strengths in making holistic assessments of the needs of patients and family/whānau. They have expertise in community networking and linking people with resources in the community that are relevant to their needs. The roots of health social work are described as a *guest* operating "under the benign control of the medical and nursing professions" (Beddoe, 2011, p. 26). Inherent within this positioning is the implication that in holding a guest status, social work is either included or excluded dependent on the understanding of what medical and nursing colleagues understand social work offers. Thus, the ability to be effective as social workers is more dependent on the meaningful relationships they hold that determine the scope of their work, rather than a prescribed or mandated definition.

Within *HiPS*, the allied health workforce is considered to be a critical component when moving to offer the patient-centred medical home (PCMH) model of primary health care delivery (Hogan, 2021). The PCMH model was originally introduced as an American interprofessional model of care for children who had complex healthcare needs. It has since evolved as "an ideal for areas of high deprivation, where multi-morbidity and high prevalence of risk factors are observed" (Hogan, 2021, p. 30). It is argued that allied health practitioners are well placed to be influential in the care coordination and case management of people from these communities. If a PCMH model is implemented, questions remain about the efficacy of allied health practitioners if they are subject to the authority of their GP and nursing colleagues. *HiPS* advocates that GPs hold the role of care coordinator, yet also indicates they do not always know what services allied health practitioners provide (Hogan, 2021, p. 7). Given this statement, the number of allied health practitioners presented in the following table (Table 1) may not reflect a workforce that is sustainable in an area of high deprivation with a population who have co-morbidities and a high need for health care.

Table 1. Staffing Requirements for an Aotearoa New Zealand PCMH Model

	FTE per 10,000 high needs patients	FTE per 10,000 non-high needs patients
General Practitioner	7.9	6.0
Nurse Practitioner	4.0	2.0
Nurse	6.0	4.5
Reception / Administration	6.7	5.0
Behaviourist / Counsellor	3.5	2.5
Social Worker / Kaiāwhina / Navigator	2.5	1.0
Health care assistant	4.0	3.0
Clinical pharmacist	1.0	1.0
Physiotherapist	1.0	1.0
Trainee doctor	1.0	1.0
Trainee nurse	1.0	1.0
Trainee allied health	1.0	1.0
Student clinicians	2.0	2.0
Manager	1.0	1.0
Total team FTE	42.6	32.0

Source: GPNZ, 2020 (cited in Hogan, 2021, p. 31).

The PCMH model outlines the following staffing resource (Hogan, 2021, p. 31):

From Table 1, it is unclear whether a social worker, a kaiāwhina, and a navigator are all employed by the PCMH or any of these could be employed interchangeably. Patient navigators are described as "trained, culturally sensitive health or social care workers who provide support and help families navigate through the various components of the health and social services systems. … it is often a role played by nurses, social workers, or other allied health professionals" (Hogan, 2021, p. 25). There is risk in assuming a social worker has the same knowledge and skills as a kaiāwhina or navigator.

"A social worker is a qualified and registered professional. Social work is a practice-based profession … that promotes social change and development, social cohesion, and the empowerment and liberation of people" (International Federation of Social Workers, 2014, p. 1). "Kaiāwhina represent people within the health and disability sectors who support tāngata (people) to live well, embrace and exercise tino-rangatiratanga (self-determination) in navigating their own journey to pae ora, a healthy future" (Ministry of Health, 2021, p. 9). Kaiāwhina bring cultural expertise to their role and may also have a formal qualification. This raises questions as to the information regarding professional qualifications and regulation the author had access to when preparing *HiPS* (Hogan, 2021).

The development of allied health *ambassadors* to overcome barriers between integrating primary care and allied health professionals is promoted (Hogan, 2021). The strength of the ambassador role is to act as a mediator or broker between both medical and allied health professionals. This proposal is one of intentional recruitment to ensure professional networks and pathways exist to facilitate referrals between all parties. A secondary purpose is for members of different allied health professions to be appointed to the ambassador role within the same geographic area to ensure cross-pollination of networking relationships and access to allied health professionals. This is an extension to the scope of practice for a senior practitioner (Hogan, 2021).

Weaknesses

Workforce model of care

Notwithstanding the qualifications, knowledge and skills members of the allied health workforce hold, the report lacks clear and comprehensive detail of how this might occur. Attention is given to general practice and the need to transform the systems which historically maintain and finance general practice as a cornerstone of health within Aotearoa New Zealand. Many general practices are considered unsuitable to provide person-centred care for people with long-term or complex conditions due to being “profit-maximising” and “unidisciplinary” (Hogan, 2021, p. 6). This creates an opportunity and a necessity to consider an alternate GP model of care that is for community based, not-for-profit and focused on providing interprofessional healthcare (Hogan, 2021). These are based in communities where people experience complex care needs, high levels of deprivation and minority populations (Hogan, 2021). Funding for community based PCMH models would include a mix of fee for service payments, financial incentives to meet performance targets, a population-based capitation payment, fees to cover overheads, and a prospective care management and coordination fee to cover labour costs. Further work needs to be undertaken to develop the financial arrangements that fund this model (Hogan, 2021).

Given the overreliance on GP-centric literature throughout *HiPS*, it raises questions about why other literature was not included (Hogan, 2021). It also raises questions as to the degree of consultation that was undertaken with the regulatory boards and professional associations that monitor and guide the practice of members of the professional allied health workforce. None of this is evident within the report. Nor does the report offer the experience of interprofessional care from the perspective of the various professional disciplines that make up the allied health workforce in Aotearoa New Zealand. Within *HiPS*, the examples given of interprofessional collaboration maintain GPs holding a pivotal role in the healthcare equation (Hogan, 2021). When one professional discipline is privileged over others, it is difficult to determine how a change in the provision of healthcare will occur. By exploring the experience of various members of the healthcare workforce in the provision of interprofessional collaboration, it is considered that a more robust model of interprofessional collaboration might be arrived at.

