"We are able to practice in the way other professionals wish they could practice"

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Early intervention with young families in Māngere, South Auckland

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Abstract

The early years of life are critical, however it is widely acknowledged that our existing support efforts for these years don't work well for young families/whānau experiencing multiple stressors. An early intervention approach which has gained considerable empirical support is that of 'nurse-family partnership/home visitation.' One application of this approach in Aotearoa New Zealand is a prototype initiative called 'Start Well' in South Auckland. The current study aimed to explore the level of family harm and psychological distress for whānau engaged with Start Well, and how Start Well has engaged/supported with this. A case note review was followed by descriptive analysis of the data. Findings indicate that although family harm is commonly assumed to be dyadic in nature, there were usually more than two people involved in family harm incidents for the Start Well population. Grandmothers took protective action during a significant minority of family harm incidents. The topic of family harm was raised (without the use of a formal screening tool) on average 73 days into service engagement, resulting in an unusually high positive disclosure rate. Families remained engaged despite mandatory reporting, and data indicates that as whānau increasingly disclosed family harm to Start Well over time, clinicians were able to provide assistance that was effective in reducing further incidence. Conversations about psychological distress were recorded as occurring frequently and conversationally. This resulted in a high rate of disclosure and an unusually high rate of access to further mental health support where needed - including to a limited-access maternal mental health respite facility. However, findings suggest that further support may have been differentially available. Overall, findings suggest that Start Well, working from an effective commissioning/contracting environment, is able to invest heavily in relationship and to use clinical skills effectively, enabling successful partnership with whānau to address family harm and psychological distress. Recommendations for policy and clinical practice are made.

For Ann Shaffer

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Table of Contents

10

11

List of Tables

List of Figures

List of Abbreviations and Selected Key Terms

Abbreviations

ACE   Adverse Childhood Experiences

DHB   District Health Board

GP   General Practitioner

IPV   Intimate Partner Violence

MSD   Ministry of Social Development (New Zealand)

NZ   New Zealand

OECD   Organisation for Economic Co-operation and Development

OT   Oranga Tamariki

PBI   Place-Based Initiative

ROC   Report of Concern

SASWB   South Auckland Social Wellbeing Board

UK   United Kingdom

USA   United States of America

WCTO   Well Child Tamariki Ora

WHO   World Health Organisation

Selected Key Terms

'Psychological distress' is the broad term used in this research to refer to non-specific mental health difficulties which may or may not meet threshold for DSM-5 diagnostic criteria, but which may nevertheless have significant health, wellbeing and economic impacts (Prochaska, Sung, Max, Shi, & Ong, 2012). This is a term (anecdotally) used broadly throughout health in Aotearoa New Zealand (NZ) at the present time, and it is also used by nurse-family partnership proponent David Olds (Olds et al., 2010).

'Whānau' is defined by the online Māori dictionary (www.maoridictionary.co.nz) as "extended family, family group, a familiar term of address to a number of people. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members." Te Puni Kōkiri (2010) remind us that the terms 'family violence' and 'whānau violence' are not considered to be interchangeable, with the former referring primarily to the nuclear family, and the latter referring to the wider concept of whānau defined by whakapapa, and wider connectedness, rights and responsibilities to hapū and iwi. In the context of this research, the term whānau is often used a little differently, to refer to the individuals and families engaged with the Start Well service. This term was preferred by the service to other terms frequently used in research and practice, such as 'client,' 'service user,' 'consumer' and 'tangata whaiora,' because it is seen as being both inclusive of more than just the enrolled mother, and more connected with the Start Well service than a term such as 'client' would suggest – i.e., part of the Start Well 'whānau.' This usage is intended with respect, but if it is incorrect I do apologise.

Glossary of Te Reo Māori

Unless indicated otherwise, the translations of terms below are provided by the online Māori Dictionary (*www.maoridictionary.co.nz*), with the understanding and caution that many concepts from Te Ao Māori simply cannot be directly translated or understood in their fullness using Te Reo Pākehā.

Aotearoa	North Island - now used as the Māori name for New Zealand
Hapū	Kinship group, clan, tribe, subtribe - section of a large kinship group and the primary political unit in traditional Māori society. It consisted of a number of whānau sharing descent from a common ancestor, usually being named after the ancestor, but sometimes from an important event in the group's history. A number of related hapū usually shared adjacent territories forming a looser tribal federation (iwi).
Iwi	Extended kinship group, tribe, often refers to a large group of people descended from a common ancestor and associated with a distinct territory
Kaimahi	Worker, employee, staff
Kaupapa	Purpose
Kaupapa Māori	Māori approach
Koha	Gift, present, offering, donation, contribution - especially one maintaining social relationships and has connotations of reciprocity
Manaakitanga	Hospitality, kindness, generosity, support
Mātauranga	Knowledge, wisdom, understanding, skill

Mokopuna	Grandchild, grandchildren, descendant
Pākehā	New Zealander of European descent
Pēpi	Baby, infant
Pūrākau	Myth, ancient legend, story
Reo	Language
Tamariki	Children
Tāne	Husband, male, man
Tangata whaiora	Preferred term for consumers in Aotearoa New Zealand from a consumer perspective (Moeke-Maxwell, Wells, & Mellsop, 2008).
Tangata whenua	Hosts, indigenous people
Tauiwi	Foreigner, non-Māori
Te Ao Māori	The Māori world (Carey, 2016).
Te Reo Māori	Māori language
Te Rito	The young centre leaf of the harakeke
Te Tiriti	Te Reo Māori version of the Treaty of Waitangi
Tikanga	Correct procedure, custom, habit, method, way, code, meaning, plan, practice, convention, protocol - the customary system of values and practices that have developed over time and are deeply embedded in the social context
Wāhine	Female, women, feminine
Waka	Canoe, conveyance
Whakawhanaungatanga	Process of establishing relationships, relating well to others
Whānau	See section on key terms above

Introduction

"A stitch in time saves nine" – old English proverb.

A number of years ago I worked at a residential parenting programme for mothers seeking to retain (or obtain) custody of their children from the then Child Youth and Family child protection agency. This experience is one of the strands of whakapapa leading to my interest in Start Well: the service explored in this research. Many of the women in the residential programme were in their thirties, and had lost custody of the children they'd had in their teens due to child protection concerns. Now older and with young children again, they were willing to do whatever it would take to avoid a repeat of the past, even if it meant leaving their families, partners and communities behind to engage in an incredibly demanding and foreign-feeling residential programme. At the time, I felt the service was useful and taught valuable skills, but I worried about the exclusion of fathers and whānau, and about how difficult it seemed to be for women to apply these skills once back with their families, in their normal environments outside of the service. The Start Well mothers, in many ways, are experiencing the same challenges as those in the residential programme – they're just 15 years younger and still living at home. Rather than waiting, it seems to makes intuitive sense to offer early assistance to these families to enable them to 'start well' now?

Another strand of the whakapapa leading to my interest in Start Well is my own experience of becoming a parent. I am a heterosexual, cisgender woman, and the daughter of educated, financially comfortable Pākehā parents. Though I have experienced some adversity in life, I have also experienced enormous privilege; perhaps nothing more so than the privilege of having a mother who was sufficiently stable, supported and untraumatized to be able to provide warm, engaged, sensitive loving care. Having given birth to my own first child during the course of this research, I have experienced a new level of insight into the

incredible joy but also incredible challenge of trying to enable a child to 'start well.' Despite excellent partner and family support, financial security and a warm, dry home of our own, my mental health has suffered at times. After giving birth I reflected on the stories of the Start Well families that I had caught glimpses of as I'd read their case notes, and I held a new sense of wonderment and awe: how on earth do people adjust to life as a parent when their partner is beating them up? When they don't have a place to live, or know where their next meal is coming from? New parenthood is wonderful but it's also extremely hard, even without any additional layers of difficulty. It's also a period of life which is temporary, but has ongoing, life-changing effects – for better or worse - for parents, children and partner relationships.

For this reason, new parenthood offers funders and policy-makers a unique window to efficiently use their resources to make a significant difference. Despite this, it takes considerable social and political will to resource our most stressed families with the help they need make it through the gauntlet of new parenthood. It seems politically safer, and cheaper (at least in the short run), to structure our services in the ways that work for our systems, to talk about individual agency without materially improving living circumstances, and to forcibly remove vulnerable children from stressed situations. These are not inevitabilities; they are decisions that we make.

Social investment ideology represents one potential alternative. It attempts to 'invest' early in those most at risk of poor outcomes later in life (Baker, Evans, & Hennigan, 2020), to break the intergenerational transmission of social disadvantage (Hemerijck, 2018). Start Well originated from this ideology, and is an attempt at exploring what it could look like to provide a high level of relational support and resource to young families under stress, still living in their own communities.

Start Well is a resource-intensive intervention, but so too is ineffective business as usual for whānau experiencing multiple stressors (Stafford, 2021) - the population that Start Well serves. Even so, where considerable public resource is at stake there is a need for accountability and for consideration of opportunity costs. This research therefore sought to explore the effectiveness of Start Well, and the unique attributes of Start Well, as best as possible given the limited data available. More specifically, it explored:

1. What is happening in terms of family harm for whānau engaged with Start Well and how has Start Well engaged/supported with this?

2. What is happening in terms of psychological distress for whānau engaged with Start Well and how has Start Well engaged/supported with this?

My wildest hopes as to the outcomes of the research are that in some small way, it might contribute to both a sense of confidence in early intervention, and a humanizing of the systems which whānau experiencing multiple stressors are forced to interact with. I am keenly aware that as a middle-class Pākehā woman, my ideas about how to achieve this are far less useful than those of Māori, Pasifika and whānau themselves. Nevertheless, my own two cents is that through its high-trust contracting and commissioning environment, Start Well has been equipped to illuminate the effectiveness of some of the elements of service that are inherent to Te Ao Māori and Pasifika approaches (e.g. relationship first). If the illustration of Start Well's success can add to the evidence base in favour of Governments and contractors placing trust in such approaches (within Start Well and without), that would be a wonderful thing.

A quick note on the title of this research: the first part of the title is a quote from a Start Well clinician, used by the service for its own communications. Though I did not interview clinicians as part of this research, I asked (and was granted) permission to use this quote in the title, as I think it succinctly summarises some of the research's findings.

The structure of the thesis is as follows. Chapter One begins by exploring the research base for 'home visitation' as an early intervention service model for assisting whānau experiencing multiple stressors, including with regard to two particular stressors: family harm and psychological distress. Some of what is known about these particular stressors is also presented, alongside a critique of the 'business as usual' interventions intended to assist. Chapter Two outlines the methodology used in the current research, and Chapter Three outlines its results. In Chapter Four I discuss findings with reference to literature, making recommendations for clinicians, services, policy-makers and funders accordingly.

Chapter 1 – Literature Review

Introduction to Literature Review

Around the world, it is increasingly understood that the early years of life form a critical foundation for subsequent wellbeing in every holistic sense of the word. Simultaneously to this realisation, health, child protection and social service systems globally are recognising that their attempts to assist families in these early years fail to serve some segments of their populations. Why? Who? What have we tried, and what would be better? These are big questions with multiple answers. We need to understand the context but we also need a narrower focus. This chapter begins by introducing one population who receives less-than-ideal service from existing systems: whānau experiencing multiple stressors. I then introduce a service model which has some promise for assisting this population: 'home visitation.' Local examples of this service model are provided, including the subject service of this research: Start Well. This is followed by a description of a few other related models, for context and comparison: Whānau Ora, the Swindon 'Life' programme, and Well Child Tamariki Ora. Finally, I consider two particular difficulties which often face whānau, and how these are typically conceptualised and responded to internationally and in Aotearoa New Zealand (NZ): family harm, and psychological distress associated with pregnancy and new parenthood. Start Well's approach to addressing these difficulties (as written in its own documentation) is briefly described.

Engaging Whānau Experiencing Multiple Stressors

What am I talking about when I say 'whānau experiencing multiple stressors?' Many terms are used in policy, practice and research: 'hard to reach', 'underserved' and 'disengaged' being just a few. The application of such deficit-based terms to the whānau/families themselves rather than the services having difficulties engaging them is of course unfortunate and in many cases victim-blaming. Identifying reasons for engagement

difficulties and proposing and evaluating solutions is a whole field of study in its own right, and some authors do a better job than others of researching and writing from a strength-based perspective. This review provides just a brief sample of the research, as follows.

A systematic review of literature relating to 'hard to reach' families in the United Kingdom (UK), United States (USA), Canada and Australia found a variety of service or family-related factors (or both) associated with families being 'hard to reach', or services being hard for families to access or accept – including illiteracy, the service not listening, long waiting lists, unwelcoming settings, high staff turnover, lack of transport, domestic violence, addictions and fears of losing control of the situation (Boag-Munroe & Evangelou, 2012). Writers across the field of research offered reparative advice along the following themes: work holistically, build trust by taking time to engage and offering longer-term service, address organisational barriers to access, involve fathers, and use snowball referral methods (Boag-Munroe & Evangelou, 2012).

A Families Commission report on early-intervention support for 'vulnerable' whānau/families provides a benchmark for service 'drop-out' rates: 35 percent to 70 percent (Gray, 2011). The Hawaii Healthy Start home visiting programme found that around 10 to 25 percent of families chose not to take part, and between 20 and 67 percent left before the end of the programme" (Gray, 2011, p. 3). Australian home visiting service 'right@home' reported a programme completion rate of 87.3% at child age two years; this was considered to be higher than normal relative to other home visiting programmes reported in research (Kemp et al., 2019). Those most unlikely to complete programmes tend to be younger, from lower socioeconomic groups, have less social support, have more life stress, have lower levels of education, experience more mental health difficulties and experience family violence (Gray, 2011). Trusting relationships with clinicians have been found to be critical to

successful engagement for such whānau/families, and these "may take some time… in one case, 18 months was considered too short" (pp. 3-5).

A 2020 evaluation of Family Start (see more in a later section) found that just under half of all exits from the programme were 'unplanned,' i.e., due to disengagement; evaluation attributed this to 'high need' whānau being "challenging to keep engaged" (Carter et al., 2020, p. 12). Where whānau did remain engaged, evaluation attributed this to the ability of clinicians to build trusting relationships with them via time investment in whakawhanaungatanga/relationship-building (often over and above paid work hours due to contract limitations) and being led by the whānau/family's priorities (Carter et al., 2020).

Home Visitation

Description and research outcomes

Home visitation programmes provide sustained in-home support for families from pregnancy onwards (Olds, 2006). The rationale for this timeframe of service delivery is that this period of time offers an opportune moment to prevent a host of adverse maternal, child and family outcomes that are not only important in their own right but also influence future individual and family trajectories (Olds, 2006). A key proponent of the home visitation form of service delivery, David Olds, describes the nurse-family partnership model of home visitation as having three major goals: (1) improving pregnancy outcomes by improving prenatal health, (2) improving child health and development by helping parents provide more sensitive and competent care, and (3) improving parental life course by helping parents complete education and find work (Olds, 2006). Home visitation programmes have a long history dating back as far as the 1880's (Sweet & Appelbaum, 2004), with service delivery of the nurse-family partnership expanding beyond research contexts in 1996 (Olds, 2006) and home visiting programmes of various forms subsequently being adopted at scale in some places, most notably in the USA.

In practice, home visiting programmes vary along many dimensions including the types of families served, targeted behaviours or outcomes, type of service delivery staff, length and intensity of services, types of services provided and so on, but are linked by their method of service delivery (in the home), their goal of helping children by helping their parents, and their focus on prevention and on younger children (Sweet & Appelbaum, 2004). Traditionally programmes have worked more with mothers than with fathers, but more contemporary approaches are more likely to involve both parents (Sweet & Appelbaum, 2004).

Home visiting programmes have been found to produce a range of modest positive effects including reduced risk of child mortality (Vaithianathan, Wilson, Maloney, & Baird, 2016), improved infant developmental outcomes (Olds, 2006; Sweet & Appelbaum, 2004), and improved maternal life course (Olds, 2006). Regarding family harm specifically, outcomes to date are mixed but promising. Although some research has found disappointing results regarding the effectiveness of home visitation for addressing IPV (Tung, Williams, Ayele, Shimasaki, & Olds, 2019), other research has found reductions in child maltreatment (Dodge, Goodman, Bai, O'Donnell, & Murphy, 2019), including over a 15-year period (Eckenrode et al., 2017). As a result of promising research outcomes, the World Health Organisation (2010) (WHO) has highlighted home visiting as a promising primary prevention strategy for reducing child maltreatment, and international literature recommends home visitation as an early intervention, family-centred intervention to address family harm in a way which counters the failings of prevailing fragmented approaches which address individuals separately and at the point of crisis (Tiyyagura et al., 2020). Locally, home visiting has been endorsed as an effective response to family harm (Expert Advisory Group, 2013; New Zealand Government, 2021). Regarding mental health specifically, outcomes to date are similarly mixed but promising. For example a systematic review found that, for

women at 'high risk' of family dysfunction or postnatal depression, home visitation resulted in a significant reduction in postnatal depression (Shaw, Levitt, Wong, Kaczorowski, & McMaster University Postpartum Research Group, 2006). However at 18 year follow up of their research, Olds et al. (2019) found no enduring effects on maternal depression. Dodge et al. (2019) reported positive effects of home visiting on maternal mental health, and Tandon et al. (2020) found that home visiting programmes involved in quality improvement activities achieved improved rates of screening for postpartum depression, higher rates of referral to evidence-based support services, and reduced symptoms for those who accessed services.

The mechanisms by which such results are obtained are not entirely clear (Sweet & Appelbaum, 2004), but nevertheless, favourable impacts have been found in review to be sustained at least one year after programme enrolment, results are not limited to racial, ethnic or socioeconomic subgroups, and few unfavourable effects are reported (Sama-Miller et al., 2017). It may be that home visitor relationships with whānau in themselves have a therapeutic effect (Adams, Hooker, & Taft, 2022b). Relationships of trust have been found to facilitate both disclosure of family harm and retention in services (Adams et al., 2022b), likely enabling effective clinician-family collaboration. Benefits may also be partially due to the ability of home visiting to effectively address the broader, social determinants of wellbeing (Shim & Compton, 2018). More specifically, home visiting programmes aim to reduce family harm by improving family functioning and parenting (Duggan et al., 2007), and by use of a strengths-based approach (Wolfe & Jaffe, 1999). Adams, Hooker, and Taft (2022a) found that home visitor clinical expertise, communication skills, family violence expertise and 'bringing yourself' were all important elements of effective family harm work within home visitation services.

The resource-intensive nature of home visiting programmes has been raised as a reason to carefully consider whether their outcomes justify their costs (Sweet & Appelbaum,

2004). Olds (2006) concluded from his research that the functional and economic benefits of the nurse-home visitation programme are greatest for families at greater risk, with cost savings for the Government attributable to the benefits accruing to this group. Consequently, Olds (2006) argued for targeted rather than universal application of the model. By evaluating one of his programmes, Olds et al. (2010) concluded that overall cost savings (to the Government) had been made by the programme, in the form of reduced public benefit costs (e.g. Medicaid, food stamps, welfare payments); this remained true at 18-year follow-up (Olds et al., 2019).

Home visiting programmes in Aotearoa NZ

In Aotearoa NZ, three programmes meet the description of an intensive early intervention home visiting programme: Family Start, Early Start and Start Well. An extended Well Child Tamariki Ora (WCTO; more on this in a later section) service in the Hawke's Bay, and a nurse-social worker partnership in the Bay of Plenty, also have elements of this approach.

Hawke's Bay and Bay of Plenty services

The Bay of Plenty service involves a partnership between a paediatric liaison nurse and a social worker who visit families in their homes, however it does not always involve the same quantity or longevity of service (O'Connor, 2015).

The Hawke's Bay service began as a one-year Plunket pilot provided to 21 teenage mothers, involving Plunket WCTO service provision by one consistent Plunket nurse (Skerman, Manhire, Thompson, & Abel, 2012). The pilot was evaluated as being successful in part because it was able to keep 20 of the 21 mothers engaged in the service for the first year of their babies' lives, although not without significant effort for some (Skerman, Manhire, Abel, & Thompson, 2015). Family violence and particularly intimate partner violence (IPV) was found to be common among the service's clientele, and difficult to deal

with (Skerman et al., 2015). One nurse described how a significant investment of time in the relationship enabled a young mother to eventually disclose current and historical family harm to her: "it had taken eight months, no, more, nine months, 10, but in the end she confesses all this stuff that is going on. And I was able to make a move on that. So I think that's a real success" (Skerman et al., 2015, p. 38). Funding for this service was not continued despite positive evaluation, however 2020 confirmation of three-year pilot funding for services in Counties Manukau, Rotorua Lakes District and Tairāwhiti have been linked to its success (https://www.health.govt.nz/our-work/life-stages/child-health/well-child-tamariki-ora-services/enhanced-support-pilots).

Family Start

Family Start is a voluntary, intensive home visiting programme available to pregnant mothers and families with preschool children at heightened risk of adverse outcomes, aiming to improve their health, education and social outcomes (Vaithianathan et al., 2016). It was first introduced in 1998 and now operates in many regions across Aotearoa NZ (Vaithianathan et al., 2016). Children are enrolled in the programme before birth or in their first year (Carter et al., 2020). Family Start aims to: "encourage whānau to build strong bonds between parent and child, develop whānau safety awareness, teach whānau about healthy lifestyle choices and child nutrition, health visits and immunisations, and develop parenting confidence" (Carter et al., 2020, p. 6).

Family Start was first evaluated in a quasi-experimental study in 2016: Vaithianathan et al. (2016). This study found that Family Start engagement was linked with reduced post neonatal infant mortality, and an increased rate of notification to child protection agency Oranga Tamariki (OT).

A second, process evaluation was completed by Carter et al. (2020). This evaluation found that whānau describe Family Start as a valuable service that has improved their lives

(Carter et al., 2020). It found that the programme model is mostly effective, and especially for Pākehā providers and families (Carter et al., 2020). However, Māori and Pasifika providers raised concern that the time-bound nature of some activities do not allow adequate time to build relationships of trust, and do not fit with principles of whanaungatanga (Carter et al., 2020). One clinician said, "often it takes longer to build trust, especially with clients who have negative past experiences with Government agencies. We have to overcome that history and build a relationship of trust before we start talking about goals (etc)" (Carter et al., 2020, p. 19). There was suspicion among some whānau Māori – especially younger parents – that Family Start clinicians were 'watching' them on behalf of OT, leading to fear and 'hiding' or declining participation in the programme (Carter et al., 2020). Māori and Pasifika providers also noted that the programme model tended to focus on a Pākehā conceptualisation of family, "in that the service is set up to engage with a primary caregiver(s) rather than the wider whānau, aiga or fāmili who play a role in the child's care and development" (Carter et al., 2020, p. 19).

The 2020 evaluation reported a high level of fidelity to the programme manual except where changes were made in order to better meet the needs of whānau/families (Carter et al., 2020). For example, Māori and Pasifika providers reported that "whānau typically responded well to intensive engagement, particularly at the beginning of the trust building process" (p. 4), so they modified their practice to allow this, but were not funded to undertake the additional work. Providers and clinicians also raised concerns that over time their role has moved from supporting 'lower needs' whānau/families with parenting, to intensively supporting 'high needs' whānau/families with a wide range of difficulties, placing unsustainable strain on the service and its clinicians (Carter et al., 2020). Clinicians reported working unpaid overtime and struggling to take annual leave (Carter et al., 2020). Given this, there was a strong call from providers and clinicians to change the current funding model and

caseload expectations (Carter et al., 2020). This is particularly important given that "previous evaluations and interviews with OT personnel found that the regular, intensive home visiting feature of the programme design is critical to achieving the intended outcomes" (Carter et al., 2020, p. 16).

The evaluation also reported on the benefits of Family Start engagement with whānau as perceived by other service providers (e.g. child health services). These services considered it beneficial to have the Family Start worker regularly visiting and supporting whānau both as a "set of eyes" (where they had concerns for whānau wellbeing but lacked capacity for regular contact), and as a means of facilitating their engagement with whānau they may otherwise struggle to reach (Carter et al., 2020)

The evaluation recommended that caseload expectations be reduced (from 1:16 to 1:14, both higher than Start Well), and that kaupapa Māori and Pasifika providers be supported to align the delivery of the programme to Māori and Pasifika worldviews (Carter et al., 2020).

Early Start

Early Start is a home visiting service aiming to serve whānau with infants facing severe social, economic or emotional challenges in Christchurch (Fergusson, Boden, & Horwood, 2012). The service was set up in the mid-1990's, partly in response to findings of the longitudinal Christchurch Health and Development Study, such as the finding that the young people raised in the most disadvantaged 5% of the cohort had risks of severe maladjustment more than 100 times the risks for those in the most advantaged 50% (Fergusson et al., 2012; Fergusson, Horwood, & Lynskey, 1994). Caseloads are higher than for Start Well (1:10-20); engagement duration is similar (up to five years) (Fergusson et al., 2012). Early Start was set up as a Randomised Controlled Trial and has been evaluated at multiple time points, most recently in a 2012 nine-year follow up: Fergusson et al. (2012).

This evaluation found lower rates of parental reported physical child abuse, lower rates of hospital attendance for non-intentional injury (accidents), higher rates of parental reported competent parenting, and fewer parental reported childhood problem behaviours, but no differences in rates of OT contact for child abuse and neglect, and no evidence of benefit for family violence or maternal depression (Fergusson et al., 2012). Outcomes were similar for whānau Māori and whānau tauiwi (Fergusson et al., 2012). Evaluation considered that promising results were attributable to the research base of the programme, the use of professionally trained staff and the development of standards and service manuals for the programme (Fergusson et al., 2012). The lack of demonstrable parental and family outcomes were considered attributable to a need to develop better links between home visiting services and other family related services (Fergusson et al., 2012).

Start Well is another home visiting service, and the subject of this research.

Start Well

Start Well in context of the Place-Based Initiatives

A Place-Based Initiative (PBI) is a locality based approach to empowering local sector leaders to address social issues in their communities through local, collaborative and evidence-informed decisions (*Start Well Interim Learning Report*, 2021). Common to most PBI's is a focus on geographical locations with disadvantage (Crimeen, Bernstein, Zapart, & Haigh, 2018). Cabinet selected three PBI sites in 2016, one of which was South Auckland - resulting in the establishment of the South Auckland Social Investment Board, now referred to as the South Auckland Social Wellbeing Board (SASWB) (Smith, Lamb-Yorski, et al., 2019b; *Start Well Interim Learning Report*, 2021).

The SASWB is an agency-led PBI consisting of representation from thirteen Government agencies (*Start Well Interim Learning Report*, 2021). It reports to the Ministry of Social Development (MSD) and to the national Social Wellbeing Board, which itself

reports to the national Social Wellbeing Committee, comprised of Government ministers. The national Social Wellbeing Board was established by Cabinet in 2018, evolving from earlier social sector governance arrangements including the Social Investment Board (Social Wellbeing Board, 2020). The national Board "works on complex issues that require a high degree of integration across agencies and the social sector, and advises Ministers" (Social Wellbeing Board, 2020, p. 3).

The SASWB vision is: all children in South Auckland are healthy, learning, nurtured, connected to their communities and culture, and building a positive foundation for the future (*Start Well Interim Learning Report*, 2021). The SASWB operates a number of initiatives, one of which is Start Well.

What is Start Well?

The following information was provided by Start Well in the form of internal documentation. Start Well is a home-visiting initiative with a focus on supporting Māngere mothers under the age of 20 and their wider whānau, from pregnancy through to when the youngest child in the family turns five. It is a low ratio (not explicitly specified, but approximately 1:8 in practice) co-worker model pairing senior social workers and expert paediatric nurses to work intensively with whānau, drawing on elements of the universal WCTO service. There is no limit to the number of hours practitioners can spend with families, and no pressure to 'close the file' should the family require little assistance for a time. This is referred to as a 'flex up, flex down' model, and it allows for different types of support as needs change, e.g. crisis work versus proactive work to foster independence. Start Well works in a 'whole-of-whānau' way, whilst keeping pēpi at the heart of the journey. Start Well began work in Māngere at the end of 2017.

Target population

Start Well's clientele is not specified in official documentation as being anything other than 'mothers under 20 in Māngere,' but in practice the cohort would fit the descriptions of 'high need' and 'hard to reach' whānau as written elsewhere. For example the 2020 Family Start evaluation defined 'high needs' whānau as follows: "those affected by insecure and inadequate housing, family violence, alcohol and drug addictions including methamphetamine, mental health issues including high rates of anxiety, incarceration, intergenerational exposure to OT, immigrant and refugee whānau (some of whom have past trauma) and whānau in crisis" (Carter et al., 2020, p. 27). This definition would likely also apply to Start Well's clientele, as depicted in Figure 1 below. Note that the image in Figure 1 is for illustrative purposes only; it does not refer specifically to the participants of this research and was prepared by Start Well for another audience (*Start Well Interim Learning Report*, 2021). However it does give a snapshot of typical stressors facing mothers engaged with Start Well (i.e., many stressors). Therefore, for the purposes of this research, I refer to Start Well's target population as 'whānau experiencing multiple stressors.' Referrals for the initial cohort (which comprised the study population) primarily came from District Health Board (DHB) midwives, with the addition of a few other professional agencies (e.g. OT), and then via snowball referral (e.g. family members of enrolled mothers).

Figure 1. Typical number and form of stressors affecting enrolled Start Well mothers.

Mum	Justice Sector Involvement	Alcohol and/or drug struggles	Mental Health/Psychological Distress	Unemployment/Financial hardship	Pregnancy/Previous Unborn Alert	History of family Violence/Harm	Intergenerational Trauma/CYF Hx	Housing/Transiency	No Qualification	Oranga Tamariki Involvement	Total number of stressors
1				X	X	X	X				4
2	X	X	X	X	X	X	X	X	X	X	10
3	X	X		X	X	X		X	X		7
4		X	X	X	X	X					5
5	X	X			X	X		X			4
6	X	X		X	X	X	X	X	X		8
7		X	X	X	X	X	X	X			8
8	X		X	X	X	X			X		6
9		X		X	X	X	X	X	X	X	8
10		X		X	X	X	X	X	X	X	8
Total	5	7	4	7	9	10	7	8	6	5	

Purpose

The purpose of Start Well is as follows:

- To build and sustain meaningful relationships with whānau, nurture through manaakitanga, and evolve through learning from whānau.

- To shed light on the way universal and targeted services can be combined in a way that enables support to be flexibly tailored to the specific needs of each family, by 'flexing up' and 'flexing down' as needed.

- To understand what support offering is of value to whānau and what flexibility of support provision is needed to deliver this.

- To provide quality care reflecting both the priorities of whānau as well as the knowledge and skill of professionals through a relationship-based service where practitioners work in partnership with whānau.

- To influence system change based on evidence and insights gathered.

Principles of practice

Start Well's 'principles of practice' include being 'whānau-centred and whānau-led, working in a strength-based way, prioritising consistent, trusted relationships built over time, working with whole whānau and "doing what it takes" (*Start Well Interim Learning Report*, 2021, p. 2).

