"Programs may need to reconsider 'universal' strategies... targeting far too many parents who will never maltreat their children anyway, while failing to provide sufficient focus and intensity for those who are truly at-risk"

Chaffin 2004
Foreword
It gives me pleasure to provide a comment on the latest in a series of evaluations which the Family Help Trust has commissioned in order to better understand the processes and outcomes of its work.

This report is of particular interest. The introduction provides a context in which it is possible to appreciate the urgency, in New Zealand, of implementation of effective interventions to protect children and enhance family functioning.

Family Help Trust’s intervention is revealed as highly unusual if not unique in its targeting only high-risk families and is thus likely to be of interest internationally.

In colloquial terms, FHT is working with a client group which, in the words of Director Libby Robins is “extremely hard and street-wise”. It is a client group that is often bypassed as being ‘at the heavy end’ and therefore not enrolled in services, because of the difficulty of working with them. FHT’s well-qualified and trained staff are equal to the task.

Evaluator Dr Mark Turner is candid about the limitations of the evaluation, noting that it is “indicative of possible trends, not confirmed evidence of programme effectiveness”. Evaluation is complicated by the fact that the service “is designed to meet the specific requirements, circumstances and problems of a given high-risk family, rather than imposing a standardized programme on all families”.

Programme families represented a substantial challenge in the light of the incidence of head injury or concussion, mental health problems, substance abuse, criminal offending, adversity in childhood and prior CYFS involvement.

Significant decreases were noted in CYFS involvement and in reported violence of mothers toward their child/ren. An extremely encouraging
pervasive and consistent trend towards decreasing partner violence and abuse was also found.

In an interesting echo of the “Early Start” evaluation, the Family Help Trust was found to be most effective in assisting mothers to acquire new skills and behaviours in parenting their children but was less effective in addressing long-standing lifestyle issues relating to substance abuse, mental health issues and families’ economic circumstances.

The report concludes that “FHT families were successful in improving maternal child-rearing skills and reducing child abuse risks over the first 12 months involvement with the service”.

A mystery remains. That is the failure of Government to recognize the potential of this organization in the great challenge of making New Zealand children safer and to fund it accordingly to continue its work and to expand it.

The Family Help Trust has established a rare expertise in one of the most difficult but critically important areas of social service. To my mind it represents social enterprise of a remarkable kind. It is an organization that deals proactively and effectively with a population that would otherwise be unlikely to receive necessary assistance.

This report should be read by all those concerned for New Zealand’s children and families, but most particularly by policy analysts and Government decision-makers.

Lesley Max
CEO
Great Potentials Foundation

Co-Patron
Family Help Trust
Table of Contents

Foreword................................................................................................................................. ii
Acknowledgements.................................................................................................................... vi
Executive Summary .................................................................................................................... 1

CHAPTER 1 INTRODUCTION ................................................................................................. 4
1.1 Background .......................................................................................................................... 4
1.2 Neglect/Violence and Young Children: Risk Factors and Effects ..................... 6
1.3 Background on Early Childhood Home Visitation ................................................. 10
1.4 Effective Elements of Home visitation services ....................................................... 13
   1.4.1 Targeting High-Risk Families ................................................................. 16
   1.4.2 Summary of Home Visiting Services Effectiveness ................................. 20
1.5 New Zealand Services ................................................................................................. 23
   1.5.1 Family Help Trust .................................................................................. 25
1.6 Evaluation options ......................................................................................................... 30
1.7 Summary ......................................................................................................................... 33

CHAPTER 2 METHOD ............................................................................................................. 35
2.1 Aims and Objectives ......................................................................................................... 35
2.2 The evaluation design ...................................................................................................... 35
2.3 Data Analyses ................................................................................................................ 36
2.4 Limitations of the research methodology ................................................................. 37
   2.4.1 Sample Selection Bias .............................................................................. 40
   2.4.2 Errors in Measurement ............................................................................ 40
   2.4.3 Recording Errors: ...................................................................................... 43

CHAPTER 3 TARGET FAMILY CHARACTERISTICS AT INTAKE ........................................ 45
3.1 Mother of Baby (MOB) Recruitment .............................................................................. 45
3.2 Socio-demographic and Background Characteristics of MOB ............................. 49
   3.2.1 Demographics .......................................................................................... 49
   3.2.2 Maternal Childhood ................................................................................ 50
   3.2.3 Health and Forensic History ................................................................... 51
   3.2.4 The Characteristics of Partners ............................................................... 53
   3.2.5 CYFS Involvement .................................................................................. 54
3.3 Comparisons with Previous Cohorts .......................................................................... 55
3.4 Summary ........................................................................................................................... 56
Chapter 4 OUTCOMES AT TWELVE MONTHS .................................................. 58
  4.1 Child-Associated Outcomes .............................................................. 59
    4.1.1 Parental Behaviour Associated with Child Rearing ....................... 59
    4.2.2 Health & Safety of child(ren) including CYFS involvement .......... 61
  4.2 Family Psychosocial Functioning ..................................................... 66
    4.2.1 Maternal Health ........................................................................... 67
    4.2.2 Mother Psychosocial Functioning .................................................. 68
    4.2.3 Family Relationships .................................................................. 70
    4.2.4 Family Economic and Material Well-being .................................. 72
  4.3 Summary ........................................................................................... 74

CHAPTER 5 DISCUSSION .............................................................................. 76
  5.1 Retention Rates .................................................................................. 77
  5.2 Comparison with Other Home Visiting Services ................................. 77
  5.3 Limitations ........................................................................................ 79
  5.4 Comments on Selected Areas of Psychosocial Functioning .................. 80
    5.4.1 Child Abuse .................................................................................. 80
    5.4.2 Basic Needs of Child ...................................................................... 81
    5.4.3 Domestic Violence ......................................................................... 83
    5.4.4 Social Isolation ............................................................................. 85
    5.4.5 Alcohol and Other Drug Use .......................................................... 87
    5.4.6 Economic and Material Well-being ............................................... 89
  5.5 Conclusions ....................................................................................... 90
    5.5.1 Concluding Comments .................................................................. 92

Appendix I Risk Factors for Referral to Family Help Trust .......................... 94

References .............................................................................................. 97
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Executive Summary

Family Help Trust is a long-term home-based early intervention child protection programme designed for pregnant women and their families who are considered ultra high-risk for child abuse and family dysfunction. This evaluation provides an account of the twelve month outcomes of 55 Family Help Trust families. The design, major outcomes and conclusions of this evaluation are summarised below.

Chapter 1 sets the background for the evaluation of the Family Help Trust programme and provides a brief overview of home visiting. Examination of the literature shows that many home visiting services are not effective in preventing child abuse. The key features of successful services include:

- A strongly theory-based approach using evidence-based best practice
- The use of professionally-trained staff
- Support from community and governmental stakeholders
- Emerging evidence and opinions of key researchers suggest that services should be re-tooled to focus on families most at-risk of child abuse.

The present evaluation examines a crucial gap in the current understanding of home visitation services by studying the twelve month outcomes of a group of ultra high-risk clients.

Chapter 2 describes the evaluation design and the limitations of this methodology. When using prospective longitudinal research designs without a control group, the results must be treated with caution as it is not possible to say that any improvements wouldn’t have occurred without Family Help Trust input. Nevertheless it is possible, and extremely informative, to examine any changes in this challenging population.
Chapter 3 examines the referral process and provides a descriptive profile of the socio-demographic backgrounds of the families recruited. Comparison with previous cohorts showed Family Help Trust families are socially disadvantaged. The mothers reported a background of adversity in childhood, and there were relatively high levels of criminality, substance use and mental health problems. Of significance, three-quarters (78.2%) had prior Child, Youth and Family Services (CYFS) involvement. Internationally, many similar programmes specifically exclude those with prior child protection agency involvement.

Chapter 4 provides an examination of changes over the first twelve months on a series of key issues that have previously been associated with poor prognosis for children and low family functioning generally. Fifty-five families (78.6% of those recruited) had twelve month data available. The results of Section 1, which focused on key child-related outcomes are extremely encouraging and point to significant improvements in a number of key areas including parental behaviours associated with child rearing and the health and safety of child(ren) in the household. Section 2 also found indications of significant improvements in social support and family violence. However, there was less evidence of positive changes in lifestyle behaviours (such as parental substance abuse, mental health and family economic circumstances) of the Mothers of Baby (MOB).

Chapter 5 provides an overview and analysis of the results of this evaluation and places these findings in the context of previous studies. Given the difficulties previous research studies have had finding any positive improvements from home visitation services, the results of the present evaluation are extremely encouraging. This is all the more so given that these clients have only been receiving Family Help Trust input for twelve months and many authors report that it is unlikely results can be achieved in this timeframe.

While the lack of a control group does not allow definite conclusions about causality, this evaluation shows that ultra high-risk families can make
significant improvements in crucial child abuse prevention areas over twelve months. As such, this research is the first evaluation to show that positive changes can occur in the lives of this ultra high-risk cohort. It provides valuable information that can help guide clinical practice and provide governmental social agencies and policy analysts with an evidence base for improving family functioning and reducing the incidence of child abuse and neglect.
CHAPTER 1 INTRODUCTION

1.1 Background

In recent years New Zealand’s child abuse and murder statistics have been the subject of much public concern and debate. For example, in a recent UNICEF report, New Zealand had levels of deaths resulting from child maltreatment that were four to six times higher than the average for OECD countries (UNICEF, 2003). Babies under a year old are at much higher risk in New Zealand than elsewhere, accounting for 30 percent of all child deaths from maltreatment here against 24 percent in other developed countries (Ministry of Social Development, 2006).

The numbers of children who die from maltreatment represent the “tip of the iceberg” of children who are maltreated, neglected or abused. An Australian study (Australian Institute of Health and Welfare 2001, cited in UNICEF (2003)) found that for every child death from maltreatment there will be on average 150 substantiated cases of physical abuse and 600 cases if neglect, and sexual and emotional abuse, are included.

Hospital admissions for intentional injury are another source of information on trends in child maltreatment. In the five years to 2004, there were 426 hospital admissions for intentional injury involving children under five. On a population basis, this represents an average of 30 admissions per 100,000 children in that age group each year (Ministry of Health, Public Health Intelligence data analysed by the Ministry of Social Development; cited in Ministry of Social Development (2006)).

\footnote{While these figures are often quoted in New Zealand, it must be borne in mind that these findings need to be treated with caution, as the small numbers involved can produce highly variable rates even though they are averaged over a five year period.}
In New Zealand the number of children receiving state sector social work services has increased by more than 50 percent in the past three years. In the year to June 30 there were 16,173 children receiving attention from the governmental child-protection agency Child Youth and Family Service (CYFS), up from 10,763 in 2003 (Dyson, 2006).

In addition, neglect or abuse of children during the first three years of life can result in lasting damage to the children physically as well as psychologically, as critical brain development is taking place at this time (Perry, 2004). This brain damage results in functional abnormalities in the cognitive, emotional, behavioural and social functioning of neglected and abused children. As well as being a critical time for brain development, the birth to three years age group is also the time that children are more at risk of being abused. Recent reports released from the U.S. Center for Disease Control and Prevention (CDC), for example, indicate that the younger the infant, the greater the risk for fatal maltreatment, even indicating that the highest risk for fatal maltreatment occurs on the first day of life (CDC, 2002). This risk of death by maltreatment is three times greater for under-ones than for those aged one to four, who in turn have twice as much risk of death resulting from abuse than children aged 5 - 14 years (UNICEF, 2003).

Family social position, which includes measures of parental education levels, family occupational status, parental age and ethnicity, have been identified as being predictive of a wide range of health, social and behavioural outcomes (Fergusson, Horwood, & Lynskey, 1994); (Shaw & Emery, 1988). The most disadvantaged families, while representing only 3 to 5% of the population, are over-represented in measures such as psychiatric admissions, use of medical departments, educational dropout, and involvement with the Department of Justice.

Interventions targeting families vulnerable to the risks of child abuse and neglect aim to improve the outcomes of these families, ultimately leading to better lives for both parents and children. Improved family functioning also results in benefits for society, with potential for reduced involvement with
prisons, hospitals, psychiatric institutions, and truancy services. Based on existing research findings, New Zealand’s Public Health Commission has set targets for parenting interventions that include increased antenatal contact for women identified as high risk; and increased postnatal contact, in the form of home visiting, for high risk parents (Ministry of Health, 1994).

1.2 Neglect/Violence and Young Children: Risk Factors and Effects

The Children, Young Persons and Their Families (CYPF) Amendment (No. 121) Act 1994 defines child abuse as “the harming (whether physically, emotionally or sexually), ill treatment, abuse, neglect, or deprivation of any child or young person”. Child abuse and neglect have far-reaching and damaging effects on both individual and societal levels, with the personal costs to the families adding to the costs in areas such as health, education and crime. A range of cross-national studies show that child death from maltreatment occurs predominantly in the context of poverty, psychological stress and limited support (MSD; 2006).

A definitive source of information on New Zealand’s situation comes from the Christchurch Health and Development Study, a longitudinal cohort study of 1265 children born in the 1970s. The family’s social position was found to be predictive of a wide range of health, social and behavioural outcomes (Fergusson et al., 1994).

The key findings of research in this area is that multiple-problem teenagers tend to come from multiple-problem home environments, which are characterised by family dysfunction, impaired child rearing practices, social disadvantage and parental psychopathology (Yoshikawa, 1994). These multiple problems mean that intensive services are required that address multiple issues.
In terms of child homicide in New Zealand, a recent report by CYFS (Ministry of Social Development, 2006) found that risk factors for parents are listed as poverty, low education, unemployment, youth, mental illness (including drug or alcohol abuse), being the victim of family violence as a child and having a history of offending. The report also found that "Parents with high health needs (such as mental health issues or intellectual or physical disability) may require additional support to adequately care for their children. Currently the extent of these support services is underdeveloped." (Ministry of Social Development, 2006; page 8).

UNICEF’s (2003) cross-nation study found that, while ethnic minorities often have higher levels of child maltreatment, “… it seems likely that the operative factor is not ethnicity but poverty (which disproportionately affects ethnic minority families)”. According to recent figures (Jensen et al., 2006) approximately a quarter of New Zealanders face some degree of financial hardship, and that just over a third of all children have been found to experience severe hardship. The highest rates of severe hardship were found among Maori, Pacific and sole-parent beneficiary families.

It has long been understood that negative outcomes for children are more likely to occur when several risk factors interact (Schorr, 1989). These factors can include premature birth, poor health and nutrition, failure to develop warm, secure and trusting relationships early in life, child abuse, family stress, and failure to master school skills. The children identified by Schorr as being in greatest need of intensive interventions to reduce the risk of long term damage included those growing up with a mentally ill, alcoholic, or drug addicted parent, or an isolated parent. This United States-based research also identified poverty and living in an impoverished neighbourhood as major risk factors for negative outcomes. Although New Zealand may not have the same levels of poverty as the United States, socio-economic status of the family is still an important consideration when assessing whom to include in interventions.
MacMillan (2000), who conducted a meta-analysis of research on child abuse prevention for the Canadian Government, found that the main risk factors for abuse were low maternal age and single parent status. Additional risk indicators for physical abuse were male sex of child, recent life stressors, maternal psychiatric impairment, low maternal education level, lack of attendance at prenatal classes, substance abuse and low religious attendance. For neglect, the risk indicators included parental sociopathic behaviour and substance abuse, while sexual abuse had additional risk indicators of low maternal age and parental death.

Low family socio-economic status, including low family income and low parental education levels, correlates with poorer physical, cognitive, linguistic, social and emotional outcomes in children (Brooks-Gunn, Fuligni, & Berlin, 2003). Poverty has effects on pre- and post-natal care, birth weight, infant mortality rates, illness and physical health problems, medical care, home conditions, achievement test scores, childhood behaviour problems and high school completion. Often coinciding with poverty are risk factors, such as minority ethnicity, single parenthood, and low parental education.

Ethier, Lemelin and Lacharite (2004) found that children who were chronically maltreated were at higher risk of developing clinical levels of problems such as depression and anxiety in later childhood and early adulthood. There are links between various dimensions of maltreatment, such as aggressive behaviours, rejection by peers, and social withdrawal (Bolger & Patterson, 2001). These links are already well established by school age. An important explanation for the associations between childhood neglect and later problems has been provided by Perry (2002; 2004).

Perry (2004) has studied the effects of neglect and violence on brain development. “Neglect” is defined as the absence of critical organising experiences at key times during development (Perry, 2002). Neglect of children during the first three years of life can result in lasting damage, as there is critical development occurring in the brain during this time. Functional abnormalities are found in the cognitive, emotional, behavioural and social
functioning of neglected children because of this damage. Perry reports that, in the United States, more than 85% of children removed from their parents because of abuse or neglect have disturbed attachment capacity. A relationship exists between disordered attachment and increased risk of violent and aggressive behaviours.

The neural systems responsible for cognitive, emotional, social and physiological functioning develop in childhood and, therefore, childhood experiences are essential in shaping these systems. Children require attentive and nurturing care in infancy in order to optimise their functional capacity. Early exposure to unpredictable stress, such as violence in the home, can result in deficits in childhood development (Perry, 2004). The lack of predictability and control makes events more destructive or traumatic. Children growing up in violent, chaotic environments develop the overactive and hypersensitive stress-response neural systems, leading to hypersensitivity to external stimuli, hyper-vigilance, and a persistent stress-response state. These “survival tactics”, although appropriate for the dysfunctional home environment, are less appropriate for children in their later school and peer relationships. A traumatised child, in a persisting state of arousal, finds it difficult to sit in a classroom and learn. The capacity to internalise new verbal cognitive information requires activation of portions of the frontal and related cortical areas, which can only occur when a child is in a state of attentive calm. The damage caused by living in violent or neglectful homes, especially when children are less than three years old, is long lasting and has a very profound impact on society.

It is important to target children in the first three years of life, not only because this is a crucial period for brain development, but also because child abuse is most prevalent in this age group. In the United States, it was found that of the 900,000 children determined to be victims of abuse in 2002, the birth to 3 years old group had the highest rate of victimisation while those under one year old were the largest group of victims (Department of Health and Human Services, 2004).
The Christchurch Health and Development Study used longitudinally collected data to examine the childhood history of a group of young people who had developed severe behavioural difficulties by the age of 15 years. The study found that the most disadvantaged 5% of the children (reared in severely disadvantaged, dysfunctional or chaotic home environments) had over 100 times the likelihood for maladjustment than the most advantaged 50% of the cohort (Fergusson et al., 1994). The implications of this study were that in order to address the issues of childhood and adolescent problems, those from dysfunctional home environments need early and appropriate input.