For example, within the proposed model, palliative care services are described as both Tier 1 and Tier 2 services. Within Aotearoa New Zealand, there are two categories of palliative care: generalist and specialist. Those who require generalist palliative care are primarily looked after within the community by their primary health care provider, usually a GP, with support and advice from community and specialist services as needed. For those recipients of specialist palliative care services, they are under the oversight of an interprofessional team who have specific training in palliative care, who aim to provide holistic care in conjunction with their GPs and community health services (Ministry of Health, 2009).

Health social workers who work in palliative care may be employed in the community, in hospitals and in hospices. They are familiar with working collaboratively in interprofessional teams. Palliative care social workers are concerned with resolving problems, or where matters arise relating to social or psychological factors (Payne, 2004). This might include access to suitable housing, immigration matters, and other family/whānau stressors. Referral to social work may occur where there is concern about the needs of the carer and family/whānau including future bereavement concerns. Palliative care social workers hold specialist knowledge on current models of grief and loss.

Within *HiPS*, Māori, Pasifika, the disabled and the rural community are only mentioned in the context of being drivers for change in the way health services are delivered (Hogan, 2021, pp. 7–8,15,20). *HiPS* does not provide any examples of how interprofessional collaboration currently occurs within these communities, what services already exist, and/or the benefit to their specific communities (Hogan, 2021). *HiPS* fails to acknowledge that within the community of allied health professions, they have members who belong each of these demographics (Hogan, 2021). These voices are missing from the report.

Interprofessional collaboration

HiPS refer to two international initiatives (Centre for the Advancement of Interprofessional Education [CAIPE], 2022; Nolte, 2005) advocating at a policy level to promote systemic change to reshape the workforce so that interprofessional collaboration is embedded into the healthcare system (Hogan, 2021). Whilst this is useful, it fails to acknowledge and explore evidence of interprofessional collaboration already occurring within Aotearoa New Zealand. This is considered a weakness in the report.

The National Centre for Interprofessional Education and Collaborative Practice (NCIPECP) is based at the Auckland University of Technology (AUT). At its opening, Minister Ryall spoke of the Government's belief that interprofessional collaboration was "crucial for improving the significant health workforce crisis we have inherited" (Ryall, 2009, p. 1). NCIPECP's purpose is to provide leadership, facilitation and the promotion of person-centred collaborative practice, education and research which benefits the health and social outcomes for all in Aotearoa New Zealand (AUT, n.d.). Since that time, NCIPECP has published research across a range of professional disciplines nationally and internationally. That the work of NCIPECP is not present in *HiPS* (Hogan, 2021) is disappointing as their research is intentional in its culturally responsive approach to person and whānau-centred care (Auckland University of Technology [AUT], n.d.).

Within Aotearoa New Zealand, social workers are familiar with working as part of an interprofessional team. This is especially the case when working in health settings. Giles' (2016) research explored the social workers' perception of interprofessional teamwork in a major regional hospital. Eleven out of 16 health social workers within the hospital were interviewed. The findings of the research highlighted the benefits of holistic care when interprofessional meetings were well facilitated. These included clear communication and effective coordination of care between members of the interprofessional team and the person and family/whānau they were attending to. In contrast, when interprofessional meetings were poorly facilitated, it was found that the person who was the focus of care was often treated as if they were a "site of disease"; discussions tended to be more perfunctory, and, at times, had an overemphasis on avoidance of risk (Giles, 2016, p. 30). When this occurred, there was a greater likelihood that social work and patient concerns were devalued. This resulted in a higher incidence of patient and family/whānau distress and poorly coordinated discharge planning. The effective inclusion of social workers into the interprofessional team has significant benefits for the team, the patients and family/whānau with whom they work (Giles, 2016). Although this example occurs within a hospital environment, it highlights tensions which can occur within the interprofessional team. Whilst these findings cannot be generalised to other settings, they may be transferable to other settings where interprofessional collaboration occurs.

Opportunities

Structural workforce issues

At first reading, a huge opportunity exists within *HiPS* to reshape healthcare delivery in Aotearoa New Zealand (Hogan, 2021). If the 30,000 members of the allied health workforce were enabled to practise at the top of the scope of their practice, opportunities for innovation and creativity to shape the design of healthcare services in a way that is specific to the needs of the communities would occur. *HiPS* proposes a workforce planning approach that focuses on skill flexibility, skill development, and the development of new roles to meet the needs of the population in which they are situated (Hogan, 2021). In focusing on the needs of the community, this has the potential to drive the training so that it is community specific. This ignores the knowledge and skills held by members of the allied health workforce who hold a broad base of skills that adapt to a range of environments. An associated threat to the engagement of allied practitioners is their relatively low numbers across 29 professional groups. This may require active recruitment and training into these professions to boost the workforce requirements.

In response to the New Zealand Ministry of Health's Primary Health Care Strategy and the ongoing call for comprehensive integrated healthcare to address issues of inequity, one of the strategies implemented was to establish social workers in primary health care (PHC) organisations (Ministry of Health, 2001). Research exploring the perceptions of, and experiences gained through including, social workers in PHC teams in Aotearoa New Zealand has occurred (Döbl et al., 2017). Benefits included enhanced communication between all services, as well as ease of access to people of low socio-economic status and those from ethnic minorities. For those people who had complex psychosocial needs, including trauma, being able to access a social worker located within their primary care provider enabled easier acceptance of social work intervention. Following the Christchurch earthquakes in 2011, the importance of social workers in the PHC team environment was especially valuable (Döbl et al., 2017).

The lack of ongoing government funding to support social workers being employed within the PHC model was challenging. This was evidenced by social workers being required to "provide evidence of its usefulness with respect to financial gains rather than to improved healthcare provision" (Döbl et al., 2017, p. 126). Issues of equality and power were noted across various levels: between people who accessed health services and health professionals, between professions, and within the healthcare system itself (Döbl et al., 2017).

The knowledge, skills, values and practice approach social workers brought to the PHC team was considered to complement and address a gap in the knowledge and skills of their medical and nursing colleagues. Many of the issues social workers attended to were endemic within the community and impacted all aspects of each person's health (physical, emotional, psychological, spiritual and family/whānau). These included poor access to housing, food insecurity, workplace conflict, unemployment, poverty, obesity, terminal illness, disability, depression, loss and grief, caregiver distress, social isolation, emotional volatility, family/whānau dynamics, immigration issues, domestic violence and abuse (Döbl et al., 2017).

