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an exploration of the family partnership model in new zealand

HELEN WILSON AND ANNETTE HUNTINGTON

SCHOOL OF HEALTH AND SOCIAL SERVICES
MASSEY UNIVERSITY WELLINGTON

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EXECUTIVE SUMMARY

This report documents the project undertaken to explore the potential value of the Family Partnership Model (FPM) for New Zealand agencies and organisations that work with families in the community. The FPM focuses on the process of establishing an effective working relationship with families and therefore has the potential to build the capacity of a diverse range of practitioners who work with families. It is not a new initiative but adds value to existing services and programmes.

The FPM is an integrated approach which has the potential to address three key issues affecting the provision of family support: the identification of unmet mental health need in the community; barriers to inter-agency collaboration; and the need for skilled clinical supervision for front-line practitioners. By addressing these problems within a single framework, this model can help community agencies to engage and work more effectively with children and their families.

The FPM is already being implemented in New Zealand by the Royal New Zealand Plunket Society through a partnership with the Ministry of Social Development's Family and Community Services, which is a service delivery arm of the Ministry of Social Development. Since 2006 a number of FPM courses have been offered nationally, with participants from various government and community agencies.

There is a growing body of evidence that this approach benefits both the practice of front-line workers and the lives of families. However, to date, evaluations of this model have not examined the effects of inter-agency collaboration on service delivery and family outcomes as a result of the training. Although there is only anecdotal evidence, it appears that if practitioners undertake joint training underpinned by a common language and goals, the FPM can facilitate inter-agency communication and collaboration in the

interests of children and their families. With this in mind, the authors approached relevant agencies and organisations across sectors for their views on the model and its potential for their front-line staff and service users.

The agencies and individuals who provided feedback considered that, on the whole, the FPM has applicability and value in the New Zealand context. After considering these responses alongside an examination of the literature, the authors concluded that a cross-sector strategy for funding and training staff in this model could be considered at a policy level. This would be consistent with the move towards co-ordinated approaches to service delivery across government, particularly for vulnerable families.

Since increasing numbers of New Zealand practitioners, both professional and paraprofessional, are already being trained in this model, rigorous evaluations of its effectiveness in the New Zealand context are essential, particularly if the FPM is to be implemented more widely in the future. It would also be useful to include an assessment of the impact of FPM training on inter-agency communication, particularly if the training has been undertaken jointly across sectors.

The advantage the FPM has is that the training can benefit people generally as it is not limited to professionals. As a short course focused on improved communication, it is an effective way to build the capacity of non-professionals from all backgrounds to work effectively within their own communities.

If the FPM is shown to improve practice and benefit New Zealand families then consideration at a policy and operational level of how it can most efficiently and cost-effectively be integrated into staff development training could be undertaken. This may include an investigation of its potential for inclusion in core training (in undergraduate nursing, social work or medicine, for example), and also whether it might benefit paraprofessionals or parents themselves.

1. INTRODUCTION

This report describes the Family Partnership Model (FPM)¹ and explores its potential for family support services in the New Zealand context. The objective of the study was to assess interest in this model by the various agencies and organisations which have contact with families in the community and to seek their views on its appropriateness for their staff and service users.

The FPM provides an integrated approach to interacting with families that increases the skills of staff in existing services to equip them to identify or refer families with psycho-social issues, and intervene if necessary. The FPM can be incorporated into the work of practitioners from a wide range of agencies and organisations and has the potential to build inter-agency communication. A further fundamental characteristic of the FPM is recognition of, and a requirement for receiving FPM-related supervision to enhance, not to replace, professional clinical supervision. Training is centred on the processes involved in developing and maintaining an effective working relationship between the practitioner and the family. This relationship building is directed at parents when the children are very young, but the communication skills which underpin the process are also useful for working with older children and adolescents. For example, in the UK the FPM approach is also used in counselling work with children in schools.

The FPM training course is focused on making explicit the qualities and skills necessary for practitioners to engage with and assist families effectively, and each step of this helping process. A key feature of the model is that it provides a common, rather than context- or

discipline-specific, approach, and therefore can be used by practitioners from different agencies that have contact with families. The FPM has value for all practitioners regardless of professional background because it focuses on communication, adding this essential tool in family engagement to the professional or specific knowledge and expertise that each worker brings to their practice. In this way, as Keatinge, Fowler, Briggs, and Clark (2004, p. 5) claim, the FPM can be considered as “a vehicle for delivering professional and technical expertise” more effectively.

The FPM has been working well for families in the UK for over 25 years (see Appendix II), and has been piloted successfully in a number of European cities (Papadopoulou et al, 2005). Closer to home, FPM training is being offered to practitioners from different disciplines in all Australian states and territories. Over the past two years the Royal New Zealand Plunket Society (Plunket Society), in partnership with the Ministry of Social Development’s Family and Community Services has been training their staff and a limited number of practitioners from other agencies and organisations.

Because of the potential benefits of the FPM for practitioners from diverse agencies and organisations, the researchers expanded the general understanding of primary care practitioners. Practitioners who work with families, such as nurses working for the Plunket Society, in public health and general practice, and general practitioners, were included; but in addition we included groups in the community who are in contact with families in other capacities, such as the police, early childhood teachers and social workers. Throughout the report ‘practitioner’ is used as a generic term for all relevant workers.

¹ The Family Partnership Model was originally called the Parent Adviser Model.

2. BACKGROUND

This section discusses some of the issues relating to the provision of family support services in New Zealand, focusing in particular on those which could in part be addressed by the integration of the FPM into staff development and training. The need for effective family support services has been highlighted by frequent reports in the New Zealand media of child abuse and neglect, which generated widespread concern. Recent years have seen the development of a number of early intervention programmes, most of which have high drop-out rates. Often those that drop out are the most deprived families (see Fergusson, Horwood, Ridder, & Grant 2005; Kerslake Hendricks & Balakrishnan 2005; Livingstone, 1998; Ministry of Social Development (MSD), 2005a). In spite of funding being directed by successive governments into a range of new family support initiatives, there are still some families in which child abuse and neglect appear to be commonplace.

Child maltreatment is a multi-dimensional problem, involving complex interactions between individuals, families and communities (Saville-Smith, 2000). There is evidence that maltreatment is associated with socio-economic deprivation, fragile social networks, criminality, violence and substance abuse (Saville-Smith, 2000). There is no argument that the complexity of this problem and its multi-factorial basis require solutions at every level. This means addressing the structural, community and individual factors which make it difficult for parents to maintain their own health and wellbeing, as well as those of their children. This report, however, is concerned with the role of family support services, and the ways they can work, both individually and collaboratively where necessary, to improve the situation for vulnerable families in ways that do not further disempower and marginalise them.

The authors have noted three significant issues raised in the literature which affect the ability of practitioners to work effectively with families. Firstly, front-line practitioners need to have more education in the identification of and intervention in child and family mental health problems (Lacey, 1999; Ministry of Health, (MoH) 1998). This refers to mild to moderate mental health problems which may not always need a clinical diagnosis, such as behavioural difficulties with children, mild parental depression and stress. Equally importantly, however, it includes the ability

of practitioners to identify and make appropriate and prompt referrals for more serious conditions which require specialist diagnosis and intervention. Secondly, a number of policy reports have documented the urgent need for better communication and collaboration between the agencies and sectors that work with families (MSD, 2006; Office of the Commissioner for Children, 2000; Pakura, 2003). And thirdly, there is recognition of the importance of practitioners having regular access to skilled clinical supervision for effective and safe interventions (Braun, Davis & Mansfield, 2006; Brown, 2000; Sainsbury Centre for Mental Health, 2000).

These issues are not only referred to in policy documents and discussed in academic journals, but are also apparent in the practice arena. As each new case of child abuse or neglect is highlighted in the media, professionals working in the field of child health and welfare are increasingly speaking out. For example, after two infants recently died from abuse, a paediatrician from Auckland's Starship Children's Hospital suggested that there was a need to approach child protection as a public health problem, to increase the knowledge and awareness of primary care practitioners and for government and community agencies to work together (Kelly, 2007).

The call for a public health approach to child protection is also the considered view of Australian experts working in this field (O'Donnell, Scott, & Stanley, 2008). They argue that growing numbers of notifications for abuse and neglect in Australia mean it is difficult to provide a service that, apart from any other implications, is sustainable in terms of workforce capacity. Instead they suggest that a public health approach would provide a "platform of universal preventative services, secondary prevention with targeted services for at-risk families, and interventions at various levels depending on the risk of harm to the child and the needs of the family" (p. 329). Similarly, in New Zealand it has been noted that the volume of notifications exceeds the ability of staff and their agencies to respond in time (Brown, 2000). Therefore, a preventative approach which builds the capacity of primary care practitioners across agencies and organisations to intervene before problems escalate could be appropriate in New Zealand.

In New Zealand there are universal maternal and child health/tamariki ora services, and a number of other

services (such as early childhood education) that have contact with large numbers of families in a non-stigmatising way. Many of these services have emerged from the New Zealand context to meet the unique needs of families. Whatever their characteristics, however, the success of these services is still dependent on practitioners' ability to engage with families and maintain strong and open relationships so that problems can be identified and addressed early.

This is not an argument against current child protection strategies, but a call for preventative action where possible. Building the capacity of existing services to respond promptly to family difficulties can prevent the escalation of problems. If this can be done at the primary care level, then it is likely that some of the burden would be removed from child protection services, allowing them to focus on the more challenging family situations.

The FPM guides practitioners in the establishment of respectful relationships, not only with families, but also with staff from other agencies. At the same time it is a clear model which has the potential to address some of the key factors relating to good practice described above, such as the identification of unmet mental health needs in the community, encouraging inter-agency collaboration and providing FPM-related supervision to enhance, not replace, specific clinical supervision. These factors are examined in more detail below.

2.1 Community mental health

For the past 20 years, policy documents and reports have repeatedly highlighted the inability of our specialist mental health services to meet the needs of a large proportion of our troubled children and their families² (Health Funding Authority (HFA) 1998; Mental Health Commission (MHC), 1998, 2007; Ministry of Health, 1998; Minister of Health, 2005; New Zealand Board of Health Committee on Child Health, 1987).

As Finlayson, O'Brien, Makenna, Hamer, and Thom (2005, p. 4) have claimed, New Zealand has a "history of problematic and inadequate mental health services", in which workforce issues have traditionally been neglected.

There now appears to be an acceptance that, even with increases in funding, mental health services

are unlikely to meet the need (Capital and Coast District Health Board, 2005; HFA, 1998). This is supported by recent data suggesting that although services for children and young people have grown substantially, access rates still fall far short of targets, especially for Māori and Pacific children (MHC, 2007). In general, although Māori have high levels of hospitalisation, they have relatively little contact with community and primary care services for mental health problems (Baxter, 2007), suggesting there is scope for better preventative work in this area by community agencies.

