RESEARCH REPORT APRIL 2014

A DIVISION OF FAMILIES COMMISSION

SUPERU

SOCIAL POLICY EVALUATION AND RESEARCH UNIT

EFFECTIVE PARENTING PROGRAMMES

A review of the effectiveness of parenting programmes for parents of vulnerable children

Families Commission Kōmihana ā Whānau

The Families Commission was established under the Families Commission Act 2003 and commenced operations on 1 July 2004. Under the Crown Entities Act 2004, the Commission is designated as an autonomous Crown entity.

Our main role is to act as an advocate for the interests of families generally (rather than individual families).

Our specific functions under the Families Commission Act 2003 are to:

- encourage and facilitate informed debate about families
- increase public awareness and promote better understanding of matters affecting families
- encourage and facilitate the development and provision of government policies that promote and serve the interests of families
- consider any matter relating to the interests of families referred to us by any Minister of the Crown
- stimulate and promote research into families; for example, by funding and undertaking research
- consult with, or refer matters to, other official bodies or statutory agencies.

Our specific functions under the Whānau Strategic Framework (2009–2012, p. 5) are to develop an operating environment which is regarded by whānau, Māori, iwi and key stakeholders as representative of an organisation that:

- listens to the voice of whānau
- has regard to the needs, values and beliefs of Māori as tangata whenua, as required under Section 11(a) of the Families Commission Act 2003
- promotes and maintains whānau strength and resiliency
- promotes whānau ora through the activities of advocacy, engagement, policy development and research.

Families Commission Amendment Bill currently before Parliament, amends the principal Act of 2003. In addition to its main advocacy function, it introduces a new social policy monitoring and evaluation function. Once passed, our main functions will be:

- to act as an advocate for the interests of families generally
- to monitor and evaluate programmes and interventions in the social sector, and provide social science research into key issues, programmes and interventions across that sector.

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ISSN 1177-3545 (Print)
ISSN 1178-1289 (Online)

ISBN 978-0-478-36941-0 (Print)
ISBN 978-0-478-36942-7 (Online)

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Foreword

We all agree that there is an urgent need to reduce the high number of vulnerable children in New Zealand who are at risk of harm now and in the future. But there is less clarity about how we can actually address this issue.

One solution is to help parents of vulnerable children, better care for and nurture their children.

This authoritative report by the Families Commission reviews the evidence on the effectiveness of parenting programmes, as a way of reducing the risk of maltreatment of vulnerable children aged 0–6 years. We looked at both national and international evidence to identify parenting programmes that work and those that do not work, including for Māori and Pacific peoples.

This report contributes to the body of evidence needed to improve outcomes for vulnerable children, as part of the Government's Children's Action Plan.

We found that parenting programmes can bring about positive changes in parenting, child health and child behaviour, helping to reduce some of the parental risk factors associated with child maltreatment.

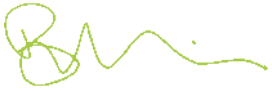
The review identifies the key elements of successful programmes. It tells us that how a programme is implemented can be just as important as what is implemented. It also tells us there is no silver bullet – no single programme meets all the needs of parents of vulnerable children.

This is a complex environment and these families don't live in silos. They are often grappling with a mix of issues including drug and alcohol abuse, family violence and maternal depression. A better understanding of the effectiveness of New Zealand parenting programmes is needed so a process can be put in place to improve them.

While the Families Commission does not deal directly with vulnerable children or their families, we are part of the answer.

I am proud of this robust quality research and our work in this area does not stop here. We will continue to work with government, local government and other agencies to give them best-practice evidence about what works. We are engaged with those who fund, make or deliver parenting programmes to use this work. We will work together to make a difference for these children and their families.

Accessible evidence that is understood and acted upon is essential to resolving the challenging issues of reducing risk of maltreatment of children.



Belinda Milnes
Families Commissioner

1. EXECUTIVE SUMMARY

Introduction

The urgent need to address New Zealand's high rate of child maltreatment has led to the search for effective interventions to reduce child maltreatment and its main risk factors. The 2012 White Paper for Vulnerable Children highlighted the importance of positive parenting practices for optimal child development and the value of supporting parenting, especially in the early years. An action from the White Paper was for SuPERU to review and report on effective parenting programmes by the end of 2013.

For the purposes of this review we focused on parenting support programmes for parents of vulnerable children aged zero to six years. This included parent education, parent training programmes and home visiting programmes, but excluded general support that does not address parenting (such as financial assistance, mental health and drug abuse programmes). We aimed to provide evidence on the effectiveness of parenting support programmes in reducing maltreatment, or the risk of maltreatment, of vulnerable children.

We first reviewed international research, determining common features of successful programmes overseas. We then reviewed the evidence for the effectiveness of New Zealand programmes. The review highlighted a number of issues related to the effectiveness of programmes (such as programme implementation) and these are also covered in this report.

International review

Our review of international research focused on programmes that had been evaluated using randomised control trials or other rigorous research designs with comparison groups. We identified a number of well-supported parenting interventions, targeting a range of outcomes for parents and children. These interventions have shown small to moderate positive effects on a range of parenting behaviours, as well as on child development and attitudinal outcomes.

Few programmes, however, demonstrably reduced child maltreatment, despite improving parenting. Those with the most evidence of a reduction in maltreatment are:

- Nurse-Family Partnership (US)
- Early Start (New Zealand)
- Parent-Child Interaction Therapy (US)
- SafeCare (US).

These programmes also had various other positive child and parenting outcomes, although they were less successful at changing parental issues, such as drug and alcohol use, domestic violence and maternal depression.

The parenting programmes in the review ranged from the universal to the targeted. Examples of the levels and outcomes targeted are:

- ante-/postnatal health visitor programmes, generally delivered universally and aimed at improving health outcomes for children
- comprehensive home-visiting programmes, which can have positive benefits for children and parents, although some have required improvement in response to earlier evaluation findings (eg Healthy Start)

- parent education and training programmes, such as Triple P and Incredible Years, which are effective in addressing child conduct problems and promoting positive parenting
- programmes such as HIPPY and Parents as Teachers, which are also effective in promoting positive parenting and children's school readiness
- parenting programmes delivered in the early education environment (eg Chicago Child-Parent Centers and Early Head Start)
- parenting programmes working with parents of infants, often to improve attachment – these have been developed but are less well-supported (though some promising programmes are currently being piloted and evaluated)
- programmes developed to work with specific groups of parents, such as those separating or in prison; some of these have shown positive results
- programmes targeted at parents and caregivers of children who have been maltreated. These programmes often work with caregivers in out-of-home placements, with the goal of reducing placement breakdown.

Common components of effective programmes

Attempts have been made to identify common elements or components of effective programmes and to include these evidence-based components in programme design and practice. Attention to these components can be used to monitor and improve practice and might serve as the basis for developing new programmes. Common elements or components of effective parenting programmes included factors related to:

- staffing and infrastructure (eg staff qualifications, training and support)
- programme design (eg clear programme logic and goals)
- programme delivery (eg adequate frequency and duration, individualised planning)
- programme content (eg focus on child behaviour and positive parenting strategies)
- ongoing monitoring and evaluation for programme improvement.

The components interact, and no one element will ensure success, so further studies are required to really understand the active components of programmes. The importance of components is also likely to vary by programme type, with different skills required to deliver a group education programme compared to intensive home visiting.

Engagement and retention

Engaging and retaining parents in programmes is crucial to their success. Parenting support programmes must first identify those parents who would benefit from their programme, then recruit them into the programme and maintain their active participation for as long as is beneficial. Success with engaging parents should be seen as one element of an assessment of a programme's effectiveness.

Research has shown a number of factors that seem to limit participation by parents, including:

- characteristics of the parent (eg access to information and attitudes to help-seeking)
- characteristics of the programme (eg advertising and outreach)
- structure and delivery (eg home– or centre-based, transport and childcare support)
- the system within which the programme is embedded (eg service networks).

Various suggestions have been made to encourage parental participation, including more active promotion of programmes, taking time to engage parents, and addressing practical barriers through the provision of childcare or transport assistance. There are still significant gaps in our knowledge of what can be done to maximise parent participation.

Implementation of parenting programmes

In choosing a parenting programme it is important to consider 'what works for whom and under what conditions'. Selection of a programme then depends on three crucial questions:

1. What outcomes do you want to achieve?
2. Which parents do you want to work with?
3. Which context do you work in?

Answering each of these questions requires determining the needs of parents in an area, the best way to address these needs (often a series of options), and whether the available options are feasible in the area (in terms of the availability of skilled staff and other specialist services, for example).

International research and evaluation evidence has also shown that one of the challenges to running effective parenting programmes is the implementation of programmes to scale and in different contexts. A number of implementation frameworks have been developed to provide practical guidance on programme selection and implementation. Factors to consider include:

- programme appropriateness (aims and outcomes that match local needs)
- who is targeted
- the delivery setting
- costs
- accessibility
- technical assistance required to set up and run the programme
- the degree to which the programme can be adapted
- cultural appropriateness.

New Zealand parenting programmes

In keeping with a multi-level response model, various parenting support programmes are available in New Zealand:

- universal programmes (eg Well Child/Tamariki Ora) and community-delivered education programmes (SKIP and Parenting Toolbox)
- programmes to address the specific needs of parents with children displaying behavioural problems (eg Triple P and Incredible Years)
- programmes targeting at-risk groups (such as prison programmes)
- comprehensive home-visiting services (eg Early Start and Family Start).

Our review has shown that there are few well-designed studies examining the effectiveness or impact of New Zealand parenting programmes. With the exception of Early Start, few studies have used comparison group designs to assess impact. The review was therefore limited in its ability to assess the effectiveness of New Zealand programmes. With regard to programmes working with the parents of vulnerable children in New Zealand, we concluded:

- The Early Start programme has good evidence of effectiveness, and is cited internationally as an evidence-based programme.
- The Incredible Years programme is supported by international evidence. A recent New Zealand evaluation indicates that it is operating successfully.
- Triple P is also supported by international research and some research in New Zealand.
- The Parents as First Teachers (PAFT) programme is based on the US Parents as Teachers (PAT) programme, which is regarded as an evidence-based programme. A recent evaluation suggested

the programme had some positive health benefits for children and reduced conduct problems, but the design did not include a randomised comparison group.

- Home-visiting approaches are supported by international research. A 2009 review of New Zealand's Family Start home-visiting programme (available in targeted areas across the country) suggests, however, that there has been uneven implementation of the home-visiting model and evaluations to date have not enabled a judgement to be made of the effectiveness of the programmes.
- The HIPPY programme aims to help parents prepare their children for formal schooling. There is good overseas, and some New Zealand, evidence that the programme is successful in its aim.

Parenting programmes for Māori whānau and Pacific peoples

Research on parenting programmes observed that considering parents' culture was important for designing and delivering programmes. Parenting responsibilities, roles and behaviours are in part culturally determined. The engagement and retention of parents in programmes is more likely when programmes take account of their culture. Some programmes have been developed specifically for Māori, using Māori conceptual frameworks (Whānau Toko i te Ora and Te Atawhaingia te Pā Harakeke), and some international programmes have been adapted for different cultural groups. Our review found relatively little research on the effectiveness of parenting programmes specifically designed for Māori and Pacific parents. Given the over-representation of these groups in the vulnerable children population, this knowledge gap is significant and needs addressing through further programme development, research and evaluation.

Economic analysis of parenting programmes

Cost-benefit analysis has been used as a tool in the UK and USA to guide the selection of programmes in many areas (such as child welfare, justice and health). Overseas examples show that such analysis can be useful in decision-making as the results often, but not always, indicate quite significant returns on investment from different programmes. This analysis supports early intervention using a mixture of proven programmes, with some programmes having a return of investment of as much as 30 percent. With the exception of Early Start, we do not have the measures of programme impact available in New Zealand to conduct a rigorous cost-benefit analysis.

Conclusion

Internationally, few parenting programmes have been shown to actually reduce maltreatment of children; many, however, have been shown to bring about positive changes in parenting, and in children's health and behaviour. It can be argued, therefore, that they have reduced some of the parental risk factors associated with maltreatment.

More research studies support the effectiveness of parenting programmes to address children's behaviour problems, compared to programmes working with parents of younger children (those targeting early parent-child attachment, for example). Studies also suggest that younger, first-time parents are more likely to benefit from parenting programmes. Home-visiting and parenting education and support programmes have been shown to have small to moderate positive effects on children's health and development, and on parents' behaviours, attitudes and beliefs.

Although the optimal combination of programmes has yet to be determined, it is generally acknowledged that a mixture of universal, targeted and re-abuse prevention programmes is needed. New Zealand has a range of programmes, some of which target specific risk groups.

Without rigorous evaluation, however, it is currently difficult to make definitive judgements about the effectiveness of New Zealand parenting programmes. Most are based on overseas programmes with evidence of effectiveness, but unless they are implemented with sufficient fidelity they may not be effective in the New Zealand context. In this review we have not tested the fidelity with which individual programmes have been implemented, but this is an important next step in ensuring their effectiveness.

No one programme is going to suit all parents' needs, nor is it possible to target all the potential outcomes with a single stand-alone programme. This requires programme funders and providers to determine the needs of the community and to match these with the appropriate programmes. While investing in evidence-based programmes is important, it is also recognised that such programmes are far from perfect and that investment is also required to innovate and improve on existing programmes.

Going forward

There is a need to plan for the longer term: to develop better evidence for the effectiveness of current New Zealand programmes; to identify programmes (international and home-grown) that might work in the New Zealand context; to pilot selected programmes and evaluate their impact; to implement to scale those showing promise; and to continue to monitor within a constant programme-improvement framework. Consideration needs to be given to providing programmes of sufficient intensity and making sure programmes align with best practices internationally.

Some of this work is already under way, with agencies funding studies to assess the impact of parenting programmes in some areas. When parenting support programmes are reviewed again in the future, it is hoped that this information will enable more definitive conclusions to be reached than is possible at present.

2. INTRODUCTION

2.1 The White Paper review

The 2012 White Paper for Vulnerable Children recently reviewed New Zealand's response to children who are vulnerable to poor developmental outcomes (New Zealand Government 2012). The White Paper and associated Children's Action Plan (2012a) detail the Government's response to the initial Green Paper. It describes what it is 'doing to address the factors that place children at risk of becoming vulnerable, as well as the factors that protect children from vulnerability' and outlines 'major changes to the way in which children at risk of, or experiencing, maltreatment are identified and have their needs responded to' (Volume ii p 2).

The White Paper defines vulnerability as follows:

> *Vulnerable children are children who are at significant risk of harm to their wellbeing, now and into the future, as a consequence of the environment in which they are being raised, and in some cases, due to their own complex needs. Environmental factors that influence child vulnerability include not having their basic emotional, physical, social, developmental and/or cultural needs met at home or in their wider community.*
>
> *This definition reflects the fact that, while highly vulnerable children can be easily distinguished from children who have comparatively few vulnerabilities, there is no single commonly agreed threshold used to distinguish 'vulnerable children' from 'non-vulnerable' children in research and across jurisdictions.* (p 31)

The White Paper discussed the need to identify at-risk children and provide appropriate services and programmes for their families. In particular, it focused on very young children who are at risk of maltreatment.

A number of other recent policy initiatives have also highlighted the importance of parenting in contributing to positive individual and societal outcomes. For example, the Drivers of Crime Ministerial Meeting (2009) noted that poor parenting contributes to crime, and concluded that government should be 'providing parenting advice, support and intervention, from pregnancy and through to early childhood years, particularly to vulnerable families (those in poverty, young mothers, parental criminality)'.

Finally, the Better Public Service targets include a number of goals that might reasonably be expected to be affected by the quality of parenting. In particular, those targets aimed at supporting vulnerable children[1] and reducing crime[2] include:

- Result 2: Increase participation in early childhood education.
- Result 3: Increase infant immunisation rates and reduce the incidence of rheumatic fever.
- Result 4: Reduce the number of assaults on children.
- Result 7: Reduce the rates of total crime, violent crime and youth crime.
- Result 8: Reduce re-offending.

The reduction in child maltreatment, as measured by assaults on children, is therefore one of the current targets set by government. Successfully achieving these goals will depend in part on identifying and implementing effective interventions, including those for parents of vulnerable children.

The Children's Action Plan called for the Social Policy Evaluation and Research Unit (SuPERU) of the Families Commission to:

> *...be tasked with finding ways to improve outcomes for vulnerable children. This work...will drive a focus on learning what works and ensure that knowledge gets to front-line providers and funders. A first priority will be reviewing and reporting on effective parenting programmes.*
>
> *By the end of 2013 the SuPERU will review and report on effective parenting programmes.*

1 http://www.ssc.govt.nz/bps-supporting-vulnerable-children
2 http://www.ssc.govt.nz/bps-reducing-crime

In the context of the White Paper the focus of this review is on the parenting support programmes that aim to address the parental risk factors associated with poor developmental outcomes, and in particular the risk of child maltreatment.

2.2 Child vulnerability

An increasing body of knowledge shows that the early years of a child's life are crucial to a wide range of later-life developmental outcomes (Kilburn and Karoly 2008; Shonkoff, Garner, Siegel, Dobbins, Earls, McGuinn & Wood 2012). Experiences in the family, with parents and caregivers, at pre-school and school, with peers, and in neighbourhoods and communities are all important to subsequent development. While positive experiences promote development, adverse life experiences provide challenges to that development.

It is, therefore, considered important that risks are addressed as early as possible, before any long-term damage is done to the child. The recognition of the need to address developmental risks early on has led to the development of a range of early childhood interventions. More latterly, the beneficial effects of strengthening resilience have also been included as intervention targets. As Kilburn and Karoly (2008) state:

> *Research findings from the past decade and a half increasingly emphasize the importance of laying a strong foundation in early childhood and that there is a range of early childhood programmes that can successfully put children on the path toward positive development and prevent poor outcomes in adulthood.* (p 2)

2.3 Child maltreatment

One of the most significant risk factors for poor developmental outcomes is child maltreatment (Gilbert, Widom, Browne, Fergusson, Webb & Janson 2009). Children who are maltreated are more likely to have a range of negative outcomes, affecting brain architecture, psychological functioning, mental health, health risk behaviours, and social functioning (Mikton & Butchart 2009; Gilbert et al. 2009). These outcomes are not confined to childhood, but extend into adulthood – for example, in terms of educational achievement, relationships, employment and involvement in criminal activity. There are significant societal costs to addressing these negative outcomes, and through children and young people not achieving their potential (Kilburn & Karoly 2008).

Child maltreatment is a general term that covers a range of abuse and neglect types (sexual and physical abuse, neglect, and emotional or psychological abuse, for instance). The legislated definition of child abuse and neglect in the United States is:

> *At a minimum, child abuse is defined as an act or failure to act on the part of a parent or caretaker which presents an imminent risk of serious harm or results in death, serious physical or emotional harm, sexual abuse or exploitation.* (Child Welfare Information Gateway, 2013, p 10)

In New Zealand, Child Youth and Family (2013) advice uses the following terms to refer to the different types of child maltreatment:

- Physical abuse – is any behaviour which results in physical harm to a child.
- Sexual abuse – is any act where an adult or a more powerful person uses a child or young person for a sexual purpose.
- Emotional abuse – is a pattern of behaviour that attacks a child's emotional development and sense of self-worth.

- Child neglect – is defined as failure to meet a child's essential needs through inadequate parenting and lack of responsibility. Neglect is about what parents and caregivers don't do. We all understand that parents are not able to meet all their child's needs all the time, but it is persistent neglect of a child's need which results in some form of harm. Neglect can include physical neglect, neglectful supervision, emotional neglect, medical neglect and educational neglect. (p 1)

Recent analysis suggests that 5.4 percent of all New Zealand children have a finding of maltreatment by age five (Vaithianathan, Maloney, De Haan & Dare 2012). Official data underestimate the true incidence, however, as retrospective self-reports suggest that up to 30 percent of children experience some form of maltreatment by adulthood (Gilbert et al. 2009). Data on notifications for care and protection to Child Youth and Family services (2011/12) indicate that those requiring further action typically involve young children (36 percent are for children under five years of age) and mainly result in findings of emotional abuse, followed by neglect and physical and sexual abuse. Almost half (46 percent) of notifications requiring further action involved Māori children, and 11 percent of children identified with a Pacific ethnic group. A third were identified as European.

It needs to be noted that these findings are highly dependent on reporting policies, the classification system used and the operational definitions of the abuse and neglect terms (Gilbert et al. 2009). For example, the proportion of findings with emotional abuse has doubled in the past six years, in part because of changes in police reporting policy and the processing of notifications (Gulliver & Fanslow 2013). For similar reasons it is problematic to compare the rates for different countries, where definitions and recording practices can hamper comparisons.

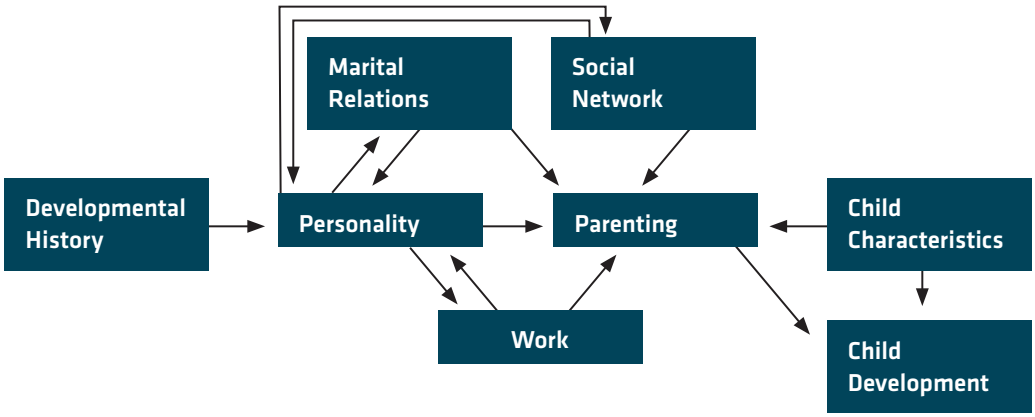
International researchers find that most child maltreatment is likely to be the result of acts carried out by parents, or through lack of care by parents (Barth and Haskins 2009).[3] Ronan, Canoy and Burke's (2009) review of research found that neglect and emotional abuse are more common than physical abuse, with sexual abuse being the least common. In terms of who was responsible for the abuse, they report that the risk of physical and emotional abuse from immediate family is higher than for sexual abuse. Sexual abuse is most often perpetrated by acquaintances or other relatives (Gilbert et al. 2009). Ronan et al. also note that studies find the majority of incidents of abuse are not reported to anyone. The implication of this is that many more children than are counted in the official figures experience parenting that detracts from their optimal development. Finally, some children experience multiple types of maltreatment and are maltreated on multiple occasions; further, maltreatment involving multiple children in a household is common, especially in cases of neglect or psychological abuse (Gilbert at al. 2009).

3 US data indicate that parents are responsible for 80 percent of child maltreatment (Schaefer 2010).

2.4 Models of determinants of parenting and child development

Child development is the result of a wide range of influences, including parental behaviour.[4] Belsky (1984) proposed a model of the relationship between parenting and child development. His 'process model' (more recently termed a developmental-ecological model) built upon Bronfrenbrenner's ecological model of human development. It identifies the range of factors at multiple levels (individual, family, school and community factors) that influence parenting behaviours, which in turn are linked to children's developmental outcomes. The original model is shown in Figure 1 and has been widely cited since its initial publication (Belsky 1984).

Figure 1 Belsky's determinants of parenting process model



While much research has focused on identifying risks, more recent research has also focused on identifying resiliency factors: those factors that reduce the risk of negative developmental outcomes among children in adverse environments (Jaffee, Caspi, Moffitt, Polo-Tomás & Taylor 2007). There is increasing recognition that no single factor is either sufficient or necessary for poor outcomes for children, and this has led to an alternative conceptualisation of risks to child development (MacKenzie, Kotch & Lee 2011). Recent research considers the accumulation of risks as crucial to eventual outcomes, with multiple risk factors being more important than any one particular risk (Fergusson & Horwood 2003).

As Belsky's model suggests, parenting behaviours are an important component of healthy child development. When children experience poor-quality parenting they can be denied experiences that are essential for their optimal development. At their most extreme these behaviours would be classed as child maltreatment (physical assaults, lack of care and sexual assaults, for example). Research also indicates that the impact of such maltreatment is best predicted by considering the accumulation of stressors children face (Jaffee et al. 2007), with risk factors operating and interacting at multiple levels (within the child, the home and the community).[5] Recent studies have also found that the cumulative risk model is superior to Belsky's model in predicting child abuse potential (Begle, Dumas & Hanson 2010). Further research is required to confirm these findings and to extend them using measures of maltreatment, as well as abuse potential.

In considering child maltreatment, this approach implies that we need to 'account for the reciprocal impact of multiple factors, from parenting practices and beliefs that have direct influence on the child to more distal community and economic factors that can only impinge on the child through their impact on more proximal actors' (MacKenzie et al. 2011 p 1639). Such a model also has implications for intervention approaches, recognising the need to address the risks associated with multiple factors across multiple ecological levels.

4 To help with readability, the term parent will be used to refer to both biological parents of a child and anyone in a caregiving relationship to the child (eg foster parent or grandparent).

5 For example, the ecological-transactional perspective of Cicchetti et al. (2000).

While this review will focus on parenting (a proximal factor), it is clear from the model described above and from the research evidence that a wider range of factors both directly and indirectly affect child development. In particular, factors that influence parental wellbeing are important in hindering or promoting good parenting. For example, maternal mental health, drug and alcohol abuse and family violence are all significantly associated with an increased risk of poor outcomes for children (Shonkoff, Garner, Siegel, Dobbins, Earls, McGuinn & Wood 2012). In part this is because these issues affect the adults' ability to parent effectively (Hutchings & Gardner 2012). Specific specialist programmes are often needed to address these issues, and some of these programmes may contain a parenting component or be linked to a parenting programme.

Finally, it is important to note that risk factors, such as poor parenting, are often associated with a range of poor child development outcomes (such as health, education and social development) (Mackenzie et al. 2011). As a result parenting programmes can potentially target, and have an impact on, many outcomes in multiple child development domains.

2.5 Risk factors for child maltreatment

The 2012 White Paper for Vulnerable Children summarised the research that on a range of parent and caregiver, child, relational, school, community and societal factors associated with an increased risk of maltreatment (see Box 2.1 for some examples). These risk factors are likely to vary for different age and population groups.[6] They will also vary in their relative risk for different types of maltreatment (see Stith et al. 2009 for a meta-analysis of risk factors associated with child maltreatment).

Box 2.1 Examples of risk factors associated with child maltreatment

Risk factors in parents and caregivers

An increased risk of maltreatment is associated with the presence of certain factors in the parent or other family member. These include the parent or caregiver who:

- has difficulty bonding with a newborn child – as a result, for example, of a difficult pregnancy, birth complications or disappointment with the baby
- does not show nurturing characteristics towards the child
- was maltreated as a child
- displays a lack of awareness of child development or has unrealistic expectations that prevent them understanding the child's needs and behaviours – for instance, interpreting the child's perceived misbehaviour as intentional, rather than as a stage in its development.

Risk factors in the child

Saying that certain risk factors are related to the child does not mean that the child is responsible for the maltreatment they suffer, but rather that they may be more difficult to parent because they:

- were an unwanted baby or failed to fulfil the parent's expectations or wishes – in terms, for instance, of their sex, appearance, temperament or congenital abnormalities
- are an infant with high needs – one, for instance, who was born prematurely, cries constantly, is mentally or physically disabled, or has chronic illness
- cry persistently and cannot be easily soothed or comforted.

6 These 'risk factors' are not necessarily causal factors in child maltreatment, but have been identified as being more common in those experiencing maltreatment (Gilbert et al. 2009).

Relationship factors

Risk factors for child maltreatment that may apply to relationships with family, friends, intimate partners and peers include:

- lack of parent-child attachment and failure to bond
- family breakdown – such as problems with a marriage or intimate relationship – that results in child or adult mental ill-health, unhappiness, loneliness, tension or disputes over custody
- violence in the family, between parenting partners, between children or between parenting partners and children.

Community factors

Characteristics of community environments that are associated with an increased risk of child maltreatment include:

- tolerance of violence
- gender and social inequality in the community
- lack of or inadequate housing
- lack of services to support families and institutions and to meet specialised needs
- high levels of unemployment
- poverty
- transient neighbourhoods
- a local drug trade.

Societal factors

Factors in a society that can contribute to the incidence of child maltreatment include:

- social, economic, health, and education policies that lead to poor living standards, or to socio-economic inequality or instability
- social and cultural norms that promote or glorify violence towards others, including physical punishment – as depicted in the media, in popular music and in video games
- social and cultural norms that diminish the status of the child in parent-child relationships.

(New Zealand Government 2012b)

The most commonly cited issues facing those working with parents of children at risk of maltreatment are substance abuse, parental mental illness, domestic violence and behaviour problems in children (Barth 2009).[7] Substance abuse is more strongly associated with neglect, with parents being less responsive to their child's needs and prioritising drug use over childcare. Children may also suffer from the effects of parental drug use prior to their birth (as in foetal alcohol syndrome). According to Barth there is less evidence linking parental ill health to child abuse, but depressed mothers have been found to have more difficulty maintaining interactions with their children. Parenting by depressed mothers tends to be more harsh, controlling and negative, and such mothers may be more emotionally insensitive and unsupportive, withdrawn and aggressive (Gustafsson & Cox 2012). The irritability that is often a symptom of depression may also lead to difficulties responding to children. Domestic violence adds to parents' stress and can negatively affect parenting, in addition to the direct effects of children witnessing such violence (Cuthbert et al. 2011; Cummings & Davies 2010). Frequent and severe domestic violence is associated with harsh and inconsistent parenting, including acts of physical and psychological aggression directed

7 The first three factors have been referred to as the 'toxic trio' (Cuthbert, Rayns & Stanley 2011).

at children (Jouriles, McDonald, Rosenfield, Stephens, Corbitt-Shindler & Miller 2009). Research suggests that between 45 and 70 percent of children living in homes where there is violence are likely to be physically abused themselves (Gustafsson & Cox 2012). Finally, a parent's misguided responses to difficult behaviour can lead to them using inappropriate discipline, which at the extreme can lead to child maltreatment.

The risk factors mentioned above often co-occur in the most at-risk groups (Gilbert et al. 2009). The Christchurch Health and Development study found that a range of family and parental factors were associated with child maltreatment, including 'maternal age, maternal and paternal education, family standard of living, and family socio-economic status at birth, parental attachment (at age 15), changes of parents (by age 15), parental history of illicit drug use, parental history of criminal offending, maternal and paternal care, and maternal and paternal over-protection' (Fergusson, Boden & Horwood 2008). This study also found support for the cumulative nature of risk, with children who experience a greater number of risks being more likely to have a range of poor developmental outcomes (Fergusson & Horwood 2003). This underscores the need to address multiple risk factors rather than any single factor in isolation.[8]

In addition, community-level factors can contribute to risk, with one US study finding that living in an 'unsafe neighbourhood' reduced children's resilience following maltreatment (Jaffee et al 2007). This finding is a reminder that not all child maltreatment is perpetrated by parents or caregivers; unsafe neighbourhoods can put children at risk (Komro, Flay, Biglan and the Promise Neighbourhoods Research Consortium 2011) and impede their recovery after adverse experiences.

A range of protective factors have also been outlined (US Department Health and Human Services 2003), including:

- secure attachment with children
- supportive family environment, including extended family
- stable family relationships
- having household rules and parental monitoring of the child
- parental employment and high parental education
- adequate housing
- access to health care and social services
- supportive adults outside the family who serve as role models or mentors.

Many of the child maltreatment risk factors reviewed in this section are parental risk factors that might be targeted through a parenting intervention. Such an intervention typically aims to change parents' behaviour, attitudes, and beliefs, and may seek to improve the quality of the parent-child relationship. Many of the parenting programmes reviewed in this report have been developed to address these parental and relational factors, with the goal of reducing the risk of child maltreatment. Other programmes have been developed for purposes such as helping parents to improve their children's behaviour, cognitive abilities, school readiness, or physical development. Often programmes target more than one of these outcomes.

As Barlow et al. (2007) conclude:

> *Questions remain, however, about how best to enable improvements in parenting in vulnerable families where parenting skills are poor, social and environmental risk factors are high, and a considerable risk of abuse or neglect exists. Children growing up in such families have a high incidence of emotional and behavioural problems, school failure, delinquency in childhood and adolescence, and psychological and social difficulties as adults.* (p 229)

8 Recent research using longitudinal data in the UK suggests that a challenge to addressing multiple risks is the diverse nature of these risks and combinations of risk. In their population sample there was no dominant combination of risks experienced by children (Sabates and Dex 2012).

2.6 Parenting programmes

A framework can be useful for organising the range of parenting support programmes that have been developed. In terms of a public health prevention framework, programmes can be classified by the degree of targeting involved. Definitions vary, but three levels of prevention are generally recognised internationally (RAND, 2010). Using maltreatment prevention as an example, these levels are:

Primary (universal): aimed at the general population for the purpose of keeping abuse from happening (public awareness and education campaigns, for example).

Secondary (selected): aimed at a particular group with increased risk to keep abuse from happening (such as parent education programmes in high schools for teen mothers and home visitation).

Tertiary (indicated): aimed at preventing abuse from happening again to those who have already been victimised (respite and crisis care). This level of prevention may include treatment for the original abuse.

Programmes do not necessarily fall neatly into these categories, and some, such as Triple P, tailor the programme for the different levels of intervention. Programmes may also be delivered in a range of different settings, including in primary health care, hospitals, early childhood centres, community centres and parents' homes.

The basic principle underlying parenting programmes is that a change in parents' behaviour will result in a change in children's wellbeing. By promoting positive parenting behaviours and reducing negative behaviours, programmes promote positive child development. Promoting parent-child warmth, affection and attachment; the appropriate use of discipline, control and punishment; reducing the risk of maltreatment; and stimulating children's cognitive and language development are all potential goals of such programmes. As we have seen above, however, Belsky's model (Belsky 1984, 1993) and recent research findings (Howard & Brooks-Gunn 2009) suggest that while parenting behaviours are important, other factors (such as parents' mental health, community support and poverty) will influence child development and the likelihood of child maltreatment. The more intensive programmes, such as home visiting, often include components to address these wider issues.

Programmes are typically 'directed at helping parents to develop more appropriate expectations of their children, to learn how to treat them with empathy and nurturance, and to use positive discipline instead of corporal punishment' (Barth 2009 p 99). The desired outcome is improvement in a range of child outcomes (for example, internalising and externalising behaviour, cognitive or educational skills, social skills or pro-social skills, and health) through improving parenting. As Kaminski et al. (2008) note, programmes differ in content, goals, delivery settings, delivery techniques and the types of families served. The variety of programme goals and child outcomes targeted poses a challenge in comparing impact between programmes.

A group of parenting programmes have been developed to help parents deal with children's disruptive behaviour (Incredible Years and Triple P, for instance). Conduct disorders are the biggest source of referral to child mental health services in the UK and are also a significant concern in New Zealand, and a number of effective programmes are available for parents of these children (Advisory Group on Conduct Problems 2011; Hutchings & Gardner 2012). These types of programmes are generally referred to as parenting education or training programmes.

Although reducing children's disruptive behaviour is likely to also reduce the likelihood of child maltreatment, in part by teaching parents appropriate management techniques, such programmes typically begin once disruptive behaviour is evident. As this behaviour is often the child's response to earlier 'poor' parenting (Latimer, Wilson, Kemp, Thompson, Sim, Gillberg, Puckering & Minnis 2012) there is a place for parenting programmes that work with parents early on in the child's life (often in the form of antenatal or home-visiting programmes). Home-visiting programmes have

been seen as the most appropriate early intervention for high-risk families (Howard & Brooks-Gunn 2009). These programmes typically aim to provide parents with information, emotional support, access to other services, and direct instruction on parenting practices. Delivery in the home provides opportunities to use skills in a natural environment, use flexible approaches, assess child safety, increase participation and provide practical support (Asawa, Hansen & Flood 2008).

It is, therefore, important when reviewing the research and evaluation evidence to consider the goal of the programme, its intended outcomes, and the groups it targets. While the focus of this review is on parents with young children, there are also programmes for older children and young people. For example, the skills-based curricula for children have been developed for school-aged children and show some promise (Asawa et al. 2008). There are also interventions to assist children and young people in coping with the effects of maltreatment (Barlow et al. 2006) and community prevention programmes (Daro & Dodge 2009). These programmes are outside the scope of this review. Many programmes aim to address the wider ecological factors contributing to family and parental functioning, such as community development initiatives, budgeting services, family violence programmes, alcohol and drug services and mental health services. Unless these programmes have a significant parenting component they are not part of this review.

Finally, we are focusing in this review on 'parenting support programmes', but such a category has in the past been used to cover a range of activities. As well as individual programmes, there are also interventions at the service model and systems-of-care level. Systems of care are concerned with finding better ways or models to integrate a number of programmes or services for families, in recognition of the need to provide a range of services addressing the multiple needs of at-risk families and children. These are not part of this review.

2.7 Review method

The goal of this review is to assess the effectiveness of New Zealand support programmes for the parents of vulnerable children aged zero to six years. In the context of this review we are defining parenting support programmes as those programmes that seek to improve the wellbeing of vulnerable children through assisting their parents, or other adults acting in a parenting role (such as grandparents, parents' partners or other members of the family), in parenting more effectively. This includes parent education and parent training programmes, but excludes general support that does not address parenting. In keeping with the White Paper's (2012) focus on early intervention, the parameters of the review include programmes aimed at children antenatally and up to six years of age. In keeping with the focus of the White Paper and the Plan of Action, a major goal of this review is to provide evidence on the effectiveness of parenting support programmes in reducing maltreatment, or the risk of maltreatment, of vulnerable children.[9]

The review will therefore encompass the following:

- Parent education: the broad process of providing parents with specific knowledge and child-rearing skills, usually through activities implemented by professionals (for example, activities directed at attaining developmental skills, managing behavioural issues, and enhancing learning opportunities). Information about local health and social support systems may also be provided.
- Parent training: a subset of parent education, involving the direct teaching of skills to parents (such as behaviour modification programmes, in which parents learn how to identify and manage children's behaviour, using reinforcement principles).
- Parent support: services designed to support and strengthen family functioning, such as playgroups and parent information and support groups. These are generally comprehensive services, linking to other services and providing parenting education and training.

While specific parenting programmes fall within the above categorisation, there are interventions that operate at the level of systems, such as those focused on co-ordinating services. Unless it is clear that there is a parenting support component integral to interventions at this level (as

9 For a recent wider review of interventions to prevent child maltreatment and associated impairment see MacMillan et al. (2009).

with SafeCare), these interventions are beyond the scope of this review.[10] As requested in the White Paper (2012), an important component of the review will be to consider what works in New Zealand's unique social and cultural context. The review will, therefore, consider the evidence base on effective approaches for Māori and Pacific peoples.

The approach to the review was shaped by the need to systematically review the research and evaluation evidence within the time available. While this evidence base is relatively well-developed for international programmes, high-quality impact evaluations for New Zealand programmes are rare (notable exceptions are the RCT (randomised control trial) of Early Start (Fergusson, Boden & Horwood 2013)[11] and the recent benchmarking evaluation of Incredible Years (Sturrock & Gray 2013).

The approach taken was to initially review the international literature to identify evidence-based parenting support programmes and the common features of successful programmes (Chapter 3). Considering the time available, it was decided to commission a focused rapid evidence assessment to identify programmes that had been shown in RCTs to reduce child maltreatment, or the key risk factors for maltreatment (such as harsh and inconsistent discipline), in at-risk groups. The common features of these programmes were then isolated. In addition, we consulted a number of key review papers and the clearinghouses that systematically assess and rate evidence for programme effectiveness more generally. This information was then used to assist with the review of the main New Zealand programmes.

The second step was to describe the range of parenting support programmes in New Zealand and to review the research and evaluation evidence base for these programmes (Chapter 4). This information was collected by contacting the main agencies responsible for funding the programmes, through a request to the Ministry of Social Development's Centre for Research and Evaluation (CSRE), web searches and where necessary requests for information to programme developers. It also built on a previous Families Commission review of parenting programmes (Kerslake Hendricks & Balakrishnan 2005).

It is important to consider the main target groups when determining the appropriateness of adopting an evidence-based programme, in a context different from that in which it has proven effective. For example, cultural practices are likely to affect the implementation of programmes. This review has, therefore, included reviews of the research and evaluation literature on parenting programmes for Māori (Chapter 5) and Pacific parents (Chapter 6). This is in keeping with the 'braided river' approach advocated by McFarlane (Advisory Group on Conduct problems 2011).

Previous reviews and current research on evidence-based social programmes (RAND 2010; Lee, Aos, Drake, Pennucci, Miller, Anderson & Burley 2012; Axford, Elliot & Little 2012) have noted:

- the difficulty in identifying, engaging and retaining the parents of vulnerable children in programmes (Chapter 3)
- the challenges of successfully implementing programmes that have proven effective in a different context (Chapter 6)
- the importance of taking into account, where possible, the relative costs and benefits of programmes (Chapter 7).

These issues are also considered in this review.

Finally, an assessment was made of the extent to which the New Zealand programmes were effective, by synthesising the preceding review elements (Chapter 8). We considered the New Zealand research evidence, the international evidence and the features noted as being common to successful programmes.

10 Such system-level interventions typically rely on linking parents to the type of parenting programme reviewed in this report.

11 In this randomised control trial, parents are randomly allocated to attend the programme or placed in a control group (who do not attend the programme).

3. INTERNATIONAL EVIDENCE

3.1 Approach to the international evidence review

In recent years there has been considerable interest in how to use evidence to inform policy development (NESTA 2011; Puttick 2011; Wessels et al. 2013). Just what counts as evidence has also been the focus of debate (Nutley, Powell & Davies 2013; Axford & Morpeth 2013). While randomised controlled trials (RCTs) have been considered the 'gold standard' (see for example Howard & Brooks-Gunn, 2008; Chorpita et al., 2005), there has been discussion of the need to widen the evidence base, particularly in areas as complex as parenting and family relationships (Mattox & Kilburn 2012). Recent years have also seen the publication of guides to aid in the understanding and interpretation of evidence (Puddy & Wilkins 2011; Mattox & Kilburn 2012; Wessels et al. 2013).

There has also been concern with the quality of some RCTs, with attention to the need for more statistical power, longer-term follow-ups, independent trials and trials of programmes in practice rather than in an 'ideal' developmental context. However, despite these discussions, there is general agreement that RCTs, or quasi-experimental designs with comparison groups, provide the best evidence of programme impact (Howard & Brooks-Gunn 2008; Puddy & Wilkins 2011; Mattox & Kilburn 2012).[12] Randomised controlled trials provide the strongest evidence that any differences found in outcomes between a programme and comparison group can be attributed to the programme. Ideally a review of the evidence for the effectiveness of parenting support programmes would be conducted through meta-analysis or systematic review (Puddy & Wilkins 2011).[13] However, these approaches can be costly in terms of the time and the personnel required (at least a year to identify, extract and analyse all relevant studies) (Hemingway & Brereton 2009). A related but less time-consuming and resource-intensive approach, the rapid evidence assessment (REA), has been developed in recent years. REAs are reviews that use methods to accelerate or streamline traditional systematic review processes, facilitating the synthesis of evidence in an area within a short time period (Ganann, Ciliska & Thomas 2010).

There has also been considerable growth in evidence-based clearinghouses, such as the Promising Practices Network; Blueprints; the California Evidence-Based Clearinghouse for Child Welfare; and the Washington State Institute of Public Policy (see Box 3.1). These clearinghouses generally adopt similar standards of evidence to assess and categorise programmes in terms of the research and evaluation evidence for effectiveness. Typically, programmes are categorised on an effectiveness continuum – for example, from 'well-supported', to 'promising' and 'undetermined' (Puddy & Wilkins 2011). More recent refinements have included consideration of the degree to which evidence-based programmes have been implemented in different settings (replication) and the degree to which they provide information (such as programme manuals) that assist with implementation in different contexts (Blueprints 2013; Puddy & Wilkins 2011; Mattox & Kilburn 2012). For example, the US Centers for Disease Control and Prevention guidelines (Puddy & Wilkins 2011) include consideration of both experimental and contextual evidence (for example, feasibility, acceptability and utility) in their classification of interventions.

The results presented in this chapter draw upon all these sources. Firstly we commissioned a focused REA of the international evidence for parenting interventions for parents of children aged up to six years who are at risk of maltreatment (Parenting Research Centre 2013). The REA involved a systematic search through a number of electronic bibliographic databases for published research studies of parenting programmes that had targeted this at-risk group of families. In addition, New Zealand websites were searched and international systematic reviews were used to identify programmes. This rapid review was focused on identifying programmes with child maltreatment outcomes.

To widen the scope of the review, the REA was then supplemented by a review of recent systematic reviews; these focused on evidence-based interventions to reduce child maltreatment (Avellar & Supplee 2013; Barlow et al. 2006; Butchart 2006; Chaffin & Friedrich 2004; Lundahl, Nimer & Parsons 2006; MacLeod & Nelson 2000; Mikton & Butchart 2009; Pecora et al. 2012; Reynolds, Mathieson & Topitzes 2009) and those focused on general wellbeing (Bakermans-

12 This review is focused on programme impact. Other evaluation designs are better suited to assessing programme design, development and implementation, and to describing in some detail the operation of programmes (Wessels et al. 2013).

13 A meta-analysis is a systematic review that includes assessment of effect sizes.

Kranenburg, van IJzendoorn & Juffer 2003; Barlow et al. 2012; Pinquart & Teubert 2010; Sweet & Appelbaum 2004). As might be expected, there is considerable overlap in the programmes in each set of reviews. The Cochrane[14] and Campbell[15] collaboration databases of systematic reviews were also searched for relevant reviews.

The researchers also used information from some key recent reviews of current initiatives to prevent child maltreatment (Barth 2009; Howard & Brooks-Gunn 2009; Waldfogel 2009; Barlow & Calam 2011) and from a number of online clearinghouses (see Appendix 1).

3.2 Programme types and outcome domains

As the previous chapter discussed, there are a number of ways to categorise parenting interventions. Programmes can be classified by the target population – primary (the general public), secondary (those at risk) and tertiary (preventing re-victimisation) – or by their mode of delivery (for example, home visiting or group-based education or training). Programmes can contain a range of modes of delivery (a group with some home visiting, for example) and be adapted for different audiences (such as those at risk or those who have maltreated their children).

Programmes can potentially target, and have an impact on, a wide range of outcomes, some related to child maltreatment. It is therefore important to consider measures relating to a range of outcomes. For the more comprehensive home-visiting programmes these can include child health, development and safety (Well Child and dental visits, injuries and hospital visits, for example); changes in parenting behaviours (such as parent-child attachment, parental stress, sensitivity, and use of harsh discipline) and parental outcomes (including social support and maternal mental health) (Howard & Brooks-Gunn 2009).

