

THE DEVELOPMENT OF EARLY START

The intent of this workshop is to look at issues in the development of population based intervention programmes using the development of the New Zealand Early Start programme as a model. The workshop will be presented in three modules that look at three general topics.

THE DEVELOPMENT OF EARLY START (Cont)

- 1. The research foundations of Early Start.**
- 2. Translating research into a programme.**
- 3. The evaluation of Early Start.**

The emphasis will be upon the practical lessons learned in developing Early Start and on challenging some contemporary assumptions about the development of community based programmes.

MODULE 1

THE RESEARCH BACKGROUND

The impetus for the development of Early Start came from the findings of the Christchurch Health and Development Study (CHDS). The CHDS is longitudinal study of a birth cohort of Christchurch born children that has been studied since 1977.

CHRISTCHURCH HEALTH AND DEVELOPMENT STUDY: AN OVERVIEW

- **Initial Study Group (cohort):** All children born in the Christchurch urban region during April to August 1977.
- **Number studied:** 1,265.
- **Ages studied:** Birth, 4 months, 1 year, annual intervals to 16 and again at 18 and 21.

CHRISTCHURCH HEALTH AND DEVELOPMENT STUDY: AN OVERVIEW (Cont)

- **Sources of Information: Parents, School Teachers, Children, Official Records.**
- **In general terms, the study has aimed to provide a running record of the social background, health and development of a large group of Christchurch born children as they move from infancy into adulthood.**

MODULE 1

THE RESEARCH BACKGROUND (Cont)

In the early 1990's the research began to focus on the characteristics and childhoods of “multiple problem” teenagers. Using methods of latent class analysis, the research identified a small group (2.6%) of teenagers who were characterised by pervasive and severe problems.

Comparisons of rates (%) of problem behaviours in multiple problem and other teenagers

Measure	Multiple Problem Teenagers	Other Teenagers	p
Early sexual activity	100.0	5.9	<.001
Conduct/oppositional disorder	100.0	8.3	<.001
Police contact for offending	55.0	8.3	<.001
Cannabis use	88.9	7.5	<.001
Alcohol abuse	40.7	4.0	<.001

Comparisons of rates (%) of problem behaviours in multiple problem and other teenagers (Cont)

Measure	Multiple Problem Teenagers	Other Teenagers	p
Substance abuse (other than alcohol)	55.6	3.1	<.001
Mood disorder	22.2	6.1	<.001
Suicidal ideation	29.6	6.9	<.001
Low self esteem (bottom decile of SEI score)	22.2	10.3	<.05
	N = 27	N = 915	

THE CHILDHOODS OF MULTIPLE PROBLEM ADOLESCENTS

Multiple problem teenagers tended to come from:

- a) Socially disadvantaged homes characterised by limited parental education, low socio-economic status and depressed living standards.**

- b) Family environments characterised by parental conflict, marital violence and parental separation/divorce.**

THE CHILDHOODS OF MULTIPLE PROBLEM ADOLESCENTS (Cont)

- c) Family environments characterised by impaired child rearing practices, exposure to child abuse and limited childhood experiences.**

- d) Family environments in which one or both parents had significant substance abuse problems or a history of criminal offending.**

THE CHILDHOODS OF MULTIPLE PROBLEM ADOLESCENTS (Cont)

However, what distinguished the multiple problem group from other teenagers was not the presence of a single risk factor (such as poverty; family violence or child abuse) but rather exposure to an accumulation of risk factors spanning: social disadvantage; family dysfunction; impaired child rearing environment and parental maladjustment.

THE ACCUMULATIVE RISK MODEL

To examine the impact of multiple risk factors on risks of multiple problem behaviour, a simple point score method was used. This method assigned one point for each disadvantage factor recorded and the extent of disadvantage was given by the sum of the points for each individual. The Table below shows the relationship between the points score and rate of multiple problem behaviours.

Distribution of disadvantage score and rate (%) of multiple problem behaviours

Score	% of Sample	Number of Multiple Problem Teenagers	Rate (%) of Multiple Problem Behaviour
0-6	54.5	1	0.2
7-12	29.8	7	2.5
13-18	10.3	8	8.3
19+	5.4	11	21.6
TOTAL	100.0	27	2.9

SOME IMPLICATIONS OF THE ACCUMULATIVE RISK MODEL

The accumulative risk model has a number of important implications for the development of intervention programmes. These implications are:

SOME IMPLICATIONS OF THE ACCUMULATIVE RISK MODEL (Cont)

- 1. That multiple problem teenagers were largely concentrated in the 15% most disadvantaged group of the population.**
- 2. What identified the families at risk of having a multiple problem teenager was an accumulation of adverse factors rather than a single specific factor.**

SOME IMPLICATIONS OF THE ACCUMULATIVE RISK MODEL (Cont)

Together these findings suggested that the most effective approach to developing effective interventions was through programmes that:

