

Q How long has Family Start been operating?

A Family Start was first introduced in 1998 in 3 pilot sites and expanded to another 13 sites in 1999 and 2000. Enhancement of the programme and a second expansion occurred in phases between 2005 and 2007. By the end of 2007 Family Start was operating in 30 out of the country's 74 city and district council areas. There has been no further expansion of the programme since that time.

Q Why did MSD commission this work?

A A number of studies and reviews of Family Start have been conducted over the years. These have tended to find that families selected to be interviewed value the programme. But they have also highlighted variation in practice and performance across providers. None of these previous studies has been able to establish the effectiveness of Family Start in improving outcomes. This new study was commissioned to fill that gap.

Q Did the study find positive impacts?

A Yes. Results indicate that the enhanced Family Start programme that was phased in to new areas between 2005 and 2007 was associated with statistically significant positive impacts in a number of domains.

Positive impacts are found for Family Start children overall, and for Māori and Pacific children who participated in the programme.

Impacts on Service Utilisation

Like the Early Start randomised controlled trial, findings indicate positive impacts on connection to some health services and to early childhood education.

The study estimates that compared to a matched control group who had similar characteristics but lived in areas where Family Start was not available, children who received Family Start had:

- a higher likelihood of being fully immunised in their first 2 years
- a higher rate of participation in early childhood education at age 4.

In addition, mothers had a higher rate of use of community-based mental health services in the first year post-birth.

Impacts on Mortality

The most striking finding from the study is evidence that Family Start reduced post-neonatal mortality. The evidence of a programme impact is strongest and most persuasive in the case of Sudden Unexplained Deaths in Infancy (SUDI) and injury deaths.

Mortality results are very promising and consistent with emerging evidence from home visiting studies in the United States.

They are of particular interest in the New Zealand context because infant mortality rates are high compared with other OECD countries. Rates of SUDI, while falling, are especially high, particularly for Māori infants. The results suggest that the expansion of the Family Start programme may have accounted for some of the narrowing in ethnic disparity in infant mortality that occurred over the period covered by the study.

Q What are the methods used in the study?

A The study uses two separate “quasi-experimental” methods.

One method involves estimating the effect of the programme on children and mothers who received Family Start by comparing their outcomes with those of a “matched control group” who had similar characteristics but lived in areas where Family Start was not available.

The other method involves estimating the change in outcomes for high needs groups of babies and mothers when Family Start is made available in their area. This second method is useful because it captures potential “spill-overs” where later children, other family members and neighbours might benefit from a programme without being the direct recipients of it.

Q What are “quasi-experimental” methods?

A Quasi-experimental studies are non-randomised studies. These are frequently used when it is not logistically feasible or not ethical to conduct a randomised, controlled trial—the “gold standard” of causal research design. Ethical considerations would include the withholding of an intervention that has known benefit.

Q What will happen in response to the study?

A The results of this study will inform the on-going development of Intensive Home-Visiting services in New Zealand.

Q The study uses some very sensitive data. Did it have ethics approval? How were the data kept safe?

A Ethics approval was granted by the Central Region Health and Disability Ethics Committee in June 2014.

Data were de-identified prior to analysis, and accessed by the research team through the secure Statistics New Zealand Data Lab and a secure server at MSD. Strict rules were in place to ensure the security of the data and to make sure that results could not identify individuals.
