Family Start Process Evaluation Final Report:
a summary and integration of components
of the process evaluation phase

June, 2003

Acknowledgements

Disclaimer

Preface

The objective of this report was, as its name implies, to develop from a range of completed and draft key research and operational documents a final report on the development and implementation of the Family Start programme and the process evaluation findings. The reports informing this text were:

- Family Start Programme Operating Guidelines (1998)

- Process Evaluation Plan (1999)

- Feasibility Study: Phase One Report (Asiasiga, Borell, and Reedy, 2000)

- Co-funders' Recommendations for the Family Start Initiative (2000)

- Family Support Programmes: A Literature Review (Gray, 2001)

- Family Start Programme Logic Report (Martin, 2000);

- Process Evaluation of Family Start Prototype Sites: Progress Report (Faisandier et al., 2000); Family Start Process Evaluation Fieldwork Round Two Report (2002). These reports on the fieldwork were undertaken as part of the process evaluation and include interviews with: staff, whānau, other agencies in each of the three locations, and government officials associated with Family Start policy and implementation.

- Project Specifications for the Evaluation of the Family Start Extension Sites (Evaluation Associates Ltd., 2000)

- A memo from the Evaluation Management Group (EMG) to the Health, Education and Social Services Senior Officials Group (HESSOG), circa August 2000, that outlined the framework for approaching the outcome/impact evaluation.

Accordingly this report substantially extends the account of the implementation and early development phases reported on in the fieldwork reports; at the same time, in presenting an analysis of the fieldwork data, it is constrained by the range of data reported on and the analysis that was developed in the draft fieldwork reports.

Executive Summary

Family Start is a Government initiative developed during the mid 1990's and aimed at improving life outcomes for children in families at risk. Family Start is a government-funded, community-based programme that provides intensive, home-based support services for up to five years to families where the mother at the time of referral is in her second or third trimester of pregnancy, or has an infant less than six months of age.

The objective of Family Start is to work with families in a "strengths-based" process that will improve children's well-being and development, parents' personal and family circumstances, and parents'/caregivers' parenting capability and practice.

From the outset, evaluation of this initiative was considered an intrinsic part of the programme, to inform both implementation processes and further policy development. This report pulls together the early evaluation work around Family Start. The major activity in the early stages of evaluation was around the process evaluation (the evaluation of implementation). The process evaluation took place in the first prototype sites over a two-year period (1999-2001). However, other activities undertaken to prepare for the later outcome/impact evaluation are also included in this account where they provide a fuller context for the interpretation of findings/learnings thus far.

The three primary research questions that the process evaluation sought to address were:

- Has the Family Start Programme been implemented according to the Family Start Programme Operating Guidelines (1998) provided by Government Policy?
- Has the Family Start Programme been implemented successfully, according to the Policy Makers, Providers, Clients and the Community?
- Have the theoretical and practical components of the Programme been satisfactorily developed?

This report relates to the evaluation of the development and implementation of the Family Start programme at three prototype locations, one in a provincial northern city, one in a major urban area, and one in a city in the centre of the North Island. All three locations had high populations of either Māori or Pacific peoples. The sites opened their doors in late 1998.

The report draws together a range of completed and draft key research and operational documents, undertaken as part of the process evaluation. The documents informing this report were:

- Family Start Programme Operating Guidelines (1998)
- Process Evaluation Plan (1999)
- Feasibility Study: Phase One Report (Asiasiga, Borell, and Reedy 2000)
- Co-funders' Recommendations for the Family Start Initiative (2000)
- Family Support Programmes: A Literature Review (Gray 2001)
- Family Start Programme Logic Report (Martin, 2000);
- Process Evaluation of Family Start Prototype Sites: Progress Report (Faisandier et al., 2000); Family Start Process Evaluation Fieldwork Round Two Report (2002). These reports on the fieldwork were undertaken as part of the process evaluation and include interviews with: staff, whānau, other agencies in each of the three locations, and government officials associated with Family Start policy and implementation.
- Project Specifications for the Evaluation of the Family Start Extension Sites (Evaluation Associates Ltd., 2000)

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Key Findings

Establishment

Timing

Commentary from the sites suggested that insufficient time had been allowed to get the service up and running, given the work that is required to develop a service from scratch. Stakeholders at two sites suggested that, although Family Start was based on a model of service collaboration, the contracting process and service environment was competitive. Some agencies were concerned that new services presented a threat to available funding for services in their area.

Governance

Governance structures and arrangements varied. Where the provider was a coalition of more than one agency, there were challenges in developing working relationships. One site brought to the Family Start dimension of its work a history of successful service delivery in closely related activities. It was a single iwi provider, with an established board taking an active operational role in the work of the organisation. As a consequence, the organisation did not have to commit energy and resources to establishing and maintaining a coalition board. In contrast to this site, the other two had to build their coalition partnerships as well as develop their Family Start organisations.

Staff Recruitment, Development & Training

The Family Start Programme Operating Guidelines (1998) describe the basic organisational structure. Governance Boards had responsibility for the oversight and development of the programme, and the managers who were appointed to each site had overall responsibility for the day to day work and management of site activities, and employment of other staff. Additional staff included supervisors, whānau[1] workers and administration staff.

Whānau workers, using a strengths-based model, were expected to develop close and positive relationships with the families with whom they worked. They were to help them define and achieve attainable goals. An expected consequence of working with the whānau workers was that the mothers should gain confidence, skills and problem-solving capacities, as well as undertaking defined tasks aimed at achieving better life outcomes.

A five-day initial training programme was delivered to staff as they joined Family Start. Managers were responsible for developing on-going training. The process evaluation did not set out to evaluate training for Family Start staff. However interview commentary did indicate variable responses to the preliminary training; some stakeholders perceived the original training of Family Start staff was of insufficient depth to adequately prepare staff for their roles.

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[1] Family Start case workers are usually referred to as "whānau workers" throughout this document. This term recognises the large number of Māori participants in the programme and the strong Māori emphasis in the delivery of services. However, one site used the term *kaitiaki*, a word that translates as "caretaker," "manager," and "trustee."

Staff members were predominantly female, but over time there was greater recognition of the value of having male workers. All sites endeavoured to employ staff with the cultural competencies appropriate to working with the client group.

The literature review on parent support and development programmes, conducted as a component of the evaluation, noted that training was critical to the success of such programmes. It noted that successful programmes needed to be staffed by professionals, or highly trained paraprofessionals with ongoing supervision. The review also noted the need for attention to be paid to the ethnicity of staff when delivering services for minority groups.

The first round of interviews with referral agencies and support agencies in at least one site reflected a level of concern about the skills of staff recruited and there were suggestions that this concern affected the willingness to refer clients onto Family Start. In the second round of interviews with the referral agents, this concern appeared to have lessened.

Service delivery

Recruitment and retention of Family Start clients

Between June 15, 2000 and June 15, 2001, 444 families were referred to the prototype Family Start sites. Of these, 165 were referred to Site Three, 182 to Site Two, and 97 to Site One. While there were variations across the sites, "low-income status" and "lack of resources" were significant presenting factors across all three. Two-fifths of all mothers reported low educational qualifications, and nearly half of all mothers reported frequent changes of address.

Over the year under review, the supervisors assessed 390 families as meeting the Family Start criteria, while 27 families were assessed as not sufficiently meeting the minimum criteria for entry. (There were a few referred families for whom no data on criteria were recorded.) Acceptance on the programme, however, did not mean that all clients continued with it. The database revealed that some clients decided they did not need the support, or did not want the programme, or could not be contacted following their initial meeting with the whānau worker (sometimes due to relocation of the whānau).

The intensity level of service delivery for each family was determined jointly by the supervisor, the whānau worker, and the family. There was a close similarity between Site Three and Site One, where the majority of families referred were initially assessed with moderate- and low- intensity needs. Site Two developed its own policy in relation to determination of intensity, stipulating that, until the full assessment was completed, all families were enrolled as "low intensity".

Basic household necessities (stove, fridge and hot water) were present in virtually all homes, but at Site One and Site Two a significant number of families did not have heating. At Site Two, a large number of families did not have a telephone. At all sites, many families did not have access to a vehicle. Mothers at two sites reported that nearly half the average household income was spent on accommodation.

The age spread of mothers enrolled on the programme was wide, ranging from under 18 years to over 40. The number of women in the "31 years plus" age bracket was especially noticeable at Site Two, where slightly over a third of the women referred were in this bracket. Almost four-fifths of the clients in Site Three and Site One identified themselves as Māori, while around one-third of those in Site Two did so. Site Two had a very wide range of Pacific peoples. The ethnic spread of the mothers and their partners was similar.

General educational levels of mothers were highest in Site Three. They were lowest in Site Two, where 20% had attended primary school only. As with the mothers, the partners' educational levels reflected a high proportion of Pacific peoples with only primary education.

The dependence of mothers on government benefit income was consistent across all sites. Very few mothers had an external source of income from salary or wages. Although approximately half of all babies were living in families where the mother shared responsibility with a father/partner, across the sites from 27% to 42% of mothers reported having sole responsibility for their children.

Work with mothers

Face-to-face time between whānau workers and mothers averaged out at all sites at something over three and a half hours per month, while average non-contact time ranged between two and four hours. The time devoted to the very few high-need families was more than that devoted to low- and medium-need families, confirming that the aim of Family Start to provide differential levels of service for families with varying levels of need was being met.

The activities undertaken by whānau workers included personal support, advocacy and practical help. Workers also encouraged mothers to undertake parent education, training and development courses.

The programme originally intended to ensure that whānau workers interacted with families, whānau, and possibly peer groups and wider communities. In practice, sites defined their responsibility as working primarily with babies and their mothers. By the second round of interviews, male whānau workers had been appointed at all sites to work with fathers.

A feature of the programme is that services should be progressively reduced over time, on the assumption that the families would increasingly be able to respond to situations without assistance. It was not clear from the fieldwork how this process of reduction was being managed in the context of worsening circumstances or an unchanging level of need. The evaluators noted that a planned progressive reduction in service provision may not correspond with the actual level of a family's needs, even if they had been on the programme for a time, or sufficiently take into account changes in circumstances.

Mothers' accounts of the Family Start programme

Some of the mothers described excellent service, about which they were very positive, and there was a general indication that they thought the programme was valuable in principle, even if some of the assistance they had received had not met a high standard. However, where mothers were very dissatisfied with their whānau worker, they were also dissatisfied with their service provider. Mothers at Site Three were more positive than those at the other two sites. At Site One, over half of those interviewed expressed some dissatisfaction with the service they had received.

Overall, more than half of the mothers spoke of positive changes in their own behaviour and/or changes in their children, which they related, directly and indirectly, to the help they had received from Family Start. The comments also pointed to the necessity for the programme to employ quality, trained staff, and for those staff to be working with a clear sense of direction, with quality supervision and organisational accountability.

Individualised plans, goal-setting and exits from the programme

Two key dimensions of the programme are the development of individualised plans and the early elaboration of measurable, achievable goals. Mothers did identify issues, but the data did not reveal how individual goals were articulated in order to deal with these issues, or what tasks were

associated with the goals. About a quarter of the goals were achieved within three months of their being set in Site Three and Site Two, and nearly half in Site One. The evaluation noted difficulties with the use of the database in relation to goals, and variation in the measurability of goals across whānau workers and sites.

Of those who had exited the programme, only two mothers at Site Two and none at Site One could be designated 'planned exits or graduations', that is, those leaving had met their designated goals within Family Start. Site Three was the exception, in that 18 mothers were recorded as planned exits over the year June 2000 to June 2001. These were, however, directly related to Site Three's policy that any mother who chose not to continue on the programme would enter a planned exit process involving consultation with the kaitiaki and supervisor. About three-quarters of those originally enrolled in Site Two and Site One were still on the programme a year later.

In terms of retention rates of high-intensity families, none had exited at Site One by June 15 2001. At Site Two, where the policy was that no family would be initially classified as high-intensity, none of those classified as medium-intensity had exited by June 15, 2001. At Site Three, seven out of the 13 initially classified as high-intensity had left the programme by June 15, 2001. The exit variable was interpreted somewhat differently at each site, but the database indicated that relocations to other areas were common, confirming that Family Start was operating in the context of a very mobile population and suggesting that premature exits were to be expected.

Ongoing issues with implementation

Local expressions of operating guidelines

There was always an expectation that the Family Start Programme Operating Guidelines (1998) would be implemented in ways particular to different sites and communities. In these three prototype sites, the differences included:

- management (and recording) of intensity levels as families entered and moved through the programme, and of exits.
- responding to the wider family/whānau. Site Three, which appeared to be established more quickly and to develop community credibility, also was the site that most rapidly expanded the focus of the service and developed initiatives with the wider family, including work with fathers, and provision of educational opportunities for the younger mothers.

It is not clear to what extent those differences impacted on service delivery, nor to what extent variations were a product of the demands of particular communities, or were a product of the extent to which sites had been able to progress beyond the immediate demands of establishing the core infrastructure, skills and credibility. There was however a strong impression that those sites who had moved through the initial establishment phases most smoothly were also then able to expand the range of services in strategic ways.

Parents as First Teachers (PAFT)

PAFT was regarded with suspicion by some stakeholders, particularly in relation to when it should be delivered and the degree of priority afforded it, whether it was effective, and whether workers had sufficient skills to deliver it. Further, the Family Start Programme Operating Guidelines (1998) required Family Start providers to reduce hours of service to higher need families over time. When these hours were progressively reduced for families assessed as low-intensity, the programme could not be delivered within the specified hours of service.

Relationships with referral and support agencies

Nearly all Site Three referral agency representatives had a positive view of Family Start and its kaitiaki. They also identified a number of areas where work could be developed or changes made. Māori service providers raised some concerns, but overall saw Site Three as providing trained staff who engaged with whānau in ways not possible for most other agencies.

Support agencies in Site Three were also very positive about Family Start. Some collaborative working relationships had been developed, the referral systems were working well, and problems were dealt with directly. The service was considered to be filling a substantial gap. Areas of concern included the size of workers' caseloads, the problems of long-term relationships between workers and clients, and ethical issues relating to the employment of kaitiaki with whānau connections.

Feedback from referral agencies at Site Two was largely very positive at the time of the second interviews, in contrast to concerns that had been expressed earlier. Hospital staff and health workers believed the programme was developing well, but the mainstream Well Child provider associated with the service continued to express reservations and did not refer clients to Family Start.

The fact that whānau/aiga workers were able to assist clients with a wide range of problems within the context of a culturally-appropriate service was seen as valuable since it allowed families to deal with a worker of their own ethnicity. Areas of concern touched on both structural and professional issues.

At Site One the hospital-related referral agencies, although very positive about the changes that were taking place at the site at the time of the second round of fieldwork, also raised structural and professional issues bearing on the effectiveness of the work that had been done. Only a few support agencies in Site One were willing to be interviewed in the second round of fieldwork, a fact that may well have reflected a lack of networking between Family Start and those agencies, and a lack of faith in the programme under previous management.

Credibility

The credibility and therefore the viability of a new organisation are closely linked with the credibility of its staff and with its demonstrated capacity to carry out its tasks. Other community organisations will only have confidence to refer to and work with Family Start services if they are confident in the competence of the staff to deliver appropriate services.

At the time of the second round of fieldwork in 2001, commentary from stakeholders (mothers, referral and support agencies, and site providers) indicated that standards and levels of service across the three sites differed and that the sites were operating with different degrees of effectiveness. There were some identifiable factors relating to the differences in effectiveness in service delivery, in community receptiveness, and in the positive endorsement of the programmes by the services' clients. These were:

Provider-associated issues

Two of the sites had to build their coalition partnerships and develop their organisations from the ground up, in a very short timeframe. Although there was no reduction of funding to the prototype sites when the expansion sites were rolled out, there was a perception from the prototype sites that they received less support from the co-funders during this time.

The establishment difficulties experienced by the two sites at governance level raise questions about how such difficulties can be understood and what, in the context of a prototype programme, the responsibilities of the funding/oversight organisations are.

Availability of trained and knowledgeable staff

The work required of whānau workers is complex. Successfully adopting a supportive role requires a clear understanding of that role, its associated complexities, and the skills to perform it effectively. Information-giving and competent referral practices call on detailed knowledge as well as understanding of ethical implications. Goal-setting and the devising of individualised plans call for particular skills. Those funding and establishing new services need knowledge and understanding of the work they are expecting to be done and the resources that are needed to carry it out. The evaluation findings highlight the need for high quality training prior to the start-up date, and for ongoing training, involving quality supervision and accountability practices.

Evaluation issues

The design and implementation of the evaluation needed to take account of multiple stakeholders' needs. The process evaluation took place parallel to development work on the outcome/impact evaluation.

Methodology and timing of evaluation

Discussion of the outcome/impact methodology highlighted the tensions arising in trying to meet the expectations and requirements of the multiple stakeholders. There was an expectation of timeliness from government officials, yet service providers were clear about the need to take time for informed participation to occur. Service providers were also clear that the methodology chosen needed to be acceptable to the communities in which they worked. The providers were fully occupied establishing a new service while also assisting with the process evaluation and the early discussions of the outcome/impact evaluation.

Database issues

The development of the database was originally intended to serve the needs of the providers, the co-funders and the evaluation team. In practice, this proved to be more difficult than anticipated. The amount of consultation required to work with providers about their needs and the purposes of the database was underestimated. Confounding factors included one site already having a database, the variation in level of computing skills across sites, insufficient early training, and suspicion about the uses to which the database might be put. The processes underscored the need for full consultation with all stakeholders, sufficient early training, clear responsibilities for the database at local and central levels, and clear information about uses and ethical processes.

Some issues with actual database use have emerged with early analysis. Inconsistent use of some fields has been recognized, and the difficulties of defining some other fields have also become apparent. For instance, it is now clear from the database that establishing measurable goals with clients is challenging, and not always achieved. (This has implications both for the evaluation, and for the Family Start programme itself.) It is also apparent that the database is unable to capture differences in local practices. For example, the recording of intensity levels is managed in different ways by different sites, and the database did not record changes in intensity levels over time.

Despite those difficulties, and the development of a fully functioning database having taken longer than anticipated, the database should now provide useful information for the outcome/impact

evaluation. For instance, initial analysis in conjunction with the process evaluation has provided some context for interpretation of outcome measures of child health.

Consistency of evaluation approach versus local context

It is a challenge to provide overall evaluation outcomes for a programme where there is considerable local variation in implementation. The operating guidelines permit local variation in how the programme is to be delivered, and each site has specific contextual issues to engage with. It can be difficult to assess to what extent various outcomes in implementation are due to the requirements of the programme (as described in the operating guidelines) and the specific ways in which these are implemented, or the extent to which they are a result of other factors. The literature review (Gray 2001) highlighted that the evaluation and review of family support programmes presents significant challenges.

Evaluation expertise

Evaluation of Family Start has highlighted the complex set of skills required to successfully undertake an evaluation of a complex social service intervention. Quantitative and qualitative evaluation skills are needed, in addition to theoretical understanding of the concepts behind the Family Start project (i.e. a theoretical understanding of parent support and development) and cultural competence in working with Māori and Pacific providers. Officials were unable to source all this expertise in one team. Accordingly a number of separate contracts were let around the process evaluation and the early outcome/impact evaluation work. A high level of co-ordination, support and synthesis was required.

Interpreting the findings

The objective of the process evaluation was to describe, analyse, and assess service delivery in order to identify key factors that might lead to successful implementation of the Family Start programme nationally, if future roll-out was to occur. There was no intention that the process evaluation would provide specific recommendations regarding whether or not roll-out should occur. Prior to programme outcomes being evaluated, it is essential to know more about programme integrity; this information assists in the consideration of outcomes, because it is important to know what components of a programme were actually implemented when outcomes are being considered.

The number of families agreeing to take part in the interviews was much lower than expected, resulting in the final sample size being smaller than anticipated. (This low consent rate appears to be an ongoing issue for such evaluations.) The reasons for this low consent rate are not clearly documented, but the consent rate appeared to be influenced by low interest levels in the evaluation when the whānau workers broached the topic with clients (which may or may not relate to the 'enthusiasm' levels of the whānau workers when discussing the evaluation). Initial consent did not always result in participation, for example, if the evaluator was unable to make contact with the client, or the client did not appear for an interview at the scheduled time. As the interview data were gathered from a non-random group of clients, caution must be used in interpreting the data. It is also clear that the project implementation differed across sites, and local contexts were important factors in this. Consequently, findings should not be generalised across sites.

The data analysis reflects early attempts at bringing together the complex set of evaluation skills required for this kind of evaluation work. The reader will find some questions yet to be answered. Nevertheless, the data are an important record of the evaluation to date, and provide useful indicators of issues deserving further consideration.

Given these caveats, there can be no definitive answers to the three basic research questions for this process evaluation, although responses to each question have been developed.

1) Has the Family Start Programme been implemented according to the operating guidelines provided by Government policy?

Yes, although concerns arose with the interpretation of the guidelines in relation to:

o *intensity;*

o *caseload;*

o *delivery of PAFT/Ahuru Mowai and Born to Learn;*

o *the total number of clients in each programme;*

o *the skill mix and training of staff;*

o *the involvement of wider whānau in the programme;*

o *the identification and description of goals; and*

o *exit protocols.*

(Part way through the process evaluation, in early 2000, the co-funders reviewed the operation of the programme with the prototype sites and made a series of recommendations to HESSOG about the operating guidelines.)

2) Has the Family Start Programme been implemented successfully, according to Policy Makers, Providers, Clients and the Community?

Different answers emerged at each site regarding the relative degree of successful implementation.

o *Site Three was performing well, and Site Two had established good relationships with its coalition partner.*

o *At Site One, clear difficulties emerged. Difficulties at this site were reported both by other agencies in the community, and by the Family Start clients themselves.*

3) Have the theoretical and practical components of the Programme been satisfactorily developed?

Gray's (2001) literature review highlighted that the most successful family-focused intervention programmes have strong theoretical underpinnings, with clear goals that are determined in partnership with the target community.

o *The extent of development of the theoretical and practical components of the Family Start programmes participating in the process evaluation varied from site to site.*

- *As the sites had varying levels of implementation, programme elements also varied in their degree of development.*

- *The programmes all showed movement towards some of the required theoretical components.*

- *However, there were variations in whānau workers' abilities to set clear goals for their whānau, which appeared to be an area of difficulty.*

Issues for Future Consideration

If a decision were made for future roll-out of the Family Start programme, then it would be important to consider:

Establishment issues

- Timing – the establishment phase can take much longer than planned for. It is likely to take two to three years before a programme is fully operational. This has implications for any associated evaluation (see below).
- Community consultation vs. competitive tendering
- Existing/available governance infrastructures within a community
- Relationships between the proposed Family Start service and existing services in a given location
- PAFT/Ahuru Mowai and Born to Learn – the degree of fit within the Family Start programme

Fit between programme and target group

- Family mobility and programme geographical boundaries limit the fit between the Family Start programme and the target group. Family Start operates within the context of a very mobile population in which family relocations to other areas were common. Limited geographical boundaries for the provision of Family Start mean that for mobile families there is unlikely to be continuity of service.

Family Start Programme Operating Guidelines

- The process evaluation highlighted the quite different ways in which the Family Start Programme Operating Guidelines have been implemented in the three prototype sites.

- The guidelines should be viewed as the basis from which services will develop. This allows providers flexibility, but also ensures that the necessary level of consistency is achieved to ensure that services are developed and delivered in line with the goals, objectives and desired outcomes of Family Start.

- Guidelines need to be revisited on a regular basis.

Staff skill mix and training

- Provider capacity and capability, including relationship management

- The quality of initial and ongoing training. Gray's (2001) literature review emphasised that training and supervision are critical components of a successful programme. (Note: although the process evaluation did not evaluate training per se, it identified training issues requiring further investigation.)

Evaluation

- Timing – evaluation must be built into the programme design from its inception.

- Scope/focus – there must be clear identification of the scope and focus of an evaluation, in relation to existing information already collected in other Family Start or parent support and development evaluations.

- Compliance costs – participation in an evaluation places an additional load on programme providers and clients, as well as introducing an intervention.

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Chapter 1: Setting the Scene: The Development of the Family Start Project

Family Start is a Government initiative developed during the mid 1990's and aimed at improving life outcomes for children in families at risk. From the outset, evaluation of this initiative was considered an intrinsic part of the programme, to inform both implementation processes and further policy development.

This report pulls together the early evaluation work around Family Start. The major activity in the early stages of evaluation was around the process evaluation (the evaluation of implementation). However, other activities undertaken to prepare for the later outcome/impact evaluation are also included in this account, as they provide a fuller context for the interpretation of findings/learnings thus far.

