The Development of Early Start

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EARLY START PROJECT LTD

A Joint Venture consisting of:

The Family Help Trust

Christchurch Health and Development Study

Royal NZ Plunket Society (Southern Region)

Pegasus Medical Group (95)

Rakau Te Kura (MWWL)

Kaumatua (B Tainui)

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ACKNOWLEDGEMENTS

This report describes the results of a pilot study to examine the feasibility of setting up intensive family support and home visitation to at risk families in Christchurch. The success of this endeavour has depended critically on the work of a large number of individuals and organisations who have worked on, collaborated with or supported the project.

First and foremost are the members of the Early Start field organisation headed by Mrs L Robins who have worked tirelessly and enthusiastically to ensure the project has been a success. The family support workers who have delivered services to the families described in this report include: Karen Austen, Monica Erasmussen, Clare Garrett, Te Rangihau Dunn, Tupou Tavui, Susan Smith, Margaret Parks and Carol Bartle.

A factor that has undoubtedly contributed to the success of Early Start is that the programme has been developed and supported by a consortium of providers who have contributed in various ways in the development of Early Start. These organisations include: the Family Help Trust; the Southern Regional Office of the Royal New Zealand Plunket Society; the Pegasus Medical Group; the Rakau Te Kura branch of the Maori Women's Welfare League and the Christchurch Health and Development Study. Members of these organisations who have served on the consortium include: David Close (Family Help Trust); Geoff Instone (Plunket, Southern Regional Office); Jan Egan (Plunket, Southern Regional Office); Jenny Carter (Plunket, North East Sector); T Kipa (Rakau Te Kura MWWL); B Tainui (Kaumatua); L Gray (Pegasus Medical Group) and Mark Hunter (Plunket, Southern Regional Paediatrician). Particular thanks are due to Mrs B Tainui, Mrs T Kipa and Mr H Kipa for their wise and thoughtful advice about ways of ensuring that the service was culturally appropriate for Maori families.

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Whilst all of these groups (and many others) have contributed to the development and success of the Early Start programme, the views stated here are those of the authors and we are, of course, responsible for any errors or shortcomings in the report.

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EXECUTIVE SUMMARY

This report provides an account of the development, progress and outcomes of a pilot study of the Early Start programme applied to a group of 51 families who have participated in the programme for up to 18 months. The major findings and conclusions of this evaluation are summarised below.

1. Client Recruitment and Characteristics: Chapter 2 provides an account of the processes used to identify and enrol Early Start clients. It concludes that these processes are adequate since of the 69 families identified by Plunket Nurses as being potentially eligible for family support, 51 (74%) participated in the Early Start programme. The major source of client loss was the family's refusal to the Plunket Nurse to make a referral to Early Start. This chapter also presents a profile of client families and reveals that most were subject to multiple difficulties that spanned: socio-economic disadvantage; unsatisfactory childhood experiences of mothers; maternal adjustment problems and unsatisfactory partnership relationships.

2. Service Provision: Chapter 3 gives an overview of the service provision methods used by Early Start. This service provision is characterised by three key features. First, the service maintains high contact with client families, with these families visited at home on average 53 times over the 18 month period. Second, for each family a personalised family support plan is developed to address key issues and difficulties faced by the family, with this plan being updated and revised at regular intervals. Third, the service has developed linkages and networks with a wide range of service providers in the areas of child and family health and welfare. This combination of intensive home visitation, a personalised family support plan and linkages with providers, provides client families with a consistent source of advice, support and mentorship in dealing with the difficulties and stresses they face.

3. Child Health: Chapter 4 examines the health history and health care of children in Early Start. This analysis suggests that a clear benefit of the programme is likely to be in the area of ensuring high levels of medical contact surveillance and care of children. This benefit was particularly clear in the area of immunisation and well child checks with Early Start children being almost invariably up-to-date with these provisions.

4. Parenting and Child Abuse Risks: Chapter 5 presents evidence to suggest that with increasing participation in the programme, there were improvements in parenting and a reduction in child abuse risks.

5. Parental Psychological Adjustment: Chapter 6 examines changes in parental psychological adjustment over the course of the programme. There was clear evidence to suggest that participation in Early Start was associated with a dramatic reduction in rates of depression amongst client mothers. However in other areas including substance abuse, criminality and partner relationships, little change was observed.

6. Family Economic Circumstances: Chapter 7 examines change in family economic circumstances over the course of the programme. Relatively little change was found and throughout the programme Early Start families remained relatively impoverished and largely welfare dependent.

7. Client Satisfaction: Chapter 8 reports on a survey of client satisfaction. This survey suggested that the great majority of clients saw the services as supportive and culturally appropriate. Over the course of the pilot programme only two clients withdrew because of dissatisfaction with the programme.

8. Overall Conclusions: The data gathered in this study support four major conclusions about the Early Start programme. First, that the client identification methods used by the programme produced an acceptable level of programme participation. Second, that the Early Start programme had developed an organisation and infra structure that provided for consistent home visitation, supervision of service provision and linkages with other provider organisations. Third, there were apparent benefits of the programme for client families, with these benefits being most evident for child health care and parenting, and least evident for family economic functioning. Fourth, that the programme was seen as supportive and culturally appropriate by its clientele. However, whilst the results of this evaluation are generally positive, it is important to note that they fall far short of demonstrating the benefits of the programme conclusively. Such evaluation requires a randomised field trial in which a group of families receiving the programme is contrasted with an equivalent group of families not receiving the programme. The present report, however, supports the view that the progress made in the development of Early Start is sufficiently promising to justify the development of such a field trial.

CHAPTER 1

INTRODUCTION

Early Start is a Christchurch based programme that is being developed by a Consortium of providers that includes: the Family Help Trust; the Christchurch Health and Development Study; the Southern Regional Office of the Royal New Zealand Plunket Society; the Pegasus Medical Group Ltd; and Maori representatives. The aims of this consortium have been to develop an intensive home based family support system to meet the needs of high risk families and their children. This report provides a descriptive account and process evaluation of this programme as it was applied to a pilot group of 51 families enrolled in the programme for a period of at least 18 months. The specific aims of the report are to describe:

- The background history that led to the development of the Early Start programme.
- The processes by which client families were recruited.
- The range of family support services offered to families.
- The progress of families and children receiving the service.
- Client satisfaction and a range of issues relating to the ethics of early intervention.

It must be stressed that the aims of the report are largely to provide a descriptive account of the Early Start programme, the reasons for its existence and the ways in which it works. Whilst this account is often suggestive of the fact that the programme is successful in its aims of mitigating the risks faced by children in high risk families, the descriptive methodology used in this report precludes the making of strong conclusions about programme efficacy. To assess this efficacy it is necessary to conduct a randomised field trial in which a group of children receiving the Early Start programme is compared with a randomly assigned group of children not receiving this programme. Such a trial is planned for the future. However, before initiating a systematic trial to evaluate the efficacy of Early Start it was believed to be necessary to conduct a pilot project and process evaluation to determine whether the programme could run in the way intended and deliver the kind of services expected of the programme. This report is devoted to providing this necessary descriptive prelude to more systematic experimental research.

The Development of the Early Start Programme

The impetus for the development of the Early Start programme began in the early 1990s as a result of growing recognition of increasing rates of psychosocial problems in children. These issues spanned disruptive behaviour patterns and truancy [(1)]; adolescent substance use and abuse [(2-4)]; child and adolescent mental health [(5-6)] and youth suicide [(6-8)]. It became

increasingly apparent that these problems frequently overlapped and frequently involved a relatively small minority of children who came from disadvantaged, dysfunctional and often chaotic home environments.

These issues were highlighted in a study conducted by the Christchurch Health and Development Study that used longitudinally collected data to study the childhood history of a group of young people who had developed severe behavioural difficulties by the age of 15 years [9]. This analysis revealed, in nearly all cases, the presence of childhood and family histories marked by a wide range of disadvantages and difficulties including socio-economic disadvantage, family conflict and instability, impaired child rearing practices, limited childhood experiences and restricted life opportunities. The most striking finding of the study was that young people reared in the most disadvantaged 5% of the cohort had risks of severe maladjustment that were over 100 times the risks for young people in the most advantaged 50% of the cohort. The clear implication of this result was that if substantial progress was to be made in the area of addressing childhood and adolescent problems there was a need to address the difficulties and stresses faced by children reared in severely disadvantaged, dysfunctional or chaotic home environments.

Traditional solutions to addressing the problems of at risk families have largely centred around income maintenance or similar programmes that attempt to improve the economic well being or material standards of high risk families. However, inspection of the childhoods of multiple problem children in the Christchurch Health and Development Study clearly suggested that it was unlikely that economic initiatives, by themselves, would address the many social, emotional and personal problems faced by these high risk families. For this reason the search for solutions began to move away from a focus on the provision of traditional welfare services and towards the identification of programmes that provided at risk families with direct support in the areas of parenting, childrearing and life skills.

A turning point in this process came at a conference convened by the Mental Health Foundation in 1994. At this conference, participants agreed that future programmes need to focus upon methods of home based visitation designed to meet the needs of at risk families. It was also suggested at this meeting that the Hawaiian Healthy Start programme provided a model that might be adapted to the New Zealand context. Healthy Start is an Hawaiian programme that has been in existence for over 20 years [10, 11]. This programme involves two stages - population screening and service delivery. In the first stage, mothers giving birth are screened using standardised screening measures to identify at risk families. Families meeting specified criteria are then offered the Healthy Start programme. Families who accept the offer (between 80% to 90% of those eligible for the programme) are then provided with intensive family support provided by a Family Support Worker.

In late 1994 representatives of the Family Help Trust and the Christchurch Health and Development Study met to discuss the possibility of developing a home based family support programme modelled along the lines of Healthy Start. It was agreed that this would be desirable and that an important first stage of programme development was to conduct a process evaluation of the programme by enrolling a group of 50 families into a pilot project aimed at assessing the extent to which the principles underlying Healthy Start could be adapted to a Christchurch social context. Key issues to be examined in this pilot study included:

- Could ethically acceptable methods be developed to identify at risk families?

- Was it possible to develop an effective, culturally appropriate and non stigmatising home visitation programme to meet the needs of at risk families?

- How effective was this approach in leading to improvements in the well being of children, including child health, parenting and life opportunities?

The group faced two hurdles in translating this plan into a viable project. The first was to find an effective method of identifying families at risk. Initial exploration of this issue suggested that the most promising systematic method for identifying at risk families was through Plunket nurses. In Christchurch, Plunket nurses see an estimated 95% of mothers shortly after birth and the Plunket Society has developed strong linkages with other service providers to ensure that at risk families are visited. For these reasons the emerging Early Start group contacted the Southern Regional Office of the Royal New Zealand Plunket Society to enlist its co-operation in the project. After a period of negotiation, the Southern Regional Office agreed to become members of a consortium of providers whose aims were to examine the feasibility of developing a family support service targeted at high risk families and based upon the principles of Healthy Start.

The second hurdle was that of obtaining funding for programme development. In the first instance, the consortium were successful in obtaining initial funding to support the project from Canterbury Trust Bank Community Trust. The acquisition of this funding placed the consortium in a position to develop concrete plans to develop a home based family support service for at risk families. It was recognised that the success of any such service would depend critically on the extent to which the service was seen as culturally appropriate and relevant by Maori. To put in place mechanisms to ensure that the programme was developed in a way acceptable to Maori, the Early Start Consortium invited two Maori representatives (Mrs B Tainui and Mrs T Kipa) to join the consortium as directors. Both Mrs Tainui and Mrs Kipa had extensive experience in issues relating to Maori Heath, and particularly child health, and both had served as advisors and consultants to the Plunket Society. In addition to her role as a director of the Early Start programme Mrs Tainui was appointed as Kamatua to the programme.

To gain further background in this area, two representatives of the Family Help Trust visited the Hawaiian Healthy Start programme in early 1995 to learn first hand about methods of screening and to study the service delivery used in Healthy Start.

The development of Early Start received considerable impetus in 1995 as a result of a nation-wide tour made by Dr Calvin Sia and Ms Gail Breakey from the Hawaiian Healthy Start programme. In this visit, the representatives toured New Zealand providing an overview of the Hawaiian programme and its underlying principles.

The development of the programme was further assisted by support from the Southern Regional Health Authority who provided the Early Start programme with further funding to develop service provision in this area. In this process the Southern Regional Health Authority also recommended that the consortium was expanded to include representatives of the Pegasus Medical Group thereby ensuring close linkages between the programme and general practitioners.

The net result of this process was that by mid 1995 a consortium of providers including - the Family Help Trust; the Christchurch Health and Development Study; the Plunket Society;

Maori representatives and the Pegasus GP group had been assembled. Key staff from the Family Help Trust had received preliminary training in Hawaii and the consortium had gathered sufficient funding to support a pilot project based around a series of 50 families.

By October 1995, the consortium was in a position to recruit staff, provide staff training and to enrol families in the programme. The remainder of this report provides an account of the programme and its development from October 1995.

Overview of Early Start and its Principles

Whilst the development of Early Start was inspired by the work of Healthy Start it is important to recognise that Early Start is not an attempt to transplant an overseas programme into a New Zealand context. Rather, the aims of the Early Start consortium have been to adapt the general principles of the Healthy Start programme to a Christchurch context. The key features of the Early Start programme are described below:

1. Client Identification: A detailed account of the application of this client identification system is given in Chapter 3. Briefly this system involved a three stage process. In the first stage, Plunket Nurses applied broad and general screening criteria to identify at risk families. Any family meeting these criteria was referred to Early Start. In the second stage, families were enrolled into Early Start for a one month probationary period. This period gave the family an opportunity to become acquainted with the programme and also give the programme an opportunity to learn about the family. In the third stage, an indepth needs assessment of the family was made and families meeting prespecified criteria were invited to join the programme on a longer term basis. At each stage of this process, signed consent was obtained from families to ensure that families were enrolled into the programme on an informed basis.

This system of client identification was designed to steer a middle course between the population based screening methods used by Healthy Start and the demands of treating families in an ethical and non stigmatising way. This has been achieved by the development of a client identification system that combines elements of population screening, client referral and needs assessment to identify at risk families. This approach has advantages and disadvantages when compared with the population based screening method used by Healthy Start. As noted above the major advantage of this approach is that it avoids many of the difficulties that arise in the application of population screening methods and ensures that clients are enrolled into the programme on the basis of a comprehensive needs assessment rather than on the results of a screening measure. The potential disadvantage of the multi stage process is that it provides multiple opportunities for families to decline services before they have been fully informed about these services.

2. Service Provision: Early Start provides a system of home based family support and visitation provided by trained Family Support Workers whose task is to support, empower and assist families to address a wide range of issues relating to child rearing, parenting and family functioning. An important feature of the programme is that the services provided to families are tailored to meet the family's particular circumstances and needs rather than being based on a predetermined programme that assumes that one size will fit all. This flexibility of the service provision, however, makes it difficult to provide a concise account of the work of Family Support Workers. Nonetheless the essential

features of service provision can be summarised by noting that the work of Family Support Workers is directed at encouraging positive family change in the following areas:

- **Child health**

  Ensuring that children have adequate access to and utilisation of child health services including: immunisation; preventive health care and timely visits for childhood morbidity. The key features of the service that lead to the achievement of this goal include: a) ensuring that all families are enrolled with a single general practitioner who acts as the health care provider for the family; b) support and encouragement of mothers in their utilisation of child health care services; c) the development of close liaison and linkages with key health care providers including general practitioners, Plunket Nurses and other services.

- **Maternal wellbeing**

  Ensuring that the physical, social and emotional health of the child's mother is supported, protected and sustained. It is almost self evident that good maternal functioning is a prerequisite for effective and positive child rearing. Accordingly, a large amount of the work of Family Support Workers involves providing social, emotional and practical support for mothers. This function spans a wide range of activities that may include support for the mother in dealing with issues of: marital or partnership difficulties; family violence; substance abuse; maternal mental health problems; and other sources of social and emotional stress.