Evaluation to date

In 2019 an evaluation was commissioned "to assess the PBI model as a mechanism for collective action to address complex needs" (Smith, Lamb-Yorski, et al., 2019a, p. 4). The evaluation reviewed the work of the SASWB, and with regard to Start Well drew on "whānau-centred case studies, stakeholder interviews, a collaboration rubric, and supporting documents and data" (Smith, Lamb-Yorski, et al., 2019a, p. 4). Evaluation concluded that whānau have a positive service experience and emerging positive outcomes, and that the SASWB has also been able to identify system barriers and opportunities through its ways of working with whānau (Smith, Lamb-Yorski, et al., 2019a). Though the evaluation concluded that it is not currently feasible to quantify the impact of PBI's on whānau wellbeing outcomes, it did write to Start Well's ability to overcome some of the barriers to access typically faced by 'hard-to-reach' whānau:

> "Over time, the new whānau-centred way of working has enabled services to rebuild relationships and trust. Whānau interviewed for the Start Well case study greatly appreciated cross-agency engagement focused on their holistic needs. Whānau valued that agencies were able to support them and address the issue causing them the most significant distress at that time (and not the issue the agency deemed important based on their policy or practice setting)" (Smith, Lamb-Yorski, et al., 2019a, p. 110).

This quote speaks to the success of Start Well's cross-agency collaboration, which is related to its unique commissioning/contracting environment.

With regard commissioning/contracting, the evaluation reported on an event in 2018 which saw the five-year funding approved by a prior Government called into question (Smith, Lamb-Yorski, et al., 2019a). Approval for ongoing funding was ultimately granted, but in the

interim period of uncertainty, this "stress test for the collaboration and goodwill developed by

the SASWB across Government agencies" (p. 100) resulted in a willingness to identify

funding sources across Government agencies (Smith, Lamb-Yorski, et al., 2019a). This event

can be viewed as quite radical in the context of a Government commissioning model which is

competitive and "pitches providers against each other rather than supporting them to work

together with a whānau-centred focus" (Smith, Lamb-Yorski, et al., 2019a, p. 100).

Traditional commissioning models disproportionately disadvantage Māori and

Pasifika whānau in South Auckland who are over-represented among whānau presenting with

multiple complex needs:

> "These whānau require intensive intervention which costs more as it requires time and
> trained professionals who are the right fit and able to engage with them. Some
> stakeholders noted Māori and Pacific providers who may be providing such services are
> constantly scrutinised by funding agencies in a way which implies they do not know
> how to manage their money. [A Governance Board stakeholder said]: 'So there's
> institutional racism - thinking they don't know how to manage their money, they're too
> busy giving koha left, right and centre'" (Smith, Lamb-Yorski, et al., 2019a, pp. 100-
> 101).

Exploring collective commissioning and contracting models is part of the wider work

of the SASWB (Smith, Lamb-Yorski, et al., 2019a), and is also relevant to Whānau Ora: a

different but related model (to Start Well), which I describe next.

Related Models

Three models with relevance to Start Well are introduced for context and comparison:

Whānau Ora, the Swindon 'Life' programme, and WCTO. Each has relevance for a different

reason, as will be explained below.

Whānau Ora, and commissioning as an approach

Whānau Ora has a different kaupapa (purpose) to home visitation services, but is

relevant for a few reasons: (1) it is a service which also seeks to help whānau achieve

wellbeing (2) its funding via a commissioning model is a similar model to that of Start Well;

and (3) it is cited by Walker (2022) as an example of recent Government efforts to 'join up' social services with the aim of delivering flexible, strengths-based, culturally appropriate support to whānau.

Whānau Ora, which can be translated as 'family wellbeing' is a service which seeks to build whānau resilience and the skills and resources of members to manage their own affairs in order to reach their goals (Smith, Moore, Cumming, & Boulton, 2019). Fundamental to the vision of Whānau Ora is that providers should work with *whānau*, rather than with just one or two people within a whānau. Launched in April 2010, Whānau Ora "has succeeded in engaging whānau who were not connected to mainstream social services, or for whom the fragmentation of existing services had led to poor outcomes" (Smith, Moore, et al., 2019, p. 506). It has achieved this via trusting relationships with whānau (Savage, Leonard, Grootveld, Edwards, & Dallas-Katoa, 2016; Smith, Moore, et al., 2019) and by using a flexible and responsive approach which allows clinicians to deal with "whatever is immediate" (Smith, Moore, et al., 2019, p. 518).

Whānau Ora's success has been attributed in part to a commissioning model which allows whānau to lead their own capability building in pursuit of their aspirations (Smith, Moore, et al., 2019). That said, commissioning, funding and accountability have remained difficult for Whānau Ora throughout its history:

> "Conventional funding and accountability structures rather than the (recommended) innovative arrangements… were chosen, driving it towards a framework of state-determined and individualised outputs delivered within an essentially competitive provider sector… (Additionally), in the wake of the 2008 Global Financial Crisis… a decision was made to reduce the proposed $1 billion appropriation for Whānau Ora to $130 million of repurposed existing funding… More than one-third was utilised for administration" (Smith, Moore, et al., 2019, pp. 522-523).

In Whānau Ora's second (and current) phase, three non-Government commissioning agencies are contracted by central Government to invest directly into communities, reporting

against an outcomes framework to a governance group comprised of six Ministers of the Crown and the chairpersons of six iwi (Boulton, Gifford, Allport, & White, 2018).

There is a whole field of literature around commissioning as an approach, defined by the NZ MSD as "the interrelated activities, including but not limited to planning, engagement, funding, procurement, monitoring and evaluation that need to be undertaken through third-party providers to ensure people, whānau and communities who need support get the support they need" (Ministry of Social Development, 2020, p. 5). There is enthusiastic interest in commissioning as well as acknowledgement that it is still undergoing development, with some viewing its evidence base as ambiguous (Boulton et al., 2018). Suffice it to summarise here that the aim of commissioning is to operate from the 'ground up,' such that contracted providers can determine what their service should be based on the needs of whānau, and the commissioning agency then hold the providers accountable to doing what they say they will do (Boulton et al., 2018). This is meant to be a 'high trust' environment in which providers are able to 'get on with the work' knowing that commissioners trust them (Boulton et al., 2018). The Aotearoa NZ Government officially adopted a Social Sector Commissioning approach in 2018 (Ministry of Social Development, 2020), in an attempt to improve the way it works with social sector providers, so that they are "supported to be effective and responsive to the needs of communities" (New Zealand Government, 2021, p. 40).

In the case of Whānau Ora, some providers view the degree of oversight and monitoring on the part of the Crown to be excessive (Boulton et al., 2018), while simultaneously some members of the public/media have raised concerns about insufficient accountability for taxpayer funds in the Whānau Ora 'high trust' model (Patterson, 2015). These divergent views likely reflect wider uneasy Crown-Māori and tauiwi-Māori relations,

reflected in a recent Waitangi Tribunal claim on behalf of the Whānau Ora Commissioning

Agency (Hayden, 2020).

A particularly relevant (to this research) recent development in the Whānau Ora story

is the creation of two-year early intervention prototype Ngā Tini Whetū, which is:

> "An innovative social service prototype... The objectives of Ngā Tini Whetū are to (1) support whānau by navigating them towards a brighter future, preventing injuries and averting a care, protection or youth justice intervention from OT, and (2) reduce the number of incidents of family harm and improve access to services for whānau Māori using a Whānau Ora approach" (AIKO, 2021, p. 6).

Ngā Tini Whetū intends to change the way Government agencies and Crown entities

collaborate and partner with kaupapa Māori organisations and commissioning models

(AIKO, 2021). Momentum has been slowed by the Covid-19 pandemic, but findings to date

include the following: there are high levels of trust and collaboration between agency senior

leaders but more work is needed to embed a collaborative approach, time is needed to allow

whakawhanaungatanga between agencies, there has been a slow shifting towards a strength-

based way of working and an understanding of what it means to commission, and work is

needed to build internal capability and an understanding of what it means to partner

effectively with Māori (AIKO, 2021). These are encouraging early beginnings; a final

evaluation report is expected in late 2022.

The Swindon 'Life' programme

The Swindon 'Life' programme is briefly described here as it provides an illustration

of the power (and resource effectiveness) of coordinated, relationship-centred practice for

whānau experiencing multiple stressors. In 2009, 'social entrepreneur' Hilary Cottam

worked with 'complex dysfunctional families' in the UK city of Swindon who were receiving

'assistance' from multiple services across multiple Government agencies at a cost of around

£250,000 each per year (Stafford, 2021). Her research estimated that there were

approximately 100,000 families with similar circumstances in the UK, collectively incurring

costs of £25 billion per year (Stafford, 2021). Cottam attributed this high degree of spending to "Government services (being) delivered in agency 'silos' with no coordination, no overall plan or direction and no outcome focus - (leading to) an endless treadmill of futile, expensive activity" (Stafford, 2021, p. 26). Cottam's 'Life' intervention with the same families involved delivery of those services that the family chose as helpful, by the professionals that the family chose, with a goal and plan determined by the family (Stafford, 2021). 'Life' was delivered over 18 months at a cost of £19,000 per family and resulted in families "no longer requiring special Government services… often for the first time in generations" (Stafford, 2021, p. 26). The approach was later replicated in Wigan, UK (Naylor & Wellings, 2019).

Well Child Tamariki Ora (WCTO) and its 2020 review

WCTO is of relevance to Start Well firstly because Start Well itself is a WCTO provider, and secondly because WCTO was recently reviewed, with review results painting a clear picture of the population WCTO fails to adequately serve; this is the same population which Start Well seeks to better serve.

WCTO is "a series of health assessments and support services for children and their families from birth to five years. It also includes health promotion activities ("Well Child/Tamariki Ora services," 2018) and provides an opportunity for early intervention via screening and referrals to other services (Ministry of Health NZ, 2020). WCTO is universally provided to all families in Aotearoa NZ, with 85-90% of children being served by Plunket and the remainder by a range of smaller Māori, Pacific and public health providers (Ministry of Health NZ, 2020; Tuohy, 2010). WCTO was reviewed in 2020, with inequality and inequity in outcomes being one of the key issues explored (Ministry of Health NZ, 2020; "Well Child Tamariki Ora Review Update: June 2019," 2019).

The WCTO review highlights "pēpi, tamariki and whānau who are Māori or Pacific, have disabilities, are in state care or have high needs" as its 'priority population groups' (Ministry of Health NZ, 2020, p. 1). The review found inequitable outcomes for these priority groups, reporting "strong anecdotal feedback from providers that the programme does not prioritise or resource them to deliver culturally responsive models of care or to adjust service delivery to respond with intensified care for whānau with higher needs" (Ministry of Health NZ, 2020, p. 21). It also found that "the current model for how services under the WCTO programme are purchased is contributing to fragmentation and inequity in access and outcomes" (Ministry of Health NZ, 2020, p. 27). Highlights of the review's findings include the following: whānau value having the same practitioner over time, who they can build a trusting relationship with; whānau want providers to acknowledge the shared role of parenting by mother, father and the wider whānau; more time and less prescribed delivery is required, to support the development of trusting relationships between whānau and practitioners, and to enable whānau-led approaches; some of the screening tools currently in use may not be acceptable to Māori and Pacific people and all whānau, and may be increasing inequity; one whānau Māori research participant said, "All the important stuff has happened between visits. The visits are a tick box. I prefer genuine conversations about how things are going"; contracts and accountability currently focus on delivery of outputs, which disincentivises integrated, whānau-led and relationship-based service delivery; the mix of central and local commissioning creates a competitive environment and siloed services; and providers experience tension between funding and contracting requirements and their ability to respond to community needs and expectations (Ministry of Health NZ, 2020, pp. 32-35).

The WCTO review recommends "a joined-up system that is able to respond flexibly to support (priority populations)" (Ministry of Health NZ, 2020, p. 1). This is said to require strategic alignment across the wider health and disability and social service systems, and

across health services including maternity, primary care, immunisation and oral health services (Ministry of Health NZ, 2020).

Having considered how Start Well and related services seek to serve whānau experiencing multiple stressors, we now turn to explore one particular stressor: family harm.

Family Harm

Family harm - introduction

Violence of various forms sadly takes place in many Aotearoa NZ homes. This review surveys a range of literature on the topic of family harm: its definitions, its scale and nature, its impact, its drivers, and responses aiming to prevent it or alleviate its effects. The review will conclude by describing how family harm is approached by Start Well.

What is family harm? Definitions

The term 'family harm' is defined in various ways, as are a number of other terms often used interchangeably, such as family violence, domestic violence, and whānau violence. An Aotearoa NZ review of the literature argued that a universal definition is not possible given the lack of comparability between information sources (Lievore, Mayhew, & Mossman, 2007), and because family harm represents "a broad spectrum of behaviours ranging from inadvertent, isolated or not very harmful acts, through to deliberate, ongoing and severe violence" (Lievore et al., 2007, p. 4). While *this* review does not attempt to either resolve this issue or provide an exhaustive list of all possible definitions, it does provide a high-level definition of family harm and the definitions of family harm used in this research, definitions from Te Ao Māori and other non-Western cultures, and some newer ways of thinking about family harm from academia.

High-level family harm definition

In 2002 the landmark Family Violence Prevention Strategy 'Te Rito' defined family violence in the following way:

"Family violence covers a broad range of controlling behaviours, commonly of a physical, sexual and/or psychological nature that typically involve fear, intimidation or emotional deprivation. It occurs within a variety of close interpersonal relationships, such as between partners, parents and children, siblings, and in other relationships where significant others are not part of the physical household but are part of the family and/or are fulfilling the function of family" (Ministry of Social Development, 2002, p. 8).

A 2013 Expert Advisory Group report and Te Aorerekura (see later section) both add to this definition that family harm can be a pattern of behaviour in which individual acts may seem "minor" (Expert Advisory Group, 2013, p. 4; New Zealand Government, 2021).

Family harm is often conceptualised as an umbrella term, which can be segmented into categories based upon the dyadic relationship between perpetrator and victim, and/or by the form of violence used. Categories based on relationships frequently include the violence that occurs between intimate partners and ex-partners (often termed IPV), the maltreatment of children by adults, violence perpetrated by younger family members towards elderly members of a family (often termed elder abuse), and the violence that takes place between other family members, such as sibling abuse (Family Violence Death Review Committee, 2017; Lambie, 2018). Categories based on the form of violence used frequently include physical violence, sexual violence, emotional or psychological violence or abuse, and neglect.

Definitions used in this research

The definitions chosen for use in this research can be found in Appendix B; they were selected in many cases for comparability to existing research, and include those used by Family Start and OT (Child Youth and Family, 2011; Ministry of Social Development, 2016), those used in the locally-replicated WHO's global prevalence study of violence against women (Fanslow & Robinson, 2004; World Health Organisation, 2013), a definition of "coercive and controlling behaviours" within intimate relationships (Family Violence Death

Review Committee, 2017, p. 108), a definition of psychological abuse (Pico-Alfonso, 2005) and a definition of intrafamilial violence (Family Violence Death Review Committee, 2017).

Definitions from Te Ao Māori and other non-Western cultures

Western perspectives of family harm tend to focus on individual survivors and perpetrators (Dobbs & Eruera, 2014). Māori perspectives are wider, including the view that "intimate relationships do not exist in isolation (King, Young-Hauser, Li, Rua, & Nikora, 2012, p. 94), and including the historical and ongoing violence of colonisation (Pihama, Cameron, & Te Nana, 2019) and institutional racism (Te Puni Kōkiri, 2010). Pihama et al. (2016) argue that the idea of 'private' relationships was a colonial introduction, effectively denying collective responsibility and accountability for violence. Prior to this, for example, violence against wāhine Māori was viewed as an extremely serious transgression of tikanga, with whānau and collective responses to and punishment for such transgressions being well documented in contemporary times and within pūrākau (Pihama et al., 2016).

Pasifika notions of family are similarly not directly comparable to Pākehā notions, with the former covering an extended network of family members (Lievore et al., 2007), as well as village and sometimes church communities, rather than just the individuals directly concerned (Rankine et al., 2017). Family harm represents a disruption of the balanced relationships needed for wellbeing (Rankine et al., 2017), and in some cultures is understood as "a fundamental disruption of the va (sacred space) or violation of tapū (forbidden and divine sacredness) of people" (New Zealand Government, 2021, p. 14).

Writing on 'ethnic' perspectives (those of people who identify with ethnic groups originating from Asia, Africa, Europe, the Middle East and central and South America), Simon-Kumar (2019) notes that, while family harm occurs throughout society, violence in particular communities can take particular cultural forms. For example, violence expressed through co-habiting members of a family is more common in ethnic communities, with

generational dynamics (such as mothers in law often occupying a key role of power in a household) often shaping the nature of violence, particularly for women in communities of Asian origin (Simon-Kumar, 2019).

Newer understandings from academia

Some writers have critiqued the field's interest in measuring discrete incidents of particularly the violence between partners, as this can "obscure the reality of IPV" (Kelly & Westmarland, 2016, p. 114). Some newer approaches view family harm as a pattern of harmful behaviour which often involves coercive control, rather than solely as discrete, isolated incidents of violence (Family Violence Death Review Committee, 2017; Kelly & Westmarland, 2016).

A related newer approach relevant to IPV has been to re-focus from defining and measuring acts or cessation of physical violence, towards defining and measuring progress towards preferred relationship characteristics, such as an improved relationship underpinned by respect and effective communication, having expanded 'space for action,' and safe, positive and shared parenting (Westmarland & Kelly, 2012). The rationale for this approach is that it is quite possible for physical violence to stop while women and children continue to live in environments of tension and threat (Westmarland & Kelly, 2012).

Another newer approach is to focus on the converse of family harm by identifying family strengths (Asay, DeFrain, Metzger, & Moyer, 2016, p. 350). These strengths can be seen as the foundation upon which a new and better life can be built (Asay et al., 2016, p. 357). This approach has been highlighted as a promising new direction for addressing violence among young people (Dickson & Willis, 2017). Such approaches may also provide a useful counter to research and prevention work with whānau Māori which has utilised deficit-based, individually-oriented, 'service-provider/researcher focussed' and/or pathologizing approaches (with research often being conducted by Pākehā researchers) (Dobbs & Eruera,

2014). Dobbs and Eruera (2014) write that there are still significant gaps in the literature and practice regarding whānau and collective responses to violence, and strategies based on strengthening whānau (Dobbs & Eruera, 2014). It is likely that strength is to be found within whānau Māori collective approaches to raising children (Pihama et al., 2019), as well as the common contributions of those in the 'grandparent generation' to the nurturing of children, facilitated by shared living arrangements (Pihama, 2011). Similarly, King et al. (2012) write that "a focus on the strengths within Te Ao Māori can be used to incorporate Māori values into intimate relationships" (p. 94).

A strengths-based approach may also be more culturally appropriate for Pasifika; research has found that Pacific peoples prefer to talk about healthy relationships and processes for dealing with violence, rather than focussing on blame and victims (Rankine et al., 2017). Shared family living arrangements are also common among Pasifika, and seen as conducive to positive family relationships (Faleolo, 2020).

The scale and nature of family harm

The scale and nature of family harm is difficult to nail down, but many attempts have nevertheless been made. This section begins by providing some statistics indicating prevalence of family harm both internationally and in Aotearoa NZ, then discusses both the limits of data sources and the differential experience of family harm for different communities. I then look at the impact and drivers of family harm.

International statistics

Due to a lack of consensus as to the definition of family harm, prevalence and incidence estimates can be difficult to produce, particularly across very different global regions. The statistics provided in this section are meant to provide an example rather than an exhaustive list of the types of statistics available internationally. As one example, World Health Organization (2021) statistics indicate that 26% of ever-partnered women aged 15

years and older have been subjected to physical and/or sexual violence from a current or former male intimate partner at least once in their lifetime; World Health Organisation (2018) statistics indicate that almost one quarter of adults (23%) worldwide report childhood experiences of physical abuse.

As another example, an Organisation for Economic Co-operation and Development (OECD) study found that lifetime prevalence rates of physical and sexual IPV ranged from 10% to almost 40% across the OECD for women, with prevalence rates for physical violence being three times higher than rates for sexual violence (OECD Family Database, 2013). Child death rates due to negligence and maltreatment vary widely across the countries of the OECD, with the USA having the highest child death rates followed closely by Mexico; Aotearoa NZ is near the middle of this table (OECD Family Database, 2013).

Aotearoa NZ statistics

A 2007 review of data concluded that the Aotearoa NZ research base on family harm is considerable, and similar to that of relevant comparator countries (Lievore et al., 2007). However, Lambie (2018) argued that we have an inadequate understanding of the form and range of family harm, and Te Aorerekura acknowledged that we have insufficient reliable data on "the violence used against disabled people, children, young people, older people, ethnic and LGBTQI+ communities" (New Zealand Government, 2021, p. 68). Some of the available data is presented below.

Administrative/official data (that collected by Government and its agencies) indicates that family harm is rife in Aotearoa NZ, with the latest statistics from the NZ Family Violence Clearinghouse reporting that in 2016 there were 118,910 family violence investigations by NZ Police (or about one every five minutes), 5,461 applications for protection orders, 6,377 recorded male assaults female victimisations, 2,708 reported sexual offences against an adult over 16 years, 2,163 reported sexual victimisations against a child

aged 16 or under, and 16,394 findings of abuse or neglect of a child (in 2015/16) (New Zealand Family Violence Clearinghouse, 2017). OT statistics for the year ended June 2020 report that during the year 12,861 children (around 1.1% of the population) had been found to be abused or neglected (Oranga Tamariki - Ministry for Children, 2021).

A number of researchers have made attempts to identify the scale of family harm incidents that do not make it to the attention of authorities, using a variety of different methods. Three examples are provided here.

The NZ Crime and Safety Survey attempts to build a comprehensive picture of the incidence of family harm in Aotearoa NZ by going door to door and confidentially asking 8,000 New Zealanders about their experiences of crime (NZ Ministry of Justice, 2019). The most recent survey found that 80,000 adults had collectively experienced more than 190,000 discrete incidents of family violence in the last 12 months, and 90,000 adults collectively experienced almost 200,000 incidents of sexual assault (NZ Ministry of Justice, 2019). When extended to lifetime prevalence, the 2018 NZ Crime and Safety Survey found that one in six New Zealanders had experienced IPV in their lifetime, and one in three women had experienced sexual violence (NZ Ministry of Justice, 2019).

A second example is a population-based cluster-sampling study undertaken in Auckland and Waikato, which found that 15% of participants in Auckland had experienced at least one act of physical violence inflicted by non-partners in their lifetime, 9% had experienced sexual violence by non-partners, and 33% of ever-partnered women had experienced at least one act of physical and/or sexual violence by an intimate partner (Fanslow & Robinson, 2004). A second, comparable study completed in 2019 compared prevalence rates, finding that rates of psychological IPV had reduced over the period, lifetime intimate partner sexual abuse rates did not change, and lifetime prevalence rates of

controlling behaviours and economic abuse increased (Fanslow, Malihi, Hashemi, Gulliver, & McIntosh, 2021).

Finally, a cross-sectional study which randomly selected male and female participants from three regions of Aotearoa NZ found that "physical violence by non-partners was most commonly experienced by men (39.9% lifetime exposure) compared with 11.9% of women. More women (8.2%) experienced lifetime non-partner sexual violence compared with men (2.2%)" (Fanslow, Malihi, Hashemi, Gulliver, & McIntosh, 2022, p. 1).

Are these statistics accurate?

It is widely accepted that family harm is often not reported to authorities, making 'administrative' data a poor measure of actual incidence (New Zealand Family Violence Clearinghouse, 2016). Though other data sources such as the NZ Crime and Safety Survey are likely to be incomplete measures as well, they go some way towards broadening the picture of family harm incidence in Aotearoa NZ. For example, the results of the 2018 NZ Crime and Safety Survey suggest that 73% of family violence incidents are not reported to Police (NZ Ministry of Justice, 2019).

Another source able to broaden the picture of family harm incidence in NZ is the Family Violence Death Review Committee, which found in 2017 that for the 83 people killed in IPV between 2009-15, 33% of female primary or suspected primary victims were unknown to police, meaning that there were no police records of IPV in either the death event relationship or in any previous relationship (Family Violence Death Review Committee, 2017). Only 40% were known to police as IPV victims in the death event relationship (Family Violence Death Review Committee, 2017).

Differential experiences of family harm for different communities

Like other indigenous populations, Māori are over-represented in family violence statistics as both victims and perpetrators (Dobbs & Eruera, 2014), experiencing (relative to

tauiwi) more incidents of family violence (NZ Ministry of Justice, 2019), more incidents of

IPV (NZ Ministry of Justice, 2019), more psychological violence (NZ Ministry of Justice,

2019), and a higher incidence of death due to IPV, intrafamilial violence, child abuse and

child neglect (Family Violence Death Review Committee, 2017).

Māori have long been clear that this within-whānau violence is not part of traditional

Māori culture (New Zealand Government, 2021; Pihama et al., 2019; Te Puni Kōkiri, 2010);

rather it "reflects the patriarchal norms of the colonising culture, as well as trauma from the

widespread fragmentation of Māori social structures that were enforced during and after

colonisation" (Family Violence Death Review Committee, 2017, p. 11). This includes the

fragmentation of the inherent balance and complementarity of tāne and wāhine (New Zealand

Government, 2021). Tamariki Māori are adored and revered within tikanga Māori (Pihama,

2011), and early European settlers observed that whānau Māori interactions were

characterised by love and respect (The Māori Reference Group For The Taskforce For Action

On Violence Within Families, 2009). The majority of tamariki Māori are not maltreated but

rather loved and nurtured (Dobbs & Eruera, 2014). Though it is beyond the scope of this

review to further explore the reasons for higher rates of family harm for Māori, much has

been written on this topic and I would refer interested readers to the references used in this

section.

Similarly, family harm is not part of Pasifika culture; discussion of the incidence of

violence in Pacific communities must involve an understanding of Pacific peoples' social and

political history, the cultural relationships between men and women, and the influence of

missionaries and of migration (Rankine et al., 2017). With this context in mind, the literature

appears to suggest that Pasifika families may experience higher rates of family harm

perpetration and victimisation: one study found that, relative to NZ Pākehā, Pasifika young

people are twice as likely to experience sexual abuse or coercion, and three times as likely to

be exposed to family violence (Fa'alili-Fidow et al., 2016). The Pacific Youth 2000 study found that "approximately 36% of Pacific students had witnessed adults hitting or physically hurting a child in their home in the last 12 months and 22% had witnessed adults physically hitting or hurting other adults" (Helu, Robinson, Grant, Herd, & Denny, 2009).

Women are also disproportionately affected by family harm, with the latest New Zealand Crime and Safety Survey reporting that victims of family violence are 71% female (NZ Ministry of Justice, 2019). For IPV this figure increases to 77% (NZ Ministry of Justice, 2019). Two thirds of adults killed by IPV during the period 2009-2015 were female (Family Violence Death Review Committee, 2017). Additionally, women make up 71% of victims of sexual assault, and experience 80% of sexual assault incidents (NZ Ministry of Justice, 2019). Where women use violence it is more likely to be in response to a partner's violence ("fighting back") (Fanslow, Hashemi, Gulliver, & McIntosh, 2022).

Multiple intersecting disadvantages associated with ethnic, class and gender group membership mean that "those living with the most harmful levels of family violence are also often experiencing multiple forms of disadvantage and discrimination" (Family Violence Death Review Committee, 2017, p. 11). As an example of this, the highest rates of IPV are found among young, cohabiting adults of low socioeconomic status, particularly when they have children (Lievore et al., 2007).

Co-occurrence of forms of family harm

The fact that some groups are differentially affected by family harm is made worse by the fact that where family harm exists, it is likely to be co-occurring. The association between IPV and child abuse and neglect was not discovered until the 1990's, but has since become well documented (Chan, Chen, & Chen, 2021). Administrative data from Aotearoa NZ mirror international fundings in this regard, with The Family Violence Death Review Committee finding that "77% of the male offenders of fatal physical abuse and/or grossly negligent

treatment deaths (of children) were known to the police for abusing the mother of the deceased child/female partner and/or a prior female partner(s)" (2017, p. 10). The Committee also found that for the 91 IPV deaths between 2009 and 2015, 104 children or young people were normally resident at the home of the deceased or the offender, and 65 were present at the death event. The concept of 'polyvictimisation' has also emerged, referring to two or more types of victimisation rather than repeatedly occurring episodes of one type of victimisation; however its research base remains limited (Chan et al., 2021).

Impact of family harm

These figures aren't just numbers; they represent real lives being adversely affected. The impact of family harm is significant, primarily for the individuals, families and whānau involved, but also for societal systems and economies, as follows.

Research has consistently shown that exposure to family harm has a substantial impact (Lambie, 2018). One area of impact is on mental and physical health, both in the short and long term (OECD Family Database, 2013), via "complex and interconnected neural, neuroendocrine and immune responses to acute and chronic stress" (World Health Organisation, 2013, p. 7).

For children specifically, there is a substantial body of research documenting the impact of children's 'exposure' to violence between important people in their lives, even when this 'exposure' is 'indirect,' e.g. experiencing the aftermath, or hearing about the event (Artz et al., 2014). Effects include the development of neurological disorders, physical health problems, mental health challenges, conduct and behavioural problems, and delinquency (Artz et al., 2014). Given these findings, Powell and Murray (2008) rightly point out that when we refer to children as having 'been exposed' to family harm this terminology suggests an emotional distance between the violence and the child which simply does not exist. Regarding other forms of violence perpetrated against children, an international body of

literature on 'Adverse Childhood Experiences' (ACEs) has established the impact of

adversity in childhood (including exposure to/experience of family harm) on adult physical

and mental wellbeing (Hashemi, Fanslow, Gulliver, & McIntosh, 2021). Impacts include

increased risk of: tobacco use, risky sexual behaviour, depressed mood, illicit drug use, poor

health/quality of life, obesity, psychological distress and suicidal ideation (Petruccelli, Davis,

& Berman, 2019). In Aotearoa NZ, exposure to ACEs has been found to be associated with

subsequent exposure to IPV and non-partner violence (Fanslow, Hashemi, Gulliver, &

McIntosh, 2021), as well as poor mental health, disabilities and chronic physical health

conditions (Hashemi et al., 2021).

Some of the particular adverse effects of IPV (in addition to death and injury) include

reduced positive parenting by victims (Chiesa et al., 2018), reduced offspring attachment

security (McIntosh, Tan, Levendosky, & Holtzworth-Munroe, 2021), poor self-perceived

health (Sanz-Barbero, Barón, & Vives-Cases, 2019), poor mental health (Sanz-Barbero et al.,

2019), and adverse sexual and reproductive health outcomes (World Health Organisation,

2013).