Social workers who were situated in a community PHC identified as having high needs and wishing to support holistic health reported being well supported in the workplace and satisfied with their conditions of employment (Döbl et al., 2017). For employers, it was critically important that they and their colleagues understood what the social work role entailed to build effective working relationships both with the people and families/whānau of the community with whom they worked. Information sharing by social workers between service receivers, health professionals, and external agencies was vital in maintaining communication between all parties. Professional supervision for social workers ensured they continued as a 'safe' practitioner for all whom they worked alongside. A recommendation was made that to enable social workers to continue to be located within PHC teams, an ongoing commitment to funding is needed (Döbl et al., 2017).

Funding models

People who are unable to privately access allied health professionals due to cost generally turn to their GP to access those services (Hogan, 2021). If, in turn, they cannot afford to visit their GP, they are excluded from accessing the healthcare they require.

> The right care at the right time, delivered in the right way for the right person is impossible to achieve if the public health system does not employ the right mix of professionals. Allied health professionals are highly trained, highly specialised practitioners who can offer safe and effective, evidence-based interventions for a wide range of conditions.
> (Hogan, 2021, p. 22)

The funding model proposed in *HiPS* recommends financial incentives are provided for teams who meet quality and efficiency targets, extending this to including meeting equity targets (Hogan, 2021). Interprofessional teamwork is more apparent in not-for-profit community organisations who exhibit the following qualities: salaried team members, interdependent incomes, whole of team funding, and service contracts hold explicit expectations for interprofessional collaboration (Hogan, 2021). Given one of the stated aims within *HiPS* is for "cost containment" a model of risk stratification is offered which categorises patients according to diagnosis, and the needs assessed to meet the unwell person's health care needs, adjusted for demographic and other factors which can include both objective and subjective information (Hogan, 2021, p. 41).

With a move to align payment to service models that are financially motivated, and the expectation that Tier 1 teams demonstrate capacity and evidence of interprofessional collaboration, this is both an opportunity and a threat to the successful implementation of the recommendations of *HiPS* (Hogan, 2021). The greatest opportunity is enabling members of the allied health workforce to participate in interprofessional collaboration. The greatest threat is that financial incentives and penalties will inhibit the ability of interprofessional teams to collaborate in a way that is most meaningful to the community they serve. While accepting there is a need for contracted organisations to meet a minimum set of standards, concern is raised that when teams are required to meet a set of specifications, this may become a maximum in service delivery thus inhibiting innovation. The following example provides evidence of this risk when the accountability requirements of government contracted services operate at cross-purposes to holistic care provided by community organisations (Dormer, 2014).

Dormer (2014) undertook research with government officials and non-government organisations to explore matters of collaboration and accountability. The research highlighted tensions that occur when an alternate model of practice (Whānau Ora) is developed that devolves decision making for a particular population back to the community. Whānau Ora was developed "to foster a greater sense of local community and individual responsibility" (Dormer, 2014, p. 835). Finding a model that meets the needs for community organisations to attend to the needs of their clientele as well as the accountability needs of government organisations who provide funding is both challenging and a source of tension. It is considered both parties need to develop an understanding of the aspirations and limitations of the other (Dormer, 2014). If funding organisations have one set of criteria for delivery of services that are neither compatible nor congruent with the core mission of a community organisation, this can constrain and limit the effectiveness of any services that are delivered.

The experience of Whānau Ora exposed the difficulty in measuring outcomes where service delivery is values-based and focuses on enhancing the mana (strength) and wairua (spirit) of Māori. Dormer (2014) described efforts that build mana and wairua as "aspirational". Interviews with officials engaged in funding Whānau Ora initiatives, revealed a reluctance to allow tino rangatiratanga (self-determination) due to contractual requirements that included standards of professionalism, how whānau are to be treated and expected outcomes for services delivered. It was concluded that, depending on which side of the negotiating table one sat, these tensions contributed an ongoing experience of coercion versus empowerment (Dormer, 2014). Rather than focusing on accountability that was finance- or outcome-focused; in 2012, Minister Turia advocated for outcomes to be focused on the stories and feedback given by the people Whānau Ora worked alongside (Dormer, 2014). This was more meaningful and relevant. The stories of change to the welfare of Māori whānau wrought over time are the strongest indicator of effective collaboration and provision of care. A change to a more collaborative style of accountability is necessary when implementing meaningful change to "seemingly intractable social problems that are not unique to New Zealand" (Dormer, 2014, p. 844).

The funding models that accompany the changes to the health and disability sector are both an opportunity and a threat to successful implementation. Unless they take account of issues that have already been raised in a meaningful way, any initiatives run the risk of being undermined and unable to fulfil their mandate. A further threat is that funding providers may not fully appreciate the value of the cost of employing allied health professionals at the top of their scope of practice thus constraining the ability of the workforce to meet the requirements of contractual agreements. Allied health professionals working in the community are not second-class professionals when compared to their colleagues employed in statutory organisations, therefore the terms and conditions of employment, including salaries, need to reflect this.

Associated with this, and implied within HiPS, is the lack of knowledge of the skills and knowledge allied health professionals bring to interprofessional collaboration (Hogan, 2021). National and international research has found health care administrators and managers lacked an understanding of what social workers could contribute to the organisation (Hobbs & Evans, 2017; Lévesque et al., 2019). This resulted in a reductive and simplistic view of social work within the organisation, including exclusion from consultation and discussion about decisions that directly impacted their practice. The systemic power imbalance was a source of frustration by health social workers and considered to be discriminatory and stigmatising (Hobbs & Evans, 2017; Lévesque et al., 2019). In situations where innovative services are created as occurred with social workers employed in PHC teams, yet ongoing funding is challenging, this can have a negative effect on the morale and productivity of affected team members (Döbl et al., 2017).