- **Parenting skills**

  Helping mothers acquire and develop adequate parenting skills. As is described in Chapter 2, many of the mothers enrolled in Early Start have experienced socially and emotionally impoverished childhoods. These childhood experiences have often provided them with limited opportunities to learn adequate parenting skills. A major role of Family Support Workers is to provide advice, support and role models to assist and encourage mothers in the acquisition of adequate parenting skills. In addition, Early Start has devised its own parenting programme "Teachable Moments" that has been designed to meet the specific needs of mothers involved in Early Start. This programme was devised as it became apparent that many mothers in Early Start were reluctant to use parenting programmes because of their feelings of personal inadequacy. Teachable Moments provides a safe environment in which mothers can acquire parenting skills without feeling threatened or inadequate.

- **Family economic functioning**

  Improving Family Economic Functioning: Poverty and/or depressed material conditions are common amongst families enrolled in Early Start. These difficulties appear to arise from two sets of factors that conspire to place families at risk of poverty and material hardship. First, the majority of families are dependent on welfare benefits as their sole source of income and second, many families have limited budgeting and financial management skills. This combination of limited income and poor management skills makes families vulnerable to a wide range of economic problems and difficulties. An important function of the family support provided by Early Start is to assist families in

reducing the level of economic stress and difficulties they face. These issues are addressed by ongoing attempts by Family Support Workers to: a) encourage families to seek budget advice and to develop financial management skills; b) encouraging families in debt to reduce their debt burden (and particularly hire purchase commitments); c) assisting families to find accommodation and household goods that they can afford; and d) encouraging, where applicable, mothers to reduce their welfare dependence and to supplement family income by part time employment.

- **Crisis management**

Support and Assistance with Family Crises: Families enrolled in Early Start are crisis prone owing to their limited economic circumstances and personal backgrounds. An important function of Family Support Workers is to act as a source of support, advocacy and mentorship in times of family crisis. Key areas in which such crises emerge include: marital relationships; family economic problems; substance abuse; family violence and difficulties with the law.

3. Case Load and Extent of Service Provision: Providing adequate family support to high risk families is labour intensive and owing to the demands of providing indepth support, Family Support Workers have a case load of approximately 15 families. The size of this case load may vary depending on the mix of families within the case load. The provision of family support is designed to follow a sequence in which with increasing family change, the extent of support and assistance reduces. The Early Start programme is aware of the need to encourage independent family functioning and of the risks of families becoming dependent on Family Support Workers. To reflect the process of transition over the course of the programme, service provision is organised into a series of levels reflecting the needs of families. These levels are:

- Level 1 - All clients enter the Early Start programme at level 1. This level requires a time allocation to the client of 2 hours per week and involves weekly home visitation.

- Level 2 - Clients who have spent some time in Early Start and are making progress in addressing difficulties move to level 2. This level requires a time allocation of 1 hour per week for the client and one home visit per fortnight.

- Level 3 - This level of home visitation is for families who have made substantial progress in addressing family problems and who are meeting their child's needs well. Families on this level receive a time allowance of ½ an hour per week and one home visit per month.

- Level 4 - This level is for families who have become self reliant and are able to address their problems without support. Families at this level receive a home visit every 3 months to maintain contact with the programme and to confirm that progress is being sustained.

In addition to the above service levels, some families facing severe crises or difficulties may be allocated to additional services that require at least 2.5 hours contact per week with the family and more than one home visit per week. This level is most commonly used in cases when families first enter the programme and where there is ongoing concern that children are at serious risk of child abuse or neglect.

4. Staff Selection, Training and Supervision: An important feature of Family Support Workers is that these workers do not provide a specialist service such as that provided by nurses, social workers, counsellors and similar professionals but rather act as a family mentor and advocate who assists the family in addressing the day to day problems that it encounters. These job demands require that Family Support Workers have a sound training in a relevant discipline such as nursing or social work/services coupled with the interpersonal skills and abilities to engage families in the Early Start programme. In addition it is important that workers have an understanding of the Treaty of Waitangi and an awareness of cultural issues. The Early Start programme also recognises the right of Maori clientele to have access to Maori Family Support Workers and also encourages Maori Family Support Workers to develop linkages with local Iwi, Hapu and other relevant organisations.

Selection of Family Support Workers is conducted by a panel that includes the programme manager (Mrs L Robins), the clinical manager (Mrs H Grant) and at least one of the Maori directors (Mrs B Tainui and Mrs T Kipa). Skills sought include: a) evidence of relevant educational background; b) awareness of cultural issues and obligations under the Treaty of Waitangi; c) experience in dealing with high risk families; d) evidence of good interpersonal skills and sound judgement.

To provide workers with a general background to their task, Early Start has devised a 4 week training programme which provides a background on a wide range of issues relevant to family support work.

The Early Start programme places considerable emphasis on regular supervision and support of workers. There are two reasons for this emphasis. First, the task of dealing with the problems of high risk families can often prove to be very stressful and workers are in need of regular supervision and support to reduce these burdens. Second, regular supervision ensures that the Early Start services are delivered in a uniform way and that workers are clearly advised about the boundaries of their role. To achieve these objectives each Family Support Worker receives a period of two hours clinical supervision per week from the programme's clinical supervisor (Mrs H Grant). In these sessions, each case in the worker's case load is reviewed, cases notes are prepared and checked, and forward planning for each client family is discussed. In addition, these sessions, provide ample opportunity for workers to discuss particular issues that are of concern to them.

5. Documentation: An important component of the Early Start programme has been the development of a systematic case note system to record both service delivery and client progress. Case notes include both checklist questions and narrative sections that make it possible to chart the history of contacts, family transactions and family outcomes over time. All case notes are reviewed and checked for accuracy at 3 monthly intervals by the clinical supervisor (Mrs H Grant). The material recorded in this system of case notes provides the primary source for the data described in later sections of this report.

CHAPTER 2

CLIENT RECRUITMENT, CHARACTERISTICS AT INTAKE AND RETENTION

Client Recruitment

As explained in the previous chapter, Early Start uses a three stage process to identify client families. The first stage of the process involves initial screening by Plunket Nurses to identify potentially at risk families who are, subject to signed consent, referred to Early Start. The second stage involves initial contact between the Early Start Family Support Worker and the client. In this stage, clients are enrolled, subject to signed consent, for a probationary period of one month. At the end of this probationary period, a full needs assessment of the client family is made and a decision based on the Kempe Family Stress Checklist (KFSC) [10] score is made about the client's future involvement with Early Start. Clients with KFSC scores in excess of 25 are offered level 1 home visitation (at least once per week) whereas those with KFSC scores below 25 are offered level 4 home visitation (one contact per 3 months).

These procedures were applied to recruit families for the pilot study of Early Start in the following way:

1. Over the period from October 1995 to February 1996, Plunket Nurses in the Eastern and Central districts of Christchurch were requested to refer to the Early Start Programme all newly enrolled families who met simple screening criteria. These criteria spanned a series of 11 items relating to family features and were based on the initial screening criteria used in the Healthy Start programme. Nurses were advised that families who scored positive on any two criteria should be considered eligible for Early Start. To avoid any adverse implications of population screening, nurses did not fill out screening criteria forms on each subject but rather conducted an informal assessment in which they decided whether the family met these criteria. Nurses were also advised to refer any family to Early Start if they had other concerns about the family. After nurses had established that a family could be eligible for Early Start they then introduced the programme to the family and obtained signed consent forms from the family to make a referral to Early Start. After consent had been obtained a letter of referral was sent to the Early Start programme. To protect family privacy this referral letter contained no other details than: a) in the opinion of the Plunket Nurse the family may benefit from the Early Start programme; b) the family's contact details and telephone number. This process was decided in consultation with the Southern Regional Health Authority and the Royal New Zealand Plunket Society Ethics Committee and aimed to ensure family privacy and rights by ensuring: a) that screening was done clinically rather than on the basis of a formal screening measure; b) that families were only referred to Early Start after signed and informed consent was provided and c) that no

information about the family was transmitted by the Plunket Nurse other than that they may benefit from Early Start support.

2. Families were then contacted by Early Start and enrolled in the programme for an initial one month period. This probationary period served two functions. First, it permitted an indepth assessment of the family's needs and the extent to which these needs were best served by Early Start. Second, it permitted families to become familiar with the Early Start worker and programme so that they could make longer term decisions about programme enrolment on an informed basis.

3. During the initial one month period, data were gathered on client families in two ways: a) by a structured interview conducted shortly after the family had enrolled in the programme; and b) case note material gathered by the family worker. These data were used to rate the extent of family need using the Kempe Family Stress Checklist. This measure is used in the Healthy Start Programme and provides a numerical score representing the extent of family stresses or difficulties. Families with Kempe Stress Checklist scores of 25 or greater were deemed to be eligible for the programme. Completion of the Kempe Stress Checklist was conducted by the Project Director in conjunction with the relevant family worker.

4. Families with Kempe Stress Checklist scores of 25 or greater were then offered long term entry into the Early Start Programme at level 1 home visitation. This requires at least weekly visits from Family Support Workers. Families not meeting this criteria were not abandoned but rather were assigned to level 4 visitation in which the Family Support Worker visited the family once every three months.

Table 2.1 provides a summary of the recruitment process. This table shows that:

- Plunket nurses saw a total of 396 new families over the recruitment period.

- Of these 396 families, 69 (17.4%) were deemed by the Plunket Nurse to be potentially eligible for Early Start.

- Of the 69 eligible families, 58 agreed to Early Start contact and 11 declined this contact.

- Of the 58 families referred to Early Start, 55 families agreed to enrolment in the programme and three declined enrolment.

- Of the 55 families enrolled in the programme for the probationary period, 51 entered the programme on a long term basis and four did not. In three of the four families, failure to enter the programme was due to the family moving from the Christchurch region or to the family's needs being better met by another agency.

Table 2.1: Early Start enrolment and loss statistics

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

b) Sources of loss to recruitment

	N	% of Losses
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

The data in Table 2.1 can be used to construct a series of statistics which summarise the effectiveness of the client identification and the sources of client loss. In particular:

- The programme was successful in recruiting 73.9% of the eligible 69 families identified by Plunket Nurses.

- The sources of client loss arose from: refusal by families to permit the Plunket Nurse to refer the family to Early Start (61.1% of client loss); the family declining to enter the programme following initial Early Start contact (16.7% of client loss) and withdrawal or unavailability after the initial month (22.2% of client loss).

In the original planning of the programme it was hoped that it would be possible to recruit in the region of 90% of eligible families. The above statistics suggest that the actual recruitment rate fell below this target. The predominant reasons for this centre around the refusal or failure to agree to referral to the Early Start Programme. Of the 58 families referred to Early Start just under 90% agreed to involvement in the programme.

Family Characteristics

After initial enrolment into the programme, client families were administered a standardised interview which provided a psychosocial profile of the family and its circumstances. The

purposes of this interview were twofold. First, it permitted Family Support Workers to gather relevant background details on families using a systematic questionnaire that spanned a wide range of aspects of family functioning. Second, this interview provided the basis for psychosocial profiles of the client families at the point of programme enrolment. It should be noted here that initially, Family Support Workers were uncertain about the extent to which such a formal interview could be administered or would provide useful information. Subsequent experience has allayed these misgivings and after an initial learning period the interview was administered within between 30 minutes to one hour and Family Support Workers have stated that it provided them with baseline information about the family that would have been difficult to gather by any other means. The information gathered by the initial interview provides the basis of the account of the client profile given below.

Demographic Background

Table 2.2 provides a demographic description of the group of 55 client families initially enrolled in the Early Start Programme in terms of educational levels, age, ethnicity, marital status/living arrangements, family size and home ownership. The table shows that mothers in client families frequently lacked formal educational qualifications, that the majority were Pakeha, most were living as single parents in the absence of a cohabiting partner and that the age distribution of the sample varied widely from mothers aged less than 20 to mothers aged over 35. Family sizes varied from one child to five children with the majority of mothers having only one child. Only a small number of families (11%) owned their own home.

Table 2.2: Socio-demographic characteristics of families enrolled into Early Start (N = 55)

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

Maternal Childhood

A finding in studies of disadvantaged or stressed families is that frequently the parent figures in these families have themselves been subject to unsatisfactory or dysfunctional childhood circumstances. This issue is examined in Table 2.3 which shows maternal accounts of the extent to which mothers reported exposure to various sources of difficulty, adversity or abuse during their childhood. The profile that emerges from this table suggests that frequently

mothers were subject to a variety of adverse conditions during childhood. These conditions spanned exposure to parental divorce/separation and multiple family situations, lack of parental care and supervision, parental alcohol and drug problems, and exposure to child abuse or neglect. Whilst not all mothers reported each of the outcomes listed it was apparent from the inspection of case histories that the great majority reported at least one and often many of the difficulties shown in Table 2.3. To examine this issue a simple childhood adversity index was constructed by summing up the number of childhood family and related difficulties reported by the mother. This analysis confirmed the view that often mothers had been exposed to adversity and particularly multiple adversities in childhood. All but three of the mothers reported at least one of the difficulties listed in Table 2.3 and the median number of childhood difficulties reported was six.

When these results are taken in conjunction with the findings in Table 2.2 the account of the client population is clearly that of a generally socially disadvantaged group of families in which the majority of mothers had been subject to multiple sources of adversity during their childhoods.

Table 2.3: Rates (%) of childhood adversities (prior to age 16 years) reported by mothers enrolled in Early Start (N = 55)

Measure	N	% of Mothers
Family Stability		
Raised in single parent family	29	52.7
Parents separated/divorced	16	29.1
>2 Changes of family situation	25	45.5
Parental Conflict/Substance Use		
Ongoing parental conflict	37	67.3
Witnessed violence between parents	21	38.2
Parents frequently drugged or drunk	24	43.6
Child Abuse/Neglect		
Frequent beatings, physical ill treatment	19	34.5
Mother subjected to child abuse	32	58.2
Witnessed physical abuse of sibling	14	25.5
Constantly ‘scapegoated as ‘black sheep’ of family	28	50.9
Lack of parental care	15	27.3

Measure	N	% of Mothers
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
Economic Hardship		
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

Teenage Adjustment

Part of the questioning examined the mother's reports of psychosocial problems including alcohol abuse, juvenile offending, drug abuse and mental health problems during adolescence. Table 2.4 shows the frequency with which mothers reported these problems and it is evident that a sizeable majority (82%) of mothers reported adolescent difficulties and particularly sexual assault, absconding from home, problems with drugs/alcohol and problems with the law.

Table 2.4: Rates (%) of psychosocial problems (prior to age 16) amongst mothers enrolled in Early Start (N = 55)

Measure	N	% of Mothers
Running away from home	28	50.9
In trouble with Police	16	29.1
Problems with alcohol	10	18.2
Got involved with drugs	23	41.8
Went to Youth Court/Children's Court	8	14.5
Got pregnant	14	25.5
Sexually assaulted	31	56.4
Admitted to psychiatric hospital	3	5.5

Measure	N	% of Mothers
At least one of the above	44	81.8

Adjustment in Adulthood

Questioning about teenage adjustment was supplemented with questions about the mother's personal adjustment as an adult. Table 2.5 shows the number of mothers reporting that they had previous difficulties with the Police, alcohol abuse, drug use or mental health problems. Again, it is evident that a substantial majority of the women studied had experienced problems in these areas and further analysis showed that of the 55 mothers enrolled in the Early Start Programme 71% reported having a previous history of criminal offending, alcohol or drug abuse or mental health problems.

Table 2.5: Rates (%) of adult adjustment problems amongst mother's enrolled in Early Start (N = 55)

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

It was possible to supplement the measurement of mental health issues by more detailed questioning of the mothers about current symptoms of depression using symptom measures derived from the Composite Diagnostic Interview Schedule (CIDI) [(12)]. This measure makes it possible to assess on the basis of symptom report data the extent to which women met standardised (DSM-IV) [(13)] diagnostic criteria for major depression. It was found that of the 55 women enrolled in the Early Start programme, 34 (62%) met criteria for major depression at the time of the initial interview. Later we will describe the ways in which these cases of depression were managed.

The Characteristics of Partners

The majority of mothers recruited into the project were single parents who were raising their child in the absence of a cohabiting male partner. However, a number of these women reported having a male partner who was not living in the household. To the extent that both cohabiting and non-cohabiting partners are likely to exert some influence on family

functioning and behaviour it is informative to examine the characteristics of the male partners nominated by the client families. Table 2.6 gives a profile of the psychosocial characteristics of male partners including their history of criminal offending, substance use and mental health problems. Predictably the psychosocial profile of male partners is similar to that of mothers, but it would appear that male partners were more prone to criminality.