Structure of the report

The objective of this report is to describe and discuss the work commissioned as part of the evaluation of the development and implementation of Family Start:

- *Feasibility Study: Phase One Report* (Asiasiga, Borell, and Reedy, 2000). This reports on discussions with sites about the evaluation in 1999;

- *Family Start Programme Logic Report* (Martin, 2000). This sets out the logic examining the assumptions and intended outcomes of Family Start, and includes reports of interviews about the logic held with government officials and providers;

- *Family Support Programmes: A Literature Review* (Gray 2001). This review is of (primarily) American family support projects. It was intended that the findings of this review, through its identification of what internationally are understood to be key issues in the development of family support programmes, should more fully inform the fieldwork and analysis of the interviews gathered during the fieldwork;

- *Process Evaluation of Family Start Prototype Sites: Progress Report (Faisandier et al., 2000); Family Start Process Evaluation Fieldwork Round Two Report (2002).* These reports address the two rounds of fieldwork; and

- *A memo from the Evaluation Management Group (EMG) to the Health, Education and Social Services Senior Officials Group (HESSOG)* (circa August 2000). This memo outlines the framework for approaching the outcome/impact evaluation.

Chapter 1 sets the scene by describing the context and background to the development of Family Start as a service. Chapter 2 describes the process evaluation methodology, and the database development; Chapter 3 describes findings from related evaluation activities (the feasibility study, the literature review, and the programme logic exercise). Chapters 4 and 5 describe the findings, and Chapter 6 draws the issues together with some concluding comments. Appendix 1 sets out the specified programme logic matrix; Appendix 2 sets out the supplementary logic as developed from the provider interviews.

Part 1: The Context — The Strengthening Families Strategy

The Family Start project is part of the Government's Strengthening Families initiative, an initiative developed during the mid-1990's and aimed at improving life outcomes for children in families at risk. In particular, the strategy focuses on positively influencing:

- health status,
- educational attainment,
- the ability to form positive relationships, and
- the prevention of persistent offending in such families.

Drawing on an extensive research base, the two key assumptions informing the development of the strategy were:

- what happens in families profoundly affects life outcomes for children; and
- a collaborative approach by ministries and a wide range of agencies in working with families is a more effective approach than one where each sector or agency operates separately and unilaterally.

In relation to policy development, the strategy focused on the development of joint working relationships on two planes: between ministries and at the grass- or flax-roots with local agencies. Rather than working independently from each other to improve outcomes for children at risk, key ministries worked towards the development of intersectoral policies and adopted a process of joint reporting to groups of ministers on related work programmes.

The second point of development focused on achieving local co-operation across government, iwi, and non-governmental organisations in the provision of services to individual families at risk. This approach was based on an acknowledgment of the actual implications of recognising the ethnic diversity of New Zealand, and it required that local preventative initiatives were responsive to conditions and issues peculiar to each locale. It was expected that increasing collaborative relationships between local agencies and ministries, as well as between ministries, would assist the target population to achieve better health, increase educational attainment, improve job prospects, improve family relationships, and increase capacity for families to contribute to their society and, as part of that, to their children's well-being.

On 24 October 1995 Cabinet required that a long-term strategy to strengthen families at risk be developed. Cabinet directed Health, Education, Treasury and Social Welfare officials (subsequently expanded to include those from Te Puni Kokiri, Pacific Island Affairs, Women's Affairs, Youth Affairs, and Justice) to report back to the Social Policy committee by 21 November 1995 with the terms of reference for a policy:

> *to enhance the capacity and self-reliance of families and whānau in their role of raising healthy and capable individuals, with an emphasis on families with children aged 0 – 6 years and on "high-risk" families.* [2]

The emphasis on enhancing the capacity of families with young children reflected international studies and local longitudinal research findings carried out by the Christchurch Health and Development Study and the Dunedin Multi-disciplinary Study. The research generated by both

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[2] [CAB (95) M40/9]

studies highlighted the relationship between the presence of early risk factors in individual families and later, more negative, life outcomes.

Cabinet further requested that the officials:

> *undertake a stocktake of existing policies and programmes within the Health, Education and Welfare sectors which impact on, or directly support, the strength of families, including policies and programmes targeted at high risk families with children aged 0 – 6 and also policies and programmes directly targeted at high risk families.[3]*

In order to advance this work, the Strengthening Families Steering Committee was established in February 1996. It was chaired by the Department of Social Welfare (DSW) and constituted by senior officials from Treasury, Ministry of Education (MoE), Ministry of Health (MoH), and the Department of Prime Minister and Cabinet (DPMC). Subsequently, a core group of officials from Health, Education and Welfare (HEW) took primary responsibility for the work, and have continued to meet and oversee its development.[4]

The stocktake of programmes that was undertaken during 1996 identified 140 existing programmes costing approximately $300 million. The analysis of the orientation and structure of the existing programmes indicated that there was a lack of programmes focusing on intensive intervention with at risk families with young children. Although programmes in New Zealand, such as the Early Start Service in Christchurch, and the Family Link Service in Dunedin, were offering home-based services to at risk families, and a range of social and health-related agencies including Māori agencies were already in the field, the policy analysts concluded that generally services across New Zealand did not fully meet the necessary criteria: the delivery of a service to families with young children that was intensive, home-based and holistic. The more detailed requirements of such programmes, if they were to enable successful interventions with families with young children, were substantial. A review of the literature completed in 1997 (Robson 1997) suggested that such programmes needed to include the following attributes:

- multiple systems and setting interventions;
- multiple component interventions (e.g. a parent-focused dimension incorporating family support, and a focus on the child through the provision of high quality early childhood education and health care);
- multi-year interventions;
- interventions promoting formal and informal networks;
- interventions addressing the enhancement of competency;
- vocational and educational training for parents; and
- interventions focused on earlier rather than later involvement with families.

In December 1997, Cabinet agreed to establish what was initially called a Targeted Family Service.[5] (Its name changed to Family Start in mid-1998). Services were to be delivered by home visitors. The key dimensions of the programme picked up on the above issues. The programme required that

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[3] [CAB (95) M46/5A] 4 December 1995.

[4] This group is now called the Health, Education and Social Services Senior Officials Group (HESSOG).

[5] 15 December 1997 [CAB (97) M 47/19]

workers were, first, to engage not only with the family and children, but also with their informal and formal networks, that is, their extended family, school, work, peer groups and community. Second, the work was placed in a strengths-based paradigm.[6] The workers were to identify all family members' needs and develop with them a plan to meet those needs that drew on the families' (nuclear and extended) strengths and those of their community. Third, this new service was not designed or intended to replace any currently available services, but to operate collaboratively with them.

The initial implementation work was carried out by officials from Health, Education, Pacific Island Affairs, Women's Affairs, Te Puni Kokiri, Health Funding Authority, Early Childhood Development, Community Funding Agency and the Department of Social Welfare (DSW), but the Chief Executives of Health, Education, and Social Policy (previously DSW; now the Ministry of Social Development [MSD]) had the joint responsibility of implementing Family Start at a national level. Three government agencies were to be co-funders of the project: the Health Funding Authority (HFA: now subsumed into MoH); the Community Funding Agency (CFA: now subsumed into Child, Youth and Family) and Early Childhood Development (ECD). This group was responsible for contracting providers and monitoring services in addition to reviewing the model and recommending desirable changes to HESSOG. A Family Start co-ordinator, also a government official, was responsible for facilitating communication between groups, including the evaluation team.

The initial work, completed by 25 February 1998, included establishing joint purchasing processes between the Health, Education and Welfare areas; carrying out community consultations; selecting and contracting with appropriate providers; and developing an appropriate evaluation framework for the implementation of the programme. Family Start was funded using a lead funder approach, meaning that each co-funder took the lead in contracting and monitoring a service.

Initial sites were selected in 1998. All three sites were in the North Island. Two had a high percentage of Māori. A third site had a high proportion of Pacific families. The sites chosen for the

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[6] Neither of the process reports provides a definition of this key term. This omission may have occurred because it was expected that each site would develop and operationalise their own definition. However, for the purposes of this report, in part because it highlights the inherent complexity of the work that was to be undertaken, it seems useful to draw on an account of strengths-based work that sets out four general principles and attends to their implications. Strengths-based work is based on the following set of beliefs:

1. that all persons and environments have strengths that can be harnessed to improve quality of life.

2. that client motivation is enhanced by a consistent emphasis on strengths, particularly as defined by the client.

3. that discovering and building on strengths is best achieved through collaboration and partnership between client and worker.

4. that all environments contain resources, actual and potential, which can be mobilized for change (Kemp, Whittaker and Tracy 1997: 61-62).

Strengths-based work is understood as of particular value in environments/locales that often seem "devoid of opportunities and hope." Such work highlights the potentiality of networks and "the resourcefulness and tenacity of the individuals and families who negotiate" complex environments and circumstances daily, and acknowledges the importance of looking for "naturally occurring strengths, potentialities, and resources, wherever these are found, in the lives and everyday environments" of those for whom services are being provided. (Kemp, Whittaker and Tracy, 1997: 62-63)

initial Family Start development were designed as prototype sites, so placing an emphasis on organisational learning about community development projects.

The prototype sites were chosen by the Transitional Health Authority (THA), Community Funding Agency (CFA) and ECD, in consultation with TPK and the Ministry of Pacific Island Affairs. Criteria for the prototype site selection required sites to:

- have clearly defined community boundaries to facilitate the evaluation;

- have no other significant pilot programmes or new initiatives in operation that could affect the evaluation;

- have a high proportion of Māori or Pacific Peoples in the populations;

- have sufficient community resources to enable the effective establishment of the service (e.g. ability to recruit suitable staff);

- be of sufficient size to sustain the operation and evaluation of a service; and

- have demonstrated health, welfare and education indicators pointing to a high proportion of at risk families.

In May 1999, the government provided funding for thirteen extension sites.

Evaluation context

In 1998 policy officials requested research and evaluation staff in a range of government agencies to provide advice on an evaluation approach. Policy officials accepted advice that both a process and an outcome/impact evaluation were required, and that the outcome/impact evaluation should only proceed once the programmes were established and fully operational. Decisions about the outcome/impact evaluation methods could not be determined at central government level alone, but needed to be worked out in co-operation with the Family Start providers once the programmes were underway.

The process evaluation took place in the first prototype sites over a two-year period (1999-2001). It was soon clear that evaluation of Family Start would require a complex set of skills. Quantitative and qualitative evaluation skills were needed in addition to theoretical understanding of the concepts behind the Family Start project (i.e. a theoretical understanding of parent support and development) and cultural competence in working with Māori and Pacific providers. Officials were unable to source all this expertise in one team. Accordingly a number of separate contracts were let around the process evaluation and the early outcome/impact evaluation work. A high level of co-ordination, support and synthesis was required.

Planning for the outcome/impact evaluation included a feasibility study, programme logic (with officials and Family Start providers), a literature review (including evaluation of family support programmes), and investigation by officials of appropriate models for the evaluation of the extension sites. In 2000, a decision was made to combine the outcome/impact evaluation for the prototype and extension sites (previously planned as two separate evaluations). This was an EMG recommendation, accepted by HESSOG.

Part 2: The Family Start Programme

Family Start is a government-funded programme, targeting the 15% of most at risk families. The objectives of the Family Start programme are to improve children's well-being and development, parents' personal and family circumstances, and parents'/caregivers' parenting capability and practice.

The voluntary nature of whānau involvement in Family Start stresses the importance of the programme being relevant to the culture, environment, needs and capacities of the family. Family Start must "begin where the family/whānau are".

Family Start was designed to provide support and assistance for targeted families for between one to five years, in a decreasing number of hours per year, depending on the level of intensity of service that each referred family was assessed as needing. It sought to ensure that services were acceptable and culturally sensitive to families through the employment of whānau or aiga workers or family workers.[7]

The Family Start Programme Operating Guidelines

The Family Start Programme Operating Guidelines (1998) developed for the providers set out the basic conceptual and operational structures of Family Start. The guidelines stated:

> *These ... have been produced as a comprehensive description of the Family Start Programme and are to be used as the basis for the provision of the service which will be delivered by the three providers in the pilot locations. The Guidelines are targeted primarily at management of the provider organisations, and focus on the development and delivery of the Family Start Programmes from a management perspective. As each location and preferred provider must have the freedom to develop and deliver services in a way which reflects local need, culture and community, the Guidelines should be viewed as the basis from which services will develop. While this allows providers the necessary flexibility, it will also ensure that the necessary level of consistency is achieved in order to ensure that the programmes develop and deliver services in line with the goals, objectives and desired outcomes of Family Start.* (p.1)

The guidelines foregrounded flexibility (within some operational constraints) in service delivery and the importance of local and cultural knowledge in the development of appropriate and community-based services. At the same time, each service was expected to deal with a certain number of clients a month. The numbers were calculated taking 15% of the expected birth rate per 100 families. At Site One, for example, the population was 46,000. A birth rate of 1.757% births per 100 families meant that Family Start would be dealing with 121 clients per year; a figure that translated into between 11 and 12 new clients each month (Family Start Programme Operating Guidelines: 33).

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[7] The use of "whānau worker" reflected both the large number of Māori families in the programme, and a Māori style of service delivery. One site also employed the word "kaitiaki" to describe their workers, a word that translates as "caretaker" "manager" and "trustee." It highlighted the complexity of the role and emphasised the collective responsibility of iwi to their whānau. Another site, with a high Pacific and especially Samoan caseload, called their workers "aiga." However, because this word is not used by other Island peoples, it could be seen to be exclusive rather than inclusive.

Core values and principles

The guidelines affirmed a strengths-based approach which was to include:

- the development of a child-centred and family-focused service with the needs of the child and their family determining the types and mix of services to be provided;

- meeting those needs through providing a service where family/whānau workers had a primary responsibility to establish a supportive and effective working relationship with the family to ensure the achievement of agreed goals;

- ensuring that the delivery of services was culturally appropriate for children and their families, with agencies, programmes and services meeting the specific cultural and ethnic needs of the clients; and

- basing the mode of service delivery on the principle that regular and frequent home visits, which sought to address the broad spectrum of family needs, would be more successful than single-focus programmes (Family Start Programme Operating Guidelines, p6).

The principles set out the roles and responsibilities of both clients and service providers in the processes of service delivery. The principles placed a basic obligation on parents to ensure, at a minimum, their children's safety; the providers' role was to work with the parents to ensure that this minimum was achieved through a process which was responsive to individual need and was aimed at parents achieving better life outcomes.

Parents enrolled in the Family Start programme were to receive a service that:

- was culturally relevant and professional;

- provided access as early as possible in the client's (that is, the baby's) life to a comprehensive range of services to address the physical, cultural, emotional, social and educational needs of the baby and its family and whānau;

- ensured that parents were full participants in all aspects of service delivery, including programme development and service evaluation;

- provided services on the basis of an agreed, individualised family plan so that the range of necessary and appropriate services was delivered in a timely, co-ordinated and therapeutic manner;

- provided services within the least restrictive, most normative environment;

- delivered services in a manner that reflected and built on the strengths of families, their culture and community; and

- delivered services in a manner that reflected the provisions and principles of the Treaty of Waitangi. Such principles include partnership, participation and active protection of the cultural, spiritual, economic and social environment (Family Start Programme Operating Guidelines: 6-7).

The Family Start organisational structure

The organisation at each prototype site that was to deliver these services was to be a grass- or flax-root organisation. A board was to have governance responsibilities. The manager was to report to board members on a monthly basis. The manager's responsibilities included organisational

management, ensuring accountability, developing and managing the service, attending to HR issues, supervision and training, and managing the public relations side of the organisation. From the start, supervision was recognised as a key element of a professional service. Each service was to employ a supervisor to provide professional support, and cultural supervision was also to be made available to the whānau workers.

Stating that the key factor in the success of Family Start lay in the capacity of the whānau workers to establish supportive and effective working relationships with the families with whom they worked, the operating guidelines stated clearly that these workers should be highly skilled, with the group collectively being able to ensure that it held the requisite (and extensive) knowledge base required for the work (Family Start Programme Operating Guidelines 1998: 23-24 addresses the required knowledge base and associated skills and attributes). It was recognised that while not all workers would hold professional qualifications, all were expected to "have a sound knowledge base of child health and development and parenting" (Family Start Programme Operating Guidelines 1998: 22) and all were to be capable of discharging their work and being responsive to on-going training possibilities. Each organisation was supported by an administration officer.

The client group

Family Start was initially targeted at the most at risk families with newborn infants or with infants of up to six months of age. Because there were concerns that self-referrals could both swamp the service and result in too many lower-need families being accepted on the programme, families were to be referred by designated referral agencies, that is, lead maternity carers, hospital maternity services and Well Child providers. It was considered that these providers would be most likely to be in contact with the mother in the latter stages of pregnancy and following the birth of the child. In order to target the most at risk 15% of families, the operating guidelines (as noted earlier) specified the number of families per year who should be referred according to the birth statistics of each of the prototype sites.

Although it was expected that whānau workers would work primarily with the family and whānau, the baby was nominated as the client because the "baby is the reason for the referral to Family Start services" (Co-funders' recommendations for the Family Start Initiative, March 2000: 4).

Referred families were to go through an initial assessment process to ensure that they met one or more of the following twelve criteria widely considered to indicate at risk families. These criteria are set out in Table 1.

Table 1. At risk assessment criteria for entry into Family Start

1. Unsupported parent	**7**. Relationship problems
2. No or minimal antenatal care	**8**. Low income status
3. Young mother	**9**. Lack of essential resources
4. Mental ill-health	**10**. Frequent change of address
5. Substance abuse	**11.** Low maternal educational qualifications
6. Family history of abuse	**12**. Sudden Infant Death Syndrome factors
	(where not covered by the above 11 criteria)

Once referred, families were to go through an initial assessment process to check their eligibility and the appropriateness of the referral. Following an initial acceptance on the programme, the family was to be allocated to a whānau/aiga worker, selected on the basis of ethnicity if relevant. At this point, a more detailed assessment process was to take place over a four week period. The objectives of this assessment were to complete a fuller assessment of needs, establish a strong relationship between whānau worker and family, and develop an individualised plan reflecting both the strengths and needs of the family and whānau. A key element of the plan was that it should involve the family's identifying achievable goals; in turn, these goals would inform the nature and focus of assistance. The Family Start Programme Operating Guidelines (1998: 61) stipulated that the "plan should have clarity regarding what is to be achieved, and [is] to be viewed as a living document, a basis for service delivery, open to continual reassessment and evaluation." A further purpose of the assessment was that it should inform the level of intensity to which the family would be assigned. The level of intensity to which a family was assigned was to establish the expected duration of enrolment in the programme and the quantity of help to be provided by Family Start whānau workers.

Table 2. Hours of service according to allocated intensity of service required

Intensity level   **Hours of service**

	Year 1	Year 2	Year 3	Year 4	Year 5
High	250hrs	160hrs	12hrs	12hrs	12hrs
Medium	150hrs	52hrs	4hrs	(3 years of Family Start service)	
Low	60hrs	(1 year of Family Start service)			

Family Start was to provide support and assistance to families, often in very concrete ways. The work could range from providing transport to get to key appointments, to helping with food preparation, to offering parental guidance, to assisting families to get access to mainstream services, and helping them access resources. A key dimension of the work was the families' formulation, with the assistance of their whānau worker, of goals and an accompanying plan to achieve those goals. These goals and plans were intended to form the basis of the work that was to be undertaken by the family and worker. Workers were expected to manage a caseload of 16 clients.

The Parents as First Teachers (PAFT) programme[8]

In addition to the practical support services noted above, families were also to receive 30 hours of training over a three year period in this programme. The Family Start Programme Operating Guidelines (1998: 64) about the incorporation of the child development component noted that "although resolving immediate crises or meeting essential material needs may be the initial focus of service delivery, delivery of PAFT should commence as soon as possible".

PAFT's objectives were to provide parents with more information about their baby's developmental needs and actions and teach them positive ways of interacting and playing with the baby (using common household objects) to enhance its cognitive and motor development. Initially, some consideration was given to ways of formally measuring the babies' developmental progress and a number of instruments were reviewed before it was concluded that the unreliability of instruments in making valid predictions (except at the extremes) about the developmental status of children under one year, and the need for those applying them to hold relevant professional qualifications, meant that it would be inappropriate for whānau workers to use them.

Whānau workers were to deliver PAFT through "capitalising on learning moments as they present naturally, e.g. modelling behaviour management techniques and placing the actions of the child within a developmental context" (Family Start Programme Operating Guidelines: 65). PAFT was available to be delivered as a Māori immersion programme and the parent resources were available in Samoan, Nuiean, Tongan, Tokelauan, Fijian and Cook Island languages. Whānau workers were to receive a minimum of four days training so that they could deliver the programme, and PAFT was to be delivered within the allocated Family Start hours for each family.

Exiting the Family Start Programme

The operating guidelines set out details about how each family's transition off the programme was to be managed. Briefly, this was to involve an evaluation of outcomes, to focus on what had been achieved as a result of being on the programme and to address how the family would manage independently. Each such meeting was to review:

- outcomes and identified needs and how these had been addressed;

- the family's achievements;

- an assessment of Family Start; and

- parents' needs for further support and how this was to be managed.

This last step involved a process of "independence planning" (Family Start Programme Operating Guidelines: 77). Finally, when the family left the programme, it was intended that there should be some formal acknowledgement of the cessation of service delivery, to be undertaken in a manner consistent with each family's values and culture.

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[8] When Family Start began in 1998, the education component of the programme was based on PAFT. In 1999, Ahuru Mowai/Born to Learn was launched, but this was not relevant to prototype sites.

Revisions to Family Start Programme Operating Guidelines

In early 2000, the co-funders reviewed the operation of the programme with the prototype sites and made a series of recommendations to HESSOG about the operation of the programme. In the report entitled 'Co-funders' Recommendations for the Family Start Initiative' (March, 2000), the recommendations/commentary by the co-funders and providers included:

- reaffirming that the client of the service was the baby ─ not, as two sites had assumed, the whānau (on the basis that the workers were intended to work primarily with whānau). At the same time, they re-affirmed that workers' engagement with whānau *was* part of their role;

- noting the inconsistencies across the three sites around the process of allocating and retaining clients to specific intensity levels;

- recommending that a degree of flexibility in the delivery of hours up to a maximum of 250 per year be adopted, because the programme did not permit a re-assessment of intensity levels or take into account fluctuations in need, and recommending that the providers develop a definition for determining intensity levels to be used across Family Start sites to give national consistency;

- suggesting that self-referrals be accepted; that all general practitioners could refer to Family Start, and that consideration be given to increasing the types of agencies defined as designated agencies;

- increasing the referral window to include the second trimester of pregnancy and a six month post-birth period;

- recommending that flexibility be introduced into the length of the assessment period, so taking into account the difficulties of working with very at risk families. Whānau workers should, nonetheless, aim to complete assessments within the five day and four week assessment periods that had been previously determined;

- recommending that Family Start services seek to achieve a balance in staff qualifications, competencies, and clinical and cultural experience, and that supervisors have formal supervision;

- recommending that issues around PAFT training be addressed and the contracts for training reviewed; and

- recommending that, to avoid the tension between some Family Start services and other providers, the support role of Family Start should be clearly articulated in contract management processes and in relationships with other service providers.

HESSOG accepted the majority of the recommendations. It did not accept, however, the change to the hours of service to be delivered to families or the extension of the service to include self-referrals, because of a concern that the service could become overloaded with low intensity families.

Summary

The Family Start programme was the outcome of intensive and extensive work undertaken by key ministries over a number of years. In 1998, implementation began in the three prototype sites. Thirteen further sites were announced in 1999.

The operating guidelines sought to overcome a range of tensions inherent in any national programme of this nature:

- national consistency and local adaptation to varying conditions;

- identifying the 15% *most at risk*, but *delivering* what has been termed a *strengths-based* programme;

- establishing additional services that are to be complementary rather than competitive with existing services.

In addition to setting up the programme, a range of evaluation activities was initiated. The nature of this activity is covered in the following two chapters.

Chapter 2: Approaches and Methods in the Family Start Evaluation ─ Process Evaluation/Database Development

The evaluation of Family Start has two aspects – a process evaluation, and an outcome/impact evaluation. The process evaluation took place in the three prototype sites, from 1999-2001. It involved interviews with providers, government officials, referral and community agencies and mothers in the programme. Additionally, providers entered data on a centrally developed database, and this was analysed as part of the process evaluation.

The outcome/impact evaluation will be on-going to mid-2003 and is built on work begun in parallel with the process evaluation. That initial outcome/impact evaluation work is reported on in this report where it informs the interpretation of the process evaluation data. (This work includes the feasibility study; the literature review; programme logic, and some early work around the design of an outcome/impact evaluation for the extension sites).

The Process Evaluation (1999-2001)

The collaborating ministries (Health, Education & Social Development) commissioned the development of a process evaluation plan. The plan was submitted to and approved by the Health ethics committees in Auckland and Bay of Plenty.