Though Kahui and Snively (2014) rightly note that family harm would be

unacceptable even if its economic cost was zero, the economic cost is astronomical. Public

costs include those for medical care, mental health services, police time, and absences and/or

reduced productivity at paid and/or unpaid work (OECD Family Database, 2013). As an

example of a quantification of this cost, the average lifetime costs derived from childhood

IPV exposure in the US have been estimated to be over $50,000 per victim (2016 US dollars)

(Holmes, Richter, Votruba, Berg, & Bender, 2018). Over an annual birth cohort of young

adults, these costs amount to over US$55 billion nationwide (Holmes et al., 2018). Given

these high costs, UK economists have claimed that even marginally effective interventions in

the family violence domain can be economical (NICE, 2013). Locally, responding to family

violence accounts for 41% of frontline Police Officers' time (New Zealand Family Violence Clearinghouse, 2017). In 2014 the combination of child abuse and IPV was estimated to be costing NZ between $4.1 and $7 billion each year, the high end estimate being equivalent to 60% of what NZ earned from dairy exports in 2013 (Kahui & Snively, 2014). Current estimates are that Government alone is directly spending $1.5 to $2 billion annually on the consequences of family and sexual violence (New Zealand Government, 2021).

Drivers of family harm

There are several theoretical models for the causes of family harm. Some of the most commonly used include biological theory (which proposes that violent behaviour is biological and organic), individual psychopathology theory (which proposes that violent behaviour is rooted in individual psychopathology), couple and family interactions theory (which proposes that family violence is rooted in faulty interactions within a family system), social learning and development theory (which proposes that violence is learned behaviour which is modelled, rewarded and supported by families and/or the broader culture), and societal structure theory (which proposes that family violence is caused by an underlying power imbalance which can only be understood by examining society as a whole) (Wolfe & Jaffe, 1999). As an example of the latter, feminist thinking has been particularly influential in the family harm field, grounded in the principle that IPV is the result of male oppression of women in a patriarchal system (McPhail, Busch, Kulkarni, & Rice, 2007). The Duluth Power and Control wheel is a particularly well-known feminist model (Havard & Lefevre, 2020), although due to its fundamentally individualistic orientation it is seen by some as inappropriate for use with those from collective cultures (Rankine et al., 2017).

Māori commentators have noted that although family harm is known to occur in every strata of society, social and economic disadvantage do impact on the likelihood of a particular family experiencing family harm (Dobbs & Eruera, 2014). Further, the impact of colonisation

on Māori is recognised as both a significant driver of family harm (Dobbs & Eruera, 2014) and an extreme form of family harm in its own right (Pihama et al., 2019; Te Puni Kōkiri, 2010). In line with this, the Waitangi Tribunal has, at the time of writing, commenced the Mana Wāhine Kaupapa Inquiry, which is hearing claims of prejudice to wāhine Māori as a result of Te Tiriti breaches by the Crown (New Zealand Government, 2021).

Nga Vaka O Kāiga Tapu is a conceptual framework for addressing family violence in seven different Pacific communities in New Zealand (Taskforce for Action on Violence within Families, 2012). It identifies situational, cultural and religious factors contributing to family harm for Pasifika, including migration, socioeconomic disadvantage, beliefs that women are subordinate to men, and the fusion of cultural and religious beliefs including (mis)interpretations of Biblical texts (Taskforce for Action on Violence within Families, 2012). Rankine et al. (2017) also note the significance of housing changes associated with migration, given that traditional open-plan housing used in many Pacific islands enables other family members to protectively intervene in situations of family violence. The current high cost of housing in Aotearoa also contributes to stress on families, disproportionately affecting Pasifika (and Māori) (Taylor, Bradford, & Foster, 2020).

The NZ Crime and Safety Survey attempted to obtain victims' perspectives of family violence causes (NZ Ministry of Justice, 2019). The survey found that, according to victims, alcohol was a common causative factor, as well as arguments and jealousy (NZ Ministry of Justice, 2019).

Research has found that there is a relationship between the violence that occurs within a family, and violence in the community in which the family lives. One component of the relationship is that community attitudes and wider economic and sociocultural factors can foster a culture of violence (or not), perhaps most notably a culture of violence against women (Chavis & Hill, 2008). Conversely, research has also found that strength/resilience

within families with regard violence can ripple out into the community, and vice versa (Boyd et al., 2022; Gorman-Smith, Henry, & Tolan, 2004).

Though currently a correlation rather than clear causative factor of family harm, a commonly reported phenomenon in the field is seasonal trends in incidence rates. Though seasonal trends appear to be clearly visible, the reasons for them (i.e., why particular seasons are associated with higher rates of family harm incidence) is not clear, and the particular 'higher incidence' seasons vary from country to country, for example, the Finnish Winter (Koutaniemi & Einiö, 2021), Australian summer (Duncan, Mavisakalyan, & Twomey, 2021) and Jordan spring (Al-Hawari & El-Banna, 2017). Some argue that large numbers of observation years are required to establish seasonal trends more reliably, and that findings of seasonal trends may be statistical artifacts (Carbone-Lopez & Lauritsen, 2013).

Our understandings of family harm cause invariably influence our responses: the topic to which we now turn.

Responses to family harm

There are a great many forms of response to family harm. This section starts by introducing a public health framework for conceptualising responses to family harm to provide context, followed by a brief overview of some of Aotearoa NZ's national legal/policy responses to family harm in recent years. Two secondary prevention strategies are then discussed: screening for family harm and mandatory reporting laws. This is followed by a discussion of indigenous and Pasifika responses to family harm, followed by an overview of factors affecting uptake of supports, and issues facing the Aotearoa NZ family harm field.

Public health framework for conceptualising responses to family harm

Responses to family harm are sometimes categorised using a notion borrowed from public health of primary, secondary and tertiary prevention (Wolfe & Jaffe, 1999). Primary prevention involves efforts to reduce the incidence of a problem before it occurs; secondary

prevention involves targeting those showing early signs of a problem and working to minimise it; tertiary prevention involves attempts to minimise the course of a problem once it is clearly evident and causing harm (Wolfe & Jaffe, 1999).

Key Aotearoa NZ national legal/policy responses to family harm in recent years

Official national Government responses to family harm are a fairly recent phenomenon in Aotearoa NZ (Powell & Murray, 2008). Prior to the 1980's, police in Aotearoa NZ had a 'non-intervention' policy towards domestic violence, attending incidents to protect the peace and preserve life rather than to investigate a criminal offence (Benschop, Coombes, Morgan, & Gammon, 2012). This approach was informed by a mainstream societal view that what occurs in the home is private – referred to by Benschop et al. (2012) as the 'public private divide.' The non-interventionist police approach began to face criticism from the feminist movement in the early 1980's (Benschop et al., 2012). By 1983, 25 women's refuges were established across Aotearoa NZ with the aim of providing protection and safety for victims, and bringing domestic violence into the public arena (Benschop et al., 2012). Police also adopted a pro arrest policy in 1987, with the aim of holding offenders accountable and ensuring victims received appropriate support – however there were a range of concerns about how the policy was implemented (Benschop et al., 2012).

The Hamilton Abuse Intervention Project Pilot was established in 1991, modelled on the Duluth Abuse Intervention Project approach from Minnesota (Benschop et al., 2012) and an early local attempt at a coordinated, multi-agency approach.

In 1993, the Ministry of Justice reviewed the Domestic Protection Act, leading to the introduction of the Domestic Violence Act (Benschop et al., 2012). The Act defined domestic violence as including psychological abuse, sexual abuse and children witnessing violence (Benschop et al., 2012). It also stipulated that behaviours which may seem minor in isolation should be seen as abuse when they form a pattern (Benschop et al., 2012). Our legislation

was later described as some of the best in the world, however we were seen to have "among the worst of performances" due to an over-emphasis on investigative/punitive approaches relative to supportive/therapeutic interventions, a need for more primary prevention efforts, and societal inequity (Hassall & Fanslow, 2006, p. 2).

The Te Rito NZ Family Violence Prevention Strategy of 2002 advocated for a multi-faceted approach to preventing family violence, guided by nine principles including taking a holistic, collaborative approach, providing for the diverse needs of specific populations, and early intervention (Ministry of Social Development, 2002).

In July 2018, the International Committee on the Elimination of Discrimination against Women expressed concern regarding Aotearoa NZ's "absence of a national action plan or comprehensive strategy for the prevention and elimination of gender-based violence" (Interim Te Rōpū, 2021, p. 3). As part of its changes at that time, the Government established the Joint Venture for Family Violence and Sexual Violence - to create an integrated and effective system for addressing violence, by bringing the chief executives of Government agencies together (https://www.justice.govt.nz/justice-sector-policy/key-initiatives/addressing-family-violence-and-sexual-violence/work-programme/). The Joint Venture's establishment followed examples in Australia, Canada and the UK (Interim Te Rōpū, 2021). The Joint Venture Agency, together with distinct Māori body 'The Interim Te Rōpū,' then developed a national strategy to eliminate family violence and sexual violence, 'Te Aorerekura.'

Te Aorerekura is an ambitious 25-year plan with a strong focus on primary prevention and the role of tangata whenua and community leadership (New Zealand Government, 2021). It "recognises that it will take a generation to enable the social changes required to achieve (its) vision" (New Zealand Government, 2021, p. 4). Its objectives include adopting a strength-based, wellbeing-focussed approach, mobilising communities through sustainable,

trust-based relationships and commissioning relationships grounded in Te Tiriti, and increasing accessibility and integration of responses (New Zealand Government, 2021).

Secondary prevention strategy: screening for family harm

The aim of screening for family harm is to create an opportunity for disclosure and/or a change in perception about violence, and to enable intervention towards improved safety (Hegarty et al., 2020).

In research, screening is often referred to as being either 'routine' (ask everyone) or 'case-based' (only ask under certain conditions, e.g. suspicion of abuse) (Stöckl et al., 2013). The World Health Organisation (2013) in its most recent advice recommended the latter. A Cochrane systemic review in 2015 found that routine enquiry about IPV in healthcare settings can somewhat increase the identification of women experiencing IPV, but at a low rate relative to best prevalence estimates; screening also does not appear to result in a reduction of IPV, and there is insufficient evidence to determine whether it increases uptake of specialist services (O'Doherty et al., 2015, p. 2).

Most screening tools for child abuse and neglect are intended to identify nonaccidental injury in children presenting to healthcare settings and are not appropriate for use in preventative settings (Cutfield, Derraik, Waetford, Gillon, & Taylor, 2019). A US Preventive Services Task Force (2004) review concluded that the child abuse screening instruments which do exist have been found to have limited ability to predict child abuse or neglect.

No family harm screening tools have been validated for the Aotearoa NZ context (Cutfield et al., 2019). Internationally, a systemic review of ten tools for IPV screening found that three tools had stronger psychometric values: Women Abuse Screen Tool (WAST); Abuse Assessment Screen; and Humiliation, Afraid, Rape and Kick (HARK) (Arkins, Begley, & Higgins, 2016). However, Hegarty et al. (2020) argues that further testing of tools

is critically needed. There is little in the way of research regarding the conversations which take place between women and health professionals without the aid of formal screening tools (Creedy, Baird, & Gillespie, 2020), however Signorelli et al. (2020) found that the single question, 'in the last 12 months did you ever feel frightened by what your partner says or does?' has the potential to identify a majority of women experiencing IPV.

Regarding the *means* of asking, a 2015 systemic review found evidence that computer-assisted self-administered questionnaires may increase odds of disclosure in health settings relative to face-to-face interviews or written questionnaires (Hussain et al., 2015). However, in the UK it has been suggested that formal screening/assessment processes may be alienating and stigmatising for 'hard to reach' groups (Gray, 2011).

The *way* practitioners ask and respond is of critical importance: 'communication style' (Bacchus et al., 2016) and showing care in asking have been linked to positive experiences (Spangaro, Koziol-McLain, Rutherford, & Zwi, 2020), as have offering support and validation where a disclosure is made (Spangaro et al., 2020).

Service parameters and resourcing also have a role to play in terms of how clinicians are equipped (or not) to provide continuity of care and to take the time to build a sufficiently trusting relationship before asking about violence. Research has found that both are important (Adams et al., 2022b; Bacchus et al., 2016; Spangaro, Herring, Koziol-McLain, Rutherford, & Zwi, 2019; Stöckl et al., 2013). This may especially be the case for marginalised groups, as illustrated by a quote from an Aboriginal study participant in Australia: "She wouldn't just bring that up straight away. We'd talk about other things as well. And then I gradually told her more about J. and how he used to hit me" (Spangaro et al., 2019, p. 796). For this reason, repeat screening is important wherever possible: a US study has found that disclosure is often a staged process as trust develops (Bacchus et al., 2016), and recent Australian (Hegarty et al., 2020) and UK (Cleaver, Maras, Oram, & McCallum, 2019) reviews of evidence

recommended that clinicians ask more than once as women may not be ready to disclose on the first occasion.

As a benchmark for screening rates, findings from a review of 35 studies of screening by 'frontline' health-care providers (e.g. nurses, physicians, midwives) across nine countries reported low rates of screening ranging from 2% to 50% of women screened, with the majority of studies showing rates of between 10 to 20% (Alvarez, Fedock, Grace, & Campbell, 2017). In terms of benchmark disclosure rates, an Australian study found that just five percent of women experiencing violence in the 12 months postpartum had disclosed this fact to their General Practitioner (GP) (Woolhouse et al., 2019). In a Victorian Maternal and Child Health population, the disclosure rate was 1.3% (Hooker, Nicholson, Hegarty, Ridgway, & Taft, 2020).

Research suggests a variety of experiences for those being screened, depending on their historical and contextual experiences, and on how screening was done. For example, one Australian study found that of 32 women who had experienced violence and were interviewed 16 weeks after antenatal IPV screening, most regarded their experience of screening positively, but a few did not, due to a lack of care in asking, a lack of support and validation, and a lack of continuity of care (Spangaro et al., 2020). Where there were positive impacts these included naming the abuse, unburdening, and taking steps to safety (Spangaro et al., 2020). Aboriginal women in the same study reported fear about their children being removed by the statutory child welfare organisation should they choose to disclose family harm in response to screening (Spangaro et al., 2019). US research found that some women screened for IPV during perinatal home visits expressed ambivalence about screening and/or fears about possible consequences, including worsening abuse and unwanted police involvement (Bacchus et al., 2016). This study concluded that screening "may be less tolerable to women who are still with the abuser and wish to remain in the relationship"

(Bacchus et al., 2016, p. 358). An Australian study of pregnant women's perceptions of routine family violence screening by midwives found that those women who had historically experienced family violence or were currently experiencing violence were less comfortable with screening, and said they may not disclose due to fear of their partner, shame, fear that disclosure may lead to referral to child protection services, and lack of trust in the midwife (Creedy et al., 2020). American (Bacchus et al., 2016) and German (Stöckl et al., 2013) studies have also suggested that capacity to trust a clinician with a disclosure of family harm can be influenced by prior experiences of child sexual abuse.

In the Aotearoa NZ WCTO context, clinicians are theoretically expected to complete multiple family violence assessments during engagement with families (Cutfield et al., 2019). Clinicians are advised to "be attentive to interactions between caregiver and child" (rather than directly asking about child abuse and neglect), and rather than using a specific screening tool for IPV, to ask "specific, direct, and clear questions about different types of IPV and a women's feelings of safety and fear" (Cutfield et al., 2019, p. 321). It is unclear what screening actually takes place in practice, however; indications are that repeat screening does not occur, and that some WCTO providers intentionally screen in a way that reduces the likelihood of receiving a disclosure, due to feeling underprepared to respond (Cutfield et al., 2019).

Instruments for the detection of IPV use and general violence *use* have also been developed for use in healthcare settings in the US (e.g. Elbogen et al. (2014); Ernst et al. (2012)), and a small number of studies have begun to explore their use in routine care (Portnoy et al., 2020). Portnoy et al. (2020), for example, found in their research that a decision to disclose violence use (or not) was closely related to the degree of perceived rapport and trust with the person asking.

Overall, this field of research is still emerging, and results are mixed thus far as to whether screening is experienced positively, whether it results in positive impacts in terms of successful referral and/or reducing incidence of harm, and whether routine or case-based enquiry is best. Asking on multiple occasions, with a sense of care, within the context of an ongoing relationship of trust can help, along with offering validation and follow-up support when a disclosure is made.

Secondary/tertiary prevention strategy: mandatory reporting of harm to children

A common secondary/tertiary prevention strategy is to task statutory child protection agencies with intervening where family harm affects children. One means of achieving this is via mandatory reporting guidelines/laws.

Mandatory reporting laws have been enacted around the world, requiring designated professionals (e.g. doctors, teachers, social service providers) to report suspected cases of child abuse and neglect to child protection authorities (Mathews, 2012). Despite mandatory reporting being commonplace there is a lack of consensus regarding its costs and benefits (Nouman, Alfandari, Enosh, Dolev, & Daskal-Weichhendler, 2020). For example, some are concerned that it may produce excess unwarranted reports, leading to investigations which infringe on privacy, cause distress to innocent parents, and divert Government resources away from deserving cases (Mathews, 2012). Others raise concerns about the criminalisation of child abuse and neglect, which may lead to the precedence of legal process over support provision (Nouman et al., 2020).

It is not currently possible to determine from the research whether the overreporting claim is justified, and further, "there is strong evidence showing that the majority of identified cases of severe maltreatment are the result of reports by mandated reporters" (Mathews, 2012, p. 302). Nevertheless, reporting can be difficult for practitioners, who fear making false negatives (choosing not to report leading to serious harm to a child) and false

positives (choosing to report leading to unnecessary stigmatisation of a family) (Nouman et al., 2020). Practitioners also fear how reporting may affect their relationship with their client (Nouman et al., 2020; Schwab-Reese, Albright, & Krugman, 2022), and describe not reporting due to concerns about the child protection system (Vulliamy & Sullivan, 2000).

An unfortunate side-effect of mandatory reporting is that it can affect family willingness to engage with any form of service (Douglas & Walsh, 2015). For example, American research has found that mandatory reporting laws reduce help-seeking for over a third of family violence survivors, and that reports when triggered make the situation worse for most survivors (Lippy, Jumarali, Nnawulezi, Williams, & Burk, 2020). Local research has found that teenage Māori mothers experience the interwoven relationship between hospital social workers, school social workers and child protection social workers as intimidating and as a breach of their trust (Adcock, 2016). Similarly, Family Start clinicians described "the environment of fear in which many whānau live – that their children will be taken from them by OT" (Carter et al., 2020, p. 68). That said, for those who did choose to engage with Family Start, almost all whānau/families interviewed at evaluation said that they felt safe to share openly with their Family Start clinician despite the clinician's responsibility to report to OT (Carter et al., 2020).

Of course, as Douglas and Walsh (2015) write in the Australian context, "the problem is not mandatory reporting per se, but rather the ineffectiveness of the child protection system" (p. 502). In Aotearoa NZ, MSD has acknowledged that its statutory child protection agency OT is "not preventing or adequately protecting children from harm" (Ministry of Social Development, 2015, p. 4). The effects of these failures fall disproportionally on Māori, who make up 57% of children involved with OT (Ministry of Social Development, 2015). Whānau stories of experiences with OT are often devastating. For example, Adcock (2016) reported that one of her research participants felt 'thingified,' or dehumanized, by the way

she was treated by OT. Tatana (2020) reported ongoing "institutional racism, systemic collusion, culturally incompetent kaimahi, unmonitored practices and processes that perpetuate the continued failing of mokopuna Māori by OT" (p. i). A high profile recent news story raised the concerns that Māori whānau have long held about OT to the consciousness of mainstream Aotearoa NZ (Tatana, 2020), leading to the eventual pressured resignation of its CEO and Government promises of change. These disproportionate effects of doctrinaire child protection practices on Aotearoa NZ's indigenous population mirror the experiences of indigenous populations in other colonised countries (Cook, 2020). In summary, the fear whānau Māori feel about the possible effects of OT intervention in their lives affects their ability to engage with support services, thus directly affecting their ability to receive the care and support which would likely reduce the perceived need for OT to intervene.

Research suggests that "where child protection systems focus on working with mothers to support them to retain care of their children, the experience of mandatory reporting may be more positive" (Douglas & Walsh, 2015, p. 502). This is a worthy goal. For other support services in the meantime, the most effective remedy to fear is trusting relationships (Douglas & Walsh, 2015). Suggestions for achieving this include clear consenting processes at the beginning of engagement, and consulting with families before making a report to child protection services (Douglas & Walsh, 2015). Additionally, an occupational environment which supports practitioners to work flexibly with families, and practitioner comfort when discussing concerns with families, have been found to be significant factors influencing practitioner actions to maintain relationships with families through mandatory reporting processes (Tufford & Lee, 2020).

Family harm responses with indigenous populations

International research indicates that interventions intended to assist with family harm generally target either perpetrators, victims or children alone, to the neglect of integrated

treatments for whole families (Domoney et al., 2019; Tiyyagura et al., 2020). Partly for this reason, mainstream approaches to addressing family harm in indigenous populations have been identified as being problematic (Dobbs & Eruera, 2014). Due to the centrality of relationships for Māori (Te Puni Kōkiri, 2010), both individual and collective healing of family harm is needed (Pihama et al., 2019). For example, collective education with a whole whānau to deal with whānau violence may be preferable to Western frameworks emphasising a victim's separation from a perpetrator (Te Puni Kōkiri, 2010). Family-based approaches such as 'For Baby's Sake' in the UK (Domoney et al., 2019) are a new phenomenon in a field more accustomed to (Western) individual or couple-based interventions (Dobbs & Eruera, 2014; Tiyyagura et al., 2020), however they are not new to Māori (Te Puni Kōkiri, 2010). Wilson (2016)'s model for addressing intergenerational violence among whānau Māori is one example of a whole-family practice model which works across the public health spectrum of family harm prevention. Wilson (2016) argues that showing families new ways of parenting and addressing conflict, and supporting them to use these new means, is key to ceasing the transmission of violence with families, because "when you don't know what you don't know, you do what you do know (because) you don't know any other way" (p. 36). She also argues for the importance of grandmothers in both tending and nurturing the young, and supporting young mothers.

Family harm responses with Pasifika peoples

Similarly, Western interventions (including those encouraging victims to develop an independent sense of self) are not appropriate for Pasifika (Fa'alau & Wilson, 2020; Rankine et al., 2017). For services seeking to assist Pasifika families in contemporary Aotearoa NZ, time is needed for relationship development (Ioane, 2017), and this must be supported by funding criteria (Fa'alau & Wilson, 2020). Engagement with the whole family is also likely to be important (Ioane, 2017), as is consideration of holistic determinants of wellbeing (Fa'alau

& Wilson, 2020). In keeping with this literature, Nga Vaka o Kāiga Tapu (Pacific family violence framework) emphasises taking a relational, strengths-based approach (Taskforce for Action on Violence within Families, 2012).

Factors affecting uptake of supports, and issues facing the Aotearoa NZ family harm field

The 2018 NZ Crime and Safety Survey found that although more than 90% of victims were aware of family violence support organisations, only 10-12% of victims contacted them (NZ Ministry of Justice, 2019). The reasons most often given for not seeking such support were "Did not need help" (30%), "Wanted to handle it myself" (22%) and "Private matter" (17%) (NZ Ministry of Justice, 2019, p. 127). Ninety-four percent of victims sought help from their family/whānau rather than support services, and the type of support most often sought was someone to talk to (NZ Ministry of Justice, 2019).

A lack of service uptake may be due in part to the perceived inadequacy of either the design of services or the effectiveness of their implementation (or both). For example, international research with indigenous populations has indicated a scepticism of the ability of justice and legal systems to manage the violence they experience (Dobbs & Eruera, 2014). For Pasifika, there may be a reluctance to seek help outside of the family, due to shame and/or seeing doing so as not in the family's interests (Gosche, 2017).

Service effectiveness is likely affected by a lack of system coordination, resulting in repeat assessments and piecemeal intervention achieving minimal engagement from 'high risk' families (Lambie, 2018). "Many frontline staff know what is needed, but have caseloads that make effective, long-term collaborative work impossible" (Lambie, 2018, p. 7). This results in inefficiencies of funding use, a lack of integration and "a multiplicity of service providers but no overall service" (Expert Advisory Group, 2013, p. 8). Partly for this reason, local research has revealed the need for children affected by family harm to receive care

which focuses specifically on their needs, to avoid becoming lost in disjointed, adult-focussed processes (Yates, 2013).

Start Well and family harm

Preventing and responding to family harm is a significant part of Start Well's work. Start Well's description of its family harm practice in its Standard Operating Procedure document includes the following:

> "Workers may be involved in most aspects of family violence work with a family. This may include: receipt of original disclosure and development of trust; partnership/goal setting with whānau to address initial concerns; referral to outside agencies to provide support and address risk (including continuing to share care throughout the process); practical support to receive assistance, including transport, refuge access, police/justice/legal system attendance; attendance with whānau to outside agency/professional meetings; ongoing emotional and practical support with the ability to flex up and down as needed. Clinicians may provide holistic support for all whānau members as appropriate. The Start Well team focus will remain on a practice style that upholds relationship, partnership, and empowerment rather than screening and program delivery."

Family harm - summary

This review has sought to provide an overview of the substantial field of research and practice around the issue of family harm. Though there are no magic solutions, newer definitions, learnings from Māori and Pasifika, and a focus on family strengths hold promise, as do some of the responses to family harm being used internationally and in Aotearoa NZ, including home visitation services such as Start Well.

Psychological Distress

Introduction

Psychological distress also sadly affects many Aotearoa NZ whānau. This review surveys international and local literature regarding the psychological distress associated with pregnancy and new parenthood, and international and local responses. The review will conclude by describing how Start Well responds to psychological distress.

International research on psychological distress

Perinatal psychological distress has been a focus of interest for centuries, perhaps because perinatal mental ill-health is the commonest complication of child-bearing (Howard & Khalifeh, 2020). This section provides a brief overview of the vast field of research exploring rates of perinatal psychological distress, contributing factors, consequences, and what reduces risk, as well as a brief mention of research into paternal psychological distress.

Research has found that women are around 22 times more likely to experience psychiatric admission in the month following birth than in the pre-pregnancy period, even for those without prior psychiatric illness (Howard & Khalifeh, 2020). It has been estimated that "for each woman requiring psychiatric admission following birth, 2.5 require outpatient treatment and 12 receive pharmacological treatment in primary care" (Howard & Khalifeh, 2020, p. 314). Suicide is a leading cause of death during the perinatal period, with deaths more often occurring in the second half of the first postpartum year, possibly linked with not receiving active psychiatric care (Howard & Khalifeh, 2020). It is thought that postnatal mental disorders often begin during or before pregnancy (Howard & Khalifeh, 2020).

Postnatal depression is a particularly researched form of psychological distress (Russell, 2014). It is known to affect approximately 10-15% of new mothers, and risk is elevated for mothers facing other psychosocial stressors such as poverty, relational discord and life stressors such as bereavement (Tsivos, Calam, Sanders, & Wittkowski, 2015). Despite its high incidence, postnatal depression is known to be difficult to detect (Leahy-Warren, McCarthy, & Corcoran, 2012). The most significant factor in the duration of postnatal depression has been found to be the delay in its recognition and treatment, making early detection and intervention imperative (Leahy-Warren et al., 2012). Though postnatal depression receives particular research and clinical attention, it often co-occurs with other mental health conditions and trauma-related symptoms (SmithBattle & Freed, 2016).

Research suggests a higher rate of psychological distress for teenage mothers (Russell, 2014). The most common diagnoses associated with early parenthood are anxiety, depression, post-traumatic stress disorder and stress-related conditions such as adjustment disorder (Webb, Ayers, & Rosan, 2018). Teenage mothers experience depressive symptoms at a rate two to four times higher than their childless peers and older mothers, and these symptoms tend to persist and remain high into mid-life (SmithBattle & Freed, 2016). This may be due in part (or in majority, as argued by Collins (2010)) to the fact that teen mothers have often experienced high levels of psychological distress as children due to social disadvantage and adversities which precede pregnancy; for example, almost 50% of pregnant teenagers have a history of child sexual abuse, which often co-occurs with other childhood traumas (SmithBattle & Freed, 2016). This may then be compounded by the stress of parenting, financial hardship associated with parenthood, and the stigma of early pregnancy (SmithBattle & Freed, 2016). Despite the above, psychological distress is often overlooked in the care of teen mothers (SmithBattle & Freed, 2016).

It is important to address mothers' psychological distress for a number of reasons. First and foremost, the imperative is humanitarian, to alleviate suffering and to prevent suicide. Second, depression originating in pregnancy or postpartum has been found to have a continued impact on women many (e.g. 14) years later (Schmied et al., 2013). Third, it potentially impacts upon the mother-child dyad and outcomes for the child. For example, maternal psychological distress has been linked with reduced responsivity to infant cues, reduced parenting capacity, harsher parenting, less securely attached children, more developmental delays for children, an increased risk of child behavioural problems (Leahy-Warren et al., 2012; Russell, 2014; SmithBattle & Freed, 2016; Walker, 2022), and an increased risk of infant psychopathology (Howard & Khalifeh, 2020; Karimzadeh, Rostami, Teymouri, Moazzen, & Tahmasebi, 2017; Tsivos et al., 2015). It is important to note, though,

that there is limited understanding of the protective factors which account for a large proportion of children being unaffected by exposure to significant antenatal maternal illness (Howard & Khalifeh, 2020). There is some evidence that a healthy co-parent can buffer children against the adverse effects of another parent's mental illness (Howard & Khalifeh, 2020). Finally, there is an economic imperative to address mothers' psychological distress. For example, a UK economic analysis estimated the cost to UK society of not addressing maternal mental health difficulties to be £8.1 billion for every annual cohort of women giving birth, with most of this cost being attributable to long term adverse consequences for the child (Bauer, Parsonage, Knapp, Iemmi, & Adelaja, 2014). These costs are estimated to equate to five times the cost of improving perinatal mental health services (Mellor, Payne, & McAra-Couper, 2019).

Fathers are also at risk for depression, anxiety and trauma-related symptoms (Howard & Khalifeh, 2020; SmithBattle & Freed, 2016). Though paternal psychological distress has been less studied, emerging research has indicated its potential negative impacts on the couple's relationship, the mother's mental health, the father-child relationship, child development, decreases in positive parenting behaviours and increases in negative parenting behaviours including child maltreatment (Howard & Khalifeh, 2020; Webb et al., 2018).

Attempts to address psychological distress internationally

Given the broad field of responses to psychological distress, this review focuses tightly on some of what is known about contemporary attempts to address psychological distress amongst young mothers, and especially those facing adversity. I look first at strengths and protective factors, followed by mental health service offerings, and the utility of screening for psychological distress. I discuss some of the barriers teenage mothers face to accessing mental health service offerings and conclude with a brief mention of fathers and wider family members.

Regarding strengths and protective factors, teenage mothers' aspirations to improve their lives and to be good parents have been found to contribute to strength and resilience (SmithBattle & Freed, 2016). Teenage mothers have also been found to rely heavily on close family members (including partners) for support, with very few accessing formal systems such as teachers and mental health professionals (VanDenBerg, 2012). Where such family and/or partner support exists, it has been found to play an important protective role (SmithBattle & Freed, 2016). Where teenage mothers are able to develop positive and corrective experiences with supportive adults, these have been found to "repair difficult childhoods and promote mothers' resilience" (SmithBattle & Freed, 2016, p. 33).