One form of intervention that has received considerable attention is home visiting. Prior research has suggested that home visitation programmes are one type of intervention that can result in positive benefits for both parents and children (Gomby, Culross, & Behrman, 1999); (Olds, 2002); (Olds, 2006).

1.3 Background on Early Childhood Home Visitation

Home visitation is defined as a programme that includes visitation of the parent(s) and child(ren) in their home by trained personnel (such as nurses, social workers, other professionals, paraprofessionals, or community peers) who convey information, and/or offer support, and/or provide training. Visits must occur during at least part of the child's first two years of life, but may have been initiated during pregnancy, and may continue after the child’s second birthday (Guide to Community Preventive Services; 2003).

Several theoretical orientations underpin the potential beneficial effects of home visitation services. Human ecology theory (Bronfenbrenner, 1979) clarifies the importance of the social environment in child development, while attachment theory (Erikson, 1950) stresses the importance of a close relationship with parents for healthy child development. Home visitors can play a role in strengthening attachment by giving guidance on effective
parenting. Home visitors may work to modify harmful patterns of relationships that were learned during the parents’ own upbringing.

Programmes may include (but are not limited to) one or more of the following components: training of parent(s) on prenatal and infant care; training on parenting; child abuse and neglect prevention; developmental interaction with infants/toddlers; development of problem solving and life skills for parents; assistance with educational and work opportunities; and, linkage with community services. Parent education is only a part of what is required to strengthen families and achieve optimal outcomes for children (Gray; 2001). Programmes may be accompanied by the provision of day-care, parent group meetings for support and/or instruction, transportation, and other services. Such interventions have been found to improve the behaviour of maltreated children, when delivered before they reach school (Ethier et al, 2004). In the US context, research suggests that home visiting services that are well-designed are cost effective (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004).

In a review of family support programmes, Gray (2001) suggests that the aims are to:

- overcome poverty and disadvantage through targeting children’s cognitive development and pre-school education (child-focused)
- promote child welfare through a holistic family approach (family-focused)
- provide parent training or empowerment in order to change parenting practices (adult-focused) and, ultimately, child outcomes.

The literature suggests that early intervention with at-risk families may help to reduce the social chaos they experience, and improve outcomes for the children, thus breaking the cycle of disadvantage (Hawaii Department of Health, 1992); (Olds, 2002). The US Task Force on Community Preventive Services conducted a systematic review of scientific evidence of the effectiveness of early childhood home visitation for preventing violence.
The most scientifically rigorous programme evaluation of a comprehensive home-visiting program, and arguably one of the most rigorous evaluations of a child abuse prevention program, is the Prenatal/Early Infancy Project (developed by David Olds and colleagues (Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Olds & Kitzman, 1990); (Olds et al., 1986; Olds, Henderson, & Kitzman, 1994; Olds & Kitzman, 1990); (Olds et al., 1997); (Olds, 2006). Another important evaluation of home visiting has been that of Early Start in Christchurch (Fergusson, Horwood et al., 2005).

Other initiatives that have similar aims include:

Macmillan (2000), in a Canadian review, found that the most successful intervention to prevent child abuse was frequent home visitation for disadvantaged families by nurses, beginning prenatally and extending until the child was two years old. This type of intervention was found to prevent child maltreatment and associated outcomes such as injuries and health care encounters (MacMillan, 2000). The following section will examine the effective elements of home visitation services.
1.4 Effective Elements of Home visitation services

Gray's (2001) literature review of the child abuse prevention area included a section specifically on home-based programmes. She found mixed results, depending on the type of programme, its aims, and its target audience. She went on to outline a number of elements that, from the literature, seem to be important to a successful programme. These elements are:

- Clear goals;
- Agency support;
- Targeting the neediest population;
- Balancing the needs of both parents and children;
- Designed to suit the needs of the client;
- Culturally appropriate;
- Have specific strategies to address problems;
- Delivered at a time in the client's life that matches the programme's goals;
- Staffed by professionals or highly trained paraprofessionals with ongoing supervision;
- Flexible in delivery intensity to suit families' needs;
- Delivered according to programme design;
- Adequately resourced;
- Address factors outside the programme that affect family functioning.

(Gray, 2001)

Gray concluded that the most successful family-focused intervention programmes have strong theoretical underpinnings, with clear goals that are determined in partnership with the target community. In addition to these elements, an Australian review (Vimpani, Frederico, & Barclay, 1996)
suggests that the most effective parenting skills programme takes place on the families "own turf". In a meta-analysis of studies about what works in Family Support services, it was found that working with family and social networks contributed as much as 40% to the effectiveness of family support services (along with the quality of the relationship, 30%; client hopefulness 15%; and the nature of the helping technique only 15%) (McKeown, 2000).

Another New Zealand review of factors associated with familial caregivers’ physical abuse and neglect of children (Ministry of Social Development, 2000) identified a significant shift towards multidimensional explanations that include complex interactions among individuals, families, communities and cultural systems and concluded that treatment and prevention services need to reflect such complexities. This review concluded that three dynamics seem to co-occur with child maltreatment:

1. socio-economic deprivation – within the family and the neighbourhood and as contributor to levels of individual stress
2. fragile social networks- for individuals this involves dissatisfaction with friends and family relations. For families it is characterised by lack of reciprocity with family, including isolation from extended family among those involved in abuse, and for neighbourhoods by a lack of stable formal and informal networks and services
3. criminality, violence, and substance abuse are important aspects of familial and individual probabilities of being involved in child maltreatment. These activities also disrupt and undermine community social structures, and formal and informal networks.

This complex interaction of factors suggests that intensive multimodal interventions are required to make changes in circumstances for these at-risk families. An analysis of 20 research projects initiated in the UK following the implementation of the Children Act 1989 concluded that children are better protected by strengthening their family and social network supports than by spasmodic, incident focussed interventions (Department of Health, 1995).
There have been continued suggestions that changes in family social, emotional and economic functioning are prerequisites for changes in child health and well-being (Chaffin; 2004). Therefore, it has been suggested that the major pathway through which home visitation programmes may lead to positive child outcomes is through family level changes although Fergusson and colleagues (2006) have recently suggested that family level changes may not be required to bring about improvements for at-risk children.

Child abuse and neglect is a complex and multi-factorial social problem which cannot be viewed in isolation from broader social/environmental issues (Vimpani et al., 1996). Outcomes are influenced by the quality of neighbourhoods and community life as distinguished by a range of social and economic indicators such as physical and social infrastructure, as well as factors such as safety, neighbourhood cohesion, social capital and access to adequate community resources (Coulton, Korbin, & M., 1999); (Chase-Lansdale, Gordon, Brooks-Gunn, & Klebanov, 1997); (Shirley, Adair, & Anderson, 2000).

A series of longitudinal studies by Olds and colleagues (Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Olds & Kitzman, 1990); (Olds et al., 1986; Olds, Henderson, & Kitzman, 1994; Olds & Kitzman, 1990); (Olds et al., 1997); (Olds, 2006) have indicated that for disadvantaged families in the United States, intensive home visiting by nurses in the first two years of life effectively improved both short and longer term child, parent, and family well-being. The programme has been tested in three separate large-scale, randomised, controlled trials (RCT) with different populations living in different contexts.

Results from these trials indicate that the programme has been successful in achieving two of its most important goals: a) the improvement of parental care of the child as reflected in fewer injuries and ingestions that may be associated with child abuse and neglect and better infant emotional and language development; and; b) the improvement of maternal life course,
reflected in fewer subsequent pregnancies, greater work-force participation, and reduced dependence on public assistance and food stamps (Olds, 2006).

Olds found that fifteen years after prenatal and early childhood home visitation by nurses, there were significantly reduced reported serious antisocial behaviour and reduced use of substances on the part of adolescents born into high-risk families compared to a control group (Olds et al., 1998). The characteristics of the successful approaches have been suggested by Olds and Kitzman (1990) to be:

i) a programme based on an ecological framework that takes into account multiple rather than single factors;

ii) the visitor needs to visit often enough to develop an alliance with the families; and

iii) the programme should be directed towards families at greatest psychological disadvantage.

1.4.1 Targeting High-Risk Families
There is a tension between the need to cater for vulnerable families and to support all families in their parenting role. One argument in favour of general services is that targeting services may stigmatise families and deter access. The high levels of mobility amongst vulnerable families suggest an argument for a universal approach with extensive geographical coverage. Moran, Ghate, & van der Merwe (2004) note that generally there is a trade-off to be considered between the costs of providing a universal preventative programme (in which some low-risk families will not need the programme) versus the provision of a more selective programme targeted at high risk groups, which will typically cost more.

Many services in Europe are universal (Bilukha et al., 2005) and other targeted services, both internationally and locally, focus on the middle-risk
Fergusson (2002) has suggested that “…when we screen out we are actually screening out the most disadvantaged 15 per cent…” (page 30). This is based on an assumption that nothing can be done for the higher-risk families.

“…there is some data in my research that suggests, that the families that are going to win are the middle-risk families, not the families that are so bad that nothing is ever going to change, nor the families that are so good… but the families who unless something is done for them may sink.” (Fergusson, 2002; page 30).

One service attempted to implement a home visiting service for mothers (based on the Olds; (2006) model) who had previous child protection agency contact. All families in this RCT were followed for an average of three years after recruitment. Unfortunately, this service could not show any improvements in abuse compared to a control group. Physical abuse was reported in 33% of the families that received nurse home visits compared to 43% of the 72 control families. The rate of abuse or neglect was 57% in the intervention arm and 67% of families in the control arm had at least one report of abuse or neglect. MacMillan and colleagues concluded that "Despite the positive results of home visitation by nurses as an early prevention strategy, this visit-based strategy does not seem to be effective in prevention of recidivism of physical abuse and neglect in families associated with the child protection system” (MacMillan et al., 2005; page 1786). Chaffin & Friedrich (2004) have suggested that the Nurse Family Partnership model may not be that successful in reducing child maltreatment.

Commentators have suggested traditional services that concentrate on low to medium risk families may not be the best use of resources (Cowan, Powell, & Cowan, 1996); (Olds et al., 1999); (Olds & Kitzman, 1990). In a review of 27 years of home visitation experience, Olds (2006) summarised their

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2 However, it is important to bear in mind that many home visitation services use the term “high-risk” indiscriminately when they actually mean ‘low’ or ‘middle’ risk. As an example of this phenomenon, many home visitation services screen out women with a previous history of contact with child protection services (for example, Duggan et al., (1999)).
experiences by saying: “One of the clearest messages that has emerged from this program of research is that the functional and economic benefits of the nurse home-visitation program are greatest for families at greater risk.” (page 21). Chaffin (2004) recommended that programmes may need to reconsider 'universal' strategies or other strategies that target relatively low risk groups of parents.

“The possibility needs to be considered that prevention programs may expend effort inefficiently by targeting far too many parents who will never maltreat their children anyway, while failing to provide sufficient focus and intensity for those who are truly at-risk.” (Chaffin; 2004; page 593)

In addition, a cost benefit analysis in the US (Aos et al., 2004) determined that “some forms of home visiting programs that target high-risk and/or low-income mothers and children are also effective, returning from $6,000 to $17,200 per youth” (page 4).

There is a growing body of research and international thinking that suggests that those families with new infants that have serious risk features do better in home visiting services than their less at-risk counterparts (Chaffin; 2004; Duggan, Fuddy, Burrel, Higman, McFarlane, Windham & Sia., 2004; Gomby, Culross, & Behrman; 1999). The recent Early Start Evaluation Report by Fergusson and colleagues (Fergusson, Horwood et al., 2005) also suggests this may be a useful strategy. “…there was some suggestion the programme offered greater benefits to Māori, older mothers, and families facing high levels of disadvantage.” (page 77).

However, apart from Family Help Trust, there do not appear to be home visiting services, either in New Zealand or internationally, that have provided intensive home-visiting family support exclusively to this ultra high-risk group. Rather, there are sub-sets of such clients within larger cohorts that have received identical services. The literature (Duggan, Fuddy, Burrel, Higman, McFarlane, Windham & Sia., 2004; Gomby, Culross, & Behrman; 1999)
suggests that such generic services are not focussed on changing parental risk behaviours; for example, substance abuse, criminal offending, and abusive parenting. Many existing services use a strengths-based intervention that fails to prioritise care and protection issues within this model (Centre for Child and Family Policy Research; 2005; Duggan, Fuddy, Burrel, Higman, McFarlane, Windham & Sia., 2004; Gomby, Culross, & Behrman; 1999).

Criticism has also centred on the use of inexperienced staff, who were not well trained or supported by their programmes (Centre for Child and Family Policy Research, 2005); (Duggan et al., 2004); (Olds & Kitzman, 1993). Many services report not being able to cope with high-risk families with multiple problems (Centre for Child and Family Policy Research, 2005); (Duggan et al., 2004). A review of recent research concluded that “…it seems likely that extremely well-trained visitors are needed to serve families that face multiple complex issues…” (Gomby et al., 1999; page 18).

In a controversial commentary on the home visitation field, Chaffin (2005) states, in terms of home visiting services calling themselves child abuse prevention services:

“Programs such as Healthy Families have self-identified and marketed themselves to policy makers, legislators, communities, and professionals primarily as child maltreatment prevention programs, even if they have not presented themselves that way to consumers. I have advocated for years that this is a mistake and that the programs are more accurately characterized as maternal and child health enhancement programs, and should market and fund themselves accordingly” (page 244).

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3 In New Zealand, a common reason given by external agencies for not working more closely with Family Start when assisting clients was a perceived lack of training among Family Start workers (Centre for Child and Family Policy Research, 2005).
In summary, despite increased interest in this area, there are very few (if any) services seeking out and working with the ultra high-risk families that are the target population of Family Help Trust.

1.4.2 Summary of Home Visiting Services Effectiveness

In 1996 the Australian National Child Protection Council published a review of Home Visitor Programmes in Australia in the context of preventing child abuse and neglect. This report concluded that home visitor programmes provide opportunities for children at risk and their families to reach their full potential and participate productively in the community (Vimpani; 1996). In February 2002, the US Centers for Disease Control and Prevention Task Force on Community Preventive Services concluded "there is strong evidence to recommend home visitation to reduce child maltreatment." The group based this recommendation on a review of 25 studies that found overall a 39 percent reduction of child maltreatment in high-risk families (Bilukha et al., 2005); (Children's Bureau Express). However, some of these studies were not of a high quality and the actual effectiveness of these services is the subject of ongoing debate. A feature of the current debate is the contention that home visiting service do not show good results in preventing child abuse (Chaffin, 2004; Chaffin & Friedrich, 2004).

Recently, several reviews have shown disappointing results for home visitation services both nationally (Centre for Child and Family Policy Research, 2005) and internationally (Chaffin, 2004). The issue of home visiting programmes was comprehensively reviewed in an issue of The Future of Children in 1999. (Gomby et al., 1999) summarise findings of evaluations from six programmes and highlight key areas of change needed for programme improvement. They describe findings of programme evaluations in 1999 as follows:

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“These findings are sobering. In most of the studies described, programs struggled to enrol, engage, and retain families. When program benefits were demonstrated, they usually accrued only to a subset of the families originally enrolled in the programs, they rarely occurred for all of a program’s goals, and the benefits were often quite modest in magnitude.” (page 9).

Gomby et al. (1999) concluded that “none found significant effects on all or even a majority of the measures employed, and many revealed no positive effects at all” (p 12). Despite the generally poor findings in this area, there is evidence that well-designed home visitation programmes, based on evidence-based best-practice, may be of use (Fergusson, Grant, Horwood, & Ridder, 2005). The most persuasive support in this area comes from the work of Olds and colleagues, who developed the Nurse Family Partnership program (Olds et al., 1998; Olds, Henderson, Kitzman, & Cole, 1995; Olds et al., 1997; Olds et al., 1994). Evaluations of this programme have shown both long- and short-term benefits.

The strongest method for assessing long-term outcomes is to randomly assign eligible parents to groups that do or do not receive the programme's services and then to follow the development of both groups over time. In this manner, strong inferences can be made about the changes that are seen in the group that are assigned to the programme. This approach has recently been employed by Fergusson and colleagues in looking at a group of at-risk families in Christchurch (Fergusson, Grant et al., 2005; Fergusson, Grant, Horwood, & Ridder, 2006).

The study used a RCT design in which 220 families receiving the Early Start programme were contrasted with a control series of 223 families not receiving the programme. Families were enrolled in the programme after population screening conducted by community health nurses. This evaluation suggested that the Early Start programme failed to lead to parent- and family-related

5 The problems inherent in this type of research design have been discussed by (A. M. Tomison, 2000).
benefits in the areas of maternal health, family functioning, family economic circumstances, and exposure to stress and adversity. The study did find significant differences in child-related outcomes, including child health, preschool education, child abuse and neglect, parenting, and behavioural adjustment. In summarising his results, Fergusson (2002; page 36) stated:

“We found that the program was very successful in encouraging new learning. Any area of new learning, like immunization, going to the doctor, how to resolve problems or using services, the service was very good at, but in changing old behaviour and habits the service was virtually ineffective. It did not reduce rates of substance abuse, crime, unemployment or these kinds of difficulties. In other words, you can teach people new parenting behavior but changing old predispositions seems to be much harder.”

While the randomised, controlled trial design is the strongest method for assessing long-term outcomes, there are a number of ethical issues that must be addressed before consideration can be given to using this method. Foremost among these issues is withholding treatment from half the people that might benefit from access to the service.  

The problems with conducting RCTs in these types of settings are summarised by Barlow & Stewart-Brown (2005)

“Trials that involve participants as active agents in initiating psychological and behavioural changes are fundamentally different from trials of treatments that involve the participants as passive recipients (as is the case for many medical interventions). Such trials are delivered by people with differing levels of skills, to families with different histories, preoccupations, circumstances, different levels of readiness for change, and different levels of commitment to the process, all of which determine whether an intervention of this nature

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6 Family Help Trust have decided that they are not prepared to withhold treatment and are therefore content to limit the strength of any findings accordingly. Looking at changes over time without a control group means that it is not possible to directly show that any changes are unequivocally due to the input of the Family Help Trust.
proves to be effective. The implication of these differences is that the impact of such interventions is likely to be small, and there is, as such, a need for much larger (and more expensive) studies.” (page 1752)

In summary, despite poor results from a number of programmes, there is some evidence to suggest that well-designed and resourced home visitation services are of some benefit. Building on the popularity of home visiting services internationally, a number of New Zealand parenting programmes have been developed in recent years, and these are discussed below.

