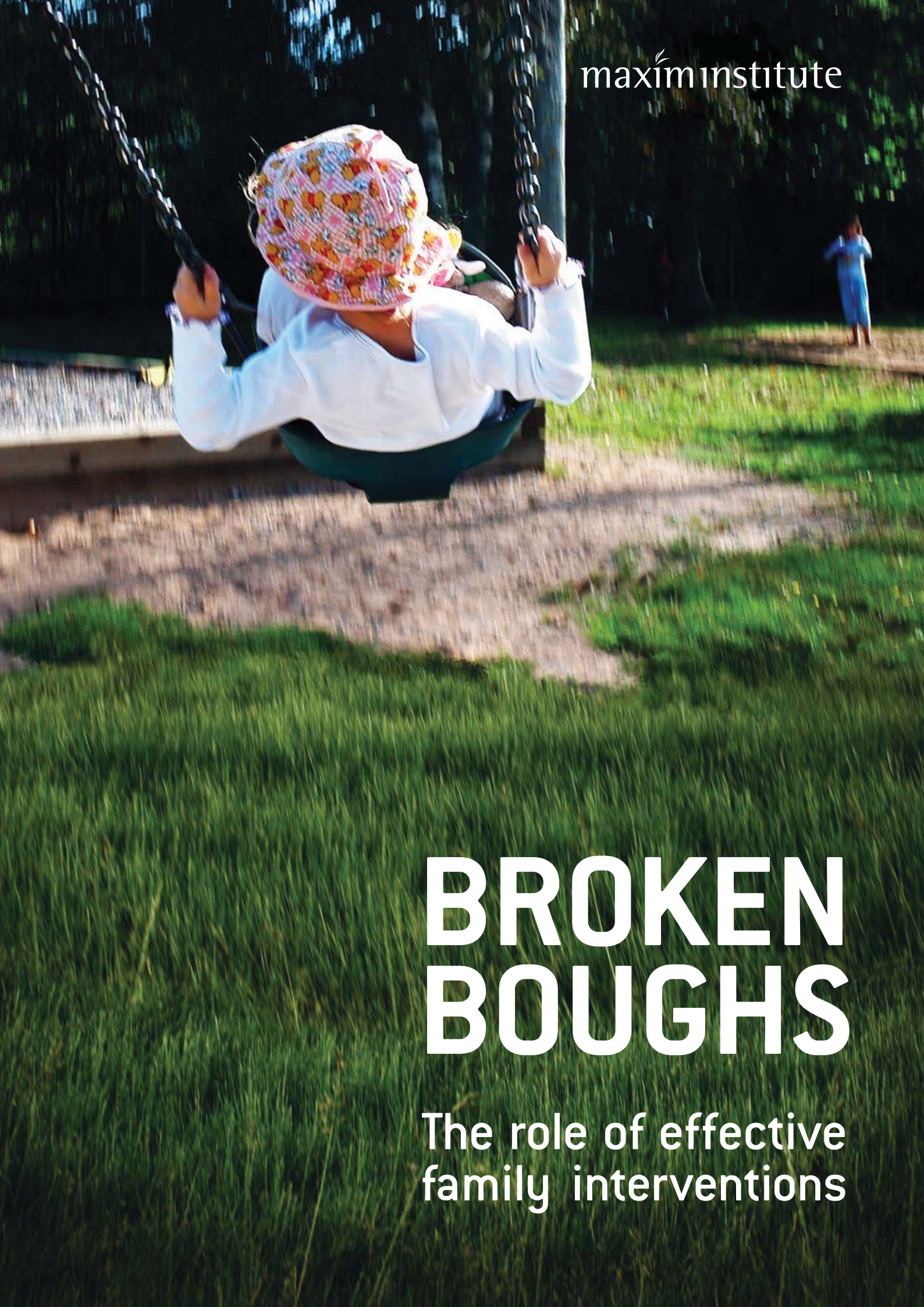

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BROKEN BOUGHS

The role of effective family interventions

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The role of effective family interventions

BY DANIEL LEES AND ALEX PENK

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EXECUTIVE SUMMARY

Too many New Zealand children are mired in dysfunction. Abuse and poor parenting mark their early lives, setting them on a grim trajectory of anti-social behaviour leading to negative outcomes like substance abuse, poor health and crime. But though the problems are bleak, we needn't throw in the towel. Effective family intervention programmes hold out real hope of change, of reversing the slide into dysfunction. The best hope is found in funding programmes that really work, and getting in early.

No-one can afford to ignore the issue. While serious family problems impact most directly and painfully on individual family members, their effect spreads to wider society as well.

This report focuses on two such family problems, child abuse and neglect, and anti-social behaviour/conduct problems, and programmes that respond to them. Effective responses are required because the problems are widespread. For example:

- in 2007-2008, there were 20,560 findings of abuse or neglect, after care and protection notifications resulted in investigations;[1]
- around five percent of children will need interventions to address conduct problems,[2] and this figure climbs to 15 to 20 percent of Maori children.[3]

Conduct problems and anti-social behaviour have serious consequences, including "higher rates of domestic violence, separation and divorce, higher rates of injury and hospitalisation, and a shortened life expectancy."[4] The related costs can be substantial. New Zealand-based research estimates "that the lifetime cost to society of a chronic adolescent antisocial male is $3 million."[5]

It is crucial that interventions designed to address these problems are actually shown to work. This means intervention programmes should be rigorously evaluated. Programmes that do not work are not only a waste of limited resources, they may actually cause harm by "crowding out" programmes that do work. They may even make things worse for the families enrolled in them. Evidence-based programmes are those that have demonstrated significant results in research after quantitative evaluations have been conducted, that is, after children's actual outcomes have been measured. Effective programmes do not guarantee improvement for every child, but they do give us the best chance of making a difference.

Not all intervention programmes are the same. There are a number of different approaches to such programmes. We conclude that the preferred approach to family intervention is to develop and implement programmes that are family-focused, intervene early and are targeted to children and families that are at risk or experiencing actual problems. However, it is important that we implement a suite of effective programme types, addressing a range of contexts (home/parents and school/teachers), a variety of ages and providing a range of treatment types and approaches (such as multisystemic therapy for adolescents).[6]

It is beyond the scope of this report to consider all the programme types that could make up such a package. Instead, we focus on reviewing two of the programme types that can be used with younger children: home visitation programmes and parent management training programmes. This is because these are among the most effective programme types (though this does not mean every programme of these types is effective) and a number of such programmes are already running in New Zealand, with some receiving significant government funding.

Home visitation programmes target a wide range of outcomes including improvements in children's physical health and reduction of child abuse. They may include services like budgeting advice and provide links to other social services.

Parent management training programmes aim to improve parenting practices, because "parental skill in handling disagreements and conflicts during the pre-school years ... [is] a key determinant in the development of antisocial behaviour in children."[7]

This report surveys the main home visitation programmes and parent management training programmes running in New Zealand that: are currently receiving direct government funding; and that, if effective, have the greatest potential to impact rates of abuse and neglect, and/or conduct problems. (For example, by addressing associated inadequate parenting or family dysfunction.) It asks whether those programmes have been evaluated and what those evaluations show. (Privately funded programmes are outside the scope of our review, as are programmes that might be indirectly government-funded.)

This approach identified the following programmes:

A. Home visitation programmes:

- Family Start;
- Parents as First Teachers;
- Early Start;

B. Parent management training programmes:

- Whanau Toko I Te Ora;
- The Parenting Programme;
- Incredible Years;
- Triple P.

Unfortunately, with the exception of Early Start, Incredible Years and Triple P, these programmes have either been insufficiently evaluated and/or the evaluations that have been carried out show very little, if any, results associated with the programmes. Nevertheless, these programmes receive 2009-2010 funding of around $37.448 million, with Family Start receiving the largest share of this figure. This compares with $1.959 million in 2009-2010 funding for Early Start and the Incredible Years, with some further unquantified amounts for Incredible Years and Triple P.

This report then begins to identify some of the best, most effective home visitation and parent management training programmes available worldwide, via a preliminary review of the literature on such programmes. This survey is introductory—a comprehensive review would no doubt disclose other exemplary programmes—but it does demonstrate that there are high-quality, proven programmes available. Unlike the review of current New Zealand programmes, this international review was not limited to government-funded programmes.

This approach identified the following exemplary, evidence-based programmes:

A. Home visitation programmes:

- Nurse-Family Partnership;
- Early Start;

B. Parent management training programmes:

- Incredible Years;
- Triple P;
- Strengthening Families (Kumpfer et al).

Each of these programmes is reviewed through a framework intended to assess its strengths and weaknesses, as shown by the research evidence. The goal is to narrow down the selection to the programmes that can have the greatest impact on our outcomes of interest.

One crucial element of this assessment was the issue of cross-cultural application. It cannot simply be assumed that exemplary programmes that are designed overseas are necessarily appropriate in New Zealand, particularly for Maori, Pasifika and Asian communities.

There are various ways in which internationally designed programmes can be adapted for use in New Zealand, but before any adapted programmes are rolled out on a large scale, they should be carefully piloted and evaluated to check whether they will actually work.[8] There is also debate over whether programmes involving Maori should be designed and implemented by Maori, for Maori, in order to be effective and culturally appropriate.

Based on our research, we make the following policy recommendations:

1. **Three programmes should be further implemented and funded: Early Start, the Incredible Years and Triple P. However, Early Start should also be independently evaluated**

in another location outside of Christchurch as soon as possible.

2. **A comprehensive review of exemplary, evidence-based home visitation and parent management training programmes should be undertaken to identify other programmes that might be suitable for implementation and funding in New Zealand.**
3. **Funding should be carefully allocated. Existing funding from unproven and/or ineffective programmes like Family Start and Parents as First Teachers should be re-allocated to evidence-based programmes. Continued funding should be conditional on programmes continuing to demonstrate that they are effective and delivered with fidelity.**
4. **Rigorous evaluations are required. Intervention programmes should be subjected to thorough quantitative evaluation processes. Programmes developed overseas should be carefully piloted and tested in New Zealand before they are regarded as effective for New Zealand populations, and before they are implemented widely.**
5. **Prevention is preferable to cure. Families in at-risk circumstances should be referred to appropriate programmes as soon as possible.**
6. **Programmes should encourage self-sufficiency. Interventions should encourage families to become strong and self-sufficient, not dependent on on-going intervention and monitoring.**
7. **Programmes should apply the "sufficiency principle" and be targeted accordingly. Levels of intervention provided should be proportionate to families' needs.**
8. **Cost-effectiveness is important. It should be possible to see that the benefits of implementing an intervention outweigh its costs.**
9. **We should commit to a long-term process of programme development and implementation. "[A] generational problem will take a generation to fix."**[9]

We need to be patient and to work carefully to identify real, effective solutions to the problems confronting us. Quick fixes might be superficially attractive, but they are unlikely to be effective. We can, however, make an immediate start by committing to address the problem adequately. This means putting the focus squarely on rigorous evaluations and funding programmes that really work. The consequences of failure are too severe not to get this right.

ENDNOTES

1 Ministry of Social Development, "The Statistical Report 2008," (Wellington: Ministry of Social Development, 2009), 134, "Table 5.3. Trends in the findings of investigations of care and protection notifications requiring further action." Note that "Number of investigations may not relate to numbers of children or young people, as there may be more than one investigation related to the same individual in the same year. Numbers of investigations also may not relate to numbers of notifications assessed as requiring further action, as one investigation may address more than one such notification."

2 W. Blissett et al., "Conduct Problems: Best practice report," (Wellington: Ministry of Social Development, 2009), 13.

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SECTION 1

Problems facing New Zealand children and their families

Too many New Zealand children are mired in dysfunction. Abuse and poor parenting mark their early lives, setting them on a grim trajectory of anti-social behaviour leading to negative outcomes like substance abuse, poor health and crime.

These serious family problems affect us all. They impact most directly and painfully on individual family members, but their effect spreads to wider society as well, for example through higher treatment costs for health problems or higher crime rates and threats to personal security.

These problems create substantial personal and social costs and affect people over their whole life course. But though the problems are bleak, we needn't throw in the towel. Effective family intervention programmes hold out real hope of change, of reversing the slide into dysfunction. The best hope is found in funding programmes that really work, and getting in early. There is a moral obligation to respond to these issues effectively and compassionately, and there are also practical and economic benefits associated with responding well to severe behavioural problems and child maltreatment.

The focus of this report is on identifying intervention approaches that are capable of addressing two key problems that affect children's life outcomes: child abuse; and anti-social behaviour or conduct problems. There are effective interventions that can have effects on abuse, and others that can address conduct problems. We will suggest that both types of intervention are necessary as part of a larger package designed to improve outcomes for children and families in New Zealand.

However, not every intervention that is intended to make a difference is actually effective. This means raising some hard questions about what actually works. We cannot afford to ignore these questions. There are family intervention programmes that can make a difference for those who need it most, but ineffective programmes do no favours to anyone.

The structure of this report is as follows:

- **This section** goes on to consider the prevalence of child abuse and conduct problems/anti-social behaviour, and the prevalence of selected risk factors for those problems, to give some idea of the size of the issue. It also considers recent political interest in intervention programmes;
- **Section 2** discusses the importance of rigorous evaluation to determine whether programmes are effective, and some of the different ways to approach family intervention and different programme types. We focus on two selected programme types that are capable of returning good results with younger children—home visitation and parent management training programmes;
- **Section 3** reviews home visitation and parent management training programmes that are currently directly funded by the New Zealand government, and that, if effective, have the greatest potential to impact rates of abuse and neglect, and/or conduct problems (for example, by addressing associated inadequate parenting or family dysfunction);
- **Section 4** sets out the results of a preliminary review of the international literature to begin to identify some of the best, most effective home visitation and parent management training programmes. Unlike the review in section 3, this review was not specifically limited to government-funded programmes;

- **Section 5** considers implications for Maori, Pasifika and Asian populations, including the issue of cultural adaptation of existing programmes and the development of kaupapa Maori programmes;
- **Section 6** presents our conclusion and policy recommendations, based on the evidence we have reviewed.

PREVALENCE OF CHILD ABUSE AND NEGLECT

News of child abuse and neglect is in the headlines with alarming regularity, and the most tragic cases end in death. Names such as Coral-Ellen Burrows, Chris and Cru Kahui, and Nia Glassie have been burned into the national consciousness. We can get a sense of the scale of the problem by looking at several different types of data: findings of abuse or neglect; number of Child, Youth and Family clients; child maltreatment deaths; and child deaths from assault.

The most recent figures from the Ministry of Social Development reveal that in 2007-2008, there were 20,560 findings of abuse or neglect, after care and protection notifications resulted in investigations. They included:[1]

- 8,664 findings of emotional abuse (42 percent of findings);
- 2,321 findings of physical abuse (11 percent of findings);
- 1,003 findings of sexual abuse (5 percent of findings);
- 4,302 findings of neglect (21 percent of findings).

In 2008, Child, Youth and Family had 27,562 clients, of whom 47 percent were under 10 years of age.[2]

In 2003 a UNICEF report found that New Zealand is one of five countries with "levels of child maltreatment deaths that are four to six times higher than the average for the leading countries."[3] Although cautious about the international comparisons on which this figure was based, a more recent New Zealand report found that, "In the five years to 2003, 38 children under 15 years of age died as a result of maltreatment, a decline from 50 in the previous five-year period."[4] Younger children are more likely to die from maltreatment,[5] and although cautious about producing ethnic breakdowns (because of "small numbers and volatility for child death statistics"), the same report noted that between 1999 to 2003, "Maori children died from maltreatment at an average annual rate" double that for "New Zealand European and other children."[6]

Finally, focusing only on assault, we see that in 2005 (the most recent year for which data is available), five children under the age of three died of assault.[7]

The sad fact is that much of this child maltreatment is inflicted by members of the child's household or family.[8] In addition, child maltreatment deaths only "represent the 'tip of the iceberg' of children who are maltreated, neglected or abused."[9]

PREVALENCE OF ANTI-SOCIAL BEHAVIOUR

Children are displaying concerning levels of problem behaviours. These are not minor or insignificant—they include "antisocial, disruptive, aggressive, dishonest and related behaviours ... in adolescence these behaviours will become elaborated to include delinquency, risk-taking, precocious sexual conduct and other related behaviours."[10]

An expert Advisory Group on Conduct Problems has been set up to advise the Ministries of Social Development, Health, Education and Justice about this issue. They warn that:[11]

> conduct problems in childhood are precursors of a wide range of adverse outcomes in adulthood. These adverse outcomes include criminal offending, imprisonment, alcohol and substance abuse, teen pregnancy, mental health problems, suicidal behaviours and poor physical health. In addition, these problems are associated with limited educational achievement, higher welfare dependence and limited earnings. The linkages between conduct problems and teen pregnancy and family functioning also raise important issues about the inter-generational transmission of conduct problems. **There is probably no other common childhood condition that is associated with such far-reaching and pervasive developmental consequences.**

The problems do not just affect one life, but are inter-generational in scope, as "children who engage in high rates of antisocial behaviour are at considerable risk for a large number of adverse

outcomes as adults," according to Dr John Church of the University of Canterbury. These adverse outcomes include "higher rates of domestic violence, separation and divorce, higher rates of injury and hospitalisation, and a shortened life expectancy."[12]

Violent behaviour is increasing in schools and is being observed in younger children—some as young as five and six—according to anecdotal indications.[13] In 2007, 27,000 high school students and 6,595 primary school students were temporarily or permanently stood down from school.[14] Teachers report a growing concern regarding the lack of discipline among children and violent behaviour occurring in schools, and some teachers are concerned for their safety.[15]

A recent New Zealand report states that "approximately 4.5% of the primary and intermediate school population demonstrate conduct disorder/severe antisocial behaviour."[16]

The problem is relevant to both boys and girls although they exhibit these problems to differing degrees at different stages. The Christchurch Health and Development Study tells us that among seven to 13 year olds, 83 percent of children with severe conduct problems were male, whereas by the age of 15 there was no significant difference between the numbers of girls and boys with severe behavioural problems.[17]

The expert Advisory Group estimates that around "5-10 per cent of young people will display conduct problems of sufficient severity to merit intervention. The majority (75 per cent approximately) of these young people will be male."[18] However, some ethnic groups are at greater risk than others. The figure climbs to "15-20 per cent of Maori tamariki and taiohi"[19] and anecdotal evidence suggests "that there are higher rates of conduct problems in Pacific children and young people."[20]

Similarly, Church estimated that "about 7 to 9 per cent of all boys" brought up during the 1970s became "life course persistent antisocial children who go on to become delinquent youth and then adult offenders." He said that "[t]he proportion for girls is unknown because the measures of antisocial development which were used in the 1970s did not work to identify antisocial girls."[21]

The related costs can be substantial. New Zealand-based research estimates "that the lifetime cost to society of a chronic adolescent antisocial male is $3 million."[22] Another estimate is that "the public cost of providing services to children with severe conduct problems is about 10 times the cost for children without conduct problems. This costing does not take into account the distress caused to both the individual and those around him/her by severe conduct problems."[23]

PREVALENCE OF SELECTED RISK FACTORS

Various stresses and risk factors are used by professionals to identify families that may benefit from intervention. Some of the stresses and risk factors used by particular programmes are described in section 2. Here, we briefly survey statistics that are representative of the proportion of families facing some of these difficulties. This is not comprehensive, but it does provide some idea of the extent of the problems.