The potential outcomes considered in this review are presented in Box 3.1; they closely resemble the factors identified in the White Paper (Box 2.1). The programmes reviewed were not restricted to a single outcome, such as maltreatment, since relatively few evaluations have measured that specific outcome (Mikton & Butchart 2009).[16] Using child maltreatment as a primary outcome measure can be problematic because of the need for lengthy follow-up, the low base rate for substantiated maltreatment in the population and the fact that higher levels of contact with professionals for those in programmes can lead to higher rates of reporting of any maltreatment. This 'surveillance effect' may explain the relative lack of positive findings for programmes, particularly those with home visiting (Howard & Brooks-Gunn 2009).[17]

14 http://www.cochrane.org/
15 http://www.campbellcollaboration.org/
16 Mikton and Butchart's (2009) review suggests that direct measures are more likely for home-visiting evaluations (44 percent) than for parent education evaluations (17 percent).
17 Although Chaffin and Bard (2006) find that this is not a major problem for evaluation of programmes.

Box 3.1 Outcomes framework for the analysis of effective parenting interventions for parents of vulnerable children aged up to six years.

Child development: normative standards for growth and development; antenatal and infant development (for example. antenatal and parental smoking and mother's alcohol or drug use, foetal and early childhood exposure to trauma or abuse, birth weight, breastfeeding, immunisation).

Child behaviour: includes both internalising and externalising behaviour difficulties; problem behaviour; consistent parenting; child behaviour management; positive child behaviour and prosocial behaviour.

Safety and physical wellbeing: includes optimal physical health and healthy lifestyle (adequate nutrition, free from preventable disease, sun protection, healthy teeth and gums, healthy weight, free from asthma, adequate exercise and physical activity, healthy adult/parent lifestyle); safety (safe from injury and harm, free from abuse and neglect).

Parent-child relationship: includes parent-child interactions (positive interactions between parents and children, emotional warmth and responsiveness, absence of hostility); consistency and reliability.

Basic childcare: for example, bathing, putting baby to bed, clothing, food and nutrition, child self-care, avoidance of neglect.

Family relationships: includes the parental relationship and relationships between other family members (child free from exposure to conflict or family violence; positive family functioning; stability in relationships; connection to primary caregiver; connection to family); social relationships and social support (connection to school and friends, connection to community, connection to culture).

Educational participation: for example, enrolment in early childhood education, school readiness and performance.

Systems outcomes: notification and re-notification to agencies, maltreatment investigations and re-investigations, verified maltreatment investigations and re-investigations, referrals to agencies, presentation to hospital emergency department, help-seeking behaviour, out-of-home care, length of stay, placement stability.

The range of potential outcomes measured also makes the comparison of evidence-based programmes challenging. Programmes do not always target or measure the same outcomes, so they are difficult to compare on the basis of different impacts (for instance, improved knowledge of child development versus improved parent-child relationship). In order to deal with the potentially overwhelming number of possible outcomes from any intervention, reviews often prioritise outcome areas, choosing those on which to assess the programmes (Mathematica Policy Research 2012). Given the White Paper's focus on preventing maltreatment, this review has given particular attention to this outcome, and so focuses on those factors considered strongly indicative of this outcome. These include child abuse reports, proxy measures of maltreatment (such as hospitalisations) and proximal risk factors (such as parents' reports of the use of harsh discipline).

It is also important to consider the size of any change in outcome measure – that is, to consider not only the type of effect but also its quantum of effect (McCartney & Rosenthal 2000). Effect size is a method for standardising the degree of change in the outcome measure, which enables the outcomes from different studies to be compared. Effect sizes of .20 are regarded as small; .50 as medium and .80 as large (Cohen 1988).[18] Effect size and the nature of the outcome need to be considered together when assessing the practical significance of findings. Depending on the outcome sought, a small change in an important outcome (such as child abuse) may be of more practical significance than a medium change in a more distal outcome (connection to school and friends, for instance). Where possible we present information on the effect size of any reported impact.

18 Cohen's d has some liabilities when applied to rates, as large reductions in rates can often produce small d values. For example, the evaluation of Early Start showed that the programme reduced parentally reported child abuse by 50 percent over a nine-year period. The effect size (0.29) was relatively modest, however. For many purposes the attributable risk is a better measure.

3.3 Identification of programmes

The REA and our wider review of the international literature identified a number of parenting interventions that have shown some success in working with parents of at-risk or vulnerable children. These programmes have been tested using control or comparison groups and have shown influence on child development, child health, parenting behaviours, maternal health and/or child maltreatment. The programmes are presented in Table 1, in terms of the three levels of prevention discussed earlier and the outcome domain.

Table 1: Summary of parenting support programmes for parents of vulnerable children (aged zero to six years), with outcome domain

Parenting programme	Child development and school readiness	Child health	Positive parenting	Child mal-treatment	Maternal health
Primary					
SEEK (postnatal)		✓	✓	✓?	
Pre-/postnatal care – eg Family Foundations	✓	✓	✓		✓
Triple P (System)				✓?	
Secondary (home visiting)					
Nurse-Family Partnership (0–2 years)	✓	✓	✓	✓	✓
Early Start (0–5 years)	✓	✓	✓	✓	
SafeCare (0–5 years)				✓	
Healthy Families America (New York) (0–5 years)	✓	✓	✓	✓?	✓?
Hawaii Healthy Start (enhanced)			✓		
Child First (0–5 years)	✓			✓?	✓
Parents as Teachers (0–3 years)	✓		✓	✓?	
HIPPY (approx. 3–6 years)	✓		✓		
Family Connections (5–11 years)	✓		✓		✓
Infant Health and Development programme (0–5 years)	✓				

✓ – evidence of impact in this outcome domain; ✓? – for child maltreatment, some evidence of impacts but potential issues with study design or analysis (eg only applied to sub-group).

Parenting programme	Child development and school readiness	Child health	Positive parenting	Child mal-treatment	Maternal health
Parent education and training					
Parent Child Interaction Therapy (PCIT) (0–6 years)	✓		✓	✓	
Triple P (versions for all age groups)	✓		✓		
Incredible Years (0–12 years)	✓		✓		
1-2-3 Magic: Effective Discipline for Children (2–12 years)	✓		✓		
Family Check-Up (2–17 years)	✓		✓		
Play and Learning Strategies for Infants (PALS) (0–3 years)	✓		✓		
Toddler-parent psychotherapy (depressed mothers)			✓		
Child-parent psychotherapy (family violence)					
Project Support (4–9 years)	✓		✓		✓
Parents Under Pressure (2–8 years)	✓		✓		
New Beginnings & Children in the Middle (US post-divorce) (all ages)	✓		✓		

✓ – evidence of impact in this outcome domain; ✓? – for child maltreatment, some evidence of impacts but potential issues with study design or analysis (eg only applied to sub-group).

Parenting programme	Child development and school readiness	Child health	Positive parenting	Child mal-treatment	Maternal health
Pre-/school-based					
Chicago Child-Parent Centers (3–9 years)	✓		✓	✓?	✓
Early Head Start (0–3 years)	✓		✓		
Tertiary					
Attachment and Biobehavioural Catch-Up (ABC) (0–6 years)	✓		✓		
Early Intervention Foster Care (EIFC) (0–5 years)			✓		
Keeping Foster Parents Trained and Supported (KEEP) (5–12 years)	✓		✓		
Homebuilders (Intensive Family Preservation Services) (0–17 years)			✓		

✓ – evidence of impact in this outcome domain; ✓? – for child maltreatment, some evidence of impacts but indirect measures used or potential issues with study design or analysis (eg only applied to sub-group).

3.3.1 Primary prevention

Primary prevention programmes are targeted at the general population, including those who are, or are soon to be, parents or caregivers. These include interventions provided by universal service providers, such as midwives, health visitors, children's centre workers and GPs – those with a role in health promotion, identification of risk and delivery of support. Programmes at this level have the benefit of being less likely to stigmatise families, as they are available to all, rather than those identified as at-risk.

A recent example of a population-level intervention is the adaption of the Triple P programme[19], which was developed and trialled in the US (Prinz, Sanders, Shapiro, Whitaker & Lutzker 2009). Prinz et al. found statistically significant effect sizes for three independently derived population indicators: substantiated child maltreatment, out-of-home placements of children, and child maltreatment injuries. A recent review (Wilson, Rush, Hussey, Puckering, Sim, Alley, Doku, McConnachie & Gillberg 2012), however, questions these findings, suggesting the study 'actually demonstrated an unexplained rise in reports in control areas rather than a drop in Triple P intervention sites'. Other population-level programmes have not been rigorously evaluated (Barth 2009). For example, a common universal public health approach is to use media campaigns to raise public awareness of issues. Mikton and Butchart (2009) found that apart from one review (MacLeod & Nelson 2000), previous reviewers had concluded that evidence was either mixed or insufficient for programmes operating at this level.

19 http://www.triplep.net/glo-en/home and http://www.triplepcentre.net.nz/

Palusci and Haney (2010) note that a problem with public campaigns is that they often lack clear behavioural directions that the general public can embrace and feel empowered to impose on others in their community. Further, as we have seen, much maltreatment involves neglect, which is less amenable to identification and to addressing through public health interventions. Public campaigns have been shown to increase parents' knowledge or recognition of an issue but have not been tested in terms of actual behaviour change. The exceptions to this may be interventions to prevent shaken baby syndrome (examples discussed below).

Parents have also been approached to join community support groups, and some programmes have used community volunteers to deliver health promotion to first-time at-risk mothers, such as the Community Mothers Programme (Johnson et al. 2000). These programmes provide access to social networks as well as practical information and advice. While a social support component improves home-visiting outcomes (MacLeod & Nelson 2000), Barlow et al. (2006) concluded that on their own these types of interventions were not effective.

Pregnancy has been described as a 'magic moment' or 'window of opportunity' to engage parents who are motivated to do the best for their child (Cuthbert et al. 2011; Palusci & Haney 2010). Programmes can teach parents and caregivers to cope with an infant crying and how to provide a safe sleep environment for their infant, and promote positive parenting (for an example see Box 3.2). A recent review by Pinquart and Teubert (2010) found that 'early parenting education programmes for expectant and new parents produce a significant positive effect' (p 323) on a broad range of outcomes (including parenting, child abuse and neglect, parental stress, health-promoting parental behaviour, child development, parental psychological health and couple adjustment). In terms of effect size, many of these are practically meaningful. Interestingly, they found only weak evidence for generalisation of effects, with the effects found aligning closely with the outcomes targeted by the programme. New Zealand's Well Child service (discussed in the next chapter) and the UK Healthy Child programme (Shribman & Billingham 2009) are both examples of this type of assistance provided to new parents. Given sufficient reach, they offer the opportunity to address parenting deficits and to identify parents needing extra support, possibly by linking them to more intensive services.

Box 3.2 Example of a promising primary prevention programme

Family Foundations

This study investigated the ability of a psychosocial prevention programme implemented through childbirth education programmes to enhance the coparental and couple relationship, parental mental health, the parent-child relationship, and child outcomes. A sample of 169 heterosexual, adult couples expecting their first child was randomised to intervention and control conditions. The intervention families participated in Family Foundations, a series of eight classes delivered before and after birth, which was designed as a universal prevention programme (ie applicable to all couples, not just those at high risk). Intent-to-treat analyses utilising data collected from child age six months through to three years indicated significant programme effects on parental stress and self-efficacy, coparenting, harsh parenting, and children's emotional adjustment among all families, and maternal depression among cohabiting couples. Among families of boys, programme effects were found for child behavior problems and couple relationship quality. These results indicate that a universal prevention approach at the transition to parenthood focused on enhancing family relationships can have a significant and substantial positive impact on parent and child wellbeing.

Feinberg, Jones, Kan, and Goslin (2010)

Health clinics and doctors' surgeries also provide the opportunity to deliver general parenting programmes or interventions. Some programmes targeting specific behaviours have shown evidence of success, in particular those aimed at stopping carers from shaking babies (Dias, Smith, deGuehery, Mazur, Li & Shaffer 2005; Dubowitz, Feigelman, Lane & Kim 2009). An example is the United States Safe Environment for Every Kid (SEEK) intervention. Involving paediatric resident education in a primary care medical setting, it has shown promising results by reducing maltreatment reports and harsh parenting, and improving immunisation (Dubowitz et al. 2009). Palusci and Haney (2010) believe that such pre-emptive guidance for all families offers a good chance of reducing child maltreatment and violence.

3.3.2 Secondary prevention

Secondary prevention interventions are delivered to groups who are considered at greater risk of child maltreatment. There are two main groups of interventions at this prevention level: home-visiting programmes and parent training and education groups (although there is sometimes overlap in terms of programme content and delivery).

Home-visiting programmes

Home visiting is acknowledged as one of the more successful approaches to preventing child maltreatment and addressing risk factors, and a number of programmes have been developed and evaluated (Howard and Brooks-Gunn 2008). A general description of home-visiting programmes is provided in Box 3.3. Young (under the age of 25), first-time mothers, who are engaged before the start of the third trimester of pregnancy, appear the most likely candidates to benefit from home-visitation programmes (Lawson, Alameda-Lawson & Byrnes 2012). The frequency of visiting varies with the age of the child, and programmes typically work with families for a number of years (from birth to up to two to five years of age, for example) (Howard & Brooks-Gunn 2008).

Box 3.3 General description of home-visiting programmes

Because young children are more likely than older children to be maltreated, the goal of some of the home-visiting models in the HomVEE review is to prevent or reduce the incidence of child abuse and neglect. To achieve this goal, home visitors typically work with parents to improve knowledge, skills, and behaviors that are associated with maltreatment. For example, they may educate parents on how to interact with their children in a more responsive manner, teach them alternative ways to discipline their children, or provide strategies for meeting their children's developmental needs. They may also attempt to decrease the numbers of stressors that may make families vulnerable to inappropriate parenting. For example, home visitors may work to enhance children's functioning by improving child health and development or connect families with community resources (such as mental health and substance abuse services).

Parenting education is often provided, either through didactic or experiential approaches. Some models use a structured curriculum to provide these services; others take a more flexible approach by addressing specific parenting needs identified during home visits. To a lesser extent, home-visiting models integrate parenting interventions that have been found to improve specific parenting behaviors (for example, responsive interactions and positive behavioral support). In addition, home visitors may provide information to parents about child development or safety practices in the home.

http://homvee.acf.hhs.gov/

Three programmes are consistently rated as well-supported home-visiting programmes – the Nurse-Family Partnership programmes of David Olds, the Christchurch-based Early Start

programme and the SafeCare programme. These programmes are described in more detail in the next section on maltreatment outcomes, and in the case of Early Start in the New Zealand section.

One of the earlier home-visiting programmes was the Hawaii Healthy Start (HSP) programme, which was then used as a model to develop the Healthy Families America (HFA)[20] programmes. Slack et al. (2009) reviewed the evidence for these programmes and reported mixed results, partly due to the fact that the variable quality of evaluation designs and differing evaluation strategies made comparisons across studies difficult. Most studies found no impact on reported child abuse and neglect, although there was some evidence of reductions on measures of risk (such as parents reporting harsh and aggressive behaviours towards their children) (see also Howard & Brooks-Gunn 2008; Harding, Galano, Martin, Huntington & Schellenbach 2007). Of note, the evaluations reported high levels of programme attrition (50 percent over two years) and in the Hawaii Healthy Start programme only one percent of the families received weekly home visits.

Another widely cited programme is Parents as Teachers (PAT), a parent education, family support and school readiness programme for parents from pregnancy until kindergarden. It focuses on promoting child development and school achievement through parent education, delivered both in the home and through parents' groups. Parents as Teachers has been shown to result in improvements in child development outcomes (Avellar & Suplee 2013), and Slack et al. (2009) cite research providing some support for PAT in reducing child maltreatment. A study of a teen-parents-as-first-teachers programme incorporating case management (Reynolds et al. 2009) found that although PAT on its own was not effective in lowering child maltreatment, when combined with case management the programme lowered risk.

The Home Interaction Programme for Parents and Youngsters (HIPPY) is another programme whose goal is to increase the school readiness of young children (usually aged three-and-a-half to five years) (Nievar, Jacobson, Chen, Johnson & Dier 2011). An RCT found some evidence that HIPPY had a positive impact on classroom adaptation and academic self-image (Baker et al. 1999), and other research has found positive effects on school achievement and parents' engagement in their children's learning (Nievar et al 2011). There is however, no evidence of its impact on other child maltreatment risk factors.

There are a number of other home-visiting programmes with varying degrees of evidence of effectiveness. The Washington State Institute of Public Policy (2012) includes in its review of programmes a category of 'other' home-visiting programmes to reflect the diversity of these programmes. Their analysis suggests a range of positive effects on child development from these programmes. Examples are outlined below.

> Child First (Child and Family Interagency, Resource, Support, and Training)[21] is a comprehensive, home-based, therapeutic intervention targeting multi-risk young children and families. It was developed to prevent or diminish serious emotional disturbance, developmental and learning disabilities, and abuse and neglect. It is delivered by a professional to individual parents in their homes in 24 weekly sessions. In a recent RCT Child First mothers had less parenting stress at the six-month follow-up, lower psychopathology symptoms at the 12-month follow-up, and less protective service involvement at three years post-baseline relative to usual care mothers (Lowell, Carter, Godoy, Paulicin, & Briggs-Gowan 2011). Families were more connected to services and children showed fewer externalising and language problems.
>
> The Infant Health and Development Programme was an eight-site randomised controlled trial testing the efficacy of early intervention to enhance the cognitive, behavioural, and health status of low-birth-weight premature infants. Between the birth of a premature child and the age of three, programme families receive paediatric follow-up, home visits, parent support groups, and a systematic educational programme provided in specialised child developmental centres. Evaluations (Brooks-Gunn et al. 1994) found benefits to children's cognitive development and fewer behavioural problems, but the differences with the control groups decreased over time.

20 http://www.healthyfamiliesamerica.org/home/index.shtml
21 http://www.childfirst.com/cf/page/home-visiting-intervention

Family Connections is a multifaceted, community-based service programme that works with families in their homes and in the context of their neighbourhoods to help them meet the basic needs of their children and reduce the risk of child neglect. The programme targets at-risk families with children aged five to 11 years and lasts between three and nine months. Although not yet subject to an RCT, research comparing different levels of the programme has shown some evidence of positive changes over time in protective factors (parenting attitudes, parenting competence, social support); diminished risk factors (parental depressive symptoms, parenting stress, life stress); and improved child safety (physical and psychological care of children) and child behaviour (DePanfilis, Dubowitz & Kunz 2008).

Parent education and training programmes[22]

Parent education and training programmes are typically centre-based and delivered in group settings.[23] They aim to improve parents' child-rearing skills; increase parental knowledge of child development; modify parents' attitudes (towards physical punishment, for example) and perceptions of child behaviour (as age-appropriate rather than naughty); and encourage positive child management strategies (Mikton and Butchart 2009). Two meta-analyses of such interventions reported small and medium effect sizes on these risk factors and on direct measures of child abuse (Lundehal et al. 2006; Geeraert et al. 2004).

Good evidence is available for interventions to help parents cope with children who have conduct problems. The Triple P programme[24] and the Incredible Years programme[25] have been regarded as well-supported programmes for this group of parents (Advisory Group on Conduct Problems 2011).

Triple P is a well-researched Australian-developed program that was originally designed for parents of children with behavioural problems and has since been expanded in scope. It covers five levels of intervention with increasing intensity at each level (universal, selective, indicated, early intervention and treatment), with a specific programme for parents at risk of maltreating their children (Pathways Triple P; see New Zealand section for more detail). The programme is delivered by a professional and targets child development, parenting behaviours, child behaviour and the parent-child relationship.

A recent systematic review and meta-analysis of the Triple P Programme conducted at the University of Queensland showed evidence supporting the short and long-term effects of each of the five levels of the programme on child, parent and family-level outcomes (Sanders et al. 2013).[26] Parents show improvements in positive parenting, parenting satisfaction and efficacy, and children show reductions in behaviour problems. Independent evaluation of the programme in Australia found more than 90 percent of parents who took part were more confident in their parenting, and six months after parents had been part of the programme children were behaving significantly better. The quality of evidence for each version of Triple P varies, however, with good evidence for the effectiveness of Triple P Level 4, compared to weaker evidence for Teen Triple P. A recent systematic review (Wilson et al. 2012) has questioned previous findings, concluding 'we found no convincing evidence that Triple P interventions work across the whole population or that any benefits are long term' (see Sanders, Pickering, Kirby, Turner, Morawska, Mazzucchelli, Ralph & Sofronoff 2012 for a response).

The Incredible Years BASIC programme[27] is designed to improve family interaction and prevent early and persistent anti-social behaviour in children aged two to 10 years (see New Zealand section for more detail). It involves 12 weekly two-hour sessions for parents, delivered by a trained facilitator to groups of up to 12 parents.[28] Incredible Years also has variations targeting specific groups and issues. For example, the basic programme focuses on parenting skills, while the advanced programme focuses on parents' interpersonal skills. The topics include play, praise, limit-setting and dealing with misbehaviour, and groups involve discussion, videotape modelling and the

22 These programmes are often described as parent behaviour management training or more briefly as parent management training.
23 These programmes may also include some in-home one-on-one work with the family.
24 http://www.triplep.net/glo-en/home and http://www.triplepcentre.net.nz
25 http://www.incredibleyears.com/
26 Regardless of the level of Triple P implemented, small-to-moderate effect sizes were found for children's social, emotional and behavioural outcomes.
27 www.incredibleyears.com
28 Latest guidance suggests that this can be extended to 14 or even 18 weeks.

rehearsal of parenting techniques. There are also programmes for children (the Dina Dinosaur Social Skills and Problem-Solving Curriculum) and teachers.

The programme has been shown to be effective in reducing child conduct problems and increasing effective parenting (Webster-Stratton & Reid 2010) and is regularly cited as a well-supported programme. The Incredible Years programme has recently been adapted for use with at-risk populations (Hughes & Gottlie 2004; Webster-Stratton & Reid 2010). Webster-Stratton & Reid describe the adaptions made to the programme in order to make it more relevant for the at-risk population. While citing some research evidence that Incredible Years works with this group, Ronan et al. (2009) conclude 'although developed primarily to prevent conduct disorder, this parenting program does currently have some demonstrated support for assisting at-risk families, including those who have documented maltreatment More evaluation, however, is necessary to ascertain its full potential in preventing child maltreatment or its recurrence' (p 203). Although a recent study supported the effectiveness of Incredible Years for those with a history of child maltreatment (Hurlburt, Nguyen, Reid, Webster-Stratton & Zhang 2013) more research is needed to measure actual child maltreatment outcomes.

A long-standing intervention targeting seriously disobedient or destructive behaviour in children is Parent Management Training (PMT). This programme, which has been in operation for 30 years, is aimed at older children and has been shown to reduce delinquency and arrests. Parent Child Interaction Therapy (PCIT) grew out of Parent Management Training and targets children and families involved in child welfare systems (see detailed review below). It is an intervention with good evidence of effectiveness in reducing child maltreatment and associated risk factors (Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, Jackson, Lensgraf & Bonner 2004). Unlike some of the above group-based programmes, PCIT is focused on the parent-child dyad, involving relatively intense work with parents in a clinical or home setting.

Parenting interventions have also been developed for parents undergoing major family disruption. Parenting education programmes for separated parents (such as New Beginnings and Children in the Middle) are available in the United States and have been trialled in other countries. They tend to be relatively short programmes (four to 10 hours) whose aim is to teach parents about the impact of separation on children, normal child reactions to separation, and how to reduce couple conflict. An RCT of New Beginnings (Zhou, Sandler, Millsap, Wolchik & Dawson-McClure 2008) found improved parenting practices and parent-child relationships, and decreased child externalising. While children with parents in conflict are at heightened risk of child maltreatment, other programmes have been developed targeting parents with one or more of what is known as the 'toxic' trio of risk factors (mental health issues, substance abuse and domestic violence).

Therapeutic programmes for children that also involve parents have been developed for children with depressed mothers (toddler-parent psychotherapy, for example, has been shown to improve attachment – see Toth, Rogosch, Manly & Cicchetti 2006) and children witnessing domestic violence (child-parent psychotherapy, for instance) (Cuthbert et al. 2011). Project Support aims to reduce conduct problems in children exposed to intimate partner violence. The intervention involves teaching mothers child-management skills and providing them with instrumental and emotional support. Children in families in the Project Support condition, compared with those in the comparison condition, exhibited greater reductions in conduct problems. Mothers in the Project Support condition, compared with those in the comparison condition, displayed greater reductions in inconsistent and harsh parenting behaviours and psychiatric symptoms. Changes in mothers' parenting and psychiatric symptoms accounted for a sizable proportion of Project Support's effects on child conduct problems at the end of treatment (Jouriles et al. 2009).

An example of a promising programme for substance-abusing parents is Parents Under Pressure (PUP), a programme for methadone-dependent mothers with children aged two to eight in their full-time care. This Australian programme consists of 10 modules delivered over 10 to 12 weeks by trained psychologists. It involves home-based delivery and focuses on multiple factors (marital conflict, social support, housing, legal advice, parental psychological functioning, and intervention in other contexts such as schools) in order to improve parents' relationships with their children.

Research (Dawe & Harnet 2007) found that at six-month follow-up the parents had less parenting stress, lower child-abuse potential, less rigid or harsh parenting beliefs and attitudes and fewer child behaviour problems.

Involvement in early childhood education is regarded as beneficial for vulnerable children. Zoritch, Roberts and Oakley (1998) conducted a systematic review of the health and welfare effects of daycare, noting that many of the interventions included a focus on promoting positive parenting and had home-visiting components. Their review mainly considered outcomes for children (cognitive and health outcomes) and mothers (employment, education and welfare receipt, for example), although some included mother-child interaction measures. They found eight RCT trials of non-parental daycare. Zoritch et al. (1998) found that the studies indicated improvements in child wellbeing, especially enhanced cognitive development and school achievement. Studies also reported increased maternal employment and education and some evidence of improved mother-child interactions. These interventions were not specifically targeting child maltreatment.

One preschool education programme with evidence of positive child maltreatment impact is the Chicago Child-Parent Center (CPC) programme (Reynolds & Robertson 2003). This preschool education programme targets children in low-income households and is coupled with family support services, including home visiting. While the focus is on enhancing children's involvement in education, families also receive health services and free or reduced-price meals. A study using a quasi-experimental design found that enrolment in the programme was associated with lower rates of child abuse and neglect by age 17 years (Reynolds & Robertson 2003) as well as better educational outcomes.

A more recent review by Waldfogel (2009) concluded that 'researchers have not yet conducted formal evaluations of whether childcare prevents maltreatment among families whose cases are open with CPS. But studies of Head Start and other childcare programmes suggest that childcare services can help reduce maltreatment' (p 200). Head Start and Early Head Start RCTs found that parents were less likely to report spanking their child. Waldfogel (2009) suggests this may have been due to time spent in childcare relieving parental stress, by exposing children to alternative forms of discipline and making them more visible to others who might report maltreatment. A large randomised trial of Early Head Start showed that at three years of age children had better cognitive and language development, better attention and less aggression. Parents were more emotionally supportive and provided more language and learning stimulation (by reading more, for instance) (Love, Kisker, Ross, Constantine et al. 2005).

There are also a number of programmes that have produced promising results when working with at-risk groups. As discussed above, some of these are evidence-based programmes targeting conduct disorder that have recently been adapted to address the needs of parents with vulnerable children generally. Other programmes have been designed to work with parents of very young children, often with a focus on improving parent-child attachment (Asmussen 2011). Promising programmes include the following.

Play and Learning Strategies for Infants (PALS)[29] delivered a 10-session curriculum that targeted each of the four aspects of a responsive parenting style (affective-emotional style with positive affection and high levels of warmth and nurturance, responses that are contingently linked to children's signals, and acceptance of children as unique individuals). Delivery included using educational videotapes featuring mothers with similar backgrounds; a facilitator coaching parents' use of key behaviors during videotaped interactions with their infants; supporting mothers in critiquing their videotaped practised behaviours; and planning for how to use the target behaviors across the week. Research indicated that compared to an attention control group, the PALS parents showed increases in affective emotional and cognitively responsive behaviours at three-month follow-up (Landry, Smith & Swank 2006). This in turn led to improved social and cognitive development in children.

Family Check-Up is a brief intervention aimed at preventing the development of conduct problems. Initially for parents of older children, it has been adapted for use with toddlers. An RCT found reductions in disruptive behavior and greater maternal involvement, and that the

29 http://www.123magic.com/

programme was particularly effective for children at greater risk for a persistent trajectory of conduct problems (Shaw, Dishion, Supplee, Gardner & Arnds 2006).

1-2-3 Magic: Effective Discipline for Children is another brief intervention, comprising three weekly group sessions and a one-month booster. The focus is supporting effective discipline (using the video 1-2-3 Magic) and reducing parent-child conflict. A randomised controlled evaluation of a four-session psychoeducational group for parents of preschoolers with behaviour problems, delivered in community agencies, found improved parenting practices and a reduction in child behaviour problems (Bradley, Jadaa, Brody, Landy, Tallett, Watson, Shea & Stephens 2003).

A number of other programmes have received some attention and are widely used, but have yet to be assessed for their impact using RCTs.

The Mellow Parenting programme[30] aims to enhance parent-child attunement, child behaviour, and child development. It is an intensive programme which runs one full day per week for 14 weeks for parents with a child under five. An unpublished Department of Health study using a comparison group is referred to by Statham (2000) in her review of UK parenting programmes. This study found that compared to the comparison group, the Mellow Parenting group showed significant improvements in the mother's mental state, the child's behaviour and observed mother-child interaction.

Nuturing Parenting[31] is a parent education programme that focuses on reducing abusive or neglectful behaviour. Although this programme has not been evaluated using control groups, there has been some evidence that increased dosage resulted in fewer child maltreatment notifications (Maher, Marcynyszn, Corwin & Hodnett 2011).

3.3.3 Tertiary prevention

Interventions at this level are designed to address the effects of abuse and to prevent its recurrence. Addressing the effects of maltreatment may involve some clinical treatment focused on the child, but may also involve participation by parents, especially in interventions for younger children. There is evidence for the effectiveness of these interventions; those aimed at addressing trauma (eg Trauma-focused CBT [TF-CBT]), based on cognitive-behavioural theory (eg Cognitive Behavioral Therapy for Sexually Abused Preschoolers [CBT-SAP]), and psychotherapy (eg Child-Parent Psychotherapy [CPP]) (MacMillan et al. 2009). Examples of individual therapeutic programmes with positive RCT findings include The Mothers and Toddlers Program (Suchman et al. 2010) and toddler-parent psychotherapy (Toth et al. 2006).

The placement of children in out-of-home care is a common response to severe maltreatment. Interventions have been developed to improve the effectiveness of these care experiences for children by working with foster carers and sometimes with parents. Leve, Harold, Chamberlain, Landsverk, Fisher, and Vostanis (2012) recently conducted a systematic review of interventions for children in foster care. They identified eight 'efficacious evidence-based interventions for foster families'. These interventions had all been subject to at least one RCT, with outcome measures mainly concerned with the stability of placement and child safety, and to a lesser extent children's wellbeing. The interventions they identified that were relevant to the current review were:[32]

- Attachment and Biobehavioural Catch-up (ABC) – designed to help caregivers facilitate healthy regulation of their child's behaviour and stress responses. It is for children under the age of six years who are at risk of maltreatment or those who have been maltreated. Delivery is to individual carer-child dyads in the home or foster home. It targets child development, child behaviour and the parent-child relationship, usually in 10 sessions. An RCT (Sprang 2009) showed that post-intervention participants had significantly less child abuse potential, internalising and externalising behaviour problems in children, and parental stress.

30 www.mellowparenting.org
31 http://www.nurturingparenting.com/
32 Multisystemic Therapy (MST) is a well-evaluated programme, but for older youth who are serious offenders.

- Multidimensional Treatment Foster Care (MTFC) – a wraparound service aimed at equipping foster parents with parenting and other fostering skills, carried out in a home setting. Different versions of the programme have been developed for different age groups. The most relevant for the current review are the Multi-Treatment Foster Care for Preschoolers (MTFC-P) and the Early Intervention on Foster Care Program (EIFC). An EIFC RCT was conducted in the US (Fisher, Burraston & Pears 2005) which found fewer placement breakdowns at 20-month follow-up.
- Keeping Foster Parents Trained and Supported (KEEP) – group intervention lasting six weeks that included training, supervision and support to foster parents in applying behaviour-management strategies. The intervention was found to be effective in reducing behavioural problems in children, and increasing positive reinforcement by caregivers and the stability of placements (Kinsey & Schlosser 2012).

Kinsey and Schlosser (2012) conducted a recent systematic review of foster-care interventions, although they did not confine the studies to RCTs. While concurring with Leve et al. (2012) on the effectiveness of the programmes described above, they comment that the most successful tend to be wraparound services, most of which have a caregiver-training element. They find little evidence that group carer-training programmes work, suggesting that the varied needs of the children in care mean a more individualised approach is needed. They conclude 'it may be that short-term training groups for carers cannot adequately cover the variety and complexity of difficulties foster children may experience, so have little impact' (p 29).

The Intensive Family Preservation Services and Homebuilders model has been used extensively with families in the child welfare system, though recent reviews have concluded that results have been disappointing (Chaffin et al. 2004; MacMillan et al. 2008). A 2012 review by Channa et al. showed that intensive family-preservation programmes had a medium and positive effect on family functioning, but were generally not effective in preventing out-of-home placement. Intensive family-preservation programmes were effective in preventing placement for multi-problem families, but not for families experiencing abuse and neglect. Moreover, the effect on out-of-home placement proved to be moderated by client characteristics (sex and age of the child, age of parents, number of children in the family, single-parenthood, non-white ethnicity) and programme characteristics (caseload).

Evidence based programmes shown to reduce child maltreatment outcomes

As noted above, relatively few programmes have shown clear RCT evidence of measured reductions in child maltreatment. In part these findings may reflect the short follow-up periods of most studies, which when combined with the low base rate for child maltreatment and difficulties accessing maltreatment records, mean few studies have this outcome measure. Table 2 presents the four main programmes identified by the REA that have shown reductions in measures of reported child maltreatment in at-risk families. This is followed by a description of each of these programmes. As discussed earlier, there is also some evidence for positive child maltreatment outcomes for programmes discussed in the previous sections (SEEK, PAT, Healthy Families and CPC), although the evidence is sometimes mixed or the supporting studies have limitations.

Table 2: Programmes with evidence of reduction in child maltreatment reports	
Programme	**Findings**
Nurse-Family Partnership (USA)	Avoidance of punishment (46 months follow-up) 48 percent decline in rates of child abuse and neglect at 15-year follow-up
Early Start (NZ)	Non-punitive attitudes (nine years follow-up) Parents report fewer agency contacts for physical child abuse (nine years follow-up) Fewer visits to hospital for injury or accidents (nine years follow-up) Less physical punishment (nine years follow-up) Fewer severe physical assaults on child by parent (nine years follow-up)
Parent-Child Interaction Therapy (USA)	Fewer physical abuse re-reports (2.3 years follow-up)
SafeCare (USA)	Less repeat maltreatment (seven years follow-up)

The **Nurse-Family Partnership (NFP)**[33] is a long-running home-visitation program from the USA developed by David Olds (Olds, Henderson, Tatelbaum & Chamberlin 1986).[34] Its target group is vulnerable first-time mothers, such as adolescents, single parents, those of low socio-economic status or those with little education. Individual parents are visited in the home during the antenatal and postnatal periods by nurses. The programme is delivered in fewer than 10 prenatal sessions and an average of 20 to 25 postnatal sessions, each lasting for just over one hour. Participation ceases when the child reaches two years of age. The aim of NFP is to prevent or reduce negative child outcomes, including maltreatment, by providing support to at-risk mothers during pregnancy and in their first child's early years.

In this intervention, nurses work directly with mothers. The intervention is delivered to parents by linking families to needed services – housing, income and nutritional assistance – as well as to childcare and educational vocational training. Parents develop individualised service plans and the nurses help to clarify parents' goals. Parents are provided with problem-solving skills, praise and encouragement. Structured session guidelines are used and plans are developed for each visit. Information covered in the visits includes health-related behaviour during pregnancy and the early childhood years, the care parents provide to their children, and maternal personal life-course development information such as family planning, educational goals and participation in the workforce.

The NFP programme has been evaluated extensively since its inception in the 1980s. Results from these studies have included the following findings for those receiving the intervention:

- by two years, significantly fewer visits to the hospital emergency department than those in the control group
- significantly less restriction and punishment of children and a larger number of appropriate play materials compared with those in the control group
- significantly fewer hazards in the home and less avoidable punishment than those in the control group (46 months old)
- children aged between 25 and 60 months had significantly better outcomes than controls for behavioural coping problems, number of visits to the emergency department and number of days in hospital.

33 http://www.nursefamilypartnership.org/
34 These descriptions come from the REA.

- assessment at 15 years of age found that there were significantly fewer substantiated reports of child abuse and neglect when compared to the control group (Olds et al. 1997) and there was a significant reduction in maltreatment reports compared to the control group (Eckenrode et al. 2000).

These significant differences between groups in child maltreatment outcomes only started to emerge when the children were older. Effects were not observed in the early years of the evaluation.

Early Start[35] is a New Zealand programme aimed at vulnerable Christchurch families caring for children under five years of age. Risk factors evident in families involved with Early Start include domestic, family or intimate partner violence and parental substance abuse. This is a professional-delivered home-based intervention. Individual families participate for up to five years, with the number of visits varying from a maximum of one per week to a minimum of one per month. The programme commences with an assessment of family needs, issues, challenges, strengths and resources. Individualised service plans are developed. There is a focus on relationship development between the worker and the family, in which there is collaborative problem-solving focused on family challenges. Families receive support, teaching, mentoring and advice to help them use their strengths and resources.

The content includes information about child health and safety, such as timely medical visits, compliance with immunisation and wellbeing checklists and home safety. Parenting skills information is also provided, including parental sensitivity, positive parenting and non-punitive parenting. There is support for parental physical and mental health, such as the reduction of unplanned pregnancies and early detection and treatment of depression, anxiety and substance abuse. Other content includes information about economic and material wellbeing (budgeting and employment, for example), positive adult relationships and crisis management.

Early Start has been subject to one RCT. Post-intervention results (Fergusson, Grant, Horwood & Ridder 2005; Fergusson, Horwood, Ridder & Grant 2005) indicate that the intervention group, when compared to the control group, had significantly longer duration of early childhood education, greater scores for positive and non-punitive parenting attitudes and a smaller percentage of parental reports of the use of severe physical assault. At the nine-year follow-up point (Fergusson, Boden & Horwood 2012, 2013), the intervention group had significantly fewer internalising or externalising behaviour problems; a higher parenting score; a smaller percentage of visits to the hospital for accident or injury; a smaller percentage of parent-reported harsh punishment; a lower score for physical punishment; better scores on the strengths and difficulties questionnaire; fewer severe physical assaults by a parent; and a smaller percentage of agency contacts for physical child abuse.[36]

Parent-Child Interaction Therapy (PCIT)[37] is a programme that specifically targets the relationship between parents and their children. It has been evaluated for families with children aged up to six years at risk of maltreatment or with a history of maltreatment. The intervention is delivered by a professional to individual parent-child dyads in a health setting or the home. The outcome domains targeted in PCIT are child behaviour, safety and physical wellbeing, and parent-child relationships.

PCIT involves didactic presentation to parents, as well as direct coaching of parents while they are interacting with their children. Parents are praised for appropriate responses to children's behaviour and there is immediate remediation for corresponding inappropriate responses. Treatment continues until parents achieve 'mastery', in which they successfully and consistently demonstrate strategies learned and express a clear understanding of their own change and their role within the family system. Content delivered in PCIT relates to child behaviour management, such as the use of labelled praise, reflecting or paraphrasing children's appropriate talk, and use of behavioural descriptions for the child's positive behaviour. Other content includes avoiding the use of commands, questions or criticism, the use of effective instructions and commands, and following through on direct commands via labelled praise or time out.

35 http://earlystart.co.nz/

36 While Early Start parents reported fewer agency contacts for physical child abuse, and fewer hospital visits, they did not report less contact with Child, Youth and Family compared to control families. The researchers are unclear as to the explanation for these differences (Fergusson et al. 2012).

37 http://pcit.phhp.ufl.edu/efficacy.htm

Participants in PCIT have been shown to have short-term gains in reduced externalising of problems by children, reduced behaviour intensity, and reduced stress (Thomas & Zimmer-Gembeck 2011). A second study (Thomas & Zimmer-Gembeck 2012) found that post-programme, the standard 12-session PCIT group had significantly better results than a waitlist control in children's behaviour problems and intensity, and internalising and externalising behaviour, and in parents' stress, verbalisations and sensitivity. Long-term PCIT outcomes have been reported by Chaffin et al. (2004), who found that parents in the standard group had fewer re-reports of physical abuse than the other two conditions (treatment as usual control and PCIT with counselling) at 2.3 years. PCIT groups also had significantly fewer negative parent behaviours than a control group.

SafeCare[38] is a service model delivered in the home by professionals to individual families. The service commences with an assessment of parents' skills, using observations and checklists. Parenting skill deficits are addressed via active skills training, verbal instructions, discussion, modelling, role-play, feedback and praise. Parents are given homework tasks and skills are taught to 'mastery' criteria in both simulations and actual interactions. Content delivered in SafeCare includes information on parent-infant interactions, basic caregiving structures, parenting routines, home safety (such as assessing the home for hazards and teaching parents to remove hazards and child-proof the home) and children's health care. Planned activities training is also included, whereby the parents are taught time management, explaining rules and expectations to children, reinforcement, incidental teaching, preparing activities, and discussing outcomes.

One RCT study of SafeCare targeted caregivers of children under five years of age presenting with risk factors such as substance abuse, mental health issues or intimate partner violence (Silovsky, Bard, Chaffin, Hecht, Burris, Owora, Beasley, Doughty & Lutzker 2011). These authors found significantly fewer reports of domestic violence in the intervention group compared to the control group at completion of the service. In another US RCT (Chaffin, Hecht, Bard, Silovsky & Beasley 2012), SafeCare was delivered in the same mode to families with a history of maltreatment, with children aged less than 12 years. The service lasted for six months. Follow-up at seven years indicated that recidivism rates (further maltreatment) for the treatment group were significantly lower than for the control group.

It is also possible to review the evidence for programmes in terms of the type of abuse and risk factors they target. A growing body of research suggests that different types of maltreatment have distinct causes and consequences (Hildyard & Wolfe 2002; Kim & Cicchett 2006), and evaluation studies indicate that programme effects have been more modest for some forms than others (Duggan et al. 2004; Skowron & Reinemann 2005). For example, while a low socio-economic background is associated with neglect and physical abuse, it does not appear to be associated with the risk of sexual abuse (Ronan et al. 2009).

Pecora et al.'s 2012 list of intervention strategies with evidence of effectiveness by type and subtype of child maltreatment is reproduced in Appendix 2. Their results suggest that some programmes may be effective for specific types of maltreatment, while others (such as home visiting) address a range of risk factors associated with most types of maltreatment.

Few parenting programmes specifically target sexual abuse. Sexual abuse prevention is more likely to involve working with children (mainly in the older age groups) and be aimed at teaching them safety skills (Palusci & Haney 2010). On the other hand, physical abuse and neglect are more likely to be addressed through parenting interventions. Palusci and Haney's review also concluded that there was little evidence detailing programmes and practices designed specifically for primary prevention of psychological abuse.

38 http://publichealth.gsu.edu/968.html

3.4 Common components of evidence-based programmes[39]

One approach to the challenge of embedding evidence-based programmes, or interventions, into everyday practice is to identify common elements or components of these programmes and to include these evidence-based practices in routine practice. As Garland et al. (2008) suggest, 'training in common elements of evidence-based programmes can provide a foundation for improved practice, emphasising the ongoing development of critical treatment skills that are likely to apply to a variety of clients' (p 507). However, as in the general area of intervention programmes or treatments (Weisz et al. 2011), the identification of 'common components' or 'evidence-based practices' for parenting programmes is an inexact science at present (Garland et al. 2008).

Despite these cautions it has been argued that a common components review can be useful where resources are limited. The Center for Disease Control and Prevention (2009) examined components of parent training programmes. They argued that the identification of components associated with effective programmes enables these components to be integrated into existing programmes, 'thereby minimising costs, training needs, and other barriers that often discourage the adoption of evidence-based strategies' (p 1). Attention to these elements can be used to monitor and improve practice and might serve as a basis for developing new programmes.

While a review of programmes shows there is much in common (both in content and delivery), a limited number of exploratory studies have sought to identify evidence-based practice or programme elements. Approaches to identifying these components or practices have ranged from narrative reviews of evidence-based programmes (Shulruf 2005), canvassing the views of staff (Caton 2007) or subject experts (Garland et al. 2008), and the use of more systematic approaches (Chorpita et al. 2005) such as meta-analytic techniques (Kaminski et al. 2008). Some have examined the impact of the presence versus absence of programme components (see Nurse-Family Partnership's trial of professional versus non-professional staff). The typical approach has been to identify elements common to evidence-based programmes, but as Weisz et al. (2011) note this is not the same as identifying the most effective elements.

While the common components lists derived from these different approaches have considerable overlap, there are also differences. In general it is agreed that the presence of any one component will not ensure programme success, and, conversely, that the absence of a feature will not ensure failure (Chorpita et al. 2005). Components interact, and more refined studies are required to really understand the active components of programmes. For example, there is a lack of detail around the practices of staff in working with parents (developing a therapeutic alliance). Components such as training and qualifications may serve as proxies for such microskills.

Common components

The rapid evidence assessment found a number of common components of better-supported programmes identified by the review. All of the interventions showing an impact on child maltreatment included in the REA were home-based, yet this does not suggest that this was a key characteristic of success. In fact, there were interventions based in the home that rated poorly in the REA. Fourteen common elements among the effective interventions were identified in the REA; these are presented in Box 3.4.

39 Sometimes also referred to as principles, active ingredients or best practices (Small, Cooney & O'Connor 2009).

It should be noted that these elements reflect the focus of the REA and the relatively greater evidence for the effectiveness of parent education and training programmes (such as Triple P and PCIT) compared to more general early years parent support. The predominance of US-developed programmes also limits assessment of culture components, although there is an increasing body of evidence for both the adaptation of these programmes and the development of programmes to serve different cultural groups (see for example Barlow, Mullany, Neault, Compton, Carter, Hastings, Billy, Coho-Mescal, Lorenzo & Walkup 2013; Chaffin, Bard, Bigfoot & Maher 2012). Cultural components are discussed in later chapters considering parenting programmes for Māori and Pacific parents.

All of the effective interventions identified were delivered by a professional.[40] One example of this is the study of Olds, Robinson, O'Brien, Luckey, Pettitt, Henderson and Talmi (2002), involving the Nurse-Family Partnership home-visiting programme. Olds and colleagues found that the NFP programme was not as effective if it was delivered by staff with less education and training, compared to registered nursing staff.

Howard and Brooks-Gunn (2009) also suggest, in their review, that home-visiting programmes using paraprofessionals have shown relatively little impact, although they suggest this may depend on the nature and goals of the programme. Those targeting health may best be delivered by nurses, while those targeting parenting sensitivity may be most effective when delivered by psychologists (see also Pinquart & Teubert (2010) for similar findings with regard to child mental health). A recent study by Barnes (2012) also suggests that having sufficiently skilled family support workers deliver a structured programme is important. Her study found that volunteers providing unstructured proactive support to potentially vulnerable families produced no evidence of enhanced infant development.

