

Parents as First Teachers Evaluation: Phase II Report

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Executive Summary

Parents as First Teachers (PAFT) is a low-intensity home visitation programme for parents with children pre-birth through to three years of age. In New Zealand, it is targeted to families facing particular challenges to their parenting. This report is the second of two reports from the evaluation.

This report provides:

- an assessment of the need for PAFT
- an assessment of PAFT's effectiveness for children and families
- insights from fieldwork on how PAFT could be enhanced.

The need for PAFT

Our analysis shows that there is a need for home-based intervention to support families who may otherwise have difficulties with parenting, such as young or un-partnered parents, and parents with low levels of education.

Quality of parenting is linked with a range of child outcomes. Parenting is a modifiable factor contributing to child outcomes. National data on parenting practice indicates parents in single-parent households and those who are less educated are less likely to look for parenting information and advice, or attend parenting classes, than other parents. Taking support to parents in their homes or to a place convenient to them, overcomes many of the barriers to accessing support. Home visitation also provides opportunities to monitor the child in their home environment and provides privacy for families to discuss their concerns.

Expectations for changing children's outcomes should be modest

Expectations for changing children's trajectories with parent education and support should be very modest, where structural determinants of child outcomes (poverty) and other stressors (family violence, drug and alcohol abuse and parental mental health) are not addressed. In addition, the literature on home visitation programmes and PAFT shows a mixed picture of effectiveness, with impacts being modest, and inconsistent across outcome domains from study to study.

PAFT's effectiveness

PAFT was associated with better child outcomes for some families. PAFT may be most effective where there is greater need and where families have the resources to engage with the programme.

Analysis of outcomes for PAFT children at age 4 sourced from national screening of child health and development (B4School Checks) suggests increased amounts of PAFT are associated with:

- higher participation in B4School checks overall
- less need for referral or further assessment for hearing and conduct issues overall.

Sub-group analysis of PAFT families suggests increased amounts of PAFT are associated with:

- better vision and conduct results for nuclear families with mothers who identify as Māori
- better conduct and developmental results for nuclear families with mothers identifying with 'other ethnicities' (that is, not European and not Māori)
- better hearing results for nuclear families with European mothers.

We did not find an association between amount of PAFT and results for single parents living alone or with extended families.

We have reasonable confidence in the hearing and vision screening results from B4School Checks. However, the behavioural and development screening tools are still 'bedding in' nationally. Given a year, we could be more confident of these results as indicators of programme effectiveness.

PAFT children were just as safe as children in the general population

Children associated with PAFT were more likely to be referred to Child Youth and Family than children in the general population. However they were no more likely to have a finding of maltreatment than children in the general population.

Families reported a range of benefits of participating in PAFT

Families reported that PAFT improved their knowledge, ability and confidence in parenting. This was true for all types of families, with little variation between sub-groups.

Conditions for successful implementation

PAFT's effectiveness could be enhanced through promoting stronger expectations of parenting change at personal visits and trialing alternatives to group meetings

From our analysis of the design and implementation of the programme, assessed through site visits with six providers, we recommend:

- ensuring educators are equipped to challenge concerning parenting practice when it occurs
- clarifying with families about how PAFT is intended to support child outcomes, including an expectation of family participation and change where parenting is sub-optimal
- trialing alternatives to group meetings that help families connect with each other *and* support their efforts in using positive parenting skills learnt on the programme.

Staff retention and quality are fundamental to strong child outcomes

A combination of educator quality and staff retention emerged as important organisational factors for maximising PAFT benefits. Retention is important for continuity of relationships with families. Relationships with families are core to delivering PAFT. Educator knowledge and skills (quality) are critical both for engaging families and ensuring families are receiving accurate information about their child's development and their parenting practices. Maintenance of high-quality educators and staff retention relies on strong organisational policies and practices that support staff and provide a working environment where high quality staff are encouraged to stay. PAFT providers identified funding as a concern in maintaining the quality of the programme.

PAFT addresses some of the risk factors associated with child maltreatment

Our analysis indicates PAFT would need to be more intensively and flexibly delivered, and perhaps augmented by a case-management approach for dealing with more serious family concerns, to better meet criteria associated with reducing child maltreatment.

The value of PAFT

We consider the current evidence strong enough to support continuing to fund PAFT until evidence to the contrary emerges. Taking the association between lower reported conduct concerns and increased PAFT as an example, we can not rule out the possibility that PAFT could be contributing to significant cost savings in the longer term.



Chapter One: Overview of the Evaluation

The Parents as First Teachers programme

PAFT began as a home-based early intervention programme for parents of children from pre-birth to three years.¹ PAFT is based on the US Parent as Teachers programme (PAT).² While PAT was developed as a universal and flexible programme, in New Zealand PAFT is targeted to families facing some challenges to their parenting. These include:

- low family income
- young age of mother
- family structure
- lack of family or community support
- lack of parenting information.

PAFT providers are contracted by the Ministry of Social Development (MSD) to offer a minimum of 25 personal visits over three years per family.³ This averages to about eight visits per year per family, putting PAFT at the low-intensity end of home visiting programmes. PAFT's goals have been amended over time to suit the institutional context of PAFT funding. The following long-term goals are taken from current PAFT contracts:

- to assist families/whānau to support their children to learn, grow and develop to realise their full potential
- to ensure children have improved readiness and school success
- to ensure children have fewer unaddressed vision/hearing health issues
- to break the cycle of abuse and neglect so that the next generation will be free from violence
- to encourage parents to be more involved in early childhood education, school and community.

Ahuru Mōwai Born to Learn is the name of the curriculum used in PAFT (and Family Start, a high-intensity home visiting programme). The MSD team managing the contracts for PAFT is known as the Ahuru Mōwai team.

¹ PAFT is not necessarily delivered in people's homes. It is delivered at a mutually agreed-upon place by the parent-educator and the family.

² We note that PAT USA have substantially redeveloped their curriculum in the last few years. Affiliates are required to comply with the new approach by 2014. A comparison of the new and old approaches of PAT USA can be found at Appendix 5.

³ When PAFT was originally introduced as part of National's Toward 2000 education strategy, any parent who wanted PAFT could get it subject to it being offered in their area and there being capacity. It moved to explicit targeting in 2000.

The evaluation

In March 2009 CSRE undertook a rapid review of the PAFT programme. We noted that New Zealand evidence for the effectiveness of PAFT was dated and recommended a robust process and outcomes evaluation to fill this information gap. The review also noted the evidence for home visitation programmes internationally was mixed, often reporting modest results, across a range of areas, with little consistency between studies.

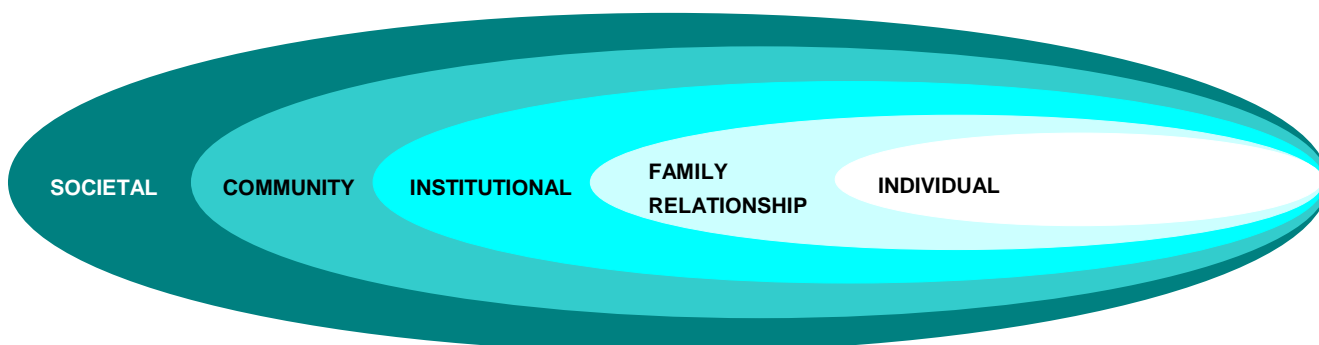
The evaluation has been conducted in two phases. In Phase One we examined the need for PAFT, programme quality and the mechanisms that lead to positive change. In Phase Two, reported here, we focused on PAFT's effectiveness.

We started the evaluation with two assumptions informed by our understanding of the parenting and early intervention.

- Outcomes for families are shaped by multiple influences.
- Home visitation programmes like PAFT does some good for some people some of the time.

How a programme or intervention makes a difference in the lives of a family depends on the type of family, the nature of the intervention and the wider social context. The home visitation literature to date suggests precisely this level of complexity in terms of explaining home visitation outcomes (Astuto & Allen, 2009). Presented simply, and borrowing from an ecological model,⁴ the levels of influence on families and children looks like this:

Figure 1. The socio-ecological model



The child is the individual at the centre of this model. Wider influences are mediated by the child's relationship with their families. PAFT is one part of the institutional context working with families. As an intervention, PAFT is primarily focused on enhancing the relationship between child and family by sharing knowledge and skills about parenting and child development. The referral and group meetings mechanisms in PAFT also link families to wider resources and social networks at the community level.

We suggest PAFT's sphere of influence is at the individual, family and community levels. The evaluation has been geared toward finding the conditions at these levels where PAFT has maximum benefit and where PAFT does not work so well. We also attempt to take multi-causality into account,

⁴ This is a visual presentation of the ecological model used in child maltreatment discussions here and abroad (eg Fanslow, 2005, and WHO, 2006).

recognising that the same outcome can be reached by different paths. In other words, there may not be ‘one way’ that PAFT works but several, depending on the family, the community and the way the programme is delivered.

Questions guiding the evaluation as a whole are:

- What is the need for the current PAFT programme?
- How effective is PAFT in:
 - achieving programme quality?
 - making a difference to the lives of parents and children?
- Does the current curriculum contribute to reducing child maltreatment?
- Is PAFT worth the money we spend on it?

This report

This report focuses on parent and child outcomes of PAFT while revisiting some of the analysis from Phase One to answer the evaluation questions.

We look at the need for PAFT in Chapter two. We report on PAFT’s effectiveness for children and families in Chapter three. Chapter four is devoted to explaining the effectiveness findings through the use of fieldwork. We include an assessment of how PAFT stacks up against criteria associated with reducing child maltreatment from the literature. Chapter five contains our conclusions about the value of PAFT.

Table 1 gives an overview of the outcomes assessed and the data sources used to evaluate the outcomes. These are discussed in further detail in the methods and measures section at the end of the report.

Table 1. Data sources for the evaluation		
How well is PAFT delivered?	Where is PAFT making a difference?	
	Parent outcomes	Child outcomes
MSD administrative database	Parents survey using UISPP ⁵	B4School Checks
Provider six-monthly reports	Provider outcome stories from biannual reports	
Case studies in six sites	Case studies in six sites	
Organisational survey		

⁵ UISPP – University of Idaho Survey of Parenting Practice is a psychometric tool for measuring self-assessed growth in parenting practice.



Chapter Two: The Need for PAFT

Summary

Our analysis shows there is a need for home-based intervention to support families who may otherwise have difficulties with parenting, such as families headed by young, or un-partnered parents and families with low levels of education.

Quality of parenting is linked with a range of child outcomes. Parenting is a modifiable factor contributing to child outcomes. National data on parenting practice indicates parents in single-parent households and those who are less educated are less likely than other parents to look for parenting information and advice or attend parenting classes. Taking support to families in their homes or to a place convenient to them overcomes many of the barriers to accessing support. Home visitation also provides opportunities to monitor the child in the home environment and provides privacy for families to discuss their concerns.

When attempting to change children's trajectories with home visitation focused on parent education and support and where structural determinants of child outcomes (poverty) and other stressors (family violence, drug and alcohol abuse and parental mental health) are not addressed, expectations should be conservative. Indeed, the literature on home visitation programmes and PAFT shows a mixed picture of effectiveness, with impacts being small, and inconsistent across outcome domains from study to study.

Everyone needs parenting support. However children in families facing adverse circumstances have poorer outcomes.

In the Phase One Report for this evaluation we noted that

'Experts in the field of child and family support suggest all parents need a range of information and skills to ensure the best outcomes for their children. However, parents living in poverty, experiencing mental health problems or parenting alone may require particular support (Centre for the Developing Child, 2007, Mackay, 2004, WHO, 2006). Children of families living in these circumstances are more likely to experience poorer cognitive, social or psychological outcomes than children living in more advantageous conditions.' (MSD, 2010 p.4):

Other family factors related to child maltreatment include the presence of intimate partner violence and drug or alcohol addiction (Bath, 2009).

One of the things that might not be working well in families facing adverse circumstances is parenting. Offering parenting support could lead to better child outcomes.

Reviews of the association between parenting quality and child outcomes link parenting to a range of child outcomes. Connor and Scott (2007) found evidence linking parenting quality with children's externalising behaviour (conduct disorder), internalising behaviour (depression), cognitive/educational outcomes, social competence and peer relationships and biological/physical outcomes (accidents, obesity, risk-taking behaviour). They note, however, that the extent to which this relationship is causal is open to question. The apparent impact of the quality of parenting on child outcomes might be mediated by genetic factors shared between parents and children, or broader social factors (for example, poverty, neighbourhoods, and parent relationships). They also note evidence suggesting that children's characteristics shape parents responses to them.

It is probable that the quality of the parent—child relationship influences child development (especially in the early years), though it may be mediated by other factors. Evidence of the impact of parent education programmes on such specific childhood difficulties, as conduct disorder, (MSD, 2007) suggest the quality of the parent—child relationship is modifiable.

Families in adverse conditions are less likely to access available parenting supports. Personal visits mitigate some access issues for parents and have some other benefits.

The Phase One report of this evaluation found 'national data on parenting practice indicates parents in single-parent households and those who are less educated are less likely to look for parenting information and advice or attend parenting classes than other parents.'

Home visitation mitigates some of the barriers to accessing parenting advice and support cited in the literature (see Moran, Ghate and van der Merwe, 2004) by taking the information to parent's homes. Home visitation provides an opportunity to reach families who are socially or geographically isolated, tailor services to families, and reach families with very young children (Gomby, 2005). In addition, home visitation services are indicated in areas where there is no other parent support, or where the quality of early childhood services may be low. Interviews with PAFT staff for the case studies supported these themes and identified the following additional benefits for home visits.

- Home visits support the development of a strong relationship between families and educator. This is a key mechanism enabling educators to influence families.
- Home visits allow monitoring of the home environment from a health and safety point of view, including the functioning of the wider family.
- Home visits allow monitoring of child development in all aspects in an environment where the child is comfortable.
- Home visits allow educators to work in with the needs of the family. This includes moving with families if they are itinerant.
- Home visits allow privacy for the family to discuss any issues that might arise and impact their children.

The Parenting Survey conducted for the evaluation, as well as our analysis of regular parent surveys conducted by providers, indicates families appreciate home visits.

Stories collected for case studies supported the idea that some families would not access parenting information if it was not taken to them. These are families who are lacking in confidence, are socially or geographically isolated or suffer from mental health problems like post-natal depression.