Teen parenthood

"The teenage birth rate in New Zealand is relatively high by OECD standards," with the highest rates of teen pregnancy occurring in Maori and Pasifika communities.[24]

In 2006, births to women aged 19 or under accounted for 7.4 percent of all births in New Zealand. Broken down by ethnic group, European teenagers accounted for 44.4 percent of these teenage births, Maori teenagers accounted for 41.5 percent, Pasifika teenagers accounted for 11.3 percent, Asian teenagers accounted for 2.0 percent, Middle Eastern, Latin American and African teenagers accounted for 0.4 percent in total, and teenagers from "other" ethnic groups accounted for 0.2 percent.[25] Looked at another way, teenage births made up 16.9 percent of all births to Maori women that year, 9.5 percent of all births to Pasifika women, 6.2 percent of all births to European women and 1.9 percent of all births to Asian women.[26]

The high proportion of teenage parents who are Maori and Pasifika, proportionate to other ethnic groups, may partially explain some of the higher rates of negative social statistics in these communities. This highlights the need for programmes that will work in Maori and Pasifika communities, an issue that is addressed in section 5.

Substance abuse

A United Nations report has shown that New

Zealand has one of the highest rates of substance abuse in the world. The report indicates that approximately 3.4 percent of our population use methamphetamine, while ecstasy is used by 2.3 percent of the population.[27] An older survey indicated that approximately two percent of those surveyed admitted using tranquillisers or solvents for recreational purposes, with less than one percent having used tranquillisers or solvents in the past twelve months.[28]

Parental depression

National and international evidence suggests that "about one third of people who consult general practitioners (GPs) have a mental health problem or illness at the time of the consultation, or have experienced one in the past year."[29]

Results of the New Zealand health survey indicate that overall one in every forty adults (2.5 percent of the population) have been diagnosed with a serious mental disorder at some point, including bipolar, depressive disorder or schizophrenia. Women are slightly more likely than men to experience these clinical levels of mental illness (3.2 percent vs. 2.1 percent).[30]

The significant difference between these two statistics—one third of the population versus 2.5 percent—can probably be accounted for by the fact that the smaller number are those who were officially diagnosed with mental illness and therefore had significant life challenges, whereas the larger number included those experiencing mild depression or anxiety.

Implication

A tentative implication from the above statistics is that families and children who are at greatest risk and in need of assistance may make up around three to seven percent of the population. This is consistent with the advice on prevalence from the expert Advisory Group on Conduct Problems, noted earlier.[31]

RECENT INTEREST IN FAMILY INTERVENTIONS

The importance of family interventions has been recognised by political parties. Several of the parties campaigning at the 2008 general election specifically referred to intervention programmes in their policies. The ACT Party advocated for a mentor system for at-risk families.[32] New Zealand First proposed "expanding such programmes as 'Family Start' and home based support," and said it would "develop Parents as First Teachers (PAFT) programmes across the country."[33] Family Start and PAFT are reviewed in section 3. Similarly, the Green Party proposed to "support early, pre-school intervention programmes working with children at risk." They also proposed to "create an integrated framework for children and families to monitor the development of every child and young person through co-ordinated planned assessments at key life stages."[34]

Shortly after taking office at the end of 2008, the Minister for Social Development, Paula Bennett, identified early intervention as an important strategy,[35] and one of the briefings she received pointed out that there is a lack of specialist behaviour services, in particular for young people (aged 0-7) and teenagers (13-17 years).[36] An "inter-agency plan" has been developed "to improve the interventions provided to children and young people with conduct disorder/severe antisocial behaviour."[37]

In a speech in 2006, the former Children's Commissioner Dr Cindy Kiro outlined a ten year vision for family intervention, calling for "the establishment of an integrated framework for children and their families."[38] Her proposal suggested assigning every child in New Zealand a case worker, who would oversee and assess the child's progress through four major stages in their lives. It would involve following children from birth until age 17 and assessing their cognitive, emotional, physical and social development. The intention for such a programme is to more readily identify children and families who are in need of help so they can be referred to service providers.[39] However, the proposal is not well targeted to risk factors and actual problems. It therefore has the potential to intervene in normal, functioning families who may neither need nor want assistance, which is a waste of resources.

In February 2008, the previous Prime Minister Helen Clark launched a system of "B4 School Checks," which is designed to screen all new entrant children aged four or five, before beginning primary school. A Ministry of Health website describes the

B4 School Check as follows: [40]

> The B4 School Check is a health and development assessment for pre-schoolers. The purpose of the B4 School Check is to promote health and wellbeing in pre-school children, and to identify any health, developmental or behavioural problems that may have a negative impact on the child's ability to learn and take part at school.

The Check includes assessment of children's hearing and vision, their height and weight, their behavioural and developmental outcomes and their oral health, with referrals to appropriate health, educational or social service providers where necessary.[41] Behavioural outcomes are measured using the Strengths and Difficulties Questionnaire (SDQ). This widely used measurement scale includes 25 assessment items, five measuring possible emotional symptoms, five gauging conduct problems, five assessing hyperactivity or inattention and five measuring problems with peer associations.[42] These items include whether a child is "Considerate of other people's feelings," "Often loses temper," "Often fights with other children or bullies them," "Can stop and think things out before acting," or has "Many fears, easily scared."[43] Currently $10 million per annum is allocated for this initiative.[44]

While this is a screening programme, rather than an intervention per se, it begs the question whether effective interventions are actually available to respond to any behavioural problems identified. It can also be asked whether it is an efficient use of public money to screen families in the absence of any particular grounds for concern.

Nevertheless, "[d]elivery of the Check started in four DHBs (Waikato, Nelson Marlborough, MidCentral and Lakes) in June 2008. The remaining DHBs across the country started delivery of the B4 School Check from September 2008."[45] There have, however, been difficulties with implementation, with the Minister of Health stating that he will "re-evaluate the way the programme is delivered at the end of [2009]."[46]

Most recently, the Minister of Social Development announced a new initiative called First Response, designed to follow up "low level" notifications of domestic violence to prevent subsequent events of child abuse. The initiative will include non-governmental organisations who will visit affected families and, among other things, make referrals to "appropriate services or programmes." The programme will be trialled from November 2009 "and will be evaluated closely to see if it makes a difference to child abuse rates in the area."[47]

OVERLAP WITH CHILD MENTAL HEALTH PROBLEMS

The problem behaviours that this report focuses on, and the treatments for them, are different in nature to "psychiatric disorders" like "childhood phobias, traumatic stress disorder [and] childhood depression."[48] They are also different to disabilities like learning disabilities, and to interventions for those disabilities. Treatments and interventions for such disorders and disabilities are outside the scope of this report.

However, that is not to say that mental health problems can be neatly separated from conduct problems. In young children, both types of problem can have identical symptoms, so they can be difficult to distinguish and they may also co-exist. Indeed, conduct problems are sometimes referred to as a subset of mental health problems.[49]

Where mental health problems co-exist with conduct problems, they may limit the effect of programmes intended to treat the conduct problems. Therefore, "it is clear that to be effective it is important that programmes and interventions for conduct problems are embedded in a wider system of services directed at ensuring the health, adjustment and wellbeing of young children." While this report focuses on interventions that respond to the problems of child abuse and anti-social behaviour, we must not downplay the importance of interventions and treatment for child mental health problems.[50]

CONCLUSION

The problems are serious and urgent. Not surprisingly, there are many different ideas about the best way to intervene in families to combat child abuse and conduct disorder. For example, some would like to introduce universal programmes covering every family in New Zealand, while others prefer solutions targeted to families showing risk factors and/or evidence of actual problems. Some advocate measures like boot camps as a response to well-developed problem behaviours in adolescents. Others urge responses that take effect earlier in life and that are designed to prevent problem behaviours

occurring or stop them developing into more serious problems later in life. Section 2 discusses some of the competing approaches to family intervention, with a view to discovering which approaches are most effective.

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SECTION 2

Evaluation and approaches to family intervention

The problems identified earlier demonstrate that many families are in need of some kind of intervention or assistance. This will particularly be the case where inter-generational bonds and community ties have eroded to leave them without support. However, it is crucial that interventions intended to provide this support are actually shown to work. This means rigorous evaluations are required, and this section will explain why.

Evaluation is what tells us whether a particular programme is really effective at achieving its goals and making a difference for the children and families it is meant to help, so it is crucial to get evaluation right and to pay careful attention to the results. This might sound obvious, but unfortunately programmes do not always live up to this standard. In some cases, families who need help may be enrolled in programmes that have not been shown capable of providing it. The negative consequences for these families, and for all of society, hardly need stating.

This section will also consider some of the different approaches to intervention. For example, some approaches would primarily target "at-risk" families, while others would apply to every family, regardless of any risk factors or problems in those families. Finally, this section considers different types of family intervention programmes, which might vary in the age they target or the context they work in. The aim is to consider which programme types are the most effective. Effective programmes do not guarantee improvements for every child, but they do give us the best chance of making a difference.

WHY EVALUATION IS ESSENTIAL

Evaluation is critically important when assessing whether a programme actually works and addresses the problems it is supposed to. Programmes that do not work are not only a waste of limited resources, they may actually cause harm by "crowding out" programmes that do work. Even worse, families who are enrolled in an ineffective programme may have more serious problems when they exit the programme. This is because their problems may have increased untreated, or the programme may have even made them worse. This, in turn, may lead to those families having no confidence in other, effective interventions and refusing to try them. Practitioners delivering the ineffective intervention may also come to believe that the families' problems are incapable of treatment, if they do not realise the intervention is ineffective.

The way that programmes are selected, implemented and evaluated is therefore vital. Even though participants and programme facilitators may like certain programmes, rigorous processes of selection, implementation and evaluation that go beyond co-ordinator and participant satisfaction are required so that the limited resources spent on such programmes will have the desired effect.[1] In this context, qualitative feedback evaluations, similar to customer satisfaction surveys, are of little value. Parents' enjoyment of the course or perceptions of change do not necessarily reflect meaningful family development or actual change.

The story of the Scared Straight programme illustrates the importance of rigorous evaluations:[2]

> In this programme young offenders were exposed to the realities of prison life in an attempt to 'scare them straight.' Initial, uncontrolled evaluations of the programme provided positive reports and all participants were of the view that the programme was beneficial. It was only when

> the results of randomised trials became available that it became apparent the programme was, in fact, harmful and increased risks of crime.

Unfortunately, this lack of evaluation is not an isolated story. Writing in 2003, Church stated that:[3]

> Many of the interventions which are currently being provided for adolescents with severe antisocial behaviour difficulties are interventions which have never been shown to have a positive effect on the future quality of life of the antisocial adolescent. Included under this heading are probation and parole, individual counselling, group counselling, family counselling, activity centres, alternative education programmes, mentoring, outdoor programmes, vocational counselling, and deterrence programmes such as shock incarceration (boot camps) and "scared straight" programmes. The continued widespread use of interventions which have never been shown to have a beneficial effect raises important questions about the need for outcomes-based research on these programmes, and for new programmes to be based on evidence of their likely positive effect on outcomes.

Evidence-based programmes

Evidence-based programmes are research-based and target the factors that are observed to cause the problem in question.[4] To be evidence-based, programmes must also have demonstrated significant results in research after quantitative evaluations have been conducted. Quantitative evaluations examine children's actual outcomes. They involve the collection and analysis of survey data, often based on a combination of parents' and practitioners' assessments of particular children's outcomes. The outcomes are often rated on scales ranging from one to four, or one to five with graduated responses (for instance, one might represent "child hardly ever displays oppositional or defiant behaviour," whereas five might represent "child often displays oppositional or defiant behaviour"). These ratings would usually be taken twice: the control group and programme group children would be measured before and after programme implementation. Statistical analysis is used to see if there are any substantial differences following the programme.

Given that there are limited resources and the agencies that implement family interventions genuinely want to help families, it is surprising that most of the programmes employed worldwide are not evidence-based. Karol Kumpfer observes that in the US, "over the past 20 years, prevention researchers have developed and tested a number of effective parenting and family interventions; however, only about 10% of practitioners are implementing these and only about 25% are implementing them with fidelity."[5]

A possible explanation for this puzzling situation is offered by Kumpfer who writes: "Practitioners often do not implement science-based programmes because they frequently want to create and implement their own programmes." This argument seems to hold weight in the US when the breakdown of programmes is examined. Of the interventions that currently run there, "Only about 10% are evidence-based; 30% are commercially marketed programs; and about 60% are developed by practitioners."[6] Overlooking tested and proven programmes is troubling given the urgency of the issues and the importance of wisely managing resources in this vital sector.

Lack of evaluation and failure to implement evidence-based programmes is a major problem. Cost is not a legitimate reason for not conducting evaluations or failing to implement interventions with reliable evidence bases, as well-tested and demonstrably effective programmes can have greater benefits and be more cost-effective and potentially cost-saving compared to those that do not produce the intended outcomes. Evaluation issues are discussed in more detail under "Determining programme effectiveness" in section 4.

DIFFERENT APPROACHES TO INTERVENTION

There are a number of different approaches to intervention programmes. Four key differences we will consider here are whether interventions:

- are family-focused or child-focused;
- intervene early or late in a child's life;
- focus on prevention or treatment;
- are universal or targeted to at-risk families.

Family-focused versus child-focused interventions

Generally speaking family interventions fall within

two broad approaches: child-focused interventions and family-focused interventions. Within these two general theoretical frameworks there are also more specific categories of intervention, such as home visitation programmes, family skills training, parental education and family therapy. Overall, effective family-focused programmes such as home visitation programmes are associated with more powerful benefits for families and children than child-focused programmes.

A recent compilation of meta-analyses and large scale literature reviews shows that the most effective programmes include behavioural parent training, family skills training and in-home family support.[7] This is why family-focused interventions such as parent management training programmes and home visitation programmes are generally chosen for use with high-risk families.

Unfortunately, while there has been growing concern about the increase in anti-social behaviour from youth and a parallel realisation that the quality of parenting contributes significantly to these behaviours, most of the intervention work to date has been child-focused, rather than family-focused,[8] and adolescent-age focused.

This does not mean child-focused interventions are irrelevant or should not be used in conjunction with family-focused interventions. Indeed a variety of different child-focused, evidence-based interventions have also been categorised as exemplary. Karol Kumpfer has highlighted the importance of having a variety of interventions, as there will be a variety of needs in different families; "A broad range of different family interventions are needed because different parenting and family skills are needed for children of different ages and for different types of families."[9] This point is emphasised under "Types of family intervention programme," later in this section. However, child-focused interventions are more effective for older children and for the most severe cases.

Early versus late intervention

Ideally, intervention should take place early. This has three primary advantages. Firstly, the chances of successful intervention are higher when intervention is early, and decline as the child becomes older.[10] Secondly, there are clear benefits to the families involved, as actual and potential problems prevented or treated early will have less damaging impacts on the family long-term. Thirdly, broader social costs will be lower if this is done well.