Consequently, there are increasingly frequent calls for a new model of service delivery which builds the capacity of 'non-mental-health' primary care providers in the community to identify, assess and manage mild to moderate mental health problems, backed up by consultation, liaison and support from specialist mental health practitioners (Capital and Coast District Health Board, 2005; Minister of Health, 2005; MoH, 1997a, 1998, 2001; MHC, 1998, 2007; New Zealand Board of Health Committee on Child Health, 1987). This strategy is consistent with recent calls for a shift to a public health model of child protection with a focus on non-stigmatising community-based services (Kelly, 2007; Scott, 2006). A universal approach is particularly appropriate since identifying children at risk of injury or death through abuse or neglect is acknowledged to be extremely difficult (MSD, 2006).

Mild to moderate mental health disorders of children and adults can often be managed by primary services (MHC, 2007; MoH, 1998). This can reduce the burden on mental health specialists and free them to focus on children and young people with the most serious problems (Capital and Coast District Health Board, 2005; MHC, 1998; MoH, 1997a, 1998, 2001; New Zealand Board of Health Committee on Child Health, 1987). However, the training for primary care practitioners in child mental health is frequently limited or fragmented (Sebuliba & Vostanis, 2001), and these workers are often ill-equipped to deal with such problems (Lacey, 1999; MoH, 1998). Thus a new way of working will require extra training in the identification of psycho-social problems for those front-line practitioners who have contact with families (New Zealand Board of Health Committee on Child Health, 1987; MoH, 1997b, 2001).

² Latest data from 2006 show that the six-monthly access rate is 0.4 percent for children under nine years of age whereas the target is one percent (Mental Health Commission 2007, p. 78).

2.2 Inter-agency collaboration

The importance of inter-agency collaboration is receiving increased recognition, particularly at policy level (HFA, 1998; MHC, 1998; MoH, 2001; MSD, 2006). One report says, "...greater collaboration among government agencies and better-integrated service delivery [is] an essential way to address complex social problems and achieve better outcomes for citizens" (MSD, 2003, p. 2). The failure of agencies to communicate has been identified as a key factor in high-profile child homicides both in New Zealand (Office of the Commissioner of Children, 2000; Pakura, 2003) and the UK (Department of Health, Home Office and Department for Education and Employment, 1999; Stanley, Penhale, Riordan, Babour, & Holden, 2003). Research showing that a significant number of New Zealand families seek help from multiple agencies (Pavuluri, Luk, & McGee, 1996) suggests that collaboration is essential, not only to protect children from harm, but also to provide a seamless and appropriate service to all parents who need support.

In spite of calls for inter-agency collaboration, there is little robust evidence to date on the direct impact of inter-agency work on patient or client outcomes either overseas (Abbott, Townsley, & Watson, 2005; Polivka, 1995; Sloper, 2004) or in New Zealand (Sanders & Munford, 2003). While the direct outcomes for children and families may not yet be unequivocally substantiated by research, indirect effects from improved inter-agency working have been observed (Whittington, 2003). These effects include prompt and appropriate referrals (Moran, Jacobs, Bunn, & Bifulco, 2006; Norman & Peck, 1999; Polivka, Kennedy, & Chaudry, 1997), the establishment of common aims and objectives, an understanding of other practitioners' roles and responsibilities (Atkinson et al, 2002, cited in Whittington, 2003), and better personal and professional relationships (Abbott et al, 2005). As Leathard says:

The professions involved in joint working across health and social care services stand to gain much, in principle, from an interprofessional approach. The positive factors include: the sharing of knowledge and resources; enabling a more satisfying and supportive work environment, the widening of professional perspectives; encouraging overall service planning; achieving objectives more fully and economically; as well as maximising specialist skills (2003, p. 337).

There are three models of integrated service delivery operating currently in New Zealand to facilitate inter-agency collaboration (MSD, 2003). They are case management, one-stop shop and joint-funded service provision (MSD, 2003). Of these, the best known example is Strengthening Families, which operates widely in communities throughout New Zealand. This initiative uses a service co-ordination process with multiple agency and family involvement to assist families in high need (MSD, 2005b). Bringing agencies together to address complex family problems using a formal process or structure such as Strengthening Families has been shown to be beneficial for families (MSD, 2005b). However, the success of any such arrangement still depends on effective communication to ensure everyone is heard and respected.

It has been argued that "amongst NGOs ... the scramble for short-term and incomplete funding seems to have created competition and nervousness that work against interaction and co-operation" and that this "environment has the potential to augment the risk to children and their families" (Brown 2000, p. 88). If this is the case, it suggests that open communication is needed between family support services, not only between front-line staff, but at all levels within and between agencies.

2.3 Clinical supervision

The importance of skilled clinical supervision for all front-line practitioners working with families is well recognised in the literature (Braun, et al, 2006; Brown, 2000; Davis, et al, 1997; Sainsbury Centre for Mental Health, 2000). Clinical supervision has been defined as "a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations" (Department of Health, 1993, cited in Sines & McNally, 2007, p. 308).

It is important to note here that safety of care in New Zealand also includes cultural safety, where the concern is with the practitioner as "the bearer of his or her own culture and attitudes, and consciously or unconsciously exercised power" (Ramsden, 2002, p. 109). It is important that there is ongoing support for all front-line practitioners to examine their relationship with families in this light. In this way, supervision provides the time and space for practitioners to debrief,

reflecting on their thoughts, feelings and actions in a safe and supportive setting (Hadfield, 2000).

Research shows that employees consider it important to have dedicated time set aside for supervision (Sines & McNally, 2007). There is also evidence that supervision may influence the retention of families in services (McGuigan, Katzev, & Pratt, 2003). This is likely to be due to well-supervised practitioners working more confidently and skilfully within professional boundaries in the most complex situations, which can maintain the trust and engagement of parents. In addition, as Goddard, Saunders, Stanley, & Tucci, (1999) argue, supervision is important for the protection of the practitioners in their decision-making.

Although it is recognised that many factors affect family outcomes, the aim is for services to provide the best possible care for families in the community. Effective services are those in which practitioners have the skills and knowledge to engage and maintain relationships with families and communicate effectively with staff from other agencies; the ability to recognise, and refer clients with mental health problems promptly and appropriately, intervening where necessary; and the opportunity to reflect on and examine their practice through access to skilled clinical supervision. The FPM, which integrates these key factors into a single framework underpinned by a cost-effective training course, is described below.

3. THE FAMILY PARTNERSHIP MODEL (FPM)

The FPM, in which these essential components of good practice are integrated, is centred on effective communication in order to build the capacity of existing family support services to engage and work with families in the community. This model is a comprehensive and integrated way of working with families, and has been developed over the past 20 years by Hilton Davis and his team from Guy's Mental Health NHS Trust and the Child and Adolescent Directorate of Lewisham in the United Kingdom (Davis & Rushton, 1991; Davis & Spurr, 1998; Davis et al, 1997).

The FPM was initially set up to work with parents of children with physical or intellectual disabilities (Buchan, Clemerson, & Davis, 1988), but was extended in response to the evidence that there were children in the community with significant mental health needs which could not be addressed because of chronic shortages of specialist child mental health practitioners (Attride-Stirling, Davis, Day, & Sclare, 2000).

This finding prompted the development of the FPM to fit into a tiered system of mental health service delivery which is consistent with that of the United Kingdom NHS Health Advisory Service (see Appendix I). In this structure, front-line workers, such as child health nurses, general practitioners, teachers and social workers (Tier 1), are educated to help children and families with mild to moderate mental health problems, and expedite their referral to specialised mental health services in higher tiers when the problems are more severe. By building the capacity for 'non-mental-health' professionals to identify and intervene early with families' psycho-social difficulties, this model makes the delivery of professional expertise more effective (Keatinge et al, 2004).

In New Zealand, with the exception of Canterbury District Health Board (Swadi, 2005), mental health services are not specifically structured according to a formal tiered model to our knowledge. However, equivalent services are as follows. In New Zealand the front-line staff are the same as those who fall into the Tier 1 level of the FPM model. These include nurses, general practitioners, midwives, social workers and early childhood workers and other teachers. New Zealand Tier 2 equivalents would be Child and Adolescent Mental Health Services, counsellors, psychologists and primary care mental health workers. Some of this group would also provide

services at Tier 3 level within multi-disciplinary teams. Tier 4 equivalents are highly specialised outpatient teams and inpatient units, eating disorder and sexual abuse units. Whatever the particular system, seamless and timely referrals by agencies across and between tiers are essential for effective interventions with vulnerable families.

3.1 FPM training

The overall aim of the FPM training is to provide practitioners with the communication skills to establish and maintain effective working relationships with families. This is underpinned by the principle that families are respected, and outcomes are achieved through a partnership based on negotiating all stages of the interaction. Interventions aim to address the needs of the family as a whole, since it is recognised that children are affected significantly by how well the parents function (Davis et al, 1997).

The FPM is based on a short training course centred on a detailed examination of, and discussion about, the qualities, skills and processes involved in engaging and helping parents (see Davis, 2007b for more information). This course is standardised according to a published manual (Davis, Day, & Bidmead, 2002b) and consists of 10 weekly three-hour meetings. The purpose of this timeframe is to provide participants with opportunities between sessions to practise the particular skills covered by each session in the field and to reflect on this experience, both personally and within the group. In addition to the weekly skills practice, participants are given a book about the FPM (see Day, et al, 2002b) which they are expected to read. Each chapter of this text follows the course sessions closely and helps participants to consolidate information from each session and to prepare for the next. At times the course may take place over five weeks at weekly intervals of six hours for reasons of expediency and cost, if facilitators have far to travel.

The FPM training is based on adult education principles and is interactive, drawing on the expertise and skills of participants through discussion and role-playing of the client-practitioner encounter. Throughout the course, facilitators model the process as they interact with participants. If the training involves participants from different agencies, there are opportunities to gain more understanding of the different roles and responsibilities of other practitioners.

3.2 Theoretical perspectives

The FPM offers an eclectic framework for the building of effective relationships which is informed by a number of theoretical perspectives. The first of these relates to Rogers' seminal work in which he argues that psychotherapeutic change is governed by the same process regardless of the specific approach or professional knowledge of the therapist (Rogers, 1957, cited in Rushton & Davis, 1992, p. 1). This is supported by recent research which highlights the importance of the "therapeutic alliance" for positive treatment outcomes for both children and adults (Green, 2006, p. 432). In the FPM, this is expressed through certain personal qualities, such as respect, empathy, genuineness and integrity, considered essential to an effective working relationship.

More recently, training content has been influenced by Egan's approach which describes the helping process as "a progression of stages which provide the counsellor and client with a series of fundamental tasks each requiring the use of specific skills" (Rushton & Davis, 1992, p. 2). These steps include active listening, prompting and exploration, empathetic responding, encouraging, enabling change in ideas, negotiating and problem management (Davis, 2007b). There is an understanding that with the support and guidance of the skilled practitioner the parent can generally identify their own solutions to difficulties. This is a strengths-based approach which is intended to enhance the self-esteem of the parent.

Finally, there is Kelly's (1991) personal construct theory. This assumes that individuals are involved in the process of constructing models in order to make sense of events, and that there are alternative ways to perceive a situation (Rushton & Davis, 1992). The advantage with construct theory is that it provides a single framework which enables participants not only to meet the needs of families but to examine how their own perceptions influence assumptions about the people they are aiming to help (Rushton & Davis, 1992). Construct theory can have useful application in situations where parental perception of a child is unrealistic and negative, particularly since this has been shown to have implications for child maltreatment (for example, see Saville-Smith, 2000).