- 1. Target at risk families.**
- 2. Provide extensive interventions to address a wide range of family problems.**

YOSHIKAWA'S CRITERIA

In the early 1990's relatively little had been written about early intervention programmes targeted at behavioural rather than cognitive outcomes. However, an important contribution to this issue was made by Yoshikawa in his description of effective programmes. Yoshikawa suggested that the features of programmes that were likely to be effective were:

YOSHIKAWA'S CRITERIA (Cont)

- 1. Targeting: Since problems tend to concentrate in a minority of families who need substantial assistance, it is important that resources are targeted at meeting the needs of these families.**
- 2. Extensive Support: Because the issues associated with multiple problem families are extensive, it is important that programmes are extensive in their treatment of issues.**

YOSHIKAWA'S CRITERIA (Cont)

- 3. Home Visitation: Since many of the issues faced by multiple problem families occur within the home context, it is important that programmes are delivered by methods of home visitation.**
- 4. Extended Duration: The extent of problems requires long term programmes of up to 5 years duration rather than short term programmes.**

DISCUSSION QUESTIONS

The development of Early Start was largely motivated by an attempt to transform Yoshikawa's criteria into a viable family support programme targeted at high risk families. This decision raises a series of issues about:

- 1. The ethics of targeting: It has been suggested by some that programmes that target high risk groups may end up stigmatising these groups.**

DISCUSSION QUESTIONS (Cont)

- 2. Home visitation: What are the potential strengths and limitations of home visitation?**
- 3. Programme content: What areas should such programmes target?**
- 4. Programme duration: For how long should programme delivery last?**

MODULE 2: THE DEVELOPMENT OF THE EARLY START ORGANISATION

In the early 1990's there was growing concern in New Zealand about a series of issues relating to the health and wellbeing of children and young persons. These issues included: child abuse; youth suicide; truancy; school behaviours and juvenile crime.

MODULE 2: THE DEVELOPMENT OF THE EARLY START ORGANISATION (Cont)

All these outcomes are linked by the common theme that a disproportionate number of young people at risk of these outcomes come from multiple problem backgrounds. The findings of the CHDS thus focussed attention on the need to develop intensive home based interventions aimed at this population.

THE FOUNDATION OF EARLY START

The foundation of Early Start can be traced back to a meeting in 1993 between the Christchurch Health and Development Study and the Family Help Trust (FHT). The FHT had been using methods of home visitation to work with prisoner families.

At this meeting it was proposed that the work of the FHT should be extend to conduct a pilot study of the benefits of home visitation with at risk families.

The group was successful in attracting initial seeding funding from the Canterbury Trustbank Community Trust.

FORMING THE CONSORTIUM

It soon became apparent that to develop the programme would require co-operation from a range of community groups. As a result of this, a Consortium of providers came together to develop the Early Start programme. These providers included:

- 1. The Christchurch Health & Development Study.**
- 2. The Family Help Trust.**
- 3. The Royal New Zealand Plunket Society.**
- 4. The Pegasus GP group.**
- 5. Māori representatives.**

INITIAL OBJECTIVE

Although members of the Consortium were enthusiastic about developing a programme of home visitation for at risk families, they all had limited experience in this area. For this reason, it was decided that the most prudent course of action would be to conduct a pilot study of a sample of 50 families over an 18 month period. The aim of this pilot study was to examine the overall feasibility of developing a home based family support service.

KEY ISSUES IN THE PILOT STUDY

- 1. Could families be screened in a non stigmatizing way?**
- 2. Could families be persuaded to participate?**
- 3. Could services be delivered to families?**
- 4. Did services have an apparently beneficial effect?**
- 5. How did clients perceive the service?**

DEVELOPING THE SCREENING SYSTEM

A key phase of programme development was to devise a system that made it possible to identify, shortly after birth, those children born into high risk family environments.

Here, the involvement of the Plunket Society made a major contribution to programme development.

The Plunket Society nurses see in the region of 95% of children born within 2 months of birth. Coverage is higher than this for at risk births. These factors mean that it was possible for Early Start to use the Plunket Society as a screening and referral source.

THE SCREENING SYSTEM

After lengthy discussion, debate and consultation, the Early Start Consortium devised the following screening system:

- 1. Step 1 - Initial Screening: Plunket Nurses assessed all of their clients on a simple 11 item checklist that identified possible adverse family factors. Nurses were asked to refer any family that had 2 or more adverse factors or any family that they had concern about.**

THE SCREENING SYSTEM (Cont)

- 2. Step 2 - Assessment Phase: The families referred to Early Start were then contacted and invited to participate in Early Start for a one month initial period. This period gave Early Start an opportunity to conduct an in depth assessment of family needs and families an opportunity to assess the service provided by Early Start.**