A number of interventions to improve maternal mental health have been trialled, including some targeted specifically towards teenage mothers such as group therapy, relaxation or massage and co-parenting interventions with young couples (SmithBattle & Freed, 2016). There is also increasing interest in the antenatal (as opposed to just postpartum) period for provision of mental health support (Signal et al., 2017). Where psychological and/or psychosocial support can be accessed, it has robust evidence of effectiveness, including via Cognitive Behavioural Therapy, Interpersonal Therapy and listening visits (Howard & Khalifeh, 2020).

Screening is often recommended in order to identify those experiencing psychological distress, however some evidence suggests that for those with histories of trauma and/or those with mental health difficulties, disclosure may be difficult and routine enquiry may not be acceptable (Kingston et al., 2017; Yapp et al., 2019). Currently the evidence base appears to suggest that case-based enquiry by well-trained and well-supported practitioners may be effective and is less likely to cause harm than universal screening by health practitioners who are not skilled in talking about mental health (Howard & Khalifeh, 2020).

SmithBattle and Freed (2016) argue that nurses undertaking screening with teenage mothers are themselves best placed to then address any identified psychological distress, rather than referring on. This argument is made on the basis of their view that "referring teen mothers to traditional (mental health) care is rarely effective" (SmithBattle & Freed, 2016, p. 34). Schmied et al. (2013) similarly highlight a need to address system issues beyond referral.

A key system issue is that, "despite the availability of effective evidence-based treatments for depression and anxiety, many 'harder-to-reach' social and patient groups experience difficulties accessing treatment" (Lamb et al., 2015, p. 2865). This may particularly be the case for mothers under the age of 25 (Howard & Khalifeh, 2020). Barriers to access include unclear thresholds for escalating care, poor infrastructure for sharing information and, on the part of mothers, perceived stigma of mental illness, lack of time (due to competing demands of parenting, work and school), lack of transportation, lack of childcare, fear of custody loss, and anxiety about the possible effects of psychotropic medications (Howard & Khalifeh, 2020; SmithBattle & Freed, 2016).

As one method of attempting to address access barriers, attempts have been made to offer mental health support 'in-house' where teenage mothers are already engaged with a more generalised support service (as opposed to referring to external community mental health services) (Russell, 2014). A 2014 randomised control study aiming to explore whether there is a research basis for in-house mental health service provision was unable to establish that it produces a significant difference in outcomes; that said, the service within which mental health support was being offered itself had just a 55% rate of completing at least one follow up (Russell, 2014).

Finally, efforts to support the psychological wellbeing of fathers and wider family members are also important, both in their own right and because of their likely positive impacts on mothers' and infants' wellbeing (Howard & Khalifeh, 2020). International

guidelines on perinatal mental health do recommend that services primarily supporting women involve and support their partners and wider family members too (Howard & Khalifeh, 2020), but it is unclear how often this actually occurs in practice. Regarding interventions to support the psychological wellbeing of new fathers, the most recent systematic review of this topic identified only 11 studies, several of which had significant methodological limitations (Rominov, Pilkington, Giallo, & Whelan, 2016). Research into family interventions is also extremely limited (Howard & Khalifeh, 2020).

Aotearoa New Zealand research on psychological distress

This section provides an overview of psychological distress prevalence in Aotearoa NZ, both generally and in the ante- and post- natal period. This is followed by a brief discussion of drivers, and some examples of lessons the field can learn from Māori and Pasifika perspectives on psychological wellbeing.

General picture of psychological distress in Aotearoa NZ

Approaches to measuring psychological distress in Aotearoa NZ include rates of mental health service use, the suicide rate, and population surveys such as the NZ Health Survey and the World Happiness Report (Mulder, Bastiampillai, Jorm, & Allison, 2022). The Covid-19 pandemic has likely had a significant impact on societal distress and wellbeing, but this impact is not commented on here for two reasons: (1) some official data (such as mental health service data) for this period is not yet available; and (2) the data collection period for the current research ended in February 2020, just before the pandemic began. For the period preceding the pandemic, then, data shows that increasing numbers of New Zealanders have been accessing mental health services over the past decade (Mulder et al., 2022). The NZ Health Survey indicated rising depression and anxiety symptomatology from 4.5% in 2011/12 to 8.6% in 2017/18, with latest figures indicating a stabilisation at 7.4% in 2019/20 (Mulder et al., 2022). Each year, around one in five New Zealanders experience mental

illness or significant mental distress (New Zealand Government, 2018). The suicide rate appeared to stabilise in 2019/20 (Mulder et al., 2022), however for young people it's among the highest in the OECD (New Zealand Government, 2018). On the World Happiness Report, Aotearoa NZ ranked ninth out of 149 countries in 2020 (Mulder et al., 2022). As is the case for family harm, though, different communities have differential experiences of psychological distress, as follows.

The NZ Health Survey found that those living in the most deprived decile were around 30 times more likely than those in the least deprived decile to experience clinical levels of anxiety and depression symptomatology (Mulder et al., 2022). Similarly, suicide rates for the lowest quintile in 2016 were between two and three times higher than the least deprived quintile (Mulder et al., 2022). Suicide rates for Māori are also higher than for tauiwi, as is the case for other indigenous populations around the world who have experienced European colonisation (Bennett & Liu, 2018). Whereas one in five New Zealanders experience mental illness, the figure is one in four for Pasifika, who also have higher rates of suicidal behaviour (Kapeli, Manuela, & Sibley, 2020).

Prevalence of psychological distress in the ante- and post- natal period

The Growing Up In New Zealand longitudinal study found that 11.9% of pregnant women reported depressive symptoms in the third trimester (Waldie et al., 2015), and a systematic review of Australia and Aotearoa NZ longitudinal research found that approximately ten to twenty percent of women experience moderate to severe depression during the year after birth (Schmied et al., 2013). Overall these rates for Aotearoa NZ are internationally comparable (Signal et al., 2017). Devastatingly, suicide is a leading cause of perinatal maternal death in Aotearoa NZ (Mellor et al., 2019; Walker, 2022), with rates seven times higher than those seen in the United Kingdom (Signal et al., 2017).

Regarding rates for Māori specifically, 22% of wāhine Māori have been found to experience depressive symptoms during pregnancy, compared to 15% of tauiwi women (Signal et al., 2017). For anxiety, rates have been found to be 25% and 20% for Māori and tauiwi respectively (Signal et al., 2017).

Pasifika women have been found to experience symptoms of postnatal depressive or psychological disorder at a rate of 16.1% at six weeks post-birth, and 12.2% at 12 months post-birth (Gao, Paterson, Abbott, Carter, & Iusitini, 2007).

Drivers of psychological distress

Local research indicates that the strongest predictors of psychological distress following birth are a previous history of depression (Schmied et al., 2013; Signal et al., 2017) and a poor partner relationship (Schmied et al., 2013). Experiences of physical family violence during (and before and after) pregnancy are common locally, and have been linked with experiences of psychological distress (Schmied et al., 2013; Walker, 2022). Other predictors include becoming a mother at a young age (Signal et al., 2017), 'significant life stress' (Signal et al., 2017), lower educational achievement (Stevens et al., 2021), lower socioeconomic status (Stevens et al., 2021), and being a single parent (Stevens et al., 2021).

For Pasifika mothers specifically, IPV has been found to be associated with greater risk of psychological distress (Gao, Paterson, Abbott, Carter, & Iusitini, 2010). Pasifika children are more likely to experience psychological distress if their mothers are distressed (Gao et al., 2007; Kapeli et al., 2020). Pasifika fathers are more likely to experience psychological distress in the first six years of their child's life if they are a heavy smoker, separated or single, or unemployed (Tautolo, Schluter, & Sundborn, 2009).

Māori and Pasifika perspectives on psychological wellbeing have much to teach us all

Aotearoa NZ's understandings of and approaches to psychological distress and wellbeing, while British in orientation since colonisation, have been greatly enriched by Māori thinking and practice (Coleborne & MacKinnon, 2006; Durie, 2011). There is much to learn and to do in this regard, and even if there were space in this review to do the literature justice, I certainly don't possess the knowledge to do so. Suffice it to mention here a few contributions from Te Ao Māori and from the Pacific – in full knowledge that there are many more.

A holistic, whole-of-person approach to wellbeing – as articulated by Māori psychiatrist Tā Mason Durie in Te Whare Tapa Wha – has been advocated as a means of improving Māori experiences in the mental health system (Durie, 2011).

Similar holistic approaches have been described by Pasifika, for example the Seitapu framework of clinical and cultural competency (Pulotu-Endemann et al., 2007), and the widely used Fonofale model (Kapeli et al., 2020). As a specific example of a holistic focus which honours a 'Pacific way of life', psychological treatment elements incorporating nutrition, physical activity and healthy relationships are recommended for Pasifika whānau (Kapeli et al., 2020; New Zealand Government, 2018), and would likely benefit whānau of all ethnicities. Involvement of family in mental health treatment (where desired) is also encouraged in Pasifika models (Kapeli et al., 2020; Lino, 2021) – something that has long been sought by Māori and other tauiwi groups alike (Gawith & Abrams, 2006).

Finally, with regard wellbeing specifically related to childbirth, both "Māori and Pacific cultures have long understood the importance of adequately supporting birthing parents and babies during the crucial perinatal period… Birthing parents and new babies are accorded special status, and rituals and traditions during and after pregnancy uphold and

surround new parents and babies with collective support… A growing body of scientific and academic research is now catching up with these cultural practices" (Walker, 2022, p. 14).

Attempts to address psychological distress in Aotearoa NZ

This section provides a brief overview of the recent 'He Ara Oranga' report in its context, followed by examples of contemporary approaches to addressing mental health difficulties in the ante- and post- natal period. A critique of these service offerings follows, including a discussion of barriers to service access.

He Ara Oranga in context

Following the rapid closure of psychiatric hospitals in Aotearoa NZ as part of the mid-20th century reform movement, (Allison, Bastiampillai, Castle, Mulder, & Beaglehole, 2019), most (91% of) mental health clients in Aotearoa NZ are now treated exclusively by community mental health services, with only nine percent receiving inpatient care (Allison et al., 2019). Coleborne and MacKinnon (2006) argue that the rapid closure of institutions has been followed by decades of systematic neglect by the state, leading to a lack of the infrastructure and financial supports which would be necessary for a workable system of community care. The result of this, they argue, is an "increasing burden placed on families to care for family members with mental illness, without adequate support or respite services in the community" (Coleborne & MacKinnon, 2006, p. 376). Regarding resourcing in recent times, mental health funding increased at a rate higher than population growth between 1994 and 2015 (Gawith & Abrams, 2006; Mulder et al., 2022), the number of psychiatrists and psychologists almost doubled from 2005 to 2015 (Mulder et al., 2022) (population increase for the period was 112%), and rates of psychotropic medication prescription increased by more than 50% over the same period (Mulder et al., 2022). Despite these increases, evidence does not indicate improved mental health at a society level (Mulder et al., 2022). The comparability of this to other high-income countries offers no comfort (Mulder et al., 2022).

It is not clear whether continued funding increases have simply not been sufficient to address outstanding infrastructure deficits from the era of deinstitutionalisation, or if the use of funds is failing to achieve intended outcomes.

A 2012 Mental Health Commission Blueprint report detailing 'how things need to be' in order to improve Aotearoa NZ mental health and wellbeing, recommended responding earlier and more effectively to mental health issues, improving equity of outcomes across populations, improving access to mental health supports, and improving partnerships across Government (Mental Health Commission, 2012). All of these recommendations appeared again in He Ara Oranga: the Government's "once in a generation" mental health report (Allison et al., 2019, p. 724). The report had a mandate to "look beyond the health sector to other sectors and social determinants that influence mental health outcomes" (New Zealand Government, 2018, p. 7).

He Ara Oranga uncovered difficulties with access to mental health support across the country: "the cruelty of being encouraged to seek help from unavailable or severely rationed services," and "a gloomy picture of a system failing to meet the needs of many people" (New Zealand Government, 2018, p. 10). During the Inquiry a 'striking degree of consensus' emerged from 'most parts' of Aotearoa NZ about the need for a new direction in mental health: one that emphasises wellbeing and community, with more prevention and early intervention, and more cross-Government action (New Zealand Government, 2018).

The report makes several recommendations, including extending psychological therapies to those experiencing mild to moderate depression and anxiety, facilitating mental health promotion and taking a whole-of-Government approach to tackling the social determinants of wellbeing (New Zealand Government, 2018), as also advocated by Tā Mason Durie (2011). Greater cross-sector collaboration is recommended to improve commissioning

and to reduce service fragmentation (New Zealand Government, 2018), as is the case for proposed family harm approaches.

He Ara Oranga aims to avoid early intervention efforts being 'crowded out' of funding decisions due to the priority and urgency placed on tertiary services. It notes that "over the last 20 years, addressing the social determinants of wellbeing and investing in prevention in a deliberate and integrated way has become a focus internationally. For example, the United Nations Sustainable Development Goals 2015 have a strong focus on social determinants such as poverty, housing, and child and maternal health" (New Zealand Government, 2018, p. 147).

Approaches to addressing psychological distress in the ante- and post- natal period

In Aotearoa NZ, psychological distress is usually managed through the primary healthcare sector, i.e., GP practices (Filoche, Lawton, & Stanley, 2016). Service offerings include assessments, brief interventions (including counselling) and medication reviews, funded across all DHB's and targeted to priority groups including Māori, Pasifika and those on low incomes (Lockett, Lai, Tuason, Jury, & Fergusson, 2018). Around 31% of GP patient interactions have been found to include a mental health component, with around half of those resulting in a prescription for medication, and 20% requiring a referral to secondary mental health services (Murton, 2020). Access to secondary mental health services for more severe mental health conditions is via referral (often from GPs and midwives) to community-based multi-disciplinary teams, with many DHB's having dedicated maternal mental health teams (Filoche et al., 2016).

There is currently no formal mental health screening programme in Aotearoa NZ, but The National Maternity Monitoring Group has recommended that all DHB's "develop maternal mental health referral pathways to guide assessment and screening throughout the perinatal period and to aid referral to appropriate services" (Mellor et al., 2019, p. 28).

Currently, midwives report assessing women's mental health using informal means including 'taking in' subtle signals continually over time, and acting on 'inklings,' using formal screening processes selectively in order to test concerns and to validate referral to maternal mental health services (Mellor et al., 2019). Midwives interviewed by Mellor et al. (2019) reported concern about the proposed introduction of routine universal antenatal screening without a corresponding availability of appropriate maternal mental health services for those screening positive for mental health difficulties.

These approaches don't seem to be working well

There is broad concern about mental health service access and service delivery in Aotearoa NZ, especially for particular groups (Graham & Masters-Awatere, 2020; Suaalii-Sauni et al., 2009). The following is a brief summary of the available evidence relating to issues with psychological service delivery in general, for mothers, for Māori, Pasifika, and 'high risk' whānau.

Though positive intent for mental health service delivery is present within the Aotearoa NZ health sector, "there is recognition… that in many areas these services are lacking" (Signal et al., 2017, p. 169). For example, adults with internalising disorders have been found to require a high level of support from primary healthcare, yet experience more barriers to accessing these services, and report less positive experiences with GP's (Lockett et al., 2018). Secondary services have been described as 'overwhelmed,' and there is a shortage of psychiatrists (Murton, 2020). "Many GPs report a vicious cycle of emergency referral and short term hospitalisation before a lack of DHB resources sees the patient released back into GP care" (Murton, 2020, p. 19).

For mothers specifically, few (less than 50%) seek assistance from mental health services (Schmied et al., 2013; Signal et al., 2017), with tauiwi being more likely to do so than Māori (Signal et al., 2017). This may be partly due to the multiple barriers to accessing

mental health support, including long wait times, unavailability of services, cost and transport difficulties, and different health beliefs (Schmied et al., 2013).

For Māori, experiences of racism within Aotearoa NZ society – regardless of where specifically they occur – have been found to affect subsequent engagement with the health system (Wild, Rawiri, Willing, Hofman, & Anderson, 2021). The health system itself is also experienced as hostile and alienating for whānau Māori (Graham & Masters-Awatere, 2020). Regarding mental health specifically, Māori experience "delayed diagnosis, late intervention, and often no intervention" (Durie, 2011, p. 33). Perhaps as a consequence, Māori are more likely to receive mental health treatment via compulsory treatment orders, and to experience seclusion practices while in treatment (Bennett & Liu, 2018). Tapsell, Hallett, and Mellsop (2018) found that Māori patients were far more likely to be admitted as inpatients for depression, whereas tauiwi were more likely to receive outpatient services. They speculate that this may be due to differences in access to services and/or how Māori are treated once in services (Tapsell et al., 2018). Haitana, Pitama, Cormack, Rangimarie Clark, and Lacey (2022) found that Māori experiencing Bipolar Disorder were adversely affected by multiple structural barriers including limited hours of service delivery, a deficit focus and inadequate emphasis on staff wellbeing leading to a lack of staff care for whānau, all of which led to 'navigation fatigue.' Their recommendations include increasing options/availability of respite care, offering flexible appointment scheduling and prioritising whakawhanaungatanga (Haitana et al., 2022).

Regarding Māori mothers specifically, they and their infants are more likely to experience poor health outcomes during and after childbirth than their Pākehā counterparts, and *young* Māori mothers are even further at risk (Adcock, 2016). Qualitative research has found that in their interactions with the health system, teenage Māori mothers overwhelmingly report feeling not listened to, not respected and not cared for (Adcock,

2016). Many report feeling that GP's are a 'waste of time and money' due to insufficient

engagement and a sense of 'rushing' (Adcock, 2016). This is despite higher rates of

psychological distress documented in research (Signal et al., 2017). Rather than the higher

rates for Māori mothers that they expected to find, Filoche et al. (2016) found that during

pregnancy and in the first year post-birth, Māori and Pākehā mothers had similar rates of

access to secondary mental health services. Consequently, the mental health disorders of

Māori mothers are underdiagnosed (Filoche et al., 2016).

Pasifika generally are less likely than the general population to access professional

mental health assistance (Fa'alogo-Lilo & Cartwright, 2021; Suaalii-Sauni et al., 2009),

despite higher rates of psychological distress than non-Pacific, non-Māori people (Ataera-

Minster & Trowland, 2018). Regarding mothers specifically, Filoche et al. (2016) found that

during pregnancy and the first year post-partum, Pasifika mothers had significantly lower

rates of access to secondary mental health services than Pākehā women. One possible reason

for these findings is different understandings of the causes and remedies for psychological

distress (Kapeli et al., 2020). For example, Suaalii-Sauni et al. (2009) report that Pacific

peoples often view mental disorder as having a spiritual cause, and seek healing via

traditional healers. A preference for seeking support from friends, family and/or the church

may also contribute (Ataera-Minster & Trowland, 2018; Fa'alogo-Lilo & Cartwright, 2021),

in addition to a lack of knowledge about how to access formal mental health services (Ataera-

Minster & Trowland, 2018; Fa'alogo-Lilo & Cartwright, 2021; Suaalii-Sauni et al., 2009).

Another reason for lower access to mental health services is that the available services

do not meet the needs of Pasifika people. For example, 'mainstream' mental health services

have been found to often lack understanding of the collectivist cultural values and practices

of Pasifika, including spiritual beliefs (Fa'alogo-Lilo & Cartwright, 2021). Pacific peoples

often need to juggle multiple caregiving responsibilities, (Suaalii-Sauni et al., 2009), which

may impact upon their ability to attend appointments. Complex and restrictive service infrastructure and language may both alienate families and hamper the efforts of Pasifika staff to offer effective service (Kapeli et al., 2020). As an example of the latter, Suaalii-Sauni et al. (2009) raised concerns from Pacific mental health providers about documentation and reporting requirements, with current funding unable to cover 'extra mile' tasks completed as part of holistic Pacific models of care. Some Pacific youth have also raised concerns about current models of Pacific mental health service delivery which seem to bias the 'island-born' Pacific adult perspective (Suaalii-Sauni et al., 2009).

Recommendations for improving service delivery to Pasifika include enabling culturally appropriate relationship development and wider family involvement in treatment (Fa'alogo-Lilo & Cartwright, 2021), improving access to respite care (Suaalii-Sauni et al., 2009), and facilitating access to the right community support workers who are able to act as the 'people interface' between stressed families, unwell consumers and unfeeling bureaucracies (Suaalii-Sauni et al., 2009).

Regarding 'high risk' whānau, the 2020 Family Start evaluation reported that one of the factors making its work with increasingly 'high needs' families time consuming for clinicians was the need to spend long periods of time assisting whānau to access 'hard to locate or scarce services,' with mental health services and counselling being the primary examples given (Carter et al., 2020). That said, where mental health support could be accessed it was identified by clients as having a substantial impact on their wellbeing (Carter et al., 2020). Research with women at 'high risk for antenatal substance use and mental health disorders' found that rates of engagement with mental health and drug and alcohol services was low both at one and twelve months post-birth, possibly due to accessibility, acceptability and service integration issues (Stevens et al., 2021). Stevens et al. (2021) recommended addressing challenges around discontinuities in care from the antenatal to postnatal period,

alongside shortcomings in holistic treatment of the mental health needs of the infant in conjunction with those of the mother.

What else helps

Support to navigate the health system has been found to be useful for whānau Māori (Graham & Masters-Awatere, 2020). Where psychological distress is related to IPV, cessation of violence, support at disclosure and ongoing informal support have been linked with positive mental health outcomes (Pir et al., 2021). Not having to wait for service access can restore people to their own support structures faster, avoiding lengthy, costly and ineffective service support (Mental Health Commission, 2012). Other (non-service) factors which have been found to support psychological wellbeing in Aotearoa NZ include social support, neighbourhood cohesion including neighbourhood permanence, and alignment with social and cultural norms (Farewell et al., 2021).

Start Well and psychological distress

Start Well describes its approach to assisting with psychological distress/mental health as follows: understanding current need through relationship and deliberate, regular, worker-led conversations about psychological distress/mental health; using a clinical assessment where appropriate, e.g. the Edinburgh Postnatal Depression Scale; safety planning; journeying with whānau to meet any identified needs; deliberately allowing the person to steer the ship and upholding them as expert in their own life; and sharing care with formal mental health services, making use of whatever resources appear to be of most benefit for families/whānau.

Psychological distress – summary

This review has sought to provide an overview of the substantial field of research and practice around the issue of the psychological distress associated with pregnancy and new parenthood. Aotearoa NZ ways of understanding psychological distress are enriched by

Māori and Pasifika perspectives, which along with evidence-based practices offer hope for a field besieged by difficulties in service implementation and practice. Home visitation services such as Start Well may be able to assist in the promotion of psychological wellbeing as well as assisting with service access.

Conclusions

This literature review has explored a number of ways in which family harm and psychological distress affect whānau and families, and how traditional service offerings and commissioning practices tend to fail those experiencing multiple stressors. My review of research outcomes for 'home visitation' as a service model and commissioning as a means of funding indicates that these approaches hold promise for assisting whānau experiencing multiple stressors with both family harm and psychological distress. The next chapter outlines how the current research explores family harm and psychological distress outcomes for local home visitation prototype Start Well.

Chapter 2 - Methodology

Introduction

This chapter begins by describing the process for obtaining ethical approval for this research. The socioeconomic context and participants involved in the research are then described, followed by a description of the Start Well team. Descriptions of the research procedures used for data collection include a rationale for and description of the overall approach taken, an introduction to case note review as methodology, research questions, research variables and planned analyses, a description of the method of data collection, a list of existing data used in the research, and a description of how the reliability of data was explored using inter-rater reliability experiments. This is followed by a description of how the data was analyzed. The chapter concludes with active reflection on my process of coming to the research, and what I was hoping to find.

Ethics

Ethics approval for evaluation of the Start Well initiative was applied for and obtained by the South Auckland Social Investment Board from the New Zealand Ethics Committee in March 2018. Permission for myself (Heather Dallaston) to be added to the existing application as a researcher was granted on the 23rd of September 2019. Permission for my research assistant to be added to the existing application was granted on the 11th of February 2020.

Socioeconomic Context

The Start Well office is (or was, at the time of this research) located in Māngere, and the service was originally intended to serve the Māngere community. Following the research period the whānau catchment broadened across South Auckland. The participants of this research entered the service either living in Māngere or having no fixed abode; for the duration of the research period the majority lived in Māngere.

The New Zealand Index of Deprivation is an area-based measure of socioeconomic deprivation in New Zealand (https://ehinz.ac.nz/indicators/population-vulnerability/socioeconomic-deprivation-profile/). It measures the level of deprivation for people in each small area and is based on nine Census variables. Decile one represents areas with the least deprived scores, while decile ten represents areas with the most deprived scores. Māngere is primarily comprised of areas meeting criteria for deciles nine and ten of the deprivation index, with a few areas meeting criteria for deciles seven and eight (https://ehinz.ac.nz/indicators/population-vulnerability/socioeconomic-deprivation-profile/).

Participants

The total number of mothers who were enrolled with the Start Well service between its inception in November 2017 and the final date for data collection (31 January 2020) was 34. The final date for data collection was informed primarily by the researcher's timeline for completing the research. Of these 34 mothers, three were excluded from data collection due to there being insufficient data on file for them. One of these three did not engage with the service at all; two others withdrew from the service shortly after enrolment, choosing other/former service providers instead (Plunket/Family Start). A fourth mother who did withdraw before the end of her pregnancy due to moving away was included as she had completed a significant amount of work with Start Well during a long pre-birth engagement. The final sample therefore consisted of 31 mothers. It should be briefly noted that Start Well's 'drop-out rate' as reported here is approximately 9%, which is far below the 35-70% reported drop-out rate for other therapeutic services for similar populations (Carter et al., 2020). It is also similar to the levels of an Australian home visiting service (Kemp et al., 2019) and a Hawke's Bay Plunket pilot service (Skerman et al., 2015), both of which were considered to be unusually successful in keeping a keep a comparable proportion of mothers engaged.

As at the 31st of January 2020 (the last date for data collection), the mean age of the participants was 21.8 years (SD = 6.2), although this mean is somewhat skewed by the fact that three mothers in the cohort were both enrolled in the service as the mother of an infant *and* the mother of another mother enrolled in the service (reflecting snowball referral processes). As depicted in Figure 2 below, most mothers (N=23) had one child as at the final date for data collection, but some had two (N=6) or three (N=2) (not counting any pregnancies with children not yet born as at 31 January 2020). Twelve children belonging to nine mothers entered the service having already been born (as opposed to in utero), either because they were the older sibling of a child who was in utero at the time of the mother's enrolment, or because their mother was a family referral (e.g. the sister of another enrolled mother).
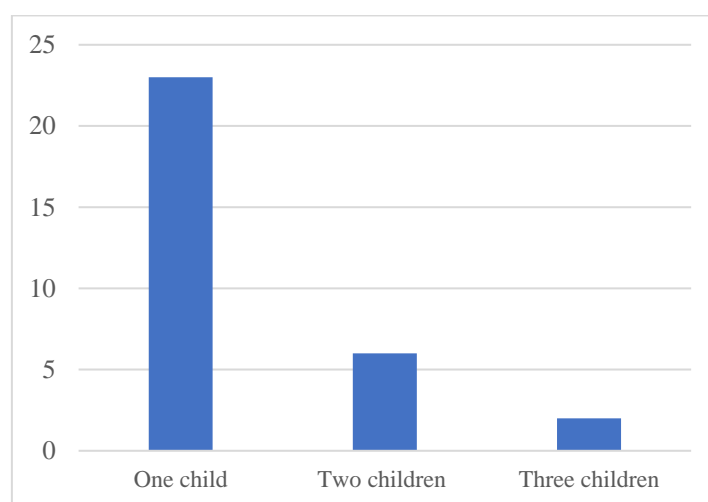
Figure 2. Number of children per Start Well mother, as at the final date for data collection.

The majority of mothers began their engagement with Start Well in the first few months of service provision (between Dec 2017 to May 2018), but a number were added subsequently. This meant that they had been engaged with the service for differing amounts of time. As depicted in Figure 3 below, as at the final date for data collection, three mothers had been referred to the service less than 12 months prior, 18 mothers had been referred to

the service between 12 and 24 months prior, and ten had been referred to the service between

24 and 27 months prior (27 months prior marking the commencement of the service).
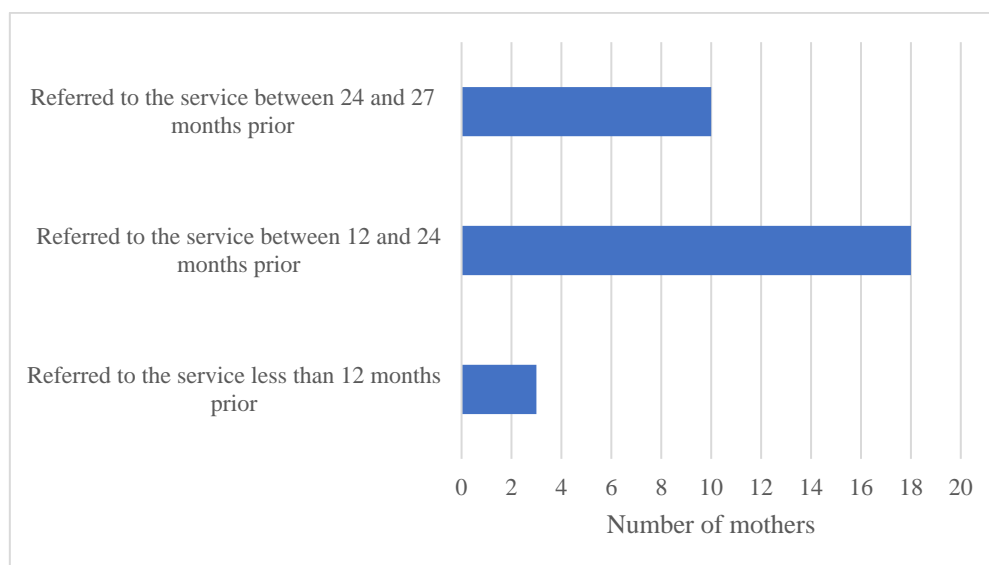
Figure 3. Amount of time each Start Well mother had been enrolled with the service, as at the

final date for data collection.

