



Thriving Communities Healthy Families

Final Evaluation Report

**Theresa Doherty
Richard Eccleston
Institute for the Study of Social Change
University of Tasmania**

May 2016

Contents

Executive Summary.....	3
Key Policy Learnings for implementing Place Based Initiatives.....	4
1 Introduction.....	5
2 Place Based Initiatives	6
3 Project Governance	6
3.1 Service Agreement.....	7
3.2 Memoranda of Understanding	7
3.3 Project Reference Group.....	7
4 Planning and Evaluation Activities.....	8
4.1 The Thriving Communities Healthy Families Project Plan.....	8
4.2 Framework for Evaluation.....	8
4.3 Overarching Evaluation Plan	8
4.4 Theory of change.....	9
4.5 Evaluation Methodology	11
5 Results	11
5.1 Outputs	11
5.2 Short Term outcomes.....	15
5.3 Medium Term Outcomes	16
5.4 Long term Outcomes.....	18
5.5 Evaluation Capacity Building	18
6 The TCHF Projects.....	19
6.1 Being Place Based.....	19
6.2 Derwent Valley Community House	22
6.3 Eastern Shore Community House (East Devonport)	26
6.4 Maranoa Heights Community House.....	30
6.5 Northern Suburbs Community House (Rocherlea)	34
6.6 St Helens Neighbourhood House	38
7 Summary of Findings	42
7.1 Program Design and Delivery.....	42
7.2 Evaluation Elements.....	44
8 Policy Learnings	46
8.2 Building evaluation capacity	50
9 Concluding Comments.....	50
10 References	51
11 Appendices	53
11.1 Appendix A-project timeline	53
11.2 Appendix B- Evaluation Plan 2015	54
11.3 Appendix C- Key Informant Interview Questions.....	55
11.4 Appendix D- Mid Term Evaluation Report 2015	59
11.5 Appendix E - Data definitions for Activity Reports.....	60

Executive Summary

The Thriving Communities, Healthy Communities pilot project has been a successful Place Based Intervention. Neighbourhood Houses are well positioned to undertake place-based work because it aligns well with their existing community development model of practice. All five projects demonstrated the key elements of place based program design and implementation; spatial and social targeting, program flexibility and local autonomy, joined up working and capacity development. Other elements such as specific new community led governance structures and adequate lead times were not fully demonstrated but this is due to the relatively short project implementation timeframe.

All five projects met their key objectives of engaging with disenfranchised, hard to reach families and building or strengthening partnerships with local support services and organisations. All projects engaged with evaluation capacity building.

While each project is unique, commonalities have emerged in approaches to engagement with 'at risk' families and partner organisations, which may be replicable across the wider neighbourhood house network. The most successful strategies for engaging with families were peer-to-peer initiatives, one on one outreach activities, being a presence in the community and group work. Having outreach capacity and building strong personal relationships were key elements of engaging with other organisations. Underpinning all engagement with families or organisations is time and trust.

The timeframe for a project of this complexity was inadequate. In effect the first year of the program was focussed on building trust and relationships leaving only 18-20 months for program implementation. This is not sufficient to embed changes in how services work with the disenfranchised and to build a long term focus.

Despite the short time frame, all projects were able to demonstrate positive impacts on the families they worked with. All projects reported that families had better knowledge and awareness of available services and were more confident in accessing services. Families were also less socially isolated. Specific projects reported specific outcomes for families, for example reengaging in education, training and the workforce or more positive parenting practices. Within such a short time frame it is not possible to determine whether these impacts will spread to the wider disadvantaged community. There were conflicting views as to whether or not changes were sustainable without some ongoing program support.

All projects reported enhanced collaboration with local service organisations and in some cases new important partnerships were forged with local schools which augur well for future place based initiatives. An important aspect of successful joined up working was organisations working cooperatively and playing to their particular strengths rather than attempting to be all things to all clients. Projects also reported positive changes in how neighbourhood houses were perceived by other community organisations. They believed the Thriving Communities project had raised the profile of the houses and other organisations were now more aware of the range of services and professional expertise provided by houses. Much of the success in engagement with organisations can be attributed to the flexibility and adaptability of the Healthy Families' Worker role.

The complex nature of community development approaches across different community settings presented challenges for program design, implementation and evaluation. Despite

this, NHs have demonstrated their expertise and adaptability while juggling multiple demands of determining community priorities, engaging with and responding to disenfranchised people, as well as developing their own evaluation capacity.

Key Policy Learnings for implementing Place Based Initiatives

- The complex and evolving nature of ‘at risk’ and disenfranchised populations require flexible and responsive services, therefore PBIs need to respond to changing needs.
- Multiple strategies can be used to successfully engage with ‘at risk’ and disenfranchised populations and different strategies can be used at different stages of engagement. However, outreach capacity and peer networks are key strategies for engaging with the hard to reach and sharing information.
- PBIs require sufficient lead-time to build trust and relationships with the community and other service organisations. There is need for a permanent flexible (outreach) resource to build relationships and facilitate the process.
- A minimum of five years program implementation would support full engagement by the community and local services into PBIs.
- Successful delivery of PBIs requires stable, dependable and predictable policy, political commitment and adequate funding.
- Comprehensive evaluation of PBIs requires methodologies that can clearly demonstrate causality, attribution and cost effectiveness. This requires a long-range view, sufficient investment and support to fully embed an evaluation culture within community service organisations.

1 Introduction

In May 2013 the Minister for Health announced \$580,000 to implement a place based health promotion intervention for at risk, disenfranchised families with young children in Tasmania. Population Health, Department of Health and Human Services entered into a service agreement with the then Tasmanian Association of Community Houses (TACH), now named Neighbourhood Houses Tasmania (NHT), to broker the funds and manage the project. Thriving Communities – Healthy Families (TCHF) commenced in July 2013 with an intended six months design and planning stage to be followed by two years of program implementation.

Following an expression of interest (EOI) process, five Neighbourhood Houses (NH); Maranoa Heights (Kingston), Derwent Valley, St Helens, Northern Suburbs (Rocherlea) and Eastern Shore (East Devonport) were funded to design and implement place-based projects in their communities. Each appointed a part time Healthy Families Worker (HFW) and received a small amount of additional resources (\$3000) to be used in location specific programs.

In keeping with the place-based ethos, NHs were given very broad directions in which to frame their specific projects. They were asked to

‘develop a project that will build on our [NH] existing strengths to contribute to improved health and wellbeing by engaging ‘at-risk’ families of young children; working effectively in partnership with others; and participating in capacity building initiatives that aim to build healthy settings for living, learning and working.’ (REF)

NHs were seen as ideal sites to implement the TCHF program because they already embodied a place based approach to working with their communities. That is, they were locally focused and working in a community development framework. As well as focussing on capacity building for their communities, the TCHF project also included a planning and evaluation capacity-building component for the Healthy Families workers and house coordinators. This was in recognition of relatively low levels of formal evaluation practice in small community services organisations and that NHs had few resources for planning and evaluation training. It also pre-empted planned changes to an outcomes framework for purchasing community services by the Tasmanian government.

The successful implementation of this project hinged on a number of important assumptions:

- Firstly, NHT had the resources and knowledge to auspice this type of project.
- Secondly, NHs can utilise the project resources to engage ‘at risk’ families and this engagement will lead to increased social connection within the community for those families.
- Thirdly, through collaboration and partnership with government and non-government organisations, communities are empowered to influence decisions about resources and services for local families.
- Finally, in terms of planning and evaluation, that participating NHs were supported by NHT and through the partnership with UTAS to plan, implement and collect evaluation data about local interventions, and this data was relevant and ‘fit for purpose’ to inform future decision making on PBIs (HGPRG 2014).

2 Place Based Initiatives

Place-based approaches draw on a social determinants of health model which recognises that health outcomes and health behaviours are shaped by social, economic and environmental factors (Dahlgren and Whitehead, 1991) and that these outcomes are, in part, mediated through 'place'. Australians living in socio-economically disadvantaged areas experience poorer outcomes across a range of health status indicators, including mortality, morbidity, life expectancy, health risk behaviour and self-assessed health (ABS 2012). Families with young children, living in socially disadvantaged areas, are more likely to experience social exclusion, family relationship and parenting challenges, and overall poor health and wellbeing than families living in more advantaged places.

Place based policies have gained popularity as a means to address the complex interplay of factors which impact on health and wellbeing of a particular populations (Rushton, 2013, Wilks et al, 2015) and are seen as one platform to reduce health inequity. They target communities rather than individuals or high-risk groups, and recognise that as localities differ, '...each will raise unique solutions' (CCCH 2012, 5). Place based approaches value community-specific definitions of health needs and solutions and governance models. They build community engagement and capacity to facilitate individual, systems and cultural changes that promote health and wellbeing in situationally and culturally relevant ways (Cummins et al. 2007). To do so, they enlist the disadvantaged population to challenge the basis of their marginalisation. They make a location knowable and manageable through localised decision making. Place base interventions therefore represent a '...convergence between economic discourses, and discourses of inclusion, urban health and public health...within social policy' (Rushton 2013, 109).

The NH model aligns with PBI in operating in a responsive way to the unique needs of each location and being governed by community-led management committees.

PBIs are concerned with both location and the people within the location (Wilks et al, 2015, Griggs et al 2008, Katz 2004) and usually focus on areas of entrenched disadvantage. How areas are represented, delineated administratively, and how services and infrastructure are distributed, are the outcomes of social relations and power struggles within society. 'Places, spaces, flows and circuits are socially constructed, temporarily stabilized in time/space by the social glue of norms and rules, and both enable and constrain different forms of behaviour' Cummins et al. (2007, 125).

The TCHF with its focus on building capacity, reconnecting disenfranchised families to the community and organisations working more collaboratively has elements of both people and place but the main focus is on people- the at risk and disenfranchised.

3 Project Governance

The TCHF project utilised a number of governance instruments and mechanisms including a Service Agreement between NHT and DHHS, individual Memoranda of Understanding (MOU) between NHT and participating NHs and a high level Project Reference Group with key stakeholder representation. The TCHF project coordinator reported to the NHT executive officer and was the chief liaison between NH project workers and the UTAS evaluation team. NHs were required to provide individual project and evaluation plans to NHT and thereafter a

six monthly progress report. NHT was required to submit six monthly progress reports to DHHS as per conditions of the service agreement. Population Health (now known as Public Health Services) managed the service agreement on behalf of DHHS.

Each Project sat within the community-led model of governance integral to the NH model. HFWs were operationally responsible to the House Coordinator who also provided overall project direction.

3.1 Service Agreement

The Funding Agreement between DHHS and NHT identified a set of key performance indicators to monitor

- Engagement of NHs with the TCHF project.
- Engagement of families of young children (the target group) with TCHF projects.
- Partnerships functioning between NHs and relevant stakeholders.
- Participation by NH in capacity building initiatives to build healthy settings for living, learning and working in their neighbourhoods.

3.2 Memoranda of Understanding

The MOU articulated the roles and responsibilities of NHT as the allocator of the TCHF funds and the NHs as the recipients of those funds. NHT was responsible for the Grant Agreement with the Tasmanian Government, the appointment of the part-time project coordinator, support of the participating houses, overall coordination, implementation and evaluation of the TCHF. Further NHT took responsibility for coordination of the reference group and working collaboratively with key stakeholders.

Each NH was responsible for the grant agreement with NHT, appointment of the part-time Healthy Families Worker, coordination and implementation of the local level project, outreach and engagement with target group families and collaboration with project partners and other participating NHs. The MOU also included statement of agreements for communication and decision making, dispute resolution and termination and for copyright and intellectual property. MOUs were signed in February/March 2014.

3.3 Project Reference Group

NHT convened the Project Reference Group (PRG) and membership comprised NHT, DHHS, Tasmanian Medicare Local (TML), Tasmanian Early Years Foundation and the University of Tasmania. A representative of the participating NHs joined the PRG following the recruitment of the Healthy Families Workers. The PRG agreed to meet at least three times per year.

The project reference group held one formal meeting in April 2015 and ongoing communication between NTH and DHHS was maintained through receipt of Service Delivery Reports in February, August and December 2015.

NHT and UTAS engaged in an ongoing albeit informal dialogue throughout the project.

4 Planning and Evaluation Activities

4.1 The Thriving Communities Healthy Families Project Plan

The TCHF project coordinator developed a draft project plan and timeframe for key project milestones in late 2013/early 2014. This included the recruitment of Healthy Families Workers and completion of specific project and evaluation plans for each participating house. The initial timeframe had envisaged all project workers commencing work by January 2014. Due to delays in recruitment and appointment processes for HFW and a project coordinator and the signing of MOUs, which was not complete until March 2014, there was additional time pressure placed on houses to deliver project and evaluation plans. One house replaced the HFW after a three-month probation period, which caused further delays in project planning for that house. Please see Appendix A for the projected and actual project timelines.

4.2 Framework for Evaluation

The original TCHF evaluation framework took a two tiered approach. An overall evaluation plan for the project and individual house specific evaluation plans were developed in a collaborative action learning process between UTAS, NHT and the five NHs. Following completion of the mid project evaluation report (Doherty and Eccleston 2015) in March 2015, the evaluation plan was reviewed and an amended plan was agreed upon. Please see Appendix B.

4.3 Overarching Evaluation Plan

The purpose of this evaluation is to test the efficacy of a place-based approach for supporting at risk populations in the pilot communities, build the evidence base for place based policy interventions and inform future place based program development and implementation.

Therefore the first level of evaluation examines the TCHF as a whole and aims to answer a number of questions:

- Why work with these ‘at risk families’?
- How well did the engagement strategies work?
- How were needs/priorities determined?
- How did NHs decide on what activities to implement?
- To what extent did the families engage in these activities/programs?
- Were these the families the project intended to reach?
- Were families satisfied with programs (how well were needs met)?
- Did anything change for the families (as a result of the TCHF program)?
- Which partners engaged in the process?
- Did any new models of governance emerge?
- Did communities increase their capacity to work in a place-based way?

The next level of evaluation uses a comparative evaluation approach which seeks to determine what worked in what circumstance to effect positive change within the at risk families in the different communities and to what extent this is transferable to other at risk communities. Each of the pilot projects can be thought of as a case study trialling different methods to engage different groups and implementing different strategies to effect change. Where local circumstances support a reasonable comparison, the evaluation will examine

- Differences in short to mid-term outcomes for different client groups.
- How well partnerships worked.