The plan identified three major research questions:

- Has the Family Start Programme been implemented according to the Family Start Programme Operating Guidelines provided by Government Policy?

- Has the Family Start Programme been implemented successfully, according to the Policy Makers, Providers, Clients and the Community?

- Have the theoretical and practical components of the Programme been satisfactorily developed?

In order to answer these meta-level questions, the key questions the process evaluation was to attend to were:

- What was provided, to whom, and to what standard?

- Is the Family Start Programme recruiting and retaining families who are most likely to benefit from its service?

- Are there differences in the achievement of goals, and families' recruitment and retention in the programme, according to family characteristics?

- What are the views of stakeholders and families on the acceptability and effectiveness of Family Start?

- What are the key factors that lead to the successful implementation of the Family Start Programme?

- Are there any unanticipated factors that have impacted on the implementation of the Programme? (E.g. unrelated social and economic changes in the wider New Zealand social and economic climate).

- What are the possible improvements that could be made to Family Start?

The range of issues on which data were to be collected, and the different locations/positions that needed to be covered, required - as the plan made clear - a multi-method data collection approach. In addition to data obtained through a database, the evaluators reviewed documentation relating to providers' policies and procedures for service delivery. These included documents pertaining to quality assurance processes, safety procedures for field staff, staff recruitment and developmental processes, and memoranda of understanding completed with other service providers.

The evaluation design required that the evaluators should undertake two visits to the field. The first was intended to focus extensively on the initial implementation processes and resultant issues and was to be undertaken within the first twelve months of the sites having been established, that is between September 1999 and June 2000. The second phase of the fieldwork, to be carried out between March and June 2001, was intended to look at on-going developmental issues and their implications as these related to the organisations and their modes of service delivery. Two reports have provided the basis for that reported here: Process Evaluation of Family Start Prototype Sites: Progress Report (Faisandier et al., 2000); Family Start Process Evaluation Fieldwork Round Two Report (2002). Interviews were conducted with families (predominantly with mothers) on the Family Start programme; providers; referral and support agencies; and central government agency officials.

Central to the implementation of the process evaluation was the contracting of researchers who demonstrated cultural competence in working with Māori and Pacific providers (which in practice means key members of the evaluation team being of Māori and Pacific descent, and the overall approach of the team being compatible with Māori and Pacific world views), as well as being able to deliver a perspective usable for policy development.

In all the interviews conducted at the sites, the evaluators matched, as much as possible, the ethnicity of interviewee and interviewer. When the interviewers did meet with a mother who was not of the same ethnicity as themselves, the mothers were offered the opportunity to continue the discussion at another time with an interviewer who was of the same ethnicity.

The original plan defined a series of research questions. The researchers in the field worked on the set of questions to make them more viable, by making them low level impact/stress on the mothers they interviewed, and used the following three questions as the core of their approach:

- How did you come to Family Start?

- What has been planned with you?

- How are things going?

(Questions from the longer schedule were used as prompts.)

Entering the field

The evaluators were formally welcomed at two sites with a pōwhiri. At the conclusion of each pōwhiri, the evaluators introduced themselves and worked through key issues about the evaluation process with the staff. They spelt out the key processes that they would be following, with particular reference to their commitment to be positively responsive to issues of ethnicity when interviewing clients, and to discuss issues about which the sites were concerned.

Early contact between evaluators and the sites raised the following issues:

- Concerns about the appropriateness of the client information sheets and the proposed interview schedules. (The evaluators in the field made adaptations to the interview schedule, and ethics committee approval was granted for changes to the consent forms.)

- Concerns about the site staffs' role in the recruitment of Family Start clients to the evaluation. In order to consistently recruit families to the evaluation, the Guidelines requested that families be asked to participate in the evaluation when Family Start workers first saw them. As most first meetings with mothers took place when the mothers were feeling stressed, staff disagreed with the obligation to raise the question of participation in the evaluation. (It was subsequently agreed that evaluation discussions with the client would occur in the first 6 weeks of contact.)

- Staff were anxious that the covert objective of the evaluation was to assess the quality of the work done at each site, without there being sufficient account taken of the issues and time involved in establishing a new service.

- Database issues (covered in an upcoming section.)

- Confusion and anxiety at needing to discuss the outcome/impact evaluation methodology at the same time as the process evaluation was being set up.

Doing the fieldwork

The interviews

On-site interviews with the three Family Start organisations, in the form of individual or group interviews depending on preference, were carried out in both rounds of interviews with:

- members of the Family Start boards;

- the staff (including, because of levels of staff turnover especially at Site One, some staff who had left not long before the site visits); and

- Family Start clients (nearly all of whom were Māori and Pacific mothers).

Focus group interviews were carried out at all sites in the first round of interviews, and with two sites only in the second round, with representatives of a range of local organisations (most of whom were designated referral agents for Family Start) who had had contact and/or had worked with Family Start workers.

Interviews were also carried out in Wellington with representatives from HESSOG and the co-funders (then ECD, CFA and HFA).

The focus of the questions asked varied according to which group was being interviewed. For example, the interviews with the referral and support agencies focused primarily on these agencies' accounts of issues facing the Family Start sites as they developed their work, and their experiences of and relationships with their local organisation. Clients were asked about their experiences of referral to Family Start, as well as for an account of the nature of the goal-setting processes and their assessment of the service.

A process for selection of client respondents had been designed at the outset of the evaluation in order to provide a consistent approach to selection of families for interviews across all sites, and to avoid any sampling bias. Family Start workers were to ask the first three to five families referred at the beginning of each month to participate in the interviews. This process was expected to yield a sample of 15% of all families referred to the programme. However, with a 50% decline rate by

clients selected in this way, in May 2000, it was agreed that any families in a given month who had agreed to participate in the process evaluation (at the time of their initial assessment) would be contacted by evaluators to discuss their being involved in the evaluation. The sites did not keep records about why clients declined to participate in the evaluation.

Thirty-four mothers were interviewed in the first round of interviews and sixty in the second. The interviewers had hoped to re-visit those whom they had interviewed earlier but this did not always happen because of difficulties of making contact with the families, appointments were not always kept, and because respondents had exited the programme. It is also worth noting that the interviews were conducted almost solely with the mothers as in the process of implementation of service delivery the mother – rather than the whānau or extended family – became the focus of most work. The interview process itself was not typically straightforward as the interviewers often found themselves holding babies, interacting with other children, and trying to manage an interview situation where the respondent was also having to negotiate the demands of their other children.

Some of the interview data were taped and notes were developed from the tapes. In the client interviews, where the evaluators considered the clients were not comfortable with their using a tape recorder, the evaluators took notes, which were then written up in long hand/entered onto computer. The interview data analysis processes were largely restricted to an identification of themes. The database and the review of client files provided substantiating information about the referral process (whether the service was meeting its service specifications about the speed with which clients would be visited, how the initial contact was carried out, and so on).

Analysis of the Database

Database purpose

The purpose of the database was to:

- meet the needs of co-funders for monitoring;
- provide data for evaluators to analyse for the process and outcome/impact evaluations; and
- assist providers in their own record-keeping and quality assurance processes.

Each of the three prototype Family Start providers was contracted to set up a local computer network and enter data relating to families into a specially designed database. A very comprehensive set of information about Family Start, including the individual details of the mothers, their partners, and the babies concerned, was entered in a series of computer "screens" at each site, and the information so obtained was automatically converted into a series of statistical tables, containing ID numbers only.

For evaluation purposes, the information was downloaded on-line to a central location, to allow analysis by the evaluation team. Total confidentiality was therefore preserved, and the evaluators had no knowledge of the names or personal details of the families involved, other than in the aggregate from the ACCESS tables downloaded. Reporting on the database analysis was integrated into the September 2000 report, and additional analysis was undertaken during 2001.

Database issues

Teething problems

A considerable number of issues arose with the development of the database. They are recorded here in some detail both as a record of the intent and outcomes of the database development, and to serve as useful information for those planning to set up databases for such programmes in the future.

A trial version of the database was progressively modified during 1999 and the early part of 2000, and the final version was in place by mid-2000. The initial development, however, did not proceed as smoothly as had been hoped. In the early stages of the programme, high levels of anxiety and even mistrust of the database and its use for the process evaluation were expressed across all three sites. There were concerns about the nature of some of the questions, about aspects of the operating guidelines, and about ethical matters in relation to families who were admitted to the programme but did not want to participate in the evaluation. Database accessibility for reporting purposes was also an issue for the sites. It also became clear that further computer training, specifically in database entry procedures, was going to be necessary in the three sites.

Following extensive consultation and a large amount of work, a revised version of the database was developed, taking these concerns into account. However, Site Three was particularly anxious about the purposes of the database and who would have access to it. They believed that some questions being asked were invasive of client privacy and emphasised weaknesses. As a result, they initially entered minimal data and used their own database. Consequently, the data they collected did not fully correspond with the data collected at the other two sites.

There is no doubt that the recording on a database of the dynamic flow of families through a programme, by means of a series of "snapshots" as they enter, progress, and finally exit, is a very complex operation. It is complicated by such things as the changing nature of the families being assessed (partners and caregivers may change over time), the difficulty in obtaining reliable information from a vulnerable group, and definitional problems about such things as exactly who is the client, what is an "unplanned exit", and how high, medium and low intensity of need are to be defined and the relation of this definition to the level of service being offered. The entry of "volatile" data subject to continuous update, such as the information in a baby's health and development record, also adds to the complexity. Those involved in data entry to the database worked hard in what was a relatively new and unfamiliar method of data-gathering, to ensure accurate information was entered. But particularly in the early stages of development of the database, its complexity caused difficulties.

The database was originally designed to make reports to co-funders a straightforward task for providers and co-funders alike. But because of initial difficulties with the database, the co-funders of the programme requested from the providers paper copies of the information that they required, instead of the computer-generated reports of ostensibly the same information from the database. As a result, the paper copies that were used ended up being different from what the database was supposed to provide more efficiently. This led to confusion on the part of providers about the use of the database, which then became regarded as solely related to the evaluation.

Unreliable data

- There were considerable *time lags* in entering particular pieces of information, meaning some tables were incomplete. This showed up particularly in the entry of mother, partner and child details. It also may have resulted in some incomplete "snapshot" code sequences.

- There was a concern that a large number of questions required evaluations, which involved *sensitive matters* (e.g. family history of drug abuse), that were not easy for the whānau workers to assess, certainly not at the outset. Workers may have been reluctant to enter such information. Some reported that they were required to be intrusive at an early stage in the evaluation, before they had established rapport with very vulnerable families.
- Some *inaccuracies* in entering data were detected in the early stages, which suggests there may have been more which were not detected, in spite of the error checks built into the database.
- There were some inconsistencies in the reports of mothers' and partners' second *ethnic affiliation*.
- There were a few miscodes of the computed variable *mother's age*, presumably caused by incorrect recording of mother's date of birth.
- There was a considerable amount of missing data in the *maternal health* section, particularly in Site One. The reasons for this included:

  - insufficient data entry skills;

  - no rationale for staff assessment and prioritising of issues; and

  - variations across the sites on whether an internal policy existed.

- Some of the screens required *mandatory responses* to certain key questions before the screens could be exited, and this led to the insertion of "notional" results. An example was the screen asking for weekly household income. When this could not easily be ascertained by the whānau worker, figures of $0.01 or $10 were commonly used to "get out of the screen". As in all research of this type, household income is a difficult variable to measure reliably, involving as it does some knowledge of the combined income of all the adults who take primary financial responsibility for the baby's needs. A "Not Yet Known" response was not available in the trial version of the database, but was incorporated into the final version to help solve this difficulty.

- Another example of missing data were the data on the child's father and mother's partner. It was mandatory from the outset of the entry onto the programme to enter this information, but such information may not have been available at that time. There was pressure not to make information on partners mandatory in the revised database, because it was seen to be intrusive. This, of course, meant that in some sites the question produced incomplete results. From the outset, no information at all on partners of mothers was entered on the database in Site One, and so no information on the influences of family structure is available from that site. Elsewhere, generally, information on family composition was incomplete.

Definitions

As the database developed, some definitional problems began to emerge. For example:

- Exactly who was the client, the baby or the primary caregiver (almost exclusively the mother)? This difficulty became apparent when mothers were allowed to enter the programme some months prior to the birth of their baby. And precisely how should twin babies be coded, and who was the client in such instances?

- What was a "planned" exit (e.g. does a transfer from one Family Start site to another count as a "planned" or a "premature" exit)? This matter was brought to the fore by the practice at one site, whereby a mother who chose not to continue on the programme would enter a planned exit

process with the kaitiaki with a view to possible re-entry at some later date. Should this be classified as a premature exit or not?

- The coding of the mother's occupation was another area where clearer definitions were needed. The vast majority of entries simply gave "mother", "parent", "home executive" or similar, which was not really what was required.

- There was also some ambiguity over how to interpret entries where both the name of a doctor and the name of a medical centre (or the mainstream Well Child provider) were given.

Many of these definitional problems were solved during the various revisions, but it took time and much consultation, and their occurrence illustrates some of the difficulties in this type of evaluation research.

Needs and goals

The intricate nature of the recording of *needs and goals* created major complications in the analysis. Goals were established at an early opportunity after a mother had been enrolled on Family Start, and were recorded in more or less the mother's own words, after some adjustment by the whānau worker or supervisor for entry into the database. Any number of personal goals could be entered, and these could be of any type. Some specific issues associated with the goal-setting practices employed by the sites follow:

- About one in every eight of the recorded goals was not in fact a goal at all, but a statement of what had already occurred. Some of these statements had implications for the future (in terms of successful completion of a course of training, for example), but some did not, e.g.:

  Aunt starts training programme

  Is now in her new flat

  Has moved in with father to save money

  Joined playgroup

  J. is lucky to have so much family support

- Some of the goals were short-term and well-defined, but the large majority were long-term and less specific, e.g.:

  Needs driver's licence

  Kick Start 2000 parenting programme

  Mother would like to take each day as it comes

  Would like to be able to pay bills

  To continue with schooling

- In general, mothers did not have clearly defined goals recorded on the database. This makes comparison of success rates problematic over a designated time period, such as the year considered by the present report.

- The times between the various assessments of progress towards goals (on the five-point scale) differed, depending on the frequency and timing of visits by the whānau worker. It was intended that these should be no longer than three months apart, but they varied considerably in spacing.

- At these visits, new goals were often added, making a very dynamic and fluid operation, which proved difficult to analyse systematically over the year.

- There were also discrepancies in the subsequent classification of goals into the ten need categories. For example, "To sit driver's licence" was sometimes classified under Education/Training, and sometimes under Other. "Mother wanting to attend parenting programme" was sometimes classified under Education/Training and sometimes under Parenting Capability & Practice. Some variation in categorising qualitative information of this sort is inevitable, but it needs to be done reliably if the need categories are to have meaning in the analysis. Some large discrepancies between sites may be attributable to differences of this type.

However, discussions between the database analyst and the fieldworkers indicate that in fact the data collected through the database system reflected the issues being noted by the fieldworkers well. Later reports from the sites indicate that the database will be functioning sufficiently well to act as a useful adjunct to the outcome/impact evaluation.

Summary

The account of the evaluation methodology and approach highlights the issues involved in working on what is perceived to be a high stakes evaluation process (i.e. provider awareness that evaluation results may affect funding) while sites were setting up their processes. The importance of awareness and understanding of Māori and Pacific cultures and protocols cannot be underestimated. The development of a database is critical to evaluation processes such as this and will inform greatly the outcome/impact evaluation. The time, communication and training required for this to work effectively cannot be underestimated. The prospects for the database to fulfil a useful role in the outcome/impact evaluation are good.

Chapter 3: Related Early Evaluation Activities (designing the outcome/impact evaluation; programme logic; literature review)

In parallel with the implementation of the process evaluation, work was proceeding on the outcome evaluation. This is briefly introduced within this larger report on the process evaluation because the early information from this further informs the interpretation of the process evaluation. It highlights the complexity of both the project and the evaluation - there are multiple expectations of various stakeholders in relation to each.

Designing the outcome /impact evaluation

Prototype sites

The first phase of the outcome/impact feasibility study undertaken at Site Two in 1999 was intended to assess initially which of several different outcome/impact evaluation designs could be best implemented, and then to undertake a short trial of the preferred option. The first part of the feasibility study was a consultation process, using a series of focus group interviews to canvas with community stakeholders (the provider, referral agencies, support agencies and community groups) which impact evaluation design should be trialled and which scoring instruments and questions might be used to measure the outcomes of the Family Start programme. Although the intention was consultative, the policy officials' group had restricted the range of evaluation designs to four options: a randomised control group design, variations of a national norms design, a comparison group design, and a regression-discontinuity design.

It was evident from the consultation phase, and from other information gathered by the project manager and the Evaluation Management Group (EMG), that the second phase of the feasibility study of the trial of a preferred method was not itself feasible as the consultation phase indicated that none of the suggested options were viable. During subsequent discussions with Family Start providers (as well as consideration of work done around the outcome/impact evaluation of the extension sites), some design preferences emerged that were further developed by officials, and a design was subsequently agreed to by both HESSOG and the provider sites.

Extension sites

The decision to evaluate the extension sites was made separately and, to begin with, had a separate path of development. A design phase was commissioned which involved consultation with the extension sites. The information from this study informed the final decision about outcome/impact methodology for both the extension and the prototype sites when the two evaluation processes were combined. This outcome/impact evaluation is now in progress and will be reported on in late 2003.

The Programme Logic

Programme logic makes explicit the programme's theory as represented by those involved in its development and implementation. The Family Start programme logic was intended to explore the assumptions underpinning Family Start and assist with designing the outcome/impact evaluation through identifying potential outcome indicators and measures.

The first Programme Logic Report was substantially completed in December 1999. Its main purpose was to help inform some aspects of the design of the evaluation, particularly the development of outcome measures. The development of the programme logic required, first, the development of the logic matrix itself and, second, discussion of the logic with two major stakeholders: government policy officials and a (smaller) number of providers from the prototype sites.

Two versions of the programme logic matrix were developed through consultation with the stakeholders. In October 2000 the two versions were integrated into one programme logic matrix. This matrix included a hierarchy of outcomes and factors affecting their achievement. Also included were some possible outcome indicators for each level of outcome in the hierarchy. The programme logic was then used to inform the design of the outcome /impact evaluation.

In her report Martin (2000) described the processes she used for developing the programme logic, highlighted methodological issues and discussed the results and key issues arising from the first stage of the development of a programme logic for the Family Start programme.

Programme logic methodology

Martin used a process to develop the programme logic similar to that described by Funnell (1997, 1999). It involved a review of key documents and a discussion of this review with all stakeholders.

In this instance, the key document analysis included the Family Start Programme Operating Guidelines, purchase documents (between co-funders and providers) and policy papers. Martin compiled an outcomes hierarchy for Family Start from these documents and developed an initial draft matrix of success criteria, factors influencing outcomes, and programme activities and resources. Appendix 1 sets out the specified programme logic matrix; Appendix 2 sets out the supplementary logic as developed from the provider interviews.

Following the analysis phase, Martin undertook key informant interviews with policy makers and co-funders to expand on and clarify the programme logic as extrapolated from the document analysis. Because individual interviews rather than group discussions were held, she asked a series of open-ended questions rather than attempting to go through the entire matrix in detail. However, some interviewees were particularly interested in looking at and commenting on the outcomes hierarchy.

The questions Martin asked were based on those used by Funnell (personal communication) and Patton (1997) when interviewing stakeholders. They covered such topics as participants' views about the beliefs and values underlying the programme; what they thought the programme was trying to achieve in the short and long term, what success would look like, what activities the programme required to achieve its goals and what factors might affect the desired outcomes. She analysed the interviews and revised the draft matrix accordingly.

A similar process to the above was carried out with most managers and supervisors at the three sites.[9] They were sent a background paper before the interviews outlining the principles and purpose of programme logic and the process being used to develop the Family Start programme logic. Martin did not discuss with them the process of the construction of a matrix and did not show them

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[9] However, the Pacific supervisor from the Pacific site was unavailable for an interview with the result that there was no specific input from a Pacific perspective.

the specified programme logic shown to providers. This was partly so that discussions would not be influenced by what policy makers and co-funders had said and partly because of time constraints.

Outcomes from the programme logic exercise

The summary results from the policy makers' and providers' consultations are set out below and the specified and providers' programme logic matrices are set out in the Appendices. There were some differences between these logics, reflecting officials' and providers' very different positions within organisational and government structures, their knowledge of the local community, and their cultural knowledge.

The programme logic interviews highlighted an awareness of factors and constraints that might well affect how the successfulness of the programme was assessed overall. There was a concern that very high expectations of the programme and what it might deliver (Family Start as a "magic cure-all") could not be met.

The initial development phase

In relation to the initial development phase, all officials commented on the need for multiple factors to be present if the programme was to have a strong start. These factors included:

- the time needed to set the programme up in each community or "the time to get it right;"

- the choice of provider i.e. the chosen provider had to have credibility and acceptability within the local community, needed to be seen as other than yet another government agency, and should reflect the target population;

- the quality of the whānau workers, who were expected to be multi-skilled and who needed to represent the target population especially in terms of culture and ethnicity. The level of skill required was noted as a potential problem especially in smaller communities with less of a skill pool to select from;

- the quality of the initial training for workers, given the huge expectations and demands on workers, and the need for on-going quality training; and

- resourcing levels which, although adequate at the outset, needed to be maintained to ensure the workload of workers remained manageable and to ensure that managers were able to pay for highly skilled staff.

Wider structural constraints

Officials cited a number of significant structural factors (such as institutional racism and the broader socio-economic climate) as affecting families' capacities to achieve, especially when measured against the higher outcome levels. Furthermore, gains by individual families also had to be placed against gains within the wider community. For example, a lack of a general improvement in employment opportunities might well place those Family Start families in a better position than non-Family Start families to compete successfully for scarce work. Individual families may register an improvement in their circumstances (Outcome Level 6) but overall, there may not be much in the way of social and economic gains for the wider community (Outcome Level 7).

Part of the Family Start objective was that it should facilitate clients' access to other services, particularly in light of respondents' acknowledgement of the low uptake of certain government services and resources by particular groups in New Zealand, many of whom were those targeted by Family Start. However, how this "fact" is to be read affects how the "problem" is approached. Both

officials and Family Start providers considered that reasons for the low uptake of services provided by mainstream providers were because clients often experienced some providers as alienating, culturally inappropriate and at times hostile. Recognising the relevance of such factors placed the onus for change more on the agency and less on its clientele. Furthermore, the commonly held assumption that at risk families were not aware of available services and resources (and so did not use them) was open to question. Typically, service uptake requires financial resources (e.g. cost of travel to get to the doctor). Accordingly, many families with very limited finances might well have to prioritise decisions about spending.

The strategy of increasing referrals to services also assumed that those services were available in the community and resourced to an adequate level. These factors could not be assumed for all communities. The officials considered that long-term effectiveness required policies to address the barriers constraining uptake of services and the identification of strategies for overcoming these barriers.

Finally, some interviewees talked about possible impacts that Family Start might have on the wider community. Anecdotal evidence from one site, where the provider was very well established, suggested that Family Start was widely accepted and supported within that community and that some of the programme's positive messages (e.g. about parenting) might well have a wider impact than was first envisaged. Respondents considered that this "ripple effect" could become one of the unanticipated results of the programme.

Summary of discussions with providers

In general, there was a high level of agreement between providers from the three sites about the value of the programme's stated kaupapa/philosophy. The adoption of principles such as strengths-based approaches, operating holistically, strengthening families, developing models appropriate for local communities, being proactive rather than reactive, and the importance of developing collaborative relationships with families were seen as very valuable by staff from the three service providers.

It appeared that the overall outcomes hierarchy was largely consistent with how providers viewed their own programmes. However, providers placed less emphasis than did officials about overall savings to government (Level 7) and more on benefits to the families on the programme (Level 6). These benefits were frequently talked about in terms of improvements to local - especially Māori - communities.

Finally, it should be noted that the respondents were extremely positive about the Family Start programme, describing it as proactive, innovative, "outside the box" and bold. A number of the staff said they had actively chosen to work with Family Start, often in preference to "mainstream" jobs, because of the huge opportunity and potential they saw for making a real difference.

Differences between officials' and providers' reading of the logic

While there were some broad similarities in the readings provided to the outcomes hierarchy for the three sites, there were two significant differences from those of the officials. One related to the role of other agencies in improving life outcomes for children from at risk families and the other related to the determining of goals and outcomes.

Role of other agencies in improving life outcomes

The most noticeable difference was that the service providers considered that one of the short-term goals of Family Start was to develop and model alternative mechanisms for service delivery that could be adopted by mainstream agencies. The requirement on providers to develop their own systems of service delivery was something that could spill over to affect how other agencies (especially WINZ and CYFS) delivered services to their clients *because* the way these other agencies dealt with families was understood as a significant factor in whether or not such families' circumstances improved.