A clear common delivery element of many of the effective interventions was that a structured curriculum or planned sessions were used when implementing the intervention. Many of the interventions commenced with an assessment of the family, parents and child, and then an individualised intervention or service plan was developed for or with the family. Often, the content of the intervention was delivered through discussion.

A central common element in the content provided in the interventions was about child behaviour and strategies to manage it, with nearly all interventions teaching this to parents. Sometimes this was referred to in general terms, such as child behaviour-management techniques, positive parenting techniques for increasing desired behaviour, and non-punitive measures for decreasing undesired behaviour. Specific behaviour-management strategies that were common across several interventions included providing routines and clear rules, explanations, limits and instructions; praise for target behaviours; the use of time out for reducing unwanted behaviours; and the use of reinforcement, rewards and charts for target behaviours.

Information about and strategies to promote positive parent-child interactions, and for the regulation of parents' and children's emotions, were also common to several interventions.

An additional content element common across several interventions related to children's wellbeing, including health, development and safety (how to care for a child's health, what typical development is and how to ensure a child's safety, for example). Lastly, several effective interventions focused on supporting parental and family wellbeing and life course, touching on parents' mental and physical health, nutrition, budgeting, education and employment.

The research evidence on this is mixed, however, with one recent review suggesting that while linking to other services is thought important, 'providing parents with ancillary services as part of the parent training programme was also associated with smaller program effects, a result found in other meta-analyses' (Center for Disease Control and Prevention 2009 p 7). The reviewers suggest that there is a risk of diverting providers' and parents' attention from the task of acquiring new parenting skills and behaviours. This finding may be specific to the group-based parenting programmes, rather than the multi-component home-visiting interventions, but it does argue for caution in using components to determine a programme's effectiveness.

40 These are workers holding degrees in relevant disciplines, such as social work, nursing or psychology. Para-professionals, on the other hand, are workers who may have less relevant qualifications and who have been trained to deliver the intervention.

Box 3.4 Common elements of the 'effective' interventions identified in the REA

Delivery

1. The intervention is delivered by a suitably qualified and trained **professional**.
2. A **structured curriculum and planned sessions** are followed often with the use of a manual, although there may be flexibility for individual circumstances.
3. The intervention commences with an **assessment** of the family, parent and child, which may include their current needs, concerns, skills, strengths, functioning, interactions, resources and supports.
4. An **individualised plan** is developed for each family, parent and/or child. This is typically based on the outcomes of the assessment and may be developed with input from the family.
5. The intervention content is delivered by **discussing** the material with the family, rather than by didactic teaching.

Content

6. **Information about children's behaviour** is provided to parents, such as what constitutes typical behaviour, reasons for misbehaviour and parental responses to behaviour.
7. Parents are taught how to provide an environment where children know what to expect and **know what is expected of them**, thereby increasing their opportunities to behave well and reducing the likelihood of misbehaviour. Specific strategies taught to parents included providing children with **routines**; providing **clear rules** to children; explaining parents' **expectations** of the children; clearly **setting limits**; and providing **clear** instructions for children.
8. Parents are taught strategies or techniques for **managing children's behaviour**, such as ways to increase desired behaviour and deal with misbehaviour.
9. Parents are taught to use '**positive parenting**' strategies for increasing desired behaviour, suggesting that behaviour is managed by fostering healthy interactions between parents and children, by focusing and building on strengths in behaviour. Specific strategies mentioned were **praising** children, which is particularly powerful when praise is **labelled** or accompanied by a descriptor of the behaviour that is being praised ('great job putting away your toys' instead of 'great job', for example); and providing **reinforcement or rewards** when children display a desired behaviour. This works well when the parent has clearly described the expectations to the child and also if the child knows what the positive consequences of the good behaviour will be (the reinforcer). **Charts** (such as star charts) for recording and tracking the occurrence of desired behaviours are often used in conjunction with praise and reinforcement
10. Parents are taught to use '**non-punitive**' measures for decreasing misbehaviour that involve alternative methods of dealing with it. These do not involve punishment but do involve clear and reasonable consequences. The most commonly used strategy in the effective interventions was '**time out**'; other strategies mentioned included planned ignoring and quiet time. Time out would be most effective when used as part of a set plan for managing behaviour in which the child is aware that time out is the consequence of pre-identified misbehaviour; the child knows what time out entails and the parent follows through with the plan as set.
11. Parents are provided with information about **parent-child interactions**. This includes ways to promote positive parent-child interactions, what positive relationships are, and examining current interactions and responses to each other.
12. Parents and children are provided with strategies to help them **regulate their emotions**, such as understanding emotions; anger-management training; and preventing, detecting and dealing with depression, anxiety and fear.

13. Parents are provided with information about **children's health, development and safety**. This includes developmental milestones, what typical development is and is not, how to care for the health of children, information about illness, how to provide a safe home and environment, and measures to protect a child from harm and abuse.
14. Parents are provided with information about and support for **parental and family wellbeing and life course**. This element of the intervention focuses on what the parents, households and families need in order to be cared for and provided for. It includes looking after the physical and mental health of parents and supporting their access to education and continued employment, as well as considering the nutrition, physical activity and financial needs of the family. It involves helping parents access services and supports to meet immediate needs, as well as future planning.

Many of the above features were identified by other reviews (see for examples Moran, Ghate & Van Der Merwe 2004; Shulruf 2005; Garland et al. 2008; Asawa et al. 2008; Center for Disease Control and Prevention 2009; Small et al. 2009; Wessels et al. 2013). Wessels et al. note that 'parent guidance programmes that simply talk to parents are not as effective as those which give parents the opportunity to actively apply what they are learning through, for example, role-play and practice at home' (p 6). The recent Advisory Group on Conduct Problems (2011) suggested the following elements were common to the programmes they identified as recommended or promising.

a. All programmes use non-punitive problem-solving approaches which attempt to address the sources of the children's problem behaviours.
b. All are founded in a clearly articulated theoretical framework regarding the aetiology of conduct problems. These theoretical frameworks include Social Learning Theory and Cognitive Behavioural Psychology.
c. All programmes are manualised making it possible to transfer the programme to a new context.
d. The evaluation of all programmes has been founded on a prevention science model and the use of randomised controlled trials.
e. A final feature that unifies many of the tier 2 and 3 programmes is that these programmes are designed for clinical application and require the oversight and supervision of trained clinicians including psychologists, psychiatrists or social workers with clinical training. (p 27)

3.4.1 Common issues in assessing the effectiveness of parenting programmes

Our review of international research and evaluation evidence highlighted a number of issues to consider when choosing evidence-based programmes, and a number of gaps in our knowledge. The research reviewed above indicates that some programmes are more effective with specific at-risk groups. This would suggest that it is important to provide the right programme to the right group at the right time, to maximise the return on investment (Kilburn & Karoly 2008). In order to provide the right programme to the right group it is important to assess for risk or need and to match these to programme type and intensity.

A related lesson from recent reviews is that dosage (number and frequency of attendance or home visits) matters. For example, Maher (2011) evaluated the impact of the Nurturing Parenting Program on allegations of abuse and neglect to examine the relationship between programme dosage and subsequent maltreatment. Findings indicated that caregivers who attended more sessions were significantly less likely to be reported for child maltreatment, holding other factors constant. As Kilburn and Karoly (2008) note, 'there may be minimum levels of service required to realise effects, and more intensive programs may offer greater total benefits' (p 17). This does not

mean that programmes should be as long as possible, as there are likely to be diminishing returns (that is, for every month beyond the optimum length there are fewer benefits).

The introduction noted the multi-factorial nature of risk factors, with the implication that programmes for the most vulnerable families need to address these in order to be effective. Findings from international research would suggest that while more comprehensive programmes can be effective at improving some aspects of parenting and parental functioning, other family and parental issues require more specialist intervention. Howard and Brooks-Gunn (2009) conclude from their review of home-visiting programmes that 'the effectiveness of home-visiting programs is limited and that those that have well-defined goals in certain domains are most likely to evidence effects' (p 132). They recommend that high levels of stress or mental illness are better treated in other settings. Other experts have noted this issue and warned that specialist skills may be required to address mental health, substance abuse and violence issues (Barth 2009).

Conversely, it is unclear whether specialist programmes for issues such as partner violence, alcohol and drug abuse and mental health problems can successfully include parenting components. While there is some evidence that residential programmes for mothers in methadone treatment can successfully include a parenting element, Barth (2009) commented on the 'paucity of research on interventions that simultaneously address mental health problems and parenting problems' (p 101). He suggests that while the evidence points to harsher parenting in families with family violence, it also suggests that dealing with the violence may have a more important influence on child outcomes than attending a parenting programme (Gustafsson & Cox 2012).[41] Research on the Nurse-Family Partnership programme noted a need to address family violence more effectively within the programme, as effectiveness was limited when mothers experienced significant violence. Consequently, the programme was adapted in an attempt to address this issue better (Eckenrode et al. 2000).

As Percora et al. (2012) conclude, 'more research is needed on how to sequence substance abuse treatment, mental health services or domestic violence interventions with evidence-based parenting skills interventions' (p 6). While some parents might benefit from parenting programmes prior to specialist treatment, others may need to progress with treatment of their own needs before benefiting from a parenting intervention. This issue speaks to the need for individual assessment and planning, as the issues for each parent and family are likely to be different, as are their strengths.

Issues of programme implementation are discussed later, but an oft-raised issue in reviewing evidence-based programmes is the extent to which programme content and delivery is prescribed – that is, the degree to which staff must follow programme guidelines (fidelity), compared to the degree to which there is flexibility in delivery and content (Moran, Ghate & Van Der Merwe (2004). A related issue is how quality and fidelity is maintained (through supervision, recording and assessing sessions, staff self-reporting, peer review and booster training, to provide a few examples). This issue is related to that of programme quality, where trading off quality for greater quantity may come at the cost of effectiveness.

An example of the importance of many of the above issues is the comparison by Ronan et al. (2009) of Early Start and a similar, but less effective, Australian programme (Family Care). They suggest that Early Start achieved better outcomes because of its better staff training, higher level of intensity and duration, and attention to measuring programme fidelity. Finally, a significant issue raised in reviews of parenting support programmes is the challenge of engaging and retaining parents in programmes; this is dealt with in some detail in the next section.

41 That is, the negative parental and child behaviours are largely a response to the violence, rather than a lack of parenting skills.

3.4.2 Recruitment, engagement and retention

A significant issue with parenting support programmes is the challenge of identifying those most likely to benefit, recruiting and engaging them in programmes, and keeping them engaged for sufficient duration to bring about benefits (Whittaker & Cowley 2010). Axford et al. (2012) estimate that only about a third of invited families enrol in prevention programmes, and rates of drop-out often exceed 50 percent. The typically stressful lives of those most in need require programmes that reach out to families and do all they can to maintain their active participation (Cortis et al. 2009).

The problem of reaching those in need of help who would benefit from programmes has led to a variety of responses. Identifying at-risk groups through services that have contact with a wide section of the population is one common approach. Early intervention home-visiting programmes (such as Hawaii Healthy Start) have sought to identify and recruit parents and families at birth (or antenatally). In New Zealand, Well Child checks provide an opportunity to identify parents who may require assistance, and staff training and protocols provide guidance for referring those who may require more intensive support (Well Child/Tamariki Ora Programme Practitioner Handbook, 2013). Plunket delivers Well Child/Tamariki Ora checks to over 90 percent of babies, although engagement with high-risk mothers may be rather less (Dwyer 2009).

Another approach is to identify and recruit parents in settings such as hospitals, doctors' surgeries and early childhood education settings. Such an approach requires some process of assessment of risk and need, and referral to appropriate services. Opportunities to identify families who need help also come from a variety of other sources and depend on the relationships of trust developed between potential referral sources and programme staff. Referrals from other sources also rely on others knowing about the programme, the services it offers and the referral process, which can require proactive relationship building and programme promotion (Axford et al. 2012; Robertson & Pryor 2009). An evaluation of the Family Help Trust (Turner 2009) found that referrals came from a number of sources, including a methadone clinic, the probation service, hospital social workers, Child Youth and Family and hospital midwives.

It may be possible to target those groups known to be least likely to seek help (Moran et al. 2004). The recent evaluation of Parents as First Teachers (Praat et al., 2010) noted that 'parents in single-parent households and those who are less educated are less likely to look for parenting information and advice or attend parenting classes than other parents' (p 4).

Having identified those who might benefit from a service or programme, staff must then work to engage parents in the programme and to retain their interest and participation over time. Howard and Brooks-Gunn (2009) suggest that the failure of many home-visiting programmes to have a measureable impact may be due to the relatively high percentage of the parents who in reality receive little treatment. They suggest that 'selecting home visitors who are well-trained and culturally sensitive to the families they serve will likely encourage mothers to accept home-visiting services' (p 137). In New Zealand this is a particularly acute issue, in part because of our diverse ethnic population (discussed in Chapters 5 and 6), but also owing to factors such as relatively high residential mobility. Having motivated and skilled staff, from the local community, is likely to result in higher engagement and retention (Cortis et al. 2009).

The degree to which targeted programmes are able to identify, recruit and engage parents should be one of the criteria by which effectiveness is assessed. The Early Start evaluation was able to provide details of family engagement and retention. It found that Plunket nurses identified 13 percent of screened families as eligible for Early Start (on the basis of agreed screening criteria) and three-quarters of these families opted to engage with the service (Fergusson et al. 2005). After one year most of those who engaged were still in the service (with 10 percent classed as inactive and 17 percent as lost from the service). By 24 months, just under two-thirds were receiving the service; this had fallen to less than 60 percent at 36 months (one in six were inactive and 25 percent had been lost from the service). The movement of families out of the area, withdrawing

from the service and engaging with other services were the main reasons families were no longer engaging with Early Start (Fergusson et al. 2005).

A recent review by Cortis, Katz and Patulny (2009) noted individual, provider, programme, neighbourhood and social factors that influenced participation by 'hard-to-reach' families (Table 3). They point out that the definition of 'hard-to-reach' depends on context – for example, whether the programme is a population-level service (in which case the 'hard-to-reach' might be sole mothers) or targeted at specific groups (where parents of a specific culture may not engage).[42] They prefer to think of 'hard-to-reach' as involving the outcome of the relationship between the service and the potential client group, rather than as a 'fault' of either group.

Table 3: Factors influencing participation by 'hard-to-reach' groups (from Cortis et al. 2009)

Individual factors
› lack of access to information
› attitudes that discourage help-seeking
› fear
› misperceptions about services (e.g. stigma attached to participation)
› lack of parental motivation to change
› potential costs and benefits of services
› communication difficulties
› hostility to interventions by family members
› daily stresses and complexities
Provider factors
› lack of service promotion
› limited outreach and entry points
› staff lacking relevant skills
› lack of client-centred practice approaches
Programme factors
› limited funding and funding structures
› not delivered via a non-profit auspice (although there is much variation among non-government organisations)
› lack of targeting of interventions to vulnerable families early in a pregnancy
› wrong mix of specialist and generalist, targeted and universal services
› multiple entry points instead of using single entry points for an array of co-ordinated services
› lack of support for transport, childcare and appropriate scheduling
Neighbourhood and social factors
› social norms and expectations do not promote service use
› social disorganisation and poor social capital in the community
› social and geographical isolation (and associated transport difficulties)
› absence of service network or 'initiative fatigue' in a community

42 Various terms are used to describe those who might benefit from a programme, but whom programmes find it hard to engage – hard-to-reach or marginalised families are two examples.

A range of supports has been suggested to help address these issues.[43] Asawa et al. (2008) suggest that providing transportation, meals, flexible meeting times, catch-up sessions, and childcare for families helps to increase participation rates. Many of these factors may require culturally appropriate responses, such as translations of publicity materials and engagement with local community organisations (churches and marae, for example).

Cortis, Katz and Patulny (2009) asked participants in their study to propose strategies for engaging hard-to-reach families. They suggested a range of approaches: ensuring the programme was relevant for community needs; outreach and promotion; having non-stigmatising entry points and using naturally occurring opportunities to engage target groups; providing food and incentives; building relationships, networks and partnerships; ensuring adequate capacity; and staff training, skills and continuity. Axford et al. (2012) consider it important that time and resources are allocated to recruitment, and that staff are trained in how to present and describe the programme to potential participants. As they point out, research suggests that parents prefer programmes that are proven to improve children's behaviour.

The Family Partnership Model (Davies & Day 2010) has shown promising results in helping home visitors engage with vulnerable parents. Clinical therapies have developed explicit motivational strategies to keep clients motivated and engaged with therapy, and this is being tried in more general services and parenting programmes. Nock and Kazdin (2005) included a specific Participant Enhancement Intervention in an intervention for parents with children exhibiting problem behaviour. They found that spending 15 minutes during sessions focused on encouraging parental motivation significantly improved attendance and adherence to the intervention.

While these might be seen as approaches seeking to encourage participation, recent approaches to working with 'troubled families' in the UK use a more assertive approach (Department for Communities and Local Government 2012). This approach is described as 'persistent, assertive and challenging', where

> *The family intervention worker acts as an intermediary in the use of sanctions by other agencies – which may mean asking other agencies to accelerate threat of a sanction (criminal justice, child welfare, social housing) to exert maximum pressure on families to change, or to slow down their use of sanctions in situations where enforcement action might undermine the progress a family are making* (p 28).

We are not aware of any rigorous assessment of this approach to date.

A recent innovation for working with drug-using parents is to target them through the justice system and to use the appearance before the court as an opportunity to engage them in programmes. Drug courts were initially developed in the US and are being trialled in the United Kingdom (Harwin & Ryan 2008). In the UK the drug court trials are targeting drug-abusing parents who have offended and are appearing before the court, and offering a voluntary wraparound service. There are some promising results from the US evaluations (Harwin & Ryan 2008) but the results from the UK evaluations have not yet been reported.

Our review of parenting programmes found that relatively few had any significant participation by fathers. Pinquart and Teubert's 2010 review of parent education programmes for new parents found most participants were mothers (89 percent), although there were a few programmes specifically for fathers. Others have pointed out the need to address specific barriers to participation by fathers, such as the scheduling of programmes during work time (Cortis et al. 2009; Gordon, Oliveros, Hawes, Iwamoto & Rayford 2012). Lack of engagement by fathers can negatively affect mothers' involvement, as was found to be the case for some mothers approached to participate in Hawaii's Healthy Start Program (Cortis et al. 2009). The Promising Practices Network identified three programmes that appeared promising in maintaining regular involvement by fathers with their children: Family Foundations, Parents' Fair Share and Father/Male Involvement, a preschool teacher education programme encouraging involvement by fathers. However, the effectiveness of programmes in changing fathers' parenting behaviours is a significant knowledge gap.

43 Many of these issues will be discussed in Chapter 6 in relation to implementation considerations.

Finally, while a high retention rate is desirable, relatively scarce programme resources can often lead to the need for trade-offs in the allocation of resources. Where there is excess demand for a service, how much of the limited staff resource should be allocated to engaging and retaining hard-to-reach parents when they might be used to work with those who want to engage with the service? While greater efforts are needed to engage and retain parents, more research is needed to assess the optimal balance between service delivery and service engagement.

4. NEW ZEALAND PARENTING PROGRAMMES

While the previous chapter reviewed evidence for the effectiveness of overseas parenting support programmes, the focus of the current review is an assessment of the effectiveness of New Zealand programmes. This chapter describes the main New Zealand parenting programmes and the results of any research and evaluation of them. There are relatively few studies, however, of New Zealand programmes that have employed control or comparison group designs, so we are limited in the extent to which we can draw conclusions as to their effectiveness.

It also needs to be noted that the focus of this review is on parenting support programmes that aim to improve parental attachment, childcare and nurturance in order to reduce the risk of child maltreatment or its recurrence. There are parenting programmes with other goals (such as parental participation in schools) that work with people other than parents (teachers or children, for instance), and those that target parents of older children (aged six years plus). These are outside the scope of this review. There are also systems-level interventions (Strengthening Families, Whānau Ora, and Children's Teams, to name a few) that are not covered by this review. These interventions are designed, in part, to improve access to the parenting programmes reviewed below.

4.1 New Zealand parenting programmes

A number of initiatives delivered in New Zealand address parenting issues. Some are programmes or interventions and others are information-based support strategies. Some are generic parenting programmes and others target specific populations, such as teenage parents. Various social service organisations throughout the country offer parenting programmes of one form or another; many are tailored to the specific needs of the community at the time. There is generally little or no descriptive information about these programmes.

Programmes are grouped under the following broad headings:

- Health initiatives
- Supporting teenage parents
- Community development approaches
- Generic parenting programmes
- Home-visiting early intervention
- Educational programmes
- Targeted programmes
- Correctional parenting programmes
- Mentoring initiatives.

4.1.1 Health initiatives

Well Child/Tamariki Ora

Description and target population

Well Child/Tamariki Ora (core services) is a free service offered to all New Zealand children from birth to five years. The programme consists of a series of health assessments and support services for children and their families. It also includes health promotion and is an important gateway for parents to access targeted and specialist health care, education and social services (Ministry of Health 2013). Additional visits are provided to 'high-need' families, including those who present with multiple complexities and whose long-term unmet needs require a long-term co-ordinated approach to care. Access to additional visits is also provided to families who present with high need related to health, social and economic issues that are modifiable through planned intensive support, usually over short periods of time.

Delivery and service providers

Well Child/Tamariki Ora services are delivered throughout New Zealand by accredited providers. Plunket is one of the main providers of this service and undertakes home visits for babies in the early weeks, and then clinic or further home visits for children up to five years old.

From birth to four-to-six weeks, there are four Well Child core health checks provided by the lead maternity carer (usually a midwife or GP). These take place:

- at birth (newborn examination)
- 24 to 48 hours (health and development assessments)
- during the first week
- during the first two to six weeks.

From four-to-six weeks to four-to-five years of age there are a further eight core Well Child health checks available from an accredited Well Child provider. These are scheduled for important stages in the child's development:

- four to six weeks
- eight to 10 weeks
- three to four months
- five to seven months
- nine to 12 months
- 15 to 18 months
- two to three years
- four to 4.5 years – the B4 School Check is the final Well Child health check.

Details of assessments to be undertaken at each stage, and material to guide providers, are set out in a programme practitioner handbook produced by the Ministry of Health (2013). This complements the health book held by the parent, in which the provider documents visits made and actions taken, along with health and developmental information on the child. Well Child providers also keep their own records on families involved with the service.

Additionally, a free all-hours phone advice service for parents is provided by Plunket. PlunketLine is staffed by registered Plunket nurses, who have a postgraduate qualification in Well Child/Tamariki Ora. Parents can ring to seek information and support about a number of issues, including:

- children's health and illness
- parenting practices
- community linkages
- breastfeeding
- nutrition.

Funding

The Well Child/Tamariki Ora service is a universal screening, surveillance, education and support service offered to all New Zealand children and their whānau. In recent years there have been over 60,000 births per year in New Zealand (Statistics New Zealand 2013). The national Plunket service is responsible for approximately 85 percent of service coverage; the balance of service coverage is the responsibility of local providers who are contracted via District Health Boards, but funded by the Ministry. These local providers are predominantly Māori and Pacific providers. In 2012/13 the total funding for the programme was $60.39 million, including $16.7 million for additional visits delivered under the national agreement. The service is free to families. PlunketLine is also funded by the Ministry of Health. In 2012/13 the total funding for phone-based parent advice services was $9.47 million, including PlunketLine (parenting advice for children aged zero to five) and the proportion of funding for Healthline for calls from or about children aged zero to 14. The 2013 Plunket Annual Report states that PlunketLine responded to 94,722 calls.

New Zealand evaluation findings

The effectiveness of the Well Child/Tamariki service has yet to be evaluated.

4.1.2 Supporting teenage parents[44]

Extended Well Child/Tamariki Ora service

Description and target population

The Extended Well Child/Tamariki service for teenage mothers was developed in 2011. The pilot service arose from research that found this group was not well engaged with the Well Child /Tamariki Ora service and that their parenting needs, which were specific to their age and circumstances, were not being well met (Skerman 2010 cited in Thompson, Manhire & Abel 2012). The goal of the service is to address these deficits by making early contact with the pregnant teenager and supplementing the standard Well Child service by the addition of two antenatal visits, one early postnatal visit and additional needs-based visits. All these services are delivered in the home by one dedicated Plunket nurse with the aim of enhancing the relationship between the teenage mother and the provider.

Delivery and service providers

This programme is delivered by Plunket in the Hawke's Bay area. Plunket is the largest Well Child provider in the area and there are currently three staff in the Hawke's Bay Young Parent Team – two Plunket nurses and a Community Karitane nurse (Brown 2012).

Funding

The one-year pilot Extended Well Child/Tamariki Ora service was made possible through financial support provided by the Vodafone Foundation and the Hawke's Bay District Health Board. The core and additional Well Child/Tamariki Ora checks delivered to the families were and continue to be

44 The Ministry of Education funds 14 teen parent units in schools to enable teenage parents to continue their schooling.

funded by the Ministry of Health under the national contract, which affords Plunket the flexibility to deliver additional service to families assessed as requiring additional support, including in the antenatal period.

New Zealand evaluation findings

An evaluation of the pilot Extended Well Child/Tamariki service for teenage mothers was undertaken by a team from the Hawke's Bay Eastern Institute of Technology (Thompson et al. 2012). The aim was to assess the outcomes, successes and challenges of the pilot service; the evaluation employed both qualitative and quantitative data collection and analysis.

The one-year pilot commenced in February 2001 and involved a nurse who identified as Māori caring for 21 babies born from May to July 2011 and their mothers and whānau – this was the pilot sample (Thompson et al. 2012). There was a control group of a further 24 babies born in Hawke's Bay to teenage mothers during the same timeframe who did not receive the extended service. Qualitative data were collected from the Plunket Client Information Systems for both the pilot and control groups. Interviews were undertaken with key informants, pilot staff and 15 of the teenage mothers who received the extended service.

There were statistically significant differences between the pilot and control groups on the number of postnatal Plunket nurse contacts and the number of postnatal recommendations (usually to a GP team) made to the teenage mothers. The pilot group rated better on both measures (Thompson et al. 2012). They also showed higher rates of breastfeeding and completed immunisations, which tend toward better health outcomes. In addition, six of the control group discontinued the service, in contrast to only one of the pilot group. Teenage mothers interviewed expressed high levels of satisfaction with the service and their relationship with the Plunket nurse.

Although the period of the pilot was too short to be able to fully appreciate child health outcomes, clearly some positive trends were evident (Skerman et al. 2012) and overall evaluation findings indicated that the formula for the service was successful.[45] There needs to be recognition, however, that this success is highly dependent on the personal characteristics of the nurse and the organisational structure and support that she has to enable her to deliver the service with confidence (Thompson et al. 2012). The importance of the development and maintenance of relationships with other organisations and services was also noted. And, crucially, caseloads must be carefully managed, particularly as the period of ongoing contact with each client is five years, alongside the continuous addition of new clients. The pilot evaluation only covered a 12-month period.

Teen Parent Intensive Case Workers

Description and target population

Teen Parent Intensive Case Workers help the most vulnerable pregnant and parenting teenagers stay in education and prepare for future employment (Family and Community Services 2013d). They also connect at-risk teen parents and their children to the services and support they need, such as antenatal care; housing, budgeting and parenting services; Well Child services; and early childhood education. Preventing further unplanned pregnancies is also an aim of this service.

The Teen Parent Service does not employ a structured or specified programme delivery. The service each young parent receives is tailored to their needs and situation (Centre for Social Research and Evaluation (CSRE) 2009).

Delivery and service providers

The Ministry of Social Development implemented the Teen Parenting Service in 2007. Service co-ordinators facilitated access to services for teen parents by helping them to develop a plan to address their needs and providing intensive case management (CSRE 2009). In 2010 the existing Teen Parent Service co-ordinators became 'intensive case workers' under an extended funding

45 That is, early intervention and extra visits (including two antenatal) by one consistent nurse leading to the development of a good nurse-parent relationship.

regime and the number increased from nine to 19 (Ministry of Social Development 2010a). Intensive case workers are required to be registered social workers and/or have a tertiary qualification. These case workers are supported by community volunteers who are often teenagers themselves. The service is currently provided by 18 community organisations throughout the country, including Thrive Teen Parent Support, Jigsaw, Barnardos and Family Works Southland (Family and Community Services 2013d).

Funding

This is a government-funded service, managed by Family and Community Services within the Ministry of Social Development, and is free to participants. Currently $2.02 million dollars is allocated to this service.

New Zealand evaluation findings

A qualitative evaluation of the Teen Parent Service co-ordinators (now known as intensive case workers) initiative ran from soon after the implementation of the service in 2007 through to 2009. At this stage the programme was delivered at eight locations selected on two main criteria: high numbers and/or rates of children born to young parents and high levels of deprivation.[46] Information was collected from parent data-collection forms, and interviews with co-ordinators and young parents provided contextual information (Centre for Social Research and Evaluation 2009).[47]

Results showed that the service was well-implemented and was operating in accordance with the policy intent (CSRE 2009). It was noted, however, that many Teen Parent Service co-ordinators carried caseloads greater than what was recommended in the original policy, and therefore were not always able to focus on the most vulnerable teen parents.

Young parents, predominantly female and aged between 14 and 19 years old, appeared to be well-engaged with the service. Forty-seven percent of young parents using the programme were Māori and 13 percent Pacific. Approximately half of those engaged in the programme did so while still pregnant (CSRE 2009). Co-ordinators in all sites were working directly with young people and their families and networking with other agencies that offered relevant services to young parents. There was no set limit on the length of time parents were engaged with the service. Co-ordinators made exit decisions on a case-by-case basis – for example, when use and intensity of service required lessened naturally or when the young parents had completed their plan. Often young parents are referred on to services that require less intensive support, such as Family Start. There was no information on numbers of young parents who may have disengaged from the service prematurely.

The evaluation found that young parents participating in this service had been helped to access a variety of services that can be expected to improve their health, education and social outcomes. The teen parents and Teen Parent Service co-ordinators who took part in the evaluation were clear that the initiative is needed in their communities and that the service was making a difference (CSRE 2009). The evaluators cautioned that they did not attempt to assess the achievement of longer-term outcomes or the sustainability of improvements noted. It was also noted that young people experienced a number of barriers to accessing the service, including lack of confidence and knowledge of what services were available, lack of transport and discouragement from families and partners. Although a small number of fathers engaged with the service, the evaluators commented that there was a clear need to develop strategies to engage and support young fathers. Where a provider delivered both the Teen Parent Service and other services in a community, the profile of the Teen Parent Service was sometimes less visible, which may have affected whether or not the young parent was referred to the most appropriate service.[48]

46 This was indicated by New Zealand deprivation index scores of 8–10.
47 Completed forms for 221 young parents, including 17 young fathers who were associated with mothers using the service, were analysed.
48 The Teen Parent Service is the more intensive of the two support services.

4.1.3 Community development approaches

Strategies with Kids, Information for Parents (SKIP)

Description and target population

SKIP was launched in 2004 as a government initiative aimed at reducing the use of physical punishment on New Zealand children under the age of five.[49] Since then it has developed into a collaborative network of national and local organisations working together to support New Zealand parents.

Researchers note that SKIP is not a parenting programme but a research-informed approach to promoting positive parenting, delivered to parents and caregivers and their communities via partnerships between government and NGOs (Woodley & Metzger 2012).

The approach:

- partners with national organisations like Barnardos, Plunket, Parents Centre and REAPANZ, to strengthen what they do and find new ways to work with parents
- funds a range of community projects that support local parents
- provides free parenting resources for communities, organisations and parents
- has established and trained a network of SKIP champions who support parents at a local level.

Three key pieces of research on parenting practice have influenced how SKIP works. They are the *Gravitas Research and Strategy Report* (2005), *The Discipline and Guidance of Children: A Summary of Research report* (Smith et al. 2004) and *Whānau Whakapakari: A Māori-centred approach to child-rearing and parent training programmes* (Herbert 2001).

The initial SKIP strategy was to target all families with children from birth to five years. In recent years, however, SKIP has increasingly focused on parents who are less likely to engage with conventional support (such as migrant groups, teen parents, single parents, and parents living in areas of high deprivation). SKIP's initial aim to prevent abuse by reducing physical punishment has widened to include the prevention of all forms of abuse and neglect. SKIP now explicitly focuses on keeping children safe through the promotion of positive parenting.[50]

Delivery and service providers – national partnerships

A team at the Ministry of Social Development (MSD) supports the SKIP network of individuals, community groups, government agencies (including the Ministries of Health and Education), workplaces and national NGOs.[51] Partnering with national organisations ensures parents get consistent key messages through the organisations they are most likely to come into contact with. SKIP has established collaborative partnerships with key organisations including Plunket, Barnardos, Parents Centre, Space NZ Trust, and Pasifika groups (Kerslake Hendricks & Balakrishnan 2005).

Funding and support for communities

In 2012 SKIP funding[52] supported 44 community collaborations, mainly targeting parents who do not engage with conventional support agencies or systems.[53] As well as funding, SKIP also offers training in brain development, media, facilitation, connecting and mentoring and the Family Partnership Model.

49 Personal communication with Family and Community Services, Ministry of Social Development, 4 February, 2014.
50 See footnote 49.
51 See footnote 49.
52 The Local Initiatives Fund, which has been changed from two rounds a year to an on demand model.
53 See footnote 49.

Parenting resources

More than one million free SKIP resources are ordered each year by parents, caregivers, and organisations working with parents and caregivers. Resources include pamphlets, posters, fridge magnets and DVDs in te reo Māori and English (Woodley & Metzger 2012). Resources in Pacific and other languages can be downloaded and printed from the SKIP website, and parents can seek specific advice via email or on the SKIP Facebook page. SKIP also funds Whakatipu resources developed specifically for Māori whānau, featuring child development information, activities and tikanga-based learnings.[54] All SKIP resources are based on the six principles of effective discipline (backed by research) and give simple graphic messages that can be readily understood by a wide audience.

SKIP is increasingly using social media to reach new generations of parents. As well as the website and Facebook page, SKIP has developed two smartphone and tablet apps. One, based on the Whakatipu resources for Māori whānau, uses the story of Maui to promote brain and child development information. The other, aimed at young dads, is designed to encourage parent-child interaction, stimulating brain development.[55] Other SKIP initiatives aimed at fathers include a collaboration with midwives on a series of resources that promote closer involvement by fathers before and immediately following the birth of their child.[56]

Funding

SKIP is funded by Family and Community Services within the Ministry of Social Development; it started as a three-year project in 2004 and in 2006 was given ongoing funding (Woodley & Metzger 2012). SKIP's budget is currently $2.28 million.

New Zealand evaluation findings

In 2009, Point Research was commissioned to review SKIP (Woodley & Metzger 2012). The researchers interviewed SKIP staff (n=8), held focus groups with parents (n=75) and talked to community organisations (n=12) and four national organisations. The review focused on success factors, using complexity theory and a community developmental evaluation approach.

The review noted that SKIP's strengths lay in utilising existing community capacity, through a community development model, to:

- foster organisational community innovation
- use social marketing to convey the SKIP messages
- maintain effective cross-sector partnerships
- encourage a universal approach aimed at all parents
- make freely available resources.

Parents reported that SKIP contributed to more conscious and confident parenting, feeling more supported and having strengthened social networks (Woodley & Metzger 2012: iii).

More than 90 percent of parents and caregivers surveyed for the ongoing evaluation stated that their parenting had improved as a result of their involvement.

54 This resource was developed in collaboration with the Āhuru Mōwai (Māori PAFT) team.
55 This was co-funded by Vodafone.
56 See footnote 103.

4.1.4 Generic parenting programmes

Parenting Education ProgrammE (PEPE)

Description and target population

The PEPE programme is aimed at supporting parents through the different stages of their child's early development. It consists of a series of five courses designed to support parents in their role, build their confidence, and connect them with other parents, local sources of support and resources in their area (Royal New Zealand Plunket Society 2013a).

The PEPE courses cover the period from a child's birth until they attend school. They are:

- Your New Baby – covering the first six weeks
- Your Growing Baby – covering from six weeks until baby is rolling or crawling
- Your Moving Baby – for when baby is moving but not yet walking
- Your Active Toddler – covering from about 14 months to about 2.5 years
- Your Curious Young Child – covering from 2.5 years until the child is at school.

All courses except for 'Your Growing Baby' consist of one session of up to two hours over a three-week period. 'Your Growing Baby' consists of one session of up to two hours over a four-to-six-week period (Plunket 2013b).

Delivery and service providers

PEPE has been developed and is delivered nationally by the Royal New Zealand Plunket Society (Plunket 2013a). Plunket is a nonprofit charitable trust and the largest provider of free support services for the development, health and wellbeing of children under five in New Zealand (Plunket 2013c). Plunket nurses provide support through home and clinic visits, mobile clinics and PlunketLine, a free telephone advice service for parents (Plunket 2013d). Plunket staff include registered nurses with a specialist qualification in Well-Child/Tamariki Ora nursing and kaiāwhina (Māori health workers), and community Karitane (including Māori and Pacific health workers) who are educated in a wide range of parenting and health issues to give extra support to family and whānau (Plunket 2013d).

Plunket also have a course for fathers available in some areas. Called Dads4Dads, it has been designed for fathers of children under the age of one year. The course is facilitated by fathers and covers key issues that relate to parenting and fatherhood (Plunket 2013a).

Funding

PEPE is funded by community and volunteer sources, and is supported by the Ministry of Health and KPS Ltd (formerly Karitane Products Society). Plunket courses are free to all participants (Plunket 2013a).

4.1.5 Home-visiting early intervention

Early Start

Description and target population

Early Start is a Christchurch-based intensive home-visiting service that was established in the 1990s as the result of growing recognition of the increasing rates of psychosocial problems in New Zealand Children (Fergusson et al. 2012). The service was influenced by the Hawaiian Healthy Start home-visitation programme. Early Start provides services to the most disadvantaged 15 percent of the population: families or whānau with newborn babies in difficult social and family circumstances that may put at risk the health and wellbeing of their children (Fergusson et al. 2005, 2012).

The target population includes mothers who are pregnant or who have an infant and who are facing challenges (such as mental health issues, addictions, family violence, transience, limited education and social skills). Referrals are accepted for mothers 24 years and under from three months antenatal to nine months postnatal and for all other mothers over 24 years from six months antenatal to nine months postnatal. The service provided is entirely voluntary, long-term (up to five years) and home-based, and promotes healthy child development within a nurturing family environment.[57]

The overall aims of the home-visitation process are to assist, support and empower families to address issues relating to childhood wellbeing and family functioning. The function of the family support worker is not to provide treatment, therapy or specialised advice; rather it is to assist families seeking such treatment, therapy and advice (Fergusson et al. 2005). The programme itself is not structured; services are designed to meet the needs of individual families.

Originally, Early Start did not contain a systematic parenting component to their programme, and instead relied on the skills and abilities of individual family social workers to fulfil this function (Fergusson et al. 2005). This limitation has since been addressed by incorporating the following structured parenting programmes into Early Start:

- Partners in Parenting Education (PIPE) for those aged –zero to three
- Triple P Level 4 for the three-to-five-year-olds
- Incredible Years Toddler for those aged 12 to 18 months
- Getting Ready for School for the four-to-five-year-olds.[58]

Families and whānau are assessed and grouped into the following levels for intensity of service delivery.

- Level 1: High need: One to two hours of home visitation per week.
- Level 2: Moderate need: Up to one hour of home visitation per fortnight.
- Level 3: Low need: Up to one hour of home visitation per month.
- Level 4: Graduate: Up to one hour of contact (phone or home visitation) per three months.

All families enter the programme at Level 1 and, over time, advance depending on progress in the areas of child health, parenting, child abuse and neglect, parental health, family violence, and economic wellbeing. A monitoring process allows family workers to provide advice, support and assistance as problems or issues emerge (Fergusson et al. 2005).

Delivery and service providers

All the clinical staff at the Early Start Project have professional qualifications, with backgrounds in nursing, social work, early childhood education, teaching or other related fields (Early Start 2013b).

57 http://www.earlystart.co.nz/whofor.html
58 Email communication with Hildegard Grant, General Manager, Early Start, 23 September 2013.

A process of weekly supervision by dedicated programme supervisors supports family workers and ensures programme fidelity (ibid).

Funding

Early Start is contracted to and receives funding from the Ministry of Social Development, Canterbury DHB, Department of Child, Youth and Family and the Christchurch City Council to work with families and whānau (Early Start 2013b). They are funded to work with 250 families. The service is free to families and whānau.

New Zealand evaluation findings

Preliminary results from an evaluation based on a randomised control trial indicated that Early Start produced benefits in the areas of early childhood education, health, child abuse, parenting and child behaviour (Fergusson et al. 2005). A nine-year follow-up of this sample produced similar positive results for the intervention group (Fergusson et al. 2013). Refer to the international section of this report for more detail on these findings. The evaluations showed the programme was not successful in changing parental issues, such as depression and family violence. Early Start is currently developing an enhanced version of the programme, which will include such features as a group-based cognitive behavioural therapy for maternal depression, a home-based budget advisory service, and group-based parent advice using Incredible Years Toddler.

Family Start

Description and target population

Family Start was established in New Zealand in 1988. It is a family-focused, child-centred early-intervention programme that provides intensive home-based support services for high-risk families. Families can enter the programme from when the mother is three months pregnant and up to when a baby is a year old. Families can qualify for enrolment on the presence of any one of the following criteria:

- mental health issues
- drinking, using drugs or gambling
- abuse when parent or caregiver was a child
- serious problems with partner or family/whānau
- not being sure how to make sure the child is healthy and developing
- a child with disabilities, or needing special care
- Child, Youth and Family are or have been involved with the family/whānau
- young parents with other challenges who need extra support.

Families who do not come onto the programme can be referred to another agency. Participation in the programme is voluntary. Once on the programme, children can remain until they start school. The intensity of services delivered to the family (the frequency of home visits) is determined by the Strengths and Needs Assessment. This assessment forms the basis of services accessed for the family and support provided. It involves scoring six domains (child, parenting, basic needs, whānau/community and specialist services support and positive outlook/sense of the future). High – and medium-intensity families may require at least weekly visits and low-intensity families at least fortnightly visits. The Strengths and Needs Assessment is repeated at regular intervals to assess progress (at least once every six months).

Families and whānau exit the programme after meeting their identified goals, and improving connections with family and whānau and community, and their ability to apply their own resources and others available to them. All parents receive a parent-education programme – Āhuru Mōwai/Born to Learn.

The overall aims of Family Start are to:

- improve health, education and social outcomes for children
- improve parents' parenting capability and practice
- improve parents' personal and family circumstances.

A Family Start whānau worker visits the family regularly (weekly at first). They:

- assess the family's situation
- help them make an individual plan focused on goals for the child's wellbeing and safety
- offer the family advice and guidance about achieving their goals
- encourage parents to ensure the child gets appropriate health care and early childhood education
- connect the family with other services, agencies or resources they might need
- provide monthly Āhuru Mōwai /Born to Learn parenting education sessions.[59]

(Family and Community Services 2012).

Delivery and service providers

Family Start is administered by Family and Community Services within the Ministry of Social Development. It is similar to Christchurch's Early Start programme in that they are both home-visiting models targeted at the most at-risk families (Fielding 2011), although they are not equivalent programmes, having developed different approaches (Fergusson, personal communication). Regional offices manage Family Start contracts and monitor providers' progress against key performance indicators. Programme support is provided by Family and Community Services (Davies & Roberts 2013). Family Start is offered at 32 locations throughout New Zealand.

Family-Start-funded programmes target high-risk families in locations chosen because of their moderate-to-high levels of deprivation. These areas are identified by the Statistics New Zealand Deprivation Index. All Family Start providers are NGOs and they include family, social services and health agencies and iwi organisations (there are currently 19 iwi-focused organisations out of a total of 32 providers). The programme manual was last updated in April 2013 (currently in draft) to assist providers in maintaining service consistency.

There is no mandatory requirement for family and whānau workers to have a professional or tertiary qualification, but 81 percent are currently qualified to diploma level or higher. A competency framework within Family Start provides a guide to the skills and experience required for staff to work at different levels of the programme and whānau workers are encouraged to gain formal social work, education or health qualifications.

Funding

Family Start is funded through Family and Community Services within the Ministry of Social Development and is free to participating families and whānau. Currently funding for Family Start (including Early Start) is $30.6 million. There are 5000 children in Family Start as at 31 December 2013.

New Zealand evaluation findings

There has been significant government investment in Family Start. Although an outcome evaluation was undertaken, methodological limitations constrain the conclusions that can be drawn about the impact of the Family Start programme (Kerslake Hendricks & Balakrishnan 2005). The outcomes described in the report were based on information collected on less than a fifth of the eligible programme participants, because of difficulties in collecting follow-up data from some participating families and the non-participation of other eligible families. The Ministry of Social Development cautioned at that stage that it could not conclusively be stated how much

59 These are the New Zealand adaptations of the Parents as First Teachers (PAFT) parenting programme and involvement is compulsory for all families receiving Family Start services.

benefit the programme had for participants, or whether any gains observed in the evaluation would have been achieved without all or parts of the intervention. Subsequently, the government has made improvements to and continued to invest in Family Start. Overseas evidence shows that high-intensity, home-based early-intervention programmes (similar to Family Start) can improve outcomes for vulnerable children and families (Kerslake Hendricks & Balakrishnan 2005).

Early evaluations (2005, 2007) have informed the development of service delivery, including the tightening of service specifications and operational guidelines (Fielding 2011). In 2009 the Minister for Social Development and Employment commissioned an independent review of the Family Start and Early Start intervention programmes.[60] This review (Cribb 2009) concluded that there was strong evidence for Early Start producing positive results for children and improving outcomes for New Zealand's most at-risk families. The evidence for the effectiveness of Family Start, however, was rather less convincing. Recommendations were made for potential areas of improvement, including provider and workforce development; working more closely with individual providers; developing and implementing a national evaluation framework; and ensuring that the programmes reach the families most in need (Cribb 2009).

The 2010 evaluation of Family Start was an integral part of the Ministry of Social Development's reponse to this review. This was supported by a research project commissioned to provide evidence for decisions on the revitalisation of the programme (Fielding 2011).

The 2010 evaluation was qualitative in nature, and data-collection was based on interviews with key informants and the analysis of information from the internet-based monitoring and reporting system (FS-NET) that had been introduced in 2008 (Fielding 2011). Of the 5,339 families referred to Family Start between October 2009 and October 2010, 74 percent (3,975) were located and engaged in the programme.[61] It was noted that high refusal and drop-out rates in high-risk populations are not uncommon; there was no indication, however, of the numbers who had disengaged from Family Start over this period. Key findings included the following points.

- Providers reached many families with high needs and were adept at engaging families.
- There is currently no indication as to how many families in the highest needs group should make up the client base for providers.
- Efforts need to be made to identify more of the most-at-risk families prior to the birth of their child.
- The benefits of engaging with Family Start should be widely disseminated nationally, regionally and locally.
- Strong and responsive relationships between families and their workers are crucial to enhancing engagement in the programme.
- Providers need to be mindful of adhering to programme requirements yet responding flexibly to maintain engagement with families.