3.3 Supervision

The clinical supervision of frontline practitioners is an integral component of the Family Partnership Model. The tiered UK structure (Appendix I) provides for supervision and consultation by Tier 2 practitioners, who are also available to take referrals from frontline practitioners. In the Oxford study practitioners were provided with access to group supervision every eight weeks and one-to-one consultation where necessary, with the supervisor available for consultation between sessions (Barlow et al, 2005). In New Zealand the importance of supervision for frontline practitioners is increasingly recognised, but costs may prohibit regular access to skilled supervisors. However, Braun, Davis and Mansfield (2006, p.21) say, "supervision is crucial to service provision in which psychological and social issues are involved. Helping can be a difficult task, in which the practitioner is frequently exposed to the distress of others and [there is] uncertainty about outcomes achievable".

While supervision is seen as critical to the success of FPM, the emphasis in New Zealand – which was reinforced in Dr Crispin Day's visit in 2008 – is on the way that introducing FPM into the supervision process reinforces the learning on the course, and assists with embedding the model in practice. In New Zealand, supervision has not been linked to the tiered system of care. It is important to note that while FPM supervision can enhance professional clinical supervision, it cannot replace it.

3.4 Advantages of FPM approach

The particular advantages of the FPM approach are that it:

- > builds on and develops the capacity of universal and targeted services that work with families
- > engages with families using a non-stigmatising partnership approach which encourages their recruitment and retention in programmes and services
- > is consistent with New Zealand cultural safety imperatives which prioritise the establishment of a relationship of trust and equality, based on respect for individual diversity

- > provides more expertise to a greater number and range of families by adding to the skills of front-line workers
- > promotes earlier identification by front-line staff of psycho-social problems, to ensure prompt intervention and referral
- > may prevent the development of mental health problems and in some measure free up specialist mental health practitioners to work with families with moderate to severe psycho-social problems
- > breaks down inter-agency barriers, encouraging collaboration and communication to facilitate early identification, and appropriate intervention or referral
- > promotes a common language and understanding of goals among agencies, disciplines and sectors through the common training module
- > has built-in professional consultation and clinical supervision for front-line staff.

A partnership approach to working with families which starts from parents' own expertise and insights is considered to be most effective (Osofky & Thompson, 2000). This is not surprising, as there are indications that stigma or the perception that they are not coping may inhibit some parents' willingness to ask for help (Colton, Drury, & Williams, 1995; Keller & McDade, 1997; Phoenix, 1991; Quinton, 2004). Parents want to be heard and respected, and they value professionals they can trust (Jack, DiCenso, & Lohfield, 2005; Quinton, 2004; Stanley et al, 2003). These are prerequisites for positive outcomes since, according to Brooks-Gunn, Berlin, and Sidle Fugliani (2000), parents must be genuinely engaged with services if benefits to the family are to be fully realised.

It has been suggested that it is the process of engagement between the service and its users, rather than the content of programmes, which may be the most significant factor in family support (Barrett, 2003; Freude-Lagervardi & Barnes, 2002, cited in Katz & Pinkerton, 2003; Moran, Ghate, & van der Merwe, 2004). This is supported by evidence that the therapeutic relationship, regardless of treatment characteristics or content, has an association with positive outcomes for children, adolescents and adults (Green, 2006; Shirk & Karver, 2003).

The emphasis on the relationship between service provider and user, rather than programme content, raises questions about the structure of, for example, some parent education classes, which are at times promoted as a possible solution to child abuse and neglect (Dominion Post, 2002, 2005; New Zealand Herald, 2005; United Future NZ Party, 2005; Ruscoe, 2002). There may be perceptions of a 'didactic' and traditional approach, which parents in families where children are most at risk may avoid because they have already experienced failure in the education system (MSD, 2006, citing Cavanagh et al, 2005). In addition, the teaching of parenting skills, which may be helpful for other parents, is less likely to be effective with parents who have mental health problems, such as substance abuse or depression. These parents often have difficulties being emotionally available to their children (Osofky & Thompson, 2000; Quinton, 2004). An experienced child psychotherapist observed recently:

The most inadequate, damaged and damaging parents need much more than someone teaching them how to behave. Education, by itself, ignores the fact that these behaviours are deeply embedded in their psyches. In attachment terms, their violent and abusive behaviours have a survival meaning for the parents and thus require a mental health approach if anything is to change. However, there is little if any appreciation of the value of, and need for, preventative intervention. And there is no real examination of what we lack in our mental health services to address the problems (Muir, 2007, p. 7; see also Karen, 1994).

3.5 Evidence of FPM effectiveness

There is a growing body of evidence that the FPM promotes child and family wellbeing (see Annotated Bibliography in Appendix II). Studies have found that it improves parental self-esteem, mother-child interaction and child behaviour, and decreases parental stress (Barlow et al, 2005; Davis & Spurr, 1998, Puura et al, 2005). Mothers in one intervention group saw their children as more affectionate, easier to handle and healthier compared with those in the control group (Davis & Rushton, 1991). Participants found the training acceptable and effective in preparing them to help with psycho-social problems and build relationships with families (Davis et al,

1997; Keatinge et al, 2004). The training significantly improves the ability to identify family needs accurately (Papadopoulou et al, 2005) and deal with family problems without needing to refer (Davis et al, 1997). The model has also been shown to be cost-effective (Knapp et al, 2005).

Since retention, particularly of the most at-risk families, is an issue for most early intervention programmes (Sherwood, 2005), it is important to note that the FPM has been found to be highly acceptable to parents (Barlow et al, 2005; Davis et al, 2005; Davis & Spurr, 1998; Day & Davis, 2006). This is demonstrated by the high 97 percent retention rate³ of the most vulnerable families over three years of a Randomised Control Trial of the FPM conducted in Oxford (Barlow et al, 2005).

To date there has been no research to our knowledge on the effects of the FPM on family outcomes in New Zealand or Australia. However, participants' evaluation feedback has shown high rates of satisfaction with the core courses run by New Zealand facilitators (Bigsby, 2007).

An added advantage of the FPM is that the training is not limited to front-line staff, but can also benefit managers or others in organisations. One study has indicated that it is also a practical and cost-effective way to build the capacity of lay people from other backgrounds to work successfully within their own communities (Davis & Rushton, 1991).

It needs to be noted that, unlike other programmes, projects or schemes for families, the FPM is not a defined programme of service delivery. For example, it is different from David Olds' Nurse-Family Partnership, which is a comprehensive nursing service aimed at low-income, unsupported mothers, delivered in accordance with consistent and comparable criteria (Nurses and Mothers, 2008). In contrast, the FPM has application for any practitioner from any field because it is concerned with the process of relationship building, not the content or method of service delivery. For this reason, although it is a model developed overseas, it can improve our indigenous community services, or for that matter, any other service.

³ The control group also had a high retention rate of 93 percent which, according to the researcher, was thought to be due to an incentive given at the time of data collection (Barlow, J. (2006). Personal communication, 15 August).

4. STUDY DESIGN

At the end of 2006 funding was received from the Families Commission Blue Skies Fund to conduct a study to assess interest in the FPM by New Zealand family support agencies and its appropriateness for their practitioners. The objective was to approach a representative range of agencies, both NGO and government, providing information on the model and seeking their views.

Although in the UK, Europe and Australia the FPM training has primarily been undertaken by practitioners from primary health care, at times staff from other community agencies have also been involved (for example, see Davis & Rushton, 1991). To date the effects of this joint training on inter-agency collaboration have not been evaluated, although there is recent anecdotal evidence from Australia and Europe that the FPM can strengthen local networks and improve communication (Davis 2007a; Lamont, 2003⁴). This is not surprising, since the training focuses on the process involved in building effective helping relationships with parents, and better communication between people generally (see Braun et al, 2006).

Consequently, it was decided that it was more relevant to take a broad cross-sector approach to the project. Rather than limit comment to services and practitioners traditionally associated with child and family health and wellbeing, such as WellChild/Tamariki Ora, practice nurses and general practitioners, we would seek the views of groups who work in various capacities with families in the community. They included the police, early childhood education, refugee and migrant services and childhood disability services. As Leiba (2003) argues, collaboration between agencies can be improved by inter-professional education and training that includes workers from the voluntary sector, housing, education and police. This view is consistent

with that of an expert in child protection, who calls for “a whole of government approach ... with strong inter-sectoral collaboration across health, housing, employment and social services” (Scott, 2006, p. 10).

In addition, because primary care services at times need to communicate and consult with specialist mental health services over appropriate interventions or referrals, meetings were also held with providers of, or practitioners from, specialist mental health services. It was important to discuss the FPM interface with their services and whether building skills of front-line staff in this way could be helpful.

The providers of specialist services were the Canterbury District Health Board, which is initiating a system of tiered mental health services, loosely modelled on the UK structure, and the Werry Centre for Child and Adolescent Mental Health, which is concerned with workforce development. Contact was also initiated with a Child and Family Service and a child psychiatrist and infant mental health clinician. We also had early discussions with and support from Capital Coast Health District Health Board Primary and Community Care management team in the expectation that we might offer a FPM inter-agency pilot in their area if funding was available.

Meetings were held over the year with Plunket Society personnel responsible for delivering the FPM core training, and members of the Ministry of Social Development's Family and Community Services (FACS), which has funded the training and dissemination of this model through their partnership with the Plunket Society. Both organisations were supportive of this work and at the end of 2006 one researcher undertook the FPM training alongside SKIP team members and practitioners from the Plunket Society, Barnardos, Parents as First Teachers/Ahuru Mōwai and Family Start, which provides a targeted early intervention programme to vulnerable children and families.

⁴ Lamont, L. (2003). Personal communication, 14 July

The Plunket Society has now trained large numbers of their own staff, including staff at managerial level, and also a number of practitioners from other agencies and organisations. By the end of 2007, 137 participants had completed the Level 1 (core) training, with 29 undertaking the Level 2 (facilitator) course and three people completing the Level 3 (train the trainer) course (see Appendix III) (Bigsby, 2007). The aim is to build up a diverse group of facilitators from different agencies (Chamberlain, 2007).

4.1 Method

Twenty-two agencies and organisations representing a wide range of services were approached by email, phone or in person. If an email approach was made, a covering letter to explain the purpose of the study was sent (for an example, see Appendix IV). If a positive response was received, a meeting was arranged with key personnel, or if that was not considered necessary, documents describing the model generally and the training specifically were forwarded either in hard copy or by email. Contact by phone and email was then made to arrange meetings where requested or address any questions.

After meetings and/or the provision of material on the FPM, agencies and organisations were followed up with a request for their views about the model's applicability in relation to their specific service provision. They were advised that comments would be included in this report, to be published by the Families Commission. Some agencies and organisations provided a hard copy in addition to an email. Eight agencies and organisations who expressed interest in the model did not provide a written response before the deadline, so their views could not be included in the report. Table 1 provides the agencies, organisations and individuals who gave us a formal written response.