More specifically: in the specified programme logic (that is, the one substantially informed by officials' accounts), it was assumed that the effect of other agencies adopting a more strengths-based approach and working more collaboratively with each other was the creation of a "ripple effect" percolating up to fairly high outcome levels. In contrast to the officials, the providers viewed such a change as a critical pre-condition to allowing real change for the target population, because they believed many of these agencies have traditionally contributed to, or at least helped perpetuate, the disadvantage faced by many families. The Family Start programme therefore could potentially play a significant role in the modification of other agencies' processes and procedures through the trialling and modelling of alternative models of service delivery.

Differences in goals and outcomes

The second major difference between providers and the officials' programme logic was that providers were less likely to identify very specific goals for the programme (and for families) than were policy makers and co-funders. Although the latter stressed that the success criteria they listed were ideals and not realistic or appropriate for every family, nonetheless, they defined very high level goals/outcomes as relevant to Family Start and as therefore providing a basis for measurements of effectiveness. Alternatively, the providers emphasised the need to select outcomes that were appropriate to the programme and clientele, noting that the programme might have to be in place for some time before outcomes such as some of those specified in the higher level goals could be achieved. Providers referred to the danger of too rigidly determining outcomes in advance because this did not allow for the possibility of the emergence of critical unintended and positive outcomes. In the context of emphasising how Family Start had adopted a strengths-based approach, providers underscored the relevance of giving value in terms of measurement to the goals and outcomes specified by the families on the programme. Providers also discussed this issue in terms of the development of alternative cultural models for Family Start and whether alternative outcomes arising from these models would be acceptable to Government. The issue was not that providers rejected the need for outcomes, but about where and by whom those outcomes were determined, how they related to the immediate and longer-term needs of the families on the programme, and the degrees of flexibility in outcome determination that had been built into the programme.

The Literature Review

The objective of the literature review (Gray 2001) was to inform policy development in relation to Family Start as well as parent support and development programmes generally. To further this objective it:

- discussed broader contextual issues in relation to parent education programmes;

- provided a brief overview of early intervention programmes, including a discussion of issues relating to service delivery and staffing;

- reviewed the effectiveness of programmes targeted to certain groups;

- considered the focus of early intervention programmes; and

- discussed factors outside early intervention programmes that could impinge on their success.

Literature review methodology

The review drew on material from a range of sources. A large body of information collected during the development of the Family Start programme was made available for review, including a number of previous literature reviews and meta-studies. This material was drawn from searches of the Australian Education Index, the Canadian Education Index, Index New Zealand, ERIC Database, The National Bibliographic Database, AUSTROM, Sociological Abstracts, ChildData CD-ROM and searches of the Ministry of Social Policy holdings.

This material was supplemented by further searches undertaken by staff at the Ministries of Education and Social Policy Information Centres, particularly for material on services for itinerant or transient families and programmes for Māori and Pacific families. Very little new material was obtained through these latter searches.

Additional information was obtained from the internet and from a search of the Expanded Academic ASAP International database, using keywords such as "parent education," "parenting programmes," "home visiting programmes," "strengthening families," "family support," and "early intervention programmes."

Reference lists on existing literature reviews and meta-studies were also explored. While it was not possible to obtain every article that appeared to be of interest, there were no obvious omissions or gaps in the literature obtained.

The great majority of the literature that Gray was able to identify and therefore review was from the United States, with small contributions from the United Kingdom, Canada, Australia and New Zealand. In reading this summary of the review, it is important to bear in mind the considerable differences in public policies between the United States and New Zealand.

The report covered education and support programmes for parents with children aged 0 to five. It did not cover child care services or early childhood education per se, which have been reviewed elsewhere.[10] It discussed programmes that:

- were home-based, centre-based or use mixed methods of delivery;

- had health, welfare, educational or family support objectives; and

- had been evaluated.

Gray decided to focus on programmes that had been evaluated for two reasons. The first was to make the review more manageable, as estimates indicated that there were more than 50,000 parenting programmes in the United States alone (Carter and Kahn 1996: 108); the second was to increase the reliability and validity of the findings of the studies reported in the review. This latter aim has been achieved to a limited extent only. Given the considerable variation in modes of

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[10] See Smith et al (2000) Early Childhood Education: A Literature Review. A Report to the Ministry of Education. Children's Issues Centre, University of Otago, Dunedin

delivery, programme settings and programme goals, it proved difficult to generalise about early intervention programmes. As Karoly et al (1998) have noted, the best that could be achieved was a discussion about what *some* programmes could do depending on their characteristics and the families they serve.

Furthermore, many of the programmes that had been subject to longer-term evaluations, such as the Elmira home visiting programme, MELD and the High/Scope Perry Pre-school Program, were set up between 20 and 30 years ago, in circumstances and settings that may have changed since then. Researchers have questioned whether programmes designed and implemented in the 1960s and 1970s can be considered to be adequate to meet the needs of young children and their parents today.

Summary of the Findings of the Literature Review

Gray (2001) observed that the terminology used in relation to parent support and parent education has varied over the years, with a trend towards a more holistic approach, commonly called *family support*. Some writers have suggested that the use of terms such as *parent education, parent training, parenting programmes* and *parent support* reflected a continuing lack of consensus on the goals of parent education. Gray noted that the social and economic context in which programmes were delivered and the availability of high quality, culturally sensitive and accessible community services influenced the effectiveness of comprehensive family focused programmes.

Gray commented on how the evaluation and review of family support programmes is fraught with difficulty. Such problems arise because of a number of factors. Such programmes may have targeted parents and/or children in families that have been identified as high-risk for poor development but have little else in common. They may have had a variety of objectives, be delivered in different ways to different recipients, and have covered a range of topics or services. For these reasons, clarity about the type of intervention being analysed, the targeted population, when the intervention was to be delivered, and what outcomes were defined is necessary.

The literature pointed to some considerable variation among home-based programmes in their goals and focus. Some programmes have targeted particular groups and others have targeted particular behaviour, especially in health-related areas. Many programmes also had individualised plans as a key element in their design, a complicating factor in attempts to generalise outcomes across programmes. Other issues complicating comparisons of evaluation studies included differences in the delivery of services, difficulties in establishing a control group, and problems in determining outcome measures.

Overall, Gray argued that the determination of the outcomes of home-based programmes have tended towards the inconclusive. Nonetheless, reviewers have identified a number of features likely to enhance programmes' success and consider that successful programmes need to:

- have clear goals;

- have agency support;

- be targeted at the neediest population;

- balance the needs of parents and children;

- be designed to suit the needs of clients;

- be culturally appropriate;

- have specific strategies to address problems;

- be delivered at a time that matches the programme's goals;

- be staffed by professionals or highly trained paraprofessionals with ongoing supervision;

- be flexible in delivery intensity to suit families' needs;

- be delivered according to the programme design;

- be adequately resourced; and

- address factors outside the programme that affect family functioning.

This list extends the list of key factors identified earlier in Chapter 1.

Centre-based programmes have provided a range of services, including child care, classes in child development and parenting, parent-child play groups, drop-in centres, counselling, information and services related to sexuality and job training. They can be divided into three main groups – those that are primarily parent-focused, those that are primarily child-focused, and those which seek to address the needs of the family.

Gray argued that evaluation issues for centre-based programmes were similar to other forms of service delivery in that differences in levels of staffing, programme length and content and style of delivery, parental involvement, and outcome measures all need to be taken into account. The range of outcome measures to test children's development has been criticised as has the lack of measures to assess positive as opposed to negative aspects of parental behaviour. Small samples and high attrition rates have also complicated the production of robust evaluations. Further, because few studies have been replicated, the validity and reliability of findings of these unreplicated studies may be open to challenge.

Commentators have agreed that in order to increase their likelihood of success, centre-based parent-focused programmes need to:

- be appropriately targeted;

- have appropriate programme content;

- be at a high level of intensity; and

- provide incentives for participation.

However, the mixed delivery programmes referred to in the literature review varied in their form and content. Some offered only parent education and an early childhood programme through a combination of home visiting and centre-based activities. Others used both home visiting and a central location to deliver a wide range of services to the child and family.

As a consequence of the above, very few comprehensive, community-based initiatives have been rigorously evaluated. Some programmes have attempted to gather information about the array of activities they managed and the populations they served, but few have undertaken a careful analysis of their costs, effects and effectiveness. To complicate things further, conventional evaluation models have not adequately captured the interactions and synergy among components or the range of outcomes such programmes are intended to achieve. External factors also need to be taken into

account. Research has highlighted the difficulty of achieving change for families who are often in challenging financial and social circumstances.

The literature suggests that mixed delivery, family focused programmes should:

- have community involvement at the planning stage;

- have clear goals and a strong theoretical base;

- be strengths-based and family focused;

- be long term;

- be of high intensity;

- be appropriately targeted;

- be culturally appropriate;

- be developmentally appropriate; and

- have well trained staff.

Most of the reviewed literature on providing early intervention programmes for minority groups discussed services for African-American and Hispanic groups. Very little available research referred specifically to services for Māori or Pacific families or to other groups, such as transient families. Gray asserted, nevertheless, that many of the principles identified in the American literature apply to culturally appropriate service provision in general, with the key elements in successful programmes for minority groups including the need to:

- assess the particular cultural characteristics of families being served, including the role of extended family, the part played by fathers in childrearing and family strengths;

- establish a dialogue regarding programme goals through an ongoing, dynamic relationship between service providers and clients;

- attend to the culture of programme staff, including the contribution of personal characteristics. Service providers of the same ethnic or cultural group may be most responsive in helping parents acquire the information and support they need to work towards their expectations for their children and to retain control over their lives; and

- consider alternative programme formats, including being flexible and adaptable to the culture of participants, and being prepared to offer home-visiting, centre-based programmes, or a mix of the two.

Although the majority of the writers whose work Gray reviewed agreed that outcomes for children were enhanced when parents were actively involved, others believed that programmes should be aimed very specifically at the target population. That is, to achieve outcomes for children programmes should be targeted at children, while programmes aiming to achieve change for parents need to be targeted at parents.

The analysis of the literature, then, suggested that programme results at that time were tentative and mixed. However, researchers argued for their continuation as part of a community-based system of

comprehensive, co-ordinated and family focused prevention and intervention services on the grounds that well resourced, comprehensive programmes could be a significant component in a larger strategy to invest in children and families (Gray 2001: 1-3).

Discussion of key findings

Gray's discussion (presented below) of key findings relating to outcomes and success of programmes such as Family Start highlights the significance of various design features that were incorporated into the Family Start programme. Equally more apparent, however, become the more problematic aspects of other features, such as the rigidity or inflexibility of aspects of the programme, and the issues addressed by the feasibility study and programme logic about the determination of outcomes and the "shape" of those outcomes. Further, as with those reviewing the programme logic, Gray reiterated that a programme such as Family Start should not be viewed as a panacea and that results may be mixed. In other words, the literature review substantiated the concerns about placing too high expectations on Family Start, because of the way such expectations can affect how outcomes are assessed. Gray wrote:

> *With the shift from single-focus early intervention programmes to a more comprehensive family-focused approach, family support programmes have become more challenging to design, harder to implement and more difficult to evaluate.*
>
> *The literature on family focused programmes is tentatively positive but hedged with cautions. Even with a well-designed, well-resourced programme, the results are likely to be mixed or disappointing. There is evidence of gains in some programmes, but not in others, of similar gains in widely different programmes, and a sobering lack of gains overall. The literature does not support the view that either home visiting or centre-based programmes alone will benefit children at risk or their families, while the evidence on comprehensive programmes is equivocal. The quality of programmes is a key factor in their success. Model programmes are often well-resourced and well-managed.*
>
> *Home visiting has worked best in small-scale projects, targeting specific groups. While there is some evidence of improved cognitive development and health benefits for children, home visiting appears to work best as a support structure for mothers/parents, increasing their self-confidence and knowledge. There is more research to show that attending early childhood education programmes can produce measurable cognitive improvement in children. Centre-based programmes can also provide support for parents, who may be encouraged to participate in activities in association with their children. The literature indicates that on their own, centre-based programmes might be ineffective at drawing in more marginalised families. Thus overall, mixed programmes do appear to reach the widest range of people and effect the greatest changes.*
>
> *The literature generally agrees that at the broadest level, family-focused interventions should:*
>
> - *identify and capitalise on the strengths of the children, family and community;*
>
> - *be multiple system/setting;*
>
> - *be multiple component - for example, having a parent-focused component which includes family support and information as well as a child-focused component which includes high quality early childhood education and health care;*

- *be multi-year;*

- *be provided earlier rather than later although interventions can still be effective at later ages;*

- *acknowledge the potential need for a continuity of services;*

- *promote both formal and informal networks;*

- *include competency enhancement;*

- *include vocational and educational training for parents;*

- *be culturally appropriate, recognising that factors in the parents' social and cultural context will have an impact on parenting;*

- *be integrated, that is include health, education and welfare services; and*

- *have reasonable expectations of the time commitment required of families and providers (Brady and Coffman 1997, Middleton and Asiasiga 1995, Robson 1997).*

The more successful programmes have strong theoretical underpinnings, with clear goals that are determined in partnership with the target community. For example, they do not aim at 'improving outcomes for children', they aim for achievable goals for parents, such as reduction in parental stress and increases in confidence as well as specific health outcomes for children. Intended participants must first identify their needs and goals. Economically disadvantaged communities often identify intermediate and short-term goals that may not be compatible with middle class values but which nevertheless must be acknowledged.

Dumka et al (1995) stress the value of researchers and practitioners working together with members of the community to ensure that programmes are well-designed, appropriately delivered and accepted by the community they are intended to serve. As well as defining the programme goal/s, members of the target group also need to be involved in selecting change objectives and methods, developing strategies for recruitment and retention and deciding on appropriate ways to deliver the programme.

Programmes also have to have effective links with existing support agencies, and where these agencies do not exist or are inadequate, they need to be developed. Some commentators suggest that programmes should have their own support systems rather than relying on existing agencies to co-operate, but in most cases this is unrealistic. A preferable approach is to identify how institutions can adapt to provide optimal support to children and families (Ministry of Community and Social Services 1989: 179).

The intensity and duration of programmes appears to be directly related to programme outcomes. Generally, whatever service is chosen needs to be available for families on a regular basis, with some suggesting that two to three times a week is preferable to two to three times a month. Flexibility is important, with a coherent programme that is responsive to the individual needs of families generally being regarded as more beneficial than a rigid adherence to a predetermined regime.

Measures also need to be in place to keep people in the programme. Clients have to be able to see how the programme relates to their needs. They also have to feel assured that they will derive some benefit from attending. Practical barriers to participating need attention. This may include crisis intervention.

Staffing requirements depend on the programme. The evidence suggests that some programmes or programme components can be provided by lay workers or paraprofessionals, others are best provided by professionals. In either case, staff need ongoing training and quality supervision. The most effective programmes keep in touch with staff constantly, offering ongoing education and help.

Evaluations are an important component of all programmes, both for the information they offer to providers and for their contribution to knowledge in the area. Many of the evaluations considered for this report, however, are methodologically flawed. Sample sizes are often small and little consideration is given to those who drop out. The Ontario report notes that even with the large number of evaluated infant and pre-school programmes, there are too few such studies that clearly establish the approximate size of expected outcomes, especially the long-term effects. In other words, do children who participate in prevention programmes clearly demonstrate meaningful and significant effects relative to comparable children who do not have such an opportunity? Few programmes focus on physical, cognitive, emotional, social, parental, community and service sector components in the same study, which make it impossible to know which component does what.

Brady and Coffman (1997) urge that in order for family support and parenting programmes to have a secure future, they need to:

- *use evaluation strategies that reflect and support the field's move towards more comprehensive initiatives;*

- *examine child and parent outcomes and needs longitudinally;*

- *choose measures that reflect intended programme outcomes;*

- *examine the relationship between parent and child outcomes;*

- *establish mutually beneficial relationships between evaluators, providers, and child development researchers; and*

- *consider using cost-effectiveness analyses as a method for measuring and reporting programme results.*

(Gray 2001: 57-59)

Summary

Read together, the feasibility study, programme logic and literature review highlight the complexity of developing a comprehensively focused programme and evaluation.

A programme such as Family Start is responding to a range of expectations and agendas, from those of government and policy officials to those of providers at community level. While there is considerable congruity, there are also significant differences.

The international literature highlights the difficulties of evaluating complex social programmes, such as those that endeavour to improve the social outcomes for high risk families. Although there is an emerging view about the features likely to enhance a programme's success, there is only tentative and mixed evidence about the effectiveness of such programmes. There continue to be

considerable theoretical and methodological challenges in designing and implementing evaluations of such programmes.

This international experience is borne out by the initial work in designing the outcome/impact evaluation for Family Start. Issues identified included acceptability of design methodology, and identification and choice of outcome measures to be used. Related issues (noted in Chapter 2) were demands on providers to assist with design of the outcome/impact evaluation while also establishing services and participating in the process evaluation; developing the tools for evaluation (the database); and locating appropriately skilled evaluators.

Chapter 4: Implementing the Services

In 1998, three prototype sites were established, all of which were to be involved in the process evaluation. This chapter describes the ways in which those sites were rolled out, some of the early challenges they dealt with, and the profile of the population to which they provided the Family Start services. The following chapter reports on some of the emerging issues as the services continued, and the initial indicators of impact on the families.

The Organisational Structure

The operating guidelines describe the basic organisational structure. Governance Boards had responsibility for the oversight and development of the programme, and managers were appointed to each site and had overall responsibility for the day to day work and management of site activities, and employment of other staff. Additional staff were supervisors, whānau workers and administration staff.

The governance boards

All boards met monthly. At two sites, in both instances those where Family Start had been constituted by partnerships between two previously unrelated organisations, the boards' role was defined as a governance role and concerned with the policy and development. At Site Three, where the service provider was a single organisation, the board maintained a much more hands-on approach, involving themselves with the operational side of the work.

The boards at Sites One and Two were constituted by coalitions. The Site One coalition was formed between a Māori agency with previous experience of contracting with Child, Youth and Family (CYF) and a mainstream Well Child provider. The Site Two coalition involved a newly formed coalition between Māori and Pacific Island service providers. In contrast to these sites, the Site Three Family Start provider was a well-established Māori service provider, providing services to its own iwi. It regarded the Family Start work as an extension of the work it was already funded to carry out.

By 2001 it was evident that the maintenance and development of the governance coalitions had been a complex and difficult process. For example, at Site One, the partnership had dissolved by November 2000 because the mainstream Well Child provider believed that its own work was becoming legally exposed as a result of the Family Start Trust's failure to meet its contractual obligations.

Following the signing of the contracts, each site had between two and three months to establish their business before opening their doors to the public. The limited time to get established and to open their doors had proved challenging. At the two sites that were starting from scratch, the work included consultative work and the building of internal and external alliances. What was also evident was that although the contracts stipulated that providers focus on service collaboration, the climate in which these new organisations were operating was a competitive one, so complicating the development of collaborative relationships with existing agencies, some of whom had doubts about the capacity of the new organisation to adequately fulfil its role.

Staffing at the sites

The managers

The managers were responsible for recruitment, retention and development of staff and for the networking with other local health and social agencies across the catchment area; these responsibilities focused on achieving organisational visibility and credibility, and on developing a professional organisation. At all sites, those appointed as managers had worked in the community in a range of different jobs, including training and client advocacy. One had had previous experience in social welfare work. In terms of formal qualifications, one had qualifications in business management and another had a business degree. All managers were Māori and were predominantly women.

Sites' experiences with their managers varied. Site One had had two managers between late 1998 to March 2001. The first manager's departure occurred in the context of staff and board conflicts and general dissatisfaction from the supporting and designated referral community organisations about the quality of service delivery. In light of such concerns, the new manager concentrated on building morale, insisting on more professional practices within Family Start, and on improving organisational visibility and credibility. By the time of the 2001 fieldwork, her work seemed to have been having an effect, given the more positive nature of the community organisations' evaluations of and feedback about the service. The evaluators reported that the manager's decision to "open the books" to the whānau workers/staff (so they were fully aware of the difficulties the organisation was facing and of the work they needed to undertake to fulfil the contract) was regarded positively by the staff.

The manager at Site Two was appointed in November 1998. Over time, the focus of her work had changed and was, at the time of the evaluation, addressing more the developmental dimension of Family Start at Site Two, as well as issues of organisational visibility and acceptance in the wider community.

Site Three had had two managers, with the first leaving in February 2000 to take up a position in one of the new Family Start organisations. During his tenure he started a process of exploring with staff the theoretical and practical application of a strengths-based approach with the result that staff at this site were able to define this term and its implications for their work. Site Three defined strengths-based practice as meaning that the workers had a responsibility to focus on whānau and encourage them to support the mother practically as well as emotionally; in relation to the mother, they worked actively to encourage any expression of interest in self-improvement. The Site Three manager appointed in May 2000 focused on placing the Family Start development within a broad community development focus, utilising the extensive whānau and community networks associated with the agency. This work resulted in cross-agency appointments that enhanced the possibility of identification of at risk clientele, the sharing of facilities with another significant Māori service provider, and the commitment to continue to assist in the educational development of young, single mothers through the provision of a school for young women who had become pregnant while still in school.

It can be argued that the changing work and foci of the different managers reflected in part the different degrees of organisational growth and consolidation at the three sites. Factors such as the forging of positive working relationships with other providers (outside of the governance coalitions) and the development of a specific focus of the work appear to be associated with positive growth. Alternatively, the need to "return to basics" in terms of seeking ways of inserting the organisation

into the community and re-focusing on basic issues associated with organisational accountability and more competent work may indicate more (as in Site One) an organisation that is struggling.

The supervisors

The information in the two fieldwork reports on the supervisors was limited. By the time of the 2001 fieldwork round, Site One had had three supervisors, all of whom were Māori women. All brought different, related knowledge of the field to their work; all were knowledgeable about the region in which they lived. No information is available about the focus of their work.

Site Two initially appointed a Pacific supervisor in November 1998. Both she and the Māori supervisor, appointed in January 2000, had social work qualifications, experience in community service and commitments to their specific communities in terms of quality service delivery. The work of both supervisors concentrated on extending professional development opportunities (providing study leave, increasing regular formal supervision sessions, developing in-house training, and maintaining an open door supervision policy for all staff) to ensure that practice issues were promptly dealt with and to strengthen management/line relationships.

Site Three had had three supervisors but at the time the fieldwork was conducted there were two only. Both were Māori, one of whom had been appointed in November 1998 and the other in July 2000. There was no information as to their formal qualifications but both came from leadership positions in other social work agencies. The second fieldwork report commented on their clear and demonstrated knowledge of social work practice, on the implementation of QA procedures and policies, on the regularity of formal supervision of the kaitiaki and on the focus on best practice approaches in service delivery.

The whānau workers

By the time of the 2001 fieldwork round, Site One had had three intakes of whānau workers. The high staff turnover (nearly 50%) could have potentially compromised the work to be undertaken, given that whānau worker stability is likely to increase the chances of engagement with and retention of stressed and highly at risk families. Of the eleven workers in employment in 2001, nine were Māori and two were Pākehā. Three had formal qualifications, while the rest all had community work experience and had worked with families in various settings. The workers were divided into two teams, with each team led by a supervisor. Each worker had a caseload of six families. This was the lowest number of cases per worker across the three sites and related to a low number of referrals initially, followed by an absence of referrals for a period because the referral agencies had lost confidence in the quality of service their clients would receive.

Site Two had twelve whānau or aiga workers, divided into a Māori and a Pacific team, and each team had a male worker. Six of the workers were Māori, one Tongan, one Tuvaluan, three Samoan and one Pākehā. Each carried an average caseload of between 12-16 cases. There was no information about the qualifications of the Pākehā worker. Most of the Māori workers had no formal qualifications but had experience of working with families in different settings. One had been an administrative assistant at the site before accepting a social work position. They had been employed between September 1999 and March 2000.

The appointment policies for the Pacific Team concentrated on the employment of ethnic-specific recruitment so as to be responsive to the range of Pacific nationalities in the service's catchment area. Recruitment policies accordingly gave weight to the employment of staff speaking a range of Pacific languages and to the aiga workers' linguistic, cultural and ethnic compatibility with their

clientele. Three of the Pacific workers held relevant formal qualifications in social work, nutrition, and nursing.

Site Three had sixteen kaitiaki, the majority of whom were Māori. Two were male. All brought experience from social, educational and health backgrounds. Most had formal qualifications and extensive community experience. Each carried a caseload of between 13-16 cases. In a context that reflected this site's valuing of education as critical to moving beyond poverty, all kaitiaki placed considerable emphasis on encouraging the mothers to achieve educationally, even if the initial training programmes some joined might be thought of as undemanding. Māori kaitiaki stressed the importance of being close to community feedback about the quality of their work; all defined quality in relation to doing what they would feel comfortable about their own families receiving.