(Fielding 2011)

In response to Cribb's report and the 2010 evaluation, the following recommendations have been implemented:

- The previous referral ciriteria have been refined to ensure Family Start targets vulnerable children and families/whānau.
- New performance indicators have been introduced to lift programme performance.
- A comprehensive review of the Family Start Manual has been completed to ensure the programme remained child-centred, based on the latest research and evidence of best practice, and that the links between programme components were consistent and clear.
- Practice Advisors have been recruited by Family and Community Services to work closely with providers to enhance front-line service delivery and programme fidelity.
- Child Safety tools have been introduced to screen children for abuse and neglect.

60 The Hon Paula Bennett.
61 Approximately 21 percent could not be contacted and the referral outcome for five percent was unknown.

The Ministry of Health also commissioned research to determine how Family Start and Well Child/ Tamariki Ora Services could be better aligned to deliver effective front-line services (Davies & Roberts 2013).

New Start and Safer Families

Description and target population

The New Start service is a Christchurch-based service developed by the Family Help Trust. The service targets families where repeat criminal offending is a major issue and situates the child as the primary client and the key focus of the service. The Safer Families initiative evolved from New Start because of a belief by providers and midwives that it was better to provide intensive support services both pre– and post-birth in order to provide an ideal opportunity to maximise good outcomes for infant or child bonding and breastfeeding, together with dealing with a raft of social problems related to improving the outcome for the unborn child (Family Help Trust 2013a).

Families who engage with either New Start or Safer Families must be living in the Christchurch area and willing to receive a home visitor. Safer Families services are available to high-risk pregnant women (post-24 weeks) exposed to a number of risk factors such as a history of childhood abuse, family violence and substance abuse (Family Help Trust 2013b). New Start services are available for parents who have been involved in the criminal justice system and referral criteria acknowledge this as follows:

- need to be a parent with at least one conviction within the previous two years
- need to be parenting a child under the age of six months or pregnant (post-24 weeks)
- if offending parent is in prison, he or she needs to be within four months of release.

Both services operate in a similar manner and provide families with a professional, experienced social worker who visits them at home (Family Help Trust 2013b). Social workers will:

- work with the primary parent and their partner to help them recognise and develop their strengths
- provide information, advice and support on the care, development, safety and protection of babies and young children and ensure regular access to appropriate medical support
- provide encouragement, assistance and support during the antenatal period
- challenge behaviour that threatens the children's physical and emotional wellbeing (this includes an unborn child)
- target high-risk problem areas, such as offending, substance abuse and other anti-social activities that impair their parenting and affect the family and society
- help with family or whānau decision-making and problem-solving, and strengthen support systems
- assist with access to other appropriate counselling or community services and courses
- continue to provide support until the enrolled child starts school.

Delivery and service providers

Family Help Trust is a charitable trust that operates child-abuse-prevention services for high-risk families in Christchurch. The Trust's early-intervention services are intensive, long-term, family-based and child-focused. They target high-risk parents with multiple-problem histories who have young families, and aim to break the cycles of inter-generational dysfunction (Family Help Trust 2013a). The Trust's initial intensive family support service began in 1990, as a result of concern that children in the care of the Director General of Social Welfare (now Child, Youth and Family) frequently left that system and 'graduated' into the prison system. Family Help Trust is affiliated with Jigsaw, a national umbrella group of child-protection services throughout New Zealand (ibid).

Funding

The Family Help Trust funds its services through a combination of Government contracts and funds from community and corporate sponsors, including the Canterbury Community Trust and the Lotteries Commission (Family Help Trust 2013c).

New Zealand evaluation findings

An evaluation (Turner 2006, 2009) exploring outcomes for families involved with Family Help Trust has been commissioned by the organisation. In designing the evaluation measures were taken at baseline, 12 months and two years (Turner 2009). The author states that owing to the lack of a control group, findings should be treated with caution. The 12-month report focused on outcomes for 55 families who had been involved with the Trust for a period of 12 months between July 2003 and June 2005 (Turner 2006). This was 78.6 percent of the eligible cohort of 70 families who had been referred to the Trust. Findings indicated that families (outcomes for individual services were not analysed) showed improvement in maternal child-rearing skills and a reduction in child-abuse risks over the first 12 months of their involvement with Family Help Trust services (ibid).

The two-year report (Turner 2009) followed up with families who had been involved with the service for a period of two years. The cohort included 38 of the original sample, which was boosted by an additional 21 families who had also been receiving services for a two-year period. Findings again indicated positive outcomes for families and broadly replicated those reported at the 12-month stage. It was reiterated, however, that it is not possible to say that the improvements were directly related to Family Help Trust services.

Parents as First Teachers (PAFT)

Description and target population

PAFT is based on research from the Harvard University preschool project that resulted in the Parents as Teachers (PAT) programme being developed in Missouri, USA (Family and Community Services 2013a). PAFT is a low-intensity home-visitation parent-education and family-support programme that focuses on families considered to be at some risk of poor parenting and child outcomes, with children in the zero-to-three age range. Families usually enter PAFT at any time during pregnancy until the baby is four months old; however, some families with older babies have been enrolled. Working from the premise that parents are their children's first and most important teachers, the aim of the PAFT programme is to help parents to participate more effectively in their children's early development and learning.

New Zealand has its own curriculum:

- Born to Learn (from PAT Missouri 2000) contains neuroscience, child development and parenting information from a western perspective.
- Āhuru Mōwai is developed from traditional Māori beliefs and practices about child-rearing and draws on Te Whāriki, New Zealand's early childhood curriculum, and Māori pedagogies.
- Te Mahere Kaupapa Māori, a third component of the curriculum, provides month-by-month practical information with a tikanga Māori and te reo focus.

The curriculum is reviewed periodically to ensure that the information on aspects such as child development, health checks and immunisations and safety regulations meet current New Zealand requirements or standards.

The key component of the PAFT programme is the personal visit. Families receive home visits of one hour from parent educators who share knowledge, ideas, and activities and provide handouts on:

- what to look for and expect as a child grows and develops
- ways families can provide exciting, educational and inexpensive experiences for their children
- using everyday experiences as learning opportunities for children

- how to help a child develop a love of books and stories
- practical ideas on creating a safe environment that is exciting and fun
- setting realistic limits for a child's behaviour and what to do about problems
- ways to help each child grow to his or her full potential.

The personal visit allows the parent educator to individualise the PAFT programme for each family and child and model appropriate parent-child learning activities. Observations about the child's growth and development are recorded at each visit (Family and Community Services 2013b). These enable the educator to reassure families when their child is developing appropriately, and identify potential problems early, assisting the family in accessing any support they require. Families are also encouraged to continue observing and monitoring their child's development. Parent educators remind parents of the importance of keeping up the Well Child/Tamariki Ora health checks for their children. Parents' and educators' observations, along with the formal screening undertaken by Well Child health agencies, help insure against undetected delays or learning difficulties during the first three years of a child's life.

Families are also offered regular opportunities to meet with other families in a group setting (ibid). These meetings may range from sessions on topics such as managing behaviour, to less structured get-togethers that both children and adults can attend.

Delivery and service providers

As of 1 July 2008, the PAFT National Centre became part of the Ministry of Social Development. It was transferred from the Ministry of Education to Family and Community Services, the part of the Ministry that focuses on early intervention and prevention services, to better align early intervention and positive parenting services for families (Family and Community Services 2013b). Family and Community Services manages and monitors 25 contracts with various organisations that deliver the PAFT programme in 36 locations throughout New Zealand. Each site has negotiated recruitment criteria based on the demographic profile of their region (Family and Community Services 2013b). Providers are contracted by the Ministry of Social Development to offer a minimum of 25 personal visits over three years per family (Praat 2011). This averages out to around eight visits per year per family, putting PAFT at the low-intensity end of home-visiting programmes (ibid).

PAFT staff are primarily 'educators' not 'social workers', and the programme focuses principally on delivering parent education. Although PAFT is a targeted programme, it is not supposed to be for the most vulnerable families (Praat 2011). Plunket is one of the leading providers of the programme. Their PAFT educators work as members of the wider Plunket teams to provide a broad and holistic approach to family wellbeing. PAFT parent educators maintain networks with other local community services to ensure they remain up-to-date with what resources are available. PAFT is then able to link families with those services that offer support outside their scope. New Zealand trainers train new PAFT parent educators and professional development is provided annually.[62]

Funding

In New Zealand, PAFT is funded by the Government and administered by Family and Community Services (Ministry of Social Development). The programme is free to participants. Currently PAFT is allocated $7.28 million and serves over 6,300 families.

New Zealand evaluation findings

There have been a number of evaluations of PAFT (Boyd 1997a, 1997b; Campbell & Silva 1997; Farquhar 2003; Praat 2011). The early evaluations of the programme pilots used comparison groups and found little evidence of programme effectiveness. The programme then underwent significant development and Farquhar (2003) reported some positive findings, albeit based on post-course

62 In 2011, the PAT programme in the USA redeveloped the curriculum; it requires all of its affiliates, including PAFT, to sign up to this by 2014 (Praat 2011). The focus is now on evidence-based practices, family wellbeing factors, parent-child activities, parental goal-setting,and strengthening families' protective factors, in addition to an enhanced prenatal section. Core competencies for educators are also addressed and a tool kit for parent educators included.

surveys and interviews (with no comparison groups). In March 2009 the Centre for Research and Evaluation within the Ministry of Social Development undertook a rapid review of PAFT (Praat 2011). The evaluation was undertaken in two phases.

Phase one examined the need for PAFT, programme quality and the mechanisms that lead to positive change.[63] It found that three-quarters of families enrolled in 2006 remained on PAFT after a year, reducing to just over half after two years. Evaluators noted that these retention rates were similar to those of other home-visiting programmes, and that nuclear families with higher incomes and European mothers were on average better engaged with the programme.

Phase two of the evaluation focused on PAFT's effectiveness and involved:

- a survey of all parents who had been involved with PAFT for a year or more as at 31 January 2011
- an organisational survey of providers
- case studies at six sites
- analysis of providers' six-monthly reports to the Ministry of Social Development
- analysis of the national screening of child health and development (Well Child/Tamariki Ora B4School Check) data.

PAFT was associated with better child outcomes, particularly for nuclear families, and may be most effective where families have the resources to engage with the programme. All parents reported positive changes in their parenting after being involved with PAFT. Unsurprisingly, however, first-time parents reported the biggest changes.

Higher participation in PAFT is associated with better outcomes for children and some nuclear families. Analysis of data indicates that for children at four years of age, overall, there is:

- higher participation in B4School checks
- less need for referral or further assessment for hearing and conduct issues.

For sub-groups of nuclear families with similar characteristics analysis suggests benefits such as:

- vision and conduct results for families with mothers who identify as Māori
- conduct and developmental results for families with mothers identifying as 'other ethnicities'[64]
- better hearing results for families with European mothers.

In order to assess the potential contribution of PAFT to reducing child maltreatment, rates of notification and substantiation of a random sample of PAFT children born in 2006 (n=100) were compared to children in the general population born the same year. It was hypothesised that PAFT children differed in that they become involved with the programme on the basis of the presence of some risk factors associated with poor child outcomes, and were thus a more vulnerable group. Findings indicated that although PAFT children were more likely to be notified to CYF than children in the general population, they were no more likely to have substantiated findings of abuse than children in the general population.[65]

4.1.6 Educational programmes

Home Interaction Programme for Parents and Youngsters (HIPPY)

Description and target population

HIPPY was developed in Israel in the late 1960s and has been operating in New Zealand since 1992 (Young 2009). Kerslake Hendricks and Balakrishnan (2005) describe HIPPY as 'a home-based programme that helps parents create experiences for their children that lay the foundation for success in school and later life' (p 63). HIPPY works with children aged between three-and-a-half and six years of age, in their last years before school, and their first year at school (p 63). There is a

63 See Praat et al. (2011).
64 That is, not European or Māori.
65 Notifications to child welfare agencies can be viewed as an indication of community concerns about or responsiveness to child abuse.

significant emphasis on transition to school. Participating families are also encouraged to attend early childhood services (Kerslake Hendricks & Balakrishnan 2005). HIPPY is targeted at high-needs families where there are indicators of likely poor learning outcomes for children.

HIPPY is delivered to families on a weekly basis with alternating one-hour home visits and two-hour group meetings (Families Commission 2013). In cases where there is low literacy or English as a second language, tutors will visit the parent more than once a week. HIPPY is a 60-week programme which families work on over a period of two years. The prime method of teaching and learning in HIPPY is roleplay.

Delivery and service providers

In New Zealand, HIPPY is managed by the Great Potentials Foundation. The Foundation is responsible for training, oversight, quality assurance, reporting and programme development (Families Commission 2013). Currently there are 36 programmes operating in low-income communities around the country. Programmes are delivered by local community providers. The New Zealand Government has committed to the expansion of the HIPPY programme, which will see the operation of 36 sites by 2014 (Great Potentials Foundation 2013a). Tutors are paraprofessionals – that is, parents chosen from the target community who undergo accredited HIPPY training. The HIPPY curriculum is comprised of 60 workbooks supported by a tutor guide. Programme performance is monitored via regular visits to each site and reporting to Great Potentials by HIPPY co-ordinators.

On average, one-third of families complete the full 60-week programme. Data gathered over four years showed on average 50 percent complete 20 or more weeks and 69 percent complete six or more weeks (Families Commission 2013). The most consistent reason for families leaving before completion is relocation – 28 percent in any one year. It is also not unusual for those who have been involved with the programme for 30 or more weeks to leave because they feel they have achieved their goals.

Funding

HIPPY programmes that are provided mainly through Family Service Centres are fully funded through the Ministry of Social Development (MSD). The programmes operated by local community providers are funded for 85 percent of operating costs through grants made by Great Potentials from MSD funding (Families Commission 2013). The remaining 15 percent is raised locally by each provider through applications, grants and donations (Great Potentials Foundation 2013b). MSD funding is currently $2.99 million, for 1215 families. The recent Great Potentials annual report indicates that in 2013 they worked with 2055 parents at 36 sites (Great Potentials 2013). The majority of HIPPY sites ask for a donation of one to two dollars a week to help with the cost of workbooks and storybooks. This is waived if the parent is unable to pay.

New Zealand evaluation findings

Within the New Zealand context, HIPPY has shown positive educational outcomes for children, and international research supports the effectiveness of the programme, both for children and parents. Research and evaluations of HIPPY programmes (see for example BarHava-Monteith, Harré & Field 1999, 2003) focused on children's ability to adapt to the classroom environment, performance on standardised tests and academic trajectories (cited in Hendricks & Balakrishnan 2005). The primary aim of HIPPY is to improve the cognitive skills and readiness for school of the four– and five-year-old participants (predictive of long-term success in education). HIPPY can also be described as a two-generational programme, however, with benefits for participating parents and caregivers as well.

BarHava-Monteith et al. (1999) carried out an evaluation of HIPPY's benefits to children and caregivers in New Zealand, as well as exploring process issues. Drawing on the work of Burgon (1997), they note that an earlier New Zealand Government evaluation of HIPPY found that HIPPY children's performance in both reading and mathematics was on a higher level than might have been expected, given their circumstances. Their overall academic progression was also described

as much faster than might have been expected. Because there were some shortcomings in the earlier New Zealand evaluation (the appropriateness of the comparison group, for example), a further evaluation was undertaken. BarHava-Monteith et al. (1999) evaluated HIPPY in two studies, comparing children who had participated in HIPPY with control groups (classmates). The evaluation found that the HIPPY children in the study scored significantly higher than non-HIPPY children on three of the six sub-tests of the Reading Diagnostic Survey and the Behavioural Academic Self-Esteem scale. Compared with comparison caregivers, HIPPY caregivers and tutors were reported to be significantly more likely to engage in formal educational activities, to carry out more educational activities with their child in a given week, and to have been involved in adult education.

4.1.7 Child behavioural management programmes

Incredible Years

Description and target population

The Incredible Years Parenting Programme was developed at the University of Washington by Caroline Webster-Stratton and her associates and is used widely internationally. The programme is being delivered in New Zealand as part of the Positive Behaviour for Learning Action Plan (Ministry of Education 2011 cited in Ehrhardt and Coulton 2013) and as a health service intervention.

Incredible Years is a parent management programme for children exhibiting conduct disorders (Sturrock and Gray 2013). It is a 14–18-session programme for parents of children aged from three to eight years of age. Weekly group sessions are held where parents come together and develop approaches to use at home with their child's challenging behaviours. Issues addressed include problem behaviours such as aggressiveness and persistent tantrums, and acting out behaviour such as swearing, whining, yelling, hitting and kicking, answering back and refusing to follow rules (Ministry of Education 2013).

The programme coaches parents in ways of:

- making time to spend time and play with their children and letting their children lead the play
- encouraging the behaviours they would like to see through setting clear rules and boundaries and using praise and encouragement
- selectively using consequences such as ignoring, loss of privilege and time out.

A core element of the programme is parents learning from and supporting each other (Ministry of Education 2013).

Delivery and service providers

The Incredible Years programme is delivered by the Ministry of Education, Special Education staff and by 51 NGOs contracted to deliver the programme in partnership with the Ministry. Eleven of the NGOs are Whānau Ora providers (Ministry of Education 2013).[66] Many also provide a range of social services to families.

Funding

Incredible Years is funded by government grants and is free to participating families. The Incredible Years Basic programme is currently funded by the Ministry of Education with $7.6 million to work with 7461 families (at December 2012).

66 See the Chapter on Māori parenting programmes for more discussion of this programme.

New Zealand evaluation findings

Findings from a preliminary evaluation of the effectiveness of the Incredible Years Basic parent programme in New Zealand were consistent with the international view that the programme is effective and culturally appropriate (Fergusson, Stanley & Horwood 2009). Data were collected on 214 parents who had attended the programme for at least nine sessions in a group setting. These included pre-test and post-test T scores on the Eyberg intensity and problem scales; pre-test and post-test scores on the parent version of the child Social Competence Scale; and parent satisfaction ratings. Pre-test and post-test comparisons indicated statistically significant improvements in behaviour and social competence scores, with effect sizes ranging from 0.50 to 0.77. Levels of parental satisfaction with the programme were high.[67] The need for more in-depth research was noted by the authors.

The aim of the Incredible Years Pilot Study was to provide Government agencies with profiles of the families participating, demonstrate programme fidelity,[68] measure both programme effectiveness and parent satisfaction, and assess the programme's responsiveness to Māori.[69] This was a two-year multiple-informant study that included mixed measurement methods, single case studies and a six-month follow-up (Sturrock & Gray 2013). The main study utilised a repeated measures design where participants were interviewed four times – at baseline, mid-programme, post-programme and six months following completion. The programmes evaluated in this study were delivered at three Ministry of Education Special Education sites in 2011 – Bay of Plenty, Canterbury and MidCentral. All parents enrolled in the course at these three sites were invited to be part of the evaluation. A total of 166 agreed and completed the baseline interview.

Parents reported significant improvement in their children's behaviour on all measures following completion of the programme.[70] A linear trend of improvement throughout the programme was evident. The results from follow-up interviews were compared with baseline data from approximately 12 months previously (Sturrock & Gray 2013). Again, behaviour scores showed a linear trend of improvement. Parents reported that their children's improved behaviours were sustained following programme completion. Teachers reported that there was also some evidence of better child behaviour at school. Results were similarly positive for parenting practices and relationships – all parents showed significant linear trends of change throughout the programme for all parenting behaviours measured.[71] The improved parenting practices were sustained six months later.

Summarised findings indicate that improvements evident at the end of the course were mostly sustained at the six-month follow-up. Significant improvements were noted in children's behaviour, parenting practices and relationships (Sturrock and Gray 2013). Although these differences were noted across all three sites effect sizes were largest in MidCentral – the reasons are unknown. The evaluators noted that at follow-up there was a small but statistically significant difference between responses by parents of Māori and non-Māori children on the maintenance of behaviour change. This suggested the need for more work on maximising gains for Māori whānau, particularly in this area.

Considering the model of delivery of the Incredible Years Hawke's Bay Parenting programme, Ehrhardt and Coulton (2013) propose that there may be some benefit to delivering the programme using a model of interagency collaboration.[72]

67 Results on all measures were similar for Māori and non-Māori parents.

68 To ensure programme fidelity Special Education developed a unified protocol for the course in the pilot that required group leaders to complete and return checklists that documented their adherence to stipulated programme processes and delivery.

69 A separate study examined Māori perspectives of the programme drawing on kaupapa Māori research methodology (see Berryman et al. 2012).

70 Measures were Conduct Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Self-control, Anxiety/Withdrawal and Social Competence.

71 Two recognised instruments were used: the Alabama Parenting Questionnaire (Shelton et al. 1996) and the Arnold-O'Leary Parenting Scale (Arnold et al. 1993).

72 The Hawke's Bay parenting programme is delivered collaboratively by Child, Adolescent and Family Services, Hawke's Bay DHB, Special Education; the Ministry of Education, Family Works, Birthright and the Napier Family Centre.

Triple P – Positive Parenting Programme

Description and target population

The Triple P Parenting Programme was developed at the University of Queensland by Matt Sanders and his colleagues in 1978 and is now used in 25 countries. Triple P is a form of behavioural family intervention based on the principles of social learning theory (Sanders et al. 2003). The goal is to enhance families' protective factors and thus reduce risk factors associated with severe behavioural and emotional problems in children and adolescents (ibid).

The Triple P programme is multi-level and targets five developmental periods: infants, toddlers, preschoolers, primary schoolers and teenagers. There are five levels to the programme, which target parents with different levels of need:

- Level 1 – media-based parent information campaign for all interested parents[73]
- Level 2 – brief selective intervention – parents with specific concerns about their child's development or behaviour[74]
- Level 3 – narrow-focus parent training – parents with specific concerns who require consultations or active skills training[75]
- Level 4 – broad-focus parent training – parents wanting intensive training in positive parenting skills – typically parents of children with more severe behaviour problems[76]
- Level 5 – behavioural family intervention modules – parents of children with concurrent child behaviour problems and family dysfunction such as parental depression, stress or conflict.[77]

(Sanders et al. 2003 p 2)

The intervention for each stage can be broad or focused to target high-risk children. Specifically, the programme aims to:

- enhance knowledge, skills, confidence, self-sufficiency and resourcefulness in parents
- promote nurturing, safe, engaging, non-violent and low-conflict environments for children
- promote children's social, emotional, language, intellectual and behavioural competencies through positive parenting practices.

(ibid)

Delivery and service providers

From its early beginnings as the basis of Professor Matthew Sanders' doctoral thesis, Triple P is currently delivered in various settings in New Zealand ranging from the Ministry of Education Special Education Early Intervention services, who deliver Standard Stepping Stones Triple P, to the use of Resilience Triple P in schools to help families and children combat bullying (University of Auckland 2013). The Werry Centre for Child and Adolescent Mental Health Workforce Development, in partnership with the Ministry of Health, Triple P New Zealand, and four District Health Boards, is in its third year of the implementation of a pilot Primary Care Triple P project in primary health (ibid). The programme is being trialled by four DHBs: MidCentral, Bay of Plenty, Counties-Manukau and Waitemata. Within this project primary health practitioners working with parents of children receive training in two brief behavioural counselling interventions for early detection of parenting challenges. These interventions are Primary Care Triple P and Triple P Discussion Group training. Practitioners also receive delivery support, and a Stay Positive communication strategy seeks to engage the community. Under the programme, parents will be able attend free community

73 This is Universal Triple P.
74 This includes Selected Triple P and Selected Teen Triple P.
75 This includes Primary Care Triple P and Primary Care Teen Triple P.
76 This includes Standard and Group Triple P, Group Teen Triple P and Self-Directed Triple P. In addition there is Stepping Stones Triple P at this level, for families of preschool children with disabilities or who have or are at risk of developing emotional and behavioural problems.
77 This includes Enhanced Triple P and Pathways Triple P. The latter programme is for parents at risk of child maltreatment and targets anger management and other risk factors associated with abuse.

workshops to discuss common parenting issues or have one-on-one sessions. If additional support is required, they can also be referred to specialist services.[78]

Funding

In 2012 the Ministry of Health allocated $4 million over three years for the DHB trials. There is no cost to participants.

New Zealand evaluation findings

Recent New Zealand evaluations on the use of Triple P include RCTs evaluating the effects of:

- Triple P online
- enhanced versions of Group Triple P (emotion-enhanced and father-enhanced)
- Group Teen Triple P.

There is currently a series of Triple P trials in progress in New Zealand, including:

- an evaluation of Triple P online with parents of children with ADHD
- an evaluation of Brief Discussion Groups Triple P
- an RCT evaluating Primary Care Triple P with Māori whānau
- an RCT comparing Groups Triple P with another intervention for parents of children with ADHD.[79]

Triple P has been extensively evaluated over the last 33 years, particularly with younger children, and is noted for its positive effects on reducing disruptive behaviour problems (Nowak & Heinrichs 2008 cited in Chand et al. 2013). Recent New Zealand research has been mainly university-based and recruits participants to take part in studies focusing on a particular level of Triple P.[80] Results from a New Zealand Triple P pre – to post-intervention evaluation (n=32) (Chand et al. 2013) have provided preliminary support for the idea that brief parenting interventions may produce favourable results for families. Another study to evaluate the efficacy of Group Teen Triple P used a longitudinal RCT.[81] The researchers noted that although the small sample size did not allow for examination of moderators and mediators of intervention effects, the Triple P group reported higher levels of parental monitoring and decreased parent-adolescent conflict in addition to a reduction in problem behaviours, which is consistent with previous studies on Teen Triple P (Chu et al. in press).

4.1.8 Parenting programmes for separated parents

Parenting Through Separation

Description and target population

Parenting Through Separation is a free information programme that aims to educate parents about the effects of separation on children and provide skills to reduce children's levels of stress during this time (Robertson & Pryor 2009). The Ministry of Justice received funding and developed the programme, which has been in operation since May 2006.

78 Media statement from Hon Tony Ryall, Minister of Health 14 March 2012. Retreved 30 October, 2013, from http://www.waitematadhb.govt.nz/LinkClick.aspx?fileticket=Qo9_4LvgLVY%3D&tabid=389&mid=892

79 Personal email communication with Professor Matt Sanders, Director and Professor of Clinical Psychology, Parenting and Family Support Centre, University of Queensland, 23 May 2013.

80 Both Victoria University of Wellington and the University of Auckland have conducted studies in collaboration with the University of Queensland (see Chand et al. 2013, Chu et al. in press, Salmon et al. in press).

81 Triple P group n=35; control group n=37. The control group received no intervention or support from the research team.

Parenting Through Separation is a voluntary programme available to parents who are separated or are thinking of separation. The programme is four hours long and is delivered to small groups by an experienced facilitator. It can be delivered in a single four-hour session or split into two two-hour sessions. Programme content covers:

- how separation affects children
- what children need during separation
- talking with children
- talking with ex-partners about arrangements for the children
- keeping children away from parental arguments
- how the Family Court works.

(Robertson & Pryor 2009 p 17)

Information pamphlets and two free DVDs – one for parents and the other for their children – are also made available to participants (ibid). Parents are encouraged to develop a plan for managing family life for the children after parental divorce or separation.

Delivery and service providers

The Ministry of Justice provides materials for providers to use in programme delivery. The programme is run at over 170 sites throughout the country by Relationships Aotearoa (previously Relationship Services) and a range of community providers including Barnardos New Zealand and Family Works (Robertson & Pryor 2009).

Funding

Parenting Through Separation is funded through the Ministry of Justice and is free to participants (Ministry of Justice 2013). Current funding is $320,000.

New Zealand evaluation findings

Parenting Through Separation was evaluated for the Ministry of Justice in 2009 (Robertson and Pryor 2009). The evaluation collected information from a range of key stakeholders, including pre-programme (n=119) and follow-up (n=81) survey information from a sample of parents who had attended the course.[82] A sample of programme providers (n=25) also provided researchers with information from pre-registration forms (n=4406) and post-programme evaluations from parents (ibid) who had attended the programme between May 2006 and September 2008. A pre– and post-programme measures design was used to assess the impact of the programme on parents.

Evaluation findings indicate that overall this course meets its main objectives; it increases parents' knowledge of issues surrounding separation and helps them to minimise its impact on their children (Robertson & Pryor 2009). Parents commented positively on course materials (particularly DVDs and handouts) and how the course was run. Measures of parent and child needs, issues of separation and child behaviour indicated statistically significant changes at follow-up compared to before the course. There was significantly less evidence of parents placing children in the middle of parental conflict and of parental conflict in general – both of which are goals of the course. Parents were also significantly more satisfied with childcare, contact and support arrangements, and reported more knowledge of separation issues and better adjustment to the breakdown of the relationship (ibid). Parents also rated their child's behaviour as less problematic at follow-up. All of these changes point to the effectiveness of the Parenting Through Separation programme, although natural improvement over time cannot be discounted as having some impact.

82 Key informants interviewed included programme providers, Family Court judges and lawyers, Ministry of Justice staff and representatives from Māori, Pacific and other NGOs.

4.1.9 Correctional parenting programmes

Prison-based programmes

Parenting With Purpose
Description and target population

The Department of Corrections currently runs the Parents Centre programme Parenting With Purpose. They fund 500 prisoner programme starts per year. The programme is offered to both male and female prisoners in all Department-of-Corrections-run prisons (except Auckland Region Women's Corrections Facility, in which Triple P is provided instead), depending on demand.[83]

This is a group-based programme designed to improve the parenting skills of prisoners and to increase their awareness of community networks that can support them with ongoing parenting and family needs. The programme helps prisoners develop the pro-social values and behaviour required for good parenting, helping offenders gain parenting skills which may help reduce intergenerational offending by reducing their children's exposure to ineffective parenting and poor role-modelling.[84] The programme aims to:

- assist prisoners in understanding the importance of their role as a parent
- foster a sense of hope in prisoners that they can build, re-establish and/or strengthen their relationships with their children, and
- mentor prisoners in their parenting-related aspirations.

(Families Commission 2013)

This programme is available to prisoners who are caregivers to children under 16 years of age. There are some caveats, however – prisoners with a history of violence towards children must complete a rehabilitative or Special Treatment Unit Rehabilitative Programme (Violence) before the parenting programme and have their inclusion in a parenting-skills course approved by programme facilitators. Offenders with child sex convictions, or who have been convicted of the manslaughter or murder of a child, are excluded from this programme. Literacy skills should also be planned and successfully completed if the offender does not have sufficient literacy to participate in the parenting-skills programme. Parenting skills should be undertaken early in an offender's sentence, as long as they meet the eligibility and entry criteria. This is so they can put their new skills into practice as soon as possible.[85]

Delivery and service provider

Parenting With Purpose is a group-based parent-education programme comprising 12 two-hour modules, developed for and delivered to prisoners by Parents Centres New Zealand Inc. This organisation has a network of 50 centres nationwide, making it the largest parenting-based infrastructure and network to support parents and their children in New Zealand (Families Commission 2013). All of their parent-education programmes have been designed and developed by the organisation to build support for all parents and families, including those who are marginalised or vulnerable to risk. Programmes have been developed using principles of best practice, well-researched resources and comprehensive measurement techniques (Families Commission 2013).

A database is maintained to capture participants' characteristics and performance and to enable monthly and quarterly reporting. Through delivery of the Parenting With Purpose programme, Parents Centres are assisting the Department of Corrections in providing services that may help reduce re-offending and other anti-social behaviour by prisoners, which can contribute to their successful re-integration into the community.

Facilitators of prisoner parenting programmes are provided with a Facilitator Guide and a comprehensive manual of guidelines, instructions and procedures for each milestone of programme delivery.

83 Personal email communication with Mark Hutton, Manager, Rehabilitation Interventions Support, Department of Corrections, 15 May 2013.
84 Refer to footnote 94.
85 Refer to footnote 94.

Funding

This programme is funded by the Department of Corrections.

New Zealand evaluation findings

There is currently an evaluation of Parenting With Purpose under way in prisons, but results are not available at this stage.[86]

Prison mother-and-baby unit programmes[87]

New Start Plus

Description and target population

The New Start Plus early-intervention service was established as a result of legislation passed in 2008 allowing women to keep their child with them in prison until the age of two years. At the request of Christchurch Women's Prison, Family Help Trust designed and began trialling New Start Plus for mothers and babies in prison in the same year (Family Help Trust 2013d). This is a long-term structured programme delivered to inmate mothers with infants and toddlers living with them in mother-and-baby units in prison. The goal of the programme is to take advantage of the opportunity these women have to focus exclusively on parenting without the distractions of the outside community and thus give their child the best start in life.

Once the pregnant mother has been assessed by the prison as being suitable for the mother-and-baby unit, a referral is made to Family Help Trust. It is possible for the organisation to visit the mother for almost three years pre-release. When the mother is released into the Christchurch community, services are continued until the child enters the primary school system (Family Help Trust 2013e). New Start Plus is a one-on-one social-work service designed to enable mothers, and partners post-release, to provide their child with the best start they can. The key service objectives are to provide mothers with:

- information, guidance and support through the pre-natal period
- support for an enjoyable breastfeeding experience
- information on ensuring a safe environment for their child, including safety from family violence and abusive parenting

And to encourage them to:

- express warmth and affection towards their growing child
- recognise and respond to their child's needs and behaviours
- initiate positive social interactions and play with their child
- use positive child-rearing methods
- provide consistent and predictable daily routines for their child
- seek appropriate medical treatment and growth and development checks
- provide nutritious first foods and monitor their child's dental care.

(Family Help Trust 2013e)

Inmate mothers who are going to be released into other regions are only provided with the basic pre-release prison service. Attempts are made, however, to find other suitable and effective services for post-release support (ibid). For the best possible outcome for both the mother and their infant, an effective post-release through service is crucial.

86 See footnote 94.

87 Women in these units can also access the Parenting With Purpose programme delivered by Parents Centre in most prisons. They also have access to Well Child providers such as Plunket.

Delivery and service provider

New Start Plus has been developed by Family Help Trust and is delivered by an in-house social worker.

Funding

This programme is funded under a contract with the Department of Corrections. In 2011, the Department of Corrections sought tenders for programmes for mothers and babies in mother-and-baby units at both Auckland Region Women's Corrections Facility and Christchurch Women's Prison. In 2012 Family Help Trust was awarded the contract for Christchurch.

New Zealand evaluation findings

This programme has not been evaluated. However, Family Help Trust have provided the Department of Corrections with bi-annual reports (Family Help Trust 2013e) of numbers of women who have been involved in the programme and a summary of life outcomes for those women who have been released into the Christchurch area from prison with their child.[88]

Auckland Region Women's Corrections Facility

Description and target population

An individual support programme is delivered to mothers with infants and toddlers up to the age of two years living with them in the Auckland Women's mother-and-baby unit. This programme provides wraparound support for mothers while they are in prison and upon their release. The Incredible Years parenting programme is also delivered to mothers in this unit.[89]

Delivery and service provider

Family Works Northern is contracted to deliver this service under contract to the Department of Corrections.

Funding

This programme is funded under a contract with the Department of Corrections. In 2011, the Department sought tenders for programmes for mothers and babies in mother-and-baby units at both Auckland Region Women's Corrections Facility and Christchurch Women's Prison. In 2012 Family Works Northern was awarded the contract for Auckland Region Women's Corrections Facility.

Community-based programmes for offenders

Purposeful Parenting programme

Description and target population

The Purposeful Parenting programme is a pilot project provided in Whangarei and Kaikohe by Parents Centres New Zealand. This three-day group-based parent-education programme has been specifically developed for offenders serving community-based sentences and is delivered over a three-week period. The aims of the programme mirror those of the Parenting With Purpose programme (Families Commission 2013).[90] Offenders' partners are also eligible to attend the programme.

88 See Family Help Trust (2009, 2011).
89 Personal email communication with Megan Coffey, Advisor, Rehabilitation Interventions Design and Support, Department of Corrections, 24 October, 2013.
90 See the section on prison-based parenting programmes for a description of the content of Parenting With Purpose, on which Purposeful Parenting is based.

Delivery and service providers

Purposeful Parenting has been developed for and delivered to offenders serving community-based sentences by Parents Centres New Zealand Inc.[91]

Facilitators of offender parenting programmes are provided with a Facilitator Guide and a comprehensive manual of guidelines, instructions, and procedures for each milestone of programme delivery.

Funding

This is a pilot programme funded by the Department of Corrections.

Conscious Parenting programme

Description and target population

The Department of Corrections has invested in innovative programmes to equip offenders with the pro-social skills necessary to develop positive relationships with their partners and children. The Conscious Parenting programme is a community-based programme for men convicted of domestic violence. The programme aims to build parenting skills in young men who have had domestic violence issues and seeks to enhance the offender's relationship with their children (Department of Corrections 2012). The programme will teach offenders to take responsibility for their actions, to reflect on the impact of their offending on their children, and to improve their social networks as they become positively involved with their children's activities.

The expected outcomes from the programme include:

- improved relationships between perpetrators of domestic violence and their children
- better outcomes for the children's wellbeing and less likelihood of violence
- increased buy-in and recognition by the perpetrator of the need to change their negative behaviours
- building a positive peer mentoring group for the parenting-programme members.

(Department of Corrections 2012)

Delivery and service providers

This programme is delivered for the Department of Corrections by Stopping Violence Dunedin in collaboration with Barnardos New Zealand (Department of Corrections 2013). Stopping Violence Dunedin already provides domestic violence interventions, but research indicates that giving relevant offenders parenting programmes as well has a stronger effect on reducing reoffending.

Funding

This programme is funded by the Department of Corrections under the 2012/13 round of their contestable initiatives fund.

91 See the previous section for details of this organisation.

4.1.10 Mentoring initiatives

SAGES – Older People as Mentors

Description and target population

SAGES is a volunteer mentoring programme that provides an opportunity for older people to share their life skills, experience and knowledge. The initiative is based on a service model developed by SuperGrans in Lower Hutt (Family and Community Services 2013f). This service is available to families or whānau and others in the community who would benefit from assistance and support with parenting and life skills. The aim is to aid people in developing skills to help them cope and become self-sufficient.

Delivery and service providers

Seventeen non-government organisations, including SuperGrans, are contracted by Family and Community Services to deliver SAGES (Family and Community Services 2013c). These organisations recruit and train volunteer mentors and match them with families. SAGES services are provided free to families or individuals.

Funding

SAGES services are Government-funded at $1.2 million per annum through Family and Community Services.

4.2 Summary

The above review has shown that there is a range of parenting support programmes available in New Zealand, covering both population-level prevention and more targeted interventions. Funding is provided by a number of different Government agencies, depending in part on the goal of the programme (health, educational preparedness, or child welfare, for example), with most programmes delivered by non-government organisations. Government is spending over $100 million to fund the above programmes, with almost $60 million of this going to the Well Child/Tamariki Ora programme and $30 million on home-visiting programmes.

New Zealand's Well Child/Tamariki Ora programme follows international practice for a universal antenatal and postnatal education and support programme. It reaches most prospective parents, but its impact has not been evaluated, although this might be difficult given its near universal reach. Plunket, which provides most Well Child services, has also developed the Parenting Education ProgrammE (PEPE). It is aimed at supporting parents through the different stages of their child's early development, but has not been evaluated for its effectiveness.

The international review has identified some home-visiting programmes as being effective in working with those families in greatest need. The Christchurch-based Early Start programme has been evaluated with an RCT, with good evidence of effectiveness on a range of outcomes. It is cited in overseas reviews as an evidence-based programme. Nationally, the Family Start programmes provide home visiting to vulnerable families. This initiative has been evaluated, but these evaluations have not allowed any conclusions to be drawn as to its effectiveness. The Cribb review (2009) suggested that Family Start programmes varied in quality and in their success with families, and that more evidence is required to establish their effectiveness.

New Start and Safer Families are Christchurch-based home-visiting services provided by the Family Help Trust. New Start targets families where repeat criminal offending is a major issue, while Safer Families is a programme for high-risk pregnant women with multiple-risk histories. The programme has been evaluated, but lack of a control group limited the researcher's ability to draw conclusions as to the programme's effectiveness.

Parents as First Teachers (PAFT) is a New Zealand adaptation of the US Parents as Teachers (PAT) home-visiting programme. Parents as Teachers has been evaluated in the US and found to produce positive outcomes in children's development and positive parenting. PAFT is available in almost 40 locations in New Zealand and has been targeted at helping the more vulnerable population. The Āhuru Mōwai /Born to Learn curriculum, which was developed by PAFT for New Zealand parents, is also used as part of the Family Start programme. The New Zealand version of PAT has had a series of evaluations, with mixed results from an early RCT (although this was on a very early version of the programme). More recent results suggest some benefits in terms of health and development outcomes for children whose parents participate in the programme. The New Zealand curriculum needs to be updated in line with developments in the PAT curriculum.

Home Interaction Programme for Parents and Youngsters (HIPPY) is a home-based programme aimed at promoting children's school readiness and success. It is based on an international programme that has shown success in promoting children's educational outcomes. It is offered in 36 locations in New Zealand and has been evaluated using non-randomised comparison groups, with results showing some benefits in terms of higher literacy scores and educational self-esteem in children who participate.

As the international review has shown, there is generally stronger evidence to support the effectiveness of child behavioural management programmes. Two of the better-supported overseas programmes (Incredible Years and Triple P) are being offered to parents in New Zealand. The Incredible Years programme has recently been evaluated in New Zealand, with promising results in terms of children's behaviour and positive parenting. A number of smaller-scale evaluations of Triple P – Positive Parenting Programme have been or are being conducted in New Zealand.

Strategies with Kids, Information for Parents (SKIP) supports local and national organisations working with families in a number of ways, including funding community projects, developing and co-ordinating a network of parenting champions, producing and distributing resources and providing training for formal and informal supporters of parents. Some of these have been evaluated, but the evaluations are small in scale and we cannot assess the effectiveness of these programmes, or of SKIP overall. In recent years SKIP has increased its focus on parents of vulnerable children.

There are also various other parenting programmes available in New Zealand. These are often designed to work with specific groups of parents. Examples include Parenting Through Separation, prison-based programmes, prison mother-and-baby-unit programmes, community-based programmes for offenders, and teen parent intensive case workers. Although some have been evaluated, better, larger-scale evaluations are required before we can be confident these are having a positive impact. In addition to the programmes reviewed above other international programmes, such as Mellow Parenting, are being piloted in New Zealand. There is a place for the development and piloting of new programmes, particularly for those parents who are not engaging with current ones, but they have yet to reach a point at which they might usefully be evaluated for their effectiveness.

5. MĀORI PARENTING PROGRAMMES WITHIN THE CONTEXT OF WHĀNAU

Research on the effectiveness of parenting programmes highlights the importance of considering programme context (see Chapter 7). This context can have a significant influence on the success of the programme when it differs from the context in which the programme was initially developed and trialled. The culture of programme participants and their understanding of parenting and parenting roles are likely to influence the success of programmes.

This chapter considers Māori cultural frameworks that inform the role of parenting and the aspects of the New Zealand's cultural context that might affect the suitability of overseas-developed programmes for use in this country. It also reviews programmes that have been developed for these cultural groups and the degree to which international programmes might need to be adapted in order to assist parents from these cultures. As there is relatively little research assessing programme impact for Māori and Pacific parents the discussion in this, and the next chapter, draws on a wider range of sources.

Mātua rautia te tamaiti

One child, many parents

This section provides a *te ao Māori* perspective on effective parenting programmes within the context of whānau. It draws heavily on two related reports that were commissioned by the Families Commission in 2012. A synthesis of these two reports (see Pihama 2012 and Cram 2012) was undertaken. The 2011 report by the Advisory Group on Conduct Problems was also reviewed, in particular the chapter by Angus McFarlane (2011) entitled '*Te ao Māori* Perspective on Understanding Conduct Problems'.

An important consideration throughout the literature is the place of the Treaty of Waitangi in relation to Māori children. Irwin (2011) writes that:

> *Under Article Two of the Treaty of Waitangi, Māori children have a right to have the determinants of their wellbeing framed as Māori children, located within whānau, hapū and iwi social structures of te ao Māori (the Māori world). Under Article Three Māori children also have rights as citizens to be afforded the duty of care extended to all New Zealand children.*[92]

This view is also supported by Dr John Waldon in *Tamariki Māori: Protection and Rights of Māori Children*, first presented as a background report to the United Nations Committee for the Rights of the Child by Action for Children and Youth Aotearoa Incorporated (ACYA) in 2010. Dr Waldon argued that it was the right of Māori children to be raised within the Māori language and culture as these were promised in the Treaty of Waitangi (Article 2) and also as part of the Convention of the Rights of the Child (Article 30 p 2).

Tā te tamariki tana mahi wawahi taha

It is the job of the children to smash the calabash

92 See submission by the Families Commission to the Māori Affairs Select Committee on the determinants of the wellbeing of Māori children, 19 December 2011.

5.1 Approach to methodology and conceptual thinking

Three main approaches were taken to developing the review of selected literature. The first was to implement a wānanga (workshop) process. Wānanga is recognised as a culturally relevant method of contributing thinking from a Māori worldview and perspective. It establishes a place for the use of traditional knowledge and practices to be contemporised for use in the present and future contexts.

> *Within te ao Māori, wānanga is considered to be concerned with the maintenance of pre-existing knowledge and also for the creation of new knowledge, thinking and ideas.* (Royal, 2004).

The second was to establish a Māori Experts Advisory Group (MEAG) with members who are recognised as having knowledge, backgrounds and in-depth expertise in te ao Māori (academics, practitioners and community members, for example).

The third was to review published and peer-reviewed literature on kaupapa Māori parenting programmes. A Google and Google Scholar search was conducted in addition to library searches using the MSD Knowledge Centre catalogues and databases, the National Library catalogue Te Puna and Research New Zealand to locate thesis and journal items.[93] A search of EBSCOhost and Austrom databases was also undertaken. This revealed a limited amount of available literature and highlighted the paucity of evidence-based evaluations of kaupapa Māori parenting programmes.

Nā te moa i takahi te rātā

The young rātā when trodden on by a moa will never grow straight

5.2 Discussion on the key themes from the selected literature

Whānau-centred parenting

A major theme throughout the literature was that parenting should not occur in isolation from whānau, but should include extended whānau members. This view was expressed by members of the expert group in their wānanga on this topic. This group saw parenting and the raising of children as a whānau activity and believed that whānau are not alone (or should not be alone) in that responsibility.[94]

The selected literature for this review also saw parenting as something to be undertaken by the extended whānau and involve both males and females.[95] It was culturally accepted and expected that through whānau obligations and responsibilities adults were enabled to take a caring role in the parenting of Māori children (Pihama 2012). According to Cram (2012) Māori children are members of whānau, hapū and iwi, and the responsibility for their upbringing and care therefore extends beyond their immediate family.

Herbert (2011) argues that by failing to situate parenting within the wider context of whānau and hapū you run the risk of rendering the diverse whānau structure as invisible, thereby losing the richness and depth of parenting practice. She also suggests an approach that supports households, as the 'contemporary reality' for many Māori children is that they are brought up in households with parents or a single parent.

93 This yielded only one relevant item.
94 Experts Group Wānanga 14 March, 2013.
95 Wānanga Kaupapa Māori reference group held 14 March, 2013, Families Commission, Wellington.

