

Empowerment evaluation of Te Taiwhenua o Heretaunga
Family Start: Improving service delivery.

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Abstract

This thesis explores child maltreatment in New Zealand by considering service delivery of the Family Start programme at Te Taiwhenua o Heretaunga through an empowerment evaluation. The purpose of this research is to evaluate the service delivery process of the Family Start programme at this site to inform the organization and other Family Start key agents of possible improvements to service delivery so that the Family Start programme is best able to reduce the risk factors that are known to influence child maltreatment in New Zealand. The best possible service delivery by kaupapa providers supports sustainability and the continuity of service with Māori through continual funding. The two objectives of this research are to look at how well the Family Start programme is implemented at Te Taiwhenua o Heretaunga and to consider the cultural appropriateness of service delivery.

Community psychology is the paradigm within which I position myself. I respect the values of community psychology that aim to improve the position of disadvantaged people through their participation in social change and community development. Te Taiwhenua o Heretaunga is a kaupapa Māori provider and I see an empowerment evaluation as a tool for internal evaluation to assist organizations who value self determination in their own practice. Both quantitative and qualitative data were collected and analyzed. There are two objectives to consider service delivery; firstly process aspects of service delivery are looked at and secondly the cultural relevance of service delivery to the population receiving the Family Start programme at this site. These are described as nine points about service delivery. The aim is to provide an empowerment evaluation for Te Taiwhenua o Heretaunga to inform, assist and improve service delivery of the Family Start programme in a culturally appropriate manner.

The findings suggest better understanding is needed by Te Taiwhenua o Heretaunga Family Start staff, about the programme intentions, the use of tools such as Born to Learn/Ahuru Mōwai, individual family plans, service delivery levels, maintaining health records and ways to encourage collaboration between agencies. Te Taiwhenua o Heretaunga are shown in this research to be reaching

the intended population for the Family Start programme, and service delivery appears to be culturally relevant to the clients on the programme at this time.

The findings are limited by the fact that access to some information was restricted by Te Taiwhenua o Heretaunga Family Start management. Consequently, this research looked only at service delivery, and not the benefits of or barriers to the actual programme. The effectiveness of the programme in reducing child maltreatment is important but could not be measured in this research. Reducing child maltreatment is the main aim of the Family Start programme and would be measured through client outcomes. This research considered service delivery to see if the Family Start programme is offered optimally to assist the aim of reducing child maltreatment.

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To Marei, thank you for believing in me and giving me the opportunity to grow academically. I wish to extend my aroha and manaaki to my fellow kaimahi and to extend my awahi to you all as we grow and learn together.

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I am part Māori and very proud of this heritage. Working for a kaupapa organization has been awesome and I am pleased to have had the opportunity to work with Māori for Māori in conducting this research.

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Preface

Child maltreatment has many forms, the most severe resulting in death. My interest in the cause and prevention of violent acts especially against children has come from having four members of my own family murdered in one domestic incident.

The impact of this has affected three generations so far and the effects are difficult to describe. While murder is the most extreme act of violence, emotional and psychological maltreatment, whether intentional or accidental, have devastating outcomes as well.

I hope to gain some insight to prevent this horrible violence for others.

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1.1 Introduction

This research looks at the service delivery aspects of the Family Start programme at Te Taiwhenua o Heretaunga. The intention is to evaluate implementation of service delivery because I accept the assumption that the Family Start programme would assist to reduce child maltreatment if delivered as intended. Research informs us that child abuse occurs predominantly in the context of domestic violence and witnessing domestic violence is generally considered the most common form of emotional child abuse (Fergusson, Boden & Horwood, 2006). The literature review intends to show how the Family Start programme has been informed to address the risk factors so this research can focus on service delivery of the programme.

The Family Start programme has been designed to address the risk factors for child maltreatment and to provide prevention through an interagency collaborative approach (Ministry of Social Development, 2008). Delivered as a home visiting service, the Family Start programme provides education on parenting skills, childrearing practices, and supports childhood preventative health strategies (Ministry of Social Development, 2008). Empirical research is a community psychology ideal which respects knowledge that comes from evidence and experience (Dalton, Elias & Wandersman, 2007). Therefore, both quantitative and qualitative data provide information for the research. The quantitative data will be used mostly to evaluate the service delivery implemented at Te Taiwhenua o Heretaunga and the qualitative data will be used to explore if the service delivered at Te Taiwhenua o Heretaunga Family Start is culturally relevant to the population receiving the programme.

Chapter one introduces child maltreatment by providing some background that shows a range of maltreating behaviours that have been used by New Zealand parents and caregivers within a short time period. The behaviours used against their children include beating babies, burning children, neglecting to get medical

help and allowing young children to be exposed to harmful substances. Time is important in these examples to illustrate that these children have had prolonged exposure to these behaviours. This list of abuse and neglect incidences demonstrates that acts of child maltreatment are not accidental acts but are deliberate, lengthy choices, made by adults. I have shown where Family Start providers are positioned in interagency work that deals with child maltreatment in New Zealand. I have shown that the significance of this research is to empower and improve service delivery of the Family Start programme by informing Te Taiwhenua o Heretaunga through an internal evaluation. I offer nine points to assist the data collection and analysis and I explain the rationale of all nine points. I begin chapter one with the thesis outline.

1.2 Thesis Outline

Chapter One provides the background and introduces the aim and significance of this research. The researcher is introduced and the thesis is outlined here.

In Chapter Two, I provide a literature review to background child maltreatment issues that will be relevant to the research. Child abuse and neglect are defined and views shared. Human rights, prevalence and risk factors for child maltreatment are followed by a discussion on the response to child maltreatment in New Zealand. Policy and prevention in New Zealand introduces ministries and agencies involved in addressing and reducing risk of child maltreatment in New Zealand. This leads to discussion about the Family Start programme and social service delivery. I will introduce Te Taiwhenua o Heretaunga and outline the interagency approach and kaupapa service delivery.

In Chapter Three, I will discuss community psychology as part of the methodology. Here I share some thoughts about the values and assumptions about community psychology and describe empowerment evaluation as a theoretical approach. I follow by discussing the method used to carry out this research. The method includes a consultation process, ethical issues and approval, questionnaire design and development, selection and recruitment of participants, and details of the data collection procedures, storage and confidentiality.

Chapter Four, provides the research findings. Firstly, the participant demographic data is presented. The findings align with the nine points of the service delivery process mentioned previously, to look for the aspects of service delivery of the Family Start programme at Te Taiwhenua o Heretaunga that can be improved. Qualitative data is grouped thematically to provide the findings for cultural relevance in service delivery at Te Taiwhenua o Heretaunga Family Start.

Chapter Five provides the discussion.

In Chapter Six I conclude this thesis. Here I offer points for future discussion that come from the findings that assist to address the risk of child maltreatment, and support the prevention of child maltreatment through the Family Start service delivery by looking at Te Taiwhenua o Heretaunga.

1.3 Background

Child maltreatment is frequently mentioned in the media. While the accuracy of some information may be questionable, the number of incidences and descriptions I share for a two month period are scary reading. I share this list to demonstrate how often and severe child abuse and neglect is for some New Zealand children. I have deliberately used older data because I want the identity and family circumstances to be unknown to demonstrate my point. That it could be any of us, if we do not understand the context and risk factors for abuse. I consider that we all have a tendency to form clearly defined groups when we hear information that we do not like. These groups are them and us. I think knowing the identity or circumstances of abusers assist to reinforce this mental trick, and we are often able to reduce the impact by telling ourselves, it would never happen to us and it does. I have used data taken from June and July because the media suggests that domestic violence occurs more near Christmas when financial and social pressures are more stressful for families (NZHerald, 2005) and I wanted to show an average time. I share only two months because any longer and the information is overwhelming, any shorter, it might be considered an isolated group of examples.

June 2007

- Porirua child admitted to Wellington Hospital with serious head injuries
- Remuera boy dies after a beating – trauma to the head
- Newborn baby found dead in Alicetown
- Twenty two month old Tokorua toddler with severe burns left for 17 hours before being taken to the hospital
- West Auckland toddler in hospital with serious multiple arm and leg injuries suffered at different times

July 2007

- Hawke's Bay father shoots his daughter with an air rifle
- Two Christchurch children found in a 'P' lab
- Three year old Rotorua girl dies after 3 weeks of abuse
- Baby 12 weeks old in Rotorua hospital with head injuries
- Five year old high on 'P'

Source: (Family Integrity, nd).

I think a list such as the list above illustrates child maltreatment in New Zealand better than statistics to introduce the topic because numbers tend to depersonalize the incidences. Here I intend to show that we are talking about children, who depend on adults and I want to illustrate the importance of providing social service programmes to support and educate parents and to prevent incidences like these.

Child abuse and neglect are handled by Child Youth and Family Services (CYFS) in New Zealand (Child Youth & Family Services, nd). On its website, CYFS inform readers that anyone can report concerns about perceived risk for the abuse and neglect of children to a social worker or the Police (Child Youth & Family Services, nd). This notification is followed by an investigation to establish if further action is needed. If so, an assessment follows to verify if concerns are founded and what action is needed (Child Youth & Family Services, nd). Less serious notifications are passed onto support agencies like Family Start providers

through a referral process (Ministry of Social Development, 2008). Once a family/family member is interviewed the Family Start provider weighs referral criteria and position availability before deciding on offering a position on the programme (Ministry of Social Development, 2008). Clients can be referred to the Family Start programme by several agencies, family or as self referrals (Ministry of Social Development, 2008). If concerns about care and protection issues are verified as part of the assessment process, a shared care process may continue with the Family Start provider and CYFS (Child Youth & Family Services, nd). In this case, the Family Start provider delivers the Family Start programme and maintains regular contact with the family through home visits with the intent to keep an eye on the safety of the child or children. Child Youth and Family Services are informed and act on any concerns for the safety of the child or children and the Family Start provider supports the family/family member as an advocate in the Child Youth and Family Services process (Child Youth & Family Services, nd).

Care and protection issues for children are all addressed through CYFS social workers and interagency collaboration (Child Youth & Family Services, nd). The process is managed by care and protection coordinators within CYFS and through Family Group Conference (Child Youth & Family Services, nd). There is a care and protection resource panel to give advice to CYFS staff, but they have no direct power. Although the website suggests social workers, Police and CYFS are required by the law to seek advice from the panel at critical times (Child, Youth & Family Services, nd). The care and protection resource panel is made up of selected community members to provide a range of professional, community and cultural knowledge and experience for critical cases (Child Youth and Family Services, nd). Some iwi social service workers are included on this panel. It is good to note that Te Taiwhenua o Heretaunga is part of a kaupapa Māori voice to Child Youth and Family Services by having a representative on the care and protection panel in Hastings.

In the late 1980s New Zealand went through major changes in public management. Services were redistributed among government and Non Government Organizations (NGOs) (High and Complex Needs Unit, 2007). Te

Taiwhenua o Heretaunga is an NGO. Although government agencies and non government agencies work together to maintain and improve the wellbeing of people in New Zealand this partnership is unequal (Social Advisory Council, 1986). Child Youth and Family Services employ the care and protections workers and the social workers who investigate and manage child maltreatment cases in New Zealand. CYFS coordinators and social workers are employed by the government to carry out the legislative requirements of the CYFS Act 1989 (Child Youth and Family Services, nd). As a community organization Te Taiwhenua o Heretaunga offer preventative services but do not investigate or substantiate child maltreatment cases (Child Youth and Family Services, nd). Some research suggests there is a vast difference between government and non government agencies due to their funding base and attitudes to helping or changing people's behaviours (Social Advisory Council, 1986). Research and past experience informs us, that in social service delivery, a government agency has an assured future while NGOs have not (Social Advisory Council, 1986).

The health status of Māori has been said to be, on average, the poorest of any ethnic group in New Zealand and the Government and the Ministry of Health have been active to reduce the health inequalities that affect Māori (Ministry of Health, 2002). Māori experience inequalities in educational attainment and income as well as in health (Statistics NZ, 2006, 2007). Māori are highly represented in child abuse and neglect statistics also (Duncanson, Smith & Davies, 2009). There is a need for service delivery to be culturally relevant to assist Māori with improvements. Māori have double the rate overall of child deaths due to maltreatment (Connolly & Doolan, 2007). Social service delivery to Māori in the past showed a lack of cultural understanding and the Māori Advisory Committee in 1986 provided evidence to rectify this (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1986). Māori service delivery to Māori acknowledges the importance of cultural considerations (Te Puni Kōkiri, 2000). Māori are important service delivery agents and to maintain funding quality is needed. This empowerment evaluation intends to show the benefit of internal evaluations to inform and improve capacity for iwi organizations. Māori have been included in social service delivery mostly after

programmes have been researched and developed (Te Puni Kōkiri, 2000). Therefore delivery is the most likely component for Māori to have input with.

There appears to be two major governmental approaches in addressing child maltreatment issues in New Zealand. Firstly, that Child Youth and Family Services provide a partnership with iwi and other social service agencies to deal with identified issues (Te Puni Kōkiri, 2000), and, secondly the Ministry of Health views violence within families as a health issue and works to develop policy and interventions to prevent it (Fanslow, 2002). The first of these points is related to response to concerns and supports ways to address risk factors once identified, through interagency collaboration with CYFS. Secondly, the Ministry of Health's view that family violence is a health issue is centered on preventative programmes through education, routine health checks, immunization schedules and regular contact with families. It is not my aim to discuss the success or limitations of these two approaches but to show that the Family Start programme is designed to do both.

Research suggests that part of the purpose for the interagency collaborative approach was to address the past fragmentation in social services (High and Complex Needs Unit, 2007). CYFS is the lead agent in the interagency collaboration process in New Zealand (High and Complex Needs Unit, 2007). Past literature has recognized that CYFS did not have a Treaty of Waitangi framework (Te Puni Kōkiri, 2000). The High & Complex Needs Unit (2007) informs us that the Treaty of Waitangi has a central position in interagency collaboration in New Zealand and there is a desire to increase the partnership with Māori in the social services. Te Puni Kōkiri (2000) suggests there are potential benefits from using the Treaty of Waitangi framework to inform the partnership between Māori and the crown in the social services. I agree. The three articles of the Treaty of Waitangi are basically 1) The right of governance; 2) Authority over things Māori; and 3) Protection and full citizenship (Waitangi Tribunal, nd). The principles of these articles are: participation, partnership and protection (Waitangi Tribunal, nd). To translate these principles to the social service intervention, the Family Start programme, is of relevance to this discussion. The purpose of the Family Start programme is to address the high rate of child maltreatment in New

Zealand (Ministry of Social Development, 2008). Māori participation in the development of the Family Start programme is very hard to find and it is likely that Māori were not partners in the development. Statistically, Māori appear to be high intended users of the Family Start programme due to the inequalities in health, education and social circumstances (Connolly & Doolan, 2007). Therefore, culturally relevant programmes and service delivery, are important to protect Māori from institutional racism. Evaluation is used to inform the funders in social service delivery. This is an important reason for Māori to be able to participate in the evaluation process to empower self directed choices in the social service setting.

Research is needed to inform and assist social service delivery in New Zealand because evidence is needed to inform development as an ongoing commitment to improvement. Child welfare agencies and managers recognize a need to improve organizational performance and accountability (McBeath, Briggs & Aisenberg, 2009). Although evidence based research on social service programmes for child welfare is plentiful there is limited research about how well these programmes are delivered (McBeath et al., 2009). This point was mentioned by our current Minister of Social Development recently. Paula Bennett suggested that more research is needed to see if the Family Start programme is being delivered as it should be (Laxon, 2009). Good evaluation is important to ensure the \$29 million annual cost of Family Start assists the reduction of child maltreatment in New Zealand (Laxon, 2009). An empowerment evaluation will inform Te Taiwhenua o Heretaunga of structural processes needed to assist improvements in service delivery, so that time is available for cultural practices in service delivery to be enhanced as well.

An empowerment evaluation is a tool for an organization or group to take stock of their performance (Fetterman, 2002). There are three steps involved in an empowerment evaluation. These are establishing a mission, taking stock and planning (Fetterman, 2002). Establishing a mission is conceptualized in this Family Start empowerment evaluation as an attempt to improve service delivery to give the Family Start programme the best chance to reduce the risks of child abuse and neglect. Taking stock involves considering the Ministry of Social

Development's perspective on service delivery requirements to compare this with the actual service delivered at Te Taiwhenua o Heretaunga and to offer this to Te Taiwhenua o Heretaunga to inform the Family Start management team. Planning is then able to be based on the findings if Te Taiwhenua o Heretaunga chooses to do so. Training in identified areas can be planned and initiated; there is an opportunity to address any barriers to service delivery that may be found and development of new policy and strategy can be undertaken.

Organizations and communities have their own culture and ways of doing things. I respect this idea, and see working with an organization as preferable to working on it, to enhance results. The Social Advisory Council (1986) suggests that every community has its own way of doing things, its own means of communication, and pace of operation and its own trusted leaders and if these ways are not respected and other ways are introduced, there is bound to be suspicion and resistance (Social Advisory Council, 1986).

Child maltreatment in New Zealand concerns children who rely on adults to keep them safe and to help them reach their potential. I have provided an outline for handling child maltreatment issues and briefly explained how Child Youth and Family Services engage with Family Start providers. I briefly mentioned the poor health and social outcomes for Māori to provide support for including the principles of the Treaty of Waitangi to support using an empowerment evaluation. I have discussed the rationale for looking at service delivery, rather than the efficacy of the Family Start programme.

1.4 The Researcher

Psychology has been a recent development in my life. I began serious study late into my forties. I have been highly influenced by working class thinking and rural life experiences before academic learning.

Domestic violence and murder have featured in my family of origin. At school I saw children hit, verbally abused and emotionally degraded. Rumours of sexual abuse were common in our community.

During my time as a relief teacher I saw evidence of child maltreatment repeated in the next generations. I was shocked by the frequency of occurrence. It seemed that little had changed since I attended school.

I began my journey in psychology as a response to seeing children struggle at school when their social, emotional and safety needs were not being met.

In the last eighteen months I have worked for Te Taiwhenua o Heretaunga as part of the kaupapa service delivery to people in challenged communities. As a kaimahi in the Family Start programme I was privileged to have had experience at the coal face in the prevention of child maltreatment.

When I discussed undertaking a Master's thesis the kaihautu (cultural leader) at Te Taiwhenua o Heretaunga was supportive of the opportunity to explore and evaluate the service delivery of the Family Start programme at this site.

1.5 Significance of this Study

Service delivery is an important aspect of social service provision. Programmes and their design elements must be researched to provide the best possible interventions for governments to invest in to address child maltreatment. It is important to see if the service is delivered as expected and to inform the service providers of areas for improvement to achieve best outcomes. The Minister of Social Development, Paula Bennett suggested recently that there is a need for detailed evaluation in Family Start delivery to determine whether services were being delivered as planned because a discovery that a similar model elsewhere has failed to reduce child abuse due to concerns with service delivery (Laxon, 2009).

This investigation is an empowerment evaluation (Fetterman & Wandersman, 2005). Because of the nature of the population that receives the Family Start programme, and Minister Paula Bennett's concerns, service delivery is important to ensure access and implementation is optimal. This empowerment evaluation intends to provide evidence for Te Taiwhenua o Heretaunga to improve service

delivery of the Family Start programme. Internal awareness of the service delivery performance will assist the organization to manage the delivery of the Family Start programme and to assist to improve capacity and future ownership of delivery performance.

1.6 Aim of the Research

The aim of this research is to support Te Taiwhenua o Heretaunga Family Start to enhance service delivery, so that the Family Start programme is delivered optimally to provide clients the best possible opportunities for reducing risk factors to prevent child maltreatment.

Service delivery was evaluated following much of the service delivery process. Service delivery has been divided into nine points to assist the research process. These nine points are important aspects of service delivery according the Ministry of Social Development Guidelines (Ministry of Social Development, 2008) and include the ideal for service delivery to be culturally relevant.

The nine points used in the research are:

- 1 Referral criteria
- 2 Response
- 3 Referrer feedback
- 4 Strengths and needs assessments
- 5 Time
- 6 Individual Family Plans
- 7 Born to Learn/Ahuru Mōwai
- 8 Health checks
- 9 Culturally relevant service delivery

The rationales for these points are as follows.

Point 1: Referral criteria

Point one refers to the referral criteria. The referral criteria are essentially the risk factors that clients come to the Family Start programme with. These risks are subjective because there is not a standard measure for them and multiple referrers can specify areas of risk based on their own assumptions. These referrers can be professionals, agency staff, family members or the clients themselves.