1.5 New Zealand Services

A review of New Zealand Parenting Programmes is provided by Hendricks & Balakrishnan (2005). The review highlighted a need to consider the development of a parent education programme that is universally available and accessible. This seems to be the course adopted by the New Zealand government in recent years in spite of the conclusions reached by international experts (Chaffin, 2004); (Olds & Kitzman, 1990) suggesting the usefulness of targeting programmes at high-risk families. A consistent criticism of services for children and families in New Zealand is that they are poorly coordinated in the communities in which they exist. This is particularly true in the area of child abuse prevention (McClay, 2000); (Brown, 2000).

A brief summary of several important New Zealand programmes are listed below:

**Early Start**

Early Start is a family-based home visiting early intervention programme located in Christchurch. The providers involved in Early Start are the Christchurch Health and Development study, the Family Help Trust (initially), the Royal New Zealand Plunket Society, the Pegasus GP Group and a group of Māori representatives. Families participating in the programme were referred to Early Start by Plunket, based on a checklist of risk factors. Those
families that consented have been given access to a variety of services through home visits by a Family Support Worker. All family support workers had nursing or social work qualifications and attended a 5-week training program. The overall aims of the home visitation process are to assist, support and empower families to address issues relating to childhood wellbeing and family functioning. The function of the Early Start Family Support Worker is not to provide treatment, therapy or specialised advice; rather it is to assist families to seek such treatment, therapy and advice (Hendricks & Balakrishnan, 2005). The evaluation of Early Start (Fergusson, Horwood et al., 2005) has been discussed above (page 21).

**Family Start**

Family Start is a child-centred, family-focused, government-funded home-based early intervention parenting programme, with the goal of achieving better outcomes for at risk families. Family Start targeted to capture the 15 percent of the population most at-risk of poor life outcomes in each location. The Family Start programme was established in 1998 as part of a wider strategy to strengthen families. It provides intensive home-based support services for families with high needs, to ensure that their children have the best possible start in life. The programme co-ordinates services to improve the functioning of the whole family, provide parenting advice, and assist each family to improve their personal circumstances. Family Start is funded and managed by the Ministries of Health, Education and Social Development. The programme is delivered by contracted service providers.

There has been significant government investment in Family Start. Although an outcome/impact evaluation was undertaken within the last few years (Centre for Child and Family Policy Research, 2005), methodological limitations constrain the conclusions that can be drawn about the impact of the Family Start programme. The outcomes described in the report were based on information collected on less than a fifth of the eligible programme participants, because of difficulties in collecting follow-up data from some participating families and the non-participation of other eligible families. The Ministry of Social Development cautions that it cannot conclusively be stated
how much benefit the programme had for participants, or whether any gains observed in the evaluation would have been achieved without all or parts of the intervention.

**Parents As First Teachers (PAFT)**
This is a parent education and family support programme which focuses on the zero to three age range. It targets families considered to be at some risk of poor parenting and outcomes for children.

**HIPPY (Home Interaction Programme for Parents and Youngsters)**
This is a home-based programme that helps parents create experiences for their children to lay the foundation for success in school and later life. It targets high-needs families where there are indicators of likely poor learning outcomes for children.

1.5.1 **Family Help Trust**

Family Help Trust was established in 1990 with the aim of providing high-risk families with skills to improve their lives. Initially, Family Help Trust offered the “New Start” service, which provided intensive home visitation targeted at the children of chronic offenders.

In 1992 and 1993 Family Help Trust made two separate approaches to the Regional Health Authority in an attempt to acquire the funds to work with high risk mothers and newborn infants. However, these approaches were unsuccessful and it was not until late in 1994 that Family Help Trust, with the assistance of Professor David Fergusson, and in response to the findings of the Christchurch Health and Development Study\(^7\), were successful in raising the first funds for what was later to be known as Early Start.

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\(^7\) The Christchurch Health and Development Study identified around 3-5% of families who were over-represented in the measures of social dysfunction, such as crime statistics, psychiatric admissions, educational dropout and hospital admissions.
In 1995, Family Help Trust, as part of a consortium including the Christchurch Health and Development Study, Plunket, the Pegasus Medical Group and Māori representatives, developed “Early Start”: an intensive home based family support system working with (what were considered at the time) high-risk families and their children. The intervention aimed to reduce the number of psychosocial problems, such as disruptive behaviour patterns and truancy, adolescent substance abuse, mental health issues and youth suicide, experienced by this high risk group (Fergusson, Horwood & Lynskey, 1994). It was believed that early intervention with these families would reduce their involvement in “social chaos” (Robins, 2004).

The “Early Start” programme was largely based on the Healthy Start Program, a similar venture established in Hawaii in 1975. The Healthy Start Program (HSP) was designed to prevent child abuse and neglect and to promote child health and development in newborns of families at risk of poor child outcomes (Duggan et al., 2004; Duggan et al., 2000; Duggan et al., 1999). It was based on Kempe’s lay therapy programme (Gray, Cutler, Dean, & Kempe, 1979). Family characteristics that were considered when deciding on entry to the service included ethnicity, mother’s age, parental substance use, domestic violence and children at extreme risk. HSP utilised a population-based screening method, which differs from the “Family Help Trust” method of client referral and needs assessment.

Another major difference is that the HSP programme screens out families with current or previous involvement with child protection services. This effectively means that the HSP families were at the lower end of the risk continuum compared to Family Help Trust families. Although it was understood that targeting the higher risk families would most probably result in more modest outcome results, it was felt that this would be the best use of resources (Robins, 2004).
At Family Help Trust, families are identified by midwives and others using simple screening criteria, and are then given a more comprehensive interview by social workers. The programme aims to assist the targeted families in areas such as child health, maternal wellbeing, parenting skills, family economic functioning and crisis management.

Christchurch has an average annual birth population of around 5000. In 1997, Professor Fergusson, principal investigator of the Early Start project in Christchurch, estimated that around 10% of these children would meet a criterion of needing ‘some’ support (Fergusson, Horwood, & Grant, 1999). In 2001, Family Help Trust asked hospital midwives to calculate how many of these 500 would meet a high risk criterion. In response, the midwives estimated that approximately 100 babies (2%) born each year were of serious care and protection concern to them. Since this time, Family Help Trust has focussed exclusively on these infants, but has been unable to provide resources to all those families referred to the service and has been obliged to maintain a waiting list.

Although Family Help Trust assumed from comments by researchers such as (Fergusson, 2002) that targeting the most at-risk families would probably result in more modest outcomes, it was felt that this would be the best use of resources, as these are the families who are over-represented in negative outcome measures mentioned throughout this review. Subsequently, it appears that this is the very group who may be the best target of such interventions (Chaffin, 2004); (Gray, 2001); (Olds et al., 1999); (Olds, 2006).

After resigning all interests in the Early Start programme, Family Help Trust introduced the “Safer Families” intervention in 2001. This service targets pregnant women who are considered ultra high-risk for child abuse and neglect, and family dysfunction. It also differs from other interventions in the extent of the risk or dysfunction exhibited by its target population. Many of the

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8. By way of comparison, while Family Help Trust focus on the highest 2% of at-risk children and Early Start aim for the highest 10%, the main New Zealand home visitation network (Family Start) is focused on the 15% of most vulnerable children.
families have multiple risk factors, including young maternal age, substance addictions, family violence, and previous involvement with Child, Youth and Family Services.

The philosophy behind these interventions is that the cycle of disadvantage that exists for some families needs to be broken in order to improve the life chances of the children. It is hoped that this will reduce their potential for repeating negative outcomes, such as early childbearing, school failure and juvenile crime. The programme aims to assist the targeted families in areas such as child health, maternal well being, parenting skills, family economic functioning and crisis management. Fundamentally however, the purpose of Family Help Trust is to prevent child abuse and neglect with the child as the primary client.

“We have exclusively recruited social workers, mainly older women with no nonsense attitudes who are not intimidated by clients who are extremely hard and street wise. The agency has child protection as its principle mandate, the child is the primary client and all interventions are centre around increasing safety for this child” (L Robins; personal communication; August, 2005).

Another feature of Family Help Trust is that in contrast to other New Zealand services (with the notable exception of Early Start, who use a mixture of nurses and social workers), Family Help Trust use only qualified Social Workers as case managers. There is growing evidence to suggest that effective home visitation requires that services recruit appropriately trained staff rather than paraprofessionals (Bilukha et al., 2005); (Chaffin, 2004); (Fergusson, Horwood et al., 2005); (Olds, 2006).

Evaluation of Family Help Trust
The ‘systems evaluation’ model, (Pietrzak et al. 1990), broadly categorises evaluations into three forms: input evaluation; process evaluation and outcome evaluation.
i) **Input evaluations** are an attempt to understand the effective elements of a service from a review of the literature and/or the experiences of existing services. The input evaluation of Family Help Trust included academic input from Professor Fergusson and two representatives of the Family Help Trust visiting 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.

ii) **Process evaluations** are designed to investigate programme integrity. In July 2002, Christchurch Safer Community Council, now named Safer Christchurch, donated the funds for the Family Help Trust to evaluate the Safer Families service. This evaluation was carried out by the University of Canterbury Social Work Department and the service outcome section was released in the later part of 2003.

In June 2004 the Family Help Trust commissioned a review of their data collecting system, to ensure that various recommendations from the University evaluation had been completed satisfactorily. The reviewer (Fiona Robertson, Social Work Consultant) scrutinised a number of areas including: financial accountability, staff culture, accuracy of MOB (mother of baby) information collection, management and supervisory functions, communication, and an examination of a random selection of MOB files to ensure that they passed the ‘acid test’. Staff and board members were interviewed.

The report concluded that the agency was functioning well in all areas and deserved a score of 9/10 in this regard. A positive culture existed throughout the agency, social workers felt well supported by management and within their supervisory environment, financial accountability was thorough and transparent, and information contained in MOB files would stand up to court examination. Family Help Trust has now decided to commission an independent outcome evaluation of client families.
iii) Outcome evaluation, discussed below, is designed to assess the extent to which a programme or intervention affects participants on a set of specified outcomes, variables or elements. The purpose of this report is to describe an outcome evaluation of Family Help Trust.

1.6 Evaluation options

The importance of evaluating the efficacy of programmes, in order to develop and test strategies to improve effectiveness, has been emphasised by researchers (Duggan et al, 2004); (Fergusson, Horwood et al., 2005); (Olds, 2006). As Chaffin (2004) points out, more rigorous outcome testing of these programmes is necessary in order to achieve reliable progress in the field of child maltreatment and abuse prevention. New Zealand is currently committed to a strategy of home visitation services for at-risk families, despite a lack of evidence-based practice to guide implementation. The poor standard of evaluation both nationally (Centre for Child and Family Policy Research; 2005) and internationally (Chaffin; 2004) means that policy analysts are not adequately informed about optimal methods of reducing family dysfunction and child abuse.

Programme evaluations are perceived as providing a relatively objective means of quality assurance and a systematic method of data collection and analysis. They may enable an analysis of service utilisation and the profiling of service users; inform ongoing improvement and refinement of programme content; provide a measure of overall programme success for funding bodies and stakeholders and thus, can inform public policy decision making (A. M. Tomison, 2000).

Outcome evaluations are designed to assess the extent to which a programme or intervention affects participants on a set of specified outcomes, variables or elements. That is, how has participation in the programme affected participants' lives? Any change is assumed to result from participation in the program; the validity of this assumption may be tested by
comparison between samples in the target population (that is, via the comparison of one or more 'treatment' groups with a 'no treatment' comparison) (US Department of Health and Human Services 1995). Efficacy trials investigate whether an intervention works under ideal circumstances, while effectiveness studies investigate whether an intervention works when applied in the 'real world' (Streiner, 2002).

The US National Committee on the Assessment of Family Violence Interventions (Chalk & King, 1998) used the degree of experimental rigour or strength of evidence present in an evaluation to produce a hierarchy of outcome evaluation designs, for which there is general consensus. That is, the extent to which specific evaluation designs can determine the unique effects or impact of a prevention programme or other intervention, beyond any change that may have occurred because of any other factors.

At the lowest level of evidence in the outcome evaluation hierarchy are non-experimental designs, simple pre- and post-test analyses, case studies, anecdotal reports, or client feedback and satisfaction measures. Such studies can and do produce useful information, such as a profile of the characteristics, experiences and presenting problems of participants, or enable the identification of programme implementation or process issues. In spite of their utility as 'important building blocks' (Chalk and King 1998), little control is able to be exerted over the programme environment and the resultant data is insufficient to accurately determine causation or programme impact.

However, these evaluations are extremely important, given the difficulty of developing randomised, controlled trials in the social services. These difficulties have been discussed by A. M. Tomison (2000). Tomison suggests that while there may always be a place for empirical ‘flagship’ RCT evaluations with a broad outcome focus that may ‘prove’ a programme’s effectiveness, there has been some recognition that experimental rigor in isolation is often an unsuitable means of evaluating social programmes. The basis for any alternative to empiricism is the development of a comprehensive evaluation framework that can enable service providers to make the most of
their resources and exploit any evaluation opportunities (A. M. Tomison, 2000).

Longitudinal data is a combination of cross-sectional and time-series data. It follows a number of individuals across a number of time periods. Time series data collects information (for example alcohol use) across time, whereas cross-sectional studies gather data from a sample of the population at a fixed point in time. Thus, an advantage of longitudinal studies is that they allow the researcher to control for individual characteristics when looking for group trends.

No single evaluation can answer all the questions of interest about a programme, nor is any evaluation perfect, which means that readers must carefully weigh the intended purpose of the evaluation and the evaluation's strengths and weaknesses before deciding what conclusions can credibly be drawn from its results. Because this evaluation design was not a randomised controlled trial, the reported outcomes below can only be considered indicative of possible trends, not confirmed evidence of programme effectiveness.

Programme effectiveness is very difficult to determine. In a review of outcomes and effectiveness of Family Support Services, Statham (2000) warns that there are multiple influences on families' lives that may be difficult to monitor and measure, particularly given the complexities of improvements and setbacks that may be experienced. Design limitations of some evaluations have meant that it has not been possible to conclude that the programme evaluated has been solely responsible for causing the positive changes observed amongst participants. More rigorous evaluations will need to take place to generate further knowledge about the effectiveness of these programmes and to build a stronger evidence base.
1.7 Summary

Research has suggested that flexible services, provided by professionally qualified and trained staff that meet the complex needs of at-risk families, may help reduce child abuse and associated poor child outcomes. Further, the highest at-risk families may benefit from the service most, provided adequately trained and resourced staff are utilised. Family Help Trust has developed a home visitation service that is designed to meet the specific requirements, circumstances and problems of a given high-risk family, rather than imposing a standardised programme on all families. Given there are limited funds available for child welfare programmes, it is essential that those prevention programmes that are funded actually provide evidence to show they are effectively reducing the risks of child maltreatment.

This evaluation details findings from the external evaluation of Family Help Trust. The research is of particular importance, given that Family Help Trust is the only service that could be identified anywhere that deals specifically with this ultra high-risk group. Examination of the outcomes from this unique cohort will be of international interest. A more comprehensive understanding and documentation of the value, effectiveness, and limitations of the Family Help Trust programme and processes, gathered from the present evaluation, will have four major beneficial outcomes.

Firstly, it will provide information to guide how the Family Help Trust model might be improved, revised and enhanced. Secondly, it will enable people to better replicate such a model in other services interested in encouraging and supporting home visitation services in this challenging cohort. Thirdly, it will contribute to a knowledge base of what factors and programme components can best support 'ultra high-risk families' participation in Family Help Trust, to assist other research and implementation efforts in this area. Finally, evaluation of the effectiveness of Family Help Trust will enable key stakeholders to move ahead with the knowledge that quantifiable improvements in the lives of at-risk children are being achieved.
In summary, an evaluation of the effectiveness of Family Help Trust will provide governmental social agencies and policy analysts with a strong evidence base for improving family functioning and reducing the incidence of child abuse and neglect.
CHAPTER 2 METHOD

This section outlines:

- the aims and objectives for the evaluation
- the evaluation design
- data analysis
- limitations of the research methodology.

2.1 Aims and Objectives
The aims of the present study are to describe the characteristics of Family Help Trust families at referral to the service and identify the short-term outcomes for children and their families in the key domains of:

i) Child-associated outcomes, including parental behaviours associated with child rearing and the health and safety of any children

ii) family psychosocial functioning, including health and well-being of Mother of Baby (MOB), family functioning and economic well-being

Specifically, the present evaluation seeks to examine changes in family functioning and child welfare over the first twelve months of involvement with Family Help Trust.

2.2 The evaluation design

For assessment of the outcomes among target families, the evaluation used a prospective longitudinal design (Time 1 and Time 2). A comprehensive interview questionnaire comprising structured, semi-structured and open-ended questions was developed. Data was collected from families (primarily the MOB) by case managers, with an interval of twelve months between the
two data collection periods. In all cases, these ratings were made by the Family Help Trust social worker on the basis of their contacts with the family, questioning of the Mother of Baby (MOB) and observations of the mother. Examination of changes in a variety of indicators over these twelve months serves as a basis for evaluating the initial effectiveness of Family Help Trust.

**Data Gathering Systems:** All outcome data is now based around two major interviews with families.

- The first, called the Intake Interview contains over 100 background questions and is administered to families immediately after service consents have been obtained.
- The second, administered within a two-week period of the intake interview, is called the Progress Report and asks over 450 questions. The Progress Report is repeated every six months.

For the purpose of the present evaluation, the six-month Progress Report was not available for analysis. After the interview schedule was finalised, a consultant was contracted to develop an appropriate database.