Early intervention "provides an opportunity to divert those on an antisocial pathway away from this pathway before behaviour patterns have become consolidated and resistant to change." However, interventions are needed across the full range of ages for two reasons. "First, early intervention will not be successful in all cases and there will be a need for the ongoing treatment and management of those for whom early intervention is not successful." Second, while early intervention can work for children who develop problems early, other children will not develop conduct problems until adolescence. Suitable interventions need to be available for this group as well.[11]

However, the "early onset" group "experience the most severe and continuing adjustment difficulties throughout their lives and ... as a consequence, consume the largest proportion of social services expenditure."[12] It is therefore reasonable to give particular attention to this group, particularly as, "[p]rior to school entry, it is estimated that there is a 75-80% chance of halting existing severe antisocial behaviour in young children and increasing pro-social behaviour. Programme effectiveness drops sharply with age."[13]

While much public attention focuses on adult "violent offenders" and adolescents on the path to becoming violent offenders, Church points out that, "Because no one views an antisocial 6-year old as a threat to public safety, the child receives no service. What we fail to notice is that 40 per cent of antisocial 8-year olds will have become frequent offenders by the age of 18 and that early intervention (at the point of school entry) is the only crime prevention strategy which has ever been shown to be effective."[14] Similarly, because anti-social behaviour "is easier to contain in younger children than in their older counterparts," intervention may not take place until considerably later, by which time it will be much harder to make a difference.[15]

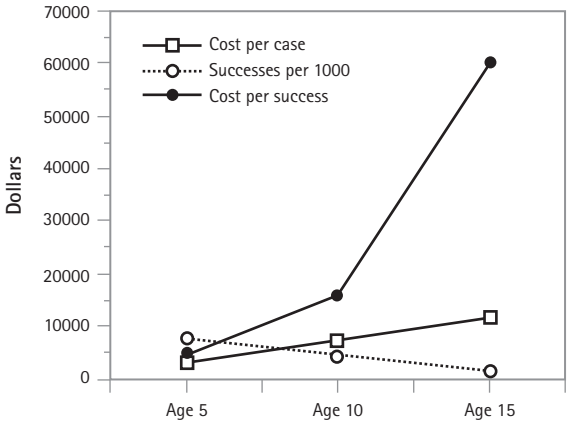
A UK report puts it much more bluntly:[16]

> The policies of late intervention have failed and the alternative must be tried. Every time we hear of the latest stabbing or shooting and the media-political reflex to 'get tough on crime' our response should be to get ahead of the short-term problems and rectify the social and cultural

influences that have created 17-year-olds who are anti-social, criminal, and so lacking in basic human empathy that they commit such crimes.

Many late interventions, like boot camps, that attempt to put young offenders back on the straight and narrow may come far too late to have much effect. By contrast, the potential of early intervention to prevent future crime has received attention in the form of the former Government's Effective Interventions package.[17] Certainly some later interventions are required (see "Types of family intervention programme," later in this section), but it is clear that wherever possible, it is best to effect change earlier, rather than later.

Figure 2.1. Cost of normalising the development of one antisocial child at ages 5, 10, and 15 given intervention costs of $4,000, $8,000 and $12,000 and success rates of 80%, 50% and 20%



Source: J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behavioural Difficulties: A review of the research" (Wellington: Ministry of Education, 2003), 156.

Prevention versus treatment

Some family-focused programmes are primarily preventative. They introduce policies that support families in their children's early years before significant problems arise, teaching families the skills needed to reduce stress and increase their ability to raise children well. Some of these programmes even begin prenatally. Home visitation programmes fall into this category with a broad range of outcomes targeted.

Other family-focused programmes primarily focus on identifying and treating existing conduct disorder or behavioural problems during early childhood and beyond. This treatment approach seeks to correct negative parenting cycles and therefore correct behavioural problems early, before children mature and continue in cycles of anti-social behaviour that have broad social implications. Parent management training programmes fit into this category.

However, there is some overlap between the two approaches, as home visitation programmes often teach parenting skills in order to achieve their aims and some parent management training programmes have a preventative effect.

Universal versus targeted programmes

Some family interventions are designed to apply universally to all families, such as the "integrated framework" recommended by the former Children's Commissioner, described earlier. Others are targeted to families displaying risk factors or experiencing actual problems.

Broad, universal initiatives are likely to be extremely costly. There are more efficient ways of screening families that need support and the reduced cost of targeted measures means more funding could be put towards interventions that are directed to those who really need them. Broad initiatives such as that proposed by Dr Kiro could even make things worse, for example by encouraging parents to leave it up to case workers to ensure children are meeting developmental goals.

In the long-term this undermines what these initiatives aim to achieve. That is because parent management training programmes and home visitation programmes aim to encourage and assist families in parenting, with the intention of fostering self-sufficient, well-functioning families, rather than dependency.

A universal approach is often said to be necessary so that families who are enrolled in the programme are not stigmatised. However, it is questionable whether this concern outweighs the need to avoid intervening in families who neither need nor want intervention. Not only could this approach discourage families from taking responsibility for their children's development, it is also a waste of scarce resources, and would quite possibly create resentment of the programme by those families who do not need it.

There is an alternative that sits mid-way between universal recruitment and targeted recruitment of individual families. This is to have "targeted communities," where a programme is universal within "targeted geographical areas" and "all children [in that area] are born members." This approach is said to reduce the stigma associated with such programmes.[18] Similar concerns are raised as with the universal approach. That is, supplying services to families who do not need or want them is a waste of resources, and compulsory enrolment in the programme is likely to be resented by those families. There also seems to be a risk that targeting particular communities will actually stigmatise those communities and everyone who lives in them.

While the Advisory Group on Conduct Problems was prepared to contemplate universal screening of all children to identify those in need of intervention, they commented that:[19]

> the major priority within New Zealand is not the identification of children with conduct problems but rather the development of services to address these problems. At present the number of effective and well-evaluated programmes for managing conduct problems in New Zealand is very limited with the result that New Zealand does not have the service or workforce capacity to address an anticipated 5 per cent of referral from the 3-7 year-old population.

For all these reasons, universal interventions or "targeted community" approaches are not desirable. Recruiting individual families is a preferable approach. Because prevention programmes aim to prevent problems like abuse and conduct disorder before they occur, they can be targeted by identifying families with particular risk factors for these problems. For example, the Early Start programme, developed and run in New Zealand, uses the following: young age of mother, parental substance abuse, lack of social support or a history of family abuse.[20] Similarly, PAFT selects potential participants based on: low socio-economic status, "young age of mother," single parenthood, "lack of family/community support" and "lack of parenting information."[21] Parental depression is another risk factor singled out in some programmes as it can also predict substantial problems in children's development.[22]

Because treatment programmes are designed to treat existing problems, the basis for targeting for these programmes is the existence of actual problems (not risk factors, as the risk in question has already materialised). For example, when serious conduct problems are identified in young children—such as hurting animals or babies—they and their family should be referred for treatment.

This does not mean that targeting should be too tight, or that access to interventions should be too restricted. Serious conduct problems should obviously be treated, and "mild" or "moderate" conduct problems in young children should be taken seriously as well, as these problems could accelerate to become severe conduct problems in adolescence. One way this could happen is through self-referral. That is, families with concerns about their children's behaviour can refer themselves for treatment programmes. This is one way to ensure that relevant families receive services they need while avoiding the limitations of tight targeting and without universalising services.

Conclusion: Approaches to family intervention

It therefore seems that the best approach to family intervention is to develop and implement programmes that are family-focused, intervene early and are targeted to families that are at risk or experiencing actual problems.

This does not mean that other approaches are irrelevant. As has been noted, child-focused programmes have an important role to play as part of an overall suite of interventions.

Similarly, while it is generally most efficient to prevent and treat problems in the early years before they escalate, social services should be set up with a life course perspective in mind. That is, there should be a range of programmes available for families across the course of their lives, from pre-natal care to drug prevention services for teens to parenting courses, in order to most significantly affect positive inter-generational change in society.[23] This is because while early intervention has the potential to prevent problems before they arise or to arrest them in their early stages, not all families will take part in these programmes. In addition, there are other stages in life that present potential problems. While early intervention may avert severe behavioural problems and associated risks, if the children treated through those programmes do not have access to appropriate

support as young parents, for example, their children could develop behavioural problems.

So if early, family-focused approaches to intervention are a priority, what specific programme types meet this description?

TYPES OF FAMILY INTERVENTION PROGRAMME

Within the field of family-focused interventions, there are a number of different programme types. A recent report from the expert Advisory Group on Conduct Problems identified "a recommended portfolio of interventions … identified on the basis of a group consensus about the types of intervention that were most likely to be effective."[24] For children up to the age of five, home visitation programmes were recommended, while for children aged three to 12 the portfolio included parent management training programmes.[25]

Within the field of family-focused interventions there are also other effective programme types for a range of ages. The Advisory Group's recommended portfolio also included teacher management training programmes, "interventions that combine both parent and teacher management training," and "classroom-based programmes that lead to improved management of conduct problems in the classroom."[26] Indeed, the Advisory Group considered that combined "home and school" programmes generally "have greater effects than home-based or teacher-based interventions alone and Church suggests that combined home and school programmes offer the best programme option."[27]

The importance of school-related interventions is clear; as children age, they will spend increasing amounts of time at school and out of the home. For the best outcomes, both teachers and parents must be expected and equipped to manage and train the children in their care.

It is therefore important that we implement a suite of effective programme types. They should address a range of contexts (home/parents and school/teachers), a variety of ages and involve a range of treatment types and approaches (such as multisystemic therapy for adolescents).[28] The suite of programme types selected now should not be set in stone either, as it is likely that over time other programme types will show sufficient evidence of effectiveness.[29]

Nevertheless, it is beyond the scope of this report to enquire into all of these different programme types. Instead, we will focus on reviewing two of the programme types that can be used with younger children: home visitation programmes and parent management training programmes. This is because these are among the most effective programme types—although this does not mean that every programme of these types is effective—and a number of such programmes are already running in New

Table 2.1. Recommended portfolio of interventions for the treatment and management of conduct problems

Intervention	Age		
	3-7	8-12	13-17
Parent Management Training	✓	✓	-
Teacher Management Training	✓	✓	✓
Combined Parent/Teacher Programmes	✓	✓	-
Classroom-based Intervention	✓	✓	-
Cognitive Behaviour Therapy	-	✓	✓
Multi-modal Interventions			
Multisystemic Therapy	-	✓	✓
Functional Family Therapy	-	✓	✓
Treatment Foster Care	-	✓	✓

Source: W. Blissett et al., "Conduct Problems: Best practice report," (Wellington: Ministry of Social Development, 2009), 39.

Zealand, with some receiving significant levels of government funding. The next two sections will consider particular programmes in detail.

The remainder of this section will briefly summarise key features of home visitation and parent management training programmes.

HOME VISITATION PROGRAMMES

Home visitation programmes target a wide range of outcomes including children's physical health, reduction of child abuse, improving access to early childhood services and reducing child behaviour problems. Therefore, some of the components used in parent management training programmes, such as teaching parenting skills, are also used in home visitation programmes. However the focus and the implementation of home visitation programmes are far broader than those of parent management training programmes. This is because they involve a range of services, often including budgeting advice, counselling about personal development and advice about prospective educational opportunities, as well as providing links to other social services.

Home visitation programmes involve education and support in the primary family context—the home. This can function in a range of different ways, from a healthcare worker visiting a family, to a combination of school and parenting programmes, or social workers and therapists engaging in longer-term work with families. As has been noted, home visitation programmes generally focus on preventing problems before they arise, rather than treating existing problems. Given this, they use risk factors to identify families that will benefit from the programme.

There are probably two reasons for higher effect sizes in some home visitation programmes when compared to other family-based programmes. The first is that they are more resource- and personnel-intensive than other types. Secondly, because they are more resource-intensive, only families with the greatest challenges are allocated to them. Because there is greater scope for improvement in those families, it follows that effect sizes tend to be largest in those contexts.

Home visitation programmes usually begin in relation to an "index" child who triggers service delivery, and who may not be the oldest child in the family. The programme may begin when the mother is still pregnant with the index child, or after he or she is born. The programme may be delivered over a period of years, and visits may be weekly, fortnightly, monthly, or may vary with the child's age and the presence of risk factors. Achieving good results depends on delivery by highly trained professionals. In some cases, two professionals are required per visit in order to ensure safety and to see that the programme is delivered faithfully to its design. Home visitation can be quite an invasive intervention, as it involves paid professionals entering the family home and trying to alter the way the family functions.[30]

There is a degree of tension between delivering such a programme faithfully to its design and the flexibility often associated with home visitation programmes. Nurses and practitioners visiting families often respond to the particular need or problem confronting the parent(s) at that time, and "[t]his is widely seen as one of their strengths." However, if visits deviate too far from the planned programme and curriculum, practitioners may no longer be implementing the programme as designed, so their intervention may no longer be effective in meeting its stated aims.[31]

It should be noted that not all home visitation programmes are effective. In fact, "the results of many home-based interventions have been disappointing and few positive effects have been found," although high-performing programmes can also be identified.[32] In particular, given the focus of this report, it is important to note that not all home visitation programmes demonstrate effects on child abuse rates, even where this is an intended outcome.[33]

PARENT MANAGEMENT TRAINING PROGRAMMES

The aim of parent management training programmes is to improve parenting practices, as they have a flow-on effect on children's behaviours. Church notes that "parental skill in handling disagreements and conflicts during the pre-school years … [is] a key determinant in the development of antisocial behaviour in children."[34]

Parent management training programmes generally treat parents in groups, usually in weekly sessions. They are often treatment-focused, intervening when particular families need support for existing conduct problems. However, they may also act as preventative measures, providing training

to families where children are at risk of developing conduct problems. Two of the programmes reviewed in section 4 (Triple P and the Incredible Years) have treatment and prevention as their goals. Parent management training programmes are not designed specifically to reduce abuse, but some positive effects in this area have been reported for some programmes.

Church and his colleagues point out that parent management training programmes are particularly targeted at children who develop early onset anti-social behavioural difficulties.[35] Importantly, these children are most at-risk of developing anti-social tendencies that persist throughout their lives, so intervening early is a good way of minimising this risk,[36] for without some form of early intervention they are likely to require the use of special education services in the future.

The first parent management training programme was developed by the Oregon Social Learning Centre (OSLC), and many of the principles now used in these programmes are derived from extensive empirical research on the development of anti-social behaviour conducted by the OSLC.[37]

Parent management training programmes derive from "social learning theory." This holds that children learn different social and anti-social ways of interacting with others through routine daily interactions and therefore focuses on teaching parents how to encourage pro-social behaviour and minimise anti-social behaviour. These programmes are often delivered to mothers, with programmes typically lasting eight to twelve weeks.[38]

Parent management training programmes tend to focus on two core issues—increasing positive reinforcement and reducing negative coercion.[39] Interestingly, the main focus is on changing parental behaviours first, as a way of improving child behaviour, rather than solely targeting children's behaviours.

The programmes seek to improve the quality of the parent-child relationship "through the use of play and other activities."[40] This is important because a poor quality relationship generally reflects poorer child behaviour and reduced parental ability to manage their child's behaviour. These programmes therefore acknowledge "the transactional model of the relationship between parenting and child behaviour" and seek to improve family relationships "as a foundation for a change in family dynamics."[41]

These programmes are all family-focused, often starting from a theoretical view of the family as a "system" and addressing parental behaviours in order to reduce the likelihood of harsh or inconsistent parenting. They start from the premise that when parenting practices improve, children's behaviour also tends to improve, in which case parents are also less likely to become frustrated with their children and resort to violence. Such programmes have the greatest effect when delivered to families with children under eight years old.

All parent management training programmes seek:[42]

> to teach the parents of "unmanageable" children how to monitor and track child behaviour, how to give clear instructions, how to teach compliance, how to refocus their attention from antisocial to prosocial child behaviour, how to attend to and reinforce appropriate behaviour, how to respond appropriately to antisocial behaviour (using such techniques as planned ignoring, natural consequences, or time-out from reinforcement), and how to anticipate and solve new child management problems. All aim to reduce the inadvertent reinforcement of deviant child behaviour and to greatly increase the reinforcement for prosocial behaviour.

The Advisory Group on Conduct Problems had this to say about parent management training programmes:[43]

> While there is substantial evidence to suggest parent management programmes can produce dramatic short-term (up to six months) reductions in child behaviour problems, less has been known about the longer-term benefits of such programmes. However, research has indicated that programme benefits up to six years after treatment have been found. ...
>
> Parent training/social learning programmes are, without a doubt, among the best researched of interventions and have shown consistent benefits. Furthermore, these programmes have the advantage that, subject to adequate supervision, they can be used by a wide range of professional groups including teachers, social workers and nurses.

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30 K. Liberty, personal communication, 3 September 2009.

31 D.S. Gomby, "Understanding Evaluations of Home Visiting Programs," *The Future of Children* 9, no. 1 (1999): 27-43, 28.

32 W. Blissett et al., "Advisory Group on Conduct Problems: Best practice report," 19.

33 See projects cited in the following studies: D. Fergusson et al., "Early Start: Evaluation Report," 79; M. Sweet and M. Appelbaum, "Is Home Visiting an Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families With Young Children," *Child Development* 75, no. 5 (2004): 1435-1456.

34 J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," 21.

35 J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," 77.

36 C. Knoster, "Implications of Externalising Behaviour Problems for Young Adults," *Journal of Marriage and Family* 65 (2003): 1073-1080; E. Thomson, T. Hanson, and S. McLanahan, "Family Structure and Child Well-Being: Economic resources vs. parental behaviors," *Social Forces* 73, no. 1 (1994): 221-242.

37 For a summary of this research, see J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," 18-32.

38 J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," 78-79.

39 T.K. Taylor and A. Biglan, "Behavioural Family Interventions for Improving Child-rearing: A Literature Review for Clinicians and Policy Makers," *Clinical Child and Family Psychology Review* 1, no. 1 (1998), 42-43.

40 T.K. Taylor and A. Biglan, "Behavioural Family Interventions

for Improving Child-rearing: A Literature Review for Clinicians and Policy Makers," 43.