Importance of incorporating Māori principles, values, and beliefs into programmes

Principles, values and beliefs within a Māori worldview have been described as important characteristics of any effective parenting programme for Māori whānau. (Herbert 2011; Cram 2012; Cargo 2008; Pihama 2012).

Whakapapa (genealogical connections) and *whanaungatanga* (relationships) are traditional cultural concepts that continually feature in the literature. Both concepts allude to rights to identity and to identifying as whānau and whānau members who are linked through whakapapa, but along with those rights come the obligations and responsibilities to express these concepts in positive and meaningful ways.

Recent research carried out by by the Families Commission (Irwin, Hetet, Maclean & Potae 2013) about 'what works' with Māori frames parenting as a key to unlocking whānau strengths by drawing from traditional concepts in empowering ways.

> *Strengthening whānau is about effective role-modelling. When we look at the nuclear, mainstream family structure, we normally identify the roles and responsibilities of mother and father. Through the Māori worldview, we see the layers of conceptual thinking, philosophy, principles, values and beliefs that are embedded in our cultural understanding and wider application of parenting. Parenting is a function that is carried out by the wider whānau. If we are talking about the importance of whānau support, then we need it put into context to understand it.* (p 3)

According to Pihama (2012 p 3):

> *Te ao Māori is a whakapapa-based society that is grounded upon the cultural systems and structures of whānau, hapū, and iwi. Each of these terms highlights the significance and centrality of being hapū; that is, being pregnant and giving birth to the next generation.*

Whānau, hapū and *iwi* are inextricably linked to each other. Herbert (2001) also highlights the functions of whakapapa and whanaungatanga in her research with *kaumatua.*

In a report that discusses the resilience of whānau in times of hardship, Baker (2012) comments that whanaungatanga provides the context for sharing production and distribution of goods within and between whānau, and that there is mana in being able to support one's whānau and others when in need as this is a reciprocal process.

Programme delivery

In Cargo's evaluation of Incredible Years (2008), Māori preferred the programme being deliverered by Māori. Cargo believes this was due to the fact that there was seen to be an element of cultural safety with someone from the same culture. This may reflect parents' desire to know and understand more about their own (Māori) identity, tikanga (customs) and traditional ways of raising children. Kaimahi (facilitators) needed to be supported with good training in all aspects of programme delivery.

This does not mean that people of other ethnic backgrounds should be excluded as deliverers of parental programmes to Māori, as some of the literature suggests that a good knowledge and understanding of the programme and how to deliver it is also valued.

Cargo (2008 cited in Cram 2012) also states that:

> *Kaupapa Māori programmes (and programmes that have been adapted to a Māori kaupapa) have highlighted what programme 'success' means from a Māori perspective. These outcomes include being Māori, using Māori kawa (protocols), using the Māori language, using marae and being creative and innovative.* (p 31)

Cargo (2008) found that giving the programme a Māori name may have acted as a barrier to whānau who did not identify strongly as Māori as they believed the programme would be delivered in the Māori language. These whānau may opt for a programme that is a non-Māori programme as a result of their own perceived inadequacy with *te reo Māori* (Māori language) and tikanga.

He taonga ā tātau tamariki (Our children are our treasures)

In traditional Māori society children were highly valued and respected. 'Māori children were and should be considered to be the greatest legacy [we have]' (Pihama 2012 p 6) to safeguard a prosperous future. They need to be cared for and nurtured. An indication of the respect that children held could be seen in the way in which oriori or traditional lullabies were often composed for tamariki when they were still in the womb. Hemara (2000) states that according to Best (1922),

> *Waiata oriori were more than just 'lullabies', which is how they are described by late 19th and early 20th century writers. He says that oriori could not be fully understood by an infant because the content was often dense and complex... On one level waiata oriori told a story. This was used to implant iwi traditions and lore into a child's mind. As the learner's familiarity with waiata grew, they would gradually come to an understanding of its meaning and intent.* (p 23)

While much of this knowledge has been diminished and devalued as a result of the rise of Western thought and knowledge through the processes of colonisation, there are still knowledgeable specialists who can often relate, explain, and teach these traditional child-rearing practices.

Amster Reedy explains that:

> *They [oriori] can form a framework for raising our children. I believe that these traditional oriori contain key references to raising strong children and healthy families and preventing children from being hurt by their parents. I've never found in these lullabies any references to punishing children. That's because our ancestors knew, if a child was hurt, it would cause humiliation.* (Morgan 2011 cited in Penehira & Doherty 2013, p 370).

What the literature indicates is that there are cultural concepts, such as oriori, that can illuminate child development and rearing in a cultural setting rather than attempts at explaining the culture (Herbert 2001).

Kaupapa Māori parenting programmes

Parenting programmes described as being kaupapa Māori programmes (by Māori for Māori) are those that have been developed from a Māori-centric worldview. The literature reviewed discussed the importance of key Māori principles and values when considering what works for Māori parents and their whānau who are facing adverse circumstances in their lives. A report by the Ministry of Education (2005) concluded that some parenting programmes showed evidence of effectiveness when working with high-needs Māori.[96] While this may be the case, other commentators argue that there is limited evidence about their effectiveness (Cargo 2008; Pihama 2012; Cram 2012). Evaluations found for this review were of the initial programme implementation or were evaluations of the pilot programmes only.

96 In a Ministerial review of targeted policies and programmes, Ministry of Education parent support and development programmes, the WTITO (Whānau Toko i te Ora) parenting support programme is shown to be effective in reaching families in high need of parental support and development. However they do not go into any detail about its effectiveness.

Culturally adapted parenting programmes

Culturally adapted parenting programmes are those that have been adapted to 'culturally match' the context in which they are to be delivered. The concern with these, according to Cargo (2008) in her evaluation of Māori experiences of the Incredible Years parenting programme (IYPP), is that they are philosophically underpinned by values and beliefs that can be different from or contrary to indigenous values.

> *Some of the participants from one sector reported being cautious about having 'no choice' about what programmes they deliver and feeling as if their indigenous status was often unacknowledged. There were also feelings that delivering the IYPP programme hinders both the delivering of Māori programmes and negates the need to learn more about our uniquely Māori practices* (p 19).

Cargo states that because many of the Māori facilitators who were delivering the programme felt that it was automatically adapted and could be termed as being more 'culturally responsive', this success could be attributed to the fact that many of these facilitators were knowledgeable in both te ao Māori and te ao Pākehā (Cargo 2008 p 19).

According to McFarlane (2011) it is important that Western science-based programmes are culturally responsive and safe for the clients of the programme. He asserts that 'when local cultural responsiveness has been included in programmes, better outcomes are achieved' (p 46). The following table developed by McFarlane (2011 pp 47–48) compares and contrasts the subtle differences that determine the cultural appropriateness and cultural responsiveness of programmes.

Table 4: A comparison of cultural appropriateness and responsiveness

Cultural appropriateness	Cultural responsiveness
Refers to programme selection and content, ie: do programme values, format and content align with the cultural values and practice of the target group? It includes: › Consultation with key groups in selection process › Inspection of programme content to determine accuracy › Client satisfaction surveys › Statistical comparison of rates of participation › Māori participation in planning of programmes › Being able to demonstrate whānau-inclusive principles such as whanaungatanga and *manaakitanga* › A holistic approach to treatment plans that addresses cultural, clinical and whānau needs › An environment that can assist in enhancing identity and connections such as classrooms, schools or government departments › A facilitator with the right credentials	Refers to the delivery of the programme and the ability to respond to fluid, authentic situations in ways that resonate with (and are therefore culturally appropriate) and affirm the culture of clients. It includes: › Māori representation at a governance level › Major consultation on the content of the programme › Implementation of culture-specific topics › Ecological approaches such as *Te Whare Tapa Whā* › A focus on *whānau ora* › Integral Māori processes and protocols such as *powhiri* and *whakawhiti korero* › A whānau liaison worker, advocate, therapist are intricate to the programme › An environment that can assist in enhancing identity and connections such as *marae* or *tūrangawaewae*, as well as schools etc. › A facilitator with the right credentials

MacFarlane et al. (2008) state that:

> *Cultural appropriateness and responsiveness are often measured by matched comparisons and measured gains by those who participated in the programme. Programmes evaluating gains using instruments alternative to norm sampling – as kaupapa Māori programmes often have to do – should identify a set of conditions that are usually present in programmes that work. The personnel might change (qualifications or ethnicity of leading figure), or the venue might alter (school, marae, historical island) – but the outcomes have a consistently better chance of success if the concepts and values are derived from a Māori worldview and expressed by way of the components listed [above].* (p 48)

Herbert (2011), however, maintains that research suggests 'that cultural values can be integrated into standard programmes and can enhance good outcomes' (p 85).

There is a need for careful consideration and balance when adapting evidence-based parenting programmes that have been developed and informed from overseas and from Western knowledge bases for use with Māori or other indigenous parents.

Social support for parenting

The literature reveals that it is important that parents, in particular young parents who are parenting alone, are able to access social support networks (Pihama 2012). The ideal is the support from family or whānau (Rawiri 2007). A recent study of the role of social support in assisting young Māori mothers coping with pregnancy, birth and the parenting role highlights the importance of social support to ensure the young parent can continue with their education and access support and services which will eventually improve the life outcomes of these mothers and their babies.

Herbert (2001) says that the overall aim of parenting programmes is to enhance parenting competence generally in relation to child abuse and neglect in an effort to improve child-management skills and to reduce child maltreatment. She also cites Griest and Forehand (1982), who state:

> *Parents and caregivers who are referred to parent-training programmes may already have many appropriate parenting skills but are not in an environment where they can implement them.* (p 8)

Herbert (2001) also discusses research on the important contribution of social and cultural environments on families and parenting functioning, and concludes that daily interactions from formal and informal social networks, and interpersonal relationships, are a vital support for parents no matter what their socio-economic status or background.

Evaluations of culturally adapted parenting programmes have shown some initial success when these have been delivered on the marae.[97] Irwin et al. (2013) describe marae as cultural sanctuaries. They say that while not all people are linked to marae, as a consequence of lack of knowledge or opportunity, marae continue to provide environments for whānau to gather, and to share skills, knowledge, resources and support.

Focusing on cultural strengths

Participants in the kaupapa Māori reference group at the wānanga expressed the view that there were positive solutions to be found within our own kawa (protocols) and tikanga (values and beliefs). Some kaupapa Māori programmes have been developed (see later section) but need further development. The wānanga participants were able to articulate a vision going forward to the year 2040.

97 See Penehira and Doherty (2013) and Herewini and Altena (2009).

We would hope that by 2040 our strengths are evident … and ways of working at different levels are recognised and validated in evidence and information. And by 2040 we've got this wellspring of evidence of information and knowledge about te reo Māori that inform the way in which services are provided. [And] we would hope that in 2040 we'd see lots and lots of evidence of families, parents, ourselves having faith in our world where our ancestral practices are being revived and we're living and breathing those things again, where we are the advocates for our ancestors about the things that they thought were important to hand on and our practices are grounded in our world view.[98]

Herbert (2011 p 74) maintains that programmes that explicitly acknowledge values and tikanga and are marae-based are inherently and distinctively strength-based. Her study emphasised their preference for a safe and non-threatening environment where they could share and be supported by other parents.

Risks to toiora (healthy lifestyles)

Cram (2012) discusses the personal risk factors that are threats to toiora (healthy lifestyles) for struggling parents and their family or whānau that prevent them from being able to achieve toiora. She describes the risks as being:

- parental problems (mental health, substance abuse, poor parenting skills, family or domestic violence)
- challenging child characteristics (low birth weight, disability or other special needs)
- family characteristics (poor relationships, large number of children, single parenthood or early parenthood)
- previous experiences of abuse or neglect (of either parents or children).[99]

According to Cram (2012 p 25) the risk factors 'are intertwined and associated factors that often fall into place along a chain of causality', in which parenting becomes undermined by these risks.

A study of conduct problems for eight-to-12-year-olds by the Advisory Group on Conduct Problems (2011) found that:

Children reared in homes characterised by multiple sources of adversity including family violence, child abuse, inconsistent discipline practices, multiple changes of parents and similar factors emerge as being at substantially increased risks of developing significant levels of conduct problems. (p 16)

Other factors discussed by Cram (2012) as identified by the Taskforce on Whānau-Centred Initiatives (2010) include full participation in society and the economy, which has become highly elusive for many struggling whānau despite the fact that socio-economic indicators show that there have been improvements over the last two to three decades. The poverty experienced by some whānau is an intrinsic part of the communities in which they live. Ministry of Health Statistics note that in 2006, 24 percent of Māori, compared with seven percent of non-Māori, lived in decile 10 (most deprived) areas; three percent of Māori, compared with 12 percent of non-Māori, lived in decile 1 (least deprived) areas (cited in Cram 2012 p 27).

Acknowledging the struggles of many whānau, Cram cites Royx (1998), who notes that

While Māori parents desire the best for their children, a lack of knowledge and understanding of Māori child development, and shortcomings in effective parenting methods which maintain and are based on Māori values and ideals, prevent the positive progression of many Māori whānau (p 27).

These statements indicate that programmes grounded in Māori tikanga and kawa may provide hope and change for some of these whānau.

98 MEAG statement from wānanga held 14 March, 2013, Families Commission, Wellington.
99 Adapted from Higgins (2010), cited in Cram (2012).

Kaupapa Māori programmes and evidence-based programmes

There are differing views about what constitutes good, reliable, robust and rigorous evidence. While it is acknowledged (McFarlane 2011; Cargo 2008) that there are very few parenting programmes that have been systematically evaluated with sufficient robustness and rigour to meet Western scientific standards in Aotearoa New Zealand, there are no kaupapa Māori parenting programmes that meet these standards. McFarlane (2011) points out:

> *There is a perception in the minds of many that kaupapa Māori programmes are not systematically nor scientifically grounded. MacFarlane et al. (2008) point out that indigenous people throughout the world have sustained their unique worldviews and associated knowledge systems for hundreds of years. This position is complemented by Kawagley and Barnhardt (1997) who contend that many of the core values, beliefs and practices associated with these worldviews have survived and are being recognised as having an adaptive integrity that is as valid for today's generations as it was for generations past.* (p 42)

This has prompted debate among many Māori theorists, researchers and evaluators and practitioners who work with whānau and communities about the need to begin discussions on what constitutes a hierarchy of evidence from a te ao Māori worldview.[100] As is emphasised by MacFarlane et al. (2008), when Māori knowledge is valued, resistance is alleviated. They add further that there is a case for a blended schema that respects both forms of evidence (Western and indigenous) and allows both to be acknowledged.

Kaupapa Māori conceptual models and frameworks for parenting programmes within the context of whānau

Our review identified a range of kaupapa Māori conceptual models and frameworks; some that are well known and used extensively and others that are not so well known or used.

The MEAG determined that the ideal conceptual framework for this review would be through the use of the Māori cultural concept of oriori, or lullaby, as there is a plethora of references to oriori in *moteatea* (traditional chants), *whakatauki* (proverbial sayings) and *karakia* (incantations). Oriori are also used to transmit traditional and tribal knowledge, and they are still used in a contemporary context. They are also used and known by nearly every hapū and iwi throughout Aotearoa New Zealand.

With this in mind, a set of principles was used to guide our thinking about which models would be the most suitable for this review when considered within the context of whānau. Those principles were:

- refrain from being judgemental
- *ngā taonga tuku iho* – valued treasures, animate and inanimate, passed down from ancestors, such as te reo Māori, land
- focus on whānau and keeping them together
- mobilising whānau
- faith in our (Māori) world
- Āhuru Mōwai as a starting point
- inclusion
- social justice
- challenging the assumptions underlying programmes and policies
- *wairua* – spiritual dimension.

The following table shows some of the Māori conceptual models that were discussed and considered along with the key concepts and explanations of their origins and purpose.

100 Experts group wānanga 14 March 2013, Families Commission

Table 5: Discussion of kaupapa Māori models, key concepts and explanations

Models	Key concepts	Explanation
Oriori	› *Tāhuhu kōrero ā whānau, ā hapū, ā iwi* – known variations throughout and within *whānau, hapū* and *iwi* › *Karakia* › *Whakatauaki* › *Whakapapa* › *Whakaū-ki-te tuakiri tāngata* (Māori identity) › *Kaitiakitanga* › *Rangatiratanga* › *Whakapakari whānau*	*Oriori* are lullabies composed for children at conception, during gestation or when they are born. They are more than just lullabies and their content is often complicated to decipher. Encapsulated within these *oriori* are references to the child's genealogy and the deeds of their ancestors, and they may also prescribe a future development pathway for the child.
Te Wheke (The octopus)	This model was developed by Dr Rangimarie Rose Pere in the 1980s. It is one of the earliest models to be developed and is well-known and used in international educational literature. The model has also been used in approaches to health. The model acknowledges a range of Māori values and beliefs described as critical elements for the development and total wellbeing of the individual and whānau. › *Wairuatanga* – the spiritual dimension › *Mana ake* – everyone, including children, has an absolute uniqueness which is a part of their own *mana* › *Mauri* – the life essence or ethos › *Hā a koro ma a kui ma* – intergenerational teachings passed down from ancestors › *Taha tinana* – need for sustenance to provide for material and physical needs and wellbeing › *Whānaungatanga* – obligations and responsibilities of whānau to each other and the need to create positive interactions › *Whatumanawa* – sustenance and emotional development of the individual and the whānau as a whole is important › *Hinengaro* – approaches to learning that arouse, stimulate, and uplift the mind are important › *Waiora* – total wellbeing if the other elements receive sufficient sustenance	The body and head of the octopus symbolises the individual and/or whānau. Each tentacle represents an aspect that requires and needs particular things in order to provide sustainance to the whānau. The suckers on each tentacle represent the facets that exist within each aspect. The eyes of the wheke represent the types of sustenance each tentacle has been able to source for the benefit of the whole. When the tentacles intertwine there is a mergence whereby boundaries are not clear-cut. According to Pere the symbolic representations of the *Te Wheke* model need to be understood in relation to each other and within the context of the whole.[101]

101 Pere (1987, 1988).

Table 5 Discussion of kaupapa Māori models, key concepts and explanations (contd)

Models	Key concepts	Explanation
Te Pāharakeke	› Whānau in its entirety is considered in this model › *Kaitiakitanga* (protection) › *Whakaruruhau* (shelter)	Whānau are likened to the flax bush. Within the heart (*rito*) of the flax bush new life comes forth and it is protected and sheltered by the outer leaves, considered to be the parents and grandparents of the young shoots. Over time the outer leaves give way to allow space and growth for the next generation. But the flax bush remains the same.[102] *Atawhaingia te Pāharakeke* uses this conceptual model.
Marae	› Everybody is important and everybody belongs: children, *whānau, pākeke, tīpuna* › Tikanga prevails › People and skills are shared › Environment and context matters › Collective ownership and responsibility › Connections to land, sea, natural resources	Expresses the importance of marae to whānau, hapū and iwi. The marae is seen as a critical hub for Māori to gather for most occasions.
Whare Tapa Whā	There are four key concepts to the *whare tapa whā* model; › *Taha wairua* (spiritual health) › *Taha hinengaro* (mental health) › *Taha tinana* (physical health) › *Taha whānau* (family health). Each of these components represents different parts of a *wharenui* (meeting house).	Developed by Professor Mason Durie in 1984 as a model of Māori health and wellness. This model is used extensively in health.
Te Pae Mahutonga	› *Mauri ora* – access to te ao Māori and cultural identity › *Waiora* – environmental protection › *Toiora* – healthy lifestyles › *Te oranga* – participation in society	Another model conceived by Professor Mason Durie. He draws on the symbolism of the Southern Cross to explain the inter-relatedness of Māori wellness. The four stars of this constellation represent the elements and the two pointer stars represent the context and environment.[103]
Tikanga Whakatipu Ririki	› *Kia mau i a rātou te ihi* – they (children) hold the delight of life › *Kia mau i a rātou te wehi* – they hold the awe of life › *Kia mau i a rātou te wana* – they hold the love of life.[104]	This model was developed by Te Kahui Mana Ririki, a group established in 2008 after public debate and concern about Māori child abuse.

102 Moko Mead (2003).
103 Cram (2012).
104 Jenkins and Harte (2011).

5.3 Kaupapa Māori parenting programmes

This section highlights Māori parenting programmes for parents and *whānau* with children from birth to six years of age. There are other programmes that have not been summarised (for example, Hei Awhina Mātua) because they relate to children who are older than the group which is the focus of this review. The programmes described here have also been evaluated.

Whānau Toko i te Ora

The *Whānau Toko i te Ora* (WTITO) national parenting programme for Māori whānau is delivered under the auspices of the *Te Roopu Wahine Māori Toko i te Ora* (Māori Women's Welfare League).[105] The programme is delivered to whānau who have medium-to-high needs in their homes by local *kaitiaki* (managers) and *kaiawhina* (support staff). Whānau are generally referred to the programme through Māori community networks, providers and government agencies in the areas where the programme operates. The WTITO programme is supported by whānau learning programmes and group support for whānau. The services are defined as being tamariki-centred and whānau-focused, and tikanga Māori is integrated throughout all aspects of development of tamariki up to five years of age (Livingstone 2002). Kaitiaki and kaiawhina are trained in the programme and participate in regional workshops from time to time.

The programme was initially trialled in three regions of the country. It was then expanded to cover six regions – Tairāwhiti, Ikaroa, Tāmaki Makaurau, Aotea, Te Waipounamu and Taitokerau. Evaluations of the WTITO national parenting programme were undertaken in 2001 (Gray 2001) and in 2002 (Livingston 2002). The sample was made up of 16 out of the original cohort of 24 whānau. In the 2002 outcome evaluation Livingston (2002 p 46) states that whānau members reported improvements (in connection to health services, housing and transport, and parenting skills and confidence, for example), it was not possible to say whether or not changes were caused by the programme, or were the result of change occurring over time – as children matured or learned from other whānau members or friends, for instance. Some of the successes of the programme have been attributed to the broad-based approach of the programme and the kaiawhina who work closely and regularly with whānau.

Another evaluation of the programme has been recently completed in May 2013. This evaluation included interviews with the senior management of the Māori Women's Welfare League (MWWL) and Ministry of Social Development management, a survey of kaiawhina (n=11), interviews with whānau (n=30) in three regions and analysis of WTITO reports. The preliminary findings show that involvement in the programme led to positive *whānau* transformations such as better connections with marae, hapū and iwi. There was more use of te reo and whānau were learning *mihi* and *pepeha*; identity and a sense of being Māori had improved, as well as relationships between parents and their children. Confidence increased for whānau and they were able to take action in a number of areas of their lives, including parenting. Thirty-eight percent of participants exited the programme early. The data indicated that the main reason for exiting the programme was achievement of the programme goals.[106]

Te Atawhaingia te Pā Harakeke

Te Atawhaingia te Pā Harakeke was developed as an early childhood programme and is based upon kaupapa Māori concepts, values, beliefs, practices and processes (Te Puni Kokiri 2008). It is a whānau-development training and support programme for Māori and iwi education, health and social-service organisations. This programme was delivered by the Ministry of Education training unit, Te Kōmako. Atawhaingia te Pā Harakeke delivered training to over 200 providers and had done so for 10 years. It did not directly deal with tamariki and whānau (McFarlane 2011).

105 The Ministry of Social Development currently provides $960,000 to fund work with 126 whānau.
106 Whānau Toko i te Ora. Evaluation findings presentation May 2013.

Two strands emerged from the programme. The first of these is *Hakuitanga/Hakorotanga,* developed and delivered to parents, and the second is *He Taonga te Mokopuna,* developed and delivered to babies and children to help them to deal with the effects of domestic violence.[107]

An evaluation of the Atawhaingia te Pā Harakeke programme, which was introduced into the Rimutaka and New Plymouth men's prisons, was completed in 1999. The Māori evaluation team indicated that the culture of the prison, which includes routines, schedules, and security procedures, proved challenging to the implementation of a tikanga Māori programme (Young, Nikora, Morrison & Ave 1999). They state that with skilled programme facilitators at both prisons they were able to develop a range of different methods to ensure a whānau or community dynamic was included in the delivery, arranging whānau days or guest speakers, for example.[108] They also encouraged the re-establishment of the men's Māori identity and whakapapa to provide a connection to whānau, hapū and iwi (Hungerford, Hutchings & Simonsen 1999). The evaluation concluded that the programme had the potential for long-term reduction in the level of family violence and the transmission of intergenerational family violence.

Tikanga Whakatipu Ririki

Tikanga Whakatipu Ririki is a parenting programme based on traditional Māori child-rearing practices. It is described as being a *kaupapa* Māori model of positive parenting designed to eliminate Māori child abuse through the transitioning of Māori parents towards positive parenting. Tikanga Whakatipu Ririki is also described as strengths-based and has three primary goals (Jenkins & Harte 2011).

The goals of parenting – this first goal requires the parents to know what it is that they want their children to be. This is where the role of waiata oriori comes into play. Oriori were often composed by grandparents and they sometimes described goals for parents to follow. They also described motivations and aspirations for the child. In this way parents were informed through these oriori.

Parenting beliefs – the second goal of the programme is to help parents understand how whakapapa connects children to the spiritual world (*te ao wairua*).

> *This relationship meant that, for children, they were ata ahua – they were the face of Io, of the supreme being. Children therefore were perfect underneath everything. This belief was what stopped any maltreatment of the child. To harm the child was to harm the atua.* (Jenkins & Harte 2011 p 29)

In order for parents to see their children in a different way they need to know and understand these beliefs. This goal also requires parents to understand that children need to be nurtured with aroha (total commitment); that they as parents are there for their children whatever happens; children have a *tūrangawaewae* (a home) which is safe and known to them; and they need to develop the *hinengaro* (mind) as this is the place where conflicts can be solved without violence (ibid p 30).

The techniques of parenting – once the first two goals have been taught and understood parents can move on towards establishing techniques of positive and safe parenting.

This programme is currently being evaluated and is also being considered for delivery through Plunket networks. It has been supported by the Whakatipu resources produced by SKIP.

107 Retrieved on 20 May, 2013, from http://www.werrycentre.org.nz,site_resources/library/Project/Evidence_Based_Practice/Atawhaingia_Māori _Model_Best_Practice

108 These events provided opportunities for the men to practise what they had learnt from the programme, such as positive interactions with their children.

The Mana Kainga Programme

This programme is described as a *Maniapoto Māori* model of family empowerment. It is rooted in a tribal iwi context and is also based upon households (*kainga*) with important regard (*mana*) for the dynamic family unit (Herbert and Te Kanawa 1998). This parenting initiative was implemented in 1995 in response to a community self-help programme which was being promoted by the Midland Regional Health Authority. It was developed into a trial programme and then evaluated. The key features of the programme were:

- recognition of the critical importance and role *wairua Māori* (Māori spirituality) plays in achieving positive developmental change with Māori clients and households
- customising a programme of improvement and self-management for each individual household
- providing a flexible service, which attempts to inform households of how and where they can access assistance for a wide range of needs
- involving, where appropriate, the parents, grandparents and whānau (extended family) in particular aspects of the programme
- securing the trust and confidence of clients by maintaining culturally sensitive and professional service-delivery standards.

The Mana Kainga model has five key components of wellbeing:

- *torangapu* (political)
- *tikanga* (cultural)
- *oranga* (social)
- *ohanga* (economic)
- *wairuatanga* (spiritual).

Poutiria te Aroha

Poutiria te Aroha is described as an approach to working with whānau which draws on the philosophy and practice of nonviolent parenting (NVP).[109] It is a 'whole-of-community' approach which includes parents, whānau, kōhanga reo, and kura involvement. In 2012 the Te Mauri Tau Trust which supported the NVP programme decided to adapt NVP to suit the Aotearoa New Zealand context. They explored the links between the NVP philosophy and practice and te ao Māori. From this exercise they were able to develop a programme which would be securely anchored within tikanga Māori.

The programme's name was derived during conversations with the late Dame Katerina Te Heikoko Mataira; consequently she summarised the kaupapa as 'Poupoua, tiritiria te aroha ki roto ki te whānau'. *Poupoua, tiritiria* is in reference to the action of implanting and firmly embedding; *aroha* in this context talks about unconditional love; and whānau represents the family in its broadest sense (Te Mauri Tau 2012). The move towards establishing a culturally anchored training model consisted of a series of wānanga and practice sessions which culminated in the trial delivery of a three-day intensive workshop. Feedback received from participants affirmed that the philosophy was well-aligned with concepts and tikanga from te ao Māori, and provides practical ways to interact with tamariki (children) that embrace and reflect a Māori worldview.

The programme delivers an intensive NVP 'train and trainer' professional development course as well as a series of courses run over a 10-week timeframe (Te Mauri Tau 2012 p 6). In 2011 a change model was developed:

> *The model is centred on the home/kainga, delivering training and support to whānau. The model reaches into places where tamariki/rangatahi are, including pre-school and school institutions. Finally, it includes service providers and support structures surrounding the whānau and community.* (ibid p 7)

109 Nonviolent parenting has been developed by the Echo Parenting and Education Centre in Los Angeles. It was formerly the Centre for Nonviolent Parenting and Education, which was established by Ruth Beaglehole. See www.echoparenting.org.

Poutiria te Aroha builds the resilience and capacity of the community to develop and deliver nonviolent parenting in all spheres of children's lives. It is a change model designed for those who are involved in learning te reo Māori and in Māori contexts. This means resources, support and learning opportunities are provided for whānau that reflect a Māori worldview and support te reo Māori interaction with children, such as the kōhanga reo and kura. The programme includes a 'men's stream' for men in fathering or care-giving roles. According to the authors and researchers of the action research report, these provide the men with beneficial opportunities to interact with each other.

Poutiria te Aroha is firmly grounded in te ao Māori through a series of wānanga that explored concepts and tikanga that support the NVP philosophy and practice (Mataira 2011). This reflects the care taken to adapt the programme – hence its cultural anchoring in *te ao Māori*. This has culminated in the development of four *pou* that anchor the programme, referred to as the 'Tuakiri' model.

- The *Tuakiri* model – recognises the intrinsic mana (status) and *tapu* (sacredness) of children arising from their being.
- Te *Whānau* – acknowledges the strength of connection through whakapapa. The dynamism of the collective supports the resilience that whānau can provide.
- *Rangatiratanga* – being ourselves, knowing our own stories and naming our own experiences. Acknowledges that one can parent with recognition of what is informing parenting choices. It is also about recognising and respecting the autonomy and capacity for self-determination in children.
- *Ako ki te kainga* – practices carried out in the home, and held within the community. Ako is also a reciprocal process whereby we teach as we learn, and learn as we teach. (ibid p 15)

The report indicates that adaptation of Poutiria te Aroha as a nonviolent parenting programme has been well-informed, rigorously and carefully developed and trialled over a three-year period. It has been included in this review as a programme that demonstrates promise, but it is still in its trial and piloting phase. Requests for the Poutiria te Aroha programme to be implemented in other communities have been made and the programme has recently been established in Kaitaia.

Oranga Whānau

Te Puni Kōkiri has funded the Oranga Whānau programme since 2009 as one of its Whānau Social Assistance Programmes. These programmes are designed to assist and support the most vulnerable whānau.

Oranga Whānau involves kaimahi who work with whānau to instill mothering or nurturing skills and general living skills in teenage mothers.[110] It promotes positive parenting, safe and healthy babies and resilient whānau.[111]

The aims of Oranga Whānau are to:

- promote the wellbeing and safety of children in Māori households
- increase access by Māori parents to antenatal and parental support
- promote the practices associated with *whāngai* (nurturing) in identified Māori communities.

Over time Oranga Whānau has become more similar to Kaitoko Whānau in that it is provided to whānau who are experienceing hardship in their lives for which they need help and support.[112]

110 The kaimahi are generally nannies or kuia (elderly women).
111 Te Puni Kōkiri (2009), Whānau Social Assistance Programmes: Weaving Whānau Together. Information sheet.
112 Kaitoko Whānau means family support. Community-based workers in Māori communities work with whānau to improve access to health and social services. Information sheet on Whānau Social Assistance Programme, Te Puni Kōkiri.

5.4 Culturally adapted Māori parenting programmes

Mātuatanga Whānau Programme

Mātuatanga Whānau is a culturally adapted Māori-centred parenting programme. It was developed in the late 1990s by Dr Averil Herbert with support from the Apumoana Marae and the Rotorua branch of the Māori Women's Welfare League, and advice from kaumātua (McFarlane 2011 p 56). The model was developed to include fundamental Standard Parenting Training (SPT) strategies as well as Māori values. According to Herbert (2001), although the SPT programmes were valued by Māori, the culturally adapted Mātuatanga Whānau model programmes were even more valued.

The programme was delivered over three sessions as part of a longer parenting and life skills project delivered by the Māori Women's Welfare League. Delivery involved use of overhead projector slides with discussion and insights shared by participants (Herbert 2001 p 56). There were indications that parents who attended more than one set of three sessions showed further gains in parenting.

Hoki ki te Rito (Mellow Parenting Programme)

The Hoki ki te Rito (HKTR) programme is described as an intensive parenting course designed to support families experiencing significant relationship problems with their babies and young children.[113] This programme is described more fully in Chapter 4.

Mothers attend a 14-week programme for one full day a week. Parents, their children, facilitators and staff all share *kai* (lunch) together. The programme is seen to be aligned to the Māori principles of:

- *Aroha ki te tangata* (to express kindness towards people)
- *Kanohi ki te kanohi* (face-to-face)
- *Titiro, whakarongo, kōrero* (look, listen, speak)
- *Manaaki ki te tangata* (to care for and look after people)
- *Kaua e takahia te mana o ngā tangata* (don't trample over the feelings of others).

The evaluators of this culturally adapted programme believe that there has been a positive response to HKTR from Māori and Pacific parents (Penehira & Doherty 2013). The pilot of the first two groups was well received by parents both in terms of engagement and completion rates. Having Māori mothers as programme facilitators worked well as it appeared to be a critical element in getting Māori parents' buy-in to the programme (ibid p 117). A strong improvement in the mental health of the mothers was found, as well as a reduction in their stress levels when parenting their children. The reasons proffered included being respected and listened to, and being able to talk about their own life experience – this was described as 'a critical point of transformation' as they were able to see the connections between how they were parented and how they were parenting their own children. Learning how to manage their anger was another key component in changing behaviours and attitudes to parenting.

The researchers noted the resource-intensive nature of the programme – it requires considerable commitment from funders, programme facilitators and parents alike – and pointed to the need for ongoing evaluation to ascertain effectiveness with the target group.

113 Ohomairangi Trust Early Intervention Service, retrieved on 22 May, 2013 from http://www.werrycentre.org.nz/site_resources/library/CAMHS%20Conferences/2010/Wed150910/Waimea/Waimea_4_45_HKTR_IMH_conference_NELSON.pdf.

Incredible Years Parenting Programme (marae-based)

Incredible Years Parenting Programme (IYPP) is an evidence-based parent-management training programme, which was developed in the United States of America. See Chapter 4 for more detail on the programme.

The programme is described as more of a culturally adapted programme than a culturally enhanced programme. The Ministry of Health and the Ministry of Education are working together to determine how the cultural enhancements can be strengthened. The Ministry of Education reports that a number of Whānau Ora providers are contracted to deliver the IYPP and that some programmes are delivered on the marae for Māori parents.[114] Evaluation and monitoring of the programme continues.

Cargo (2008), when reflecting upon the Māori experiences of delivering the IYPP programme, stated that successes and adaptability occurred as a result of having competent and experienced Māori facilitators deliver the programme. Their successes revolved around their sense of being uniquely Māori, of being adept at using Māori kawa and protocols such as *powhiri, mihi whakatau, karakia* and waiata, all of which contributed to the cultural relevance of the IYPP for Māori parents. Herewini and Altena (2009) commented in their evaluation of a marae-based IYPP group that this also attributed to the retention of the majority of the parents on the programme as a sense of group responsibility was created.

Home visiting recommended prior to the programme commencing was seen as important for identifying issues of readiness (for the programme) and accessibility. It also contributed towards better engagement of parents. Parents often cannot afford to travel to sites of delivery and food is important, as is ensuring that their children can attend and be looked after while their parents attend training (Herewini & Altena 2009).

Both a preliminary study (Fergusson 2009) and a later study (Sturrock & Gray 2013) found that the IYPP benefited Māori families. Sturrock and Gray (2013) looked at three primary areas: child behaviour, parenting practice and family relationships at the completion of the programme and at the six-monthly follow-up. They reported that while the differences between Māori and non-Māori were not significant at the programme completion, the benefits for Māori were less than for non-Māori at follow-up. The Ministry of Education (2012) reported that Māori parents were less likely to complete IYPP than non-Māori. This had resulted in calls for the programme to be delivered in a more culturally responsive manner.

Āhuru Mōwai (Parents as First Teachers/PAFT)

Āhuru Mōwai has been described as the Māori overlay to PAFT, and it provides the philosophical foundation for this programme. It was developed from Māori values and principles and extended the principles and strands of Te Whāriki, the national early childhood curriculum (Farquhar 2003). The adaptation of PAFT occurred in response to criticism from a number of early childhood educators and academics after the programme had been introduced to Aotearoa New Zealand in the 1990s.[115] Pihama (1993) expressed concerns about the lack of cultural relevance to Māori and argued that PAFT had ignored moves taken by Māori in the establishment and development of te kōhanga reo and kura kaupapa Māori.

Āhuru Mōwai was launched in August 1999 as a cultural component of the PAFT curriculum (PAFT is described more fully in Chapter 4 of this review). Family Start also uses Āhuru Mōwai as part of its shared curriculum. Āhuru Mōwai is based upon home visits and is targeted at parents with high-to-medium needs who have children aged from zero to three years. PAFT's Māori parent educators have been offered training in Āhuru Mōwai. This training is based on the five key principles of Āhuru Mōwai (Merry, Wouldes, Elder, Guy, Faleafa and Cargo 2008):

1. *Ngā kōrero ā kui, ā koro ma* – Māori oral traditions and what they say about traditional Māori child-rearing practices, from conception to young child stage.

114 Retrieved from http://www.minedu.govt.nz on 23 May 2013
115 See Pihama (1993), and Farquhar (2003).

2. *Te ira tāngata* – Māori child development, acknowledging Māori cultural values and preferences. This segment of the training focuses on the specific ways Māori children develop when child-rearing practices are based on traditional Māori values, such as *aroha, manaakitanga, whanaungatanga, whakapapa, wairuatanga, tuakana-teina* relationships, and *te mana o te tamaiti* (i.e. unconditional love, caring for others, relating to others, genealogy, spirituality, the role of older siblings and the paramount rights of the child).
3. *Ngā ahuatanga awhina mātua, hei kupenga hauora* – Māori parent support methods and avenues that assist wider fulfilment for whānau.
4. *Tino rangatiratanga* – Māori and iwi development based on te mana o te tamaiti Māori self-determination.
5. *He oranga ngākau* – Keeping yourself safe and well.

This review could not find any specific evaluations of Āhuru Mōwai, but PAFT, including Āhuru Mōwai, has been evaluated a number of times with promising findings (see for example Praat, Davie & McGray 2010). A description of these evaluations is included in Chapter 4.

Summary

The literature is supportive of the idea that programmes framed within a Māori worldview, where Māori values, principles and beliefs are included, are more likely to meet with success. It supports the view that if the participants can clearly identify themselves in the programme then there will be some measure of success in engaging and retaining those participants in the programme. Some of the literature suggests that kaupapa Māori programmes can engage and retain participants more effectively than general programmes (Adamson, Sellman, Deering, Robertson & de Zwart 2006). A growing range of programmes has been developed to serve Māori whānau in this area and many of these incorporate Māori tikanga and kawa. While few of these programmes have been rigourously evaluated, there is a growing body of practice in this area.

Gaps identified within the literature

It is difficult to say whether parenting programmes that have been culturally adapted are any more effective than kaupapa Māori programmes that are philosophically underpinned by Māori values, principles and beliefs. This is a gap in the knowledge around the effectiveness of parenting programmes in the literature we looked at for this part of the review, There is a need to build an evidence base using solid evaluation evidence.

Kaupapa Māori theorists (see for examples McFarlane 2011; Pihama 2012; Herbert 201; Cargo & Cram 2009) have indicated that there could be value in investing in programmes that match the particular cultural imperatives of the target audience. In reference to culturally adapted programmes, Cargo (2008) states careful consideration needs to be given to research, planning and implementation of these programmes.

5.5 Conclusion

Critical situations will always require critical responses and the acceptance and understanding of wider society in order to improve the lives of our families and whānau. This includes the most vulnerable members of society – our babies and our children, who reside at the centre of these families and whānau as the metaphor of the *pā harakeke* (flax plant) depicts. Now more than any other time in the history of Māori development there are opportunities to be more courageous and innovative when looking for strengths-based solutions and ways of reducing the maltreatment of children, and of making positive contributions to ensuring all families and whānau and their babies and children are thriving.

6. PARENTING PROGRAMMES FOR PACIFIC PEOPLES

This chapter discusses parenting programmes in New Zealand from the perspective of Pacific parents. It provides insights into the cultural understandings, values and contexts that are important for the development of parenting programmes likely to engage and retain Pacific parents and families. It considers that parenting interventions, programmes and policies in New Zealand need to take into account cultural considerations, especially in parenting programmes aimed at decreasing child maltreatment.

It is important to note that Pacific peoples are not a homogeneous group, but a mixture of Polynesian, Melanesian and Micronesian cultures from different Pacific Island countries. In New Zealand, there are six main groups that make up this population: Samoan, Tongan, Cook Islands, Niuean, Fijian and Tokelauan. There are also other Pacific populations in New Zealand from Kiribati, Tuvalu, Solomon Islands, Papua New Guinea, Nauru and other small Island groups (Statistics New Zealand 2006). For the purposes of this review, however, the term Pacific will be used to refer to all these populations.

The review approach is informed by obligations relating to vulnerable Pacific children in the context of the White Paper, and in terms of the recommendations of the Committee for the United Nations Convention on the Rights of the Child, which asked that the New Zealand Government 'increase local services to assist parents to raise their children, particularly services for the treatment of alcohol and drug use, and culturally appropriate services'.[116] The Children, Young Persons and their Families Act (1989) also recognises that Pacific people and their families need assistance 'to discharge their responsibilities to prevent their children and young persons suffering harm, ill treatment, abuse, neglect or deprivation'. Parenting programmes are one mechanism to increase the wellbeing of Pacific children and their families and family groups.

6.1 Protective factors of Pacific parenting

Pacific peoples' environments are rich in cultural practices, values and language. Evidence (Paterson, Taylor, Schuler & Iusitini 2012) shows that retaining connectedness with Pacific cultures, languages and values acts as a protective factor that boosts resilience against the negative impacts of socio-contextual stressors (such as low education and unemployment). A paper by Paterson et al. (2012), which focused on behavioural problems during childhood, found that

> *Across dimensions, a protective factor was found for children with mothers who described themselves as strongly aligned with Pacific traditions. These findings contribute to the limited longitudinal data specific to children from different ethnic groups and demonstrate the importance of cultural factors in developmental outcomes.* (p 231)

The finding suggests that cultural concepts and practices should inform more effective parenting programmes to resolve vulnerabilities affecting Pacific children. This requires an understanding of cultural perspectives, worldviews and practices. One of the key measures of effective Pacific parenting is whether children relate well to others, are appropriately hospitable, and can demonstrate the values of the previous generation. Parents' pride is based on how well their children can enact their cultural heritage and roles. This differs from contemporary New Zealand, in which effective parenting is often measured by children's academic achievements or financial successes.

116 White Paper for Vulnerable Children Vol II p 9.

Pacific perspectives on child development

In Pacific families and parenting arrangements children are considered gifts from the ancestors, and they therefore belong to the entire *aiga, kainga, magafaoa* or extended family clan. In Pacific thought, this includes their body, mind and spirit, and young children are taught they belong to everyone. In practice, children are taught to treat their bodies with respect and this is reciprocated and practised by those around them.

Tuputupua'e, or a child's growing-up period, is when the child is taught to be a contributing member of their household. In these Pacific cultural practices children are not just the passive consumers of everyone's nurturing – they are taught, as children, to contribute to their own wellbeing through contributing to the overall wellbeing of their family – for example, by completing tasks like picking up fallen leaves and rubbish around their houses. Childhood is a time when children are shown by their peers and family adults the skills needed for life as contributors.

A child's body is attended to by collectives of family women until it begins to change, at which point boys are cared for by men and girls by women. Pacific children, as descendants of their heritages, are prepared for their roles in relationship to their *aiga, kainga, magafaoa* or collective family.

6.2 Pacific languages and protocols as parenting tools

The parenting process for Pacific families is grounded in the belief that children are to be *fa'afailele*, or nurtured and guided through each growth point with language, with feeding, in gesture and in embodied response and body language. At the heart is the saying 'language transmits love and acceptance of the child'. These languages of word, gesture and body enable the transfer of cultural knowledge from one generation to the next. As the child grows they are taught by their biological parents or maternal aunts appropriate behaviours, etiquettes and protocols of interaction which are imparted through *sufi* or soothing words, ensuring that the child is receptive and open to learning (Masoe & Bush 2009).

The use of fagogo or narratives as a parenting tool is unique to Pacific peoples. Through the *fagogo* children and young people are taught significant life lessons to prepare them for adulthood and the responsibilities and roles that will be within their genealogical frames. Centrally, *fagogo* is grounded in the belief that children and young people's spiritual and mental development are as critical as their physical development. In Pacific cultures these elements of the relational self are interconnected and need to be nurtured as the child grows. This nurturing or feeding of the young ones with language is highlighted in the Samoan saying *'Ua molimea manusina'* (food today is the strength of tomorrow) (Masoe & Bush 2009; Kolone-Collins 2010).

Sharing narratives with children is seen as a way of feeding their minds and spirits. The Pacific parenting process is captured in the following proverb:

> *When the manusina (sea bird) returns to the tuasivi (mountains) from the faiva (fishing) each day, they always remember to take a fish for fa'afailelega (the young ones awaiting their return).* (Kolone-Collins 2010 p 89)

The need for belonging remains, and survival of languages is needed to sustain belonging. For Pacific descendants, the expectation is that while they are being raised in New Zealand, they are able to do so without losing their sense of belonging, heritage and language. This means that the kinds of parenting and early childhood programmes delivered in New Zealand need to ensure that the cultural heritage of Pacific children being raised in New Zealand is maintained or increased.

6.3 Pacific values

Pacific values underpin Pacific practices and ways of being, understanding, and interacting. These values include respect, love, humility, obligation and reciprocity, and a sense of wellness, wellbeing or harmony (Tamasese et al. 2010).

A study by Todd-Oldhaver (2004) found that Samoan values and identity provided psychological resilience that was culturally founded and appropriate for that community. Her study focused particularly on the values of reciprocity, relationships and belonging, and noted that faith in God and involvement in a church or community acted as protective factors.