Unfortunately we do not know the prevalence of these issues among PAFT parents because this information is not collected at the individual family level. Providers do provide information about the proportion of parents living without family or community support, which is a proxy for isolation. In December 2010, 40% of families enrolled in PAFT had been enrolled under the 'parents lacking family/community support' criteria.

In summary, home visitation mitigates access barriers, is appreciated by parents and allows monitoring of children in their own environments.

PAFT is successful in reaching families at risk of poor child outcomes.

PAFT is a targeted programme.

In Phase One we compared the characteristics of PAFT families with census data for New Zealanders in 2006. The analysis showed PAFT was successful in targeting and enrolling families facing some adverse parenting conditions (low income, single-parent households and young mothers). Families receiving PAFT also had a larger proportion of mothers including Māori among their ethnicities than all New Zealand mothers (31% compared with 23%).

Many PAFT families faced more than one challenging circumstance, meeting more than one of the targeting criteria for which we have information.

- Single-parent households were almost all in the lowest income brackets and had a higher-than-average proportion of mothers in the under-20 age bracket.
- Single parents living with extended family were also almost all in the lowest income brackets. Mothers were more likely to be in the youngest age bracket (below 20) compared with any other household type.
- Parents with partners living with extended family tended to be at the lower end of the income spectrum and had a higher-than-average proportion of mothers in the under-20 age bracket.

In five of the six sites we visited for fieldwork we found providers had processes for screening families into PAFT. Processes included the targeting criteria, but also took other factors into account. Factors that were particularly emphasised were the nature of the available support for the family (both interpersonal and service support), how much parents knew about parenting (with first-time parents being a proxy for this) and in some cases the mental health and wellbeing of the primary caregiver (usually the mother). If families were lacking in these areas they were more likely to be screened into the programme.

However providers also recognised that PAFT families needed to be motivated to learn and without other overriding issues. While they may have challenges, families for whom PAFT 'worked best' tended to have their basic needs met.

PAFT engages families quite well compared to findings in the available international literature. However, more vulnerable families are less likely to stay engaged with PAFT.

In the Phase One report, we looked at family engagement in three ways: whether the family stayed until the end of the programme (completions), their duration on the programme and the number of home visits received by families (dosage).

- Over three-quarters of parents were still enrolled in PAFT after a year, dropping to just over half after two years (duration).

- Forty-one percent of families enrolled in 2006 completed the programme (completion).
- The average number of home visits received by families at the time they left the programme was 15 (2006 cohort) – compared with the suggested minimum of 25 visits over three years (dosage).

We found families on higher incomes (compared with other PAFT families), nuclear families and families with older mothers stayed enrolled in PAFT longer, were more likely to complete the programme and left having received more personal visits.⁶ Programme attrition for the most vulnerable families was consistent with the experience of other home visitation programmes (Watson and Tully, 2008). Families headed by mothers who identified as Māori or Pacific peoples were also less likely to complete the programme.

Further analysis of families who exited early or completed the programme, showed that mother's age, ethnicity, income and provider explained differences in family engagement. Household structure was not a determinant of engagement once these family characteristics and provider were controlled for.

Home visitation can be a good way to support families, with some caveats.

Published reviews and meta-analyses in the home visitation field (see Astuto and Allen, 2009; Gomby, 2005) suggest home visitation services have the potential to enhance parent and child outcomes. The literature suggests home visitation is best when delivered alongside other services, for example, centre-based early childhood education of high quality (Gomby, 2005), and where families perceive a need for the service. However, where benefits are found, they are generally small, inconsistent, stronger for parents than children, stronger where the need is greatest and best when delivered alongside other services (eg ECE). Nevertheless, reviewers agree that home visitation should form part of an overall strategy for parent and child support when a programme is of high quality and has procedures in place to constantly self-monitor and strive for programme improvement (Gomby, 2005; Astuto and Allen, 2009; Daro, 2006).

There are mixed opinions in the literature about whether intervening to support parenting is effective in changing parenting or child outcomes without a change in adverse family circumstances (such as poverty, violence, alcohol and drug abuse) (Fergusson et al 2005, Bath, 2009; Moran et al, 2004; cf Shonkoff, 2010). Some studies find changes in child outcomes without a change in family circumstances (Fergusson et al, 2005). While others argue that intervention with the child 'is not sufficient to prevent developmental lags if the children are burdened by anxieties or fears as a result of disruptive life circumstances that are not being addressed directly' (Shonkoff, 2010:364).

PAFT delivers parent education in the context of a supportive ongoing relationship in the home but does not directly address families' living conditions except through referral. PAFT staff are primarily 'educators' not 'social workers'.

International and national evidence for PAFT's effectiveness has shown some modest effects for some children.

PAFT International evidence

PAFT is based on the US Parents as Teachers Programme (PAT). In line with international evidence on home visitation services in general, the PAT literature suggests PAT has the potential to influence

⁶ 82% of PAFT families had incomes below \$50,000. This compares to a household median income in 2006/2007 of \$55,976 (HES, Statistics New Zealand). PAFT families as a group have lower incomes than the general population.

parent and child outcomes. However effect sizes are small, and findings are inconsistent across outcome areas, sites and target populations.

We assessed 14 studies of PAT. While most studies found some positive effects for child outcomes, these are typically for *one measure of several measures* taken in a domain. Findings for actual reports of child abuse are limited.

Studies involving teenage mothers suggest PAT works best in the context of case-management. Follow-up comparisons at school age suggest PAT works best when complemented by later centre-based early childhood education. There is evidence that PAT benefits low-income families and families from ethnic minorities.

Below is a summary of our review. Further details are available in the appendix to this report. 'Mixed evidence' signals an even balance of positive findings and no findings for the particular outcome in the literature. 'Some evidence' signals the balance of findings in the literature are more positive than negative. 'Limited evidence' signals effects were found only for a particular group or supported by less robust evaluation methods.

For parents, we found:

- mixed evidence on improved parental knowledge of child development
- some evidence that PAT parents were more engaged in literacy promotion
- some evidence that PAT parents were 'happier in their parenting roles'.

For children we found:

- mixed evidence of early detection of developmental delays and health issues
- some evidence that PAT influences rates of potential and actual child abuse and neglect
- some evidence that PAT influences children's dispositions for learning, participation in high-quality early childhood education and positive transitions to school
- some evidence that PAT positively influences children's social development or social competence
- limited evidence that PAT influences children's self-help skills

Caution

The majority of studies of PAT reviewed here pre-date significant revisions to the PAT curriculum in the US (2000) and pre-date implementation of PAT quality standards and performance indicators (2004). More studies report on measures of children's cognitive and social development than parent outcomes.

The authors of evaluation studies suggest the absence of large or significant effects in their studies may arise from factors such as:

- wash-out effects (where families don't use the services but are still counted in the evaluation as though they are receiving services)
- ceiling effects (where both groups score highly on scales leaving little room for improvement)
- failure to deliver the programme as intended (especially at the recommended intensity).

PAFT in New Zealand

The most robust New Zealand evaluation evidence is dated and of limited use in assessing the effectiveness of PAFT today. Multi-centre randomised controlled trials of PAT using the unmodified American curriculum in New Zealand in the mid-1990s showed either no benefits in Dunedin and Gisborne (Campbell and Silvan, 1997) or only small benefits in South Auckland and Whangarei (Boyd, 1997a, 1997b). It should be noted that these evaluations were carried out at the pilot stage; it is generally accepted that outcomes evaluations should be undertaken once implementation issues have been dealt with.

A later study using mixed methods⁷ (Farquhar, 2003) and using the Ahuru Mōwai Born to Learn version of the PAFT curriculum reported benefits in multiple areas of child functioning as identified by PAFT parent educators, co-ordinators, participating families and community workers with contact with PAFT. These benefits were:

- greater interest in child's learning
- improvement in child safety and standard of care
- enhanced child health
- strengthened parenting knowledge and practices
- utilisation of support services
- changes to parent behaviours and lifestyles and parental engagement in further learning.

This study provides impact information based on the perceptions of people involved with the PAFT programme or PAFT families. It does not provide information about whether PAFT made a difference over and above other interventions. However, it is interesting to note that for some families, the PAFT educator was the only professional that families chose to work with – so for those families it is unlikely that other services could make an impact.

Conclusion

We conclude there is a need for support for families living in more challenging circumstances. Taking support to parents overcomes some of the barriers to accessing child development and parenting information. Home visitation also has some benefits over group-based parent education. PAFT successfully reaches families living in more challenging circumstances, but like other programmes has mixed results in retaining families.

We think that a home visitation programme like PAFT, focused primarily on delivering parent education, can only be *part* of the solution for improving child outcomes. Expectations for the effectiveness of home visitation programmes need to be modest as demonstrated in the patchy results in the literature. This may especially be the case when change focused at the individual/familial level leaves larger structural determinants of child outcomes (such as poverty) untouched.

⁷ Qualitative data was drawn from two sites. This data was supported by analysis of Family Exit surveys.

Chapter Three: PAFT Results

How effective is PAFT in meeting its own goals and meeting the needs of parents? Is there variation in performance of PAFT across communities?

In this chapter we first examine child outcomes. We then work backwards through PAFT's programme logic examining evidence for each link in the logic chain. This examination is completed in chapter four following.

Summary

Analysis of outcomes for PAFT children at age four, sourced from national screening of child health and development (B4School Checks), suggest increased amounts of PAFT are associated with:

- higher participation in B4School checks overall
- less need for referral or further assessment for hearing and conduct issues overall.

Analysis of sub-groups of PAFT families with similar characteristics suggests increased amounts of PAFT are associated with:

- better vision and conduct results for nuclear families with mothers who identify as Māori
- better conduct and developmental results for nuclear families with mothers identifying with 'other ethnicities' (that is, not European and not Māori)
- better hearing results for nuclear families with European mothers.

PAFT is a targeted programme, but it is not supposed to be for the most vulnerable families. Five out of the six positive associations between amount of PAFT and results of the checks were for clusters containing nuclear families (cluster four, five and six) who tended to be relatively better off. It could be that single parents alone or in their extended families who are often younger and poorer compared with other PAFT families are not in a position to learn or implement parent education. Other circumstances in their lives overwhelm potential benefits of parent education. It could also be the case that 'education' is not the intervention needed for this group.

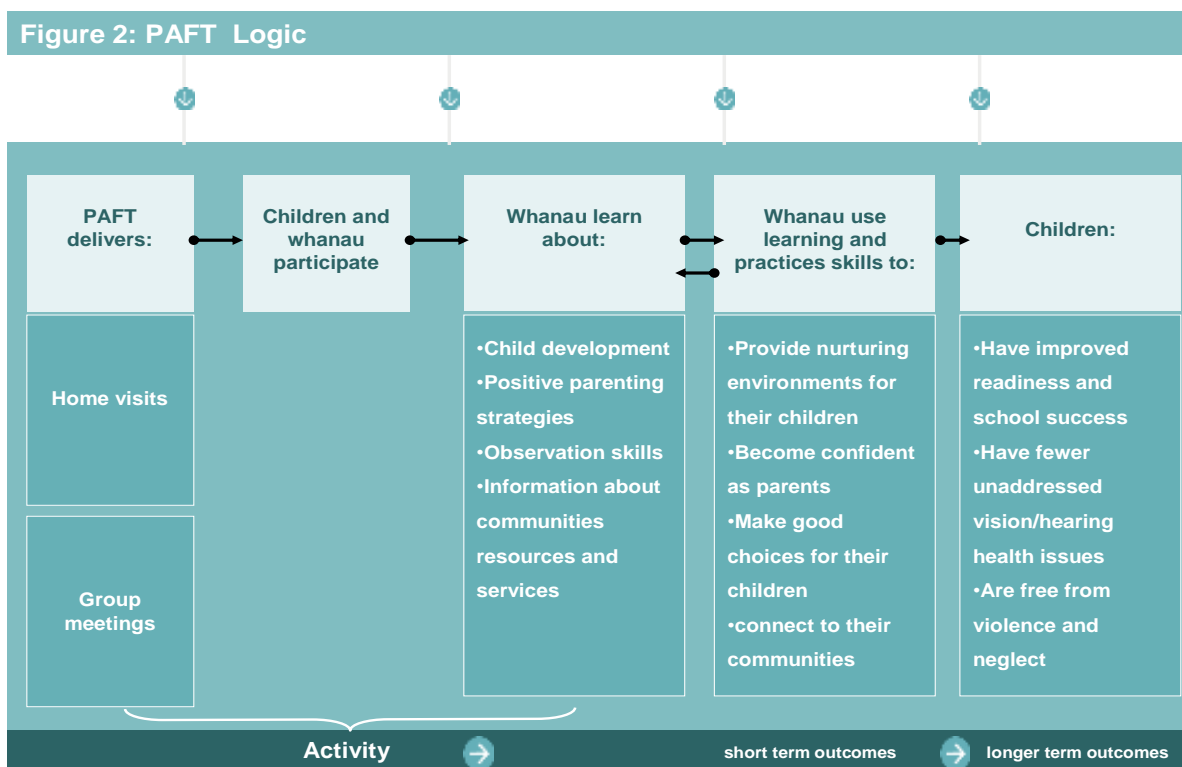
Children associated with PAFT were more likely to be referred to Child Youth and Family (CYF) than children in the general population. However they were just as likely to have a finding of maltreatment as children in the general population. PAFT children were just as safe as children in the general population.

Families reported PAFT helped them with their parenting in a range of ways clearly connected to the aims of the programme. The parenting survey and interview data suggest PAFT improved families' knowledge, ability and confidence in parenting, with little variation between sub-groups of the parenting sample. Families in every sub-group reported PAFT helped them develop in these areas of parenting.

A fuller account of these results including comparison with national averages is available in appendix 3 of this report.

PAFT outcomes

PAFT has evolved over the years. However, its intentions, mechanisms and long-term goals have remained relatively stable. We have constructed a basic programme logic of PAFT from Te Whanau Harakeke Model for PAFT and the long-term goals and outcomes for PAFT written into the contracts with providers (Figure 2). We work backward through this programme logic assessing evidence of PAFT's effectiveness against each step.



Outcomes for children

Measures and methods

We examined children's health and development outcomes using the B4School Check (B4SC) data held by the Ministry of Health. B4SC are the last WellChild/Tamariki Ora visit for children at age four before they start school (<http://www.moh.govt.nz/moh.nsf/indexmh/b4-school-check-handbook-mar2010>).

B4SC is a relatively new screening regime for children in New Zealand and is still consolidating nationally. Our discussion highlights points of caution for interpreting findings. We were helped in this assessment by Dr Pat Touhy and Sue Dashfield at the Ministry of Health.

Our indicators from each measure as well as an assessment of our confidence in the measure are outlined in Table 2 below.