The referral criteria are a list of risk factors that have been identified by research to develop the Family Start programme. These referral criteria/risk factors are: young to be a parent, unsupported mother, substance abuse, Sudden Infant Death syndrome (SIDS) factors, relationship problems, no or minimal antenatal care, mental health problems, low educational attainment, low income, a lack of essential resources, frequent change in address, a family history of abuse and previous Child Youth and Family Services involvement (Ministry of Social Development, 2008).

Point 2: Response

Point two looks at the response time for the engagement with clients after a referral has been accepted. The reason this has been considered in this research is to support the Ministry of Social Development's (2008) ideal for prompt responsiveness. Prompt responsiveness intends to address risk and provides preventative measures to reduce child maltreatment in challenged families.

Point 3: Referrer feedback

Referral feedback is the third point. The rationale for exploring whether referrers are informed of decisions to engage or decline clients, intends to support a coordinated attempt to address risks and to prevent child maltreatment by ensuring that, once risk is identified, people are not missed in service delivery. The target population for the Family Start programme is 15% of the population to capture the 5% considered to be most at risk for maltreating their children (Ministry of Social

Development, 2008). Referrals come from agencies, individuals and family members. This is a collaborative approach to preventing child maltreatment. Therefore, it appears that some agency is expected to take responsibility for a register of people with potential risk factors to support prevention. Family Start service providers are possibly the best positioned agency to record and maintain this information because, as a holistic service provider, the Family Start provider intends to address social, educational and health needs. Other agencies tend to address one aspect. Information contained in a register would involve tracking those who frequently change addresses, and this would involve service provision continuity and interagency communication.

Point 4: Strengths and needs assessments

Point four explores the use of strengths and needs assessments. Strengths and needs assessments are a tool designed to collect and collate data about family circumstances and contextual issues relating to risk factors and strengths (Ministry of Social Development, 2008). This data is used to inform service delivery commitments. Service delivery commitments are based on levels of need and are high, medium or low. Service delivery levels assist funding, informing programme evaluators and kaimahi service delivery time expectations. The Ministry of Social Development's (2008) expectation is that strength and needs assessments are completed in the first six weeks of being on the Family Start programme. The rationale for exploring this aspect of service delivery is to see if prevention of child maltreatment is supported by the intended and expected use of tools of the Family Start programme.

Point 5: Time

Point five looks at the time spent with clients in the delivery of advocacy and support that is not the Born to Learn/Ahuru Mōwai programme (BTL/AM). There is a Ministry of Social Development (2008) expectation that approximately half of a kaimahi's (support worker) work time is spent face to face with clients (I.e. 20 hours a week) and delivery of the BTL/AM is one hour a month per client. The

rationale for exploring this point is to see if clients are getting the service they are entitled to or if there are barriers for kaimahi to achieve this expectation. The Ministry of Social Development (2008) has an expectation that providers should be guided by an average of one kaimahi to 16 families.

Point 6: Individual family plans

Individual family plans are a goal setting tool that is designed to support clients to improve the circumstances that put them at risk for maltreating children. The rationale for establishing how well individual family plans are used is to explore if service delivery of the Family Start programme is supporting the implementation of addressing risk factors through kaimahi and clients working together setting goals and mapping change.

Point 7: Born to Learn/Ahuru Mōwai

The BTL/AM programme is a specifically designed parenting intervention to improve child maltreatment risk and to provide prevention (Ministry of Social Development, 2008). The rationale for exploring BTL/AM delivery is to establish whether delivery of this child maltreatment risk prevention strategy is happening at Te Taiwhenua o Heretaunga Family Start at the times intended. The goals for the Born to Learn/Ahuru Mōwai component of the programme include: improving parenting practices; ensuring secure attachments develop between parent/caregiver and the child because these reduce risk factors for child maltreatment and are said to prevent child abuse and neglect (Ministry of Social Development, 2008).

Point 8: Health Records

Point eight considers the record keeping of health checks, immunization records, and developmental milestone recordings by kaimahi. The rationale for exploring this is to gain some information about how well clients are supported to access the

services available to them. The well child checks, immunizations and developmental milestone recordings are intended to verify that children on the Family Start programme are being seen regularly by the associated health professionals. This is to support the prevention of child maltreatment through regular physical checks for early recognition of signs of abuse or neglect.

Point 9: Culturally relevant service delivery

Cultural relevance in service delivery is a Ministry of Social Development (2008) ideal. Qualitative data was used to explore the service delivery to see if it is culturally relevant to clients on the programme. This will be discussed further in the next chapter.

2.1 Introduction

Chapter two provides the literature review for this thesis. I begin by defining child maltreatment, looking at physical, sexual, emotional abuse and child neglect. I share some wider views on child maltreatment, in general, and then discuss human rights. Prevalence of child maltreatment follows. Risk factors for child maltreatment show the multiple issues involved with child maltreatment. I discuss other violence to show how important domestic violence and witnessing abuse is for child maltreatment. I share demographic characteristics of adults who abuse children before discussing the response to child maltreatment and important policy in this topic. I then discuss prevention, ministries and agencies involved with child maltreatment in New Zealand, preventative programmes, the Family Start programme and collaboration before service delivery. I introduce Te Taiwhenua o Heretaunga who are the kaupapa provider of my thesis research. The literature review finishes with tying all this discussion together to show the importance of evaluating the service delivery of the Family Start programme to empower and improve provision to prevent child maltreatment in New Zealand.

2.2 Definition

Child abuse is the physical or mental injury, sexual abuse or exploitation, or the negligent treatment of a child who is under eighteen (Ministry of Social Development, 2005). Research suggests that definitions of child abuse usually fall into four main categories: physical, sexual, emotional abuse, and neglect (Ministry of Social Development, 2005). Child, Youth and Family Services (CYFS) on their website, define physical abuse as any non-accidental physical injury done to a child by a parent or caregiver and this abuse endangers the child's physical or emotional health or development (CYFS, nd). Emotional abuse involves constant yelling, threatening, scaring a child, belittling them or playing games with their emotions (Ministry of Social Development, 2005). Sexual abuse is defined as children and youth, sometimes even toddlers and babies, being used in a sexual way by someone older, and does not include normal sexual play between children

(Ministry of Social Development, 2005). Neglect can be described as children not receiving what they need for their physical and emotional wellbeing and development and can involve physical, medical, educational, supervisory, and emotional neglect as well as abandonment (Ministry of Social Development, 2005).

Maltreatment is a term now used to cover the range of adult behaviours that can cause psychological and physical injury to children and covers physical, emotional, sexual abuse and neglect (Ministry of Social Development, 2008).

2.3 Physical Child Abuse

Physical child abuse definitions have been debated over time. The varying reasons why professionals use a particular definition often contribute to a lack of consensus between law and social service professionals (Fergusson & Horwood, 1998).

Physical child abuse is present when a child less than 18 years has been hit, either by a hand or object, been kicked, shaken, thrown, burned, stabbed, cut or choked by a parent or caregiver (Kolko, 2002). I like this definition because this would include genital mutilation and infantile injury due to shaking a baby. The discourse helps the reader to recognize that there is deliberate intention in this definition and this I feel is a big part of describing maltreatment.

Definitions of physical abuse have continuously been enmeshed in discussions and definitions around punishment (Fergusson & Horwood, 1998). The issue of deciding where the line between abuse and discipline is drawn has concerned many New Zealanders for a long time (Ritchie & Ritchie 1981, 1997; Wood, Hassell, Hook & Ludbrook, 2008).

In New Zealand there have been legislative changes that clarify what discipline of children is. Previous to June 2007, Section 59 of the Crimes Act 1961 read as:

Crimes Act 1961 No 43

(2) Every parent of a child...is justified in using force by way of correction towards a child, if the force is reasonable in the circumstances (in Wood, et al., p.19, 2008).

The passing of this bill was the culmination of dedicated work by many notable scholars, advocates and community groups since the 1960's (Wood, et al, 2008).

The outcome was that child discipline was clearly stated as:

Crimes Act 1961 No 43 (as at 1 December 2009)

(2) Nothing in subsection (1) or in any rule of common law justifies the use of force for the purpose of correction (New Zealand Legislation, 2009).

Recently (31 July – 21 August 2007) New Zealand held an anti-smacking referendum. The results showed the majority of New Zealanders wanted the so-called anti smacking law to be changed (The Yes Vote, 2009), and, 87.6% of voters said that smacking should not be a criminal offence (NZHerald, 2009). The debate has widened to become about democracy and political leaders listening to voters. Smacking as a form of punishment is not considered to be good parenting and neither is accountability through legal systems (themarch.org.nz/, 2009). The debate goes on.

2.4 Sexual Child Abuse

Sexual abuse of children is difficult to define in one statement. Literature generally agrees that contact or interactions with children that are used for sexual pleasure or stimulation of an adult or older child are child sexual abuse (Ministry of Social Development 2005). Despite the difficulties in defining child sexual abuse, an important consideration is the use of power and control over a child (Ministry of Social Development, 2005).

I see this as an important part of the definition because choice helps me to explain further considerations this literature offers. For example, definitions of child sexual abuse can include both physical contact including fondling and intercourse,

and non contact activities such as nudity and pornography (Ministry of Social Development 2005). A definition is complicated by cultural or familial norms around issues like nudity, bathing, sleeping arrangements and displays of affection (Miller-Perrin & Perrin, 2007). Reflecting back to the concept of having power or control over a child assists me to understand that child sexual abuse is sexual activity that is forced or imposed on a child.

2.5 Emotional Child Maltreatment

Three types of emotional maltreatment are often referred to and these include emotional abuse and emotional neglect. Firstly, emotional abuse includes, confining or restricting a child and includes tying or shutting in something like a cupboard. Secondly, verbal or emotional assaults are acts on a child that are belittling, denigrating, blaming, and threatening. Thirdly, emotional neglect is deliberately withholding food, shelter, sleep or economic support (Ministry of Social Development 2005). This description describes emotional maltreatment, including emotional abuse as doing something to a child; and emotional neglect as withholding activities using positional power.

2.6 Child Neglect

Emotional neglect is described as a failure to provide a child with emotional security, encouragement and support (Ministry of Social Development 2005).

Physical neglect includes failing to provide necessary health care, delaying access to health care when it is needed, abandonment, expelling a child from the home, repeatedly leaving a child with others and not wanting to care for them, inadequate supervision, nutrition, clothing, hygiene, and safety (Ministry of Social Development, 2005). This definition is clear and shows things like driving when intoxicated with a child in the car, being under the influence of substances and not attending to children, allowing children to roam around a neighbourhood without knowledge of their whereabouts and leaving a young child unattended in a car are forms of physical neglect. I understand these examples portray neglect in a physical sense as not providing the necessary action and decisions to provide safety for children as well.

I consider these definitions to be important in this discussion because it assists us to consider behaviours of commission are abuse issues and acts of omission by adults are neglect issues.

2.7 Child Maltreatment

Child maltreatment has different meanings according to contextual circumstances. A definition is important to assist knowing what the Family Start programme is designed to address. According to Bottoms and Goodman (1996), cross-cultural differences exist in what societies regard as important in the problem of child abuse. They go on to point out that in India children are considered lucky to have a roof over their heads and to have anyone to care for them at all, regardless of whether the caretaker is kind. In contrast, spanking a child has been illegal in Sweden since 1979.

Child maltreatment is the term now used to include the deliberate abuse or neglect of a child by an adult, usually the parent or caregiver (Ministry of Health, 1996). In general, child maltreatment is seen to encompass the emotional, physical or sexual abuse or neglect of a child or young person in an adult's care.

2.8 Human Rights

Human rights are the basic rights and freedom to which all people are entitled. These rights apply to children as well. These are expressed on the website, in the Universal Declaration of Human Rights (UN News Centre, nd) and through international treaties including rights for indigenous peoples.

The Bill of Rights Act 1990 is designed to affirm, protect and promote human rights and fundamental freedoms in New Zealand (Human Rights Commission, 2008). Although New Zealand does have a Bill of Rights Act 1990 and the Human Rights Act 1993, the New Zealand government has wrestled with signing the Declaration of Rights of Indigenous Peoples for several years.

Self determination goals for many indigenous people are organized around moral obligations and these are contained in the Declaration of Rights of Indigenous Peoples (IWGIA, nd). In New Zealand indigenous people continue to challenge governing systems to be included in the discussions and decisions that affect governance, well being, health and education (Durie, 2009).

Child maltreatment issues are culturally bound and meaning has been seen to change with context and time throughout history (Fergusson & Horwood, 1998). Self determination is a priority for Māori to gain governance and control over their own lives and I respect this entirely. My concern is that other minority groups may use the principle of self determination as a rationale for culturally sanctioned acts against children such as genital mutilation.

Fortunately New Zealand has signed and ratified the United Nations Convention on the Rights of the Child. This sets out that children under the age of eighteen years have the right to be protected from abuse and neglect regardless of culture (UNICEF, nd).

2.9 Prevalence

Prevalence of child maltreatment can be difficult to establish. Under reporting, problems with reporting due to the disparity in power relationships between adults and children, the use of retrospective studies and the difficulties in defining and agreeing on abuse and neglect are reasons offered (Miller-Perrin & Perrin, 2007).

Māori children under 15 years have died from physical abuse at an average rate of 1.6 per 100,000 between 2002 and 2006, while non Māori children died at an average annual rate of 0.5 per 100,000 for the same period (Ministry of Social Development, 2008). Rates for death from maltreatment are higher for children under five years of age according to the Ministry of Social Development (2006) and the highest rates are for children under one. The problem of abuse, according to the Ministry of Social Development (2008) is getting worse. When a concern is expressed to CYFS that a child or young person is at risk of abuse, neglect or

insecurity of care, a notification is recorded (Ministry of Social Development, 2008). The total number of care and protection notifications received by CYFS has increased since 2003/2004 (Ministry of Social Development, 2008) (See Table 1). However, the number of notifications requiring further action after investigation has fallen over the last two years (Ministry of Social Development, 2008). This information shows an increased concern for child welfare in New Zealand.

Table 1: The Statistical Report 2008

	2003/2004 Number	2004/2005 Number	2005/2006 Number	2006/2007 Number	2007/2008 Number
Emotionally abused	2,571	4,592	6,142	8,256	8,664
Physically abused	1,864	2,351	2,336	2,274	2,321
Sexually abused	1,149	1,424	1,291	1,194	1,003
Neglected	2,878	4,074	4,199	4,486	4,302
Behavioural/ relationship difficulties	3,325	4,355	4,657	4,461	4,154
Self harm/ suicidal	100	173	172	138	116
Not found	15,860	23,388	26,011	22,921	19,334
Total findings from investigations	27,747	40,357	44,808	43,730	39,894

Source: Ministry of Social Development, 2008

It is important to realize that these notification statistics show supply percentages and do not represent actual children involved with CYFS at the suggested times because more than one notification can be made for a child in the same time period.

Doolan (2004) informs us that child death by homicide remains much the same in New Zealand over the last 30 years while there has been a reduction in half of other developed countries. Māori have a higher rate than non Māori of child abuse deaths and the gap between Māori and non Māori is increasing (Doolan, 2004). I understand this to mean, physical child abuse is getting worse for Māori and is suggesting improvements for non Māori.

It has been recognized that age assists a child to report sexual abuse and that it is highly likely that sexual abuse of very young children goes undetected (Miller-Perrin & Perrin, 2007). Girls are more likely to be sexually abused than boys (Fanslow, Robinson, Crengle & Perese, 2007). Many experts suggest boys are sexually abused more than data suggests but underreporting is common due to social norms about male expectations, around dominance, and fears of homosexual tendencies (Miller-Perrin & Perrin, 2007).

Emotional abuse incidences may be more than statistically recorded because it is the hardest of all child maltreatment issues to substantiate (Fergusson et al., 2006). Some research suggests psychological maltreatment, a term that includes emotional abuse and neglect, accounts for 5% of child maltreatment cases. United States researchers suggest 28% of all child maltreatment cases are due to emotional or psychological maltreatment (Miller-Perrin & Perrin, 2007). In New Zealand emotional abuse is well recognized as occurring with domestic and partner violence and children witnessing this and would be higher than both of these statistics (Fergusson et al., 2006).

Psychological maltreatment may increase as children age according to some American research. This suggests children aged seven and above are more likely to experience emotional maltreatment than younger children (Miller-Perrin & Perrin, 2007).

New Zealand research suggests that child deaths due to maltreatment were committed by family members in 81% of cases and by an unknown perpetrator 4% of the time (Doolan, 2004). The findings of Doolan's research were similar to overseas research on risk factors and prevalence. There were statistically significant differences in Doolan's (2004) findings for Māori and non Māori. The child most at risk between 1991 and 2000 for death due to maltreatment in New Zealand was a male child less than one year old, who was Māori (Doolan, 2004).

The age of children who are known to be maltreated, appears to change with types of abuse and neglect. Physical abuse appears to be most serious for children under one. Emotional abuse appears to increase with age. Sexual abuse appears to be

more frequent in girls and some research suggests sexual abuse occurs more at middle childhood while others suggest age is irrelevant (Miller-Perrin & Perrin, 2007).

New Zealand research suggests that Māori are more highly represented in the statistics and than non Māori for maltreating their children (Doolan, 2004). These findings support the need for service delivery to be culturally sensitive to the intended Family Start recipients.

2.10 Risk Factors

I have considered a lot of international research to discuss the risk factors for child maltreatment because I am trying to show risk as a contextual concern and endeavouring to not have an ethnic issue. Risk is not cause. I am mindful that Māori are highly represented statistically for risk of child maltreatment. I am clear about describing risk factors for child maltreatment to show that Māori are not the cause of child maltreatment in New Zealand. Māori are more highly exposed to risk factors as are many other minority groups throughout the world.

Although the majority of the research used in this part of the review is international, New Zealand research has similar findings (Doolan, 2004).

Research from the UK, shows that there are multiple contextual influences affecting child maltreatment, and different types of maltreatment have different risk factors (Wolfe, 1999).

Research in Lancaster, the United Kingdom informs us that contributing factors for child maltreatment are: witnessing or experiencing maltreatment in childhood, experience of trauma in childhood, immaturity as a parent, parental mental or physical illness, alcohol or substance abuse, unrealistic expectations of the child, relationship issues and domestic violence (May-Chahal & Coleman, 2003). This is in-line with more recent New Zealand research (Fergusson et al., 2006).

The UK research also suggests a child who is small, young, female (sexual abuse risk increases) premature or had a low birth weight, with a disability or an insecure attachment with the primary caregiver has conditions that are risk factors that may contribute to child maltreatment (May-Chahal & Coleman, 2003).

Research by the Christchurch Health and Development Studies produced similar findings (Fergusson et al., 2006).

New Zealand research shows that social isolation, a lack of social capital, low socioeconomic status, unemployment, poor housing and a family that values privacy and seclusion are community factors that contribute to risk for child maltreatment (Fergusson et al., 2006).

American research identified risk factors for child maltreatment as: violence in the parents relationship, unemployed parents, lack of social and emotional support, poverty, stressful life events, disorganized home environments, mothers with mood disturbances, psychologically unavailable mothers (depressed), and the amount of care a mother had in her own childhood (Erickson & Egeland, 2003).

Macro level factors that are said to contribute to risk for child maltreatment are living in a society with norms allowing ownership of children, social norms that equate sexual attractiveness with innocence, purity and youth, approval of corporal punishment, cultural norms that accept violence as a way of resolving conflict and a social tendency to individualize problems (Ritchie & Ritchie, 1997; May-Chahal & Coleman, 2003).

New Zealand researchers inform us regularly of the same risk factors (Ministry of Social Development, 2005). What this shows is that New Zealand researchers are in line with global understandings of risks for child maltreatment and are not operating in a microcosm. I believe this is important because Māori are negatively represented statistically for risk of child maltreatment. I consider research outside New Zealand as well as accepting our own knowledge (New Zealand research), provides a healthy reference to establish some consensus in the findings. I believe this is important to prevent positioning knowledge against people. This is especially important for Māori in the New Zealand context because knowledge

focused negatively on any group can be interpreted as criticism and can be isolating and reduce the uptake of new information. I believe using international research were possible helps Māori to recognize that findings, apply to more people globally than themselves, and this will empower Māori to continue in problem solving and self development to address the risk factors through self determining approaches.