As depicted in Figure 4 below, 66% of participants identified as Pasifika, 23% as

Māori and 11% as European/Other. These proportions use total response ethnicity data

(where each person is allocated to all ethnic groups that they have identified with, which can

result in some people appearing more than once (Ministry of Health, 2008)). Five mothers

identified with two ethnic groups: of these four, three mothers identified with two different

Pacific ethnic identities each, one identified as Māori/Pasifika, and one identified as

Māori/European. Note that 'other Pacific peoples' is used in the graph below rather than

naming the specific identities, due to the small numbers (to avoid mothers becoming

identifiable). Overall this ethnicity profile roughly reflects the ethnicity profile of Māngere,

Auckland, where around 59% of people identify as Pasifika, 16% identify as Māori, and 12%

identify as European/Other (Auckland Council, 2019; Statistics New Zealand, 2019).
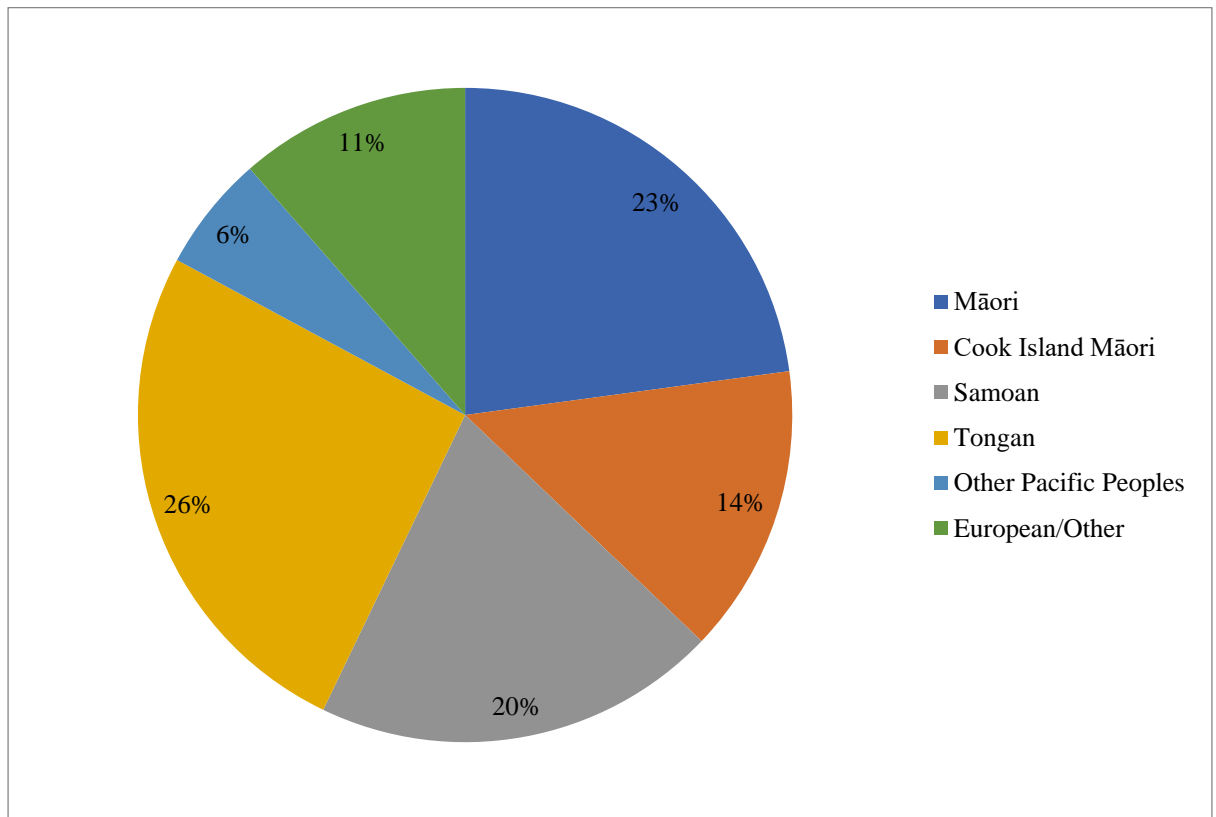
Figure 4. Participant ethnic identities.

Start Well team

The Start Well team is comprised of 7.5 full-time equivalent staff, plus the (full-time) Clinical Team Leader. Team roles are evenly split between social workers and nurses, all of whom are considered to be expert clinicians (most having more than 15 years' experience). Staff identify with a range of ethnicities including Māori, Asian/Indian and Pākehā. Staff turnover was low during the research period.

Research Procedure

Overview of procedure

As discussed further below, the structure of this study was collaboratively developed in conversation with key Start Well stakeholders. It involved conducing a retrospective case note review of selected variables for mothers who had engaged with the Start Well service between the time of the service's inception in November 2017 and 31 January 2020. A

rationale for the choice of case note review as methodology is outlined below, followed by further description of the methodology. The method for selecting which variables to explore within the available case note data is outlined, followed by a description of how data on these variables was collected. Finally, I describe the steps taken to test the reliability of the data using inter-rater reliability experiments.

Starting with an understanding of the limitations of available data

An important starting point for understanding this research is to acknowledge that an ideal/gold standard research approach was not possible, i.e., a randomized control trial with a comparison control group, and/or baseline data measures which could be compared to data collected at a later point. In reality, this is often the case for services on the ground – there is very little in the way of data collected about the implementation of evidence-based practices such as intensive home visitation (Lambie, 2018). Given this, the aim of the present research was to draw out the best information possible from the service with an understanding that any data would at best provide *possible indications* of service effectiveness or unique elements rather than being able to definitively establish causality, and limited to the data that had already been collected.

Collaborative development of approach

The approach to this research was collaboratively developed in conversation with key stakeholders from the SASWB and key stakeholders in the Start Well team. The structure of the research was iteratively developed and refined in close conversation with these stakeholders, with this process driving development of the research aims and questions, selection of methodology and selection of specific variables to collect data on.

Rationale for methodology choice

When seeking to understand how a service supports whānau, one would ordinarily ask whānau. I would like to take a moment to explain here why this course of action was not taken.

One factor is that, in parallel to my research, an 'implementation and outcomes evaluation of the PBI's report was being completed by external evaluation company Litmus. While Start Well was not the sole focus of this work, the project did involve interviews with a number of Start Well whānau. It was therefore felt that further interviews may both duplicate work and frustrate whānau. Of note, whānau interviewed reported having a positive experience of the Start Well service (Smith, Lamb-Yorski, et al., 2019a).

A second factor is that both frontline clinicians and myself were reticent to add any stress to whānau already experiencing multiple stressors, especially given that the research would likely be of little immediate, tangible benefit to them.

With these considerations in mind, Start Well stakeholders and myself concluded that the potential benefits of involving whānau directly in the research did not outweigh the possibility of unnecessarily burdening them or placing a strain on their relationships with Start Well clinicians. It was therefore decided that a case note methodology would be the least burdensome way to source information about the service.

Case note review as methodology

Case note review as a research methodology has been acknowledged for its ability to attend to detail, to be thorough and to allow for examination of both process and outcome (Howell, 2016). It has been used in health fields to measure, for example, transition between youth and adult services for people with Attention Deficit Hyperactivity Disorder (Eke et al., 2019), in social services, for example to explore frequency and causation of placement disruption for young people in non-kinship foster care (Bernedo, García-Martín, Salas, &

Fuentes, 2016), and in the justice sector, for example to explore correlates of violence

motivation, victim type and ethnicity for female youth who offend (Lim, 2014).

Despite this, case note review is not always a popular methodology due to its time-

consuming nature, particularly in fields such as healthcare, in which case notes can be

"voluminous, disorganized and sometimes incomprehensible" (Howell, 2016, pp. 35-36). It

has also been criticized for having poor inter-rater reliability (Howell, 2016). Attempts were

made to address the latter critique by using a measure of inter-rater reliability and a clear,

specific definition of variables to guide data collection (see below).

A further critique is that case note review is affected by the availability and

completeness of data in the notes (Eke et al., 2019). This is acknowledged as a legitimate

critique relevant to this research. However, Start Well's status as a prototype service has

meant that, even prior to this research, clinicians have been aware that there would be a

higher level of interest in learning from their work than would ordinarily be the case for other

services; this quite possibly may have led to a higher standard of data completeness in notes

than could ordinarily be expected.

A final critique of case note review as methodology is that the researchers

undertaking the review may not have the expertise needed to accurately interpret notes which

detail clinical practice (Eke et al., 2019). The latter critique may be addressed somewhat by

the specificity of variable definitions (see below), and in the case of this research is perhaps

less relevant due to the principal researcher's previous work experience in social services,

and her professional identity as a doctoral student of Clinical Psychology, which is an applied

qualification leading towards registration as a clinician. In other words, by virtue of the type

of academic qualification being sought by the principal researcher (myself), I may have a

higher level of the expertise required to interpret clinical notes than would ordinarily be

expected for a researcher.

Particular methods of undertaking case note review in the health sector have some relevance to this research, but relevance is limited by the often highly technical nature of both the medical case notes themselves and the analysis being undertaken using case note review. The aforementioned study exploring placement disruption in foster care (Bernedo et al., 2016) is more relevant to this research due to the similarity of the type of case notes being written in its social work context and the notes written by Start Well staff. The study's methodology involved use of a data collection sheet with predetermined fields for input of data from case notes (Bernedo et al., 2016). This is a very similar approach to that taken in this research.

Research questions

Research questions were collaboratively developed with Start Well stakeholders, with the overall aim of exploring the effectiveness of the Start Well way of working as best as possible given the limited data available. In particular, we were interested in how Start Well addresses family harm and psychological distress, given the harm both can cause to whānau, and the considerable potential for improved wellbeing should this harm be reduced.

Specific research questions are as follows:

1. What is happening in terms of family harm for whānau engaged with Start Well and how has Start Well engaged/supported with this?

2. What is happening in terms of psychological distress for whānau engaged with Start Well and how has Start Well engaged/supported with this?

Research variables and planned analysis

In order to explore each of these research questions, variables for review were collaboratively identified and defined in conversation between myself, my supervisor and key stakeholders from the Start Well team and the SASWB, with reference to literature. The variables are listed in Table 1 in Appendix A, alongside associated analyses and the number

of the relevant research question (above). Further definition of variables can be found in

Appendix B; efforts were made to define each variable as operationally as possible, and to

define 'rules' to decide if what was observed in a case file did or did not fit a particular

definition, as recommended by Dixon and Pearce (2011).

A final note on research variables is that part-way through the research period, the

SASWB funded a bespoke prototype for mental health service provision from provider 'Fresh

Minds.' The purpose of this was to understand the potential value of bringing psychological

support closer to frontline staff and whānau. It was considered that this arrangement would

enable more timely and agile access to mental health support where needed. Because this

arrangement began part-way through the research period, approaches to Fresh Minds were

not specifically recorded and reported on. That said, mention of the use of this service for

those whānau who had a high number of 'unscripted' conversations about psychological

distress/mental health is made in the Results and Discussion sections.

Method of data collection

The variables listed in Table 1 in Appendix A were encoded into a spreadsheet design

for data capture. The author then piloted use of this spreadsheet for data collection by

assessing three case files, as recommended by Dixon and Pearce (2011). This pilot resulted in

a number of changes to the spreadsheet design and the definition of variables; the three

piloted files were then re-reviewed along with all other files using the amended spreadsheet

and definitions.

Retrospective case note review of all client files was completed between 1 October

2019 and 31 January 2020. In order to conduct the case note review, the researcher accessed

each client's paper file and systematically read through it, searching for information relevant

to each variable according to their prescribed definitions in Appendix B, and entering this

information into the spreadsheet. The paper files were variable in length, from around 50 pages to hundreds of pages.

Use of existing data

In addition to the data I collected (as above), this research also makes use of data already collected by Start Well, as follows:

- Start Well mother date of birth;

- Start Well mother date of referral;

- Start Well mother ethnicity;

- Quotes from whānau and Start Well clinicians gathered and reported by Litmus – these are used where they appear to offer illustration of the meanings of data;

- Documentation from Start Well used in its own communications: an Interim Learning Report and PowerPoint slides, both of which report quotes (consented for use under the ethics approval process above) from clinicians and whānau, as well as anonymized case stories. These are used where they appear to offer illustration of the meanings of data, and are clearly marked as originating from Start Well, for transparency.

Inter-rater reliability

Following completion of initial data collection, the reliability of the data collected was tested using a measure of inter-rater reliability. Inter-rater reliability is a term which describes the extent to which two raters independently scoring the same subjects agree on their scoring (Gwet, 2012). The degree of inter-rater reliability is determined by conducting inter-rater reliability experiments (Gwet, 2012).

The principal researcher (myself) assessed all files with reference to the definitions listed in Appendix B, and a second researcher was assigned seven (i.e., 20%) of these case

files to assess independently, also with reference to the definitions listed in Appendix B. The

second researcher was an independent research assistant in the early stages of Clinical

Psychology training, employed specifically for the purpose of assisting me with inter-rater

reliability experiments, and bound to a confidentiality agreement. The seven files were

randomly chosen by selecting each fourth file from its storage location in the filing cabinet

(no particular system is used for determining storage order in the cabinet). This represents a

simple random sampling technique, which is appropriate given that the population is highly

similar for the characteristics that are key to the objective of the audit, and every file in the

population can be identified (Dixon & Pearce, 2011). Due to a desire to ensure a high degree

of data quality a twenty percent sample was chosen above the ten percent used elsewhere

(Lim, 2014).

      The resulting data was presented in an Excel spreadsheet with adjacent columns

representing the participants' case files and the different categories/dates etc. assigned to

those files by each of the two raters – a method outlined by Gwet (2012). Following this,

percentage agreement was calculated according to the method outlined by Coolican (2009),

to quantify the extent of agreement between the two raters (Gwet, 2012). As the data

collected in this research was nominal in nature, raters were considered to agree only when

their ratings were identical (Gwet, 2012). A table was then prepared to display the agreement

rate (a percentage) for each variable of interest.

      Such methods of assessing inter-rater reliability are commonly used in research

utilising case note review as methodology. As a top-end benchmark, a level of agreement of

85% was sought by a UK guide to ensuring data quality in clinical audits for healthcare

organisations (Dixon & Pearce, 2011). In practice however, a lower level of agreement is

often found. For example, an evaluation of inter-rater agreement of routine medical records

audits at a large general hospital in São Paulo, Brazil, found an overall agreement rate among

raters of 71.2% (Mafra et al., 2020). As another example, a UK study exploring the impact of Substance Use Disorder on the quality of inpatient mental health services for people with anxiety and depression used a retrospective case note review design and found levels of inter-rater agreement as follows: 30% of items reached complete agreement, 39% reached substantial agreement, and 31% reached moderate to low agreement (Williams et al., 2020). The researchers felt that this represented a high degree of inter-rater agreement (Williams et al., 2020).

Itemised results of inter-rater reliability experiments are presented in Table 2 in Appendix C. Overall, results indicate a level of inter-rater agreement which is mostly above the high-end suggested acceptability benchmark of 85% used by a UK guide to ensuring data quality in clinical audits for healthcare organisations (Dixon & Pearce, 2011). There were only two exceptions to this. The first is the 71% inter-rater agreement for the variable 'same dates recorded for the first documented conversation about family harm.' In this instance, there was one item out of seven for which there was not 100% agreement on the date; there was a difference of 15 days between the two recorded dates, with the date I recorded being later that that recorded by the other rater. The second is the 81% inter-rater agreement rate for the variable 'same conclusion drawn about whether unscripted conversations about psychological distress resulted in a positive disclosure.' In this instance, there were 13 items out of 70 for which the same conclusion was not drawn. For seven of these I thought that a positive disclosure had been made when the other rater thought not; for five the reverse was true, and for one I thought that a positive disclosure had not been made and the other rater thought it was not clear from the notes. Though these two exceptions do not reach the high-end suggested acceptability benchmark, they do still represent a level of inter-rater reliability better than or on par with the levels of inter-rater reliability found elsewhere (e.g. the 71.2% agreement found by Mafra et al. (2020)).

Analysis

A descriptive analysis of case note data was completed, directly answering the questions posed in Table 1 in Appendix A. As the data had been entered into an Excel spreadsheet, all analysis was completed using the functions of Excel: frequency counts, calculation of means, graphs and percentages.

In a small number of cases, I went back to the data or to case notes to obtain particular pieces of information. For example, for the case study reported on page 104-105 in the Results chapter, I went back to the data held for this particular mother to see whether it lined up with the story reported by Start Well (which it did). As another example, I 'cross-checked' whether the whānau members who had the highest number of unscripted conversations about psychological distress with Start Well clinicians had been supported to access further mental health support. This was not a question initially posed in the variables Table 1, but I had the data available to answer it and the answer was of interest. As a final example, I went back to the case notes to explore the ways in which my ratings differed from the other rater, to try to determine whether I may have been making some kind of systemic error – the results of these explorations are reported above.

Statistical significance was not tested due both to the small data set and to the fact that the data is frequency-based. (With frequency data the only option for assessing statistical significance is to use a chi-square test, and the latter becomes invalid when cell sizes are too small.)

Throughout this process research consultancy was provided by Ian Lambie, staff at Academic Consulting, and a University of Auckland Statistical Consultant; this was gratefully received.

Active Reflection

Reflexivity is a term and method/process frequently used throughout contemporary qualitative methodologies (Dowling, 2006). It generally refers to the researcher paying analytic attention to their role in the research by engaging in continuous reflection on the ways in which their experience has or has not influenced the stages of the research process (Dowling, 2006). The current research is not truly 'qualitative' per se, so I have not employed reflexivity in the truest sense of the word. However, the concept of reflexivity is a useful one, as it makes explicit the processes by which research is influenced by the researcher's position (Barrett, Kajamaa, & Johnston, 2020). For this reason I have included two pieces of narrative about my process of active reflection: one pre-analysis (below), and one post-analysis (at the end of the results chapter).

The results of data analysis were discussed with Dr. Hilda Hemopo (Te Rarawa me Ngāti Kuri) and Folasaitu Dr. Julia Ioane, who acted as cultural consultants and provided some input and advice, given that 23% of participants were Māori, and 66% were Pasifika. Note that Doctors Hemopo and Ioane were not involved in the research from its inception; nor were they asked to provide perspectives that would reflect all Māori/Pasifika people. Rather their input was intended to add a degree of depth and insight to the discussion of results from cultural lenses that I was not able to provide. These discussions formed part of my own post-analysis reflection.

Pre-analysis active reflection

As noted in the introduction, my own process of coming to this research includes previous work experiences and reflection on the privileges I have experienced throughout my life, including during the process of becoming a parent. These privileges affect my ability to understand some of the experiences of Start Well whānau, making the reporting of their own quotes in the Litmus evaluation an important companion to this research.

I would add one thing to that earlier narrative here, which is the distress I experienced due to my interactions with health professionals during and immediately following the birth of my son Oscar. I completed all of my data collection before Oscar's birth, with the analysis to be completed later. Oscar was born just a few days before Aotearoa NZ's first Covid-19 lockdown began in March 2020. Undoubtedly the clinicians I interacted with in these days and the days that followed would have been afraid and not at their best. Even so, I think it is fair to say that many of these interactions were suboptimal at best, inhumane at worst. Unfortunately this was consistent with some of the treatment I had received a year earlier (when Covid could not be blamed), when I had a miscarriage which turned into a three-month complicated medical ordeal. These experiences were traumatic, and had ongoing impacts on my physical and mental health. Nevertheless, I was well supported financially and by family and friends, and consequently was able to recover and to care for my son throughout. As I came back to this research following Oscar's birth I couldn't help but think: if this was my experience as a privileged, middle-class Pākehā woman, I truly shudder to think what similar experiences might have meant for someone in a less privileged position, surrounded by family and friends who held less privilege and were experiencing more stressors themselves. I know that the clinicians I encountered at these vulnerable moments in my life wouldn't have entered their professions intending for their 'care' to have this kind of effect on people. I truly think that through the demands of their work and the limits of the systems they were working within, they had had to distance themselves in some way from their own humanity in order to survive, and in doing so their ability to connect with (and care for) the humanity of others was compromised.

It was with these thoughts in mind that I returned to the work of this research, and given this, I came to the analysis with a great degree of hopefulness about what I would find. I wanted things to be better for all of us, and especially for whānau experiencing multiple

stressors. I hoped that I would see whānau receiving the mental health support they needed. I hoped to find that engagement with Start Well would lead to a reduction in family harm over time, and that whānau would feel safe to talk with clinicians about violence and psychological distress when they needed to. I hoped that I would see evidence of clinicians being equipped to work in a way that was whānau-centred and humane.

I was optimistic, but I was also aware of my optimism and in this self-awareness I was willing to be disappointed. The data, also, had *already been collected* and could not be changed at the point of my return to the work post-childbirth: my job then was just to report what the data said. I do believe that my prior specific definitions of variables to collect data on, and the use of an independent rater who assisted with the completion of inter-rater reliability experiments, were likely sufficient 'checks and balances' on my optimism. That said, my interpretation of the results as written in the discussion chapter absolutely reflect my own opinions about the need to humanize human services, which are in turn informed by my personal experiences. My interpretations are reported in the discussion chapter as such, and I believe that my explorations of relevant literature for comparison with my opinions allows for sufficient rigour in my methodology.

Chapter 3 – Results

Overview

This research sought to explore the following questions:

1. What is happening in terms of family harm for whānau engaged with Start Well and how has Start Well engaged/supported with this?

2. What is happening in terms of psychological distress for whānau engaged with Start Well and how has Start Well engaged/supported with this?

Each of these questions will be discussed in turn.

What Is Happening in Terms of Family Harm For Whānau Engaged With Start Well And How Has Start Well Engaged/Supported With This?

Results summary

Results suggest that family harm was common within the cohort of whānau engaged with Start Well, it often involved many members of a whānau, and it was gendered in nature. Most families were not known to have harmed their children during engagement with Start Well, but ROC's were made for a significant minority, and Start Well babies/children were recorded as being present during a significant minority of family harm incidents. Almost all of such cases occurred for whānau which had the highest total number of recorded family harm incidents. Protective action was taken on a number of occasions during family harm incidents, particularly by grandmothers.

Regarding how Start Well engaged/supported whānau with family harm, results overall suggest that considerable time is invested in relationship formation before the topic of family harm is raised between Start Well clinicians and whānau, and when the topic is raised it is usually in an unscripted way (i.e., not using a formal screening tool). When the conversation is raised positive disclosure rates are high. Despite Start Well often being the

source of reporting family harm incidents to Police or OT, whānau (including whānau with the highest number of incidents) remained engaged with the service. Across the cohort as a whole, numbers of known family harm incidents appeared to initially increase over time during engagement with Start Well, and then subsequently decrease.

More detailed results contributing to these themes follow.

How many family harm incidents were there, and how many people were involved?

In total there were 215 family harm incidents recorded for the cohort (attributed to 26 whānau; 5 whānau had no recorded incidents). Of the 215 incidents, 127 occurred within the period of engagement with Start Well; the other 88 were incidents which had occurred prior to engagement with Start Well (recorded either following disclosure or when information was received from another agency e.g. OT). These figures represent a high degree of family harm within the cohort.

On average, 2.5 people were involved in each incident, and in a majority of cases involving more than two people there were at least three adults involved (i.e., the third person was not usually a baby/child. There were also 14 incidents (7% of total incidents) involving five or more people. This data suggests that where family harm occurs in this cohort of whānau it is usually not dyadic in nature, i.e., involving just two people in conflict. Rather, multiple people in the family are involved (and may take protective or antagonistic roles). This suggests that a family (rather than dyadic, e.g. couple-based) approach is necessary for addressing family harm. An anonymised case study demonstrates how Start Well's all-of-family approach assisted with a reduction in the frequency and severity of family harm for one whānau:

> "Early in one whānau's engagement with Start Well, a family harm incident involving multiple family members resulted in a baby unintentionally being harmed. Start Well became aware of the incident, and following conversation with the whānau, reported it

to OT. Through subsequent engagement with Start Well one of the adults involved in the incident ('Ben') was supported to access mental health support, and the whānau decided to make their home a violence-free zone. Whānau members called Police on a couple of subsequent occasions when Ben started to become aggressive, thus averting the possibility of an escalating incident" (Start Well internal documentation, 2021).

This story is verified by the data: the first two recorded family harm incidents for this whānau were both reported to Police/OT by Start Well team members; two subsequent incidents were reported to Police by the whānau themselves.

Families were also impacted by 11 incidents of community violence (for example, being attacked by a stranger while in a public place), and two incidents of gang-related violence (for example, being impacted by witnessing an incident of gang violence while in a public place), indicating a complex picture of family harm which cannot be adequately addressed by looking exclusively at family dynamics.

Harm to children

For twenty whānau (65% of the study cohort) no ROC's were made during the study period. Further, no children were 'uplifted' (removed from the care of) their whānau due to child protection concerns during their engagement with Start Well. Though it is not possible to draw definitive conclusions from these findings, they are significant given that the population Start Well works with would otherwise be considered at high risk of engagement with the child protection system, due to a range of risk factors including many mothers having been uplifted themselves as children.

That said, there were 51 recorded ROC's to OT made across the cohort during the study period. Of these, 26 (or 51%) were for just one whānau – the same whānau which had the highest number of recorded family harm incidents (29). The majority (64%) of whānau for whom ROC's were made had experienced seven or more recorded family harm incidents.

Case notes indicated that Start Well babies/children were present during 42 (or 19.5%) of family harm incidents which occurred within the period of engagement with Start

Well. All but two of these 42 incidents occurred for whānau who had experienced a total of more than six recorded family harm incidents each (i.e., whānau experiencing a higher proportion of family harm).

Protective action

This research also aimed to identify incidents in which an individual had made an attempt to de-escalate or bring an end to an incident of family harm, without causing further harm in doing so. This role could be assigned whether or not the person was successful in their attempt, as long as they did not cause further harm. A person engaging in behaviour which met this definition was considered to have taken 'protective action.' For example, a person may have chosen to call Police, rather than engaging in behaviour which caused an incident to escalate. The previous case example on page 104-105 provides an example of this.

This data was recorded due to a desire to report strength-based information about the ways in which whānau actively attempt to avoid family harm. This data is more difficult to collect as there is little in the way of literary precedent for how to do it, and it may be less likely to be explicitly written down within a case note. In addition, it cannot be distinguished from the data whether attempts to avoid family harm are attributable to engagement with Start Well. Nevertheless, the data is still worth recording as a part-answer to the question: 'what is happening in terms of family harm for whānau engaged with Start Well?', particularly with the aim of contributing unique, strength-based family harm data to the body of knowledge on this topic.

A whānau member was recorded as clearly having taken protective action on 17 occasions (8% of the total number of incidents). A number of people within the whānau may have taken this role as depicted in Figure 5 below, but the most frequent takers of protective action were grandmothers, closely followed by other extended family members. Further

exploration of the data determined that 'other extended family members' were exclusively

female (three great aunts, one great grandmother and one maternal cousin).
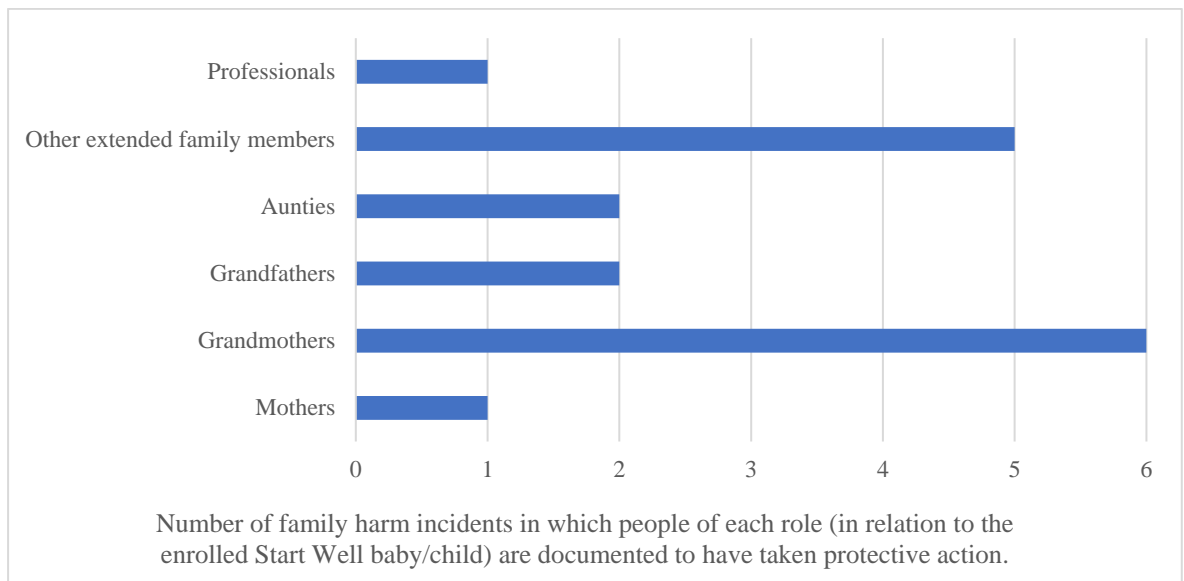
Figure 5. Takers of protective action during family harm incidents, by their relationship to

the enrolled Start Well baby/child.

Raising the topic of family harm for the first time

It took on average 73 calendar days (approximately 53 working days) from the first

engagement with each whānau before there was a documented discussion about family harm.

There was also considerable worker time invested into establishing first engagement; see

definition in Appendix B. When this conversation occurred, for 68% of whānau there was a

positive disclosure of family harm the first time the matter was raised. Two quotes below

illustrate (a) the way that Start Well clinicians prioritise investment in relationships with

whānau, and (b) how noticeable and significant this is for whānau:

> "Everything that we do is relationship-based. The real focus of Start Well is around developing relationships with whānau to enable the work to be done. You have got to invest in the relationship and the engagement to get to the point where you can actually go on a journey with whānau towards making change" (Start Well clinician, as cited in Smith, Lamb-Yorski, et al. (2019a, p. 101)).

> "They probably have a time limit for each job they do, but they have got all the time in the world to explain everything and that is something" (Start Well whānau, as cited in Smith, Lamb-Yorski, et al. (2019a, p. 104)).

Where there was not a positive disclosure on the first conversation about family harm, it may have been because there was in fact no family harm occurring. Further investigation concluded that for 13% of the cohort an initial conversation did not result in a positive disclosure of family harm, and there was never any known family harm occurring for the whānau. For one mother (3% of the cohort) a conversation about family harm was not specifically recorded; however this mother of an enrolled Start Well baby was also the mother of another enrolled Start Well mother (this was a snowball referral), and a conversation *was* recorded for the daughter who was enrolled with Start Well. For 16% of the cohort (five whānau), an initial conversation did not result in a positive disclosure but it was later discovered that there was some family harm occurring. For two of these five, the family harm in question was within the wider whānau, rather than the immediate whānau members that Start Well mothers and babies/children lived with. For another two, positive disclosures were made later, leaving just one case in which there was family harm occurring but it was never disclosed to Start Well. As will be discussed further in the next chapter, it may be significant that for this one case the mother was Māori. In summary, then: most whānau made a positive disclosure of family harm the first time the topic was raised; those who didn't either didn't seem to be experiencing any family harm within their immediate whānau, or made a positive disclosure later.

For all but one of the nine whānau which were ultimately found to have experienced more than ten family harm incidents each, a positive disclosure of family harm was made the first time the matter was raised. A quote from one of these families below illustrates the importance of the relationship in enabling disclosure of family harm:

> "It's not that this hasn't happened to me before; it's just the first time I've had someone to tell" (Start Well whānau, following being assaulted and choosing to tell Start Well about it, as cited in Start Well internal communication, 2021).

Only 10% (N=3) of these first conversations about family harm occurred in a more 'formalised' way as part of routine screening within a WCTO visit, with most conversations taking place in an 'unscripted,' conversational way, led by the worker. What's more, a positive disclosure of family harm was never received when the question was asked as part of a WCTO check. The significance of this finding is somewhat limited by the fact that the first WCTO check takes place when a child is six weeks old, and most mothers were engaged with Start Well before their child was born, meaning that many first conversations about family harm took place before any WCTO check had taken place.