Table 2: Measures and outcomes for PAFT evaluation from B4SC

Assessment domain	Tool	Indicator for evaluation	Confidence and comment
Hearing	Sweep audiometry followed by tympanometry	Number of children completing a check out of all PAFT children in the 2006 birth cohort. Number of children referred out of total children assessed.	High
Vision	Distance visual acuity Snellen and/or Parr letter-matching tests	Number of children completing a check out of all PAFT children in the 2006 birth cohort. Number of children referred out of total children assessed.	High
Developmental screen	Parental Evaluation of Developmental Status (PEDS)	Number of children completing a check out of all PAFT children in the 2006 birth cohort. Number of children with two or more 'significant predictive concerns' ⁸ out of total children assessed (ie channeled through pathway A).	Medium Developmental assessments are still 'bedding in' in New Zealand.
Behavioural screen	Strengths and Difficulties questionnaire (SDQ) Teacher and parent forms Relies on parent observation and reporting on their children's behaviour across a number of items in the last 6 months	Number of children completing a check out of all PAFT children in the 2006 birth cohort. Number of children with Total Difficulties score in the 'abnormal range' out of total children* Number of children scoring in the 'abnormal range' on the Conduct sub-scale out of total children assessed. * Total Difficulties scores adds together the results for the Conduct, Hyperactivity, Peer Problems and Emotional Scales of the Strengths and Difficulties Questionnaire.	Medium Low rates of return for the teacher questionnaire means we have not included it in our analysis. National trends suggest teachers are less likely to report behaviour concerns than parents (parent mean 6.9, teacher mean 3.9 on 'total difficulties'.) Behavioural assessments are still 'bedding in' in New Zealand.
Immunisation		Number of children completing a check for whom there is immunisation status out of all PAFT children in the 2006 birth cohort. Number of children fully immunised at the time of the check according to the National Immunisation Register (NIR) out of total children assessed.	Low. We found low agreement between parent reports and NIR. There is variability in providers to access NIR.

We looked at whether children with higher numbers of PAFT home visits had different outcomes to children who had lower numbers of home visits. We looked at the association between the number of home visits and whether children had a check (participation) and if the check showed a negative outcome or not⁹ (results).

We also grouped PAFT families sharing similar characteristics together.¹⁰ Characteristics included income of the family, family structure, mother's ethnicity and mother's age at the birth of her child. This analysis produced six sub-groups of families (see Table 3 below). By doing this we were able to look

⁸ Parental Evaluation of Developmental Status: Parent Response Form. Significant predictors of difficulties for children between 48 months and 53 months on the PEDS are in the areas of: 'global/cognitive', 'expressive language and articulation', 'receptive language', 'gross motor' and 'other' areas of development.

⁹ We used logistic regression to estimate whether the amount of PAFT received was associated with child outcomes.

¹⁰ We used SPSS two-step cluster function to cluster families. Some cases were excluded because of missing information – 90.5% of the 2006 birth cohort were clustered (2,722 families clustered out of 3,000).

at whether the association with PAFT differed for different groups of families. We refer to family sub-groups as ‘clusters’.

We have labelled clusters according to the family structure and ethnicity of the mother where this is salient. Names are given below after the cluster number. The size of the cluster follows the cluster name.

TABLE 3. Sub-groups of PAFT families used in the analysis								
Cluster number	Cluster name	Size of cluster (% of 2006 cohort)	Predominant Family structure	Ethnicity of mother	Income of household	Average age of mother (years)	Average No. home visits at exit	Completion rate
1	Single-parents	13%	Single-parents	European or Māori	lowest	24.1	13	32%
2	Single-parents with extended family	9%	Single-parents with extended family	All ethnicities	lowest	22.3	14	31%
3	Couples with extended family	9%	Couples with extended family	All ethnicities	low	24.5	13	27%
4	Nuclear European	40%	Nuclear	European	highest	27.9	19	52%
5	Nuclear ‘other ethnicity’	13%	Nuclear	All ethnicities except European & Māori	medium	28.2	14	36%
6	Nuclear Māori	17%	Nuclear	Māori	medium	26.3	14	31%

Provider variation

We also looked at whether there were differences in outcomes between PAFT providers. We know for example, that some providers are better at engaging and retaining their families than others. And we also know that there is variation among providers on our indicators of provider performance from the first phase report.

Findings for children

On average the amount of PAFT received was positively associated with participation in all checks and results for hearing and conduct results

Among children born in 2006 whose families were enrolled into PAFT:

- children in families with more PAFT visits were more likely to participate in all of the B4SC assessments
- children in families with more PAFT visits were just as likely to be referred for further assessment or treatment for their vision or development

- children with more PAFT were less likely to be in the abnormal range on the conduct sub-scale on the SDPQ (part of the behavioural assessment). Overall behaviour scores on the SDPQ ('total difficulties') were not associated with amount of PAFT.
- children with more PAFT visits were less likely to be referred for hearing difficulties.

We found provider variation in whether a check was done but not in the results of the checks once family characteristics were controlled for.

When we kept family characteristics constant, families of some providers looked like they were more likely to have a B4SC done than families from other providers.

When we kept family characteristics constant, we did not see a difference in the likelihood of children served by different providers being referred for further assessment or treatment following the B4SC.

The association with amount of PAFT received and B4SC participation and results varied for families living in different circumstances

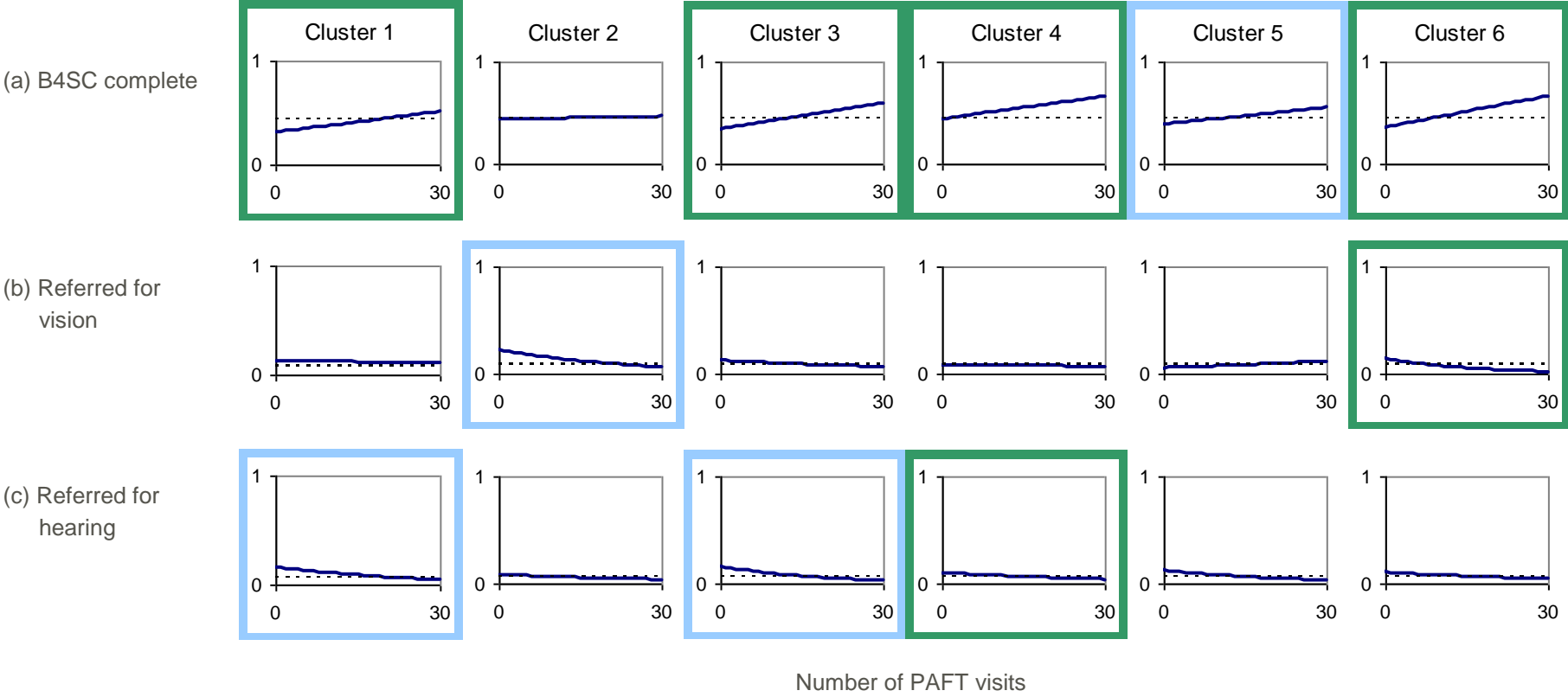
Figure 3 shows the association between having a check done and more PAFT holds to some extent for families across all clusters except cluster two. We found no association between amount of PAFT and participation in B4SC for children living with single-parents in their extended family.

Analysis of sub-groups of PAFT families with similar characteristics suggests increased amounts of PAFT are associated with:

- better vision and conduct results for nuclear families with mothers who identify as Māori
- better conduct and developmental results for nuclear families with mothers identifying with 'other ethnicities' (that is, not European and not Māori)
- better hearing results for nuclear families with European mothers.

Figure 3 on the following page summarises the findings for the association between PAFT and family clusters. A dark outline indicates a positive and statistically significant association between amount of PAFT and the result. A light outline indicates some evidence of association (though not statistically significant). The dotted line represents the national average for the 2006 birth cohort at the time we extracted the data (March 2011). The curved lines summarise the difference in B4SC outcomes for families who received different amounts of PAFT. Number of home visits are on the horizontal axis (0—30) and the likelihood of a result (between 0 and 1) is on the vertical axis.

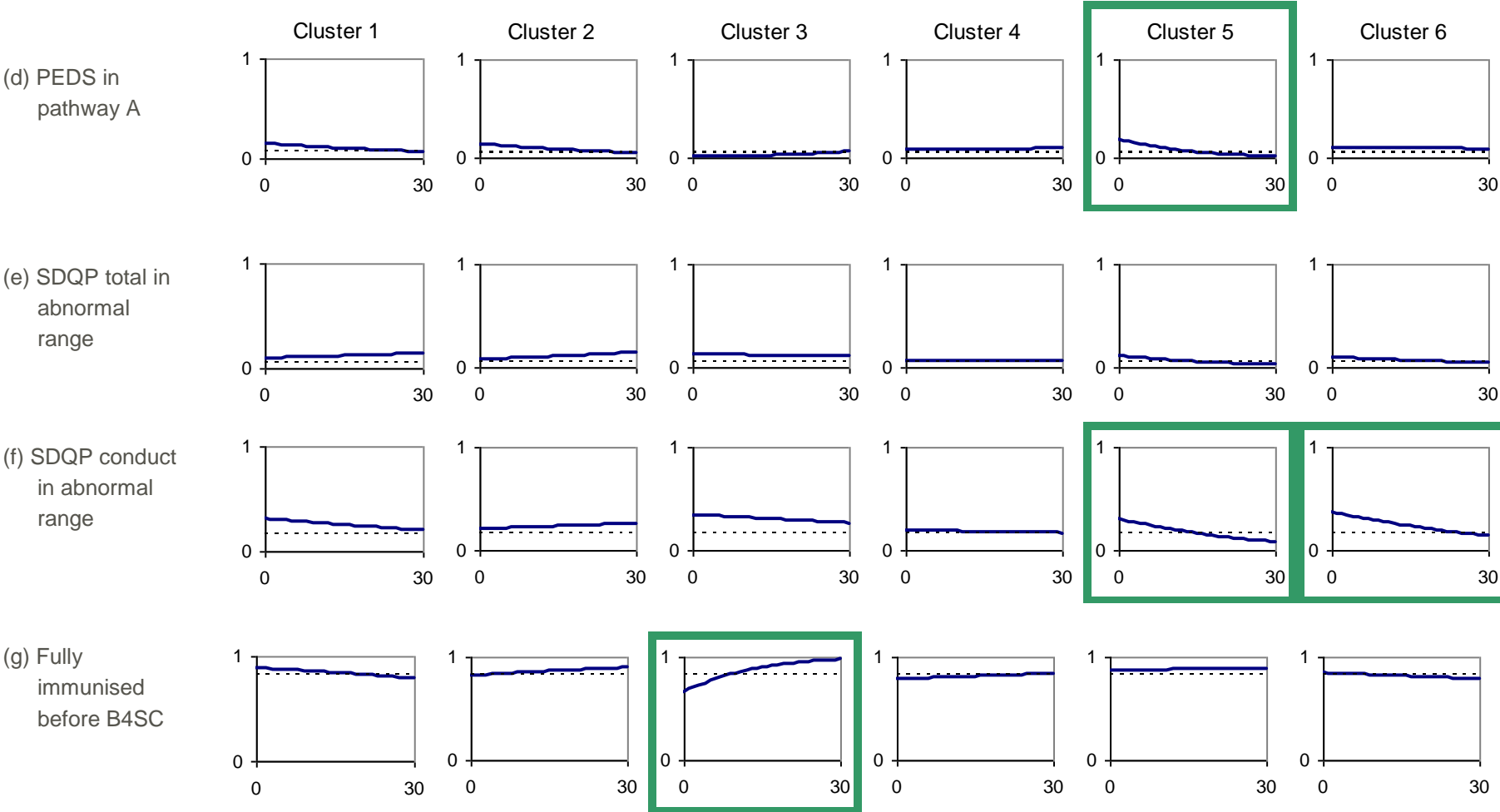
Figure 3. Association between number of home visits and B4School Check results by cluster



Key:

- positive and statically significant association between PAFT and result
- some evidence of association between PAFT and result but not statistically significant

Figure 3 (cont). Association between number of home visits and B4School Check results by cluster



How PAFT could be making a difference (or not)

This analysis suggests PAFT is associated with better results for some families in some domains. The mixed picture of results could be expected given the inconsistent results of home visitation programmes in the literature (see section one for a review).

The most reliable B4SC indicators are *vision and hearing*. Screening and referral for these outcomes follow well-established protocols in District Health Boards.

Problems with *vision* are not usually linked to structural determinants such as socio-economic status. Vision (for the most part) is biologically driven rather than being affected by environmental circumstances. Lower rates of referral for sight difficulties may reflect PAFT brokering access to vision specialists early on for children who need it. This could be the case for children living in nuclear families with Māori mothers and perhaps for children of single-parents living with their extended families.

Hearing problems are in part environmentally determined. The most direct solution offered by PAFT is early detection and referral. PAFT does not deal directly with changing the material living circumstances of family that are associated with illness leading to ear infections, for example. PAFT averages for hearing results were closer to national averages indicating less need for intervention across most of our clusters (one percentage point difference for cluster three, five and six).

PAFT was associated with a lower rate of hearing referrals for nuclear families. We have some evidence of association for better hearing results for single-parent families and couples with extended families— where the greatest disparity with national averages fell.

Taking the results of the hearing and vision results together suggests a pattern where the association with amount of PAFT is strongest where the need was greatest (barring nuclear European families). We have some evidence that PAFT may be working well at monitoring and referring children for sight and hearing difficulties where there is a need, though the association is not so strong where families are in greater hardship.

Our discussion with child health experts at the Ministry of Health suggests that a family support intervention like PAFT would be expected to make some difference to children's developmental and behaviour results.

As we have noted above, we have less confidence in developmental and behavioural screens as indicators for PAFT outcomes because of potential variability in the way these checks have been implemented across the country. Given more time, results of these screens will become more reliable for evaluation purposes.