41 K. Liberty, personal communication, 3 September 2009.

42 J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," 79.

43 W. Blissett et al., "Conduct Problems: Best practice report," 21-22, internal citations omitted.

SECTION 3

Current home visitation and parent management training programmes in New Zealand

We wanted to survey the main home visitation programmes and parent management training programmes running in New Zealand. Specifically, we wanted to see whether those programmes had been evaluated, whether the evaluations showed they are working, and how much they cost.

A Families Commission report published in 2005 had done something similar. It described "key parenting programmes funded by government," and so we used its selection criteria to begin our review. Those criteria mean that the programmes reviewed can be regarded as the main or key ones of their type in New Zealand.

To be included in the Families Commission review, "programmes were to:[1]

- receive direct government funding
- be multisite [operating out of more than one locale]
- have been running for at least one year
- seek to improve the well-being of children through assisting their parents, or other adults acting in a parenting role (such as grandparents, parents' partners or other members of the family) to parent more effectively
- be aimed at parents with children aged zero to six, or subsets thereof
- provide more than only information."[2]

It is important to emphasise that these criteria only capture programmes funded directly by government. Programmes that are run with private funding are outside the scope of our review. So are programmes that might receive some indirect government funding—that is, where general funding is given to organisations that deliver some relevant programmes, but it is not specifically for those programmes.

This criterion means that the largest programmes should be captured by the review. In addition, the best information is available for Government-funded programmes, and where public money is involved there is an extra imperative to ensure that it is being used effectively.

To identify current, potentially relevant programmes, we asked various government Ministries and Departments to provide their funding figures for "early intervention" programmes and "parenting programs such as parent management training programs."[3] Where potentially relevant, government-funded programmes were identified by these requests, we studied their supporting documents (such as reports and evaluations). We included the programmes in this review if the documents showed that they were a home visitation or parent management training programme that met the above inclusion criteria and that, if effective, have the greatest potential to impact rates of abuse and neglect, and/or conduct problems. (For example, by addressing associated inadequate parenting or family dysfunction.) This approach identified the following home visitation and parent management training programmes:

A. Home visitation programmes:

- Family Start;
- Parents as First Teachers;
- Early Start;

B. Parent management training programmes:

- Whanau Toko I Te Ora;
- The Parenting Programme;

- Incredible Years;
- Triple P.

Some of these programmes were also identified by the Families Commission report, and some other programmes identified by that report are not included because they are no longer funded or because they were different programme types or affected different outcomes. For example, we did not include the HIPPY programme in our review because its predominant aims are to impact educational outcomes rather than to directly address our outcomes of interest.[4]

Early Start, Incredible Years and Triple P were also identified in our preliminary review of exemplary programmes. That review, and those programmes, are discussed in section 4. That means that this section surveys the following government-funded programmes—Family Start, Parents as First Teachers, Whanau Toko I Te Ora and The Parenting Programme.

Unfortunately, our survey of these programmes showed that most of them have been insufficiently evaluated and the evaluations that have been carried out show very little, if any, results associated with the programmes.

A. HOME VISITATION PROGRAMMES

Family Start

Family Start is the Government's flagship programme. Aspects of it are based on Early Start. The programme is "a child-centred, family-focused, home-based early intervention programme with the goal of achieving better outcomes for New Zealand's most at-risk families at the time when a new child is born." Three Family Start sites were created in 1998 and another thirteen were created in 1999-2000.[5] There are now 31 Family Start sites.[6] Family Start also delivers Ahuru Mowai/Born to Learn, which is part of Parents as First Teachers.

Family Start's objectives are to improve:[7]

- "children's wellbeing and development and enhance life outcomes;"
- "parents' parenting capability and practice;"
- "parents' personal and family circumstances."

Participation in the programme is voluntary,[8] though families must be referred for participation.[9] It is targeted to families displaying risk factors that include: "unsupported parent," "young mother," "substance abuse," "family history of abuse," and "low income status."[10]

The Family Start programme places families into categories requiring different levels of support. "High intensity families are expected to receive up to 240 hours of service during their first year in the programme, medium intensity families up to 150 hours and low intensity families 60 hours of service. Delivery is reduced as the needs of the family decrease …." Each family receives an Individual Family Plan, where they set their own targets, and Family Start's employees work with them to ensure that their goals are consistent with, and reinforce the objectives of, Family Start. Family Start's employees then work with families to assist them to achieve these goals.[11]

In order to see whether Family Start is achieving its objectives, two evaluations have been completed. The first was a process evaluation that reviewed the programme's implementation and was published in 2003. The second was an evaluation of the programme's impact and outcomes, published in 2005. Unfortunately, the results of these evaluations were not promising. Nevertheless, Family Start receives considerable levels of taxpayer funding. The 2009-2010 funding for Family Start is $29.04 million.[12]

Although it was only designed to review the way the programme had been implemented, and did not assess the programme's effectiveness on child and parent outcomes, the process evaluation raised some early concerns. Notably, some of these concerns were also raised in the later outcome/impact evaluation. They included:

- 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."[13] It is also significant that the decision was made to implement 13 further sites even before the three original sites had been properly evaluated.
- The work that the family/whanau workers must perform is complex, and it appeared that not all workers were adequately qualified or trained for the task.[14]
- "Limited geographical boundaries" also limited the programme; as client families moved out of the areas covered by the individual sites, they also exited the programme. As the target population is "very mobile," it appeared it would be difficult to retain and assist these families.[15]

The subsequent outcome/impact evaluation was designed to evaluate:[16]

1. "short-term outcomes for children and their families;"
2. relationships between the programme and other service providers;
3. whether alterations or improvements should be made to the programme.

However, the methodology for the evaluation was unfortunately limited. Although the original intention had been to use a randomised controlled trial, the evaluation was ultimately conducted as a single group prospective design, where "one group is measured at two or more points in time," and there is no control group. That is, Family Start clients were measured for various outcomes in 2002 and again in 2003. As the evaluators pointed out:[17]

> The limitation of this design is that there may be more general changes occurring in the populations of interest. Researchers have no sure way of knowing how much of any change is due to the intervention programme and how much might be due to broader changes taking place outside the control of the intervention programme.

It appears that a more robust design was not used because of "strong provider resistance." Government officials also noted that "programme delivery was not yet stable enough for [a randomised controlled trial] design and that delivery differed across provider socio-cultural contexts."[18]

Consequently, the evaluation's findings are subject to "significant limitations"[19] and only "indicative of possible trends, not confirmed evidence."[20] The evaluators also noted that "the non-random nature of the sample selection and the relatively low participation rates by caregivers limit the generalisability of the findings."[21] In other words, the evaluation design could not be set up to produce good evidence of programme effectiveness.

Even setting this issue aside, the evaluation findings suggested very little positive impact from the programme. The strongest impact appears to have been in the area of education, as participating parents appeared to have improved their qualifications.[22] Parents were also less likely to perceive common, problematic child behaviours (like screaming) as a problem, although most such behaviours did not actually decrease.[23] They also seemed to like the programme.[24]

However, some similar concerns were raised as in the process evaluation:

- Feedback from external agencies suggested Family Start workers needed greater levels of training, qualifications and supervision.[25] Only 40 percent of the staff sample in the evaluation had a "recognised educational qualification."[26]
- "High mobility" of targeted families also meant "it is likely the programmes may have little influence over the average length of stay" for participating families, which was 13-15 months.[27] The evaluators recommended some relaxation of the strict geographical boundaries for the sites.[28]

There were also low rates of immunisation and breastfeeding in participating families, and no real change to smoking rates for the adults.[29] The evaluators hypothesised that the programme may have made a difference to rates of referral to Child, Youth and Family, but found no evidence of such a change.[30] Benefit dependency was also largely unchanged, although there was some increase in the rates of parents participating in part-time employment.[31]

Perhaps of greatest concern was the feedback from some external agencies that some Family Start workers may not have been sufficiently prepared to identify and respond to "abuse within families."[32]

In light of all this, it is rather surprising that the evaluators concluded that the evaluation "has identified a number of positive indicators that would suggest that Family Start is moving towards the achievement of its overall goal to improve outcomes for New Zealand's most at-risk families."[33] More evidence is needed before such a claim can be made.

Following the evaluation, the Ministry of Social Development announced that it was making a number of changes to the programme, including:[34]

1. making it mandatory for supervisors to have tertiary qualifications;
2. requiring "family/whanau workers to have tertiary qualifications wherever possible;"
3. developing "memoranda of understanding between Family Start sites and CYF on referrals and notifications of child abuse and neglect;"

4. including a range of "indicators" in contracts with service providers, such as "all children receive their prescribed pre-school immunisations."

Further evaluation of Family Start is ongoing. In 2007, a scoping evaluation was conducted to inform another outcomes evaluation. The methodology of the outcomes evaluation has yet to be finalised, although some consideration has been given to whether a comparison group will be used.[35]

The 2007 evaluation was intended to examine Family Start's delivery, "critical success factors" for that delivery, and "identify child and family outcomes achieved by Family Start." Family Start staff at eight sites participated in interviews and focus groups, and client outcomes were assessed by purposive sampling, where "whanau workers at each site selected cases of families who had graduated or were making progress."[36] Because the focus was on families that had made progress, the evaluation not surprisingly found that Family Start had made a difference for those families. However, as the evaluation makes clear, these results are "exploratory in nature" and collected for the purpose of informing an outcomes evaluation.[37] They are not intended to be stand-alone evidence of the programme's effectiveness. Two improvements were also made to Family Start following this evaluation, to address issues it identified in service delivery. A new "strengths and needs assessment tool" was developed and implemented in July 2008, and a new database was developed and made available from October 2008,[38] which is expected to improve information collection and assessment of child outcomes.[39]

It will be important to see whether the upcoming outcomes evaluation reveals any evidence of effectiveness following the various improvements made to the programme. At present, such evidence is lacking.

Parents As First Teachers (PAFT)

PAFT is a home visitation programme that specifically targets at-risk families. It is administered by the Ministry of Social Development, but delivered by different providers within the community, including Plunket, Family Start and Barnardos. Each participating family has a PAFT educator who regularly visits them, and aims to help them to understand children's development, teaching them about parenting and offering guidance to the family until the target child is three years of age.[40]

PAFT is based on the notion that parents are children's first teachers and can therefore positively affect educational and social outcomes when they parent well.[41] Family specialists make home visits and meet with parents in playcentres and other settings. The programme consists of "monthly visit plans, group meetings, health and development checks and referrals" to relevant agencies.[42]

PAFT was contracted to 19 different organisations between 2004 and 2006 and an additional 20 between 2005 and 2007 in 64 locations around New Zealand.[43] Funding for PAFT for 2009-2010 is $7.161 million.[44]

The initiation of the programme "had a political foundation," with PAFT as "one of the key planks in National Party education policies" prior to the 1990 general election. It was piloted following National's success at that election.[45]

An evaluation conducted in 1997 by researchers at the Dunedin Health and Development Unit found that, while parents found the programme interesting, there were no significant differences between control groups and families enrolled in the programme.[46] The authors of another evaluation concluded, "this comprehensive and thorough investigation, using both quantitative and qualitative methodologies, has uncovered very little in the way of positive, measurable results which can be attributed unequivocally to the PAFT programme."[47]

One of the later evaluations of PAFT in New Zealand was published in 2002. This evaluation assessed 400 families enrolled in the programme, in centres throughout New Zealand. The author, Sarah-Eve Farquhar, concludes that families who participated in PAFT reported improved parenting skills and greater responsibility for their children's education.[48] However, this was primarily based on parents' perceptions rather than quantitative analysis. The majority of parents involved in the programme (69.5 percent) indicated an improvement in "their [parenting] knowledge base, understanding of children, and parenting skills."[49]

This 2002 evaluation, however, cannot tell us whether children's outcomes are actually improved as a result of PAFT. No control groups were included to see how other families with similar backgrounds may also have changed or developed over that

timeframe. Much of the information gained was qualitative in nature, meaning parents were simply surveyed for their responses rather than changes in actual outcomes being measured. This means the evaluation is based only on parents' perceptions of their parenting skills and behaviours. While it is possible that their parenting really did improve, independent assessments are needed to confirm this. As the author points out, if parenting behaviours improve then it is likely that child outcomes will also improve,[50] yet this was not actually tested.

A follow-up report, also by Sarah-Eve Farquhar, found that the programme positively affected parents' views about "children's safety and standards of care," including alternatives to physical discipline, and helped to control parents' emotional issues in a way that may lead to safer environments for children.[51] Parents reported being more informed about parenting, having more realistic expectations for their children and gaining a better understanding of children's educational needs.[52] Parents also believed they experienced significant personal development, being better role-models for their children in their language and their behaviour.[53]

While these findings suggest that the programme could be positive for parents, and therefore children, most of these conclusions came from qualitative accounts of the parents' experiences of the programme. As with the 2002 report, no control groups were mentioned and the report did not use quantitative analysis to describe outcomes.

According to the Ministry of Social Development, PAFT has been improved since the 1998 evaluation, with curriculum changes and "an increased focus on issues such as brain development and parent/child attachment."[54] Nevertheless, the above research leaves a large question mark over its effectiveness, with the weight of rigorous research findings showing it has no substantial effect on children's outcomes. PAFT is modelled on an overseas evidence-based programme, but the New Zealand version has not shown the benefits of its parent programme.[55]

B. PARENT MANAGEMENT TRAINING PROGRAMMES

Whanau Toko I Te Ora

This is a national parenting programme for Maori delivered through the Maori Women's Welfare League. This service is designed and run by Maori, based on a child-centred and whanau-focused approach. The programme focuses on the child's first five years and has three main components, "home visits, education and learning, and group support." The promotion and development of "positive parenting skills, confident family functioning ... [and] learning and development opportunities for children" are key parts of the programme.[56] Funding for this programme in 2009-2010 is $0.947 million.[57]

The only existing evaluation of this programme was published in 2002. It was based on interviews of 24 children and their families who were in the programme and further quantitative analysis of 16 of these families' outcomes.[58] The evaluation indicated that compared to levels at the beginning of the programme, the majority of families enrolled showed an improvement in "parenting skills and confidence." Similarly, the majority of support workers who implemented the programme indicated that children's social, emotional and cognitive well-being improved over the course of the programme.[59] While this evaluation does compare baseline data, such as the families' outcomes prior to the programme compared with those afterwards, the methodology used did not allow the researcher to definitively conclude that the programme alone caused the changes observed in positive family outcomes. There are further limitations associated with the methods used, including lack of control groups, which make it difficult to draw strong conclusions from this evaluation.[60]

The Parenting Programme

The Department of Corrections runs The Parenting Programme, "designed to improve the ability of prisoners to safely and effectively parent their own children" upon their release. "The course is made up of a series of modules covering different skills, with a total of 32 hours of contact time delivered over four weeks." The modules include topics such as "understanding children's development and changing needs," "safe and positive behaviour management," "safe and positive discipline and control," and "building a positive relationship with your child." The Department of Corrections implements this programme with a view to reducing levels of re-offending and reducing rates of inter-generational offending.[61]

The Department of Corrections currently allocates an amount in the range of $300,000 - $350,000 for delivery of The Parenting Programme.[62] The latest evaluation of this course was undertaken in March 2008. It consisted of surveys of participants' "learning outcomes," rather than an evaluation of children's outcomes post-programme. Participants were examined on "core knowledge relating to the programme content" before and after the course. These scores were then compared and average increases evaluated. Overall, the results from 28 separate evaluations conducted in a range of prisons showed an average of 195 percent increase in course-related knowledge.[63]

However, in order to see whether such increases in parenting knowledge make a difference to child behaviour, and ultimately to offending, an outcomes evaluation is required where children's behaviour is measured pre- and post-programme. There are no plans for such an evaluation in the future.[64]

CONCLUSION

This review reveals that a number of the main home visitation and parent management training programmes currently used in New Zealand have question-marks over their effectiveness. Three of the programmes that are delivered in New Zealand were identified as exemplary by our preliminary review in the following section. However, it is the programmes with question-marks that receive the lion's share of the funding. These programmes receive 2009-2010 funding of around $37.448 million, with Family Start the largest recipient. This compares with $1.959 million in 2009-2010 funding for Early Start and the Incredible Years, with some further unquantified amounts for Incredible Years and Triple P.

However, it should be noted that one of the programmes subject to a question-mark, Family Start, will undergo another evaluation. Depending on what that evaluation shows, it may be possible to revise the conclusion of this section in a more positive direction. However, in the meantime, it is worth asking why we are spending so much on programmes that have not shown good evidence of effectiveness.

Table 3.1. Summary of direct government funding for home visitation and parent management training programmes in 2009-2010

Programme	Funding in 2009-2010 ($m)
Family Start	29.04
PAFT	7.161
Whanau Toko I Te Ora	0.947
The Parenting Programme	0.3*
Sub-total 1:	**37.448**
Early Start	1.129
Incredible Years	0.83**
Triple P	Unquantified
Sub-total 2:	**1.959**
Total:	**39.407**

* We have assumed a figure at the bottom of the budget allocation for this programme.

** This figure includes the sum of $140,000 spent on training Ministry of Health CAMHS workers to deliver the Incredible Years. There is some further unquantified funding within CAMHS.

Source: Compilation of Official Information Act responses

ENDNOTES

1 A. Kerslake Hendricks and R. Balakrishnan, "Review of Parenting Programs: A report by the Families Commission," 2/05 (Wellington: Families Commission, 2005), 9-10. Note that the review, although of government-funded programmes, did not focus on initiatives "funded through Child, Youth and Family (CYF)."