Visual picture of family harm incidents occurring over time

A graph was constructed to explore whether there may be a trend in the numbers of family harm incidents experienced by whānau (or at least those known to Start Well) over the time of their engagement with the service. This graph is shown in Figure 6 below: it represents the average monthly number of known family harm incidents across the whole cohort during the research period. A monthly average was calculated by taking the total number of incidents recorded per month divided by the total number of enrolled (i.e., between referral and closure) mothers for that month. A smoothed line was then fit to the data to aide interpretation. The shaded band around the smoothed line indicates a 95% confidence interval.
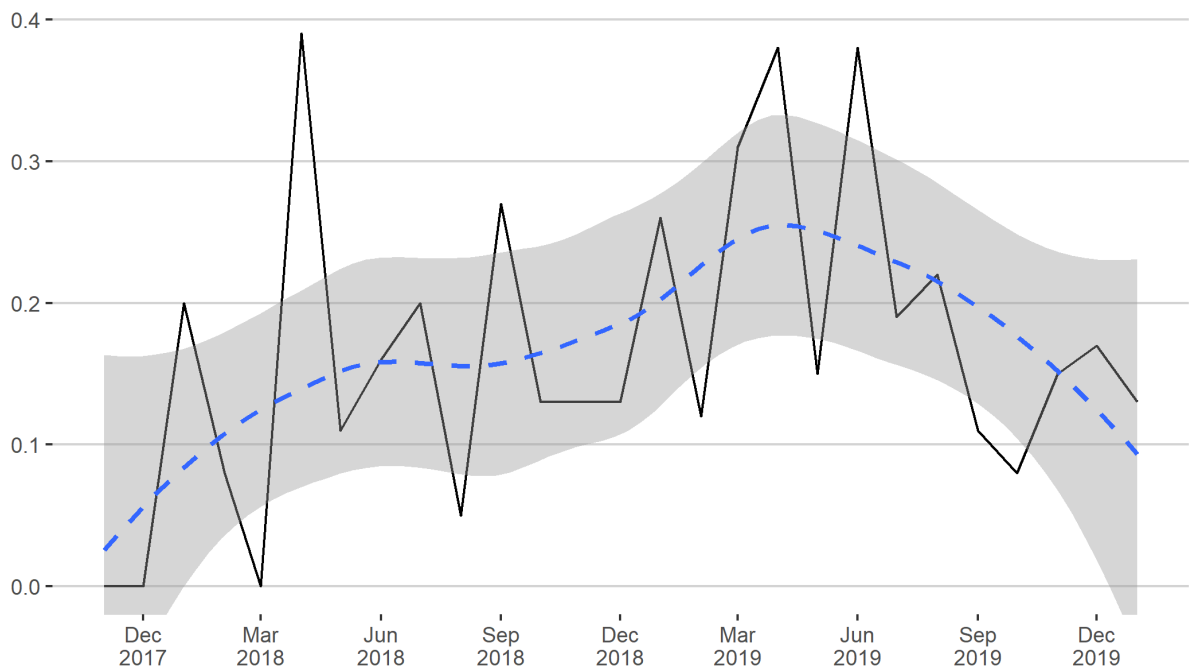
Figure 6. Monthly average number of disclosures of current family harm incidents, graphed over time, for the entire cohort of whānau engaged with Start Well.

As depicted in Figure 6, the trend line appears to show two peaks each occurring in the autumn, and two troughs each occurring in late winter/spring. This is as expected given the research base around seasonal trends in incidence of family harm. What is of interest is that the first (2018) peak is lower and the first (2018) trough is higher than their later (2019) counterparts.

Though we cannot be certain how to interpret this data, it seems to suggest that known family harm increased before it decreased, perhaps reflecting an increase in the visibility of underlying 'true' incidence followed by a reduction in incidence. This aligns with an intuitive prediction of what might occur over time given a trusting relationship effectively harnessed to address family harm. Two quotes below illustrate (a) Start Well's approach to addressing family harm with whānau, and (b) how whānau experience this:

> "It's their plan, not our plan" (Start Well clinician, as cited in Start Well internal communication, 2021).

> "With other services I felt pressured. With Start Well I felt supported, not pressured. Other services... would tell me what to do. Whereas with (Start Well), they support

what I want to do. Like, I make the decisions, and they just support me" (Start Well whānau, as cited in Smith, Lamb-Yorski, et al. (2019a, p. 104)).

Sharing care with statutory agencies where required

The data indicates that Start Well shares care with statutory agencies where required, following mandatory reporting procedures. Fifty-four percent (N=68) of all family harm incidents which occurred during the period of engagement with Start Well were reported to Police or OT. Those unreported were emotional violence towards children, verbal altercations between adults which occurred in the presence of children, disclosures from Start Well whānau about IPV involving children but within their wider rather than immediate/proximal whānau, and intrafamilial violence which did not involve children. For those incidents which were reported to Police or OT, for whānau experiencing the highest number of family harm incidents the source of report was most frequently the whānau themselves or a Start Well clinician, as depicted in Figure 7 below.
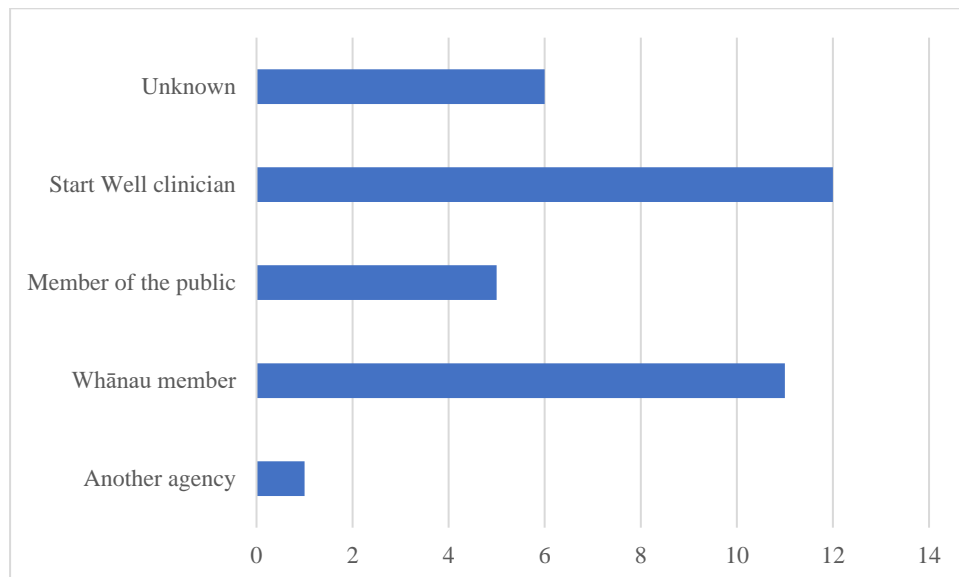
Figure 7. Source of report for family harm incidents reported to Police or OT, for the six whānau with the highest number of recorded family harm incidents during engagement with Start Well.

Despite Start Well team members often being the source of reporting to Police or OT, all of the whānau remained engaged with the service.

This research is unable to report on changes in the source of report over time, however the case study on page 104-105 suggests that whānau might in some cases become more likely to contact Police themselves over time.

What Is Happening in Terms of Psychological Distress For Whānau Engaged With Start Well And How Has Start Well Engaged/Supported With This?

Results summary

Overall, results indicate that Start Well clinicians proactively and frequently raised the topic of psychological distress, usually in an unscripted way rather than using a formal screening method or tool. This appeared to facilitate the disclosure of psychological distress when needed. Such proactive, deliberate attention to mental health also appeared to facilitate access to further mental health support (in various forms) where needed. More detailed results contributing to these themes are presented below.

Conversations about psychological distress

In total, 259 conversations about psychological distress took place in an 'unscripted' way, i.e., outside of WCTO appointments and not using a formal screening tool. A anonymized case example of how this occurs is outlined below:

> "A Start Well clinician visited a whānau member who came out of their house on the arrival of the worker and uncharacteristically gave them a hug. Picking up on their non-verbal cues, the Start Well clinician asked, "are you ok?" This conversational question, in conjunction with an established trusting relationship, resulted in the person disclosing suicidal intent and plans which the worker was then able to work with the person to avert, achieving a positive result for the person in a moment of severe psychological distress" (Start Well internal documentation, 2021).

Five of the mothers within the Start Well cohort had none of these conversations, and sixteen of the conversations (6%) were with whānau members (i.e., not mothers). These conversations were usually initiated by Start Well clinicians (N=187 conversations), but were

initiated by whānau themselves on 39 occasions. On three occasions the conversation was initiated by a professional other than a Start Well clinician, and on 30 occasions it was not clear from the notes how the conversation was initiated.

A positive disclosure of psychological distress was made on 61% of all occasions (N=159). Within this, rates of positive disclosure varied depending on how the conversation was initiated. When the conversation was raised by a Start Well worker, a positive disclosure of psychological distress was received on 52% of occasions. Whānau members appeared to initiate the conversation, for the most part, when they wanted to make a positive disclosure (95% positive disclosure rate). Case notes rarely recorded instances when such conversations were raised by other professionals (e.g. a midwife), but on each of the three such occasions a positive disclosure of psychological distress was not received.

These findings indicate that Start Well's proactive and deliberate approach to talking with whānau about psychological distress (beyond simply asking at the touch-points of WCTO appointments) contributes to facilitating access to further mental health support where needed, by proactively identifying need and by enabling whānau to initiate disclosure of distress themselves when needed. This form of engagement extends beyond Start Well mothers to other whānau members. A small amount of evidence indicates that other professionals involved with Start Well whānau do not receive positive disclosures of psychological distress.

Facilitating access to further mental health support where needed

All of the whānau experiencing higher levels of psychological distress, and many experiencing lower levels of psychological distress, were supported to access further mental health support, in the following ways.

There were eleven recorded instances of approaches to a GP to address mental health concerns. Most of these approaches were the result of a conversation instigated by the

whānau (N=4) or by a Start Well clinician working in an unscripted way (N=4). One occurred as a result of a conversation which took place in a more 'scripted' way within a WCTO appointment. It is not clear whether these approaches to a GP would have been made without the prompting and/or assistance of Start Well. Though definitive conclusions cannot be drawn from this data, it does appear unusual to see such a high degree of engagement with primary mental health care for this population, and this engagement is likely to be preventative of escalating difficulty (see next chapter).

There were 21 recorded instances of approaches to DHB (i.e., secondary) mental health services. Of these, five were a result of more 'scripted' conversations within a WCTO appointment (one for one mother, and two each for two further mothers). The remaining 16 were primarily raised by Start Well clinicians working in an 'unscripted' way outside of WCTO appointments (N=9) or by the whānau (N=6), and were for eight mothers (one or two approaches each), one child (two approaches) and three wider whānau members (one each). Where an approach to a DHB mental health service was made, the most common response from that service was to offer ongoing/longer-term service such as case management, therapy and/or therapeutic groupwork, rather than declining the referral or offering short-term crisis care only (N=12), however on eight occasions the DHB mental health service did not offer ongoing/longer-term service. The reasons recorded in the notes for ongoing/longer-term service not being offered are depicted in Figure 8 below.
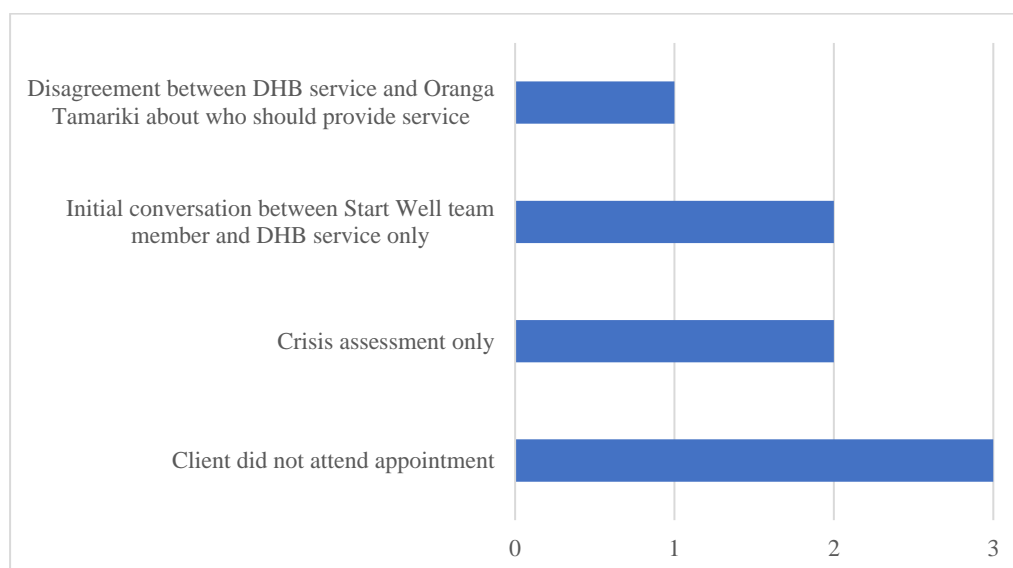
Figure 8. Reasons recorded for why ongoing/longer-term service was not offered by DHB mental health services.

For a majority of the eight occasions on which people were not offered ongoing/longer term service, the people in question were Māori (N=5 occasions for N=2 people); a minority were Pasifika (N=3 occasions for N=3 people). This is despite the fact that just 23% of Start Well families were Māori. By comparison, for ten of the occasions on which ongoing/longer term service was offered it was for Pasifika people, on one occasion it was for a Māori person, and the last occasion was for a person with combined Māori and Pacific ethnicity. These findings do not enable any definitive conclusions to be reached, but do raise a number of questions about access to secondary mental health services for whānau Māori experiencing multiple stressors – see more on this in next chapter.

Regarding use of respite, a bespoke arrangement between Counties Manukau DHB and Start Well allowed for development of a protocol for Start Well use of an existing maternal mental health respite facility, which otherwise could only be accessed via secondary maternal mental health services and with a mental health diagnosis. This is an important example of Start Well and the SASWB working to facilitate system change in order to better

meet whānau need, as well as to better utilise resources, as recorded in Start Well internal

communications and reproduced below:

> "Independently of Start Well, a maternal mental health respite facility in the Counties
> Manukau DHB was available for use by mothers who had received a mental health
> diagnosis and were 'under the care of' (had an open file with) secondary mental health
> services. The facility had a 21% bed occupancy rate.
>
> Start Well enquired about whether this facility could be made available to Start Well
> whānau, but given the existing eligibility criteria, Start Well whānau were generally not
> considered to be eligible, as they were not engaged with for secondary mental health
> services. There were also concerns about (1) who would 'hold the risk' (accept clinical
> responsibility for the safety and wellbeing of) Start Well whānau, and (2) whether
> opening the facility to Start Well whānau would mean that the facility would have to be
> opened to a wider referral base, and whether this may result in the facility becoming
> overwhelmed. The SASWB and Start Well were able to discuss this with the DHB and
> respite staff, and came up with an agreement whereby (1) Start Well would 'hold the
> risk' for whānau by remaining 'on call' for respite staff, and (2) the opening of the
> facility to Start Well whānau would be on a trial basis only.
>
> Ultimately the trial was viewed by respite staff and the DHB as being successful; so
> much so that they decided to extend the availability of the facility to GP and midwife
> referral, and for mothers without a mental health diagnosis or the involvement of a
> secondary mental health service.
>
> The trial was also viewed as successful for the Start Well whānau who used the facility
> (described below). Start Well clinicians had been concerned that two of these mothers
> were likely going to require the assistance of secondary mental health services, but
> ultimately they did not, following use of the respite facility. Though this is anecdotal it
> does suggest the possibility of a preventative effect of access to the facility in a time of
> need (and it suggests the possibility of more efficient use of resource by preventing
> further crises and the need for additional services). For a third mother, Start Well
> clinicians had not anticipated the need for further mental health support, and had
> referred her to the facility in order to allow her some respite during a time of
> considerable turmoil in her life circumstances. However, on admission to the facility it
> became clear that the mother was in fact experiencing severe mental health difficulties,
> which had not been visible before due to the chaos occurring around her. Again, this is
> anecdotal, but suggests the preventative and resource-efficient value of access to
> service in time of need" (Start Well internal documentation, 2021).

This facility was recorded as having been used by five members of the Start Well cohort. One

used two days of respite throughout their entire engagement with Start Well, another used

four days, two used approximately 13 days, and the last used 24 days. For four of the five, the

facility was used due to a combination of family harm and psychological distress/mental

health difficulties; for the fifth it was used due to psychological distress/mental health

difficulties exclusively. Though definitive conclusions cannot be drawn from this data, it does suggest that family harm is linked with psychological wellbeing, and therefore that successful interventions to address family harm may well also address psychological distress.

The data above regarding access to mental health support services was cross-checked against the data for unscripted conversations about psychological distress, to explore whether those experiencing a higher level of distress (as measured by number of unscripted conversations) were successfully supported to access further mental health support. Of the eight mothers reporting the most psychological distress, all eight were supported to access further mental health assistance. Two were supported to access maternal mental health respite, one was supported to approach the GP to request mental health assistance, two were supported to access DHB mental health service support and were offered ongoing/longer-term service which they accepted (for one of these mothers this was on two separate occasions), and five were supported to access bespoke support through Fresh Minds (see next chapter). This support to mothers facing most psychological distress was in addition to efforts to also assist mothers facing a lesser degree of distress, *and* in addition to efforts to also assist some other whānau members to access further mental health support. This indicates that Start Well clinicians were able to work holistically and effectively with whole whānau and across the spectrum of degrees of psychological distress.

Regarding *how* Start Well clinicians assist whānau to access mental health support, three quotes below illustrate (a) how Start Well clinicians do this work, and (b) how whānau experience this:

> "We understand the trauma... We step forward to make it easier for them to also step forward and pick up the phone to call the doctor. We would go, 'what's the block for you?' And work on that; then, 'what would make this sustainable for you when we're not here, how would you get to a doctor?' It just keeps on going until we know nothing could block her from that" (Start Well clinician, as cited in Smith, Lamb-Yorski, et al. (2019a, p. 106)).

"Personally, I feel that was a big stress off my shoulder having someone there to just guide me… especially at times where I feel like there's no hope - like there's no way out of my situation. So I think it's really good, I feel that it's really good" (Start Well whānau, as cited in Smith, Lamb-Yorski, et al. (2019a, p. 104)).

"Before I had no support, now there is more support with anything. I know where to get support from... Before I didn't know how to make phone calls and talk to people. Now I am making them on my own" (Start Well whānau, as cited in Smith, Lamb-Yorski, et al. (2019a, p. 105)).

Results Summary

Overall, the findings of this research suggest effective partnerships between Start Well clinicians and whānau.

Results suggest that family harm was common within the cohort, often involved many members of a whānau, and was gendered in nature. Although most whānau were not known to have harmed their children during engagement with Start Well, harm to children did occur for a minority of whānau, particularly those whānau with a higher number of known family harm incidents. Protective action was taken on a number of occasions during family harm incidents, particularly by grandmothers.

Results indicate that following considerable relational investment, unscripted first conversations about family harm frequently resulted in positive disclosures. Despite Start Well often being the source of reporting family harm incidents to Police or OT, whānau (including whānau with the highest number of family harm incidents) remained engaged with the service.

Data about known family harm incidents paint a picture of initially increasing incidence over time during engagement with Start Well, and then subsequently decreasing incidence, suggesting that the service becomes increasingly aware of the 'true' incidence of family harm over time, and is then able to successfully work with whānau to reduce harm.

Regarding psychological distress, results indicate that frequent, proactive and unscripted conversations about psychological distress, driven by Start Well and responded to

by whānau, facilitate both the disclosure of psychological distress and access to further mental health support where needed. As the converse of this, findings raise questions about access to mental health services for this population where such significant 'bridging' support is not available, and perhaps especially for Māori. Findings also suggest that family harm and psychological distress may be linked in some cases.

Post-Analysis Active Reflection

Following analysis of the data (above) I had a number of conversations with Dr Hemopo and Dr Ioane as I considered what the findings might mean. Their advice was invaluable at a general level in directing me to relevant literature and widening my perspective. Whaea Hilda, for example, invited me to consider whether socioeconomic pressures on whānau may influence family harm incidence, leading to my choosing to report the NZDep score for the Māngere area in my methodology chapter, as a means of placing the research in its socioeconomic context. Folasaitu Ioane was able to point me towards some new Pasifika literature that I had not been aware of, that was very useful in my meaning-making process.

Dr Hemopo and Dr Ioane also shared specific insights into two of the findings, which were invaluable as I was unable to find literature addressing these particular topics. First, regarding protective action being taken in a substantial minority of family harm incidents – and especially by grandmothers – Dr Hemopo expressed a lack of surprise, commenting that Māori grandmothers are very frequently involved in caring for grandchildren and would therefore be working to preserve their safety. She emphasised the importance of celebrating the fact that "grandmothers do a hell of a big job!" Dr Ioane similarly commented that these results are to be expected given that within Pasifika communities, females and in particular female elders are generally seen to have roles that nurture and protect their families. Second, regarding results indicating a reduction in family harm incidence over time, Dr Hemopo

speculated that being able to use the relationship that already exists with Start Well to address family harm following disclosures (as opposed to referring to another agency) likely facilitated collaborative and effective work.

These discussions as well as consultation with the literature informed my interpretation of results, reported in the next chapter.

This chapter concludes with two whānau quotes which illustrate the 'dogged' nature of Start Well's support for whānau:

> "I have moved around to so many houses in the last few months. And there were times I had nowhere to sleep. And there were times when (Start Well clinician) wouldn't go home until I had somewhere to sleep like a motel or at least something" (Start Well whānau, as cited in Smith, Lamb-Yorski, et al. (2019a, p. 34)).

> "I think they've helped me way more than anybody else. Like, just like when I went into emergency housing, (Start Well clinician) was the one that took me. (Start Well clinician) was the one that sat at Work and Income with me. She was the one that took me to the Salvation Army… that's a big help, and I'm so grateful. I'm so grateful" (Start Well whānau, as cited in Smith, Lamb-Yorski, et al. (2019a, p. 105)).

Chapter 4 – Discussion

Introduction

We know that the early years of life are critical; we know that our existing support efforts for these years don't work well for whānau experiencing multiple stressors; and we know that this ineffectiveness leads to multiple costly effects (human and monetary). Why aren't we doing better? Overwhelmingly the research base tells us: because our systems are competitive and disjointed, because stressors compound, and because we don't equip services or clinicians to offer the relationships of trust which would form a foundation for effective whānau-centred support. What might it look like if we could address these issues? Start Well might be able to provide a demonstration.

This research aimed to explore how a small early intervention service in Māngere assists whānau experiencing multiple stressors to address family harm and psychological distress. Findings indicate that Start Well successfully provides this support and more, and that this service provision is achieved by an interlinked combination of relationships of trust, professional skill-sets, and effective contracting/commissioning which resources 'whatever it takes' whānau-centred practice.

This chapter discusses these findings, informed by the literature and by input from Māori and Pasifika research consultants Dr Hilda Hemopo and Dr Julia Ioane. The themes of discussion - to be discussed in turn - are as follows:

- We can learn a thing or two about family harm from Start Well and the whānau they serve;

- Relational investment works when addressing family harm;

- Whānau experiencing multiple stressors require - and benefit from - support to access existing mental health services;

- An effective contracting/commissioning environment is key, and it works.

Suggestions for future research and recommendations for policy and practice are integrated into the discussion of each theme. The chapter concludes with an outline of the strengths and limitations of this research.

We Can Learn a Thing or Two About Family Harm From Start Well and The Whānau They Serve

I begin this section with a disclaimer and a rationale. Though counting and categorising family harm incidents occurring in the Start Well cohort was not a primary focus of this research, it was done for a number of reasons. First, it provides context for the other results. Second, it assists with trying to ascertain whether Start Well is succeeding in assisting whānau to address family harm. Third, it contributes to the body of knowledge about family harm in Aotearoa NZ. We have limited information about the experiences of family harm for some populations (Lievore et al., 2007; New Zealand Family Violence Clearinghouse, 2016; New Zealand Government, 2021), and what we do know is often deficit-based, in that it records instances and experiences of violence, rather than, say, attempts to resist violence. For this reason, attempts were made to experiment with recording a more strengths-based variable.

In saying this, it must be noted that counting and categorising family harm incidents can be problematic for a few reasons. First, an incidence-based picture of family harm may not accurately reflect the nature of harm, which can be cyclical in nature and governed by coercive patterns of power and control not accurately captured by 'incidents' (Kelly & Westmarland, 2016). Second, attempts to analyse incidents given the available data are necessarily primarily deficit-based, and finally: questions will always remain about how many of the incidents which truly occur are available to our knowledge for analysis.

Holding these limitations, the results of this research have three lessons in particular to teach us about family harm, each of which will be discussed in turn: (1) we often treat

family harm as if it's something which occurs in dyads, but in practice (for this population at least), there may frequently be more than two people involved; (2) protective action is often taken within this population, and particularly by grandmothers. This is something worth understanding more and supporting; and (3) where family harm is a common occurrence in a family it is more likely that babies/children will be harmed to a degree necessitating a ROC, and more likely that babies/children will be present during family harm incidents - making it all the more important that we find means of prevention.

It takes (more than) two

In summary: We often treat family harm as if it's something which occurs in dyads, but in practice (at least for this population), there may frequently be more than two people involved.

Although there is a substantial evidence base about the co-occurrence of multiple forms of violence within homes (Chan et al., 2021), the literature has little to say at a practice level about incidents which themselves involve more than two people. There does not seem to be a definition for this phenomenon, the closest definition being 'intrafamilial violence,' which still describes dyadic interactions (between family members other than parents between themselves and parents-to-children) (Family Violence Death Review Committee, 2017). Simon-Kumar (2019) does mention that violence expressed through co-habiting members of a family is more common in 'ethnic' communities, with generational dynamics (such as mothers in law often occupying a key role of power in a household) often shaping the nature of violence. Apart from this literary reference, it may be that insufficient emphasis on the experiences of those witnessing or 'exposed to' family harm may contribute to literary absence (i.e., the literature treats incidents between parents as affecting only the two parents involved to the neglect of the children's experience) (Powell & Murray, 2008), but that does not provide an explanation for the shortage of information regarding incidents involving more

than two adults. Māori and Pasifika writers (e.g. King et al. (2012); Pihama et al. (2016); Rankine et al. (2017)) have been instructive at a conceptual level, describing family harm as affecting and involving the whole whānau rather than just a dyad. However at a practice level we are still lacking in our understanding of whānau and collective experiences of and responses to violence (Dobbs & Eruera, 2014; Lambie, 2018).

This research provides some information from the practice space: results found that of all the family harm incidents recorded for Start Well whānau, on average, 2.5 people were involved in each one, and in a majority of cases involving more than two people there were at least three adults involved. There were also 14 incidents (7% of total incidents) involving five or more people.

Given the high proportion of Pasifika and Māori participants in this research, this finding may be partly due to extended whānau members living together (rather than one or two adults living alone, or alone with their children). Research indicates that, relative to Pākehā norms, Pasifika and Māori families are more likely to have shared living arrangements (Faleolo, 2020; Pihama, 2011; Pīhama et al., 2015). The degree to which this is true may partly be influenced by the disproportionate effect that rising costs of housing have on Māori and Pasifika families living in Auckland (Taylor et al., 2020). In this context, it is conceivable that a violent incident between a Pasifika or Māori couple or dyad living with other family members may lead to other members of the family becoming involved in the incident; the same event between a Pākehā couple may not involve any other family members simply because they are not present in the home with them. This is unlikely to be the sole explanation though; collective understandings about the nature of whānau and intimate relationships – as not being 'private' or existing in isolation - are also likely of relevance (King et al., 2012; Pihama et al., 2016). Although some speculation/inference is required, descriptions of the strengths and challenges of family cohabitation in the literature do give

some glimpses of ways in which living with multiple whānau members may result in multiple whānau members becoming involved in family harm incidents for better or worse; for example multiple whānau members may be involved in shared parenting (Pihama, 2011; Pihama et al., 2019), wider whānau may assist with conflict mediation (Rankine et al., 2017); cohabitation can be associated with the increased stress of socioeconomic pressures (disproportionally affecting Māori and Pasifika families, i.e., a social justice issue) (Taylor et al., 2020) and there may be differing ideas about whether or not it is acceptable to seek support from outside of the home (Gosche, 2017).

This finding matters because the field of family harm response remains primarily accustomed to Western individual and dyad-based interventions (Domoney et al., 2019), such as those based on the Duluth Power and Control Wheel (Havard & Lefevre, 2020). Such approaches are generally not effective for those from collective cultures (Fa'alau & Wilson, 2020; Tiyyagura et al., 2020). If family harm is not primarily dyadic in nature for a population, any intervention designed to assist must take this into account. Māori and Pasifika writers and clinicians have been saying this for years, recommending collective and family approaches to family harm (Dobbs & Eruera, 2014; Fa'alau & Wilson, 2020; Ioane, 2017; Taskforce for Action on Violence within Families, 2012). Presumably the involvement of more than two people in violent incidents offers additional hope and resource, because there are more than two vectors of potential positive change. Given this and given the recommendations of Māori and Pasifika writers (above), this research supports the need for holistic, relationship-based, early intervention and whole-of-family services - like Start Well – which can build on the positive potential of multi-family-member involvement. Such family-centred, early intervention approaches – and nurse family partnerships/home visitation specifically – have been recommended in the literature to counter the failings of prevailing fragmented approaches which address individuals separately and at the point of crisis

(Tiyyagura et al., 2020). Lending support to this argument is encouraging early evidence from a long-term (2.5 year), whole-of-family, early-intervention initiative to address family harm in England (Domoney et al., 2019).

The family harm literature in some cases looks beyond the family itself to the community and wider society. For example, Māori and Pasifika writers have articulated their view of the interconnected nature of violence within and beyond families, encouraging us to think more holistically about family harm (Family Violence Death Review Committee, 2017; Pihama et al., 2019; Rankine et al., 2017). International literature has reported that violence which occurs within a family can impact on the community, and vice versa (Boyd et al., 2022; Gorman-Smith et al., 2004). These perspectives were mirrored in the current research: Start Well whānau were impacted by 11 incidents of community violence, and two incidents of gang-related violence, indicating a picture of family harm which cannot be adequately addressed by looking exclusively at family dynamics.

Promisingly, taking a more holistic view of family harm intuitively predicts what the literature has found: that positive changes in families can ripple out into communities (Gorman-Smith et al., 2004) - because members of families are also members of communities and gangs. Therefore, interventions that successfully address violence within families are likely to also have positive effects on violence in the community. The converse is also true: that positive changes at the community level (such as increased neighbourhood cohesion) can ripple back into families (Boyd et al., 2022; Farewell et al., 2021). Te Aorerekura promises to mobilise communities and engage in primary prevention efforts as part of its plan to tackle family harm in Aotearoa (New Zealand Government, 2021); the findings of this research support this intention.

Recommendations

- For clinicians working with family harm: Be aware that family harm may not be primarily dyadic in nature, and harness the positive potential of collective experiences of family harm to find collective solutions.

- For services: Partner with community, church and voluntary sectors to explore community perceptions regarding family harm, and to support community-led primary prevention initiatives.