Administration workers

All sites had an administration worker. Site Three also employed a receptionist.

Working for Family Start

Family Start services were contracted to deliver two major strands of work. One was the intensive work required to support and strengthen the clients' families, and the other was the Parents as First Teachers (PAFT) programme. The client of the service was the baby and the work was intended to be undertaken with the wider family and community as appropriate. However, the whānau workers worked primarily with the mothers. For this reason, "mothers" rather than "family" has been used in referring to those with whom the workers mainly engaged.

Family Start is a very pragmatic service, delivering concrete services to its intended high risk clientele. Whānau workers, using a strengths-based model, were expected to develop close and positive relationships with the families with whom they worked to help them define and achieve attainable goals through carrying out the tasks associated with their achieving better life outcomes. Such outcomes would be the result of the families (and in this instance, primarily the mothers) being encouraged and assisted to undertake relevant training, as very few of them had any formal qualifications and most were dependent on benefits. A consequence of working with the whānau workers was that the mothers should gain confidence, skills and problem-solving capacities.

In working with the mothers and whānau, the whānau workers were expected to undertake a range of activities that would contribute towards changes in the lives of the children's families. Providing practical support involved assisting with daily tasks (such as providing transport to get the family to the supermarket), the provision of information about a wide range of at times very basic issues (e.g. meal preparation, diet, managing a household), providing information about availability of services and how to access them, as well as about areas on which the whānau workers had received training (such as how to act in a violent domestic situation). A key element of the interaction involved working towards defining achievable goals and setting tasks that contributed to the reaching of those goals.

Such work was challenging. Proffering advice skilfully and appropriately on such a wide range of issues required that, to be effective, each worker required a quite extensive information base and the ability to assess how best to impart the relevant information to each client. Workers needed the ability to understand the interrelationships of the different components of the task, to hold onto a clear sense of the direction and overall purpose of the work, and to appreciate the wider context in which mundane tasks, such as driving someone to a supermarket, may be carried out. There is some limited evidence that some of the whānau workers at Site One at least did not have this wider

conception in mind and appeared to find it difficult to sustain a focused approach to what can easily become a diffused notion of support.

The workers at the three sites brought with them very different qualifications, experiences and, presumably, very different reflections on and appreciation of those experiences. One of the concerns voiced by the officials in the programme logic exercise had centred around the sites' ability to find suitable staff to undertake the work, with the recognition that this might be more difficult in smaller and more isolated communities. It is not clear, however, if at Site One (the most isolated site and the site that experienced the most difficulty) the issue was a lack of competent potential applicants or whether more competent workers decided against seeking employment in an organisation that was struggling.

The whānau workers' role required workers to be multi-skilled. Given the variety of their educational and experiential backgrounds, this highlights the very considerable importance of adequate initial and continued training. It should be noted that the importance of training as a key factor in the delivery of a quality, safe service was re-iterated in the literature review (Gray 2001). A five-day initial training programme was delivered to staff as they joined Family Start. Managers were responsible for developing on-going training. This included attendance of whānau workers at CYF courses designed to give beginning workers basic skills and information, including information about taking safety issues into account. The commentary about these courses reported on in the draft reports suggested that some stakeholders perceived the original training of Family Start staff was of insufficient depth to adequately prepare staff for their roles.

There was something of a tension in the notion of "multi-skilled worker" implicit in the Family Start programme, the actual levels of skill held by some individual whānau workers, and issues associated with working collaboratively with mainstream and other more established agencies. The Family Start programme nominated the whānau workers as key workers with individual families because they were seen as being able to provide a culturally appropriate and responsive service. Nonetheless, it was expected that these workers would call in mainstream services as and when necessary. In practice, at one site in particular, it appeared that one key factor informing the provision of Māori and Pacific services (i.e. the issue of lack of sensitive dealings by mainstream providers with their Māori and Pacific clients) complicated the referral-on processes and the undertaking of collaborative work with mainstream agencies. In general, there were concerns, identified more strongly in the first fieldwork round but voiced in the second, that some of the whānau workers were trying to be all things to all people and might have been attempting to carry out work well beyond their capacities, so jeopardising their and their clients' safety.

There was also a concern, especially in the early stages, that a newly funded but still-to-prove-itself service might put older and more established local services out of business. Professional jealousies and organisational angst about competition also complicated the development of a collaborative, interagency approach.

There are two further, related points to be addressed as they bore on the structure and delivery of the Family Start services. First, the initial concept of Family Start had focused on developing a service that would engage with key people in each family's environment beyond those in the nuclear family. The workers should involve whānau and if necessary, the process of engagement with relevant others could include the wider community. Second, one of the strengths of the project was that while there were some prescriptions about the operation of Family Start, for instance, in relation to the timeframe for responding to and assessing new referrals and the hours of service

delivery to the different levels of need, equally, it was open to the sites to interpret other dimensions of their brief, taking their local contexts into account.

As the feasibility study and programme logic interviews with the providers indicated, there were concerns about how in practice this more inclusive service was to be delivered and evaluated. The key issues related to competence, training and to resourcing. Working with a wider group required the whānau workers to have a theoretical and practice framework in which to cast that work, to possess specific competencies and/or to have the training and supervision to enable them to undertake such wide-ranging work effectively. It also raised questions about the size of caseloads that these more broadly focused workers could be expected to carry. A 1:16 ratio would translate into a very high workload if the whānau workers were engaging with multiple whānau members and with communities.

It is likely that issues such as these contributed to what appeared to be the sites' decisions to define the whānau workers' roles more narrowly, so that they worked predominantly with the mother and baby (the client of the service). A further possibility to be considered, however, is whether this decision was also informed by gender. Despite some changes in the social environment, women continue to be socially allocated the primary responsibility for babies and the raising of children. Although one site did appoint male whānau workers early on, the whānau workers were predominantly women who may also have felt more comfortable engaging with the mothers on "women's work." Overall, it appeared that fathers were minimally engaged in the programme although fathers were present in about half of the Family Start families, and how fathers interact with their partners and their children is a significant factor in the development of stronger families.

The situation was, however, in something of a process of change and stasis. By the time of the second round of fieldwork, all three sites had employed male whānau workers and their role appeared to be (at least at one site) to work alongside the female whānau workers where the male partners were engaged in the programme and were willing to be involved in Family Start.

The Early Challenges of Family Start implementation

The September 2000 report about the first round of fieldwork carried out in September 1999-June 2000 indicated that the support during the early developmental phase of Family Start was high, with many of those interviewed (government officials, Māori stakeholders, co-funders and other stakeholders) expressing support for the model and considering that it was providing help to many families. At the same time, and unsurprisingly given the early stages of the development of the programme, the respondents pointed to a number of areas that needed to be addressed, practices that had caused difficulties or were seen as challenging in terms of the operation of the programme.

Policy development

Staff turnover within the policy agencies meant that organisational continuity was not always able to be maintained and that resource constraint meant that limited follow-through with co-funders and providers resulted in limited appreciation of the implications of specific features of the model, such as the intensity levels.

Co-funder challenges

There were a number of issues to be addressed as the programme developed.

- Tight implementation timeframes constrained the amount of ground work, planning relationship building and provider support that could be offered.

- It became evident that the PAFT-associated work was not sufficiently emphasised in the operating guidelines or contracts.

- There were perceptions that the roll-out and funding of the additional sites restricted the amount of support given to the prototype sites during the implementation period.

- Co-funders found themselves dealing with multiple accountabilities and the complete change of personnel in the co-funder group meant a significant loss in Māori and Pacific focus and input in that group.

Provider organisational arrangements and resources

- Coalition governance arrangements in two of the prototype sites proved difficult.

- Many stakeholders were concerned about the levels of skills, skill mix and knowledge held by the recruited workers and the adequacy of the training they had undergone. These issues were seen to affect the operation of critical assessment processes and whether or not families were accepted on the programme, as well as whether they exited early. These factors in turn affected the confidence of the referring agencies in making referrals; all ultimately affected how the effectiveness of the programme may be assessed. Early interviews reported a perception that during the preliminary contracting of sites, the salary ranges of whānau workers had been reduced. Some stakeholders considered the perceived funding cut may have been associated with providers recruiting less-skilled workers and paying them a smaller amount than had been anticipated.

Issues associated with the Family Start model

- The focus on outputs, introduced by the specified numbers of clients to be referred monthly, was seen as too rigid and inappropriate for beginning services.

- Time frames for the initial needs assessment were considered to be too tight and insufficiently flexible, and there were concerns that families found the assessment processes too involved and potentially off-putting to the very families they were intended to engage with.

- Providers felt constrained in their ability to engage eligible families because of factors such as the specificity of the referral criteria; the size of the referral window (but see above about the extension of this); and the number and type of approved referral agencies.

- Community stakeholder groups found the referral criteria confusing. They considered that it complicated assessments of families' eligibility, and some believed that there were across-sites inconsistencies in relation to thresholds applied to specific criteria.

- The model, with its expectations of very high need families continuing over possibly a quite extensive period of time, was not seen to be realistic. Such families are more likely to wish to

use a service for a short time, but may also want a service to which they can return at a later date. Nor was the model seen as appropriate for meeting the needs of transient families.[11]

- There were a number of issues associated with the application and usefulness of the notion of intensity levels. These were not always proving to be sensitive to need and the quantity of service delivery, and they were being used inconsistently across the sites. The initial database analysis indicated that the mean number of days a family was on the programme did not relate to allocated intensity levels.

- The referral window was seen as too limited.

- The number and range of designated referral agencies was seen as limiting engagement with eligible families. The inclusion of GPs as designated agencies as against other, more flax-root organisations was seen as very restrictive in terms of engagement with eligible families.

  PAFT was regarded by suspicion by some stakeholders, particularly in relation to when it should be delivered and the degree of priority afforded it, whether it was effective, and whether workers had sufficient skills to deliver it. Further, the operating guidelines required Family Start providers to reduce hours of service to higher need families over time. When these hours were progressively reduced for families assessed as low-intensity, the programme could not be delivered within the specified hours of service.

- The extensiveness of the networking that was required had not been fully appreciated. This was necessary to inform other providers and potential referrers about the Family Start programme itself, develop effective co-ordination and communication between agencies, and address other agencies' concerns that Family Start was a competitor for limited funding.

Cultural issues

While the Guidelines had specified that the Treaty required Māori involvement in the development of Family Start, a number of stakeholders were nonetheless concerned about the:

- lack of involvement of Māori in the original policy group and the changing composition of the co-funders group, which came to have very limited Māori representation;

- minimal consultation with Māori communities (papakainga iwi) in the setting up of the sites;

- failure to draw on important cultural expertise in the processes of establishing service boundaries;

- degree of Pākehā influence on the programme;

- low number of Māori referral agencies;

- lack of acknowledgement of the difficulties for provider coalitions that involved contracts between one or more than one ethnic group; and

- the need for a careful analysis of the data so that difficulties experienced by Māori providers were not simply equated with ethnicity.

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[11] The early database returns indicated that many families left the programme before it had been anticipated that they would, some because of relocation, others because they felt their needs had been met or that the programme was not what they wanted.

It should be noted that these issues also applied to Pacific involvement in the programme.

Many of these issues were addressed in the co-funders' review of the programme in early 2000, and their subsequent recommendations for change (see the discussion of the Revisions to Family Start Programme Operating Guidelines, in Part 2 of Chapter 1.)

The Family Start Programme and Its Clients

The Family Start referral process is designed to ensure that approximately 15% of live births within the site catchment area are referred to Family Start. This 15% is intended to comprise those families who are assessed to be most at risk of poor long-term outcomes in health, education and social well-being. Entry into the programme is via a referral process by designated referral agencies. Self-referrals are not accepted.

The client of the Family Start service is the baby, although the work is primarily done with mothers. Mothers can be referred to the service in the second trimester of pregnancy and up to six months following the birth of their child. Families are assessed for their eligibility to enter the programme in relation to twelve criteria of need that are recognised as indicative of risk.

The operating guidelines do not weight the assessment criteria. Family Start organisations are required first to assess whether clients meet the eligibility criteria, and then to determine their intensity of need, as this assessed intensity level translates into the hours of service offered to each client over a (potentially) five-year period.

Once on the programme, it is expected that mothers/families, together with their whānau worker, will develop an individualised family plan that identifies relevant needs and issues and results in the setting up of an action plan with specified, achievable goals. It is also assumed that clients will stay on the programme for the necessary period of time in order to accomplish their goals, and that at the point of terminating contact, there will be a planned exit process.

The Family Start Clients

This section reviews the characteristics of the clients who entered the Family Start programme at the three prototype sites, and indicates that the service is indeed targeting high needs families. With no data on those families who were not referred to Family Start, it is not possible to assess whether the programme is picking up all families of such high need within a catchment, or indeed if there are groups of high need families who continue to miss the opportunities for referral to Family Start.

Families and relationship to needs criteria

One of the tasks for the evaluation was to determine whether the clients referred to the service were those for whom it was designed. Between June 15, 2000 and June 15, 2001, 444 families were referred to the prototype Family Start sites.[12] 165 were referred to Site Three, 182 to Site Two, and 97 to Site One. Table 3 below sets out the relationship to the needs criteria of 417 families referred to the programme by the designated referral agencies for their assessment by supervisors as to eligibility for entry into Family Start. The figure of 417 families is used because at each site there was a small percentage of client families for whom no information on criteria had been recorded on the database. Most of these had been referred just prior to the cut-off date of June 15, 2001 and these 27 incomplete records were not included in the calculations.

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[12] This information and subsequent tables are taken from additional database analysis undertaken in 2001.

The factors in Table 3 are arranged in descending order of incidence, with the factors presenting most often across all three sites at the top of the table. The top four presenting criteria for each site appear in bold type. It should be noted, however, that no weighting was attached to any specific factor. What is apparent is that there were considerable variations across the sites in the numbers relating to seven out of the twelve criteria. "Lack of essential resources" was much less often checked at Site Three, while "family history of abuse", "relationship problems," "unsupported parent," "other Sudden Infant Death (SID) syndrome factors," and "substance abuse" were checked noticeably less often at Site Two. Conversely, Site Two had many more referrals of "young mothers" than did the other two sites, and also many more referrals identifying "no or minimal antenatal care".

"Low income status" and "lack of essential resources" were significant presenting factors across all three sites. Low maternal educational qualifications were reported by over half of the families at Site Three and Site One, and just under 50% of those at Site Two. Close to 40% of families reported frequent changes of address.

Table 3. Presenting criteria for families initially referred to Family Start for year ending June 15, 2001

	Site Three	Site Two	Site One
	N=157	N=175	N= 85
	%	%	%
Low income status	**81**	**85**	**92**
Lack of essential resources*	**52**	**75**	**74**
Low maternal educational qualifications	**56**	**48**	**62**
Relationship problems*	**59**	31	46
Frequent changes of address	41	39	41
Unsupported parent*	33	25	**53**
Family history of abuse*	42	16	51
Young mother*	22	**50**	15
Other Sudden Infant Death (SID) factors*	36	10	53
No or minimal antenatal care*	16	42	14
Mental ill-health*	17	18	42
Substance abuse*	23	6	24
Mean number of factors presenting	4.8	4.4	5.7
Range of factors presenting	0 - 10	0 - 12	0 - 10
Modal number of factors	5	5	6

* Highly significant difference between sites (p<.001)

Over the year under review, the supervisors assessed 390 families as meeting the Family Start criteria (96 (99%) at Site One, 145 (80%) at Site Two, and 149 (90%) at Site Three), while 27 families were assessed as not sufficiently meeting the minimum criteria for entry. Site One stood out as a site where virtually all those referred were enrolled on the programme. This would suggest that this site had either a very tightly-controlled referral process or a loose acceptance process.

Table 4 sets out the criteria met by those families who were admitted to Family Start, with the criteria arranged in descending order of numbers of referrals, that is, most families who were referred had low incomes but significantly fewer were referred because of substance abuse. Excluding partial results for those families whose assessments were incomplete (for whatever reason) at the cut-off date of June 15, 2001, Table 4 presents parallel results to Table 3 for those families admitted to Family Start. It would seem that there were an extra 12 families in Site One, 11 in Site Two, and 8 in Site Three with such incomplete results.

Table 4. Presenting criteria for families admitted to Family Start for year ending June 15, 2001

	Site Three	Site Two	Site One
	N=141	N=134	N=84
	%	%	%
Low income status	**89**	**98**	**93**
Lack of essential resources*	**58**	**87**	**75**
Low maternal educational qualifications	**62**	**59**	**63**
Relationship problems*	**66**	32	46
Frequent changes of address	46	46	42
Unsupported parent*	37	28	**54**
Family history of abuse*	47	18	51
Young mother*	25	**55**	16
Other Sudden Infant Death (SID) factors*	40	13	54
No or minimal antenatal care*	18	52	14
Mental ill-health*	18	18	43
Substance abuse*	26	8	24
Mean number of factors presenting	5.3	5.1	5.7

The factors in this table are arranged in descending order of incidence, with the factors presenting most often across all three sites at the top of the table. The top four presenting criteria for each site appear in bold type.

* Highly significant difference between sites (p<.001)

Most families were assessed as meeting the same four criteria as set out in Table 3 and the pattern of difference in referral rates in relation to specific criteria was repeated. Families, especially those at Site Two and Site Three, had a higher number of presenting factors at the point of admission to the Family Start programme than those initially referred to the programme.

Acceptance on the programme, however, did not mean that all clients continued with it. A substantial number of clients who were referred to and enrolled in Family Start then either decided they did not need the support, or did not continue with the programme, or could not be contacted following their initial meeting with the whānau worker. No data were available about why accepted clients did not stay with the programme.

Levels of need

At the completion of the needs assessment period, the level of service delivery for each family was determined jointly by the supervisor, the whānau worker, and the family. The intensity level assigned to a family determined the number of hours per week that the whānau worker spent with the family and the time it was expected the family would remain on the programme. The intensity levels were, however, subject to change over time, although there are no data about how often or in what direction what changes we made.

Table 5 below shows a close similarity between the spread of initial assessments of intensity levels in Site Three and Site One, but a marked difference at Site Two, as this site had developed its own policy in relation to determination of intensity.

Table 5. Intensity level of need initially assigned to families admitted to Family Start, for year ending June 15, 2001

	Site Three N = 141	Site Two N = 134	Site One N = 84
Intensity level	%	%	%
High	13	0	11
Moderate	47	19	45
Low	38	81	37
Unassessed	2	1	7

NOTE: Rounding corrections in this and following tables may mean that not all columns sum to exactly 100%.

Site Two stipulated that, until the full assessment was completed, *all* families were to be enrolled as "low intensity." This policy in part related to resource allocation, and in part to this site's interpretation of the operating guidelines. Senior staff considered that the longer assessment period following entry into the programme was necessary to provide a more accurate assessment of need.

Excluding the skewed Site Two figures, the majority of families referred at the other two sites were initially assessed with moderate and low intensity needs. There were no data demonstrating how

often and in what direction these initial assessments of need changed over time. It does seem rather surprising (particularly at Site One, an area that has measured very high on recent indicators of socio-economic need) that relatively few referrals of high intensity of need were received. This may suggest that the programme was not getting to the most at risk families, or risk was incorrectly interpreted. There was also no information available about how each site was interpreting some of the needs criteria. While some criteria are straightforward, others require much more complex interpretation to arrive at an estimation of the issue's seriousness. It may well have been that the sites were giving different weightings to issues within each of the criteria.

Home/whānau resources

Table 6 indicates that basic household necessities in New Zealand (that is, a stove, fridge and hot water) were present in virtually all homes, but at Site One and Site Two a significant number of households did not have heating. At Site Two, a large number of households did not have a telephone either. At all sites, many families did not have access to a vehicle. This would be likely to affect families' mobility (especially at Site One, where public transport is very limited), constraining such activities as visits to early childhood centres, doctors and other agencies.

Table 6. Household resources of families admitted to Family Start, for year ending June 15, 2001[13]

	Site Three	Site Two	Site One
	N = 131	N = 119	N = 72
Resource	%	%	%
Stove	98	95	93
Fridge	96	95	93
Hot water	98	92	92
Heating	83	60	65
Phone	76	58	72
Car	61	54	42

The resources in this table are arranged in descending order of presence in the family, with those most often present across all three sites at the top of the table.

No information was available from five households in Site Three, six in Site Two and nine in Site One. These numbers are however, included in the column totals, so the percentages given are likely to be slightly on the low side, particularly in Site One.

The differences across the sites in the availability of heating, phone and access to a car are all statistically significant, although the absence of heating *may* reflect the warmer climate in northern parts of New Zealand as well as families' decisions about prioritising spending.

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[13] The further reduction in client numbers in this and subsequent tables was largely due to the fact that some mothers enrolled on the programme prior to the birth of their baby. Whānau workers may also not have recorded all the additional family data required by the database.

Table 7 shows a highly significant difference between sites, with Site One mothers reporting that a much smaller proportion of their household income was spent on accommodation. When the missing information is excluded from the calculation, median percentages of income spent on accommodation for each of the three sites were: Site Three, 42 percent; Site Two, 49 percent; and Site One, 33 percent. At Site Two and Site Three, mothers reported that nearly half the average household income went on rent, board or mortgage expenses. Such costs were likely to be very burdensome.

Table 7. Percentage of household income spent on accommodation[1] for mothers admitted to Family Start, for year ending June 15, 2001

	Site Three	*Site Two*	*Site One*
	N = 131	**N = 119**	**N = 72**
Percentage	%	%	%
Over 80%	0	0	0
61 – 80%	2	7	3
41 – 60%	49	70	28
21 – 40%	40	18	35
Up to 20%	5	1	22
No information	3	5	12
Total	100	100	100

[1] Rent/board/mortgage

Age of mother

The age range of mothers at each site varied from under 18 years to 40 years plus. As shown in Table 8, a relatively small percentage of mothers at each site were aged under 18. 21% of women at Site Three, and 36% of women at Site Two, were in the 31 years plus age bracket. Because it is likely that most of these "older" women have other children, it can be hypothesised that children other than the designated client baby would have benefited from the changes in the family as a consequence of the family's participation in Family Start.

Table 8. Age of mothers admitted to Family Start in year ending June 15, 2001,

as at time of referral

	Site Three	*Site Two*	*Site One*
	N = 131	**N = 119**	**N = 72**
Age group	%	%	%
Under 18*	8	8	14
18 to 20	21	9	17
21 to 25	27	24	35
26 to 30	23	24	26
31 to 35	11	18	8
36 to 40	10	14	
Over 40		4	
Mean age	*25.3*	*28.3*	*23.0*

Highly significant difference between sites (p<.001)

 Five miscodes recording mothers supposedly under 12 years old have been excluded from the percentages in this category: 2 in   Site Three, 1 Site Two, and 2 in Site One.

At Sites Two and Three, data were gathered on the age of mothers' partners, as shown in Table 9. At both sites, the average age of the partners was greater than the average age of the mothers themselves. Again, there was a wide age spread, including partners under the age of 18 and over the age of 40. Compared with Site Three, there was a noticeably higher percentage of partners at Site Two in the 36 years plus age bracket (approximately one third of all partners).

Table 9. Age of partners of mothers admitted to Family Start in year ending June 15 2001, as at time of referral

	Site Three	*Site Two*	*Site One*
	N=96	**N=109**	No information
Age group	%	%	
Under 18*	3	2	
18 to 20	15	5	
21 to 25	28	17	
26 to 30	26	23	
31 to 35	18	20	
36 to 40	9	20	
Over 40	1	13	
Mean age	*27.0*	*31.9*	

*Three miscodes recording partners supposedly under 12 years old in Site Two have been excluded from the percentages in this category.

Ethnicity of mother

Table 10 provides a summary of the ethnicity of the mothers, recorded in consultation with the whānau worker and supervisor. In some instances, the recorded ethnicity might have been the worker's impression of the mother's identity, rather than a true self-identification by the mother herself. Two entries were allowed for ethnicity. Where two entries were given, only the first was recorded in this table.

Table 10. Ethnicity of mothers admitted to Family Start, for year ending June 15, 2001

	Site Three	*Site Two*	*Site One*
	N = 131	**N = 119**	**N = 72**
Ethnic group	%	%	%
NZ Māori	76	34	78
Fijian		1	
Tuvaluan		17	
Tongan		6	
Cook Island Māori	2	2	1
Samoan		30	
Other Pacific Islands		2	3
Asian		1	
European/Pākehā	21	9	18
Other		1	1

Almost four-fifths of the clients in Site Three and Site One identified themselves as Māori, while around one-third of those in Site Two did so. This site had a very wide range of Pacific peoples from different ethnicities. The targeted nature of the assistance programme is clearly apparent from these figures.

As Table 11 indicates, the ethnic spread of mothers' partners was similar to the ethnic spread of the mothers (shown in Table 10).