I have used mostly overseas literature to explain my points because I am writing this thesis with the idea in mind that kaupapa services are working hard to address the inequalities that put Māori at a higher risk for factors that are known to contribute to poorer outcomes including child maltreatment.

Less Māori graduate at a university a year than non Māori (Te Puni Kōkiri, 2006). Only 12% of all Māori graduates attain degree level qualifications (Te Puni Kōkiri, 2006). Wānanga qualifications account for 58% of all Māori attainment, Polytechnics 27% and the majority of qualifications are certificate and diploma level (Te Puni Kōkiri, 2006). I understand this as Māori prefer generally to recognize their own way of doing things and respect their own knowledge independently of the mainstream. When these statistics are compared with over 50% of all New Zealanders gaining qualifications in a year, Māori appear not to be well aligned to mainstream academics generally (OECD Publishing, 2009). In 2003, 16,446 Māori gained tertiary qualifications, the University of Waikato had the highest number of Māori graduates in 2003 with 440 (Ministry of Education, nd). In 2008, there were 460,400 students enrolled in tertiary education in New Zealand (Ministry of Education, nd). There were 146,943 who identified as European and 46,548 who identified as Māori (Ministry of Education, nd).

Theories about child maltreatment

Research suggests there are numerous theories and models to explain the risk factors and behaviours that contribute to and maintain physical child abuse (Kolko, 2002). Most accept that risk for physical child abuse is influenced in the relationships and reactions between the child, the parent/caregiver, the family and society (Fergusson, Horwood, & Ridder, 2005). I briefly share some theories,

about child maltreatment to demonstrate the complexities involved with explaining cause and risk factors.

The stress and coping model suggests that parents interpret child behaviours as stress and when dealing with this stress parents may lack coping skills (Hillson & Kupier, 1994). This American model suggests that child maltreatment may result from parents not managing the behaviours of their children, over reacting and using harsh discipline as a result.

The cognitive behavioural model considers the influence of parents' thinking (cognition) and behaviour in their interaction with children (Azar & Siegel, 1990). According to this American cognitive behavioural model, risk for child maltreatment can be identified by a lack of key parental skills: as a lack of developmentally sensitive expectations, maladaptive attributes, and inadequate child rearing skills, a lack of problem solving skills, a lack of coping and lack of social skills (Azar & Siegel, 1990). This model suggests that people may see their children as small adults with the capacity and reasoning of an adult and so expect a child to behave as an adult and punish harshly as a result.

The transitional model considers three stages in child maltreatment. Firstly, there is a reduced tolerance for stress and a disinhibition of aggression, including poor child rearing skills, stressful life events and a lack of socioeconomic status, lack of stability or social support (Wolfe, 1999). Poor management of crises and anger, aggression and a belief that the child's behaviour is the focus of the problem is the second stage. Thirdly, there are chronic patterns of anger and abuse, and physical punishment is part of the strict control techniques used by adults in child maltreating circumstances (Wolfe, 1999). This American model suggests aggression at a societal level permeates family behaviour and is the first response in the event of crisis.

The social information processing model, from Nebraska, suggests stressful circumstances may lead to heightened problems with abusive parents due to the way these parents perceive, interpret and give meaning to the child's behaviour

(Caselles & Milner, 2000). Abuse is already inherent in the adult's coping strategies, according to this model.

Literature that looks at the adult, suggests that risk of physical child abuse behaviours in adults, can come from exaggerated aggressive parenting practices (Fergusson et al., 2005). There are seven risk factors identified in this research for child physical abuse and these are: a parental history of abuse, depression, being a single parent, low socioeconomic status, isolation, low maternal age and substance abuse (Fergusson et al., 2005).

Sexual child abuse is any sexual activity with a child that is not consenting (Ministry of Social Development, 2005). Firstly, adults who sexually abuse children will be considered. Any behaviour that violates the rights of others is seen as part of conduct disorder and antisocial personality disorder and these are seen in sexually abusing adults (Chaffin, Letourneau & Silovsky, 2002). This suggests parents have mental health problems that contribute to sexual child maltreatment (Fergusson et al., 2006).

A popular notion in sexual abuse research has been that sexual abuse can be explained by the victim to victimizer cycle (Chaffin et al., 2002). This idea suggests that most individuals who sexually abuse children were themselves sexually abused. Really early retrospective research showed that 28% of sex offenders in one study reported being sexually abused as children (Hanson & Slater, 1988). A similar rate was found in non sexual offenders and suggests that the relationship between childhood victimization and adult abusing was not clear. More recent studies that have used prospective methodologies for determining risk and cause of sexual abuse suggest that few sexual abuse victims go on to commit sexual acts against children (Chaffin et al., 2002). Some researchers suggest that a history of physical abuse and neglect may be more important risk factors for committing sexual abuse acts (Widom & Ames, 1994).

Literature from South Carolina on child maltreatment and children's mental health suggests that young children who demonstrate sexual behavioural problems are increasing (Chaffin et al., 2002). Childhood sexual behaviours considered to be

problematic range from a preoccupation with sexual topics to serious sexual behaviours involving the coercion of other children (Chaffin et al., 2002). Burton, Nesmith & Badten (1997) found that children as young as six have sexually aggressive behaviours. According to research on children who sexually abuse, childhood sexual abuse definitions vary between cultures. Generally it is considered that childhood sexual abuse is linked to sexual behaviour occurring more frequently, interfering with a child's development, occurs with coercion, intimidation or force, creates emotional distress, occurs with children of different ability and/or development to the abuser and/or continues after intervention by adults (Chaffin et al., 2002). There are no single defining characteristics or risk factors from family backgrounds, personal histories or co morbid conditions to identify adolescents who sexually abuse children (Chaffin et al., 2002).

Preschool children who are sexually abusive were found to have higher rates of maltreatment, they were exposed to family violence, and they were found to have more behaviour problems (Silovsky, Niec, Bard & Hecht, 2007; Fergusson et al., 2005). New Zealand research supports the findings that poverty, low education, unemployment, being young, having poor mental health including drug and alcohol abuse, being the victim of family violence and a history of criminal offending are risk factors for child maltreatment (Saunders, 2006).

The most significant risk factor among maltreating parents when looking at neglect research showed a lack of understanding in the parent-child relationship by the parents (Crittenden, 2006). Parents who are emotionally neglectful are unable to see things from the child's perspective and are unable to see a child's behaviour in terms of their development, context or situation. Wolfe (1999) suggests that parents with their own unresolved issues of trust are more likely to have difficulty understanding the demands and needs of their own children and they react punitively. Maltreating parents were seen to lack impulse control especially when stressed (Hildyard & Wolfe, 2007). Some research looked at child factors for risk of child maltreatment; this includes infant fussiness and irritability, disabilities, prematurity and facial features (Chaffin et al., 2002).

American research suggests that psychological maltreatment is the core component in child abuse and neglect (Hart, Binggeli & Brassard, 1997). New Zealand research confirms these findings and suggests that emotional abuse comes from witnessing domestic violence as well (Fergusson et al., 2006).

Economic poverty, domestic violence and mental health problems are evident in families identified in child neglect cases (Fergusson et al., 2006). Maternal age at the child's birth is said to be a robust predictor of maltreatment outcomes (Mersky, Berger, Reynolds & Gromoske, 2009). Mothers with learning difficulties are often isolated within their local communities and report low levels of social support (McConnell, Dalziel, Llewellyn, Laidlaw & Hindmarsh, 2009). A lack of social support may reduce parenting confidence and research suggests that good support provides parents opportunities to discuss issues, participate in activities and to share with others (Haggman-Laitila & Pietila, 2009).

Research recognizes that teenage mothers experience challenges regarding social disapproval, a lack of confidence and lower efficacy in parenting, stress related to social isolation and intergenerational family conflict (McDonald, Conrad, Fairtlough, Fletcher, Green, Moore, & Lepps, 2009; Fergusson et al., 2005).

In summarizing this discussion on risk factors, I have grouped the information according to the ecological framework and consider child maltreatment generally.

Ecological levels

Micro level considerations include risk factors for child maltreatment that concern the parent/caregiver, then the child. Meso level risk factors show community level risk and the macro level illustrates society risk factors that have been discussed in this literature review.

Micro level risk factors concerning parents/caregivers are; a history of child maltreatment themselves or having experiences of trauma in childhood, immaturity, physical or mental health problems, alcohol or substance abuse, unrealistic expectations of the child, relationship issues and domestic violence, a

lack of coping skills, maladaptive attributes, inadequate childrearing skills, lack of social skills, stressful life events, lack of socioeconomic status, lack of stability, lack of social support, poor management skills, anger and aggression, strict control techniques with children, poor understanding of childhood development and expectations, being single and unsupported, isolation, and a lack of insight in the child's perspective.

Micro level risk factors that focus on the child are: premature birth, low birth weight, a small child, young and female in cases of sexual abuse, having a disability, an insecure attachment with the parents/caregiver, having mental health problems in the child, living with and learning aggressive and coercive behaviour and living with non biological parent/s.

The meso level risk factors for maltreatment in this review were: multiple contextual influences including poverty, unemployment, disorganized home environment, and stressful life events, lack of family and social support systems, and family domestic violence.

Macro level risk factors were: living in a society that gives rights to parents over the children, accepts sexual attractiveness ideals associated with innocence, purity and youth, acceptance of violence in society as normative, approval of corporal punishment, and a tendency to individualize problems.

There are many risk factors suggested here to consider with child maltreatment but one aspect in particular I feel needs more exploration; violence in society as normative behaviour and domestic violence; these will follow in this literature review.

Domestic violence

In most cases of child abuse, women partner abuse precedes child abuse (Doolan, 2004; Howe, 2005). Therefore, domestic violence is pivotal to this research. Violence is frightening for children to see as it disrupts security with their attachment figures and creates psychological dilemmas for them (Ritchie &

Ritchie, 1993; Howe, 2005). Men who abuse their children generally abuse their partners (Doolan, 2004; Howe, 2005). Abused mothers are more likely to abuse their children (Fergusson et al., 2006; Graham-Bermann, 2002). The more severe the aggression, the more psychological damage to the children, therefore frequency, intensity and duration are important considerations to understand the impact on children (Doolan, 2004; Howe, 2005), and to reduce risk.

Research shows abused women have high levels of stress and mental health difficulties and these often lead to alcohol and substance abuse and this reduces emotional availability to their children (Doolan, 2004; Howe, 2005). Male abusers appear to have more problems with substance abuse, personality problems and conflicts with the law (Fergusson et al., 2006; Sternberg et al., 1993; Howe, 2005). Women abused by their partners suffer from depression, anxiety, low self esteem and social isolation (Doolan, 2004; Howe, 2005). These are serious risks factors for child maltreatment as discussed earlier.

Children who grow up watching and experiencing aggression develop aggressive and anxious behaviours themselves (Howe, 2005). Children learn what they see. Observing violence is internalized. Witnessing aggressive behaviour and violence provides children with the same strategies for solving problems (Ritchie & Ritchie, 1993; Howe, 2005). Children learn unequal power and do not develop balance, or learn to use reciprocal relationship strategies with their peers or in intimate relationships (Howe, 2005).

The incidence of domestic violence between parents that is witnessed by children is estimated to be between 10% and 15% (Howe, 2005). Some research suggests 45% to 70% of children exposed to domestic violence also experience physical abuse (Howe, 2005). It is this group of children who suffer the highest level of maladjustment and psychopathology (Sternberg et al., 1993).

There is evidence to suggest that there are increased rates of neglect and psychological maltreatment for children where there is domestic violence (Ritchie & Ritchie, 1993; Howe, 2005). The relationship between domestic violence and

child maltreatment is well known by researchers (Ritchie & Ritchie, 1993; Fergusson et al., 2008; James, 1994).

2.11 Response

Child Youth and Family Services

The Child Youth and Family Services website informs us they are the New Zealand government agency that handles child maltreatment issues (CYFS, nd). CYFS are responsible for managing children and families once maltreatment has been verified through CYFS managed processes (CYFS, nd). Social service agencies work with families at risk to prevent possible maltreatment through the provision of programmes. Some suggest that just reporting suspected cases of maltreatment are not working, what is needed is early intervention with community based preventative services (NZ Council of Christian Services (nd). I would agree. Fortunately that is what the Family Start programme intends (Ministry of Social Development, 2008).

Of the children known to CYFS because of physical abuse, Doolan (2004) informs us, that one third of these children who die, die during the investigation and assessment stages. Two thirds of the children who die as a result of physical abuse and who are known to CYFS die following the decision making and intervention stages (Doolan, 2004). No children died who was part of Family Group Conferencing during this same period between 1996 and 2000 (Doolan, 2004). Reasons given were practice errors (Doolan, 2004). These errors include: poor preparation and planning for an investigation, a failure to consult and use case conferencing, poor information gathering and risk assessment and dangerous decision making (Doolan, 2004). These findings are important to this discussion because Family Start service providers are ideally positioned to work collaboratively with families at risk and with CYFS.

2.12 Policy

New Zealand has a set of laws designed to protect children and families from violence and abuse. These laws are designed to protect victims of domestic violence, address day to day care of children, and prevent the removal of children from New Zealand when care arrangements are not secured and to protect children involved with adoption application. The Children's and Young Person's and their Families Act 1999 covers and includes several other pieces of legislation (The Children's and Young Person's and their Families Act 1999). Those related to this discussion are the Children, Young Persons and their Families Act 1989 and the Care of Children Act 1998.

The Child Youth and Family Act 1989 covers a wide range of issues related to family care, protection, custody rights, adoption and visitation, and care placements. It also covers assessments on caregivers and organizations that are involved with children in these issues (The Child Youth and Family Act 1989 s 396 – s 409).

The purpose of the Care of Children Act 2004 is to promote the welfare and best interests of children and to facilitate their development by ensuring appropriate guardianship and care arrangements are in place (Care of Children Act 2004 s 13 – s 149).

In New Zealand there has been a lot of work around family violence, Māori family violence and strategic planning towards addressing the issues of family violence through preventive programmes and policy.

Te Rito: the New Zealand Family Violence Prevention Strategy has five key goals to create a violence free society in New Zealand. These are: to bring about change in attitudes by encouraging zero tolerance to violence; create an effective coordinated response to family violence through quality service; prevent family violence through education, support and early detection; ensure service delivery in family violence prevention is culturally relevant; and, to create consistency and

commitment to family violence prevention (Ministry of Social Development (2002).

In the past, service delivery has not been culturally relevant to Māori (Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare, 1986). *Puao-te-ata-tu=Daybreak* (Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare, 1986) has provided important considerations for Māori to assist improve service delivery in the social service. In 1995, a report was commissioned by Te Puni Kōkiri to explore Māori violence, the contributing factors, social impact on families and traditional approaches to address Māori family violence (Balzer, Haimona, Henare & Matchitt, 1997).

2.13 Prevention

Some have suggested that Māori violence is a learned behaviour (Kruger, Pitman, Grennell, McDonal, Mariu, Pōmare, Mita, Maihi & Lawson- Teaho, 2004). This suggests that learning new ideas would address violent behaviours. This does not address the contextual circumstances such as poverty, substance abuse, mental illness, stress and unemployment. Prevention is aimed at addressing contextual issues as well as attitudes and behaviours (Te Puni Kōkiri, 2000).

The purpose of providing programmes to families experiencing challenging life circumstances is primarily to reduce risk of child maltreatment (Te Puni Kōkiri, 2000). The former chief social worker, Mike Doolan, and New Zealand's current CYFS chief social worker Marie Connolly have made suggestions on preventing child maltreatment (Connolly & Doolan, 2007). Doolan and Connolly suggest that CYFS social workers are too quick to remove children at risk for maltreatment due to a fear of being blamed should abuse occur (Connolly & Doolan, 2007). In their research on child deaths due to maltreatment, statistics and individual causes are discussed and wider contextual factors are explored. They propose changes to the child protection system in New Zealand and suggest breaking intergenerational cycles of child maltreatment by addressing the risk factors for child maltreatment such as socioeconomic status and cultural and gender

behaviours which are wider contextual factors affecting families (Connolly & Doolan, 2007).

Ministries and Agencies

The Ministry of Social Development is the umbrella ministry for Child Youth and Family Services who are responsible to ensure safety for children and there are several other agencies within the ministry that aim to assist families and their children (Ministry of Social Development, 2008). These are Work and Income New Zealand, Working for Families, and Family and Community Services. Family and Community Services provide assistance through the Preventing Family Violence strategy, Strategies with Kids, Information for Parents (SKIP) and Strengthening Families and the Family Start programme (Ministry of Social Development, 2008).

Preventative Programme

Overholser and Fisher (2009) explain the purpose of social interventions as providing social support and involvement with agencies to confront social problems that include limited finances, unemployment and housing problems. The intention of multi level interventions is to provide change at multiple social levels in the hope that effects at each level will forge links and this will facilitate the desired change (Schensul, 2009).

The Strengthening Families programme was piloted in 1996 and sought to deal with the high and multifaceted needs of families in New Zealand who experience challenges in their circumstances (Family & Community Services, 2006). The aim was to develop the social, emotional and physical wellbeing of children and young people in families using a strength based approach (Family & Community Services, 2006). Strengthening families is a community based initiative that assists families to access services provided by government agencies. Strengthening families is supported by ACC, CYFS, the Department of Corrections, Internal Affairs, District Health Boards in each region, Housing New Zealand, Inland Revenue Department, the Ministries of Education, Health, Justice Social Development and the New Zealand Police (Family & Community Services,

2006). The aim is for agencies and families to work together to develop plans that reflect the needs of the family. The goal is to shift from crisis intervention to providing families with early support (Family & Community Services, 2006).

The Early Start programme was developed from the Christchurch Health and Development Study with a group of Christchurch providers (Fergusson, Horwood, Ridder, & Grant, 2005). The aim was to improve children's health, reduce child abuse, improve parenting skills, support the physical and mental health of parents, encourage economic and material well being and encourage stable positive relationships (Fergusson, et al., 2005). This sounds a big ask. The philosophy of the Early Start programme is:

To build collaborative, trusting and problem-solving partnerships between clients and family support workers to build on strengths and eliminate deficits to maximize the health and well being of children and their families (Fergusson, et al., p. 1, 2005).

Funding was provided by the Family Start initiative (Fergusson, et al., 2005). Recruitment of clients was done by Plunket nurses in the urban area of Christchurch (Fergusson, et al., 2005). Support staff was selected to become family mentors, preferably with nursing or social work training, awareness and understanding of Māori practices and the Treaty of Waitangi (Fergusson, et al., 2005). The Christchurch Health and Development Study provided much of the information and data that has contributed to the development of the family intervention programme including the Early Start and Family Start programmes used in New Zealand. Early Start is modeled on the Hawaii Healthy Start programme. This is the programme Paula Bennett mentions recently, as needing evaluation to see if delivery is as planned (Laxon, 2009). One of the problems I see with the Early Start programme pilot influencing the Family Start programme, is statistically there are less Māori living in the urban area of Christchurch than the average of New Zealand. Māori represent 8% of the Christchurch population (Christchurch City Council, nd). The Early Start evaluation mentioned 25% to 30% of participants identified themselves as Māori (Fergusson, et al., 2005). The Family Start programme is directly aimed predominately at Māori because the

15% of the population who experience the most challenges in New Zealand are Māori. The implication of piloting a programme with predominately non Māori and delivering to Māori assumes these cultures would be the same. In practice programme service delivery would vary depending on the cultural manner in which it is provided. Another issue is to find people who are suitably trained in nursing and social work, who are a cultural fit with the target population. Early discussion showed that Māori trained mostly up to diploma and certificate level, and were under represented in the national statistics, therefore it is likely that few Māori support workers would be available who fit this criteria. This did not appear to be a problem in the Christchurch pilot because I presume service delivery was mostly by non Māori and not culturally relevant to Māori.

The Family Start Programme

The Family Start programme has evolved from the Early Start programme and is a community based service that intends to foster improvements for families in challenging situations (Bromley, nd). Early Start was developed to reduce child maltreatment through education to reduce the use of severe punishment by parents, increasing the awareness of child maltreatment issues with parents and to reduce agency involvement (Fergusson, Horwood & Ridder, 2005). Findings suggest that family support services were most effective in assisting mothers to acquire new skills in childrearing but less effective in addressing lifestyle issues such as substance abuse, relationship problems and getting household resources (Fergusson et al., 2005). The Early Start programme was set up for mainstream populations and was offered to both Māori and non Māori. The findings showed that outcomes for Māori and non Māori were slightly different. I mention Māori and non Māori service delivery and outcomes because, statistically, Māori are more likely to have poorer outcomes.