Threats

Systemic issues to model of care

Implementing an alternate model of healthcare requires careful planning (Hogan, 2021). To remove ownership of GP practices and transition this to non-profit community health practice risks losing an element of flexibility within the workforce (Hogan, 2021). GPs in private practice are more responsive to cater to additional demand for their services. Conversely, community-owned non-profit and government-owned practices are considered to better able to meet the demand for healthcare that is appropriate to meet the diverse needs of the community in which they are situated (Hogan, 2021). Within Aotearoa New Zealand, government public health organisations (PHOs) have been funded to provide healthcare that is complementary to, and independent from, private GP practices.

Unless systemic change is supported during the transition and implementation process of integrating allied health professionals into healthcare practice, this will detrimentally affect the experience of both healthcare providers and healthcare recipients (Hogan, 2021). Some may regard *HiPS* as visionary and embracing of the inclusiveness of the allied health workforce (Hogan, 2021). Yet no information is provided regarding the process of developing interprofessional teams and what helps/hinders their effectiveness. This is the biggest threat to making change.

Interprofessional collaboration

Interprofessional collaboration does not just happen. It is a process that evolves under skilled leadership within a facilitated structure. A high trust environment and a culture of sharing power are critical factors in facilitating the successful functioning of the interprofessional team. It is when interprofessional practice is enabled to take place in an environment where all team members operate from their strengths that the potential of interprofessional teams can begin to be realised (Best & Williams, 2019).

A growing body of literature is available to support those wishing to develop, grow and support teams to function in a truly interdisciplinary manner. Research identifying the factors that contribute to the development of a quality interdisciplinary team is available, as are tools to assess the effectiveness of the interdisciplinary team (Nancarrow et al., 2013; Nancarrow et al., 2015). McNeil et al. (2013) identified triggers that hinder the effective cohesiveness of the interprofessional team. Best and Williams (2019) provided strategies to support the interprofessional team during times of organisational change and uncertainty.

Conclusion

It is considered *HiPS* falls short as it fails to go far enough (Hogan, 2021). It is GP-centric in its design. If the purpose of the report was to move from a “biomedical model of healthcare” as offered by GPs, to a more fit-for-purpose model that delivers healthcare services for people who have “complex health, disability and psychosocial issues”, it is considered that HIPS misfires (Hogan, 2021, p. 1). The act of writing a report that is based on literature about GPs by its very nature has excluded relevant literature written by members of the professional allied health workforce. Out of a workforce of over 30,000 allied health professionals, it is unfortunate that other frameworks for healthcare delivery were not considered. Given the acknowledged role of GPs as gatekeepers for patients accessing allied health professionals, to draw on the models and frameworks developed for GPs explicitly maintains the process of privileging their knowledge over that of their allied health colleagues (Hogan, 2021, p. 6). It further reinforces the lack of equity among the healthcare workforce whereby medical knowledge and models are given precedence over those developed and/or utilised by members of the allied health workforce.

When I first heard of HiPS being released, I felt excited, thinking this report would give recognition to the knowledge and skills members of the allied health workforce bring to healthcare (Hogan, 2021). How wrong I was! Taken in its entirety, I find

HiPS disappointing (Hogan, 2021). Whilst it advocates support for enabling allied health practitioners to practise at the top of their scope of practice, it fails to articulate the breadth of knowledge and skills allied health practitioners have, it fails to challenge the historical structural inequities allied health practitioners face every day. By not doing this, the report colludes with the practice of maintaining the status quo of privileging the knowledge of GPs over other professional disciplines. This renders the recommendations of the report to the level of soundbites and lacking in substance.

Received: 23 January 2024

Accepted: 24 May 2024

Published: 15 June 2024

References

Auckland University of Technology. (n.d.). *National Centre for Interprofessional Education and Collaborative Practice (NCIECP)*. Auckland University of Technology. https://ncipecp.aut.ac.nz/

Beddoe, L. (2011). Health social work: Professional identity and knowledge. *Qualitative Social Work*, *12*(1), 24–40. https://doi.org/10.1177/1473325011415455

Best, S., & Williams, S. (2019). Professional identity in interprofessional teams: Findings from a scoping review. *Journal of Interprofessional Care*, *33*(2), 170–181. https://doi.org/10.1080/13561820.2018.1536040

Centre for the Advancement of Interprofessional Education (CAIPE). (2022). *Centre for the Advancement of Interprofessional Education (CAIPE)*. https://www.caipe.org/

Döbl, S., Beddoe, L., & Huggard, P. (2017). Primary health care social work in Aotearoa New Zealand: An exploratory investigation. *Aotearoa New Zealand Social Work*, *29*(2), 119–130. https://doi.org/10.11157/anzswj-vol29iss2id285

Dormer, R. (2014). Whānau Ora and the collaborative turn. *International Journal of Public Administration*, *37*(12), 835–845. https://doi.org/10.1080/01900692.2014.917101

Giles, R. (2016). Social workers' perceptions of multi-disciplinary team work: A case study of health social workers at a major regional hospital in New Zealand. *Aotearoa New Zealand Social Work*, *28*(1), 25–33. https://doi.org/10.11157/anzswj-vol28iss1id113

Hobbs, E., & Evans, N. (2017). Social work perceptions and identity: How social workers perceive public and professional attitudes towards their vocation and discipline. *Aotearoa New Zealand Social Work*, *29*(4), 19–31. https://doi.org/10.11157/anzswj-vol29iss4id378

Hogan, S. (2021). *Hidden in plain sight: Optimising the allied health professions for better, more sustainable integrated care: NZIER report to Allied Health Aotearoa New Zealand (AHANZ)*. New Zealand Institute of Economic Research. https://www.alliedhealth.org.nz/uploads/8/8/9/4/88944696/hidden_in_plain_sight_final_23_06_2021.pdf

International Federation of Social Workers. (2014). *Global definition of social work*. https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

Lévesque, M., Negura, L., Gaucher, C., & Molgat, M. (2019). Social representation of social work in the Canadian healthcare setting: Negotiating a professional identity. *British Journal of Social Work*, *49*(8), 2245–2265. https://doi.org/10.1093/bjsw/bcz005