Table 2.6: Rates (%) of psychosocial problems amongst male partners (N = 34)

Measure	N	% of Partners
Been in trouble with the Police	24	70.6
History of criminal offending	20	58.8
Problems with alcohol	13	38.2
Problems with drugs/solvents	9	26.5
Mental health problems	7	20.6
At least one of the above	25	73.5

One area to which particular attention was paid was the extent to which women reported violent or abusive experiences with male partners. We had expected that these families would be subject to very high levels of inter-partner conflict and violence. This expectation was only partially supported. Table 2.7 shows a series of measures descriptive of the relationships between mothers and male partners. Two major conclusions emerged from this analysis. First, there was clear evidence to suggest that many of the partner relationships were unsatisfactory from the standpoint of the mothers. Women frequently complained of lack of supportive, caring relationships and reported various symptoms of conflict within the family. However, despite this the level of overt violence within families appeared to be low with only 27% of women with partners reporting overtly violent behaviours (assault or threats of violence) by their partners. This statistic should also be placed in the context of the total numbers of families enrolled in the programme: of the 55 women enrolled in the programme only nine (16%) reported overt male partner violence. These statistics were confirmed by further questioning about the extent to which partner violence had led to medical treatment, police intervention, the woman considering leaving the family home or going to a Women's Refuge. Only eight (16%) of the mothers enrolled in the programme reported partner violence of this extent.

Table 2.7: Rates (%) of interpersonal problems and difficulties reported by women with partners (N = 34)

Measure	N	% of Partners
Relationship with partner not very close or distant	11	32.4

Measure	N	% of Partners
Partner non-supportive	9	26.5
Partner provides little or no help with care for baby	14	41.2
Arguments/rows with partner	30	88.2
Physical assault by partner	8	23.5
Verbal abuse by partner	17	50.0
Put downs, criticism by partner	18	52.9
Threats of violence from partner	5	14.7
At least one of the above	32	94.1

The principal conclusion that appears to emerge from this analysis is that, whilst partner relationships were frequently unsatisfactory and conflictful in many respects, the extent of overt partner violence was lower than anticipated. It must be borne in mind, however, that it is possible that the lower than expected level of partner violence in client families may be due to a reporting bias in which mothers fail to report violent episodes.

Family Material Conditions

An important aspect of family functioning concerns the extent to which the family had adequate economic resources and housing. This issue is examined in Table 8 which shows a number of indices of family economic and material wellbeing. These include: levels of family net income; the percentage of net income spent on rent or mortgage; the number of families reporting significant debt problems; maternal views of the adequacy of family income to meet basic family needs; and maternal ratings of the adequacy and suitability of accommodation.

The predominant impression that emerges from this table is that of a group of families living in quite severely restricted economic circumstances and conditions. The vast majority (87%) of families were dependent on Social Welfare benefits. The median net weekly income of families was $293; a number that translates to an income of approximately $15,200 per annum. The majority (74.3%) of families were spending more than one third of this income on rent. Debt was a common family problem, with 60% of families reporting that they had debts (excluding mortgage payments and hire purchase) in excess of $500. Over 50% of mothers were of the view that their weekly income was inadequate or barely adequate to meet their needs, and nearly one third felt that the accommodation was inadequate or barely adequate.

Table 2.8: Measures of material and economic circumstances of Early Start families (N = 55)

% Families in receipt of Social Welfare benefits	87.3%
Median net weekly income	$293 p.w. (range: $135 - $830 p.w.)
Average proportion of weekly income spent on rent/mortgage	43.5% (range: 0% - 97%)
% Families with current debts in excess of $500 (excluding mortgage or hire purchase)	60.0%
% Families rating current income as:	
Barely adequate	30.9%
Inadequate/very inadequate	27.3%
% Families rating current accommodation as:	
Barely adequate	10.9%
Inadequate/very inadequate	20.0%

Client Retention at 18 Months

As shown in Table 2.1, 51 mothers entered the Early Start programme on a long term basis. However, after 18 months service provision the number of families receiving the service had reduced to 39. Of the 12 families no longer receiving the service, 7 (58%) had moved away from Christchurch, 3 children were in care, adopted or fostered, and 2 clients had withdrawn due to dissatisfaction with the service. Table 2.9 shows the number of families receiving the service at 6, 12 and 18 months.

Table 2.9: Number (% of original sample N = 51) receiving Early Start services at 6, 12 and 18 months

	Time		
	6 months	12 months	18 months
Number receiving service	51	47	39
% of original group	100%	92%	76%

The results in Table 2.9 clearly show that despite the loss of families over time, the great majority (92%) of those enrolled in Early Start received at least 12 months service provision.

Conclusions

The purpose of the preceding account has been to provide background material on the Early Start Programme by describing: a) the process of client recruitment and identification and b) the psychosocial profile of families enrolled in the programme. The following major conclusions emerge from this analysis:

First, the pilot programme has shown that it is possible to identify at risk families in a way that ensures relatively high participation rates and at the same time protects the rights and privacy of the family. In this study, Plunket Nurses identified about 17% of a sample of newly enrolled mothers as being eligible for Early Start. This figure is of interest in its own right to the extent that it suggests a generally high level of need for family support within the community. At the same time it should be borne in mind that recruitment was conducted within what are recognised to be higher risk districts within the Christchurch region and that the overall rate of need for the entire Christchurch urban area is likely to be smaller than suggested by this pilot study. Nonetheless, we do not feel that it is unreasonable to conjecture that the present study suggests that in the region of about 10% of all families within the Christchurch urban region may meet eligibility criteria for Early Start support.

Client recruitment amongst those identified as high risk by Plunket Nurses was generally adequate and of the 69 families identified by Plunket nurses 73.9% were enrolled in the programme. The major source of client loss occurred at the initial point of referral to Early Start by Plunket nurses and this suggests that further attention needs to be paid to improving this aspect of the recruitment process. Nonetheless, given the high risk profile of the client population a situation in which nearly three quarters of families have been recruited by the programme may be regarded as being satisfactory, although not grounds for complacency about the need to improve client recruitment rates.

Over the 18 month follow up period, 12 families ceased receiving services. In the majority of the cases (58%) the reason for the cessation of the service was that the family had left the Christchurch region. This result highlights the fact that one of the limitations of a regionally based family support service is that it cannot provide coverage for families if they leave the region in which the service is based. The relatively high mobility of disadvantaged families thus produces a situation in which service coverage is reduced. Nonetheless, the data also shows that the great majority of Early Start clients (85%) received a least 12 months of service provision. In addition, three children were no longer eligible for Early Start since they were placed in adoptive or foster homes. Only two clients have withdrawn from the service because of dissatisfaction with the service.

The psychosocial profile of families enrolled into the Early Start programme fits well with many other accounts of high risk families. Those recruited tended to be socially disadvantaged, to have been exposed to adversity in childhood, to have relatively high levels of personal adjustment problems, including: criminality, substance use and mental health problems; to be either living in a single parent family situation or in an unsatisfactory partnership relationship; and to face relatively restricted economic and housing conditions.

One of the dangers of statistical analyses is that they tend to imply that families all face

similar and common problems. This, in fact, is far from the case. Whilst the sample of families recruited into the Early Start programme had a high density of material, personal and economic difficulties, these problems combined in quite different ways to influence family functioning. In some of the client families the origins of family problems centred around parental antisocial behaviours and adjustment difficulties and particularly the abuse of substances. In other families these difficulties centred around limited abilities to cope materially, socially and economically. Other families presented a mixed profile of problems and difficulties. This heterogeneity in the nature of family difficulties is important for programme development since it clearly suggests that programmes need to be flexible and adapt to meet family needs and circumstances, rather than adopting fixed and inflexible programmes that assume that "one size fits all". As described earlier, a key element of the Early Start approach has been the development of a family support service that is designed to meet the specific needs, circumstances and difficulties of a given family rather than imposing a standardised model on all families irrespective of the appropriateness of this model.

CHAPTER 3

SERVICE PROVISION

The purpose of this chapter is to provide an overview of the services provided to families enrolled in the Early Start programme over an 18 month period. The issues to be examined include:

- The frequency of home visitation and family contact.
- An overview of the needs and difficulties faced by families enrolled in the programme.
- An overview of the range of family support services provided by Early Start.
- Linkages between Early Start and other service providers.

Frequency of Contacts with, and on Behalf of, Client Families

Table 3.1 provides an overview of the frequency of service contacts for families enrolled in the Early Start programme including: a) the mean number of home visits received by families; b) the mean number of family contacts other than home visits; c) the mean number of contacts with other agencies that Family Support Workers made on behalf of client families.[1]

Two features of the Table are of interest. First the Table shows that Family Support Workers maintained high levels of contact with their client families and, on average, visited each family at home on just under 53 occasions (2.9 home visits per family per month); made an average of over 62 additional contacts with each family (3.4 contacts per family per month); and an average of 38 contacts with other agencies on behalf of the family (2.1 agency contacts per family per month).

Second, there is a clear trend for rates of home visitation and contacts with agencies on behalf of the family to decline with the passage of time: rates of home visitation and agency contact at 12-18 months occurred at approximately 70% of the rate for the first six months. This decline in contact reflected the fact that with the passage of time, levels of service need amongst client families tended to decline. The decline in service need is reflected in the number of families who experienced changes in their service level over the 18 month

[1] Note: The numbers of families studied in this and subsequent Tables are not the same as the numbers of clients shown in Table 2.9. The reason for this is that systematic data was not collected for the small number (3) of clients who were in receipt of level 4 services.

period. As noted in Chapter 1, all families entered the programme at level 1 home visitation which requires weekly home visits. After 18 months of service provision, circumstances in 21 (58%) families had changed to the extent that these families had moved to level 2 home visitation, with the frequency of home visitation being reduced to once per fortnight. Whilst levels of home visitation declined with the passage of time, other family contacts did not reduce but remained at an almost constant level over the 18 month period. This constancy reflects the fact, that as rates of home visitation reduced with time, Family Support Workers continued to remain in telephone contact with families.

More generally, the results in Table 3.1 illustrate the highly intensive nature of the Early Start programme and the extent to which the programme involves prolonged and repeated contact between the Family Support Worker and the client family.

Table 3.1: Levels of Family Support Worker contact with Early Start families

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

Family Needs Assessment

A key element of service provision by Early Start is the development of family support plans for each family. Two plans are developed. An Individual Family Plan is developed by the Family Support Worker in conjunction with the family to address the family's short term and medium term problems and needs. This Individual Family Plan is supplemented by a Forward Casework Plan. This plan is devised by the Family Support Worker and the clinical supervisor (Mrs H Grant) to determine the longer term planning for family support and assistance. Whilst these family support plans differed depending on family needs, there were nonetheless a number of common themes in these plans. Table 3.2 reports on the major themes incorporated into family support plans. This information was obtained from the standardised case notes held by Early Start which recorded, in terms of a number of precoded categories, the major areas in which the family was in need of support.

Table 3.2: Key elements of family support plan

	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
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

The results in Table 3.2, show that family needs can be classified into three major groups:

1. Needs common to nearly all Early Start families: These needs involved over 90% of families enrolled in Early Start and included advice on basic child rearing skills and support with family budgeting. These needs reflect the facts that: a) families were recruited into the programme because of concerns about child rearing and related issues and; b) families in the programme were frequently impoverished (see Chapter 2, pages 31-32).

2. Needs experienced by the majority of Early Start families: These needs spanned a range of issues that included assistance with transport, household management, arranging child care, parenting courses and education, maternal depression and needs for counselling.

3. Needs experienced by a minority of families: These included a range of relatively specific issues relating to: assistance with addressing alcohol or substance abuse problems; employment; legal matters and further education for parents.

Family support to address these issues was provided by two general approaches. First, in cases in which the family's needs could be met from services provided by an existing agency, Family Support Workers arranged for families to be put in contact with these agencies. This process, typically, involved discussing the issue with the family members and suggesting that the family might benefit from seeking outside assistance. Where necessary, the Family Support Worker also acted in the role of a broker, in putting the family into contact with the service; providing parents with support; and arranging such matters as transport and appointment times. An overview of these referral activities is given in Table 3.3, which shows the percentages of families referred to various sources of support and assistance including Health Services; Welfare Agencies; Justice/Legal Services and Educational organisations.

Table 3.3: Percentage of referrals for support/treatment by source of support

	Time		
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)
Health Service			
Plunket family Karitane centre	54.2	4.5	2.8
Mother and babies unit	25.0	4.5	2.8
Counselling	39.6	22.7	8.3
Te Rito Arahi (alcohol & drug)	6.2	6.8	2.8
Mahu unit (methadone)	2.1	-	-
Queen Mary Centre	4.2	2.3	-
Pregnancy Help, Counselling	14.6	6.8	-
Medical specialists	45.8	38.6	8.3
Paediatric Department (Christchurch Hospital)	25.0	11.4	8.3
Other health service	20.8	18.2	13.9
Welfare Services			
St Vincent de Paul (Catholic Social Services)	18.8	6.8	5.6

	Time		
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)
Food banks	52.1	59.1	50.0
Budget Advisory Service	25.0	18.2	13.9
Catholic Social Services (respite care)	14.6	9.1	5.6
Home and Family (emergency accommodation)	2.1	4.5	-
Salvation Army (emergency accommodation)	2.1	-	-
Barnardos	29.2	22.7	13.9
NZ Income Support Service	20.8	15.9	11.1
Nurse Maude home help	4.2	2.3	-
Children & Young Person's Service	14.6	9.1	2.8
Other welfare services	14.6	15.9	13.9
Justice/Legal Services			
Legal services	33.3	29.5	13.9
PARS	-	2.3	2.8
Family Court	-	6.8	5.6
Education Services			
Parents as First Teachers	2.1	-	-
Special Education Service	8.3	-	-
Other education services	10.4	6.8	2.8

The results in Table 3.3 show a clear trend for most client referrals to take place in the first six months of service provision and to decline markedly thereafter. This trend reflects the fact that one of the first stages of implementing the family support plan was to make attempts to ensure that families utilised existing services effectively. As a result, most of the work in making agency referrals occurred during the first six months of service provision.

Whilst ensuring that client families made effective use of existing services formed an important part of the service provision provided by Family Support Workers, by far the greatest component of this work involved direct contact with the family in which by various methods, including advice, mentorship, the provision of a role model, the Family Support Worker attempted to work with the family to address its particular mix of needs and difficulties. It is difficult to describe this work using statistical tabular data, owing to the fact that the range of activities performed by Family Support Workers varied with the family context within which they were working. To convey some impression of the day to day work of Family Support Workers we present below three case histories which provide an account and overview of the way in which Family Support Workers addressed family needs in three families experiencing different mixes of personal, social and family problems. We would note that throughout this report certain personal details about families have been changed in the case history material to protect family confidentiality.

Case History 1: Mother Lilly (age 32), Partner Don (age 35), Toddler Leila (2 years) and Baby Lance (5 weeks)

Brief family/personal background information

Lilly (pakeha) and was raised in a two parent family. She is the eldest of 3 children. Lilly reports an unsettled family life, poverty, parents consuming a great quantity of alcohol, arguments and unhappiness. She spent time in foster homes, did not succeed well at school and left without formal qualifications. As a young women she became alcohol and drug dependent and lived an itinerant life style. She had tried various drug and alcohol treatments and had achieved short periods of sobriety in her life.

Partner Don (pakeha) is father to both children. He reports coming from a very unsettled background, having spent most of his early years in and out of foster homes. He was made a ward of the state and had a period of stability in his teenage years. He completed his School Certificate and entered an apprenticeship. From the time he left school he struggled with heavy alcohol consumption and addiction to cannabis.

Don and Lilly met when both were undergoing treatment for their addictions. They decided to live together in order to support each other in a life of sobriety, both wanting a life free of addictions. This is not what happened and both had periods of serious relapse. Leila was born in a period of relapse.