This evaluation will also use Wilks et al (2015) framework to critically assess the place based elements of the five TCHF projects.

Where the mid project evaluation report focussed mainly on project implementation and outputs,(see Appendix D) this final report will focus on the short and medium term outcomes agreed upon in the program logic guiding the overarching evaluation plan.

4.4 Theory of change

Best practice evaluation of PBIs recommends a well-articulated theory of change or program logic that ‘provides clear and explicit expectations about what would be the short, medium and longer term outcomes to be anticipated from the place-based initiative, prior to the intervention being implemented’ (Wilks et al, 2015, 17). Figure 1 shows the theory of change underpinning the TCHF and in Figure 2; this is represented as a program logic model, which identifies the aggregate outputs and outcomes for the project. As can be seen the TCHF had three objectives; engaging with at risk families, working in partnership with other organisations and developing planning and evaluation capacity in the participating NHs.

Figure 1 ‘If and Then’ statement Thriving Communities Healthy Families Project

<p>IF funding is made available to Neighbourhood Houses to employ Healthy Families workers (HFW) THEN, these HFWs will develop strategies to <i>engage</i> with ‘disenfranchised at risk families’ in five socially disadvantaged locations.</p> <p>IF the engagement strategies are successful, THEN at risk families will connect with the NH who will work with them to identify their HWB priorities/needs.</p> <p>IF the NH, local community organisations and services and families work together using place based principles, THEN relevant programs can be implemented to address families’ needs.</p> <p>IF the at risk families participate in these programs, THEN they will develop capacity, learn new skills and be more confident. AS A RESULT at risk families will re-engage with their communities, feel supported and safe in their communities, have better access to relevant HWB services and have improved HWB outcomes.</p> <p>IF the UTAS evaluation team work with the NH to build planning and evaluation capacity, then NH will have skills and expertise to evaluate both program performance and community outcomes.</p> <p>IF the evaluation can demonstrate that place based approaches improve outcomes for disadvantaged populations, THEN community based organisations and government can incorporate these approaches into future program design and implementation.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> • service or program development based on identified needs can be adequately funded for successful delivery • The investment to build evaluation capacity in the five Healthy Families Workers will be retained by the Houses beyond the employment timeframe of those Workers
--

Figure 2 Program Logic Model – Thriving Communities Healthy Families

INPUTS	OUTPUTS	TARGET	Short Term OUTCOMES	Medium Term OUTCOMES	Long Term OUTCOMES
			In scope	Partially in scope*	Not in scope*
DHHS Project Funding NHT Board NHT EO (John) TCHF project coordinator) Healthy Families Workers (x6) NH managers (x5) Existing community networks/partnerships in each pilot site NH pilot site specific services / programs TCHF Reference Group UTAS Evaluation team Population Health Funding Agreement Manager	State-wide project and evaluation plans NH develops project and evaluation plans (X5) NH identifies ‘at risk’ families NH runs local engagement strategies NH has mechanisms to consult with at risk families to identify priorities NH/partners/families develop PB health promotion activities NH engage partners in TCHF projects New /enhanced community partnerships/networks are created Evaluation planning and evaluation workshops and training Final project and evaluation report	‘at risk’ disengaged families of children 0-12 years Partner organisations HFW and NH	At risk disengaged families <ul style="list-style-type: none"> are aware of NH attend TCHF activities/programs gain skills and knowledge have increased capacity and confidence develop peer leadership skills have knowledge and awareness of services in their neighbourhood have a key role in program governance Partner organisations <ul style="list-style-type: none"> have knowledge and awareness of TCHF projects improve the connectedness of the local service system have a positive attitude to at risk families are responsive to local priorities/needs HFW engage in evaluation activities	At risk families <ul style="list-style-type: none"> have improved access to programs and services have increased capacity to articulate their HWB priorities are co-producers of HWB programs Communities have greater capacity to meet needs of at risk families’ Community based services/organisations work together to meet the needs of at risk families Place based approaches inform NH and partner organisations policy and programs Lay knowledge (community priorities) inform NH and partner organisations policy and programs HFW have the skills and confidence to perform evaluation activities	At risk families are safe and supported by the community Stronger families with strong attachments Parents and children have better HWB outcomes

*Implementation timeframe of TCHF does not allow for mid and long term outcomes to be fully delivered

4.5 Evaluation Methodology

The evaluation used a mixed methods approach employing both quantitative and qualitative research methods.

It draws on both quantitative and qualitative data sources

- NHT and NH planning documents.
- NH project progress (activity) reports submitted in August 2014, February 2015, August 2015 and December 2015.
- NHT Service Delivery Reports July 2014, February 2015, August 2015 and December 2015.
- Round 1 Semi structured interviews (x 12) with NH coordinators, Healthy Families Workers and NHT employees directly involved in the management and implementation of the TCHF conducted by UTAS during December 2014 to January 2015.
- Round 2 semi structured interviews (x8) with NH coordinators, Healthy Families Workers in December 2015.
- Semi structured interviews with Key Informant stakeholders (x7) `nominated by participating NH during December 2015-January 2016. (See Appendix C for interview questions)

Quantitative data were collated and analysed using Microsoft excel. Semi-structured interviews were transcribed and analysed thematically using NVivo software.

Data were synthesised and aggregated to report against the short and mid-term outcomes identified in the program logic process.

5 Results

5.1 Outputs

Outputs were reported in detail in the interim Evaluation Report (see Appendix D) (Doherty and Eccleston 2015) so these results will be summarised only this report.

All projects developed criteria to identify at risk families and these are detailed in the project specific reports in Section 6 of this document. On average 95% of people who engaged with the TCHF fit the criteria of 'at risk' (Service Delivery Report Dec 2015).

All projects used a range of strategies to engage with families. As the projects matured, it became evident that engagement strategies broadly fell into four categories

- Peer to peer
- One on one (e.g. through individualised support from HFW includes outreach work)
- Being a presence in the community (includes outreach work)
- Accessing through group work (e.g. HFW facilitating, participating or assisting with groups)

NHs reported on the engagement strategies they used, against these categories, in their final two activity reports. All Houses used each of strategy types at some stage throughout the project implementation.

As reported in the mid-term evaluation, it was extremely difficult to make any meaningful comparisons between the number of families engaging because there were different interpretations ‘at risk’ and engagement and there was no way to distinguish the *total* number of families engaging as many attended multiple events. In an attempt to standardize the total number of families both engaging and the number of new families engaging, each quarter, data definitions were agreed for the final two activity reports. (Please see Appendix E for data definitions).

Irrespective of the interpretation issue, it is clear that the number of families engaging with the projects steadily increased as the projects matured. Some caution must be used in interpreting the actual numbers as in some cases they reflect intensive one on one interventions with families and in other cases they represent group work where many families are involved in a health promotion activity such as cooking classes or peer group work. It is not possible to determine if families engaged with multiple different strategies from the available data. Table 1 shows the total number of families each house reported as engaging with the TCHF for each quarter.

Table 1 Total Number of Families Engaged in the TCHF Project s

Total # families engaged in project				
House	Jan-June 2014	July-Dec 2014	Jan-June 2015	July-Nov 2015
Maranoa Heights	7	25	69	101
Derwent Valley	19	29	70	112
St Helens	20	120	120	169
Rocherlea	No data	107	199	256
East Devonport	12	110	117	160

Source – Service Activity Reports 2014/15

Houses also reported the number of *new* families engaging with the project each quarter. Table 2 shows that the numbers fluctuated considerably but this is likely a reflection of the range of different activities conducted at different times throughout the year, for example school holiday programs. What is clear is that in the latter half of the project implementation at least 400 new families engaged with the TCHF.

Table 2 Total Number of New Families Engaged in the TCHF Project s

Total # new families engaged in project				
House	Jan-June 2014	July-Dec 2014	Jan-June 2015	July-Nov 2015
Maranoa Heights	7	22	42	31
Derwent Valley	19	29	42	42
St Helens	20	75	50	49
Rocherlea	No data	107	No data	57
East Devonport	12	110	45	50

All houses successfully engaged with partner organisations throughout the project. Partnerships can have a number of meanings. It can be a financial arrangement between funders and recipient or it can be more about a relationship where interaction, participation engagement and trust are important (Bernstein and Tolley 2011). Depending on the specific

project and at different times during the project implementation, the NHs engaged with a large number of partners or focussed on a small number of key partners to deliver programs and activities. Table 3 shows the number of new partner organisations involved with each NH in the TCHF for each quarter. Overall, NHs partnered with 93 organisations through the Project.

Table 3 Number of new partner organisation engaged in the project during each reporting period

# new partner organisations each reporting period				
House	Jan-June 2014	July-Dec 2014	Jan-June 2015	July-Nov 2015
Maranoa Heights	7	1	1	1
Derwent Valley	7	2	8	6
St Helens	10	5	17	2
Rocherlea	4	5	1	1
East Devonport	7	7	1	0

The overarching evaluation plan specified outputs and key evaluation questions. Table 4 shows these questions and summarises the results.

Table 4 Outputs, key evaluation questions and results

Outputs	Key evaluation questions	Result
NH project plans and evaluation plans developed (x5)	<p>Did NH develop project specific evaluation plans?</p> <p>Did NH project staff feel they had enough resources and support for planning and evaluation</p> <p>*Reported in mid-term evaluation</p>	<p>All NHs submitted evaluation plans</p> <p>Some Houses initially felt overwhelmed by the evaluation capacity development of the TCHF but nearing the time of project closure most felt they had gained useful and transferrable evaluation skills (Doherty et al 2015).</p>
NH identifies at risk families	<p>What criteria were used to define 'at risk'? Why?</p> <p>How similar/different were definitions of 'at risk'?</p> <p>Reported in mid-term evaluation</p>	<p>Houses used a range of criteria to identify at risk families drawing on local knowledge and understanding of their communities as detailed in Section 6 of this report</p> <p>Most houses had a core target of disenfranchised families with children under 12 but some had additional criteria such as women escaping violence or families at risk of becoming disconnected from their communities and in some houses, the target group evolved as the project matured.</p>
NH implements engagement strategy (x5)	<p>What engagement strategies did NH use to reach at risk families</p> <p>How well did they work?</p> <p>Reported in mid-term evaluation</p>	<p>A range of strategies used but falling broadly into four categories discussed above in Section 5.1.</p> <p>HFW report that new families have engaged in each reporting period, with at least 408 new families engaging in the final two reporting periods, as reported in Tables 2 above.</p>

NH/ partners / families develop place based HP strategies (X5)	<p>How well did programs match community priorities/needs</p> <p>To what extent did the programs incorporate place based approaches</p> <p>Reported in mid-term evaluation</p>	<p>Programs responded to identified project priorities and evolved to meet changing priorities as discussed in section 6.</p> <p>All programs demonstrated strong elements of PBI as discussed in Section 6 of this report</p>
Outputs	Key evaluation questions	Result
New/enhanced community partnerships/ network	<p>Did any new partnerships form</p> <p>Did any existing partnerships strengthen</p> <p>What governance structures were used to manage p/ships</p> <p>Reported in mid-term evaluation</p>	<p>All programs reported new and strengthened partnerships.</p> <p>93 new partners reported in Table 3</p> <p>No new formal governance structures emerged, however all projects used a range of informal governance arrangements or tapped into existing collaborative structures in their communities</p>
Partner organisations engage with project	<p>How many partner organisations are actively involved?</p> <p>Are there other relevant organisations that have not been engaged yet?</p> <p>Reported in mid-term evaluation</p>	<p>93 partners reported in Table 3</p> <p><u>New partnerships were developed as needed for the duration of the Project.</u></p> <p>Some houses identified partners whom they would like to have engaged with but this did not happen for a range of reasons. See discussion in Section 6</p>
<p>P&E Capacity building /support training</p> <p>UTAS evaluation focus</p>	<p>Did NH receive adequate P&E training and support</p> <p>Reported in mid-term evaluation</p>	<p>Two group evaluation workshops were held with all participating houses.</p> <p>In addition each HFW received individual P&E sessions with the UTAS evaluator and ongoing support from the NTH (TACH) program manager and house coordinator throughout project implementation.</p> <p>See mid-term report and Doherty et al 2015 for full discussions on the challenges of implementing ECB in small community based organisations.</p>

***see appendix D**

5.2 Short Term outcomes

The overarching evaluation plan specified a set short term outcomes and key evaluation questions. These are the outcomes that a project could reasonably expect to deliver in 12-18 months of implementation which in effect was the timeframe for program delivery for the TCHF. The project was officially launched in mid-2013 with a six month establishment phase, and the recruitment of Healthy Families Workers was completed by April 2014 which impacted on the allocated project planning phase and program implementation. The projects officially concluded in December 2015, which effectively allowed around a maximum of 20 months for project delivery.

Overall, the TCHF delivered on its outcomes; there was widespread awareness of the TCHF amongst at risk families and partner organisations and at risk families engaged with the program. Programs responded to community priorities and there were demonstrable positive impacts on client knowledge and awareness of services as well as increased confidence and capacity to articulate needs and access the supports to meet those needs.

Table 5 shows the short term outcomes, key evaluation questions and summarises the results

Table 5 Short Term Outcomes, key evaluation questions and results

S T Outcomes	Key evaluation questions	Result
At risk families are aware of TCHF	How did families first hear about the TCHF project Are families telling others families?	Most families heard about the TCHF through engagement strategies used by the NH. However some families were referred to the TCHF via other service providers. In excess of 400 'new' families engaged with the NH across all five TCHF projects. Key informants provided clear evidence of word of mouth and social media spreading information about the TCHF within the community.
At risk families engage with HP activities	Are families interested in the programs/ activities? Do the programs /activities meet expressed needs?	Widespread engagement with programs (See Tables 1 and 2) 95% of clients fulfil 'at risk' criteria (NTH service Delivery report Dec 2015) All programs undertook community consultation activities and where relevant responded to changing priorities in their communities.
At risk families gain skills and knowledge, have increased capacity and confidence and develop peer leadership skills	What has changed for TCHF clients	All projects report increase in client confidence and capacity to express their needs. Specific projects have a particular focus on peer leadership and skills development but all reported increased confidence and capacity in the TCHF clients. (Please see Section 6 for full discussion

At risk families have knowledge and awareness of available services	Do at risk families know where to go and how to access services Reported in mid-term evaluation	All projects report clients have increased knowledge and awareness of available services
At risk families have a key role in program/project governance	How are clients involved in project governance How is lay knowledge informing program/project	New formal governance mechanisms involving community members did not evolve in the TCHF however all projects have elements of peer led action where at risk families have taken on leadership roles particularly in the ESCH project Lay knowledge is a strong component of the ESCH project
Partner organisations (PO) have knowledge and awareness of TCHF projects	What strategies are used to raise awareness and support amongst partner organisations? How successful has NH been in gaining support? Reported in mid-term evaluation	A range of communications strategies were used to raise awareness and support of partner organisations reported in mid-term evaluation All projects report generally positive support from other organisations with some notable exceptions in some areas as discussed in Section 6
Partner organisations (PO) have a positive attitude to at risk families	Have PO changed their way they view and interact with at risk families	Not reported specifically. However some projects report that POs are more flexible and responsive in the way they deliver services and are working more collaboratively with each other.
PO are responsive to local priorities/needs	How do local need/priorities inform PO planning?	Not reported specifically. However POs of some Projects reported an improved level of connection with local communities through engagement with TCHF

5.3 Medium Term Outcomes

Medium term outcomes are strictly outside the scope of the TCHF evaluation as they would be more likely to occur around 18 months to three years into program implementation. However there is some evidence that the TCHF has achieved some of these outcomes.