Established in 1998, the Family Start programme provides home based services that are modeled on the philosophy of the Early Start programme, that encourages strong interpersonal relationships between the support worker (kaimahi) and client are desired (Ministry of Social Development, 2008).

The Family Start programme aims to be:

...an early intervention, preventative, home-based service for families facing challenges in the areas of health, welfare or education. This aims to improve and add to strengths that already exist within families and is delivered to families in a way that respects cultural needs and values, is child-centered, family focused and strength based (Ministry of Social Development, p.6, 2008).

Here the philosophy is very similar to the Early Start programme. The Family Start programme is the New Zealand government's current intervention to address the social, educational and health disparities for children under six in New Zealand (Ministry of Social Development, 2008). Born to Learn/Ahuru Mōwai is the parent/child education package that is modeled on the Parents as First Teachers (PAFT) programme and is delivered as part of the Family Start programme. Neuroscience is a major educational focus for the Born to Learn/Ahuru Mōwai programme (Ministry of Social Development, 2008). This supports educating parents about child development and realistic age appropriate expectations. Health checks for the child involve regular well child checks and immunizations according to the national health schedule (Ministry of Social Development, 2008). Observing and recording developmental milestones provides an opportunity for the early detection of delays and therefore early intervention. Regular health checks, monitoring developmental milestones and managing immunization records, has been targeted as a method to address the inequalities identified in the health statistics (Ministry of Health, 2005). Regular health checks are an opportunity for children possibly at risk for maltreatment to have physical examinations by health professionals who are trained to recognize signs for concerns (Maxwell, Barthauer & Julian, 2000). Assessments are made of the family to determine service delivery levels and to gather data about the issues to be addressed throughout engagement on the programme. These strengths and needs assessments are expected to be done at 6 monthly intervals. Individual family plans are 3 monthly goal setting tools used as a contract made between the client and support worker (kaimahi) to plan and manage change (Ministry of Social Development, 2008). Measures of progress are meant to be recorded in

these individual family plans, dated and used to contribute to the graduation from high, medium and low service delivery levels as clients proceed through the Family Start programme (Ministry of Social Development, 2008). These recorded changes contribute to the graduation eventually from the programme and provide evidence for evaluation (Ministry of Social Development, 2008)

This study is interested in the service delivery of the Family Start programme at Te Taiwhenua o Heretaunga. I intend to provide some background to social service delivery generally and about the agencies who are intended to work together to achieve programme delivery. This will provide a contextual view for Te Taiwhenua o Heretaunga as a service provider of the Family Start programme.

2.14 Collaboration

The Department of Social Welfare Act in 1971 speaks about relationships in social service delivery in Section (4 (2) (d)):

The Department shall maintain close liaison with and encourage cooperation among any organizations and individuals (including Departments of State and other agents of the Crown) engaged in social welfare activities (Social Advisory Council, p.97, 1986).

Social services were not meeting the needs of Māori in early social service delivery and did not consider Māori in programme development (Te Puni Kōkiri, 2000). The wording used in the Social Welfare Act 1971 appears to show a desire to have those other than the Crown encouraged to cooperate. This indicates that collaboration at that time was crown directed. This part of the literature review is interested in finding out if this has changed.

That early research indicated that there was a partnership in social service, (Social Advisory Council, 1986). I see there was a huge difference between government and non government agencies in 1986, due to their funding base, their philosophies and the ways they operate in the world. The partnership mentioned in the Department of Social Welfare research was unequal (Social Advisory

Council, 1986). Partnership for Māori relates to the second article of the Treaty of Waitangi and along with self determination and empowerment are Māori desires for self governance (Waitangi Tribunal, nd).

Self determination and empowerment for Māori in the social services has been a long challenge since the early work of the Māori Advisory Committee when the Department of Social Welfare were presented with Puao-Te Ata-Tu in 1986. The widening disparity between ethnic groups in New Zealand, and particularly, the poor outcomes for Māori have long been recognized (Ministry of Health, 2005). The desire to work collaboratively to address the issue of disparity between Māori and the Crown has a long history (Orange, 1989). The early English version of the Treaty of Waitangi, article one, ceded governance to the crown, and this was not what Māori intended to agree to (Waitangi Tribunal, nd).

In the late 1980s New Zealand went through major changes in public management and services were redistributed among government and Non Government Organizations (NGO) (High and Complex Needs Unit, 2007). Te Taiwhenua o Heretaunga is an NGO. According to Mick Brown (the former Principal Youth Court Judge), in his review of the Department of Child Youth and Family Services (2000), fragmentation in the social service sector was a result of non statutory agencies needing to tender competitively for limited funding (cited in High and Complex Needs Unit, 2007).

One of the first interagency initiatives introduced to address fragmentation in the social services was the Strengthening Families Strategy (1997) (High and Complex Needs Unit, 2007). In 2004, Family and Community Services (FACS) were established in the Ministry of Social Development (High and Complex Needs Unit, 2007). FACS is responsible for the coordination and the implementation of programmes that build family capacity and development and the programmes that are designed to prevent family violence including the Family Start programme (Ministry of Social Development, 2008).

Ongoing problems concerning coordination and cooperation were particularly evident in social services in the past due to the frequent changes within

government agencies and mismatched regional boundaries for different government departments (High and Complex Needs Unit, 2007). The Māori Advisory Committee produced *Puao-Te Ata-Tu in 1986*. This provided information about Māori views and the lack of consideration given by social service delivery up to this time and the impact the lack of cultural sensitivity had on Māori outcomes (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1986).

More recent literature (2007) notes that there has been a prolific growth in collaborative activity in New Zealand and this has been particularly visible in the social sector (High and Complex Needs Unit, 2007). In general terms, collaboration in this context is between government agencies and NGOs, with CYFS identified as the lead agency (High and Complex Needs Unit, 2007).

Interagency collaboration in New Zealand recognizes the central position of the Treaty of Waitangi and the increasing partnership between Māori and the Crown (Waitangi Tribunal, nd). The development of services for Māori is currently informed by projects like the Early Start programme and is based on predominately non Māori populations. Although social services have been devolved to Māori, programmes and funding continue to be Crown managed and evaluated. Māori agents suggest that the needs and priorities of Māori communities have not informed the service delivery contracting process and to achieve this CYFS will need to make some significant changes to their consultative and regional services planning processes (Te Puni Kōkiri, 2000). The position of Māori in the social service delivery is the focus of this research.

The Treaty of Waitangi as one driver for the collaboration between government organizations and Māori and suggests another has come from concerns about effective service delivery to Māori (High and Complex Needs Unit, 2007). Among the purposes this literature identifies for the partnership between Māori and the Crown is the building of capacity of government agencies and Māori organizations to deliver responsive services and to create appropriate decision making, governance, monitoring and evaluation processes (High and Complex

Needs Unit, 2007). I see empowerment evaluations are well suited to assist Māori participation in the evaluation process.

Networking, collaboration and relationship building appear to be fundamental to Māori and I see this as a quality that kaupapa services offer interagency collaboration. The desire to build partnerships between government agencies and whānau, hapū, iwi and Māori organizations and communities is clearly set out in integrated service delivery documents (Ministry of Social Development, 2003). I consider Te Taiwhenua o Heretaunga is well positioned to achieve a significant portion of the network building and community involvement needed to assist with collaboration. Te Taiwhenua o Heretaunga works from a community informed approach (Te Taiwhenua o Heretaunga, 2005).

Only one family in five where a child homicide has happened had previous contact with CYFS (Saunders, 2006). Building cross sector capacity and providing a coordinated response has the potential to strengthen families who are vulnerable. Saunders (2006) is of the view that government and community agencies need to work together to reduce child maltreatment in New Zealand. Her report shows the child deaths from maltreatment occur predominately in the context of poverty, psychological stress and limited support and providing the right support for families at the right time could make a huge difference (Saunders, 2006). The Family Start programme appears suited to do this.

There has been an increase in evidence supporting interventions in child welfare, but there is limited evidenced based research in service delivery (McBeath et al., 2009). This empowerment evaluation considers the service delivery as the main focus. I see service delivery evaluations as part of encouraging efficacy of the Family Start programme, and assessing outcomes should come after proper service delivery is achieved.

2.15 Service Delivery

Inequalities between Māori and non Māori health have been well documented in New Zealand (Ministry of Health, 2002; Ministry of Health, 2005).

Service delivery needs to be considerate and inclusive of Māori values and aspirations to meet the goals of programmes targeting Māori populations. It is recognized that Māori providers have key roles in improving access to, and the effective development and uptake of, services by Māori (Ministry of Health, 2002). There are initiatives designed to increase Māori work force development in the Family Start programme delivery. The government is offering 85 study awards in 2010, towards degree qualifications for people working for NGOs who deliver programmes such as a Family Start programme (Family & Community Services, nd). The website shows the number of study awards has increased as the Family Start programme has grown and each study award has a maximum of \$32, 750 per award available to recipients (Family & Community Services, nd).

Māori development in health has been concisely described as building the capacity of Māori participation at all levels, to enable Māori communities to identify and provide for their own health needs (Ministry of Health, 2002). Some Māori providers feel they are expected to meet higher quality standards than other groups and there is a desire to provide evidence for this through research and the dissemination of information (Ministry of Health, 2002).

Progress according to a notable New Zealand academic is the extent to which Māori knowledge is included in the ways we describe and talk about health generally (Durie, 2009). Another measure of progress reflects the change in the Māori health workforce. In 1984 there was one Māori health provider and by 2009 there were more than 270 delivering a wide range of programmes (Durie, 2009).

Te Taiwhenua o Heretaunga is one of the Māori health providers mentioned by Dr. Mason Durie. Māori organizations such as Te Taiwhenua o Heretaunga are essentially agents of the Crown to deliver Crown initiatives. In June 2000, Steve Maharey, then the Minister of Social Services and Employment, Associate

Minister of Education (Tertiary Education), and Minister for the Community and Voluntary Sector, spoke of the governments investment of \$3.1million in the new Family Start programme launched in Hastings (Maharey Office, 2000). In his address at the Beehive in June 2000, Steve Maharey mentions the limitations to programmes developed by the Crown for Māori following a visit to Te Taiwhenua o Heretaunga Family Start. He acknowledged that in time a return of this power to local people was desired. I am interested to explore the service delivery process to inform and enhance the intentions of the Family Start programme through this empowerment evaluation. I intend to explore cultural relevance in the service delivery as well.

2.16 Te Taiwhenua o Heretaunga Family Start

Te Taiwhenua o Heretaunga is an agency to deliver the programmes developed and funded by the government. Te Taiwhenua o Heretaunga are kaupapa service providers of the Family Start programme delivered in parts of Hastings and Flaxmere. This community trust organization evolved from the Tautoko Wahine Trust in 1988 to finally become Te Taiwhenua o Heretaunga in June 2007 (Apatu, 2008). I see Te Taiwhenua o Heretaunga as a positive driver for self determination for Māori in Heretaunga and feel this is evidenced in practice and is supported in its philosophy.

The purpose of this organization is clearly explained in the following moemoea or vision statement.

To have healthy vibrant whānau who have access to choice and opportunity, are living throughout our rohe in healthy and safe environments, feel a strong sense of identity, connection and community, are equipped to lead prosperous and productive lives, are proud of and enriched by their culture, and are in control of their lives (Te Taiwhenua o Heretaunga, p.1, 2005).

I think this vision statement promotes self determination among the people of Te Taiwhenua o Heretaunga. Self determination is supported by community

psychology ideals for people to participate in their own journey to health and well being (Nelson & Prilleltensky, 2005).

2.17 Summary

This literature review has discussed child maltreatment by providing generic definitions as well as specific definitions of physical, sexual, emotional abuse and neglect. Prevalence, risk factors and adult demographic characteristics of abusers have been discussed. Domestic violence and partner abuse have been discussed to illustrate the co-existence, impact and the influence of these on child maltreatment. Response to child maltreatment in New Zealand is managed by CYFS. Policies and programme are mostly mono culturally informed and developed. The Family Start programme was piloted in a predominately non Māori community. Collaboration has been discussed in relation to social service delivery in New Zealand. CYFS has authority in investigating, establishing and managing child maltreatment cases. Māori have struggled to be equal participants in social service delivery methods. The work of the Māori Advisory Committee in 1986 highlighted a need for change. Delivery of preventative programmes like the Family Start programme is generally provided by non government organizations made up of iwi providers and social service groups and this current initiative appears to be well funded.

The Family Start programme is a current government initiative implemented in New Zealand to address our high child maltreatment statistics. The kaupapa service provider Te Taiwhenua o Heretaunga is the Family Start provider evaluated in this research. Te Taiwhenua o Heretaunga Family Start provide their service to families other than Māori including Pacific Island, European New Zealanders and migrant families.

It is important that Māori work with Māori to provide service delivery of the Family Start programme because the intended recipients are likely to be Māori also. The Family Start programme has been discussed and appears to be suited to address the risks for child maltreatment. I have explained interagency roles in social service delivery and discussed the need for agencies to work together in

social service delivery. The literature review provides evidence to support this research. I intend to use an empowerment evaluation to explore current service delivery at Te Taiwhenua o Heretaunga to see if service delivery is done as intended.

3.1 Introduction

I begin the methodology section by providing a definition of community psychology, and then describe the principles, values of community psychology and explain empirical research and the ecological model (Nelson & Prilleltensky, 2005). I discuss the research design and explain the empowerment evaluation used in this research. Qualitative, quantitative and archival data are discussed followed by the methods used in this research. I describe the questionnaires and how they were developed and discuss ethical issues before outlining the consultation process. I introduce the research participants and describe how I gained informed consent, confidentiality, data collection, data storage and limitations to this research.

3.2 Community Psychology

Community psychology is premised on an ecological framework that identifies three interacting levels of society: macro (policy and regulatory institutions), meso (organizations and agencies with resources and power) and micro (individuals, families and friends living in communities) (Schensul, 2009).

Community psychology is underpinned by the values of social justice, health promotion and prevention, respect for diversity, caring, compassion and community, self determination and empowerment (Murray, Nelson, Poland, Maticka-Tyndale & Ferris, 2004). In community psychology research is generally community based action research and is value driven, attuned to power issues, committed to stakeholder participation and is action oriented (Nelson, Poland, Murray & Maticka-Tyndale, 2004). The aim of community psychology is to extend our understanding of the aetiology of health issues and to be active in improving life circumstances (Murray et al., 2004). As mentioned earlier, child

maltreatment is a social concern and a health problem in New Zealand. There are disparities in health outcomes and Māori on average are overly represented in statistics for poorer outcomes (Ministry of Health, 2002). Health disparities and power challenges affecting Māori are important community psychology issues that are related to ethnicity and deprivation in New Zealand. Community psychology can be defined as follows:

Community psychology concerns the relationships of individuals with communities and societies. By integrating research with action, it seeks to understand and enhance quality of life for individuals, communities, and societies. Community psychology is guided by its core values of individual and family wellness, sense of community, respect for human diversity, social justice, citizen participation, collaboration and community strengths, and empirical grounding (Dalton, Elias & Wandersman, p.15, 2007).

I have purposefully included this very long definition of community psychology because I want to make my position very clear about this research. The intention of this empowerment evaluation is to provide evidence to inform Te Taiwhenua o Heretaunga and other providers about improving the delivery of the Family Start programme while balancing accountability to programme evaluators and funders. Evaluating the programme is not my intention nor is considering effectiveness and outcomes from engagement in the Family Start programme. These would be very worthy research ideas in the future but my focus in this thesis is to explore service delivery aspects to ensure that the Family Start programme is given the best possible chance to do the task it is intended for, to reduce risk for child maltreatment in New Zealand.

3.21 Principles and values

The seven core values mentioned by Dalton et al., (2007) of community psychology are important in this research. Individual and family wellness from a community psychology perspective focus on the prevention of maladaptive behaviours, personal and family problems and illness, promoting health and providing support and social networks (Dalton et al., 2007). The maladaptive

behaviour that is the focus of this thesis is child maltreatment. Family violence is a family problem in many cases and the many risk factors discussed in the literature review are the individual, community and societal concerns. I discuss each of these values next.

3.22 Indigenous voices

A sense of community is a community psychology value and this refers to a sense of belonging, interdependence and support (Dalton et al., 2007). Colonization has disrupted Māori society (Orange, 1989), and many are working very hard to regain Māori cultural values and sustainability of these in the wider New Zealand society (Durie, 2009). Empowering Māori to improve the delivery of the Family Start programme will have the effect of supporting Māori community development and social capacity building.

3.23 Diversity

Respect for human diversity recognizes and understands the traditions and ways of any culture that provide distinctive strengths and resources for living (Dalton et al., 2007). Respect for Māori tradition, language and cultural norms are highly valued by Pakeha as well as Māori. Community psychology supports indigenous participation in community development (Nelson & Prilleltensky, 2005). I support Te Taiwhenua o Heretaunga's efforts to provide the best service delivery of the Family Start programme to address risk factors for child maltreatment while maintaining kaupapa values and practices.

3.24 Social justice

Social justice is the fair and equitable allocation of resources, opportunities, obligations and power in a society (Dalton et al., 2007). Social justice concerns distributive and procedural justice (Dalton et al., 2007). Distributive justice is basically about the fair distribution of resources. Procedural justice is about planning and distribution and collective decision making (Dalton et al., 2007). CYFS are the authority on child maltreatment issues in New Zealand but lack a solid foundation of indigenous history to inform decisions. Social justice is important to the discussion and research about child maltreatment in New Zealand

because Māori are over represented in statistics for health disparities and poor outcomes and have an unequal say in the distribution of health resources and programme development. Therefore the value, of social justice, is relevant to this research about improving service delivery by Māori for Māori.

3.25 Participation

Citizen participation is the value that allows all members of a community to be involved in decision making processes (Dalton et al., 2007). The value of participation suggests the clients, support workers (kaimahi), Te Taiwhenua o Heretaunga, other Family Start providers, Ministry of Social Development and CYFS are equally important in the Family Start service delivery process to reduce risks for child maltreatment.

3.26 Collaboration

Collaboration is the value of community psychology that involves the relationships between the people involved in a community and the processes of the work (Dalton et al., 2007). Collaboration is most important in this research because working together proactively to get the best out of the Family Start programme for all key agents is the preferred focus in service delivery.

3.27 Empirical research

Finally, the value of empirical grounding refers to integrating research with community action and uses both quantitative and qualitative research methods (Dalton et al., 2007). Research is not value free because we are all influenced by our cultural assumptions, context and ideas. Quantitative data alone will not assist us to understand and improve service delivery of the Family Start programme. No matter how good or bad the programme is, without consideration of the values and qualities of the people involved in the process of service delivery, exploring service delivery for the reduction of risk factors would be limited to counting the number of people through the Family Start programme. Qualitative data allows indigenous views to be expressed and sharing these views assists to validate meaning for Māori ways of being. This is important as Te Taiwhenua o

Heretaunga are a kaupapa provider of Family Start and there is little research evidence about culturally relevant service delivery.

3.28 Ecological Model

The intention of multi level interventions is to provide change efforts at multiple social levels in the hope that effects at each level will forge synergistic links and this will facilitate the desired change (Schensul, 2009).

Community psychology offers a framework to identify and consider different societal levels through the ecological model. The societal levels (macro, meso and micro) are linked and each is interrelated in the change process (Overholser & Fisher, 2009). Government policy is informed by individuals and communities. Agencies including CYFS and social service providers are dependent on funding in different ways. Programmes are government developed and funded for delivery. Individuals and communities are reliant on agencies for work and intervention and service delivery is influenced by the agencies providing the programme.

3.29 Research Design

The goal of community psychology research is to construct knowledge that challenges the societal status quo (Nelson & Prilleltensky, 2005). The aim is to collaborate with oppressed groups of people to promote well being and liberation (Nelson & Prilleltensky, 2005). My intention is not to find fault but to show the strengths that are inherent when Māori work with other Māori to provide the delivery of a service to prevent child maltreatment and improve health and social outcomes in general.