### 2.3 Data Analyses

Analysis will be conducted using a series of t-tests and repeated measures ANOVAS for continuous data and the chi squared test of independence (or Fisher’s Exact Test when the expected frequencies are small) for discrete data. Much of the data collected by Family Help Trust is dichotomous (yes or no answers) and in this instance, McNemar’s Test will be utilised. This test is typically used in a repeated measures situation, in which each subject's response is elicited twice, once before and once after a specified event occurs. The McNemar test determines whether the initial response rate (before the event) equals the final response rate (after the event). This test is useful for detecting changes in responses due to experimental intervention (in this case twelve months treatment with Family Help Trust) in before-and-after designs. Analysis of all data will be conducted using SPSS 11.5 statistical analytical software. The before and after measurements are compared and
measures of statistical significance can assist in ascertaining if the differences may be due to an actual change or may be due to chance variation. While the establishment of statistical significance has some role in the present analysis, the small sample size and low rates of occurrence of some important factors means that the present analysis will also focus on clinically relevant trends in the data. That is, changes on multiple measures of a construct (such as different aspects of mother’s health, for example) that are in the same direction but are not statistically significant will still be useful to acknowledge.

2.4 Limitations of the research methodology

There are several limitations to the present outcome evaluation that should be considered when interpreting these results. As discussed above, the evaluation involved using a prospective Time 1 - Time 2 single sample design with no control group. This design limits the robustness of the findings to exclude other possible factors, other than the contribution of Family Help Trust, leading to changes found. In addition, it was not possible to corroborate much of the self-report information for consistency with data from other sources (for example, reports of domestic violence or drug use).

A number of threats to the integrity of the results found in the present evaluation are discussed below, along with efforts undertaken to address these threats.

In subsequent chapters, various statistical procedures are used including tests of statistical significance. In order to justify any conclusions drawn from these tests, the study design must have adequate statistical power. When interpreting the results of any test of statistical significance two types of decision errors may occur:

i) rejecting the null hypothesis when it is in fact true (Type I error)

ii) accepting the null hypothesis when it is in fact false (Type II error)
**Type I error**

With such a large number of questions available for analysis, there is an increased chance of finding a ‘significant’ result (when one isn’t really there) just by chance. The increased probability of detecting intervention effects where none exist are referred to as "false positives" owing to multiple comparisons. A false positive, also called a Type I error, exists when a test incorrectly reports that it has found a positive (i.e. significant) result where none really exists.

In order to reduce the risk of Type I error in the present study, a limited number of measures were selected from the available interview questions before the evaluation took place (*a priori*). The measures preferred were selected by the following methods:

i) discussions were undertaken with key stake-holders and other interested organisations in order to establish what measures they thought would be of most interest to see Family Help Trust able to change. These organisations included representatives from CYFS, Christchurch City Council, Department of Justice, Ministry of Social Development, Children’s Commission and Department of Public Health, Canterbury District Health Board.

ii) examination of local and international literature to ascertain areas that had previously been investigated; and,

iii) discussions with Bill Pringle, Clinical Services Manager, Family Help Trust, in order to see what measures he would expect/like to see change.

**Type II errors**

Statistical tests attempt to use data from samples to determine if differences or similarities exist in a population. For example, to test the null hypothesis that the mean scores of women’s health on a test do not differ over time, a sample of women are drawn, the test administered to them, and the mean score at each time point compared with a statistical test. If the population of women attending Family Help Trust do have different mean scores on a
health question over time (that is, their health improves over time) but the test of the sample data concludes that there is no such difference, a Type II error has been made. That is, the study does not have sufficient statistical power to detect changes.

Thus, power is the probability that statistical significance will be indicated if it is present (Hair, Anderson, Tatham, & Black, 1995). Due to low numbers, the present sample has limited statistical power to detect significant changes in the group over time. This is to be expected, given the small changes seen in previous research of this type (Fergusson, Grant et al., 2005). There are two main reasons to expect only small changes in the results of this study:

i) previous studies have shown that it is hard to show significant changes in home visitation service evaluations and small changes are to be expected (Gomby et al., 1999).

ii) a further complication related to the design of this evaluation compared to many others is that Family Help Trust does not select a homogeneous (similar) group of people and administer a standard therapy. Rather, the treatment provided is tailored to the individual (and varied) needs of client families who have varying difficulties on a range of issues. The different needs and treatments mean that as (Fergusson, Horwood et al., 2005) has stated “The net result of these factors is the evaluations of home visitation programmes describe the effects of a heterogeneous treatment method applied to a heterogeneous population. Under these circumstances one would not expect to find a large effect size for a specific outcome. Rather, it would be expected that programme benefits would be evident in a pattern of small pervasive benefits…” (page 77).9

9 A limitation of the quantitative methods utilised in the present evaluation is that it averages all outcomes, so while some people may make large improvements in certain areas, these results will be counterbalanced by others who do not make improvements or deteriorate on the same measure.
Along with the problem of low numbers, the data collected by Family Help Trust is generally categorical rather than continuous\textsuperscript{10}. Statistical tests will in general be more sensitive - that is they will have more power for a continuous variable than the corresponding categorical one. Categorising data is therefore useful for summarising results, but not so useful for statistical analysis.

It was therefore decided, before this evaluation was conducted, to look for trends in the data at twelve months \((p<.1)\) and examine significant changes \((p<.05)\) at three, four and five years after initial acceptance to Family Help Trust.

2.4.1 Sample Selection Bias
Most inferential statistics assume that subjects have been sampled at random from a well-defined population (Alreck & Settle, 1995); (Mendenhall, 1979). The way the sampling units are selected may lead to under-selecting or over-selecting respondents of a certain type. Sample selection bias is introduced if those who participate in the study differ, in terms of the outcome of interest, from those who do not participate. If this occurs, the responses obtained may not represent those present in the population from which the (biased) sample was drawn. In general terms, the aims were to obtain a total sample from a well-enumerated population in order to minimise sample selection bias. In order to increase the robustness of the present findings, sample losses (which were low) are described in detail.

2.4.2 Errors in Measurement
Errors in measurement occur when there is a difference between the true value of the factor being assessed and the recorded value of the variable studied (Elwood, 1988). It has been conventional to distinguish between errors of measurement arising from test invalidity and errors arising from test unreliability.

\textsuperscript{10} For example, the number of convictions, instead of being a number from 0 to 1000 (continuous) is categorised as 0; 1 – 10; 11 – 50; 51- 100; 100+.
a) Reliability
Generally, reliability is an index of the extent to which measurements of individuals obtained under different circumstances yield similar results (Streiner & Norman, 1989). Any obtained measurement at a particular moment is determined in part by the true value and in part by conditions that bring about any departure from that value.

b) Validity
While reliability assesses that a test is measuring something in a reproducible manner, validity examines if the measure is assessing what is intended.

In general, accounting for these issues involves using scales of known reliability and validity; however, this was not possible in the present study. It is therefore of use to briefly examine some issues of particular concern to the present study.

Within the context of the present research, there are a number of factors that may introduce invalidity to the subjects’ responses. These include:

i) Recall bias: The possibility of recall bias surfaces when retrospective reports of past events are obtained. Recall of an event may be influenced by the respondent’s health status (Lewis & Pelosi, 1990). In general, to reduce recall bias a structured interview with prompts is used in this evaluation rather than relying totally on the respondent’s recall.

ii) Response bias: There are many factors that may influence a response, making it a less than totally accurate reflection of reality. At the extreme, questionnaires may end up over- or under-estimating the prevalence of a symptom or disease; or the validity of the scale may be seriously jeopardised (Streiner and Norman 1989). Major sources of response bias have been reviewed by (Alreck & Settle, 1995), and Streiner and Norman (1989) however, in the context of the present evaluation the main issue is probably
'social desirability' and 'faking good'. Generally, the response given is based on what is perceived by the respondent as being socially acceptable and desirable (Lee & Renzetti, 1990), for example people may underreport drug use or physical violence. As social desirability is commonly conceptualised, the subject is not deliberately trying to deceive or lie. When the person is intentionally attempting to create a false positive impression, it is called faking good. In general, response bias is addressed by the use of a structured interview administered by a trained social worker, who is familiar with the respondent.

iii) Instrumentation bias: Instrumentation bias refers to situations where the questionnaire instructions, scales or response options introduce bias. A review of instrumentation bias and error is provided by (Alreck & Settle, 1995) and includes:

a. Ambiguity of meaning: Many words and phrases designate different things for different people. For example, the answer to the question ‘have you visited the doctor recently?’ will depend on different individual’s interpretation of ‘recently’.

b. Leading questions: Questions may be phrased in such a way as to guide the respondent to answer in a certain way. When questions ‘lead’ the respondent to a certain answer, they create a strong bias. For example, ‘have you visited the doctor for a petty health problem in the last year?’ may lead respondents to answer in a certain way.

While it is standard practice to use measure with established norms and adequate psychometric properties to avoid the above issues, a review of published outcome measures (Evaluation Unit Ministry of Social Policy, 2001) found that none of the existing measures available were considered sufficiently sensitive or culturally appropriate for measuring change in family and child health and wellbeing in New Zealand families. They concluded that developing in-house measures was the preferred option. This method was also chosen by Family Help Trust for similar reasons.
In general, the development of questions that have been designed to take account of these threats to validity have been utilised wherever possible in the present study. In addition, the questionnaire was developed by social workers in the field and pre-tested for comprehensibility. However, the interview was developed primarily as a clinical tool for clinical practice and the issues mentioned above must be borne in mind while drawing any conclusions from the present study.

2.4.3 Recording Errors:
A final measurement error to be considered is error related to the recording of the results. For all research, collected data has to be recorded, whether manually or electronically, and in many studies the raw data is converted or manipulated to give the final variable representing the factor under consideration. Errors in data entry and coding can lead to differences between the true value and the recorded value no matter what precautions are taken in earlier steps to prevent measurement error.

Steps to reduce recording errors included consistent and thorough recording procedures and an examination of the data for outliers and logical consistency. Any mistakes were sent back to the social worker for correction. This examination was conducted on each interview by an independent volunteer who signed off the paper form before the data was entered by a professional data entry operator. In addition, 40 questions that were considered central to this evaluation were hand-checked by Family Help Trust staff for data entry errors. In this way multiple mistakes in one respondent’s twelve month data were picked up and the data was completely re-entered. In this manner, thorough and consistent data collection procedures were used to minimise recording errors.

In summary, the present evaluation seeks to examine changes in family functioning and child welfare over the first twelve months of involvement with Family Help Trust. This involves the evaluation of a repeated measures design using a custom-designed interview. Measures have been undertaken
to ensure the results of this evaluation accurately reflect the true situation at Family Help Trust. The following chapters will examine the target family characteristics and changes in functioning over the first twelve months.
CHAPTER 3 TARGET FAMILY CHARACTERISTICS AT INTAKE

The present chapter will examine the characteristics of a consecutive series of families referred to Family Help Trust. The chapter is divided into three distinct sections:

1. Mother of Baby (MOB) recruitment and treatment drop-out
2. Background description of target families
3. Comparisons with previously described New Zealand home visitation services

Generally, this chapter will examine the referral process to Family Help Trust, the screening tool used to select families, and provide a descriptive profile of the socio-demographic characteristics of the families recruited. Finally, the chapter will examine similarities and differences with previously described New Zealand home visitation service cohorts. Changes in specific measures of functioning over the first twelve months of service with Family Help Trust will be examined in Chapter 4.

3.1 MOB Recruitment

Family Help Trust is a long-term home-based early intervention child protection programme designed for pregnant women and their families who have been identified as ultra high-risk for child abuse. Family Help Trust actually currently consists of two services although they target the same high-risk group. ‘Safer Families’ is a programme for high-risk pregnant women with multiple-risk histories, while ‘New Start’ specialises in similar clients with a

For families to be accepted into Family Help Trust, they must show high scores on a series of risk factors. The risk factors and guidelines for rating each item were developed from a review of the literature, accumulated clinical experience within Family Help Trust and consultations with Christchurch Women’s Hospital midwives and social workers. High risk is determined by the use of a risk protocol that consists of ten risk areas that are scored from 0= no issues to 5= severe issues on each factor. In order to be accepted into Family Help Trust, a score of 15+ is required\(^\text{11}\). This screening tool is included in Appendix I. The ten risk factors relating to the MOB are:

- Alcohol and/or Drug use (or partner)
- Unstable home/lifestyle
- Lack of family/community support/social problems
- Low income/poverty
- Unable/unwilling to provide adequate care/history of involvement with Child Youth & Families Service (CYFS)
- MOB (or partner) history of repeat offending or young mother and/or under 18\(^\text{12}\)
- History of family violence
- Foetal abnormalities/premature difficulties
- History of mental health issues (or partner)
- Maternal history of childhood abuse

\(^{11}\) By way of comparison, Early Start (Fergusson et al., 1999), which uses a similar screening tool, requires a score of 2 (no gradient of severity), while Family Start (Centre for Child and Family Policy Research, 2005) accepts low risk clients (one or more risks from a cluster of 13 – no gradient of severity)

\(^{12}\) While Family Help Trust consists of two services (‘Safer Families’ and ‘New Start’), for the purpose of the present analysis, data from both services has been combined in order to increase the number of people able to be evaluated. In terms of risk criteria, there is one different question on the screening tool (refer Appendix I). ‘Safer Families’ clients are rated on ‘Young mother and/or under 18yrs’ while ‘New Start’ families are rated on ‘History (or partner) of repeat offending/ history of imprisonment’.
Recruitment and drop-out

The period of recruitment for the present evaluation occurred between July 2003 and June 2005. During the evaluation period, the Family Help Trust accepted 70 families. Of these families, 55 (78.6%) had twelve month data available.

Table 3.1 Reasons for Drop-out from Family Help Trust Within Twelve Months

<table>
<thead>
<tr>
<th>Exit Reasons</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Longer Eligible</td>
<td>3</td>
</tr>
<tr>
<td>Moved away</td>
<td>4</td>
</tr>
<tr>
<td>Non Compliant</td>
<td>3</td>
</tr>
<tr>
<td>Refused Services</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
</tr>
</tbody>
</table>

The reasons for non-inclusion in the present cohort are presented in Table 3.1, and show that five referrals (33%) refused services, four (26.7%, all Maori) moved away, three (20%) had the target child taken into CYFS care and were therefore no longer eligible, and three (20%) were not compliant and therefore discharged. The remaining 55 families (78.6% of the eligible cohort) are described below.

Referral Source

Table 3.2 shows the referral source of the 55 MOB (mothers of baby) who remained in treatment for twelve months and also the referral source for the 15 MOB who did not remain in the service for twelve months.

Table 3.2 Referral Source of Present Cohort

<table>
<thead>
<tr>
<th>Referral source</th>
<th>Drop-outs N=15</th>
<th>Remained 12 months N=55</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Methadone Clinic/Midwives</td>
<td>13.3</td>
<td>23.63</td>
</tr>
<tr>
<td>% Community Agency</td>
<td>0</td>
<td>20.0</td>
</tr>
<tr>
<td>% Hospital Social Workers/Midwives</td>
<td>53.3</td>
<td>20.0</td>
</tr>
<tr>
<td>% Independent Midwives</td>
<td>13.3</td>
<td>18.18</td>
</tr>
<tr>
<td>% CYFS</td>
<td>6.6</td>
<td>5.45</td>
</tr>
<tr>
<td>% Friend/self-referral</td>
<td>13.3</td>
<td>3.6</td>
</tr>
<tr>
<td>% Neonatal Unit</td>
<td>0</td>
<td>5.45</td>
</tr>
<tr>
<td>% Probation</td>
<td>0</td>
<td>3.6</td>
</tr>
</tbody>
</table>
Examination of Table 3.2 shows that of those who remained at Family Help Trust for twelve months, the biggest percentage of referrals (23.6%) came from the Methadone Clinic (10) and the hospital-based methadone midwives (3). The second-equal largest grouping of referrals were from a) the hospital-based midwives (4) and social workers (7) (20%) and b) independent community agencies (20%) (including Plunket (7) and one each from Pregnancy Help, PAFT, Project Early, and Pillars). Ten referrals were received from independent midwives (18.2%). In addition, referrals were received from CYFS (3), the neonatal unit (3) and probation (2). There was one self-referral and one referral from a friend. The majority of those who disengaged within twelve months were referred by the hospital-based midwives and social workers (53.3%).

Risk Factors at Referral

Table 3.3 provides an account of the number and percentage of women who scored three or more (which equates to moderate risk; refer Appendix I) on the risk protocol filled out by the referring agency.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and other Drugs</td>
<td>28</td>
<td>50.9</td>
</tr>
<tr>
<td>Unstable lifestyle</td>
<td>25</td>
<td>45.4</td>
</tr>
<tr>
<td>Lack of support</td>
<td>37</td>
<td>67.2</td>
</tr>
<tr>
<td>Low income/poverty</td>
<td>28</td>
<td>50.9</td>
</tr>
<tr>
<td>Prior CYFS involvement</td>
<td>30</td>
<td>54.5</td>
</tr>
<tr>
<td>History of violence</td>
<td>20</td>
<td>36</td>
</tr>
<tr>
<td>Foetal difficulties</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Mental health issues</td>
<td>22</td>
<td>40</td>
</tr>
<tr>
<td>Childhood abuse</td>
<td>18</td>
<td>32.7</td>
</tr>
</tbody>
</table>

From Table 3.3 it can be seen that at referral, over half the Mothers of Baby (MOB) had moderate issues (a score of 3+) on use of alcohol and other drugs (50.9%), lack of support (67.2%), low income/poverty (50.9%), and prior CYFS involvement (54.5%). This represents an ultra high-risk cohort assessed by the referrers, when compared to other New Zealand and international reports.
3.2 Socio-demographic and Background Characteristics of MOB

After enrolment into the programme, the MOB was administered a standardised interview which provided a psychosocial profile of the family and its socio-economic status. The purposes of this interview were firstly to enable workers to gather relevant background details on families using a systematic questionnaire that included a wide range of aspects of family functioning. Secondly, the interview provided the basis for psychosocial profiles of the families at the point of programme enrolment.

3.2.1 Demographics

Table 3.4 provides a demographic description of the group of 55 families (who remained in the Family Help Trust Programme at twelve months) in terms of ethnicity, educational levels, family size, employment and age.