Table 1: Agencies, organisations and individuals who provided feedback

Auckland Women's Health Centre Teen Parent Project
Barnardos SKIP Learning and Development Co-ordinator
New Zealand College of General Practitioners
New Zealand Police
New Zealand Childcare Association
Presbyterian Support Upper South Island
Waahi Whanui Trust, Huntley
Werry Centre for Child and Adolescent Mental Health
Child psychiatrist and Infant Mental Health Clinician
Paediatrician and Clinical Chair Hunter Children's Health Network

The researchers also took the opportunity to further disseminate information about this model to people working in child and adolescent mental health, with a presentation to the New Zealand Child and Adolescent Mental Health and Addictions Service Conference in Hamilton in September 2007 (Wilson & Huntington, 2007). This conference was particularly relevant as its theme was the importance of working collaboratively to ensure the needs of children and young people are met (Werry Centre/Waikato District Health Board, 2007, p. 2). As a result of the presentation (available online at www.werrycentre.org.nz), we were contacted by an organisation with an interest in providing this training jointly to staff of agencies working in the area (Appendix Vg). Similarly, at a Families Commission Research Seminar presentation in Wellington (Wilson & Huntington, 2008), a policy analyst from a government department expressed interest in the model for front-line workers in her domain, and we put her on to the trainers through SKIP.

5. DISCUSSION

Although meetings were held with a number of agencies, organisations and individuals, to ensure the views of the respondents are reflected accurately, discussion is limited to the formal responses (see Appendices V and VI for full responses) alongside a consideration of the literature. Because of the small number of responses, some of which are relatively short, it is not possible to infer themes or patterns, and statements must stand as the view of the responder. Responses are discussed in the following section, which also covers the limitations of the study.

5.1 Building capacity

On the whole, the groups approached were positive about the potential of the FPM for their staff and service users. However, people who employed, or worked as, social workers felt that these professionals were generally given this type of training and already had the necessary skills in this area. For example, the then Advisor, Care and Protection, at Child, Youth and Family Services advised us that the current social work training programme incorporates all the components of the FPM (Muckenberger, 2007⁵).

On closer scrutiny, one provider decided that this model could benefit his organisation and its work with clients. Vaughan Miller, of Presbyterian Social Services Upper South Island, reported:

At first glance the Family Partnership Model appeared to be a packaging of some very basic social work concepts. This is the bread and butter core of an agency like Presbyterian Upper South Island with its focus on flexible community based social work using qualified social workers. We know that strong, supportive relationships and a client/worker partnership is the critical component to sustainable change. I was unsure about introducing another variation on a theme, and another model. We have since looked at the Family Partnership Model carefully and have committed to some joint training with Plunket for three of our Family Works staff. We will then progressively look to train more staff in the use of the model throughout our region. We have decided to do this as we can see that the model integrates well with our commitment to nurturing social connection and sustainable social support networks with our clients in centered communities (Appendix Ve).

It was also acknowledged by Sue Treanor, Director of Workforce Development from the Werry Centre for Child and Adolescent Mental Health, that the FPM could benefit the primary care sector by building the capacity of front-line practitioners to identify mental health problems early and work with or refer families appropriately (Appendix Vh). She says there is a “need to increase the skills, knowledge and capacity of the primary health sector to deliver effective early interventions for mental health disorders” (Appendix Vh). This is of critical importance since there is a chronic shortfall of mental health specialists, and these shortages are:

compounded for the child and adolescent mental health workforce however, due to the relatively small size and low sector profile of infant, child and adolescent mental health, and underdeveloped pathways into the field. We must also build and sustain the level of knowledge and skills of the other workforces responding to infants, children and young people and their families and whānau; the primary healthcare workforce, other government service workforces and related community sector workforces, to deliver a comprehensive response across the tiers of service delivery (Appendix Vh).

Similarly, Dr Denise Guy, a child psychiatrist and infant mental health clinician, considers that the FPM can build:

capacity in the community workforce, improving practice and thus the possibility of improving outcomes for infants and preschoolers who have mild to moderate problems. Improved practice leads to more accurate identification of children and families’ needs and referral for additional assessment and intervention in more severe cases (Appendix VIa).

Recent attempts have been made to address workforce capacity and capability in the mental health sector. This includes Primary Health Organisation (PHO) workforce capacity and capability in managing high-prevalence mental health issues such as depression, anxiety and addictions. The Primary Health Care Strategy implementation supported the development of 25 initiatives involving 41 PHOs and 17 District Health Boards (DHBs) aimed at the development of primary mental health capability.

⁵ Muckenberger, M. (2007). Personal communication, 9 May

The focus of these new initiatives is largely on people with mild to moderate mental illness and involves “workforce development elements to support primary health-care practitioners to manage common mental health disorders” (Johnston, 2006). Dr Sue Pullon, from the Royal New Zealand College of General Practitioners, points out that these are currently being evaluated and most of them take an inter-disciplinary approach (Appendix Vf). While a number of these new initiatives do include the further education and training of staff, this is mainly limited to professionals from the health sector such as nurses and general practitioners, and it is not always clear whether any training is done jointly across agencies and sectors.

However, it is important to take a broad approach to primary care providers if services to families are to be effective. One sector that has sometimes been overlooked in terms of integrated service delivery is education. In particular, an Australian specialist in child protection suggests that services such as early childhood education are underutilised in this capacity (Scott, 2006). The advantage with universal services such as education and health is that they can provide, as she argues, an “unstigmatised platform” from which assistance can be offered to families (p. 13).

There is no doubt that early childhood education is ideally placed to detect problems early, particularly as there are rapidly increasing rates of children participating in pre-school care (MSD, 2007).⁶ As Colin Tarr, the then Director of Teacher Education from the New Zealand Childcare Association said:

As early childhood centres and schools are often the first places where concerns regarding children’s development and wellbeing may become apparent, having a responsive and coordinated approach to helping families is necessary. The FPM approach would seem to be a useful approach and set of tools to promote this (Appendix Vc).

The Projects Co-ordinator from the Auckland Women’s Centre, Annalise Myers, has seen the benefits of the FPM training in strengthening the work of practitioners. She argues that this training is important for capacity-building in the NGO sector in a professional and cost-effective way (Appendix Va). However, for this to be effective in practice, agencies in the field need to be

prepared to talk to each other and work collaboratively with the most vulnerable families.

5.2 Facilitating collaboration

Evaluations of a range of family support programmes in the UK found that a partnership with users and interdisciplinary and inter-agency co-operation were key characteristics of successful programmes (Pinkerton & Katz, 2003). According to Vaughan Milner, of Presbyterian Support Upper South Island, the FPM training provides “a common understanding of a way of working between us and Plunket [which] will benefit the clients we have in common and greatly strengthen collaborative service delivery” (Appendix Ve). This view highlights the advantages of providing a standardised training course to staff from different agencies, either as inter- or intra-agency education.

A similar point was made by Sue Fielding, Health and Education Service Manager from Waahi Whānui Trust in Huntly. She said that her agency, which is involved with other community agencies in the Huntly Addressing Violence initiative, “would be very interested in joint interagency training in the [Family Partnership Model] that will strengthen our respective services to talk and think similarly when it comes to the mental health of our children” (Appendix Vg).

These comments reflect the recognition that interagency collaboration across sectors can be problematic for community agencies (Secker & Hill, 2001). The importance of shared values and vision across family support agencies and their front-line staff in the facilitation of inter-agency communication has been highlighted in the literature (Davis & Sims, 2003; Kenny, 2002; Wimpfheimer, Bloom, & Kramer, 1990). In Australia, Polivka and her colleagues (2001) found that an awareness of personnel, goals and services of other agencies was essential for good inter-agency process and perceived outcomes (see also Darlington, Feeney, & Rixon, 2005; Johnson, Wistow, Schultz & Hardy, 2003). In New Zealand the police are working to improve relationships and information-sharing among agencies to respond more effectively to family violence, among other things (see Appendix Vd).

However, education has traditionally been delivered within one professional group or agency, which

⁶ Current rates of early childhood education participation stand at 97 percent for three-year-olds and 103 percent for four-year-olds (confirming that some of these attend more than one service) (MSD, 2007).

limits exposure to other practitioners' roles and responsibilities. In 1988 the World Health Organisation called for multi-professional education as an addition to specific disciplinary training to encourage health professionals to work together to meet the priority health needs of the population. Since then, shared or joint training is increasingly being implemented across disciplines, with one objective being to eliminate inter-agency barriers and encourage practitioner collaboration (Freeth & de Saintonge, 2000; Parsell & Bligh, 1998).

Support for joint training and development for service co-ordination has also been highlighted in New Zealand policy documents (MoH, 1997b). Joint or shared training has been recommended as a strategy to encourage the understanding, respecting and valuing of the roles of other professionals (Johnson et al, 2003; Sloper, 2004). This is supported by the findings of a review of literature on inter-agency working, which found that joint training benefited working partnerships (Tomlinson, 2003; see also Sainsbury Centre for Mental Health, 2000). Other studies have found that joint training can improve attitudes and collaboration between agencies (Parsell & Bligh, 1998; Rudland & Mires, 2005; Sebuliba & Vostanis, 2001). However, for inter-agency collaboration to be effective, families first need to be retained in services; and engagement is mediated by trusting relationships with practitioners.

5.3 Strengthening relationships

The critical importance of building strong and respectful relationships has already been discussed. At the very least, positive outcomes for families are predicated on the engagement and retention of families in services so that problems can be identified and managed promptly. However, the establishment of relationships between practitioners and service users is sometimes taken for granted. The FPM provides practitioners with the tools and knowledge to step back and critically examine their relationships with parents and families. Establishing boundaries is an important part of effective practice, since, Dr Guy says, "when professionals within helping/statutory organisations have not been able to separate themselves from identifying with parents [they] have not made decisions in the best interests of children" (Appendix VIa).

Fundamental to the FPM training is building a respectful trusting partnership with families, and in this

sense it is consistent with cultural safety obligations. Jean Ellerby, the SKIP Learning and Development Co-ordinator from Barnardos, says:

There is little doubt that the opportunity [the FPM training] offers to self critique one's skills, qualities, processes and communication, is of maximum benefit to assist in all types of relationships, whether those be parent/child, staff/client or supervisor/supervisee. The best tools we have in the work that we do within the organisation are our communication and relationship building skills. The FPM can only serve to improve these and therefore make our practice more effective. Rarely do we have the opportunity to practise and understand in such depth what we do in our relationships and to fill in parts of the process that previously haven't been acknowledged or understood (Appendix Vb).

This highlights the importance of developing relationships not only with clients but also within and across the agencies. Agencies that do not have healthy internal and external relationships are less likely to work effectively for their clients. Morrison says, "partnership with families cannot be considered separately from partnership practice between and within agencies ... if partnership is to become a reality, it must be ingrained and modelled within organisational structures, cultures and working relationships" (1996, p. 135).