- For funders: Resource holistic, relationship-based, whole-of-family services to assist whānau experiencing the highest family harm acuity.

- For funders: Ideally equip/resource Māori and Pasifika service providers to 'test and learn' methods of engaging whole families around reducing family harm/promoting family strength. This equipping and resourcing would ideally include high trust funding and commissioning models (see later section on this) as well as adequate workforce support and training/coaching.

- For academics: Conduct further practice-based research regarding whānau and collective understandings of and responses to violence, within and outside of the home.

'Grandmothers do a hell of a big job'

In summary: Protective action is often taken and particularly by grandmothers. This is something worth understanding more and supporting.

As noted in the previous section, Māori and Pacific conceptualisations of family harm are collective and holistic in nature, such that family harm and its resolution is seen to involve whole families and sometimes communities, rather than just the individuals involved (Ioane, 2017; Pihama et al., 2019; Pihama et al., 2016; Rankine et al., 2017). Given this, the finding in the current research that Start Well family members were recorded as having taken

protective actions during family harm incidents in a substantial minority of cases is not unexpected. Nor is the finding that the most frequent takers of protective action were grandmothers. Pihama (2011) and Wilson (2016) both write about the importance of those in the 'grandparent generation' to providing support and nurturance to younger generations. This view was supported by both whaea Hilda and Folasaitu Julia in their review of this research.

I was not able to find practice-based reporting of this phenomenon in the literature, again linking to the assertion by Lambie (2018) that we have an inadequate understanding of the form and range of family harm in Aotearoa NZ, or of whānau and collective responses (Dobbs & Eruera, 2014). Dobbs and Eruera (2014) lament that much of the research in this area is conducted by Pākehā researchers taking a service-provider approach; the current research fits this description! That caveat aside, this finding regarding grandmothers as takers of protective action within this population provides an example of an opportunity for clinicians to support those in families who are already working to reduce the incidence and severity of family harm.

The literature commonly reports on the gendered nature of family harm in the sense that women are disproportionately affected as victims (Family Violence Death Review Committee, 2017; Lievore et al., 2007; NZ Ministry of Justice, 2019). I was not able to find literature regarding the gender profile of family members who may take protective action during family harm incidents. The gendered nature of these findings illustrates resistance to generally accepted power discourse which positions women as helpless victims in the context of family harm. In the Start Well population we do see women as the primary victims of violence and I am certainly not questioning the overwhelming evidence of the disproportionate impact of family harm on women. It is important to note that in the Start

Well population we *also* see women standing up and taking action to prevent harm within their families.

These are hopeful findings which lend support to the argument that even for families experiencing high levels of family harm acuity, approaches which seek to identify and build on strength are relevant and deserve further development.

Recommendations

- For frontline support workers/clinicians: When working with whānau experiencing family harm, explore and support the ways in which family members (and perhaps especially grandmothers) take protective action.

- For academics: Conduct further research into the nature of protective actions taken by families in the context of a collective understanding of family harm, to better understand how to support these efforts.

Harm co-occurrence is here, too

In summary: Where family harm is a common occurrence in a family it becomes much more likely that babies/children will be harmed, making it all the more important that we find means of prevention, healing and strengthening.

There is a well-established literary precedent – internationally and locally - for the co-occurrence of various forms of family harm, especially IPV with child abuse and neglect (Chan et al., 2021; Family Violence Death Review Committee, 2017; Slep & Heyman, 2001). Of course, exposure to an incident which is primarily occurring between adults can be considered a form of direct harm to children, too (Artz et al., 2014; Family Violence Death Review Committee, 2017; Powell & Murray, 2008), with myriad negative effects (Artz et al., 2014).

The current research found that the families with the highest number of recorded family harm incidents were the same families with the highest number of ROC's to OT. In

addition, although Start Well babies/children were only recorded as being present during 19.5% of family harm incidents in total, these incidents occurred almost exclusively for the families experiencing the highest proportion of family harm. This data indicates a strong relationship in this cohort between harm to children and family harm in general. This is consistent with international and local literature (as above), and with Māori and Pacific collective and holistic conceptualisations of family harm (Ioane, 2017; Pihama et al., 2019; Rankine et al., 2017), i.e., family harm cannot be considered to be a private, dyadic experience which does not impact upon children. A positively-framed view of these findings might suggest that successful interventions to address family harm would have a significant impact in preventing harm to children.

Though whole-of-family responses to family harm are needed, research suggests that tailored treatments for children who have experienced family harm are also required as part of an integrated service response, to ensure that children's needs don't get lost in adult-focused processes (Yates, 2013). Provision for this is reflected in Te Aorerekura (New Zealand Government, 2021).

Finally, although the current research cannot shed any light on the experiences of children when police attend family harm incidents, this research in combination with the literature regarding family harm co-occurrence indicates a high likelihood that any family harm incident attended by police is likely to involve children. Given this, further research into children's experiences of and needs during (and after) these incidents may be of use, in order to inform optimal cross-sector engagement.

Recommendations

- For frontline support workers/clinicians: Be aware that family harm is likely to co-occur with harm to children, and use this information to guide your discussions with whānau when incidents come to light.

- For policy-makers: Continue to resource, evaluate and improve efforts at cross-agency collaboration (e.g. the Joint Venture, PBI's), to facilitate integrated rather than siloed responses to family harm.

- For funders: Allow for specialized treatment for children who have experienced family harm, as part of the suite of responses.

- For academics: Conduct research into children's lived experiences of family harm incidents, including of police and other agency interventions – for example by interviewing adults about their experiences when they were children.

Relational Investment Works When Addressing Family Harm

Start Well has three particular lessons to teach us about the use of relational investment to address family harm, each of which will be discussed in turn: (1) for this population, developing a trusting relationship takes time, but it facilitates disclosure of family harm; (2) a strong relationship can sustain mandatory reporting, despite discomfort; and (3) as harm becomes known it can be explored, addressed and reduced.

Good things take time

In summary: For this population, developing a trusting relationship takes time, but facilitates disclosure of family harm.

The literature reports low rates of family harm disclosure by women engaged with GP's (Woolhouse et al., 2019) and also by women engaged with Maternal and Child Health services (Hooker et al., 2020). Research has also found that women may not be ready to disclose family harm the first time they are asked, but may disclose later (Hegarty et al., 2020). A Hawke's Bay enhanced Plunket pilot reported that it could take some time before whānau were willing to disclose family harm, with the example of ten months being given (Skerman et al., 2015). Indigenous women in Australia (Spangaro et al., 2019) and women

with a history of child sexual abuse (Bacchus et al., 2016; Stöckl et al., 2013) have been found to be particularly reluctant to make a positive disclosure. Additionally, research indicates that universal screening for family harm may be experienced negatively by some women, especially where questioning is done with insufficient care (Spangaro et al., 2019) and/or insufficient trust in the person asking (Creedy et al., 2020).

This research found that the topic of family harm was usually raised by clinicians (rather than whānau) some way into engagement (73 days on average) and usually in a conversational manner (rather than using a formal screening tool). Using this method, all but three families who were later known to be experiencing family harm within their immediate families made a positive disclosure the first time the topic was raised, and two made a positive disclosure later. This is an unusually high rate of positive disclosure compared to that described in the literature (Hooker et al., 2020; Woolhouse et al., 2019). This high disclosure rate is likely due in part to a high level of family harm occurring within the cohort, but even so the fact that the overwhelming majority of affected whānau chose to disclose is notable. The time taken to develop a relationship of trust prior to asking about family harm is likely a key element in Start Well's success in this respect; taking this time has been found in research to be important (Adams et al., 2022b; Bacchus et al., 2016; Spangaro et al., 2019; Stöckl et al., 2013). Taking this time also likely aligns well with the prioritization of relationship within Māori and Pacific worldviews as articulated in the literature (Fa'alau & Wilson, 2020; Ioane, 2017; Te Puni Kōkiri, 2010), very possibly influencing the decisions whānau made to disclose the family harm they were experiencing. Start Well's slow-paced, conversational approach likely contrasts with that of most WCTO providers, given the small amounts of time other providers have available, and given that other WCTO providers frequently use formal family violence screening tools. This argument is supported by the WCTO review, which found that screening tools in current use may not be acceptable to

Māori and Pacific people, and that more time and less prescribed delivery is required, to support the development of trusting relationships (Ministry of Health NZ, 2020).

That two families made a positive disclosure but not on the first occasion of being asked supports the findings of international research that disclosure is often a staged process (Bacchus et al., 2016). It also reminds us of the importance of enquiring about family harm more than once - which Start Well clinicians did and were able to do given their ongoing relationships with whānau.

The sole case in which a positive disclosure was never made despite the occurrence of family harm suggests that for a small minority of whānau, even significant investment in relationship development is not enough. It is likely significant that this mother was Māori, given the dehumanizing (Adcock, 2016), racist (Tatana, 2020) treatment of whānau Māori by OT historically and into the present day. The literature speaks to high levels of fear of OT among Māori communities, which restricts their service engagement not only with OT but with other services too (Adcock, 2016; Carter et al., 2020). There are similar findings from Australian Aboriginal communities regarding Australian child protection agencies (Spangaro et al., 2019). To some degree this fear and reluctance to trust or engage can be assisted if other service providers (such as Start Well) are able to go the extra mile to build trust and facilitate engagement, but ultimately this is an issue which must be directly addressed by OT itself – as well as by the wider systems of society which OT exists within, which continue to perpetuate structural racism and colonisation.

Finally, the fact that 'first conversations' about family harm were most likely to be instigated by direct worker action that was not part of a regular screening process is important because it indicates that whānau may be unlikely to raise these issues themselves (at least for the first time), making direct worker action important.

Recommendations

- For frontline support workers/clinicians: focus first on building a relationship of trust, and when the time is right, don't shy away from raising the topic of family harm and exploring relationship dynamics. Wherever possible, proactively enquire more than once. If using a screening tool with a family, do so in a relational and compassionate way.

- For services: Support clinicians, so that they are best able to offer genuine care to families. Support clinicians to use their judgement as to the timing and nature of conversations about family harm.

- For OT: Continue work on developing partnerships with iwi, to develop new ways of working and to address past and current harms to whānau Māori in particular. An apology to affected whānau Māori and to Māoridom in general would be an important first step in this endeavour, as advocated by Tatana (2020).

- For Government: continue to lead efforts towards Te Tiriti-led co-governance across all societal systems, to address structural racism and colonisation, and to better allow mātauranga Māori to benefit us all.

- For funders: To enable identification of family harm for whānau experiencing multiple stressors, resource services to take the time needed for relationship formation wherever possible. I.e., resource meaningful engagement rather than assessment.

- For academics: Conduct further research into the nature of relationships and conversations about family harm which facilitate disclosure without the use of formal screening tools, especially with whānau experiencing multiple stressors.

A strong relationship can sustain mandatory reporting

In summary: A strong relationship and effective practices can sustain mandatory reporting, despite discomfort.

As noted above, the literature reports a high degree of fear among some whānau regarding the possibility of statutory child protection agency involvement in their lives (Adcock, 2016; Carter et al., 2020; Douglas & Walsh, 2015). In my view OT must continue working to change its practices so that responses are constructive in enabling families to retain custody of their children. Such redress cannot be achieved without effective Māori (and Pacific) leadership being enabled at the highest levels (Tatana, 2020). In the meantime, fear of OT can impact the willingness of whānau to engage with any form of service which they perceive as being close to the state, as they know that such services are required to report child protection concerns to OT (Adcock, 2016; Douglas & Walsh, 2015). That said, research with Family Start seems to suggest that for adjunct services, strong relationships with whānau can overcome fear to sustain engagement with support services despite mandatory reporting requirements (Carter et al., 2020).

The current research supports Carter et al. (2020)'s finding: despite Start Well clinicians often being the source of reporting family harm incidents to Police or OT, all of the whānau about whom reports were made remained engaged with Start Well.

The literature makes a number of recommendations for those trying to navigate mandatory reporting practices: focus on building relationships of trust (Douglas & Walsh, 2015), use clear consenting processes at the beginning of engagement (Douglas & Walsh, 2015), consult with families before making a report to child protection services (Douglas & Walsh, 2015), and equip clinicians to display a degree of comfort when discussing concerns with families (Tufford & Lee, 2020). The current research did not explore how Start Well clinicians navigated this process, and so I cannot make any conclusive statements on this

topic. My guess is that the degree of trust developed over time is likely to be protective of relationship continuation.

Recommendations

- For providers and frontline support workers/clinicians: Follow the guidelines from literature above in order to maintain relationship with whānau through mandatory reporting.

- For OT: Enable high quality Māori and Pacific leadership at a high level. Work collaboratively with the non-statutory workforce who are already trusted by whānau, and who are also well placed to recommend the OT actions that may be useful.

- For policy makers: institute strong, independent oversight of OT, as recommended by Cook (2020).

- For funders: To serve whānau experiencing multiple stressors, resource providers who have the time and capability to build trusting relationships, in order to facilitate engagement.

When we know, we can work together

In summary: As harm becomes known it can be explored, addressed and reduced.

International and local literature has indicated the need for more research and service development regarding how to effectively engage families at greatest risk from family harm, and particularly those for whom 'mainstream' Western approaches are not effective (Rankine et al., 2017; Te Puni Kōkiri, 2010; Tiyyagura et al., 2020). Home visiting has received widespread attention as a promising method of reducing harm (Dodge et al., 2019; Eckenrode et al., 2017; Olds, 2008; World Health Organisation, 2010). The literature is unable as yet to definitively say *why* it appears to work, but it does indicate that one likely important factor is home visitors' clinical expertise (Adams et al., 2022a). Another is the home visitor's ability

to build trusting relationships with whānau over sometimes lengthy periods of time (Adams et al., 2022b). This aligns well with the perspective of Ioane (2017), who highlights the importance of relationship for Pasifika. Similarly in her writing regarding Māori, Wilson (2016) advocates *showing* families new ways of addressing conflict, and supporting them to use these new means – which can only happen through sustained engagement and relationship. Also concordant with this view are the reports of Skerman et al. (2015): that once whānau were finally able to disclose family harm (sometimes ten months into engagement), clinicians could work with them to address it.

Findings of the current research are consistent with these arguments. Based on graphing the average monthly number of known family harm incidents across the whole cohort during the research period, findings indicate that the true incidence of family harm became more visible to Start Well over time, and that following this greater knowledge, incidence decreased.

Seasonal variation was found in these results and the particular reasons for peaks in autumn and troughs in later winter/spring are not known. This is consistent with international literature which records seasonal trends in family harm incidence, with particular seasons varying from country to country (Al-Hawari & El-Banna, 2017; Duncan et al., 2021; Koutaniemi & Einiö, 2021). Research has not been able to illuminate the reasons for this as yet.

The time trend patterns found in this research need to be interpreted with caution given the small sample size and limited measurement years; the possibility of statistical bias, confounding and artefact ('chance') cannot be excluded (Carbone-Lopez & Lauritsen, 2013). That said, these findings do align with advisor comments emphasizing the effectiveness of ongoing relationship in addressing family harm, and with the literature (above). It makes intuitive sense that as whānau became more comfortable in their engagement with Start Well

over time, they became more likely to disclose family harm and seek help, enabling clinicians to provide assistance that was effective in de-normalising violence, strengthening and reducing further incidence.

Assuming that these results do indicate that family harm is being effectively addressed by whānau with the support of Start Well, the next question is: how? Further research is required to illuminate this. Nevertheless, these are encouraging results, and significant given the need for effective means of working with whānau at greatest risk from family harm.

Recommendations

- For academics: Further research is required to illuminate the processes by which some home visitation services effectively assist families to reduce incidence of family harm.

- For funders: Home visiting services such as Start Well do appear (from the literature and from this research) to have the capacity to work with families to successfully reduce family harm incidence. Though the mechanisms by which this occurs require further illumination, this research does lend support to the argument that such services merit funding when seeking to reduce family harm incidence for whānau experiencing multiple stressors.

Whānau Experiencing Multiple Stressors Require - And Benefit From - Support to Access Mental Health Services

Findings of this research demonstrate that Start Well clinicians proactively and repeatedly raised the topic of psychological distress with mothers (and some family members). This appeared to enable (1) disclosure and (2) uptake of appropriate support services, although there is some suggestion that post-referral support was differentially

available. These themes will each be discussed, followed by a post-script on Start Well's current method for accessing further mental health support for whānau.

You can't help if you don't know

In summary: Proactive practice enables disclosure of psychological distress.

The literature reports increased rates of psychological distress for young mothers (Signal et al., 2017), those experiencing social disadvantage (Schmied et al., 2013; Stevens et al., 2021) those experiencing family harm (Gao et al., 2010; Schmied et al., 2013), those living in more socioeconomically deprived areas (Mulder et al., 2022), and Māori and Pasifika mothers (Bennett & Liu, 2018; Gao et al., 2007; Kapeli et al., 2020). Given that this list of risk factors closely describes the Start Well cohort, we would expect the current research to find high rates of psychological distress in the study population.

This did appear to be the case: the current research found that Start Well clinicians had a large number (259) of conversations with whānau about psychological distress, usually initiated by clinicians and leading to a positive disclosure of psychological distress on 61% of occasions. Most of these conversations were with mothers, but some were with other whānau members.

These findings are important for a few reasons. First, the high level of psychological distress within the cohort (as predicted) is concerning, particularly given the literature detailing ongoing mental health impacts for mothers (Schmied et al., 2013) and the high maternal suicide rates in Aotearoa NZ (Mellor et al., 2019; Walker, 2022). It is also concerning given the known adverse effects on children of parental psychological distress, including impaired attachment and increased risk of developmental delays, behavioural problems and poor health (Howard & Khalifeh, 2020; Karimzadeh et al., 2017; Russell, 2014; Walker, 2022). There are also, of course, significant down-stream economic consequences of parental psychological distress (Bauer et al., 2014; Mellor et al., 2019).

Second, these findings are of interest because they point to the important preventative function Start Well performs in monitoring mental health concerns for this cohort, all of which is over and above what most other services (who work less intensively with whānau and for shorter time periods) would be able to offer. One interpretation of this is that the frequency of conversations likely aided disclosure: perhaps by enabling proximity of disclosure opportunities to the occurrence of instances of higher psychological distress, and/or by increasing comfort with the topic via normalisation and habituation. Additionally, research indicates that supportive relationships with professionals - in themselves - can act as interventions to address psychological distress (Adams et al., 2022b; SmithBattle & Freed, 2016), and it may well have been the case that for some whānau, simply talking about psychological distress with Start Well clinicians was sufficient to address it.

Third, these results illustrate the large volume of background work that is done behind, say, a single presentation to a DHB mental health service, indicating that a significant amount of proactive support is required to support such a presentation for this population. Similar findings were made by the Family Start evaluation, which identified supporting whānau to access mental health services as one of the factors making their work increasingly time consuming (Carter et al., 2020). Such support has been found to be necessary for Pasifika families, who have said they need both practical (e.g. transport) assistance to attend appointments with mental health services, and a human interface between them and the 'unfeeling bureaucracy' of the mental health system (Suaalii-Sauni et al., 2009).

Fourth, all of these conversations that Start Well clinicians had with whānau were 'unscripted,' in the sense that they took place in a conversational way without the use of a formal screening tool. The fact that so many conversations resulted in positive disclosures of psychological distress suggests that formal screening tools and practices are not necessary for this population when a long-term, supportive relationship can be offered. This aligns with

literature which suggests that particularly for those with a history of trauma and/or mental health difficulties, case-based enquiry about psychological distress by well-trained and well-supported clinicians (rather than universal screening) is best (Howard & Khalifeh, 2020).

Fifth, the literature reports an over-emphasis in practice on individual mothers as key agents of change (Howard & Khalifeh, 2020). International guidelines recommend offering support to fathers and other family members as well, (Howard & Khalifeh, 2020), but it is unclear how often this actually occurs in practice: research into both the psychological wellbeing of fathers (Rominov et al., 2016) and into family interventions (Howard & Khalifeh, 2020) is extremely limited. The current research found that Start Well did follow the general trend reported in literature of emphasizing intervention with mothers, however the data clearly demonstrates involvement with other whānau members regarding psychological distress as well.

Finally, given differing Pasifika cultural understandings of psychological distress (Kapeli et al., 2020) and stigma associated with mental health concerns within some Pacific communities (Ataera-Minster & Trowland, 2018), the fact that high disclosure rates were achieved in this predominantly Pasifika population is remarkable, and likely speaks to the strength of the relationships formed over time (Ioane, 2017).

Recommendations

- For frontline support workers/clinicians: Do ask about psychological distress – again, and again, and again. Wherever possible, look beyond the referred mother and child dyad and also consider the psychological wellbeing of other whānau members.

- For services: In seeking to assist whānau experiencing multiple stressors, prioritise supporting support worker/clinician skill and relationship

development over regimented use of universal screening tools to identify psychological distress.

- For policy makers: Consider extension of specialized mental health services (such as Assertive Community Outreach Services or Maternal Mental Health) to better serve populations like this one. This may include consultative support to those already in relationship with whānau, rather than necessarily or solely direct service provision. Also, as recommended by Walker (2022), prioritise policies which "alleviate or remove background stress for new and expectant parents by making sure they have warm, secure, affordable housing, adequate food, and that they are safe from violence and abuse" (p. 15).

A remarkable degree of engagement with mental health services

In summary: Proactive support can facilitate access to mental health services for this population.

There is a substantial body of evidence recording the low rates of access to mental health services for mothers in general (Schmied et al., 2013), young mothers in particular (VanDenBerg, 2012), 'hard-to-reach' populations (Lamb et al., 2015), those at risk of antenatal substance use (Stevens et al., 2021), and for Māori and Pasifika in general (Suaalii-Sauni et al., 2009). Again, this list closely describes the Start Well cohort; however the current research found that whānau were assisted to approach their GP to address mental health concerns on 11 occasions, and to approach DHB (i.e., secondary) mental health services on 21 occasions. Most of these approaches were the result of a conversation instigated by the whānau or by a Start Well team member working in an unscripted way. The most common response from DHB mental health services was to offer ongoing/longer-term service such as case management, therapy and/or therapeutic groupwork (as opposed to declining the referral or offering short-term crisis care only). Though definitive conclusions

cannot be drawn from these results, such a high degree of engagement with primary and secondary mental health care for this population does seem remarkable. It also seems significant that on many occasions whānau were themselves able to raise the conversation which led to accessing further support – indicating both whānau strength and a degree of trust in Start Well clinicians.

Though this research didn't specifically explore how such high rates of engagement were achieved, findings mirror those of US home visitation services which improve rates of psychological distress identification, referral and service access (Tandon et al., 2020). It appears likely that Start Well clinicians assisted with reducing some of the barriers to access commonly experienced by such populations, as follows. A high rate of disclosure due to proactive practice was described in the last section, and this is a critical part of the process of accessing support. Not knowing *how* to access formal mental health services has also been found to be a barrier to access for Pasifika (Ataera-Minster & Trowland, 2018; Fa'alogo-Lilo & Cartwright, 2021; Suaalii-Sauni et al., 2009), meaning that having someone to disclose *to* who then knew how to facilitate access to services is likely to have been key. The current research did not record data on whether or not Start Well clinicians attended appointments with whānau, and therefore I cannot make any definitive statements on this; however from having read the case notes, my overall impression was that in many instances they did. And *if they did*, just this one aspect of support would be likely to address the following barriers to access: lack of transportation (Suaalii-Sauni et al., 2009), lack of childcare (Howard & Khalifeh, 2020), other caregiving responsibilities (Suaalii-Sauni et al., 2009), complex service infrastructure and language (Kapeli et al., 2020), insufficient engagement from GP's (Adcock, 2016), and poor service integration (Stevens et al., 2021). It is likely that the trusting relationship Start Well clinicians seemed able to form with whānau was also important.

Where it can be accessed, there is robust evidence of the effectiveness of psychological and psychosocial support for improving mental health outcomes (Howard & Khalifeh, 2020; Tandon et al., 2020). For example Family Start, who serve a similar population to Start Well's population, found that where mental health support could be accessed it made a substantial impact on client wellbeing (Carter et al., 2020). This makes it worth the effort to support families to access psychological services. Access is also likely to be preventative of escalating difficulty, which is important given the higher rates of compulsory and inpatient mental health treatment for Māori (Bennett & Liu, 2018; Tapsell et al., 2018).

Again, formalized screening was not a component of most of the conversations which led to accessing further mental health support. Cross-checking of the data revealed that all of those whānau who appeared to be experiencing the highest levels of psychological distress were assisted to access further support, i.e., none of them 'slipped through the cracks.' This is reassuring and suggests effective engagement by Start Well, despite not having formalized screening processes. Research indicates that this type of flexible and case-based enquiry by well-trained and well-supported clinicians is likely to be effective, and less likely to be harmful than formal universal screening (Howard & Khalifeh, 2020).

There is a well-established link between family harm and psychological distress (Gao et al., 2010; Schmied et al., 2013). This makes intuitive sense and aligns with the findings of this research: five members of the cohort made use of a mental health respite service made available by a bespoke agreement with Start Well. For four of the five, the facility was used due to a combination of family harm and psychological distress/mental health difficulties. The ability of Start Well whānau to use this facility for difficulties which to some degree related to family harm rather than 'pure' psychological distress makes perfect sense given the research base and the findings of the current research, but this does not represent standard

practice elsewhere. For this reason, SASWB's innovative work in brokering access to an otherwise limited access respite service is significant. Another reason that this work is significant is that Pasifika families have requested better access to respite care, as part of what would help them to engage with mental health services (Suaalii-Sauni et al., 2009). Improved access to respite has also been recommended for Māori experiencing Bipolar Disorder (Haitana et al., 2022).

Finally, as noted in the previous section, international guidelines recommend that services primarily supporting mothers also offer assistance to their partners and wider family members (Howard & Khalifeh, 2020). This research found that approaches to DHB mental health services were primarily for mothers, but two approaches were for children and three were for wider whānau members. Although definitive conclusions cannot be drawn from this data, given the body of evidence on the social determinants/collective experience of psychological distress (Ataera-Minster & Trowland, 2018; New Zealand Government, 2018), these efforts are likely to have had positive results for mothers, children and their whānau.

Recommendations

- For services primarily supporting mothers (and their funders): Consider means of extending support to other family members where possible.

- For services: Wherever possible, support clinicians to use their judgement as to the timing and nature of conversations about psychological distress. Make screening tools available, but not mandatory.

- For funders: Resource long-term, relationship-oriented services such as Start Well to facilitate (among many other positive benefits) the identification of and support for the mental health needs of whānau experiencing multiple stressors. Emerging evidence – including the results of this study - suggests that the investment is worthwhile.

- For funders: Consider means of learning from and extending Start Well's innovative work with an existing respite service.

- For academics: Conduct further research into (1) the outcomes on psychological distress of assisting multiple members of a family; (2) the longer-term impacts on psychological distress of the support Start Well offers, and (3) the mechanisms by which higher rates of mental health service engagement are achieved by services like Start Well.

Indications of differential access for whānau Māori

In summary: Results suggest that whānau Māori may have been differentially declined ongoing secondary mental health service.

Research indicates lower rates of Māori access to secondary mental health services relative to tauiwi (Durie, 2011; Filoche et al., 2016; Signal et al., 2017; Suaalii-Sauni et al., 2009). The current research found that although the most common response from DHB mental health services when approached was to offer ongoing/longer-term service to whānau, on eight occasions this was not the case. For a majority of these eight occasions, the whānau in question were Māori. This is despite the fact that just 23% of Start Well whānau were Māori. On the occasions in question, the person was either offered crisis care only, or they were not offered longer term service due to not attending appointments. While caution is required in interpreting these findings due to the small sample size and the nature of the methods used in this research, the findings do align with the existing evidence base (above) and thus merit consideration.

If we assume for the purpose of discussion that these findings do - at least to some degree - reflect the reality for young Māori mothers and their families trying to access secondary mental health services, the next question is: *why* were these whānau Māori less likely to receive longer-term service than their tauiwi counterparts? The current research did

not record data which would enable a definitive answer to this question, so we can only speculate. It could be that something about the initial engagement/assessment process was not working as well for whānau Māori as for tauiwi (which in this case were predominantly Pasifika). Findings in the literature indicate that teenage Māori mothers overwhelmingly report not being listened to, respected or cared for in their interactions with health professionals (Adcock, 2016). A lack of care or respect in the assessment process would likely weigh heavier on Māori given the cultural value placed on relationship (Te Puni Kōkiri, 2010), and the likely layering of an aversive assessment experience on top of other aversive experiences within the health system (Graham & Masters-Awatere, 2020) and within Aotearoa NZ society in general (Wild et al., 2021). Additional research has found that Māori in the mental health system are adversely affected by multiple structural barriers including limited hours of service delivery, a deficit focus and inadequate emphasis on staff wellbeing leading to a lack of staff care for whānau (Haitana et al., 2022). These factors may have contributed to whānau Māori decisions not to attend appointments beyond the first one, resulting in not being offered ongoing service.

However, missed appointments weren't the only reason for longer-term care not being offered, and the reasons for this are not clear. It could be that the reason for referral differed in some way from the reasons for which whānau tauiwi were referred. An inadequate connection within the first assessment session may have meant that mental health service clinicians decided not to offer further service. Anecdotally, given the strain on mental health services, clinicians who attend initial assessment sessions may need to argue the case of the whānau in the multi-disciplinary team environment in order for the service to agree to offer further assistance; consciously or unconsciously this clinician may be less inclined to argue persuasively for a whānau who they did not feel connected with or who in some way communicated that they were not interested in receiving the services potentially on offer.

Alternatively (or as well), it could be related to how referrals were processed. Anecdotally, referral processing within secondary mental health services is not a transparent process: in most cases there are not written/fixed acceptance criteria, or where written criteria exist, they are not adhered to due to demand being far in excess of the criteria. In some cases (again, anecdotally), referrals coordinators are said to make decisions about whether or not to accept referrals without multi-disciplinary (and multi-ethnic) team consultation. If these processes are in fact what occurs, it is beyond the scope of this research (and we do not have enough information) to debate their merits. However, intuitively, if there is not a transparent and treaty-accountable referrals acceptance process within a health system known to be racist (Graham & Masters-Awatere, 2020), this would likely create the conditions for systemic racism to thrive.

Whilst these findings do not enable any definitive conclusions to be reached, they do raise a number of questions about systemic racism and access to secondary mental health services for this population of whānau Māori, highlighting the need for more research, and perhaps proactive redress on the part of the mental health system.

Recommendations

- For clinicians engaged with whānau Māori attempting to access secondary mental health services: Support whānau to attend appointments and advocate for them within appointments.

- For clinicians employed by secondary mental health services and engaged in initial appointments with whānau Māori: Consider how to maximise the degree to which cultural safety and caring, relational engagement can be offered. Consider how you represent whānau in the multi-disciplinary team environment.

- For DHB secondary mental health services: Analyse rates of referral acceptance and service provision by ethnicity, to identify systemic racism where it exists. Proactively seek cultural advice regarding all processes, and especially referral and assessment processes.

- For funders: invest in Māori mental health workforce development, and in Kaupapa Māori mental health service provision.