<table>
<thead>
<tr>
<th>Measure</th>
<th>frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOB Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European</td>
<td>46</td>
<td>83.6</td>
</tr>
<tr>
<td>Maori</td>
<td>6</td>
<td>10.9</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Qualifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>39</td>
<td>72.2</td>
</tr>
<tr>
<td>School Cert</td>
<td>5</td>
<td>9.3</td>
</tr>
<tr>
<td>Six Form Cert/UE</td>
<td>3</td>
<td>5.6</td>
</tr>
<tr>
<td>Tertiary</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trade Cert</td>
<td>5</td>
<td>9.1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.7</td>
</tr>
<tr>
<td>Mean age left school =</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including target child, which</td>
<td></td>
<td></td>
</tr>
<tr>
<td>may not yet be born at referral)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>18</td>
<td>32.7</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>21.8</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>12.7</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>12.7</td>
</tr>
<tr>
<td>5+</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Mean Age at entry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range= 15 - 40</td>
<td>27.9</td>
<td>(SD= 6)</td>
</tr>
<tr>
<td>Target Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% at least 1 Māori Parent</td>
<td>15</td>
<td>27.3</td>
</tr>
</tbody>
</table>
Table 3.4 shows that the majority of MOB were New Zealand European, and three-quarters had no formal educational qualifications. Family sizes varied from one child to seven children with almost half the women (45.4%) having three or more children (including the client child who may have been unborn at the time of referral). The age distribution of the sample varied widely from mothers aged from 15 to 40. While only 10.9% of MOB reported being of Māori ethnicity, 27.3% of the target children had at least one Māori parent.

3.2.2 Maternal Childhood
To develop an account of the MOB social circumstances, mothers were asked a series of questions about the extent to which they had been exposed to adversity during childhood. These questions included:

- What sort of relationship did you have with your parents/caregivers when you were a child? (Up to age of 16 yrs) Please rate from 1-5, where 1 means Terrible and 5 equals an Excellent relationship.
- Were you ever placed in care as a child, either with family/whānau, foster parents or state residential care?

These results are summarised in Table 3.5, which shows that mothers reported what appear to be relatively high levels of childhood adversity. From the table, it can be seen that 70% of MOB reported experiencing physical or emotional or sexual abuse during childhood while over half (54.7%) reported being placed in care. Finally, a large percentage reported a poor relationship with their parents.
Table 3.5 MOB Childhood Adversity

<table>
<thead>
<tr>
<th>Measure</th>
<th>frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship with parents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terrible = 1</td>
<td>22</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>21.8</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>12.7</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>14.5</td>
</tr>
<tr>
<td>Excellent = 5</td>
<td>6</td>
<td>10.9</td>
</tr>
<tr>
<td><strong>Placement into care</strong></td>
<td>29</td>
<td>54.7</td>
</tr>
<tr>
<td>Reason for placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuse/neglect</td>
<td>13</td>
<td>23.6</td>
</tr>
<tr>
<td>Family violence</td>
<td>8</td>
<td>14.5</td>
</tr>
<tr>
<td>Trouble with the police</td>
<td>4</td>
<td>7.3</td>
</tr>
<tr>
<td><strong>Childhood exposure to:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Often</td>
<td>25</td>
<td>45.5</td>
</tr>
<tr>
<td>Emotional violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Often</td>
<td>25</td>
<td>45.5</td>
</tr>
<tr>
<td>Sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>5</td>
<td>9.3</td>
</tr>
<tr>
<td>Often</td>
<td>18</td>
<td>33.3</td>
</tr>
<tr>
<td>Physical or emotional or sexual abuse as a child</td>
<td>39</td>
<td>70.9</td>
</tr>
</tbody>
</table>

3.2.3 Health and Forensic History
A series of measures were collected examining the Health and forensic history of mothers referred to Family Help Trust. Table 3.6 shows the frequency and percentage of MOB reporting historical adjustment problems at referral to Family Help Trust.

Table 3.6 MOB Current Adjustment Problems

<table>
<thead>
<tr>
<th>Measure</th>
<th>frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forensic History</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Court action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issued by MOB</td>
<td>16</td>
<td>29.1</td>
</tr>
<tr>
<td>Issued against MOB</td>
<td>16</td>
<td>29.6</td>
</tr>
<tr>
<td>Criminal offences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>25</td>
<td>45.5</td>
</tr>
<tr>
<td>10 or less</td>
<td>16</td>
<td>29.1</td>
</tr>
<tr>
<td>11 - 20</td>
<td>6</td>
<td>10.9</td>
</tr>
<tr>
<td>20+</td>
<td>8</td>
<td>14.6</td>
</tr>
<tr>
<td>Previous prison term</td>
<td>17</td>
<td>30.9</td>
</tr>
<tr>
<td><strong>Employment History</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No employment ever</td>
<td>26</td>
<td>46.3</td>
</tr>
</tbody>
</table>
From Table 3.6, it is apparent that over two-thirds (70.9%) of MOB reported prior criminal offending resulting in arrest and conviction. The table also shows that almost half of the MOB (46.3%) reported never having been employed.

During the course of the intake interview, a series of questions were asked about the MOB health status prior to referral to Family Help Trust. Table 3.7 shows the frequency and percentage of reported health issues in the MOB.

<table>
<thead>
<tr>
<th>Measure</th>
<th>frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyesight</td>
<td>15</td>
<td>27.3</td>
</tr>
<tr>
<td>Hearing</td>
<td>9</td>
<td>16.7</td>
</tr>
<tr>
<td>Head injury and/or concussion</td>
<td>23</td>
<td>42.6</td>
</tr>
<tr>
<td>Mental Health Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>18</td>
<td>32.7</td>
</tr>
<tr>
<td>Manic depression</td>
<td>2</td>
<td>3.6</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>3</td>
<td>5.5</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>5</td>
<td>9.1</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>13</td>
<td>23.6</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>5</td>
<td>9.1</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>10.9</td>
</tr>
<tr>
<td>Any diagnosis</td>
<td>36</td>
<td>65.5</td>
</tr>
<tr>
<td>Regular drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>last 6 months</td>
<td>35</td>
<td>63.6</td>
</tr>
<tr>
<td>Regular alcohol use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>last 6 months</td>
<td>29</td>
<td>52.7</td>
</tr>
<tr>
<td>Pregnancy health problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>22</td>
<td>40.7</td>
</tr>
<tr>
<td>Methadone withdrawal (baby)</td>
<td>11</td>
<td>20</td>
</tr>
</tbody>
</table>

From Table 3.7 it is apparent that nearly half of MOB (42.6%) reported a previous head injury and/or concussion. One-third of MOB (32.7%) had previously been diagnosed with Major Depressive Disorder, one-quarter (23.6%) with an anxiety disorder and two-thirds (65.5%) with any psychiatric
disorder. Significantly 20% of target children had Methadone withdrawal, and two-thirds (63.6%) reported ‘regular’ drug use in the previous six months (that is; during pregnancy).

### 3.2.4 The Characteristics of Partners

Just over two-thirds (69.1%) of the MOB reported being in relationships at referral to Family Help Trust. As partners are likely to have some impact on family functioning, it is useful to examine the characteristics of the male partners nominated by the mothers. Table 3.8 gives a profile of the psychosocial characteristics of male partners including their ethnicity, history of criminal offending, employment status, substance use and mental health problems.

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>% of partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner is father of enrolled child</td>
<td>30</td>
<td>78.9</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>20</td>
<td>66.7</td>
</tr>
<tr>
<td>European</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maori</td>
<td>9</td>
<td>30.0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Living with mother of child</td>
<td>22</td>
<td>57.9</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>8</td>
<td>21.1</td>
</tr>
<tr>
<td>Actively seeking work</td>
<td>11</td>
<td>28.9</td>
</tr>
<tr>
<td>Diagnosed mental health condition</td>
<td>8</td>
<td>21.1</td>
</tr>
<tr>
<td>Substance abuse issues</td>
<td>12</td>
<td>31.6</td>
</tr>
<tr>
<td>Criminal conviction</td>
<td>10</td>
<td>26.3</td>
</tr>
<tr>
<td>Mean age at referral</td>
<td>29.3</td>
<td>(SD= 8.1)</td>
</tr>
</tbody>
</table>

From Table 3.8 it appears that the psychosocial profile of male partners is similar to that of mothers, although surprisingly, male partners were less likely to have criminal records. This finding is counter-intuitive and suggests more work may need to be done to accurately ascertain levels of criminality in
partners, should this variable be of further interest. Alternatively, it may be that MOB is not actually aware of their partner’s history.

### 3.2.5 CYFS Involvement

As Family Help Trust is predominantly a child protection agency, CYFS involvement is of paramount interest to this evaluation. Table 3.9 shows CYFS involvement with MOB at referral. Bill Pringle, Clinical Services Manager, provided all CYFS data for this evaluation after consultation with individual social workers, contact with CYFS and any another sources of information available.

<table>
<thead>
<tr>
<th>Measure</th>
<th>frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No CYFS ever</td>
<td>12</td>
<td>21.8</td>
</tr>
<tr>
<td>Previous concern but not at entry</td>
<td>12</td>
<td>21.8</td>
</tr>
<tr>
<td>On CYFS formal status</td>
<td>5</td>
<td>9.1</td>
</tr>
<tr>
<td>Investigation underway at entry</td>
<td>18</td>
<td>32.7</td>
</tr>
<tr>
<td>On CYFS formal status and investigation under way</td>
<td>8</td>
<td>14.5</td>
</tr>
</tbody>
</table>

From this table, it is apparent that three-quarters of MOBs (78.2%) had some CYFS contact prior to referral to Family Help Trust. This number is also higher than that reported by referral agencies (54.5%; refer Table 3.1; page 47). This may be because this CYFS information was collected retrospectively in order to maximise accuracy.

In summary, it would appear that a significant number of MOB have had previous CYFS involvement. This factor alone distinguishes Family Help Trust from many other Home Visitation services. For example, as discussed in the introduction (Chapter 1.5.1; page 26), the Healthy Start Program in Hawaii (Duggan et al., 1999) (on which the Family Help Trust was originally modelled) specifically excludes those with previous or current child protection agency involvement. In addition to previous CYFS involvement, MOB reported high levels of childhood adversity, substance use, mental health problems and criminal offending.
In order to look at the characteristics of the present cohort in the context of previous New Zealand cohorts, Chapter 3.3 will compare and contrast Family Help Trust with previous published reports of home visitation services.

### 3.3 Comparisons with Previous Cohorts

The aim of this section is to examine the differences between the present Family Help Trust group and previous New Zealand home visitation cohorts.

While it is apparent that the Family Help Trust cohort presents with significant social disadvantages, it is of interest to compare these characteristics with previous published New Zealand home visitation service samples. To this end, the present section will compare Family Help Trust with Early Start (Fergusson et al., 1999)\(^{13}\) and Family Start (Centre for Child and Family Policy Research, 2005)

#### Table 3.10 Comparison of Family Help Trust with Early Start and Family Start

<table>
<thead>
<tr>
<th>Measure</th>
<th>Family Help Trust</th>
<th>Early Start</th>
<th>Family Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Mother left school with no formal educational qualifications</td>
<td>72.2</td>
<td>70.9</td>
<td>62</td>
</tr>
<tr>
<td>% Mother taken into welfare care as child</td>
<td>54.7</td>
<td>21.8</td>
<td>-</td>
</tr>
<tr>
<td>% 'Was either parent abused in the past?'</td>
<td>70.9*</td>
<td>58.2*</td>
<td>42</td>
</tr>
<tr>
<td>% 'Were any previous children abused or neglected in the past?'</td>
<td>78.2**</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>% 'Either parent mental health problems'</td>
<td>65.5*</td>
<td>38.2*</td>
<td>27</td>
</tr>
<tr>
<td>% used cannabis during pregnancy</td>
<td>54.5</td>
<td>21.4</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: *=MOB only  
**=CYFS Involvement

\(^{13}\) The initial 1999 pilot evaluation was used here, as well as the more recent larger evaluation (Fergusson, Grant et al., 2005), as appropriate, for purposes of comparison.
An examination of Table 3.10 indicates that while all services are recruiting MOB with low levels of formal educational qualifications, MOB at Family Help Trust show higher levels of past abuse, previous CYFS involvement and mental health problems (including drug use). The differences between Family Help Trust (78.2%) and Family Start (8%) in the proportion of MOBs with abuse and/or neglect of previous children is particularly apparent. However, as different measures were used to assess such issues as ‘childhood adversity’ within each group, it is difficult to draw comparisons.

3.4 Summary

The aim of this chapter has been to provide background information on the Family Help Trust Programme by: a) describing the process of MOB recruitment and retention; b) relating the socio-demographic background of families enrolled in the programme and c) to examine similarities and differences between Family Help Trust and previous New Zealand cohorts.

From this account, the following conclusions may be drawn;

The socio-demographic outline of families recruited into the Family Help Trust programme is similar to, or worse than, many other accounts of high risk families. These families were socially disadvantaged, the mothers reported a background of adversity in childhood, and there were relatively high levels of criminality, substance use and mental health problems. Of significance, a high percentage of Family Help Trust’s MOB had prior CYFS involvement.

Family Start, the Government’s main home visiting initiative, aims at engaging the 15% of families most in need of support. While the Early Start programme suggested that 10% of all families within the Christchurch urban region may meet eligibility criteria for Early Start support (Fergusson et al., 1999) the higher risk criteria of Family Help Trust means the programme would be suitable for the top two percent. When compared to the socio-demographic characteristics of the Early Start cohort reported by Fergusson et al. (1999); (2005), it would appear that the two groups are similar in a number of areas
although, as expected, Family Help Trust appears to recruit a cohort with higher levels of child abuse risk factors.
CHAPTER 4 OUTCOMES AT TWELVE MONTHS

While Chapter 3 provided an account of the characteristics of families, the present chapter will examine changes in a range of risk factors over the first twelve months treatment at Family Help Trust. While tests of statistical significance are reported where appropriate, it may be of more relevance to examine trends in the data, given the low number of participants and small expected changes over this time period. Generally, the aims of this Chapter are to see if there were any changes in key indicators of child and family health and well-being over the first twelve months of involvement with Family Help Trust. Examination of these issues will enable staff to pinpoint areas of good and unsatisfactory performance, and therefore target areas for further input.

Data was gathered during the course of interviews conducted with Mother of Baby (MOB) at baseline and twelve months following acceptance at Family Help Trust. The examination of changes over the first twelve months will also provide evidence of the effectiveness of a child abuse prevention programme specifically targeted at the ultra high-risk group, which have previously been thought not to be amenable to change (Fergusson, 2002).

These factors are divided into the following sections:

iii) Child-associated outcomes, including parental behaviours associated with child rearing and the health and safety of any children

iv) family psychosocial functioning, including health and well-being of MOB, family functioning and economic well-being

Generally, the intention of this Chapter is to examine a range of factors that may inform clinical staff and stakeholders of the current state of Family Help Trust’s effectiveness over the first twelve months of service engagement.
4.1 Child-Associated Outcomes

This section provides a description of a series of issues addressing the adequacy of parental care provided to children in Family Help Trust, and any changes in these practices over the first twelve months of involvement with the service. In particular, the section examines:

i) parental behaviour associated with child-rearing; including adequate standard of housing, provision of appropriate food for any children in household, hand washing, and bedtime routine

ii) Health & Safety of any child(ren) associated with MOB including: reported assault on children, children witnessing any violence, children exposed to any drug taking activity and current CYFS involvement

Specifically, the present section examines the extent to which the provision of the Family Help Trust service produced beneficial outcomes for the child (who is the primary client of the programme) in the areas of child rearing behaviours, child abuse and antisocial behaviour around the child(ren).

4.1.1 Parental Behaviour Associated with Child Rearing

Table 4.1 examines a series of parental behaviours related to good child rearing practices. MOBs with no children under 16 (n=7) at baseline were excluded from this analysis in order to avoid any potential bias (for example, reporting 'not providing regular bedtime routine’ rather than 'not applicable'. An ‘adequate standard of housing’ measure was developed by the following method:

Housing factors were recorded at each assessment period from parental reports of those issues. These factors included issues such as,

- “is the home dry/warm in winter?”
- “do you have enough beds/bedding?”
“do you have a washing machine that works?” etc.

A ‘Standard of housing’ score was calculated by summing the number of items at each time point. Students t-test was used to examine the significance of any differences in these scores between baseline and twelve months. Table 4.1 also provides an account of the baseline and twelve month reports of change in a range of other parenting behaviours and examines significance differences using McNemar’s test for dichotomous measures (yes/no) and the The Wilcoxon signed-rank test for ordinal data.

**Table 4.1 Change in Parenting Behaviours at Baseline and Twelve Months**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>12 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>mean ‘adequate standard of housing’ score</td>
<td>7.9</td>
<td>8.8</td>
<td>.002</td>
</tr>
<tr>
<td>Provision of appropriate food for any children in household</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% provide fresh vegetables or salad for child</td>
<td>69.4</td>
<td>95.9</td>
<td>.001</td>
</tr>
<tr>
<td>% provide fresh fruit for child</td>
<td>65.3</td>
<td>98</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% provide meat/ eggs/ cheese etc. (protein) for child</td>
<td>66.7</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>% child(ren) always wash hands before eat</td>
<td>42.9</td>
<td>52.4</td>
<td>.48</td>
</tr>
<tr>
<td>% child(ren) always wash hands after toilet</td>
<td>46.4</td>
<td>71.4</td>
<td>.06</td>
</tr>
<tr>
<td>% regular bedtime routine</td>
<td>56.9</td>
<td>92.2</td>
<td>.001</td>
</tr>
<tr>
<td>% child(ren) causing concern at home</td>
<td>35.4</td>
<td>27.1</td>
<td>.34</td>
</tr>
<tr>
<td>Safe Car</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% without car warranted and or registered</td>
<td>52.6</td>
<td>29.0</td>
<td>.37</td>
</tr>
<tr>
<td>% age appropriate car seats</td>
<td>83.3</td>
<td>79.6</td>
<td>.80</td>
</tr>
<tr>
<td>% seatbelts always used for children</td>
<td>98.0</td>
<td>94.5</td>
<td>1</td>
</tr>
</tbody>
</table>

From Table 4.1 it can be seen that there was a significant increase (t(44)=-2.96; p=.002) in the mean ‘Adequate standard of housing’ score. In addition to behaviours associated with direct behaviours towards the child, a series of questions examine the safety of the car used to transport child(ren).