Monitoring *child development* and teaching families to observe and encourage their children's skills is a critical part of the PAFT programme. Our parent survey shows that child development knowledge is the biggest growth area for parents on the programme. Families we talked to during the case studies felt reassured by having an expert monitoring their children. However, amount of PAFT was not associated with better results from the development screen for any families except for nuclear families with mothers of 'other ethnicity' (that is, not Māori and not European). Given the strong emphasis on child development in PAFT, this is concerning.

Results of the *behaviour screen* are more promising, with two clusters of families reporting lower levels of conduct concerns with more PAFT – nuclear families with mothers of 'other ethnicity' or Māori

ethnicity. We note, however, reports of conduct problems were higher among all clusters in the PAFT cohort than the national average – signaling room for improvement for all families.

Taking the results of the development and conduct together suggests PAFT is associated with better results for some families where the need is greater. But this is not the case for families in greater hardship (single parents and couples with extended families) where PAFT is not associated with better conduct or development results.

How could we explain a lack of strong evidence associating PAFT with outcomes for children living with single parents on their own or with extended families (clusters one and two)?

Families of single parents living alone or with extended families had the lowest incomes of all the clusters and the youngest mothers. That is, they were parenting in more challenging situations (as far as we could tell with the data available). PAFT may not be enough to overcome the challenges facing single-parent families living in poverty, or with young mothers or both. This may especially be the case for single parents living with their extended families, as PAFT was not associated with participation in B4SC for this group.

Support for the hypothesis that other stressors such as poverty might negative PAFTs influence comes from two sources: our case studies and the literature. Five of six providers we visited told us that PAFT worked best for families who had their basic needs met and were in a position to learn from the programme. Perhaps then, these families are not living in conditions that encourage learning or changes in parenting practice.¹¹

The literature provides reasonably strong evidence that poverty is a driver of child outcomes (Duncan, Ziolel-Guest and Kalief, 2010). A recent internal review looking at the mechanisms linking poverty to child outcomes in the context of welfare receipt suggested the ‘economic resources model’ as playing the largest role (Mackay, 2010, unpublished). This model suggests ‘welfare families have fewer economic resources and are more likely to be materially disadvantaged than families that are financially self-sufficient. Poor families not only have less money to invest in their children’s schooling and to purchase other goods and services that promote healthy development, but are often preoccupied with managing economic crises and consequently have less time and energy to devote to their children.’ PAFT families living in impoverished conditions may simply lack the resources to make a difference to child outcomes.

‘Negative social support’ may also be a factor in some families. Educator interviews as well as those with families in our case studies suggest that PAFT helped parents by supporting their decisions, sometimes in the face of ‘negative social support’. That is, parenting in situations where parent’s support networks discouraged them from parenting in the way they thought best. It could be the case that delivering PAFT to young single parents or couples without changing the context of potential ‘negative social support’ (for example, by also working with extended families) negates its usefulness. The lack of findings for single parents in extended families could also be explained by young mothers not being ready to step into the parenting role. Educators also gave examples where this was the case in discussing challenges in engaging families.

¹¹ The sixth provider had a strong policy of holding on to their families especially young mothers who did not have established living arrangements (moved around) as they felt they could still get some benefit from PAFT. We note also a tendency for providers to try and help families to the extent that they could in areas where no other help was available – at least as an interim measure. This drive to help extended to families who PAFT might not be the best solution for but for whom there were no alternatives.

To sum up health and development: PAFT is a targeted programme, but it is not supposed to be for the most vulnerable families. Five out of the six positive associations between amount of PAFT and results of the checks were for clusters containing nuclear families (cluster four, five and six) who tended to be relatively better off. It could be that single-parents alone or in their extended families who are often younger and poorer compared with other PAFT families are not in a position to learn or implement parent education. Other circumstances in their lives overwhelm potential benefits of parent education. It could also be the case that ‘education’ is not the intervention needed for this group.

Child safety

To examine the contribution PAFT might make to reducing child maltreatment we compared rates of notification and substantiation of a random sample of PAFT children born in 2006 (n=100) to the general population born in 2006. PAFT children differ from the general population because they join PAFT on the basis of some risk factors associated with poor child outcomes being present. PAFT children are a more vulnerable group than the general population.

TABLE 4 PAFT and general population rates of notification and abuse for 2006 Birth cohort		
	General population	PAFT sample
Rate of notifications per 100 families	20.2	32 (±9)
Rate of findings per 100 families	6.6	6 (±4.6)

PAFT children are more likely to be notified to CYF than children in the general population¹².

Table 4 shows that at age four, 32 of the 100 PAFT children in the sample had been notified to CYFs. The confidence interval indicates the actual rate of notification for PAFT children in the 2006 birth cohort would fall between 23 and 41 children per 100.

The general population rate was 20.2 notifications per 100 children born in 2006, so PAFT children were more likely to be notified to CYF than children in the general population.

PAFT children are no more likely to have substantiated findings of abuse than children in the general population.

At age four, six of the 100 PAFT children in our sample had a substantiated finding. The confidence interval indicates the actual rate of substantiation for PAFT children would fall between 1 and 11 substantiations per 100 children.

The general population rate of substantiations was 6.6 children per 100 children born in 2006, thus PAFT children were no more likely to have substantiated findings of abuse than children in the general population.

Of the PAFT families notified to CYF in our sample, we did not find any cases where PAFT or PAFT host organisations notified families. We know from our fieldwork that educators do not make the decision to notify a family on their own. Concerns are discussed with the PAFT co-ordinator and a manager of the host agency (often not involved directly in PAFT). PAFT educators may also talk to

¹² Notifications can be seen as a indication of community sensitivity or responsiveness to child abuse.

other agencies involved with families to check family safety. The decision on who notifies is negotiated in different ways and with different parties.

We also note that in the five of the six substantiated cases, family violence was present. Intervening in family violence is beyond the scope of PAFT to influence, except by referral.

To sum up child safety: Children associated with PAFT are more likely to be referred to CYF than children in the general population. However they are no more likely to have substantiated findings of abuse as children in the general population.

Outcomes for parents

Results so far indicate PAFT is associated with some results for some children. In this section we look at results for families.

Summary

Families reported PAFT helped them with their parenting in a range of ways clearly connected to the aims of the programme. The parenting survey and interview data indicate PAFT improves families' knowledge, ability and confidence in parenting with little variation between sub-groups of the family sample. All types of families reported PAFT helped them develop in these areas of parenting.

Measures and methods

We examined outcomes for parents and families in three ways.

In Phase One we analysed outcome stories provided by PAFT staff in their biannual reports. We also used these stories to help us understand the mechanisms through which PAFT helped families.

In Phase Two we surveyed all parents who had been on PAFT for a year or more as of 31 January 2011. We also interviewed educators and parents in our case studies about what they saw changing as a result of PAFT.

We begin this section with a summary of how educators know they are making a difference before looking at results of the parent survey.

Indicators of change – educator and family accounts

For our case studies, we asked staff and families how they knew PAFT was making a difference. Educators described a range of ways that PAFT was making a difference to families including changes they were able to observe directly.

At the simplest level educators reported families were home (routinely at the time of the visit) and present during the visit. This indicates parents are appreciative of the visit and wanting to participate.

Other indicators that PAFT was making a difference were environmental changes in the home. This included moving dangerous objects out of the reach of children, making the floor (which is the babies primary playspace) cleaner, not using props that may delay the child's physical development such as jolly jumpers and excersaucers, and evidence of PAFT resources, designed to promote the child's learning, around the home.

Educators also observed changes in parenting behaviour. Notable differences were in the way parents interacted with their babies, such as talking to them more, and recognising and responding to the child's cues. Educators also observed parents making resources or doing activities with the child, and parents being able to share observations of their child's development.

Educators observed parents getting out and socialising more, joining playgroups and attending parent classes.

Educators also gave examples of changes in family functioning. These included moving out of violent relationships and members of the wider family engaging with their child's learning.

Our parent survey captures changes to parenting primarily for behaviour. These results are linked to the sorts of outcomes observed by families and their educators above. However, interview data indicate a wider range of outcomes for PAFT than are captured in our survey.

Parenting Survey

We examined changes in parenting outcomes on a standardised psychometric tool developed for Parents as Teachers – the University of Idaho Survey of Parenting Practice (UISPP, Shaklee and Demarest, 2005). Families currently on PAFT self-assessed their growth in:

- their knowledge of child development
- their confidence in parenting skills
- their ability to respond to their child
- the number of activities they did with their child.

Using the same format as the UISPP we also asked about their:

- enjoyment of being a parent
- connection to other families with children.

This tool asked parents to rate their parenting on a number of items now, and then think back to before PAFT and rate themselves on the items then.¹³ We also developed a number of statements about how PAFT helped, based on our analysis of outcome stories in Phase One. Our instruments were commented on by the PAFT contract management team and tested cognitively with parents and parent educators.

Sample

We surveyed all families who were enrolled on PAFT as of 31 January 2011 and had been on PAFT for a year at least. Children's ages ranged from 1 – 3 years. Nine hundred people returned surveys, yielding an estimated response rate of 38% (see appendix 3 for details).

Compared with all families surveyed, survey respondents were more likely to be from:

¹³ This approach to assessment is called 'retrospective pre-test' methodology. The assumption is that pre-test and post-test programme responses to any question may not be comparable because learning about parenting will cause parents to think about survey items in a new way. This was demonstrated by parents in a pre-post test evaluation of Healthy Families America that ran the retrospective pre-test methodology alongside (Pratt et al, 2000). Before you start a programme, 'You don't know what you don't know.' You might think you know a lot then realise how much there is to know as you learn more throughout the programme. So by the end, you rate your knowledge as less than you know at the pre-test before undertaking the programme. The retrospective design gets around this problem by parents rating themselves from the same reference point.

- nuclear families than other family types
- families earning above \$35,000 a year compared to families on lower incomes
- families with mothers aged over 26 years than families with younger mothers at the birth of their child
- families with a European mother than other families

Families rated their parenting knowledge, confidence and ability more highly after their time on PAFT

Figure 4 shows that respondents rated their parenting knowledge, confidence, ability and amount of time spent with their children significantly more highly at the time of the survey than before they started PAFT. The largest changes occurred where respondents showed the most room to move. The biggest changes in descending order were reported for knowledge, confidence, ability and activity items. At the time of survey respondents rated their parenting abilities most strongly followed by the amount of activities they did with their child, their confidence and knowledge of child development (in descending order).

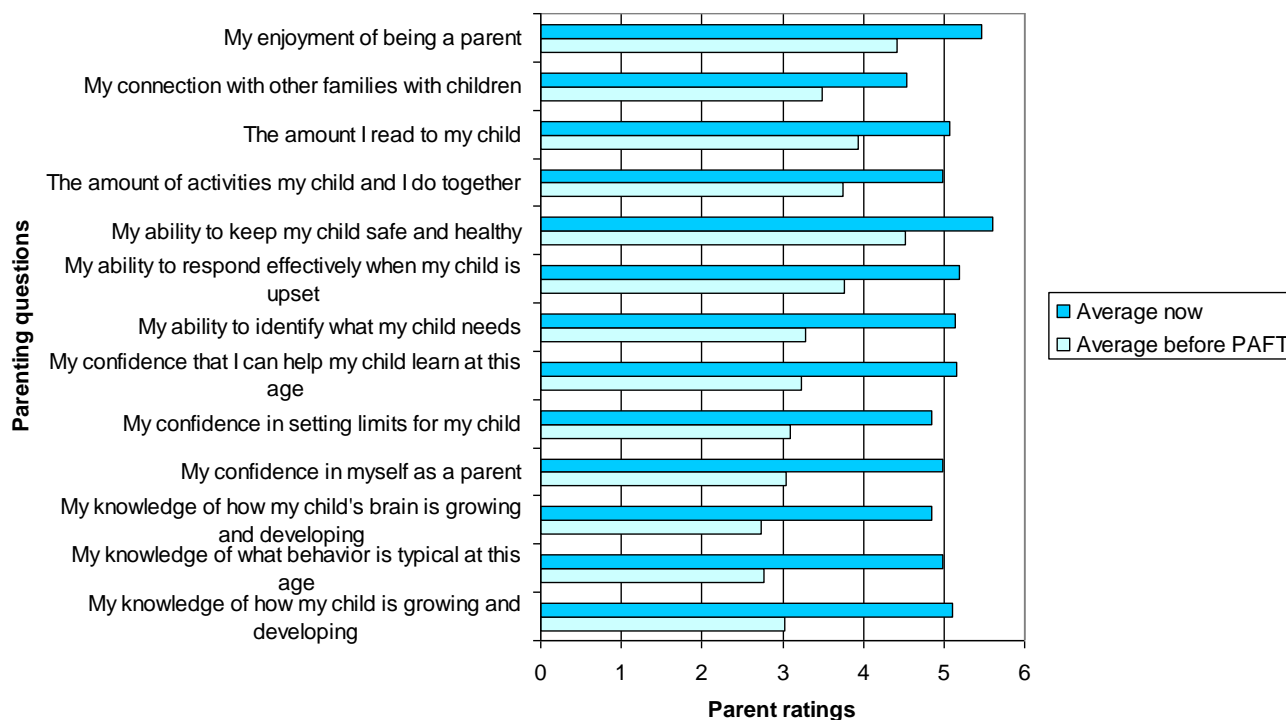


Figure 4. Change in parenting pre-PAFT and post PAFT

Our analysis found changes in parenting outcomes were consistent across families from different income levels, ethnicities, household structures and with younger and older mothers.

Parents reported positive changes in their parenting after their time on PAFT. First-time parents reported bigger changes than previous parents as one would expect.

Because parenting is influenced by multiple factors we asked how much PAFT helped with parenting.

Figure 5 shows 85% of respondents thought PAFT helped them with their parenting ‘quite a lot’ or ‘a great deal’. Reports of how much PAFT helped were consistent across families from different income levels, ethnicities, household structures and with younger and older mothers.