Table 11. Ethnicity of partners of mothers admitted to Family Start, for year ending
June 15, 2001

	Site Three	*Site Two*	*Site One*
	N=94	**N=108**	
Ethnic group	%	%	No information
NZ Māori	64	26	
Fijian	2		
Tokelauan	3		
Tuvaluan		18	
Tongan	1	4	
Cook Island Māori	1	3	
Samoan	1	33	
Other Pacific Islands		1	
Asian	1		
European/Pākehā	28	11	
Other	1	3	

Educational qualifications of mother

The educational attainment of mothers is well known to be a significant indicator of life outcomes for children. Table 12 shows that general educational levels were highest in Site Three, and lowest in Site Two. The high proportion of mothers recording primary education only reflected the large numbers of mothers of Pacific Islands origin at that site. All but two of the mothers on Family Start with no more than primary education were located at Site Two.

Table 12. Educational qualifications of mothers admitted to Family Start, for year ending June 15, 2001

	Site Three	*Site Two*	*Site One*
	N = 131	**N = 119**	**N = 72**
Qualification	%	%	%
Attended primary school only	0	20	3
Attended secondary school	70	70	77
Left school before SC, but attended course of 3+ months	6	0	3
Passed SC	6	1	6
Completed Year 12 (Form 6)	2	0	1
Completed Year 13 (Form 7)	2	3	0
Attended technical institute	2	2	1
Attended university	3	1	3
Unknown/unspecified	8	4	6

As Table 13 indicates, the mothers' partners had not achieved in the formal educational systems, although the partners in Site Three had in some instances higher qualifications than those in Site Two. This difference reflects, as it did with the mothers, a high proportion of Pacific peoples with only primary education.

Table 13. Educational qualifications of partners of mothers admitted to Family Start,

for year ending June 15, 2001

	Site Three	*Site Two*	*Site One*
	N=91	**N=110**	
Qualification	%	%	No information
Attended primary school only	0	17	
Attended secondary school	63	61	
Left school before SC, but attended course of 3+ months	8	0	
Passed SC	2	0	
Completed Year 12 (Form 6)	4	0	
Completed Year 13 (Form 7)	1	1	
Attended technical institute	3	3	
Attended university	4	3	
Unknown/unspecified	14	15	

4.2.7 Mother's financial support

Table 14 below shows an associated variable of disadvantage, that of levels of financial support. As Table 3 indicated, low-income status was a key variable in the criteria for admission to the Family Start programme. The dependence of mothers on government benefit income was clear, and this was consistent across all sites. Very few of the mothers had an external source of income from salary or wages, even irregular part-time work. The few mothers working for salary/wages covered a range of occupations, including restaurant worker, secretary, fruit picker, clerical worker, nurse aide, farm worker, trainee chef, nursery worker, and factory or warehouse worker.

Table 14. Mode of financial support of mothers admitted to Family Start, for year ending June 15, 2001

	Site Three	*Site Two*	*Site One*
	N = 131	**N = 119**	**N = 72**
Financial support	%	%	%
Family Support	38	39	35
Domestic purposes benefit (DPB)	45	28	43
Sickness benefit	8	4	13
Invalid benefit	3	1	3
Student allowance	2	1	1
Community wage	10	8	7
Accident Compensation Corporation (ACC)	1	0	0
Family assistance	3	1	3
Accommodation supplement	16	8	15
Other benefit	7	10	10
Self-employed	1	1	0
Salary/wages – 35+hours/week	11	9	1
Salary/wages – part-time regular	2	3	0
Salary/wages – part-time irregular	3	1	0
Other support	8	13	8

Multiple answers were allowed, so entries do not sum to 100%.

Occupations of partners

Of the total of 96 partners in the Site Three sample, 37 (39%) were recorded as being in paid employment, with the majority working in the forestry or hospitality industries in such occupations as bush worker, timber worker, serving in a fast food outlet, or caterer's assistant. There were two students. The occupations of the remaining 59 partners were recorded as "unemployed" or "occupation unknown," or the entry was left blank.

Of the total of 113 partners in the Site Two sample, 51 (45%) were recorded as being in paid employment. They worked almost exclusively in manual occupations, with a majority in some form of factory work. There were several sickness beneficiaries and one student, and the remainder were recorded as "unemployed" or "occupation unknown," or the entry was left blank. No information on partners' occupation was available from Site One as it was not obligatory for the whānau workers to complete this screen.

Responsibility for child

Table 15 shows that around half of all babies were living in families where the mother shared responsibility with a father/partner, but a significant number of mothers had sole responsibility for their babies, particularly in Site One. Between 30 and 40 percent of young mothers up to 18 years old had sole responsibility for their babies, and this did not differ significantly between sites. Input from the extended family/whānau members (often grandparents) occurred at all sites.

Table 15. Responsibility for child by mothers enrolled in Family Start, for year ending June 15, 2001

	Site Three	*Site Two*	*Site One*
	N = 131	**N = 119**	**N = 72**
Responsibility	%	%	%
Sole responsibility for child	34	27	42
Shared responsibility : with father/partner	56	59	47
with father/partner and whānau	5	4	3
with whānau only	2	8	6
No responsibility for child (interpretation of phrase unclear)	2	2	3

Maternal health

Table 16. Results on perinatal variables for mothers admitted to Family Start, for year ending June 15, 2001

	Site Three	Site Two	Site One
	N = 107	**N = 106**	**N = 69**
Indicator	%	%	%
Normal pregnancy	76	63	61
Baby breast-fed*	42	78	68
Low birth weight (less than 2.5kg)	15	12	4
Baby premature (less than 33 weeks gestation)	16	15	12
Health problems during pregnancy	24	13	15
Birth trauma (extended/induced labour, forceps delivery, caesarean)	22	17	16
Baby overdue	4	8	4
Baby disabled	3	2	1
Lost baby previously[1]	5	6	4

[1] Either during pregnancy or following birth.

[*] Probably significant difference (p<.05)

Table 16 was calculated from total numbers reduced because of varying amounts of missing data, particularly from Site One, and the results should be viewed with some caution. The numbers given at the head of each column are the maximum possible upon which information was available on the database. Missing data on the individual variables shown range from 3-10% for Site Three; 1-5% for Site Two; and 17-23% for Site One. There were few significant differences between sites in relation to the perinatal variables. The only differences to reach normally accepted levels of statistical significance were related to the extent of breast-feeding of the newly born infant. Mothers at Site Three reported much lower breast-feeding rates than did those from the other two sites.

The work with mothers

The services provided

The primary objectives of the whānau workers were to develop a positive relationship with the mothers and help them establish concrete goals that would assist in achieving a better life-outcome; they attempted to do this through the provision of information and support. They were also expected to encourage/assist the mothers to undertake relevant training, as very few of the mothers had any formal qualifications and most were dependent on benefits. The work would be done on a very concrete level, but in the process the mothers would gain confidence, skills and problem-solving capacities.

Time devoted to families

The programme allowed for whānau workers to spend a considerable amount of time with families, especially those assessed at the higher levels of need. Table 17 presents results of the time devoted by whānau workers to individual families who began on the programme after June 15, 2000, and were still active on Family Start at June 15, 2001. The figures given are in minutes per month on the programme, and thus allow for the fact that some families had been receiving services for the whole year, and some for just a short time. Face-to-face time appeared to be much the same across sites, averaging out at something over three and a half hours, but average non-contact time recorded was much more variable, being significantly lower in Site Three (just under two hours) and higher in Site One (four hours).

Table 17. Face-to-face and non-contact time devoted to families on Family Start, for year ending June 15, 2001

	Site Three	*Site Two*	*Site One*
	N = 88	**N = 95**	**N = 59**
	Mean mins/mth	**Mean mins/mth**	**Mean mins/mth**
Face-to-face time	220	225	213
Non-contact time*	111	150	239
Total	331	375	452

* Highly significant difference (p<.001)

Table 18 presents a further analysis of these figures by intensity level of need, across all sites, as given initially on enrolments on the programme. As the programme intended, the time devoted to the very few high-need families was significantly more than that devoted to low- and medium-need families. This confirms that Family Start's aim to provide differential levels of service for families with varying levels of need was being met.

Table 18. Face-to-face and non-contact time devoted to families on Family Start, for year ending June15, 2001, by initial intensity level of need

	High-need	*Medium-need*	*Low-need*
	N = 18	**N = 99**	**N = 124**
	Mean mins/mth	**Mean mins/mth**	**Mean mins/mth**
Face-to-face time	388	250	172
Non-contact time*	258	179	124
Total	646	429	296

* Highly significant difference (p<.001)   A finer-grained analysis of these results, by provider, showed that a similar pattern prevailed in each site.

For the 42 families in Site Three on PAFT, the mean number of minutes/per month was 19; for the 54 families in Site Two, the figure was 41; for the 31 families in Site One, the figure was 32.

Working with the mothers: support-associated activities

The different activities undertaken by the whānau workers were providing personal support and practical help and adopting an advocacy role.

Personal support

The provision of personal support referred to three main activities:

> *Responding immediately with help and personal support.* That meant "being there", being a person who was trusted and to whom the mother could turn, knowing her request for assistance would be met. As one mother said, "I was really stressing out with the kids, so I rang her and she came straight away and just helped me out for an hour. That was all I needed."

> *Demonstrating care and concern.* One woman commented on her sense of being cared for by her whānau worker and how, in this context, important issues were being addressed that had not been in the past. "She's the first person to ask me if I felt safe."

Setting a challenge. Whānau workers also offered encouragement to take up a challenge. "She has really helped me to decide to go and get some counselling, so I'm going now. I started last week."

In a similar vein, another young woman who had completed 7th form since going on the programme, and was planning further studies, spoke of the importance of her kaitiaki in providing encouragement and motivation to keep her going. "Without my kaitiaki and Family Start, I wouldn't go near a school again, never mind actually going to class."

Advocacy

The fact of having someone to assist in what were known to be testing circumstances was important. "We only got it [an emergency grant] because [the whānau/aiga worker] was there. I know without her they wouldn't have given it."

Another respondent pointed to how the worker successfully modelled non-abusive behaviour and assisted in getting an appointment. "We made the appointment the week before and when we got there [to WINZ] the woman was sick. They were telling us to come back later. If [whānau/aiga worker] hadn't been there, I would've lost it, but she made them get another WINZ lady to help us."

The provision of practical support

Practical support was also provided, often through assistance with transport. Such services were particularly valued because of a lack of public transport and the high cost of other modes of transport in areas such as Site One, where the service catchment area included both suburban and rural areas. It is easy to overlook how taken-for-granted activities such as shopping can become a high-stress and difficult experience when the shopper is coping with a number of small children and has no easy means of transport.

Information-giving

Information-giving, too, was a form of practical support and took different forms. Spending time with the mother enabled the whānau workers to give information about, at times, very basic issues to do, for example, with undertaking household tasks more effectively or diet and food preparation, issues on which many mothers were ill-informed. The workers also informed mothers about the nature and roles of a variety of services and how to access them, and assisted the mothers in making the connection with the relevant service. Workers also discussed with mothers issues about which they had had some training, such as what to do in violent situations.

Training

All Family Start sites encouraged mothers to undertake training and development services, ranging from basic budgeting and cooking to child development, health and safety awareness. These were run in partnership with other local providers, and included courses such as "Budgeting", "Home Safety Awareness", "Pukenga Matua" (a Māori Health Programme), "Pacific Early Childhood Training", "Meals on a Shoe-string", and "Crafts for Christmas."

Mothers were also encouraged to take more formal courses. Two mothers at one site were taking NZQA Certificate courses leading to four-year degree courses. Both had completed their first round of assignments and received 'Pass' grades.

Summary

The most characteristic feature of mothers admitted to the Family Start programme was their low-income status. Families also often lacked essential resources and had low maternal qualifications (particularly at Site Two). A number of families also met the acceptance criteria of relationship problems, high mobility, being unsupported parents, a family history of abuse, being a young mother, other sudden infant death risk factors, and/or no or minimal antenatal care.

The majority of families were initially assessed as requiring moderate or low intensity levels of support, although one site initially assessed all families as low intensity until a full assessment was complete. Allocation of intensity level of support to individual families did need to change over time as family situations changed. However, the database did not record such changes. However, the database does record that those families that were recorded as high needs families were receiving more contact time and that the amount of non-contact time the whānau workers needed to make available to progress the work was also more than that required for lower needs levels. However, the data suggest that Site One workers, who were carrying the lowest caseloads, nonetheless spent significantly more non-contact time than did the other two sites where workers were carrying double or more than double the caseload. At Site One, this low caseload/high non-contact time might also have been associated with the loss of direction in how to progress work and low morale amongst the workers.

The work with the mothers involved what would be an expected range of activities, given the nature of the work.

Chapter 5: Family Start Programme Implementation – Emerging Issues

Interviews with providers, referral and support agencies and mothers, plus analysis of the database, provides some insights into the issues associated with assessing the effectiveness of the implementation of the Family Start programme, and its impact on families receiving the service, and on the work of other agencies in contact with those families.

Learning from this work falls into two interconnected categories: issues around effective practice, and measuring change for the families. Effective practice refers to the ways in which the service is delivered. It is a separate challenge to assess the extent to which that service is able to enable change for the client group.

Effective practice

The process evaluation has identified a number of issues associated with the delivery of the Family Start service: where should the focus of the work be (with client, family or community?); the success of goal-setting; progressive reduction in hours of service; delivery of PAFT; programme exits; referral processes; and the relationships with other agencies in the community.

The focus of the work

While the programme defined the baby as the client, it was nonetheless expected that the whānau workers would involve families, whānau and possibly peer groups and wider communities in their work. In practice, the whānau workers defined their responsibility as working primarily with babies and their mothers. Some fathers were absent from the home, for a variety of reasons. Although Table 15 indicates that at least half of the male fathers/partners were involved to some extent in the care of their children, it was not clear how many fathers who were still living in the home were actively engaged with by the whānau workers. Only a small number of fathers and whānau were present during the evaluation interviews.

At the time of the second round of fieldwork, male whānau workers had been appointed at all sites to work with those fathers who had expressed an interest and a willingness to be involved. It is not known how the work done by the male whānau workers intersected with the work done by their female colleagues, what the size of their caseloads was, how the rationale for the criteria for seeking partner's involvement was arrived at, or whether the same criteria were used by all sites.

There was evidence that Site Three workers were connected with the community, although there is little information from the data about the nature of that work.

Goal-setting

A key dimension of the programme is the development of individualised plans and, very specifically, the early elaboration of measurable, achievable goals following enrolment in Family Start. Goals were recorded in more or less the mother's own words, after some adjustment by the whānau worker or supervisor for entry into the database. Any number

of personal goals could be entered, and these could be of any type, that is, some could be long-term, some short-term, some general, some more specific. Subsequently, the goals were entered onto the database by the whānau workers, sometimes in consultation with the supervisor, in ten need categories from a "drop-down" list, as shown in Table 20 below.

As has been noted (in Chapter 2), goal setting is not a simple process and few of the goals listed on the database were actually goals, although many of them implied a goal to be worked towards. For example, one mother's recorded goal of "interested in Playcentre involvement" when expressed as a goal could read, "To join Playcentre and become involved in its work". What is also lacking is any account of what tasks were associated with these often ill-defined goals. Knowledge of what the goal-related tasks were would have contributed to a fuller appreciation of the difficulties facing the individual women in achieving their goals and would assist in a fuller evaluation of the work of Family Start.

That noted, there are two surprisingly large differences between sites in Table 20. It is puzzling to note that 'mental and physical health' figures so largely in the self-determined goals of mothers in Site One, but 'housing/accommodation,' where there were high levels of need, does not. Other than these two, the differences, although statistically significant in five need categories, are probably not of major practical significance.

Table 20. Classification of initial goals expressed by mothers admitted to Family Start, for year ending June 15, 2001

	Site Three	Site Two	Site One
	N = 278	N = 323	N = 233
Need category	%	%	%
Baby's well-being and development*	5	13	14
Personal education and training	27	24	24
Family structure/supports*	12	9	3
Mental and physical health**	6	6	16
Housing/accommodation**	16	14	3
Occupation/employment/income*	18	13	8
Parenting capability and practice	8	6	9
Resources in home*	3	7	9
Social/spiritual goals	3	3	4
Other goals*	2	7	9

The N's for this table are the total number of different family goals recorded in each site.

* Significant difference between sites (p<.01)   ** Highly significant difference between sites (p<.001)

This table, then, establishes that mothers did identify issues to which they wished to attend. Equally importantly, this table in effect presents "issues." It does not present how individual goals were articulated in order to attend to these issues.

What is of greater interest in the extent to which goals were attained. Data is reported on this, but needs to be interpreted with caution. Not only were there difficulties in defining goals, but no account was taken of whether goals were long-term or short-term, or of whether goals were only partially achieved, so this figure is not likely to be particularly reliable. It is a relatively crude analysis, indicating that about a quarter of self-determined goals were achieved within three months of their being set in Site Three and Site Two, as were nearly half of all goals in Site One.

Table 21. Goals fully attained by June 15, 2001, for mothers enrolled on Family Start

	Site Three	*Site Two*	*Site One*
	N = 202	**N = 271**	**N = 224**
	%	%	%
Goals attained	23	23	46

The N's for this table are the total number of different family goals recorded in each site.

Progressive reduction in hours of service

A central dimension of the programme is the development of a customised family plan with each family. As has been discussed, goal-planning is difficult and the process involves a high degree of negotiation and flexibility in the development phase in order to ensure that the plan successfully matches the needs of a family. The programme also acknowledges that when a family faces markedly changed circumstances, plan breakdown can occur.

For many families, these markedly changed circumstances in family dynamics and circumstances did occur. For example, partners were released from prison, children were returned from CYF care, children suffered serious illness, there were physical accidents, and families had to meet unexpected household expenses, such as costs associated with a funeral or with car repairs.

The evaluators argued that while the Family Start programme does recognise the above complications, it is nonetheless structured so that services are progressively reduced over time. This reduction in hours is made irrespective of a mother's ongoing needs, or her progress in being a better parent, or her personal and family circumstances. However, the sites' management of the allocation of hours across the whole client group is an area for further investigation.

Delivery of the PAFT dimension of Family Start

When Family Start began in 1998, the education component of the programme was based on PAFT. All whānau workers, who received a minimum of four days training in PAFT principles and practice, were responsible for delivering this programme to the mother. As the curriculum is designed to accompany the baby's development, it was expected that PAFT would require 30 hours' input over a period of three years.

The evaluators reported on issues raised by some whānau workers about the inclusion of PAFT in the Family Start programme.

Some of the whānau workers queried the appropriateness of introducing PAFT so early in their contact with families. They argued that it was inappropriate to introduce PAFT early in their contact with families who were facing very basic survival issues or were very stressed, and that there should have been some flexibility over the timeframe when PAFT was to be introduced. While they appeared to have overlooked the discussion of PAFT in the operating guidelines that stipulated that survival needs should be addressed first, this in itself suggests that sites may not have been as knowledgeable about the Guidelines as may have been desired.

There was also an issue about the relationship of PAFT hours to input hours for low intensity families. Whānau workers were expected to deliver a specified number of hours of PAFT training over their period of contact with the family. However, these hours exceeded the number of contact hours to be delivered to low-intensity families, making it difficult for the workers to meet the terms of the contract.

The evaluation also raised questions about whether the whānau workers received sufficient training in a four-day course to deliver PAFT appropriately. There was evidence that some workers at one site did not have a good grasp of PAFT principles and practices. For instance, some workers believed that they needed to supply the toys required by the mother to interact with her baby, whereas the programme stipulated that acquiring such toys should not involve the family in expenditure and that the toys were able to be made from materials available in the home. Whether it was realistic to expect clients to undertake this task is open to question. It was also clear from commentary from some of the mothers that they regarded what they had learnt in the PAFT training as very valuable.

Exiting the programme

One of the significant design features of Family Start was the association between the level of support (intensity) and the assumption that higher-intensity families would continue longer with the programme. In terms of retention rates of high-intensity families, none had exited at Site One by June 15, 2001. At Site Two, where the policy was that no family would be initially classified as high-intensity, none of those classified as medium-intensity had exited by June 15, 2001. At Site Three, seven of the 13 families initially classified as high-intensity had left the programme by June 15, 2001. Half of these were "unplanned" exits. Nonetheless, premature exits are not necessarily indicative of programme failure. Clients who left may well have felt that they achieved enough that was important to them *at that time*. The evaluators interviewed four mothers after they had left the programme. All reported being supported by other agencies (Barnardos, a Māori community mental health worker, and kōhanga reo). Also, one of the basic tenets of social work practice, and indeed the Family Start programme, was moving at the client's pace. Furthermore, family relocations to other areas confirmed that Family Start was working with a very mobile population and suggested that premature exits were to be expected. A decrease in premature exits might occur as staff increased in confidence and skills. Conversely, if premature exits are related to the mobility of the client group, then

the exit rate may be less affected by changes in programme delivery. No firm conclusions about this can be drawn from these data.

Table 22. Throughput of mothers enrolled on Family Start programme, for year ending June 15, 2001

	Site Three	*Site Two*	*Site One*
	N = 107	**N = 106**	**N = 69**
	%	%	%
On programme (active)	65	82	81
Exited from programme:			
Planned	18	2	0
Premature	16	16	19
Re-entry	1		
Total enrolled	*100*	*100*	*100*

Issues associated with the referral process

Family Start was established as a service to which clients were referred by designated referral agencies: lead maternity carers, hospital maternity services, Well Child providers and all GPs. The professional orientation of these referral agencies reflected the "baby as client" focus of the programme.

The evaluation raised three issues about the referral process. First, there was concern expressed that flax-roots organisations such as kōhanga reo were not designated as referral agencies. Second, because GPs were often not used by the most at risk families, there were questions about the validity of their being given referral agent status over the flax-roots organisations. Third, providers expressed concern about their inability to accept self-referrals. They argued that having to re-direct a self-referred family to an approved referral agency, who would then refer the family back to Family Start in order to access services, created another 'barrier' that the most high-risk families of a community were usually unwilling to overcome.

The evaluators reported that providers felt unhappy about their inability to accept self-referrals, and found ways of working around this, for example, by simplifying the referral process for families they saw as vulnerable. The level of self-referral is a way by which many agencies measure their acceptability to the community. Providers argued that self-referral was also a culturally appropriate process, as those who had attended the service were able to vouch to others about its helpfulness and the approachability of its staff, and recommend contact. However, in deciding not to extend the referral process to accept self-referrals (see Chapter 1, Part 2, Revisions to Family Start Programme Operating Guidelines) HESSOG affirmed that Family Start was designed for families who are most

at risk. A self-referral process could jeopardise the programme, by allowing it to be flooded by lower risk, lower intensity families.

Relationships with referral and community agencies

Relationships between providers and the local referral and community agencies were recognised as important, but took particular shape in different contexts.

Site Three

In Site Three, the Family Start work was well understood by those who referred clients (so that referrals were appropriate and met the programme criteria), and the programme was regarded as having a "high profile." One agency commented, "Staff are now known by face, not just name." The pamphlet provided by Family Start was regarded as valuable as "it gave the language needed to recommend the service in a way that is non-threatening". Nearly all groups, including most Māori workers, expressed strong support for Family Start and Family Start kaitiaki. They mentioned some new developments, such as the school for young mothers, as indicative of the way that Family Start had adopted a unique approach in response to the needs of its clientele.

Referral agencies were very positive about Site Three's capacity to provide an ongoing service that backed up what other agencies could provide for a limited time only. As one commented, "Once we know Family Start are involved, we can back off." Equally importantly, Family Start was able to take responsibility for the "hands-on" work that other agencies were not funded to do. Site Three was seen as an organisation with integrity. "They walk the talk."

However, referral agencies did identify a number of areas where work could be developed or changes made. One agency stated that Family Start needed to keep to their established frameworks for the delivery of the programme and not try to "be all things to all people." They needed to work collaboratively to other agencies and make use of their skills and knowledge base. When a mother with a mental health problem had been dealt with, the worker had not involved the extended family, which compromised the outcome for this mother.

Following on from the point above, it was important that workers did not overestimate their skills. For example, workers giving information to families needed to ensure that they themselves had interpreted that information accurately (especially medical information). The building of mutually respected relationships between agencies (with specific reference to the medical staff at the hospital) would assist each group to call on the other when necessary, so avoiding a situation where workers failed to recognise the limits to their skills/knowledge.

There was some discussion about the value of reviewing the range of accredited referral agencies, as most GPs were perceived as not utilising Family Start services and it was felt that other agencies working with clients who met the criteria should be able to refer.

The establishment of a more formal process for evaluation and review of the service would be helpful. Channels for feedback needed to become more formalised. In a somewhat different vein, it was also important that Family Start workers were aware of the limitations of services to which they might refer their clients. Availability, in the

instance given of a counsellor, should not be read as indicative of that person having sufficient skills to undertake the necessary work.