A series of questions were asked looking at provision of fresh vegetables, fruit and protein (eggs, meat, cheese etc.). Respondents rated provision of these foods from 5= once or more a day; 3= 2-3 times a week; to 0= never. Over
the course of the first twelve months, mothers reported significant improvements in the provision of fresh vegetables \((z = -3.88; p < .001)\), fresh fruit \((z = -4.04; p < .001)\), and protein \((z = -4.19; p < .001)\). At referral, two-thirds of mothers were providing some fresh food, while by twelve months; almost all were reporting provision of some fresh vegetables, fruit and protein (eggs, meat, cheese etc.). However, this result may be biased by breastfeeding mothers, who do not need to put down ‘provision of fresh food’, actually being ranked as ‘0’: never providing adequate fresh food. This possibility has again been decreased by excluding MOB who reported no children under 16 at home at baseline.

By twelve months there was a significant increase \((p < 0.001\) from McNemar’s test) in the number of children who had a regular bedtime routine from 57% at referral to 92%. There was a trend towards a higher rate of children washing their hands after going to the toilet, although this improvement was non-significant \((p = .06)\). Finally, there were high rates of unlicensed cars used to transport children, although over three-quarters of MOBs report using appropriate safety restraints regularly.

### 4.2.2 Health & Safety of child(ren) including CYFS involvement

As the Family Help Trust is predominantly an abuse prevention service, collection of child health and safety data was a priority. This data was collected in a number of ways including relying on the self-report of MOB from the interviews. During the course of the interviews, a number of questions were collected on issues related to the health and safety of any children living with the MOB. These behaviours included physical and verbal assaults on the children.

For example:

- **In the past 6 months, have you hit, shaken, slapped, punched, kicked, pushed or thrown any of your children, or any other children that you have lived with?**
In the past six months, has your partner threatened to harm you or any members of your family/whānau; including your or your children’s pets-him/herself, any other members of the household, or anyone else? A series of questions on children witnessing violence were summed to give a score of any violence that was witnessed.

How often have people (including yourself) smoked cigarettes around your child/ren? (This answer was dichotomised to yes/no)

A series of questions on children witnessing or ‘being around’ drug taking behaviour (marijuana, LSD, p, etc.) were summed to give a score of any intoxicated behaviour around children.

Table 4.2 shows the presence of a number of adverse child outcomes at baseline and twelve months. The table shows the percentages of each factor and the statistical significance (using McNemar’s Test) of any differences between the two time periods. Again, it should be emphasised that trends in the data are of importance, given the low reported rates of some behaviours.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Baseline</th>
<th>12 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>% MOB struck/shaken any child</td>
<td>22.9</td>
<td>6.3</td>
<td>.039</td>
</tr>
<tr>
<td>% partner assaulted child</td>
<td>5.4</td>
<td>3.1</td>
<td>.81</td>
</tr>
<tr>
<td>% child witnessed assault on mother</td>
<td>5.4</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>% children witness any violence</td>
<td>7.2</td>
<td>1.8</td>
<td>1</td>
</tr>
<tr>
<td>% children exposed to cigarette smoke ‘sometimes’ or ‘often’</td>
<td>27.3</td>
<td>34.6</td>
<td>.42</td>
</tr>
<tr>
<td>% children exposed to any drug taking activity</td>
<td>20.4</td>
<td>18.2</td>
<td>1</td>
</tr>
<tr>
<td>% current CYFS involvement</td>
<td>56.4</td>
<td>32.7</td>
<td>.01</td>
</tr>
</tbody>
</table>

From Table 4.2, it can be seen that between baseline and twelve months, there was a significant decrease in MOB reporting striking or shaking any
child in their care. At baseline, almost one-quarter of MOBs reported striking or shaking a child in their care, while by twelve months, this had decreased to only 6.3%. There were also (non-significant) decreases in children witnessing assaults on their mothers and any violence generally. However, the low rates of these events make drawing any conclusions problematic.

Of concern in the present table is the (non-significant) increase in reported smoking around children. There are a number of possible explanations as to why reported smoking around children did not decrease over the first twelve months that have a bearing on the overall data collection. One possible explanation is that mothers stopped smoking while pregnant and then started again after the child was born. However, at baseline 70.4% of MOB reported smoking while at twelve months this had decreased to 58.2%. Another possibility is that when the social worker asked this question at baseline the MOB was not aware that smoking around children was an issue of concern and by twelve months, after repeated input from Family Help Trust staff, MOB are more aware of the issue of smoking around children and therefore report that others still do this.

A final reason may be that the MOB is not prepared to admit that people smoke around children at the baseline interview and are more willing to disclose this information at the twelve month interview. This possibility has consequences in relation to the reliability of data collected at baseline, when the social worker has not engaged fully with the MOB. It may be of use for staff to retrospectively collect data on questions that may ‘shame’ the MOB and lead to ‘faking good’ (a response bias discussed on page 42). In this way it may be possible to see how accurate baseline information is. This issue is of particular relevance for factors such as family violence and the health of the child.

Finally, there was a significant change (p=.011) in CYFS concern from baseline to twelve months. At baseline 31 families were classified as under CYFS involvement, and by twelve months this had decreased to 18. Of particular interest was that only five families who were not of concern at
baseline had CYFS involvement at twelve months, while 18 families who were classified as under CYFS involvement at baseline were no longer of concern at twelve months. Of those families who still had CYFS involvement at twelve months, eleven were rated as mild concern, while seven were moderate or high concern.

To further examine the role of CYFS in the first twelve months, information was collected on CYFS referrals and outcomes that were initiated over this time period. This information is presented in Table 4.3, which shows the frequency and percentage of various outcomes over the first twelve months, of CYFS referrals.

From the table, it can be seen that during the first twelve months, there were 18 notifications by Family Help Trust or another organisation to CYFS. Of these notifications, seven of these incidents were resolved to CYFS satisfaction during the first twelve months and eleven were on-going.

Table 4.3 CYFS Referrals Initiated During First Twelve Months (n=18)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No longer concerned</td>
<td>7</td>
<td>38.9</td>
</tr>
<tr>
<td>Some concern</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>Moderate/high concern</td>
<td>5</td>
<td>27.8</td>
</tr>
</tbody>
</table>

The significant decline in levels of concern about child abuse by CYFS over the course of the first twelve months is suggestive of the fact that Family Help Trust support may have contributed to reductions in child abuse risk. In order to provide some insight into the life circumstances of MOB at Family Help Trust, a brief summary of four case vignettes is provided below. These four vignettes are similar in that the target child was taken away from the mother’s care during the first twelve months at Family Help Trust.

MOB A: Ante-natal engagement. In crisis at the time with no fixed accommodation and soon after, moved to [rural Canterbury] where child was born. CYFS were notified in [regional CYFS Office] due to transience and lack of preparation for baby and had on and off involvement. When baby 9 months old, mother moved back to CHCH with baby so FHT re-opened file. However,
mother placed baby with a relative when CYFS became aware she was in a relationship with a sexual abuser. FHT remained involved in an effort to help mother break away from partner and set up a stable home but she would not break off contact with him so baby remained in care, under oversight of CYFS.

MOB B: Referred by midwife. Family Help Trust engagement at 6 months antenatal. Three previous children in CYFS care. CYFS opened investigation into unborn child. CYFS made decision to place baby in care at birth due to previous history of poor parenting skills, two previous negative assessments from residential parenting programmes, personality disorder of mother and low cognitive functioning of both parents. Family Help Trust stayed involved until after family group conference confirmed placement and then assisted parents to come to terms with this loss and to set up some access.

MOB C: Maternity social worker referred at 7 months antenatal. Family Help Trust became engaged at 8 months and notification immediately made to CYFS due to violent domestic relationship with ongoing abuse, lack of preparedness for baby, reluctance to accept supports, topping up methadone. CYFS placed baby in care at birth. Family group conference plan was eventual return home and this occurred with support of Family Help Trust soon after the twelve month period.

MOB D: Referred by midwife at five months antenatal. Family Help Trust engaged at 8 months antenatal. Despite support from several agencies mother increased her drug use and then went to jail for shoplifting. CYFS became involved and children placed with other family members. Family Help Trust supporting K’s caregivers.

These cases illustrate some of the difficulties inherent in research of this nature. Some definitions of successful outcome may consider having a child taken away as a poor outcome, however, as the case vignettes above illustrate, in certain situations removal is an excellent short-term outcome. The same can be said for the decrease in CYFS involvement at twelve months. The decrease is positive, but so also are the new referrals, that are,
at least to some extent, due to input from Family Help Trust. In this manner, appropriate, pre-emptive, referral to CYFS may also be seen as a good outcome.

In terms of child health outcomes, it was established that all vaccinations were completed at 6 weeks, 3 months and 5 months (except for one conscientious objector and one target child late on all three vaccinations). While the service encourages and monitors the completion of Well Child checks to ensure child development is progressing satisfactorily, they have found that verifying dates has become problematic as a result of the current existence of multiple providers and no central database.

In summary, the present evaluation has found a significant decrease in CYFS involvement and reported MOB violence toward child(ren) over the first twelve months. These are extremely encouraging results, when seen in the context of high-risk factors associated with these families.

4.2 Family Psychosocial Functioning

This section examines the extent to which there were benefits in family psychosocial functioning over the first twelve months of provision of Family Help Trust services. Specifically, this section will examine the following:

i) MOB health and well-being, including: mental health issues, use of contraception, and alcohol and drug use.

ii) MOB psychosocial functioning, including: retraining to enter workforce, support from family/Whānau and others, participation in community activities or groups, availability of a phone, and safe transportation

iii) Stability of household including: number of people in household and number of shifts in previous six months
iv) Family stability, family relationships and family violence including: currently in relationship, in violent relationship, concerns about partner’s mental health and partner’s criminal and gang-related activities

v) Family economic and material well-being including: dependence on Work and Income benefit, adequacy of income and debt issues.

Generally, the aims of the present section are to provide an account of the psychosocial milieu in which the target child is being raised.

4.2.1 Maternal Health
Data was gathered during the course of interviews conducted with MOB at baseline and twelve months following acceptance at Family Help Trust. During the course of the interview, a series of questions were asked about MOB health. These questions included such issues as treatment for specific mental health conditions and substance use. Table 4.4 provides a description of the baseline and twelve month reports of MOB health and tests for significance differences using McNemar’s test.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>12 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Issues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% treatment for mental health problem last</td>
<td>25.5</td>
<td>25.5</td>
<td>1</td>
</tr>
<tr>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% non-specific mental health problems in</td>
<td>12.7</td>
<td>18.2</td>
<td>.58</td>
</tr>
<tr>
<td>previous 6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% prescription medication</td>
<td>40.7</td>
<td>29.1</td>
<td>.23</td>
</tr>
<tr>
<td>% have regular GP for last 6 months</td>
<td>94.5</td>
<td>94.5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Contraceptive use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% using contraception</td>
<td>33.3</td>
<td>38.2</td>
<td>.16</td>
</tr>
<tr>
<td>% using contraception regularly</td>
<td>13</td>
<td>23.6</td>
<td>.26</td>
</tr>
<tr>
<td><strong>Alcohol &amp; Drug Issues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% smoke cigarettes</td>
<td>70.4</td>
<td>59.3</td>
<td>.11</td>
</tr>
<tr>
<td>% drink alcohol in last week</td>
<td>85.5</td>
<td>76.4</td>
<td>.23</td>
</tr>
<tr>
<td>% use marijuana</td>
<td>31.5</td>
<td>27.8</td>
<td>.77</td>
</tr>
<tr>
<td>% use opiates or other drugs</td>
<td>10.9</td>
<td>9.1</td>
<td>.86</td>
</tr>
<tr>
<td>% on methadone programme</td>
<td>16.4</td>
<td>18.2</td>
<td>1</td>
</tr>
</tbody>
</table>
From Table 4.4 it can be seen that there are no statistically significant changes in MOB mental health conditions, contraceptive use or substance use. However from the table it may be seen that there was a trend towards decreasing percentage of women smoking cigarettes and a trend towards increasing regular use of contraception. However, both these rates are low compared to the general population and there is room for improvement in these areas. These areas are considered by many MOBs to be situations that they still retain some control over. For example, if CYFS removes a child from the family, the MOB may comment that they will ‘just have another one’. Also with multiple partners and feelings of insecurity, it is tempting to have a baby with the present partner. Consequently, these behaviours can be very hard to change.

4.2.2 Mother Psychosocial Functioning

The following information regarding MOB psychosocial functioning was gathered as part of these assessments. A series of questions examined the extent MOB was retraining and/or undertaking education or skills training, perceived support from family/whānau, neighbours and friends, and daily activities. In addition, questions were asked on the MOBs access to a telephone. Table 4.5 provides an account of the baseline and twelve month reports of MOB psychosocial functioning and tests for significance differences using McNemar’s test.

The table shows that there were low rates of vocational training at both baseline and twelve months and this would be consistent with the demands of a new baby. From Table 4.5 it can be seen that there was a statistically significant \( p = .004 \) improvement in reported participation in community activities or groups and a trend towards increased perceived support from neighbours. It can also be seen that MOBs reported high rates of support from family/whānau and friends at both baseline and twelve months. The table also shows that there was an increase in those with access to a phone from baseline to twelve months.
### Table 4.5 Changes in MOB Psychosocial Functioning at Baseline and Twelve Months

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>12 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vocational Training</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% retraining to enter workforce</td>
<td>18.8</td>
<td>14.5</td>
<td>1</td>
</tr>
<tr>
<td>% undertaking education/skills training</td>
<td>5.4</td>
<td>9.3</td>
<td>.25</td>
</tr>
<tr>
<td><strong>Support and Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% support from family/ whānau</td>
<td>74.5</td>
<td>81.8</td>
<td>.38</td>
</tr>
<tr>
<td>% support from neighbours</td>
<td>21.8</td>
<td>36.4</td>
<td>.09</td>
</tr>
<tr>
<td>% support from friends</td>
<td>78.2</td>
<td>80.0</td>
<td>1</td>
</tr>
<tr>
<td>% get out with friends daily</td>
<td>3.6</td>
<td>10.9</td>
<td>.37</td>
</tr>
<tr>
<td>% participate in community activities or groups</td>
<td>7.4</td>
<td>23.6</td>
<td>.004</td>
</tr>
<tr>
<td><strong>Telephone Access</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% have a cell phone</td>
<td>66.7</td>
<td>81.8</td>
<td>.05</td>
</tr>
<tr>
<td>% able to afford to use cell phone</td>
<td>29.6</td>
<td>45.5</td>
<td>.13</td>
</tr>
<tr>
<td>% have land line</td>
<td>67.3</td>
<td>67.3</td>
<td>1</td>
</tr>
</tbody>
</table>

### Household Stability

A series of questions were included to examine the make-up of the household into which the target child was born. As it is not clinically relevant to examine significance of any changes in these measures, tests for statistical significance are not conducted.

### Table 4.6 Household Stability at Baseline and Twelve Months

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>12 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of adults living in household</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>18</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>21</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>3+</td>
<td>13</td>
<td>11</td>
<td>NC</td>
</tr>
<tr>
<td><strong>Number of Children under 16</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>23</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>3+</td>
<td>21</td>
<td>15</td>
<td>NC</td>
</tr>
<tr>
<td><strong>No of times shifted house in last 6 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>34</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>11</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>2+</td>
<td>10</td>
<td>6</td>
<td>.16</td>
</tr>
<tr>
<td>% MOB living with partners</td>
<td>40.0</td>
<td>47.4</td>
<td>.34</td>
</tr>
</tbody>
</table>

NC=statistics not calculated
From Table 4.6 it can be seen that at baseline 34.6% of MOB were living at home with no other adults in the house compared to 40.4% by twelve months. At baseline 23.6% of households had three or more adults living there, compared to 20% by twelve months. From the table, it can be seen that three of the households did not have any children living with them at twelve months and these cases have been examined in 4.1 above. Twenty-one (38.2%) MOB moved at least once in the six months prior to referral at Family Help Trust compared to 17 (30.9%) moving, in the previous six months, by the twelve month evaluation period. This suggests that a third of women are still mobile by twelve months. However, this may be a positive move in some cases as better accommodation may have been organised because of increased mobility issues with a new toddler.

4.2.3 Family Relationships

In order to further describe the household situation of the target child, a series of questions were asked relating to MOB relationships over the past six months. This included current relationships and other relationships in the previous six months. To examine partner substance use, a question was developed that asked “Does your partner use illegal drugs, solvents, or alcohol to the point that it is causing stress on you and your children?” This question was dichotomised to ‘never’ vs. ‘sometimes or often’.

In order to provide an account of negative aspects of these relationships, issues such as violence, abuse or fearfulness in the previous six months (regardless of whether perpetrator was a current or previous partner) were summed to give an overall score of dysfunctional relationships.

Table 4.7 provides an account of the baseline and twelve month reports of MOBs relationships and tests for significance differences using McNemar’s test.
From the table it can be seen that approximately half the MOB were in relationships at the time of being interviewed at baseline and twelve months (58.2% and 54.5%, respectively). The table shows that there has been a pervasive and consistent trend towards decreasing violence and abuse over the past twelve months. However, because the rates of abuse are low to begin with, these changes are not statistically significant. Despite the lack of statistical significance, decreases in any aspects of domestic violence has huge *clinical* significance in terms of decreased risks for child abuse (Edelson, 1999); (UNICEF; 2003).