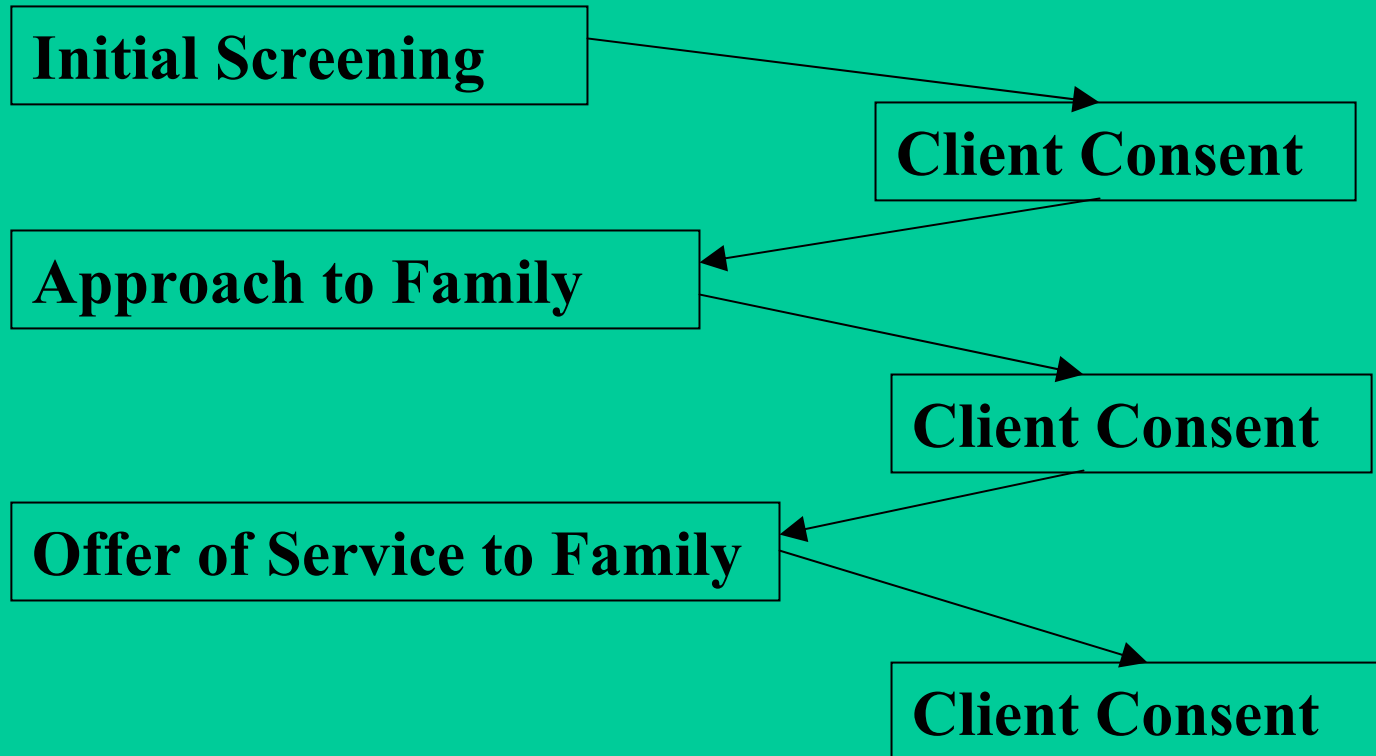
THE SCREENING SYSTEM (Cont)

- 3. Step 3 - Evaluation: At the end of the one month period Early Start evaluated the extent of family need using the Kemp Family Stress checklist. Families scoring 25 or more on this measure were deemed eligible for service provision.**
- 4. Step 4 - Offer of Service: After the evaluation process, families were then offered the service on a full time basis. Those with scores less than 25 were provided with 3 monthly visitation.**

THE CONSENT PROCESS

At the beginning of Early Start, concerns were expressed about the need for client families to enter the service on the basis of informed consent. To ensure that this ideal was achieved, Early Start required signed consent for each stage of the screening and referral process.

THE CONSENT PROCESS (Cont)



FAMILY SUPPORT WORKERS

Services to client families were provided by Family Support Workers (FSWs).

FSWs had training in either nursing or social work and also participated in a 5 week training course.

Each FSW has a client load of 15-20 families (depending on level of family need).

SERVICE PROVISION

Services are delivered to families via home visitation. The extent of service is determined by the level of family need. All families enter the service receiving weekly visitation (level 1 home visitation) and proceed over time to 3 months visitation (level 4 home visitation).

SERVICE PROVISION (Cont)

The overall aims of the home visitation process are to assist, support and empower families to address a series of issues relating to childhood wellbeing and family functioning. The function of the Family Support Worker is not to provide treatment, therapy or specialised advice, rather it is to assist families to seek such treatment, therapy and advice.