McNeil, K. A., Mitchell, R. J., & Parker, V. (2013). Interprofessional practice and professional identity threat. *Health Sociology Review*, *22*(3), 291–307. https://doi.org/10.3316/informit.741222152200410

Ministry of Health. (2001). *The primary health care strategy*. https://www.health.govt.nz/system/files/documents/publications/phcstrat_0.pdf

Ministry of Health. (2009). *Gap analysis of specialist palliative care in New Zealand: Providing a national overview of hospice and hospital-based services*. https://www.tewhatuora.govt.nz/assets/Publications/Palliative/palliative-care-gap-analysis-09-amended-v4-jun10.pdf

Ministry of Health. (2021). *Kaiāwhina workforce plan 2020-2015*. https://kaiawhinaplan.org.nz/wp-content/uploads/2021/10/Kaia%CC%84whina-Workforce-Plan-2020-2025.pdf

Nancarrow, S. A., Booth, A., Ariss, S., Smith, T., Enderby, P., & Roots, A. (2013). Ten principles of good interdisciplinary team work. *Human Resources for Health*, *11*(1), 1–11. https://doi.org/10.1186/1478-4491-11-19

Nancarrow, S. A., Smith, T., Ariss, S., & Enderby, P. M. (2015). Qualitative evaluation of the implementation of the interdisciplinary management tool: A reflective tool to enhance interdisciplinary teamwork using structured, facilitated action research for implementation. *Health & Social Care in the Community*, *23*(4), 437–448. https://doi.org/10.1111/hsc.12173

Nolte, J. (2005). *Enhancing interdisciplinary collaboration in primary health care (EICP) initiative*. www.eicp-acis.ca

Payne, M. (2004). Social work practice identities: An agency study of a hospice. *Practice 16*(1), 5–15.

Ryall, T. (2009, February 27). *Health Minister's speech to launch the National Centre for Interprofessional Education and Collaborative Practice* https://www.beehive.govt.nz/speech/health-ministers-speech-launch-national-centre-interprofessional-education-and-collaborative

Simpson, H. (2020). *Health and disability system review: Executive overview: He tirohanga whānui*. https://systemreview.health.govt.nz/assets/Uploads/hdsr/health-disability-system-review-final-report-executive-overview.pdf

Social Workers Registration Board. (2023). *Social Workers Registration Board's annual report 2022-2023*. https://swrb.govt.nz/about-us/

Treasury New Zealand. (2019). *The living standards framework: Dashboard update, 12 December 2019* (1988580633;9781988580630;). https://www.treasury.govt.nz/publications/tp/living-standards-framework-dashboard-update

Whāia te Ara Ora: Understanding and healing the impact of historical trauma and sexual violence for Māori

Leonie Pihama, Ngaropi Cameron, Mereana Pitman, Rihi Te Nana
Māori & Indigenous Analysis Ltd., Ngaruawāhia, 2021
ISBN 978-0-473-51308-5, pp.183, Paperback, $NZD45

The book *Whāia te Ara Ora* is a carefully woven whāriki which draws together mātauranga Māori from tūpuna, atua, whānau, healers, care providers, and the Māori and Indigenous worlds to explore the potential pathways for recovery from sexual violence and historical trauma for whānau Māori. The book explores the historic origins and development of family and sexual violence within whānau Māori in Aotearoa; and what survivors, whānau, and care providers believe will work to heal from these issues and prevent them in the future. This book powerfully exposes the colonial myth-making that surrounds so much of the discourse on Māori social and health issues, and continually draws the connections between historic and ongoing colonisation, capitalism, and racism and the impact of these in the lives and futures of whānau Māori. *Whāia te Ara Ora* is one outcome of the wider *He Kokonga Whare: Māori Intergenerational Trauma and Healing Research Programme* (Te Atawhai o te Ao, n.d.). This book stems from a kaupapa Māori research project within this programme that used both interviews and a survey to understand Māori experiences and understandings of sexual violence and healing (Te Atawhai o te Ao, n.d.)

The authors frame the narrative of this project with the pūrākau of Niwareka and Mataora, which in te ao Māori is the genesis of family violence and collective whānau restoration. The use of this particular pūrākau is both a literary device and an illustration of the central importance of traditional knowledges in kaupapa Māori conceptualisations of, and responses to, social issues. Pūrākau, whakataukī and whakatauākī, whakapapa, whaikōrero and oral histories are used alongside the whakawhiti kōrero of research participants and contextualising information to create a thoroughly *Māori* exploration of these 'wicked problems' and their potential solutions. The overall narrative of the book weaves in and out of historic and contemporary time, from service providers to survivor-storytellers to the words of tūpuna and tōhunga and back again. This is not a research text borne from a Western academic paradigm, this is kaupapa Māori enacted on the page.

In *Whāia te Ara Ora*, the content chapters of healthy relationships; historical and intergenerational trauma; the context of sexual violence in Aotearoa; historic and ongoing colonial disruptions to traditional Māori ways of life and relationships to self, others, and whenua; and pathways to healing are all explored in relation with each other. Both the authors and the research participants themselves clearly linked contemporary experiences of perpetrating, and being subjected to, sexual violence to wider structural violence. Particularly striking to me were the links made in the text between sexual violence and the violent imposition of Western colonial gender

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 111–113.

norms on whānau Māori; the subjugation of mātauranga and tikanga Māori through both assimilation and invasion; and the confiscation and degradation of Papatūānuku as an ongoing action of white supremacist, gendered violence. In contextualising historic sexual violence in the colonial era within the wider structural violence of colonisation and genocide, one participant said that "what was intruded upon was our soul and our spirit and our attachment to the land and to each other …" (p. 120). This whakawhiti kōrero is illustrative of the both broad and deep whakaaro that is drawn on for this book. The authors deftly weave the threads of individual experience with the broader systems and structures that have shaped generations of Māori lives for the last two hundred years.