Amount PAFT has helped

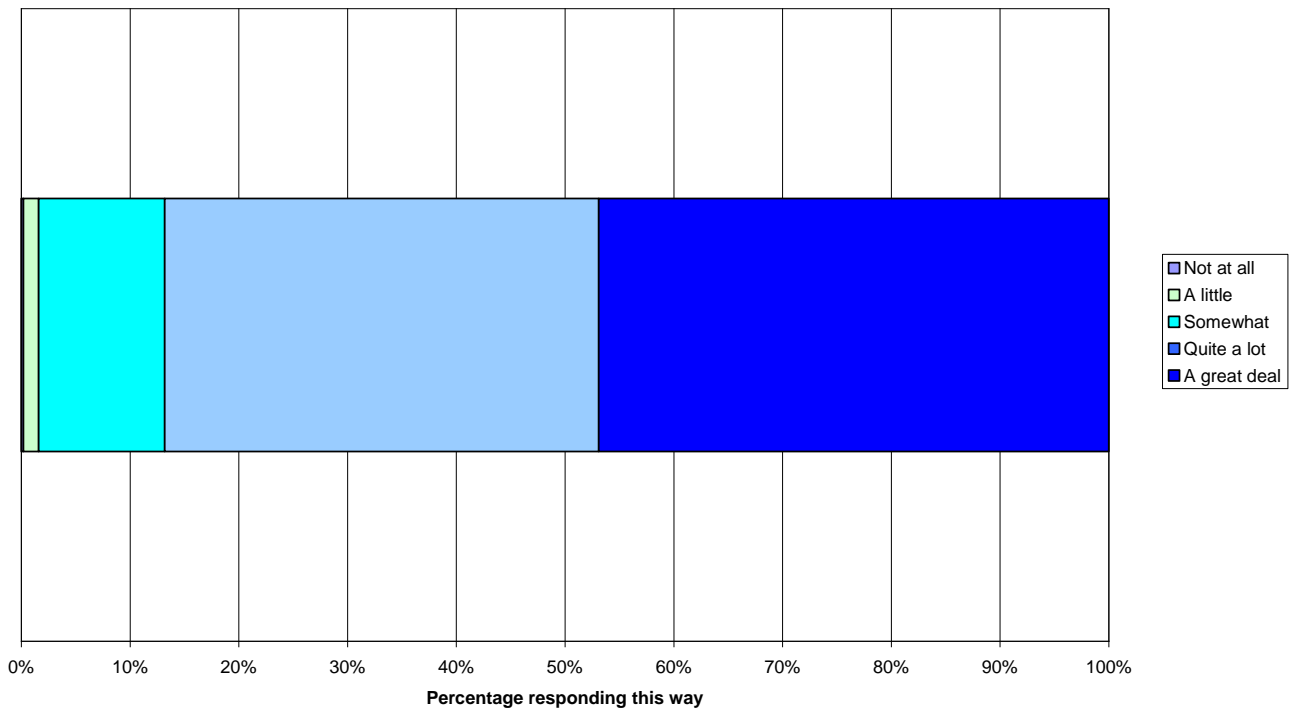


Figure 5. How much PAFT helped parenting

Those families who more strongly agreed that they had access to community resources and help in their parenting also reported that PAFT helped to a greater degree than other families. It could be that PAFT encouraged families to be connected with parenting resources so they were more aware of them. Or access to resources augmented the training received with PAFT. Or happier parents were more likely to respond positively to this question.

PAFT helped families through improving child development knowledge, affirming families and giving practical parenting strategies.

We asked families to indicate their agreement with a number of statements about how PAFT helped them. These items were developed from our analysis of outcome stories contained in provider biannual reports, responses to parent surveys conducted six-monthly with PAFT parents, and our reading of PAFT’s design (the ‘intended programme’). Results are shown in Figure 6.

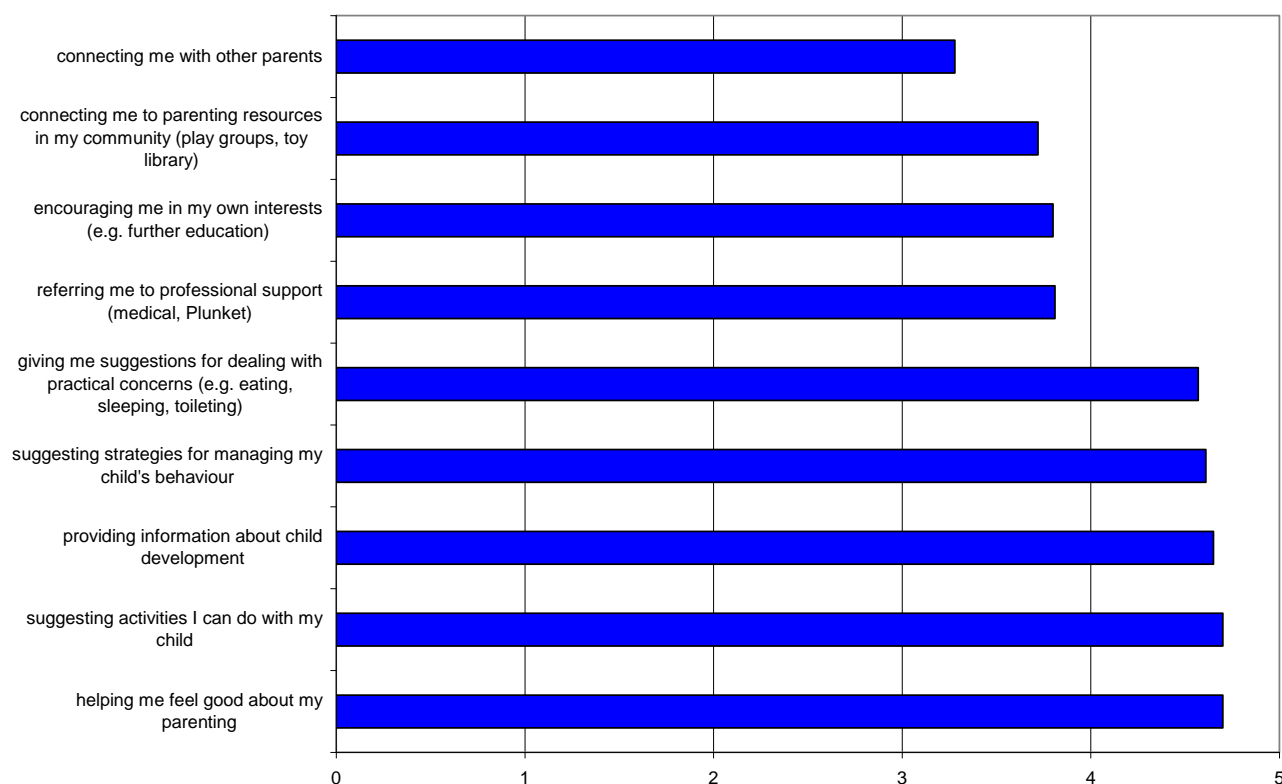


Figure 6. Family agreement with how PAFT helped them

On a scale of 1-5 where 5 is strongly agree and 1 is strongly disagree, we found strongest agreement for:

- Helping me feel good about my parenting (affirmation)
- Suggesting activities I can do with my child (things to do)
- Providing information about child development (information)
- Suggesting strategies for managing my child's behaviour (strategies)
- Giving me suggestions for dealing with practical concerns (eg eating, sleeping, toileting) (strategies)

There were no differences in agreement on these items among different types of families. On the basis of common support, we argue these are the core mechanisms by which families are helped in PAFT. These items were also strong themes in the free text comments from parents in the survey (n=600). Parents appreciated the knowledge, activities and advice received from educators and their greater feeling of confidence.

The 'referring' and 'connecting' mechanisms did not garner such high agreement nor did 'encouraging me in my own interests'¹⁴ as other items. We found a tendency for families with European mothers or in the highest income brackets to agree less strongly with these items. However differences between groups of families were very small and did not account for much variance in parent responses. That is, there are a lot of other things determining parents' ratings of how PAFT helped them compared with the demographic variables we could measure.

¹⁴ Note 'encouraging me in my own interests' is not part of the design of PAFT but is one of the outcomes parents and educators attribute to the programme according to the biannual report outcome stories and biannual parent surveys.

We also found an association between people more strongly agreeing that they had access to community and parenting resources also more strongly agreeing that PAFT helped them in each of the ways. Again this association could be explained in several ways including:

- people feeling they have good support being more likely to make the most of PAFT
- the ways that PAFT helps being facilitated by good access to resources and parenting help
- a happy response bias where some families are inclined to respond positively to all questions asked.

We note from provider Biannual reports that providers refer families to a range of health and social services. Health services include for example, Group Special Education for developmental delays and vision and hearing specialists for concerns about sight and hearing. Social services include for example, food banks, budgeting agencies and City Mission. Providers also connect families to community activities such as toy libraries, early childhood centres and play groups.

Provider variation

For 14 providers who had enough respondents (n=30) to put into a regression model, we found 'provider' accounted for a very small amount of variance in the parent change scores. That is, the 14 providers were all doing a reasonable job in helping parents change in positive directions with their parenting. Differences among the 14 providers were even smaller for the 'amount PAFT helped', accounting for only 1% of the variance in the model.

The story so far

PAFT is associated with better participation in child health and development monitoring (B4SC) for all families except for single-parents living with extended family (that is five of the six clusters we looked at). Part of the job of PAFT educators is to actively monitor children's health and development. They also encourage family members to observe their children and take action where it is needed. PAFT may be a mechanism for assisting families to better monitor and look after their children's health. Or it could be that families who seek reassurance about their children's health are more likely to enrol in PAFT and also more likely to participation in health and development monitoring (B4SC). Our current analysis cannot rule out the latter possibility.

The association between higher participation in PAFT and better child monitoring does not translate into better results for children across all these groups.

The largest cluster of families in PAFT (40% in 2006) was nuclear families, with higher levels of incomes than other family types, older mothers and mothers identifying as European. PAFT secured the highest engagement from this group. However, PAFT was not associated with better results for children in this group for three of four domains we looked at. Only hearing results were associated with PAFT. A comparison of the results for children in this group with national averages indicated some small room for improvement in behaviour and development domains – that is, there was a need but it was small compared with other PAFT clusters.

Single parents living alone or with their extended family were more likely to drop out of PAFT early. Even where they stayed, we could not find much evidence of apparent benefits for their children. These families had the lowest income of all PAFT groups and the youngest mothers. We observed a similar pattern of results for couples with extended families in the behaviour assessment. Our findings so far indicate that even if these families could be better engaged in PAFT, outcomes for their children would not necessarily be improved.

Nuclear families with Māori mothers and mothers of 'other ethnicity' were also lost from PAFT at higher rates than their European counterparts. However, where they stayed on the programme they reported better outcomes for their children in two of four domains. Children in both groups had better conduct screening results at age four. Nuclear families with 'other ethnicity' mothers also reported better developmental outcomes for their children. Children in nuclear families with Māori mothers had better sight outcomes. In sum, for nuclear families with 'non-European mothers', increased participation in PAFT was associated with better results for their children.

We also observed that substantiated child abuse findings were similar for the PAFT 2006 cohort and the general population at age four. PAFT children were just as safe as children in the general population.

Families reported PAFT helped them with their parenting in a range of ways clearly connected to the aims of the programme. We found that families who completed parenting surveys (around 40%) rated themselves highly in their ability to look after their children, the amount they interacted with their children, their confidence in their skills, and their knowledge of child development (in descending order). The parenting survey as well as interview data indicated PAFT improved families' knowledge, ability and confidence in parenting with little variation between sub-groups of the parenting sample. We don't know the extent to which these positive results are true of all families on PAFT. If we assumed they were, it would seem that for a majority of families on PAFT (with the exception of nuclear families with non-European mothers) self-assessed knowledge and ability to parent while on the programme does not necessarily translate into positive child health and development outcomes at age four.

Why is it, that higher involvement with PAFT was not consistently associated with a range of better health and development outcomes for children across the board? We suspect the effects of a parenting programme may not be enough for families living in hardship. In the following section we discuss what we have learned about PAFT design and implementation to begin to answer this question.



Chapter Four: Explaining the Results: PAFT Design and Implementation

In our results section we found PAFT was associated with better attendance at before school checks and positive child results in some areas for some families some of the time. However, for about 7 in 10 families enrolled on PAFT, PAFT was not associated with changes in behaviour or development.

Why is it that higher involvement with PAFT and self assessed ability to parent well, was not consistently associated with a range of better health and development outcomes for children for all groups?

In this section we look at what we have learned about PAFT's design and implementation to help provide explanations for these findings. We begin with PAFT's design and delivery and then assess how PAFT contributes to preventing child maltreatment.

Summary

Home visit design and delivery

We argue a *combination* of the following features of PAFT's design and implementation waters down the likelihood of changing parenting practice:

- an imperative for educators to be 'strengths-based' and increase families' confidence and competence.
- a strong emphasis on parent choice and responsibility.
- variation in educators reports of their ability or confidence to challenge worrying behaviour and little in the way in the 'written' curriculum of how to mount a challenge.
- variability in families' expectations of what their role is in the visit or that they will change their behaviour.
- little opportunity for families to practice skills and receive feedback in the home visit.

Conditions supporting implementation

- Educator knowledge and skills (quality) are critical for engaging families and ensuring families are receiving accurate information about their child's development and their parenting practices.

Child Maltreatment prevention

- Whilst PAFT is not primarily designed as a child maltreatment prevention programme, our analysis of its design and delivery found that it contains many of the attributes linked with programmes shown to reduce maltreatment.

Home visits—design and delivery

The home visit is the core of the PAFT programme. Home visits have five components that can be interwoven throughout the visit:

- rapport building – where educators ask questions about, and take an interest, in the family
- observation – where educators share observations of the child’s development and encourage parents to do the same
- discussion – where a child’s development is reviewed and new information (a topic relevant to the age of the child) is shared with the family. This is also the place where parenting issues may be raised and discussed.
- parent—child activity – where parent-child interaction is promoted through 1) an activity, 2) book-sharing and 3) follow-up from the educator
- summary – where key points of the visit are noted for parents, including key observations of the child, parents’ strengths and items or activities for parents to follow up before the next visit.

Table 5 sets out the goals of the personal visit and the ‘parent educator’ role from the curriculum.

Goals of the personal visit	Parent educator role
Increase parents’ feeling of confidence and competence as teachers of their child	Maintain rapport and develop relationship with family
Increase parent’s knowledge of child development	Provide appropriate child development and neuroscience information
Increase parents’ observation skills	Help parents develop and hone their observation skills
Provide opportunity for parents to apply knowledge	Support and reinforce the importance of the parents’ role as teachers of their children
Prepare parents for what’s coming next	Solicit and respond to parents’ questions and concerns

Two features of note in our assessment of the curriculum is that it is:

- strengths-based, emphasising what parents are doing well and geared towards helping parents feel good about, and in control of, their parenting
- geared more heavily toward improving knowledge about child development, with less emphasis on learning and practising new skills (except for observation).

We discuss the implications of these features for behaviour change.

PAFT was delivered as intended.

Across all our case studies we observed educators delivering visits that aligned with the PAFT programme design. That is, there was good rapport with the families, educators asked about their children, made observations, provided information and engaged in some sort of activity. Home visits

were highly geared towards helping parents understand their child and their child's view of the world. Educators implemented the strengths-based, partnership approach of PAFT¹⁵.

PAFT has a strong emphasis on parent choice and responsibility.

A strong theme in educators' account of PAFT in our interviews, was that 'parents were the choosers' of how they brought up their children. PAFT provided information and support but it was up to parents to decide what was right for them – which of course is true. A hall-mark of the PAFT approach for many educators was not being 'judgmental'.