2 Research has clearly shown that programmes that provide information only are less effective than those where support workers come alongside families and guide them through the parenting challenges they are facing. K. Kumpfer and R. Alvarado, "Family Strengthening Approaches for the Prevention of Youth Problem Behaviours," *American Psychologist* 58, no. 6/7 (2003): 457-465.

3 Requests were made under the Official Information Act 1982 to the Ministries of Social Development, Health, Education, and Justice, and the Department of Corrections, between 8 December 2008 and 19 February 2009, and again on 2 June 2009 following delivery of the 2009 Budget. The criterion for inclusion as a programme funded directly by government was that programmes must have "levels of funding or budget allocated" by one of these Ministries or Departments in 2009-2010. Note that the Ministry of Social Development advised that in addition to the programmes they identified, some programmes might be funded by Child, Youth and Family at a local or community level at particular sites: Ministry of Social Development, "Official Information Act response," 2 March 2009. As there is no central collation of funding information for such programmes, and as they are likely to be smaller in scale than those funded directly by Government, we excluded such "local services" from the scope of our research. The same approach was taken by the Families Commission review: A. Hendricks and R. Balakrishnan, "Review of Parenting Programmes: A report by the Families Commission," 10.

4 "HIPPY is a school preparation programme focused on pre-literacy and pre-numeracy skills ... with an explicit aim of increasing parents' awareness of their potential and strengths as home educators." G. BarHava-Monteith et al., "HIPPY New Zealand: An evaluation overview," *Social Policy Journal of New Zealand* 12 (1999).

5 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," (Wellington: Ministry of Social Development, 2005), 1.

6 Ministry of Social Development, personal communication, 17 September 2009.

7 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 1.

8 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 1.

9 Evaluation Management Group, "Family Start Process Evaluation Final Report: A summary and integration of components of the process evaluation phase," (Wellington: Ministries of Education, Health and Social Development, 2003), 23.

10 Evaluation Management Group, "Family Start Process Evaluation Final Report: A summary and integration of components of the process evaluation phase," 23.

11 A. Kerslake Hendricks and R. Balakrishnan, "Review of Parenting Programs: A report by the Families Commission," 57-58; Ministry of Social Development, personal communication, 28 September 2009.

12 Ministry of Social Development, personal communication, 17 September 2009.

13 Evaluation Management Group, "Family Start Process Evaluation Final Report: A summary and integration of components of the process evaluation phase," 94.

14 Evaluation Management Group, "Family Start Process Evaluation Final Report: A summary and integration of components of the process evaluation phase," 90. The authors of the process evaluation stated that: "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 families whom they were ostensibly helping."

15 Evaluation Management Group, "Family Start Process Evaluation Final Report: A summary and integration of components of the process evaluation phase," 96.

16 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 16.

17 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 19.

18 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 19. The process evaluation noted that service providers did not like the idea of a randomised controlled trial, because it "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:" Evaluation Management Group, "Family Start Process Evaluation Final Report: A summary and integration of components of the process evaluation phase," 98.

19 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 105.

20 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 31.

21 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 106.

22 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 102-103.

23 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 76.

24 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 78.

25 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 97-98.

26 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 23.

27 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 42.

28 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 100.

29 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 102.

30 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 55.

31 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 74.

32 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 96.

33 Auckland UniServices Ltd, "Outcome/Impact Evaluation of Family Start: Final report," 105.

34 Ministry of Social Development, *Outcome/Impact Evaluation*

of Family Start: Final report, https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/evaluation/outcome-impact-family-start/ (accessed 9 September 2009).

35 Centre for Social Research and Evaluation, "Family Start Evaluation 2007: Final report," (Wellington: Ministry of Social Development, 2007), 6; Ministry of Social Development, personal communication, 28 September 2009.

36 Centre for Social Research and Evaluation, "Family Start Evaluation 2007: Final report," 6.

37 Centre for Social Research and Evaluation, "Family Start Evaluation 2007: Final report," 22-23.

38 Centre for Social Research and Evaluation, "Family Start Evaluation 2007: Final report," 20-21.

39 Ministry of Social Development, personal communication, 17 September 2009.

40 S. Farquhar, "Parents as First Teachers: A study of the New Zealand PAFT Programme," no. 2 (ChildForum Research, 2003), 11-12.

41 S. Farquhar, "An Evaluation of the Parents as First Teachers Programme," no. 1 (Early Childhood Development, 2002), 1, 33.

42 S. Farquhar, "An Evaluation of the Parents as First Teachers Programme," 1.

43 A. Kerslake Hendricks and R. Balakrishnan, "Review of Parenting Programs: A report by the Families Commission," 26.

44 Ministry of Social Development, "Official Information Act response," 29 June 2009.

45 S. Farquhar, "An Evaluation of the Parents as First Teachers Programme," 1.

46 K. Campbell and P.A. Silva, "Parents as First Teachers Pilot Project Evaluation: Age Three Assessments. Final Report to the Ministry of Education on the Dunedin and Gisborne/East Coast Areas," (Dunedin: Dunedin Multidisciplinary Health and Development Research Unit, 1997).

47 A.D. Boyd, "Parents as First Teachers Pilot Project Evaluation (PAFT): Report on South Auckland Area," (Auckland: Auckland UniServices Ltd, 1997), 43.

48 S. Farquhar, "An Evaluation of the Parents as First Teachers Programme," 34.

49 S. Farquhar, "An Evaluation of the Parents as First Teachers Programme," 26. Participating families also experienced an increase in access to health and community services and more took up early childhood education for their children.

50 S. Farquhar, "An Evaluation of the Parents as First Teachers Programme," 33.

51 S. Farquhar, "Parents as First Teachers: A study of the New Zealand PAFT Programme," 63-64.

52 S. Farquhar, "Parents as First Teachers: A study of the New Zealand PAFT Programme," 66.

53 S. Farquhar, "Parents as First Teachers: A study of the New Zealand PAFT Programme," 70-71.

54 Ministry of Social Development, personal communication, 17 September 2009.

55 Church comments that PAFT is "an adaptation of the *Parents as Teachers* programme, an effective and well evaluated programme," but that it appears to "have become degraded in the attempt to train a large number of paraprofessionals to reproduce [it] over a large number of sites. The lesson to be learned is that the effectiveness of a particular intervention will not necessarily be reproduced following a state-wide or national implementation unless steps are taken to ensure that implementation personnel are adequately trained and that adequate quality control procedures are put in place to ensure treatment fidelity during the implementation": J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," (Wellington: Ministry of Education, 2003), 92-93.

56 A. Kerslake Hendricks and R. Balakrishnan, "Review of Parenting Programs: A report by the Families Commission," 68.

57 Ministry of Social Development, "Official Information Act response," 29 June 2009.

58 I.D. Livingstone, "Whanau Toko I Te Ora: Evaluation Report to the Ministry of Education," (Wellington: Ministry of Education, 2002), 3-4.

59 I.D. Livingstone, "Whanau Toko I Te Ora: Evaluation Report to the Ministry of Education," 63-65.

60 I.D. Livingstone, "Whanau Toko I Te Ora: Evaluation Report to the Ministry of Education," 67-69.

61 Department of Corrections, "Official Information Act response," 23 April 2009.

62 Department of Corrections, "Official Information Act response," 12 June 2009.

63 Department of Corrections, "Summary of Prison Parenting Skills Programme to May 2008" (Wellington: Department of Corrections, 2008). The evaluation is based on results measured between 6 August 2007 and 10 March 2008.

64 Department of Corrections, "Official Information Act response," 23 April 2009.

SECTION 4

Some of the best home visitation and parent management training programmes worldwide

We wanted to begin to identify some of the best, most effective home visitation and parent management training programmes available. To do this, we conducted a preliminary review of the literature on such programmes. Because this was a general review, not a systematic review, our survey of these programmes is introductory and not comprehensive.

However, existing systematic and comprehensive literature reviews and government evaluations allowed us to begin to identify some of the most rigorously tested home visitation and parent management training interventions capable of providing the greatest benefits for families. The particular exemplary programmes that we identified are discussed in detail in this section, with the goal of narrowing down the selection to those programmes that are most capable of affecting outcomes in the areas of child abuse and anti-social behaviour/conduct problems.

A comprehensive review would no doubt disclose other home visitation and parent management training programmes that could be categorised as exemplary. Nevertheless, our preliminary review demonstrates that there are high-quality, proven programmes available. These programmes, along with others that would be disclosed by a comprehensive review, can be considered for implementation in New Zealand. Indeed, three of the five programmes covered in this preliminary review are currently running in New Zealand and receiving some government funding, albeit to a limited degree.

The preliminary review had three steps:

1. We identified exemplary programmes by:
    a. Surveying systematic and comprehensive literature reviews and government evaluations;
    b. Contacting key academics in the field;
    c. Surveying websites that collate information on home visitation programmes and parent management training programmes for the highest performing programmes;[1]
2. We conducted database searches for studies that evaluated these programmes;
3. We constructed a "prevention science" framework to analyse the documents found by our searches. This framework allows the focus, strengths and weaknesses of each programme to be identified and assessed.

Note that unlike our review of current New Zealand programmes, this review was not limited to government-funded programmes.

Step 1: Identifying exemplary programmes

We reviewed several high-quality government-sponsored literature reviews that summarised and categorised specific prevention and treatment programmes, identifying the best evidence-based programmes available. They included a National Institute for Health and Clinical Excellence (NICE) evaluation, a recent interagency report from New Zealand, and a review carried out for the Office of Juvenile Justice and Delinquency Prevention in the United States.[2]

We also reviewed a number of peer-reviewed journal articles that summarised and synthesised the effectiveness of the best-performing prevention and treatment programmes.[3]

Through this we identified several exemplary evidence-based home visitation and parent management training programmes.[4] These are:

A. Home visitation programmes:

- Nurse-Family Partnership;
- Early Start;

B. Parent management training programmes:

- Incredible Years;
- Triple P;
- Strengthening Families (Kumpfer et al).

The NICE evaluation identified Triple P and the Incredible Years as programmes that are able to bring about "substantial and sustained changes in behaviour of children with conduct disorders."[5] An interagency report produced by members of the Ministries of Health, Education, Justice, Social Development (including Child, Youth and Family) and the High and Complex Needs Unit also singled out Triple P and the Incredible Years as two of the best programmes worldwide.[6]

Foxcroft et al, after reviewing 56 family intervention evaluations, recommended the Strengthening Families programme as capable of preventing alcohol misuse amongst adolescents, while few others met this criterion.[7] Similarly, Kumpfer et al identified the Incredible Years and Strengthening Families programmes as exemplary family level interventions,[8] and Hutchings et al identified the Incredible Years programme as one of the few model programmes able to both treat and prevent conduct disorder.[9]

The Nurse-Family Partnership and Early Start were identified from a review by Olds et al.[10] That review covered various home visitation programmes, with these programmes standing out in terms of their effectiveness and/or the range of outcomes they successfully affected.

Step 2: Database searches

After these exemplary programmes were identified, searches were conducted for studies that evaluated them. Our search criteria were for studies that:

1. Focused on effects on children's behavioural outcomes and/or rates of child abuse through parent management training or home visitation;
2. Were published between 1998 and 2008;
3. Were published in a peer-reviewed journal;
4. Relied primarily on quantitative data;
5. Tested the established programmes identified earlier (Nurse-Family Partnership, Early Start, Incredible Years, Triple P and Strengthening Families);
6. Compared children's and parents' outcomes pre-and post-intervention;
7. Used control groups and/or intention to treat analysis.[11]

Searches were limited to the Pro-Quest Social Science database and were conducted primarily between 24 and 25 June 2008. Broad search terms were deliberately chosen. For instance ("family" and "intervention" and "evaluation" and "Incredible Years"/"Triple P"/"Strengthening Families") or ("family" and "parenting" and "programmes" and "evaluation" and "Triple P"/"Incredible Years").

The combination of these searches, reading of reviews and contact with researchers in the field led to the inclusion and review of the studies in this section.

Step 3: Framework for review and assessment of programmes

We evaluated the relevant programmes under eight general headings. This framework was developed after reviewing a number of models for evaluating, selecting and implementing family-focused programmes.

1. Targeted needs: does the programme target the relevant needs of reductions in child abuse rates and improvements in behaviour of children with conduct problems?

2. Theoretical underpinnings: a description of the theory and philosophy underpinning each programme.

3. Review of current evidence base: do rigorous evaluations show that the programme is effective? Given the importance of programme effectiveness and of rigorous evaluations, this topic is addressed in more detail below, under "Evaluating programme effectiveness."

4. Cost-effectiveness: it is important that intervention programmes are cost-effective, as this allows the programme to reach as many families in need as possible. While cost should not be the sole determining factor in evaluating a programme, it affects the scope and extent to which the programme can practically be carried out.

Cost-effectiveness can be evaluated in several ways, and as not all programmes are evaluated for cost-effectiveness in the same way, it can be difficult to compare programmes across this dimension. The most minimal level of information involves simply calculating the cost of delivering the programme to each child or family. A more informative approach, taken by some evaluations, is to calculate the cost-benefit ratio to society that the programme provides (the amount of money saved by investing in the programme through the reduction of later social costs, or the return on each dollar invested). Another way to calculate cost-effectiveness is by looking at the cost involved to produce improvements on the behaviour scales the programme aims to affect.

If the only figures available are for cost of delivery, evaluations showing that a programme is effective do provide some indication that the money spent is returning results. However, this is less useful than calculations of cost-benefit ratios.

Note that cost-effectiveness cannot always be measured with precision, and nor does there seem to be any guarantee that the results of a cost-benefit evaluation will be replicated for every participant in the programme, or every time the programme is delivered.[12] However, while these are important cautions, they suggest merely that we should not place too much weight on cost-effectiveness evaluations by themselves, not that those evaluations are unimportant.

5. Cross-cultural application: this refers to whether or not the programme has been found to be effective in cultures or ethnic groups other than those it was primarily designed for. As the majority of the programmes reviewed in this report have been developed and evaluated internationally, their cross-cultural effectiveness is a vital indication of whether they could work in New Zealand. However, just because a programme has been found to be effective across cultures internationally does not necessarily mean that it will work in New Zealand. This would need to be tested carefully. This is discussed in more detail in section 5.

6. The "sufficiency principle": intervention programmes should be designed so that they are targeted to reach families facing the most significant challenges. Intervention should only take place where it is needed and should not be forced on families that do not want it. This "sufficiency principle" underpins, and is derived from, the Triple P programme. This is also the most efficient way to use limited resources.

7. Appropriate manuals and supplementary materials available for use: having manuals available is useful when seeking to implement a programme developed internationally. This saves time and reduces the degree to which programme developers or facilitators would need to be flown over to assist in setting up. It also helps to ensure programme fidelity.

8. Independent evidence: there should be at least one independent, rigorous evaluation of the programme's effectiveness, in addition to others that may have been carried out by the developers. Independent evidence is necessary in order to confirm the effectiveness of intervention programmes. Researchers who have not developed the programme are likely to be more critical of the intervention and appear more neutral in the eyes of policy-makers selecting programmes.

DETERMINING PROGRAMME EFFECTIVENESS

In order to be able to say that there is evidence of programme effectiveness, interventions should be subjected to thorough quantitative evaluation processes that are designed to provide a clear, rigorous and critical assessment of the impact and effect of the programme. This provides an opportunity to re-assess where funding is channelled, and make improvements or changes to programmes.

Significance: Statistical versus clinical

Defining when a programme is "effective" is difficult to resolve. This is partly because a programme may produce statistically significant results, yet this does not necessarily translate into clinically significant outcomes (large enough changes in individuals or families to make a real world difference).

Despite this, in general more evaluations need to focus on effect sizes. However, it is also important to note that even recording "moderate to large" effects

does not mean that every child in a programme will have all their difficulties addressed. Instead, "it is reasonable to expect significant and meaningful changes in many but not all cases, but only if well-validated, proven interventions are applied systematically."[13]

Note that some of the evaluations reporting results on parent management training programmes are evaluations of sessions implemented in community-based settings, rather than in randomised controlled trials. In one sense this is beneficial, as it allows a more realistic measure of the programme's effectiveness in the "real world." On the other hand, this means that insignificant results may not necessarily show that programmes are ineffective, but may show a failure on the part of the organisations implementing them to run them as designed.

Church proposes that effective programmes should be evaluated under the following headings:[14]

1. Effect size: this statistic refers to the average size of the difference between the after treatment outcomes of the programme group compared to the control group.[15]
2. Clinical significance: this refers to whether or not the programme moves children into the normative range in the targeted outcomes, for example, comparable with children who do not demonstrate clinical levels of conduct problems or children who have not been abused or neglected.

Church also notes that, to be considered "well-established," interventions must meet the following criteria:[16]

1. "at least two well-conducted group-design studies (with adequate statistical power), conducted by different research teams, showing the intervention to be either superior to an alternative intervention or else as effective as some other well established intervention;" or
2. "at least 10 well designed single case experiments which compare the intervention to another intervention."
3. "There is a treatment manual for the intervention in question."
4. "The characteristics of the children in each trial have been clearly specified."[17]

Engagement

David Olds has also highlighted the importance of having a theory of programme engagement. This is because many interventions that rely on parental participation fail to recruit and retain their target populations:[18]

> The success of parenting programmes will depend upon the degree to which parents' concerns and motivations are integrated into the programme design and effective clinical methods for behavioural change are employed by the staff.