Family situation at time of enrolment

When referred to Early Start, Lilly and Don were living together with their two children. Don was working and earning a reasonably good wage. Lilly was suffering from depression, and was struggling parenting the two children, especially Leila who presented as a clingy and grizzly child with frequent temper tantrums. Lilly stated that she did not feel bonded with Leila and the Family Support Worker observed expressions of distaste in Lilly when she was "peeling Leila off her body". Lilly would swear and shout at Leila and had sought help 6 months earlier when she had thrown Leila across the room. At the time of enrolment Lilly was breastfeeding baby Lance who was a settled baby. Lilly stated that she was well bonded to baby Lance and that she loved this child.

The family was in severe financial strife despite Don's job. Large debts had occurred during their drug and alcohol using periods. Lilly stated that she felt frustrated by their lack of money and angry at not being able to work, resenting having to parent two children. She also stated that she was not "cut out for parenting".

Their partnership was in difficulties, with frequent and severe verbal conflict. At the time of enrolment the content of their arguments tended to focus on Lilly's belief that Don had difficulties with his sexual orientation. During arguments she accused him of sexually interfering with Leila. When the arguments were over, Lilly would acknowledge that there was no basis for her accusations.

Early Start interventions

Lilly's depression was of real concern and her resistance and non-compliance to treatment a difficulty for both herself and her partner Don. With much encouragement from the Family Support Worker she consented to a referral to the Mothers and Babies Unit at Princess Margaret Hospital for an assessment and treatment plan. After more encouragement and follow-up she complied to medication, to which she responded well.

The Family Support Worker encouraged Lilly to seriously consider the repeated accusations of Don's alleged sexual interference with Leila. Following a further bout of severe partner conflict with ongoing accusations by Lilly, both parents consented to allow Leila to be examined by her GP. No evidence was found. The couple were encouraged to pay attention to the way they communicated with each other and relationship counselling was suggested. This was not taken up by the couple.

The ongoing financial crisis needed careful management. At the point of programme entry the couple had incurred such large debts that Lilly's family had taken over the financial management. This was bitterly resented by the couple. The Family Support Worker encouraged the couple to seek assistance from a registered budget advisory service and to fully comply with the jointly discussed and agreed upon management plan. She assisted the couple with prioritising spending and to view this financial management plan as a helpful tool towards debt reduction, rather than resented interference.

Lilly's attitude towards Leila was challenged by the Family Support Worker, and both parents were encouraged to attend a residential parenting programme to learn how to cope with Leila's behavioural outbursts which now included keeping the family up at night, swearing, hitting and spitting. Lilly was finding parenting more and more burdensome as Lance at this stage was beginning to be more oppositional and copying some of his sisters behaviours (according to Lilly). She was referred for counselling to explore the relationship that had developed between herself and Leila.

The children were enrolled with Barnadoes and were receiving 20 hours per week child-care. This was to allow time- out between Lilly and both children and ensure good and appropriate learning opportunities for both children.

Outcomes at 18 months in the programme

***Depression**: Lilly had responded well to medication and her depressive symptoms had disappeared. She stopped the medication after 9 months and had no further problems.*

***Financial difficulties**: After 6 months of close financial oversight, the couple managed their finances much better. They were able to move into a better suited home and a brief period of stability was achieved. Lilly enjoyed decorating her home and spent much time developing the garden.*

***Parenting difficulties**: Both parents attended the parenting programme and learned some sound parenting skills and gained insight as to how their own behaviour affected the children. Lilly was able to better relate with Leila and the Family Support Worker observed some warm interactions between both and overheard Lilly stating that she is proud of both her children.*

***Partner relations**: Progress in this area was slow and minimal change was observed. Lilly ceased accusing Don of sexually interfering with Leila, however this was replaced with other negative accusations. The couple separated, and with the assistance of the Family Support Worker reached a workable access agreement.*

***Other gains**: The children are doing well, developing and reaching milestones. All immunisations and well child checks are up to date. The family is enrolled with a single GP and has developed a good relationship. Lilly is using contraception and is vigilant as to further unwanted pregnancies. Leila is enrolled in the Kindergarten. The time-out proved to be very fruitful, with Lilly studying for her drivers licence and working part-time as a house painter.*

Case History 2: Mother Claire (age 20), Father John (age 35) and Baby Brandon (3 weeks)

<u>Family/personal background information</u>

Claire, age 20, is Pakeha and was raised in a two parent family. She is the youngest of 3, all girls. She was raised in a middle class home environment. She was not exposed to economic deprivation, attended school on a regular basis and experienced a reasonably stable childhood until adolescence. Her middle sister suffered from a depressive illness. Claire describes witnessing physical and verbal violence between her parents and heavy drinking episodes by her father. Claire stated that she frequently perceived herself as the black sheep of the family.

At the age of 13, Claire began running away from home and combined this with heavy alcohol binge drinking episodes and experimentation with a variety of drugs. She experienced a drug overdose. During this time she lived in two different foster homes. At age 16, treatment was sought for Claire by her parents for a drinking problem. During her 17th year, she underwent an abortion. Claire left school without attaining any formal qualifications.

The baby's father, John, is aged 35, Pakeha and is a member of a Christchurch gang. He has a history of violent offending, is a drug user and drug dealer. He has served several prison sentences, the last term being six years.

<u>Family situation at time of enrolment</u>

Claire was aged 20 and her baby Brandon three weeks old, when first referred to Early Start by the Plunket Service. She was living with her two sisters and a 5 year old nephew in the

parental family home. The parents had recently emigrated to Australia and the house was on the market to be sold. Her oldest sister (the mother of the 5 year old boy) was studying at Polytech and the middle sister was on a sickness benefit. Claire was attending some classes at the local community college. She had regular contact with her GP and the Plunket nurse. Claire and baby Brandon had no contact with the father John.

Family situation 6 months into the programme

The flatting arrangement with the sisters began to be problematic. Claire reported many arguments with her sisters and the Family Support Worker was told by the sisters that Claire was "not pulling her weight". Claire was socialising a lot more, often leaving Baby Brandon in the care of her sisters.

She disclosed to her Family Support Worker that her past alcohol problems had been severe, but claimed that she was not drinking at that time.

Brandon's father John was released from jail, Claire was having contact with him and his friends and John was having access with Baby Brandon. The parents disputed over access and custody. Claire moved into a flat of her own and her overall situation deteriorated. She was not paying her rent, having no food in the cupboard, no power, was being evasive to her Family Support Worker and missing medical and assessment appointments. She became very argumentative and physically hit her sister. She also owned up to having hit baby Brandon, and that she was feeling out of control and depressed. A notification was made to Children and Young Persons Service.

Claire was evicted from her flat and with the help of the Family Support Worker moved into a boarding situation where she could be monitored more carefully. During all this time she denied any problems with alcohol consumption, despite being frequently asked by her Family Support Worker. She was observed returning home very drunk and challenged as to her ability to care for baby Brandon. A second notification to Children and Young Persons Service was made.

Early Start interventions

After the initial settled period, much of Early Start interventions focussed on crisis management and close monitoring as to the safety of baby Brandon. Child care was organised. Ongoing attempts were made to encourage Claire to visit her GP to discuss treatment options for her depression. She was also linked up with a budget advisory service and counsellor. The first Children and Young Persons Service notification elicited a whanau agreement, to which Claire did not adhere.

Once Claire admitted to her Family Support Worker that she had seriously relapsed with acute binge drinking episodes and allowed her finances to be closely monitored, some treatment compliance was observed. Claire attended a drug and alcohol assessment and made contact with a counsellor. The second Children and Young Persons Service notification galvanised Claire into seriously questioning her ability to parent when drunk and to accepting treatment for her alcohol addiction.

She was referred to a residential drug and alcohol treatment programme, and supported by her Family Support Worker during this process. Child care for baby Brandon with his father John was arranged and monitored by the Family Support Worker. The Family Support

Worker physically accompanied this young mother to the residential treatment centre and maintained close contact with her by phone and letters during the 6 week residential programme.

On Claire's return home, the Family Support Worker ensured that the links were made and maintained with the AA sponsor and the drug and alcohol counsellor.

Outcomes at 18 months in the programme

***Alcohol addiction**: Claire has remained sober and has regular contact with her sponsor and attends AA meetings. Counselling has continued and she has gained good insight into her behaviour patterns.*

***Financial difficulties**: A financial management plan has been drawn up between Claire, the Family Support Worker who took on the role as budget adviser. Claire has adhered to the plan. She also took on a part time job for 10 hours a week and this eased the financial burden. She paid back all the rent owing to the landlord and hire purchase commitments. Finances were still very tight and on one occasion a food parcel was required. No money was spent on alcohol.*

***Living situation**: Claire moved into a flat and lived there on her own with child. This proved to be a very satisfactory arrangement. Access continued between John and baby Brandon. Claire applied for full custody and this was granted by the courts.*

***Other gains**: Baby Brandon attends pre-school on a regular basis. All immunisations and well child checks are up to date. Claire took on a part time voluntary job in a home for the aged. She enjoyed this very much. Her evasive and angry behaviours, still sometimes evident, are better managed as she applies newly learnt skills. She assisted another Early Start client with alcohol problems to seek treatment and supported her with this. Claire made and maintained friendships with other women from Early Start groups.*

Case History 3: Mother Lyn (age 25), Father Sam (age 38), Child Win (age 8), Baby Alex (4 weeks)

Personal and family background

Lyn (pakeha) was raised by her maternal grandmother. She is one of six children (middle child). Lyn reports an unsettled and difficult childhood. Her mother had multiple partners and Lyn has a different father to her siblings. Lyn disclosed sexual abuse by one of her mother's partners. Not much emphasis was placed on scholastic achievements and Lyn left school without formal qualifications. At this time drug taking was a regular daily occurrence. She had frequent brushes with the law. Her first child, Win, was born when she was 17. At 19 she was working as a prostitute. By the time she was expecting Baby Alex, she was injecting morphine. At 22 weeks into this pregnancy she was accepted on to the methadone programme.

Father Sam is the eldest of 4 children. His mother had a severe alcohol problem and he experienced many different home environments, moving between family members and foster situations. He talks of a "hand to mouth" existence and a harsh upbringing. He left school between the age of 12-13 and took to a life on the streets. At 15 he was made a ward of the

state and admitted to a mental institution. He has served several prison sentences. His drug addiction is long standing and his drug of choice is morphine (main-lined) and marijuana.

Family situation at point of entry

The entire family was living with Sam's mother, in cramped and unsatisfactory conditions. Both Lyn and Sam were on the methadone programme with Sam still in the process of undergoing assessment and detoxification from morphine. Lyn and Wyn were recovering from chickenpox. Baby Alex was doing well and fortunately did not require detoxification at birth.

Additional family difficulties included an itinerant life style, severe financial difficulties and poor physical and mental health by both parents. For example, Lyn was experiencing side effects from the methadone, dermatitis on her hands, back pain and circulatory problems. Sam has a history of emotional instability with acute mood swings and blackouts. Both have hepatitis C. Win (who has a different father) presented with aggressive and manipulative behaviours, was unsettled at school and had a very difficult relationship with both his mother and step father. He spent most of his time with his grandmother.

Early Start interventions

- *Close monitoring of the health status of both parents. Establishing a relationship with a single GP practice.*

- *Addressing accommodation needs. Assisting with finding more suitable accommodation, ensuring that the family received all their benefit entitlements. Helping with furnishing the new home and strongly urging the parents to keep up with rent payments, to make every effort to remain in one place and to resist the urge to keep on shifting.*

- *The Family Support Worker established contact with the methadone health professional and assisted Sam and Lyn to comply with the programme requirements.*

- *Ensuring that the baby's health needs were met and that any parenting issues were promptly attended to. Encouraging the parents to attend the "Teachable Moments" programme for parents. Assisting with Win's behaviour problems and supporting treatment in a residential treatment centre.*

- *Linking the parents with budget advice, assisting and supporting the parents to make sound financial judgements and to live within a planned budget. Monitoring the repayment of old debts.*

- *Assisting Lyn with self development courses via the Income Support Service Compass programme.*

Outcomes at 18 months in the programme

The family has settled in good accommodation and has remained in one place for 12 months. Lyn has developed good home making skills and enjoyed that aspect of her life. Their financial situation has eased, but continues to be of concern. Lyn's health has improved to some extent, she has complied well with the methadone programme and is now

on a methadone reduction regime. Sam is stabilising on methadone. He is not coping well with his mood swings, and uses marijuana on occasions. Both parents have responded well to input with Win who has now settled at school and is getting good reports. Both children are healthy, and baby is fully immunised and developmentally monitored.

Conclusions

In this chapter, we have attempted to provide an overview of the way in which the Early Start programme provided family support to client families. A number of major themes emerged from this analysis.

Level of Client Contact: A defining feature of the Early Start approach, is the frequency with which Family Support Workers maintained contacts with their client families. On average, each family was visited three times per month, with a similar number of contacts being made by telephone. This level of service provision is necessary, both to ensure that client families are involved in the programme actively, and also to address the wide range of family needs. We are aware of claims that the type of family support provided by Early Start can be achieved at lower costs by enhancing the services provided by existing agencies such as Plunket and other similar organisations with a tradition of home visitation. Whilst we are by no means opposed to the suggestion that existing services should expand their operations in this way, the Early Start experience illustrates that in any such transition there will be a need to change home visitation policies in a way that ensures high levels of family contact.

Family Needs: The families in Early Start presented with a diverse set of needs, which in various ways were all reflections of the disadvantaged and/or dysfunctional backgrounds of these families. The major needs that emerged were for: a) assistance with basic childrearing advice and skills; and b) assistance with family budgeting and financial support. These needs reflect the fact that families enrolled into Early Start, were identified as being at risk and also formed a relatively impoverished group. In addition, these families also present with a wide range of other problems relating to maternal health and adjustment; education, employment and related matters. As the illustrative case histories show, these problems combined in different ways, in different families, with the result that the family support plan needed to be tailored to the needs of the individual family, rather than being based around a prespecified programme. This feature makes it difficult to provide a detailed account of the work of Family Support Workers, since the range of activities these workers will engage in will vary from family to family.

Service Co-ordination: An important feature of the Early Start programme, is that of assisting client families to use existing health, education and welfare services effectively. Experience in the programme suggested that at the point of programme enrolment, families were often in contact with a large and uncoordinated array of services that were attempting to assist the family and in some cases up to 20 services were found to be involved in the support of a single family. An important component of the family support provided by Early Start was to attempt to rationalise this situation in which families were both in need of services, yet paradoxically overwhelmed by the array of uncoordinated services with which they were in contact. This was achieved by the development of a systematic family support plan that identified the families' major needs and those services that were in the best position to meet these needs. As a result of these actions, large numbers of client families have been referred to various agencies with this service utilisation being supported and rationalised by the assistance of the Family Support Worker.

CHAPTER 4

HEALTH OUTCOMES OF CHILDREN IN EARLY START

The aims of this chapter are to provide an overview of the health outcomes of children enrolled in the Early Start project over an 18 month period from the point of enrolment. Key issues to be examined include:

- An overview of the methods used to improve and protect child health.
- An account of the levels of utilisation of preventive health care by children and their families.
- An account of the uptake of a series of measures designed to protect and improve child health: breastfeeding; non prone sleeping; smoke free home environment; car restraint utilisation and provision of a hazard free home environment.
- An account of patterns of medical contacts for morbidity amongst children.

Principles of Service Provision

An important component of the Early Start project involves ensuring that all children are provided with high quality and timely health care including access to preventive health care, the provision of safe and healthy home environments and access to medical care for morbidity. This goal was achieved by the following strategies:

- Ensuring that each child in the Early Start project was enrolled with a single GP who acted as a health care provider to the family. Prior to the introduction of free medical visits for all children under the age of 5, Early Start guaranteed the payment of any family medical bills and where necessary provided families with subsidies to meet medical costs.
- Advice and mentorship by Family Support Workers to parents on issues of child health and child health protection.
- Liaison with key health care providers, including the family doctor, Plunket Nurses, hospital staff and other health professionals to ensure that children had timely access to services for both well child care and morbidity.
- Regular surveillance of the child's record of preventive health care and general state of health.
- Provision of personal support, and where necessary transport, to encourage parents to use health services effectively.