KEY AREAS OF SERVICE PROVISION

The aims of the service have been “manualised”. This was an important step of programme development in which specific methods and procedures were developed to address a series of broader goals and objectives. The major goals and objectives of the Early Start service are:

- 1. Child Health: To ensure that all children receive adequate well child care and timely visits for morbidity.**

KEY AREAS OF SERVICE PROVISION (Cont)

- 2. Child Protection: To ensure that all children are not exposed to neglectful or abusive home environments.**
- 3. Parenting: To assist, advise and empower parents in areas relating to parenting problems and parenting skills.**
- 4. Parental Wellbeing: To assist parents in addressing mental health and other issues that may affect family wellbeing.**

KEY AREAS OF SERVICE PROVISION (Cont)

5. **Family Economic Wellbeing**: To provide families with advice and support in addressing family budgeting and related matters.
6. **Crisis Support**: To provide families with advice and support during medical, financial, legal or other crises.

THE FAMILIES IN THE PILOT STUDY

a) Socio-demographic Background

Mean age of mother	23.5 years (range: 16 - 39 years)
% Mother left school with no formal educational qualifications	70.9%
% Mother of Māori/part Māori ethnicity	14.5%
% Single parent family	67.3%
Median family size	1 child (range: 1-5 children)
% Home ownership	10.9%

THE FAMILIES IN THE PILOT STUDY (Cont)

b) Maternal Childhood

Measure	N	% of Mothers
<i>Family Stability</i>		
Raised in single parent family	29	52.7
Parents separated/divorced	16	29.1
>2 Changes of family situation	25	45.5

THE FAMILIES IN THE PILOT STUDY (Cont)

b) Maternal Childhood (Cont)

Measure	N	% of Mothers
<i>Parental Conflict/Substance Use</i>		
Ongoing parental conflict	37	67.3
Witnessed violence between parents	32	38.2
Parents frequently drugged or drunk	24	43.6

THE FAMILIES IN THE PILOT STUDY (Cont)

b) Maternal Childhood (Cont)

Measure	N	% of Mothers
<i>Child Abuse/Neglect</i>		
Frequent beatings, physical ill treatment	19	34.5
Mother subjected to child abuse	32	58.2
Witnessed physical abuse of sibling	14	25.2
Constantly scapegoated as ‘black sheep’ of family	28	50.9
Lack of parental care	15	27.3
Mother left alone to look after herself	12	21.8
Mother taken into welfare care	12	21.8
Mother placed in foster home(s)	13	23.6
Mother placed in children’s home(s)	12	21.8

THE FAMILIES IN THE PILOT STUDY (Cont)

b) Maternal Childhood (Cont)

Measure	N	% of Mothers
<i>Economic Hardship</i>		
Family very poor	18	32.7
Often not enough food in the house	10	18.2
At least one of the above	52	94.5

THE FAMILIES IN THE PILOT STUDY (Cont)

c) Psycho-social Adjustment

Measure	N	% of Mothers
Problems with alcohol	17	30.9
Problems with drugs	21	38.2
Problems with offending	17	30.9
Mental health problems	21	38.2
At least one of the above	39	70.9

KEY ISSUES IN THE DEVELOPMENT OF EARLY START

- 1. The Development Process: Those advocating for community based programmes often propose a developmental model in which the programme is “devised by the community for the community”. The Early Start programme did not follow this “bottom up” approach. Essentially the programme was based on a “top down” organisational model in which a series of agencies with leadership in health care, service provision, research and cultural issues came together to build a programme for their community using the best available knowledge from their respective areas.**

KEY ISSUES IN THE DEVELOPMENT OF EARLY START (Cont)

The strength of this approach was that it built on existing expertise and leaderships rather than letting programme directions be shaped by an unstructured community based democracy.

KEY ISSUES IN THE DEVELOPMENT OF EARLY START (Cont)

- 2. A Balanced Approach to Family Issues: Many of those who propose family support or related programmes argue for a “strengths based” approach to build “family resiliency”. We have found serious problems with this model to the extent that it denigrates a focus on family problems as a “deficits model”. The real risk of this approach is that it can lead to the disregard of serious family issues including: physical abuse; sexual abuse and child neglect.**

KEY ISSUES IN THE DEVELOPMENT OF EARLY START (Cont)

Working with at risk families requires striking a realistic balance between:

- a) Recognising the range of problems and difficulties that these families face.**
- b) Developing strengths and skills to overcome these issues.**

These outcomes cannot be achieved by:

- Programmes that ignore deficits and focus on strengths, or,**
- Programmes that ignore strengths and focus on deficits.**

KEY ISSUES IN THE DEVELOPMENT OF EARLY START (Cont)

- 3. The Development of Organisational and Management Structures: The early development of the programme was marked by considerable conflict over management issues. These difficulties centred around the appointment of a manager who had limited management and organisational skill. From this experience, the Early Start programme has focussed on the development of a strong management model in which the organisation is based on a clear division of labour and clear lines of authority.**

KEY ISSUES IN THE DEVELOPMENT OF EARLY START (Cont)