The three paradigms of community research are post-positivist, constructivist and the critical paradigms (Nelson & Prilleltensky, 2005). The critical paradigm best suits the purpose of this research because I am exploring how well service delivery actually meets the Ministry of Social Development expectations and any findings will either support or challenge that status quo. The post-positivist view is a school of thought that values qualitative over quantitative research (Crotty, 1998). The constructivist view of gaining knowledge suggests this comes from

people's experiences (Crotty, 1998). Critical theory in literature (hermeneutics) suggests that knowledge is gained through the critical interpretation of the written language (Crotty, 1998). Critical social theory is about self reflective knowledge. Critical social theory suggests knowledge comes from criticizing the values, norms and thoughts of society (Crotty, 1998). This research is an empowerment evaluation using both quantitative and qualitative methods.

3.30 Empowerment evaluation

This empowerment evaluation is intended to assist Māori to bridge the gap by providing information to improve delivery of the Family Start programme. This research looks at the service delivery to see if it is delivered as planned and to see if it is culturally relevant to the population receiving the programme as well.

I have used an empowerment evaluation as the research method for my thesis because it is designed to encourage the self determination of programme users (Dalton et al., 2007). Empowerment evaluation aims to increase a programme's success by providing stakeholders with the tools for assessing the planning, implementation and self evaluation of the programme in use as part of the planning and management of the organization (Wandersman, Snell-Johns, Lentz, Fetterman, Keener, Livet, Imm & Flaspohler, 2005). Empowerment evaluation endeavours to balance accountability with programme improvement (Fetterman & Wandersman, 2005). An empowerment evaluation uses the concepts, techniques and findings of evaluation to foster improvement and self determination (Fetterman, Kaftarian & Wandersman, 1996).

An empowerment evaluation is a tool for an organization or group to take stock of their own performance and helps to create a culture of learning and evaluation (Fetterman (2000)). The ten principles of empowerment evaluation are; improvement, community ownership, inclusion, democratic participation, social justice, community knowledge, evidence based strategies, capacity building, organizational learning and accountability (Dalton et al., 2007). I discuss these ten principles to show how these are useful for assisting Te Taiwhenua o Heretaunga

to be self determining and improve service delivery through using an empowerment evaluation.

Improvement can be achieved through information gathered about the current service delivery. Information gathered provides a snap shot in time of the performance in service delivery. This information can be measured against service delivery expectations and the findings can be used to plan improvements. The findings provide a base measure for future evaluation to map progress in service delivery performance as an ongoing process.

Community ownership is one of the values I really like about this type of evaluation. An empowerment evaluation provides internal information to be used by Te Taiwhenua o Heretaunga as they wish. Training, development and improvements can be planned and prioritized according to organizational preferences because empowerment evaluations are not commissioned for funders.

An empowerment evaluation offers Te Taiwhenua o Heretaunga ownership in managing their performance. Having an informed approach to decision making allows Te Taiwhenua o Heretaunga a say (inclusion) in when and how improvements can be made, prior to ministry audits.

I consider democratic participation can be achieved through using an empowerment evaluation because this will provide Te Taiwhenua o Heretaunga with evidence to use in negotiations with funders and programme trainers. If service delivery is found to have barriers to meeting expectations, Te Taiwhenua o Heretaunga are in a proactive position to negotiate for change.

Social justice can be supported through the use of empowerment evaluations. For instance, through close inspection of service delivery, performance and service specifications, any barriers to achieving these may be found. Sometimes it is possible that one kaimahi carries a larger load than others, or may experience challenges that are hard to bring up in discussion. Through empowerment evaluation it may be found that the same challenges are experienced by others. If the challenges are systemic they can be easily rectified and work morale uplifted.

Community knowledge is a very important aspect that an empowerment evaluation can support, I believe. Kaupapa services often deliver several or many programmes from one organization. An empowerment evaluation should highlight what an organization does well, and this information can be used to inform other programme delivery at the same site. Once an empowerment evaluation is successfully used in one programme, it may provide a template for other internal evaluations to contribute to the organization's knowledge.

An empowerment evaluation provides systematically collected information that concerns facts, times, numbers and qualities. Although open discussions at team meetings etc. may provide good feedback, at times it is the dominant voice or favourite personality who is heard. This can distract from actual improvement. Evidence based strategies used to gather performance data provides a thorough view.

Capacity building is important for the long term growth of organizations and empowerment evaluations are a great tool to achieve this. Critical reflection using an empowerment evaluation is self informing, positive and proactive learning. Regular ongoing empowerment evaluations within an organization can provide updated evidence for learning.

An empowerment evaluation is a great method for management to see who is doing what in an organization. It has been shown that NGOs have out grown the quality they started off with, when hand -picked original staff were passionate about the programme (Ministry of Social Development, 2005). Ongoing performance evaluations can contribute to organizational accountability to reduce this type of thing.

Fetterman (2002) suggests that empowerment evaluations have three stages. These are establishing a mission, taking stock and planning (Fetterman, 2002). An outline of these three stages will assist to understand how I see this research.

The mission of this research is to improve service delivery by exploring current service delivery, with the idea that optimal service delivery will give the Family Start programme the best chance to reduce child maltreatment. Taking stock means gathering data from Te Taiwhenua o Heretaunga Family Start about current service delivery performance. Comparing these to the Ministry of Social Development's service delivery expectations, hearing kaimahi perspectives, and considering Te Taiwhenua o Heretaunga philosophies will provide a current snapshot of service delivery. Ideally client opinions would be included here. Unfortunately I was limited to the use of past annual client satisfaction surveys, so limited information was used. Planning can be based on the findings. More training was implemented soon after the findings report was given to Family Start management.

3.31 Qualitative Data

According to Highlen & Finley qualitative research from a critical perspective provides a collection of voices about the experiences of the participants (cited in Leong & Austin, 1996). Written interviews (surveys) were used to gather the qualitative data in this research and the information was interpreted like grounded theory, where common themes are looked for (Crotty, 1996). Here several perspectives were gathered mostly from kaimahi as archival data was the only data available from clients. Qualitative data came from the clients surveys and were also interpreted conceptually according to themes constructed around service delivery.

3.32 Quantitative Data

Quantitative methods are generally based on a positivist philosophy of science where data is measured, counted and used for comparison, cause and effect, frequency and testing (Dalton et al., 2007). I used quantitative data to describe the epidemiology of child maltreatment and for much of the data collection to evaluate the service delivery of the Family Start programme at Te Taiwhenua o Heretaunga.

3.33 Archival data

Archival data was used for secondary analysis for this thesis (Leong & Austin, 1996). Clients on the Family Start programme are involved in ongoing client satisfaction surveys annually with Te Taiwhenua o Heretaunga as part of the service delivery requirements. To undertake another survey and collect new data was considered by the Family Start supervisor to be unnecessary and possibly invasive.

Archival data provides information that is non reactive data because the researcher does not come into contact with the participants involved in the research (Leong & Austin, 1996). Face to face (kanohi ki te kanohi) is a preferred method when working with Māori and this was done where possible (Ngāti Kahungunu Iwi, 2002), but not with the clients because it was felt that these people are already overly inundated with agencies, processes and questioning. The clients of Te Taiwhenua o Heretaunga are considered to be the fifteen percent of the population most at risk for the maltreatment of their children and so may be wary of questions and surveys. There is a possibility that direct questioning for research could have the possible outcome of influencing the quality of the relationship between the support worker and clients and affect the quality of future service delivery. I used kaimahi client lists, needs assessments, referral criteria, and Born to Learn/Ahuru Mōwai records as the archival data collected. Archival data collection has been considered an economical way of doing research because the collection has already been done (Leong & Austin, 1996). There are advantages and disadvantages in using this method and some of these are discussed further.

Zaitzow & Fields suggest that the disadvantage of using secondary analysis is that the data is collected by someone else for different purposes (cited in Leong & Austin, 1996). This has been considered in this research; the purpose is very similar between the client satisfaction surveys and the service delivery evaluation by clients of the support workers.

The main consideration for using archival data was to minimize the impact of the questioning process and to minimize any invasive perceptions that might be

experienced by the clients. The benefits clearly outweighed any disadvantages for this research. Respect for the clients was a prime consideration in this research.

3.4 Method

The method section will start with an outline of the consultation process, followed by the method used in the research by following the service delivery process.

The method used to collect, record and to analyze data in this research was to follow the service delivery process and involved collecting data on the referral criteria, response to a referral, referrer feedback, strength and needs assessment, service delivery time, individual family plans, Born to Learn/Ahuru Mōwai, and recording of health checks. Qualitative data from the client satisfaction surveys, kaimahi and supervisor surveys were used to consider the cultural relevance of service delivery at Te Taiwhenua o Heretaunga Family Start. Data was collected from client files, the electronic data base, support workers (kaimahi) and supervisor surveys, and the client satisfaction surveys. The appendices include a letter to the Northern Ethics Committee showing support from Te Taiwhenua o Heretaunga to carry out this research (Appendix 1); a copy of the information sheet (Appendix 2); the consent forms (Appendix 3); a copy of the client satisfaction surveys used annually by Te Taiwhenua o Heretaunga (Appendix 4) and the kaimahi and supervisors questionnaires (Appendix 5).

3.5 The questionnaires

In the social sciences, surveys and questionnaires are among the most frequently used methods for research. According to Goddard & Villanova (cited in Leong & Austin, 1996) surveys and questionnaires have been described as a way of collecting information from people for descriptive and predictive purposes. A survey can be questionnaires filled out by the respondents or by an interviewer who writes down the responses given by research participants (Leong & Austin, 1996).

The client satisfaction surveys are the annual evaluation feedback used by Te Taiwhenua o Heretaunga Family Start and were not developed for this research. The kaimahi and supervisor questionnaires were developed for the ethical approval process and some changes were made as part of the ongoing negotiations.

3.6 Ethical Issues

The Family Start programme manager (kaiwhakahaere) and the department supervisor have participated in the discussions and decision making processes involved in this research to ensure that the safety of clients and kaimahi is prioritized and that the reputation of Te Taiwhenua o Heretaunga has been cared for, ethically and culturally. There is an expectation that employees act in a professional and ethical manner in accordance with Te Taiwhenua o Heretaunga's code of conduct as an example to others and to perform valued ethical behaviour (known by Ngāti Kahungunu people as nga ahua reka) (Ngāti Kahungunu Iwi Incorporated, 2002). Organizational and cultural support was provided by two staff members of Te Taiwhenua o Heretaunga and a support letter was written to support an application to the Northern Ethics Committee September 25, 2008 (Appendix 1).

Ethical approval was granted by the Research and Ethics Committee of the Department of Psychology acting under the delegated authority of The University of Waikato Human Research Review Committee on the 20th January 2009. Approval was also gained from Te Haro, the governing board of Te Taiwhenua o Heretaunga and the runanga- the representatives of the 17 marae that constitute the people that Te Taiwhenua o Heretaunga represent and provide services for.

3.7 Consultation Processes

Initial discussions were held with Te Taiwhenua o Heretaunga Family Start Manager (Kaiwhakahaere) in May, 2008 after some informal enquires to the Family Start supervisor. These discussions helped to initiate the desire of Te

Taiwhenua o Heretaunga to do their own research. The research was to be conducted according to the different research concepts identified by the Ngāti Kahungunu Iwi and documented in Te Rautaki Rangahau - Research Strategy for Ngāti Kahungunu 2026 (Ngāti Kahungunu Iwi Incorporated, 2002). These research values aim to benefit the people of Ngāti Kahungunu and the research was conducted from a Māori world view. Western ways of knowing have structured, represented and coded indigenous knowledge and thought to a degree that it becomes irrelevant whether or not indigenous people recognize themselves in this representation (Mikaere, 2003). The researcher was mindful that this research should be relevant to the people of Ngāti Kahungunu.

The thesis drafts for this research were read by a cultural consultant to ensure good cultural practice. This was to ensure that research protocols could be aligned with the cultural practices (kawa) and protocols (tikanga) of Ngāti Kahungunu iwi. This research project has been the first undertaken at Te Taiwhenua o Heretaunga so has been used to trial the research protocols that were discussed in the research strategy Te Rautaki Rangahau (Ngāti Kahungunu Iwi Incorporated, 2002). This research, therefore, has assisted Te Taiwhenua o Heretaunga to consolidate the research protocols and processes into practice for future research. The Family Start programme manager (kaiwhakahaere, and the department senior supervisor, have participated in the discussions and decision making processes involved in this research to ensure that the safety of clients and kaimahi is prioritized and that the reputation of Te Taiwhenua o Heretaunga has been cared for ethically and culturally.

This process has been ensured through the sharing of and reflection on chapter drafts, writings, questionnaires, information and consent forms. These were presented to the Family Start managers prior to inclusion to be checked for the suitability for the intended purpose of this evaluation. These drafts were then presented to the principal research supervisor Professor Jane Ritchie at the University of Waikato for feedback, consideration and confirmation.

This research is an individual endeavour. Koha was offered to the research participants after data collection was completed as a token of gratitude for the support voluntarily given to this project. Koha is a gift, present, donation or contribution. According to the University of Waikato, the giving of koha is the practice of giving a gift where the recipient does not expect this. It is an integral part of Māori culture and a significant protocol is attached to it. Traditionally, koha has taken many forms but in more recent times it has tended to be money (Director of Finances, University of Waikato, 2006).

3.8 Research Participants

The research participants are those involved in the service delivery of the Family Start programme at Te Taiwhenua o Heretaunga when this research. These key groups are the kaimahi, the two supervisors and the clients. There were 14 kaimahi (including the researcher) employed by Te Taiwhenua o Heretaunga on 20 October 2008, and one student on placement, two supervisors and an administrator, and 15 kaimahi in January 2009, two supervisors and one administrator. The researcher did not participate in the qualitative data collection done in October 2008; quantitative data from the researcher's service delivery implementation was included in the data collection. All kaimahi working at this site participated voluntarily in the research.

There were 233 active clients in the Family Start service in October 2008 and 214 in January 2009. The 87 client satisfaction surveys used were those collected in November 2007. These consisted of 87 replies from a total client pool of 192 although only 150 questionnaires were sent out. This was a decision made by the Family Start programme management team, not the researcher, and was done because those considered not likely to reply were not included in the survey to save time and resources. The administrator helped to retrieve the quantitative data for this evaluation and was given a koha (gift of money) at the same time as were the fifteen kaimahi and the two supervisors to thank them for their assistance.

3.9 Informed Consent

Information about the research (Appendix 2) was given to supervisors and kaimahi in mid October 2008 and written informed consent was collected at the time the questionnaires were given out (Appendix 3). The signed consent forms are stored with the data collected for this research.

3.10 Confidentiality

To maintain confidentiality, the data was represented collectively. There are some limitations to this as there were only two supervisors to fill in the surveys. The information collected was of a general nature and was not a concern to either participant and these limitations were discussed and made clear before the consent forms were signed.

3.11 Data Collection

Data was collected at several points in time. November 2007 client satisfactions surveys were used from stored files (Appendix 4). Kaimahi and supervisor questionnaires (Appendix 5) were carried out in October 2008 and electronic file information was collected at this time also. In January 2009 a hardcopy file collection looked at client files for each kaimahi at that time.

3.12 Data Storage

Data collected for this research remains the property of Te Taiwhenua o Heretaunga and is part of the organizations ongoing records and the data held for this research will be destroyed or given back to Te Taiwhenua o Heretaunga.

3.13 Limitations

It is important to recognize that this research is an empowerment evaluation. The purpose of considering the service delivery of the Family Start programme at this

site has been to improve service delivery practices and identify barriers that may assist.

The data is intended for this purpose only and is not intended to inform funders or programme evaluators of outcomes or programme efficacy.

Questionnaire design

The client satisfaction surveys used were designed by the management staff of Te Taiwhenua o Heretaunga Family Start before my employment at the site. The kaimahi and supervisor questionnaires were designed for the purpose of this research only.

Summary

This chapter has provided the frameworks that support the research for this thesis. The community psychology framework places indigenous people at the centre of the research focus. Community psychology values and assumptions assist to value knowledge that endeavours to rebalance societal imbalances between groups of people by offering a voice to minority groups. Māori are the group of people for whom I am providing a voice in this research.

An empowerment evaluation suits this purpose because the information collected is intended to support, improve and empower the organization rather than find fault, measured against expectations. The two frameworks of community psychology and empowerment evaluations ideally suit my intention to assist improvement of the service delivery of the Family Start programme and to provide evidence about culturally relevant service delivery. The method set out how this research was conducted.

4.1 Introduction

Demographic data from clients, kaimahi and supervisors begin the findings chapter. The nine research points- referral criteria, response, referrer feedback, strengths and needs assessments, service delivery time, individual family plans, Born to Learn/Ahuru Mōwai, health records and cultural relevance of service delivery follow. Referral criteria are the first point and several themes relating to these arose from the qualitative data collected. Qualitative findings about adversity, poverty, age, transiency and violence are shared in the referral criteria section.

Themes and discussions that concern culturally relevant service delivery ideals follow: Within this, there are findings related to the consideration of Māori and include manaaki, whakawhanaungatanga and reciprocity. The chapter concludes with a summary of the findings.

4.2 The Findings

This section begins with the demographic data of parents and clients, followed by the kaimahi and supervisors' demographic data. Each of the nine research points begins with a statement set out in a text box. This has been done to illustrate the aspect of service delivery to which the findings relate. The text box contains the Family Start Manual (2008) service delivery expectations, unless otherwise stated, that relate to the findings that follow.

Demographic data of parents and clients

The child is client in the Family Start programme and there were 233 clients in October 2008 and 214 clients on the programme in January 2009. Parents of the clients ranged in ages from 15 to 51 years, plus one grandmother of 55 years. She

was the only grandparent noted as the primary caregiver of a child. Fathers who were the primary caregivers ranged in ages from 28 to 51 years; these ten fathers were sole parents.

The average parent age was slightly over 21 years. The average age of the children on the programme was eight months and ages ranged between before birth to 71 months. The caregiver gender details recorded in hard copy files showed that there were 162 females and ten males caring for clients. Although there were 214 clients at the data collection point, there were 42 client files where no gender details were noted.

Demographic data of kaimahi and supervisors

The kaimahi and supervisors ranged in ages from 26 – 54 years of age. There were one male kaimahi and 13 females, two of European descent; two were of Pacific Island descent and the other twelve all identified as Māori. There were three kaimahi with undergraduate degrees; two of these were in social work and one was in psychology. The others either had, or were in the process of, completing undergraduate Diplomas in Social Work Practice.

Point 1: Referral criteria

The Family Start Manual says that research has shown five to six percent of children in New Zealand are in families whose circumstances put them at risk for poor health, education and social outcomes (Ministry of Social Development, p.6, 2008).

The aim of looking at the referral criteria has been to see how well the clients (parents/caregivers) relate to the issues related to risk for the maltreatment of children in their care. The issues were discussed earlier in the literature review

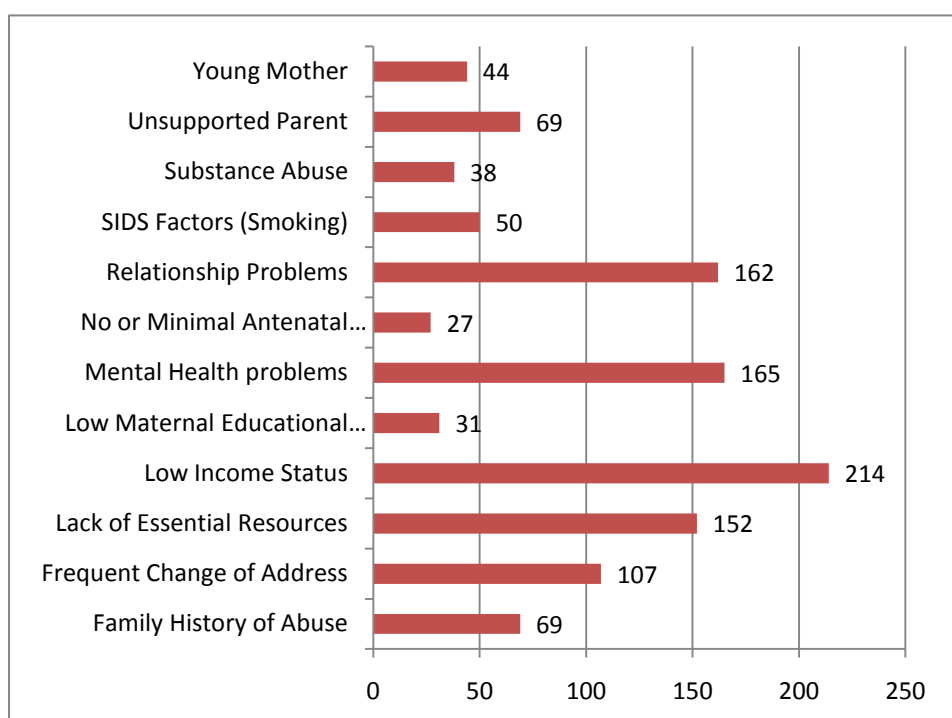
and support the criteria used in the Family Start referral process. Child Youth and Family involvement with clients was noted in 15% of those on the Family Start programme when data was collected.