Utilisation of Preventive Health Care

Table 4.1 gives a summary and overview of rates of utilisation of preventive health care services, including immunisation and well child checks. The findings show very high levels of compliance with these provisions with 100% of children being up to date with immunisations at 18 months and 97.2% being up to date with well child checks.

Table 4.1: Utilisation of preventive health services

	Time		
	6 months (N = 48)	12 months (N = 44)	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

Positive Child Health Practices

Table 4.2 provides a summary and overview of the frequency with which children were exposed to a series of positive child health practices including: breastfeeding; non prone sleeping; the provision of smoke free environments; use of car seat restraints; and the provision of hazard free home environments. The Table shows generally high, although not universal, compliance with these practices.

- Over 85% of children had been breastfed, with 54% being breastfed for at least 3 months.
- Between 80% to 90% of families had and used child car seat restraints.
- of children were placed in a non prone position whilst sleeping.
- By 18 months, (when children became generally mobile) 97% of mothers had ensured the safe storage of household poisons.
- In the region of two thirds of families provided a safe home environment and play area for their child.
- Between 34% to 47% of families had instituted a smoke free environment for their child.

Table 4.2: Rates of positive child health practices

Practice	Time		
	6 months (N = 48)	12 months (N = 44)	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

-: Statistic not applicable to age range being studied.

Medical Contacts for Childhood Morbidity

Table 4.3 shows rates of medical contacts for childhood morbidity including general practitioner visits and hospital attendances. There were relatively high rates of medical contacts for morbidity with children making, by 18 months, an average of 12.9 visits to the family doctor; 44% of children had been admitted to hospital and 55% had attended a hospital outpatient department. The relatively high rates of medical contact for morbidity may be explained in the following ways.

GP Contacts: The rates of general practitioner contacts are largely explained by the fact that Family Support Workers maintained high levels of contact with families (see Table 3.1) and encouraged mothers to visit their family doctors in response to any concern about child health. This support and surveillance resulted in a situation in which children maintained high levels of contact with the family doctor to ensure timely medical contacts for possible childhood morbidity.

Hospital Attendance: The attendances and admissions for Early Start children were largely accounted for by three groups of conditions: i) attendances for respiratory infection including asthma, bronchitis and bronchiolitis; ii) attendances for follow-up of perinatal problems or congenital conditions; iii) attendance for infections other than respiratory illness. In these respects, the hospital admission and attendance patterns of children in Early Start appear to be similar to the patterns described for the general population [(14)]. Two children were admitted to hospital because of failure to thrive, in both cases, this failure was attributed to parental neglect. In both cases, hospital admission occurred shortly after the family had been enrolled

with Early Start. No child in the programme has been admitted to hospital because of physical abuse or sexual abuse.

Table 4.3: Rates of morbidity related contacts

Measure	Time			
	0-6 months (N = 48)	6-12 months (N = 44)	12-18 months (N = 36)	Overall (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

Conclusions

The preceding account gives an overview of the child health outcomes for children enrolled in the Early Start programme over an 18 month period. The analysis leads to the following conclusions:

- The Early Start programme appeared to be successful in ensuring very high compliance to preventive health care provisions with close to 100% of children enrolled in the project being up to date with immunisations and well child checks. This success was largely attributable to the work of Family Support Workers in monitoring well child care and encouraging mothers to make timely visits for well child care and immunisations.

- Substantial progress was made in encouraging families to comply with positive child health practices including: breastfeeding; non prone sleeping; the use of care safety restraints and the provision of hazard free home environments. Again this success was largely attributable to the work of Family Support Workers in encouraging families to take up and sustain positive child health practices. There was less success in the area of the provision of smoke free home environments. This was due, largely, to the fact that in the region of 80% of mothers or their partners were smokers and encouraging personal change in this area proved difficult.

- Children in Early Start had high rates of medical contact for morbidity, particularly during the first year of life. In part, the high rate of general practitioner contact was explained by the fact that Family Support Workers encouraged their clients to visit family doctors at any time that there was a possible concern about child health. To this extent, the high rate of general practitioner visits in part, reflects increased health surveillance of children in the Early Start project.

- Whilst there were relatively high rates of hospital attendance amongst Early Start children, the reasons for attendance were similar to those in the general population with the majority of admissions being for: a) respiratory illness; b) follow-up and checks on perinatal or congenital problems; c) infection other than respiratory illness. Two children were admitted to hospital with failure to thrive as a result of parental neglect with both children coming to attention at around the point of programme enrolment No child in the Early Start programme has been admitted to hospital because of physical or sexual abuse.

CHAPTER 5

CHILD REARING AND CHILD ABUSE

This chapter provides an overview of a series of issues that centre around the adequacy of parental care provided to children in Early Start and the ways in which standards of care changed with increasing duration in the programme. In particular, the analysis examines:

- Patterns of children rearing and maternal competence amongst the study families.
- Rates of known and suspected child abuse/neglect amongst the children enrolled in Early Start.

In general, the aims of the analysis are to examine the extent to which children in Early Start were at risk because of impaired parenting, child abuse or neglect and the ways in which these risks changed with increasing exposure to the Early Start programme.

Child Rearing Practices

At three monthly intervals, Family Support Workers completed assessments of their client mothers using a series of rating scales. These scales included:

- Maternal warmth (rated as: warm; distant; cold; rejecting).
- Maternal child rearing abilities (rated as: competent; lacks experience; has little idea of child rearing).
- Adequacy of care of child (rated as: child well cared for; child's care barely adequate; child's care inadequate).
- Mother's ability to cope with family demands (rated as: mother coping well; mother has some difficulties coping; mother not coping with family demands).

In all cases, these ratings were made by the Family Support Worker on the basis of her contacts with the family and her observations of the mother.

Table 5.1 shows the percentages of Early Start families in which the mother was rated as having difficulties in the above areas after 3 months, 6 months, 12 months and 18 months of programme enrolment. The Table shows a clear trend for rates of reported difficulties amongst mothers to decline with increasing programme duration. This trend is illustrated by the fact that at 3 months programme enrolment, over 40% of Early Start mothers were rated as having difficulties in at least one of the areas described in Table 5.1. However by 18 months of programme enrolment, only 17% of mothers were rated as having these difficulties. Whilst the decline in rates of maternal difficulties is clearly consistent with the

view that involvement in the Early Start programme reduced maternal and child rearing difficulties, as we will discuss shortly, the results are amenable to alternative interpretations.

Table 5.1: Family Support Worker reports of maternal/child interactions at 3, 6, 12 and 18 months of programme participation

Measure	Time			
	3 months (N = 48)	6 months (N = 48)	12 months (N = 44)	18 months (N = 36)
Warmth				
% of mothers rated as distant, cold or rejecting	20.8	14.6	13.6	5.6
Competence				
% of mothers rated as inexperienced or incompetent	27.1	12.5	15.9	2.8
% of mothers not able to cope	29.2	27.1	27.3	8.3
Adequacy of Care				
% of children receiving inadequate or barely adequate care	25.0	22.9	22.7	13.9
Overall				
% of families with at least one of the above	41.7	41.7	36.4	16.7

To provide some insight into the processes of change occurring in maternal behaviours over the course of the Early Start programme, the case history below provides an account of a mother for whom there were major concerns about her abilities to cope with child rearing and family life at the point of programme entry but who, with support and assistance, was able to progressively overcome and address these difficulties.

Mother Anne (age 20), father Rex (age 25) and baby Kate (age 5 weeks)

Brief personal and family background

Anne (pakeha) was raised by her natural parents. She is one of three children. She reports harsh treatment by her father and witnessed much parental conflict and violence. She and her siblings were fearful of their father. Anne left home at 16 after gaining 2 subjects in her School Certificate examinations. She subsequently developed a serious drinking problem and

experimented with cannabis. During that time she was raped and needed psychiatric treatment.

Rex (pakeha) was an only child and raised by his natural parents. He reports a good and supportive home environment. He left school at 17 after completing his university entrance examinations.

Family situation at point of enrolment

The couple were living together in a flatting situation. Rex was in full time employment. Kate had been admitted to hospital with failure to thrive. Anne maintained that she was breastfeeding Kate every 3 hours. She was angry and defensive, so was Rex, who supported Anne in her statements. Kate gained weight while in hospital and was released, to be followed up on an outpatient basis.

Family difficulties

Anne and Rex had difficulties accepting a regular home visitor as they had the belief that all health professionals conspired against them. The Family Support Worker observed poor bonding between Anne and Kate. Anne had no interest in attending to her needs and had to be frequently prompted by the Family Support Worker to feed and change the baby. At times Kate was left soiled and wet and scantily dressed. She was slow to gain weight. Kate's paternal grandparents voiced their concern that Anne was screaming at Kate and Rex. Anne presented listless, tired, angry and defensive and unable to attend to any household tasks. These were done by Rex when he returned home at night. She was reluctant to speak to her GP and withheld information from her. Anne missed Kate's outpatient hospital appointments.

Early Start interventions

- *The Family Support Worker liaised closely with the GP, the Plunket nurse and hospital staff. Anne was made aware of the seriousness of the situation when a baby was failing to thrive and that it was of utmost importance for her to co-operate with the health professionals. Baby was complemented with formula and introduced to solids at 3½ months.*

- *The Family Support Worker encouraged Anne to attend (and accompanied her to) an assessment with the Princess Margaret Hospital Mothers and Babies unit. She was diagnosed with depression and prescribed medication and counselling.*

- *Frequent home visits (2-3 times a week for 6 weeks) with the Family Support Worker concentrating her input on the mother and child interactions and basic baby care. Anne's attention was gently but firmly drawn to her responsibilities as Kate's mother and she was encouraged to enjoy and play with her child.*

- *Family members were encouraged to assist and support Anne and not to be "put off" by her closed and confrontational attitude.*

Outcomes at 18 months in the programme

Anne did not respond well to the prescribed medication and was reluctant to take it. It took some time to find a medication regime that suited her needs. She did, however, form a good relationship with her counsellor and began to gain some insight into her behaviour. Her depression began to lift and Anne reported that she was feeling better. Her interactions with Kate improved and after six months of concentrated input from the Early Start Family Support Worker, Anne stated that she enjoyed her child. This was evident with Kate gaining weight, reaching her milestones and developing into a happy and smiling toddler. Anne's relationship with Kate's grandparents developed into a warm and friendly one. At this time Rex was made redundant and Anne coped reasonably well with that situation.

Child Abuse and Neglect

Parallel to the collection of assessments of parenting behaviours by mothers, assessments of the child's exposure to physical abuse or neglect were also gathered. Two approaches were used to assess abuse and neglect issues:

1. As for the assessment of child rearing issues, Family Support Workers were requested to rate their client families in terms of the extent to which they had concerns that the child was at risk of physical abuse or neglect.

2. In addition, information was gathered from Family Support Worker reports about the family's contact with other agencies for issues of child abuse or neglect. These agencies included the Children and Young Person's Service and medical services.

Table 5.2 shows the frequency with which concerns about issues of child abuse or neglect were raised at 6, 12 and 18 months of programme participation. The Table shows that with increasing duration of programme enrolment, there were reductions in levels of concern about child abuse and neglect. Over the 18 month period, 7 referrals were made to the Children and Young Persons Service because of concerns about child abuse or neglect issues. Two children were admitted to hospital with both admissions being due to failure to thrive as a result of inadequate parental care. The findings in the Table are suggestive of two conclusions:

1. The decline in levels of concern about child abuse over the course of the programme is suggestive of the fact that Early Start support may have contributed to reductions in child abuse risk. Nonetheless, it should be born in mind that the changes noted could have occurred irrespective of the support provided to families.

2. The Table also illustrates the way in which the presence of a Family Support Worker in the family may bring highly at risk families to official attention. It is important to note that of the 7 families referred to the Children and Young Persons Service, in 5 cases abuse or neglect had not occurred and the referrals were made on the basis of strong concern about the possibility of abuse. To date, no child enrolled in Early Start has been subject to physical abuse leading to injury.

Table 5.2: Concerns about actual or suspected abuse/neglect at 6, 12 and 18 months of programme participation

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

To illustrate the ways in which cases of child abuse or neglect were managed by the Early Start programme, the case history below describes the case of a family in which there were serious concerns about the risk of child abuse and the ways in which this case was managed by Early Start:

Mother Chris (age 24), Child Bob (age 4 yrs) and baby Alex (age 4 weeks)

Family background

Chris (pakeha) was raised in a middle class family and is the middle child of 3. Both her parents worked and the family was very achievement orientated. Chris completed her education to University Entrance level.

Family situation at point of enrolment

Chris was living in a small flat which was unkempt and untidy. Bob, who suffers from cerebral palsy had been placed with his grandmother by the Children and Young Persons Service due to child protection concerns. Chris was suffering from severe post-natal depression and had a gambling addiction.

Additional difficulties

Poor bonding between Chris and baby Alex. Severe financial difficulties due to Chris's gambling addiction. Poor parenting skills and an inability to assess danger. Chris presented as intellectually disabled, being slow of speech and not aware of providing a safe environment for her child. Alex was a very forward and fast developing child. There were many different agencies involved and no primary care agency. Chris was able to manipulate workers of those agencies and when challenged, she was very quick to disengage with workers.

Concern of abuse and neglect

When Alex was eight months old he was mobile. Chris's home environment was very dirty and unsafe with sharp and small objects (eg. needles, pins etc.) left lying on the floor. Chris was giving Alex sharp scissors to play with, leaving the jug cord hanging within his reach and was observed leaving a half full bucket of water standing around and not reacting when Alex stuck his head into the bucket. Alex also had a lot of falls. Chris did not heed advice nor did she seem to comprehend the danger her child was being exposed to. In addition, there was very little food in the home.

Early Start interventions

One of the first interventions was to refer Chris and Alex to the Princess Margaret Mothers and Babies unit for assessment and treatment of her depression. She was admitted for 4 weeks and followed up on release. Child care was organised to give Chris the opportunity to attend groups and counselling to treat the gambling problem. Chris was enrolled in a mothers group to learn parenting skills. She had personal instruction as to home safety. Despite all the interventions, Alex's safety did not improve.

The Children and Young Persons Service was eventually notified and an interim family group conference was called. Strict guidelines were put in place with Early Start being nominated as the primary agency. For a period of time regular unscheduled visits were established to monitor parenting behaviour and assess home safety.

At this time there was a change of Family Support Worker, and the new worker became aware that mother displayed very good skills in some areas, demonstrating the ability to follow directions without confusion. This Family Support Worker was intrigued as the mother had been described as intellectually disabled. Over time, and with the trust developing between Chris and the new worker, information was gained that this mother had achieved University Entrance. This changed the way the Family Support Worker worked with Chris. She gently and firmly challenged her to co-operate with jointly planned interventions and insisted that she take full responsibility for her actions.

The Family Support Worker made contact with grandparents and encouraged and facilitated several family meetings. Over time they began to support their daughter. Bob began to spend more time with his mother and his brother.

Outcomes after 18 months in the programme

Chris responded well to the Family Support Worker and a trusting relationship developed between them both.

She was now providing adequate and nutritious food for her child, the home environment was made safe and this was maintained over time. Her gambling was under moderate control. The four year old was returned to the care of his mother with support from her parents. The Children and Young Persons Service closed their investigation with no further action taken.

Conclusions

At first sight, the preceding analyses and case histories appear to provide strong evidence to suggest that Early Start was successful in improving maternal child rearing skills and reducing child abuse risks. In all cases, there was evidence of clear reductions in the number of women experiencing child rearing difficulties and the numbers of children at risk of abuse. These trends were evident for both Family Support Worker assessments and in contacts with official agencies, suggesting that they were not an artefact of a particular method of measurement. In addition, the case history material provides insights in the processes by which family support assisted mothers to address child rearing problems and reduce child abuse risks.

However, whilst these results clearly suggest possible benefits of Early Start in improving parenting and reducing child abuse risks, they fall far short of demonstrating this to be so. In particular, it could be argued that the improvements observed in Early Start families, had little to do with the family support provided to these families but rather reflected processes of family change that would have occurred with the passage of time, irrespective of whether the family received support. As we have commented previously, the only way of resolving such ambiguities in the interpretation of the evidence is through the use of a controlled field trial, that contrasts the outcomes of comparable groups of families who are exposed and not exposed to the Early Start programme. The results here, however, do demonstrate that the programme met the bare minimum conditions for programme efficacy, in that families appeared to show clear improvements in parenting and reductions in child abuse risk following programme entry.