- 4. Cultural Consultation: A key issue in New Zealand social policy has been an emphasis on the Treaty of Waitangi. This founding document of New Zealand guarantees the indigenous people of New Zealand protection of their rights, liberties and land. A focus of all government based initiatives is to ensure adequate Māori representation.**

KEY ISSUES IN THE DEVELOPMENT OF EARLY START (Cont)

This issue has been addressed in the following ways:

- 1. Appointing Māori to the Board of Early Start.
Currently 4 of the 8 Board members are Māori women.**
- 2. Ensuring Māori representation amongst FSWs,
currently 20% of the workforce is Māori.**
- 3. Having regular cultural training at Marae (Tribal meeting places).**

MODULE 3: EVALUATION

Parallel to the development of Early Start, systematic processes were put in place to evaluate the programme. The evaluation process involved 2 stages:

MODULE 3: EVALUATION (Cont)

- 1. Pilot Study: In the first stage of the evaluation a pilot study of 55 families enrolled in the programme was conducted. The overall aims of the pilot study were:**
 - To assess the feasibility of setting up a home visitation service.**
 - To examine possible benefits of the programme for families.**
 - To examine client satisfaction.**

MODULE 3: EVALUATION (Cont)

- 2. Randomised Trial: In the second stage of the evaluation, a randomised trial was conducted in which 220 families receiving the service were contrasted with a control series of 220 families not receiving the service. The aims of the randomised trial were to examine the extent to which children and families receiving the service showed benefits when compared to the control series. Areas examined included:**

MODULE 3: EVALUATION (Cont)

- **Child health and health care.**
- **Child abuse and neglect.**
- **Parenting.**
- **Maternal mental health.**
- **Family economic functioning.**

THE PILOT STUDY

Families for the pilot study were obtained by screening families in a region of Christchurch for a period of 3 months. The Table below describes the recruitment process.

THE PILOT STUDY (Cont)

a) Enrolment statistics

	N	% of Population
Number of families screened by Plunket Nurse	396	100
Number identified as eligible for programme	69	17.4
Number agreeing to programme referral	58	14.6
Number enrolled in programme	55	13.8
Number participating in programme	51	12.8

THE PILOT STUDY (Cont)

b) Sources of loss to recruitment

	N	% of Loss
Refused referral to Early Start	11	61.1
Refused Early Start contact after initial approach	3	16.7
Withdrew from programme after initial enrolment	4	22.2
	18	100

FAMILY CHARACTERISTICS

The family characteristics of the 55 families initially enrolled in the service have been described previously in Module 2. Nonetheless, it is perhaps worth revisiting this information.

FAMILY CHARACTERISTICS

a) Socio-demographic Background

Mean age of mother	23.5 years (range: 16 - 39 years)
% Mother left school with no formal educational qualifications	70.9%
% Mother of Māori/part Māori ethnicity	14.5%
% Single parent family	67.3%
Median family size	1 child (range: 1-5 children)
% Home ownership	10.9%

FAMILY CHARACTERISTICS (Cont)

b) Maternal Childhood

Measure	N	% of Mothers
<i>Family Stability</i>		
Raised in single parent family	29	52.7
Parents separated/divorced	16	29.1
>2 Changes of family situation	25	45.5

FAMILY CHARACTERISTICS (Cont)

b) Maternal Childhood (Cont)

Measure	N	% of Mothers
<i>Parental Conflict/Substance Use</i>		
Ongoing parental conflict	37	67.3
Witnessed violence between parents	32	38.2
Parents frequently drugged or drunk	24	43.6

FAMILY CHARACTERISTICS

b) Maternal Childhood (Cont)

Measure	N	% of Mothers
<i>Child Abuse/Neglect</i>		
Frequent beatings, physical ill treatment	19	34.5
Mother subjected to child abuse	32	58.2
Witnessed physical abuse of sibling	14	25.2
Constantly scapegoated as 'black sheep' of family	28	50.9
Lack of parental care	15	27.3
Mother left alone to look after herself	12	21.8
Mother taken into welfare care	12	21.8
Mother placed in foster home(s)	13	23.6
Mother placed in children's home(s)	12	21.8

FAMILY CHARACTERISTICS

b) Maternal Childhood (Cont)

Measure	N	% of Mothers
<i>Economic Hardship</i>		
Family very poor	18	32.7
Often not enough food in the house	10	18.2
At least one of the above	52	94.5

FAMILY CHARACTERISTICS

c) Psycho-social Adjustment

Measure	N	% of Mothers
Problems with alcohol	17	30.9
Problems with drugs	21	38.2
Problems with offending	17	30.9
Mental health problems	21	38.2
At least one of the above	39	70.9

SERVICE PROVISION

One way of examining the services provided to families is to examine the frequency of contact between FSWs and families. This is described in the Table below.

This Table shows the relatively intensive nature of the service provision with clients receiving an average of over 100 contacts over the 18 month period.