The Matauala centre in Porirua was born out of the city's Tokelauan community, and it provides an example of how the Pacific value of love has acted as a resilience factor. The essence of the project was the practice and embodiment of au, the organ where generosity and love are believed to dwell. In parents the love that comes from this organ is for their children. In the same way, the elder generation always feels this love for the children and has concern for their future. These were the motivations for the Matauala project. It was a move by elders, as parents, to create an environment for raising future generations. The centre was a place where values and practices could be passed on to their children. Love was embodied and enacted through their leadership and construction of a physical place of belonging. In the same way, across other Pacific cultures, love, *alofa* or *aroha* motivates elders and parents to teach and pass on to younger generations their *tofi* or cultural heritage. The study also noted other key cultural factors that contributed to and sustained their engagement for two decades:

- a shared culture and language
- a shared vision and sense of responsibility for creating a place of belonging
- a shared genealogical connection to *kaiga* or extended family as descendants from the same atoll
- a desire for autonomy and their own 'piece of Tokelau in New Zealand' as a gift for their descendants
- a shared sense of responsibility towards future wellbeing, which was held by elders and shared with younger people
- elders that led the way by example.

These factors helped to strengthen the community's commitment to succeed together. These factors can also contribute towards increasing the participation of Pacific parents in programmes through locating them within Pacific communities, and engaging the communities in their leadership (Tamasese et al. 2010).

6.4 Pacific identity – the primacy of the notion of the 'relational self' and collective parenting

Pacific peoples understand the 'self'' as a 'relational self' – not an individual self or person, but one that has meaning through connection with others. The notion of the relational self is important when working with Pacific peoples as it requires the understanding that they are best understood and seen in the totality of their relationships (Hau'ofa 1993). This means that a person does not exist as an individual, but that through others their being is contextually meaningful and whole. The relational self gives importance to their relationships with land, ocean, environment, people, theology and spirituality. When parenting is informed by these culturally located understandings, children can belong responsibly within the globalised context. They become confident in their own values: *faasinomaga* (belonging), *tupuaga* (genealogical lineage) and *tofi* (responsibilities); these values are recognisable as and congruent with the values held in most Pacific households.

The concept of *va tapuia* (sacred relational space) is also important to the understanding of the relational self. It asserts that the relational arrangements between people are sacred. It recognises that as long as the cultural boundaries and social arrangements (like those between women and men or boys and girls) are taught and understood, then personal and collective wellbeing can be assured. Pacific notions of the self mean that the role of parenting for Pacific parents is a collectively shared role rather than the sole responsibility of the biological parents.

The teaching of the concept of the relational self needs to begin at home while children are preschoolers, and this is perhaps part of the reason why some Pacific parents prefer not to take their children to preschool. These early years for children and their families are a time when Pacific parents and family members actively begin teaching children their position in their family and extended families. Pacific parents or grandparents, elders or *matai* within *aiga, kaiga,* or *magafaoa* are actively teaching children their *fa'asinomaga* or belonging, and *tupuaga*, or genealogical connections, from the time that they are able to speak. As children grow older, they are increasingly taught about *tofiga*, or roles and responsibilities based on their heritage.

Relationships within family and the protection of the boundaries between members is a responsibility of family elders, whose roles include teaching parenting skills. Elders and family leaders, such as *matai*, often hold the ultimate responsibility for the care and wellbeing of all descendants as interdependent and reciprocating collectives. The primary responsibilities of parents are to ensure that the next generations are skilled in what is required to maintain Pacific collective identity, in knowing and caring for places of belonging, and in carrying out cultural roles, responsibilities and genealogically defined heritage (Tamasese et al. 2010).

Pacific women who are sole parents often have a collective of parenting support provided by extended family members that builds and strengthens their resilience and provides a buffering effect against stressors (Waldegrave et al. 2011, Todd-Oldhaver 2004). A recent qualitative study of a group of 20 Pacific sole parents provides examples of how relational connectedness helps to prevent isolation. Parents were balancing parenthood, family connectedness, social relationships and work requirements to varying degrees, but all with reasonable success. A significant factor in their success was found to be the connection they had with their home countries. This was an important factor not only because 11 of them had not been born in New Zealand but because of the extent and degree of family connectedness, obligation, reciprocity and support provided from contact with their homelands (Waldegrave et al. 2011).

Many home-visiting programmes have grown out of an emphasis on the nuclear family, and the desire to support mainly women with their children's early educational development. Research with Pacific peoples has indicated that a more collective approach is needed to increase programme participation and engagement, by moving parenting programmes from individualised home-visiting approaches to a community of belonging-based initiatives (Tamasese et al. 2010). These would, ideally, focus on culturally distinctive groups such as Samoan, Cook Island, Niuean or Tongan communities. According to Rumble (2010), "parent education can help reduce the numbers of parents parenting in isolation', but these programmes should be 'set in a community development context'. Programmes developed within communities in need are the most beneficial and 'it is essential for parenting education programmes to focus on relationship building…and enable people to parent together – moving from the 'I' to the 'we'" (pp 116–117).

A Pacific parenting programme premised on these cultural elements would, therefore, be inclusive of extended family relationships. Elders would guide the cultural elements as it is their role to help teach young people ways of applying cultural values in a modern, globalised context.

6.5 Issues for Pacific families in current parenting programmes in New Zealand

We undertook a review of evaluations of current generic or mainstream parenting programmes in New Zealand to isolate any characteristics useful in the context of identifying effective Pacific parenting. Programmes reviewed included:

- Anau Ako Pasifika – an early childhood programme for Pacific families and their young children
- Home Instruction Program for Preschool Youngsters (HIPPY)
- Early Start
- Family Start
- The Incredible Years Parenting Programme (IYPP)
- Parents as First Teachers (PAFT)
- Strategies with Kids, Information for Parents (SKIP).

There were three main issues raised in the review of these programmes, which are discussed below.

Mainstream parenting programmes are beneficial for mainstream New Zealand families, but too little is known about their benefits or effectiveness for Pacific families

The evaluative evidence showed that there is a pattern of consistent Government support and investment in parenting programmes. While there is evidence that these programmes benefit non-Pacific parents, it is not clear to what extent this inculdes Pacifc parents. There was inadequate data on Pacific participation in the present parenting programmes. Further specific research on these issues for Pacific parents and families is needed.

Parenting programmes delivered in New Zealand are imported, adapted and delivered without assessing their suitability for Pacific families

The general pattern among the parenting programmes reviewed here is that they have been predominantly imported into New Zealand from another context and then adapted for mainstream New Zealand participants. There seems to be no evidence that the parenting support and educational programmes delivered to Pacific parents have been evaluated or critiqued by Pacific family, psychosocial, cultural or mental health specialists before their delivery to Pacific parents and families.

There is a general absence of basic and evaluative evidence on Pacific families and their participation in parenting programmes currently available

There is an absence of data on Pacific families and children's participation, experiences or inclusion in evaluations. It seems that either the programme hosts or deliverers are not required to report on Pacific participation and experiences, or if they do report this, then the data is being excluded from the evaluative reports, and the reason for this needs to be clarified. There may also be other complex reasons for this lack of inclusion. Whatever the reason, this needs to be resolved as it is difficult to justify increasing the participation of Pacific families in parenting programmes when there is such an evidential chasm. The lack of evidence appears to indicate a critical need for an appropriate investment in order to prove these programmes' approaches are in fact valid or effective for Pacific families.

The process of resolution could be built on two strategies: firstly, to assemble Pacific specialists and elders who can evaluate the mainstream programmes for their effectiveness for Pacific families and children and then, if appropriate, to pilot an adaptation which can be evaluated; second, a distinctively Pacific parenting programme can be developed with the assistance of Pacific specialists and elders. The Pacific parenting programme would be characterised by and authentically founded on Pacific values and concepts of parenting in the context of New Zealand. Such a programme can then be piloted and evaluated for its effectiveness from the perspectives of Pacific families.

6.6 Key considerations in the provision of parenting programmes for Pacific families

Consideration of Pacific protocols, traditions and values

The parenting programmes that have been reviewed here are grounded in Western culture, worldviews and values. These values centre on the human being as an individual who is autonomous, rational and secular. That individual may go through human development stages of childhood, adolescence and adulthood, and may prefer a nuclear family arrangement where parenting is carried out primarily by the biological parents. The goals of mainstream parenting programmes then are to enable parents or caregivers to help children and/or young people to negotiate their various life stages. The desired outcome may be the attainment of adulthood that is independent, autonomous and self-determining.

During the early stages of the implementation of Family Start programmes, the engagement of Pacific community-based organisations became a rallying point for Pacific communities and practitioners to negotiate with Government funding agencies for Pacific Family Start programmes to be established across New Zealand. Pacific Family Start sites and their Pacific family workers began to develop their own cultural models of working with families from these cultures. They developed the Family Start Pacific parenting programmes from the resources of their Pacific cultures, values, protocols and worldviews to produce the first *GAPIA – The Journeys of Pacific People into Pacific Indigenous Family Start Approaches: Cook Islands, Kiribati, Samoa, Tokelau, Tonga and Tuvalu* (2003). The GAPIA collected together their own Pacific practices based on cultural values, which went on to be tested in Family Start sites that supported the development work with their Pacific family workers.

Similar to the issues with kaupapa Māori programmes, effective parenting programmes for Pacific people need to be embedded in Pacific cultures, protocols, traditions and values. Programmes will thus be meaningful and useful for Pacific parents and ultimately for their children. Achieving this means these parenting programmes need to balance enhancing Pacific children's identity and sense of belonging within their *aiga*, *kaiga* and *magafaoa*, and increasing contemporary parental skills and capacities.

The Families Commission has carried out substantive reviews of parenting programmes. In their *Investing in the Early Years report* (2011) the Commission's findings are consistent with this review, which points to the need for parenting programmes to be culturally appropriate in both content and delivery. It also highlights the need for programmes 'borrowed' from overseas to be reviewed by representatives of the cultural groups with whom they are to be used. Just as kaupapa Māori programmes will be an option for Māori, the same logic needs to be applied to Pacific programmes.

Targeting and retention of Pacific parents in parenting programmes

Current mainstream parenting programmes are a mixture of targeted (for example, Family Start) and universally available information sharing programmes (such as SKIP). The current evaluative evidence shows that Pacific people are not being attracted into the mainstream parenting programmes, or retained in significant numbers. For example, Pacific families were under-represented at two percent in the IYPP in Hawke's Bay (Ehrhardt & Coulton 2013) and high mobility is seen to be one explanation (Kerslake Hendricks & Balakrishnan 2005).

During this review another possible explanation has emerged, indicating that the distance between the parenting programmes' values and approaches to those of the participating Pacific families is too far. Pacific parents indicated this in the Otago IYPP, and there is benefit in extended families being included, as shown in the Porirua IYP.

Any suggestion of using a process of selection for Pacific parenting programmes would be contradictory to Pacific values of transparency and practices of inclusion. It would be perceived as inappropriate and discourteous to offer opportunities to some while excluding others, and cause an embarrassing 'loss of face' that would affect participants' motivation and the wider community's support for such a programme.

A community-inclusive approach was demonstrated through a Samoan community education programme. It was a targeted, culturally specific programme dealing with abuse prevention. The Samoan Stop Abuse project (1993–1994) was delivered through a partnership between the Samoan Advisory Council and the Family Centre (unpublished reports 1993, 1994). This programme delivered a specifically designed Samoan community-based training programme in 12 Pacific communities across the Wellington region and included everyone in each community location. Over 800 Samoan elders and young people participated. The programme was based on Samoan cultural concepts like *va tapuia* (sacred relational arrangements between people) and was facilitated by Samoan facilitators who matched participants by gender and age. The Samoan Stop Abuse programme generated a Wellington-community-wide consciousness of the collective responsibility for revitalising cultural practices that increase families' and young people's responsibilities for preventing and addressing a specific vulnerability.

The notion of appropriate service delivery providers for Pacific families

Cribb's review of Family Start services (2009) noted that some services to Pacific families were being delivered by Māori and iwi providers and raised the question of what impact this had on service delivery for Pacific families.[117] Given the growth of iwi and Māori providers in the social services and health sector, it is important for this question to be included in future evaluations across the spectrum. Another reason why this question needs to be explored is due to the current trend by ministries to promote 'Pacific innovations collaborations' for the delivery of social and health programmes. These trends will likely have an impact on Pacific community groups delivering Pacific parenting support programmes to Pacific families, and monitoring their impact will be beneficial.

Parenting programmes that can support parents and families with contextual socio-economic issues

Programmes that can address Pacific people's overall socio-economic stressors (such as low educational achievement, and high unemployment, fertility and overcrowding rates) will be seen as effective for Pacific parents. This approach was found to be effective by the families in the evaluation of the Anau Ako Pasifika programme over two decades ago (Kerslake Hendricks & Balakrishnan 2005). Recent evidence is less clear, however.

117 There are currently three Pacific-specific FS providers – two are located in Auckland and one in Porirua.

Cribb's review of Family Start (2009) cites that in the earlier 2005 evaluation while families achieved their goals concerning education and training, income, housing and physical and mental health, these were assessed as adult goals and 'not necessarily linked to child development and wellbeing' (p 23). The evaluation data were unclear about the beneficial outcomes for children who were the intended beneficiaries. The evaluation also noted that 'Pacific caregivers were least likely to report that the programme helped' (p 24). In Cribb's 2009 review there was little evidence of improvement from the 2005 evaluation.

Teaching parenting skills before young people become parents

The Pacific approach to timing for parenting programmes might be more effective if it were less crisis-driven. Interventions during a crisis may heighten motivations for families at the time, but they are not ideal situations for longer-term learning and change. The participation of Pacific parents is likely to fade once the crisis has been resolved. Further research is warranted in this area, including the reasons for the mobility and drops in retention rates with Pacific participants in parenting programmes.

It is important that parenting programmes provide training about parenting for young people who will eventually become parents as they move from childhood through their teenage years to parenthood. This means contemporary parenting roles need to include the teaching of young people about the sacredness of their bodies and their own responsibilities to be conscious of their generation's impact on family genealogies.

Length of the intervention and engagement for Pacific people

Gray's review of Family Support programmes (2001) raises the issue of the low levels of engagement for vulnerable families. She suggests that a five-year intervention is too long for many families. From a Pacific perspective, the length of a family's engagement is largely dependent on the strength of the relationships between the Pacific parents and the parenting programme providers. The basis and continuation of the relationship would usually be dependent on the achievement of the agreed purposes of the relationship, unless there was a mandatory requirement that is prescribed.

There is inadequate evidence to provide an ideal length of time for interventions with Pacific families and parents. Pacific families may be best equipped to determine the value of continued intervention for themselves, and eventually how effective the programmes are for addressing their familial goals. Involving children, elders and parents in the decision-making process about the terms of engagement will ensure transparent accountability on the length of engagement. The terms of engagement for Pacific people will largely be determined by their relationship with each other, agencies or facilitators.

Recognising Pacific children's and parents' own measures of effective parenting

For many Pacific parents their measure of effective parenting is often based on how well their children enact their cultural heritage and roles. It could be helpful if these goals had a central role alongside the educational goals for children to be achievers in more competitive environments that require academic success. Other measures of effective Pacific parenting include but are not limited to the following examples:

- a child's ability to relate well to others
- a child's ability to show appropriate hospitality to elders, women relatives and school teachers
- a child's embodied practice of their cultural values and familiarity with their places of belonging
- a child's familiarity with and appropriate perspectives on family/*aiga*/*kaiga*/*magafaoa* and genealogical knowledge about earlier generations.

6.7 Definitions of the conceptual elements of effective Pacific parenting

The question of who defines what effective parenting is for Pacific peoples is the first step to identifying what effective parenting is. For Pacific peoples parenting is culturally defined, determined and practised.

If current programmes are to be evaluated by Pacific specialists and Pacific elders, then there needs to be a process by which they, and the Pacific families participating, can take part in defining what effective Pacific parenting is in the globalised context.

It is important that the definition of effectiveness for Pacific parenting and parenting programmes is developed in partnership with Pacific elders. Pacific specialists, elders and representative Pacific communities need to answer this definitive question within their own communities. The outcomes from these community based discussions would guide the delivery of programmes and evaluations of their effectiveness.

Culturally-based processes such as the Faafaletui process (Tamasese, Peteru & Waldegrave 1997) can be utilised as a method of assessing participants' considered views on the effectiveness of significant aspects of parenting programmes. This method can also be used, alongside other Pacific methodologies, to review, assess and reach consensus on ways to adapt current parenting programmes for Pacific families and children.

Meanings and definitions of effectiveness need further examination, and they must be collectively and consensually refined in order to arrive at an answer to the question of what makes parenting programmes effective for Pacific parents.

The issue of accountability when grounding mainstream parenting programmes in Pacific cultures, values and worldviews

Transparent and accountable processes that include evaluative evidence need to be part of any future mainstream parenting programme and service. Including Pacific people in these accountability processes can address cultural and gendered biases in the delivery, implementation and effectiveness of these programmes.

The recent work on Pacific conceptual frameworks to address family violence in New Zealand pointed to the need to re-conceptualise all parenting programmes and evaluation tools to enumerate their successes and vulnerabilities (Ministry of Social Development 2012).

It is important that evaluation methods are harmonised with the programmes that are being evaluated. Methods developed to evaluate Pacific programmes and services need to be developed in partnership with Pacific advisors so that they can appropriately review and include the experiences of Pacific participants, socially, culturally and spiritually, alongside other aspects being evaluated.

The next section promotes a model of Pacific conceptual frames that parenting programmes can utilise.

6.8 A model of a Pacific parenting programme – landmark frames

When attempting to develop solutions for the causes of vulnerability among Pacific children, their cultural values and worldviews will affect whether they are successful. If we develop programmes to increase belonging, based on *tofi* or inheritance, it is more likely that this kind of programme is going to feel more familiar to Pacific participants who live by these values.

The cultural frameworks below are drawn from research carried out with different Pacific cultural communities. The research involved focus groups facilitated in partnership with elders from these communities (Tamasese et al. 2010). These frameworks guide family and community life and are useful concepts to support the development of parenting programmes aiming to engage and retain Pacific families.

Table 6: Concepts or frameworks that guide Pacific community life

Cultural framework	Explanation	Significance
Tokelauan › Tuia te po ke ao	In Tokelau, it is well known that when out fishing for the night, the time just before dawn is when fishermen became very tired; a call is made by the master fisherman to the crew: *'tuia te po kea o'* (work through the night till dawn till sunrise, the children are waiting for their catch).	This Tokelauan frame or metaphor encompasses the spirit and emotional drivers that are called upon during especially difficult times.
› Tifa	The *tifa* (mother of pearl) is a metaphor for Tokelauan family life. Within families, there is scope for individual growth and space for developing individual skills in accordance with talents. When united, like the tifa, the family group is strong, but it is not until the individual members of the family and their talents are acknowledged that the treasure of the pa is fully revealed. Each tifa shell can yield several pa.	The tifa shell is a symbol of unity and strength and while the family is made up of individual selves, their real strength is revealed in collective action as a family.
Niuean › Responsibilities and obligations	In Niue relationship responsibilities are powerful motivators. For the nation of Niue, the visit of Maui Pomare, as a Māori and as a Minister of State and Commanding Officer for the newly formed regiment, carried relational, cultural and political imperatives that were strengthened by his face-to-face presence in Niue. These imperatives, combined with the Niuean sense of honour, heightened their responsibility and obligation to fulfil their roles as young men. The volunteering of an entire regiment of Niuean men was thus assured.	This frame emphasises Niue's need to honour relational imperatives. The motivator of honour was heightened through a sense of responsibility to the wellbeing of kin – that is, to New Zealand in its hour of need. Niue perceived New Zealand as kin and as a related nation on the grounds of both cultural and political arrangements, and responded as kin must during a crisis.

Table 6: Concepts or frameworks that guide Pacific community life (contd)

Cultural framework	Explanation	Significance
Tongan › Healthy perspectives of Pacific peoples	'The world of Oceania is not small; it is huge and growing bigger every day…the idea of smallness is relative; it depends what is included and excluded in any calculation of size…if we look at the myths, legends, and oral traditions, and the cosmologies of the peoples of Oceania, it becomes evident that they did not conceive of their world in such microscopic proportions. Their universe comprised not only land surfaces, but the surrounding ocean as far as they could traverse…smallness is a state of mind' (Epeli Hau'ofa, 1994). There has been many descriptions of the Pacific emphasising smallness, remoteness, underdevelopment, dependence, and incapacity. These views have confined some Pacific people in the past, physically and psychologically. This has become internalised and hinders resilience. These narrow and restricting ways of seeing ourselves do not help in the work of developing Pacific parenting programmes.	This Tongan frame emphasises the importance of supporting healthy perspectives of Pacific peoples. Families independently redefine their world in accordance with their perceptions of where the future lies for their children and their children's children. They plan for generations, for community and improvement of their families and kin groups.
Atiu Enua/Cook Islands › Shared beliefs and roles – working together	*'Kake kake i tona puku, kake kake i tona puku'* (each person must climb their own mountain). This quote is a key driver for the Atiu Enua community. It may be understood as referring to the responsibility to rise to the challenge to achieve as a community together and the responsibility to excel and succeed as a family, as a village or as an entire enua grouping.	This Atiu frame illustrates how Pacific people can be motivated to achieve their goals, through their shared belief that their roles include helping each other achieve their shared goals. Through working together they gain momentum and increase motivation to honour and affirm their mutually held interests, ambitions to achieve success, the benefits of these over time and their genealogy, which transcends the ocean and time.
Fijian › *Dui seva ga bua ko a tea* – loving and caring for others. Acts of reciprocity	*'Dui seva ga bua ko a tea'* or loving and caring for others fulfils our sense of self and wellbeing. Many contributions over the years were made because of this reciprocal principle.	This Fijian frame highlights the reciprocal nature of making contributions within the cultural frame. Loving others and caring for others in family and community as a basis for making contributions is remembered. In time these contributions are reciprocated. These contributions may be material and given but they point to a form of reciprocity that may in fact be spiritual – for example, in that we receive back a greater sense of wellbeing and we actively fulfil our relational being.

6.9 Conclusion

The lack of culturally informed Pacific parenting programmes demonstrates the clear need for investment in research, design, dialogue with the Pacific community, resourcing and roll-out of culturally informed and high-quality Pacific programmes in Pacific community settings. In addition, there is a need for Pacific evaluations of these programmes with a view to assessing their suitability and appropriateness for Pacific cultures, worldviews and values. This will aid the engagement and retention of Pacific families in parenting programmes that will be more meaningful and useful for Pacific parents and ultimately their children.

There needs to be a process of defining what 'effective' and 'parenting' mean for Pacific people. The adaptation of mainstream parenting programmes should ideally be carried out in partnership with Pacific people and in relationships of accountability to key Pacific elders. There is also a need for qualitative research evaluation alongside quantitative studies to ensure the experience of Pacific people in parenting programmes is taken into account with the numbers.

Parenting programmes need to include the understanding that the role of parenting is carried out by both biological parents and collectives of kin. Parenting in many Pacific cultures is a collective responsibility.

In addition to all the above, future Pacific parenting programmes need to be balance enhancing Pacific children's identity and sense of belonging within their *aiga, kaiga* or *magafaoa*, and increasing contemporary parental skills and capacities in New Zealand, thereby reducing vulnerabilities.

7. IMPLEMENTATION OF PARENTING PROGRAMMES

A range of issues have been identified that are relevant to the selection and wider implementation of evidence-based parenting programmes. One of the drivers of the need to consider implementation issues is the finding from some multi-site studies that effects often differ at a site level. For example, Howard and Brooks-Gunn (2009) refer to the research on the Hawaii Healthy Start programme that found positive effects for the programmes in some sites, but not in others.

Results such as these suggest that it is important to determine why programmes might work in one location (country or community), but not in another. Is this due to staff abilities, programme integrity, support for the programme in the community or access to supplementary services? It has been suggested that the Hawaii Healthy Start programme failed because staff rarely referred families to other specialist services, even when they had serious problems, and despite this being a primary goal of the programme (Howard & Brooks-Gunn 2009). The programme also had a relatively high drop-out rate and many families got fewer home visits than planned. Further evaluations of programmes based on the Healthy Start model have found the programme is more likely to be successful when it includes monitoring of programme fidelity and addresses common implementation issues.

Issues of implementation may be particularly acute when considering the use of a parenting programme that has been developed in another country. While some reviews (Knerr, Gardner & Cluver 2013) have found that evidence-based programmes are successful in countries with different cultures, this requires that the programmes be adapted to the new context while remaining faithful to the original programme design. Most of the parenting programmes in New Zealand are based on overseas-developed and trialled programmes, with local adaptions (for different cultural groups, in some examples).

The concern with ensuring successful implementation of evidence-based programmes (EBP) has led to the inclusion of these factors in the rating of programmes (see Blueprints and Dartington, HOMVEE). The United States Centers for Disease Control and Prevention guidelines (Puddy & Wilkins 2011) include consideration of both experimental (RCT) and contextual evidence (feasibility, acceptability and utility). These additional assessment criteria are sometimes used to judge whether a programme is 'dissemination-ready'. As Chaffin and Friedrich (2004) point out, 'indeed, disseminating and implementing EBPs may be more challenging than developing them' (p 1109). Put simply, it makes little difference which programme is chosen if its implementation is so poor that it bears little resemblance to the EBP. The use and promotion of evidence-based parenting programmes is not just a matter of choosing a programme; it must include making sure it is appropriate and works in context. As the preceding chapters have shown, a big part of this is ensuring its suitability and appropriateness for Māori and Pacific families. The following section is a review of implementation considerations for programmes.[118]

118 This section is taken from the Parenting Research Centre evidence review (PRC 2013).

7.1 Implementation of evidence-based parenting programmes

While the identification of effective interventions can be helpful when practitioners, agencies and policy-makers are searching for interventions in which to invest, the emphasis on identifying and cataloguing effective interventions has not been matched by a corresponding effort to systematically assess the extent to which interventions are implemented and to evaluate the impact of this on their outcomes (Aarons, Sommerfield & Walrath-Greene 2009). This is despite strong evidence that the quality of the implementation of an intervention has an impact on desired outcomes.

By 'implementation' we are referring to a set of planned and intentional activities that aim to put into practice interventions or empirically supported practices (ESPs) within real-world service settings (Fixsen, Naoom, Blase, Friedman & Wallace 2005; Mitchell 2011). Implementation is a process, not an event, and it should be distinguished from adoption, which is defined as the formal decision to use an intervention or set of ESPs (Mitchell, 2011). Effective implementation has more traditionally referred to the full implementation of all components of an intervention or practice, as planned by the original developer. More recently, implementation researchers have systematically started to examine the degree to which aspects of a programme can be adapted to meet local conditions, while maintaining the core components. This allows for local adaptation as a way to accommodate what may be needed at a system, policy or organisational level to facilitate effective implementation and sustainment of the intervention or ESP (see for example Aarons, Green, Palinkas, Self-Brown, Whitaker, Lutzker, Silovsky, Hecht & Chaffin 2012)

Implementing effective interventions is complex and challenging, and many previous efforts to implement effective interventions in the family support sector have not reached their full potential due to a variety of issues inherent in both the family support service setting and the implementation process itself (Aarons, Hurlburt & Horwitz, 2011; Mildon & Shlonsky, 2011). Without addressing these organisational and individual challenges as part of a planned, purposeful and integrated implementation strategy, interventions, even effective ones, may not produce the desired effects for parents and children. Therefore, attention to **how** an intervention is implemented is as important to child, parent and family outcomes as **what** is implemented. To ensure that government spending is directed at services and programs known to be associated with positive results, and to ensure that limited dollars are invested in interventions that are more likely to make a difference to families, we must attend to both the evidence that a intervention works, and the way that intervention should be implemented to achieve good results.

Over the last 10 years, researchers have increased their efforts to describe the process of implementation. This can include descriptions of the main steps involved in implementation or more refined conceptual frameworks based on research literature and practical experiences (Meyers, Durlak & Wandersman 2012).

Frameworks for implementation are structures that describe the implementation process and include key attributes, facilitators, and challenges (Flaspohler, Anderson-Butcher & Wandersman, 2008). They provide an overview of practices that guide the implementation process and, in some instances, guidance for researchers and practitioners in the form of specific steps to include in the planning and execution of implementation efforts, as well as pitfalls or mistakes that should be avoided (Meyers et al. 2012).

While there is no agreed-upon standard in the field, some efforts have been made to synthesise these approaches to implementation. For example, Meyers et al. (2012) conducted a synthesis of 25 implementation frameworks. Frameworks were sought across multiple research and practice areas as opposed to focusing on a specific field (see Damschroeder, Aron, Keith, Kirsh, Alexander & Lowery 2009 who focused on the health-care field). Only frameworks that described the specific actions and behaviours that can be undertaken to promote high-quality implementation were included in the synthesis. The authors argued that systematically identifying these action-oriented steps served as practical guidance for planning and executing implementation efforts. They found that many frameworks divided the process of implementation into several temporal phases, and

within these phases, there was considerable agreement on the critical elements or activities. Their synthesis found 14 elements that could be divided into four distinct temporal phases of implementation. The first two phases focus on planning for implementation, while the third and fourth incorporate the actual *doing* of the implementation.

The first phase is named *Initial Considerations Regarding the Host Setting* and contains a number of elements, all of which describe work focused primarily on the ecological fit between the intervention or practice and the host setting. Activities here commonly include assessment strategies related to organisational needs, innovation-organisational fit, capacity or readiness assessment, exploring the need for adaptation of the program or practice and how to do it, obtaining buy-in from key stakeholders and developing a supportive organisational culture, building organisational capacity, identifying or recruiting staff and conducting some pre-implementation training.

The second phase is named *Creating a Structure for Implementation.* Here the focus of the work can be categorized into two elements: developing a plan for implementation and forming an implementation team which clearly identifies who is responsible for the plan and tasks within it.

Phase three, *Ongoing Structure Once Implementation* Begins, incorporates three elements: technical assistance (including training, coaching and supervision), monitoring ongoing implementation (process evaluation) and creating supportive feedback mechanisms to ensure all relevant players understand how the implementation process is progressing.

Finally, phase four is named *Improving Future Applications.* Here the element is learning from experience, which commonly involves retrospective analysis and self-reflection including feedback from the host setting to identify particular strengths or weaknesses that occur during implementation.

The authors stressed that many of the frameworks included in the synthesis were based on what had been learned about implementation from practical experience and through staff feedback. There were few instances where studies empirically tested the implementation framework that had been applied and modified on the basis of their findings. What was more common was making modifications to implementation frameworks based on feedback received from the setting about ineffective and effective strategies; considering what others were beginning to report in the literature; and by critical self-reflection about one's effort.

Box 7.1 summarises these and other important aspects of implementation identified in implementation science literature that should be considered when selecting an effective intervention to deliver to families, and when planning for the implementation of that intervention.

Services face a range of challenges when selecting and implementing effective interventions. One significant challenge is that an effective intervention may not exist for a service provider's identified needs, selected target population, and service and cultural context. Alternatively, or sometimes additionally, the monetary cost of an effective intervention may be too high, which is a difficulty community-based services often face. While the cost of not implementing an effective intervention should also be considered in such circumstances, it is nonetheless the case that cost is often a barrier to high-quality implementation of effective interventions.

Box 7.1 Implementation considerations for parenting interventions (Wade et al. 2012).

Appropriateness of intervention aims and outcomes

- Is the intervention based on a clearly defined theory of change?
- Are there clear intervention aims?
- Are there clear intended outcomes of the intervention that match our desired outcomes?

Targeted participants

- Is the target population of the intervention identified and does it match our intended target population?
- What are the participant (child, parent or family) eligibility requirements (ages of caregivers or children, type of person, presenting problem, gender)?

Delivery setting

- What are the intervention delivery options (eg group, individual, self-administered, home-based, centre-based)?
- Is there flexibility in delivery modes that suit our service context?

Costs

- What are the costs to purchase the intervention?
- What are the costs to train staff in the intervention?
- What are the ongoing costs associated with purchasing manuals and technical assistance (eg coaching and supervision of staff)?
- What are the costs to implement the intervention with families (in terms of staff time, resources to deliver, travel cost to agency, travel cost to families, costs to families in terms of time off work and childcare)?
- Are cost-effectiveness studies available?

Accessibility

- Are the materials, trainers and experts available to provide technical assistance (ie training, coaching and supervision) to staff who will deliver the intervention?
- Is the intervention developer accessible for support during implementation of the intervention?
- Does the intervention come with adequate supporting documentation? For instance, are the content and methods of the intervention well-documented (eg in provider training courses and user manuals); are the content and methods standardised to control quality of service delivery?
- Are the intervention content and materials suited for the professionals and parents we work with, in terms of comprehension of content (eg reading level of materials, amount of text to read or write, use of complex terminology)?
- Does the intervention suit our service's access policies (eg 'no wrong door' principles; 'soft' entry or access points; community-based access; access in remote communities)?

Technical assistance required

- What are staff training needs (frequency, duration, location, cost)?
- What amount of ongoing technical assistance is required (including top-up training, coaching or supervision)?

Fidelity

- What are the requirements around the fidelity or quality assurance of delivery of the intervention components to families? That is, how well do practitioners need to demonstrate use of the intervention either during training or while they are working with families (eg are there tests, checklists or observations that they need to perform during training; are there certain things they need to do to prove/show to the trainers that they are using the intervention correctly, such as video-taped sessions, diaries, checklists about their skills or use of the intervention with families)?
- Are there certain intervention components that MUST be delivered to families? That is, if they don't do X, they are not actually using the intervention as intended.
- What are the intervention dosage or quantity requirements for effective results (ie how often and for how long do families need to receive the intervention)? Can our service meet those requirements?

Data and measurement of effectiveness

- How is progress towards goals, milestones and outcomes tracked?
- What are the requirements for data-collection (ie what measures are recommended, how often are they to be administered, who can administer them)?
- How accessible and relevant are the developer-recommended evaluation tools (ease of access, cost, ease of administration and scoring, relevance to New Zealand context)?

Languages

- What languages is the intervention available in and does that match our client population?
- Is the intervention relevant and accessible to particular cultural and language groups (eg indigenous families)?

Another significant challenge facing services is deciding the extent to which an intervention should be adapted or not to fit the context and, if done, how it should be adapted with quality and to good effect, retaining the essential elements of the intervention that contribute to its effectiveness. In general, when working with effective interventions it is best to work towards strong adherence to the intervention as is, to ensure fidelity and to avoid possible dilution of the benefits of the intervention. For example, one of the main findings of the NFP studies is that it may be inadvisable to have this intervention delivered by paraprofessionals as this form of delivery was found to be less effective than the nurse-delivered programme. It is unclear whether professionals from other disciplines, adequately trained, could successfully deliver the programme. Adaptation of this program to include delivery by other professionals, perhaps because of the unavailability of suitably trained and qualified staff, may not result in favourable outcomes.

Nevertheless, adaptation and local innovation are sometimes necessary in order to meet emerging needs and suit specific populations. In such cases it is important to evaluate adapted or innovative interventions to ensure that intended child and family outcomes are being met, and that harm is not being caused. Ideally, where an evaluation reveals that an adapted or innovative intervention demonstrates promise (that is, it has been reasonably well-evaluated and was shown to have some positive outcomes), ongoing evaluation should be performed to establish higher levels of evidence.

These implementation considerations, and the common components identified earlier, may also be used to guide the selection of providers for parenting programmes. For example, organisations should have trained and qualified staff, good staff support and supervision processes, appropriate cultural diversity, systems to ensure programme fidelity, good links with related support services and systems for monitoring performance for quality assurance and improvement.

8. ECONOMIC ANALYSIS OF PARENTING PROGRAMMES

The previous chapters have detailed how we have identified those parenting programmes with evidence of effectiveness in reducing child maltreatment or the main risk factors associated with maltreatment. In selecting interventions in a situation where resources are limited, however, it is important to take into account the relative costs and benefits of different programmes (Kilburn & Karoly 2008).

At its simplest, we may have two programmes (A and B) that are equally effective, but because one (A) is significantly cheaper than the other (B) we would direct investment into the cheaper programme (A). More typically, we are faced with comparing programmes with different effects on different outcomes. While collating costs of these programmes may be relatively straightforward, putting a value on these different outcomes is more problematic.

The preceding chapters have outlined the wide range of possible outcomes from parenting programmes. For example, parenting programme benefits might include improvements in child development and educational participation, fewer contacts with police and child welfare services, and higher immunisation rates. Positive outcomes may also result in increased costs – for example, through greater use of routine medical services (such as child health checks), although these short-term costs may be offset by long-term benefits. There is general agreement that early intervention and prevention is cost-effective (Kilburn & Karoly 2008), in that the long-run returns easily outweigh the short-term costs. This analysis assumes, however, that the most effective programmes are in place and are being implemented in such a way as to maximise benefits.

This chapter presents a brief description of the different approaches to assessing the costs and benefits of programmes. These are cost only, cost-effectiveness and cost-benefit analysis. A simple description of these approaches is given. Examples of where cost-benefit analysis for social or parenting programmes has been undertaken are then given. Finally, we discuss the feasibility of cost-benefit analysis of parenting programmes in New Zealand, and the extent to which economic analysis can be used to guide the selection of parenting programmes.

8.1 Cost only

The most straightforward approach is to look at the relative costs of programmes. This is simply looking at the cost of implementing and administering each programme, and in some cases selecting those which are the cheapest. This approach should only be used when there is strong evidence that the programmes under consideration are equally effective (Sefton, Byford, McDaid, Hills & Knapp 2002).

8.2 Cost-effectiveness

Cost-effectiveness analysis is useful where two or more programmes are being compared on the same outcome, but where changes on that outcome are not equivalent. One programme may achieve more of a specific outcome than the other, but it may also cost more. The benefits of each programme are calculated along with the cost, to produce a cost-per-unit measurement of outcome (for each programme the cost per immunisation, for example). Its purpose is to decide on the most appropriate programme to achieve a result at the lowest cost – that is, priority may be given to programmes or interventions with the lowest cost per unit of outcome gained (Sefton, Byford, McDaid, Hills & Knapp 2002).

8.3 Cost-benefit analysis

We have seen that current parenting programmes often target and achieve different outcomes (for example, parents' behaviour and children's outcomes). Comparing these diverse outcomes, which may be both short-term and long-term, and putting a cost on the benefits is challenging. Cost-benefit analysis (CBA) is an economic assessment tool that weighs up the costs and benefits of different proposals, actions, programmes or decisions. These results can then be used to rank different options.

By quantifying all costs and benefits, in common monetary units, and discounting, net benefits in today's dollars can be calculated (New Zealand Treasury 2005). Costs can be simple to calculate as they are usually expressed in monetary terms (in operating costs, for instance). The challenge with CBA can be how to identify, quantify and value the range of possible benefits in monetary terms. CBA is also a way of assessing the impact of a proposal after it has been implemented, to assess whether it is having the anticipated net benefit.

Cost-saving analysis (Kilburn & Karoly 2008) looks at costs borne by one stakeholder (such as Government) compared to the benefits to that stakeholder as a result of the programme. Cost-benefit analysis considers costs and benefits more widely, including those to programme participants and to society generally (for instance, in reduced victimisation). For example, Karoly, Kilburn and Cannon (2005) reviewed early childhood programme evaluations and found the wider benefits of programmes often, but not always, outweighed the programme costs.

Return on investment (ROI)

Return on investment is the concept of an investment of some resource, usually money, yielding some benefit to the investor. It is a performance measure used to determine the efficiency of an investment. A high ROI means that the gains compare favourably to the costs. ROI is typically calculated as follows:

ROI = gain from investment/cost of investment

Another way of expressing the monetary costs and benefits is the internal rate of return (IRR). This is calculated as the rate of return which 'equalises the stream of costs and benefits and can be thought of as the effective annualised return that a program would produce given the stream of net benefits' (Kilburn & Karoly 2008 p 17). Specifically, the IRR of an investment is the discount rate at which the net present value of costs is equal to the net present value of benefits. Two programs with the same net present value may have different IRRs if costs and benefits occur at different times.

Practical examples of cost-benefit analysis

Washington State Institute for Public Policy, 2004

In 2004, the Washington State Institute for Public Policy (WSIPP) conducted a cost-benefit analysis of prevention and early-intervention programmes for youth. It reviewed a number of existing programme evaluations and computed their effects in order to estimate long-run monetary benefits and costs. Specifically, the main research question focused on whether there were research-based programmes or policies with a real-world ability to:

- reduce crime
- lower substance abuse
- improve educational outcomes
- decrease teen pregnancy
- lower child abuse and neglect
- reduce teen suicides
- reduce domestic violence.

Study methods

There were two basic steps to this study. Firstly, WSIPP quantified the scientific research literature on prevention and early-prevention programmes that addressed the seven outcomes listed above. This was done to determine if there was credible evidence that some programmes actually worked. To be included in the analysis, WSIPP required that programmes have scientific evidence from at least one evaluation that measured at least one of the seven outcomes and that it was capable of 'application or replication in the real world' (Washington State Institute for Public Policy 2004 p 3). From the appropriate evaluation studies, the average effects of each programme on the seven outcomes of interest were computed. The cost savings from reduced use of services (justice-system costs such as imprisonment and crime-victim costs, for instance) were then calculated.

The second basic step was to estimate the comparative benefits and costs of each programme. WSIPP constructed a cost-benefit model to assign monetary values to any changes observed in crime, education, substance abuse, child abuse and neglect, teen pregnancy and public assistance outcomes. Costs of running the programme were also calculated.

Study results

Table 7 shows the results of the 2011 analysis in terms of benefits, costs, benefits per dollar of cost and benefits minus cost (net benefit). Programmes could have a positive or a negative return – that is, the costs of the programme outweigh its benefits.

Table 7: Washington State Institute for Public Policy – Monetary Benefits and Costs of Evidence-Based Public Policies							
Topic Area/Program	**Monetary Benefits**			**Costs**	**Summary statistics**		
Benefits and costs are life-cycle present-values per participant, in 2010 dollars. While the programs attain benefits in multiple areas. Also some programs attain benefits that we cannot monetize.	**Total benefits**	**Taxpayer**	**Non-taxpayer**		**Benefits minus costs (net present value)**	**Benefit to cost ratio**	**Rate of return on investment %**
Child Welfare							
Nurse-Family Partnership for low – income families	$30,325	$8,527	$21,798	($9,421)	$20,905	$3.23	7
Incredible Years: Parent Training and Child Training	$15,571	$4,083	$11,488	($2,085)	$13,486	$7.50	12
Other home-visiting programs for at-risk families	$14,896	$3,668	$11,228	($5,453)	$9,444	$2.73	5
Healthy Families America	$13,790	$4,330	$9,459	($4,508)	$9,282	$3.07	7
Parent Child Interaction Therapy: disruptive behaviour	$9,584	$3,026	$6,558	($1,302)	$8,282	$7.37	31
Parent-Child Interaction Therapy: child welfare	$9,498	$1,892	$7,606	($1,516)	$7,982	$6.27	15
Intensive Family Preservation (Homebuilders)	$10,995	$5,889	$5,106	($3,224)	$7,771	$3.41	4
Incredible Years: Parent Training	$8,488	$2,449	$6,039	($2,022)	$6,466	$4.20	12
Triple P: Level 4, Individual	$7,237	$2,371	$4,866	($1,790)	$5,447	$4.06	19
Triple P: Level 4, Group	$3,740	$1,230	$2,510	($365)	$3,374	$10.32	n/e
Parents as Teachers	$7,236	$1,616	$5,620	($4,138)	$3,099	$1.75	5
Triple P: Universal	$1,277	$580	$696	($139)	$1,137	$9.22	8
Parent-Child Home Program	$4,855	$1,137	$3,718	($5,386)	($531)	$0.88	n/e
Other family preservation (non-Homebuilders)	($70)	($52)	($17)	($2,982)	($3,052)	($0.02)	n/e

Summary of policy topics assigned to the Washington State Institute for Public Policy by the Washington State Legislature
Estimates for Washington State, as of July 2011

The table shows that the Nurse-Family Partnership for low-income families yielded the highest net benefits, at $20,905 per family. While this is an expensive programme ($9,421), our previous review has shown that it influences several outcomes, both in the short and long term. On the other hand,

'other family preservation (non-Homebuilders)' had costs exceeding benefits by $3,052, since there was no evidence of impacts on the outcomes in the CBA model.

The return on investment provides additional information on these programmes, taking into account that some are relatively cheap but have good returns. Nurse-Family partnership has a rate of return of seven percent, reflecting its relatively high costs. It is no longer the top programme on this measure. Parent-Child Interaction Therapy for disruptive behavior (31 percent) and child welfare (15 percent) have high rates of return, as does Triple P Level 4 and Incredible Years. These programmes are all relatively cheap ($1,500–2,000) compared to the more comprehensive home-visiting programmes.

Social Research Unit at Dartington, UK

In 2012, the Social Research Unit at Dartington, UK (SRU) launched a website, Investing in Children, which provided independent advice on the costs and benefits of competing investment options in children's services. They applied the economic model developed by WSIPP in the US to the UK setting, using UK data. The model takes an approach to cost-benefit analysis that is 'consistent across policy areas, cautious in its estimates and relevant to the real world of public and private sector investments in child health and development' (Social Research Unit at Dartington 2012 p 1).

The SRU stated three main reasons for using the WSIPP model in preference to alternatives. These were:

- it is cautious in its estimates and does not make rash claims
- it is consistently applied across policy areas (eg it uses the same methods to calculate costs and benefits for children in foster care and in the youth justice system)
- the results have been used to inform major policy decisions.

Method of analysis

Four different kinds of interventions were investigated. These were youth-justice interventions, education interventions, early-years interventions and child-protection and social-care interventions.

The SRU used three main steps for their cost-benefit analysis. Firstly, they assessed the evidence to see what actually works and to quantify impacts. For each policy area they carefully assessed the evidence on the effectiveness of interventions. All available English-language studies were gathered; each study included a control or comparison group and analysed administrative or survey data with advanced statistical methods. Results from each study were then combined to calculate effect sizes for each outcome and discounts were applied to take inflation into account.

Secondly, the SRU calculated the costs and benefits of interventions. The costs of delivering an intervention to a person were calculated, taking into account the ongoing costs of maintaining the intervention. The monetary benefits of each intervention were considered for participants, taxpayers and others not directly involved (such as victims of crime). Benefits were calculated for the lifetime of the participant.

Finally, because the final cost-benefit findings depend on the estimates used in the model, the SRU completed a risk assessment using a statistical technique called Monte Carlo simulation. A Monte Carlo simulation involves repeated random sampling in order to obtain a numerical result that indicates the reliability of the estimated benefit or cost of the intervention. The SRU ran the model 500 times, varying parameters like the effect size, in order to estimate the proportion of times that each intervention produced a benefit that exceeded its costs.

Results

Table 8 below shows the results of the CBA for child-protection and social-care interventions.