Families across all projects have greater knowledge of available supports and as capacity and confidence builds, they are more likely to take the next step and actually engage with the services they need.

Further all projects show very strong evidence of joined up working with partner organisations as discussed in detail in Section 6 of this report. This takes the form of sharing information and resources, collaborative planning and working in a complementary fashion where different organisations can play to their strengths.

Table 6 shows the medium term outcomes, articulated for the TCHF, the evaluation questions and results.

Table 6 Medium Term Outcomes, key evaluation questions and results

M T Outcomes	Key evaluation questions	Result
<p>At risk families</p> <ul style="list-style-type: none"> • have the skills and capacity to articulate their HWB priorities • Are co- producers of HWB/HP programs 	<p>Do at risk families know where to go for support? Reported mid-term evaluation</p> <p>Are families confident in dealing with organisations?</p> <p>How are families involved in designing/ implementing HWB/HP programs</p>	<p>Projects report that families have greater knowledge of the supports available and how to access them.</p> <p>Not measured directly but HFWs report that families in general have greater confidence and are more likely to ask for what they need or are more confident in negotiating with the schools around their children's needs.</p> <p>This ranges from being very involved as in the ESCH community leaders program project to being involved in consultation on program priorities and preferences.</p>
PO have knowledge and awareness of place based approaches	To what extent do partner organisations understand place based concepts and the potential impacts on how they do business?	Not measured.
Communities have greater capacity to meet needs of at risk families'	<p>How are community resources, skills and knowledge being used to support at risk families?</p> <p>Are there any peer support mechanism in place? Reported mid-term evaluation</p>	<p>Not measured</p> <p>All projects report some degree of peer to peer supports whether formal or informal</p>
Community based services/organisations work together to meet the needs of at risk families	<p>Have organisations changed the way they work with at risk families?</p> <p>Do organisations share information and resources?</p>	<p>Not measured directly but some evidence that organisations are more flexible in terms of where and how they deliver services.</p> <p>All projects show strong evidence of joined up working as reported in detail in Section 6. There is some evidence of organisations sharing information with prior client consent.</p>
Lay knowledge informs NH and partner organisations policy and programs	<p>Do organisations have sustainable systems/governance mechanisms to include client stakeholders in priority setting, program design and implementation?</p> <p>How do organisations access lay knowledge</p>	Not measured

5.4 Long term Outcomes

The TCHF articulated three long term outcomes

- At risk families are safe and supported by the community
- Stronger families with strong attachments
- Parents and children have better HWB outcomes

Measurement of these outcomes is beyond the scope of the present evaluation, however evidence from key informants in some projects suggests that the ‘at risk’ families who engaged with the TCHF initiatives are more socially connected and less socially isolated and have better communication skills and more positive parenting practices. These trends would underpin stronger families with stronger attachments, which in turn would impact positively on health and wellbeing.

5.5 Evaluation Capacity Building

There are a number of approaches, formal and informal, to building evaluation capacity in an organisation. They can include introduction to evaluation tools and training, workshops, technical assistance, mentoring, action research and consultation (Garcia-Iriarte et al, 2011, Preskill and Boyle 2008) which tend to focus on building individual rather than organisational capacity. Alternatively ECB can be built through collaborative evaluation experiences in complex real world situations which can build capacity in both individual and organisations (Huffman and Thomas 2008). Irrespective of the approach taken, ECB strategies should take into account the organisation’s characteristics, organisational resources, existing evaluation experience as well as the desired learning objectives. It is also important to assess an organization’s readiness to engage in evaluation capacity building process (Garcia –Iriarte et al (2011). This includes partners sharing and clarifying motivations, assumptions and expectations.

In the TCHF context, ECB was primarily a professional development opportunity for the Healthy Families workers and house coordinators to build new skills and knowledge that would help them to demonstrate client outcomes and continuously reflect on and improve their programs. Consequently ECB initially took an initial ‘training/workshop/tools’ approach followed by an action learning approach where NHs were encouraged and supported to design and conduct their own evaluation activities.

Building evaluation capacity presents a number of challenges for micro organisations with limited resources for evaluation and a low existing evaluation skills base and these challenges were discussed in detail in the mid-term evaluation report (Doherty and Eccleston 2015).

Overall, TCHF project staff perceived evaluation and building evaluation capacity as worthwhile and valuable. They saw clear benefits to having the skills to build evidence and demonstrate the outcomes of programs. However, there were some conflicts around who should be doing evaluation and whether or not building evaluation capacity in frontline service delivery personnel was an appropriate or useful enterprise. There were also conflicts between the iterative community development model of practice that characterised how the houses implemented their projects and the seeming fixed nature of Program Logic based

evaluation planning which was perceived as impacting on responsiveness and flexibility of programs to meet changing needs and the complexities faced. (Doherty et al 2015).

For most, the time commitment associated with both ECB and evaluation planning activities was burdensome. Ultimately, the funded time (18-22 hours/week) for HFW did not allow for the level of commitment to evaluation alongside the demands of project implementation. Further, the evaluation capacity-building component of the TCHF project was not initially fully articulated. As a result, during the establishment phase, there was no shared understanding between project managers, project staff and the evaluation team of the specific purpose or aims of ECB in the context of the TCHF or a mutual agreement on the approach to ECB that would best meet the needs of participants. Effort ensued in this area, evaluation plans were revised and the level of understanding was improved.

All projects produced an evaluation plan and all conducted evaluation output activities in line with their respective plans.

6 The TCHF Projects

6.1 Being Place Based

In the mid program evaluation the TCHF projects were assessed against seven criteria for being place based;

- Meet the unique needs of a location;
- Engage stakeholders in collaborative decision making;
- Tap into local resources and skills;
- Evolve and adapt to new learning and stakeholder interest;
- Cross organisational borders and collaborate;
- Shared ownership; and
- Change norms in a location.

Table 7 shows that, at mid-way through program implementation, all projects performed strongly against the first five criteria but were yet to show much progress on the final two (Doherty and Eccleston 2015) and in this final round of evaluation there has been only a small change.

Table 7 Summary of place based characteristics specifically evaluated in TCHF projects

Place based criterion	January 2015	December 2015
Meet the unique needs of a location	Criterion met by all projects	Criterion met by all projects
Engage stakeholders in collaborative decision making	Criterion met by all projects	Criterion met by all projects
Tap into local resources and skills	Criterion met by all projects	Criterion met by all projects
Evolve and adapt to new learning and stakeholder interest	Criterion generally met but slowly in some projects	All projects continue to work in an iterative and adaptive way
Cross organisational borders and collaborate	Criterion generally met but different projects face different challenges	Criterion generally met but challenges with specific organisations remain
Shared ownership	Criterion partially met but more a future prospect	Criterion partially met but may not be sustainable without ongoing support
Change norms in a location	Criterion not yet met but positive signs	Criterion partially met in some projects

Source, Key informant interviews 2014-2015, 2015-16

However there are there are alternative frameworks for evaluating PBIs such as Burstein and Tolley's (2011) five principles;

- Partnerships;
- Local and community solutions;
- Capacity-building;
- Sustainability;
- Effectiveness.

Wilks et al (2015) offer an even more comprehensive framework for evaluating PBIs including assessing key elements of program design, implementation and evaluation.

PBI program design and delivery is characterised by;

- Spatial targeting or a focus on a specific geographical area;
- Social targeting or a focus on populations;
- Flexibility of service delivery according to community need and in expenditure of funding;
- Local autonomy, whereby the local community are consulted and actively involvement in decisions making;
- Joined-up working between organisations within local areas across the government, private and community sectors; and
- Emerging forms of governance, specifically the devolution of the task of identifying issues and solutions to enhance local autonomy, the need for capacity development, and enhanced measurement and cost-effectiveness.

PBI Program implementation includes

- Capacity development which aims to build the skills needed to deliver services in different ways or to change service delivery methods;
- Lead times that are sufficient to set up programs, build relationships within communities, build capacity within service delivery organisations and ensure evaluations are in place; and

- A long-term focus, accepting that addressing entrenched disadvantage requires sustained investment and patience in realising results.

Comprehensive evaluation of PBIs include;

- Assessment of *causality* using best practice and relevant methodologies such as matched comparison areas, longitudinal data and sophisticated statistical analyses;
- Assessment of *attribution* or how to judge whether the particular PBI is working or if other factors are responsible for change;
- A theory of change—having a well-articulated “program logic” or mechanism by which the PBI effects on the key outcomes of interest can be measured;
- Residential mobility—accounting for population flows into and out of the area in the context of assessing whether a PBI is effective; and
- Cost-effectiveness—routinely analysing the costs associated with the delivery of a program and being clear about the long-term benefits in order to establish its cost-effectiveness.

In the next section we will describe each of the NH projects, their major achievements and analyse how well they meet Wilks et al’s (2015) key elements for being place based in both program design and implementation and in evaluation. Section 7 then aggregates this data and summarises the findings.

6.2 Derwent Valley Community House

6.2.1 Project aim

To engage with families in the Derwent valley area who have become isolated from their support networks and their community and who have children aged 0- 12yrs, in an Outreach capacity. Provide families with the resources and information of programs and services in the area. Make referrals to services and programs to best meet the needs of families. Facilitate events & activities to meet the gaps of the families in the DV area. Provide one on one family support to families who need assistance with parenting, challenging behaviours of their children and understanding healthy relationships. Support families to build self-esteem and confidence in parenting.

6.2.2 Project description

The Thriving Communities Healthy Families Outreach Program provided support to families in the Derwent Valley region through a range of activities. Providing one on one support in an outreach model was key feature of the project. The HFW visited families in their homes on a weekly basis or as required which overcame the transport barrier in the region. However the HFW also met with families at the community house and Ptunarra (CFC).

Women's groups were run in New Norfolk and in Ouse. As the year progressed the numbers of women attending the New Norfolk group reduced as the women became engaged in training and other groups and this group has come to a natural end. The Ouse group continues.

One off activities such as the Building Health relationships work shop and mental health week activities were also provided.

6.2.3 Partners

The DVCH has worked in partnership with a range of organisations over the life of the project including, Salvation Army Doorways Program, Glenorchy Illicit Drug Service, Anglicare, Ouse Primary School, Fairview Primary School, Family Planning TAS, Ouse Community Church, Child Protection Services, Community Corrections Officer, RAW and the Ptunarra Child & Family Centre.

The project has built on the existing strong relationship with the Salvation Army (SA), consulting and planning together and they have worked in partnership on number of programs and activities, including the Drumbeat program and the Poverty Week (2015) events. The HFW also provides one on one support to families along with the SA case manager. They attend Child Protection meetings and appointments with families and work in a complementary fashion each playing to their own strengths- The HFW provides the parenting and emotional support while the SA case workers focuses on financial support.

There have been a number of difficulties in establishing a fully collaborative partnership with the local Child and Family Centre despite ongoing efforts of the HFW.

6.2.4 Biggest challenges

There were a number of changes in NH leadership during the program and at one stage there was no NH coordinator for five months leaving the HFW without support and guidance whilst trying to establish the new role of an outreach family worker in the centre. There was a sense of that the NH committee did not have a clear understanding of the family worker role and that there was no coordinator to 'fight' for the program. The final challenge identified is winding up the TCHF and having an exit strategy for the at risk families.

6.2.5 Biggest changes for at risk families

Families are more resilient and aware of how to access services. Parents are more confident parents and have a better understanding of the ages and stages of kids and the impact of their parenting on the children.

6.2.6 Most successful Health promotion initiative

Cup Cake day, which was part of Mental Health Week activities. It gave the opportunity to talk to children about emotions and how to stay safe and included activities to take home to parents. In general the capacity to work one on one to support clients and engaging them into the NH and community events were perceived as the big successes.

6.2.7 Most important policy learning

In terms of engaging with vulnerable communities, it's really important to involve the community in the process. To work 'with' rather than 'to' and this project has allowed that to be put into practice.

Table 8 shows how the DVCH outreach project performed against the key elements for PBI program design and delivery.

Table 8 Place based elements DVCH TCHF Outreach project

Derwent Valley Community House TCHF Outreach project		
Common element	Demonstrated?	Evaluated?
Flexible delivery	demonstrated	yes
Strong Outreach model as well as provision of NH centred activities and delivery of services in other sites to meet clients' needs.		
Local autonomy	Demonstrated	yes
Responding to community identified need a strong feature. The HFW looked to the existing NH strategic plan which was already community informed to identify where TCHF programs might best fit and consulted directly with the women's group. <i>'Families are involved in consultation, planning and development but this can be difficult for both parties. If you work in a positive empowering way, people develop the skills to negotiate'</i> (KI interview 2015)		
Capacity development	Demonstrated	yes
Families are more aware of services to best meet their needs and how to access them. Families are then going on to share their knowledge with their friends, family and neighbours. (DVCH PR Dec 2015)		
Lead times	Demonstrated	yes
The TCHF project had a 6 month planning and establishment phase. However much of that was taken up with recruitment of staff so that the individual projects felt they had not really had enough lead time to really understand and scope out the projects on the ground. <i>'Going to the community and talking to stakeholders and service organisations first before the development stage – getting their feedback [would have been useful]'</i> (KI interview 2015).		