CHAPTER 6

PARENTAL PERSONAL ADJUSTMENT

The preceding chapters have focussed on the extent to which participation in Early Start was associated with positive child rearing and related outcomes. However, an important component of the Early Start programme is to provide support and assistance to parents in dealing with personal difficulties, stresses and adjustment problems. As noted in Chapter 2, client mothers in the Early Start programme were frequently characterised by an adverse psychosocial history and the presence of substantial personal adjustment problems. Clearly, the presence of these problems and difficulties is likely to have multiple consequences for maternal childrearing, the stability of the child's family circumstances and related matters. In this chapter we turn our attention to examining the extent to which increasing participation in Early Start was associated with reductions in a range of psychosocial problems and difficulties including: mental health problems; alcohol related problems; illicit drug use; parental criminality; marital conflict and family violence. In general, the aim of these analyses is to build up a profile of the extent of these personal difficulties in Early Start families and to examine changes in these problems with increasing client participation in the project.

Maternal Adjustment

Assessments of a number of aspects of maternal functioning were made by Family Support Workers at 6, 12 and 18 months. These assessments were based on the Family Support Workers' contacts with, and knowledge of, the mothers and considered a number of areas including: maternal depression, maternal alcohol use; maternal illicit drug use; and maternal criminality. Table 6.1 shows the percentage of mothers described as having these problems during the periods 0-6 months; 6-12 months and 12-18 months of participation in Early Start. Two features of the Table are clearly evident. First, there was a dramatic decline in rates of maternal depression with the passage of time. During the first six months of programme participation, nearly three quarters of mothers experienced depression, whereas over the period from 12-18 months, only two mothers suffered depression. An important reason for this decline may have been that Family Support Workers were required to report on maternal depression at regular periods and to make efforts to refer mothers with depression to medical treatment. Over the course of Early Start, 34 mothers were put into contact with medical services (usually family doctors) for depressive symptoms and 20 (58%) were prescribed anti-depressives. It seems likely that the clear decline in rates of maternal depression in mothers, in part at least, reflects the efforts of Family Support Workers in encouraging mothers with significant depressive symptoms to seek assessment and treatment.

In contrast to the dramatic decline in rates of depressive symptoms amongst mothers, there was far less change in rates of alcohol problems, illicit drug usage and drug problems, with little evidence to suggest any improvement in these areas. The reason for this is likely to be

that, amongst the mothers in Early Start, there is a minority with long standing difficulties with drugs or alcohol. Whilst family support to these mothers may mitigate the effects of their substance use on their children, the results suggest that in the short term, at least, family support does not necessarily lead to a reduction in substance use problems amongst mothers.

Table 6.1: Rates of adjustment and related difficulties amongst mothers

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

Marital Conflict and Family Violence

As noted in Chapter 2, the majority (67%) of families enrolled in Early Start involved single parent families, in which the mother was rearing her child in the absence of a cohabiting male partner. Nonetheless, a number of mothers had relationships with non cohabiting male partners. Table 6.2 shows that between 50% to 60% of mothers were in relationships with cohabiting or non cohabiting male partners. The Table also examines the partner relationships amongst those with partners. It is evident that the majority of partnerships were conflictful,

Table 6.2: Partners and relationships with partners

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

being characterised by high levels of conflict and verbal abuse. There is no evidence of any trend for the quality of partner relations to improve with increasing programme duration. However, whilst partnerships were often conflictful, levels of physical violence were relatively low and appeared to decline with increasing programme duration. The findings clearly suggest that family support did not increase the chances of women entering non-conflictful partnership relationships but it may have acted to reduce the rate of partner violence.

Characteristics of Partners

Table 6.3 provides an overview of the psychosocial backgrounds of the male partners identified in Table 6.2 in terms of: criminal behaviours; illicit drug use; alcohol problems; mental illness and employment status. These profiles reveal relatively high rates of difficulties amongst male partners, with over 90% of male partners experiencing at least one of the problems and difficulties described, with unemployment being the most common difficulty and psychiatric problems the least frequent difficulty. It is notable that quite a substantial number of partners were involved in criminal activity or engaged in substance use behaviours.

Table 6.3: Characteristics of partners

Measure	Time		
	0-6 months (N = 29)	6-12 months (N = 23)	12-18 months (N = 18)
% of partners involved in criminal behaviours	34.4	26.1	22.2
% of partners using illicit drugs	41.4	34.8	33.3
% of partners having problems with alcohol	27.6	13.0	22.2
% of partners with psychiatric problems	6.9	8.7	11.1
% of partners who were unemployed	86.2	82.6	72.2

Conclusions

In this chapter, we have examined the extent of psychosocial difficulties amongst parents in the Early Start programme and the extent to which there was evidence that rates of these difficulties reduced over the programme. The findings produce somewhat “patchy” results

showing evidence of positive change in some areas but not others. In particular, there was evidence of a dramatic decline in rates of depression amongst mothers with increasing programme participation. There are also good reasons for believing that these changes are, in part at least, a consequence of programme participation to the extent that the Early Start programme has made a concerted effort to identify mothers with significant depressive symptoms and ensure that they received appropriate assistance.

In contrast to the very clear changes in maternal depression with increasing programme participation, there was far less evidence of positive change in areas such as substance abuse, criminality and partner relations. In these areas, rates of difficulties remained relatively constant and showed little evidence of change with increasing programme participation. These results are clearly suggestive of the fact that in contrast to other areas examined in this report, behaviours in these areas were less likely to be changed by family support processes.

It is likely that there are two explanations for the relative lack of change in substance use and partner relationship problems in client families. First, as is evident from the material in Chapter 2, for many client families their problems often reflected long standing personal difficulties and problems that had their origins in the parent's own childhood. It is well known that producing changes in behaviours such as criminality, substance abuse and related areas of functioning often takes a lengthy process and that rates of success are often low. Under these conditions, it is perhaps unrealistic to expect that a family support programme will produce major changes in the life styles of at risk families within a relatively short period of time. A second factor that should be borne in mind is that the programme duration studied may have been too short for positive changes in client families to become evident. There is some evidence that might support this to the extent that the impressions of the Early Start staff are that personal change in these areas usually does not occur until families have been enrolled in the programme for at least two years. Whilst this evidence is clearly anecdotal it does suggest the possibility that had the programme been evaluated over a longer time period, greater evidence of positive changes in parental adjustment might have been found.

Although the above analysis does not support the view that Early Start was always successful in reducing rates of parental problems in Early Start families, it should also be pointed out that Early Start often made positive contributions to the management of these difficulties. In particular, a feature of many families enrolled in the programme was that they were subject to recurrent stresses and crises arising from their personal difficulties and problems. In such situations, Early Start played the important role of providing the family with support and helped to mitigate the impacts of family crises on family members and, particularly, the client child. To illustrate this point, the case history below describes an Early Start Client Family that was subject to severe and recurrent crises that centred around the problems of personal adjustment and competence faced by both parents in the family.

Mother Pam (age 22), Father Lance (age 35), Toddler Sam (age 2½ years) and Baby Win (3 weeks)

Brief family and personal background information

Pam is pakeha and one of five children (middle child). Her mother had several different partners and Pam's father did not have much contact with his daughter. Pam's mother has a

severe, chronic gambling problem and Pam reports poverty and many crisis situations. Pam experienced sexual abuse, naming one of her mother's partners as the perpetrator and states that her siblings suffered sexual abuse as well. She left school early with no qualifications.

Lance reports a very unsettled childhood. He is Maori and one of 10 children. He speaks of frequent and very severe beatings, witnessing parental violence with his mother being severely beaten, of poverty, alcoholism and severe malnutrition. He was in and out of foster homes from the age of 5, and reports being at odds with persons in authority from an early age. He has served several prison terms for a variety of crimes (violence, robberies).

Family situation at point of enrolment

Pam was suffering from severe psoriasis, postnatal depression and presented with anorexic symptoms.

She was breastfeeding baby Win. Toddler Sam was still in nappies day and night. He displayed aggressive behaviours (head-butting, hitting, scratching, pushing) towards his parents, baby sister and other children. He refused toilet training and defecated in corners of the home. His speech was limited and he was using only swear words. He was very light in weight for his age and suffered from repeated chest infections.

Family finances were in a severe crisis. Family income was via the married unemployment benefit. The family, obviously poor with very little food in the cupboards, lived in a sparsely furnished state house. Already stressed, finances were made worse by hire purchase agreements which could not be met. Hefty court fines due to major credit fraud and vehicle infringements, loan repayments for loans raised with credit companies and Income Support Services in order to pay off loans, complicated the matters further. Gaining an overview of the financial picture was made more complex by the couple making poor financial decisions, not prioritising spending and selling items still on hire purchase. Various household items and a car were being repossessed. Despite the severe shortage of money to buy food and other essential household items, both parents were heavy smokers. Their addiction was severe to the point that both waited at an ATM until midnight when the benefit payments were posted to their bank accounts in order to withdraw money to purchase cigarettes. Lance liked going out with the boys. Pam reported that he liked consuming a fair amount of alcohol and smoking cannabis.

The couple had relationship difficulties with repeated arguments that culminated in violence with neighbours calling the police. The family was isolated and constantly experiencing friction with their extended family, friends and neighbours. When Pam arrived at a playground with Sam, other parents left because of his aggression and swearing. The couple were also asked not to bring the child to the supermarket as they were not able to control his behaviour.

Lance was difficult to engage. He had alienated himself with most support agencies. He often quoted the privacy act, using this to withhold information and playing agencies up against each other. Lance frequently used threatening behaviour in order to force agencies into giving him assistance and overused food banks, relying on their assistance to feed the family. He was "banned" from all Income Support Service offices due to aggressive behaviour and the use of threatening language.

Early Start interventions

- *Ensuring that Pam's health needs (depression, psoriasis and anorexia) were being treated by establishing a relationship with one GP. Early Start assisted with the payment of doctors fees and prescription charges. The Family Support Worker sought co-operation between the GP and Early Start and facilitated the continuing involvement of the Plunket nurse in order to monitor the children's health and developmental needs.*

- *The Family Support Worker paid attention to the dire financial situation by meetings with Income Support Service and the family seeking ways to address the acute cash flow problems. She also participated in meetings with the family and the budget advisory service to engage their co-operation in a planned budget. She negotiated with other support agencies to formulate a planned assistance strategy that allowed little room for further manipulation by Lance who was encouraged to seek employment or attend work skills training.*

- *The Family Support Worker encouraged and assisted the parents to enrol toddler Sam in a child care facility. Early Start assisted with play lunch and transport until a routine was established. The Special Education Services were asked to assist the parents with behaviour management strategies. Pam was encouraged to breastfeed Win as long as possible and then Early Start assisted with baby formula when Pam weaned Win.*

- *The Family Support Worker encouraged both parents to look at their parenting behaviours and challenged any emotional or physical violence towards the children. She modelled play and gentleness towards both children and highlighted any signs of gentleness by the parents towards the children. The couple was also encouraged to look at the violence between themselves.*

- *Despite parental hostility, frequent attempts were made to raise the issue of smoking, particularly as both children suffered frequent chest infections and were exposed to smoke filled environments.*

Ongoing family difficulties

Progress in this family was very slow. Ongoing financial mismanagement led to further crisis situations. Lance continued with attempts to manipulate agencies to meet his financial needs. He stated that this was the way he provided for his family. He was resistant to seek employment. On the few occasions when he managed employment, this was short lived, lasting a few days only. The main reason being disagreements between the employer, workmates and himself. Lance was not willing to address or challenge his own behaviours, stating that "he knew it all" having completed 7 anger management courses.

An added complication was Pam's third pregnancy. Food shortage in the home continued and the children's diet was causing concern, as did Pam's anorexia. Stress levels in the home were high and it was feared that this pregnancy would not progress well.

Many different planned strategies were attempted and one that proved more successful than others was a very hands on and concrete way of modelling routine, good diet and gentle but firm interactions. The Family Support Worker and one other agency formed a partnership and began "feeding" the family. Twice a week the Family Support Worker would bring into

the home essential food items such as bread and milk, and ingredients to prepare a simple but inexpensive meal. The toddler, by now 3½ years old was enlisted to help the Family Support Worker & his mother. The table would be set and the entire family invited to sit down for a meal. This strategy, more than any other one appeared to encourage this family to embrace some different ways of organising their daily life and helped to reduce some of the stress within the family.

Outcomes after 18 months in the programme

***Parenting**: The most radical change was in this area. The parents responded to the Special Education Services support and a toileting programme was introduced for Sam. The child was beginning to respond to this. His attendance at pre-school became more regular. His vocabulary increased and his use of language improved. His aggressive behaviour lessened and eventually was not displayed at the creche any longer. Both parents began to make statements to the Family Support Worker that this child may be OK. The Family Support Worker also observed an increase of gentle and harmonious interactions between the parents and Sam. Baby Win, a more passive child, was developing well. Both parents involved themselves with the pre-school. Pam assisted as mother help and Lance helped build a fence and tidy up the playground. The arrival of the new baby in the home was much smoother and the chaos of the earlier time was not repeated.*

***Financial situation**: At 18 months the severe cashflow problems continue and crises in this area are still a feature of their everyday life. Lance has managed a few days of employment. Pam is now looking at preparing for the work force herself. The couple are slightly more open with their Family Support Worker as to their budget.*

***Parental relationship**: This has improved, with no further incidences of police involvement. Pam has learned new ways of being stronger in the relationship, however the couple remains unwilling to address their relationship difficulties.*

***Maternal ill health and depression**: A good relationship formed with the GP and Pam co-operated with and responded to treatment. There was no repeat of the severe depression after the birth of baby 3. Baby 3 was full term and had a good weight at birth, whereas the other two children were light for dates and 4 weeks early. Pam breastfed the new baby for 3 months. She now makes statements to the Family Support Worker that indicate that she will ensure no further pregnancies. Anorexia continues to be an ongoing concern, however Pam is more aware of ways to manage this.*

***Smoking**: At this point there is no change in the consumption rate of cigarettes by both parents, however some effort is made to keep the children in a more smoke free environment.*

***Social isolation**: This continues to be a problem, however contact with other parents at the creche has been beneficial. Pam also attended a morning group at Early Start. Both Lance and Pam have at odd times visited the Early Start offices. Pam also says that contact between herself and one of her sisters is less troubled.*

***Child well health**: All the children are fully immunised and their health and development is well monitored. Baby Win never exhibited the severe behaviour disturbances as did her elder brother. She developed into a happy smiling, inquisitive toddler. With more appropriate*

nourishment both children gained weight. Chest infections continued during the winter months.

***Conclusion**: Gains made with this family are very small and have required high levels of service provision. The work is, and continues to be very challenging and the Family Support Worker has to remain focussed on the tasks at hand and resist being distracted into the never ending crisis situations. Above all the Family Support Worker has to ensure a positive attitude. In order to achieve this, careful clinical supervision of all case work and personal support was essential.*

The above case history clearly illustrates the point that, although family support failed to resolve the problems within the client family, the presence of the Family Support Worker within the family considerably reduced the impacts of these crises on the family and particularly the child.

CHAPTER 7

ECONOMIC CONDITIONS

An important feature of the Early Start programme has been the provision of advice, support and mentorship to assist families with the management of their finances. As was noted in Chapter 2 many client families were relatively impoverished and were characterised by:

- High reliance on welfare benefits for economic support.
- High levels of debt.
- High proportion of income spent on rent.
- Below average or poor living standards.

This chapter examines the extent to which Early Start participation led to changes in family economic and material circumstances and also explores various barriers to positive economic change in client families.

Family Economic Circumstances (0-18 months)

Table 7.1 shows a series of measures of family economic circumstances assessed at 6, 12 and 18 months of programme participation. These measures include:

- The percentage of families dependent on Welfare benefits for their major source of income support.
- The percentage of families who, in the opinion of their Family Support Worker, were having difficulties making ends meet.
- The percentage of families unable to save any part of their income.
- The percentage of families with debts (excluding hire purchase) of greater than $500.
- The percentage of families described by their Family Support Worker as having below average standards of living.
- The percentage of families described by their Family Support Worker as being obviously poor.