Table 8: Dartington Social Research Unit estimates of costs and benefits of child protection and social care

	Co Cost-Benefit Summary									Benefit by Service Area					
Intervention	**Cost**	**Benefits to taxpayers**	**Benefits to participants**	**Benefits to others**	**Total benefits**	**Benefits minus costs**	**Benefit-cost ratio**	**Rate of return on investment %**	**Risk of loss %**	**Youth justice**	**Early years & education**	**Child protection & social care**	**Child & adolescent mental health**	**Public health**	**Other**
Child Protection & Social Care															
Family-Nurse Partnership	£6,944	£3,891	£8,520	£541	£12,952	£6,008	1.87	7	29	£220	-£932	£338	√	√	£13,326
Family Preservation	£2,469	-£228	-£113	-£25	-£366	-£2,835	0.15	n/e	100	-£16	-£16	-£151		√	-£184
Health Families America	£3,666	£768	£241	£17	£1,026	-£2,640	0.28	n/e	81	£11	£530	£122	√	√	£364
Homebuilders	£2,661	£10,406	£241	£51	£10,698	£8,037	4.02	n/e	0	£34	£40	£10,234		√	£391
Other home-visiting programmes for at-risk families	£4,666	£1,236	£1,864	£51	£3,151	-£1,515	0.68	n/e	69	£6	£27	£290		√	£2,892
Parent-Child Interaction Therapy	£1,273	£1,562	£730	£113	£2,405	£1,132	1.89	11	2	£74	£87	£1,169		√	£1,076
Parent as Teachers	£3,530	£1,263	£1,650	£43	£2,956	-£574	0.84	n/e	64	£29	£32	£443		√	£2,453
SafeCare	£265	£355	£169	£25	£549	£284	2.07	10	9	£16	£21	£264		√	£247
Triple P Universal (=Triple P System)	£118	£450	£102	£19	£571	£453	4.84	35	0	£12	£11	£386		√	£162

Source: Social Research Unit at Dartington; n/e indicates not estimated.

The table shows a range of measures relating to the costs and benefits of interventions:

- benefits minus costs
- benefit-cost ratio
- rate of return on investment
- risk of loss
- information on the service area where the benefit accrues.

The greatest net monetary benefit comes from the Homebuilders programme (£8,037), followed by the Nurse-Family Partnership (£6,008). The cost-benefit ratios indicate that the greater cost of NFP (£6,944) compared to Homebuilders (£2,661) means it has a lower cost-benefit ratio (1.87). As with the WISPP analysis, NFP has a rate of return of seven percent and a relatively low risk of loss, indicating confidence in the calculations of net benefit. In contrast, Parents as Teachers is rated as having a negative return (costs exceeding benefits by £574), with most benefits accruing outside of child protection and social care (in terms of educational outcomes, for example).

Pew-MacArthur Results First Initiative

The Pew-MacArthur Results First Initiative is a project of the Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation. This initiative works with American states to assess the costs and benefits of policy options, and to help them use that data to make decisions about policies and programmes. Having been validated by a national panel of experts, the Results First team brings the successful WSIPP cost-benefit model to other states and provides technical assistance to help them use the model to gather and analyse data, interpret results and present findings to policy and decision-makers.

Results First provides a range of services in addition to the model itself:

- Training and assistance: providing ongoing technical assistance to states as they develop their own CBA model based on the WSIPP model.
- Information-sharing: creating opportunities for states to share information and lessons learned.
- Standardised approach for valuing costs and benefits: using a well-established process for estimating costs and benefits of a wide range of programmes enables states to compare results.
- Quality assurance: Conducting comprehensive reviews of the CBA models to ensure the WSIPP model has been used and adapted appropriately.

States' use of cost-benefit analysis

Under the Results First Initiative, the Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation conducted a study to measure states' use of cost-benefit analysis in order to show how widely it was used and how important its results were deemed. The study included a systematic search and assessment of state cost-benefit studies released between January 2008 and December 2011. To derive the study's findings, researchers evaluated each state according to three criteria:

1. Production: the number of cost-benefit studies released per year during the study period.
2. Scope: whether studies assess multiple programme alternatives to compare policy choices.
3. Use: whether and the extent to which study findings influenced policy and budget decisions.

Key findings

The study found that overall, 10 states led the way in production, scope and use of cost-benefit analysis to support and influence policy decisions. These states were among the leaders in at least two of the three criteria. The top states each generally released more studies, systematically assessed the costs and benefits of multiple programme options and used the results to inform policy or budget decisions. Two states, New York and Washington, were leaders in all the criteria. In contrast, 29 states had mixed results, with each generally releasing fewer studies and making less

effort to use the results to inform decision-making, while 11 states trailed behind, releasing very few studies and making little or no effort to use results to influence decisions.

Referring specifically to the production criterion, all states and the District of Columbia conducted at least one cost-benefit study over the study period. There were 348 studies in total, with the majority concentrated in just 12 states. As to the scope criterion, 29 states and the District of Columbia used cost-benefit studies to assess multiple programme or policy options. However, only 18 percent of studies overall assessed at least two programme options. For the use criterion, 29 states reported that cost-benefit studies had directly influenced policy or budget decisions.

State officials reported some obstacles in conducting CBA and applying it to policy decisions. Most notable, comprehensive CBA requires "technical skill, solid data, time, money and staff" (The Pew Charitable Trusts, 2013). A lack of some or all of these may prevent state from conducting a CBA. Additionally, analysing long-term costs and benefits may conflict with the political process which often focuses more on short-term outcomes. They report that policy makers may often overlook proven programmes if they do not yield an immediate return on investment.

8.4 Summary

Researchers have concluded that investment in preventative programmes aimed at disadvantaged children is more cost-effective than later remediation (Doyle et al. 2009), and they suggest that investment during pregnancy may yield the highest return (Heckman 2006). Howard and Brooks-Gunn (2009) summarised the WSIPP analysis as showing that savings from interventions were primarily in the following areas:

- increased tax revenue from maternal employment
- lower use of public welfare assistance
- reduced spending for health and other services
- decreased criminal justice system involvement.

This chapter has provided a simple description, and some examples, of the use of cost-benefit analysis in the selection of child-welfare interventions. The cost-benefit approach requires that programme impact is rigorously assessed and that the full range of costs and benefits from a programme can be valued in monetary terms. The quality of the results of such analysis is highly dependent on these estimates and the assumptions underlying them. Our review of parenting programmes has shown that there are significant gaps in our knowledge of the impact of many programmes, especially their long-term outcomes, and this would significantly limit any CBA.

Results reviewed above indicate that the evidence-based programmes identified in the review of international evidence produced significant benefits over and above their costs. The Nurse-Family partnership, PCIT, Incredible Years and Triple P all show benefits exceeding costs, which is not surprising in the light of the good evidence for their impact. Cost-to-benefit ratios and measures of rates of return take into account the benefits in relation to costs, providing an additional metric to aid programme selection.This is a diverse range of programmes, however, often targeting different groups of parents and different outcomes. CBA can help with selection of programmes, but it does not determine which groups or outcomes should be targeted.

Kilburn and Karoly (2008) provide a useful discussion of how economic analysis can assist with the selection of early childhood programmes. They discuss cost-benefit analysis and return on investment measures, before considering a number of policy-decision rules that might be employed to choose between programmes. These are listed below.

Need-based – In this scenario, policy-makers implement policies that address outcomes on which a jurisdiction does particularly poorly. For example, if data suggest that child abuse and neglect are higher than in most other peer communities, a community might decide to focus on HV, the programme that specifically addresses this shortcoming.

Outcome-based – Policy-makers may simply prioritise particular outcomes on the basis of such considerations as the values of their constituents rather than using their comparative ranking on indicators.

Effectiveness-based – This decision-making rule endorses the one programme or alternative that provides the greatest impact on outcomes for a given level of funding.

Cost-saving-based – Also related to monetary payoffs, this decision-making rule requires that programmes or strategies produce enough savings to pay back their costs in the long run. In contrast to the effectiveness-based approach, in this case, a programme may have the biggest effect on outcomes of all the programmes, but, if it did not pay for itself in the long run, it would still not be selected. Instead, the community would choose the programme that produces the greatest total net benefits with the given budget.

Marginal-net-benefit-based – In this case, policy-makers would fund programmes or approaches up to the point at which the net benefits to the next person served are equal across programmes. This decision-making rule would generally result in funding multiple programs up to the levels at which the marginal net benefits were equal, in contrast to the effectiveness-based rule, whereby one 'most effective' program is selected (p 24)

Their analysis leads to the conclusion that it is best to aim for an optimal mixture of programmes. To quote Kilburn and Karoly (2008):

> *Economists would argue against choosing one 'best' program for early childhood, such as funding only universal preschool and not child-abuse prevention. Rather, economists would urge policy-makers to fund each program or service up to the point that the last person served by each is getting a similar net benefit. This is true because, if you were funding at other levels, you could raise the total net benefits to society by providing fewer services to families in the program that provided the lower marginal net benefits and more services to those in the program that provided the higher marginal net benefits.* (p 25)

In New Zealand we at present lack the information required to undertake robust cost-benefit analysis of parenting-support programmes. As discussed in the chapter on New Zealand programmes, we do not have sufficiently robust or comprehensive measures of programme impact to conduct CBA. The exception may be the Early Start programme, which, because of the RCT design, range of outcome measures and long-term follow-up, has the information required for CBA. This would, however, require monetising the programme benefits.

The above examples show that while findings from overseas may be informative, the difference in the WISPP and SRU results for the Homebuilders programme show that the results of CBA are likely to vary by country. Economic and cost-benefit analysis are important tools for assisting decision-making regarding the selection of interventions and intervention mixtures. These data need to be considered along with the actual research and evaluation evidence for these interventions.

9. SUMMARY AND CONCLUSION

There are significant costs to individuals, families, communities and society when children are unable to develop to their full potential. A number of factors can lead to less-than-optimal development, including characteristics of the child (such as disability), the family (family violence), parent-child interactions (for example, harsh and inconsistent discipline), the community (poverty and violence) and society (tolerance of violence and social welfare legislation, for instance).

Child maltreatment is an experience for a minority of children but it is a significant risk factor for a range of negative outcomes for children and adults. Addressing poor parenting practices and child maltreatment is seen as a priority both in New Zealand and overseas.

While various factors at a number of levels contribute to negative outcomes, the behaviour of parents and caregivers is of central importance. For example, child maltreatment is often the result of a parent's actions, or lack of action (as with hitting children, lack of medical care, lack of nutrition, or lack of love). This would suggest that one avenue for reducing the likelihood of child maltreatment is to work with parents, to help them be effective in helping their children develop to their full potential. A number of parenting support programmes that, at least in part, have this goal have been developed over the last 40 years. The preceding chapters have reviewed the evidence for the effectiveness of these programmes, both overseas and in New Zealand. This chapter brings together the findings from these previous chapters in order to assess the provision of parenting support to parents of vulnerable children in New Zealand.

It needs to be reiterated that the focus of this review was programme effectiveness. It is generally agreed that the best evidence of effectiveness comes through RCTs, followed by other designs with control or comparison groups. This does not mean every programme must have an RCT. If there is a body of evidence developed through RCTs that the programme has effects, it may be sufficient to monitor outcomes and compare them with other evaluations of the programme (is it having the impact we would expect from more rigorous trials, for instance?).[119] In such cases it is also necessary to ensure programmes are implemented with sufficient fidelity to the original, through monitoring programme fidelity and/or formative evaluations. Simple before-and-after designs with no or limited follow-up, however, do not provide sufficient evidence of programme effectiveness. Post-programme parent-satisfaction surveys provide useful evidence of the acceptability of a programme but again do not generally provide evidence that the programme has the desired outcomes. Post-programme follow-up to measure changes in desired outcomes (such as parenting attitudes, beliefs and behaviours, or children's behaviour) is clearly important if programme impact is to be assessed.

In considering overseas programmes the review focused on evidence from RCTs and quasi-experimental designs involving control groups. Since there are few RCTs of New Zealand programmes, it was necessary to consider a wider range of research and evaluation studies for these programmes. We also considered factors that are important to the successful real-world use of parenting support programmes: engagement and retention of parents in programmes, programme implementation and the importance of fitting programmes into particular socio-cultural contexts, including working with Māori and Pacific parents.

119 Often referred to as benchmarking (for an example of its use in New Zealand see Curtis, Ronan, Heiblum and Crellin 2009 and the recent Incredible Years evaluation by Sturrock and Gray 2013).

9.1 International programmes

Reviews have concluded that many programmes lack strong evidence of effectiveness in reducing child maltreatment (Chaffin & Friedrich 2004; Reynolds et al. 2009; MacMillan et al. 2009). Howard and Brooks-Gunn's review of home-visiting programmes (2009) led them to conclude that 'these findings suggest that home-visiting programs offer little evidence that they directly prevent child abuse and neglect' (p 134). In a similar vein Palusci and Haney's review (2010) led them to conclude that 'home visiting is not uniformly effective; parenting programs appear to improve parenting but not necessarily reduce child maltreatment; some family programs are successful in reducing physical abuse but not neglect' (p 9). While this review has focused on evidence of impact, most programme evaluations have a greater number of measures on which the programme has no impact (Avellar & Supplee 2013).

Such a conclusion needs to be tempered by the growing evidence that parenting-support programmes can improve the quality of parenting behaviours and contribute to improvements in children's development and health outcomes (MacLeod & Nelson 2000; Lundahl et al. 2006; Mikton & Butchart 2009; Peacock et al. 2013). Programmes have been shown to improve children's health, school readiness and achievement, and behaviour. These improvements in parenting should eventually lead to decreases in child maltreatment, even though this may be difficult to measure (MacLeod & Nelson 2000; Howard & Brooks-Gunn 2009) and will require long-term follow-up.

We have reviewed a range of programmes within a three-level prevention framework (universal, targeted and therapeutic). Although population-wide antenatal health visiting has a positive impact on children's health (including birth weight and immunisations) and parents' health outcomes, primary-prevention programmes have shown little evidence of reductions in maltreatment. The exceptions to date are those programmes targeting specific problems (such as head injuries in children) in primary care settings. Public media campaigns may increase knowledge, but whether or not this translates to changes in behaviour is unclear. Lundahl et al. (2006) suggest that changing long-held attitudes and beliefs is difficult and may require more time, compared to changing parenting behaviours.

Those programmes showing the best evidence of positive effects on parenting behaviours and child-development outcomes (including reduced maltreatment) are comprehensive home-visiting programmes. A range of such programmes has been developed following on from the success of the Nurse-Family Partnership programme developed by David Olds in the US. The NFP programme has recently shown promising results in the UK (Little et al. 2013), as has the Early Start home-visiting programme in New Zealand. These programmes may have greatest success in preventing physical abuse. According to MacMillan et al. (2008), less is known about how effective home-visiting approaches are in preventing sexual abuse, psychological abuse and children's exposure to family violence. Some parent-education and training programmes have also produced promising results. The stronger evidence base is for programmes targeted at assisting parents in managing their children's disruptive behaviour, although these tend to be designed for parents of older children (PCIT, Triple P and Incredible Years, for example).

There is rather less evidence of effectiveness for parent training and education programmes that work with parents of infants and younger children who are not showing signs of conduct disorder. While home-visiting programmes target the high-risk group of new parents, recent years have seen some of the evidence-based programmes for older children being adapted for this group. For example, Incredible Years has been adapted to work with the child-welfare cohort (Webster-Stratton & Reid 2010), and Parents as Teachers in the US has been further developed to target specific risk behaviours (Praat 2011). Triple P has also developed a version (Pathways Triple P) specifically for parents at risk of maltreating their children. Further research is required to establish the effectiveness of these adaptations with the new target groups.

It appears that parent-training programmes are more effective in changing parenting knowledge and attitudes than parenting skills or children's behaviour. Kaminski et al. (2008) concluded that mean effect sizes for parenting outcomes appeared larger than mean effect sizes for child outcomes, and that effect sizes for parenting behaviours and skills were smaller than the effect sizes for parenting knowledge, attitudes or self-efficacy.

Finally, there is a range of programmes developed for parents and caregivers (such as foster parents) of children who have been maltreated. These tend to focus on those caring for children who are in out-of-home care (see Multidimensional Treatment Fostercare) or involve a more therapeutic approach (ABC, for example). Some have been shown to reduce placement breakdown and improve children's behaviour.

9.2 Mixture of programmes

As can be seen from the list above, there are various parenting-support programmes aimed at different groups of parents. Some are universal and intended for the general public, others target those at risk and some seek to prevent the recurrence of maltreatment. Different programmes also target different outcomes. No one programme is going to serve the needs of all parents, and it is therefore necessary to provide a range of parenting support. Barth and Haskins (2009) make the point that what is needed are scalable options, depending on resources available. There is little research, however, on the optimal mixture of parenting-support programmes, and needs and resources will vary for different communities.

Kilburn and Karoly (2008) cite the conclusions of the review by the Center on the Developing Child at Harvard University, National Forum on Early Childhood Program Evaluation, and National Scientific Council on the Developing Child (2007): 'that a spectrum of services that address the varying needs of families is preferred over a single program approach or mode of service delivery' (p 26). Kilburn and Karoly outline the economic argument for such a conclusion (reviewed in Chapter 7), but also note that the information required to conduct the required analysis is not available for all programmes. Despite this they argue that 'a diversity of services will have a greater total net benefit to the community than choosing one strategy' (2008 p 27).

A public health approach has been advocated by Barth (2009) and Barlow and Calam (2011), among others. For Barlow and Calam the use of 'a coherent, evidence-based model throughout each level ensures that clear, consistent messages are given across the different modalities and levels of delivery' (p 251). Barth and Haskins (2009 p 4) suggest four levels of programmes:

1. A universal stage, based on a media campaign and delivery through NGOs, providing information on parenting skills.
2. Training in routine topics of parenthood (including toilet training, language development, discipline, homework, teen sexual behaviour, and nutrition); provided by NGOs and businesses.
3. More structured and intense interventions offered to parents who feel they are having problems with their children; offered by professionals, through seminars, individual sessions, multiple sessions.
4. For parents who have serious problems with their children and who themselves have dysfunctional behaviour, including family violence, addictions, mental health problems or long-term poverty. These resemble those of the third stage but would add specific elements to address parental dysfunction.

A universal element helps destigmatise and normalise participation in programmes (Barlow & Calam 2011). Barth cites the example of the Triple P multi-level system of interventions, ranging from Level 1 with its media campaign to the highly targeted Level 5 intervention for children with behavioural problems. The argument for community campaigns is that they may have relatively minor impact, but they may also be more cost-effective and have a wider reach for those missed by conventional services. Lack of evidence of impact, however, makes a judgement of their relative worth difficult, and such approaches have not featured in the systematic reviews and clearinghouses.

There is also a need to take the opportunity to target those most at risk, such as teen parents, prisoners, and drug-using mothers (Mersky, Berger, Reynolds & Gromoske 2009). Findings suggest that prevention programmes may need to target select populations and specific mechanisms associated with different types of maltreatment to maximise their effectiveness. Programmes need to vary in intensity, depending on the needs of parents. Barlow and Calam (2011) cite the principle that 'minimally sufficient' interventions should be available to all members of the community, in order to reduce the risk for the whole population. For example, not all of those at risk will require intensive home-visiting programmes, and many may be served through focused parent education and training programmes. Reynolds et al. (2010) conclude on the basis of their review that at least for some, parenting outcomes can be achieved through relatively brief and focused interventions.

One of the questions when working with families with multiple complex needs is how to address the interlinked constellation of challenges faced by these most vulnerable families – that is, how to improve parenting practices, while at the same time addressing family violence issues, drug and alcohol abuse and mental health concerns? Do these require separate specialist programmes, or is it possible to insert parenting components into an existing specialist intervention? This quandary is expressed by Barth (2009) in his review:

> *One key decision facing those who design such programs is whether (and the extent to which) a parenting program should directly address these related problems or whether efforts to improve parenting should focus primarily or solely on improving parenting skills, with the expectation that the negative effects of these other problems on parenting may recede if parenting programs are effective.* (p 96)

Barth argues for keeping a focus on one issue and sees a risk of parental distraction if multiple issues are addressed through one intervention. On the other hand, there are promising initiatives that include parenting components in the context of addressing these other parental issues (such as in family violence – see Jouriles et al. 2009). Certainly reducing stress (financial, employment and housing stress, for example) is likely to enable parents to focus more on programme participation.

An important related issue is the timing and scheduling (ordering) of interventions. There is evidence that intimate partner violence is associated with increases in maternal depressive symptoms, which in turn are associated with increases in harsh maternal parenting (Gustafsson & Cox 2012). This would suggest that parenting interventions for mothers experiencing intimate partner violence need to address both the violence and the depressive symptoms, in order to be effective in protecting children from the negative consequences of the violence. This example shows the need for further research on how to address the often multiple and interlinked challenges the most vulnerable families face, and how to time the often multiple intervention components required.

9.3 Programme components contributing to success

One suggested answer to the problem of limited resources and the need to more effectively target spending is to draw on the research and evaluation findings to identify evidence-based practices and programme components. As Barth and Haskins (2009) suggest, 'finding ways to combine the elements of effective programs to address specific community needs and build on what local service providers are already doing could lead to better services at a reasonable cost without requiring communities to adopt entirely new programs' (p 3).

There is a challenge in identifying these evidence-based practices and programme components. According to Garland et al. (2008) a common elements approach is highly speculative and exploratory. Similar elements are emerging from these reviews, however, and Table 9 summarises a range of features that seem to be common to those programmes with evidence of effectiveness.

Table 9: Common components of effective parenting programmes
Components
Staffing/infrastructure
Suitably qualified and trained professionals
Ongoing training
Professional supervision and support
Record-keeping/data-collection
Processes to maintain programme integrity/fidelity
Community outreach and good networks with other agencies
Limited caseloads, especially with home visiting
Design and delivery
Detailed programme logic (empirically-based theory/model of change)
Specified goals or outcomes
Structured curriculum and planned sessions
Programme manual (well-documented)
Cultural competence (diverse staff ethnicity matching to client group)
Considers and responds to different cultural concepts and practices
Voluntary participation, acceptable to participants
Specific target population and recruitment process
Strategies to engage and retain
Initial assessment or screening
Appropriate dose and duration
Individualised plan
Intensive/comprehensive programmes with home-visiting component
Discussion of material (not didactic)
Opportunity to practise skills
Modelling of skills
Onward referral where appropriate (e.g. health services)
Content
Child behaviour focus
Developmentally appropriate
Providing a predictable environment for the child
Managing children's behaviour
Positive parenting strategies
Non-punitive problem-solving
Parent-child interactions
Strategies to help parents and children regulate emotions
Children's health, development and safety
Parental and family wellbeing and life course (ongoing needs)
Outcomes
Ongoing monitoring and evaluation – high-quality improvement process

These components need to be considered in the light of the type of programme, and the group and outcomes targeted. The need for appropriately qualified staff is a common issue noted by reviews. The Center on the Developing Child at Harvard University (2007) stated this bluntly: 'programs that cost less because they employ less skilled staff are a waste of money if they do not have the expertise needed to produce measureable impacts' (p 22). This is particularly the case where programmes are dealing with parents with multiple complex needs, such as a mother with serious depression or substance abuse, or who is experiencing family violence. In home-visiting programmes skilled staff are important, as working with these high-risk families requires flexibility, an understanding of the programme's underlying theory of change, and a repertoire of skills and strategies to assist families. On the other hand, a different set of skills may be required if the programme is a group-based parent-education programme (group facilitation, for example).

The common elements approach does not substitute for the need to identify evidence-based programmes, or the need for the continued monitoring and evaluation of impact. There are still significant gaps in the research evidence that would allow a comprehensive examination of all relevant elements of programmes and the extent to which multiple elements work together to ensure effectiveness (Chaffin & Friedrich 2004). As Cuthbert et al. (2011) note, 'it is important to stress that it is not only the programme content, but also the skills and behaviours of practitioners in engaging and working with vulnerable families that have been found to make a big difference to outcomes' (p 40). Apart from the proxy of qualifications and training, these qualities have yet to be assessed in the research seeking to identify common components of programmes, as they are often implicit components.

9.4 Engagement and retention

As stressed in the last section, the skills and behaviours of practitioners in engaging and retaining parents in programmes are crucial to their success. Axford et al. (2012) consider that parent engagement should be seen as part of a programme rather than as something separate and outside of consideration of programme effectiveness. Parenting-support programmes must first identify those parents who would benefit from their programme, then recruit them into the programme and maintain their active participation for as long as is beneficial. Primary-level interventions may have difficulty engaging with parents of vulnerable children, particularly if they assume a high level of literacy. While programmes at the secondary level are more targeted, identifying those parents with vulnerable children can be challenging. At the secondary and tertiary level, parents may avoid programmes because of the stigma associated with participation.

Research has isolated a number of factors that seem to limit participation. These range from characteristics of the parents, and the programme's content, structure and delivery, to the system within which the programme is embedded. Various suggestions have been made to encourage parental participation, including being more active in promoting programmes, taking time to engage parents, and addressing practical barriers through the provision of childcare or transport assistance. The Incredible Years programme has been adapted to work with vulnerable groups, in part by explicitly including elements to maximise programme engagement (Webster-Stratton & Reid 2010).

To optimise effectiveness, programmes need links to the wider community and service networks. Having clear criteria and established referral pathways helps other professionals understand the potential benefit clients may obtain from a programme. Most of the secondary-intervention programmes try to engage with those at risk at the earliest opportunity – for example, the Nurse-Family Partnership works best with young first-time mothers with low socio-economic status. Programmes need to make the most of opportunities to engage with parents in a range of settings (hospital, primary care, early childhood education, Work and Income, prison, schools and community centres, for instance).

Recent research on the Family Partnership Model suggests that training staff in skills to engage with parents at the recruitment stage and including specific motivational elements in programmes can promote participation (Davies and Day 2010). There are still significant gaps in our knowledge in what can be done to maximise parental participation, however, and in particular to enhance the participation of specific groups, such as fathers.

9.5 Implementation

Successfully addressing the needs of parents of vulnerable children is not simply a matter of choosing the programme with the best evidence of effectiveness. A number of additional issues need to be considered if evidence-based programmes are to be used, whether in a different community context or in a different country. The Center on the Developing Child at Harvard University (2007) guidelines suggest considering whether there is sufficient detailed programme information (such as programme manuals) available to allow a programme to be implemented with fidelity in a different community or setting. Assessing the skills and qualifications of staff needed for a programme is also important, as is the availability of supporting services in an area (rural areas with limited services versus urban areas with a variety of services, for instance). A recent US review emphasised the need to increase the availability of mental health services for children and parents (especially for maternal depression) and the need for further professional development (Center on the Developing Child at Harvard University, 2007).

For programmes implemented across a number of sites there is evidence that differences in implementation can have a significant impact on the programme's effectiveness (Chaffin et al. 2004). Duggan et al.'s evaluation of Hawaii Healthy Start (1999) found significant differences in implementation and programme effects at different sites. Variability in implementation across sites and families may also have influenced findings in the Healthy Families programmes. The results of the Sure Start initiative in the UK are also instructive (Rutter 2006; Asmussen 2011). Areas were given directions to use 'evidence-based programmes', but it was up to the areas themselves to select and implement them. The results of the evaluation of Sure Start were very mixed ('inconclusive' according to Rutter 2006) and relatively discouraging, partly attributable to the very wide variation in what was delivered to the communities concerned. In fact, the evidence suggested that at-risk families were worse off than those in a comparison community. Rutter (2006) and others consider the wide variation in programme quality to be a major reason for these findings, along with the directive that areas should not use manualised programmes.

A number of frameworks have been developed to assist with programme implementation (Meyers et al. 2012). They provide lists of factors that should be considered in order to choose the right programme for the context. In summary, it is important to consider 'what works for whom and under what conditions' (Chorpita et al. 2005). Selection of a programme depends on:

1. the outcomes you want to achieve – eg health, parenting, or educational
2. the groups you want to work with – eg all parents, those at risk or those with substantiated abuse findings
3. the context in which you work – eg the community, its resources and existing services and service structure.

This will require determining the needs of parents in an area, the best way to address these needs (often a series of options), and whether the available options are feasible in the area (in terms of the availability of skilled staff, for example). For individual families, it is important to adequately assess needs, to determine not only the type of programme that might address these needs, but also the extent of them (programme dosage – how much – and possible duration – how long.

Implementation considerations, and the common components identified earlier, may also be used to guide the selection of providers of parenting programmes. Organisations should have trained and qualified staff, good staff-support and supervision processes, appropriate cultural diversity, systems to ensure programme fidelity, good links with related support services and systems for monitoring performance for quality assurance and improvement.

9.6 New Zealand programmes

The preceding findings can be drawn upon to assess the effectiveness of parenting support in New Zealand. The findings of the review of overseas programmes provide guidance on the range of programmes required to meet the needs of parents of vulnerable children, and have identified those with evidence of positive impact. This review has also identified common elements or components of the evidence-based programmes, but has also highlighted some of the common issues noted by reviews of these programmes. In this section we first consider the range of programmes in New Zealand and review the research and evaluation evidence of their effectiveness. We also consider the extent to which these programmes are based on evidence (Triple P and Incredible Years, for example) and the extent to which they include evidence-based components.

As Chapter 4 has shown, there is a wide range of parenting-support programmes in New Zealand. These programmes cover all levels of Barth and Haskins' typology (2009) discussed above, ranging from universal programmes (such as Well Child) and community-delivered education programmes (such as SKIP and Parenting Toolbox) through to programmes to address the specific parenting needs of parents with children displaying behaviour problems (Triple P and Incredible Years, for instance) and comprehensive wraparound home-visiting services (such as Family Start). Many are funded and delivered on a small scale in specific geographical areas, while others are Government-funded programmes available in targeted areas throughout New Zealand (Family Start and PAFT, for example).

The Well Child/Tamariki Ora programme provides coverage from six weeks to five years, and is in line with such programmes in other countries (such as the UK's Healthy Child programme). These programmes can have a significant positive effect on a broad range of outcomes (Pinquart & Teubert 2010), although the effectiveness of Well Child/Tamariki Ora has yet to be established. Given its near-universal reach, it also provides the opportunity to identify parents with high and complex needs, who can then be linked with the appropriate services and resources. The recently revised WCTO Practitioner Handbook provides clear guidance on identifying and referring parents of vulnerable children to other services, such as Family Start.

Our review has shown that there are few well-designed studies that examine the effectiveness or impact of New Zealand parenting programmes. With the exception of Early Start (Fergusson et al. 2009), randomised control trial designs have not been employed to assess programme impact.[120] While the before-and-after designs employed in some evaluations (see Incredible Years, Parenting Through Separation and Parents as First Teachers) provide some evidence that parents are gaining knowledge and changing their attitudes and behaviours, these studies would have been strengthened by use of control groups. The bulk of the other evaluations have been formative or process evaluations, or examined post-participation parent-satisfaction ratings. While useful for informing the development and operation of programmes, these evaluations do not provide strong evidence of effectiveness.

We consider the Early Start programme to have good evidence of effectiveness (Fergusson et al. 2013), although it has been more effective at changing parenting behaviours than some of the more enduring parental problems (such as family violence, maternal depression and poverty). The recent evaluation of the Incredible Years programme (Sturrock & Gray 2013) indicates that this programme is operating successfully in New Zealand, and on the basis of the RCT evidence from overseas, this programme is well supported. Triple P is also supported by overseas RCTs and is used in New Zealand. Both Incredible Years and Triple P were named as well supported

120 And an early PAFT evaluation (Campbell & Silva 1997).

programmes in the recent review of interventions to address conduct disorder (Advisory Group on Conduct Problems 2011). As part of its 'multi-level, multi-agency response to children's conduct and behaviour problems in four DHBs', the Ministry of Health is currently trialling and evaluating New Zealand versions of both of these programmes. The Ministry is also assessing the effectiveness of the Incredible Years Specialist Response initiative, which involves providing additional specialist mental health and additiction support to high-risk families participating in the Incredible Years programme.

Incredible Years and Triple P were originally designed to address parenting in the context of conduct disorders, and they tend to work with parents of older children who are starting to exhibit behavioural problems. Both programmes have been adapted to address wider child-welfare concerns, although more research is needed on their effectiveness in this context.

In New Zealand, the main programmes to support parenting by those with the greatest needs are the Family Start programme and the Parents as First Teachers (PAFT) programme. Family Start is an intensive, home-based support service for families with high needs, with the goal of ensuring that children have the best possible start in life. It was developed in 1998 and was based, in part, on the Hawaii Healthy Start model. The parenting component of Family Start is the Āhuru Mōwai/ Born to Learn curriculum, which was developed as part of the PAFT programme.

As we have seen, evaluations of the Hawaii Healthy Start and Healthy Families programmes have shown mixed evidence of them preventing either self-reported or officially reported child maltreatment (Chaffin 2004), although they do improve parenting practice and children's health. A number of issues with programme delivery have been identified, including the skills and training of home visitors to enable them to deal with issues such as family violence, substance abuse and parental depression. Parents often did not receive the full number of scheduled visits and staff did not refer to other agencies as often as they should. The researchers suggested that the programme needed 'retooling' to target the main and most proximal maltreatment risk areas. There have been subsequent changes to these programmes to address these weaknesses.

The review of the New Zealand Family Start programme (Cribb 2009) suggests that there has been uneven implementation and that the relatively non-specific programme specification under the initial model has resulted in a range of ineffective parenting programmes being used under the Family Start banner. While some may have been successful, others are not, a not-uncommon finding of research into these less-prescriptive programmes reviewed in previous chapters. We are aware that efforts are being made to improve the consistency of Family Start delivery across New Zealand. Further work is required to include more relevant outcome measures in the monitoring of programme performance and to move to ensuring that programmes include the key evidence-based components that might improve performance. We understand that a programme of work is under way by the Ministry of Social Development to build on its existing knowledge on the effectiveness of Family Start and its contribution to positive outcomes for vulnerable children. The programme of work will examine what aspects of Family Start are working well and which are not in terms of its capacity to make a difference to vulnerable children in the programme. It will also assess the impact of Family Start on outcomes for vulnerable children and involve further development of the current monitoring and reporting system.

The Parents as Teachers (PAT) programme that has served as the basis for PAFT in New Zealand has itself undergone a refocusing in recent years. In 2011 the PAT curriculum was revised to include a greater focus on child-maltreatment risk factors, and quality standards and performance indicators have been implemented (Praat 2011). While Parents as Teachers has been cited by some as being supported by positive research findings, the original programme was largely directed at cognitive development and school preparedness. The research cited in reviews of PAT largely relates to the older version of the programme, and it is hoped that more research will be undertaken on the new version. To date, however, the evidence that the PAT programme substantially reduces the main risk factors for child maltreatment is weak.

In New Zealand, PAFT is delivered to parents of at-risk children in the zero-to-three age range. The programme is of relatively low intensity, however (once a month, with parents often getting less than this). Our review of international evidence would suggest that this is too low for those

parents of the most vulnerable children (that is, those who are engaged with Family Start). We understand that the current PAT (US) design allows for varying programme intensity (weekly, biweekly and bimonthly), depending on parents' needs, as does the New Zealand PAFT; we note too that the Early Start programme uses a range of well-supported parenting interventions (such as Triple P Level 4 and Incredible Years), of greater intensity and focused more on parenting behaviours associated with the risk of maltreatment. Family Start programmes need to make use of more parenting programme options, of varying intensity and targeted at early intervention with vulnerable families. If the PAFT programme is to be continued in New Zealand it needs to be further updated in line with the changes in the US programme. We understand that the New Zealand programme is already being refocused for the more vulnerable population.

The other main evidence-based programme being delivered in New Zealand is the HIPPY programme. HIPPY has been running in New Zealand since 1992 and its aim is to help parents prepare their children for formal schooling. While there is good international evidence that the programme is successful in its aim, it is unclear how this programme would contribute to reductions in child maltreatment, or address the main risk factors for maltreatment. While success in school does have positive longer term effects, HIPPY's value in addressing child maltreatment is not proven.

While most of the main parenting-support programmes in New Zealand are based on overseas evidence-based models, it is important to consider the fit of these largely American programmes in New Zealand's policy, social and cultural context. As recent debates have shown, there are significant issues with access to health care and high-quality early childhood education in the US. This could mean that interventions for vulnerable children aimed at these outcomes in the US may have more impact than in the New Zealand context, with its more equitable access to these services. New Zealand's unique cultural context also needs to be considered in assessing the suitability of overseas programmes.

Our review has found relatively little research on programmes specifically designed for Māori and Pacific parents. Parenting and caregiving is a function of culture, and the responsibilities, roles and behaviours of various family, whānau or fono members are in part culturally determined. It has been argued that the engagement and retention of parents from these cultures is more likely when programmes take account of cultural factors. There are some programmes developed specifically for Māori, using Māori conceptual frameworks (Whānau Toko i te Ora and Te Atawhaingia te Pā Harakeke) and indications that evidence-based programmes that have been adapted for different cultural groups are effective.

Both the Early Start and Incredible Years programmes have been shown to be effective with Māori parents, albeit to a lesser extent in the recent evaluation of Incredible Years. These findings are in keeping with overseas research on the cultural adaptation of evidence-based programmes (such as Triple P). Given the over-representation of Māori in the vulnerable children population, however, this knowledge gap is significant and needs addressing. A more systematic approach to developing and trialling programmes for Māori and Pacific parents should be adopted, as improvements in the effectiveness of programmes with these whānau are likely to have major benefits.

9.7 Conclusion

The urgent need to address New Zealand's high rate of child maltreatment has led to the search for effective interventions to reduce it and its main risk factors. Our review of the overseas evidence has identified a number of parenting-support programmes that have evidence of various positive outcomes. For those parents of the most vulnerable children, home-visiting programmes show the greatest promise, as long as they are implemented with fidelity. Programmes for parents experiencing problems with their child's behaviour are also well-supported, and some of these have been adapted to serve parents of younger children and to target child-welfare outcomes. Interventions also exist for parents with children who have been maltreated, but often these programmes work with alternative caregivers, as children have been removed from their home.

Less is known about the effectiveness of universal interventions targeting general parenting in the population. While a universal health-focused parent-education and support programme has positive effects on children's health and development, it is unclear to what extent such programmes have an impact on child maltreatment. These relatively low-intensity programmes might better serve to identify parents in need of more intensive programmes.

As a recent review of the use of evidence to improve children's outcomes concluded, 'the key is to select strategies that have documented effectiveness, to assure that they are implemented well, and to be specific and clear about how their impact will be measured' (Center on the Developing Child at Harvard University 2007 p 5). No one programme is going to suit all parents' needs, nor is it possible to target all the potential outcomes with a single stand-alone programme. This requires programme funders and providers to determine the needs of the community and to match them with the appropriate evidence-based programmes. While there is evidence that a few interventions can be successful in reducing child-maltreatment outcomes, and that a larger group of programmes can successfully address some risk factors, the evidence to date has led some to conclude that 'which group of parents would benefit most from what kind of intervention with regard to which outcomes remains to be tested' (Pinquart & Teubert 2010 p 325).

Identification of evidence-based programmes is the first step in improving responses to vulnerable children. Unless there is a willingness to implement evidence-based programmes, and a systematic focus on implementing programmes with appropriate fidelity, evidence-based programmes are not likely to find their way into everyday practice. Chaffin et al. (2004) conclude 'many field practitioners appear to have never heard of, let alone used, better-supported intervention models'. There may also be resistance from practitioners to outside programmes, as with the initial resistance to PAFT (Farquhar 2003), even though parents appear to prefer evidence-based programmes (Axford et al. 2012).

While some overseas-developed evidence-based programmes have shown promise when used in New Zealand (such as Triple P and Incredible Years), it cannot be assumed that all programmes can be adapted to New Zealand's unique socio-cultural environment. In particular, we know very little about the effectiveness of programmes for Māori and Pacific parents. While there is evidence that Early Start and Incredible Years can be adapted to work with Māori, none of these programmes is totally effective. We need to explore new solutions for these groups, particularly when programmes may have problems recruiting and retaining those parents most in need. The spread of the population across New Zealand means that a full range of programmes is not feasible or affordable in areas with relatively small populations.

While investing in evidence-based programmes is important it is also recognised that such programmes are far from perfect, and that investment is also required to innovate and improve on existing programmes (Cuthbert et al. 2011). Two interesting initiatives in the US reflect this combined approach. The first is the funding of home-visiting programmes, where it has been legislated that 75 percent of spending on initiatives must be on evidence-based programmes, leaving 25 percent of funds free for investment in innovative programmes.

A second example is the US Office of Adolescent Health Teen Pregnancy Prevention grant programme.[121] There are three streams of funding: Teen Pregnancy Prevention Replication of Evidence-Based Program Models; Teen Pregnancy Prevention Research and Demonstration Programs; and Community-Wide Teenage Pregnancy Projects. The first is concerned with implementing evidence-based programmes, while the second 'supports research and demonstration programs to develop, replicate, refine, and test additional models and innovative strategies for preventing pregnancy'. Finally, the community-level funding goal 'is to demonstrate the effectiveness of innovative, multi-component, community-wide initiatives in reducing rates of teen pregnancy and births in communities with the highest rates'.

As the above review has shown, the evidence for parenting-support programmes for parents of vulnerable children is far from clear. The evidence base is relatively weak, with few studies having long-term follow-up of child-maltreatment outcomes. Reynolds et al. (2009) contrast the evidence base for child-maltreatment outcomes with the strong evidence base for early-childhood

121 http://www.hhs.gov/ash/oah/oah-initiatives/tpp/grantees/index.html

intervention on school outcomes. In such circumstances it is best to think of making evidence-informed decisions rather than evidence-based decisions, acknowledging that we are dealing with a degree of uncertainty. As Chaffin and Friedrich (2004) point out, 'where there are no fully supported interventions, one must pick from among competing models with varying levels of support' (p 1104). A number of limitations with the current evidence contribute to this uncertainty and are particularly acute in New Zealand. They include:

- the use of weak research and evaluation designs to measure programme impact, including lack of RCTs in New Zealand and often underpowered RCTs overseas
- lack of programme research and evaluation with maltreatment outcomes
- lack of long-term follow-up
- the wide range of programmes with a wide range of outcomes
- the challenge of comparing different programme outcomes – number, type and effect size
- the relative lack of programme replication, especially in different cultural contexts
- dispute over evidence quality and the need for independent evaluation
- relative lack of good impact data, making cost-benefit analysis problematic.

9.8 Looking ahead

New Zealand parenting-support programmes have been reviewed on a number of occasions over the past 10 years (Gray 2001; Kerslake Hendricks & Balakrishnan 2005; Lees & Penk 2009). Without rigorous evaluation evidence, however, it is difficult to make definitive judgements about the effectiveness of New Zealand programmes. There is a need to plan for the longer term, to develop better evidence about the effectiveness of current New Zealand programmes, to identify programmes (overseas and home-grown) that might work in the New Zealand context; to pilot selected programmes and evaluate their impact; to implement to scale those showing promise; and to continue to monitor within a constant programme-improvement framework. This approach is in line with that advocated by the recent review of responses to conduct problems (Advisory Group on Conduct Problems 2011).

Further research and evaluation is required to address the significant gaps in our knowledge of what works for Māori and Pacific parents. It may be worth considering a more systematic developmental approach in New Zealand. Given our large knowledge gaps around programmes for this growing proportion of our population, more attention should be directed to developing and evaluating innovative cultural programmes or cultural adaptations of existing programmes. These need to take into consideration the cultural principles and worldviews that guide the behaviour and practices of these communities. Given the very low participation by fathers in parenting programmes there is much to be learnt about how to engage fathers too.

The growth in the widespread use of the web and improvements in web technology have led to parenting programmes being adapted for delivery over the internet. A recent meta-analysis by Nieuwboer, Fukkink and Hermans (2013) found evidence that these web-based programmes can be effective in changing parents' knowledge-base, attitudes and behaviours, and can produce positive changes in children's behaviour. The potential benefits of web-based programmes include being able to reach a large number of individuals with a low amount of professional input, at relatively low cost, and increasing accessibility (though perhaps not for those most at risk). Technology can structure step-by-step learning, tailored to individual progress.

It is also important to promote a better understanding of the need for evidence-based programmes, an issue identified by Percora et al. (2012):

> *Strong, consistent agency leadership is essential, along with clearly communicating a compelling rationale for why this approach is so vital to meeting the needs of children and their families.* (p 10)

A more systematic dissemination of information on effective programmes and of evidence-based practices and programme components is also needed. This includes disseminating what can be learnt from successful New Zealand programmes. As this review has shown, research and evaluation findings have been valuable in identifying the weak areas of programmes, with resulting improvements in response to adverse findings. Studies across sites can also identify those sites that are doing well, and suggest adaptations that might improve outcomes. Continuing evaluation and monitoring can ensure programmes are being delivered as designed and are achieving the expected improvements in parenting and child development.

Studies do not have to be RCTs, and there are circumstances where their use may not be practical (for instance, limited timeframes, national implementation, or the cost of an RCT on a small scale, or a low-cost programme exceeding the benefits of the trial) or ethical. For example, it is not ethical to deny parents participation in evidence backed overseas programmes. In such circumstances alternative quasi-experimental designs (such as benchmarking and matching designs using administrative data)[122] also provide good evidence of effectiveness. Programmes with overseas evidence of effectiveness probably do not need New Zealand RCTs, but those without this level of evidence require rigorous evaluation if their effectiveness is to be established. Apart from evaluation and research, there is also a need to develop a monitoring framework that includes measures of the accuracy of targeting (where appropriate), engagement and retention, programme fidelity, and realistic measurement of outcomes. When parenting support programmes are reviewed again in the future, this information will enable more definitive conclusions to be reached than is possible at present.

122 As mentioned in the report, the Ministry of Social Development is currently investigating the use of administrative data to evaluate the impact of Family Start.

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APPENDIX 1: EVIDENCE-BASED PRACTICE RESOURCES ON CHILD AND FAMILY SERVICES

Promising Practices Network (PPN) on Children, Families and Communities

PPN is a group of individuals and organisations who are dedicated to providing high-quality evidence-based information about what works to improve the lives of children, families, and communities.

http://www.promisingpractices.net/

What Works Clearinghouse

An initiative of the US Department of Education's Institute of Education Sciences, the What Works Clearinghouse was created in 2002 to be a central and trusted source of scientific evidence for what works in education.

http://ies.ed.gov/ncee/wwc/

Home Visiting Evidence of Effectiveness (HomVEE)

The Department of Health and Human Services launched HomVEE to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home-visiting programme models that target families with pregnant women and children from birth to age five.

http://homvee.acf.hhs.gov/

Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Model Programs Guide

The OJJDP Model Programs Guide is designed to assist practitioners and communities in implementing evidence-based prevention and intervention programmes that can make a difference in the lives of children and communities.

http://www.ojjdp.gov/mpg/

California Evidence-Based Clearinghouse for Child Welfare (CEBC)

CEBC provides child-welfare professionals with easy access to vital information about selected child-welfare-related programmes.

http://www.cebc4cw.org/

Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (NREPP)

NREPP is a searchable online registry of more than 250 interventions supporting mental health promotion, substance-abuse prevention, and mental health and substance-abuse treatment.

http://www.nrepp.samhsa.gov/

Blueprints Healthy Youth Development

Blueprints for Healthy Youth Development helps match children's needs to cost-effective programmes that have been proven to help them reach their full potential.

http://www.blueprintsprograms.com/

ChildTrends Lifecourse Interventions to Nurture Kids Successfully (LINKS)

LINKS summarises evaluations of out-of-school-time programmes that attempt to enhance children's development.

http://www.childtrends.org/what-works/links-syntheses/

Coalition for Evidence-Based Policy (CEBP)

CEBP seeks to increase government effectiveness through the use of rigorous evidence about what works in social interventions.

http://coalition4evidence.org/

Washington State Institute for Public Policy

WISSP has reviewed research and published an inventory of evidence-based, research-based, and promising practices for a range of social interventions.

http://www.wsipp.wa.gov/default.asp

Department for Education UK – Parenting Programmes Commissioning Toolkit

A section of the DfE website is for parents and commissioners looking for parenting programmes and interventions. Programmes have all been independently evaluated using an evidence-based approach to show that they work.

http://www.education.gov.uk/commissioning-toolkit

Guide to Community Preventive Services

The Guide to Community Preventive Services is a free resource to help you choose programmes and policies to improve health and prevent disease in your community. Systematic reviews are used to answer these questions:

- Which programme and policy interventions have been proven effective?
- Are there effective interventions that are right for my community?
- What might effective interventions cost; what is the likely return on investment?

www.thecommunityguide.org Click on "Topics" and select "Violence"

Child Welfare Information Gateway

The Child Welfare Information Gateway connects child-welfare and related professionals to comprehensive information and resources to help protect children and strengthen families. They feature the latest on topics from prevention to placement permanency, including child abuse and neglect, foster care, and adoption.

https://www.childwelfare.gov/

World Health Organization – Violence Prevention: The Evidence

The purpose of this website is to provide a violence prevention resource for policy-makers, practitioners and others working to tackle and prevent violence.