Long-term focus (sustainability)	Partially demonstrated	yes
It takes time to get a program working effectively and then it's disappointing when the funding finishes. It can almost be impossible for long term sustainable change to happen for families due to programs being funded for such a short period of time. (DWCH PR Dec 2015) While the TCHF is no longer funded, the DVCH will continue to support relationships, (e.g. with Salvation Army and Anglicare) and continue to work with new and existing partners to maintain a presence at DVCH.		
Spatial targeting	Demonstrated	yes
The Derwent Valley Community House is in New Norfolk and provides services throughout the Derwent Valley region, a rural area north of Hobart. The Derwent Valley LGA is highly disadvantaged and consistently scores in the lowest quintile on the SEIFA index of socioeconomic disadvantage (ABS 2011)		
Social targeting	Demonstrated	yes
TCHF targeted families <ul style="list-style-type: none"> • Living in low socio- economic area or backgrounds • Domestic Violence survivors • Trauma survivors • Poor attachment to family, peers and community. • Low confidence and self-esteem in parenting 		
Joined-up working	Demonstrated	yes
Increase in services engaging with the DVCH. Services have attended the NH for the first time and continued to come and meet with clients there.		
Governance	Partially demonstrated	yes
Governance processes evolved as the project matured. Rather than set up a formal governance structure for the project, there were regular meetings between the HFW and key partners (e.g. CFC & Salvation Army)and a Regular liaison lunch with other Derwent Valley service providers/ The HFW attended Real Action forward thinking (RAFT) and local P&F meetings. Specific planning groups were established for specific activities (e.g. the Ouse pamper day) At the completion of the Salvation Army and CFC have set up a family service monthly meeting to share resources and ideas of how to best need needs of families in the community.(TCHF activity reports 2014/2015)		

Table 9 shows how the DVCH outreach projects performed against the PBI key evaluation elements.

Table 9 Evaluation elements DVCH TCHF Outreach project

Derwent Valley Community House TCHF Outreach project	
Evaluation element	Demonstrated?
Establishing causality	Not demonstrated
Outside the scope of this evaluation given the timeframe of the program and the resources available.	
Attribution	Demonstrated
As a result of the TCHF, at risk families are more resilient, more confident and knowledgeable about parenting and have greater knowledge and capacity to access services. The program has challenged at risk families to see a better future and to set personal and achievable goals so they can reach their full potential and be happy. (KI interview) <i>'I am no longer surviving, I am living'</i> local parent DW	
Theory of change—Articulated	Demonstrated
Program logic developed identifying program activities (outputs) and short, medium and long term outcomes	

Theory of change—Measured	Partially demonstrated
<p>Outputs measured in four activity reports submitted to NHT</p> <p>DVCH provided case studies that demonstrate the impact of TCHF on parents. One young mum was living in isolation and ‘feeling stuck with no support’, until she engaged with TCHF and was able to access opportunities that have opened up for them. This parent is now able to better manage her children’s behaviour, has returned to school and is volunteering at the Neighbourhood House, the children are at a new school, and are participating as a family in activities.</p> <p>An evaluation of after school activities undertaken by DVCH TCHF shows increased levels of engagement by families with the NH and with other families, and improvements in children’s problem solving skills and social behaviours. A survey of Partners in 2016 indicates that partner organisations have observed “real long term changes in (their) lives”, “families better off since becoming involved with TCHF”, and “groups that have supported families to connect with each other”.</p>	
Residential mobility	Not demonstrated
<p>Derwent Valley is consistently rated as one of the most disadvantaged areas in Tasmanian (IRSD rating in lowest quintile) with significant levels of intergenerational poverty. No data on residential mobility of at risk groups, however discussions with HFW reveal that many of the target families are ‘established’ locals living in multi-generational households.</p>	
Cost-effectiveness	Not demonstrated
<p>Outside the scope of the TCHF evaluation</p>	

6.3 Eastern Shore Community House (East Devonport)

6.3.1 Program aims

Provide capacity building training and practical experience to develop community leaders (CL). Work with potential leaders to develop strategies to engage disadvantaged families. Provide opportunities for potential leaders to gain experience in engaging and supporting families. Support new leaders to respond to the needs of families and link them with services and programs.

6.3.2 Program description

The Community for Community (C4C) is the only totally peer-led TCHF initiative. The Eastern Shore Community House had originally conceptualised their project as a relatively standard health promotion program/engagement strategy 'Kommunity Kids' focussing on healthy eating and physical activity for children living in a very disadvantaged public housing area of East Devonport. When this approach did not gain the traction they expected, they reviewed and started again. Consequently, they lost several months in terms of program implementation. In the C4C initiative, the NH and the CFC identified potential community champions, who in turn identified others. Importantly the original eight champions came from the disadvantaged communities but they had their own peer networks, which they could use to engage with disenfranchised families. The HFW facilitated regular meetings for the C4C which were attended by local services providers and supported capacity building but the champions identified community priorities and developed a calendar of events to engage with 'at risk' families. Once engaged, the families are more likely to come to the CH or the CFC where they can be connected with services to meet their needs and the CH learns where the gaps are in terms of service provision. For example, the Kids in the Kitchen cooking partnership with the local school, was a response to finding out that children often have responsibility for providing meals in the home. Through this program there was a recognition that children were coming to school hungry so the CH teamed up with the school to extend the Breakfast club and provide lunches.

6.3.3 Partners

Community and other organisations in East Devonport are very supportive of TCHF and there has been no negativity. The CFC, Housing Choices and the local primary school are the three most important partners. There were some early issues with the CFC which was about them being resource constrained, which meant the social inclusion worker could not attend weekly meetings with C4C leaders.

6.3.4 Biggest challenge

The initial challenge was about identifying and inviting the CL. Some said no at first but are now involved even if they are not formally committed.

'The [biggest] challenge is to let go and let the community do it' (KI Interview 2015).

6.3.5 Biggest change for at risk families

Families attend more events; are more socially connected and are comfortable approaching service providers. They know which services best suit their needs.

6.3.6 Most successful Health promotion initiative

While the ESCH did not directly nominate a most successful health promotion intervention they discussed the things that had worked well in their community. The first C4C project, a community BBQ attracted around 106 children and their families of whom 30% were new to the NH. The other significant success was around healthy food. Again as a direct result of the C4C, fruit platters and salad sandwiches are provided as an alternative to sausages and bread at Kommunity Kids activities. As a result children have better access to fresh fruit and vegetables.

6.3.7 Most important policy learning

‘If you let people grow at their own pace, they will actually fly themselves. Don’t jam things down their throats- give them what they want, not what we think they need. Most people know how to fix their problems if they are given access and knowledge. That’s what this project has done – people can fly and take off.’ (KI interview 2015)

Table 10 shows how the ESCH C4C project performed against the PBI planning and implementation elements.

Table 10 Place based elements ESCH Community for Community program

Eastern Shore Community House Community for Community Project		
Common element	Demonstrated?	Evaluated?
Flexible delivery	Demonstrated	yes
Peer led model with a focus on delivering services to the community in the community by the community.		
Local autonomy	Demonstrated	yes
Responding to community identified need is a strong feature. The C4C community leaders are themselves members of at risk families and use their peer networks to identify and respond to community need. Further they are advocates for families in articulating community needs to service providers. <i>‘The community leaders (CL) are communicating information to their immediate families and friends and then people will come to us (NH) and say they heard about something at one of the events. Information is being spread throughout in the community.’</i> (KI interview 2015) <i>‘There is no point in filling the house with service providers if they are not what the community wants. The community said exactly who they wanted and that’s what they got’</i> (KI interview 2015).		
Capacity development	Demonstrated	yes
A strong feature of this program was developing capacity in the community leaders as articulated in the program objectives <ul style="list-style-type: none"> • Provide capacity building training and practical experience to develop community leaders • Work with potential leaders to develop strategies to engage disadvantaged families • Provide opportunities for potential leaders to gain experience in engaging and supporting families • Support new leaders to respond to the needs of families (link them with services and programs etc.) 		
Lead times	Demonstrated	yes
The TCHF project had a 6 month planning and establishment phase. The initial HFW left the program after three months and at this stage the program was completely reviewed and there was a significant shift in focus from delivery of health promotion activities in a specific disadvantage locality towards the peer to peer C4C program. In effect this contracted the program delivery phase (12 months) but expanded the lead time.		

Long-term focus (sustainability)	Contested	yes
<p>At the cessation of TCHF funding, the ESCH aim to continue to support the C4C and invite other services to support them. They will also assist the CLs to organise fund raising activities and sourcing of donations.</p> <p>Responses were mixed as to the long term sustainability</p> <p><i>'The CL group still needs support even though NH has stepped back a bit- we provide the room and facilities.'</i></p> <p><i>Between the main two services providers (CFC and Housing Choices) and the CH they could develop a model that works.'</i> (KI interview 2015)</p> <p><i>'This project ... will naturally die. The reason is the CLs themselves, once their confidence grew and their self-esteem grew, they felt the need [to move on], that the handbrake on their lives was living in East Devonport. So 100% of the CLs have left East Devonport.'</i> <i>'The CLs all want to come back and share their knowledge and skills with the next group of CLs who come through. But they see East Devonport as a place you need a hand to get out of.'</i> (KI interview 2015)</p> <p><i>'I think it is [sustainable] - but sustainable is a terrible word for me! Nothing is sustainable because it isn't-we live a changing world- it's definitely made a change for the people involved in it and this change also goes through their friends and families- it's a ripple effect but we need to keep it going.'</i> (KI Interview 2015)</p> <p>Since restarting CFC in March 2016 (delayed by community house renovations) CLs have returned with new CLs and the intension to broaden the ages of future CLs to reach more of the community and make the project sustainable; this includes recruiting members of East Devonport progress groups. Additionally, two large projects are being planned for the next six months for East Devonport residents.</p>		
Spatial targeting	Demonstrated	yes
<p>East Devonport is a suburb of Devonport a major port city in North West Tasmania. East Devonport is one of the most disadvantaged areas in Tasmania and is consistently in the bottom decile of the SIEFA IRSD (ABS 2011). SEIFA for East Devonport – 803</p>		
Social targeting	Demonstrated	yes
<p>TCHF originally targeted 'at risk' families with children aged 0–12 years living in East Devonport through the Kommunity Kids program.</p> <p>However, this strategy was not effective and the program then targeted potential community leaders (champions) who were themselves from 'at risk families' but had extensive social networks. – They were all from a low-socio economic background, lived in East Devonport, with children aged 0-12 years. They had a range of health issues, mental health issues and health risk factors (smoking, obesity, drug and alcohol use).</p>		
Joined-up working	Demonstrated	yes
<p>Support organisations are not working in silos but working alongside each other (ESCH PR 2015).</p> <p><i>'It [the C4C meetings] gave partner organisations an 'in' to work with a hard to reach group. Ordinarily they (CSOs) would have not much chance of connecting with these seriously disadvantage families ... if you just look at the people who now engage with the CFC- there are a myriad of services at the CFC that people would never have engaged with before'</i> (KI interview 2015).</p> <p><i>'It's very important to have collaboration and partnership with other services in the local community. Other service providers are now more aware of who we (NH) are and of the Community Leaders'</i> (KI interview 2015)</p>		
Governance	Demonstrated	yes
<p>The main governance structure to evolve is the fortnightly Community 4 Community meetings which provide service providers with an opportunity to become involved in the planning of activities and events that are organised by the Community 4 Community members.</p> <p>In earlier program stages, the Child and Family Centre's Community Inclusion Worker regularly attended weekly C4C meetings and other organisations (Housing Choices, City Mission) attended meetings occasionally but communicated through email.</p>		

Table 11 shows how the ESCH C4C projects performed against the PBI key evaluation elements.

Table 11 Evaluation elements ESCH Community for Community program

Eastern Shore Community House Community for Community Project	
Evaluation element	Demonstrated?
Establishing causality	Not demonstrated
Outside the scope of this evaluation given the timeframe of the program and the resources available.	
Attribution	Demonstrated
<p>As a result of the TCHF,</p> <p><i>'Families attend more events (more socially connected) and are comfortable approaching service providers. They know which services that best suit their needs'.</i></p> <p><i>'Significant improvement in HWB of disenfranchised families'</i></p> <p><i>'... it's across the board - social, emotional and mental, as well as, physical and nutritional gains'</i> KI interviews 2015</p>	
Theory of change—Articulated	Demonstrated
Program logic developed identifying program activities (outputs) and short, medium and long term outcomes.	
Theory of change—Measured	Partially demonstrated
<p>Outputs measured in three activity reports submitted to NHT.</p> <p>Client satisfaction with a major community event measured through a short survey.</p> <p>HFW asked partner organisations about program impacts and they believed they had resulted in increased collaboration amongst organisations and positive changes in clients in terms of social isolation.</p>	
Residential mobility	Partially demonstrated
<p>All original Community Leaders have moved out of East Devonport to the other side of the river, as a result of building capacity, realising their own potential and seeing the location as a barrier to increased opportunity. However they still retain contacts with the TCHF as many have families and friends who still live in the area.</p>	
Cost-effectiveness	Not demonstrated
<p>Outside the scope of the TCHF evaluation. However, half of the initial community leaders are now in employment or training. This is likely to represent significant savings in income support payments as well as the potential for these people to more fully engage in the community and the economy. It should be possible to estimate the cost benefits of this result against the investment in the TCHF.</p>	

6.4 Maranoa Heights Community Centre

6.4.1 Program aims

The Eat-Play-Lead initiative aims to support economically and socially disadvantaged women with children 0-12 and have experiences of trauma:

- reduce levels of parenting stress
- increase confidence in parenting abilities
- develop parent / child bonds
- increase capacity to access specialist support
- become socially connected
- increase leadership capacity;

And for partnership organisations to be aware of and support the TCHF project.

6.4.2 Program description

Eat- Play- Lead (EPL) was originally conceptualised as a sequential NH centre based program which would engage at risk families initially through food related activities, move on to active play and positive parenting activities which in turn would foster leadership skills and capacity building in the community. As the program evolved it changed to We Eat, food education, preparation and communal meal for mums and kids; We Play, supported creative play for kids, mums attend small group self-development activities, group food preparation and meal sharing; and some outreach activity. The MHCC is a very small organisation and to a large extent, the HFW has to deal with ‘what comes through the door’ as well as delivering the TCHF program.