'On the first visit I'll say, "I might have a degree in education, I might've been in early childhood for this many years but I see myself as an information giver, and I'm not here to tell you what to do. You'll pick up what you like, you'll love some parts of it and other parts you'll disagree on, and that's absolutely your business. It's a free programme, and free information for you to take as you like".'(Educator)

Parents and caregivers appreciated this approach, for example:

'You choose your own way. It's not like anything is being pushed onto you. I think that is where [my educator] has helped me the most. People say so many different things about how to parent and you're getting all this knowledge from everywhere and who do you believe? So you take from it what you want to take from it and I can run it past [my educator] and she is able to explain why'. (Parent)

PAFT provides a 'take it or leave it' choice for parents. Typically, several options for encouraging children's learning or managing behaviour are presented in the current curriculum. Options are supported by reasons why they might be good to do. This has the advantage of providing flexibility to suit the circumstances and values of parents. It also enables educators to maintain a friendly and supportive role. Some educators said that they told families in their initial visits that PAFT was not rigid or prescriptive, and this makes a big difference to a family's willingness to participate.

However implicit here is the possibility that families could refuse all options – that is, no change in their behaviour was also acceptable. The strong emphasis on 'choice' may dilute the influence of PAFT.

We recommend that where there is robust evidence that particular practices are enhancing and others are detrimental – educators should make this clear to families.

Some educators were 'strengths-based' AND offered a challenge.

The potential tension for educators is maintaining the quality of their relationship with families in the context of influencing, and, if necessary changing parenting practice.

In the context of this strengths-based, non-judgmental approach, we asked educators what they did if they saw parenting behaviour they were concerned about. Some educators were able to immediately talk about strategies or give examples of how they challenged worrying parenting behaviours (see Figure 7 below) while others seemed to struggle a bit with the idea of having to challenge families.

¹⁵ Fifteen percent of educators in the organisational survey said they 'stick to the scheduled personal visit plan' while 75% said they 'tailored the scheduled personal visit plan to the current concerns of the family.'

Figure 7. Strategies for challenging families when needed.

The quote below illustrates some of the strategies educators used to raise an issue while preserving their relationship with the family.

'At the end of the day it is about the child's safety first and foremost. And they're [parents] really good when you say, "you know, this is about your child's safety and if anything were to happen to him and I hadn't said anything then, you know, it would be like you hear on TV – oh well why didn't she say something?" And they take it on a bit more too because then they know that they have a responsibility as well for that.' (Educator)

Strategy 1: Discussing the consequences of certain courses of action

- The example implies that a certain behaviour or circumstance, if not checked, could 1) harm the child, or 2) attract negative judgements of the educator and the parents of the child. These are two possible consequences of the behaviour if the parent educator did not raise an issue. While the specific issue is not talked about in this instance, making parents/carers aware of the possible consequences of their behaviour is a technique to influence parenting decisions that is talked about by educators and observed in home visits
- Discussing the consequences of behaviour allows parents to decide for themselves what to do, given they know what the possible consequences are.

Strategy 2: Bringing it back to the safety of the child

- Explaining why a situation could become dangerous for the child appeals to parents' sense of wanting to do the best for their child. It also works with the understanding that both parents and the educator are involved in the programme because of their shared concern for the child. The educator would be remiss if she let a safety issue go unnoticed.

Strategy 3: Invoking the 'other': Social norms and/or the authority of research

- 'How would it look' invokes the sense of people looking on and judging behaviour. This is a strategy that educators use both to keep themselves toeing the line and to help parents appreciate the seriousness of a situation. The appeal to social norms helps construct the educator as being compelled to say something that may be hard to hear for the parents, even if she feels uncomfortable about doing it.

Strategy 4: Reinforcing the role of the parent as decision maker, responsible for what happens to their child

- 'If anything were to happen' and 'why didn't she say' reinforces the culpability of the people involved in the care of a child for what happens to that child. While the educator is referring to herself in this instance, she notes how families 'take it on a bit' where they realise their joint responsibility for the child.

Strategy 5: Appeal to compulsion: I have to tell you this.

- The educator signals she doesn't feel comfortable telling them about the risk but is compelled to by the circumstances.

Once an issue has been raised using these strategies, educators can offer alternative courses of action for families.

We noted a lack of guidance in the written curriculum about ways to positively challenge parents. We found some variability in educators' ability or confidence to challenge families. We recommend that equipping educators with skills to challenge families where this is needed could be looked at for future development.

Parents varied in their expectations of what their role was in the visit and whether they changed their behaviour.

We asked families in our case studies what their role was in the programme. What did they expect to do or get out of it?

We found families varied in their perceptions of their role in PAFT. In many cases this was a difficult question for people to answer. Families hadn't given much thought to what they had to do. One parent, for example, saw PAFT as "in-home education", that required very little parental input, while others were unable to say what their role in PAFT was, aside from making themselves available for appointments.

'I let [my educator] do her thing. She invites me in, and sometimes we'll sit down and we'll do little things with [my daughter]. So she does do that. But more often than not I'll sit back and watch over it and allow [my daughter] to have that one-on-one time'. (Parent)

We also asked families if they felt PAFT changed their behaviour. Again reports varied. Some families were quite clear that PAFT had changed the way they parented:

'Yeah, I think it has. I think, well, because I come from a family of nine kids so you know, I've already been there, done that work. looking after kids and that sort of thing, but it is - it's a lot different when it is your own baby, you know ... But PAFT has helped me in ways of - about understanding their, like, baby's learning. Like learning everything. So PAFT has definitely helped me in that way' (Parent).

Others did not consider PAFT had 'changed' their parenting but gave examples of how they felt supported by PAFT or PAFT helped them. It may have been that the word 'changed' challenged the 'self-efficacy' of the parents or implied they were deficient to begin with. The following quote is from a parent who did not feel PAFT changed their behaviour, but gave an example of using the resources:

'I don't know about like changing parenting, but it helps with parenting. Like, not having someone else is, you know, 'what shall we do in this situation?' I ring up [educator] and say, 'what do I do?', and she can give advice, yep' (Parent)

It was also clear from responses to questions about the benefits of PAFT that families appreciated and took on the knowledge afforded through the programme.

'[I think I] play with her more and want do things with her to help her learn because before I would've sort of just thought that she'd just entertain herself, like I could just put her in front of the TV and she'd just play by herself. Yeah, [my parent educator] helped me realise that I have to do things with her. It's good, especially when she copies things that I do or if I teach her stuff and she does it back, it's really good.' (Parent)

PAFT provided families with choices. Families liked having choices and saw their educators as informed and expert providers of advice. Families were not necessarily clear about their role in the programme. We gathered from some of the families we talked to that they did not necessarily feel a strong expectation that they would do anything differently as a result of being on PAFT. The extent to

which families saw PAFT as changing their parenting varies. Despite this lack of clarity, families identified ways they or their children were helped, supported and ‘tweaked’ and gave examples of things they might not otherwise do if PAFT wasn’t in their lives.

Behaviour-change literature suggests that having ‘an intention to perform’ a behaviour is one of three factors that needs to be present in order for a person to actually make a change (Donovan and Henley, 2003)¹⁶. We recommend that being clear to families about how they can best participate and use resources brought by the programme could be useful in strengthening PAFT’s impact.

Inside the home visit –some opportunities to practice skills and receive feedback

The literature about understanding successful strategies within the home visit seems to be coalescing around the idea that ‘coaching’ is required to best engage parents and optimise their chances of learning new behaviours (Basu et al, 2010; Campbell & Sawyer, 2009; Peterson, et al, 2007).

In this context, coaching encompasses a range of strategies used to engage parents during a home-visit. One of the central features of coaching is that parents learn new skills with their child while an educator observes and offers feedback. It is a triadic interaction between educator, parent and child, focused on improving parent—child interactions.

The ‘parent—child’ activity component of the PAFT home visit is where educators explicitly have an opportunity to coach parents. At this point, educators set up an activity to do with the child, may model how to do the activity and encourage parents to do it. In our case-studies we observed that the ‘parent—child activity’ of the visits varied to the extent that it was ‘parent-child’ compared with ‘educator-child’. Parents’ involvement in the parent—child activity was inconsistent. This was borne out by the small amount of time given to ‘coaching’ in the visits.

Our sample of observations across six providers and 21 home visits (21 families, 1590 observation periods) suggests a very small amount of time was spent actually coaching parents (2.5%). Interactions involving the educator, parent and child were more likely to involve modelling (18.7% of time on the visit). This is where parents observe the educator working with their child. Modelling is based on well established social-learning theory, but it does not give an opportunity for parents to work with their child with support from an educator.

Educators spent over half the visit interacting primarily with parents (51.9%) with activity focused on providing information (27.7% of the visit) listening (16.2%) and asking for information (11.8%).

The content of home visits was overwhelmingly focused on child development (72.7%) with less time devoted to parenting issues (4.6%).

Home visits are only an hour long. Given the amount of material educators are expected to impart to parents, time for ‘coaching’ is short. The coaching literature suggests that practising skills with supportive feedback is the best way to learn them. Consolidating learning in this way moves it from knowledge to practice. We recommend some thought be given to the balance of activities within the home visit. We note that PAT USA’s new approach has a strong focus on supporting parent—child interaction and parenting. We turn now to another platform for consolidating learning – PAFT group meetings.

¹⁶ The other two are: having the skill or equipment to perform the behaviour and their being no impediments to performing it.

Group meetings

Group meetings are intended to connect families with each other and provide further opportunities to offer information and advice to parents. Social support is important and is a recognised protective factor for positive child outcomes.

However, group meetings appeared to be the most difficult part of the PAFT curriculum to implement. We found just over half of providers (54%) met their targeted hours for group meetings between 2006 and 2009 and only a third of families who answered the PAFT survey agreed with the item stating PAFT helps by 'connecting with other parents'.

Five of the six providers we spoke to in our case studies found it difficult to get good attendance at group meetings. The exception to this rule was 'fun-oriented events' such as Christmas parties and graduation.

Providers could not always run PAFT group meetings close to where families live. This diminished their potential to connect families who could easily get together outside of organised meetings, especially where families have limited access to transport.

Our assessment of this information is that group meetings were not the strong suit of the PAFT programme. However, our case studies revealed that providers, with the encouragement of the Ahuru Mōwai team, were developing other strategies for connecting parents to each other, often in the context of also providing parenting advice and support. These strategies included the following:

- collaborating with other providers and/or taking PAFT to existing groups. (One educator described how she worked with a group set up by a local Plunket. She took PAFT information, resources, activities and her expertise to group settings where there might be a mix of PAFT and non-PAFT families.)
- encouraging participation in other early learning environments (for example, Play Centre)
- encouraging families to enrol in shorter-term parent and child initiatives run by the host provider. (In one area for example families could enrol in 'baby space' and 'play space', and in another organisation, PAFT ran playgroups for all families supported by the organisation)
- encouraging families to go to child focused activities in their community, such as story time at the library. (One provider was trialing educators taking the family to community activities, or at least attending activities with families. The goal was to encourage families to access resources, activities and networks already available in their community).

In one area educators directly connected individual families to each other. Educators talked about asking the permission of families to pass on their details to other PAFT families in the neighbourhood. In this way, PAFT was a conduit for making connections with families that both shared the programme and shared a vicinity.

There is an opportunity for PAFT to redesign the group meeting approach, learning from new strategies providers are trialing. There may be advantages to families practicing their parenting in a community of learners sharing a common approach to parenting.

Design conclusions

Our case studies provide some evidence that PAFT could be strengthened by:

- making it clear to families when behaviour is detrimental or enhancing, especially where there is robust evidence to make a case

- ensuring educators are equipped to challenge concerning parenting practice when it occurs
- clarifying with parents how PAFT is intended to support child outcomes, including the expectation of parental participation and change
- trialing alternatives to group meetings that help parents connect with each other and support their efforts to use positive parenting skills learnt on the programme.

Conditions supporting implementation

Looking beyond the individual visit and group meetings, we explored conditions that supported successful implementation of PAFT.

Using outcomes in the B4SC as a basis for assessing provider performance, we ranked providers according to their outcomes on a seven-point scale. We compared top providers (a score of 5 or better) with the bottom providers (0- 2), to discern any relationship between outcomes and providers' performance indicators constructed for Phase One of the evaluation. We visited two providers in the top range so we have a bit more insight about what contributes to their success.

Our findings indicate that there was no one provider factor linked to positive child outcomes, but there were some strong tendencies and combinations of factors that seemed to support better outcomes. These were related to suggestions in the home visitation literature about what is important for providers to have in place to maximise programme benefits¹⁷. Our analysis indicates:

- Providers with stronger child outcomes tended to have fewer families in the most vulnerable clusters – but not exclusively so. Providers with poorer child outcomes had a higher proportion of families living in more vulnerable clusters.
- Providers with stronger child outcomes tended to have a combination of good staff retention coupled with well-qualified educators (diploma or higher qualification). Providers with poor child outcomes did not have so many qualified staff and retention was poorer.

Drawing on our experience of the two providers with strong child outcomes that we visited, we also observed the following conditions:

- All educators were experienced in delivering the programme (5 years or more), with three out of five having early childhood or social work qualifications.
- Educators had a range of strategies for engaging families, building relationships and also challenging families when they needed to. Retention in these programmes was high compared with providers with poorer child outcomes.
- Organisations had policies for dealing with safety concerns for children or whanau that were understood by educators. These policies involved raising a concern, discussing it with seniors, and coming to a joint decision about whether involvement of other agencies, like CYF was called for.
- One organisation was highly networked with the local service agencies and so concerns about families could be checked out informally, families could be jointly monitored by agencies and pathways for referral seemed clear.
- One organisation was highly networked into the local community. Educators were ethnically a good match for the client base, potentially providing local support for sticking with the programme and using the learning.

¹⁷ In our review of the home visitation literature for Phase One of the evaluation we found 'competent staff' – usually proxied by 'level or type of qualification' was associated with stronger client outcomes (Daro, 2006; Gomby, 2005, Sykora, 2005).

- Both organisations had procedures for screening clients into the programme. The procedures were based on collecting as much information about families as possible, either through seeking as much information from referrers as possible or by visiting the family before making a decision to enrol. Their assessment of whether a family needed PAFT and whether PAFT was a good match for the family was enhanced by this information.

Implications of conditions analysis

PAFT's core is delivery of parent education in the context of supportive relationships with families. Retention is important to continuity of relationships with families. Educator knowledge and skills (quality) are critical for engaging families and ensuring families are receiving accurate information about their child's development and their parenting practices. Educators are seen by families as reliable sources of information on both these issues. If concerns are raised by families but assurance is given by educators, we think families are unlikely to take their concerns further.

Achieving high-quality educators and staff retention relies on strong organisational policies and practices that support staff and provide a working environment where high-quality staff are encouraged to stay. In this context, provider concern about PAFT funding levels are salient. Better remuneration potentially helps to retain staff and, where there is turnover, to employ staff of high quality.

How the PAFT curriculum contributes toward reducing child maltreatment

As noted earlier children associated with PAFT were more likely to be referred to CYF than children in the general population. However they were no more likely to have a finding of maltreatment than children in the general population.

To assess the potential of the PAFT programme to reduce child maltreatment we examined the literature assessing the:

- risk and protective factors related to child maltreatment
- impact of home visitation and parent education programmes on rates of child maltreatment.

The literature is somewhat divided on how well home visitation and parenting programmes reduce child maltreatment. There is more agreement about the risk factors associated with child maltreatment.