Inspection of the Table shows that over the 18 month period there was virtually no change in these percentages, showing clearly that the programme involvement had failed to lead to any detectable improvements in the economic or material standards of client families. As a group,

families entering Early Start were highly Welfare dependent and relatively impoverished and remained so over the first 18 months of programme participation.

Table 7.1: Economic circumstances in client families at 6, 12 and 18 months

Measure	Time		
	6 months (N = 48)	12 months (N = 44)	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

* Number not recorded

Barriers to Economic Change

The clear lack of success of Early Start in producing change in family economic circumstances raises the important issue of the various factors that may have posed barriers to programme success in this area. There appear to be a number of explanations of the relative lack of change in economic conditions in client families. These include:

1. Client Resistance to External Influence or Control of Personal Finances

As noted in Chapter 3, relatively large numbers of Early Start clients were referred to Budget Advisory Services (See Table 3.2). In addition, in other families, Family Support Workers provided informal budgeting advice and assistance. However, despite these efforts, many Early Start clients were relatively resistant to changing their patterns of expenditure as a result of advice by either budget advisers or Family Support Workers. To illustrate this trend we describe a case in which a family was facing recurrent economic crises owing to budgeting problems and the various steps that were taken to manage and reduce these problems.

Mother Lisa (age 21) and baby Lexi (4 weeks)

Family background

Lisa (Pakeha) was raised by her mother in a single parent family. She is the youngest of 2 children, and reports very poor economic circumstances, a struggle to meet the demands of daily living, and at times not having enough food in the house to feed the family. When Lisa

was 10 years of age her mother remarried and Lisa did not get on with her stepfather. Family life was problematic and children often missed school. She did not complete her schooling.

Family situation at point of entry

The family was living in a small flat which was reasonably furnished. Lexi's father was involved but not living with Lisa. There was no evidence of post natal depression, but Lisa was a very anxious mother. Baby Lexi had a reflux problem and was very unsettled. Lisa was receiving the Domestic Purposes Benefit and all additional entitlements. She was in a severe financial crisis and her family was no longer willing to assist financially.

Recurring economic crisis

Lisa was an impulsive shopper and her favourite past time was shopping. She impulsively bought a car which was mechanically unsound. She did not have the funds to register or warrant the car and incurred numerous fines which she ignored.

Lisa then sold that car, purchased another car and raised a loan with a private finance company to cover all outstanding debts and the purchase of the new car, incurring high interest charges of 33%. This led to financial hardship whereby Lisa was unable to meet the rent, power, phone, food, petrol etc. This led to further court actions, incurring further debts. During this time Lisa continued to purchase indiscriminately.

Early Start interventions

Lisa was encouraged and supported to seek assistance with a registered budget advisory service. The Family Support Worker accompanied Lisa on numerous appointments and assisted with repeated budget plans.

A summary instalment order was applied for. The Family Support Worker accompanied Lisa to court and advocated for periodic detention in lieu of a custodial sentence to pay back the outstanding traffic and court fines.

Early Start assisted with outstanding power bills, food parcels, and negotiated with Income Support Service to assist with rent arrears.

Lisa was encouraged to seek counselling to address the problem with her ongoing shopping.

Outcomes after 18 months in the programme

Lisa's financial situation continued to decline. She resisted and evaded all interventions and did not heed any advice offered. She was expecting others to sort out her financial difficulties and took no responsibility for her situation. Baby Lexi was used as the reason of her not being able to follow through and any challenging situation was met by Lisa taking Lexi to the GP with various medical complaints. She did not keep to her probation conditions and is now facing a possible jail term.

What is very clear from this case illustration is that despite extensive efforts to assist the family with budgeting, there was considerable resistance on the part of the mother to accept this advice. The case history above represents an extreme example where extensive efforts to

provide budgeting advice were resisted. Nonetheless in a substantial number of Early Start families, there was clear evidence of the fact that families were resistant to attempts to assist them with financial management and budgeting and usually only accepted such advice when they were facing very serious financial problems.

2. Adequacy of Income Support

As noted earlier, the majority of families in Early Start were dependent on welfare benefits as their primary source of income. In part, the difficulties described in Table 7.1, reflect the fact that a number of families found it very difficult to manage on current benefit levels. Below we give a case history of a family that faced financial difficulties, despite prudent management of the family budget.

Mother Susan (age 23), Father Liam (age 23), baby Richard (age 4 weeks)

Family background

Susan (Pakeha), was adopted into a large middle class family. She describes a difficult, at times distant relationship with her adoptive mother and a close bond with her adoptive father. Her mother's parenting style was at times harsh and punishing whereas she talks of her father as being loving and that he frequently had to protect her from her mother. He died when she was 14 and at that time Susan states that she "went off the rails a bit".

Liam (Pakeha), experienced a poverty stricken, very unsettled childhood. He became a regular intravenous drug user at an early age and has spent time in prison. Contact between Susan and Liam is sporadic. Due to past violence between them, Susan has a protection order in place.

Family situation at time of enrolment

Susan and Richard were living in a tidy, clean, well organised and furnished flat. Richard was being breastfed and the Family Support Worker observed warm mother child interactions. Susan is a smoker, however she recognised the importance of a smoke free environment for her child and only smoked outside, away from the baby.

Difficulties identified

Susan was isolated, with very little family support which was made difficult by the strained relationship between Susan and her mother.

At the time of enrolment, Susan was also struggling with a severe depression and tight economic circumstances. She had been in receipt of the Domestic Purposes Benefit for 4 weeks only and had lived on the sickness benefit once she could no longer work. She had to borrow money from the Income Support Services and her mother in order to furnish the flat. She had a further debt of $800 (counselling and a bicycle).

Her income from the Domestic Purposes Benefit was $246 per week and her budget was: rent $130; food (+-) $40; hire purchase payments for a wall unit $10; transport (bus and taxi) and power and other household expenses $40. This left $26 for any other living costs and the repayment of the $800 debt and the money owed to her mother.

Susan was a very careful shopper with good cooking skills. Breastfeeding Richard kept the food bills low. She carefully budgeted her income and put the needs of baby Richard before her own.

Early Start interventions

Susan was not attending to her own health needs as she found it very difficult to pay for GP visits and prescription charges. In order to attend to Susan's depression, Early Start paid for her medical bills and prescription charges. Most of the interventions were targeted at Susan's depression and child care needs.

Susan also needed support with making her budget stretch to cover any unforseen bills or expenses and to find a way to pay her outstanding debts. A disability benefit was organised for her to cover her medical bills and assist with a telephone.

Outcomes after 18 months into the programme

Susan has had some periods where she was free of depression. She has made some friends with other Early Start mothers and is not as house bound and isolated as at programme entry. The relationship with her mother has improved slightly.

Her economic circumstances are as tight as ever and any additional expenditures such as the breakdown of her washing machine, TV licence, bank fees, replacement of household items (sheets and towels), clothing for herself and Richard, Richard's additional nutritional needs once he was weaned and planning for Christmas (an important occasion in Susan's large family circle) continued to cause Susan huge anxiety. Her repeated depressions have interfered with her ability to earn any additional income.

3. Limitations on Earning Power

It is intuitively clear that many of the problems of both limited income and welfare dependence described above could be reduced by mothers entering the work force to supplement family income by part time or full time work. As part of Early Start, consideration was given to addressing this issue by encouraging mothers to enter paid employment. This approach encountered two major barriers:

Variation in maternal coping abilities: In a number of families, it was clearly apparent that it would have been unwise and perhaps even hazardous to encourage maternal work force participation. In these families, mothers were often having extreme difficulties in coping with the tasks of child rearing and maintaining a home. Under these conditions, the dual demands of work force participation and family life was clearly ill advised. Below we give a case history that illustrates the ways in which serious coping problems limited the mother's ability to enter the work force on either a part time or full time basis.

Mother Betty (age 25), Father Paul (age 27), children Sam (age 5 years), Peter (age 2 years, Jack (age 6 months)

Family background

Betty (Pakeha) the eldest of 4 children, was raised in a climate of family disharmony. She was exposed to family violence, poverty, incest, and experienced the early death of 2

brothers. Her mother has a borderline intellectual disability. Not much is known about Betty's father. She left school with no qualifications.

Paul (Pakeha) talks about witnessing extreme parental violence, a father with a severe alcohol problem, poverty and a very harsh upbringing characterised by frequent beatings. He was in and out of foster homes. He obtained no formal school qualifications. Paul has 3 children to different partners and has no contact with these children.

Family situation at time of enrolment

Betty, Paul, Peter and Jack were living in a small sparsely furnished one bedroomed home. Conditions were cold and cramped. The household items included a good TV and a vast collection of model cars.

Sam, who has a different father was in foster-care, visiting the family every second weekend. He was removed from the family due to harsh handling by both parents.

Betty has a learning disability, very low self esteem and does not cope well with the challenges of day to day living. Paul makes most of the family decisions and handles the family finances. He also assists in the home with the daily routine. The family has a car.

One of the few positives was that Betty was breastfeeding baby Jack.

Difficulties encountered by family and the Family Support Worker included the following:

- *Betty was obviously depressed and did not comply with any treatment regimes.*
- *Sam and Jack suffer from muscular dystrophy, Peter is unaffected.*
- *Jack was slow in reaching milestones and suffered from severe chest infections.*
- *Although Betty visited one GP, she did not report a trusting relationship between the GP and herself and therefore withheld important health information.*
- *The relationship between Betty and Paul was in difficulty. At a later stage Betty disclosed physical violence between them.*
- *The children's immunisation regime was interrupted with parents not keeping to appointments.*
- *Betty had a great deal of difficulty with the tasks of childrearing and both parents used harsh disciplinary methods with Peter. Both children received little warmth from Betty who found close physical contact with her children difficult.*
- *Due to Betty's learning difficulties she had problems with understanding, following and performing the very necessary exercises for baby Jack. There was also an unwillingness to stimulate him, preferring him to be passive.*
- *Betty was very isolated and lonely, being totally dependent on Paul.*

Early Start interventions

- *Assisted the family with moving into more appropriate accommodation.*
- *Addressed the baby's delay by referrals to physiotherapy, a paediatrician, CCS (Cripple Children Society) and the Muscular Dystrophy Society.*
- *The Family Support Worker role modelled warm and loving behaviour towards the children and encouraged Betty to do the same. Betty was encouraged to breastfeed Jack as long as possible.*
- *Assisted Betty to make contact with another GP, and supported and facilitated the formation of a trusting relationship.*
- *Encouraged couple counselling to address issues of violence.*
- *Encouraged Betty to attend parent education and attend a special education group in her area.*
- *Ensured adequate respite care for the family and arranged for free ambulance service for baby Peter in case of a medical emergency.*

Outcomes after 18 months in the programme

Baby Jack is responding to the regular physio, close health monitoring, special education input and his mother's intermittent attempts at stimulation. His development continues to be delayed, however he is now sitting unaided and is beginning to move himself around. He has survived two severe choking episodes.

Betty has formed a good relationship with her GP and has accepted treatment (medication and counselling) for her depression. Attending every "Teachable moments" course has given her the opportunity to learn new skills in a safe environment, make contact with other mothers in the programme and has eased her participation with the special education mothers' group. She is taking some steps towards becoming less dependent on Paul.

Parenting behaviours by both parents have improved. The Family Support Worker has observed an increase in warm and loving interactions between the parents and both Peter and Jack. Contact with Sam continues to be intermittent.

Betty's and Paul's relationship continues to be fraught with difficulties.

***Conclusion**: This family is a high user of the service and progress is very slow. Additional volunteer hours have been allocated to reinforce and practice new learned skills. The problematic personal histories of both parents, combined with the extra health needs of the baby and Betty's learning difficulties add additional stress to the family.*

It is clear from the above account, that this mother was not in a position to enter the work force and that had work force participation been imposed upon her, it would have been unlikely that she would have been able to cope with the dual demands of paid work and home life.

Skill limitations: As noted in Chapter 2, many of the mothers enrolled in Early Start had limited education and this, in turn, limited their job opportunities. In addition, the educational limitations faced by mothers were often exacerbated by the fact that they had no recent work force experience. These dual factors of limited education and limited work force experience conspired to prevent many women who were in a position to work from entering the work force. To address these issues, Early Start workers have been encouraging mothers to obtain further educational qualifications and training. The case history below gives an account of the ways in which this support provided one young women with the opportunity to begin to make a transition from welfare dependence to full work force participation.

Mother Bonnie (14 years) and baby Cody (3 months)

Family background

Bonnie gave birth to Cody at age 14.

Bonnie's school history was one of truancy and non-achievement. Little is known of Bonnie's father.

Bonnie's sense of achievement was to have a little baby. She was therefore very pleased with the birth of Cody. Bonnie has no contact with Cody's father and did not want his involvement.

Family situation at time of enrolment

Cody was 3 months old when Early Start first made contact with Bonnie who was living with her mother. The household consisted of Bonnie, Cody, Bonnie's mother and a 2 year old half sister.

Bonnie was theoretically doing correspondence school but was not handing in her assignments. As Bonnie's relationship with her mother was very stormy and conflictual, she wanted to leave home but did not have the funds to do so. Bonnie was partially breastfeeding Cody and was interacting well with him. Cody appeared well cared for, but Bonnie had difficulties coping with and managing to meet his daily needs. Both Bonnie and her mother were heavy smokers.

Family assessment and Early Start interventions

Four major problems surfaced within the first months of the Early Start service delivery.

- *Bonnie and especially her mother were reluctant to have Early Start involved. The assigned Family Support Worker worked very hard promoting the concept that engagement into Early Start was a positive decision made by Bonnie. At first it was important to ensure that Bonnie's mother was comfortable with the service and the weekly involvement of an outside agency in her household. Once mother was comfortable, work with Bonnie and Cody could begin. .*

- *Bonnie was presenting with a social phobia. She was reluctant to leave the home environment and refused to go out for a walk, go shopping or take a bus. She spent her day "sitting around" and arguing with her mother. Neither Bonnie, nor her mother would consider a referral to a specialist unit. After 3 months of intensive input by the*

Family Support Worker, Bonnie agreed to accompany her on a walk with Cody in the pram. Once this was achieved, walks were part of the planned interventions and eventually Bonnie began to go out by herself.

- *Bonnie was not attending to her educational needs. The Family Support Worker actively encouraged and supported Bonnie to complete her assignments and to view school work as an important asset. Bonnie complied reluctantly. When she turned 15, the Family Support Worker assisted her with applying for a school exemption and then enrolled her in a life skills course offered by the YMCA. Bonnie enjoyed this course and had her first taste of achievement. She learned the road code and got her learner's licence. She completed a first aid course, made some friends and took the bus every day to attend the course. Upon completion of this course she embarked on another course in the beauty industry.*

- *Conflict and power struggles between Bonnie and her mother continued. The lack of independent finances were the cause of many battles and Bonnie desperately wanted to leave home. Time was spent mediating between the two women and the Family Support Worker modelled appropriate relationship behaviours and assisted with communication skills. Bonnie was encouraged to co-operate with her mother, learn home management skills, attend to her baby and continue with her education. The mother was asked to recognise Bonnie's achievements and to praise her daughter.*

<u>Achievements at 18 months participation in the programme</u>

At age 16 Bonnie had a CV with genuine achievements. Cody is developing well, reaching all his mile stones and attending day care on a regular basis. His immunisations and well child checks are up to date. Like any young mother, Bonnie struggles at times with his demands and needs, but is open to suggestions and often finds solutions to problems as they arise. Bonnie has moved into a little house on her own and is beginning to establish her independence. She has a flatmate and is attending an evening course in hairdressing. She is linked with a young mothers' group and has enrolled herself with a budget advisory service. She is gaining confidence with cooking and shopping, an area where the input of the Family Support Worker was crucial. The relationship between Bonnie and her mother is warmer and supportive, with both attending a parenting course together (Teachable Moments).

Bonnie states that she feels more confident and can scarcely remember "how I was when I first met you (the Family Support Worker)".

<u>Current family plans</u>

Bonnie wants to be a good mother to Cody and is open to learning parenting skills. She wants to complete her course in hairdressing. She qualifies at the end of this year and has already been offered a part time position. Bonnie's ambition now is to be off the Domestic Purposes Benefit by age 18.