According to some, motivating parents to want to change is the most fundamental issue. Once this happens behavioural change may take place relatively quickly.[19] However, the difficulty that all intervention programmes seem to face is that "those most in need tend to be the most difficult to engage in treatment, and the first to drop out."[20] As Church points out, "no early intervention, no matter how well designed, is going to be 100 per cent effective," simply because a certain proportion of parents will drop out of every intervention.[21]

Measures which may help increase retention of participants include "home visits to explain the programme, payment for participation, frequent reminders and multiple tracking procedures for locating families who move."[22] One study explains that "the real power is achieved by sitting down with the parents, in their homes if possible, explaining the importance of their participation and making it easy to get them to come to the meetings …."[23]

Implementation

A key issue is to ensure "implementation fidelity," which is "a determination of how well a programme is implemented in comparison to the way the programme was delivered during the randomised controlled trial (RCT) on which evidence of its effectiveness is based."[24] If a programme's delivery is not faithful to its design, it is unlikely to be effective. According to the Advisory Group on Conduct Problems, "the failure of many well-designed programmes to be effective once transplanted has been due to failures in implementation fidelity

rather than to shortcomings in the original design and conceptualisation of the intervention."[25]

Measurement of outcomes pre- and post-programme

Child and/or family outcomes need to be measured prior to entry into the programme, ideally in conjunction with a control group, and then compared with behavioural outcomes or parenting styles post-programme, and again at follow-up.[26]

Randomised controlled trials

One of the most commonly used and robust forms of evaluation, yielding the highest level of clinical reliability, is the randomised controlled trial.[27] This involves randomly assigning identified families and children from the targeted group (for example, children with conduct problems) to either participate in the programme or to join a wait-list/control group. It is important that the families are randomly chosen from all of those in the targeted group to either receive the intervention or to remain untreated. Outcomes are tested multiple times to prevent the inherent characteristics of families and/or the developmental stages families naturally go through, from confounding the results.[28]

There are ethical issues related to the use of control groups who receive no intervention, as these participants may not get the benefit of services they may need.[29] One way to minimise this is to ensure families in the control group are offered the standard services,[30] perhaps with the offer of completing the evidence-based programme at a later date. However, this does not remove the ethical dilemma altogether, because some families may miss out on the most effective service delivery. This is an unavoidable consequence of designing this type of robust evaluation, which is necessary to determine whether programmes that are meant to help really do make a difference.

Fergusson and his colleagues also point out that until there is evidence of programme effectiveness from a randomised controlled trial, it cannot be concluded that the control group members are actually missing out on a beneficial programme in any case.[31] It has yet to be shown that the programme is effective, and it may never be—that is the point of the trial. Control groups members may, in fact, be spared from participating in an ineffective or even harmful programme.

In order to further decrease the possibility that family characteristics explain some of the differences between intervention families and those in the control or wait-list group, any families that drop out of the programme should have the same experimental measures tested as well. This examines whether there are further selection factors operating among the families that stay in the programme—for example, they may be more motivated to become better parents compared to families that leave the programme, meaning that positive results could be attributed to this motivation, rather than to the programme.[32]

A. HOME VISITATION PROGRAMMES

The Nurse-Family Partnership

David Olds developed the Nurse-Family Partnership in the United States after helping out in a day-care centre for disadvantaged children more than 30 years ago. He realised that the help they were providing was often too late and really needed to occur earlier in life. Soon afterwards Olds and his colleagues began to develop an intervention programme for at-risk families. The Nurse-Family Partnership developed from that base.[33]

A distinctive aspect of the programme is the employment of nurses to conduct the home visits. "Nurses were selected to be the home visitors because of their formal training in women's and children's health and their competence in managing the complex clinical situations often presented by at-risk families." Nurses were also selected because they are perceived to be credible and to adhere to high standards of "ethics and honesty."[34]

Targeted needs

This programme targets first-time low-income mothers and their families, especially teenage parents. It is designed to improve their well-being and outcomes from pregnancy onwards by addressing health-related behaviours such as smoking, alcohol and drug use as well as teaching responsible and competent care for children.[35]

Theoretical underpinnings

The Nurse-Family Partnership derives its theoretical

basis from human ecology, self-efficacy and attachment theory. The theory of human ecology proposes "that children's development is influenced by how their parents care for them, and that, in turn, is influenced by characteristics of their families, by social networks, neighbourhoods, communities, and the interrelations among them." As a result, nurses seek to involve "other family members, especially fathers and grandmothers, in the home visits, and [to link] families with needed health and human services."[36]

The theory of self-efficacy "suggests that individuals choose those behaviors that they believe (1) will lead to a given outcome, and (2) they themselves can successfully carry out." Visiting nurses build on this principle by educating mothers about "the influence of particular behaviours on their own health and on the health and development of their babies. The nurses then help parents establish realistic goals and small achievable objectives that, once accomplished, increase parents' reservoir of successful experiences. In turn, these successes increase parents' confidence in taking on larger challenges."[37]

Attachment theory holds that a strong mother-child bond in the first 24 months is crucial for children's socio-emotional development in later life.[38] Prospective longitudinal research has shown that when infants do not develop a strong bond with their mothers during childhood this can have detrimental and often long-term effects.[39] Risks for anxiety, depression and psychological distress are all heightened in the absence of a strong attachment relationship between mothers and children. The programme therefore actively "promotes sensitive, responsive, and engaged caregiving in the early years of the child's life," to prevent insecure attachment.[40]

Review of current evidence base

A study published in 2002 indicates that mothers involved in the programme showed improved care of their children and mothers' life course development improved, in comparison to control groups.[41] The children also had "fewer injuries and ingestions that may be associated with child abuse and neglect," and mothers were more likely to become engaged in the workforce and less likely to be fully dependent on welfare. The authors concluded that the programme was most effective for families with the highest number or severity of risk factors and that during the first two years of infant development the programme was most effective in families where mothers had little self-belief in their ability to change their lives, prior to joining the programme.

As the programme was initially developed to be delivered by nurses, the limited number of nurses in any given community potentially restricts its implementation. Because of this, a recent trial tested the programme using para-professionals.[42] This study involved three groups: mothers visited by nurses, those visited by para-professionals, and a control group that was not treated by the programme but received free developmental screening and referrals to existing agencies. Overall, the study found that while para-professionals could positively affect the lives of those they visited, nurse-visited women showed greater gains.

Cost-effectiveness

Four independent studies have found the Nurse-Family Partnership to be a cost-effective programme, both in terms of absolute costs (delivery) and in terms of the cost-benefit ratio to society. The majority of the programme costs are associated with nurses' salaries rather than training and hiring of additional staff.[43]

The Washington State Institute for Public Policy concluded that for the Nurse-Family Partnership the benefits per family over the course of the evaluation equalled US$26,298, while the cost per child was US$9,118. Therefore, the "benefit minus costs" figure per child was US$17,180. This equates to a return of US$2.88 for every dollar invested in the programme.[44] This estimate pertains to the average family enrolled. For the highest risk families enrolled, the return on investment is even higher. The RAND Corporation estimated this to be around US$5.70 per family for every dollar spent.[45]

Cross-cultural application

While the Nurse-Family Partnership had shown positive results in samples with white women, until recently there had been few assessments of the programme with ethnic minorities. A recent evaluation tested the potential long-term effects of the Nurse-Family Partnership in a sample of primarily African-American women in the US and found positive effects for mothers and children in this group.[46]

The "sufficiency principle"

As is to be expected with a home visitation programme, this programme involves nurses visiting families' homes, so it is high-contact. However, the families targeted are those in the high-risk bracket, so the programme does match the "sufficiency principle."

Manuals and supplementary materials

As it is one of the most established programmes there is a sufficient degree of supplementary material available, including manuals.[47]

Independent evidence

The Nurse-Family Partnership has been subjected to multiple randomised controlled trials. However, they are not independent.[48]

Early Start

Early Start is a "research based fully evaluated long term and intensive home visiting service,"[49] developed in 1995 based on findings by Professor David Fergusson's team in the Christchurch Health and Development Study. This service is provided to families in Christchurch, New Zealand, offering support for new parents, encouraging and educating participants to nurture a stronger family and to learn and develop good parenting skills. It also assists parents who struggle with violence or addiction.

Early Start involves trained family support workers visiting the homes of families selected into the programme, often through screening criteria applied by Plunket nurses. An important aspect of the programme is that the implementation of Early Start is tailored to each family, according to their particular needs or difficulties, as opposed to being based on a one-size-fits-all approach. Early Start delivers Triple P as part of the overall programme.

Early Start has increased in size since its first trials in 1995, and now receives funding from the Ministry of Social Development, the Canterbury District Health Board, the Christchurch City Council and the Department of Child, Youth and Family. It provides services to 251 families, reaching a total of 439 children.[50] Funding for Early Start from the Ministry of Social Development is $1.129 million for 2009-2010.[51]

Targeted needs

The service specifically targets families "where social and family circumstances may put at risk the health and well-being of their children."[52] The family support workers focus on key areas such as child health, ensuring that children's immunisation schedules are up-to-date. Maternal well-being is also focused on, with workers providing social, emotional and practical support for mothers. Visiting professionals also teach about crisis management, budgeting skills and parenting skills. "Reduction of child abuse" is a stated goal.

Theoretical underpinnings

The primary foundation of Early Start is derived from empirical observations made during the pilot stages of the programme, rather than being driven by a particular theoretical model during its development.[53] Three theories do, however, provide a background and justification for the inception of Early Start. These are the social learning perspective, attachment theory and the childhood trauma perspective.[54]

The social learning perspective stresses the importance of early child development and socialisation. According to this perspective, when children experience poor and inconsistent parenting and chaotic environments this can lead to dysfunctional behaviours in children, including delinquency and later substance abuse. The childhood trauma perspective is based on the observation that children brought up in "at-risk" circumstances may be exposed to "traumatic events including: physical abuse; sexual abuse; emotional abuse and interparental violence and conflict," with a negative impact on their future outcomes.[55] Attachment theory is outlined in the preceding discussion of the Nurse-Family Partnership.

The developers of Early Start note that because all three of the above dynamics may lead to a range of developmental problems in children, a multifaceted approach is required.

Review of current evidence base

Early Start has shown good results for families of children up to three years of age. According to an evaluation conducted in 2005, families enrolled in this home visitation programme suffered lower levels of child abuse and neglect, had better physical health,

improved parenting practices, higher utilisation of preschool education and better behavioural outcomes than those in the control group. This is impressive as many overseas programmes only showed significant differences in two or three of the six categories at the time of evaluation.[56] However, the evaluation did not find any evidence of effects on maternal and family outcomes, such as maternal health, family violence and "family exposure to stress and crisis."[57] Note also that control groups were exposed to the standard family services. The average effect size for outcomes targeted for this review were moderate.[58]

At the time of the 36 month follow-up, the percentages of child abuse and neglect were nearly three times higher in the control group than in the programme group.[59] This is important because a recent meta-analysis of home visitation programmes showed that few of these programmes saw reductions in rates of child abuse, even though many observed other benefits for families.[60]

Cost-effectiveness

Given that the existing evaluation indicates that Early Start is effective, it appears that the money spent on the programme is returning results. However, there are no published studies measuring the programme's cost-effectiveness.

Cross-cultural application

While there is only one evaluation of Early Start, its development in New Zealand gives it an obvious advantage of cultural relevance to this country. The random sample generated in the existing evaluation included an over-representation of Maori in both the programme group (24.8 percent) and the control group (26.7 percent).[61] Detailed analysis focused on Maori ethnicity and observed outcomes showed that "the programme benefits for Maori tended to be as good if not better than those for non-Maori."[62]

The "sufficiency principle"

The Early Start programme focuses on families that fit high-risk profiles and involves specialists visiting the families' homes. As the programme does provide services to families with the highest needs, it is reasonable to assert it follows the sufficiency principle.

Manuals and supplementary materials

The Early Start evaluation, published in 2005, includes detailed information about the programme and also serves as a manual or information source for interested parties.

Independent evidence

There is only one evaluation of Early Start, and it is not independent.

B. PARENT MANAGEMENT TRAINING PROGRAMMES

The Incredible Years

There are different types of Incredible Years programmes, but the main ones implemented in New Zealand are the parenting programmes, which were developed in the United States. Facilitators meet with groups of parents of children with conduct problems, guiding them through key principles, monitoring their progress and giving feedback on interactions between parents and children. The groups consist of six to eight parents who meet for 12-20 weeks. While it is designed to treat children who are already displaying severe behavioural problems, the programme simultaneously aims to prevent further problems occurring in the future.

This programme builds on parents' strengths, beginning with parent-child play, praise for children, incentives, limit setting, then moving on to problem solving and finishing with disciplinary techniques. Within these broad topics parents learn skills such as social and emotional coaching and how to promote toddlers' language development. There are take-home assignments for parents to reinforce these techniques. Videos are also used to generate discussion and practical activities such as role plays and homework are used, in order to instil the concepts as they are taught.[63]

The Werry Centre trains the Ministry of Health's Child and Adolescent Mental Health Services (CAMHS) workers in the Incredible Years, and the Ministry provides funding of around $140,000 in 2009-2010 for this. "Most CAMHS provide the Incredible Years programme and one CAMHS provides the Triple P programme. However, information about the specific level of funding within CAMHS for these programmes is not kept …."[64] The Ministry

of Education also funds Incredible Years to the tune of $0.69 million in 2009-2010.[65] In addition, Family Works, a division of Presbyterian Support, also provides the Incredible Years programme.[66]

Targeted needs

The official website explains that:[67]

> The Incredible Years parent training intervention is a series of programs focused on strengthening parenting competencies (monitoring, positive discipline, confidence) and fostering parents' involvement in children's school experiences in order to promote children's academic, social and emotional competencies and reduce conduct problems. The Parent programs are grouped according to age. Babies & Toddlers (0-3 years), BASIC Early Childhood (3-6 years), BASIC School-Age (6-12 years) and ADVANCE (4-12 years).

Theoretical underpinnings

The programme is based on cognitive behavioural therapy.[68] This approach identifies thought processes, assumptions, behaviours and beliefs that influence negative moods or interpretations of events. Clients are taught how to replace maladaptive thoughts and beliefs with new beliefs (cognitive) and different practices (behavioural).[69]

Review of current evidence base

The Incredible Years has been successful, with moderate to strong effects recorded in changing parent-reported child behavioural problems. It has received an exemplary rating after being assessed by researchers contracted by the American government.[70] It is also recommended by the American Psychological Association Task Force, as it meets strict criteria for "empirically supported mental health intervention for children with conduct problems."[71]

Two studies indicate that the Incredible Years programme can effectively reduce rates of conduct disorder in children, even when carried out in a community setting.[72] This is important because interventions may work well enough in clinical trials, yet to be truly effective they must also work when put into practice at the community level.

One evaluation of the Incredible Years parenting programme in New Zealand has been published.[73] The programme evaluated outcomes for children of single mothers who completed the course in Tauranga. A very small sample size means that no significant conclusions can be drawn from the study. However, according to teachers' observations, children who completed the course exhibited fewer problem behaviours and mothers' depression and stress levels were reduced post-programme. According to the mothers who took part, the overall quality of their relationships with their children also improved, as did their parenting confidence.

Beauchaine et al set out to identify which factors were associated with positive effects for the Incredible Years programme and possible factors that might alter the efficacy of the programme in different family contexts.[74] Identifying these moderating factors is extremely important. This is because programmes are often most effective for a particular type of family, usually about two-thirds of the families in a given sample. Identifying factors that are linked with effectiveness therefore has the potential to help develop programmes for "children who do not benefit from current treatment approaches."[75]

Their results showed that the Incredible Years programme was more effective for "children of younger mothers, children of fathers with substance abuse histories, and children with comorbid symptoms of anxiety/depression."[76]

Cost-effectiveness

A number of studies have been conducted on the cost-effectiveness of the Incredible Years programme. An evaluation in Wales concluded that it would cost approximately £1,344 "to return the average child in this intervention to below the clinical cut-off point" for conduct disorder.[77] Another study, carried out in the United States, showed the average cost of delivery was US$1,579 per child in 2007.[78]

Cross-cultural application

There is a growing body of evidence showing that the Incredible Years programme is effective cross-culturally.[79] Designed in the US, it has exhibited positive results in Britain, Canada and Norway,[80] and in African-American, Asian, Pasifika, Caucasian and Hispanic/Latino communities.[81] In addition, a "preliminary" evaluation of Incredible Years in New Zealand found that the programme is "culturally

appropriate and equally effective for Maori and non-Maori people," though more detailed investigation was recommended.[82]

Although it has been effective primarily within English-speaking nations, material is available to help deliver the programme to other cultures.[83]

The "sufficiency principle"

The sufficiency principle is applied acceptably as the programme targets high needs families—those with children displaying severe behavioural problems.

Manuals and supplementary materials

Workbooks, manuals and various books on delivering the programme are available.[84]

Independent evidence

Independent trials have successfully shown this programme to be effective in meeting the needs of parents struggling with children displaying the most serious behavioural problems.[85]

Triple P: Positive Parenting Programme

Triple P has its early origins in New Zealand and the final stages of development occurred in Australia. It is unique because it provides "five levels of intervention on a tiered continuum of increasing strength and narrowing population reach."[86]

The first level of the course is aimed at all families and includes a media component for dissemination at the population level—that is, it is delivered in communities, rather than to individual families. The second level of the course includes a seminar series, regular contact with primary care professionals and an option to receive information on parenting teenagers. The third, fourth and fifth levels involve parent and child education in conjunction with opportunities to put the course principles into practice. Level one is aimed at the breadth of parents wanting to "up skill" their parenting techniques, while level five is specifically designed to assist families who have oppositional children and/or "where parenting difficulties are complicated by other sources of family distress (e.g., relationship conflict, parental depression, or high levels of stress)."[87] The universal level aims to prevent conduct disorder occurring. If it does occur, levels four and five of the programme are designed, like the Incredible Years, to treat it.