The Family Start programme intends to reach 15% of all families to ensure the five to six percent most at risk for poor outcomes, which can contribute to risk for child maltreatment, are included in the service delivery (Ministry of Social Development, p.6, 2008).

The purpose of this data is to see if the Family Start programme, delivered at Te Taiwhenua o Heretaunga, is reaching the intended target population.

The data collected on referral criteria was obtained from client hardcopy files on the 7th January 2009. There were 214 clients in the service at that time.

Figure 1: Referral criteria for Te Taiwhenua o Heretaunga Family Start October 2008



These findings show that all of the families engaged in the Family Start programme at Te Taiwhenua o Heretaunga had low income status. It is no surprise to see that three quarters of these people lacked essential resources as well. Essential resources were not defined in the referral criteria. Mental health problems were the second highest referral criterion recorded, followed by relationships problems. Having a family history of abuse and frequent changes in address appeared in approximately one third of families at this time.

Poverty

While noting that the wilful murder of children spans the economic spectrum, children who live in poor families have a higher risk of fatal child maltreatment (Ministry of Social Development, p.13, 2006).

Low income and a lack of resources were common issues found in the referral criteria data collected. The term ‘lack of resources’ comes with the Family Start programme as a referral criterion but is not described in the manual specifically as what constitutes a lack of resources. So, what one person may consider is a lack of resources may not be seen as adequate by someone else. Remembering that the referral criteria are used by various agents, clients themselves and CYFS, a diverse interpretation is likely. There were around three quarters of the clients who lacked essential resources when starting on the Family Start programme at this site. Essential resources have not been defined in the service manual or by Te Taiwhenua o Heretaunga Family Start so this will vary. Low income was universal among the client group as well. Understanding issues related to poverty assists service delivery and this was shared by kaimahi during this research. I will illustrate these points with quotes collected from kaimahi as part of the surveys for this research.

Most kaimahi I have worked with have similar life experiences.

Some of our whānau live in the low socioeconomic bracket, where poverty restrains their lives, so we can understand what kind of life they lead.

One kaimahi mentioned poverty in her own upbringing and she indicated that having good support mitigated some of the effects of poverty. The statement here shows how understanding the culture of poverty assists kaimahi with service delivery by providing understanding and empathy. One kaimahi said:

I remember having holey shoes that my father tried to repair with cardboard. The difference is we had good support unlike our families (those on the Family Start programme).

Poverty, low income and a lack of resources affected nearly all the families in this study.

Adversity

Analysis of the literature was used to suggest how adversity could transfer between childhood and adulthood – noting that this does not always happen (Ministry of Social Development, p. vi, 2006).

Due to a lack of access to clients to explore their experiences of adversity, I used those shared by kaimahi as this showed empathy and understanding for hardship. I felt empathy and understanding of the circumstances of clients added positively to how kaimahi worked with clients. Some kaimahi related how living through their own challenges positively positioned them to understand and work to empower and encourage others in similar circumstances.

Loss, grief, health and financial challenges, if you can work through things no matter how great they may seem you can overcome anything. These

things can't be learnt through books. Through adversity you become stronger, more understanding, have empathy, are more appreciative and can help others who are hurting, which in turn helps you.

Most kaimahi recognized the challenge they faced with some families and enjoyed the challenge to help them gain some control in their lives.

I feel that we are working at the harder end of the community and I enjoy the challenge of being able to walk beside people that at times need a hand to live their lives rather than spend their whole lives reacting to life.

Adversity concerns income and the availability of money as well as resources. Financial challenges appear to be common among single parent families. One kaimahi related her experience of this in the surveys. She showed how living through being single with a family affected her and showed that discrimination and systemic challenges accompanied financial problems as well.

Raising three children on the DPB (domestic purposes benefit) for four years gave me some insight into WINZ systems, pressures and the discrimination that beneficiaries face.

Experiencing adversity appeared in the findings to assist service delivery through empathic understanding of client contexts and circumstances.

Age

Becoming a parent at a young age increases the risk of fatal child maltreatment (Ministry of Social Development, p.13, 2006).

Low maternal age and few or no qualifications are referral criteria for the Family Start programme as well. Low maternal age involved 44 of the mothers at the time of data collection at Te Taiwhenua o Heretaunga Family Start. For the population that the Family Start programme targets, the seemingly low number of young mothers on the programme is mitigated by Te Taiwhenua o Heretaunga running a Teen Parenting service as well. Most teenage mothers graduate to the Family Start programme at around 19 years. The Teen Parent programme has young mothers from 12 years on.

Transiency

Frequent changes of address by parents/caregivers concerned change in address more than twice in the last twelve months. This is referral criteria 10 (Ministry of Social Development, p.36, 2008)

Frequent changes in address were recorded for half those on the Family Start programme at Te Taiwhenua o Heretaunga when the data was collected. During my time as a kaimahi, I had one client who moved 5 times in 5 months, so the explanation does not capture the full picture. This criterion is important to reduce risk for child maltreatment and is related to the third point in this research, referrer feedback.

Violence

The relationship between family violence and fatal child maltreatment, according to the Dunedin study, showed women who became mothers before 21 were twice as likely to have been victims of family violence than those without children at this age and men who fathered children by 21 were more than three times as likely to be perpetrators of partner abuse as men who were not fathers by age 21, and the most violent relationships occurred among young parents (Ministry of Social Development, p.14, 2006).

There were interesting findings from kaimahi. I used kaimahi opinions because they were added into the kaimahi surveys and I was not able to get this data from clients. Kaimahi who had lived in violent situations either as partners or as children shared their opinions. This shows that not everyone growing up in the context of violence becomes violent or accepts this behaviour. Knowing about violence did appear to support service delivery of the Family Start programme.

Kaimahi showed empathy, understanding and non judgmental attitudes. Kaimahi expressed understanding of people living in violent situations and accepted that time was important to support change.

Having been in a violent relationship myself helps because I understand them (mothers). They don't have to stay in any situation if they no longer desire to stay there. That if life needs to change in order to keep you and your children safe then with support through the processes they can make change at their own pace.

Understanding how changing from a violent situation is difficult for some. To be able to make changes can take time and a readiness for some people as evidenced here.

I was in a violent relationship I finally worked up the courage to leave him and like a lot of my clients; I used the same excuses when I took him back every time.

There was one kaimahi response that took a zero tolerance stance on the subject of domestic violence.

Having grown up in a home where domestic violence happened frequently, made me determined that I was never going to have any of that in my own home and never expose my children to that kind of abuse ever.

There was no factual data collected on violence just these qualitative accounts by kaimahi. It is unknown exactly how many parents in this client group have abuse or maltreatment histories but the high incidence of mental health problems and some substance abuse suggest there may be more than what appear in the referral data. It is possible that non disclosure has occurred.

Mental health problems

Having mental health problems and relationship issues featured in approximately one third of all referral cases at Te Taiwhenua o Heretaunga Family Start. Mental health problems and substance abuse appear to have some coexistence. However, substance abuse did not appear to be high among the population of this study although mental health problems did.

There is a possibility that substance abuse was more likely to be recorded in the referral criteria as mental health problems due to the legal consequence of drug taking behaviours and a possible perceived risk of being reported.

Point 2: Response

There is a service delivery intention where the first visit from a supervisor is expected within five working days following receipt of a referral (Ministry of Social Development, p.13, 2008).

Quick responsiveness is a service delivery ideal of the Family Start programme (Ministry of Social Development, 2008). This was measured by collecting data that looked at the time between a referral coming in and the first contact made by a supervisor.

The individual hardcopy files showed the time between the referral date to the initial contact date for each file ranged between one and four days at Te Taiwhenua o Heretaunga Family Start over the last year.

Client satisfaction feedback showed 81 of the 87 respondents felt they had been contacted promptly after the referral and these respondents were happy they had been given adequate information about the Family Start programme at the beginning. Most of the feedback was positive.

Seventy seven of the 87 respondents said they were happy with the amount of information they received about the service, including information provided about client rights and obligations.

Responsiveness in this part of the research relates only to the initial visit made to a client following a referral and does not refer to kaimahi responsiveness to clients.

Point 3: Referrer feedback

The Family Start provider is expected to confirm and notify a referrer of either acceptance or decline of a referral onto the Family Start programme (Ministry of Social Development, p. 14, 2008).

Referrer feedback was investigated and it was found that only CYFS and the Police received formal written confirmation. This advised them of acceptance or decline by Te Taiwhenua o Heretaunga Family Start. Family and other professional referrers were not advised. Referrer addresses were mostly not recorded on the referral sheet. No information was available to show how many were declined from the Family Start programme.

Referrers could be lead maternity care providers, general practitioners, hospital staff in maternity or neonatal wards, well child providers, Plunket, early childhood educators, Work and Income case managers or Strengthening Families coordinators, (Ministry of Social Development, 2008).

Referrals came from the following areas: This information was taken from the client hardcopy files on the 7th January 2009.

• Doctors and health centers	40
• Family Start transfers from other areas and from our own service	11
• Midwives	7
• Child Youth and Family Services	31
• Teen Parents	6
• Preschools	2
• Self referrals	45
• Ministry of Social Development	2

• Plunket or Tamariki Ora	10
• Work and Income New Zealand	9
• Housing New Zealand	5
• Hospital- pediatrics, children's ward and maternity services	28
• Police	2
• Others and those not specified	15

Child Youth and Family were involved in fifteen percent of the cases studied.

Building the capacity of agencies across the spectrum of services to identify those at risk and to respond quickly in a co-ordinated way is more likely to meet the needs of those vulnerable children who have been specifically identified as high risk (Ministry of Social Development, p.viii, 2006).

There are no formal records of who was sent a referral feedback letter either in hardcopy or electronic files. The importance of this relates to collaboration and an interagency approach to service delivery.

Point 4: Strengths and needs assessments

There is a service delivery expectation that a strengths and needs assessment is completed within the first six weeks of being on the Family Start programme (Ministry of Social Development, p. 16, 2008).

Data was collected on strengths and needs assessments to consider how long these took to provide the information needed. Strengths and needs assessments contribute to assigning a service delivery level: high, medium or low.

The October 2008 data retrieval showed that there were 70 of the 223 client base at that time for whom no strengths and needs assessments were ever done. This represents nearly 32% of clients. The January 2009 data collection from the hardcopy files showed that 50 clients still had no strengths and needs assessments. This showed an improvement from the 70 out of 223 (nearly 32%) in October 2008 to 50 out of 214 clients in January 2009 (nearly 24%).

While it may appear that this research prompted an 8% improvement in these statistics, it is worth noting that the exits of nine families from the programme during that time interval accounts for four percent of this improvement.

The accuracy of the Strengths and Needs Assessment and the relationship established between the kaimahi and the family form the foundation for successful service delivery (Ministry of Social Development, p.16, 2009).

The goal of strengths and needs assessments is formalizing a working relationship between the family and kaimahi through rapport building and collecting information to inform service delivery. The strengths and needs assessments provide supervisors and managers of evidence that the relationship between clients and kaimahi is a working relationship and not informal support.

Table 2: Time to complete strengths and needs assessments October 2008

Time in months	Families on the programme
Less than 1 month	0
1 to 3 months	29
3 to 5 months	17
5 months and over	176

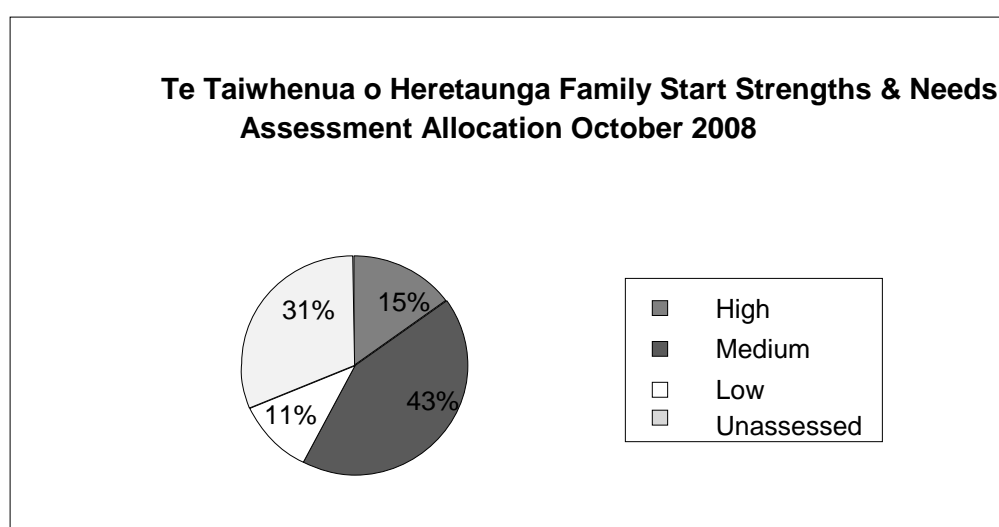
Table 2 demonstrates the length of time strengths and needs assessments have taken to produce at Te Taiwhenua o Heretaunga Family Start. The information in Table 2 indicates there are some big time challenges to meet service delivery expectations and discussion on this will follow. There are 223 clients mentioned in the Table 2 results because 10 files were not available to at the October 2008 data collection. Most of these were exited before January 2009. The strengths and needs assessments are an important aspect of service delivery because this is how service delivery levels are determined.

The strengths and needs assessment stage is important in determining the level of service provision required, based on assessed information regarding the nature of the family's needs, the priorities of those needs and the family's strengths and abilities (Ministry of Social development, p.16, 2008).

On average the data showed that it took five and a half months to complete a strengths and needs assessment at Te Taiwhenua o Heretaunga Family Start. On inspection of hardcopy files, many of the completed strengths and needs assessments were prepared by original kaimahi (previous to the current kaimahi) and these families had been on the programme for well over a year. The second data collection of strengths and needs assessments taken in January 2009 was not displayed in a table.

Of interest to service delivery is the allocation of service levels: high, medium or low. Figure 2 shows the data collected on this.

Figure 2:



There were 34 (15%) clients recorded as high needs, 94 (43%) medium and 25 (11%) low needs and there were 70 (31%) clients for whom an allocation had not been determined on the 20th October 2008. This information will be important in the discussion about service delivery (See Chapter 5). The data shows the lack of strengths and needs assessments. Considering table 2 and figure 2 together shows that at least 150 clients have had their service delivery determined without the completion of the first strengths and needs assessment.

Service delivery levels assist with planning and workload allocation. Knowing the client's needs would assist supervisors, department managers and kaimahi with workload and time management. The Ministry of Social Development's expectations for service delivery levels are shown in the following table.

Table 3: Ministry of Social Development (2008) Service Delivery Expectations

Level	Time Allocation
Assessment Phase	Approximately 3-4 hrs per week for 4 –6 weeks
Low Intensity	Approximately 2.5 hours per fortnight
Medium Intensity	Approximately 2.5 hours per week
High Intensity	Approximately 4 hours per week

Source: Ministry of Social Development (2008). Family Start Manual

There are vast differences in time expectations of the service delivery levels that have been determined from strengths and needs assessments as indicated in Table 3.

Point 5: Service delivery time

Time spent visiting families face to face is important for addressing social isolation, providing regular support and maintaining an eye on children at risk for maltreatment (Ministry of Social Development, 2008).

Time spent visiting families face to face would have provided interesting data to show what contact families received regularly as part of the service delivery package at Te Taiwhenua o Heretaunga Family Start. I was unable to gather this information due to the restriction to the FS-net data base. This is the Ministry of Social Development data base where information is entered about provider activities for Family Start service delivery.

Regular contact is important for addressing social isolation and providing regular support and has been seen to be important to reducing risk for maltreatment of children. However, I was not permitted to access the FS-net data base to collect data on kaimahi face to face hours

Point 6: Individual family plans

Individual Family Plans (IFP) provides a structure and course of action to guide kaimahi and families in goal setting and problem solving (Ministry of Social Development, p. 20, 2008).

There were 11 IFP where strengths and needs assessments had never been carried out.

The guidelines' expectation is that individual family plans will develop from strengths and needs assessments (Ministry of Social Development, p.20, 2008).

Individual family plans are intended as quarterly reviews (Ministry of Social Development, p.21, 2008).

Assessing the quality of Individual Family Plans (IFP) was outside the agreed parameters of the evaluation. However, I was able to conduct a quantitative analysis. The number of IFPs were counted and these were divided by the number of families who were on the Family Start programme at Te Taiwhenua o Heretaunga at that time.

There were 813 IFP done for the 223 families at the October 2008 data collection. This averaged 3.6 IFP for each family in total regardless of the time each family had been on the Family Start programme. Twenty one families had developed over 20 IFP with their kaimahi; nearly all these were done by kaimahi previous to the one engaged with these families and were over a year old.

The average time for families to be on the Family Start programme when this data was collected in October 2008 was one year and 10 months. Each family should have an average of seven IFP done to meet service delivery expectations, as an individual family plan is expected 3 monthly. In the 22 month average period, for each family on the Family Start programme, when the data was collected in October 2008, each family had an average of 1.1 individual family plans complete, instead of the expected 7.

All Family Start services must be delivered on the basis of an individual family plan (Family and Community Services, p.26, 2006).

An individual family plan is a document developed with the family that identifies their needs, reflects and builds on their strengths. It changes to recognise their progress towards increasing independence (Ministry of Social Development, p. 20, 2008).

The aim of individual family plans is to make changes, to solve problems and to work towards independence.

Some kaimahi discussed problem solving in the questionnaires. Here is one comment from the data collected on service delivery.

To watch someone developing and solving problems for themselves is a great success.

Other kaimahi reflected on the positive aspects of engaging in problem solving and seeing the rewards when goals are accomplished.

I enjoy seeing the babies and other children noticing the different things they are doing every time you see them. I love sharing the joy with them when they achieve their goals.

This shows that kaimahi understood that the Family Start programme is about solving problems and delivering the Born to learn/Ahuru Mōwai programme but there is a lack of awareness of the individual family plans as the tool to achieve this.

The core components of Family Start and the information gathered in the strengths and needs assessment is the basis for individual family plans development (Ministry of Social Development, p.20, 2008).

Individual family plans are reliant on the strengths and needs assessments in the Ministry of Social Development specification, therefore these poor results were likely because such a large number of clients did not have strengths and needs assessments completed in the expected timeframe.

Point 7: Born to Learn/Ahuru Mōwai

Born to Learn/Ahuru Mowai delivery is expected within the first month of the client being on the programme, then monthly to at least 10 hours annually (Ministry of Social Development, p. 24, 2008).

The time between the first contact made by the supervisor and the first delivery of the Born to Learn/Ahuru Mōwai component was measured in days. The results ranged from zero to 330 days for the 214 families involved with this data set. This worked out to be an average of 57 days, or a few days over eight weeks. This is much more than the 30 days specified.

There were 45 families who had not received any sessions of Born to Learn/Ahuru Mōwai. This represented slightly over 21% of the families on the Family Start programme at Te Taiwhenua o Heretaunga in January 2009. I was unable to determine why so many families had not received the Born to learn Ahuru Mōwai sessions.

The outcomes for the Born to Learn/Ahuru Mōwai component of the programme include: improving parenting practices; ensuring secure attachments develop between parent/caregiver and the child because these reduce risk factors for child maltreatment and are said to prevent child abuse and neglect according to literature (Ministry of Social Development, p.23, 2008).

The Born to Learn/Ahuru Mōwai research findings at Te Taiwhenua o Heretaunga were not in line with the service delivery expectations. The first delivery of the Born to Learn/Ahuru Mōwai took too long and 45 families had not received any Born to Learn/Ahuru Mōwai programme delivery.

Two kaimahi mentioned how much they valued the Born to Learn/Ahuru Mōwai programme.

This is what was said.

Born to Learn/Ahuru Mōwai information is such amazing information for our families which would have been wonderful on a personal basis. I have learnt that the Born to Learn programme is a very necessary important job and I love learning about it. I think that the time taken to deliver this programme should not be rushed.