Table 4.7 Description of Relationship Functioning, at Baseline and Twelve Months

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>12 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of relationship(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% in relationship &gt;2 weeks in past 6 months</td>
<td>75.9</td>
<td>61.8</td>
<td>.11</td>
</tr>
<tr>
<td>% currently in relationship</td>
<td>58.2</td>
<td>54.5</td>
<td>.72</td>
</tr>
<tr>
<td>% living with partner</td>
<td>40.0</td>
<td>47.3</td>
<td>.34</td>
</tr>
<tr>
<td>% current partner is father of target child</td>
<td>54.5</td>
<td>41.8</td>
<td>.039</td>
</tr>
<tr>
<td>% partner involved in parenting and/or financial decisions</td>
<td>49.1</td>
<td>47.3</td>
<td>1</td>
</tr>
<tr>
<td>Violence in relationship(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% frightened or terrified of partner</td>
<td>9.1</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>% in violent relationship</td>
<td>10.9</td>
<td>3.6</td>
<td>.12</td>
</tr>
<tr>
<td>% assaulted by partner</td>
<td>10.9</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>% laid charges, complaints or court orders against partner</td>
<td>7.9</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>% other abusive relationships in previous 6 months</td>
<td>11.1</td>
<td>3.7</td>
<td>.36</td>
</tr>
<tr>
<td>% partner has mental health condition that causes stress in family</td>
<td>14.5</td>
<td>12.7</td>
<td>1</td>
</tr>
<tr>
<td>% (with partners) with concerns about partner’s mental health</td>
<td>23.1</td>
<td>7.7</td>
<td>.23</td>
</tr>
<tr>
<td>% partner’s substance use ‘distressing’</td>
<td>16</td>
<td>8</td>
<td>NC</td>
</tr>
<tr>
<td>% partner charged, convicted, or sentenced</td>
<td>21.1</td>
<td>12.5</td>
<td>NC</td>
</tr>
<tr>
<td>% partner imprisoned</td>
<td>15.3</td>
<td>6.3</td>
<td>NC</td>
</tr>
<tr>
<td>% partner gang involvement</td>
<td>10.5</td>
<td>3.1</td>
<td>NC</td>
</tr>
</tbody>
</table>

NC=not calculated as numbers of MOB with partners at both time points is too small for analysis

From this analysis, the extent of overt partner violence was lower than anticipated. In reporting similar findings, Fergusson et al. (1999) suggested that it is possible that the lower than expected level of partner violence in
target families may be due to a reporting bias in which mothers fail to report violent episodes due to shame. This issue has been discussed above (page 63) in relation to smoking around the child(ren) and again reinforces the need for careful assessment of sensitive issues.

An example in support of this argument is the percentage of MOB (who are in a relationship) who report ‘some conflict’ with partner. The rate is 28.1% at baseline, but 46.7% by twelve months. Unfortunately, it is not those reporting ‘abusive relationships’ that have downgraded this report to ‘some conflict’ but rather those reporting ‘no conflict’ at baseline now admitting ‘some’. Again, this points to the need for some retrospective data gathering once the social worker has engaged with the MOB and knows more about the relationship situation.

As an example of this issue, a social worker who had been working with a client for two years reported that she had no idea that the MOB was experiencing spousal violence— it took the client this long to disclose it. Identification of domestic violence is crucial because research suggests that even the most successful home visitation services are not successful when there is domestic violence present (Eckenrode et al., 2000). Unfortunately, due to the changing nature of the relationship between the social worker (interviewer) and the MOB it is possible that reported changes are due to this changing relationship, rather than changes in the actual factor of interest.

4.2.4 Family Economic and Material Well-being

A number of measures were used to describe the economic and material well-being of the families enrolled at Family Help Trust. These measures included questions on benefit status, employment, adequacy of income, debts and stress associated with debts. Table 4.8 provides an account of the baseline and twelve month reports of economic and material well-being and tests for significance differences using McNemar’s test.
Table 4.8 Rates (%) of Family Economic and Material Well-being at Baseline and Twelve Months

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>12 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>% mother full-time caregiver</td>
<td>83.3</td>
<td>96.3</td>
<td>.016</td>
</tr>
<tr>
<td>% on work and income benefit</td>
<td>94.4</td>
<td>87.0</td>
<td>.29</td>
</tr>
<tr>
<td>% any work (paid or voluntary)</td>
<td>11.1</td>
<td>22.2</td>
<td>.11</td>
</tr>
<tr>
<td>% actively seeking work</td>
<td>5.6</td>
<td>5.6</td>
<td>1</td>
</tr>
<tr>
<td>% adequate income to provide enough food each week</td>
<td>72.7</td>
<td>61.8</td>
<td>.14</td>
</tr>
<tr>
<td>% used food bank</td>
<td>18.5</td>
<td>35.2</td>
<td>.049</td>
</tr>
<tr>
<td>% debts over $500</td>
<td>78.2</td>
<td>74.5</td>
<td>1</td>
</tr>
<tr>
<td>% high stress associated with debt</td>
<td>56.6</td>
<td>45.3</td>
<td>.21</td>
</tr>
<tr>
<td>% partners contribute financially ‘all the time’</td>
<td>53.8</td>
<td>76.9</td>
<td>.07</td>
</tr>
</tbody>
</table>

From Table 4.8 it can be seen that families at Family Help Trust are living in reduced economic circumstances. Families are in debt and worried about this level of debt. While there was a slight (non-significant) decrease in the percentage of families dependent on Social Welfare benefits (94.4% to 87%), the vast majority of families were still welfare dependent. Debt was commonly reported, with the majority (78.2% at baseline and 74.5% at twelve months) of families reporting that they had debts (excluding mortgage payments) greater than $500. In addition, approximately half the families (56.6% and 45.3% respectively) reported high stress associated with this debt.

Unfortunately, there was a decrease in the number of families who reported adequate income to provide enough food each week (down from 72.7% to 61.8% by twelve months) accompanied by a statistically significant increase in the percentage of families using food banks (35.2%). Perhaps a silver lining to be taken from this increase in use of food banks is that social workers were able to persuade MOB to use these services. Inspection of Table 4.1 (page 60) shows significant increases in the percentage of MOB reporting that they are providing adequate levels of fresh fruit and vegetables to the family. On the positive side, for those families with partners at both baseline and twelve months, there was an increase in partners contributing financially ‘all the time’.
4.3 Summary

Chapter 4 has provided an examination of changes over the first twelve months on a series of key issues that have previously been associated with poor prognosis for children and low family functioning generally. The results of Section 1, which focused on key child-related outcomes are extremely encouraging and point to improvements in a number of areas including parental behaviours associated with child rearing and the health and safety of child(ren) in the household.

Section 2 also found significant improvements in social support and family violence. However, the design of the present study, which does not include a control group, means that this research is unable to conclusively say that the changes are due to the input from Family Help Trust. Specifically, without a control group, it is not possible to show that this high-risk group would not have improved anyway. Perhaps once their child was born, the MOB would have improved in the areas shown in this chapter anyway. However, this conclusion is less likely for two reasons.

Firstly, many of the MOBs have had previous CYFS involvement (78%) and have generally not shown an inclination to improve with these children. Secondly, national and international studies have suggested that cycles of violence and abuse tend to perpetuate and the poor outcomes shown in many previous outcome studies tends to point to changes not occurring without appropriate intervention (e.g. MacMillan et al; 2005).

While the present analysis shows that the MOBs showed important changes in parenting behaviours, family violence and social isolation, which may or may not have been due to Family Help Trust input, there was less evidence of positive changes in lifestyle of the MOBs. Specifically, in a number of areas including parental substance abuse, mental health and family material circumstances, relatively little change was observed in client families. Similar results have been found in previous research, notably by Fergusson and
colleagues (Fergusson et al., 1999); (Fergusson, Horwood et al., 2005) and these issues will be discussed in Chapter 5.
CHAPTER 5 DISCUSSION

The purpose of this chapter is to provide an overview of the results of this evaluation and place these findings in context.

Specifically, this Chapter will:

i) summarise the retention rate and the characteristics of the present cohort as described in Chapter 3 and place these findings in the context of previous research;

ii) summarise the threats to the validity (limitations) of the present evaluation as outlined in Chapter 2; and,

iii) examine some of the key outcomes highlighted in Chapter 4. In order to supplement the quantitative findings, a series of case vignettes are reported to give a more detailed account of changes over the first twelve months of contact with Family Help Trust.

Generally, the aims of the present chapter are to provide a synthesis and summary of the present evaluation. This evaluation; a) describes the recruitment and retention of a series of consecutive enrolments to the Family Help Trust Service in Christchurch; and b) examines the twelve month changes in a series of measures developed to evaluate the performance of Family Help Trust. In general, the results of this evaluation are extremely positive, given the short duration of the intervention and the limited success achieved by many national and international services.

This evaluation suggests that over the first twelve months, Family Help Trust families are most effective in acquiring new skills and behaviours associated with parenting their children, but are less effective in dealing with long-
standing lifestyle issues relating to substance abuse, mental health issues and family economic circumstances.

5.1 Retention Rates

The twelve month retention rate (78.6%) found in the present review is similar to that found in previous home visitation services. Guterman (2001), in a review of services, found a median retention rate of 87% at 6 months after service initiation (ranging from 74% to 100%), in contrast to retention rates ranging from 49% to 72% through two to four months of services for centre-based prevention programmes. There appears to be a similar retention rate for families referred to Family Help Trust when compared to other New Zealand home visitation services. Family Start reported a 60% retention rate at 13 months (Centre for Child and Family Policy Research, 2005), while Early Start had 73.6% retention at twelve months (Fergusson, Grant et al., 2005).

This indicates that Family Help Trust has a similar retention rate at twelve months as other New Zealand and international services. However, any subject loss can decrease the ‘generalisability’ of the study findings. That is; the degree to which the results of this evaluation may generalise to other home visitation populations. If, for example, all the people who were not going to get any benefit from Family Help Trust ‘dropped-out’ then it is not valid to say that we could expect the same outcomes for all high-risk families. Although this does not affect the internal validity of the trial results, the extent to which findings may generalise to all families who are eligible for the programme is unknown. Although this is always an issue, the relatively high retention rate diminishes the problem in the present evaluation.

5.2 Comparison with Other Home Visiting Services

The present sample of Family Help Trust families appears to have higher rates of risk factors than other New Zealand home visitation services. In order to highlight differences between Family Help Trust and other New Zealand
services, Table 5.1 shows a comparison between Family Help Trust and the Family Start services evaluated in 2005 (Centre for Child and Family Policy Research, 2005). As this report examined four services, Table 5.1 shows the range of scores for these Family Start services. In addition, the table shows results of the evaluation of Early Start\textsuperscript{14} (Fergusson et al., 2005; Fergusson et al 1999).

\begin{table}
\centering
\caption{Comparison of Family Help Trust with Early Start and Family Start}
\begin{tabular}{|l|c|c|c|}
\hline
Measure & Family Help Trust & Family Start & Early Start \\
\hline
\% either parent abused in the past & 70.9\textsuperscript{1} & 27-59 & 44.7\textsuperscript{1} \\
\% any previous children abused or neglected in the past & 78.2\textsuperscript{2} & 6-12 & - \\
\% mother left school with no formal educational & 72.2 & 54-74 & 70.6 \\
\% either parent has a history of mental health problems & 65.5 & 10 – 51 & 38.2 \\
\% mother taken into welfare care as child & 54.7 & - & 21.8 \\
\% families with current debts in excess of $500 (excluding mortgage or hire purchase) & 78.2 & - & 60 \\
\% dependent on welfare benefits & 94.4 & - & 93.8 \\
\% problems with offending & 54.5 & - & 30.9 \\
\hline
\textsuperscript{1} = only Mother assessed \\
\textsuperscript{2} = previous CYFS involvement \\
\end{tabular}
\end{table}

From Table 5.1 it can be seen that Family Help Trust MOB have much higher rates of previous abuse (including mother being taken into welfare care as child), CYFS involvement with previous children, MOB mental health problems, issues with high debt and MOB offending. These findings are consistent with the assertion in Chapter 1.5 (page 27) that while Family Help Trust focus on the highest 2% of at-risk children and Early Start aim for the highest 10%, the main New Zealand home visitation network (Family Start) is focused on the highest 15% of most vulnerable children.

\textsuperscript{14} There were two separate evaluations of Early Start; the rates of occurrence of relevant factors in Table 5.1 have been taken from both evaluations for the purpose of this comparison.
5.3 Limitations

The limitations of the current research design have been discussed in Chapter 2 (pages 37-43) and include the lack of a control group to compare outcomes against, use of non-standardised measures with unknown reliability and validity, and a small number of participants, all of which reduce the ability of the present evaluation to ‘prove’ that Family Help Trust makes a significant difference to the lives of the client child and their families. Olds & Kitzman (1993), in a review of home visiting research, make the point that:

“Studies are only as convincing as their research designs permit them to be, and their results can properly be generalized only to populations similar to those who participated in the studies.” (page 56).

A final limitation of the present study is that changes in outcomes are limited only to the previous six months rather than the whole of the preceding twelve months. For example, only reports of ‘assault by partner’ occurring between six months and twelve months with Family Help Trust are recorded and no information was available for the purposes of the present evaluation on assault in the time between acceptance and six months. The drawback of this strategy is that any serious assaults (for example) occurring between baseline and six months have not been reported in the present evaluation. In order to mitigate this fact, information on CYFS referral, which is a key marker of interest in the present evaluation, was collected independently of the Family Help Trust database and any CYFS involvement has been reported above (pages 61-66).

In summary, while this evaluation suggests that the programme is successful in its aims of reducing the risks faced by infants in ultra high-risk families, the descriptive methodology used in this evaluation excludes the making of strong conclusions about programme efficacy.
5.4 Comments on Selected Areas of Psychosocial Functioning

To place the findings of the present evaluation of Family Help Trust in context, section 5.4 will examine the implications of the present findings by examining the available literature and presenting case vignettes that illustrate certain changes in individual family functioning. These vignettes support the quantitative results presented so far in this analysis and serve as a reminder of the actual issues dealt with by home visitation services working with high-risk families.

5.4.1 Child Abuse

Findings from Elmira indicate that children in the home visitation service are less likely to be abused or neglected than a control group during the first two years of the children’s lives (Olds et al., 1986). While some researchers suggest that measures of referrals to organisations such as CYFS do not provide an accurate picture of the true level of abuse, given that not all child abuse is reported, the number of referrals to child protection agencies are the figures that key stakeholders (such as government funders and politicians) are most interested in. Chaffin (2005) suggests that measures such as referrals to child protection agencies are the key outcome for any service claiming to be engaged in child abuse prevention.

“Nonetheless, if the programs advertise themselves as child abuse prevention, and are funded with child abuse prevention monies, then that is how they should be evaluated.” (page 244).

Chaffin further questions the validity of proxy measures of maltreatment (e.g., injury, hospitalisation for injury or ingestion of inappropriate materials, or psychometric scales of attitudes to child punishment). Information on CYFS referrals is therefore of high priority in the present study. The statistically significant decrease in CYFS concern about children over the first twelve months is an important finding. Many services do not achieve positive outcomes in preventing child abuse (Chaffin, 2005), especially in a high-risk cohort that includes those with previous child protection agency contacts (e.g.
MacMillan et al., 2005). A recent report suggests that New Zealand, at seven deaths per thousand births, has the second highest child mortality rate in the developed world (Commonwealth Fund; 2006).

In order to provide some insight into the life circumstances of MOB at Family Help Trust, a brief summary of four case vignettes is provided in Chapter 4.2.2 (pages 64-65).

5.4.2 Basic Needs of Child
Over the first twelve months of Family Help Trust, there were statistically significant improvements in the percentage of MOB reporting positive parenting behaviours (such as provision of healthy food, child(ren)’s personal hygiene and a regular bedtime routine. Table 4.1 (page 60) shows a clear trend for rates of positive parenting behaviours to improve by twelve months. Previous reports have found similar changes in child rearing practices (Fergusson et al., 1999), and Chaffin (2005) has suggested that most home visitation services are more accurately characterized as maternal and child health enhancement programmes. Certainly a main focus of the Early Start service (Fergusson, Horwood et al., 2005) is child health.

A further issue that this evaluation has not been able to assess is the extent that medical help has been offered to target children as some of this information is presently not available for analysis. This is unfortunate, given the findings of Fergusson et al. (1999) whose 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.” (page 6).

The present evaluation also found that the Family Help Trust target children were up to date with immunisations. However, information on number of child-related contacts with family doctor, hospital attendances for accidents/injuries and accidental poisoning, and enrolment with preschool
dental services are currently not assessed. Future research should include the extent to which Family Help Trust is able to achieve satisfactory levels of medical care for high-risk children, as these factors were accidentally left out of original data interview system while it was being developed.

In order to discuss changes in addressing the needs of children, use is made of a case vignette prepared by Family Help Trust social worker and Bill Pringle, Clinical Services Manager.

**Case 1**

*Referred by Methadone Clinic one week before birth of baby. Also referred to CYFS by midwife because of chaotic household.*

*Three older children in care of CYFS for past three years. Children removed because of mother’s chaotic lifestyle, drug abuse, transience, chaotic household, offending and imprisonment.*

*Mother has an anxiety disorder and social phobia.*

*Currently on probation for theft.*

*No drivers license, car unwarranted and unregistered.*

*History of extremely difficult interaction with statutory agencies and very suspicious of social workers and helping agencies. CYFS considered mother to be too dysfunctional to return children to her care. Access to her children fraught with problems. Had been in CYFS care herself as young person with major substance abuse issues.*

*Family Help Trust social worker has supported mother to deal appropriately with CYFS, WINZ, HNZ etc. Several times the worker has challenged mother on her behaviour and each time has had to work very hard to keep her on board with the service.*

**After twelve months:**

- Mother had only one further offence.
• She was completing her probation and anger management course.
• She was having regular access with her eldest child (age 8). CYFS looking at the possibility of him returning to her care.
• There has been only one change of address, into more appropriate accommodation.
• Mother providing appropriate physical care to her child and up-to-date with Well Child checks and immunisations.
• Mother complying with medication for her anxiety and not abusing other drugs.
• CYFS have closed investigation regarding environment for baby, satisfied with progress being made.

5.4.3 Domestic Violence
Domestic violence has been well documented as a key risk factor in physical child abuse and neglect (Edelson, 1999), and has also been shown to be a factor in decreasing the degree to which families benefit from home visitation (Eckenrode et al., 2000). This is particularly troubling, given that cases with factors like substance abuse or domestic violence may be the most concerning and important cases for prevention efforts (Chaffin; 2004). Children are more likely to be abused in homes where partner abuse occurs (UNICEF; 2003). Surveys from industrialised countries show that 40% to 70% of men who use violence against their partners also physically abuse their children and about half of women who are physically abused by their partners also abuse their children (Tajima, 2002). In a review of home visiting service effectiveness, Bilukha et al., (2005) report that the evidence on improving intimate partner violence is currently insufficient to determine effectiveness.

While relatively low levels of domestic violence were reported in this sample, it is a major issue when present. Any change in this is of immense importance. In order to illustrate this point, use is made of a case vignette prepared by a Family Help Trust social worker under the supervision of Bill Pringle, Clinical Services Manager.
Case 2

Referral from obstetric social worker at CHCH Women’s Hospital at seven months antenatal. Four year old child in care of father out of NZ.