This consideration is reflected in the comments of an Australian paediatrician who did the FPM training:

As a service manager, I've found the skills are valuable in my management role, both in dealing with staff and also in negotiations with managers senior to me. Organisational climates would be a lot healthier if all managers showed attitudes of respect towards staff, were careful and accurate listeners, and had and used the skills of demonstrating empathy, or working with other staff at problem-solving without taking over, and gently challenging others' assumptions when necessary (Appendix VIb).

As these comments suggest, the advantage with the FPM is that the training is not limited to professionals but can benefit people generally. As a short course focused on improving communication, it is also an effective way to build the capacity of non-professionals from all backgrounds to work effectively within their own communities.

5.4 The New Zealand context

In New Zealand there is a requirement for service providers and practitioners to meet Treaty of Waitangi obligations. According to Tolich (2004, p. 14), to be culturally safe in any setting a practitioner should “understand her/his culture and the theory of power relations”. This notion of cultural safety is based on the reality that practitioners are rarely totally conversant with the values, beliefs and practices of other cultures. Instead, an awareness by practitioners of their own cultural standpoint, particularly in terms of the power vested in that position vis-à-vis the client, is considered fundamental to safe practice (Ramsden, 2002). In practice, the FPM is consistent with cultural safety imperatives, which put the onus on the New Zealand practitioner for “the professional acquisition of trust ... [and] an obligation to provide care within the framework of recognising and respecting the difference of any individual” (Ramsden, 2002, p. 118). The appropriateness of this model for Māori whānau and Pacific Aiga would be a useful area for further exploration.

The notion of cultural safety highlights the importance of clinical supervision. As discussed earlier, supervision allows the time and space for practitioners to reflect on their thoughts, feelings and actions in a safe and supportive setting (Hadfield, 2000). This provides the opportunity to explore issues around safe practice with families in terms of power relationships, and how one’s attitudes and feelings may affect practice in ways that might be unhelpful, or even harmful to clients.

As Dr Guy points out, the FPM provides guidance on:

...supervision that is ongoing and regular, modelling the helping processes, addressing the reverberation between the experiences of the professionals and the experiences and characteristics of the parents and children. This type of supervision is rarely in evidence in New Zealand within these universal [WellChild Framework] and targeted community interventions. As a consequence the difficulties of engaging and retaining at-risk families is

superficially understood and the outcomes of the interventions poorer than they should/could be.

The importance of good supervision cannot be emphasised enough in this work and is a critical strength of the FPM (Appendix VIa).

However, there are issues with adequate resourcing for this model to be effectively implemented in New Zealand. The provision of skilled clinical supervision, whether in a group or one-to-one, is time-consuming for staff, and also incurs an added service cost if practitioners need to be replaced. Skilled supervisors also need to be appropriately remunerated.

In addition, as Dr Sue Pullon, from the Royal New Zealand College of General Practitioners, says, “communication between front line providers in different sectors (especially across the education/social development/health boundaries) is an inordinately time consuming process, added on top of already full workloads” (Appendix Vf). It is difficult to know how to solve this problem, as time is always in short supply for busy practitioners, and funding does not usually ring-fence non-contact time in this way. However, the question to be asked is: If we are serious about the wellbeing of our families, can we afford to ignore this important component of effective practice?

5.5 Limitations

There are a number of limitations to this study which need to be acknowledged. At times there were difficulties either contacting an agency or organisation to arrange a meeting, or, after contact, obtaining a formal response for inclusion in this report. Time limitations and practical considerations meant that some groups could not be contacted at all or did not supply responses before the deadline. It is acknowledged that this report therefore covers a small number of services and should be read with this limitation in mind. Comments by participants are not representative of common themes but the viewpoint of the commentator. In addition, there is likely to be a bias in favour of the model, since those groups with reservations may have been less likely to follow up a request for a meeting or provide a response.

6. CONCLUSION

A number of agencies have expressed interest in the FPM and some are training, or have already trained, their staff in this approach. Conference and seminar presentations on the FPM by the authors have also drawn interest from policy analysts and practitioners. This suggests the FPM has potential for existing services working in the field with New Zealand families.

Although training has at times been undertaken with participants from different agencies both in the UK and New Zealand, it is not known how this has affected their collaboration in situations where they are working with the same families. It is possible that a deliberate strategy to train people from the same geographical areas, but from different agencies, might encourage collaborative relationships, and there is anecdotal evidence to this effect (Davis, 2007a; Lamont, 2005⁷). However, it would be important to evaluate not only the effects of inter-agency collaboration, but also its contribution to meaningful and measurable family outcomes.

It is recognised that agencies often provide supervision for their staff, but it is not known how regularly, and whether it is peer supervision or a higher level of clinical supervision. There is no doubt that supervision adds to service overheads, not only in staff time but also the costs of professional supervisors. However, regular access to skilled supervision for practitioners working with complex family problems is essential for optimum family outcomes.

As Davis, Day, and Bidmead suggest, the way forward may be:

...to develop a network that forms an effective system of care, and not a set of discrete workers with entirely different and seemingly unrelated roles. A system of care refers to a universal service that works with parents systematically to promote the psychosocial development of their children to prevent problems from arising, to identify special need early, and to evaluate effective strategies at the appropriate level of specialisation... (2002a, p. 5).

As a short, focused additional training module, the FPM may be an effective way of improving existing services, whether universal or targeted, by helping front-line practitioners to work more skilfully to intervene or refer promptly in complex family situations. It also has additional value as the skills gained can improve communication generally in any setting.

The FPM also has the potential to eliminate barriers between agencies and organisations, building trust and encouraging communication across sectors. Training in this approach will take time, money and commitment from government, stakeholders and practitioners. However, better support services which can recognise family difficulties before they escalate, and help practitioners to work together where problems are complex, can be cost-effective and beneficial for children and their families.

⁷ Lamont, L. (2003). Personal communication, 14 July

7. IMPLICATIONS FOR POLICY AND PRACTICE

In view of the interest expressed in the FPM from a range of service providers, and the growing evidence of its effectiveness, the authors consider that a cross-sector strategy for funding and training staff in this model could be developed at policy level. This would be consistent with the move to co-ordinated approaches to service delivery across government, particularly for vulnerable families.

Since increasing numbers of New Zealand practitioners, both professional and paraprofessional, are already being trained in this model, rigorous evaluations of its effectiveness in the New Zealand context should

be undertaken. This is essential if the FPM is to be implemented more widely in the future. It would also be useful to include an assessment of the impact of FPM training on inter-agency communication, particularly if the training has been undertaken jointly across sectors.

If evaluations show that the FPM improves practice and benefits New Zealand families, then consideration at policy and operational level of how it can most efficiently and cost-effectively be integrated into staff development training across sectors can be undertaken. This may include an investigation of its potential for inclusion in core training (in undergraduate nursing, social work or medicine, for example), and also whether it might benefit paraprofessionals or parents themselves.

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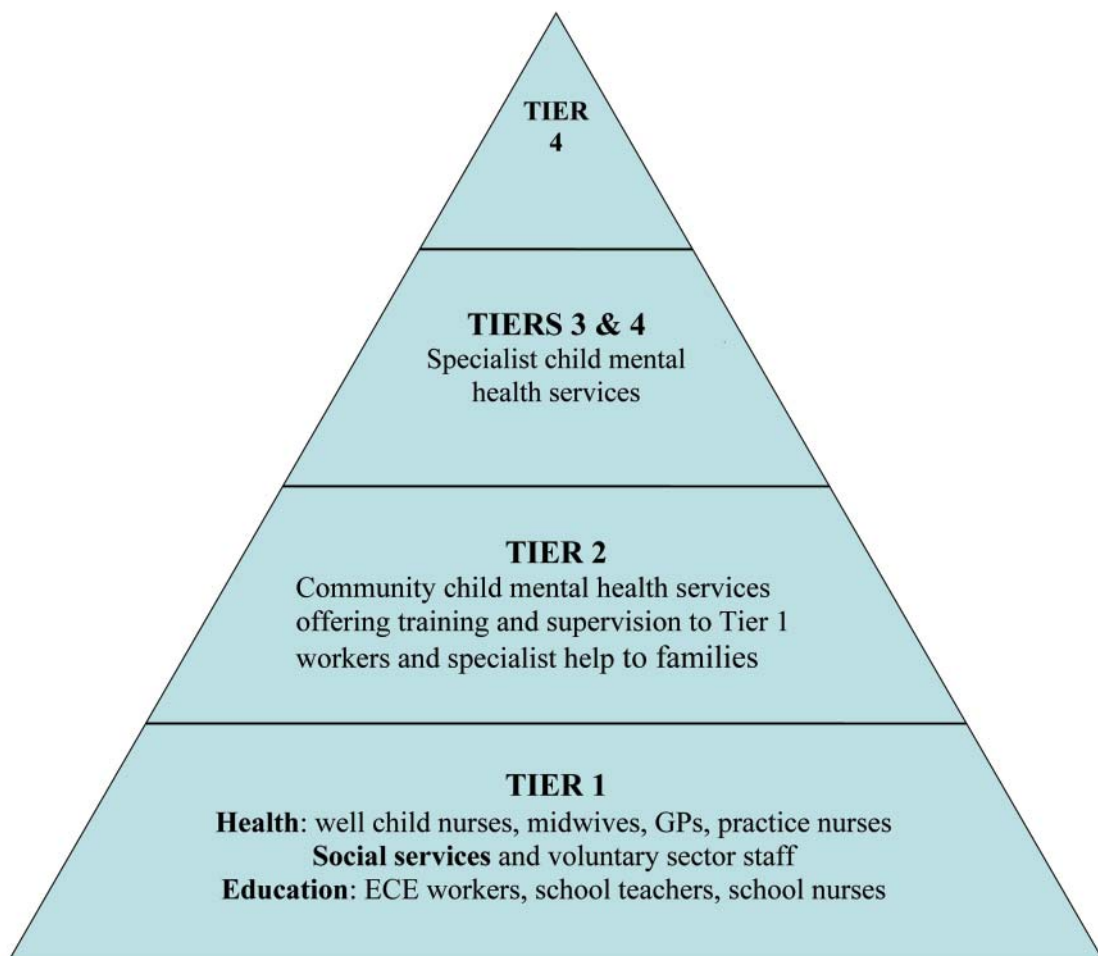
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APPENDIX I

Tiered child mental health services

As developed by Guy's Mental Health NHS Trust and the Child and Adolescent Directorate of Lewisham



Source: Day, C. (2002).

APPENDIX II

Annotated evaluations of the Family Partnership Model

Barlow, J., Stewart-Brown, S., Davis, H. et al. (2005). *The Oxfordshire home visiting study: Final report.*

This three-year multi-centre RCT of the effects of home visiting using the partnership approach with vulnerable families found that the intervention group mothers had improved confidence, mental health and attunement with their infant and concluded that the partnership model can affect home visitors' practice in ways which are valued by professionals and parents. Although many of these parents were initially hostile towards the health visitor, there was an extremely high 97 percent retention rate, indicating satisfaction with the intervention.

Davis, H., Dusoir, T., Papadopoulou, K. et al. (2005). "Child and family outcomes of the European Early Promotion Project". *International Journal of Mental Health Promotion*, 7(1): 63-81.