Most parents and caregivers responded positively to receiving the Born to Learn/Ahuru Mōwai programme and mentioned that they found the parents' handouts reasonable to understand and the majority found the information very useful.

Te Mahere kaupapa Māori is a supporting resource for the practical implementation of the Ahuru Mowai (Māori version of the Born to Learn programme) and these programmes come with manuals, that provide all the working knowledge needed to implement the programmes successfully (Ministry of Social Development, p.24, 2008).

Increasing knowledge of early childhood development is an intention of the Born to Learn/Ahuru Mōwai programme and this new knowledge intends to support improved parenting practices (Ministry of Social Development, p.23, 2008).

Point 8: Health records

The kaimahi will ensure families are aware of the health and development needs of their children and of the Well Child/Tamariki Ora health services available in their area. To ensure these and immunization uptake are recorded in the client's file (Ministry of Social Development, p.24, 2008).

Developmental milestones, health screening and immunizations data were used to see how well kaimahi managed to support clients in having health checks done. These are all part of service delivery expectations and are indicators that measure the extent to which outcomes are achieved (Ministry of Social Development, 2008). The developmental milestones data showed that 61% of families had their child's milestone records done in the January data collection. The health checks at this time showed 65% of family records completed. The immunizations records showed 73% of files completed.

Kaimahi have not checked or recorded all of this data. This does not signify compliance or non compliance of immunizations because immunizations can be done by well child providers, Plunket and doctors without being recorded by kaimahi.

The findings show that about one third of kaimahi records are not being kept regarding health checks, developmental milestones and immunization records.

Point 9: Culturally relevant service delivery

Culturally relevant service delivery is expected in the Family Start service delivery (Family and Community Services, p.8, 2006).

The aim of this objective was to see if service delivery is culturally relevant. Qualitative data was collected from supervisors and kaimahi through questionnaires. The client satisfaction surveys provided limited data for assessing caregiver perspectives. The client is generally the Family Start child but the client satisfaction surveys refer to the parent/caregiver as the client in this case.

There were two European and two Pacific Island kaimahi at the time this research was carried out. The other kaimahi and supervisors identified as Māori. Only one European kaimahi had experienced challenges with cultural competency. She was supported by the other kaimahi during home visits until she was accepted by her clients. In her first year with Family Start she changed from working with more than 50 clients. Cultural competency was gained by peer support with other kaimahi and supervision. The client population of Te Taiwhenua o Heretaunga includes many gang affiliated families. The Mongrel Mob families are generally more reluctant to allow outsiders in. I mention this because there are several cultures involved here: poverty, drugs, gangs and ethnicity. It is unknown how many families at this site have gang affiliations.

Cultural relevance to Māori

Family providers must be responsive and sensitive to the cultural and social beliefs, values and practices of all cultural groups (in particular Māori, Pacific and Migrant groups) so they have the opportunity to enjoy at least the same level of health, education and welfare as European New Zealanders (Family and Community Services, p.8, 2006).

In the service delivery of the Family Start programme this is what I found from the kaimahi. Kaimahi were keen to help people move forward in their lives and said:

Learning about different backgrounds and culture in the community help us to understand other people. The cultural resources available at Te Taiwhenua o Heretaunga are good.

Several kaimahi spoke about supporting self determining behaviours for Māori directly, like this example.

Helping our Māori whānau in need is what I like most. By encouraging and supporting them through a process of change. To empower my clients, and show there is always a way to turn a bad situation into a good situation.

Kaimahi spoke about how they felt valued through being able to practice Māori customs and work in a kaupapa way with people. Here are several kaimahi views.

I enjoy the holistic approach.

Having a genuine love for the children in these whānau helps me to be able to work with the whānau.

I enjoy being able to give something (pay it forward) in the hope that someone is there for my whānau when I cannot be there.

I enjoy the spiritual atmosphere that encircles us. Work begins with a waiata and a karakia. This sets my wairua that I take with me when I go out into the community.

Reciprocity is an important concept for Māori. The idea of paying it forward relates to reciprocity. Self acceptance is an important value in any culture and the expression by the kaimahi to work in accordance with Māori ways showed this.

It's best to be yourself and everything will just come naturally. To offer options, benefits and consequences and being able to empathize with those I work for (clients). I feel that as long as the initial relationship building process is done well, that they trust you, and that confidences are kept, that they know you are genuine. Service delivery needs to be done in a natural caring way.

These sentiments express a shared cultural understanding and acceptance.

Manaaki –caring for people

All providers must demonstrate a willingness and ability to apply the principles of partnership, participation and active protection of Māori interest in their managerial, employment and service delivery policies and practices (Family and Community Services, p.8, 2006).

Manaaki is the value for caring for people and manaakitanga is hospitality (Organic Explorer, nd).

This was said about kaimahi by a kaimahi.

I have witnessed the genuine love and care that kaimahi have for the families that they work with. I have seen trying times but the kaimahi has managed to remain professional.

Most kaimahi expressed positive feelings for work colleagues and said this assisted them in delivering the service at Te Taiwhenua o Heretaunga Family Start.

Having a great bunch of fellow workers helps me in my work. Having colleagues who are very supportive in and out of the work arena is an added bonus.

Having supportive colleagues helps me to focus on the positives in my life, through their sharing of knowledge and experiences.

One kaimahi spoke about how Te Taiwhenua o Heretaunga encouraged self determining opportunities for the staff in a culturally sensitive way for Māori.

I think that Taiwhenua does a really good job nurturing staff. This is evident in the annual hui, biannual staff team building days, the special days like mothers' and fathers' day breakfasts and presentations. Also the staff are able to attend a tangi of family members during work hours. Tikanga and kawa are an important way to acknowledge the Treaty and unify staff.

Several kaimahi reflected on the value of having supervision to advance their work practices and to make sense of some challenges. I saw support through supervision as a type of manaaki. Kaimahi appear to recognize the importance of

supervision to ensure quality of service through providing training and knowledge they do not have.

Supervision weekly makes one feel safe in this work. Having a great bunch of fellow workers and good supervisors who understand every part of the job is important.

I feel well supported through supervision and peer supervision. Having cultural lessons (Tikanga) and weekly supervision is important.

Support was mentioned in many accounts given by kaimahi. This is one example of providing support in an empowering way.

Providing opportunities to talk and listen is important. It is good to have an ability to empathize and not judge, to make suggestions and not give orders or demands. This allows clients to make their own decisions with kaimahi support.

The value of support has been highlighted in kaimahi feedback for this research and here is one shared view:

You are committed to helping them reach their full potential, achieve their goals, be better parents and be an asset in their communities, even if we can help just one whānau out of 16, this is an awesome achievement.

Clients (parents/caregivers) had this to say about service delivery.

Having good communication and listening skills is important.

The knowledge kaimahi bring to the relationship about babies, child development and child care practices are really great.

Patience, empathy and support are appreciated and most (parents/caregivers) enjoyed being visited in their homes.

The kaimahi demonstrated knowledge of good rapport building and cultural awareness for the client base they were working with.

Don't judge, give guidance. Not telling them what to do. Know your client knows that you care by going the extra. Kaimahi need to be approachable. Building a good rapport is essential.

Clients need to feel comfortable, not threatened or demeaned to build a relationship with their kaimahi.

It helps when you are truly genuine about wanting to help someone, having empathy, being an attentive listener, being respectful of cultural differences and human rights, being professional but in an informal way.

Kaimahi are expected to be competent in cultural appropriateness when delivering the Family Start programme (Ministry of Social Development, p.77, 2008).

Kaimahi shared their perspectives on the importance of leadership in the delivery of the Family Start service. It appears that kaimahi rely heavily on the expertise of management and supervisory staff.

Support at management level is crucial to kaimahi and service delivery.

Being able to have input into how things run, getting praise for what you do and given encouragement from other kaimahi is important.

Good leadership, supportive colleagues who have patience and amazing experiences helps in my job.

Several kaimahi mention a desire to help other Māori. This is what one kaimahi wrote in the questionnaire.

Helping our Māori whānau in need is what I like most, by encouraging them.

Kaimahi recognized the importance of change in their colleagues' lives as well.

The people I work with are the bomb and I love going to work just to hear what changes each of them have made in their own lives.

One kaimahi wrote about a desire to help clients address substance abuse and domestic violence.

To be able to help them to see the big picture i.e. that there is a life out there besides drugs, alcohol and domestic violence.

Others noted how difficult problem solving was and how determination and support helped change eventually.

I have been in situations like some of my clients. For example I was in a violent relationship and my children and I suffered greatly but, through trial and error, I made changes, put in the commitment and over time we made real change for ourselves.

One of the kaimahi had this to say about fathers and a desire for their involvement and support.

Acknowledge the role of dads, because there are always dads where there are children and most that we work with are in the background. We need to capture these men and help them share the responsibility in raising their children whether they are with the mother or not. It's not about telling them but giving them options in a hands on way.

These are positive thoughts about the inclusion of fathers in the Family Start service delivery. Some clients (parents/caregivers) mentioned a desire to have a

men's programme as part of the Family Start service. There are many issues for and against father involvement with their children post separation and this requires further research and is beyond the scope of this research.

Whakawhanaungatanga

Whakawhanaungatanga- sometimes understood as a process of getting to know each other (McNatty, 2001).

There is evidence to suggest that kaimahi at Te Taiwhenua o Heretaunga have managed to create meaningful bonds with their clients because many related in familial ways described below by kaimahi.

Treat them like whānau and always be respectful and listen.

Whakawhanaungatanga and respect them for who they are can gain good rapport.

I look at it as adopting or taking under my wing these mothers and their children who just need a little or a lot of help.

I think of them as being one of my own children.

Making connections through names or photos on the wall and making them feel important.

Several positive accounts of whanaungatanga were shared by kaimahi. Many aspects of Māori customary practices are intrinsically woven into the service delivery process at Te Taiwhenua o Heretaunga Family Start as indicated in the questionnaires above.

4.3 Summary

I have found that the Family Start programme was delivered to the intended population at Te Taiwhenua o Heretaunga. Most clients were low income, and suffered from a lack of essential resources. The lack of resources affected about two thirds of the clients. A lack of resources has not been clearly described by the Ministry of Social Development specifications or Te Taiwhenua o Heretaunga Family Start. Kaimahi understanding of poverty and empathy was demonstrated. Mental health problems and relationship issues were seen in about three quarters of the clients. Nearly half of all clients reported that they changed addresses frequently, more than twice a year. About one third of clients recorded a history of family abuse as a referral criterion. The referral criteria of SIDS (Sudden Infant Death Syndrome) factors (were understood by kaimahi as whether the mother smoked or not), substance abuse and youthful parents featured in around twenty percent of client records. Minimal or no antenatal care and low maternal qualifications were recorded in about ten percent of client cases. The surveys contributed to the findings on poverty, adversity, age, transiency, and mental health problems. The qualitative data from kaimahi showed a desire to address violence and some understanding of the impact but no quantitative data was recorded to show how many families were affected by violence at this site. CYFS involvement was the only indicator.

Response times were good with supervisors getting back to clients within the 5 day expected. Referrer feedback findings showed only two agents were formally notified of decline or acceptance onto the Family Start programme. These were the Police and Child Youth and Family Services. No records for referrals, whether accepted or declined were found at Te Taiwhenua o Heretaunga showing that there is no register of all the potential clients who come to the notice of this provider.

Strengths and needs assessments took nearly three times as long as was expected to complete and over one third of clients had never had a strengths and needs assessment. There was no data available to assess the time spent delivering the Family Start service by kaimahi to clients from Te Taiwhenua o Heretaunga. The

findings on individual family plans were poor. Born to Learn/Ahuru Mōwai delivery was very poor. One client waited nearly one year for the first BTL/AM delivery and, on average, clients waited nearly two months. Twenty one percent of clients had never received any of the BTL/AM when this research was carried out. Previous kaimahi produced many of the current strengths and needs assessments. Health records, developmental milestone summaries and immunization records were lacking in over thirty percent of clients files.

The findings show that forty percent of clients on the programme at the time of this research had not been visited for over twelve months.

Findings about the cultural relevance of the service delivery were positive. The practice of Māori custom was shown to be important to kaimahi. Helping others in a kaupapa way was highly valued by kaimahi. Important values mentioned were the concept of reciprocity, practices of waiata and karakia to open the day, and self acceptance as Māori. Manaaki was mentioned and included support, supervision and peer supervision and were valued by kamahi in this research. Whakawhanaungatanga was found to be a positive way to greet and build rapport with clients.

The findings showed several areas needing improvement in the service delivery process. Cultural relevance in service delivery was very positive.

In this chapter I discuss the findings by following the nine points used earlier. These are the referral criteria, response, referrer feedback, strengths and needs assessments, service delivery time, individual family plans, Born to Learn/Ahuru Mōwai, health records and cultural relevance in service delivery.

The referral regime of the Family Start programme says that having one identified area of concern is sufficient for acceptance to the programme (Ministry of Social Development, 2008). The findings show a high level of multiple concerns and risk factors among the clients at Te Taiwhenua o Heretaunga Family Start during this period. Some clients are affiliated to gangs and it seems understandable they may be reluctant to engage with the Family Start programme for fear of criminal repercussions. This illustrates the importance of the special skills and understanding needed by kaimahi to engage well to provide service delivery in this context.

Poverty, low income and a lack of essential resources were high among the clients of Te Taiwhenua o Heretaunga Family Start. The evaluation of the Early Start programme suggested that was one of the programmes main limitations was not addressing poverty or lack of resources (Fergusson, Horwood & Ridder, 2005). The Family Start programme endeavoured to address this problem. From my experience as a kaimahi I know that Te Taiwhenua o Heretaunga Family Start do actively assist families with essential resources. Further research would show the extent and benefits this aspect of service delivery provides to improve contextual factors that are possible risk factors for child maltreatment.

Approximately half the clients had the referral criterion frequent change of address. Young couples in stress often move between families of origin, leave current partners and leave an area to avoid family and gang pressures. I have seen this myself as a kaimahi in the Family Start programme at Taiwhenua o Heretaunga. Conflicts can have a devastating impact on children and their well-being and research suggests that it is important to provide intervention for parents

in conflict in order to increase their awareness of the consequences of their behaviours on their children (Sarrazin & Cyr, 2007).

I support promoting collaboration between agencies and Family Start service delivery providers to help provide unified care and support for families who choose frequent change of address in challenging circumstances. Frequent change in address is a Family Start referral criterion. An American study showed frequent change in address for children contributes to the development of adolescent alcohol and marijuana use, major depressive disorder, anti-social personality disorder and nicotine dependence (Buu, DiPiazza, Wang, Puttler, Fitzgerald & Zucker, 2009). Research indicates that parental psychopathology, family socio-economic status and residential instability are all significant risk factors for the development of substance abuse and other co-morbid psychopathology (Buu, et al., 2009). A frequent change in addresses often highlights deeper issues that require the support of services to promote opportunities to enhance better outcomes for children and reduce risk for poor outcomes. I suggest the development of a referral register to assist agencies to communicate and manage information about families who frequently change addresses.

Mental health problems were a referral criterion for three quarters of the client population in this study. The very high proportion of clients with mental health problems is a red flag for service delivery because knowledge of mental health issues and access to supporting intervention are important foci for skills development for kaimahi, supervisors, and interagency support. Service delivery should be programme specific and kaimahi should not be expected to work outside their area of competencies. Mental health service delivery, whether in the community or a clinical setting, requires specific qualifications. Training in this area may assist kaimahi working with clients who have mental health problems, but trained specialist supervision would be more important. Mental health service delivery has had its own challenges in the past, and this is beyond the scope of this thesis, but I mention boundaries in practice for service delivery to safe guard kaimahi and to support assisting clients to access the appropriate avenues for specific services. Kaimahi are not covered by the Health Practitioners' Act (2004) because they do not belong to a professional body. Kaimahi are neither social

workers nor health practitioners. Even if qualified in social work, a kaimahi is employed as a support worker.

Although having a family history of abuse was present in around a quarter of client referral details, it is possible some under reporting has occurred. Mental health conditions were not specified in the referral criteria but the high rate of multiple risk factors might suggest more clients with historical abuse, violence and sexual abuse histories. In my own caseload more than half talked about past abuses.

Maternal mental health may have a profound effect on child development including the risk of developing the same disorder (Macfie, 2009).

Wellness impacts on a parent's ability to parent well. Our data showed that many clients (parents/caregivers) experience mental health problems. Motherhood is recognized as a challenging role and the challenge to motherhood is amplified for women living with psychiatric conditions (Lagan, Knight, Barton & Boyce, 2009). Maternal schizophrenia is known to have an adverse effect on the quality of mother-child interaction and children of parents with severe mental illness run a higher risk of poor mental health and social outcomes (Duncan & Browning, 2009). There is an urgent need for professional advocacy to support women who are mentally unwell in their transition to motherhood (Lagan et al., 2009).

The referral criteria findings showed the Family Start programme is reaching the population identified as most at risk for child maltreatment at Te Taiwhenua o Heretaunga.

Responsiveness by supervisors was shown by the findings to be very good; (within four days) unfortunately this was not supported by good use of the Family Start programme components by kaimahi. The components not well used by kaimahi were: doing a first strengths and needs assessment in reasonable time, then at 6 monthly intervals to follow; delivering the Born to learn/Ahuru Mōwai programme in the first month, or at all in over 21% of cases; spending the required time with clients; setting and measuring goals using the individual family plans; supporting and recording the health checks and immunization records for

clients. It is possible that there are valid reasons for these findings. It was found that some clients had not been seen for some time and exit summary should have been done to allow new active clients on the programme. A need for training, understanding of the programme rationale, prior formal learning to engage with the programme, time, and workload considerations are all possible barriers to achieving the desired outcomes. Research is needed to verify barriers. It is possible the findings that show no delivery of the Born to Learn/Ahuru Mōwai programme may have been affected by non active clients on the client role who should have been exited as well. Further research to determine this is needed at Te Taiwhenua o Heretaunga Family Start.

Referrer feedback was an area in this research that did not show good results. The underpinning rationale may have been missed during inception of the programme. Te Taiwhenua o Heretaunga Family Start is part of a regionally coordinated attempt to address risk for child maltreatment and is one of the Māori, Pacific and other social service agencies who are local referral contacts for child abuse concerns (Fanslow, 2002). Barriers to addressing child maltreatment in the past have included a lack of formal protocols and institutional support for responding, perceived lack of time to address the problem and lack of confidence in referral agencies (Fanslow, 2002). The response to this was to encourage collaboration between government agencies, iwi, Māori groups, local authorities, community and voluntary sector groups and Pacific peoples (Fanslow, 2002). It is necessary for all agencies to discuss and agree on protocols to guide interagency activity.

Regional coordination is needed to provide long term coordinated direction for community development and service delivery and, to be effective, the key agents including Te Taiwhenua o Heretaunga need to have identified the government's strategic objectives and to be able to translate this into action at a local level (Fanslow, 2002). If referrers do not get confirmation either of acceptance or decline by other agencies, there are no protocols in place to ensure that needs are being met or that action has been taken. Developing an overview and coordinating activity has been recognized as a barrier to service delivery previously because agencies plan and deliver services independently (Fanslow, 2002). Collaboration and feedback among referral agents is important to the service delivery because

shared knowledge reduces the chances for systemic gaps. I believe there is a need to investigate an interagency register to address this concern.

Strengths and needs assessments are an operational or meso level concern that can be addressed through training and capacity building within the organization of Te Taiwhenua o Heretaunga Family Start. The approximate 30% non allocation of service delivery levels suggests that Te Taiwhenua o Heretaunga Family Start may not be meeting the specific needs of the clients. Further investigation is needed to support current supervisors in mentoring the kaimahi in programme components, or the organization needs to access external training to meet competency levels. The collaboration literature suggests that some agencies have spent more time building relationships than they have on improvements to services (High and Complex Needs Unit, 2007). There is an understanding that service delivery, collaborative skills development and progress will differ among providers and within wider timeframes (High and Complex Needs Unit, 2007). Therefore, addressing non exited clients and developing better strengths and needs skill capacity are recognized by the programme planners as part of provider growth.

Knowledge of the face to face hours spent by kaimahi with clients would have provided data whether families were visited to addressing social isolation and to providing support and advocacy as part of meeting the service delivery expectations. I was not permitted to access this from FS-net. FS-net is the Ministry of Social Development data collection site. Without this data it is difficult to ascertain whether structural processes influence the amount of time that kaimahi spend with clients or if there are barriers to service delivery at all.