We have taken a broad view identifying criteria for our assessment based on risk factors, strategies for mitigating risk and features of programmes that the literature suggests should be in place if child maltreatment is to be reduced. We have assessed PAFT against these criteria.

We note that PAFT and its parent, PAT, were not primarily designed as child maltreatment reduction programmes. PAFT may contribute to a reduction in child maltreatment by addressing some risk factors (eg harsh parenting) or through increased surveillance of the child. It does not set out to directly address some of the strongest risk factors associated with maltreatment, for example, family violence, drug and alcohol abuse or mental illness.

Staff interviewed in our case studies identified the surveillance role that PAFT provides through being home-based, as one of its strengths:

'You see how the family is functioning, who is in the household. How parents are interacting with the child in their home environment and with other children and visa versa – seeing how the child relates

to parents and with other members of the household. Also, around attachment and how they behave and respond - are they frightened, are they rigid –all those things we look for. We can't see that otherwise. We have had cases where they might come here, but you don't get to see the realities of their every day household. You can't smell the drugs, see the booze around or things like holes in the wall - all those things. How relaxed the child is – are they relaxed with mum and with dad? Overcrowding, damp conditions – health related things too.' (PAFT provider)

Where there is suspected violence in the home or child maltreatment, families can be linked to other services to provide the more intensive support they need. Respondents in our case studies gave a number of examples of how they had successfully brought in other services such as CYF whilst maintaining an ongoing relationship with the family and continuing to deliver the PAFT programme.

However, when assessing PAFT against child maltreatment prevention criteria it is important to keep in mind that these criteria are not what the programme was originally designed for. In spite of this, PAFT rates considerably well.

We assessed PAFT in terms of structure of the programme (targeting, design and staff) and curriculum content.

Tables 6 and 7 below summarise our findings.

Table 6. Child Maltreatment Prevention Rating from PAFT structure

Criteria	Design Rating	Implementation	Evidence
Targeting			KEY: CS= case studies; Admin= administrative data; PS=parent survey OS=Organisational survey; Lit=literature
Targets young and first-time parents	Mixed	Yes	Contract: In 2009—12 period target criteria for mothers under 20 ranged from 5-12% across the programme and 17—26 % for mothers aged between 20 and 25; Admin: 21% of families enrolled in 2006 had mothers under 20 at the time of baby's birth; PS: 90% of survey respondents were first-time parents. CS: Families more likely to be screened in if first-time parents
Focuses on families in greater need	Mixed	Mixed	Admin: Income, family structure and age of mother demographic suggests family with challenges. CS: Lack of support and lack of parenting information particularly emphasised by providers. Lit: Features in literature associated with maltreatment (drug and alcohol, violence, mental health, child conduct disorders) not targeted.
Begins prenatally till at least 2 yrs old	Yes	No	Admin: In the 2006 cohort matched to the B4SC data and CYFS data, 9.2% of babies were enrolled before they were born. 5.7% enrolled when the baby was 1 month old or less. 69% enrolled when baby was four months old or less. Enrolments of baby over four months requires special approval.
Programme design and Staff			
Home visiting combined with individual help and group education	Yes	Variable	Admin: Home visiting targets were met 73% of the time between 2006—2009. Half of providers (54%) met their targeted hours for group meetings between 2006—2009. PS: 76.5% of parents answered group meetings question. 59% expressed some level of satisfaction with them and 38% were fence sitters. CS: 5 of 6 cases report issues with running PAFT group meetings. A range of solutions implemented.
Is flexible in duration and frequency so can adjust to level of need	Yes	No	Flexibility was curtailed by contracted high case loads; CS: Individual Educators reported doing more than the monthly visit with families.
Broad coverage of a range of family issues WHO (2006)	No	Mixed	CS: Educators may end up dealing with a range of issues according to family need.
Provides measures to reduce stress by improving social and physical environment	Indirectly	Mixed	Referral rate from PAFT varies with provider.
Goals are clearly set out and plans in place for achieving outcomes CSRE (2008)	Yes for monthly visits. No individual family plan	Mixed	Each home visit has a goal but these are not selected with the family.
Uses nurses or trained professionals	Yes	Mixed	The PAFT Management Supplement specifies that educators have a minimum qualification of a Teaching Diploma in Early Childhood Education or an equivalent qualification and/or experience in education, health or social work. Educator details current to Dec 2010 show: 73% had a diploma or higher and 12.2% had one or more certificates. Of those in PAFT with a diploma or higher, 62% were in education, 7% were in social work 17% were in health and 10% were other. 9% had some relevant experience (HIPPY, Family Start, Play centre) and 4% were unknown experience or qualifications. 3 educators were working towards relevant degrees (2.4%). This compares to Family Start in 2008 where 63% of workers or supervisors had a diploma or higher.
Has educators who are the same ethnic group as participants	No	Provider dependent	National average of educators to mothers shows good mix (phase 1 report) PS: 94% of families surveyed were satisfied or very satisfied that PAFT supports the culture of their family

Table 7. Child Maltreatment Prevention Rating from PAFT Curriculum

Criteria	Design Rating	Implementation	Evidence
Programme Content			KEY: CS= case studies; Admin= administrative data; PS=parent survey OS=organisational survey; Lit=literature
Teaches child development in combination with providing practical parenting and child management skills	High	Yes	PS: High parent ratings in this area on PS in terms of change scores and how PAFT helped. CS: Largest proportion of time spent in this area in home visit observations.
Establishes a positive view of their child	High	Yes	CS: Strong theme in case studies interviews with staff and parents, and observation of visits supported this. PS: 'My enjoyment of being a parent' received the highest rating for how parents feel 'now' of all items in the survey.
Encourages infant—parent attachment	High	Yes	PS: High scores in enjoyment of being a parent along with high scores in reported parent ability to 'identify what their child needs' and to 'respond effectively when my child is upset – suggests a strong degree of attachment. These items all changed in positive direction when parents compared themselves to before they'd been on PAFT. No demographic differences
Is strengths based	High	Yes	CS interviews with staff and parents and observation of visits support this. PS suggested helping parents feel good about their parenting is one of the key mechanism through which PAFT works.
Discourages physical discipline and provides alternative discipline strategies	Medium	Yes	CS: staff reported of this was brought up in first visit and again as required
Teaches self control and problem solving strategies	Low	Not assessed	
Supports paternal involvement	Low	Not assessed	CS: fathers involved in some visits. Admin data for 2010 indicated about 20% of fathers participating in PAFT Home visits. We have no benchmark for comparison.
Encourages improved social support systems (e.g. extended family, peer support)	Low	Mixed	PS: Connection with other families received lowest rating in change score. In 'how PAFT helps' rating – only 38% of families agreed or strongly agreed that PAFT helped them by connecting with other parents. CS: educators work to bring in fathers, and encourage families into community activities.
Links parents to high quality child care	Low	Mixed	Admin: Range of ECE participation 17—86% (Dec 09 Phase One report) CS Link to ECE emphasised as an exit strategy for PAFT clients by educators. Very strong links with ECE in at least two of five cases observed. PS context: 89% of parents agreed or strongly agreed they had access to a playgroup, crèche or preschool that they would be happy for their child to attend.
Addresses mental health, substance abuse and inter-partner violence through referrals	Low	Mixed	OS: 92% of staff survey strongly agreed or agreed that 'the organisation has clear procedures for managing suspected child abuse/maltreatment' 3 providers where staff didn't agree OS: 94% of staff agreed or strongly agreed there were 'clear procedures for referring clients on when needs arose.' four providers with staff who didn't agree. PS: 58% of parents expressed some agreement that PAFT helped them by referring them to services. A third neither agreed nor disagreed. European mothers, households earning over \$50K, and nuclear families were less likely to agree that PAFT helped this way than other groups.

In terms of the structure of the programme, PAFT met or partially met eight of ten structural criteria in its design and eight of ten structural criteria in its implementation (Table 6).

In terms of content of the curriculum, the curriculum design included some content on ten factors. The frequency with which these factors were addressed in the design of the curriculum varied (Table 7).

- four of ten content factors were addressed in multiple visits
- one of ten content factors occurred in at least three visits and
- five content factors were explicit in one or two home visit plans.

We assessed eight of ten factors in implementation of the curriculum.

- five of eight content criteria assessed were implemented
- three of eight content criteria assessed were implemented to some extent.

For PAFT to better meet structural features of criteria we identified it would need to be more intensively (or flexibly) delivered and perhaps augmented by a case-management approach for dealing with more serious family concerns.



Chapter Five: The Value of PAFT

Is PAFT worth the money we spend on it?

We consider the current evidence strong enough to support continuing to fund PAFT until evidence to the contrary emerges.

PAFT occupies a special niche in family support in New Zealand. In the sites we visited, PAFT was implemented with fidelity to its strengths-based approach. We have found evidence from a range of sources that suggests PAFT improves the quality of life for at least some of the families and children on the programme.

With respect to children, evidence to date, suggests PAFT is associated with lower rates of reported childhood:

- conduct problems for two groups
- developmental issues for one group
- visual referrals, certainly for one group and possibly for a second
- hearing referrals, certainly for one group and possibly two more.

If we take findings for the conduct scale of the B4SC as an example, we cannot rule out the possibility that PAFT could be contributing to significant cost savings in the longer term.

The interagency plan for Conduct Disorder and Severe Antisocial Disorder (2007) suggests conduct disorder in younger children is one of the strongest predictors of poor outcomes in adulthood. It cites a New Zealand study (Scott, 2003) indicating that the lifetime costs to society of a chronic adolescent antisocial male is \$3 million dollars.

What we know is that PAFT costs about \$148.11 a visit. Average visits at exit for a family in the 2006 cohort were 16. The average cost per family of delivering PAFT in 2010 dollars was \$2,369.76. In today's dollars the cost of delivering PAFT to each of the clusters is as follows:

Cluster	Number of families	Average number of visits at exit	Cost per family
1	315	13	1925.43
2	222	14	2073.54
3	231	13	1925.43
4	1045	19	2814.09
5	324	15	2221.65
6	427	14	2073.54

Confidence in our estimates of PAFT's effectiveness for different families, and an understanding of the mechanisms bringing about change, could be improved by further mixed-method analysis incorporating B4SC assessment. The reliability of indicators drawn from B4SC will improve with time. We could also use data matching to pull together a wider range of family and child data to allow the use of propensity matching to construct a comparison group for PAFT families. This, in turn, would allow for an estimate of the impact of PAFT on which to base conventional cost-effectiveness measures.

We note the point of cost-effectiveness measures is to give some indication of how much it costs to deliver a particular outcome amongst competing delivery mechanisms.¹⁸ At the moment there is no comparable programme to PAFT in New Zealand. Family Start comes closest but it is targeted at the most vulnerable families and has different mechanisms and goals to PAFT. In any event, there is no cost-effectiveness data for Family Start either.

We consider the current evidence is strong enough to support continuing to fund this programme until evidence to the contrary emerges.

Our analysis shows that there are specific opportunities to enhance PAFT. Some of the issues identified in the evaluation are already being addressed by the Ahuru Mōwai team and providers. These relate to group meetings and educators' abilities and confidence to challenge families where required. We recommend examining the changes to the PAT US curriculum for guidance in developing home-grown solutions to enhancing PAFT's effectiveness.

¹⁸ Commonwealth of Australia, Introduction to Cost-Benefit Analysis and Alternative Evaluation Methodologies, January 2006.

Chapter Six: Methods and Measures



In this section we give an overview of data sources and analysis used in this evaluation.

Table 1 is reprinted here to guide the discussion.

Table 1. Data sources for the evaluation		
How well is PAFT delivered?	Where is PAFT making a difference?	
Performance	Parent outcomes	Child outcomes
MSD administrative data-base	Parents Survey using UISPP	B4School Checks
Provider six-monthly reports	Provider outcome stories from Biannual Reports	
Case studies in 6 sites	Case studies in 6 sites	
Organisational Survey		

Administrative data

Demographic data on families and information about retention were based on the PAFT individual enrolment and exit database held by the Ahuru Mōwai team in Family and Community Services.

Provider six-monthly reports

Performance data were based on providers' six-monthly reports to the Ministry. This information came to us already grouped at the provider level so there is little opportunity to link provider features with individual outcomes. Information collated over a four-year period provided a picture of PAFT's recent performance (2006 to 2009). The exception to this was analysis of retention data: here we included information back to 2003 to provide a context for recent trends in retention.

For measures of engagement (early exit, dosage and completion) we used:

- chi-square tests to determine whether differences in engagement outcomes (eg between nuclear families and single-parent families) were statistically significant
- logistic regression models to examine the relative contributions of demographic characteristics and providers to differences in engagement outcomes.¹⁹

¹⁹ Ibid footnote 14.

Parenting survey

We measured parent's perceptions of what has changed for them with the programme and how PAFT helped them with our parenting survey.

The survey was based on a standardised psychometric tool developed for Parents as Teachers – the University of Idaho Survey of Parenting Practice (UISSP, Shaklee and Demarest, 2005).

The approach to assessment is called a 'retrospective pre-test' methodology. The assumption is that pre-test and post-test programme responses to any question may not be comparable because learning during the course of a programme will cause respondents to evaluate their knowledge in a different way. This was demonstrated by parents in a pre-post test evaluation of Healthy Families America (a home visitation programme) where a retrospective pre-test methodology ran alongside (Pratt et al, 2000). This study found that some parents rated themselves worse at the end of a programme than at the start – even though they felt they had learned a considerable amount. This was essentially a 'you don't know what you don't know' phenomenon. Before the programme parents over-estimated their parenting knowledge when they didn't appreciate how much there was to know about raising a child. After the programme they realised how much there was to know and rated their knowledge more modestly. The retrospective design gets around this problem by parents rating themselves from the same reference point in time.

The parent survey was a mail-back questionnaire sent to all families who were enrolled in PAFT as at January 2011 and who had been enrolled in PAFT for at least a year.

The response rate for the survey was 38%. Compared with all families surveyed, survey respondents were more likely to be from:

- Nuclear families than other family types
- Families earning above \$35,000 a year compared to families on lower incomes
- Families with mothers aged over 26 years than families with younger mothers at the birth of their child
- Families with a European mum than other families

We used regression models to look at whether there were differences in:

- how parents rated their improvement in parenting on the UISSP scale
- how much parents thought PAFT had helped them
- how strongly parents agreed with statements about how PAFT helped

between families with different demographic characteristics.

Organisational survey

We collected information about the organisational conditions of providers delivering the programme with our organisational survey.

We surveyed educators and managers from 33 providers and had responses back from at least one staff member from 31 providers. The response rate was 78% (n=115/148). We had no responses from a Christchurch based provider for the parenting or organisational survey (due to subsequent earthquakes) so staff and family associated with this provider are excluded from our analysis.

Items in the organisational survey were developed from The Capacity Assessment for Māori and Iwi providers of CYF Social Services (Cram et al, 2005). The survey also asked about educator practice.

We intended to link parent outcomes with provider conditions – however low response rates from parents have not allowed us to do that in a robust way. However the survey has given us some information about educator practice and some of the strengths and challenges of PAFT from a provider point of view.