Using a group comparison design, an evaluation of family outcomes of a similar project across Europe (developed internationally but based on the Family Partnership Model), the European Early Promotion Project (EEPP) showed a number of differences favouring the intervention group, particularly in regard to mothers' satisfaction with the service. The Greek sample showed the most significant improvements, including less depression, higher self-esteem, better relationships with partners and better relationships with their children, who showed fewer behavioural difficulties.

Davis, H., & Rushton, R. (1991). "Counselling and supporting parents of children with developmental delay: A research evaluation". *Journal of Mental Deficiency Research*, 35: 89-122.

Volunteers trained in the Parent Adviser Scheme (now Family Partnership Model) from different disciplines, including education and health, plus a parent from the Bangladeshi community, were employed to visit both Bangladeshi and English-speaking families of children with intellectual or physical disabilities. Compared to randomly allocated controls, mothers in the intervention group showed significant and positive changes in ratings of perceived support and family functioning, and in their constructions of their child, themselves, their partners and their family relationships. The children also showed improvements in developmental progress and behaviour. Greater benefits occurred with the more deprived and poorly supported families.

Davis, H., & Spurr, P. (1998). "Parent counselling: An evaluation of a community child mental health service". *Journal of Child Psychology and Psychiatry*, 39(3): 365-376.

Comparisons were made between a group of families who received the services of specially trained health visitors or paediatric clinical medical officers, and a group of families who received standard services only. These groups were reasonably matched on all demographic variables. Families were considered to be very needy, with 70 percent of children judged to have more than one problem and 38.3 percent three or more. According to information received from the referrers, 43.2 percent of families would have been referred elsewhere (mainly to specialist child mental health services) if this scheme had not existed. There was evidence of higher parental self-esteem, less parental stress and fewer emotional difficulties, more positive constructions of their children by parents, better home environments and decreased child behavioural problems. The nurses, and the parent-nurse relationship, were also seen very positively by the mothers.

Davis, H., Spurr, P., Cox, A., Lynch, M., Roenne, A., & Hahn, K. (1997). "A description and evaluation of a community child mental health service". *Clinical Child Psychology and Psychiatry*, 2(2): 221-238.

The training course for the community children's mental health service, provided to health visitors and paediatric community medical officers, was considered acceptable to non-mental health professionals and effective in preparing them to work with psycho-social problems. It was also found to be acceptable to both referrers and parents, and beneficial for a majority of families living in a very deprived inner-city community, as assessed by the workers.

Day, C., & Davis, H. (2006). "The effectiveness and quality of routine child and adolescent mental health care outreach clinics". *British Journal of Clinical Psychology*, 45: 439-452.

Using a quasi-experimental design, this study showed that outreach child mental health services operating at the primary care interface made a considerable reduction in the severity of children's problems, distress and impairment, and particularly behavioural difficulties, but had no effect upon outcomes for children's emotional problems or parental stress. High ratings of satisfaction were obtained for many aspects of service delivery.

Keatinge, D., Fowler, C., Briggs, C., & Clark, M. (2004). *Report: Evaluation of Family Partnership Model (FPM) training and its possible impact on child and family health nurses' practice and client care*. University of Newcastle and Hunter Health.

An evaluation of Level 1 training found that the 16 participants in this training (including social workers, doctors and senior clinical nurses) found FPM had a positive effect on their ability to build relationships with families, on their communication skills, self-awareness and ability to reflect on practice.

Knapp, M., Barrett, B. et al. (2005). "Primary prevention of child mental health problems using primary health care professionals: Cost comparisons". *International Journal of Mental Health Promotion*, 7(1): 95-102.

Training and supervision of primary health-care professionals in the primary prevention of children's mental health problems was found to be inexpensive and does not appear to affect total costs related to service use in the two years immediately following the intervention.

Papadopoulou, K., Dimitrakaki, C., Davis, H., Tsiantis, J. et al. (2005). "The effects of the European Early Intervention Promotion Project training on primary health care professionals". *International Journal of Mental Health Promotion*, 7(1): 54-62.

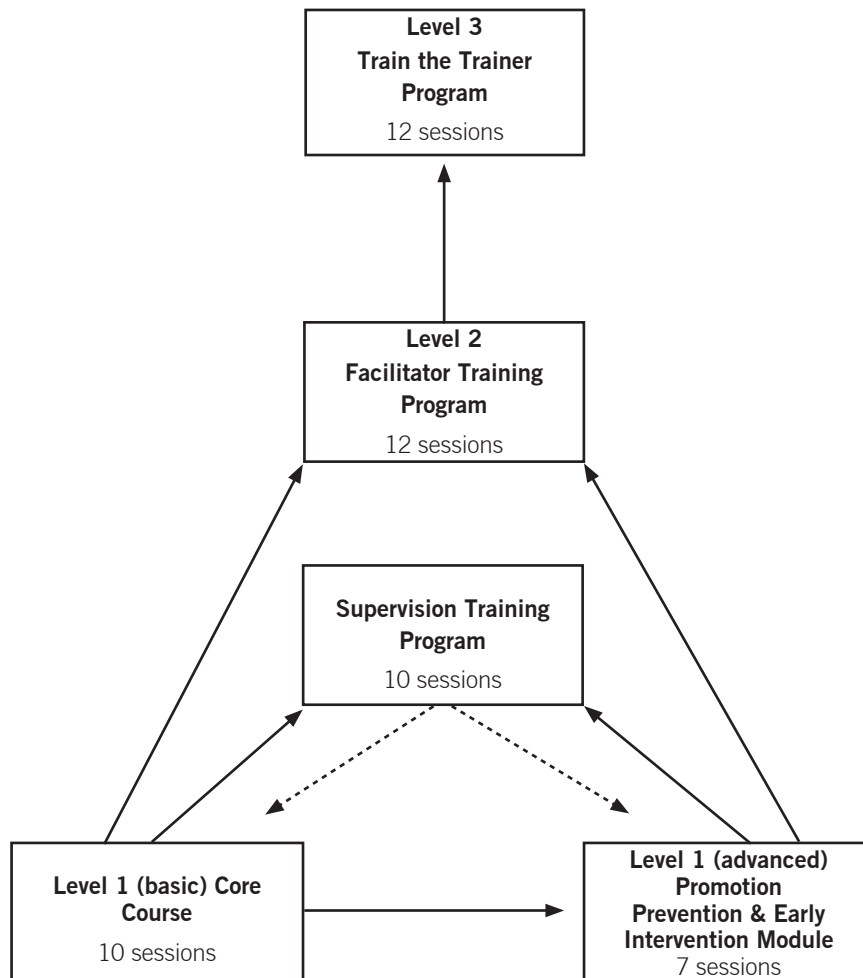
Using a quasi-experimental group comparison design, the intervention group of primary health-care professionals who received special EEP training showed an improvement in knowledge and perceived self-efficacy, and a significant improvement in their accuracy in recognising families' needs, compared with the comparison group.

Puura, K., Davis, H., Cox, A., Tsiantis, J., Tamminen. (2005). "The European Early Promotion Project: Description of the service and evaluation study". *International Journal of Mental Health Promotion*, 7(1): 17-31.

Using a comparison group design, the effects of the intervention on mother-child interaction were assessed across participating countries. This found that there were some positive outcomes for some of the samples, excluding Cyprus and Serbia, which showed no significant differences between the groups. The Greek sample showed the strongest effects, with smaller effects in the UK and Finland.

APPENDIX III

Family Partnership Training Australia



Available at www.fpta.org.au

APPENDIX IV

Sample letter to groups

We are researchers based in the School of Health Sciences at Massey University. We have recently received funding from the Families Commission to assess the feasibility of introducing a model of training, called the Family Partnership Model, to practitioners from a variety of sectors who have contact with families having difficulties with parenting. The key feature of this model is that the people who have contact with families, such as nurses, general practitioners, social workers and the police, use a common approach when working with families in difficulty. Because this model builds the capacity of existing services rather than introducing new initiatives, it is an extremely cost-effective way to improve service quality.

This model has been developed in the UK over the past 20 years and the training gives a common language for front-line workers from the various agencies and sectors which have contact with families. This encourages and facilitates inter-agency collaboration and co-operation in the interests of the child. Since this failure to communicate across agencies has been identified as a major factor in a number of recent child homicides, introduction of this model has the potential to make significant improvements in child and family outcomes.

Research has shown this training to be effective in the UK and Europe. It has been introduced to all states in Australia, and in New Zealand the Plunket Society is training their staff in this model. However, if it was implemented across all agencies and sectors which have contact with families, it could offer an extremely innovative approach to co-ordinated service delivery which has not been attempted to date.

As part of our feasibility study, we would like to meet with you to discuss the potential of the Family Partnership Model in the New Zealand context. We are very interested in your opinion regarding the implementation of this model in the primary health care sector and whether you think it could have something to offer your staff.

Yours sincerely

Helen Wilson and Annette Huntington

APPENDIX V

Organisations' responses

a) Auckland Women's Centre Teen Parent Project

The Auckland Women's Centre Teen Parent Project aims to promote positive parenting, effective non-physical discipline strategies and SKIP messages to teen and lone mothers of birth to five-year-olds in Auckland, by working collaboratively to strengthen our community's understanding of the needs of teen parents, offer a peer development programme, non-physical discipline seminars, newsletters and positive parenting events.

In 2006 the Auckland Women's Centre (AWC) had the Young Mothers Support Programme (YMSP) externally evaluated as part of a Te Rito project. At the time I had just joined the Centre staff as the Project Co-ordinator; however, I had designed and facilitated the YMSP group for 12 months as a contractor. Even though the result of the evaluation was overwhelmingly positive, I found the process of being evaluated unsatisfactory. This was mainly because the core of our work, which is relationship-based partnerships, was not acknowledged to the extent that we value them. The evaluation did not truly measure the outcomes we attach to our work with young mothers.

This experience raised my awareness that as a practitioner I desire a framework which is outcome-driven and partnership-based. I searched the internet for frameworks or models which had been evaluated as successful in these aspects and I came across the Family Partnership Model (FPM).

I became very interested in exploring the theory and practice of FPM after reading the papers available online by Hilton Davis. In a conversation with Kim Chamberlain from SKIP I discovered FPM was being introduced into New Zealand through a partnership with Plunket and SKIP. I was very excited to hear that it was already being implemented in New Zealand and I have had the opportunity to watch some professionals strengthen their practice by training in FPM.

Subsequently, I have watched a DVD of Hilton Davis' visit to New Zealand and approached the AWC management collective about implementing FPM within our agency to strengthen our practice with mothers, in particular our Teen Parent Project. We are now providing a number of services and projects that work within the framework of the Youth Development Strategy (YDS) principles. FPM would provide the strengthens-based framework described within the YDS which would enhance our ability to achieve positive outcomes for young parents and their children.

The AWC and the NGO sector need FPM training and infrastructure to build their capacity. Using evidence-based frameworks will ensure that the services and programmes provided are focused on positive outcomes for families which are professional, cost-effective and provide long-term change.