- For academics: Conduct research into the reasons for lower rates of access to secondary mental health services for whānau Māori.

Post-script: Bespoke mental health support

In summary: To test a different approach to psychological support for Start Well whānau and staff, the SASWB invested in a bespoke 'test and learn' approach.

Concerns have been reported in the international and Aotearoa NZ literature about the degree of support needed to assist whānau to access existing primary and secondary mental health services. For example, in the US nurses have reported choosing to assist mothers with psychological distress themselves rather than referring them on to mental health services, due to a perception that such referral is rarely effective (SmithBattle & Freed, 2016). As noted earlier, the 2020 Family Start evaluation reported that one of the factors making work with increasingly 'high needs' families time consuming for Family Start clinicians is the need to spend long periods of time assisting whānau/families to access mental health services (Carter et al., 2020). The previous section illustrated for the current research that even the very high level of support able to be offered by Start Well was not enough to overcome challenges to accessing secondary mental health services for some whānau.

To understand the potential value of bringing psychological support closer to frontline staff and whānau, the SASWB funded a bespoke prototype for mental health service provision from provider 'Fresh Minds.' It was considered that this arrangement would enable

more timely and agile access to mental health support where needed. In practice, this involved two Clinical Psychologists basing themselves at Start Well offices a couple of times per week, making themselves available to see whānau either at Start Well offices or in the community (*Start Well Interim Learning Report*, 2021). Often sessions were arranged on the day, and in the form of both individual and whānau sessions. Medication support was arranged via primary care where required. Psychological support included management of mood, support with issues related to trauma, coaching Start Well clinicians around mental health to support workforce capability, practical strategies for living in a changeable situation and managing day to day, and providing positive appraisal to mothers about their parenting and encouraging them to interact with their tamariki in a way that fosters attachment (*Start Well Interim Learning Report*, 2021).

Because this arrangement began near the end of the research period, approaches to Fresh Minds were not specifically recorded and reported on. I am unable to comment from the data on the effectiveness of this arrangement, except to say that some of the whānau experiencing the highest degree of psychological distress accessed mental health support in this way.

A 2014 randomised control study aiming to do a similar thing (offering in-house mental health support within an existing support service for teenage mothers) was unable to establish that the in-house provision produced a significant difference in outcomes. That said, the service within which mental health support was being offered itself had just a 55% rate of completing at least one follow up, demonstrating a level of engagement comparable with other similar support services for teenage mothers but far below that of Start Well (Russell, 2014). One would imagine that such an approach might be useful for reducing barriers to service access, including by eliminating wait times, as recommended by Blueprint II (Mental Health Commission, 2012).

Recommendations

- For clinicians: Where existing mental health services are not working for whānau, advocate for your service to 'think outside the box' in terms of service delivery models.

- For academics: Conduct further research into the effectiveness of in-house, relational and flexible psychological service provision within services already engaged with whānau experiencing multiple stressors (including but not limited to Start Well).

Effective Commissioning/Contracting Environment: "We Are Able to Practice in The Way Other Professionals Wish They Could Practice."

Start Well's home visitation approach is one that holds promise here as well as elsewhere, e.g. Fergusson et al. (2012) and Olds et al. (2019). Its results as reported here seem favourable, and I believe that's in part because it is a well-designed service executed by experienced clinicians – that's worth learning from and repeating. But what must not be missed about this story is its noticeable absences compared to the stories of other services: no case load requirements, no time limits on day-to-day engagement and a long time-frame for overall engagement (i.e., until the youngest child turns five), no pressure to discharge during more settled periods, no tick-box screening tools to be used at pre-determined times. The cause/s of these absences cannot be definitively pin-pointed by this research, as this was not something for which I officially collected data. Nevertheless, these absences still merit discussion for the following reason: Start Well's own description of how it works in its documentation (*Start Well Interim Learning Report*, 2021), reports about how Start Well works in evaluation to date (Smith, Lamb-Yorski, et al., 2019a), and the descriptions of practice I read in the case notes, are all so different from other services in the ways mentioned above, that the results I have reported here must be understood in that context.

Having worked in social services and DHB's, I know first-hand that what is delivered on the ground is very much influenced by what is funded and contracted. Arguably this is how it should be, given that such services are taxpayer funded. To understand Start Well's notable absences at the level of practice, therefore, we must consider what happens at the level above that of service delivery: funding and contracting. The first element to understand at this level is relations *between* funders, given that Start Well has many. Previous evaluation of Start Well indicates that partnerships at the SASWB level have been effective in enabling cross-agency methods of whānau-centred working (Smith, Lamb-Yorski, et al., 2019a). This has required "a level of courage and calculated risk taking to move away from traditional approaches and trial new ways of working" (Smith, Lamb-Yorski, et al., 2019a, p. 28). Smith, Lamb-Yorski, et al. (2019a) attribute the SASWB's success in this regard to a combination of shared vision, building on existing collective action (via police family harm initiative Whāngaia Ngā Pā Harakeke), working in a 'whatever it takes' way to test cross-agency ways of working, and building the capability of frontline providers to adopt a whānau-centred way of working. An example of the strength of this collaboration and its 'whatever it takes' mentality was recorded by Smith, Lamb-Yorski, et al. (2019a) when a moment of uncertainty about whether Government funding for SASWB would be ongoing resulted in a demonstration of willingness to identify funding sources across government agencies. This was seen as a significant event in a the context of traditionally competitive Government commissioning models (Smith, Lamb-Yorski, et al., 2019a). Encouragingly, a similar willingness to work together has been seen at the senior leadership level for Whānau Ora prototype Ngā Tini Whetū, although early evaluation suggests that more work is needed to embed a collaborative approach, and that time is needed to allow whakawhanaungatanga between agencies (AIKO, 2021).

The success of these cross-agency partnerships at the commissioning/contracting level are likely a key component of what enables Start Well to practice effectively on the ground. That is, Start Well's holistic approach on the frontline likely builds upon the foundation of funding and policy infrastructure which thinks and acts holistically, and is committed to supporting the wellbeing of whānau over protecting individual budgets. If this approach could be taken on a broader scale, it would significantly contribute towards addressing the recommendations of a number of significant reports, including He Ara Oranga, Te Aorerekura and recent Pasifika report Bula Sautu (Health Quality & Safety Commission, 2021). We have more to learn about how to make this work; Start Well, the SASWB and Ngā Tini Whetū may be able to help.

A second element to understand at the level of funding and contracting is relations between funders (as a collective, in this case), and service providers. The results of our poor history with regard funder-provider relations is a majority of approaches within our systems which don't account for time to engage, let alone to build trusting relationships – it's often 'tick box' engagement (Ministry of Health NZ, 2020) which doesn't fit with principles of whanaungatanga (Carter et al., 2020). This means we over-invest in assessment and under-invest in meaningful engagement; our services remain siloed and as a result, often fail to meet peoples' needs (Lambie, 2018). This is especially true for Māori, Pasifika and 'high needs' whānau/families (Carter et al., 2020; Ministry of Health NZ, 2020). There is some evidence to suggest that where contracts do not meet the needs of whānau, adaptations may be made by services resourcing extra work out of pocket, or by clinicians working longer hours and doing more than they are contracted to do (Carter et al., 2020). This is a phenomenon termed 'extra mile' work by Suaalii-Sauni et al. (2009), and may be more prevalent among Māori and Pasifika services and clinicians, as was found for Māori and Pasifika providers of Family Start services (Carter et al., 2020). Though admirable, this is not sustainable for clinicians and

services in the long-run, and it certainly should not be necessary. Te Aorerekura explicitly acknowledges that "low trust, transactional commissioning services can limit the flexibility and responsiveness of services", and aims to support change in this regard (New Zealand Government, 2021, p. 39).

There are indications that Start Well and the SASWB are getting this right, as follows: (1) frontline clinicians acknowledge, "with Start Well there is nothing you can't address. We are able to practice in the way other professionals wish they could practice;" (2) the results of the current research seem favourable in terms of Start Well's ability to assist whānau to address family harm and psychological distress; and (3) whānau themselves (interviewed for the nationally-led evaluation) reported feeling heard and appreciating Start Well's holistic way of working, which allows clinicians to support whole whānau across a wide range of challenges (Smith, Lamb-Yorski, et al., 2019a). It appears that Start Well's position as a prototype of the SASWB (which was a PBI set up to work in a fundamentally different way) allows it to effectively operate according to effective underlying principles espoused elsewhere, such as in Te Ao Māori, Pasifika values and the professional codes of social workers and nurses. These are principles which are often difficult to enact under more traditional contracting environments: put relationships first (Ioane, 2017); Be responsive to what whānau actually want (Stafford, 2021); Work with the whole family (Gawith & Abrams, 2006; Kapeli et al., 2020; Lino, 2021); Be guided by the person, not the contract (Suaalii-Sauni et al., 2009).

In contrast, Whānau Ora service reach has been hampered by inadequate funding under a commissioning model (Smith, Moore, et al., 2019), and tensions around accountability have arguably resulted in burdensome oversight and reporting requirements for providers (Boulton et al., 2018). This difference of experience between Whānau Ora and Start Well may be partly due to the innovative nature of the cross-agency collaboration at the

SASWB level (Smith, Lamb-Yorski, et al., 2019a). It could also be (in part) that the uneasy

relationship between Treaty partners has influenced Whānau Ora's difficulty in achieving

similar success at the funding/commissioning level. This is reflected in the Waitangi Tribunal

claim relating to funding for Whānau Ora (Hayden, 2020), and is illustrated by the following

quote from a Start Well stakeholder: "There's institutional racism (in the) thinking (that

Māori and Pasifika providers) don't know how to manage their money" (Smith, Lamb-

Yorski, et al., 2019a, p. 101). I contrast these two services in order to argue that effective

commissioning/contracting is entirely possible, with Start Well and the SASWB as exhibit A.

Whānau Ora has already demonstrated successful practice (Smith, Moore, et al., 2019); it's

likely that it could do more if it was sufficiently trusted and supported at the

commissioning/contracting level. Whānau Ora's prototype Ngā Tini Whetū offers a ray of

hope that Government Crown entities may learn to better collaborate and partner with

kaupapa Māori organisations (AIKO, 2021). Early indications are that although work is

needed to build internal capability and an understanding of what it means to partner

effectively with Māori, there are high levels of trust and collaboration between agency senior

leaders (AIKO, 2021); this bodes well.

 In my view the collaborative effort at the contracting/funding level to make an

approach like Start Well work is worth it, because it's what's needed for whānau

experiencing multiple stressors. As noted earlier, the cohort of Start Well whānau are those

who have previously had (and without Start Well would likely continue to have) very little or

no engagement with health and social services (Smith, Lamb-Yorski, et al., 2019a) – whānau

which services find 'difficult to engage' and who tend to 'slip through the cracks.' This was

clearly evident as I read through case notes, seeing how on many occasions other health and

social services attempted to assist Start Well whānau but were unable to 'track them down'

and/or to engage effectively with them when they did make contact. On many occasions other

services relied upon Start Well clinicians to facilitate engagement with their services, and/or Start Well clinicians assertively advocated for whānau, for example for them to be allowed to attend a GP appointment when they were 15 minutes late. The 2020 Family Start evaluation reported similar findings (Carter et al., 2020). It is likely that without the trusted relationship, practical support to attend appointments and 'flex up flex down' service delivery able to be provided by Start Well, whānau would not have been able to access adjunct support, and this would have led to knock-on difficulties (and costs to the system). Cost comparisons in the UK have found that, for the most marginalized families, intensive interventions save costs when compared to the repeat-assessment-and-ineffective-intervention model of business as usual (Stafford, 2021). Home visitation specifically has also been found to result in cost savings at 18-year follow-up (Olds et al., 2019). This is great news for funders, but it's not the main argument: justice is the imperative.

Recommendations

- For policy-makers/funders: Consider the extension of cross-sector, collective funding approaches for intensive services like Start Well for whānau experiencing multiple stressors, using high-trust commissioning approaches without burdensome reporting requirements. Allow opportunities for relationship development between funders and avoid competitive commissioning practices. Allow providers to set their own case-loads, and as much as possible to set their own reporting targets derived from direct whānau engagement. Commissioning bodies should also be directly accountable to Māori and Pasifika leadership to counter systemic racism within the commissioning process.

- For academics: Conduct a cost/benefit analysis of Start Well compared to business as usual. Explore how the commissioning model for Start Well has worked in practice, to learn from its successes.

Strengths And Limitations of The Research

Strengths

Start Well has already been evaluated via the method of whānau and clinician interviews. Such interviews are very important, particularly to ensure visibility of the experience of whānau/whānau voice. They also have their own limitations: as noted for the Family Start evaluation, "programme providers, workers and clients… are likely to have an interest in the programme's continuation. Whilst their perspective is valuable, and critical for evaluation, it is not neutral" (Carter et al., 2020, p. 10). The data from the current research is arguably fairly 'neutral' in its orientation, in that case notes were interrogated by an external party without a vested interest in the service. In that respect, this study can add to the very important whānau and clinician perspectives gained in prior evaluation.

The degree of inter-rater reliability for this study - for all variables – was better than or on par with the levels of inter-rater reliability found elsewhere. Standardisation of measurement is recognized as one strategy for enhancing inter-rater agreement (Zegers et al., 2010); this strategy was used in this research with good results. The high rate of agreement suggests a degree of robustness to the findings, which is important given the somewhat abstract nature of some of the variables measured (e.g. whether someone was taking a 'protective' role within a family harm incident).

Finally, this study contributes to the body of knowledge in a number of research-poor areas, for example: collective experiences of family harm (Dobbs & Eruera, 2014), the phenomenon of violence being resisted within families, how to facilitate disclosure of family harm and psychological distress for whānau experiencing multiple stressors, and how to

effectively engage families at greatest risk from family harm - particularly those for whom 'mainstream,' Western approaches are not effective (Duggan et al., 2007; Rankine et al., 2017; Te Puni Kōkiri, 2010; Tiyyagura et al., 2020). It also contributes to the limited body of 'practice-based' evidence, and enablers of services that are impactful for whānau experiencing multiple stressors.

Limitations

A key limitation of this research is its small sample size (due to the small cohort served by Start Well). This limited the validity and usefulness of statistical analyses. This could only be remedied by a longer research period, or if the service significantly expanded to include many more families.

A second key limitation is that, given the high proportion of Māori and Pasifika participants in the research, ideally I would have sought Māori and Pasifika governance from its inception. Though Dr Hemopo and Dr Ioane very graciously offered their time and wisdom to assist in interpretation of my results, this is no substitute for collaboratively shaping research questions and analyses. This is an important learning for me, and my main regret.

As noted earlier, case note review as a methodology is affected by the availability and completeness of data in the notes (Eke et al., 2019). This is acknowledged as a legitimate critique relevant to this research. However, Start Well's status as a prototype service has meant that, even prior to this research, clinicians have been aware that there would be a higher level of interest in learning from their work than would ordinarily be the case for other services; this quite possibly may have led to a higher standard of data completeness in notes than could ordinarily be expected.

No matter how complete the notes, though, it is not possible to know the extent to which the notes accurately reflect practice. In general terms, it is likely that not every

conversation/piece of work is documented. More specifically, some conversations/pieces of work are probably more likely to be documented than others. For example, it is likely that clinicians would document disclosures of family harm, but they may be less likely to document an 'unscripted' conversation about psychological distress in which no positive disclosure was received. That said, as written above Start Well's notes may be a little different in nature from the notes of other services given the service's status as a prototype: in my view (through a clinician lens), notes were unusually long and comprehensive (e.g. the note for one interaction was frequently two or more typed pages), so this is likely less of a limitation than it may be for other services.

Conclusions

As I reflect on the results of this research, what is clear to me is this: When it comes to assisting young whānau experiencing multiple stressors to address family harm and psychological distress, what's needed isn't new ideas, but rather the time, resourcing and inter-system collaboration to allow clinicians to do what they already know is best. I.e., time to build relationship, the freedom to raise sensitive conversations their way (rather than according to a specific timeframe or using a form), and a frankly dogged approach to walking with whānau right the way through to problem resolution. AND this needs to be built upon support for those clinicians, so that they can learn, feel safe, and retain the care with which they entered their professions. We all intuitively know this as human beings. When we're in struggle, we don't want to have to talk to ten different people with clipboards about whether we do or don't qualify for their limited services. We want someone who cares, who we know and trust to walk with us - and we want them to stay with us until we're feeling ready to walk on our own. I'm proud of our political and policy systems for having the courage to fund a service like Start Well. Long may the courageousness continue.

Appendices

Appendix A: Research Variables and Associated Analyses

Table 1

Research Variables And Associated Analyses

Variables	Associated analysis	Relevant research question
Dates of each known family harm incident for each whānau	How many family harm incidents were there? What is the visual picture of family harm incidents occurring for whānau over time during their engagement with Start Well?	1
People involved in each family harm incident	How many people were involved in each family harm incident?	1
People involved in each family harm incident (including witnesses)	On how many occasions was the enrolled Start Well baby/child present during recorded family harm incidents, and how did this relate to the number of family harm incidents recorded for each whānau?	1
Protective action taken during family harm incidents, who took this action, and their relationship to the enrolled Start Well baby/child	On how many occasions was someone recorded as having taken protective action during a family harm incident, who took that role, and how did this relate to their relationship to the enrolled Start Well baby/child?	1
Dates of all Reports of Concern (ROC's) made to Oranga Tamariki, the form/s of violence involved and who made the report	How many ROC's were made across the whole cohort during their engagement with Start Well, for what, how many for each whānau, how did this relate to the number of family harm incidents recorded for each whānau and who made the report?	1
Engagement date and date of first documented discussion about family harm	How long did it take before there was first a documented discussion about family harm?	1
Source of initial conversation about family harm (regular screening process as part of WCTO appointment; raised by clinician; raised by whānau; not clear from the notes)	How were initial conversations about family harm initiated?	1
Positive disclosure about family harm made on first	When the initial conversation about family harm occurred, was a positive disclosure of family harm made?	1

conversation (yes; no; not clear from the notes)		
For each whānau were any family harm incidents known of during their engagement with Start Well, either through disclosure or information from another source (e.g. a POL) (yes; no)	How does positive disclosure rate at first conversation relate to what later became known about the degree to which each whānau was affected by family harm?	1
Number of visits to a GP due to a mental health concern, for each WCTO period and following any unscripted conversations about psychological distress, and how were these attempts initiated (in a WCTO appointment; raised by whānau; raised by Start Well clinician; raised by GP; not clear from the notes)	On how many occasions were attempts made to address mental health/psychological distress via a GP, and how were these attempts initiated?	2
Number of attempts to access support through a DHB mental health service, for each WCTO period and following any unscripted conversations about psychological distress, and how these attempts were initiated (in a WCTO appointment; raised by whānau; raised by Start Well clinician; not clear from the notes)	On how many occasions were attempts made to address mental health/psychological distress via DHB mental health services, and how were these attempts initiated?	2
Response from DHB mental health service (ongoing/longer-term service not offered; offered and rejected; offered and accepted; not clear from the notes)	When contacted, what response did DHB mental health services provide?	2
Reason for ongoing/longer-term care not to be offered by DHB mental health service (free text)	Where ongoing/longer-term care was not offered by a DHB mental health service, what was the reason?	2
Dates of all unscripted conversations about psychological distress (outside of WCTO	On how many occasions did Start Well clinicians and whānau have unscripted conversations (outside of WCTO appointments) about psychological distress?	2

appointments) for each whānau		
Source of unscripted conversation about psychological distress (raised by clinician; raised by whānau; not clear from the notes)	How were unscripted conversations about psychological distress initiated?	2
Positive disclosure about psychological distress made for each unscripted conversation about psychological distress (yes; no; not clear from the notes)	On how many occasions was a positive disclosure of psychological distress received during an unscripted conversation about psychological distress?	2
Whānau who used maternal mental health crisis respite facilities, reason/s for use, and number of days used	How many Start Well whānau used maternal mental health crisis respite facilities, for how long and for what reason/s?	2

Note. 'Report of Concern' (ROC) is the term used by OT to describe an official approach to them to share concerns about a child or young person's wellbeing. As at the time of writing this approach may be made by anyone, and is made either by phone call to an OT call centre, or by emailing a form to OT. A ROC is essentially treated as an allegation, which at the point of report is not yet substantiated. Once received, a ROC is assessed by OT as either requiring further action/investigation or not. Should it be assessed as requiring further action, OT will open an investigation. A description of this investigation and its possible implications is beyond the scope of this study; suffice it to say here that a ROC is one possible indication of harm to children, but has the limitation of not yet being considered substantiated by the country's official child protection agency. The present study did not have access to all ROC's received by OT for Start Well whānau. The ROC's referred to in the case notes (and therefore included in data collection) are only those known to Start Well. Usually, Start Well knew of the ROC because it was a Start Well clinician who made the report. On some occasions Start Well knew about the ROC because OT informed them, usually on request. On

a small number of occasions (10% of all ROC's known to Start Well) the ROC was made by another agency, who then informed Start Well.

Appendix B: Data Definitions

Definitions applicable to all outcome areas

First contact/engagement date was defined as the first date on which a call, text, email or face to face contact was made with a whānau. An attempted contact with no response from the whānau was not counted.

Definitions related to family harm

A family harm incident was considered to have occurred if one or more of the following forms of violence could be identified from the notes.

A person was considered to have been 'involved' in the incident if they were physically present in the location at the time of the incident, even if they were in another room (e.g. a child sleeping in a bedroom).

Forms of incident:

- Note that, for our purposes, abuse was considered to have been perpetrated by a person under the age of 18 if that person was the child's parent, or acting in the role of parent (e.g. a partner of a parent).

- Child physical abuse: "any behaviour which results in physical harm to a child" (Child Youth and Family, 2011, p. 12).

- Child sexual abuse: "any act where an adult or a more powerful person uses a child or young person for a sexual purpose. This may be 'consensual' or not… sexual abuse may include physical sexual acts, or could be things like exposure to pornographic material and internet sites, or sexual conversations. It often begins with (and includes) some form of grooming, which is when the person prepares the child for sexual contact by lowering their inhibitions and gaining their trust" (Child Youth and Family, 2011, p. 12).

- Child emotional abuse: "a pattern of behaviour where the child is rejected and put down. They may be isolated, constantly degraded and criticised, or negatively compared to others" (Child Youth and Family, 2011, p. 12).

- Neglect of child: "physical neglect (not providing the necessities of life like a warm place, enough food and clothing), neglectful supervision (leaving children home alone, or without someone safe looking after them during the day or night), emotional neglect (not giving children the comfort, attention and love they need through play, talk, and everyday affection), medical neglect (the failure to take care of their health needs), educational neglect (allowing chronic truancy, failure to enrol children in school, or inattention to special education needs)" (Child Youth and Family, 2011, p. 10).

- Adults arguing in presence of child: verbal altercation between adults (including teenage parents) which results in a police and/or OT report, where a child was known to be in the same building. If the reason for a ROC was a police contact record (i.e., a police report of a family harm incident sent to OT), it was assumed that an argument took place in the presence of a child.

- Adult physical altercation in presence of child: physical altercation between adults (including teenage parents), where a child was known to be in the same building. If the reason for a ROC was a police contact record, it was assumed that an altercation took place in the presence of a child.

- Adult sexual assault in presence of child: sexual assault between adults (including teenage parents), where a child was known to be in the same building. If the reason for a ROC was a police contact record, it was assumed that an assault took place in the presence of a child.

- Child hospital admission for non-accidental injury (NAI): medical report that a child's admission to hospital was the result of a non-accidental injury.

- Note that, for our purposes, partnership in a romantic sense (as referred to in the following definitions) is as defined by Work and Income New Zealand (2019): A person is considered to be a partner of a victim if the pair are either married, in a civil union, or in a de facto relationship, AND have a degree of companionship such that the pair are committed to each other for the foreseeable future, and are financially dependent on each other. A person is considered to be an ex-partner if they were formerly a partner of the victim (as per the definition above), but are no longer.

- Partner physical violence: has occurred to a victim if s/he has been slapped, or had something thrown at him or her; pushed, shoved, or had his or her hair pulled; hit with a fist or something else that could hurt; kicked, dragged or beaten up; choked or burnt; threatened with or had a weapon used against him or her (Fanslow & Robinson, 2004).

- Partner sexual violence: has occurred to a victim if s/he has been physically forced to have sexual intercourse; had sexual intercourse because s/he was afraid of what his or her partner might do; or been forced to do something sexual s/he found degrading or humiliating (Fanslow & Robinson, 2004).

- Partner emotional violence: "verbal attacks (insults, humiliations), control and power (isolation from family and friends, impeding decision-making, economic abandonment), pursuit and harassment, verbal threats (victim and family's life threatened, threats regarding the custody of children, intimidating phone calls) and blackmail (economic or emotional)" (Pico-Alfonso, 2005, p. 184).

- Partner coercion (intimidation including threats, jealous surveillance, stalking, shaming, degradation, destruction of property and/or violence directed at children and/or pets), and/or control tactics (isolation including restricting the victim's contact with family, whānau, friends and networks of support, monitoring their movements and restricting their access to information and assistance; deprivation, exploitation and micro-regulation of everyday life including limiting access to survival resources such as food, money and cellphones, and/or controlling how the victim dresses) (Family Violence Death Review Committee, 2017).

- Ex-partner physical, sexual or emotional violence, or coercion and/or control: as per the above definitions, but where the parties involved are ex-partners rather than current partners (as per the above definition).

- Intrafamilial violence: "all forms of abuse between family members other than IPV or abuse of children by adult family members or parents. It includes the abuse/neglect of older people violence perpetrated by a child against their parent, violence perpetrated by a parent against an adult child and violence among siblings" (Family Violence Death Review Committee, 2017, p. 108). Note that, for our purposes, this includes violence of all forms between persons who regularly live in a household together even if they are not related, AND between persons who are related but do not regularly live in a household together.

- Community violence impacting on whānau: incidents where discrete incidents of violence occurring in the local neighbourhood are seen to directly impact upon whānau.

- <u>Gang violence impacting on a whānau:</u> discrete incidents of violence perpetrated by a gang in the course of their 'gang business' which impact directly upon the whānau.

<u>Protective action taken</u> within an incident: This definition was of my own construction, in an attempt to allow identification of a more strengths-based variable. 'Protective action' was considered as having been taken where the notes made it clear that an individual had made an attempt to de-escalate or bring an end to the incident of family harm, without causing further harm in doing so. This role could be assigned whether or not the person was successful in their attempt, as long as they did not cause further harm. This may have included help-seeking behavior such as phoning police, if the intent appeared to be to bring an end to the incident. Where an incident was averted completely, the reader must have been able to point to evidence of the likelihood of a specific family harm incident had the protective action not been taken.

A <u>documented conversation with a whānau about family harm</u> was considered to have occurred if a case note detailed a conversation between a clinician and any member of the whānau, in which:

- Family harm in any of its forms (see forms definitions above) was mentioned;

- Regardless of whether the clinician or the whānau raised the issue;

- Regardless of the length of the discussion.

- This could include a screening conversation initiated by a Start Well clinician, where the whānau member denied any form of family harm.

- If it was not clear whether a conversation occurred or whether the case note only reflected the clinician's observations, this was not counted as a conversation.

A <u>first documented conversation with a whānau about family harm was considered to have resulted in a positive disclosure of family harm</u> if the person disclosed an experience of family harm fitting any of the definitions listed in this guide, currently or historically.

Definitions related to psychological distress

A <u>documented conversation with a family about psychological distress </u>was considered to have occurred if a case note detailed a conversation between a clinician and any member of the whānau, in which:

- Symptoms of mental unwellness (including but not limited to depression, anxiety, suicidality, paranoia, delusions) were discussed;

- And/or a desire for and/or methods of improving or maintaining psychological wellbeing were discussed;

- Regardless of whether the clinician or the whānau raised the issue;

- Regardless of whether the conversation explicitly referred to any members of the whānau;

- Regardless of the length of the discussion.

- This could include a screening conversation initiated by a Start Well clinician, where the family member denied any symptoms of mental unwellness.

- This could include conversation about holistic determinants of psychological wellbeing, as long as some link was made to psychological wellbeing or distress.

- If it was not clear whether a conversation occurred or whether the case note only reflected the clinician's observations, this was not counted as a conversation.

A <u>documented 'unscripted' conversation with a whānau about psychological distress was considered to have resulted in a positive disclosure of psychological distress</u> if the

whānau disclosed symptoms of mental unwellness (including but not limited to depression, anxiety, suicidality, paranoia, delusions), for themselves or for someone in their whānau currently or historically.

Response from mental health service was categorised as follows:

- 'Ongoing/longer-term service not offered': notes indicated that the DHB mental health service did not offer ongoing service/longer-term care beyond crisis care or consultation with the referrer. This included situations where the service did initially intend to offer ongoing/longer-term service (e.g. therapy, case management, medication, therapeutic group work), but appeared to close the file because the whānau did not attend an appointment.

- 'Offered and rejected': notes indicate that the DHB mental health service did offer service beyond short-term crisis care (e.g. therapy, case management, medication, therapeutic group work), but the whānau did not wish to take up the offer.

- 'Offered and accepted': notes indicated that the DHB mental health service did offer service beyond short-term crisis care (e.g. therapy, case management, medication, therapeutic group work), and the whānau accepted the offer, attending at least one appointment.

- Where one of the above three situations could not be clearly established from the notes, 'not clear from the notes' was selected.

Appendix C: Results of Inter-Rater Reliability Experiments

Table 2

Inter-Rater Reliability Agreement Rates by Variable of Interest

Results domain	Variable	Agreement rate between raters
Family harm	Are the same dates recorded for 'engagement' date?	100%
	Are the same dates recorded for the first documented conversation about family harm?	71%
	Is the same conclusion drawn about how the first family harm conversation was instigated?	86%
	Is the same conclusion drawn about whether first family harm conversations resulted in a positive disclosure?*	100%
	Are the same dates recorded for family harm incidents?	93%
	Was there agreement regarding whether 'protective action' was taken during a family harm incident, and who took it if so?*	96%
	Are the same forms of violence selected for each family harm incident?*	100%
	Are the same ROC's recorded (same dates)?	100%
	Is the same source recorded for each ROC?*	100%
	Are the same forms of incident selected for each ROC?*	86%
Psychological distress	Are the same dates recorded for 'unscripted' conversations about psychological distress (i.e., that took place outside of WCTO appointments)?	89%
	Is the same conclusion drawn about whether 'unscripted' conversations about psychological distress resulted in a positive disclosure?	81%
	Was the same conclusion made about whether or not a GP appointment was made following an 'unscripted' conversation about psychological distress?*	100%
	Was the same conclusion made about whether there was a new approach to DHB mental health services following an 'unscripted' conversation about psychological distress?*	100%
	Was the same conclusion made about whether the DHB mental health service offered ongoing/longer-term care, and whether this was accepted by whānau or not?*	100%
	Are the same number of approaches to GP and DHB mental health services recorded, and the same DHB	100%

	mental health service response, following a WCTO check?

Note. For variables marked with an asterisk, agreement rate was calculated for those instances in which the same incidents (i.e., same date) had already been identified by both raters, i.e., agreement rate for these specific variables was not further penalised where there was disagreement on incident dates.

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