As important as the rigorous contextualising of family and sexual violence among whānau and hāpori Māori as an outcome of colonial violence, is the exploration of approaches to healing. The final content chapter of the book is rich with whānau reflections on the aspirations of tikanga and kaupapa Māori-based restoration for survivors, perpetrators, whānau, communities, and hapū and iwi Māori. The research participants and authors discuss with clarity the transformative potential of kaupapa Māori violence prevention and healing programmes that utilise the strengths of whānau, whanaungatanga, and mātauranga Māori. The barriers to implementation—among others, a largely monocultural neoliberal funding environment—are also thoughtfully examined. Again, the authors continually return us to the interconnected nature of the individual- and whānau-level problems *and solutions* to the structures that (re)produce them. The book clearly positions tikanga and mātauranga Māori, whakapapa, hapū and iwi, and tino rangatiratanga as the solutions to family and sexual violence. The authors remind us that Māori communities have the knowledge, skills, and experience to support better outcomes for Māori, in ways that are appropriate for, and responsive to, Māori cultural and spiritual needs. What has been taken by force is the power to define what Māori needs and Māori outcomes look like in individualised and prescriptive health and social services, and the resources to make those potential futures a reality.

I first read *Whāia te Ara Ora* while practising in a Māori mental health service. The book mirrored the narrative understandings many of the whai i te ora wāhine had of their own experiences as survivors of family and sexual violence. Many of the wāhine I worked with consistently understood individual experiences of harm and trauma within the context of the historic and modern structures that create hardship, isolation, and an ensnarement in child protection and justice systems that often punish women and mothers, and remove the hope of restoration and balance to family and community relationships. The second time I read this book, it was while teaching social work students about the ongoing violence of colonisation and racism in Aotearoa, and the strength and ingenuity of Māori resistance. In both instances, reading this book breathed life into the idea of what kaupapa Māori research and services can look like.

For social workers in Aotearoa, this book prods and pulls at our espoused professional values of social justice, advocacy, and the liberation of oppressed peoples. In its unrelenting grounding of contemporary problems as the descendants of historic and ongoing processes of colonisation, the book challenges us all to work towards the redress of the physical, psychological, and relational violence of colonisation. For social workers in the global context, there will be echoes of the same work needed in your back yards: continued struggles within, or in solidarity with, Indigenous self-determination and anti-racism movements, and a reminder of the importance to strive for culturally responsive practice in political and funding environments that often prioritise monocultural and overly prescriptive social work services. *Whāia te Ara Ora* is an essential text for understanding the historic and structural roots of contemporary Māori and Indigenous social issues.

References:

Te Atawhai o Te Ao. (n.d.). *Impact of sexual violence on Māori. https://teatawhai.maori.nz/research-projects/he-kokonga-whare/the-impact-of-sexual-violence-on-maori-project/*

Glossary of te reo Māori terms:

Whāriki – woven mat

Mātauranga Māori – Māori knowledge and knowledge systems

Tūpuna – ancestor(s)

Atua – god(s), preeminent ancestor(s)

Whānau – extended family

Pūrākau – important story or narrative

Te ao Māori – the Māori world

Whakataukl – cultural proverb where the author is unknown

Whakatauākl – cultural proverb where the author is known

Whakapapa – genealogy or lineage

Whaikōrero – formal oratory

Whakawhiti kōrero – dialogue, in this case from research participants

Tōhunga – expert(s)

Kaupapa Māori – Māori approach or agenda

Tikanga Māori – Māori cultural practices and ways of being

Papatūānuku – Earth mother, ancestor to all Māori

Whakaaro – thoughts or opinions

Hāpori Māori – Māori communities

Hapū – tribe

Iwi – grouping of tribes with ties to a common ancestor

Whanaungatanga – reciprocal relationships between whānau or other communities

Tino rangatiranga – absolute and enduring authority – the power of self-determination

Whai i te ora – people who utilise mental health services

Wāhine – women

Reviewed by **Kendra Cox**, (Te Ure o Uenukukōpako, Whakatōhea, Ngāi Tūhoe, Ngāti Porou), Waipapa Taumata Rau University of Auckland.

The Sage handbook of decision making, assessment and risk in social work

B. J. Taylor, J. D. Fluke, J. C. Graham, E. Keddell, C. Killick,
A. Shlonsky, & A. Whittaker (Eds.)
SAGE Publications, 2023
ISBN: 9781529790191, pp.656, hardcover, $AUSD243 from booktopia.com.au

Working with risk … if ever there was a phrase which has more bedevilled social work! This handbook does not seek to resolve that issue, instead it deliberately walks a line between neither promoting risk-aversion in social work and avoiding an over-emphasis on risk.

Aotearoa New Zealand is well-represented in this very impressive list of international contributors. Emily Keddell co-edits this handbook and is, of course, well-placed to produce this book given her expertise about how we address (and, in my view, fear) risk in this country. The handbook is structured along four themes: (1) professional judgement; (2) assessment, risk and decision processes; (3) assessment tools and approaches; and (4) developing and managing practice.

Within the professional judgement section sits our first chapter from local voices. Tracie Mafile'o and Jean Mitaera write with Halaevalu F. Ofahengaue Vakalahi in "Collective cultures, risk, and individual judgement" about the value of Pacific (and Indigenous) social work approaches. What came through very clearly was that Pacific-led responses are founded on group decision-making and that social workers must recognise the cultural collective process of the Pacific.

Through examples from other research, the authors remind the reader the power that social workers have should be used for the benefit of others. More importantly, the authors recognise that, within Pacific culture, it is the elders who hold power and lead the decision-making process—but then how does a social worker work in that dynamic? Through humility, through relationships that genuinely seek to understand the stories the family hold and the wishes the family strives for. The authors offer a cultural humility framework while a discussion of the two domains again directs the reader to the need for respectful, trusting, and honouring relationships. The authors make compelling arguments that through these processes can the power within collective decision-making strengthen social worker assessments.