Annalise Myers
Projects Co-ordinator
Auckland Women's Centre

b) *Barnardos New Zealand*

Barnardos New Zealand is one of the country's largest not-for-profit, child-focused organisations. For more than 30 years, Barnardos New Zealand has worked in the community to help children receive the education, care and support they need. Barnardos aims to improve the lives of children – to ensure that Ko Ngaa Tamariki I Te Tuatahi/Children Come First.

As the only Barnardos employee who has completed the Family Partnership Model training and the FPM facilitators' training, it is difficult to give a perspective on this model from an organisational point of view. Providing an objective critique is also compounded by the fact that this is, I believe, a social work model, and as a trained social worker who has previously practised aspects of service delivery and staff management in this manner, I would personally see it as an extension and improvement of my current practice.

I can, however, comment on my view of the FPM and the appropriateness of it to the services that I have knowledge of as well as its application to relationships within the organisation.

There is little doubt that the opportunity it offers to self-critique one's skills, qualities, processes and communication, is of maximum benefit to assist in all types of relationships, whether those be parent/child, staff/client or supervisor/supervisee. The best tools we have in the work that we do within the organisation are our communication and relationship-building skills. The FPM can only serve to improve these and therefore make our practice more effective. Rarely do we have the opportunity to practise and understand in such depth what we do in our relationships and to fill in parts of the process that previously haven't been acknowledged or understood.

I think the biggest difficulty is in selling the product. It is not something you can describe on paper or even talk about in a particularly convincing way. It is something you have to experience, which enables a change in relating patterns due to effective role modelling, new understanding and ongoing opportunities to practise and receive feedback about your performance. On paper it looks like a composition of traditional social work skills, qualities, values and ethics and could therefore easily be dismissed as such.

My own personal belief is that, with good facilitators (and they are the key to the success of the training) I would find it difficult to believe that anyone could not benefit in some way from the training. The training is about relationships and participation in those relationships. If our relationships were less problematic and less threatening, wouldn't our outcomes, productivity and ability to make and facilitate change be far greater?

The questions for the organisation are:

- What are the visible benefits of having a partnership model in operation throughout the organisation?
- Who would be the benefactors internally and externally?
- Do the required levels of investment of staff time and organisational finances outweigh the benefits of a more effective method of practice and how does one measure such results?

Jean Ellerby
SKIP Learning and Development Co-ordinator
Barnardos
9/11/07

c) *New Zealand Childcare Association/Te Tari Puna Ora o Aotearoa*

The NZ Childcare Association represents nearly 500 community-based and privately-owned early education childcare services in New Zealand. With 16 teaching bases nationwide it is one of the largest providers of initial early childhood education in the country. Our professional development programmes are tailor-made for the needs of the ECE sector.

The national office is based in Wellington and co-ordinates the key activities including membership services and advocacy, professional development programmes and teacher education.

29 November 2007

Helen Wilson
Honorary Research Associate
School of Health Sciences
Private Bag 756
Massey University
Wellington

Dear Helen

Re Family Partnership Model

We enjoyed meeting with you and Annette Huntington recently to discuss the Family Partnership Model (FPM) work you have been developing.

Working closely with families and whanāu is central to early childhood education and care services and having support and training opportunities from programmes such as FPM would be beneficial in helping co-ordinate efforts and services to help ensure positive outcomes for children.

The promotion of communication between agencies that have contact with families such as teachers, nurses, GPs, voluntary sector organisations etc is to be applauded. As early childhood centres and schools are often the first places where concerns regarding children's development and wellbeing may become apparent, having a responsive and co-ordinated approach to helping families is necessary. The FPM approach would seem to be a useful approach and set of tools to promote this.

We wish you well with its ongoing development.

Naku noa, na



Colin Tarr
Director Teacher Education

d) *The New Zealand Police*

New Zealand Police is the lead agency responsible for reducing crime and enhancing community safety.

Thank you for the opportunity to provide comment on the attached Family Partnership Model training information and proposal. The approach and envisaged outcomes of the proposed training of this model seem sound. Police are working to improve inter-agency relationships and work across agencies to address recidivism, repeat victimisation, youth offending and family violence. An initiative that would improve this is worth investigating further.

We are strengthening our overall response to family violence and any participation would need to be viewed in light of other work underway.

Police at this stage would be interested in having further discussions about the development of a pilot if you receive funding to go ahead with this.

Belinda Himiona
Manager Family Police Team
Police National Headquarters

e) Presbyterian Support Upper South Island

Family Works is the Family and Youth Services division of Presbyterian Support Upper South Island. We are a not-for-profit social service agency, working to make a lasting difference to the vulnerable and disadvantaged in our community. Our services are available to all people in need regardless of their beliefs. Our staff work alongside families and children supporting them to make a lasting difference in their lives. We provide services that are time generous and strongly based on restoring people's sense of optimism and connection with others.

At first glance the Family Partnership Model appeared to be a packaging of some very basic social work concepts. This is the bread and butter core of an agency like Presbyterian Upper South Island with its focus on flexible community-based social work using qualified social workers. We know that strong, supportive relationships and a client/worker partnership are the critical components to sustainable change. I was unsure about introducing another variation on a theme, and another model. We have since looked at the Family Partnership Model carefully and have committed to some joint training with Plunket for three of our Family Works staff. We will then progressively look to train more staff in the use of the model throughout our region. We have decided to do this as we can see that the model integrates well with our commitment to nurturing social connection and sustainable social support networks with our clients in centred communities. We also see that having a common understanding of a way of working between us and Plunket will benefit the clients we have in common and greatly strengthen collaborative service delivery. I am appreciative of the willingness of Plunket to create such opportunities across the sector and of the support from the Families Commission and MSD.

Vaughan Milner
Chief Executive
Presbyterian Support
Upper South Island

f) Royal New Zealand College of General Practitioners

Report from:

Dr Sue Pullon, on behalf of the Royal New Zealand College of General Practitioners (RNZCGP).
Member BOE

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The Family Partnership Model: an innovative way of strengthening existing services and working effectively with young families in a multi-agency setting.

Thank you for the opportunity to comment on the proposed pilot study to test the Family Partnership Model in a New Zealand setting. (This tiered system of service delivery, utilising both front-line workers, child health nurses, GPs, social workers, as well as child mental health specialists, is based on the Lewisham model from the UK. So far, training has been well received by salaried Plunket nurses in New Zealand, although as I understand, not yet in collaboration with other sectors.) You are particularly interested in the view of general practitioners about such a scheme, which you intend to pilot in 2008.

Following our discussion, reading through the documentation supplied, and consulting several colleagues, the main points are summarised below.

1. Any intervention that can enable existing services to work more effectively together to identify and assist children and families with mental health issues makes good sense.
2. Current mental health in primary care initiatives. Any pilot needs to take good account of current training in management of mild to moderate mental health conditions, in the primary care sector. There are currently a number of primary care mental health initiatives being evaluated across the country. Most of these take an interdisciplinary approach and the results should inform the need for, and shape of, a specific pilot of the Family Partnership Model.
3. Training. Training front-line workers is only the first step in an ongoing process if it is to be effective. In the pilot, attention needs to be given to not only the training sessions for health and education professionals, but also strengthening links and prompt referral processes between front-line providers and secondary specialist providers. Follow-up 'maintenance' training, with an audit cycle, would greatly increase robustness.
4. Interprofessional training. The stated intent to provide training sessions for a range of health and education professionals together is excellent. However, to achieve meaningful interprofessional learning that results in more collaborative practice, tutors from several disciplines will have to have input into the course structure, there will need to be time spent on getting consensus about the aims and outcomes from the project, and time spent on defining and agreeing on respective roles and responsibilities for each person in the team. The pilot study should also address credit systems for ongoing professional development for all participants (eg, teachers must gain ongoing education credits, nurses must be able to count this course for annual reaccreditation, GPs need to be able to gain CPD points). Organisers need to arrange this with professional organisations/regulatory bodies in advance of any training; it may involve getting NZQA accreditation for the courses so the training can be built on and able to be credited to other postgraduate education.

5. Recognising current structural barriers to intersectorial care. Front-line workers are already busy, and current structures act as significant barriers to inter-sectorial communication. At present, communication between front-line providers in different sectors (especially across the education/social development/health boundaries) is an inordinately time-consuming process, added on top of already full workloads. On the other hand, if the planned intervention can remove these boundaries, and provide some funded non-contact time for communication, collaborative practice will be greatly improved.
6. Dedicated IT solutions to communication need to be included in the proposal. Efficient online client/patient records that can be shared across primary and secondary health care and with educators and social workers (such has been used in Counties Manakau DHB for integrated chronic condition management care), email advice systems and online referral systems are essential.
7. Resourcing the programme. However, any such intervention must be adequately resourced on an ongoing basis. Otherwise, the scheme runs the risk of simply placing increased expectation on front-line workers, without any increased means to deliver.
8. Scheme evaluation. Both the training and the programme as a whole need evaluation for at least a year, and preferably for a longer period. Both process and outcome evaluation measures need to be assessed, and further funding dependent on the evaluation results. The evaluation should be funded and conducted independently.
9. Resourcing particularly for primary care services. The UK model on which the Family Partnership Model is largely based operates in a different funding environment in the UK. (In the UK, all primary health care professionals are remunerated solely by the government, not from patients directly.) Whether we like it or not, primary care services in New Zealand are currently funded from multiple and ring fenced sources, meaning that an ongoing funding stream would need to be available for remuneration at practice level for nurse/doctor/allied health professional time. Something similar to CarePlus could work for these families. Access to the funding could be predicated on adequate training etc.
10. Resourcing for other services. I'm not so familiar with funding for social workers and teachers, but it's hard to imagine that schools have spare money to fund a teacher's/school counsellor's time to liaise and co-ordinate other services, over and above what they do already. Either they get some similar funding, or they have very easy access to the team co-ordinator for an area, who takes on the co-ordinating role. The primary care team (ideally a trained and funded nurse position, backed up by GP input) could take the lead, but so could others – as long as there was agreement about roles and responsibilities (see above).
11. From an average GP's point of view. GPs and practice nurses are as concerned as anyone about New Zealand's appalling health statistics in the area of child abuse and the frequently associated mental health problems of not only children but also their parents and extended families. Most would welcome realistic ways to improve the situation, if both the training and the programme itself (especially practice nurse time) were adequately funded. If not funded, any such programme could be resented, causing more harm than good in a particular locality. As far as the initial training is concerned, GPs and practice nurses are used to jointly participating in short education sessions, and would welcome the chance to attend with teachers and social workers. The courses would need to be short, out of office time and free of charge. If held during working hours, additional funding to cover the resultant workforce shortage would be needed.

In summary, this is an exciting initiative that may well be able to be adapted for use in New Zealand across several sectors. The pilot project warrants considerable support, as long as it is framed to include training as part of an adequately funded package of care.

Dr Sue Pullon

g) Waahi Whānui Trust, Huntly

Waahi Whānui Trust is an iwi provider that offers mental health and addiction services, such as AOD and Dual Diagnosis outpatient counselling, and some generic counselling, including groups for men on domestic violence, substance use and communication. Therapeutic groups for women are also available. There are also Parents as First Teachers (PAFT), Family Start and Home Interaction parenting programme services. For children there is an early learning childhood service and educational programmes for children witnessing violence. Social services provide budgeting advice and social workers in schools. There is also a marae development arm to this complex.