SERVICE PROVISION (Cont)

	Time			
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)	Overall 0-18 months (N = 36)
<u>Family Support Worker home visits</u>				
Mean number of visits	21.4	18.2	15.5	52.8
<u>Family Support Worker direct client contacts (meetings, hospital visits, phone calls, etc)</u>				
Mean number of contacts	18.9	23.0	17.7	62.3
<u>Family Support Worker indirect contacts on behalf of clients</u>				
Mean number of contacts	15.1	13.7	10.3	38.4

SERVICE PROVISION (Cont)

The services delivered to families varied according to family need. The Table below describes the key elements of the family support plans at times: 0-6 months; 6-12 months and 12-18 months.

SERVICE PROVISION (Cont)

	Time		
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)
Budgeting advice	83.3	90.9	83.3
Support/treatment for alcohol abuse	16.7	15.9	19.4
Support/treatment for drug abuse	18.8	13.6	19.4
Meeting child's basic care needs	93.7	93.2	77.8
Arranging respite care/child care	47.9	59.1	52.8
Assistance with legal matters	35.4	38.6	33.3
Assistance with transport	66.7	70.5	61.1

SERVICE PROVISION (Cont)

	Time		
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)
Household management	66.7	61.4	55.6
Parenting courses	60.4	65.9	52.8
Monitoring of depression	64.6	63.6	75.0
Support with counselling (individual/family/ couple)	56.3	54.5	61.1
Support with parent self help groups/courses	43.7	59.1	52.8
Support with employment	12.5	22.7	36.1

OUTCOMES OF PILOT STUDY

a) Child Health

	Time		
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)
% up to date with immunisation	100	97.7	100.0
% up to date with well child checks	100	95.5	97.2

OUTCOMES OF PILOT STUDY (Cont)

a) Child Health

Measure	Time		
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)
% Breastfed (ever)	87.5	-	-
% Breastfed for 3 months or longer	54.2	-	-
% Non prone sleeping	100.0	-	-
% Smoke free environment	39.6	34.1	47.2
% Age appropriate car seat always used	81.2	81.8	91.7
% Safe storage of household poisons	62.5	84.1	97.2
% Hazard free home environment	47.9	72.7	63.9
% Safe play area for child	-	52.3	66.7

OUTCOMES OF PILOT STUDY (Cont)

a) Child Health

	Time			Overall 0-18 months (N = 36)
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)	
Mean (range) number of GP contacts for morbidity	4.7 (0-16)	4.9 (0-17)	2.9 (0-11)	12.9 (0-38)
% Admitted to hospital	31.3	25.0	11.1	44.4
% Attending hospital outpatient department	35.4	36.4	30.6	55.6

OUTCOMES OF PILOT STUDY (Cont)

b) Child Abuse and Neglect

Measure	Time		
	6 months (N = 48)	12 months (N = 44)	18 months (N = 36)
% for whom concern existed about possible abuse/neglect	45.8	38.6	27.7
No. of families notified to Children and Young Persons Service because of concern about abuse/neglect	3	4	0
No. of children admitted to hospital because of abuse/neglect	2	0	0

OUTCOMES OF PILOT STUDY (Cont)

c) Maternal Mental Health

Measure	Time		
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)
% Mothers with depression	72.9	29.5	5.5
% Mothers with alcohol problems	14.6	25.0	11.1
% Mothers using illicit drugs	14.6	18.2	11.1
% Mothers with a significant drug problem	12.5	13.6	13.9
% Mothers arrested or convicted	6.2	11.4	0.0

OUTCOMES OF PILOT STUDY (Cont)

d) Maternal Conflict and Family Violence

Measure	Time		
	0-6 months	6-12 months	12-18 months
% Mothers with partners	60.4	52.3	50.0
<u>Characteristics of relationship (for those with partners)</u>	(N = 29)	(N =23)	(N = 18)
% Having significant conflicts with partners	96.6	91.3	94.4
% Subject to verbal abuse by partner	82.8	69.6	72.2
% Subject to physical violence by partner	31.0	17.3	5.5

OUTCOMES OF PILOT STUDY (Cont)

e) Economic Circumstances

Measure	Time		
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)
% Dependent on welfare benefits	93.8	-	83.3
% Family having difficulties making ends meet	91.7	95.5	91.7
% Family unable to save	89.6	88.6	88.9
% Families with debts in excess of \$500	68.7	59.1	63.9
% Families with below average living standards	75.0	75.0	66.7
% Family obviously poor	20.8	18.2	16.7

OUTCOMES OF PILOT STUDY (Cont)

f) Client Satisfaction

	Yes, a lot	Yes, a little	No, not at all	Did not answer
Helped me to understand what my baby/children's needs are in order to grow and develop	66.6%	33.3%	-	-
Helped me to enjoy playing with my baby/children	56.4%	35.8%	7.6%	-
Helped me to talk to and to interact with my baby/children.	53.8%	43.5%	2.5%	-
Helped me to feel more at ease when I asked for help	61.5%	30.7%	7.6%	-