My view is that the chapter also (inadvertently) challenges the terminology within the wider handbook around "professional judgements" (of which there is an abundance). If we are to decolonise social work assessments and decision-making, then perhaps principled judgements might replace professional judgements. That might be some way of meeting the authors' hope of moving Pacific-Indigenous approaches from the sidelines in "professional" judgement discourse. In the recent and excellent *Tu Mau* issue of this journal, the editorial noted that Pacific social workers "often find themselves in spaces of resistance, reclaiming and reframing for themselves, their families, and the Pacific communities they work with" (Crichton-Hill et al., 2023, p. 1). My hope is that this chapter goes some way to recognise the valuable contributions Pacific social workers make and the value of Pacific social work.

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 114–115.

In stark contrast to that approach which values relationships and humility is "The devil in the detail: Algorithmic risk prediction tools and their implications for ethics, justice and decision making" by Emily Keddell. This, it should be recognised, is written for an international audience and the local discerning reader will no doubt be familiar with Dr Keddell's research warnings of risk prediction tools in Aotearoa New Zealand. Who could forget the crest of the "risk prediction by algorithm" wave in 2015 when (some have argued, in a stopped-clock moment) the then Minister of Social Development blocked an observational study of 60,000 babies to identify those at risk of child abuse, with a stroke of her pen: "not on my watch! These are children, not lab rats" (McLean, 2015, para. 9). Many of us exhaled, but Dr Keddell has remained vigilant.

This chapter contains an interesting discussion about how algorithmic tools work and the issues in using them in child protection, but I found all of these were best summed up (but the author would argue as incomplete, I suspect) with her concern that "decisions that become data points used in algorithmic tools are also subjective and variable" (para 11). When the author discusses the experience of social workers in using predictive tools, I found myself thinking "if only they could read this chapter, then there would be very little appetite for using them"… but the expertise on display here could possibly make this argument a little inaccessible for some. I hope not, because Keddell delivers a vastly more knowledgeable but no less scorching "not on my watch" to the social work world. Notwithstanding that small observation, with the imminent return of 'Social Investment' this chapter is critical reading for social workers in Aotearoa New Zealand.

There are a couple of honourable mentions to make. I found the interdisciplinary chapter "Legal aspects of decision-making process in social work" to be of interest. Written by a medical doctor and an attorney, their analysis of risk assessment in the court system provided an important non-social-worker insight about social work. But what caught my attention more than anything was their view that "trial lawyers know and employ the power of storytelling" (para. 27). What struck me was the confidence of lawyers to celebrate being able to move between professionalism (again, a frequently used word in this handbook) and storytelling, yet my experience is that social workers might be guilty of trying to prove their professionalism by avoiding storytelling. In this regard, the chapter by Dr Laura Cook titled "Intuition in social work practice" was a welcome inclusion. An unapologetic and important piece of work advocating for knowledge born of relationships and connections.

I reflect on what this handbook has made me consider. The subjectiveness of the algorithm being seen as a safer alternative to the subjectiveness of social worker knowledge. The power of the social worker above the humility of the Pacific approach. Structured and evidence-based knowledge placed ahead of intuition. Professionalism, whatever that means.

This handbook demonstrates we have (more than) enough knowledge to be brave in our decision-making. The question remains whether social work will to be brave enough in our assessment and decision making to acknowledge risk rather than to react to it. We should back ourselves.

References

Crichton-Hill, Y., Mafile'o, T., & Veukiso-Ulugia, A. (2023). Resistance, reclaiming and reframing: Relationship-based Pacific social work practice. *Aotearoa New Zealand Social Work*, *35*(2), 1–7.

McLean, E. (2015, October 4). Call to stop child abuse risk modelling study. *Otago Daily Times.* https://www.odt.co.nz/news/national/call-stop-child-abuse-risk-modelling-study

Reviewed by **Darren Renau**, PhD student, Massey University

Defining the boundaries of disability critical perspectives

Licia Carlson and Matthew C. Murray (Eds.)
Routledge, London, 2021
ISBN 9780367684167, pp.156, paperback, $NZD75

The book *Defining the boundaries of disability: A critical perspective,* provides a number of perspectives on the identity of disability situated in many contexts. The editors, Licia Carlson and Matthew C. Murray, are both professors of philosophy focusing on areas around social justice and inclusion. Reflecting this background, the volume cleverly asks contributors to reflect on the commonly expressed phrase, "we are all disabled," from academic, artistic, and autobiographical perspectives. The authors critique the concept in principle and the meaning beneath it, providing numerous examples of the underlying ableism, epistemologies, and orientations that frame the idea that disability is an identity that *everyone* will inhabit at one point or another.

The concept, 'we are all disabled' (or its linguistic relative, 'we will all become disabled one day') is a frequent but conceptually lazy teaching device and advocacy lever. The notion is used by many (including me), In theory, to 'prod' people into thinking about the world they would want when they or their relatives reach that point. The popularisation of such a concept concerns and aggravates the scholars in this volume because it misses the nuance and complexity of inhabiting different identities and arbitrarily tries to 'dissolve' the distinctions between peoples, as if it is conceivable to have a notion that 'we are all' anything.

The essays, poems, and reflections centre around five main elements, bringing in a mixture of academic literature, social justice in practice, and personal reflections. First is the ways in which disability is enacted in a range of different settings, both by people with disabilities and weaponised against these groups. Second is critical examinations of the power dynamics in particular situations, for example, disability (under) representation in academia, the fraught landscape of depending on frequently undependable systems, structures, and support as a disabled person. Third is the limits and problematising language around 'designing for everyone' and universal design and the clash for equitable civil rights. Fourth, the ways in which music, art, and poetry can provide ways to explore the concept of 'we are all disabled' as a thought-provoking poetic device rather than a hollow cliché. Finally, the difficulties, disembodiment, resilience, and adaptability that disabled people (were forced to) experience and display during the Covid-19 pandemic. The ways in which these skills and knowledge can scaffold for planning future crises.