The We Play mothers are resourceful and share information with each other. They are able to articulate their needs and to tell service providers what will work for them in their circumstances. They have built up ‘natural support systems’ and are meeting outside the centre providing support to each other through for example babysitting each other’s children, having a BBQ or having dinner at each other’s houses. They have in effect built a peer network from a base position of being quite socially isolated.

While there has been some outreach activity, this has not been a major component of EPL. There are some tensions in this community about vulnerable people feeling threatened and under surveillance if service providers come to their homes, in part due to unhappy experiences with other outreach services (e.g. Drug and Alcohol Services, Child Protection).

6.4.3 Partners

While EPL does not have an extensive network of formal partnerships with external organisations, relevant community organisations are well informed about the project, and its activities and it is well supported by key partners such as the Kingston Community Health Centre. The project also has broad support from community members who use their own social network to encourage their peers to participate in the program. Partnering with individuals in the community has been the most successful action in terms of reaching the target group.

6.4.4 Biggest challenge

Both the HFW and the house coordinator were new to the Maranoa Heights area when the TCHF commenced. Not knowing anyone in the community and building trust with the community was a big challenge. Time was also identified as a challenge.

At the beginning of the project MHCC believed there was a lack of clarity around project expectations and the scope of responsibility for evaluation and project management became blurred leading to confusion a lack of clear direction for the project.

6.4.5 Biggest change for at risk families

- Reduced isolation
- A need for connection being met at a level the person defined for themselves
- Natural supports being developed and nurtured (e.g. some participants now exchanging child care outside program)
- Increased knowledge of supports and services available
- Increased confidence using and/or approaching services
- Empowered to direct new program and Centre activities

6.4.6 Most successful Health promotion initiative

For the MHCC the success was in creating a safe environment for mothers and their children to feel accepted and supported. However, it was more than just providing the physical space, it was the opportunity for the parents to discuss the issues they were facing and work out possible solutions and options for support. So the other important success were the natural peer support systems that evolved and continued beyond the TCHF project.

6.4.7 Most important policy learning

Building relationships with community members takes time, which is very important but is under acknowledged. The MHCC is usually a one-person centre so having an extra person to have the time to give to other people in the community is very important and it allows the house coordinator to do her work while someone else does this work with the community.

Table 12 shows how the MHCC EPL project performed against the PBI key planning and implementation elements.

Table 12 Place based elements MHCH Eat-Play-Lead program

Maranoa Heights Community House Eat- Play- Lead Project		
Common element	Demonstrated?	Evaluated?
Flexible delivery	Demonstrated	yes
The original Eat Play Lead concept was a centre based sequential program delivery approach but as the TCHF evolved, it changed quite significantly and became a mix of one on one activities, some workshops and training and peer-to-peer networking. A lot of crossover between the TCHF and the day to day work of the NH resulting in the HFW responding to multiple community needs- baby clothes , furniture, lack of food, domestic violence, tenancy support, emergency transport for medical appointments. HFW negotiated for the child care nurses to come to NH instead of the community health centre because at risk clients felt uncomfortable at the CHC		

Local autonomy	Demonstrated	yes
Needs identified through collation of interviews the NH had with local women and service providers and clustered into the EAT PLAY LEAD concept which is about self-care, child development, education, leadership, social skill development and self-confidence. (KI interview 2015) <i>'I can see is this program (TCHF) gives them (the community) an opportunity to say 'this is what suits us'. (KI interview 2015)</i>		
Capacity development	Demonstrated	yes
KI interviews with MHCC staff and stakeholders point to capacity building in the community. Women are forming peer networks and sharing information with each other. Community members are moving on with their lives and becoming less reliant on the CC. One Key informant commented that the TCHF had given <i>'women in the community an opportunity to be involved in a meaningful way – to gain confidence- to be involved in the community, perhaps not as typical leaders, but to help shape their community'</i> (KI interview 2015). While another commented, <i>'It's more about the relationships and opportunity to connect to something that is NOT a protective service or DHHS. So this is not about being a client of a service, more about growing potential as a person'</i> (KI interview 2015)		
Lead times	Partially demonstrated	yes
The TCHF project had a 6 month planning and establishment phase. Both the HFW and the House coordinator were new to the area and had to build a trust relationship with the local community, which impacted on the timeliness of program development and implementation. <i>'[if embarking on the project again] I would spend more time talking to other services and building pathways and partnerships.'</i> (KI interview 2015)		
Long-term focus (sustainability)	Demonstrated	yes
<i>'Yes absolutely they [peer networks] are [sustainable]'</i> (KI interview 2016). <i>'I was really impressed by the women [from NH] - their confidence and willingness and motivation to take things into their own hands.'</i> (KI interview 2015)		
Spatial targeting	Demonstrated	yes
Maranoa Heights is a suburb of serious socioeconomic disadvantage located within Kingborough, a wealthy local government area (LGA) in Southern Tasmania. <i>'Because it is perceived as a nice area, it is one of the places that women seeking housing and escaping from domestic violence will be placed (by Human Services). However there is stigmatisation of these families and a perception that Maranoa Heights is where the 'bogans' live'. (KI interview 2015)</i>		
Social targeting	Demonstrated	yes
The project focussed on women who were socially and economically disadvantaged, with experiences of trauma, and with children aged under 12. (Progress Report 2014/15)		
Joined-up working	Demonstrated	yes
<i>'From service providers there has been a bit of a shift in how they see the houses/community centres which are usually seen as being a bit passive. However, now there is more of a professional respect for what we (MHCH) do. Some of it is that we have done a bit of work with the high school and we communicate quite regularly with them. That place based concept of getting other institutions to foster community need and be more supportive and get involved is important'</i> (KI interview 2015) <i>'[NH] is more of a collaborator now- we [local CSO] had very limited contact with the NH house prior to the project- I can refer clients who are at risk of becoming involved with Child Protection or parents with poor skills '</i> (KI interview 2015)		
Governance	Partially demonstrated	yes
No new formal governance structures Informal dialogue ongoing Quarterly Interagency network meeting but does not always happen.		

Table 13 shows how the MHCC EPL project performed against the PBI key evaluation elements.

Table 13 Evaluation elements MHCC Eat-Play-Lead program

Maranoa heights Community House Eat-Play-Lead project	
Evaluation element	Demonstrated?
Establishing causality	Not demonstrated
Outside the scope of this evaluation given the timeframe of the program and the resources available.	
Attribution	Demonstrated
As a result of the TCHF, 'People feeling more comfortable about coming to NH. They don't feel judged [because] the NH is a safe environment ' (KI interviews 2015) Families are not so isolated, have increased knowledge of supports and services available, greater confidence using and/or approaching services.	
Theory of change—Articulated	Demonstrated
Program logic developed identifying program activities (outputs) and short, medium and long term outcomes.	
Theory of change—Measured	Partially demonstrated
outputs measured in four activity reports submitted to NHT Evaluation activities include participant and partner feedback that shows that TCHF has “provided participants with a new support network”, introduced them to the resources available at Maranoa Heights Community Centre and supported people move from isolation into volunteering.	
Residential mobility	Partially demonstrated
MH is a public housing area and there is evidence of some families trying to move out of the area in response to safety concerns related to relationship breakdown, domestic violence, and child protection issues and a perceived increase in the use of 'ice' and increasing violence experienced by residents. However there is a core stable community.	
Cost-effectiveness	Not demonstrated
Outside the scope of the TCHF evaluation	

6.5 Northern Suburbs Community House (Rocherlea)

6.5.1 Program aims

The Lunchbox Heroes - Healthy Families aims

- Increase the connection with the Community Centre with families who may otherwise be disconnected or disengaged.
- Provide skills, information and to connect with families experiencing poor nutrition and issues of food affordability and security.

6.5.2 Program description

The LunchBox Heroes project began as a healthy eating health promotion activity and resources working with local parenting groups such as pre kinder and playgroups and with the East Tamar primary school kinder classes. It was very much an outreach design with the HFW going to the places where families and children are, including community events, to provide information on healthy eating and becoming a presence in the community. As the program has matured, the focus of the HFW has shifted to the twice-weekly delivery of the 'Cooking Club' at East Tamar Primary School in partnership with the Smith Family. This small group work allows the HFW to get to know children personally and tailor the program to their needs. These children are often responsible for preparing a meal at home in the absence of a parent so the program has adapted to that in terms of modifying recipes and addressing safety issues. The program continues to evolve with plans to run joint child parent classes.

There has been a flow on effect in the community where there has been a shift in awareness of healthy eating and its impact on children. The school has engaged with the Move Well Eat program and there are many complementary activities such as the NH Veggie box program and physical activity programs to support families.

6.5.3 Partners

Key partners are the Smith family and the East Tamar Primary school. There has been a big shift in the relationship with the school. It is more equal with both parties having different things to offer to the partnership.

There was a strong pre-existing relationship between the Smith Family and the NSCH with a history of collaboration and this relationship has continued to grow through the cooking program. The NH also works closely with the Childhood networkers, funded under the Communities for Children program, who provide services for younger children. There is no CFC in the area.

The other potential partner the TCHF would have liked on board was Child Health and Parenting Services (CHAPS). CHAPS nurses had previously provided services from the NH but had recently undergone organisational changes and this practice had ceased.

6.5.4 Biggest Challenge

NSCH identified two major challenges

- Time for set up
- The impact of the school merger between Rocherlea and Mayfield to create the East Tamar Primary School. The school had its own issues to manage, leaving little room

for additional activities outside the school curriculum. This made access to the school and the target group of children under 12 very difficult in the first year of the program. However, the HFW built up a strong trust based relationship and as discussed above the organisations now have a solid partnership which delivers mutual benefits.

6.5.5 Biggest change for at risk families

The focus of the NSCH project was very much on nutrition and they have seen an increase in the knowledge and awareness of eating well and being healthy. Further they report more openness around children's wellbeing and people being open to making a change. In general, the community is more willing to ask questions, are reconnecting with the NH and e and being more proactive about their own needs

6.5.6 Most successful Health promotion initiative

The Cooking Club which is delivered in partnership with the Smith Family and the local primary school. There is the direct benefit of learning about nutrition and cooking healthy food but it's also an opportunity to better understand what's going on in families and finding ways to support them better. They also nominated the Lunchbox heroes program delivered early on in the project as a success. It can be delivered in the school or in a park and is easily transferrable to other NH because the resource kit developed by the HFW.

6.5.7 Most important policy learning

Engagement with disenfranchised families is 'about being informal- finding informal ways for meeting with families and letting them discuss things with you.' (KI interview 2015).

Table 14 shows how the NSCH LunchBox heroes project performed against the PBI key planning and implementation elements.

Table 14 Place based elements NSCH LunchBox Heroes program

Northern Suburbs Community House LunchBox heroes program		
Common element	Demonstrated?	Evaluated?
Flexible delivery	Demonstrated	yes
The NSCH program was very flexible demonstrating an outreach focus, delivering program activities at multiple sites where children and families are and the HFW being a presence at multiple community events. <i>'Community members here in the Northern Suburbs [are] happy to become involved in groups as long as the location and times were convenient to them. In order to gain access to the children within our community, the Healthy Families role has evolved to meet that community in the groups and locations where they already are'</i> (PR August 2015). <i>'What is really beneficial ... being willing, able and having the flexibility to go where people are'</i> (KI Interview 2015)?		
Local autonomy	Demonstrated	yes
The NSCH use a community development model of practice so are constantly consulting with their community. Nutrition and food security were the prominent issues to emerge during the TCHF consultation. - <i>'The community consultation elicited lots of questions about what to feed children at school. Parents were happier to discuss what children ate at school because it was less of a personal judgement about what they were fed at home community'</i> (KI interview 2015).		

Capacity development	Demonstrated	yes
<p>Community capacity was built through skills development and knowledge particularly around healthy eating and community members sharing their learning experiences. There was an increase in confidence and families had a greater capacity to articulate their concerns and speak out about the issues that impact on them.</p> <p><i>'the mums can share what they have done with the HFW or the children in the cooking program - there is the opportunity that once people are given that learning and education, they pass it on.'</i> (KI Interview 2015).</p> <p><i>'the prime reason for supporting the TCHF project was not so much about healthy food –it was more about cooperation, team work, being able to work in a difficult environment'</i>(KI Interview 2015).</p>		
Lead times	Partially demonstrated	yes
<p>The TCHF project had a 6 month planning and establishment phase. Both house coordinator and family worker were established in the house prior to the TCHF however, it was still necessary to build relationships and trust in the first year of the program.</p> <p><i>'Maybe we didn't realise up front that the relationship building was so vital and maybe it needs its own phase- so relationship building and community consultation is the first stage of the program and that might take 12 months '</i> (KI Interview 2015).</p>		
Long-term focus (sustainability)	Partially demonstrated	yes
<p>There are indications of sustainability in the program. There are strong social media networks in this area and strong relationships with key partners which augur well for the future. However views differ on whether the community is ready to step up and take the lead on running programs such as the cooking club.</p> <p><i>'We don't have a community leader, we have great volunteers but neither is keen to run the cooking club and certainly the cost of running the program – cost of providing the food [Smith Family is happy to help with that]– but it would be difficult without someone to drive and lead'</i> (KI Interview 2015).</p> <p><i>'I believe that by the end of this term, there will be identified parents who will be stepping up and asking for more and asking what they can do and if we can keep things going ourselves. It's too early to know if that will actually happen'</i> (KI Interview 2015).</p>		
Spatial targeting	Demonstrated	yes
<p>Families located in the Rocherlea/Mayfield suburbs in the Launceston local government area. These suburbs consistently rank within the lowest decile for social disadvantage (ABS, 2011),</p>		
Social targeting	demonstrated	yes
<p>Focussed on families that were known to the local school and local community centre through previous involvement or they were friends of friends who knew about the community centre but had to yet engaged</p> <ul style="list-style-type: none"> • Early years (pre-school) children • Families of children up to 12 <p><i>'Constantly evolved about who is at risk and how to access those at risk families – it changes a lot'</i> (KI Interview 2015)</p>		
Joined-up working	Demonstrated	yes
<p>There is clear evidence of joined up working in this TCHF project, especially with key partners the Smith Family and East Tamar Primary school despite the challenges presented by the school merger in the first year of the project . This has had flow on effects for how the NH is working with other organisations and other projects.</p> <p><i>'The increased relationship with East Tamar Primary has totally changed [the] project for the better. We worked hard in 2014 to develop the trust and relationship and this has paid dividends in the first half of 2015-with access to the students that is far greater than we could have expected. We now have almost unlimited access to student who are all the right age and in the demographic we are targeted towards in this project.'</i> (PR August 2015).</p> <p><i>'through the school this year, everyone knows the HFW from the NSCH... all other workers [NH] are getting better access to the school – there has been a change in referrals to the NH- awareness and accessibility has changed.'</i> (KI Interview 2015).</p> <p><i>'I would say we [community centre] work much more with other people now than we did two years ago.'</i> (KI Interview 2015).</p>		
Governance	Not Demonstrated	yes
<p>No formal governance mechanism emerged. Governance was via informal meetings and by email (PR February 2015)</p>		

Table 15 shows how the NSCH LunchBox Heroes project performed against the PBI key evaluation elements.