In New Zealand, Triple P is currently delivered through Early Start and by one of the Ministry of Health's Child and Adolescent Mental Health Services, meaning no separate funding figures are available for Triple P.[88] It is also delivered by some iwi and non-governmental organisations.[89]

Targeted needs

The programme was developed to "assist parents to promote their children's social competence and manage common developmental and behavioural problems."[90] Parents are taught how to help develop their children's "social and language skills, emotional self-regulation, independence, and problem-solving ability." To this end, they are taught techniques such as how to monitor "problem child behavior," provide positive feedback for good behaviour, arrange "engaging activities in high-risk parenting situations," use "directed discussion and planned ignoring for minor problem behavior," give "clear, calm instructions" and support "instructions with logical consequences, quiet time (non-exclusionary time-out) and time-out."[91]

Theoretical underpinnings

Triple P is based on the hypothesis "that effective parenting is a common protective pathway to reduce the risk that children and adolescents will develop" serious emotional or behavioural problems. It is also based on the assumption that there is a greater chance that parents will develop good skills if competent parenting is valued and supported by society as a whole. This is why a population-based approach, with a media component, has been developed.[92]

The programme uses a self-regulatory approach, encouraging parents to look at their own cultural context in order to make goals that are relevant to them.[93]

Triple P's multi-level system is guided by a minimal intervention approach, called the "principle of sufficiency." The ethos of this principle is that "the differing needs of parents will require differing levels of support."[94]

Review of current evidence base

The evidence base for Triple P is extensive, with the effectiveness of the programme having been

thoroughly established.[95] Triple P has also received the highest possible rating on the California Evidence-Based Clearinghouse website, a site that helps identify and disseminate evidence-based programmes.[96]

A 2008 study assessed all available evaluations of Triple P (55 studies in total).[97] The meta-analytical technique used allows researchers to synthesize and summarise the effect size of a group of studies. The results showed that parental behaviours and child outcomes improved comprehensively compared to those in control groups, with a strong tendency for parents' relationship quality to improve and for these effects to remain constant over time. The overall effect sizes for parenting and child behaviour outcomes were moderate.[98] High-risk families showed greater benefits than other families in the final evaluation.[99] As expected, effect sizes for children's behavioural problems and parental behaviours were stronger at level four and level five, with level five demonstrating the largest effect sizes overall.[100]

In light of the "high prevalence rates of child problems and ineffective or inadequate parenting," Sanders argues that there is a need for "interventions that can be disseminated on a large scale in a cost-effective manner."[101] Triple P is the first intervention to be tested at a population level, both in Australia and the United States, in two studies.

The first study showed the population-level intervention was effective in reducing children's psychological problems and emotional difficulties, but was not effective for "conduct problems, hyperactivity and peer relationship difficulties." There were significant effects on parental behaviours, however, that could indicate that children's outcomes may improve over time as these behaviours begin to take effect.[102]

The second population-based study involved testing across eighteen counties in the United States. Counties were randomly selected to either participate in the intervention or to act as a control group. The results showed that children in families exposed to the programme were less likely to be victims of abuse.[103] These results are preliminary only, however. Further studies will be required to confirm these findings.

Cost-effectiveness

In a study focused on Queensland, Australia, the costs of delivering Triple P "to 572,701 children aged between 2 and 12 ... was A$19.7 million (Level 1, $240,000; Level 2, $5.8 million; Level 3, $5.7 million; Level 4, $4 million; Level 5, $3.6 million) with an average cost of A$34 per child" for the whole programme, that is, across all levels.[104] However, this figure does not tell us a great deal, as the average cost for each level of the programme will be quite different.

Nevertheless, because "[t]he costs of conduct disorder for children and adolescents in Queensland until the age of 28 years are A$1.4 billion," this meant that if only 1.5 percent of children with early conduct disorders were referred to the Triple P programme it would already be paying for itself. If any more than 1.5 percent of children with conduct disorder went through the programme it would save money.[105]

Cross-cultural application

Triple P has shown significant effects in Australian aboriginal populations and African American families, and also in China, Japan, Norway and England.[106]

The "sufficiency principle"

Triple P is intended to adhere to the sufficiency principle, intervening at the level required for individual families. The fact that the programme has several levels "allows the strength of the intervention to be tailored to the assessed needs and preferences of individual families."[107]

Manuals and supplementary materials

There are various manuals available for both practitioners delivering the project and parents going through the course, and training in course delivery can be provided.[108]

Independent evidence

There have been sufficient independent evaluations of this programme.[109]

Strengthening Families

The Strengthening Families programme is a parenting programme developed in the United States, not to be confused with a different initiative of the same name run in New Zealand. Strengthening Families (NZ) supports families that need to access a variety of services from government agencies and NGOs, coordinating their interactions.[110] By contrast, the

US-developed programme was "originally designed for children of parents addicted to alcohol and drugs."[111]

Strengthening Families is generally held in community centres, churches, schools or social service centres, often involving a meal before the more formal instruction begins. In this natural and informal context, with their children present, parents get a chance to practice the skills they are learning.[112]

Strengthening Families begins by focusing on what the children do well. The use of the phrase "catch them being good" is used to get parents thinking differently about their children, rather than concentrating on discipline as a starting point. This approach tends to help bring about a stronger bond and more trust between parents and children.[113]

Targeted needs

The programme's primary goal is "to reduce youth [adolescent] substance use and other problem behaviors." Training to improve parenting skills is one of the intermediate steps to achieving this goal.[114]

Theoretical underpinnings

This programme is based on cognitive-behavioural social learning theory and family systems theory.[115] Social learning theory proposes that behaviours develop through imitation and interaction in settings where such behaviour is encouraged. Anti-social or problematic behaviour leads to either negative or positive responses, or negative or positive outcomes. If problem behaviours are reinforced they are then likely to become entrenched.[116]

Family systems theory holds that parental behaviours and interactions affect children and in turn child behaviour affects parental well-being and behaviour.[117] Therefore affecting positive change in parent behaviours will have a flow-on effect and benefit children.

The programme combines aspects of "three evidence-based drug prevention approaches—a behavioural parent training group and a children's social skills training group run simultaneously in different rooms, and a family session where the families come together" and put the course content into practice. The family session at the end of the evening includes activities such as "positive play, family meetings, effective communication styles, and effective discipline methods."[118]

Review of current evidence base

Strengthening Families is effective in reducing substance use in young adults.[119] Early indicators suggest that the programme may also reduce emotional problems during adolescence.[120]

While evaluations of the Incredible Years programmes found similar results for the programme when based in community centres compared to original trials, an evaluation of Strengthening Families returned significantly weaker results in a challenging community-based setting.[121] The authors propose this was because the course was not delivered as faithfully to the original design as it could have been. For example, the parent and child sessions—where parents and children are given different content—were delivered in close accord to the original curriculum. Yet in the family sessions, only around 60 percent of the original course content was covered, with sessions being far shorter than they were meant to be. The authors conclude that this report joins a number which indicate some evidence-based programmes are not as effective in the community setting as initial evaluations would suggest.[122]

One of the general limitations with many evaluations has been relatively short-term assessment periods, with very few continuing assessment beyond three years.[123] Therefore, Richard Spoth and colleagues set out to test the possible effects of Strengthening Families, five and a half years after initial outcomes were measured. The results showed that there was a significant reduction in substance abuse for children enrolled in the programme, compared with those in the control group. In particular, there was a 23 percent reduction in marijuana use for those in the group. The programme also appeared to have had a greater impact in reducing substance use for those in higher risk groups, compared to those in the main sample.[124]

Cost-effectiveness

A cost-benefit evaluation for the Strengthening Families programme, carried out by the National Institute on Drug Abuse (NIDA) in the United States, shows a net benefit of US$10 for every dollar spent.[125] The Washington State Institute for Public

Policy estimated that, per youth, the cost of this programme was US$851 for a benefit of US$6,656. This gave a "benefits minus costs" figure of US$5,805 per youth, which was a return of US$7.82 for every dollar invested in the programme.[126]

Cross-cultural application

Cross-cultural effectiveness has been shown, with Strengthening Families being successfully adapted for a number of different cultures, including for families in Spain,[127] Canada,[128] Holland,[129] and perhaps most significantly for New Zealand, Pasifika families based in the US.[130]

The "sufficiency principle"

The majority of the Strengthening Families modules meet the criteria of minimum intervention. The programme is primarily targeted at high-risk families and operates for fourteen weeks, using the minimum amount of time necessary to deliver the material. One aspect of the programme (for 10-14 year olds) is designed to be universally implemented, with the aim of counteracting experimentation with drugs during this critical time.

Manuals and supplementary materials

Manuals and supplementary materials are available for Strengthening Families.[131]

Independent evidence

The effectiveness of this programme has been demonstrated in several independent studies.[132]

Limitations of the studies

The studies of parent management training programmes that we reviewed suffer from some general limitations. These limitations affect studies of all of the programmes above, and they include failure to measure control group outcomes long term,[133] failure of all families to complete aspects of the course,[134] and possible cultural differences between the original target population and New Zealand that may inhibit programmes' effectiveness here, especially for interventions focused on substance use.[135]

Much of this research literature also fails to report the clinical significance of programme effects; that is, the degree to which children's behaviour moved from being problematic into the normal range of behaviours for their age. Attention often focuses on whether results are statistically significant, but this is not the same as showing clinical significance or real-life impact.[136] Finally, the vast majority of studies are short-term, rather than long-term assessments (more than three years), though there are exceptions.[137]

SUMMARY OF PROGRAMME CHARACTERISTICS

Nurse-Family Partnership

It appears that the outcomes most strongly affected by this programme are those associated with maternal well-being/life course. While the Nurse-Family Partnership has a number of benefits, it does not primarily address behavioural problems in children or necessarily reduce levels of child abuse. There is no substantial body of evidence showing the cross-cultural effectiveness of the programme, although effects in African-American groups have been observed.

Early Start

This programme has shown promising results on child abuse outcomes and children's behavioural problems. Crucially, it was developed and tested in New Zealand and has been shown to work in Maori families. However, Early Start has not been independently evaluated, nor have there been any cost-benefit evaluations to date.

Incredible Years

Within the relevant domains specified in this review, Incredible Years led to significant changes, reducing levels of behavioural problems in children, with large effect sizes being measured.[138] The Incredible Years also seems to deliver its strongest effects in high-risk communities, including families with young mothers, families with substance abuse, and families where children experienced depression.

Triple P

Triple P has been shown in a number of evaluations to have positive effects on children's behavioural well-

being. Early indicators also suggest that population-level implementation of the programme may reduce rates of child abuse. The programme has returned positive results across a range of cultures and, because it was initially developed in New Zealand and many of the evaluations have been conducted in Australia, it is likely that it will exhibit a good cultural fit in New Zealand.

Strengthening Families

The primary outcomes this programme affects are substance abusing behaviours in the teenage years. While programmes targeted at reduction of substance abuse are certainly worthwhile, Strengthening Families does not primarily address children's conduct problems or child abuse. Initiatives that focus on early stages of child development are likely to prevent substance abuse as well by targeting the predictors of these behaviours.

Table 4.1. Summary of programme characteristics

✓ = sufficiently demonstrated, ✗ = not sufficiently demonstrated

	Targets selected needs *	Effectiveness	Cost-effectiveness	Cross-cultural application	Sufficiency principle	Manuals	Independent evaluations
Nurse-Family Partnership	✗	✓	✓	✗	✓	✓	✗
Early Start	✓	✓	✗	**	✓	✓	✗
Incredible Years	✓	✓	✓	✓	✓	✓	✓
Triple P	✓	✓	✓	✓	✓	✓	✓
Strengthening Families	✗	✓	✓	✓	✓	✓	✓

* Refers to the degree to which the programmes target the needs selected in this review: severe behavioural problems, child abuse and the predictors of these outcomes, most importantly, parenting practices.

** Early Start is unique with respect to this category because it has been developed and runs in New Zealand. Assessments of other programmes' cross-cultural relevance are being used to approximate their likely application in New Zealand, but this is not necessary for Early Start.

ENDNOTES

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3 K. Kumpfer and R. Alvarado, "Family Strengthening Approaches for the Prevention of Youth Problem Behaviours," *American Psychologist* 58, no. 6/7 (2003): 457-465; D.R. Foxcroft et al., "Longer-term Primary Prevention for Alcohol Misuse in Young People: A systematic review," *Addiction* 98, no. 397 (2003); D.L. Olds, L. Sadler and H. Kitzman, "Programs for Parents of Infants and Toddlers: Recent Evidence from Randomised Trials," *Journal of Child Psychology and Psychiatry* 48, no. 3 (2007): 355-391.

4 Interventions that are primarily individual therapy, such as Parent-Child Interaction Therapy, were outside the scope of our review.

5 N.I.C.E, "Parent-Training/Education Programmes in the Management of Children with Conduct Disorders," 28.

6 Ministry of Social Development, "Inter-Agency Plan for Conduct Disorder/Severe Anti-Social Behaviour (2007-2012)," 52. Other interventions are also identified, including multi-modal interventions such as multisystemic therapy. Instead of being family-focused, these interventions are primarily child-focused and use a broader range of treatment methods, including individual therapy and school-based treatments. Therefore, they fall outside the scope of this review.

7 One of the reasons this programme was singled out was the evaluation method; it included an intention-to-treat analysis. D.R. Foxcroft et al, "Longer-term Primary Prevention for Alcohol Misuse in Young People: A systematic review."

8 K.L. Kumpfer, R. Alvarado and H.O. Whiteside, "Family-Based Interventions for Substance Use and Misuse Prevention," *Substance Use & Misuse* 38, no. 11 (2003): 1759-1787. As with the Interagency Report by the Ministry of Social Development conducted in New Zealand, Karol Kumpfer also identifies a number of additional programmes. Again the other exemplary programmes are primarily therapy-based (Functional Family Therapy), focused only on reducing drug use (preparing for the Drug Free years) or focused on foster children (Treatment Foster Care). Therefore, they also fall outside the scope of this report.

9 J. Hutchings et al., "Parenting Intervention in Sure Start Services for Children at Risk of Developing Conduct Disorder: Pragmatic Randomised Controlled Trial," *British Medical Journal* 334, no. 678 (2007): 1-7.

10 D.L. Olds, L. Sadler and H. Kitzman, "Programs for Parents of Infants and Toddlers: Recent Evidence from Randomised Trials."

11 Intention-to-treat analysis involves assessing the outcomes of children and/or families who leave the programme. This means researchers can be more certain about the actual effects of the programme as selection bias of the participant families is minimised i.e. it could be that families who remain in programmes are more motivated to want to change and would therefore have sought help from another source and showed improved outcomes anyway. D.R. Foxcroft et al, "Longer-term Primary Prevention for Alcohol Misuse in Young People: A systematic review."

12 A. Kerslake Hendricks and R. Balakrishnan, "Review of Parenting Programs: A report by the Families Commission," 2/05 (Wellington: Families Commission, 2005), 14-15.

13 W. Blissett et al., "Conduct Problems: Best practice report," (Wellington: Ministry of Social Development, 2009), 36.

14 J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," 13-14.

15 Effect sizes (Cohen's d) are considered small in the range 0 - .2, moderate in the range .2 - .5, and strong or large in the range .5 - .9. In some cases the correlation will go beyond 1.0, which can mean the outcome you are measuring and the dependent variable are the same factor. Alternatively, some effect sizes go beyond 1.0 and indicate there is a particularly strong effect. J. Cohen, "Quantitative Methods in Psychology," *Psychological Bulletin* 112, no. 1 (1992): 155-59; R.J. Grissom and J.J. Kim, *Effect Sizes for Research : A Broad Practical Approach*, (Mahwah, NJ: Lawrence Erlbaum, 2005).

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22 J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," 160, citing J.B. Reid, "Prevention of conduct disorder before and after school entry: Relating interventions to developmental findings," *Development and Psychopathology* 5 (1993): 243-262.

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Difficulties," 160.

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SECTION 5

Implications for Maori, Pasifika and Asian populations

There is an increasing diversity of ethnic and cultural groups in New Zealand society. This means that particular attention should be paid to whether programmes designed overseas are appropriate in New Zealand, particularly for Maori, Pasifika and Asian communities. One of the potential difficulties associated with adopting family interventions designed and evaluated overseas is that cultural and contextual differences in New Zealand may undermine the efficacy of the programmes. It has been argued that "'there is an ethical imperative' to ensure that interventions developed for the dominant culture do not negatively impact a child's own cultural values, competencies or language."[1]

One response to these concerns is to adapt overseas programmes so that they are suitable for a new cultural context. It is also argued that with respect to Maori, programmes need to be developed by and for Maori, based on kaupapa Maori, and that merely adapting other programmes, or ensuring that "generic" services provide good outcomes for Maori, is insufficient.

CONTEXT

The majority of people in the 2006 Census identified as European New Zealanders (67.6 percent), and Maori were the next largest ethnic group at 14.6 percent of the population. The Asian and Pasifika ethnic groups had increased the most since the previous Census, with the Asian ethnic group now making up around 9.2 percent of the population and the Pasifika ethnic group accounting for 6.9 percent.[2]

It has been projected that by 2051 the Maori population will have doubled in size, when compared to a 1996 baseline, and will make up 22 percent of the total population. This is because of higher birth rates among Maori than among non-Maori.[3]

The increasing proportion of Maori in New Zealand, combined with statistics that show Maori are over-represented in many negative social outcomes, increases the importance of implementing programmes that will work for Maori.