There was some confusion regarding the role of the parent body in relation to the Family Start dimension of that organisation, because of the similarity of names between the parent body and the Family Start programme. Most of the agencies who were interviewed considered that each ought to have a distinctive name.

The need for the employment of quality staff was reiterated, as was the need for the provision of good supervision. There were some concerns expressed about the implications of Site Three employing workers who had previously been employed by CYF, because the often negative view of CYF held by many in the community could make those workers unacceptable to clients in small towns. Additional Pākehā staff were regarded as necessary, as there were increasing numbers of Pākehā families involved in Family Start and it was important to have the choice of workers.

The hours worked by kaitiaki were regarded as excessive by some agencies, but it was also noted that the workers seem to be managing this well.

Three main issues were raised by Māori service providers. One related to the possible duplication of services. Some Māori organisations felt that, rather than establishing another service, any further development of Family Start in other areas should recognise the similar work already being done by other agencies.

The second related to the Family Start framework being seen as imposed by Pākehā. Because of this, and regardless of their respect for the kaitiaki, some Māori providers had decided against using the service.

The third related to whether Site Three was meeting the needs of long-term families. Some agencies, mainly Māori, considered they were better able to meet the needs of these more challenging and needy families at the extreme end of the service, although it was not clear what evidence was being advanced to support this claim.

Overall, however, Site Three was regarded as a distinctive service, increasingly seen as providing trained staff capable of working with families and engaging with whānau in ways not possible for most other agencies. The workers were considered to have extensive connections into the community and with other local agencies, and the kaitiaki were seen as generally working in very successfully with other professionals. Kaitiaki were prompt in their response, and if not available at any time were reliable in returning calls. Urgent referrals were addressed promptly. That there had been a query about this site taking students on placement indicates the regard in which the agency was held. The level of confidence in the service improved considerably between the two rounds of fieldwork.

A range of community organisations were also interviewed. Overall, the commentary from these groups was very positive, with praise for the establishment of the young mothers' school and the men's support group. The support agencies noted an increase in the professionalism of the work done by the kaitiaki, and thought the ways in which they worked empowered families. Kaitiaki had played a valuable role in ensuring that vulnerable families attended appointments with other agencies. Some collaborative working relationships had been developed, the referral systems were thought to be

working well, and problems were dealt with directly. One agency considered that it was now not seeing families it would have been in contact with before, because they were now Family Start clients, and these families seemed both stronger and better informed than did non-Family Start clientele. The service was considered to be filling a substantial gap.

There were three areas of concern. One related to the numbers of cases (13-16) carried by each kaitiaki, and it was considered that this ratio should be monitored. Another issue was whether the development of a long-term relationship might result in more superficial work being done because a "friendship" role might result in issues not being addressed. The third raised some ethical issues about employing kaitiaki with whānau connections. While this connection was regarded as a significant strength of the service, it also potentially raised ethical issues. However, Site Three was regarded as having good ethical standards and there was no evidence of these being ignored.

Site Two

The feedback from the referral agencies interviewed in relation to work undertaken at Site Two was largely very positive, although it also recognised that the work at the site needed further development. This was in contrast to the more widespread concerns that had been expressed earlier.

By the second round of interviews, hospital staff and Pacific health workers had been referring regularly to Family Start and, with some reservations, believed that the programme was developing well. The mainstream Well Child provider, however, continued to express strong reservations and did not refer clients to Family Start, considering that families "deserved better" and that Family Start was being treated as "better than nothing" for high-need families, a cheap option to a complex problem. It should be noted that the mainstream Well Child provider agency was the only one to express such strong reservations; moreover, it had not discussed any of the reservations it had with Site Two, who had not been aware of them prior to the evaluation round. Further the one (more junior) worker from this agency who was affirmative of the Family Start service had strong whānau connections and dropped in often to follow up face to face on the outcome of referrals. Knowing what weight to give concerns has been difficult, especially since it is hard to know how well-informed the staff were if they were not using the service. However, some of the issues corresponded to issues raised by mothers at that site. For this reason, the concerns are referred to within this section of the report, but should be placed in the context just outlined.

The elements of the programme that were positively mentioned related to ease of the referral process and (from the hospital workers) the satisfactory delivery of services. It appeared that a key factor in external workers having confidence in the service related to their having developed a strong working relationship with the Family Start workers. Health workers also referred to the improved networks that had been established. Two agencies had developed programmes in conjunction with Family Start that they considered were working well.

The fact that whānau/aiga workers were able to assist clients with a wide range of problems (transport, accessing health, gambling and counselling services) within the

context of a culturally-appropriate service was seen as valuable since it allowed families to deal with a worker of their own ethnicity.

A number of areas of concern were raised.

Participants questioned the rationale for the decisions about the geographic boundaries of the Family Start programme because of the way they served to exclude close-by high need families. There was also a concern that transient families, common in that area, were not being picked up. Most considered that the boundaries issue should be addressed immediately.

One worker questioned the need for referrals to come from health professionals only, and felt that, with greater awareness about the programme, other agencies and individuals would make appropriate referrals. One agency felt that the Parents as First Teachers programme (PAFT) was not a priority for high-need families, and was concerned that it was too much to expect Family Start workers to provide PAFT as well as everything else.

The major concerns voiced by the agencies related to key professional issues in service delivery, one relating to the referral process, the other to issues of professional work. Agencies expressed concern that there was insufficient feedback once referrals were made – they needed to know if the client had been picked up, what had happened subsequently, and to have a named worker to contact if they needed to make subsequent contact. They were also concerned that Family Start clients were often in crisis and needed a lot of encouragement to agree to a referral to another agency. When a referral was made but was not picked up immediately, these families tended to be lost.

A worker from one agency was concerned that Family Start workers were not always referring on appropriately. The development of stronger community networks could assist in resolving this issue.

Most of these concerns were voiced by the mainstream agency that had to all intents and purposes stopped referring clients to Family Start because they regarded the service to be overly dependent on the calibre of the individual worker, and believed that this calibre varied considerably. Their concerns related to a range of issues, including those relating to the referral process and to the failure of Family Start to respond to earlier criticisms of their work, which included: a perceived lack of supervision and experienced staff within Site Two, which compromised the quality of service delivery; that untrained workers were carrying out assessments of families with very complex needs and the process of prioritising issues was being left to untrained staff; feedback from some families who thought that some whānau/aiga did not know what they were meant to be doing; awareness that some whānau/aiga did not appear to appreciate the specifics of their tasks; the breaking of confidentiality; failure to carry through on commitments; and a lack of networking with other agencies, which compromised Family Start's ability to provide a good service.

Site One

The agencies interviewed in the second round of fieldwork at Site One raised concerns related to structural and professional issues.

There were questions about the inappropriateness of the inclusion of PAFT in the Family Start programme because of the lack of specialist training for whānau workers in delivering the programme. Further, the absence of delivery skills could mean that families faced with a number of significant crises were not able to pick up on the value of what was being offered, because it was offered at the wrong time.

Problems were perceived with the geographical boundaries set for the service as they excluded a large number of needy families.

Inadequate training was identified in the first round of fieldwork as an important issue. Interviewees in the second fieldwork round considered that training issues were beginning to be addressed by this site, but that there was still some way to go before whānau workers provided a consistently good service. They stated that while there was very good work being done by some workers, others appeared to have little or no training. Interviewees acknowledged, however, that with new management structures in place and training issues at that time beginning to be addressed, staff morale was much higher and the attitudes and professionalism of Family Start workers were starting to improve.

One interviewee stated that as well as a high level of training, workers needed very strict standards of practice to adhere to, in order to be able to measure the quality of the service they were providing. This interviewee considered that whānau workers were faced with complex ethical issues and needed considerable skill to negotiate a path through such issues.

Hospital staff, who had continued contact with Family Start and were interviewed at the second round, were very positive about the changes that were taking place. Moreover, there was acknowledgement of the value of the approach taken by the new manager, who had been working to implement major changes, to seek feedback about the service, and to respond undefensively to criticism in order to rebuild community trust.

An improved and more detailed referral form had been developed. Referral agencies' previous concerns about the three-step process of referral and assessment had been taken on board. The current process involved the whānau worker making the initial visit and assessment, so that the family had only to tell their story twice (once to the referring agent and once to the whānau worker), rather than three times, as before.

Referrals were being acted on immediately, by the appropriate person (the whānau worker), and a supervisor was now monitoring the process. Information was being sent out to the referral agency detailing the worker's name, their plan and dates of immediate appointments. Turnaround time from referral had dropped from one month to two to three days.

There were also improvements in the sharing of information. Whānau workers were now advising the referral agencies of new addresses when families moved. Doing so was an important safety issue in protecting children who might be abused. The fact that workers

were now doing so also reduced the feeling from other agencies that they were working at cross purposes with Family Start.

Agencies considered that the appointment of two male whānau workers and their involvement with clients could well improve the safety of other family members.

Agencies identified the development of a more professional approach. Whānau workers were no longer complaining about what they had described as a very limited role, and were more appreciative of how the provision of very practical help was a significant part of assisting families to achieve better life outcomes. As a consequence of this, they were no longer discharging families as soon as the referred crisis was over but were keeping such cases open (as with transient families), and staff appeared to be more fully understanding the value of longer-term work and monitoring of at risk families. This was particularly important in light of the cutbacks in funding to services offered by the mainstream Well Child provider, which had resulted in decreased contact with families and some at-risk families getting less support from the Well Child provider than was desirable. Therefore it was considered all the more imperative that an organisation such as Family Start existed.

At the time of the second round of interviews, the feedback from support agencies about the service delivery from this site was mixed. Of the seven agencies that participated in the interviews or had phone interviews, four had little to say because they had had no contact with Family Start over the previous six months. The evaluation team considered that the small number of agencies who were willing and able to be interviewed probably reflected an ongoing problem of lack of networking between Family Start and support agencies, and a lack of faith in the delivery of the programme under previous management. Most felt that not much had changed and that there were ongoing serious issues about the site's capacity to discharge its role adequately. It should be noted, though, that these agencies may not have been as well informed as the referral agencies of the changes that had been put in place. They had had little input into the review that took place of the Site One programme, and less work had gone into networking with them than had gone into working with the referral agencies.

Barnardos had begun to receive referrals from Family Start (two in the three months prior to the fieldwork) and Family Start had undertaken more active networking with this organisation. This had helped improve the programme's profile and opened the door to a better working relationship. One result was greater clarity over roles. One of the Women's Refuges had had no referrals from Family Start in the previous three months. The other Refuge found that they were receiving fewer referrals, and the referrals they got from Family Start tended to be only to provide respite care for families, indicating that the whānau workers were not tapping into other services Refuge provided. They expressed concern that Family Start was not encouraging clients to use Refuge educational programmes. Barnardos also felt that Family Start used their service in a similar way, only for childcare rather than for their expertise in early childhood development. All agencies agreed this sites' ability to deliver a service was limited at that time.

Mothers' Accounts of the Family Start Programme

The objective of the Family Start programme is to improve the circumstances of its clientele. Understanding how the service is regarded by those who have used it is a key element in evaluating the dimensions of a successful initiative. However, the evaluation team found that there was a high refusal rate in relation to requests for interviews and the decision was made to move from the attempt to generate a random selection of mothers, to the whānau workers only approaching those whom they thought likely to accede to a request for an interview. In the final round of interviews, 25 mothers were interviewed at Site Three (five follow-up mothers from the first round, and 20 new mothers who had more recently joined the programme). At Site Two, six follow-up and 20 new mothers were interviewed; and at Site One, nine follow-up interviews and 20 new interviews with mothers were carried out. The interviews focused on the mothers' experiences with their whānau workers, as these workers in effect represented the programmes.

There were no data on the criteria guiding the whānau workers' decisions about whom to approach for interviews and there was a danger that they may have only approached those whom they considered would offer positive commentary. In the event, however, it appeared that the process resulted in commentary that was not in all instances fully endorsing of the service. Some of the mothers had had excellent service, about which they were very positive, and there was a general indication that they thought the programme was valuable in principle, even if some of the assistance they had received had not met a high standard. However, some mothers were very dissatisfied with their whānau worker and were also dissatisfied with their service provider.

There were site-specific reactions to the programme, with the commentary from mothers associated with Site Three being very positive. Both of the following comments highlight how the whānau worker's interventions had presented the women with undreamed of, different and attainable realities. One woman said,

> I'm supposed to be locked up in the house with a baby, not going to school. My kaitiaki helped me understand what it is to plan for a future for myself and my baby.

Another, her comment underscoring how change also involved the active and positive participation of her whānau, said,

> Our kaitiaki helped gather both of our whānau and we all sat down to work out how they could help me with myself and our children.

The commentary from mothers at the other two sites was not as fully affirmative of the help they had received. While nearly all the interviewed mothers at Site Two were positive in their evaluations of the assistance they had received, five raised concerns about the lack of action/assistance from workers (although three said that supervisors had been notified of their concerns and had addressed them). One mother said her worker came round and watched TV with her, but nothing more definite appeared to have happened. Another woman had concerns about confidentiality in a small ethnic community where it was already easy for everyone to know about others' personal circumstances.

At Site One, however, over half of those interviewed expressed some degree of dissatisfaction with the assistance they had received from their whānau worker. Mothers said workers had not followed through on what they had said they would do. For one woman, this resulted in her losing interest in what had been proposed:

> *My cousin is on Family Start, too, and she told me about some workshops they've been running. When I asked my whānau worker about it, all she said was she'd get back to me. That was last year. So I don't bother now.*

There were comments too about workers not sharing among themselves information each had collected about community resources/possibilities, so that what mothers were told depended on what worker they had and that individual worker's knowledge base, rather than on the collective knowledge of the organisation. Other concerns related to a lack of practical assistance coming from the workers.

Site One is based in a relatively small town, and specific communities are likely to know a lot about members' personal circumstances. One mother expressed lack of confidence in her worker.

> *Her family's worse than mine. I don't want someone who's got no ideas for herself telling me how to improve myself.*

Although there were variations across the sites in the degree of positive comments made by individuals, it is important to note that over half of the mothers interviewed spoke of positive changes in their own behaviour and/or changes in their children, which they related, directly and indirectly, to the help they had received from Family Start. They considered the programme to be valuable, irrespective of the fact that they may have had some less positive experiences with their whānau workers.[14] For example, some mothers said,

> *I wish I'd known all of this when I had the other kids.* (Pointing to milestone developments in her PAFT folder)

> *I really try, I stop now [hitting the child] because I know it's a stage he's got to go through, that's what you learn down at Family Start.*

> *Since I've been doing my licence, I shocked my brother. He came to pick the kids up and I told him to go back and get the van, I wasn't going to let him put the kids in the back of his wagon – they've all got their own seats.*

> *I used to have trouble with the big ones [young teenagers] hitting them. I really stop and think now, there's another way to deal with this – she [counsellor] has made me do that.*

The comments from the mothers at Site One and Site Two raise several issues. First, they point to the problems inherent in working supportively. Without the worker having a clear sense of direction, quality supervision and organisational accountability, such work,

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[14] There were a number of reasons as to why some mothers did not offer a positive assessment of Family Start. Some had only recently started on the programme and it was too early for them to identify changes. Some mothers, when asked, did not report any changes, while others had not reflected on the changes that had occurred. Further, although some mothers did not report changes, their whānau workers had observed changes (and related them to the evaluators).

although well-intentioned, may too easily lack focus and in effect result in a stalemate. The more diffuse and complex the family situation is the more holding onto a sense of direction is necessary. This includes workers being clear about the next specific steps to be taken and how these may be taken, in part to avoid workers feeling overwhelmed by the family's situation, and being able to call on quality supervision. Equally, without clearly defined organisational expectations that are built into everyday practices, workers may not necessarily share information about resources.

Second, it is important for such organisations to employ quality, trained, respected staff. However, in small communities, where many skilled people have left, and where the general educational level of the population is not high, this may present a particular difficulty, thus highlighting the need for tailored training programmes. What also needs to be noted is that in small communities it may also be easy for individual workers to be unfairly open to criticism by those whose actual knowledge of their circumstances may be limited and/or inaccurate.

The commentary also emphasises the need for confidentiality and its practice to be a key component of a quality service.

Skilled workforce

The importance of a skilled workforce comes through all the interviews. The work that the whānau workers are intended to do appears on one plane to be relatively straightforward. The work is described in the deceptively simple concepts frequently used in the human service delivery area: *support, advocacy, information-giving, referral* and *goal-setting*. In practice it turns out to be much more complicated, and not at all self-evident in terms of practice. Successfully adopting a supportive role requires a clear understanding of that role and its associated complexities: what does being supportive mean in a range of very different circumstances? When does support become disempowering? When is support being exploited and what are reasonable courses of action? What worker behaviours are not supportive? What is the larger context in which the supportive work is located?

Equally, information-giving calls for a reasonable grasp of the field, the ability to translate at times complex material, knowing when to seek further information and when to refer on. Competent referral practices require the development and observation of protocols and procedures (whose rationale must also be understood and agreed with); awareness of one's own limitations; detailed knowledge of the local services, and so on. Moreover, all such work has particular ethical implications, which also need to be understood conceptually and practically.

Goal-setting and the devising of individualised plans also call for particular skills and a certain degree of persistence in order to define measurable, achievable goals and plans with clients who are most unlikely to have done anything like that before.

Factors such as these highlight the importance of those establishing new services, at both the policy and operational level, having a detailed knowledge and understanding of the work they are expecting to be done and of the resources that are needed to carry it out reasonably successfully.

Sufficient training prior to the start-up date is absolutely critical if a service that is simultaneously simple yet very complex, as is Family Start, is to succeed. While there may well be some shared components of that training, it is also necessary to take into account the local variations in skills, knowledge, appreciation of the task, and so on, to develop site-specific training. It is deeply ironic that the staff of a service that is intended to make a difference to the most at risk families were themselves not all adequately prepared for the task, and some may as a result have inadvertently further complicated the lives of the families whom they were ostensibly helping.

Furthermore, that training needs to be ongoing to upgrade existing workers' skills and to provide training to new workers, through both quality supervision and accountability practices, as well as through the provision of in-service training.[15]

Organisational credibility

The sites followed different paths in their development and implementation of Family Start. By the time of the second round of fieldwork, it was apparent that Site Three (beginning from the strongest position) had gained substantial community recognition, and Site Two was seen as an increasingly credible organisation. In other words, both were organisations to which others in the field were prepared to refer clients. Such recognition was vital, given the referral process that had been set up. Site One, however, still lacked credibility. A review of the experiences of organisations that began at very similar times and had arrived at different spaces, suggests that gaining organisational credibility is assisted by:

- the employment of experienced managers able to sustain and impart the guiding principles of the service;

- being able to actively demonstrate, not just assert, the value of a culturally appropriate service. This involves being clear about significant points of difference in practice from the mainstream, and the positive and negative effects of those differences. As the evaluators observed in relation to Site One, a strong Māori presence did not result in a liberatory or progressive mode of service delivery. The cultural competence of the workforce, whilst important, is not on its own sufficient for success;

- being aware of issues of local knowledge as these relate to the employment of staff. In small communities, where there is considerable information available about others' lives, it is important that organisations are sensitive to this. For example, employing as a whānau worker someone who is known by the community to have struggled with their own problems may well tell against the service's credibility.

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[15] The evaluators noted that the quality of service delivery at Site One may have been affected by some whānau workers' reluctance to participate in certain training programmes. This was evident in three whānau worker interviews conducted at this site: "*It's one thing to train, but what really counts is being with these mothers and sharing their problems.*" "*I am a whānau worker, not a [sic] admin person. It's not my job to do data entry and I'm too busy to do it – so I don't see why I should do database training.*" "*Their [national training provider] cultural stuff was so weak I'm better off just doing what I know.*"

This is a difficult issue to raise. It should not be read as asserting that an individual who has experienced substantial personal and family difficulties should not be employed by programmes such as Family Start; it is saying that in order to maintain organisational credibility organisations may need to be very clear about the skills they are seeking in employees, and their corresponding work history and capacity[16]. Management should also be prepared to publicly support those whom they appoint;

- being seen to be able to provide a reasonably professional service; and

- developing and maintaining organisational visibility. This requires networking and networking is a time-consuming and often "backstage" activity. Allocating importance to this work may well affect caseload sizes. It was also apparent from some commentary that networking and building links into the community should not be the prerogative of a few staff only. All staff need to be involved in developing their own links into the community, as such work feeds into their capacity to work more effectively.

Measuring change

This process evaluation is not intended to provide evidence as to the extent of change or the impact of the Family Start programme for the clients and their families. Rather, the process evaluation has provided an opportunity to identify issues to inform the interpretation of the usefulness and validity of the data collected via the database, and to identify early indications of areas where the programme may be making a difference

Outcome indicators

The process evaluation is only the first stage of a wider evaluation of the programme. From the outset, there has been the intention to include an outcome/impact evaluation, to be carried out once the services were well established. However, as discussed in Chapter 3, planning for this began early. One aspect of this was discussion about what were the most useful indicators of change to use.

Initially it had been intended that measurements of success would be linked to the client (the child) and there was a comprehensive review of a number of instruments measuring child well-being and development. This was undertaken in August and September 1999.[17] The subsequent decision not to use these instruments was informed by:

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[16] The providers, in their discussion of the programme logic, touched on this issue in the context of commentary about planning and the need for training in how to develop a plan. "They commented on the need for workers to have goals and visions for their own lives. This allows workers to model the importance of having personal and family plans. It was noted that this has been a challenge for some workers .... However, it is a vital part of the process in convincingly imparting the importance of having a plan." (Martin 2000: Part 2:7)

[17] These included the Battelle Developmental Inventory, Family Needs Scale, Edinburgh Postnatal Depression Scale, and the Drug Abuse Screening Test.

- recognition of the inappropriateness of using such scales outside of a clinical setting;

- recognition of the lack of training of the whānau workers who would have been responsible for applying these instruments;

- advice that it would be difficult to gain informed consent from Family Start mothers/caregivers to use these instruments; and

- the well-documented unreliability of instruments in relation to their predictive validity for children under one year of age, except at extremes of function.

As a result, child health and development success measures were linked to:

- the registration of children with a single GP or Well Child provider; and

- aiming for a 95% immunisation rate for Family Start children.

This information was recorded in the database, but initial analysis of that database and interviews with providers identified some issues to be considered in interpreting that data.

a. Enrolments with care providers

These are set out in Table 19.

Table 19.   Post-natal enrolments in services by June 15, 2001 for mothers admitted to Family Start during the year ending March 15, 2001

	Site Three	*Site Two*	*Site One*
	N = 104	**N = 110**	**N = 70**
	%	%	%
Enrolled with primary care provider	75	78	71
Enrolled with Well Child provider*	74	82	55

* Highly significant difference between sites (p < .001)

 NOTE: The Ns given at the head of each column are the maximum possible upon which information was available on the database. Missing data on the individual variables shown range from 7-9% for Site Three; 3% for Site Two; and 11-16% for Site One.

A period of three months after referral was allowed in each site for enrolment in services, and hence Table 19 is calculated over a different period from the other tables in this report, for mothers who were referred to Family Start over the year ending March 15, 2001. The figures were calculated to allow the full three months to elapse by 15 June for those enrolling towards the end of the period.

There is one highly significant difference in this table. As noted earlier, Site One mothers, many of whom were under 18 years, appeared slower to enrol in Well Child provider services, and this is a characteristic of many young mothers. There was also

some evidence to suggest that the systems might not be fully in place there to provide for prompt enrolment.

Accepting such measurements as indicative of an agency's success or failure is, however, complicated. A mother's circumstances can mean that registering with a single GP or Well Child provider may not be easy. Unpaid bills with a GP (or a number of them), transport to the GP (usually with other pre-school children), 'not liking the Plunket nurse' or other individual staff, and cost (as not all services accessed for under-6s are free) were some of the issues that made registration difficult for these families.

b. Immunisation

This was a difficult measurement of the effectiveness of the programme, because of a variety of reasons contributing to the absence of reliable data on the levels of immunisation of Family Start babies. To avoid any stigma associated with having not done so, mothers tended to report that they had got the baby immunised. In order to avoid situations where mothers might feel they were being 'checked on', whānau workers did not always ask to see their Well Child booklets to confirm the baby had been immunised. In some instances, accessing these records may well have been difficult, given the mobility of many Family Start families and the numbers of different providers that some had used. At one site at least, immunisation was seen as a political issue, with the whānau workers insisting that their role was to give the mothers information about immunisation so they could make the decision themselves. There was, however, no report on how the workers presented such information, or its accuracy.