Table 15 Evaluation elements NSCH LunchBox Heroes program

Northern Suburbs Community House LunchBox Heroes program	
Evaluation element	Demonstrated?
Establishing causality	Not demonstrated
Outside the scope of this evaluation given the timeframe of the program and the resources available.	
Attribution	Demonstrated
<p>As a result of the TCHF,</p> <ul style="list-style-type: none"> Families have greater willingness to talk about their concerns-Greater openness about their struggles More aware of the links to service and who might be able to connect them with help Community as a whole has realised that more time and energy needs to go into feeding children well. <p><i>'Whole range of things supporting families and the community and TCHF sits amongst that. Everyone is doing their bits' (KI Interview 2015).</i></p>	
Theory of change—Articulated	Demonstrated
Program logic developed identifying program activities (outputs) and short, medium and long term outcomes.	
Theory of change—Measured	Partially demonstrated
<p>Outputs measured in four activity reports submitted to NHT</p> <p>The project utilised the Most Significant Change methodology to demonstrate outcomes.</p>	
Residential mobility	Not demonstrated
No data collected.	
Cost-effectiveness	Not demonstrated
<p>Outside the scope of the TCHF evaluation. However it is likely that the outreach focus of this project reaches the otherwise disenfranchised population, who in turn benefit from downstream health promotion activities rather than upstream interventions.</p> <p><i>'The HFW provides exceptional value for money- amazing impact into the community that government can't reach. Value increases as relationships continue to build. \$ for \$ there is far more value with the outreach approach' (KI interview 2015)</i></p>	

6.6 St Helens Neighbourhood House

6.6.1 Program aims

- To engage ‘at risk’ families of young children into existing health promotion, community development and parenting support programs to contribute to improving health and wellbeing.
- To work effectively in partnership with other health service providers and key stakeholders to address issues that exist at neighbourhood level, such as social isolation, poor or fragmented service provision that leads to gaps or duplication of effort and limited economic opportunities.
- To engage ‘At Risk’ Families, and maintain engagement of those engaged, so that they are participating and involved in creating and developing capacity building initiatives and programs that foster leadership skills to support sustainability whilst aiming to build healthy settings for living, learning and working.

6.6.2 Program description

The Thriving Communities-Healthy Families Project St Helens Neighbourhood House is a multi-faceted program incorporating strong outreach elements, centre based health promotion activities, group work, workshops and training activities and peer to peer support. It has enhanced and created robust networks with local and visiting service providers and the St Helens Early Years Reference Group and the Break O’Day Child and Family Centre Advisory Group. It is characterised by a strong focus on information sharing to avoid duplication of services and working collaboratively with other service organisations.

As the program has evolved, Mental Health has emerged as a significant issue in the community exacerbated by gaps in services and gaps in knowledge of how to navigate existing services. The TCHF project has worked one on one with clients, both in preventive work and in linking them to appropriate mental health services. They have created a mental health directory which is used by community services, hospitals and GPs who are now more aware of the continuum of mental health services available in the Break O’Day area.

6.6.3 Partners

The SHNH TCHF project has engaged with a large range of partners, creating new relationships and strengthening existing ones. The HFW role was pivotal in this as it provided the extra resources and time to focus on partnership building. Both the HFW and the house coordinator were well known in the community which they believe gave them an advantage in building relationships and trust. Further, the increased capacity allowed for a deeper level of collaboration, shared planning and working with partners to find solutions to service gaps.

They identified time as a barrier to creating relationships given that community organisations are resource stretched and won’t commit to supporting a program unless they prove to be sustainable to ensure community expectations are not unrealistically raised and dependent ability increased and then service withdrawn. There is a further issue in ensuring that new programs are not duplicating existing ones which is not always clear given the complexity of state and federal funding and the tendency toward short term funding. It’s important to be transparent and demonstrate that new programs are there to value add and fill gaps and work with existing programs, not to duplicate otherwise trust breaks down quickly and ‘turf wars’ can emerge.

6.6.4 Biggest challenges

Two major challenges were identified

- The time for a new community support person to build trust with both community members and services.
- The short term funding of the project and the impact this has on developing trusting relationships and long term positive outcomes for services and families.

A more minor challenge was translating the ‘jargon’ of place based approaches into community friendly language.

6.6.5 Biggest change for at risk families

The stand out change for the St Helens project is that families feel more connected with peers and community and not so socially isolated which results in good outcomes for families and children. The project also reports increased self-esteem, which results in increased capacity for people to engage with training. Families are also more connected into services and are more likely to realise the benefits of getting the help they need, for example with mental health issues.

6.6.6 Most successful Health promotion initiative

Building relationships with clients and linking them into appropriate services around mental health.

6.6.7 Most important policy learning

The more the HFW understands the available resources and develops those relationships with the other services on the ground, the more the HFW can see where families can link in and what’s appropriate for those families. Future PB programs need a minimum of five years funding.

‘we need to advocate for policy change- we need to talk about the short term funding - we have demonstrated in a short period of time the things that are been achieved- but people will stop engaging if funding is cut- their trust is decimated... people get used to being let down so they learn to get what they can. This program bought a two-way relationship; it’s not just service provision but about building capacity and you can’t demonstrate those outcomes in two years’ (KI interview 2015).

Table 16 shows how the SHCH TCHF project performed against the PBI key planning and implementation elements.

Table 16 Place based elements TCHF Project SHNH

TCHF Project St Helens Neighbourhood House		
Common element	Demonstrated?	Evaluated?
Flexible delivery	Demonstrated	yes
The NH is sited in St Helens but the TCHF works throughout the Break ‘O’Day area including Fingal, St Mary’s and Cornwall. The project has taken very flexible approach, particularly in its engagement strategy by going to the places where families are anyway -the school yard at pickup/ drop off time or at the school carnival and being a presence and getting known at community events. In terms of service delivery, it has used different sites for different activities including school holiday programs, mothers groups and has had a strong outreach focus.		

Local autonomy	Demonstrated	yes
<p>NH conducted a local survey to find out what sort of activities people were interested in and what sort of support and resources they would need. Feedback from the survey and one on one conversations were used to inform the activities.</p> <p><i>'It's all about what the community wants, not about someone telling families what they should be doing'</i> (KI Interview 2015).</p> <p><i>'TCHF has been one of the highest impacts, hands on programs and has delivered outcomes for this community - it's about response to community needs and bringing community together to respond to those needs'</i> (KI Interview 2015).</p>		
Capacity development	Demonstrated	yes
<p>The TCHF has demonstrated capacity development in community members and other organisations. For example, the members of the Empowered women's group are sharing the responsibility for the group and taking on a semi leadership role. It's more than a community place based activity; it's a vehicle for building members' skills and confidence to lead a workshop and communicate with service providers but the short time frame does not allow for this to be fully realised.</p> <p><i>'If you could have an extra couple of years of support for the program then you would have community members with the skills to engage with others in their community'</i> (KI interview 2015).</p> <p>Families are also more confident about articulating their needs and having the skills to navigate the service system. <i>'families ... have a good understanding of what's available now and happily say 'this is what I need and I think this is how to access it, can you let me know if that correct?'</i> Most of the time they have it down pat and that is very powerful for them.' (KI interview 2015)</p> <p>In terms of partnerships, the TCHF is building capacity through providing existing partners with new partners as the lynchpin in keeping abreast of other developments in areas such as mental health, Housing Connect, Drug and Alcohol services.</p>		
Lead times	Partially demonstrated	yes
<p>The TCHF project had a 6 month planning and establishment phase. Both House coordinator and family worker were established in the NH prior to the TCHF however they found it still takes time to build relationships and trust when launching a new initiative.</p> <p><i>'Would spend more time on project planning- to work with UTAS and the five other projects.</i></p> <p><i>Lost opportunity to work together because of the time frame- TACH/ UTAS resources not fully utilised – there was a capacity to build amongst the NH but not enough time for that to happen'</i> (KI Interview 2015)</p>		
Long-term focus (sustainability)	Partially demonstrated	yes
<p>There is a concern that, despite developing the TCHF through a 'sustainability lens' and the focus on building capacity that people who are 'currently connected (to services) but are socially isolated will fall back into isolation...we know from talking to the school and other services there will be a massive gap when TCHF has gone' (KI Interview 2015).</p>		
Spatial targeting	Demonstrated	yes
<p>Families located primarily in St Helens, St Marys and Fingal and within the Break O'Day local government area. These locations consistently rank within the lowest two deciles for social disadvantage (ABS, 2011).</p>		
Social targeting	Demonstrated	yes
<p>Quite broad but two main foci</p> <ul style="list-style-type: none"> families (children 0-12) with poor support networks, minimal engagement with services or programs or schools or may have parenting challenges or health and wellbeing issues families new to the area who were engaged but at danger of becoming disengaged due to the lack of social connections 		

Joined-up working	Demonstrated	yes
<p>Joined up working is a very strong feature of the St Helens TCHF. There is clear evidence of collaborative planning between key children's services (CFC, early learning coordinator, CHAPS). Solid existing partnerships, built on strong interpersonal relationships between workers that are 'an integral part of the success of this project' and 'have ensured [TCHF] are able to brainstorm our thinking on both engagement and health promotion strategies that will fit our community and are not just generic strategies that may not suit this area' (PR August 2014).</p> <p>A major achievement is the mental health directory which</p> <p><i>'is used by lots of other services, hospitals and GPS who are now a lot more aware of the preventative stuff and what MH services are here. Then they can support families to navigate the services and connect to where they need to be. So we've had counsellors come here (to the NH) or to the school to see people- where people feel a bit safer rather than people having to go to where they (MH services) are'</i> (KI Interview 2015).</p> <p><i>'Because [the HFW] has pulled groups together, like the mental health peer support group, and has a strong presence in the school, and that has flowed on to the parents' forum, it's got other services sitting up and saying we CAN do things differently'</i> (KI Interview 2015).</p> <p><i>'As opposed to two organisations that work separately in our community for change, together we can improve the outcomes for the families in our community – we are two different organisations but have some very shared goals- it's a beautiful opportunity to build the relationship to better meet community needs. There are things the school can do that the NH can't and there are things the NH can do that we (school) can't and there are the things that we can do together'</i> (KI Interview 2015).</p>		
Governance	Partially demonstrated	yes
<p>While no new formal governance structure emerges, the TCHF has demonstrated multiple forms of governance. These include of different ways of co- planning. The HFW developed the MH professional network in response to an identified need to connect MH professionals. It is now registered with the national Mental Health Professionals Network and workers in the field regularly comment on its importance for professionals to connect to share service information, community needs and offer each other peer support.</p> <p>The NH are also part of the CFC Early Years' Service Integration Group that meets twice a year.</p>		

Table 17 shows how the SHCH TCHF project performed against the PBI key evaluation elements.

Table 17 Evaluation elements TCHF Project SHNH

TCHF Project St Helens Neighbourhood House	
Evaluation element	Demonstrated?
Establishing causality	Not demonstrated
Outside the scope of this evaluation given the timeframe of the program and the resources available.	
Attribution	Demonstrated
<p>Key informants identified a range of outcomes attributable to the TCHF</p> <ul style="list-style-type: none"> • families feel more connected with peers and community • is increased self-esteem • families are more connected into services • children and parents have better engagement with the school • parents have changed the way they are speaking and communicating <p><i>'Families are more aware of services and more confident in accessing services – may have known it was there previously but may not have engaged because they couldn't take that first step'</i> (KI Interview 2015).</p>	
Theory of change—Articulated	Demonstrated
Program logic developed identifying program activities (outputs) and short, medium and long term outcomes	
Theory of change—Measured	Partially demonstrated
<p>outputs measured in four activity reports submitted to NHT</p> <p>Families supported by the project continue to give feedback, verbal and/or written, indicating a significant decrease in feelings of social isolation and disconnection with their community</p>	
Residential mobility	Demonstrated
High transient population	
Cost-effectiveness	Not demonstrated
Outside the scope of the TCHF evaluation. However, the SHNH believes that the HFW is a highly cost effective strategy in terms of early intervention and capacity to address needs in vulnerable families	

7 Summary of Findings

Each house developed its own PBI in its own way responding to its own community, and the particular skills, strengths and interests of the Healthy Families Workers and house coordinators. In keeping with community development practice, the projects have continued to evolve as they have been implemented. Despite their different approaches, all houses reported positive impacts for clients who had engaged with the TCHF, particularly in terms of increased confidence, increased social connectedness and awareness and knowledge of services and willingness to actually engage with services.

‘... families attend more events (are more socially connected) and are comfortable approaching service providers. They know which services that best suit their needs’ (KI interview 2015).

‘It can be very slow to build trust in a relationship before they disclose they have issues and need support and then it’s another big step to actually meet with someone and get that support. It’s a developmental process’ (KI interview 2015).

‘...that level of independence from the centre [NH] is a real positive- when they can hold their own with their natural support systems. It frees up space to help new families who are just at the beginning of that journey’ (KI interview 2015).

‘...[there are] shifts within our community in awareness and wanting to learn more- TCHF is a strong part of that- as people become confident they start to ask the questions’ (KI interview 2015).

‘...there are always people who are more vocal and can express what they want but others sit back-but as a relationship develops, people are more likely to articulate their needs. If you work in a positive empowering way, they develop the skills to negotiate- it’s a new way of working for people (KI interview 2015).

7.1 Program Design and Delivery

The Thriving Communities Healthy Families initiative demonstrated all of Wilks et al (2015) PB elements to some degree in terms of program delivery and implementation and some of the evaluation elements. All projects were spatially targeted to the catchment areas of the participating Neighbourhood Houses. Social targeting was addressed through the focus on ‘at risk families’, albeit this was interpreted slightly differently by each house. Nonetheless projects generally focussed on disenfranchised and socially isolated families with young children.