Professor Mason Durie, a leading contributor on Maori research and development from Massey University, argues that mental health services have historically come from a Euro-centric perspective, yet over the last twenty or thirty years this has changed:[4]

> Indigenous peoples have emphasised the importance of their own explanations of behaviour based on distinctive world-views, and have drawn attention to the different understandings that they bring to mental health and to mental health services. It is now reasonably well accepted that psychiatry cannot be practiced outside the values and attitudes of society, nor can it be adequately understood beyond the cultural norms of a particular group or population.

While Durie is particularly focused on psychiatry in this passage, there are also clear implications for parent management training programmes and home visitation programmes.

In addition, "varying social and cultural norms of different ethnic groups" means that "principles and methodologies" of programmes developed overseas may not be relevant here. Addressing the treatment of conduct problems in New Zealand Asian families, it has been noted that there are a range of reasons why a programme developed overseas may not be suitable for such families. One such reason relates to "concepts of conduct problems." "[S]ocial norms and interpretations of acceptable or maladaptive behavioural patterns are recognised differently by

various ethnicities …. For instance, hyperactivity is considered quite differently in Korea and in Taiwan."[5]

ADAPTING PROGRAMMES TO WORK ACROSS CULTURES

Broadly speaking, there are three methods used to adapt programmes to work across cultures. The first involves deep structural change to fit into the cultural context of the new host nation. The second approach is to use presenters who are from the same ethnic group of the families to whom the programme is delivered. So for example, a Samoan facilitator could be trained to deliver a given programme in a community where there is a large proportion of Samoan families. The third possibility is that some programmes may already have been carefully crafted so as to work across various cultures and may only require minimal adaptation. These three approaches are not mutually exclusive.

Deep structural change to fit cultural context

Adapting programmes at a deep structural level involves looking at the beliefs and assumptions that underpin the programme, comparing them to the target culture and adapting them accordingly. It is argued by some that cultural adaptations need to involve more than surface-level changes like having presenters from ethnic minorities.[6]

There is, however, a tension between the importance of delivering evidence-based programmes with fidelity to their original design, while also acknowledging and responding to cultural differences. This has been described as the "fidelity-adaptation tension." One of the key issues flowing out of this tension is the common difficulty of recruiting and retaining families into programmes. While too many culturally related adaptations could potentially undermine the fidelity of a programme, and therefore its efficacy, failing to make any changes could result in fewer families enrolling and/or higher attrition rates.[7]

When cross-cultural considerations are taken into account and when adaptations of the course are made in reference to them, this can increase participant retention significantly. Obviously, then, the ideal is an evidence-based programme that stays true to the original design, while also taking cultural differences into account. However, evidence on the effectiveness of deep structural change is mixed.[8]

Intentionally training and placing presenters from relevant cultural groups

A second approach involves intentionally choosing and training facilitators from various ethnic groups. The advantage of this approach is that if a programme was developed and tested overseas, fidelity to the course content can be kept while potentially also recruiting and retaining families from different ethnic groups.

David Olds, the designer of the Nurse-Family Partnership, has realised the importance of promoting trust in programme facilitators, seeing it as fundamental to the success of interventions. This is one of the reasons why nurses were chosen for his programme, being widely respected and trusted.[9]

Church also points out that:[10]

> The effectiveness of parent training interventions is dependent in part upon the cultural competence of the parent educator who must be able to communicate with parents in their own language and who must be sufficiently trained and experienced to be able to establish a positive interpersonal relationship both with parents from a variety of different cultural backgrounds and with parents who are experiencing major problems in their personal lives. These are important requirements for parent educators who will be working with Maori and Pacific Islands parents.

For example, achieving "Pacific cultural competence" means that "[a]long with assuring a patient's trust, … Pacific peoples' knowledge and realities are considered valid and significant."[11]

Use of existing programmes with minor adaptations

A third option is to make use of existing programmes that have already proven to be effective cross-culturally and could be tailored for use in New Zealand with relative ease. Church comments that all of the parenting programmes he reviewed "could be readily adapted for use in New Zealand because they have been developed to the point where both the procedures and the staff training which need to be provided have been set down in some kind of implementation manual."[12]

Adapting programmes for Maori

When considering whether and how programmes might need to be adapted for Maori, it is useful to consider Durie's outline of the essential elements for Maori mental health practices that have been corroborated through several Maori health perspectives:[13]

> A frequently discussed Maori health perspective is known as Te Whare Tapa Wha, a construct that compares good health to the four sides of a house and prescribes a balance between spirituality (taha wairua), intellect and emotions (taha hinengaro), the human body (taha tinana) and human relationships (taha whanau). This perspective has been used as the basis for policy and planning and has been incorporated into assessment tools, treatment packages, and outcome measures.

Durie also discusses a framework intended for use in public health settings.[14] Though it is not intended for home visitation programmes or parent management training programmes, the principles throughout are likely to be pertinent to these programmes. This is because the majority of the programmes outlined in this report have taken into account the relational interconnections within families, as does Durie's framework. As the Advisory Group on Conduct Problems noted, "Culturally relevant best practice must incorporate a clear understanding of the importance of Whanau in the intervention logic and programme process. ... [C]onduct problem interventions for Maori must be aimed at working with the Whanau, rather than just tamariki or taiohi."[15]

The components of Durie's framework for Maori health care include "three goals, a set of principles, three pathways and performance criteria."[16]

The goals are:[17]

1. "equitable access;"
2. "the promotion of human dignity;" and
3. production of "the best possible health gains measured against reliable benchmarks that accommodate differing health perspectives."

The principles are:[18]

1. "indigeneity," which translates into the right for indigenous people (Maori) "to retain their own distinctive cultural identity" and avoid practices which assume assimilation is the end goal;
2. "clinical expertise," which means that Maori expect programmes delivered to them to be "best practice," informed from a sound evidence base;
3. "cultural competence," which means "that health care workers should be competent at the interface between their own culture and the culture of others."

Implementing adapted programmes

Of course, in order to implement programmes in full, a more comprehensive assessment of the connection between particular programmes and cultural context would need to be carefully set out. Whether internationally designed programmes can be adapted for use in New Zealand by training and placing facilitators from appropriate ethnic groups must be examined on a case-by-case basis. Deeper structural change may be needed for some programmes.

The Advisory Group on Conduct Problems has constructed a recommended framework for implementing a programme in a new cultural context. It involves:[19]

- "Adaption of programme to new context ....
- Pilot studies to develop provider skills and examine the feasibility and potential benefits of the programme for the client population.
- RCTs [randomised controlled trials] ....
- Use of the results from randomised trials to conduct formative research to improve the intervention model.
- Population dissemination of the treatment model."

As part of this process, it is recommended that "effective cultural consultation and participation by Maori should take place at all stages of the development and evaluation of new services."[20]

DEVELOPING KAUPAPA MAORI PROGRAMMES

The above approaches all involve adapting various programmes, to a greater or lesser extent, that have been developed for other cultures. However, another way to try and ensure that programmes deliver results for Maori is for new programmes to be developed and evaluated by Maori, for Maori, based on kaupapa Maori.

Discussing the impact of rights and obligations under the Treaty of Waitangi, the expert Advisory Group on Conduct Problems concluded that "there should be parallel processes of policy development" incorporating Western and Maori views. An expert Maori advisory committee—Te Roopu Kaitiaki—was established to give the Group policy advice from a Te Ao Maori (Maori world view) perspective.[21]

Te Roopu Kaitiaki have undertaken to develop a "separate report outlining principles of developing kaupapa Maori responses for Maori tamariki, taiohi and whanau experiencing conduct problems."[22]

Te Roopu Kaitiaki also commented on the issue of evaluation. They endorsed an evidence-based approach, but noted that indigenous knowledge must be considered in parallel as a "layer of evidence and ... part of the entire evidence base." Significantly, this approach "does not diminish the use of randomised controlled trial (RCT)-based evidence because it has a different construct of testing for reliability from a Western paradigm."[23]

CONCLUSION

If programmes developed overseas are to be implemented in New Zealand, they will need to be examined carefully to see whether and how they should be adapted, a process that should involve consultation with affected groups including Maori. The implementation process recommended by the Advisory Group on Conduct Problems should be followed.

Developing programmes that are based on kaupapa Maori may result in new options that can sit side by side with "generic" programmes that have been adapted from overseas and/or that show good evidence of effectiveness in New Zealand. If programmes based on kaupapa Maori demonstrate effectiveness in randomised controlled trials and according to Maori knowledge, they should be incorporated into the suite of interventions available.

Some argue that programmes must be developed by Maori, for Maori in order to be effective for Maori and to be culturally appropriate. We should note that Maori are entitled to choose whether to participate in a "generic" programme or one based on kaupapa Maori—it should not be assumed that Maori should all be directed towards a particular programme or that Maori are a homogenous group whose needs will all be met by one programme.[24]

Nevertheless, the arguments about service development and provision by Maori, for Maori need to be resolved, and Te Roopu Kaitiaki's report will be of great interest. In general, however, it seems reasonable to say that all programmes, however they are developed, should meet rigorous standards of proof of effectiveness. This requirement should not be waived for kaupapa Maori programmes because, as Durie points out, Maori, like anyone, are entitled to best practice.

ENDNOTES

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SECTION 6

Conclusion and Policy Recommendations

The central theme of our conclusion and recommendations is that family intervention programmes are likely to become an increasingly important response to problems, such as child abuse and anti-social behaviour, that threaten our social fabric. It is crucial that we intervene early with programmes that really do make a meaningful difference to these problems, for the sake of the families and children affected by them, and for all of society. With limited resources for these programmes, and other policy priorities competing for funding, it is essential that funding is allocated as wisely as possible, in accordance with the evidence.

POLICY RECOMMENDATIONS

1. Programmes for further implementation and funding

Because this report only provides an introductory review of well-established effective programmes, a more comprehensive review of home visitation and parent management training programmes would be desirable. No doubt such a review would identify other excellent, evidence-based programmes that are worthy of funding and implementation. Nevertheless, because the three programmes singled out by our preliminary review all happen to be running in New Zealand to some degree, we can reach some reasonably firm conclusions about current programme funding.

Based on our research, we recommend three programmes for further implementation and funding: Early Start, Incredible Years and Triple P. Of the programmes we reviewed, these three have the greatest potential to make a change to our out-comes of interest—abuse and neglect, and anti-social behaviour.

However, our recommendation of Early Start is qualified by the lack of independent evidence. Therefore, we recommend that this programme is independently evaluated in another location outside of Christchurch as soon as possible.

2. A comprehensive review of exemplary, evidence-based home visitation and parent management training programmes should be undertaken

Work is already in progress to develop and implement "an effective behavioural service for 3-7 year-olds."[1] This provides an opportunity to consider which effective interventions should be included and funded as part of this service, and should include a comprehensive review to identify other exemplary home visitation and parent management training programmes that might be suitable for implementation and funding in New Zealand. Identified programmes should be carefully assessed for their potential to address the problems of abuse and neglect, and conduct disorder.

3. Funding should be carefully allocated

Existing funding from unproven and/or ineffective programmes such as Family Start and PAFT should be re-allocated to evidence-based programmes.

The Advisory Group on Conduct Problems reached a similar conclusion, saying that "policy priorities and funding in the area of the treatment and management of conduct problems should focus on programmes of proven efficacy for which there was evidence from at least two randomised trials."

This does not mean that programme selection and funding should be set in stone. As the Advisory Group said, it is possible "that interventions and programmes that do not meet this stringent criterion will be shown at a later date to be effective. At that point such programmes should be included in the portfolio of policies aimed at effective treatment of conduct problems."[2] However, programme funding should be carefully allocated to programmes that have been shown to achieve real results, and programmes should be subject to on-going evaluation, with continued funding conditional on programmes continuing to demonstrate that they are effective and delivered with fidelity.

As the Advisory Group also said, "Investments in early prevention ... should be proportional to the evidence for programme efficacy. Programme investment on a national level should not take place until efficacy is proved in randomised trials."[3]

4. Rigorous evaluations are required

Intervention programmes should be subjected to thorough quantitative evaluation processes. Evaluations should be designed to provide a clear, rigorous and critical assessment of the impact and effect of the programme. This provides an opportunity to re-assess where funding is channelled, and make improvements or changes to programmes. In particular, the forthcoming evaluation of Family Start needs to be critically considered as early evaluations suggested the programme had no substantial effect on promised child outcomes.

Evidence of effectiveness in overseas trials is promising, but not sufficient by itself. Programmes should be carefully piloted and rigorously evaluated in New Zealand before they are regarded as effective for New Zealand populations, and before they are implemented widely. As noted above, they should also be subject to on-going evaluation to ensure they continue to deliver results.

Church offers a stinging, but relevant, critique:[4]

> Perhaps it is time for those who are funding educational research in New Zealand to begin to develop some quality control standards which can be applied to future research contracts. One of the first things which needs to be considered in this regard is the rule (widely accepted elsewhere) that an evaluation is an investigation which collects outcome data, that is, data which provides a measure of the effect or impact of the programme or service on the development or learning of the children that the programme or service was designed for.

5. Prevention is preferable to cure

A preventative approach should be preferred, where possible. Families in at-risk circumstances should be referred to a programme as early as possible. This approach is not only more effective, it is also more cost-effective to implement initiatives early on before problems are entrenched or exacerbated. However, different needs, stages and ages require a package of different programmes, and interventions aimed at middle childhood and adolescence, rather than the early years, will necessarily require more of a treatment focus.

6. Programmes should encourage self-sufficiency

The aim of family intervention programmes should be to encourage families to become strong and self-sufficient (that is, not dependent on on-going professional support) while encouraging inter-generational connection and support. Government or community assistance for at-risk families should be provided for as long as needed, but should work towards providing families with the skills and abilities to parent well independently.

Proposals for universal schemes that seek to monitor the on-going progress of all children at key stages will be costly and their main benefit will be their ability to screen families for those that need support. However, there are other, more cost-effective ways of achieving this—such as the approach used by Early Start—that will not use up valuable resources that could be used on these frontline services. Universal programmes could also undermine the goal of self-sufficiency, by encouraging parents to rely on case workers to monitor their children, rather than taking responsibility to parent well themselves.

7. Programmes should apply the "sufficiency principle" and be targeted accordingly

Intervention programmes should be designed so that they are targeted to reach families' particular

needs. Therefore, those facing the most significant challenges, such as families with a history of domestic violence or substance abuse, will require the highest levels of support, while those with fewer problems will require a "light touch" approach.[5]

Again, this would rule out universal monitoring of all children by case workers, as this provides a high level of intervention whether or not any need for it has been shown.

8. Cost-effectiveness is important

It is important that intervention programmes are affordable as this allows them to reach as many families in need as possible. In-home family support programmes, such as Early Start and the Nurse-Family Partnership, necessarily involve more resources and higher costs; however, early intervention may well save significant resources in the long-term. It should be possible to see that the benefits of implementing an intervention outweigh its costs. Except for Early Start, the programmes recommended have been tested and cost-effectiveness has been demonstrated.

However, the Advisory Group on Conduct Problems noted that cost-benefit analyses should be treated cautiously where "they apply to programmes developed, evaluated and costed outside of New Zealand. ... [I]t is important that these costs and benefits are evaluated within a New Zealand context as part of the process of programme development."[6]

Cost-effectiveness evaluations should therefore be completed in New Zealand for all the programmes recommended.

9. A long-term goal

Finally, addressing the problems of child abuse and conduct disorder is not likely to be a short process. The Advisory Group on Conduct Problems considered that fully implementing a suite of rigorously evaluated, effective and suitable interventions is likely to take 15-20 years.[7] And as the UK think tank, the Centre for Social Justice has said, addressing cyclical problems of social dysfunction requires "an end to the short-term-quick fix – a generational problem will take a generation to fix."[8]

We need to be patient and to work carefully to identify real, effective solutions to the problems confronting us. Quick fixes might be superficially attractive, but they are unlikely to be effective. We can, however, make an immediate start by committing to address the problem adequately. This means putting the focus squarely on rigorous evaluations and funding what really works. The consequences of failure are too severe not to get this right.

ENDNOTES

1 Ministry of Social Development, "Inter-Agency Plan for Conduct Disorder/Severe Anti-Social Behaviour (2007-2012)," (Wellington: Ministry of Social Development, 2007), 36.

2 W. Blissett et al., "Conduct Problems: Best practice report," (Wellington: Ministry of Social Development, 2009), 27.

3 W. Blissett et al., "Conduct Problems: Best practice report," 29.

4 J. Church, "The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties," (Wellington: Ministry of Education, 2003), 153.

5 M. Sanders, K. Turner and C. Markie-Dadds, "The Development and Dissemination of the Triple P-Positive Parenting Program: A multilevel, evidence-based system of parenting and family support," *Prevention Science* 3, no. 3 (2002): 173-189.

6 W. Blissett et al., "Conduct Problems: Best practice report," 28.

7 W. Blissett et al., "Conduct Problems: Best practice report," 28.

8 G. Allen and I. Duncan Smith, "Early Intervention: Good Parents, Great Kids, Better Citizens," (London: The Centre for Social Justice and the Smith Institute, 2008), 20-21.

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Responsibility for the views and opinions expressed in this report, and for any errors or omissions, rests with us.

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