As a service provider of collaborative initiatives to Address and Reduce Family Violence in the Huntly District (Huntly District Agencies Addressing Violence), I find the information regarding the Family Partnership Model very informative (along with other partners of the Huntly Addressing Violence initiative (which include but are not limited to: Police, Victim Support, two Social Services and a Drug & Alcohol, Dual Diagnosis & Generic Counselling service). We would be very interested in joint inter-agency training in the above stated model that will strengthen our respective services to talk and think similarly when it comes to the mental health of our children.

Our 0-5-year-old agencies, ie, Plunket, PAFT, HIPPY, GSE, Maternal Mental Health (to name a few) are key agencies where children and families come to their attention of needing appropriate support.

I particularly draw your attention to what the Family Partnership Model addresses based on its strength-based principles and the necessity to engage and work with families in order to achieve positive and effective outcomes.

Sue Fielding
Health and Education Service Manager
Waahi Whānui Trust
Huntley

h) *The Werry Centre for Child and Adolescent Mental Health*

The Werry Centre for Child and Adolescent Mental Health is housed within the Department of Psychological Medicine in the Faculty of Medical Sciences, University of Auckland, and hosted by Auckland Uniservices Ltd. The Werry Centre incorporates workforce development for the child and adolescent mental health sector, teaching in child and adolescent mental health and research in the child and adolescent mental health field and workforce development in this field.

As the New Zealand Centre for Child and Adolescent Mental Health Workforce Development we are very aware of the need to increase the skills, knowledge and capacity of the primary health sector to deliver effective early interventions for mental health disorders. There is evidence to suggest that this training contributes positively to inter-agency networking and communication, which can only benefit families accessing a cluster of services.

The following is an abstract from the 10-year strategic framework for CAMHS workforce development: Whakamarama te Huarahi (Werry Centre, 2006):

“A key issue facing the child and adolescent mental health sector is workforce shortages. These shortages need to be seen in the context of health sector workforce shortages generally. They are compounded for the child and adolescent mental health workforce however, due to the relatively small size and low sector profile of infant, child and adolescent mental health, and underdeveloped pathways into the field.

We must also build and sustain the level of knowledge and skills of the other workforces responding to infants, children and young people and their families and whānau; **the primary healthcare workforce, other government service workforces and related community sector workforces, to deliver a comprehensive response across the tiers of service delivery.**”

(Emphasis added)

The Family Partnership Model could prove to be a very effective method of enhancing both the capability and capacity of the sector. The model has been demonstrated to be effective in Britain and Europe and research is needed in the New Zealand context to ascertain its applicability here.

Sue Treanor
Director Workforce Development
Werry Centre

APPENDIX VI

Individual responses

a) Dr Denise Guy

Child Psychiatrist and Infant Mental Health Clinician

The work of Helen Wilson in identifying the ways in which the Family Partnership Model (FPM) could strengthen existing services that are working with young children and their families is thoughtful and deserving of support.

The FPM has been developed, implemented and evaluated thoroughly in the context of different services in different countries and capitalising on this to strengthen New Zealand initiatives should be investigated. Studies utilising the approach can be reviewed and they demonstrate the model's applicability to a variety of contexts:

- health, education and social care (for instance, prevention of childhood obesity with the Royal College of Paediatrics and Child Health)
- its use with practitioners from a variety of disciplines
- its use internationally across different cultures and ethnic groups.

For the last two years Plunket in collaboration with SKIP has trained staff in the (FPM) and are developing a small workforce that has the capacity to train others in this model. This is a resource that could be influential in the training and development of professionals implementing target and universal programmes.

New Zealand has been developing and resourcing a number of such initiatives identifying and supporting families with young children. Many of these are developed in liaison with health, education and social services and rolled out from the Ministry of Social Development and include Parents as First Teachers and Family Start. The evaluations from these programmes have not shown the positive outcomes and capacity to engage all referred families that were hoped for.

New Zealand needs to be using models of care that show improvements in the psycho-social wellbeing of parents and the development and wellbeing of young children and the FPM offers this because it focuses on the processes of helping.

The FPM has added value in providing an explicit model of helping, a practical set of guidelines that support the process of making a partnership (a relationship) and within that partnership exploring the problems, setting goals, planning strategies and implementing them. Many of the current programmes have particular programmes to implement/skills to be taught, such as parenting programmes, giving parents developmental knowledge and ensuring immunisations happen, but don't attend to the processes around helping.

Thus one of the key aspects of the model is clear delineation of the qualities needed by the helper in addition to the knowledge and skills that constitute their expertise. The basic qualities are included in selection and recruitment of staff. The qualities initially seem so common sense that the sophisticated body of knowledge they reflect may not be valued by an individual's first reading about the model. For example, **personal integrity**

"To be trusted to help, one needs to have sufficient emotional strength and self-awareness to stay whole and not be pulled out of shape by the emotional vulnerability of others. This also relates to the notion that although one must be able to empathise, at the same time the helper must be able to think differently, to entertain alternative views to those held by parents and to offer those if appropriate" (p. 10; Braun, D., Davis, H., & Mansfield, P., *How helping works: Towards a shared model of process*, Parentline Plus, 1-23, 2006).

I have referred to this in the light of comments made in reviews of child deaths in the country when professionals within helping/statutory organisations have not been able to separate themselves from identifying with parents and have not made decisions in the best interests of children (p. 23, Office of the Commissioner for Children, *Report of the investigation into the deaths of Saliel Jalessa Aplin and Olympia Marisa Aplin*, November, 2003).

The FPM additionally provides guidance around:

- Management practices that support practitioners to function properly and the knowledge of interpersonal processes necessary to this task.
- Supervision that is ongoing and regular modelling of the helping processes, addressing the reverberation between experiences of the professionals and the experiences and characteristics of the parents. This type of supervision is rarely in evidence in New Zealand within these universal (Well Child Framework) and targeted community interventions. As a consequence, the difficulties of engaging and retaining at-risk families is superficially understood and the outcomes of the interventions poorer than they should/could be. The importance of good supervision cannot be emphasised enough in this work and is a critical strength of the FPM.
- Building capacity in the community workforce, improving their practice and thus the possibility of improving outcomes for infants and pre-schoolers who have mild to moderate problems. Improved practice leads to more accurate identification of children and families' needs and referral for additional assessment and intervention in more severe cases.

Given that New Zealand has some resource in professionals trained in the FPM it would be very useful to address the potential impact of the model if, for example, it was piloted within one Family Start initiative and evaluated against another Family Start that did not use these explicit guidelines around helping.

Dr Denise Guy
Child Psychiatrist and Infant Mental Health Clinician
MBChB, FRANZCP, Cert. Child Psychiatry
30/11/07

b) Professor Graham Vimpani

I've been a paediatrician now for 35 years and was expected to naturally acquire or have communication skills which would enable me to engage with parents with difficult problems. Although I found out I had indeed acquired and could turn on when necessary many of the skills through years of practice, I realised I didn't always put them into action. The course challenged me to recognise that they are always necessary.

The best part of the course was the skills practice. As a service manager, I've found the skills are valuable in my management role, both in dealing with staff and also in negotiations with managers senior to me. Organisational climates would be a lot healthier if all managers showed attitudes of respect towards staff, were careful and accurate listeners and had and used the skills of demonstrating empathy, or working with other staff at problem solving without taking over, and gently challenging others' assumptions when necessary.

Professor Graham Vimpani
Clinical Chair
Kaleidoscope in Greater Newcastle
Hunter Children's Health Network

Blue Skies Research

- 1/06 *Les Familles et Whānau sans Frontières: New Zealand and transnational family obligation*, Lunt with McPherson & Browning, March 2006.
- 2/06 *Two Parents, Two Households: New Zealand data collections, language and complex parenting*, Calister & Birks, March 2006.
- 3/06 *Grandfathers – Their Changing Family Roles and Contributions*, Wilton & Davey, March 2006.
- 4/06 *Neighbourhood Environments that Support Families*, Witten, Penney, Faalau, & Jensen, May 2006.
- 5/06 *New Communication Technologies and Family Life*, Weatherall & Ramsay, May 2006.
- 6/06 *Families and Heavy Drinking: Impacts on children's wellbeing*, Systematic Review, Girling, Huakau, Casswell, & Conway, June 2005.
- 7/06 *Beyond Demography: History, ritual and families in the twenty-first century*, Pryor, June 2005.
- 8/06 *Whānau is Whānau*, Walker, Ngāti Porou, July 2006.
- 9/06 *Supervised Contact: The views of parents and staff at three Barnardos Contact Centres in the southern region of New Zealand*, Gibbs & McKenzie, August 2006.
- 10/06 *New Zealanders' Satisfaction with Family Relationships and Parenting*, Robertson, August 2006.
- 11/06 *Korean Migrant Families in Christchurch: Expectations and experiences*, Chang, Morris, & Vokes, October 2006.
- 12/06 *The Role of Whānau in the Lives of Māori with Physical Disabilities*, Collins & Hickey, September 2006.
- 13/06 *New Spaces and Possibilities: The adjustment to parenthood for new migrant mothers*, DeSouza, November 2006.
- 14/06 *New Zealand Cultural Norms of Parenting and Childcare and How These Relate to Labour Force Participation Decisions and Requirements*, McPherson, November 2006.
- 15/06 *Towards a Statistical Typology of New Zealand Households and Families: The efficacy of the family life cycle model and alternatives*, Crothers & McCormack, December 2006.
- 16/07 *The Family Court, Families and the Public Gaze*, Cheer, Caldwell, & Tully, April 2007.
- 17/07 *Fairness, Forgiveness and Families*, Evans, Yamaguchi, Raskauskas, & Harvey, April 2007.
- 18/07 *Managing Multiple Sclerosis and Motherhood: Women's stories*, Payne, McPherson, & Crerar, May 2007.
- 19/07 *Diverse Forms of Pacific Families and their Financial Decision-making Approaches*, Koloto & Katoanga, September 2007.
- 20/07 *Lifelines: Young New Zealanders imagine family, friends and relationships across their life-course*, Patterson, Peace, Campbell, & Parker, September 2007.
- 21/07 *Older Adults' Experience of Family Life: Linked lives and independent living*, Breheny & Stephens, November 2007.
- 22/08 *Whānau Socialisation Through Everyday Talk: A pilot study*, Tomlins-Jahnke & Durie, January 2008.
- 23/08 *Strengthening Rural Families: An exploration of industry transformation, community and social capital*, Goodrich & Sampson, April 2008.
- 24/08 *Grandparents in Rural Families: Young people's perspectives*, Keeling, Glasgow, & Morris, July 2008.
- 25/09 *Settling in: Parent-adolescent family dynamics in the acculturation process*, Stuart, Jose, & Ward, February 2009.
- 26/09 *Sent Home: The impact on the family of a child's exclusion from school*, Smith, March 2009.

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