Mother on methadone in pregnancy programme; topping up with Ritalin. Mother depressed and into prostitution. At time of referral she was in a violent relationship and had been beaten up while pregnant. She had used Women’s Refuge several times but been banned for stealing and drug use. She was highly anxious and had very difficult and conflictual relationships with statutory agencies. She was very transient and staying in emergency accommodation. Midwife made referral to CYFS for above reasons, mother’s lack of preparedness for baby and reluctance to accept support.

CYFS decided to remove baby from mother’s care at birth and Family Group Conference decided that mother would need to work toward resuming care of her child.

The FHT social worker supported mother to get a protection order and to stay away from baby’s father. She has spent countless hours negotiating between CYFS and mother to enable baby to transition slowly back into mother’s care and to minimize the conflict between those parties. Without the support of FHT it seems very unlikely that a return home would have been achieved and the child would have remained in the custody of the Chief Executive.

At twelve months:

- FHT social worker assisted mother to get into her own accommodation shortly after enrolment and at twelve months she remained there.
- She had not had direct contact with her ex-partner and has maintained the protection order. She has not had to use domestic violence services.
• After twelve months the child is having regular access at her mother’s home and is being transitioned back into her mother’s care.
• Mother is not topping up on other drugs and is maintained on methadone.
• She has not returned to prostitution nor resorted to crime.
• The FHT social worker visits regularly to help mother with her anxiety and to negotiate with other agencies when necessary. Mother has retained the services of FHT when initially she was very reluctant to have us involved.
• The plan is that this child is placed permanently back in her mother’s care within a period of six months.

5.4.4 Social Isolation

Human ecology theory (Bronfenbrenner, 1979) (influential in the theoretical underpinnings of home visiting) clarifies the importance of the social environment- including not only the influence of parents, but also of social networks, neighbourhoods, communities, and cultures- in child development. Home visitation is seen as strengthening the capacities of parents in successfully relating to their social environment and gaining access to social resources (Bilukha et al., 2005). Studies have reported that social isolation, long identified as a risk factor for physical child abuse and neglect (Thompson, 1995), also appears to play a role in hindering families’ participation in home visitation services.

The reality is that most parent-child interactions and family life still take place away from the view and influence of the home visiting staff. Most families do not turn to these professionals for help, rather parents more commonly turn to other family members, to friends, (or have no one) to help them develop and maintain positive parenting patterns. Home visitation services, while often touted as a bridge for the transmission of social support (e. g. (Weiss, 1993)), have largely failed to make meaningful inroads in improving the supportiveness of families social networks, a central risk element in physical abuse and neglect (Guterman, 2001).
Perry (2004) emphasised that a key element of home visitation programmes is to increase the number and quality of relational interactions by bringing more healthy adults into the lives of children. While the MOB reported high levels of support from family and friends at both time points in the present evaluation, the increase in support from neighbours and participation in community activities are of special interest. Social isolation is an area of immense interest by many New Zealand governmental and social agencies\(^\text{15}\).

In order to illustrate a case of social isolation and changes made over the first twelve months, use is made of a case vignette prepared by a Family Help Trust social worker and Bill Pringle, Clinical Services Manager.

**Case 3**

*Referral by a pre-school early intervention service at five months ante-natal.*
*Two children aged three and four at home. An older child in foster care in Australia.*
*Mother separated from father of the children.*

- *Mother on the methadone programme but almost daily use of opiates and weekly use of marijuana.*
- *History of attention-seeking behaviours, possibly factitious disorder.*
- *Self-harming.*
- *Resistant to counselling.*
- *Budgeting difficulties.*
- *Serious behavioural problems with 4-year-old child. Inconsistent parenting and regular use of smacking.*
- *Mother driving without a driver’s license.*
- *Very isolated from community supports.*

\(^{15}\) In the authors consultations with key governmental and community stakeholders, social isolation and positive social interactions away from gangs, crime and drugs, were repeatedly mentioned as key factors they would like to see addressed by Family Help Trust. The results of this evaluation show that they are heading in the right direction.
Social worker discussed alternative parenting/discipline methods, accompanied mother to appointments with Alcohol and Drug Service, supported mother to get drivers license, took seriously what mother reported in terms of physical and emotional symptoms so that mother had to take natural consequences of her stories.

At twelve months:

- Drug use has reduced to weekly opiates and two-monthly use of marijuana.
- Mother has joined Plunket playgroup and has support from local church group.
- Referral for budgeting has been made.
- Mother is no longer hitting the children and uses timeout. Focussing on reducing her yelling at the children and practicing positive attention techniques with them.
- Mother now has her restricted driver’s license.
- She is attending counselling regularly. She has admitted to social worker that she has made up stories to get attention.
- Strengthening Families meeting process in place.

5.4.5 Alcohol and Other Drug Use

Substance abuse triples the risk of child maltreatment (Guterman 2001, cited in UNICEF 2003) and is extremely difficult to treat (Comfort, Loverro, & Kaltenbach, 2000). In the present evaluation there were (non-statistically significant) decreases in cigarette smoking and alcohol consumption and low levels of reported substance use at both time points. It should be borne in mind that changes in behaviours such as alcohol and drug treatment are particularly hard to achieve and can take a long period of time (Orwin, Francisco, & Bernichon, 2001). Unfortunately, in the progress interviews no questions are included specifically examining current mental health or substance abuse disorders, so it is difficult to examine how Family Help Trust is performing in these important areas. Of concern was the slight increase in
reported cigarette smoking by others around children, and this is an area that deserves greater attention from Family Help Trust social workers (page 62).

In the Family Start report (Centre for Child and Family Policy Research, 2005), at baseline, 50% of caregivers reported they drank alcohol; compared with 45% at twelve months. Similarly at baseline, 50% of caregivers were smokers. This had risen to 54% at twelve months.

While on average, minimal changes in alcohol and other drug use were reported over the first twelve months, clinically significant changes have been reported by some families. The following case vignette illustrates the changes in one family over the period of the present evaluation.

**Case 4**

*Referral from midwife at seven months antenatal. Family Help Trust engaged one week prior to delivery. One previous child had died at two months of cot-death. Family living in isolated rural community. Both parents on methadone programme and topping up with other drugs. Hospital considered notification to CYFS but decided on referral to Family Help Trust.*

*Information discovered by Family Help Trust social worker:*

- baby sleeping in bed with parents
- parents smoking around baby
- car being driven unwarranted and unregistered
- mother’s own parents had been addicted to heroin and injected her with heroin at age 16
- Mother’s poor personal health including rotten teeth.
- Fraud convictions
- Both parents manipulative and resistant to outside involvement

*The social worker established at the start that if this was going to work there needed to be an honest relationship between worker and MOB and that she*
knew they would try to manipulate her. She challenged them on their attempts to procure other drugs and to keep this from her.

She also worked on self-esteem issues and building up their self-confidence as parents, talked about their relationships with their own parents and their desire not to repeat those mistakes. The social worker provided lots of information on parenting, nutrition etc.

The social worker has supported the parents with their methadone clinic appointments. She has been consistent, available, understanding of setbacks, but also challenging

After twelve months:
- Parents smoke outside
- Methadone dosage has halved and topping up minimal
- The car is now registered and warranted (parents saved up for this)
- Relationship with own parents has improved
- Child sleeps in her own bed
- Mother sources parenting information from the library
- Mother attending a computer course and has part-time employment
- Father looking for work
- Both stopped committing crimes
- Parents thirsty for information that will make them better parents and their child is the centre of their lives.

5.4.6 Economic and Material Well-being
When parents are poor, less educated, or mentally ill, they tend to have little money, time or energy to devote to developing children’s human capital, less time for supervising children, and are less able to buy resources for their children. They can afford housing only in disadvantaged neighbourhoods that provide low quality schools and less social control (Flouri, 2004). Despite these obvious difficulties, it was not anticipated that substantial increases in employment and financial security would be reported at twelve months
because a) mothers would be busy with their newborn child and the additional pressures of paid employment would be detrimental; b) almost half the MOB had never been in paid employment before; and, c) most MOB had no educational qualifications and this would limit their job opportunities anyway. These issues are compounded by the fact that only 5.6% reported looking for work at each time point.

Many MOB’s reported being worried about financial issues, making use of food banks and not having enough money to provide enough food each week. This is an issue that is beyond the control of social agencies, such as Family Help Trust, and needs to be addressed at a higher level.

The present evaluation found high rates of benefit dependence at both baseline and twelve months. In the Family Start report (Centre for Child and Family Policy Research, 2005), a Government benefit was the main source of income for 58% of caregivers at twelve months. At baseline, only 13% of caregivers were in paid employment at the time they were interviewed; this had risen to 40% at twelve months. In the Early Start report (Fergusson et al., 1999), 93.3% were welfare dependent at baseline, while this had dropped to 83.3% by 18 months (twelve month data was not available for this item). This indicates that MOBs were less able, or inclined, to seek employment than previous New Zealand cohorts.

5.5 Conclusions

The preceding analyses and case vignettes appear to support the hypothesis that Family Help Trust families were successful in improving maternal child rearing skills and reducing child abuse risks over the first twelve months of involvement with the service. In most of the measures there was data indicating clear decreases in the number of women reporting poor parenting practices, CYFS concern and other factors that have previously been associated with risk of abuse (in particular domestic violence and social isolation). In addition, the case vignettes provided insights in the processes by
which Family Help Trust assisted mothers to address child rearing problems and reduce child abuse risks.

In line with the conclusions reported by Fergusson (2006), the results of this evaluation undoubtedly suggest that home visitation programmes such as Family Help Trust do not, and possibly can not, offer a complete answer to family social and economic problems. This suggests that such programmes need to be conceptualised as one element of an integrated approach to assisting families from dysfunctional and disadvantaged home environments. UNICEF (2003) notes that strategies to reduce child abuse will not be successful “without addressing the question of economic poverty, which … is the close companion of physical abuse and neglect” (page 21).

Given the nature of issues faced by client families of Family Help Trust, large changes over twelve months would not be expected. As Fergusson and colleagues (2005) suggest (after three years of treatment); “what one would expect to find is that effective programs would show the pattern of small but pervasive benefits that are evident in this evaluation.” (page 808). The lack of significant findings in some areas in the present evaluation is not surprising given that longer duration programmes produce larger effects (Olds, 2006).

In a review of home visitation services, programmes of less than two years duration did not appear to be effective (Guide to Community Preventive Services; 2003). For example, Fraser, Armstrong, Morris, & Dadds (2000) found no evidence of sustainable changes in home visitation services at twelve months. It is extremely hard to achieve shifts in entrenched behaviour patterns over such a short period of time. Family Help Trust is planning to review the two year outcomes of this cohort and it is hoped that the extremely positive trends reported in this evaluation are consolidated and enhanced.

From the description of the background characteristics of mothers in the present cohort, it is apparent that for many families their problems are associated with established personal problems that had their origins in the mother’s own upbringing. Research has established that changes in
behaviours such as criminality and substance abuse can be a long process and that rates of success are often low (Comfort et al., 2000).

Fergusson, Horwood et al., (2005) suggest programmes such as Early Start (and in light of the present results, perhaps also Family Help Trust) may be better at promoting “new learning” in areas relating to child health and development, than in addressing long-standing personal, financial and related problems (changing ‘old learning’). The results of the present evaluation certainly support this interpretation to the extent that child-related outcomes showed important improvements over the first twelve months.

Given these findings, it is not surprising that Family Help Trust was not able to show significant changes over the first twelve months on some of these ‘old learning’ issues. Further follow-up evaluations at 24-months and longer will give more information on the ability of Family Help Trust to change these behaviours. The failure of this evaluation to find changes in MOB lifestyle factors is not an issue of significant concern because recently, Fergusson et al., (2006) found that ‘home visitation programs may provide benefits for child-related outcomes in the absence of parent- or family-related outcomes’ (page 781). Also Family Help Trust is focused on preventing child abuse and providing a good start to the at-risk child who, after all, is the primary client of the service.

5.5.1 Concluding Comments
The present evaluation examines a crucial gap in the current understanding of home visitation services by studying the twelve month outcomes of a group of high-risk clients. These ultra high-risk clients are exactly the group that leading researchers in the area suggest should be the target of future interventions. This evaluation represents the first attempt to examine outcomes in this challenging group.

Given the overwhelming expectations engendered from the literature of poor outcomes and certainly no immediate change in the first few years, the results
of the present evaluation are extremely encouraging. While it can not be shown that the positive changes shown in the present evaluation are due to Family Help Trust, this can be strongly inferred given the historically poor outcomes of high-risk families. Examination of the target cohort at two, three, and five years will be extremely interesting and will provide further directions for both clinical staff and key stakeholders.
Appendix I Risk Factors for Referral to Family Help Trust

Note: Q6 for New Start families is actually: History (or partner) of repeat offending/history of imprisonment rather than Young mother and/or under 18yrs. All other questions are identical.

Referral Criteria (Safer Families)

Date: ..........................
Patient Name....................... Hospital No...........
Ward: (if appropr)........... (Circle)

In-Patient  Out-Patient

House Address:.................................................................

If baby born (Full Name)......................................................

If baby not born when due (date) ...........................................

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<thead>
<tr>
<th>No.</th>
<th>Factor</th>
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<tbody>
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<td>1</td>
<td>Alcohol and/or Drug use</td>
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<td>Unstable home/lifestyle</td>
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<td>3</td>
<td>Lack of family/community support/social problems</td>
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<td>Low income/poverty</td>
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<td>5</td>
<td>Unable/unwilling to provide adequate care/history of Child Youth &amp; Families service</td>
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<td>6</td>
<td>Young mother and/or under 18yrs</td>
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<td>7</td>
<td>History of Family Violence</td>
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<td>8</td>
<td>Foetal abnormalities/premature difficulties</td>
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<td>9</td>
<td>History of mental health issues</td>
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<td>10</td>
<td>Maternal History of childhood abuse</td>
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Does client have criminal history – within last two years?

Yes  No

Total Score..........................

Maximum score = 50
(Minimal score for referral = 15)

SCAN meeting scheduled yes/no  SCAN meeting ...... (date)
### RISK FACTORS GUIDELINES: Safer Families (to be read in conjunction with referral criteria)

<table>
<thead>
<tr>
<th>No:</th>
<th>Risk</th>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td>1</td>
<td>Alcohol and/or drug use</td>
<td>Previous history - no evidence this</td>
<td>Occasional use of alcohol/drug</td>
<td>Monthly recreational use of alcohol/drug/ bingeing/stable on methadone treatment</td>
<td>Weekly drug or alcohol use</td>
<td>Daily use of alcohol or drugs or both</td>
</tr>
<tr>
<td>2</td>
<td>Unstable home/lifestyle</td>
<td>Recently left a stable situation</td>
<td>Has moved twice in previous 12 months</td>
<td>Living in unsuitable situation</td>
<td>Living in grossly overcrowded circumstances</td>
<td>No fixed abode Transience No stable environment</td>
</tr>
<tr>
<td>3</td>
<td>Lack of family/community support/social problems</td>
<td>Previous history of family dysfunction, no evidence this pregnancy/now</td>
<td>Limited social skills/developmental and/or intellectual disability</td>
<td>Some conflict with family members/obvious developmental/intellectual disability</td>
<td>Constantly in conflict with family members/significant symptoms of both disabilities</td>
<td>Unable/unwilling to engage with helping agencies/major or multiple disabilities</td>
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<tr>
<td>4</td>
<td>Low income/poverty</td>
<td>On benefit, no other means of income</td>
<td>Poor budgeting skills, seeking help</td>
<td>Has utilized food banks occasionally</td>
<td>Consistently requires food parcels, can’t manage</td>
<td>Financial chaos/large debts</td>
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<tr>
<td>5</td>
<td>Unable/unwilling to provide adequate care/history of CYFS</td>
<td>Has had historical CYFS involvement, but not within the last three years/needs some assistance but is unwilling</td>
<td>Has had historical involved with CYFS, but not within the last 18mths/some assistance from community agencies concerning parenting</td>
<td>Has had historical involved with CYFS, but not within the previous six months/community agency involvement due to considerable parenting difficulties</td>
<td>C &amp; P concerns raised by other agencies/C &amp; P referral made</td>
<td>CYFS currently actively involved/considerable concern from other agencies/Professionals</td>
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<td>Safe Protection Factors</td>
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<tr>
<td>6</td>
<td><strong>Young mother and/or under 18yrs</strong></td>
<td>Under 18 yrs of age/has some support</td>
<td>Under 17 yrs of age/minimum support</td>
<td>Under 16 yrs of age/little support</td>
<td>Under 15 yrs of age/no support</td>
<td>Under 18 yrs of age/isolated/no supports/intensive parenting support required</td>
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<tr>
<td>7</td>
<td><strong>Childhood history/adult history of family violence</strong></td>
<td>Has previously been in a violent environment/relationship</td>
<td>Previously used Women’s Refuge/use of support agencies</td>
<td>Had used Refuge on a number of occasions</td>
<td>Currently living in a violent environment/relationship/recent incident of physical assault/violence</td>
<td>Protection order in place/interim custody orders/court process/currently in Refuge</td>
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<tr>
<td>8</td>
<td><strong>Foetal abnormalities/premature difficulties</strong></td>
<td>Premature birth under 40wks/methadone baby/previous history of a premature birth</td>
<td>Methadone baby undergoing withdrawal/unborn child probable withdrawal from methadone</td>
<td>Moderate developmental delay</td>
<td>Physical disabilities and/or developmental delay</td>
<td>Severe foetal abnormalities/developmental global delay/premature birth under 26wks</td>
</tr>
<tr>
<td>9</td>
<td><strong>History of mental health issues</strong></td>
<td>History of minor mental health issues/anxiety/stress related episodes (undiagnosed)</td>
<td>Previously diagnosed with mental illness</td>
<td>Currently diagnosed with a mental illness</td>
<td>Currently diagnosed with a mental illness and on medication</td>
<td>Mental health service/sector teams involved with mother</td>
</tr>
<tr>
<td>10</td>
<td><strong>Maternal History of childhood abuse</strong></td>
<td>Identified history of childhood abuse/no longer impacting on functioning</td>
<td>Identified history of childhood abuse/has some impact on functioning</td>
<td>History has significant impact/lacking insight to activate treatment</td>
<td>Personal functioning a major issue/unrealistic expectations concerning their current pregnancy</td>
<td>Severe history requiring treatment/maternal history of foster care</td>
</tr>
</tbody>
</table>
References