Summary

The process evaluation identified a number of issues to be considered in establishing effective practices in the Family Start programme. It is important to be clear about the client's immediate needs, but also about where the focus of the work should be to effect longer-term change for that client. There are challenges in working with some of the operational expectations in ways that both assist the mothers/whānau and provide useful information for evaluation of the effectiveness of the programme – this was so for the goal-setting expectation, and for managing requirements for the appropriate level of intensity of support, the reduction of hours over time, and managing exits. These challenges reflect the complexity of working with such high need families, with fluctuating levels of need, and often mobile lifestyles.

A critical aspect of a successful programme is the creation and sustaining of good relationships with referral and support agencies, affected by both personal relationships and by the quality of the work of the service at any particular site. Without organisational credibility at the local level, referral agencies will not be confident to refer families to the service, nor will the service be able to effectively access services for their clients.

Skilled staff are central to implementing an effective programme.

The initial analysis has also identified some of the contextual issues that affect the interpretation of the outcome data for the client group.

Chapter 6: Conclusions

This evaluation raises two areas for consideration – the learnings that relate to the programme itself, and those that relate to the practicalities of evaluating a complex social programme.

The Family Start Programme

The evaluation of the Family Start Programme has identified a number of issues that have impacted upon the implementation of the programme. It has also identified areas where changes could and have been made as the programme has developed.

Establishment

Timing

Commentary from the sites suggested that insufficient time had been allowed to get the service up and running, given the work that is required to develop a service from scratch. Stakeholders at two sites suggested that, although Family Start was based on a model of service collaboration, the contracting process and service environment was competitive. At these two sites established human services agencies regarded the Family Start organisations as newcomers to the field, with untried staff, and as competing for scarce resources.

Governance

There were some identifiable factors relating to the differences in effectiveness in service delivery, in community receptiveness, and in the positive endorsement of the programmes by the services' clients. These were provider-associated issues and issues relating to the availability of trained and knowledgeable staff.

Site Three brought to the Family Start dimension of its work a history of successful service delivery in closely related activities. It was a single iwi provider, with an established board taking an active operational role in the work of the organisation. As a consequence, the organisation did not have to commit energy and resources to establishing and maintaining a coalition board. In contrast to this site, the other two had to build their coalition partnerships and develop their Family Start organisations from the ground up in what appears to have been a very short timeframe. Unsurprisingly, the more established social service organisations in the vicinity of Site Two and Site One were sceptical of the capacity of the new Family Start organisations to discharge their role and each of these organisations had therefore to prove itself.

The difficulties experienced by the two sites at governance level raise questions about how such difficulties can be understood and what, in the context of a prototype programme, the responsibilities of the funding/oversight organisations are. Should such difficulties be defined as unexpected internal problems and therefore the responsibility of the (new) organisation to resolve as best it can, or should problems like these be seen as more normative, as something that may well be expected in contexts where service groups coming from very different knowledge bases and philosophies are seeking to

work together? In a context where government has a direct interest in initiatives like Family Start succeeding, a fuller knowledge of how Site One and Site Two attempted to resolve their difficulties would have been useful; it suggests further that, at the time of their formation, such coalitions need overtly to take possible difficulties into account so that part of the process of development becomes setting up a process that enables them to attempt to work through those issues and identify when additional assistance is required.

Different implementation processes/site variation

The first round of fieldwork indicated that stakeholders considered that Family Start as a principle was a good idea, but that time was needed to see how the sites developed. At the time of the second round of fieldwork in 2001, commentary from a more restricted group of stakeholders (the mothers, referral and support agencies and site providers) indicated that standards and levels of service across the three sites differed and that the sites were operating with different degrees of effectiveness.

By the middle of 2001, Site One, where the coalition board had dissolved, could be characterised as struggling to provide a reasonable level of service and as urgently needing to re-build its credibility with its designated referral and support agencies and with some of its clientele. In addition to problems at the level of governance, there had been internal strife and changes in senior staff, and a number of the original whānau workers had left. The new manager was seeking to turn around demoralised staff and increase the very low rate of referrals and caseloads held by staff. Site One demonstrated the difficulties of regaining organisational credibility and visibility once these have been lost or compromised.

The Site Two coalition board had also experienced difficulties, including having to manage an initial lack of credibility. However, with one exception, the designated referral agencies considered that the quality of the service was improving. The agency had been able to attract more experienced and qualified senior staff who, it must be presumed, were able to offer more professional oversight of the agency's work and to provide a higher quality of supervision and support. In both Site One and Site Two, with different degrees of emphasis, there were issues for organisational stakeholders and for some mothers about the adequacy of training for whānau workers. These concerns extended to whānau workers' understanding and discharge of their roles, their capacity and willingness to liaise and collaborate with other agencies, service ethics (the preservation of confidentiality), and the workers' ability to recognise the limitations of their own knowledge.

In contrast to these two sites, Site Three had located itself more strongly within its community and had developed programmes, such as the school for young mothers, that moved beyond a face-to-face mode of service delivery and reflected this site's concern with the educational achievements of members of its iwi. While the issues raised about insufficient inter-agency collaboration, the limits of kaitiaki knowledge, and the need for respect for confidentiality (especially given the iwi-focused nature of this service) also applied to this site, these concerns were much more muted than they were with the other two sites. Some local Māori agencies were critical of Site Three Family Start and were not referring clients to it, but the evaluators suggested that it was difficult to determine the basis for the proffered criticism.

On-going issues in implementation

Recruitment & Retention of families

The rationale informing Family Start assumes that families assessed as having high and moderate needs will stay with the programme for some time. In practice, this expectation was not met as a significant number of clients did not continue on the programme for as long as was expected. There was, however, no detailed information as to whether those assessed as having the highest needs were more likely to leave the programme early. Equally, no information was available on the characteristics of those families who stayed with the programme.

However, it is clear that Family Start is dealing with a population that includes some very mobile families, who will exit the service early. Limited geographical boundaries for the provision of Family Start mean that for mobile families there is unlikely to be continuity of service.

Local expressions of operating guidelines

There was always an expectation that the operating guidelines would be implemented in ways particular to different sites and communities. In these three prototype sites, the differences included:

- management (and recording) of intensity levels as families entered and moved through the programme, and of exits.

- responding to the wider family/whānau. Site Three, which appeared to be established more quickly and to develop community credibility, was also the site that most rapidly expanded the focus of the service and developed initiatives with the wider family, including work with fathers, and provision of educational opportunities for the younger mothers.

It is not clear to what extent those differences impacted on service delivery, nor to what extent variations were a product of the demands of particular communities, or were a product of the extent to which sites had been able to progress beyond the immediate demands of establishing the core infrastructure, skills and credibility. There was however a strong impression that those sites who had moved through the initial establishment phases most smoothly were also then able to expand the range of services in strategic ways.

Relationships with referral agencies

Effective Family Start services require good relationships with both referral and community agencies, and a demonstrated capacity of the organisation and individual staff to carry out their tasks.

The work of Family Start proved to be complex, given the high needs of the client population. The Family Start programme required staff who were culturally knowledgeable as well as collectively having information and knowledge about a wide range of subjects, and a high level of interpersonal expertise. Of the three sites, it appeared Site One in particular had most difficulty in locating staff with the requisite

knowledge and skills range (a factor that underscores the regional dimensions of capacity) and that Site Three had least difficulty in this respect.

Parents as First Teachers (PAFT)

PAFT was regarded with suspicion by some stakeholders, particularly in relation to when it should be delivered and the degree of priority afforded it, whether it was effective, and whether workers had sufficient skills to deliver it. Further, the operating guidelines required Family Start providers to reduce hours of service to higher need families over time. When these hours were progressively reduced for families assessed as low-intensity, the programme could not be delivered within the specified hours of service.

Some of the whānau workers queried the appropriateness of introducing PAFT so early in their contact with families. They argued that it was inappropriate to introduce PAFT early in their contact with families who were facing very basic survival issues or were very stressed, and that there should have been some flexibility over the timeframe when PAFT was to be introduced. While they appeared to have overlooked the discussion of PAFT in the operating guidelines that stipulated that survival needs should be addressed first, this in itself suggests that sites may not have been as knowledgeable about the Guidelines as may have been desired.

The evaluation also raised questions about whether the whānau workers received sufficient training in a four-day course to deliver PAFT appropriately. There was evidence that some workers at one site did not have a good grasp of PAFT principles and practices. For instance, some workers believed that they needed to supply the toys required by the mother to interact with her baby, whereas the programme stipulated that acquiring such toys should not involve the family in expenditure and that the toys were able to be made from materials available in the home. Whether it was realistic to expect clients to undertake this task is open to question. It was also clear from commentary from some of the mothers that they regarded what they had learnt in the PAFT training as very valuable.

One of the questions raised by the providers interviewed for the programme logic (and addressed in the literature review) was about the dominance of high-level government outcomes for Family Start and the degree to which outcome objectives need to be more specific in relation to the populations they address. In part, as the feasibility study indicated, the question revolved around the extent of Māori and Pacific input into the development of the programme, whether outcome objectives that are highly relevant to their communities were included, and what factors constrained the inclusion of such objectives. It appears that there were some limitations on the incorporation of alternative ways of knowing and valuing into the Family Start programme.

Evaluating Family Start

The evaluation of Family Start contributes to various agendas. Government and policy officials are looking for information to inform future policy development and funding decisions. Providers wish to know how to improve their services. However, they are also concerned that evaluation does not impact negatively on funding decisions, nor impact in unhelpful ways on their clients. Providers are also keenly aware of potential

workload issues in evaluation processes, e.g. the time taken to meet with evaluators and to approach clients for consent for their participation.

Therefore, the design and implementation of an evaluation needs to take account of multiple stakeholders' needs. Early issues for the evaluators centred on two areas – intensity of evaluation activity at the sites while they were in the early stages of implementation, and discussion and debate about the methodology to be used in the outcome/impact evaluation.

Providers were already completely occupied with getting their services fully operational when they were also asked to participate in the process evaluation. In addition, one site was also invited to participate in focus groups to discuss possible outcome/impact evaluation methodologies. While evaluation continues to be an additional demand on sites over and above service delivery, the sites do acknowledge that evaluation is critical to inform further funding decisions and service development.

Discussion of the outcome/impact methodology highlighted the tensions arising in trying to meet the expectations and requirements of the multiple stakeholders. There was an expectation of timeliness from government officials, yet service providers were clear about the need to take time for informed participation to occur. Service providers were also clear that the methodology chosen needed to be acceptable to the communities in which they worked. For instance, they were not sympathetic to a randomised controlled trial, which would require some families to be denied access to the Family Start programme. While in any design the number of families receiving the service would have remained constant, providers were uncomfortable about the perceived unfairness.

The development of the database was originally intended to serve the needs of the providers, the co-funders and the evaluation team. In practice, this proved to be more difficult than anticipated. The amount of consultation required to work with providers about their needs and the purposes of the database was underestimated. Confounding factors included one site already having a database, the variation in level of computing skills across sites, insufficient early training, and suspicion about the uses to which the database might be put. The processes underscored the need for full consultation with all stakeholders, sufficient early training, clear responsibilities for the database at local and central levels, and clear information about uses and ethical processes.

Some of the issues with the database have emerged with early analysis. Inconsistent use of some fields has been recognized, and the difficulties of defining some other fields have also become apparent. For instance, it is now clear from the database that establishing measurable goals with clients is challenging, and not always achieved. (This has implications both for the evaluation and for the Family Start programme itself.) It is also apparent that the database is unable to capture differences in local practices. For example, the recording of intensity levels is managed in different ways by different sites, and the database did not record changes in intensity levels over time.

Despite those difficulties, and the development of a fully functioning database having taken longer than anticipated, it should now provide useful information for the outcome/impact evaluation.

It is a challenge to provide overall evaluation outcomes for a programme where there is considerable local variation in implementation. The operating guidelines permitted local variation in how the programme was to be delivered, and each site has specific contextual issues to engage with. It can be difficult to assess to what extent various outcomes in implementation are due to the requirements of the programme (as described in the operating guidelines), the specific ways in which these are implemented, or a result of other factors.

Evaluation of Family Start has highlighted the complex set of skills required to successfully undertake an evaluation of a complex social service intervention

- Quantitative evaluation skills;

- Qualitative evaluation skills;

- Theoretical understanding of the concepts behind the Family Start project (i.e. a theoretical understanding of parent support and development);

- Cultural competence in working with Māori and Pacific providers (which in practice means key members of the evaluation team being of Māori and Pacific descent, and the overall approach of the team being compatible with Māori and Pacific world views).

Officials were unable to source all this expertise in one team. Accordingly a number of separate contracts were let around the process evaluation and the early outcome/impact evaluation work. A high level of co-ordination, support and synthesis was required.

Concluding Comments

The process evaluation has highlighted the quite different ways in which the Family Start Programme Operating Guidelines have been implemented in the three prototype sites. All sites have provided services to families that meet the expected criteria, but the establishment and success of those services has been influenced by a number of factors. Factors include: governance structures; time available (and necessary) to establish relationships with referral and community agencies and necessary internal practices; availability of appropriate staff and subsequent credibility of the service; ease of use and applicability of the database. There were some preliminary difficulties with the initial operating guidelines, but most of these were addressed in an early review. Database establishment has taken time, with some measures being interpreted or applied in distinctive ways in some sites.

Sites have responded to the challenges of establishment in various ways and with varying degrees of success. Initial indications are that the site that already had established governance structures and established community credibility has been able to move more rapidly to expand the focus of the service from the mother to the wider whānau and community.

An outcome/impact evaluation has now been commissioned. Sites chosen for evaluation include one of the sites that was also part of the process evaluation, but in addition there are three other sites. The final report of the outcome/impact evaluation is due in mid-2003.

Appendix 1 - *Family Start: Specified Programme Logic*

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside control of Programme	Programme Activities and Resources
7. Reduced long-term costs and/or increased long-term benefits to the community ↑	7. Reduced social and economic costs, and increased benefits to Government and the community ↑	Reduction in overall level of benefit dependency, especially intergenerational benefit dependency Reduced demand for social services by most at-risk families and resources freed up for other families Lower levels of crime, domestic violence, child abuse/neglect Hospital/health costs reduced Local communities strengthened through increased participation of families Family Start an accepted part of the community and able to have wider influence on attitudes and values e.g. about parenting Local service providers work collaboratively together	How the programme is perceived Degree of ownership by the community Facilitation of relationships with agencies	Poverty/financial constraints Institutional racism Economic climate – employment opportunities Training courses available Benefit levels	Positive promotion of Family Start philosophy and activities Programme provider is part of the community Development of protocols and positive relationships

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside control of Programme	Programme Activities and Resources
6. Life circumstances/ chances of individual are improved/ long-term objectives are achieved ↑	6. Long-term gains are made including: • improved life outcomes for at-risk children in areas of health, education and welfare; • improved personal and family circumstances;	Reduced levels of child abuse and neglect, illness and injury, mortality Reduced levels of hearing loss at school entry Increased no. of school leavers with formal qualification Reduced rates of tobacco, alcohol and drug consumption; teenage fertility; under 16 offending; youth suicide; road traffic deaths for 15-19 years; truancy More independent lifestyle including less benefit dependency Stable living situation including standard and security of housing, material needs Adults in training or employment Increased adult self-esteem, confidence, positive social interactions; overall family stress reduced; families strengthened		Poverty/financial constraints Institutional racism Economic climate – employment opportunities Affordability of housing Dramatic changes in family's circumstances Resilience of family How entrenched the problems are Availability of training opportunities	

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside control of Programme	Programme Activities and Resources
	• improved parenting practice and capability ↑	Establishment of formal and informal networks/ participation in community/ marae Parents confident about parenting Improved parenting abilities			
5. Short-term objectives for individuals are progressively achieved ↑	5. Short-term improvements are achieved relating to: • child health and development • social, educational, training and employment outcomes for adults	Registration with single GP for child and primary caregiver 95% of children immunised Safer home environment Financial/budgeting problems successfully dealt with/ able to pay bills Adults in training or employment Alleviation of housing problems Support, advice, information, referral regarding legal matters,	Knowledge and skills of workers to provide wide range of support and advice Ability of workers to make appropriate referrals to other agencies	Economic climate e.g. availability of jobs Benefit levels Availability and resourcing level of other services and agencies in the community Family's readiness and willingness to participate in programme Dramatic changes in family's circumstances Resilience of family How entrenched the problems are	Recruitment of multi-skilled staff Broad-spectrum training for workers Quality of training Development of effective relationships with other agencies and services including written protocols

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside control of Programme	Programme Activities and Resources
		alcohol/drugs, domestic violence, mental health		Availability of training opportunities	
		Strong family/whanau/ community networks and participation in community activities			
		Confidence, self-esteem, skills, improved relationships			
	• child educational development	Parents understand child development milestones and age appropriate activities	Number of hours available for delivery of PAFT and other aspects of family plan	Number of hours available for low intensity families to complete PAFT	Quality PAFT training for workers
		Positive parent/child interactions			Resources and child development manuals provided to workers
	↑	Participation in childhood education/ children enrolled in quality childhood education		Availability of quality early childhood programmes in community	Management of hours. Families are able to switch to general PAFT if Family Start hours are insufficient

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside control of Programme	Programme Activities and Resources
4. Individualised programme is put in place to match objectives ↑	4. Home-based, child-centred and family-focused services are delivered by family/whanau workers according to individual family plan, reducing in intensity over time Family Start services are complemented by other agencies where necessary ↑	Plans are delivered within hours allocated to family Plans are monitored and adjusted where necessary Graduation to lower service level within specified time frame Successful referral to other agencies where necessary Positive relationships with local Maori and Pacific groups/ agencies Implementation and review process is a collaborative one Family positive about Family Start Low early exit rates	Manageability of workers' workload Adequacy of administrative and support systems for monitoring and review Quality of relationships with other agencies/services Knowledge of workers about services and resources available from other agencies Continued rapport and good relationship with family	Manageability of workers' workload Severity of crises/problems Dramatic changes in family's circumstances Availability and adequacy of resourcing level of other agencies and services in the community Level of resources necessary for Family Start to retain quality workers	Managers and supervisors monitor and adjust workloads where necessary Systems are streamlined and coherent so workers not overloaded Manager and other staff develop relationships with other key agencies to allow successful referrals Staff training to ensure all workers are aware of other services and resources available in their communities Hui and fono held with appropriate Maori and Pacific groups

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside control of Programme	Programme Activities and Resources
3. Realistic objectives are set for (and with) the individual ↑	3. Individual family plans are developed with appropriate objectives and activities for each family, and which are consistent with overall Family Start outcomes ↑	Family agrees with and supports plan Family fully involved in development of plan/ planning utilises strengths-based approach Plans are tailored for each family but are consistent with overall Family Start outcomes and include key elements e.g. PAFT Plans are realistic and attainable	Development of rapport and collaborative relationship Family/whanau worker's understanding of purpose and components of a successful plan	Readiness of family and willingness to participate Severity and scope of family's problems	Appropriate staff are recruited and training in strengths-based models given (if needed) Quality training for workers maintained Staff are trained in planning processes and objective setting
2. Needs and prospects of individual are accurately assessed ↑	2. Needs and strengths of each family are accurately assessed through collaborative process between family and worker ↑	Needs assessment completed within 4 weeks Assessment report contains all the required elements Families are assigned to the correct intensity level 33%, on average, of families each intensity level Families are satisfied with process and agree with assessments	Appropriateness of workers assigned to each family especially re culture/ethnicity Appropriateness of provider selected for each community Manageability of workers' workloads Appropriateness of 12 criteria for assessing needs Development of rapport & collaborative relationship with family	Availability of information from referral agents Manageability of workers' workloads Readiness of family and willingness to participate	Build effective relationships with referral agents to ensure access to information Ensure agents are clear about type of information required Recruit and train appropriate staff for target population – proportion of Maori and Pacific staff to reflect target population

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside control of Programme	Programme Activities and Resources
		Families are well informed about Family Start and their rights Support is initiated within one working day of assessment where necessary			Ensure needs assessment process does not overwhelm family
1. Target group access programme	1. At-risk families are correctly identified by referral agents and enrolled on Family Start programme	15% of live births are referred to Family Start No more than 25% inappropriate referrals Most at-risk 5% are referred	Referral agents' support/understanding of programme Referral agents' understanding of the 12 criteria Appropriateness of criteria for correctly identifying at-risk families Appropriateness of provider selected for each community Sensitivity/ responsiveness of Family Start staff when informing families about the programme Time needed to set up programme	Population demographics (proportion of live births may be greater or less than 15%) Referral agents' resources/infra-structure (to participate in programme)	Manager develops good working relationships with referral agents Appropriate staff are recruited and trained – proportion of Maori and Pacific staff reflect target population Quality training for workers

Appendix 2

Supplementary Programme Logic for Family Start – Provider Input

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside Control of Programme	Programme Activities and Resources
7. Reduced long-term costs and/or increased long-term benefits to the community ⬆	7. Reduced social and economic costs and increased benefits to Government and the community ⬆	Reduced benefit dependency within target population Reduced demand for services of other agencies and resources freed up for other families		Unemployment Local infrastructure Poverty	
6. Life circumstances/ chances of individual are improved/long-term objectives are achieved ⬆	6. Long-term gains are made including: • improved life outcomes for at risk children in areas of health, education and welfare; • improved personal and family circumstances; and • improved parenting capability and practice ⬆	Families are more independent Less intervention by agencies, including Family Start Greater use of own, especially whānau, networks to resolve problems/issues Families are well-informed and able to make positive choices for themselves Intangible and unexpected outcomes are recognised as success		Types of policies, attitudes and services of other agencies Severity and duration of family's problems Poverty	Continue to promote a truly interagency approach Continue to focus on "getting the process right" Careful supervision to minimise dependency on workers

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside Control of Programme	Programme Activities and Resources
5. Short-term objectives are progressively achieved ⬆	5. Short-term improvements are achieved relating to: • child health and development; • social, educational, training and employment outcomes for adults; and • child educational development ⬆	Families have information, advice and advocacy to allow them to make the best decisions for themselves Goals and achievements are appropriate to the needs and strengths of each family- "success" is defined by families Intangible outcomes and unexpected outcomes are recognised as success Whānau/family networks are strengthened	Legal problems e.g. benefit fraud and immigration issues	Legal problems e.g. benefit fraud and immigration issues Constraints by co-funders/govt especially regarding definition of success Quality of services available from other key agencies	Advocacy, support and advice to resolve legal problems Ongoing collaboration with family to set and achieve goals Focus on getting the process right – belief that families will make the right decisions given the right resources Active networking by workers to locate wider whānau and facilitate contact Ongoing co-operation and collaboration with other agencies
4. Individualised programme is put in place to match objectives	4. Home-based, child-centred and family focused services are delivered by whānau workers according to individual family plan,	Families are able to progress at own pace – plans are adjusted accordingly	Ability to vary intensity of service delivery according to needs of families at particular times not proscribed formula	Availability of local services and infrastructure	Ongoing training for all workers especially unqualified workers or those without previous

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside Control of Programme	Programme Activities and Resources
⬆	reducing in intensity over time Family Start services are complemented by other agencies where necessary ⬆		Manageability of worker's workload	Reporting demands by co-funders (including database) Quality of services available from other key agencies in the community	experience of working with families Develop positive relationships with key agencies in the community Staff training includes awareness of entitlements for families
3. Realistic objectives are set for (and with) the individual ⬆	3. Individual family plans are developed with appropriate objectives and activities for each family, and which are consistent with overall Family Start outcomes ⬆	Families are able to start thinking beyond immediate situation and towards a future Plans are tailored for needs and pace required by each family	Ability of workers to model goal-setting and planning in their own lives	Readiness of family to engage in planning Severity of immediate needs Suitability of time frames as specified by policy	Worker's training includes development of plans and goals for their own lives Work at pace of each family and set goals appropriate for each family's situation
2. Needs and prospects of individual are accurately assessed ⬆	2. Needs and strengths of each family are accurately assessed through collaborative process between family and worker	Families are successfully engaged on the programme/ supportive of the programme	Appropriateness of workers	Types of interaction families have had with previous agencies	Promote Family Start as a community, rather than government, agency

Generic Outcomes Hierarchy (for case management programme)	Outcomes Hierarchy for Family Start	Success Criteria and Standards	Factors within Control of Programme	Factors outside Control of Programme	Programme Activities and Resources
	↑			Suitability of time frames as specified by policy	Recruit and train appropriate staff
1. Target group access programme	1. At risk families are correctly identified by referral agents and enrolled on the Family Start programme	Most at risk families are identified and referred	Agents' understanding and interpretation of the 12 criteria	Types/range of agents approved to make referrals	Develop good working relationships with approved agents
				Approved agents' knowledge of and level of interaction with target group	Position Family Start within local community in a positive, proactive way
				Appropriateness of provider contracted	
		Appropriate Family Start programme for local community is established		Relationship with co-funder, including degree of adherence to guidelines proscribed	Develop models, especially Māori models, and employ workers appropriate for local community
				Time available to establish programme	Develop good working relationship with co-funder

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