The individual family plan is a tool to encourage problem identification, goal setting and to prescribe a course of action to address an identified problem (Ministry of Social Development, 2008). The findings in this research suggest this tool is under used and possibly not well understood. Addressing issues that compromise positive outcomes are well identified and understood in New Zealand health literature (Ministry of Health, 2005). Mechanisms to address family violence and child maltreatment have been developed and implemented to address

concerns when identified and provide preventative actions as well (Fanslow, 2002). One of the barriers found in this research to kaimahi using individual family plans was not doing strengths and needs assessments as expected. The findings on individual family plans are a flow down result of not doing strength and needs assessments.

It is clear that early detection and follow up of risk factors are needed to address child maltreatment in New Zealand (Ministry of Social Development, 2008). Working with others to solve problems supports skill development and enhances outcomes (Kegler, Norton & Aronson, 2007). Also, there is an increased need for knowledge based systems for supporting case workers in decision making and planning interventions in the social services industry (Wang, Cheung, Lee, Kwok, 2007). During my 18 months at Te Taiwhenua o Heretaunga, there was no training on child maltreatment detection, or on protocols to address concerns. I consider that the individual family plans included in the Family Start programme are an important mechanism for clients and kaimahi to work together to plan for change. Change in behaviour, circumstances and attitudes are the key objective to manage activities and behaviours that put people at possible risk for maltreatment of children. I see change through a supported problem solving process as the key to empowerment that can enhance self determining behaviours to promote individual growth and development and reduce factors in the circumstances that possibly place children at risk. Family Start programme trainers are the primary drivers behind training and sharing the programme intentions but the service designers share the responsibility in communicating how these mechanisms are designed to work.

In my opinion, the Born to Learn/Ahuru Mōwai programme has been well designed to address the risk of maltreatment to children by providing regular visits, supporting parenting practices and offering stimulation for the children and the parents (Ministry of Social Development, 2008).

Early delivery of the Born to Learn/Ahuru Mōwai programme intends to link families with the key services that provide specialist intervention (Ministry of Social Development, 2008). If early and regular delivery of the Born to

Learn/Ahuru Mōwai is not achieved, this reduces the intentions of the programme, to reduce risk of child maltreatment.

The Born to Learn/Ahuru Mōwai outcomes are:

To increase parental knowledge of early childhood development and to improve parenting practices, to ensure that secure attachments are formed between the parent/caregiver and the child, to provide early detection for developmental delays, and health issues, to prevent child abuse and neglect, to increase children's interest in learning, encourage early childhood education and to maximize family and community base support systems (Ministry of Social Development, p.23, 2008).

I have listed the objectives of the Born to Learn/Ahuru Mōwai programme because I consider that failing to provide this component reduces the impact of the whole Family Start programme, which is to reduce risk of child maltreatment among families experiencing challenges.

Encouraging community involvement is a goal of the Born to Learn/Ahuru Mōwai programme in order to maximize the support available in the community (Ministry of Social Development, 2008). Another aspect of service delivery that was not collected in this research was the participation in community days and Mums' groups provided by Te Taiwhenua o Heretaunga Family Start. Records of these are held by the Family Start management but were not made available for inclusion in this research. Both these group sessions of service delivery are focused on providing aspects of the Born to Learn/Ahuru Mōwai programmes and foster peer support for clients and active engagement at a group/community level. Te Taiwhenua o Heretaunga also provide food, drinks, t-shirts, hats, etc.

Two kaimahi and one parent said support could come from the fathers of the clients (children on the programme). Research into programmes designed to promote paternal involvement and positive outcomes is scarce (Pruett, Cowan, Cowan & Pruett, 2009). It appears there are pros and cons for having fathers involved in children's lives where there are abuse issues and concerns. Some

research tells us that the invisibility of fathers of children involved with welfare agencies suggests that, by failing to work with fathers, agencies are not doing the best for the mothers and the children (Brown, Callahan, Strega, Walmsley & Dominelli, 2009). Other research, that also supports paternal involvement, found that poor father-child relationships lead to poorer health for the children (Fabricius & Luecken, 2007). Encouraging and working with fathers is a part of service delivery beyond the scope of this research but would be worthwhile to do in future.

Health care providers are recognized as key players in New Zealand's effort to eliminate family violence (Fanslow, 2002). The thirty percent lack of records for health checks, immunizations and developmental milestones suggests that either there is a lack of understanding by Te Taiwhenua o Heretaunga Family Start and that this has been passed onto kaimahi, of the importance of health care visits to prevent child maltreatment or that there are clients on the programme who should have been exited and this is distorting the findings. Follow up on the 30% of clients mentioned here will assist to establish if some clients are inactive by looking at the last time these clients were visited. I mentioned earlier that 40% of Te Taiwhenua o Heretaunga Family Start families had not been visited by a kaimahi for over twelve months.

Te Taiwhenua o Heretaunga Family Start service demonstrated early responsiveness by supervisors once a referral was received from an agent, and was being culturally relevant to the client group but was not meeting service delivery expectations according to the Ministry of Social Development guidelines.

Māori people, along with other minority people, are concerned that researchers have been slow to acknowledge the importance of culture and cultural differences as key components in successful research practice (Bishop, 1996). With this in mind, I restate the positive findings from the kaimahi that support the importance of tikanga (practice of culture) for Māori when working with Māori.

I consider this research fits well with the values of community psychology because I have been able to highlight the cultural strengths of service delivery and

identify areas for improvement through using an empowerment evaluation. The highlights are Te Taiwhenua o Heretaunga Family Start is reaching the intended population; there appears to be a good fit between kaimahi and clients culturally (although clients' opinions would have assisted to establish this); kaimahi are well informed and supported culturally by Te Taiwhenua o Heretaunga who provide kaimahi with good opportunities to develop and maintain cultural competencies including weekly Māori lessons, and daily waiata (singing) and karakia (prayers). This empowerment evaluation has identified areas in service delivery that need to be improved to meet service delivery expectations as required by the Ministry of Social Development (2008). The areas needing improvement are: interagency collaboration; the amount of time kaimahi spent with clients and what this time involves; training and support to achieve strengths and needs assessments, individual family plans, Born to learn/Ahuru Mōwai at a competent level and within the expected time frames; keeping health records; coming to a unified understanding of referral criteria; providing kaimahi with trained supervisors to support the high number of clients with mental health problems; and supervisory support that provides training and professional advocacy.

Interagency collaboration requires the development and implementation of interagency protocols to communicate and support Family Start clients in a unified manner. This includes having a referrer feedback system at Te Taiwhenua o Heretaunga Family Start to inform other agencies if referrals are accepted in to the programme. Frequent change in address is a referral criterion that was high among the clients at Te Taiwhenua o Heretaunga. Interagency protocols would assist to support transient clients by informing other agencies already working with them so alternative support could be arranged.

The time spend by kaimahi with clients is a very important service delivery aspect for the Ministry of Social Development, and this was not able for use. Time spent engaged with clients is what the Crown is investing in to reduce the risk factors for child maltreatment. Particularly important to this is reducing domestic violence and partner abuse through providing support and advocacy to implement individual family plans, regular health checks, providing the Born to Learn/Ahuru Mōwai programme, regularly engaging in the discussions that challenge

destructive behaviours that children are exposed to, and acting on concerns when found. A review of time spent with clients is needed in my opinion to explore if there are organizational barriers to kaimahi to meet the service delivery expectations. This may involve not knowing what to do. Based on my own initiation into the Family Start programme at Te Taiwhenua o Heretaunga, one week spent reading the manual with little interaction with a supervisor to clarify meaning is inadequate preparation to take on the complexities of the Family Start programme and to understand the multiple responsibilities placed on kaimahi. I note that most kaimahi have arrived in their positions with an expectation to train. Most have experiential learning as opposed to formal learning prerequisites. Client allocations are recommended by the Ministry of Social Development to be 16 per kaimahi and at Te Taiwhenua o Heretaunga several kaimahi had over 20 clients each.

Training and support for kaimahi and supervisors are needed at Te Taiwhenua o Heretaunga Family Start. Some kaimahi are achieving service delivery expectations regarding strengths and needs assessments, individual family plans and Born to Learn/Ahuru Mōwai programme delivery but many are not. In the back of the service delivery manual are competencies that are required by kaimahi to meet service delivery according to the expectations of the Ministry of Social Development (2008) and these are intended to be managed by supervisors and managers of the Family Start programme.

Keeping health records, immunization schedules, health checks, and monitoring development is needed at this site. It is possible that training, including explanations of the rationale for these things, may assist their implementation.

I think it is very important that kaimahi have suitably trained supervisors to support them. A high number of clients at Te Taiwhenua o Heretaunga Family Start have mental health problems. Kaimahi are employed as support workers and fall between the Health Practitioners Act 2004 because kaimahi are not health professionals, and the Social Workers Registration Act 2003, because none are registered social workers. This includes the supervisors. A lack of trained

supervision was mentioned by Fergusson recently in the media discussion about the Family Start service delivery (Laxon, 2009). .

In my opinion, a unified understanding by referral agents, the Ministry of Social Development and Family Start providers of the referral criteria would assist service delivery and establish common standards to aim for. For example a lack of resources is common among the clients on the Family Start programme at Te Taiwhenua o Heretaunga. Working in the field helped me to see that a lack of resources means something different to various clients. For some a lack of resources is having Sky TV and a 42" screen but no food, I see this as poor choices, not a lack of resources.

The findings suggest that kaimahi have strengths and weakness in the service delivery process. Strengths are cultural sensitivity for clients and weaknesses are challenges with aspects of service delivery components. These weaknesses need to be addressed.

Te Taiwhenua o Heretaunga, as service providers of the Family Start programme, participate at an interagency level through representation on the care and protection panel of Child Youth and Family Services, but do not have protocols with other agencies to support aspects of the Family Start programme in service delivery, such as communicating with referral agents.

This research showed the Family Start programme as a work in progress. I considered aspects of service delivery of the Family Start programme at Te Taiwhenua o Heretaunga using an empowerment evaluation. This showed areas in the service delivery that needed to be developed at Te Taiwhenua o Heretaunga Family Start if the service is to be delivered as intended.

Undertaking an internal evaluation has provided Te Taiwhenua o Heretaunga with specific information that has already been acted on. Training has been done in programme service delivery tools such as strengths and needs assessments, individual family plans, delivery of the Born to Learn/Ahuru Mōwai programme, recording and advocating for regular health checks and immunization schedules.

This research supports the current concerns about service delivery of the Family Start programme mentioned by the minister Paula Bennett. Te Taiwhenua o Heretaunga have been proactive in developing their service delivery practices through this empowerment evaluation.

Te Taiwhenua o Heretaunga Family Start are reaching and maintaining service delivery with the intended population for the Family Start programme, those most at risk for child maltreatment due to their challenging circumstances. And, service delivery was found to be culturally relevant to the population receiving the Family Start programme from this site.

Service delivery of the Family Start programme at Te Taiwhenua o Heretaunga has been explored through a community psychology approach to frame the findings according to values that support growth and development for Māori.

Using an empowerment evaluation is a non judgmental approach to exploring service delivery that assisted me to provide information to inform Te Taiwhenua o Heretaunga of areas needing improvement while validating culturally relevant service delivery aspects.

Findings suggest improvement in interagency communication about clients who experience frequent changes in addresses might be assisted by an investigation into a register and better use of feedback protocols to referrers.

The findings show kaimahi are able to provide service delivery to the intended population, those most at risk for possible maltreatment of their children. Kaimahi are providing a culturally relevant service delivery to the client base at Te Taiwhenua o Heretaunga Family Start. Kaimahi are delivering the Family Start programme with empathy, understanding and cultural relevance to a hard to reach population. Te Taiwhenua o Heretaunga are able to support addressing poverty by supporting kaimahi to access essential resources to support clients. Te Taiwhenua o Heretaunga encourages staff in developing and maintaining cultural competencies, and encourages the day to day use of tikanga (the practice of customs).

Te Taiwhenua o Heretaunga have shown the capacity to support an evaluation that considers their own practices knowing that the findings will be available to a broader audience. Te Taiwhenua o Heretaunga has been open, to assist growth and development not only for themselves and are willing to provide learning opportunities for individuals as well.

Te Taiwhenua o Heretaunga are leaders in Māori health and social service provision not only in Hawke's Bay (Heretaunga) but in the broader context of New Zealand as the first Māori health organization who deliver full clinical mental health services equally alongside mainstream service delivery. Te Taiwhenua o Heretaunga have willingly engaged in exploring service delivery aspects of the Family Start programme and I see this as a positive drive to improvement.

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Appendix 1: Iwi support



Te Taiwhenua o
HERETAUNGA

25 September 2008

Northern Ethics Committee

Tena koutou katoa

Re: Masters Dissertation for Gaylene Little

This letter is in support of the application made to the committee from Gaylene Little an employee of Family Start, Te Taiwhenua o Heretaunga.

As part of her research with Family Start whanau (clients) and kaimahi (workers) I will be providing oversight with direct supervision provided by Kara Edwards, Family Start Senior Supervisor. My role will entail reviewing information to participants and the engagement process to ensure informed consent from all participants, overseeing the sample selection and evaluating the researchers practice and impact on the sample group. Marei Apatu our Kaihautu will be providing the Maori cultural supervision component and regular reports made to our Tautoko Whanau Runanga comprising of board and community representation.

If you wish to discuss these matters with me directly, please contact me on 873 0971.

Naku noa na

Lewis Ratapu
Kaiwhakahaere
Tautoko Whanau me Whakaakoranga

Appendix 2: Information Sheet

INFORMATION SHEET

Te Taiwhenua o Heretaunga Kaimahi Whanau /Supervisors

PURPOSE OF THE RESEARCH

To identify the strength based approaches used in the delivery of the Family Start / Tautoko Whanau service at Te Taiwhenua o Heretaunga. These strengths influence client access, whether they stay with the Family Start /Tautoko Whanau and whether these clients use the Born to Learn that is provided by Kaimahi Whanau. If there are strengths or skills that can be identified these may be developed and used in future practice.

WHAT THE RESEARCHER WANTS FROM YOU

Your honest opinions about what you think matters for clients and yourself for the Family Start /Tautoko Whanau program. This research is not a performance appraisal or work related measure, the idea is that as front line workers you have a unique chance to see what really works. Your past experiences may assist the way you work with people and this is of interest to the researcher. Your challenges and work experiences may have provided important life skills that can not be learnt through institutional learning experiences.

The researcher is interested in what aspects of your own life and how your work with Family Start / Tautoko Whanau has helped your own situation. Your feedback and suggestions to improve this service is a front line perspective. This is valued by the researcher as first hand experience. This will provide a unique illustration for this service delivery evaluation showing what we do best and why.

THE RESEARCHER

I am a graduate student from the University of Waikato currently engaged in a Master's thesis to complete a Master's degree in Social Science majoring in Psychology.

My supervisor is Professor Jane Ritchie who will oversee the entire evaluation / thesis process.

My supervisor from Te Taiwhenua o Heretaunga Family Start /Tautoko Whanau is Lewis Ratapu who will oversee the participant selection and data collection processes and will liaise with Te Haro and the runanga on my behalf.

Marei Apatu is the kaitiaki for this thesis and will be the cultural supervisor to enhance and ensure kawa and tikanga are maintained according to the Ngati Kahungunu protocols.

Any concerns can be addressed through Jane Ritchie at j.ritchie@waikato.ac.nz
Or Marei Apatu Te Taiwhenua o Heretaunga, Orchard Road, Hastings.

WOULD YOU LIKE TO BE PART OF THIS RESEARCH?

Contact: Gaylene Little
Te Taiwhenua o Heretaunga
Tel 873 0974 Extension 823

I will arrange a time and place that is convenient for all.

THANK YOU FOR YOUR CONSIDERATION TO HELP WITH THIS SERVICE DELIVERY EVALUATION

This research has been approved by the Psychology Department's Research and Ethics Committee and any concerns about this research can be directed to the current convenor Dr Robert Isler, email r.isler@waikato.ac.nz

Appendix 3: Consent Forms

University of Waikato
Psychology Department
CONSENT FORM

PARTICIPANTS COPY

Research Project: **Tautoko Whanau Service Delivery Evaluation at Te Taiwhenua o Heretaunga**

Researcher: **Gaylene Little**
University Supervisor: **Professor Jane Ritchie**
Te Taiwhenua o Heretaunga Supervisor: **Lewis Rarere**
Te Taiwhenua o Heretaunga Tikanga Kaitiaki: **Marei Apatu**

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee (Dr Robert Isler, phone 07 838 4466 ext. 8401, email r.isler@waikato.ac.nz).

Participant's
name.....Signature.....Date.....

University of Waikato
Psychology Department
CONSENT FORM

RESEARCHER'S COPY

Research Project: **Tautoko Whanau Service Delivery Evaluation at Te Taiwhenua o Heretaunga**

Researcher: **Gaylene Little**
University Supervisor: **Professor Jane Ritchie**
Te Taiwhenua o Heretaunga Supervisor: **Lewis Rarere**
Te Taiwhenua o Heretaunga Tikanga Kaitiaki: **Marei Apatu**

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee (Dr Robert Isler, phone 07 838 4466 ext. 8401, email r.isler@waikato.ac.nz).

Participant's name.....Signature.....Date.....

Appendix 4: Client Satisfaction Surveys



Family Start Hastings

Client Satisfaction Survey

Name (optional):

Kaimahi Whanau:

1. When you were first referred to our service did you receive adequate information about our service?

☐ Yes ☐ No ☐ Other

Comments:

2. Did you receive a visit from our Supervisor within 5 days of your referral?

☐ Yes ☐ No

If no, please specify:

3. Were you left enough information of our service including client rights and obligations?

☐ Yes ☐ No

4. Did you request any immediate support during the first initial visit?

☐ Yes ☐ No

5. a). Have you had more than one whanau worker?

☐ Yes ☐ No

b). How did you feel about the change to a new worker?

6. What are the most important skills or abilities your Kaimahi Whanau worker has?

7. Did you feel comfortable being visited in your own home?

☐ Yes ☐ No ☐ Sometimes

Comments:

8. Were the visits frequent enough?

☐ Just right ☐ Not often enough ☐ Too often
☐ Other (please comment)

9. a). When setting goal plans were you given feedback on your progress?

☐ Yes ☐ No

b). When you achieved a goal, were you satisfied with the outcome? Did you feel supported by your Kaimahi Whanau worker?

☐ Yes ☐ No

If no, please specify:

10. a). How often did you receive Born to Learn?

☐ Always ☐ Most times ☐ Sometimes
☐ Never

b). Were parent handouts and home visit forms easy to understand?

☐ Yes ☐ No ☐

c). How did you find the information provided?

☐ Useful ☐ Not useful ☐ Very useful

11. Was information provided on other community agencies? (i.e. WINZ, budgeting, housing, health specialists etc.)

☐ Yes ☐ No

12. If yes, did you use any of these services?

☐ Yes ☐ No

If yes, please specify:

13. What areas do you feel need improvement within Family Start?

14. Do you have any other comments?

Please place this survey in the attached envelope and mail.

Thank you for taking the time to complete this survey.
Your feedback is much appreciated.

Appendix 5: Kaimahi & Supervisors Questionnaires

KAIMAHI SURVEY

1. What do you like about your role as a kaimahi with Family Start?
2. Have you had similar experiences to those you work with as a kaimahi? If you are comfortable to share that's great.
3. What do you think helps you to work with the clients involved with Family Start?
4. Could someone without children / life experiences relate as well with these mummies?
5. Do you feel formal learning helps to build the rapport needed to engage with these mummies?
6. What do you feel is the easiest way for clients to contact you or is it best for you to contact them? How and why do you think this is?
7. What things about the fit between Kaimahi and client do you think makes the relationship work?
8. How long have you worked as a kaimahi whanau?
9. How have things improved for you since you have been a Kaimahi at Te Taiwhenua o Heretaunga?
10. What do you think assists this?
11. What are your thoughts and ideas about improvements to build relationships with our whanau great?

SUPERVISOR SURVEY

1. What strengths do you feel are important for Kaimahi to have to:
 - Engage with whanau?
 - To build rapport with whanau?
 - To develop relationships with whanau?
 - To maintain and facilitate relationships with whanau members?
 - And to facilitate the desired outcomes of the Family Start program?