OUTCOMES OF PILOT STUDY (Cont)

f) Client Satisfaction (Cont)

	Yes, a lot	Yes, a little	No, not at all	Did not answer
Helped me to make good use of other community services	51.2%	43.5%	5.1%	-
Have you generally felt supported by your Family Support Worker	89.7%	7.6%	2.5%	-
The Early Start programme has treated me and my family in a way that is culturally appropriate and sensitive	92.3%	5.1%	-	5.1%
I feel that my Family Support Worker understands and respects my cultural background and values	69.2%	20.5%	2.5%	7.6%

MAJOR CONCLUSIONS FROM PILOT STUDY

- **Client identification methods produced an acceptable level (79%) of programme participation.**
- **It was possible to deliver a programme of family support to at risk families.**
- **There were clear programme benefits in areas involving “new learning” including: child health care; parenting; the management of maternal depression.**

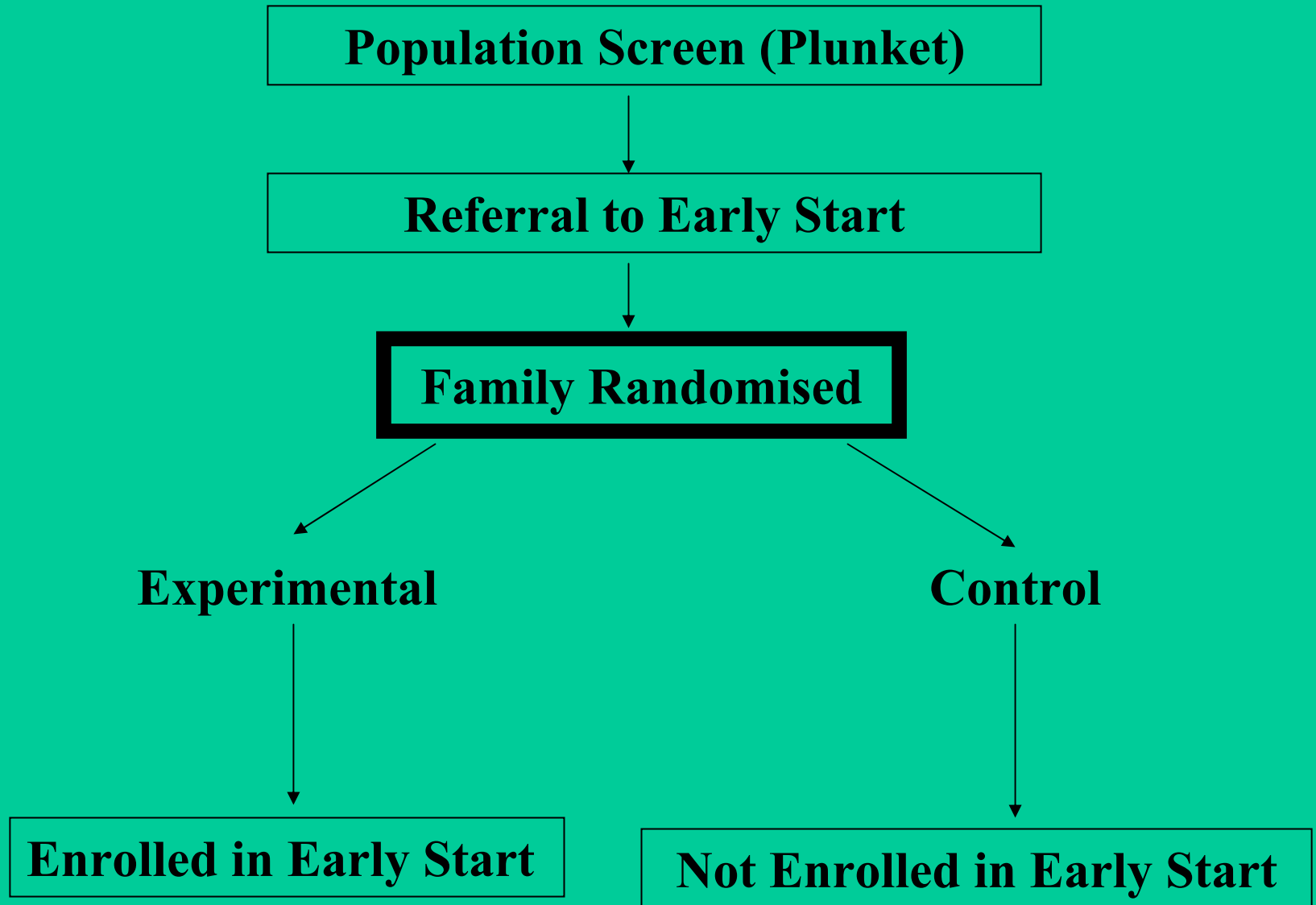
MAJOR CONCLUSIONS FROM PILOT STUDY (Cont)

- **The programme was less successful in addressing such issues as parental substance use, family conflict, and depressed family living standards.**
- **The great majority (over 90%) of programme participants felt the programme was worthwhile, helpful and culturally appropriate.**

THE RANDOMISED TRIAL

The second stage of the evaluation involved a randomised trial in which 220 children and their families receiving Early Start were contrasted with a randomly assigned series of 220 children and families not receiving the service.