The TCHF was deliberately non prescriptive in terms of program design and service delivery and all projects demonstrated flexibility whether this meant working in an outreach capacity, providing one to one services, service providers working out of the neighbourhood house or developing peer networks. Expenditure of funding was not particularly flexible given that most of the resources went to employing a community development worker as prescribed by the grant conditions. However all projects had a small amount of discretionary funding for health promotion activities. Projects also demonstrated a willingness to review initial concepts when they did not meet their community needs and in the case of the Eastern Shore

Community House, completely revised their approach 12 months into program implementation. Four out of the five projects demonstrated a strong outreach focus while the remaining project used outreach in a more limited way. Wilks et al (2015, 12) see outreach work as linked to service flexibility and as an important means of engaging disenfranchised people to the organisations and interventions which can support them.

Local autonomy, which is strongly associated with flexible delivery was a feature of the TCHF, and reflects the community development approach of the NH network. Local autonomy feeds into community ownership and community cohesion and is likely to 'generate enthusiasm and commitment amongst participants' (Wilks et al, 2015, 8).

Engaging with the disenfranchised was one major objective of the TCHF and the other was to work in partnership with other organisations to create better outcomes for those families. Therefore 'joined up working' is an integral component of the TCHF and this was evidenced through both the new partnerships formed and the established partnerships strengthened as the project was implemented. Joined up working recognises that the complexity and multiplicity of problems in a disadvantaged location requires a coordinated response and that no one organisation can do it all. Playing to each other's strengths is crucial to delivering people focussed holistic services (Wilks et al 2015).

Governance can be a fraught issue for of PBIs. There is a tension between governments' enabling flexibility in service delivery and enhancing local autonomy and the need to cede some accountability for government funds to local communities (Wilks et al, 2015). TCHF projects demonstrated a variety of governance models but no formal community led mechanisms emerged. What was evident was a cross collaboration particularly between the HFW and other local organisations. This took the form of regularly attending other organisations meetings and joining already established multi-disciplinary networks through to informal catch ups by phone and email. This did allow for a greater coherence around planning and coordinating programs and activities to meet community priorities and needs. Community members were involved to varying degrees in project governance but there was a general perception that despite capacity being built, they were not quite ready to step up yet and the HFW retained a pivotal role in facilitating, managing and delivering programs This can be attributed to the project timeframe, given that on the ground program implementation was less than two years.

Capacity development includes 'technical assistance in the form of resources and training pertinent to the implementation, operation and evaluation of PBIs' (Wilks et al, 2015, 12). Capacity development was an objective of the TCHF. The project included a specific evaluation capacity building component for participating NH staff but projects also demonstrated capacity building in their communities as a result of their programs. Again building capacity is central to how NH operate but the HFWs in particular demonstrated those 'skills in communication, management and partnership working... considered to be key to the success of PBIs' (Wilks et al, 2015, 12).

Wilks et al (2015) define 'Lead Times' as set up periods used to build relationships within communities, build capacity within service delivery organisations and ensure evaluations are in place, prior to program implementation. While the TCHF project included a six month lead time, it was generally agreed that this was not enough. Even in projects where the TCHF staff were well established in their communities, six months was too little time to build trust and partnerships while simultaneously designing and implementing their PBIs.

Long-term focus takes into account that disadvantaged areas have long term and complex problems to address which require a sustained effort to effect change. Time frames of 10 to 25 years have been suggested as necessary to effect positive changes in entrenched disadvantage (Wilks et al 2015). While all TCHF projects included sustainability in their approaches, the short timeframe did not allow projects to become completely embedded. It was a common response that projects were just beginning to ‘hit their straps’ as the funding ended. Despite this, all projects believed they had built capacity in their communities and that in turn might sustain some of the positive changes achieved. Specifically a number of the projects had created strong ongoing partnerships with schools and community organisations which is one way to maintain a long term focus (Wilks et al 2015.) While there was no long term focus in terms of ongoing funding for the healthy worker positions, a number of projects were investigating other options for continuing these functions through alternate funding sources.

Table 18 summarises the performance of the TCHF projects against the key PBI planning and delivery elements. All projects demonstrated spatial and social targeting, flexible delivery, joined up working, local autonomy and capacity development. Lead times were built into the TCHF but this element was only partially met by the projects given that all believed the time allowed was inadequate. No specific new formal governance structures emerged but all but one project had informal governance arrangements. All projects believed they had elements of sustainability,

Table 18 Summary of performance against PBI planning and delivery elements

Common PBI elements	# of TCHF project to demonstrates element		
	Yes	Partially met	No
Spatial targeting	all		
Social targeting	all		
Flexible delivery	all		
Local autonomy	all		
Joined-up working	all		
Governance	1	3	1
Capacity development	all		
Lead times	2	3	
Long-term focus (sustainability)	1	4	

7.2 Evaluation Elements

One of the ongoing criticisms of PBI evaluations is the methodological designs usually cannot demonstrate causality. In part, this is the nature of PBIs themselves- they do not easily lend themselves to the randomised control type studies which can calculate causal inference. Quasi-experimental designs, such as matched comparison groups or longitudinal studies using administrative or survey data , are possibilities for more robust methods of establishing causality (Wilks et al 2015). However, such studies are costly and time consuming and the generally small budget allocations for evaluation and short timeframes of projects do not lend themselves to such methodologies.

| This is the case for the TCHF; the total evaluation budget (\$50,000 over two years) did not allow for any sophisticated causality studies, the time frame of the project was very short (two and a half years), the five projects were quite different making a common data set to

inform a statistical analysis problematic. This is not to say that a quasi-experimental design is not possible for future projects of this type but they would need to take a much longer view and be adequately resourced.

The TCHF programs did not happen in isolation. There were other PBI activities and health promotion interventions going on in the five locations. For example, at least three locations had a Child and Family Centre and some had Communities for Children programs and Launch into Learning programs. However, the evaluation asked all key informants if they believed the TCHF had impacted specifically on families and communities and the majority said yes. Some key informants saw the TCHF more as a component of a bigger push to make a difference in disadvantaged areas so were less willing to attribute changes directly to any one intervention.

Each of the TCHF projects developed a theory of change and/or a program logic model as part of their evaluation capacity building. Despite this presenting a number of challenges as discussed earlier, each house created an evaluation plan, informed by a theory of change and conducted evaluation activities.

Wilks et al (2014) argues that a major concern from a PBI evaluation perspective is that people who might benefit most, leave the area. The St Helens project identified from the very beginning the transient nature of their 'at risk' population and this was a major issue with both engagement and supporting vulnerable families in an ongoing way. By comparison, the Eastern Shore project found that once their community leaders were empowered, they were moving on to greener pastures because they felt the location itself was dragging them down. Nonetheless the community leaders remained engaged with the project from out of area. The Maranoa Heights project has a high concentration of public housing clients and observed both a core stable group and another group constantly on the move due to fear of violence or perceived threats to safety.

Wilks et al (2014) found that cost benefit analyses (CBA) were largely missing from PBI evaluations; because they need to take a long term view and the benefits can take years or decades to emerge. This is also true of the TCHF evaluation. Again, the short timeframe, small evaluation budget and multiple nature of the project made CBA outside the scope of this evaluation. However, at the most rudimentary level, there could be some post hoc analysis performed. The overall funding for the project is known and all projects reported changes in families, which may be able to be costed in a generic way. For example, is it possible to calculate the dollar value of a long term unemployed person re-entering the workforce or engaging in training to become job ready or of HP interventions that keep children in their own homes as opposed to out of home care?

Table 19 summarised how the projects performed against the evaluation elements. All TCHF projects demonstrated attribution and all articulated a theory of change. All measured the theory of change to some degree mostly through output reporting while a number also measured outcomes as part of their own evaluation activities. No projects measured causality or cost effectiveness.

Table 19 Summary of performance against PBI evaluation elements

Common PBI elements	# of TCHF project to demonstrates element		
	Yes	Partially met	No
Causality			all
Attribution	all		
Theory of change—Articulated	all		
Theory of change—Measured		all	
Residential mobility	1	2	2
Cost-effectiveness			all

8 Policy Learnings

This report builds on the previous mid-term evaluation report (Doherty and Eccleston 2015) and as such seeks to provide a summative evaluation of the TCHF project and perhaps more importantly to identify policy learnings for future PBIs. The key objectives were to engage with disenfranchised families and to work in partnership with other organisations using place based principles and all five projects clearly met these objectives. This is not surprising given that neighbourhood houses have a community development model of practice which aligns well with place based theory. The advantage that the TCHF conferred on these five neighbourhood houses was that it provided for a specific resource, the Healthy Families Worker, to actively engage with the at risk and disenfranchised families in flexible and innovative ways. Therefore, the TCHF was *not* a health promotion program with a prescribed set of activities, which delivered services to a prescribed group of clients. It is the flexibility of the TCHF that gives it its strength but also makes it more challenging to evaluate and determine the elements, which are transferable in a policy sense.

8.1.1 Understanding ‘at risk’

The mid-term evaluation found that the houses operationalised the concept of at risk through ‘a process of community consultation, drawing on their own knowledge and that of other service providers, the existing community ‘profile’ and demographics and the perceived gaps in support for particular groups in the community’ (Doherty and Eccleston 2015). In this evaluation process, we asked key informants if their understanding of ‘at risk’ had changed as the program matured. While most believed it had not, this was qualified by a greater appreciation of the complexity and the vulnerability of their clients’ lives. What did change was how the program responded to the clients as relationships and understanding grew. For example as the understanding of ‘at risk’ broadened, communication styles and language changed to meet the needs of the ‘new’ audiences.

As key informants said

‘... lots of these families have complex issues and it takes time - TCHF can start working with families early and connect them before things go further- before the children get older and you have a whole other generation who are not connected and not attending school’ (KI Interview 2015).

‘No the clients did not change-but delivery of the program changed. When we first started we had a specific idea of what the program was and how it would be delivered

but things evolve and change and grow as community needs change. But the clients did not change' (KI Interview 2015).

'We knew that living in such a rural and isolated community and working with families with children aged from 0-12, that those factors alone can put them at risk. We can see clearly that some families are more prone to be at risk because of poverty, unemployment, drug and alcohol use, lack of transport but we can't discriminate. Some of the families that we work with, on the surface they don't seem 'at risk', but they are' (KI Interview 2015).

One key informant differed, saying

'[It] constantly evolved about who is at risk and how to access those at risk families – it changes a lot' (KI Interview 2015).

8.1.2 Engaging with the disenfranchised

While each project is unique, some commonalities in approaches to engagement with 'at risk' families emerged. Four main categories of engagement occurred as the program was implemented

- peer-to-peer initiatives
- one on one activities with the HFW
- outreach activities and being a presence in the community
- group work

All the projects used a combination of strategies, at different stages throughout the life of the program. Overall, being a presence in the community was the most common approach to engagement and group work the least common, (Progress reports July 2015, Dec 2015) but in some projects, a particular strategy dominated due to project design or the skills base of the HFW. For example, in East Devonport, the C4C which was a peer led model used peer-to-peer initiatives extensively.

8.1.3 Outreach

Having an outreach capacity emerged as an important factor in engaging with and providing services for disenfranchised families. In terms of engagement, outreach took the form of the HFW being a presence in the community; being in the places where families gather anyway and becoming a known face. As families became more accustomed to the HFW being around and grew more trustful, opportunities for engagement, without stigmatisation, arose.

Outreach, in some projects was about the HFW delivering one on one service to clients, going to their homes or meeting them in places where they felt comfortable. In other projects, it was about delivering programs in other settings such as schools or playgroups or the CFC.

'When the school has a sports day or an outreach program, we can now be there because the NH knows that those things are happening and I can be there' (KI Interview 2015).

'Because the HFW is outreach, she can go into the community, meet people in their homes, go over to the Salvation Army, or go meet with the IFS team leader to see if there are any at risk families who might benefit from TCHF program' (KI Interview 2015).

However outreach work was not universally embraced. In one project, outreach work was only a minimal part of the program because of perceived overtones of surveillance and invasion of privacy. Families can be distrustful of being judged and found wanting, due to previous experiences.

‘Outreach comes with all sort of baggage for some people-notions of surveillance and mistrust of systems...people have already had Mental Health, Drug and Alcohol and Child Protection in their lives and they’re ‘done to death’ with outreach. They don’t want more people in their homes’ (KI Interview 2015).

Outreach was also an important aspect of engaging with other services and all of the HFW tapped into existing cross-organisation governance arrangements as well as attending the regular meetings of other services and reaching out to potential partners.

‘I have been able to bring a lot of services to the CH by being an outreach worker and being out in the community’ (KI Interview 2015).

8.1.4 Peer to peer

The TCHF demonstrated a number of different peer-to-peer ways of working. As the ESNH found, people including the hard to reach, disenfranchised and disadvantaged, have their own social groups and social networks. For them, the strategy of identifying people, with leadership potential, from those groups, to engage with their peers was very successful. It bridged the gap between the NH and the hardest to reach people, who would not otherwise have connected with the NH.

‘The thing that came out of this project was a very good model to use in the future to support those people, refer those people and help them, improve their quality of life and health and wellbeing. The C4C was a very good way to engage with the people who would never come to the community house’ (KI interview 2015).

While ESCH designed a specific peer-to-peer program as the TCHF centrepiece, other houses supported mothers groups and women’s groups from which peer networks naturally emerged as clients became more confident and empowered. For example, at MHCC, more proactive women shared information with others on how best to access services or find furniture or additional food.

People also took advantage of technology and tapped into virtual networks, for example the Launceston mothers network where mothers who had engaged with the TCHF shared information with others.

‘I noticed a lot of trails around nutrition and tips and lunch boxes and mentions of the [TCHF] program. It’s very powerful- the mums can share what they have done with the [HFW] or the children in the cooking program’ (KI interview 2015).

8.1.5 Time and trust

Irrespective of the strategy, time to build relationships and trust underpins engagement with the disenfranchised. The key informants, both project workers and partner stakeholders

repeatedly identified time and trust as the key to engagement and distrust as a barrier to families in need getting the requisite supports they need. One key informant said

‘...it is about building that trust so that people will actually access services. It can be very slow to build trust in a relationship before they disclose they have issues and need support and then it’s another big step to actually meet with someone and get that support. It’s a developmental process’ (KI Interview 2015)

Other key informants said

‘... lot of families are very scared that their children will be removed- you can do all the reassuring you want, but until they actually engage with you and understand that you are not here to take the children- that takes a long time to build that trust – it can take months’ (KI Interview 2015).