Some of the essays and constructions that stood out to me were "Power, disability and the academic production of power" in Matthew C. Murray's reflections on the philosophical underpinnings of 'we are all disabled" and what the concept leaves out. "*We are all disabled: The conundrum of problems and solutions,*" where Madeline Dewelles examines the representation of disability and

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 116–117.

the perceived university and 'being special,' and what these put in the foreground, imply, centre, and leave out. "*We are all disabled, until we are not*", where Teresa Blankmeyer Burke gives a personal reflection on being confronted with the term 'we are all disabled' to counter her request for qualified support. "Being deafness", where Michael E. Skyer explores the ontological tensions between biomechanical hearing loss and 'deaf gain' in the way people are treated.

While I am not a social worker, based on my experience as a health advocate, this could be a valuable resource for social workers working with whānau and individuals with long-term health conditions. The chapters on support structures and institutional dynamics in particular could serve both people in clinical practice or those who work in the areas of policy development, professional development or research.

This is an excellent volume with important points made in an interesting and innovative way. I would have preferred a greater grounding in how the others construct their critical orientations in the first section—some of it was a little unclear—along with further exploration of definition and boundaries as critical start points. The editors talk about the volume being intended for a broad audience, including philosophers, historians, activists, clinicians, and moral theorists. I would agree with this assessment; however, when this volume is introduced to any audience, it should be carefully considered. It›s not a 'beginner's text.' To me, these works are best suited to supplement more senior scholarship or experienced activism reporting or action research, particularly with the range of approaches. While the volume relies heavily on American references, legal frameworks, and social justice movements, the underlying elements can be adapted to Aotearoa New Zealand, especially the deconstructing 'we are all disabled' as part of the often repeated '1:4 New Zealanders have a disability'.

The part of me that has a love of neatness and completion would have liked to have been offered an alternative to 'we are all disabled.' Of course, relying on such conventions and tropes would defeat the purpose and unifying message, that lumping everyone and every difference together under a supposed rallying cry is problematic and delegitimises the struggle for rights by individuals and groups. Instead, the boundaries of disability are messy, fluid, and reflect unique and complex constructions of identity, especially in a post-Covid-19 world.

Reviewed by **Amy Hogan**, Heath Advocate/Master's Candidate University of Auckland

Social work practice during times of disaster: A transformative green social work model for theory, education and practice in disaster interventions

Lena Dominelli
Routledge, Milton Park Abington Oxton UK, 2023
ISBN 978-0-367-61645-8 (hbk); 978-0-367-61644-1 (pbk);
978-1-003-10582-4 (ebk), pp.309, $NZD68.40

AOTEAROA
NEW ZEALAND SOCIAL
WORK *36(2)*, 118–119.

The necessity for social workers in disaster settings is becoming more likely in the context of the climate emergency. Disasters are predicted to continue and intensify, and Aotearoa has seen its fair share of disasters over the past few years. With Cyclone Gabrielle, Covid-19 and the White Island disasters fresh in our minds, this text showcases some of the roles social workers can take in supporting community at times of disaster.

Social work practice during times of disaster is a contemporary text from a seminal writer in social work literature. The founder of Green Social work, Professor Lena Dominelli, has written a go-to guide on how to use social work practice in the disaster context. I read this book in an eBook format.

The book has a two-part structure: Part 1 is entitled "Disaster interventions in local and national context in the UK"; Part 2 takes a more international perspective with "Learning lessons from disasters occurring in other countries".

Part 1 examines case studies of disasters from the United Kingdon in recent years. Covering the Covid-19 pandemic (chapter 3), the failure of social work to respond to climate change (chapter 4), extreme weather events (chapter 5), the Grenfell fire disaster (chapter 6) and terrorist attacks (chapter 7). In these chapters, Dominelli looks at each type of disaster and discusses the impacts of them on the social world looking at how a physical disaster can quickly become a social disaster when it impacts people's lives. Here she endorses "human rights-based service delivery" (p. 110) as an approach to working in disaster response, with examples from UK flooding events highlighting the social work interventions that happened at the time.

She also looks at wildfires, giving examples from Scotland England and Wales, Northern Ireland and Canada and linking these to climate change. There is an exercise useful for teachers on wildfires as well as guidelines on how to respond.

As disaster response is heavily reliant on the local policy and resources available in the region, readers outside of the UK may find the first section helpful as an example of how these were managed. The remaining chapters, 8-12 (Part 2), cover international natural disasters, storm surges, hurricanes, earthquakes, volcanic eruptions (chapters 8 & 9), which cover a range of disasters from a typhoon in the Philippines to a superstorm in Cuba, flooding in New York and in Pakistan. Each comes with helpful exercises to help the reader digest the information and reflect on an aspect of disaster recovery, policy, or practice. Guidelines for social work interventions are also available.

Later in Part 2, Dominelli looks at human-made financial disasters (chapter 11) which is an interesting and not commonly thought of type of disaster alongside natural disasters. She describes the history of financial disasters such as the Wall Street crash and its social implications and the financial crisis of 2007 to 2009 with the resulting exacerbation of structural inequities, globalised economics and neoliberalism creating negative impacts on climate policy.

In this chapter, she puts context to the connections between the global financial systems, climate and disasters around the globe, impacting communities and social systems where those with fewer resources are being forced from their homes and livelihoods. She advocates that "local communities can engage in acts of local solidarity concerned with managing and re distributing resources and protecting individual rights to mitigate hardship and affect social policies" (p. 230).

Professor Lena Dominelli's intention in writing this book was to "provide crucial material to support the development of social work practice during disasters and curriculum that equips social workers to assume disaster intervention roles with integrity and effectiveness" (p. 1) using the lens of Green Social work to contextualise disaster practice (chapter 1). Overall, I will say she has achieved this goal. Disasters are very much here to stay and will become more prevalent in the uncertain climate time to come.

I would definitely recommend this as a foundational text for anyone who is unfamiliar with the social work role in disaster work or is interested in learning more about the urgent need in this very relevant emerging area of social work practice.

As our profession prepares to support humanity facing an uncertain future, we, as the social work community, need to upskill and work together across borders to build resilience. This text is yet another great resource from one of our key writers in the field.

Reviewed by **Lynsey Ellis**, Social Work Field Education Team Coordinator & Senior Professional Clinician
Massey University | Te Kunenga Ki Purehora | School of Social Work