It is evident from this case history that in the longer term, this young woman will be in a position to enter the work force on a full time basis and thus eliminate her dependence on welfare benefits.

Other factors: Other factors that also conspire to prevent work force participation have included: i) lack of availability of suitable jobs; and ii) child care difficulties and costs.

Consideration of the above begins to reveal why the Early Start programme was relatively ineffective in producing positive change in the economic circumstances of client families. This limitation arose from a series of barriers that conspired to keep client families at relatively impoverished levels. These factors included: a) client resistance to budgeting and financial advice; b) difficulties in dealing with unexpected costs for families on low incomes; c) the inability of some mothers to cope with the dual demands of work force participation and parenthood; d) limited educational and skill levels that reduced access to work force participation; and e) structural factors including the availability of work and the affordability of child care. When these barriers to change are considered, it becomes clear why the Early Start programme had limited success in encouraging economic change in client families, since such change often required personal change within the client and also changes in the range of employment opportunities available to her.

Conclusions

At the inception of the Early Start programme, one of the expectations was that through the process of family support it would be possible to produce positive changes in family economic circumstances. The above findings clearly suggest that virtually no change occurred in these conditions during the first 18 months of the programme. The majority of Early Start families were Welfare dependent and impoverished at the point of programme entry and remained so 18 months later. The experience of the programme may, however, provide some insights into the factors that contribute to the depressed material standards in at risk families. In general, debates about this issue have tended to present two polarised views of the origins of these problems. The first view, emphasises the behaviours of the client and argues that families must assume responsibility for their own economic wellbeing and that welfare benefits should be seen as provisions in times of crisis, rather than long term sources of income. The alternative view emphasises the responsibility of the Government to provide income support to less fortunate members of the community and implies that the presence of families in economic hardship is an indicator of the failure of Welfare policy. These views are largely distinguished by the extent to which they assign responsibility and blame to the individual or to the State.

The experiences of Early Start suggest that both positions are likely to contain an element of truth but also contain an element of distortion. It is apparent from the experiences of the programme, that in some cases families in economic hardship are, in part at least, authors of their own misfortune by failing to heed reasonable advice about budgeting and management issues. This issue is clearly illustrated by case history of Lisa which described a situation in which despite very extensive efforts to assist with budgeting, the determination of the mother to manage her financial affairs and ignore budget advice, led to a situation in which the family was in recurrent economic crisis, from which it had to be extricated on multiple occasions. It is equally true, however, that we came across circumstances in which even the most prudent individual would have found it impossible to make ends meet. This situation is illustrated by the case history of Susan where it is clear that despite prudent management, the family's economic circumstance were such that it was unable to make ends met when faced with unexpected costs.

It seems reasonable to argue that many of the economic problems faced by at risk families could be addressed through entry into the work force. However, it became apparent during the course of the programme, that there were a number of barriers to the implementation of this approach. First, for the minority of mothers who were facing severe difficulties with child rearing and family life, it was clear that these women were unlikely to be able to cope with the dual demands of work force participation and family life, and that entry into the work force could have proved to be disastrous for both mother and child. This situation is illustrated by case history of Betty, where it is clear that it would have verged on the foolhardy to have encouraged this mother to take on the responsibilities of work, when she was barely able to cope at home.

Second, many clients faced barriers to work force participation as a result of educational limitations and limited work force experience. In these cases, further education and training were clearly needed to assist the woman's transition back to the work force. This situation is clearly illustrated by case history of Bonnie, which describes a state of affairs in which the young woman involved was well on the way to making a transition from welfare dependence to full work force participation.

The above analysis suggests that many factors tend to conspire to limit the economic circumstances of at risk families. These barriers may be personal, they may relate to a mismatch between benefit payments and family needs and they may also reflect various personal, educational and related barriers that limit work force participation. When the range of factors relating to economic change in at risk families is considered, it becomes more apparent why family support programmes such as Early Start show such limited success in producing positive economic change, at least in the short term. To produce such change clearly requires a social and economic environment that recognises the contribution of both personal factors and social policy to family economic wellbeing. Whilst family support programmes, such as Early Start, can encourage and facilitate economic change, they are not in a position to create the mix of both policies, advisory structures and incentives that are likely to be required to produce positive economic changes in at risk families.

CHAPTER 8

CLIENT SATISFACTION

Previous chapters have looked at the Early Start programme from the standpoint of the services received by client families. This chapter examines the reactions of client families to the services provision and is based on a self report survey completed by Early Start clients administered to 46 clients after 12-15 months of service provision. Of the 46 clients enrolled, 39 (85%) returned a questionnaire. In this survey, clients were asked to respond to a series of questions concerning their reactions and perceptions to the service. The responses to the survey were anonymous and confidential and it was made clear to client families that their Family Support Worker would not be supplied with their responses. Clients were urged to provide a frank assessment of the service.

Responses to Client Survey

Table 8.1 shows responses to a series of 8 self report questions concerning the services provided by Early Start.

Table 8.1: Responses to a client satisfaction survey conducted during 1 January-31 March 1997 (N = 39)

	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%	-
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%	-

	Yes, a lot	Yes, a little	No, not at all	Did not answer
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%

The Table shows:

In the region of half to two thirds of client families felt that Early Start had helped them a lot in understanding their infants and child development; with playing with their children; interacting with their children; feeling at ease about asking for help and making good use of community services. In the region of one third of clients reported that Early Start had helped them a little in these areas. Only 3 clients reported that they had not been assisted in all of these areas by Early Start. The general profile that emerges is clear, with the majority of Early Start clients feeling that Early Start had assisted them a great deal, about a third feeling the service had been helpful and a small minority feeling that the service was not helpful. Overall, 90% of clients felt that their Family Support Worker was highly supportive of their family and only one client complained that the Family Support Worker was not supportive. With one exception, clients felt that the Early Start programme had treated them in a culturally sensitive way and had understood and respected their cultural background and values.

In general, the profile that emerges from this brief survey is clearly that of a service which was seen as a positive, supportive and culturally appropriate by the majority of its clients.

Complaints About the Services

The figures in Table 8.1 can also be supported by case note material on complaints made to the service about the service provider. Over the 18 month period, Early Start has received two complaints about the service from its clients. These complaints and their resolution are described below:

Complaint 1

This complaint was not made directly to the Early Start service, but to a visiting Plunket Nurse. The client was not satisfied with the assigned worker, stating that she did not like her manner and the way questions were asked of her.

Action: The supervisor, Plunket Nurse and the client met to discuss the nature of the Family Support Worker and client relationship. The client was adamant that she wanted to continue with the service, but that she did not like the Family Support Worker and asked for a change of worker.

<u>Resolution</u>: The client's request was granted and a new Family Support Worker was assigned to the family. The different Family Support Worker/client relationship proved to be satisfactory.

Complaint 2

The client telephoned the Early Start supervisor expressing dissatisfaction with the service provided by the assigned Family Support Worker. A full discussion took place between the supervisor and the client identified that: a) the Family Support Worker declined to act as an intermediary in a marital dispute between herself and her estranged husband; and b) that the Family Support Worker had given information regarding the Early Start programme to her (client's) lawyer.

<u>Action</u>: Investigations showed that the Family Support Worker had indeed refused to act as intermediary and had acted on instruction from the Programme Manager. She had offered alternatives and suggested that this was a legal matter. The client had also requested that the Family Support Worker advise her (client's) lawyer of the Early Start involvement.

<u>Resolution</u>: This matter could not be resolved and the client was not open to a change of worker. The client withdrew from the programme.

CHAPTER 9

SUMMARY AND CONCLUSIONS

This report has provided a descriptive account and process evaluation of a pilot programme in which the Early Start programme was developed on, and applied to, a pilot series of 51 clients. The major aims of this pilot study were to:

1. Examine the extent to which it was feasible to identify and enrol high risk families in the programme, using a client identification system based upon referrals from Plunket Nurses.

2. Describe the range of services provided by the Family Support Workers to client families.

3. Examine the outcomes experienced by client families in key areas spanning child health, parenting behaviours; family economic circumstances and parental personal adjustment. To examine overall levels of client satisfaction with the services, this pilot process was planned as being preliminary to the conduct of a randomised field trial, as it was felt that it would be premature to make a large investment in a field trial until it had been shown that: a) the client identification system was feasible; b) methods of service provision had been developed and refined; c) there was evidence of positive outcomes for client families; and d) there was evidence that the service was perceived as being effective, supportive and culturally appropriate by its clients.

In general, the results of the pilot evaluation are positive and suggest the Early Start programme has met all four criteria: client identification was adequate; the service has developed a wide range of services and has developed close linkages and networks with local service providers; there is generally consistent evidence of improvements in child health care, parenting and a number of other aspects of family functioning in client families and the great majority of families view the service in a positive light. These indications are sufficient to justify a suggestion that the programme should move forward to the formal stage of conducting a randomised field trial in which a series of families receiving the service will be contrasted with an equivalent series of families not receiving the services. Below, we examine a series of issues that have emerged from this study and which are relevant to the planing of a field trial.

Client Recruitment and Retention

As the findings in Chapter 2 show, the Early Start programme was able to enrol nearly three quarters of all of those identified by Plunket Nurses as being potentially eligible for the programme. Whilst this level of family recruitment is acceptable, it is clear that there is room for improvement in recruitment rates. The principal source of family loss arose as a result of families refusing to permit their Plunket Nurse to make a referral to Early Start. It is likely that this source of loss can be reduced. In particular, in the pilot stages of the programme, Plunket Nurses were relatively unfamiliar with a programme that had yet to be implemented.

It is likely that this lack of familiarity made it more difficult for Plunket Nurses to convey the potential benefits of Early Start to their clients. Now that Early Start has been in operation and the nature of the service has become more clear, it is likely that Plunket Nurses will be in a better position to promote enrolment in the programme than was the case in the pilot study. There are clear indications that this has occurred since further recruitment into the Early Start programme using Plunket referrals has achieved a higher rate of programme participation, within the region of 90% of those identified as being at risk, being referred to the programme. These considerations suggest that with appropriate care and planning it should be feasible to enrol in the region of 90% of eligible families into the programme. It is likely that this eligible group will comprise in the region of 10% to 15% of the population. The data in Chapter 2 suggested that 17% of families in a relatively high risk area of Christchurch, were found eligible for the programme. This suggests that when the approach is applied to the entire Christchurch region, including lower risk suburbs, the proportion of high risk families identified will be lower than in the pilot study but it is felt unlikely that this proportion will fall below 10%.

A clear difficulty with a regionally based service is that with the passage of time, subjects may move outside of the region and thus will become inaccessible to the service. In addition, families may drop-out of the service as a result of the child leaving the family and entering alternative care, or the family withdrawing from the services. Estimates from the pilot study suggest that these sources of sample loss are likely to reduce the number of families still receiving the service after 18 months to about 80% of the number originally enrolled. This suggests the need for the planning of trials to budget for about 10% to 15 % sample loss due to outmigration and other sources of sample loss per annum.

Service Delivery

What is most apparent from the case histories provided, is the highly diverse needs of families and the highly diverse range of demands placed on Family Support Workers. This diversity proves both a strength and liability of the programme . The strength of the programme is that it has been designed to respond flexibly to a wide range of family needs, rather than providing a specific programme on the assumption that one size will fit all. The liability of this approach is that it proves very difficult to provide a succinct and comprehensive account of the process of service delivery. However, it will be apparent from the summary account in Chapter 3 and the case histories presented throughout the report, that the essential features of the service involved frequent home visitation and regular contact with the families; the development of liaison and networks with local services; and the recruitment of a work force that has sufficient insight and flexibility to both recognise and respond to family needs. It has also become evident that an important feature of this process is regular clinical supervision of workers by a single clinical supervisor who has both an overview of the service and the client families.

Potential Benefits and Limitations of Family Support Interventions

Whilst the present study cannot provide a definitive answer about the extent to which the provision of Early Start leads to improvement in the health, wellbeing and life opportunities of children when compared with existing available services, the results nonetheless, are suggestive of a number of conclusions about both the strengths and limitations of family support programmes. In particular, the results in Chapters 4 to 7 suggest that some goals of

the Early Start programme are readily achievable whereas others are less easy to achieve. In particular:

1. The findings in Chapter 4 shows that a major strength of family support is that it encourages good access to and utilisation of health services. These benefits were particularly evident in such areas as immunisation and the utilisation of preventive health services with children in the programme having a near perfect record of attendance at these services. In addition, the results suggest that the programme was also effective in encouraging positive child health practices such as breastfeeding, the provision of a hazard free home environment, non prone sleeping and (to a lesser extent) the provision of smoke free environments.

All of these findings are suggestive of the conclusion that regular and supportive home visitation can lead to clear improvements in the standard and quality of health care and health care protection that children in at risk families receive. It seems reasonable to conjecture that changes in health care delivery and protection are likely to be amongst the largest and most readily achievable gains of intensive family support.

2. The findings in Chapter 5 produce evidence of relatively clear and consistent improvements in parenting over the course of the programme, with these improvements being evident in both patterns of mother child interaction, child abuse risks and agency referrals. These improvements clearly suggest that participation in the Early Start programme may have led to positive improvements in both parenting skills and a reduction of child abuse as a consequence of the close contact between families and Family Support Workers. It must be borne in mind, however, that the changes observed over the course of the programme could have occurred irrespective of whether or not the family was provided with support.

3. The findings in Chapters 6 and 7 suggest that whilst family support may lead to improvements in health care and parenting behaviours, these methods may have lesser efficacy in leading to life style changes in parents. In particular, in a number of areas including parental substance abuse, parental relationships and family material circumstances, relatively little change was observed in client families. The only area in which clear and dramatic gains were observed was in the recognition and treatment of maternal depression with participation in the Early Start programme being associated with a majority of mothers being referred to treatment and support for depressive symptoms. An apparent consequence of this support being a large reduction in the number of mothers subject to depression.

The limited success of the Early Start programme in producing major life style changes in the areas of substance abuse, parental relationships and material circumstances can be explained in two ways. First, it may be that life style changes of this type take a relatively long time period to effect, with the result that benefits were not clearly evident over the 18 month period of the evaluation. Alternatively, it may be that family support processes are not effective in leading to life style changes, although they may lead to change in health care utilisation, parenting practices and child abuse risks.

Reading between the lines of the evidence and the case histories, this evaluation clearly suggests that in the short to medium term, family support services are most effective in assisting mothers to acquire new skills and behaviours in rearing their children but are less

effective in addressing long standing life style issues relating to substance abuse, partner relationships and family material circumstances.

Client Satisfaction and Ethical Issues

When the idea of developing the Early Start programme first emerged, there were concerns expressed that the programme could prove to be stigmatising and seen in a negative light by the client population. There were also concerns about the extent to which a mainstream programme would be able to deliver services in a culturally appropriate ways. The findings of this evaluation suggests that such concerns were seriously overstated. As the results in Chapter 8 show, the great majority of the Early Start clientele perceive the service as being supportive, helpful and culturally appropriate. The level of client appreciation of the service is reflected in the fact that only 2 of the clients originally enrolled in the programme had withdrawn from the programme because of dissatisfaction with the service. It is clear that, had the programme been seen as stigmatising or culturally inappropriate by its clients, a far larger number of families would have withdrawn from the service.

Overall Assessment

The work in developing Early Start over the last four years has provided a pilot study and a demonstration project that examines the feasibility and potential contribution of this approach. In general terms, the results of the pilot study suggest that there are good reasons for believing that a structured and well supervised programme of home visitation can have benefits for both children and families, with these benefits being most manifest in the areas of health care and parenting and least evident in the area of family economic circumstances and functioning. These conclusions clearly support the view that further developmental work should take place to explore the contribution of this approach to child health and well being with the emphasis of this work being upon controlled field trials to assess the extent of benefits received by children exposed to early intervention. At the same time, the results of the pilot study make it quite clear that family support is not a panacea for all family problems and that in the short to medium term these methods are relatively ineffective in leading to life style change or changes in economic circumstances. For these reasons, it is important that family support services are seen as an adjunct to existing services and not as a replacement for these services. It is quite clear, that even with family support, many families are in need from input from multiple professional services and agencies.

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