‘you have that flexibility and trust which is an important part of working in the community ...it took me a year to build the trust and then we have had a wonderful year of successes. With the community, like everything it takes time - Trust building and relationship building is such an important factor’ (KI Interview 2015).

8.1.6 Investing for the long term

Wilks et al (2014) suggest that the successful delivery of PBIs requires stable, dependable and predictable policy. O’Dwyer et al (2007) agree, concluding that PBIs need political commitment, adequate funding and unchanging program objectives in order to work optimally. The need to break out of the short-term program funding cycle, when working with disadvantaged communities, was a regular theme in discussions with key stakeholders. It was closely related to building and maintaining trust with disenfranchised people. These people often have an existing trust deficit due to their previous experiences of supports disappearing when the funds run out.

It takes courage for marginalised community members to even engage with a new service or support worker, let alone enter onto an ongoing relationship. As discussed above, many are fearful of being judged harshly, particular around parenting skills, mental health and drug and alcohol issues. In many cases, it has taken the HFWs a year to become established as a trusted community resource but may take even longer for the clients to take the first step to actually access the support services they need. The short term funding of the TCHF (essentially 20 months implementation) makes it difficult to maintain that trust despite the best efforts of HFW to build sustainability into their projects.

‘It happens a lot in this community-programs get launched and developed in our community and then disappear and the community gets very distrustful of new programs. We can keep the program rolling on until March next year [2016] but after that will be a fight to keep it going. We are achieving so much and it will be devastating to let it go’ (KI Interview 2015).

‘...but people will stop engaging if funding is cut; their trust is decimated. So they say “what can you do for me”, but the behaviour won’t change. People get used to being let down so they learn to get what they can’ (KI Interview 2015).

8.2 Building evaluation capacity

There was an assumption that building evaluation capacity, as a staff development opportunity, was self-evidently of benefit to individual participants and would promote an evaluation culture within the Neighbourhood Houses. Further, there was an assumption that the Healthy Families Workers, once introduced to relevant evaluation concepts, tools and methods, would engage with evaluation as a positive endeavour. The reality was somewhat different. Ultimately, the ‘technical’ approach to ECB, adopted by the evaluation team did not suit the needs of the TCHF projects. The short timeframe and the limited resources available for ECB did not allow for a strong trust based relationship to form between the evaluation team and each sub-project. Evaluation was not a positive continuous reflective practice that enhanced the TCHF experience, but another demand on already stretched project resources

The TCHF experience suggests that when the focus of the ECB is on frontline workers already juggling competing demands in a time poor environment, it is likely to be seen as more a burden than a benefit. Neighbourhood House employees needed to build a partnership with the evaluation team prior to embarking in the ECB journey but limited time and resources did not allow for this especially when the TCHF project was fragmented into five separate projects. A partnership would have allowed trust to build and participants to gain confidence to apply evaluation skills and knowledge to their practice.

It seems clear that building evaluation capacity through ‘contract’ training did not really work in this project and perhaps something more akin to an ongoing mentorship model between community organisations and evaluation ‘expertise’ would be a better option for future ECB endeavours.

9 Concluding Comments

Overall the TCHF was a successful example of a PBI and achieved much in its relatively short time frame. The Neighbourhood House network is well situated, in terms of its model of practice, its physical locations and its relationship with the communities it serves to promote and facilitate PBIs. However, Neighbourhood Houses need ongoing support to do this. The project demonstrates clearly the need for PBIs to take a long-term policy view if they are to shift communities out of entrenched disadvantage and create a more positive future. This implies a move away from short term ‘programmatic’ funding cycles toward a model which takes a realistic account of the time needed to build trust and relationships and to plan, effect and measure change in disadvantaged Tasmanian communities.

10 References

- Australian Bureau of Statistics (2011) 'Catalogue 2033.0.55.001 - Socio-economic Indexes for Areas (SEIFA)', 2011
- Australian Bureau of Statistics (2012) 'Australian Health Survey: First Results, 2011–12', ABS Catalogue no 4364.0.55.001
- Centre for Community Child Health (2012) Place-based Initiatives Transforming Communities: Proceedings from the Place-based Approaches Roundtable, 21 March, Melbourne, Australia
- Cummins, S., S. Curtis, A. Diez-Roux, S. Macintyre (2007) 'Understanding and representing 'place' in health research: A relational approach', *Social Sciences & Medicine*, 65(9): 1825-1838
- Churchill B, Doherty B, Hansen E, and Eccleston R (2012) 'People & Place. Developing a Research Program for Understanding and Addressing Place-based Health Inequities in Tasmania', Literature Review prepared for Department of Health and Human Services, Tasmania
- Dahlgren G. and M. Whitehead (1991) 'Policies and strategies to promote social equity in health', Stockholm: Institute of Future Studies
- Doherty BT and Eccleston R (2015) Thriving Communities Healthy Families, Mid-Project Evaluation Report, Institute for the Study of Social Change, July 2015
- Doherty, BT and Eccleston, R and Hansen, E and Natalier, K and Churchill, B (2015), 'Building evaluation capacity in micro community organisations more burden than benefit?' *Evaluation of Journal of Australasia*, 15, (4) pp. 29-37. '
- Campbell, M., & Meadows, P. (2001). What works locally? Key lessons on local employment policies. York: York Publishing Services.
- Garcia-Iriarte E, Suarez-Balcazar Y, Taylor-Ritzler T, and Luna M (2011), 'A Catalyst-for-Change Approach to Evaluation Capacity Building', *American Journal of Evaluation* Volume 32, Number 2, 168-182
- Griggs, J., Whitworth, A., Walker, R., McLennan, D., & Noble, M. (2008). Person- or place-based policies to tackle disadvantage? Not knowing what works. York: Joseph Rowntree Foundation.
- Health Governance and Promotion Research Group (2014) Thriving Communities, Healthy Families-Project Evaluation Framework
- Huffman D, Thomas K and Lawrenz F. (2008) 'A Collaborative Immersion Approach to Evaluation Capacity Building', *American Journal of Evaluation*, Vol. 29 No. 3, September 358-368
- Katz, B. (2004). Neighbourhoods of choice and connection: The evolution of American neighbourhood policy and what it means for the United Kingdom. York: Joseph Rowntree Foundation.
- O'Dwyer, L. A., Baum, F., Kavanagh, A., & Macdougall, C. (2007). Do area-based interventions to reduce health inequalities work? A systematic review of evidence. *Critical Public Health*, 17, 317–335.

Burstein M and Tolley E (2011), 'Exploring The Effectiveness Of Place-Based Program Evaluations', Report prepared for the Policy Research Initiative

Preskill, H and Boyle, S (2008) 'A Multidisciplinary Model of Evaluation Capacity Building', American Journal of Evaluation, Volume 29 Number 4, 443-459

Rae, A. (2011). Learning from the past? A review of approaches to spatial targeting in urban policy. Planning Theory and Practice, 12, 331–348.

Rushton, C (2014) 'Whose place is it anyway? Representational politics in a place-based health initiative', Health and Place, Vol. 26 (pp100-109)

Wilks, S., Lahausse, J and Edwards, B (2015) 'Commonwealth Place-Based Service Delivery Initiatives Key Learnings project', Research Report no. 32, Melbourne: Australian Institute of Family Studies.

11 Appendices

11.1 Appendix A-project timeline

	Planned	Actual
Funding announced	June 2013	
Project commenced	July 2013	
Expressions of interest lodged	18 October 2013	
Successful applicants announced	1 November 2013	
MOUs NHT and NH signed	29 November 2013	
Recruitment Healthy Families Workers	Nov-Dec 2013	Jan- April 2014
Campbelltown meeting 1- meet UTAS	December 2013	
Project and worker commence	January 2014	Feb-June 2014
Campbelltown meeting 2- evaluation w/shop	April 2014	
Project plans complete	June 2014	August 2014
Evaluation workshops	May-June 2014	June 2014
Evaluation plans complete	June 2014	December 2014
Activity Report 1	June 2014	August 2014
Activity Report 2	December 2014	January 2015
Mid-term Evaluation report	March 2015	April 2015
Activity Report 3	June 2015	August 2015
Final activity Report	December 2015	December 2015
Final evaluation report	March 2016	

Source TCHF project plan 2014

11.2 Appendix B- Evaluation Plan 2015

Insert pdf

11.3 Appendix C- Key Informant Interview Questions

Neighbourhood House Key Informant semi structured Interview questions Round 1 (Nov/Dec 2014)

Program implementation

1. How did you define 'at risk' families for this program?
 - Why these families and not others in your neighbourhood?
 - Did you have other families who wanted to participate but did not fit your description?
2. How did you engage with your at risk families?
 - Specific strategies used
 - Number of different strategies
3. How well did your engagement strategies work
 - Did you have to change strategies?
 - Did you reach the people you wanted to reach?
 - Was responded better/worse than you expected?
 - Any negative/positive feedback from the community
4. Did your NH offer any new health promotion activities or expand any existing activities because of this project?
 - List them
5. How did you decide what health promotion activities to offer?
 - Did community have a say in what was offered
 - Did activities respond to communities expressed needs/priorities
6. Did any of your at risk families get involved in designing or running activities?
 - In what way?

Placed based interventions

7. What is it about your TCHF project that makes it "place based"?
 - Meet the unique needs of a location
 - Engage stakeholders in collaborative decision making
 - Tap into local resources and skills
 - Evolve and adapt to new learning and stakeholder interest
 - Cross organisation borders and collaborate
 - Shared ownership
 - Change norms in a location
8. How different is this to the way you usually work?
9. Did any of your at risk families get involved in designing or running activities?
 - In what way?
10. Have you created any new systems or management arrangements to include your families in ongoing priority setting or program development and implementation?

Partnerships

11. What strategies did you use to raise awareness of and support for the TCHF project amongst local organisations?

12. How successful do you think they have been?
 - How much support have you gained?
 - Which organisations?
 - Any surprises/unexpected allies?
13. Did you form any new partnerships as a result of this project?
 - How many partner organisations are actively involved?
 - How did the partnership evolve?
 - How is the partnership managed/governed?
14. Did any existing partnerships strengthen/ weaken?
 - In what way?
15. Have you had any positive/negative feedback from partners about the TCHF project?
16. Are there other relevant organisations in your area who have not engaged with the project?
 - Do you know why they have not engaged?
 - Are there any organisations in your area that have undermined the project?
17. Do you think local organisations have changed the way **they** work with at risk families as a result of the TCHF project?
 - Have changes been made to the content/organisation/timing/delivery of existing programs?
 - Are organisations working more collaboratively
 - Do you share information/resources/facilities?
18. Has your NH changed the way it works with local other services and organisations?
 - What are you doing differently
 - Are there barriers/enablers to change?

Evaluation capacity building and training

19. How realistic were the planning and evaluation expectations of this project?
20. Has the planning and evaluation training and support met your needs
 - Would have like more? Different?
21. Do you see a need for ongoing planning and evaluation support for your organisation?

Impacts of program

22. Have you noticed any changes in at risk families as a result of TCHF project?
 - What sort of changes
 - Most important?
23. Do at risk families now have better knowledge of available services in this area?
24. Do at risk families know how to access the services they need?
25. Overall what has been the greatest challenge to implementing the TCHF project in your area?

Neighbourhood House Key Informants semi structured interviews Round 2 (Oct/Nov 2015)

Program implementation

1. Did your ideas of at risk families change much as the program was implemented?
2. Did this change the way you engaged with families
3. Overall what would you say is the most important thing you have learned about engagement with families?
4. Do you think the NH is viewed differently by the community as a result of TCHF

HP interventions

5. What would be the most successful HP intervention you have done with the community
6. To what extent are HP activities self-sustaining

Placed based interventions

When we last talked, all the projects were showing strong signs of being place based
So it would be good to get an idea of how much that has progressed in the last year.

- Meet the unique needs of a location
- Engage stakeholders in collaborative decision making
- Tap into local resources and skills
- Evolve and adapt to new learning and stakeholder interest
- Cross organisation borders and collaborate
- Shared ownership
- Change norms in a location

Partnerships

7. Did your relationship with partner organisations change over the life of TCHF?
8. Has your NH changed the way it works with local other services and organisations?
9. Are there other relevant organisations in your area who have not engaged with the project?
10. Do you think local organisations have changed the way **they** work with at risk families as a result of the TCHF project?

Impacts of program

11. Have you noticed any changes in at risk families as a result of TCHF project?
12. Do at risk families now have better knowledge of available services in this area?
13. Are they more confident
14. Do they see a better future for themselves and their children

General

15. Overall what has been the greatest challenge to implementing the TCHF project in your area?
16. If you were doing the project again what if anything would you differently

Neighbourhood House key stakeholders Semi structured interview questions

Nov 2015-Jan 2016

Program implementation

1. How did you first hear about the TCHF?
2. What is your understanding of the project
3. What is your understanding of the role of the Healthy Families Worker?
4. Do you think community members see the NH differently because of the TCHF?

Partnerships

5. Do you (your organisation) see the NH differently because of the TCHF?
6. Did your (organisation/ personal) relationship with the NH change over the life of TCHF?
7. Do you think the NH has changed the way it works with *other* local services and organisations?
8. Do you think local organisations have changed the way **they** work with at risk families as a result of the TCHF project?

Impacts of program

9. Do you think anything has changes for risk families as a result of TCHF project?
10. Do you think at risk families now have better knowledge of available services in this area?
11. Are they more confident?
12. Do they see a better future for themselves and their children?
13. What do you think was the most useful thing that the TCHF did for this community?
14. What if anything could have been done differently in this project?

11.4 Appendix D- Mid Term Evaluation Report 2015

Will insert a PDF copy here

11.5 Appendix E - Data definitions for Activity Reports

family	A family group or an individual representing a family group
partner	Any organisation or service entity that makes a contribution to achieving the goals and objectives of the THCF project
engagement	Contact with the Project by way of being informed about or participating in an activity associated with the Project (less formal)
support	An activity or action under the auspices of the Project intended to achieve outcomes for the person, family or group. E.g. 1:1 support, participation in a group session (more formal)
supported	Participating in an activity or action intended to achieve outcomes for that person, family or group