OVERVIEW OF RECRUITMENT PROCESS



CHARACTERISTICS OF FAMILIES AT POINT OF ENROLMENT

	Experimental	Control
<u>Social Background</u>		
Mean age of mother	24.5	24.4
% Mother lacked educational qualifications	68.9	67.3
% Mother of Maori ethnicity	25.5	27.5
% Single parent family	63.8	63.5
% Pregnancy unplanned	76.0	76.3

CHARACTERISTICS OF FAMILIES AT POINT OF ENROLMENT (Cont)

	Experimental	Control
<u>Maternal Childhood</u>		
% Raised in single parent family	56.1	50.2
% Interparental assault	29.6	34.6
% Child abuse	36.7	37.0
% Mother ran away from home	42.9	49.3
% Teenage alcohol problems	20.4	19.4
% In trouble with Police	33.2	34.1

CHARACTERISTICS OF FAMILIES AT POINT OF ENROLMENT (Cont)

	Experimental	Control
<u>Family Features</u>		
% Welfare dependent	88.8	90.1
Mean family income (\$ per week)	344	342
% Family in debt (excl. mortgage)	42.4	52.6
% Assaulted by partner	34.2	25.0

OUTCOMES AT 1 YEAR

After 1 year of service provisions there were relatively few differences between the experimental and control groups in the areas of:

- a) Well child care.**
- b) Home safety.**
- c) Maternal mental health.**
- d) Family economic circumstances.**

However, there were some emerging differences in the area of preschool education, child abuse risks and parenting.

DIFFERENCES AT 1 YEAR

Measure	Experimental	Control	p
Attending preschool education	50.5	38.9	<.05
Mean hours attended	13.1	10.2	<.05
Maternal warmth	4.2	4.0	<.10
Maternal sensitivity	4.4	4.2	<.10
Contact with welfare agencies for abuse/neglect issues	4	16	<.01

OUTCOMES AT 2 YEARS

The 2 year evaluation has not been completed but data are available on nearly 60% of the sample. The 2 year evaluation shows an increasing pattern of differences between the experimental and control series.

DIFFERENCES AT 2 YEARS

Measure	Experimental	Control	p
% Attending preschool	69.0	56.0	<.05
Mean number of home safety features	6.4	5.9	<.05
Current maternal depression	10.4	13.4	>.40
% Consulted doctor for depression	29.0	19.0	<.05
% Medications for depression	28.0	17.0	<.05

DIFFERENCES AT 2 YEARS

Measure	Experimental	Control	p
% Attended hospital (past year)	33.6	42.3	<.10
% Mother hit child in last week	32.8	40.8	<.10
Number of families in contact with welfare agencies for possible abuse/neglect	11	23	<.01

CONCLUSIONS FROM TRIAL TO DATE

It is clear that the provision of Family Support via Early Start did not produce large and immediate changes in families. However, over time there is an emerging trend for the experimental families to fare better than control families in a number of areas including: preschool education; home safety; maternal depression; child abuse risk. We anticipate that these differences will increase in the third and subsequent years of the trial. An important issue will clearly focus on examining the differences in children at the point of school entry.

REASONS FOR LIMITED SUCCESS OF RANDOMISED TRIALS OF EARLY INTERVENTION

Recent literature reviews have suggested that randomised trials of home visitation have often failed to show benefits with successful trials being the exception rather than the rule.

REASONS FOR LIMITED SUCCESS OF RANDOMISED TRIALS OF EARLY INTERVENTION (Cont)

There may be a number of reasons for this:

- 1. Control groups may receive similar services via alternative routes. Controls are not “untreated” they receive less treatment.**
- 2. Change in families may be difficult to achieve and progress may be slow and limited.**
- 3. Interventions may not provide sufficient input or the right type of input.**

THREE LESSONS WE HAVE LEARNED ABOUT SUCCESSFUL CHANGES

- 1. The programme needs to develop clearly defined programme goals about desirable outcomes (eg, increasing levels of immunisation).**
- 2. The programme needs to develop a clear specification of the processes and used to achieve the outcomes (eg, involving parents actively in considering immunisation; providing support; offering transport if needed).**

THREE LESSONS WE HAVE LEARNED ABOUT SUCCESSFUL CHANGES (Cont)

- 3. The programme needs to closely monitor achievement of targets at regular intervals (eg, Who is fully immunised, who is not, what are the reasons for non immunisation?)**

In the end a strategy of doing simple things well seems to work best.