The website includes three key databases providing access to abstracts of peer-reviewed articles on violence-prevention studies (Evidence-Based); ongoing violence-prevention research trials (Trials Register); and key publications and resources on violence prevention (Resources).

http://www.preventviolence.info/evidence_base_hr.aspx

Note – based on RAND (2010).

APPENDIX 2: INTERVENTION STRATEGIES WITH EVIDENCE OF EFFECTIVENESS BY TYPE AND SUBTYPE OF CHILD MALTREATMENT (PECORA ET AL. 2012)

Subtype of child maltreatment	Prevention or intervention strategies	Website link
Neglect: general and undifferentiated, including severe and chronic neglect	**Supported and well-supported:**	
	Chicago Child-Parent Centers***	http://www.waisman.wisc.edu/cls/cbaexecsum4.html
	Healthy Families America Home Visiting for Child Well-Being***	http://www.healthyfamiliesamerica.org/home/index.shtml
	Nurse-Family Partnership***	http://www.nursefamilypartnership.org/
	Project Connect parent drug treatment programmes**	http://www.cfsri.org/projectconnect.html
	SafeCare**	http://publichealth.gsu.edu/968.html
	Triple P Positive Parent Partnership***	http://www.triplep.net
	Promising:	
	Alternative/Differential Response practice strategies*	http://www.differentialresponseqic.org/
	Chicago Child-Parent Centers*	http://www.waisman.wisc.edu/cls/cbaexecsum4.html
	Cognitive Behavioural Treatment (CBT) for anxiety or depression*	http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001848/frame.html
	Colorado Adolescent Maternity Program (CAMP) with home visiting.*	http://www.thechildrenshospital.org/news/pr/2009-news/Childrens-CAMP.aspx
	Crisis nurseries*	http://www.archrespite.org/
	Dialectic behaviour therapy for parent substance abuse*	http://behavioraltech.org/index.cfm and http://behavioraltech.org/resources/crd_results.cfm
	Early Start – New Zealand*	http://earlystart.co.nz/
	Family economic support strategies including stronger TANF and employment programmes and other anti-poverty interventions.*	http://www.nccp.org/
	Good Beginnings*	http://www.goodbeginnings.org.au/
	Nurturing Parenting Program*	http://www.nurturingparenting.com
Child physical abuse: undifferentiated	**Supported and well-supported:**	
	Chicago Child-Parent Centers***	http://www.waisman.wisc.edu/cls/cbaexecsum4.html
	Healthy Families America***	http://www.healthyfamiliesamerica.org/home/index.shtml
	Incredible Years***	http://www.incredibleyears.com/
	Nurse-Family Partnership***	http://www.nursefamilypartnership.org/
	Parent Child Interaction Therapy (PCIT)***	http://pcit.phhp.ufl.edu/efficacy.htm or http://pcit./phhp.ufl.edu/
	Triple P Positive Parent Partnership***	http://www.triplep.net
	Promising:	
	Alternative/Differential response practice strategies*	http://www.differentialresponseqic.org/
	Chicago Child-Parent Centers*	http://www.waisman.wisc.edu/cls/cbaexecsum4.html

Subtype of child maltreatment	Prevention or intervention strategies	Website link
Child physical abuse: undifferentiated (contd)	**Promising:**	
	Crisis nurseries*	http://www.archrespite.org/
	Dialectic behaviour therapy for parent substance abuse*	http://behavioraltech.org/index.cfm and http:// behavioraltech.org/resources/crd_results.cfm
	Enhanced Pediatric Care for Families at Risk*	http://www.umm.edu/pediatrics/seek_project.htm
	Family economic support strategies including stronger TANF and employment programmes, and other anti-poverty interventions.*	http://www.nccp.org/
	Good Beginnings*	http://www.goodbeginnings.org.au/
	Healthy Start Program, Enhanced Model***	http://www.healthystartassoc.org/
	Nurturing Parenting Program*	http://www.nurturingparenting.com/
	Safe Environment for Every Kid (SEEK) Project*	http://www.umm.edu/pediatrics/seek_project.htm
Neglect: emotional maltreatment	Attachment and Biobehavioral Catch-up*	http://icp.psych.udel.edu http://www.cebc4cw.org/program/attachment-andbiobehavioral-catch-up/detailed
Neglect: poverty as a major factor	Family economic support strategies including stronger public assistance (TANF) and employment programmes, and other anti-poverty interventions.*	http://www.nccp.org/
Neglect: improper or lack of supervision	SafeCare**	http://publichealth.gsu.edu/968.html
Neglect: with maternal depression or other forms of mental health disorders	Behavioural Activation Treatment for Depression (BATD)*** (Note that BATD does not target any specific from of maltreatment but is effective for lowering depression.)	http://www.addiction.umd.edu
	Cognitive Behavioral Treatment (CBT) for anxiety or depression***	http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001848/frame.html
	Cognitive Therapy for Anxiety or Depression***	http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001848.pub4/abstract;jsessionid=5A5FD868A6AD72C90D830E9F178EDE13.d02t04
	Incredible Years***	http://www.incredibleyears.com/
	Intensive Short-Term Dynamic Psychotherapy (ISTDP)** (Note that ISTDP does not target any specific form of maltreatment but is effective for lowering depression.)	http://www.istdp.com
	Mindfulness-Based Cognitive Therapy (MBC)***	http://www.mbct.com/

Subtype of child maltreatment	Prevention or intervention strategies	Website link
Neglect: medical or lack of proper health care	**Supported and well-supported:**	
	Enhanced Pediatric Care for Families at Risk* SafeCare**	http://www.umm.edu/pediatrics/seek_project.htm http://publichealth.gsu.edu/968.html
	Promising:	
	Safe Environment for Every Kid (SEEK) Project	http://www.umm.edu/pediatrics/seek_project.htm
Neglect: substance abuse as a major risk factor	Dialectic behaviour therapy for substance abuse*	http://behavioraltech.org/index.cfm and http:// behavioraltech.org/resources/crd_results.cfm
	Family drug courts and benchmark hearings*	http://www.ndci.org/sites/default/files/nadcp/ PCP%20FINAL.PDF
	Project Connect parent drug treatment programmes*	http://www.cfsri.org/projectconnect.html
Physical abuse: abuse accompanied by domestic violence	Nurse-Family Partnership***	http://www.nursefamilypartnership.org/
Physical abuse: abuse due to parent-child conflict	No research-based interventions were found with direct effects but we believe that Functional Family Therapy should be tested for this outcome	
Physical abuse: abusive head injuries such as shaken baby syndrome	**Supported and well-supported:**	
	Healthy Start Program, Enhanced Model**	http://www.healthystartassoc.org/
	Promising:	
	Hospital-based education programs.*	http://dontshake.org/; http://www.wchob.org/shakenbaby/
Psychological abuse	Healthy Families America Home Visiting for Child Well-Being***	http://www.healthyfamiliesamerica.org/home/index.shtml
Sexual abuse	Circles of Accountability and Support to prevent re-victimization.*	http://www.csc-scc.gc.ca/text/prgrm/chap/circ/proj-guid/index-eng.shtml

Note: Interventions are grouped by child maltreatment type and subtype where there is some evidence that the intervention is effective for preventing particular forms of child abuse or neglect. The number of asterisks indicates the strength of the evidence base for the strategy according to the California Evidence-Based Clearinghouse for Child Welfare, defined earlier in the paper.

Evidence of effectiveness levels:
*Promising research evidence.
**Supported by research evidence.
***Well-supported by research evidence.

APPENDIX 3: OVERVIEW OF KAUPAPA MĀORI AND CULTURALLY ADAPTED PROGRAMMES

Programme	Features	Evaluations/authors	Objectives/aims
Whānau Toko i te Ora. WTITO (Māori Women's Welfare League)	Kaupapa Māori programme delivered through home visits to high-to-medium needs whānau in six regions throughout the country. WTITO is funded by MSD.	In 2001 an evaluation of the pilot was done in three regions. Recently evaluated again in 2012/13. Livingstone (2002), Pipi (2012)	Literacy, house care, cooking and hygiene, financial management, child development, resource production, Māori values and concepts in child development, Māori cultural topics
Atawhaingia te Pāharakeke	Developed as an early childhood programme based on kaupapa Māori. Designed by highly qualified Māori ECE experts. Training delivered free to iwi providers. Has two components: Hakuitanga, Hakorotanga (delivered to parents), He Taonga te Mokopuna (delivered to children). Is no longer funded. Training is still delivered by resource people on an as-needs basis.	Evaluated in 1999 by the Māori and Psychology Research Unit, Waikato University. Cargo & Cram evaluated this programme in 2003.	There are three main aims: › Trains providers to manage functions and systems for the safe and effective delivery of He Taonga te Mokopuna and/or Hakuitanga, Hakorotanga › Trains facilitators to safely and effectively deliver support to children affected by DV › Trains facilitators to deliver support to parents.
Tikanga Whakatipu Ririki	Kaupapa Māori programme based on traditional Māori child-rearing practices. Has an emphasis on eliminating child abuse and maltreatment.	Is in the process of being evaluated. Jenkins & Harte (2011) were the authors of the literature.	It has three goals: 1. The goals of parenting 2. The beliefs of parenting 3. The techniques of parenting.
Te Mana Kainga	An iwi/community approach to whānau rangatiratanga (family empowerment). Provided opportunities to inform key issues in parental and family participation in support programmes where there were issues of risk.	Not known if an evaluation has been done or whether the programme is still operating (Herbert & Te Kanawa 1998)	Provides an example of iwi/hapū-based approach to parenting.
Poutiria te Aroha	Poupoua, tiritiria refers to the action of implanting and firmly embedding 'aroha'. It speaks of unconditional love. 'Aroha' is seen as a central support.	Is a new programme which has been trialled on a whole-of-community basis. Action research and evaluations have been completed at each major phase throughout the trial of the programme. The programme is still being piloted and there are moves to formally evaluate it.	Poutiria te Aroha is based on the philosophy and practice of nonviolent parenting by the Echo Parenting and Education Centre (EPEC) in Los Angeles. It is a programme that has been culturally anchored by concepts and beliefs within te ao Māori.

Programme	Features	Evaluations/authors	Objectives/aims
Oranga Whānau	Based on Māori values and principles, Oranga whānau has been developed to help and support whānau, especially young mothers, in the care and nurturing of their babies and young children. Oranga Whānau promotes positive parenting, the safety and health of babies and children, and resilient whānau. Kuia or nannies work with young parents in their own homes to share knowledge, practices, values and experiences with them.	An internal evaluation of the programme is in the process of being completed.	The main aims are: › To promote the wellbeing and safety of children in Māori households › To increase access by Māori parents to antenatal and parental support › To promote the practices associated with whāngai (nurturing) in identified Māori communities.
Cultural adaptations			
Mātuatanga Whānau programme	This is a culturally adapted Māori-centred parenting programme. It was developed in the 1990s with assistance from Apumoana Marae, the Rotorua branch of the MWWL & kaumatua.	Herbert (2001) as part of her Phd thesis. Not known if evaluations have been completed thus far.	Her Phd research demonstrated that through the use of standard parenting training (SPT) strategies and Māori values culturally adapted parenting programmes can be made more effective and enjoyable for Māori parents.
Hoki ki te Rito	This parenting programme has been culturally adapted from the Mellow Parenting programme developed in Glasgow. Aim of the pilot was to evaluate the effectiveness of Hoki ki te Rito for Māori mothers in South Auckland.	Evaluation of the pilot has been completed and entailed an 'open trial design'. Mothers self-reported on competence, stress, and wellbeing. Coded videos of mother-child interactions.	**Tino Rangatiratanga** Described as the ability to live and behave in ways that are culturally appropriate and healthy. Taking responsibility as an adult and parent to develop a family environment which can operate at its optimum potential for whānau well-being. **Tāonga tuku iho** Refers to cultural aspirations and Māori knowledge such as te reo (language), mātauranga (knowledge), tikanga (protocols), ahuatanga (ways of being).

105 See Penehira & Doherty (2013) and Herewini & Altena (2009)

Programme	Features	Evaluations/authors	Objectives/aims
Hoki ki te Rito (contd)			**Kia piki ngā raruraru o te kainga** Mediation of socio-economic disadvantages and aspects as a result of colonisation. **Whānau** Extended family principle, perceived as being the collective with communal notions of responsibility.[105]
Incredible Years Parenting Programme	Adapted from an American parenting management training programme developed by Carolyn Webster-Stratton. It consists of 14–18 sessions for parents of children aged between three and eight years of age.	A number of evaluations have been done. It has been described more as a cultural enhancement rather than a cultural adaptation. There are a number of Whānau Ora providers who have been contracted to deliver IYPP. Some have been delivered on marae (Cargo 2008)	Aims are to improve parenting behaviour and interaction with children.
Āhuru Mōwai (PAFT)	The Māori name given to the Parents as First Teachers programme. PAFT has been adapted from an American programme to better reflect New Zealand, Māori and Pacific contexts.	It has been evaluated a number of times in 1991, 2010 & 2011.	**Ngā kōrero ā kui ma ā koro ma** – Māori oral tradition about child-rearing practices. **Te ira tangata** – Māori child development acknowledging Māori cultural values. **Ngā ahuatanga awhina mātua, hei kupenga hauora:** Support and avenues for parents and extended whānau. **Tino rangatiratanga** – automony based upon the rights of the child and Māori self-determination. **He oranga ngakau** – keeping safe and well.

APPENDIX 4: ADDITIONAL NEW ZEALAND PROGRAMMES

Secure Beginnings

Description and target population

Secure Beginnings is an individually tailored parenting program designed to support a parent in identifying the strengths and challenges in their relationships with their infants and preschool-aged children (Dayspring Trust 2013a).[124]

After undergoing a comprehensive assessment process, parents are supported by a specialist in their home. Using video review and reflective discussion, parents will be able to observe and reflect on their own experience of parenting (Dayspring Trust 2013b). The 14-to-20-week programme offers parents an easy formula which they can use to recognise and respond to their child's emotional needs. The aim is for parents to develop an understanding of their relationship with their child rather than learning behavioural management strategies and techniques (ibid). The theory proposes that a better understanding of their child's behaviour will allow a parent to assess the child's needs and be able to respond appropriately to challenging behaviour.

Secure Beginnings is based on the Circle of Security© programme.[125] The programme offers parents a user-friendly diagram to help recognise and respond to their child's emotional experience (ibid). Secure Beginnings is suitable for any parent with infants and preschool-aged children who may be interested in understanding and improving their relationship with their children or may be struggling with managing challenging behaviours.

- Participants – should ideally be the child's primary carer and commit to participating in a 20-week programme.
- Assessments – involve parent interviews and structured playroom sessions and take place at the Child Health Unit at Waitakere Hospital.
- Weekly sessions – can take place in the home or in a clinic room at Dayspring Trust at Waitakere Hospital.
- Individualised programme – all sessions are videoed and edited; this forms the basis of each participant's individualised programme.

(Dayspring Trust 2013b).

Delivery and service providers

Dayspring Trust is a Christian-based Charitable Trust that has been supporting families since 1980, especially women, children and those living with mental illness. Secure Beginnings is a joint service between Dayspring Trust and the Waitemata DHB Marinoto Child and Family Mental Health Service. The Secure Beginnings clinicians receive supervision and support from an accredited supervisor in order to maintain fidelity to the Circle of Security© model.

The Dayspring Trust is also an accredited provider of the Triple P and Toolbox parenting programmes (Dayspring Trust 2013d) and a registered agency for the Circle of Security Parenting© DVD (Dayspring Trust 2013b).

Funding

The Secure Beginnings programme is funded under a contract with the Waitemata District Health Board (Dayspring Trust 2013c). This service is free to participants.

124 Although it is not specifically stated that this programme targets any particular group of parents or children, it is delivered jointly by the Waitemata DHB Marinoto Child and Family Mental Health Service and the Dayspring Trust. It is also referred to in a Ministry of Health (2012) policy document on services for perinatal and infant mental health.

125 Circle of Security Parenting Training© is an eight-chapter DVD-based parent-education programme. Training in the delivery of Circle of Security and Circle of Security Parenting has been in New Zealand since 2008 (Attune Consulting 2013). The programme presents video examples of secure and problematic parent-child interaction, healthy options in caregiving, and animated graphics designed to clarify principles central to the attachment-focused programme. The DVD can be used in group settings, home visiting, or individual counselling (Dayspring Trust 2013b).

New Zealand evaluation findings

The Secure Beginnings programme has not been evaluated, although the availability of its parent programme Circle of Security in New Zealand was referred to in a Ministry of Health (2012) policy document concerning the development of perinatal and infant mental health services. The need for evaluation was noted by the Ministry (Ministry of Health 2012).

The official Circle of Security website noted, in October 2012, that the New Zealand sponsor of the programme (Circle of Security 2013), Michelle Ball of Attune Consulting, reported that a research project (utilising a semi-randomised control trial) was currently under way in Wellington. The aim of this project was to assess the effectiveness of the Circle of Security Parenting programme within a sample population of parents with children aged 12 to 48 months. It was reported that results should be published early in 2013 (ibid).

Supporting Parents Alongside Children's Education (SPACE)

Description and target population

The SPACE programme was originally developed within the Hutt Playcentre Association before being launched to Playcentre Associations and other community organisations nationwide (SPACE 2013a). SPACE is governed by the SPACE New Zealand Trust, a not-for-profit organisation which is registered with the Charities Commission. The SPACE programme focuses on the needs of first-time parents and their babies, and has been designed to support parents through the first year of their child's developmental journey. Participants attend weekly sessions of 2.5 hours over a period of 30 to 40 weeks (SPACE 2013b).

Parents and babies join the SPACE programme when the child is around zero to three months of age. Older babies may sometimes join existing sessions if spaces are available. SPACE sessions are held at Playcentres, or other suitable community venues. The environment is set up to encourage interactions between the parents, babies and facilitators (SPACE 2013b). Sessions provide support and information for parents and opportunities for interaction between parent and child, centred on play. One unit of the SPACE programme, for example, provides an introduction to early childhood areas of play and an orientation to early childhood care and education services. Parents are provided with handouts on the various group-discussion topics and areas of play.

Delivery and service providers

The SPACE programme is offered by 32 organisations in many regions throughout the country. Providers include Playcentre associations, faith-based organisations and community organisations (SPACE 2013c). Some SPACE providers run multiple programmes, whereas others may only run one or two programmes at a time. The sessions are run by facilitators who have knowledge, experience, and training in early childhood care and education (SPACE 2013d).

Funding

SPACE NZ Trust receives funding from the Ministry of Social Development (SKIP) and philanthropic trusts such as the Tindall Foundation (SPACE 2013c). Where the individual SPACE programme provider meets the Ministry of Education's ECE licensing requirements, their under-twos funding can be accessed.

New Zealand evaluation findings

SPACE has developed an evaluation framework in collaboration with Martin Jenkins Consultancy, but the programme has not been evaluated at this stage (SPACE 2013c).

Mellow Parenting

Description and target population

Mellow Parenting was developed in Glasgow by Dr Christine Puckering and her colleagues in the mid-1990s. The programme is designed for parents of children under five with a high or critical level of need (Research in Practice 2009). It is particularly designed for parents with mental health problems, including depression and postnatal depression; parents with alcohol misuse problems; parents on parenting orders; parents with anxiety or stress; and parents with parent-child maltreatment problems or with children on the child protection register (ibid). The programme has spread internationally including to New Zealand, where it is delivered by two Auckland-based providers (the Anglican Trust for Women and Children (ATWC) 2013).

Assessment criteria state that New Zealand programme participants must:

- Live in the Counties Manukau District Health Board area when first referred, either by an agency or by the family themselves
- Be the main caregiver of at least one child aged under five at the time of referral
- Be aged over 16 years on the day of consent
- Want help with parenting, be willing to participate in the group and not be referred as a result of court order.

(ATWC 2013)

Mellow Parenting is based on Attachment Theory, and the assumption that individuals' experiences of being parented are directly linked to the way they, in turn, parent their own children (Stasiak 2010). Programme modules address the needs of mothers and children at different stages of development from antenatal to preschool (Mellow Parenting 2013).

The programme includes:

- free transport to and from the weekly group sessions, if clients are unable to provide their own
- shared lunch times for children, parents and staff
- structured parenting workshops
- individual analysis of video-taped family mealtimes
- activities, outings and 'homework' to develop and reinforce new parenting skills.

(ATWC 2013)

Delivery and service providers

Mellow Parenting is an intensive programme run by facilitators based at ATWC's Otahuhu site over a period of 14 weeks. Participants attend for one day each week. During parent-only sessions, children are cared for by childcare staff (ATWC 2013). Video-taped recordings of mother-child interaction are used as an assessment tool and to help parents reflect on their behaviour and their children's responses (Stasiak 2010).Recently the programme has been extended to other Auckland sites (Pukekohe and Papatoetoe). In addition, Ohomairangi Trust, a kaupapa Māori early-intervention service in Auckland, has culturally adapted and piloted Mellow Parenting (Penehira and Doherty 2013).

Funding

Mellow Parenting is funded by Counties Manukau District Health Board. Following an assessment, families living in the Counties Manukau area can attend Mellow Parenting free of charge (ATWC 2013).

New Zealand evaluation findings

Two evaluations (pilot study and main study) of the Mellow Parenting/Hoki ki te Rito (kaupapa version) have been undertaken by the Department of Psychological Medicine at the University of Auckland (Stasiak 2010). The results have not been published but they present some promising findings.

A pilot study was conducted in 2008, and it included qualitative feedback from focus groups and interviews with parents. The sample was comprised of two groups of mothers (n=16) who enrolled in the Mellow Parenting programme; the retention rate was 87.5 percent (n=14) (Stasiak 2010). These women were seeking support for significant parenting problems with preschool children. Data were collected on the mother's health, parenting stress, and the child's development and behaviour, at three points in time (ibid).[126] Results indicated statistically significant reductions in levels of frequency and intensity of parenting stress and improved mental health status. Both of these outcomes persisted into follow-up. There were insufficient data on children to allow analysis (ibid).

The aim of the main study was to replicate the pilot study results. The sample included both Mellow Parenting and Hoki ki te Rito and comprised seven groups of mothers (n=55); the retention rate was 72.7 percent (n=40) (Stasiak 2010). Data were collected at four points in time[127] and a stepped-wedge design was utilised.[128] Results replicated those of the pilot study: significant improvements in maternal mental health and reductions in frequency and intensity of parenting stress from pre-intervention to post-intervention (ibid). All of these improvements were maintained at follow-up.[129] Findings for children were also positive. There was a significant drop in negative developmental findings for children as measured by the Ages and Stages Questionnaire (ASQ), and also a downward trend (although not statistically significant) in children's negative behaviour.

The results of these two studies are encouraging; the programme has high retention rates and there is evidence of positive changes for both mothers and children and a high degree of satisfaction from both participants and facilitators (Stasiak 2010). Recommendations for further research were made: a larger, representative sample size; a longer follow-up period; a randomised control trial; and possibly a direct comparison with another parenting programme were all suggested.

Dayspring Trust – Maternal Mental Health Services

Description and target population

This is a community mental health support-work service based in New Lynn, Auckland, which provides professional assistance for women between the ages of 18 and 65. The service focuses on maternal mental health and provides services to women who have had a recognised psychiatric or drug-or-alcohol-related disability for a period of six months or more (Dayspring Trust 2013d). The service and programmes are also designed to meet the needs of mothers with babies or young children. Support is provided for younger women with babies or young children who have experienced severe postnatal depression or are living with an existing mental health issue (ibid). These women are supported in their own homes to enable them to cope with the demands of parenting and childcare.

A range of services is provided, including:

- advocacy (Work and Income, for example), advice (budgeting) and information (pre-employment training, for instance)
- parenting courses and mothers' support groups
- recovery programmes (psycho-drama) and counselling

126 These were baseline, post-intervention and two-month follow-up.
127 This was when participants were waitlisted, pre-intervention, post-intervention and at three-month follow-up.
128 Data collected while participants were waiting for the group intervention were compared with those collected after the intervention and at follow-up.
129 There had been no changes on these measures while participants were waitlisted.

- life-skill courses
- personal plans.

Creche facilities are provided for mothers who attend programmes (Dayspring Trust 2013d).

Services are available to Waitemata DHB residents and people receiving clinical services from the Waitemata DHB Adult and Maternal Mental Services or Primary Care (Dayspring Trust 2013d).

Delivery and service providers

Dayspring Trust provides these services. This is a faith-based organisation, specialising in the support of families, particularly women, children and those living with mental illness.[130]

Funding

The Trust is funded through contracts with Government (Waitemata DHB, FACS, MSD) and other sources of contestable funding (Lotteries, ASB, Auckland City) (Dayspring Trust 2013c). Services are free to participants.

New Zealand evaluation findings

We have been unable to locate any research or evaluation of this programme.

Early childhood education (ECE) centre-based Parent Support and Development (PSD)

Description and target population

Early childhood education (ECE) centre-based Parent and Support Development Service (PDS) was designed to focus specifically on improving outcomes for vulnerable children from birth to three years of age (Ministry of Education 2006). The service differed from other early-intervention initiatives in that it was a targeted intervention, delivered by way of a universal service (ECE centres) (Martin Jenkins 2010).

Specific objectives of ECE centre-based PSD were:

- improving effective parenting by vulnerable parents, building on their skills and knowledge
- increasing participation and engagement in ECE by vulnerable children and their families
- improving consistency between what children learn at home and in the ECE environment
- supporting vulnerable parents in building social support systems and informal networks.

(Martin Jenkins 2010 p 13)

The shape and content of the service was 'site-specific' and developed by individual ECE centres in consultation with their local community. The range of potential activities included:

- educational activities – to develop parenting skills and provide parenting information
- social support activities – to provide or facilitate social support networks for parents
- outreach activities – including referrals to other services, home visits to families, supporting families in becoming involved in ECE, and promotion of the service at a community level.

Delivery and service providers

The ECE centre-based PSD programme was trialled over a three-year period from 2006 to 2009 by the Ministry of Education and delivered by staff at ECE centres. A total of 18 pilot sites were selected, in part on the basis of the high concentration of vulnerable families living in the surrounding area (ibid). The sites offered a wide range of activities including educational, social support and outreach activities.

130 See the section on the Secure Beginnings Programme for more information on the Dayspring Trust.

Funding

This initiative was part of a package of services funded under the government Early Intervention Programme/Kia Puāwai strategy and was led by the Ministry of Education in collaboration with the Ministry of Social Development (ibid). The pilot ECE sites were funded to provide PSD for a three-year period beginning in 2006. Services were free to participants.

New Zealand evaluation findings

A qualitative process and outcomes evaluation of the programme was undertaken by Martin Jenkins and Associates over the life of the pilot. Data-collection involved several phases and methods, including telephone interviews with site managers (n=18), analysis of monitoring data for the period 2007/8 and case-study research at eight pilot sites (Martin Jenkins 2010).

The evaluation revealed significant variability in programme implementation across pilot sites and some apparent departures from the original intent as outlined in sites' proposals (ibid). This was in part due to the fact that, in some sites, the person responsible for writing the proposal was different from the person who managed the implementation. This suggests there is a strong need for consistent management guidance at a service level, to ensure better alignment between programme intent and programme reality.

The variability in implementation revolved around three key focus areas, and attempts were made by the Ministry to help sites address these over the three-year period. Areas of variability were:

- **Definition of the target group** – some sites defined the target group as *all* parents, with an enhanced focus on vulnerable parents, whereas other sites defined the target group as parents of children between zero and five years of age. This influenced the implementation of PSD at pilot sites.
- **Emerging operating models** – some sites viewed the programme as an opportunity to offer value-added services to the parents of children enrolled in ECE (described as 'closed' sites), whereas others viewed the programme as a service available to all parents in their community (described as 'open' sites).
- **Type of PSD activities offered by pilot sites** – some took a structured, *intentional* approach to delivering PSD, while others took a more *developmental* approach (that is, sites focused primarily on creating increased opportunities for networking and support with the anticipation that this would result in parents acquiring parenting knowledge and skills).

The data showed that a wide cross-section of parents (n=2246) participated in the programme over the two-year monitoring period:

- the majority were female (88 percent)
- over half identified as European, and over one-third as Māori
- over a third were aged 25 years or younger[131]
- more than one-third had no qualifications[132]
- almost 60 percent were not in paid employment
- two-thirds had only one child aged under five years.

Although the programme was intended to focus on vulnerable parents, the overall proportion of participating parents identified as vulnerable by PSD workers was relatively low (17 percent). This is probably because all pilot sites provided services to all parents regardless of their vulnerability, as many sites were of the view that seeking out vulnerable parents would stigmatise them (Martin Jenkins 2010).

131 This figure includes 13 percent who were under 20 years of age.
132 Almost one-third held a tertiary qualification.

The activities available to parents varied by site; levels of participation were used as a proxy indicator of levels of engagement in PSD. There was some variation between sites, but all showed the same general pattern over the two-year period:

- almost half of all parents (n=2246) came for a small number of sessions (one to five)
- the proportion of parents attending further sessions then fell steadily from about one-sixth attending six to 10 activities to less than five percent attending 26 to 30 activities
- fifteen per ent of parents attended 30 or more activities – this was the highly engaged group.

Almost 40 percent of parents participated in 11 to 15 activities, which equated to approximately three months' engagement with the service (ibid).

From an evaluation perspective, the diversity of sites' approaches made it difficult to compare across pilot sites using a common standard or criterion. However, the findings indicated that the programme was beneficial for all concerned: parents, children, pilot sites and communities. Yet significant challenges in programme implementation were also noted, particularly in relation to targeting vulnerable parents within a universal service.

Interviews with parents indicated that positive outcomes were achieved for them and their children. Parents learnt about a wide range of things from specific topics relating to parenting (such as dealing with challenging behaviours, toilet training, seatbelt safety, sleeping) to general life skills (such as financial literacy and dealing with domestic violence). In particular, parents reported an improvement in the quality of their family life, increased confidence in their parenting abilities, reduced social isolation, an enhanced sense of belonging to the community and increased access to other services. Children benefited from the programme through improved parenting and, in some instances, through increased access to ECE, although this was limited by full rolls in many pilot sites.[133]

Pilot sites reported that the programme had encouraged them to develop new networks, furthered their reach into the community and expanded their focus. The key challenges for pilot sites were in attracting and engaging vulnerable parents in PSD. Although sites were located in areas where high numbers of vulnerable parents lived, this was not sufficient for vulnerable parents to attend the programme. Sites needed to make concerted efforts to engage vulnerable parents in the programme; they struggled with this and often felt they did not have the tools and strategies to reach vulnerable parents. Other challenges identified by the evaluation included difficulties in finding and securing suitably skilled PSD workers,[134] limiting the number of additional children who could participate in ECE; and a lack of clarity as to how sites could strengthen the connection between home and the ECE environment.

One of the expectations of the programme was that the pilot sites would evolve and grow into community hubs. This would allow other agencies and services to use the ECE centre, thereby increasing the community's access to a range of services. Pilot sites that most successfully achieved this tended to be sites that focused strongly on parents' needs and offered a separate designated parent space to promote parental engagement and contact.

Communities also benefited as the programme facilitated greater interagency collaboration, including joint activities and sharing infrastructure or costs for services (Martin Jenkins 2010). Perhaps the most significant benefit was the growing sense of community and belonging fostered among participants.

133 This gave them access to high-quality learning opportunities and the chance to form relationships with a wider group of peers.
134 ECE teachers are trained to work with children, not vulnerable parents.

Parenting Toolbox

The Parenting Place (formerly Parents Inc)

Description and target population

Toolbox is a six-week parenting course of two-hour facilitated sessions. The aim is for parents to gain a 'toolbox' of ideas to handle the inevitably challenging role of parenting (The Parenting Place 2013). Group sessions are informal and often held in someone's home. Participants are provided with a comprehensive manual, video clips of 'experts' are viewed and parents take part in exercises that are designed to encourage interaction (Woodley 2013). Parents are provided with practical strategies, support and encouragement. The topics covered in the course include:

- parenting or caregiving with love, warmth and care
- open communication
- setting boundaries and limits
- enjoying your children and creating a memorable childhood
- taking care of yourself as a parent
- having the parenting support that you need.

(Woodley 2013 p 4)

Toolbox can also be delivered on a one-to-one basis where families are really struggling with parenting. There are Toolbox courses designed to meet the needs of parents and caregivers with children of varying ages. These are:

- Early years – for parents with children in the zero-to-six-year age group
- Middle years – for parents with children in the six-to-12-year age group
- Tweens and teens – for parents with children in the 12-years-plus age group.

In response to a clear need, a Toolbox course for grandparents was launched in 2012. This is specifically designed for grandparents and whānau caregivers who have generally had a pre-existing relationship with a child before assuming their care. The course consists of nine hours of practical parenting advice; resources provided include three DVDs and a manual which they can work through individually at home or in a group (Woodley 2013).

The development of a Toolbox parenting course that specifically meets the needs and is delivered in a way that is appropriate for Māori is currently under way (Parenting Place 2013).

Delivery and service providers

The Parenting Place is an Auckland-based not-for-profit incorporated society founded in 1993 by Ian and Mary Grant. The organisation aims to provide support and solutions for all parents and develops and delivers a range of practical workshops, including Toolbox, with this in mind.

Toolbox courses are available throughout New Zealand. There are 18 regional co-ordinators and two support co-ordinators supporting 650 currently approved volunteer facilitators (Parenting Place 2013). All facilitators are trained by Parenting Place staff, and are required to undergo a police check and be able to provide two referees to attest to their suitability to deliver Toolbox. Facilitators are provided with a course guide that includes the content of the participants' manual supplemented by guiding notes for the facilitator.

Toolbox providers include a wide variety of community and social agencies, such as Barnardos, Plunket, Family Start, school teen parenting units, Family Works, and the Waipareira Trust (Parenting Place 2013). Toolbox courses are also offered by some community probation services in Auckland and at the one women's and two men's prisons in the Auckland region.

In 2012 75 percent (n=4410) of those enrolled in Toolbox courses attended the five out of six sessions required to complete the course.

Funding

Primary funding sources for Toolbox include Government, donations, fundraising and some corporate support (Families Commission 2013). The Parenting Place has a current contract with the Ministry of Social Development relating specifically to the caregiver community (adults who are not the birth parent of the children they are raising).[135] The cost of a Toolbox course is $250 per participant; this includes the manual. Subsidies are available to those who cannot afford this.[136]

New Zealand evaluation evidence

The effectiveness of Toolbox is currently being evaluated by Point Research to fulfil the requirements of the Ministry of Social Development contract (Woodley 2013). The evaluation consists of interviews with a variety of care givers and two surveys – pre-course and post-course.[137] All Toolbox participants from May 2012 to mid-February 2013 were invited to take part in the evaluation.

The pre – and post-course questionnaires were completed by 1,653 parents and caregivers.[138] Results from the analysis of responses were promising. Most parents and caregivers reported that the topics covered had had an influence on their caregiving. They were coping better (85 percent), had more confidence as a parent or caregiver (89 percent), changed their parenting behaviour (84percent) and been reassured that they were doing the right things as a parent (84 percent). Almost all participants said that they had gained new parenting skills and strategies (98 percent) and were now enjoying parenting (90 percent). Overall participants were satisfied with course facilitation and the manuals.

The first interim report from the evaluation (Woodley 2013) shows some promising results. A final report is due mid-August 2013 and will include a full review and data from interviews with 15 caregivers.

Young Parent Payment parenting programmes

Description and target population

The Young Parent Payment, which has been available since 1 July 2013, is a weekly Work and Income (WINZ) benefit which helps young parents aged 16 to 18 years (WINZ 2013a).

Recipients of a WINZ Young Parent Payment are required to engage with a community-based Youth Service provider (WINZ in some areas). Other requirements include completion of a parenting course delivered by an approved provider; enrolment of their child with a Primary Health Organisation(PHO); registration of their 'under-fives' with a Well-Child provider such as Plunket; and completion of the schedule of required health checks under this service (Youth Service 2013a).

Approved YPP parenting programmes should:

- consist of five to six modules comprised of 10 to 12 hours of learning
- be able to be completed within a three-month period
- provide the parent with a certificate on completion
- include a client evaluation on completion of the programme
- have no more than 15 participants in each group (Youth Service 2013b).

Modules should include information on:

- reading babies' cues

135 The contract is to 'develop and enhance the Toolbox programme specifically for kin caregivers, vulnerable families, whānau Pasifika and grandparents' (The Parenting Place 2013).

136 Owing to a significant amount of fundraising the course is generally offered at the subsidised price of $67.50 per person or $90 per couple. There has been a noticeable increase, however, in the number of requests for additional subsidies due to financial hardship (ibid).

137 The post-course survey included a retrospective component where participants were asked to reflect on how well they were doing as a parent at the start of the course (Woodley 2013).

138 The pre-course questionnaire was completed by 1968 parents and caregivers and the post-course questionnaire was completed by 1653 parents and caregivers (ibid). It is not clear whether a proportion of those who completed pre-course questionnaires did not complete the programme or whether they just did not complete the post-course questionnaire.

- child development – what to expect by age and stage, sensory learning and age-appropriate activities
- brain development (and the importance of the first three years)
- conscious parenting – considering what sort of parents they want to be
- managing behaviour (such as crying and tantrums)
- keeping children safe (preventing abuse and neglect, providing a safe environment)
- managing stress (developing strategies to cope with the demands of parenthood)
- the importance of play for infants (ibid).

Delivery and service providers

Parenting programmes are delivered by 15 approved providers throughout the country, including Barnardos, Anglican Family Care, Childhood Matters NZ, Birthright, Relationships Aotearoa, Playcentre, the Parenting Centre, Te Whare Ruruhau o Meri Trust and Plunket (Work and Income 2013b).

The programmes provided include commonly used programmes such as PEPE,[139] SKIP,[140] Toolbox[141] and Circle of Security Parenting,[142] as well as those developed in-house by some providers (Work and Income 2013b).

Funding

This initiative is fully Government-funded and free to participants.

New Zealand evaluation findings

There are no evaluations for this initiative, although where individual parenting programmes that are part of the initiative (such as SKIP) have been evaluated this is discussed under the main heading for that programme.

Thrive Teen Parent Support Trust

Description and target population

Thrive Teen Parent Support Trust was established in 2010 as a dedicated teen parent service in Auckland. The trust has developed a programme for teen parents which has grown rapidly and includes positive parenting schemes, support programmes for vulnerable teen mothers, young fathers' support groups, childbirth education, parenting workshops and one-to-one support (Tindall Foundation 2012). Thrive uses a youth-development approach to achieve its vision that young parents can reach their full potential by being connected and secure within their families and communities. The Trust connects with the 300-plus teenage parents on their database through newsletter, their programmes and Facebook (ibid).

The Trust runs a mentoring group exclusively for young fathers under the age of 24 that meets on a fortnightly basis (Facebook 2013). The group programme for young mothers is co-ordinated by Trust social workers and covers a range of topics including self-esteem goal setting, parenting, relationships and family planning (ibid). Sessions are planned so that the issues that are most relevant to the group at that time can be addressed.

Trust social workers provide longer-term intensive support to on a one-to-one basis to young parents who are struggling in any aspect of their lives including whānau, relationships, housing, safety and health (Facebook 2013). The aim is to help them to create action plans for the future in the context of their family and community.

139 PEPE is delivered by Plunket.
140 SKIP is delivered by Barnardos.
141 Toolbox is delivered by the Parents Centre.
142 The Circle of Security Parenting programme is currently offered at the Hawke's Bay School for Teenage Parents in Napier (Work and Income 2013c).

Delivery and service providers

Thrive Teen Parent Support is a charitable trust. There are 15 staff members, 13 of whom were or are young parents themselves (Tindall Foundation 2012).

Funding

The development of the Trust was funded by the Tindall Foundation over a period of three years (Tindall Trust 2012). An endorsement from the Foundation has helped the Trust to generate other sources of funding to ensure long-term sustainability.

New Zealand evaluation findings

As part of their ongoing commitment to developing whānau-centred support services and initiatives, the Trust engaged Point Research Ltd to undertake a research project. This project focused on identifying the needs of whānau and how whānau support for pregnant teens, young parents and their children can be improved (Point Research 2013).

Data were collected via focus groups with young parents and their whānau, and individual interviews. Three young parents who are part of the Thrive staff took a leadership role in this project (Point Research 2013). Research results are not yet available.

Parenting Support for Teen Fathers[143]

Teen Fathers Plus

Description and target population

Teen Fathers Plus was developed and piloted in 2009 and made available to the community in 2010 (Ministry of Social Development 2010b). It is a group programme for young fathers based in Waitakere and is available to young men 24 years of age and under who are fathers or about to become fathers (ChangeWorks 2013a). Over nine 2.5 hour sessions the group discusses issues related to becoming a father, such as:

- what it means to be a father
- education about child development
- relationship issues
- responsibilities
- conscious parenting
- connecting young fathers with others and their community.

Most of the young fathers are visual learners so the programme includes drama, ritual, trust and practical activities to ensure that the participant is connected with the topic (Vodafone Foundation 2012). At the end of the course the young men can continue their contact with each other by becoming part of a support and mentoring group (ChangeWorks 2013a).

143 As part of the Teen Parent Initiatives announced in the 2010 Budget, the Ministry of Social Development produced a resource booklet to support organisations and agencies working with teenage fathers – see *Supporting Teen Fathers: A Resource for Service Providers*, Ministry of Social Development (2010).

Delivery and service providers

Teen Fathers Plus is a collaborative project initiated and co-ordinated by HealthWEST, Changeworks Trust and Barnardos (Ministry of Social Development 2010b). The Changeworks charitable trust was formed in 2006 and is an organisation dedicated to working with young people and their families to stop violence and abuse (ChangeWorks 2013b). The programme was designed by Ron Hepworth, a family therapist and counsellor from ChangeWorks. Courses are facilitated by Ron in collaboration with Junior Tavai, a social worker from HealthWEST PHO (Awhina Health Campus 2013). In 2013, this programme is being delivered for the first time outside of the West Auckland area by Thrive Teen Parents Trust in Mt Albert in collaboration with HealthWest (Vodaphone 2012).

Funding

Teen Fathers Plus is community-funded and free to participants.

New Zealand evaluation findings

We have been unable to locate any research or evaluation of this programme.

SuperGrans

Description and target population

SuperGrans began operation in 1994 and today is an organisation of nine registered charitable trusts which operate branches throughout the country. They operate an in-home mentoring and support service open to individuals and families who want practical assistance and support in learning the basics of home management and life skills to improve their families' wellbeing and self-esteem. SuperGrans do not only work within the family home; they also organise workshops and courses specifically created to increase and enhance existing skills that will complement clients' home-based learning or allow them to gain new skills (SuperGrans 2013).

Delivery and service provider

Skilled and knowledgeable volunteers provide practical assistance and support by offering home-based, one-on-one tuition and demonstration of practical home management and life skills. Field co-ordinators will oversee the programme and work with both volunteers and clients to ensure it is advancing and both clients and volunteers are satisfied with the progress being achieved.

Funding

SuperGrans provide free services to clients. The Trusts are funded through financial support from private philanthropic organisations, individuals and government agencies.

New Zealand evaluation evidence

We have been unable to locate any research or evaluation of this programme.

Raising Children in New Zealand

Description and target population

Raising Children in New Zealand is an audio-visual website providing information on parenting the under-threes. Parents can learn about about the importance of the early years and how they can get their children off to a great start (Raising Children in NZ 2013a). This resource has been developed by a wide range of multidisciplinary experts and is for all New Zealand families regardless of socio-economic status, ethnicity or class. It aims to provide parents and caregivers with well-researched, unbiased, realistic information from qualified people (Raising Children in NZ 2013b).

The website provides access to a number of modules that describe child development and provide parenting information:

- Newborn/Pēpi hou
- Infant/Tamaiti piripoho
- Crawler/Tamaiti ngōki
- Toddler/Tamaiti kōhungahunga
- Two years old/Rua tau te pakeke

These include video clips of celebrity parents talking about the issues covered in each section (Raising Children in NZ 2013a).[144]

The website also provides information on important topics for parents such as breastfeeding, developmental milestones, and the challenges and joys of being a parent (Raising Children in NZ 2013a). There is also a DVD resource available for purchase featuring stories concerning children's first three years. This DVD is provided free of charge to every first-time parent of a newborn in New Zealand by their Plunket or other Well Child/Tamariki Ora nurse. Barnardos Centres also have copies of the DVD available to borrow (Raising Children in NZ 2013b).

Delivery and service providers

Raising Children in New Zealand is a joint initiative between Plunket, Barnardos, Family and Community Services (Ministry of Social Development), the Ministry of Health and the Lion Foundation (Raising Children in NZ 2013b).

Funding

Funding is provided by partner agencies and organisations. Funding for free DVDs provided to first-time parents of newborns has been secured until mid-2014 (Raising Children in NZ 2013c).

New Zealand evaluation evidence

We have been unable to locate any research or evaluation of this programme.

You and Your Child (Plunket)

Description and target population

This website provides an electronic version of the *Thriving Under Five* book, which has been written to help parents with all aspects of raising healthy and happy children (Plunket 2013c).

The resource includes a number of sections providing information on the sorts of things a new parent will need to know about the needs of children from zero to five years of age. Topics covered are age-appropriate and include (ibid):

- Connecting and communicating
- Food and nutrition
- Health and daily care
- Sleep
- Development
- Play and learning
- Safety.

There are also sections on illness and strategies to utilise in the case of medical emergencies such as burns or choking (Plunket 2013c).

144 Celebrities involved include former Silver Ferns Captain Bernice Mene, All Black Cory Jane, television presenters Sonia Gray and Jude Dobson and actors Monique Bree and Kiel McNaughton.

Delivery and service providers

This resource has been developed by the Royal New Zealand Plunket Society. Hard copies are also supplied to mothers by their Plunket nurses.

Funding

The Royal New Zealand Plunket Society receives funding from a number of sources including Government and industry.

New Zealand evaluation evidence

We have been unable to locate any research or evaluation of this programme.

Reports are available on the Commission's website or contact the Commission to request copies:

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