Case studies

We used case studies to look at how PAFT supports families within a local context. We aimed to identify variations in practices and conditions that contribute to family engagement and outcomes.

We selected sites based on the engagement rates of their families. We visited a mix of sites on this basis. Ideally we would have liked to select sites on the basis of their child outcomes. Child outcomes were not available to us at the time we needed to approach potential sites for fieldwork.

At each of six sites we interviewed staff involved in implementing PAFT. These included managers, co-ordinators and educators. In some sites this also included clinical team leaders.

We asked two educators in a site to select two families each who would be willing for us to observe their visit and talk to them about their experience of being on PAFT. We coded behaviour at 21 home visits using a structured observation protocol - the Home Visit Observation Form- Revised taken from a study by Peterson, Luze, Eshbaugh, Jeon, & Ross Kantz, (2007). Inter-rater reliability for coding behaviour was 86%.

We used cross-case analysis to draw out common themes and differences in interviews with providers and parents.

B4School Checks data

We examined children's vision, hearing, development and behaviour outcomes using the B4School Check (B4SC) data held by the Ministry of Health. B4School Checks are the last WellChild/Tamariki Ora visit for children at age four before they start school. B4School Checks are the last WellChild/Tamariki Ora visit for children at age four before they start school (<http://www.moh.govt.nz/moh.nsf/indexmh/b4-school-check-handbook-mar2010>)

We matched PAFT enrolment data for children born in 2006 with the same cohort of B4SC data, mainly based on name and date of birth fields. We were able to match 95% of the PAFT children born in 2006 to their B4SC data (2839 children).

Propensity matching – constructing a comparison group for PAFT families

Ideally we wanted to use propensity matching to construct a comparison group for PAFT children from the B4SC data. That is, to identify a group of children in the B4SC data who did not receive PAFT but whose families have similar characteristics to the PAFT children.

However propensity matching is a technique that relies on having rich data about participant families and potential comparison families available so the groups are as alike as possible. The B4SC data has little information about families that we could use – essentially we were limited to gender, ethnicity of the child, location (we used Territorial Authority) and NZDep decile. We thought that the comparison

group, though it looked the same on paper on the four variables we had available, might have some big differences to our PAFT families. For example, we didn't have information about 'social isolation' or 'needing parenting information' or the 'household structure' or 'income' of our families – which are all criteria used to screen families into PAFT.

Given these limitations we have opted for a dose-response of analysis of the data.

Dose-response analysis

We looked at whether PAFT families with higher numbers of home visits had different outcomes to families who had lower numbers of home visits. We assumed families screened into PAFT would have more in common with each other than a general population.

While our dose response analysis posits that 'more PAFT' might lead to more noticeable changes in child outcomes, we cannot be sure that it is PAFT that is making the difference. For example, it may be that (unobserved) factors associated with early exit are also related to child outcomes, so that associations between number of PAFT visits and child outcomes are really about the underlying differences in the families who received only a little or a lot of PAFT.

We used logistic regression models to examine and summarise the relationship between the amount of PAFT a family received and how likely it was that:

- they had a check (participation)
- the outcome of the check was negative (that is further assessment or treatment was required – the results)

Our models allowed for the relationship between the amount of PAFT and B4SC outcomes to be different for sub-groups of families sharing similar characteristics. The six 'clusters' of families we used were based on family structure, family income mother's ethnicity and age at the birth of the child.²⁰

For some of the B4SC outcomes there were substantial differences between boys and girls, and between different parts of the country. So our models also controlled for gender and location (grouped as Auckland, other main urban areas, urban and rural).

The results from the models tell us, for each cluster of families, whether child outcomes were associated with the amount of PAFT received. That is, the analysis provides information about both:

- the estimated *size* of the difference in outcomes between families who received a lot of PAFT and those who received only a little PAFT
- and an indication of how *certain* we are of the difference (confidence intervals and p-values).

Because of smaller numbers in some clusters, even large looking associations for some outcomes are not 'statistically significant' by conventional standards. We have interpreted these findings as their being 'some evidence' of a relationship between PAFT and outcomes, but not 'strong evidence'.

²⁰ We used the two-step cluster function in SPSS to form the clusters of families. Some cases were excluded because of missing information – around 90% of the matched PAFT families were assigned to a cluster (2564 children).

Analysis of child outcomes by provider

We also used logistic regression models to examine differences in child outcomes between providers, while controlling for the influence of differences in the demographic characteristics of families they are working with.

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Appendix 1: Review of PAFT literature

Review of PAT International literature

Parent knowledge: Mixed evidence on improved parental knowledge of child development

Five papers specifically measured parent knowledge. Two papers reported data from the same multi-site RCT for different ages, and in one case, a follow-up study at one site only. The multi-site study found a small positive (non-significant) effect overall for parent knowledge at age 2 for PAT parents (Wager, Spiker, Hernandez, Song & Gerlach-Downie 2001a). In one site (of 3) the effect was significant for the knowledge of child emotional development sub-scale (Wagner et al, 2001a). No significant effects on parent knowledge were found at age 3 follow-up (Wagner, Lida, Spiker, Hernandez & Song, 2001b). Drotar et al (2005) found no differences between PAT and non-PAT parents on knowledge of infant development. In an article discussing two PAT implementation projects in California, Wagner and Clayton (1999) found no impacts on parental knowledge.

Parent behaviour/skills (including Home environment): PAT parents more engaged in literacy promotion

Four of five papers reporting on parent behaviour or skills found differences in favour of PAT in at least one measure of parent behaviour.

One multi-site RCT found small positive effects at age two across three sites (Wagner et al, 2001a) for language/literacy promotion. This effect was also found at age three at one follow-up site (Wagner et al, 2001b). Two studies found PAT parents were more likely to read to their children and enrol them in pre-school. Path analysis suggests these behaviours were associated with school readiness and 3rd grade achievement (Pfannenestial, Seitz & Zigler, 2002; Zigler, Pfannenestial & Seitz, 2008). In an article discussing two PAT implementation projects in California, Wagner and Clayton (1999) found positive impact on parent acceptance of child behaviour for PAT families in one site. This finding was replicated for teen parents in the second site when PAT was delivered alongside case-management.

Parent attitude: PAT parents 'happier in their parenting roles'

Two of three papers report positive effects for parent attitudes.

Wagner et al (2001a) found significantly increased parental happiness in caring for children at age two assessment in one of three sites. Re-analysis in the follow up study found a small positive effect for parental happiness at year one in a different site (Wagner et al, 2001b). Trends toward higher parental happiness were also found in years two and three at the follow-up site.

Child outcomes

Early detection of development delays and health issues: Mixed evidence

Three of six studies reporting on health outcomes found differences in favour of PAT families. One study found fewer motor developmental delays among PAT children (Drazen and Hurst 1993). Wagner, Clayton, Gerlach-Downie & McElroy (1999) found physical development at 2 years was

better for PAT babies. A multi-site RCT found children were more likely to be up to date with immunisations averaged across sites Wagner et al (2001a).

Child abuse and neglect

Actual abuse

Two of three studies found no difference in reports of abuse (Drazen & Hurst, 1993; Wagner, Cameto and Gerlach-Downie, 1996). A later follow-up study on teen mothers showed reduction in reported cases of abuse (Wagne & Clayton, 1999).

Potential abuse (that is, unintentional injuries, trips to A&E, parent stress)

One study found a small effect favouring PAT (-0.2) for injury treatment or emergency treatment (-0.24) across three sites at age two years (Wagner et al 2001a).

Children's dispositions for learning, participation in quality early childhood education and positive transitions to school

Child development:

Eight of ten studies found significant differences in favour of PAT children on at least one measure of cognitive development or achievement (Coleman et al, 1997; Drazen and Haust, 1993 and 1996; Wagner et al, 1999; Pfannensteil & Seltzer, 1985; 1989; Drotar et al, 2005; Pfannenstiel, Seitz & Zigler, 2002; Zigler, Pfannensteil & Seitz, 2008).

Two studies showing positive effects were randomised trials, while others have some sort of comparison group but are generally of lesser quality. One study found no effect for PAT but a small effect for PAT plus case-management for teen parents (Wagner et al, 1999).

Social development

Five of six studies measuring social development or social competence found at least one difference in favour of PAT children.

Differences in social development were apparent at age two for children of teenage mothers (Wagner et al 1996) and social competence at age three (Drotar et al, 2005). Wagner et al (1996), found PAT, PAT plus case management and case management only groups scored higher on measures of social development than the no-services group. Wagner et al (2001a) found differences in social development at age two for low income parents in one of three sites. Small effects for parent reported pro-social development were found at ages two and three by Wagner et al (2001a and b). Pfannensteil & Seltzer (1995) found differences in favour of PAT children or social development skills at age three. These differences were not sustained at follow-up using a different measure at first grade (Pfannensteil & Seltzer, 1989).

Self-help

Four studies measured child self-help with two finding positive effects.

Wagner (1999) found differences in self-help for PAT children of Latina mothers. No differences in self-help were found in the multi-site evaluation of PAT at age one and two (Wagner, 2001a). The follow-up at one site at age three found small but non-significant effect for self-help skills among children from PAT families (Wagner et al, 2001b).

Caution

The majority of studies of PAT reviewed pre-date significant revisions to the PAT curriculum in the US (2000) as well as implementation of PAT quality standards and performance indicators (2004). More studies report on measures of children's cognitive and social development than parent outcomes.

Authors of evaluation studies suggest the absence of large or significant effects in their studies may arise from factors such as:

- wash-out effects (where families don't use the services but are still counted in the evaluation as though they are receiving services)
- ceiling effects (where both groups score highly on scales leaving little room for improvement)
- failure to deliver the programme as intended (especially at the recommended intensity).

Appendix 2: B4School Check cluster characteristics

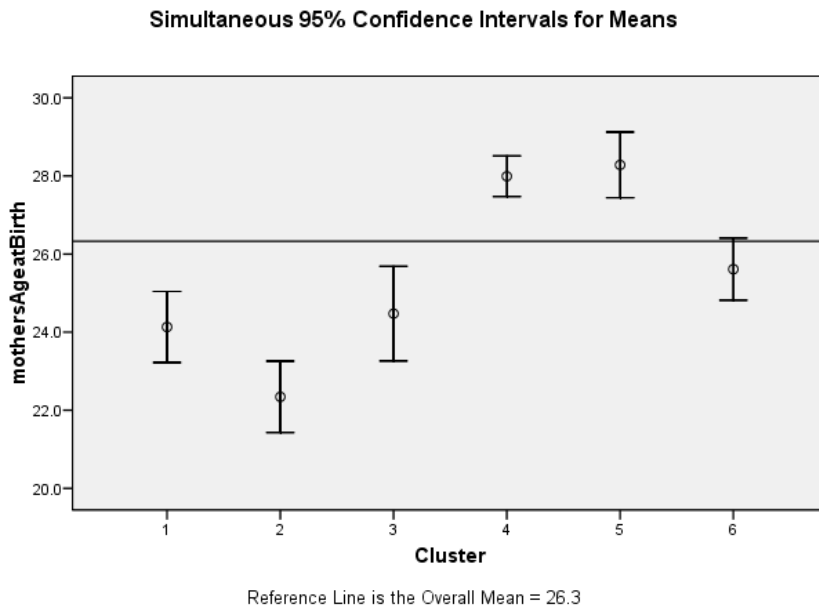


Figure 7. Age of mother by cluster group membership

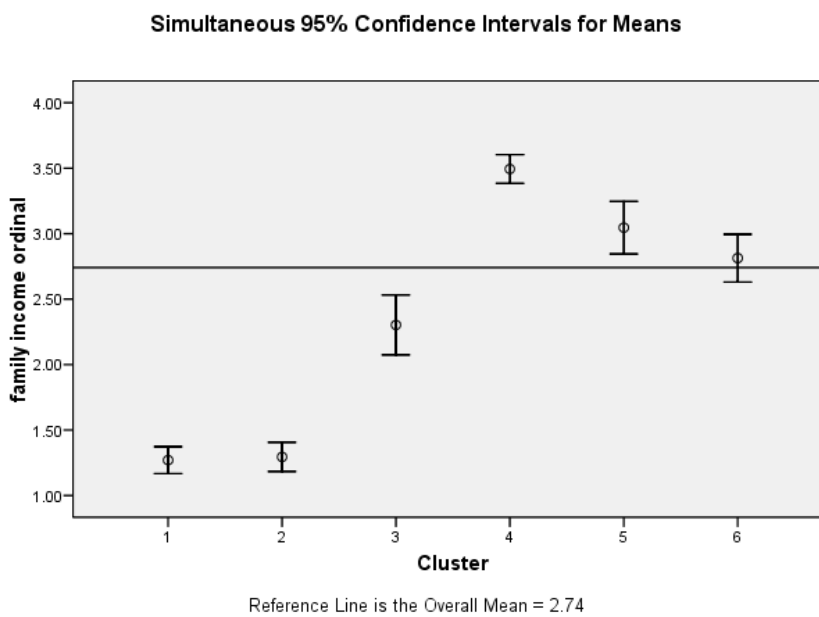


Figure 8. Income of household by cluster group membership

Fig 8: We used the following income categories collected at enrolment as a 5 point continuous scale for aiding clustering of families. 1 = below \$20,000 2 = \$20,000 to \$25,000 3 = \$25,001 to \$35,0000 4 = \$35001 to \$50,000 5 = above \$50,000

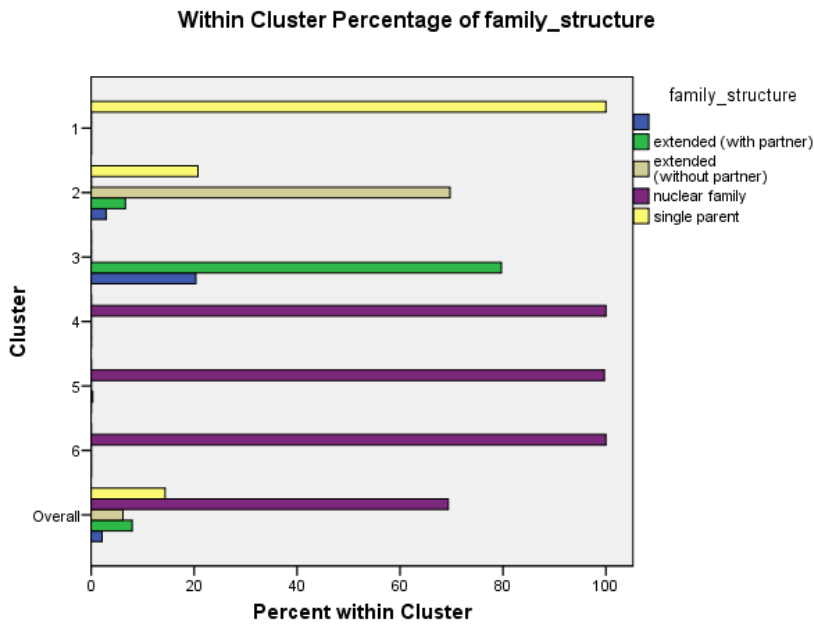


Figure 9. Family Structure by Cluster

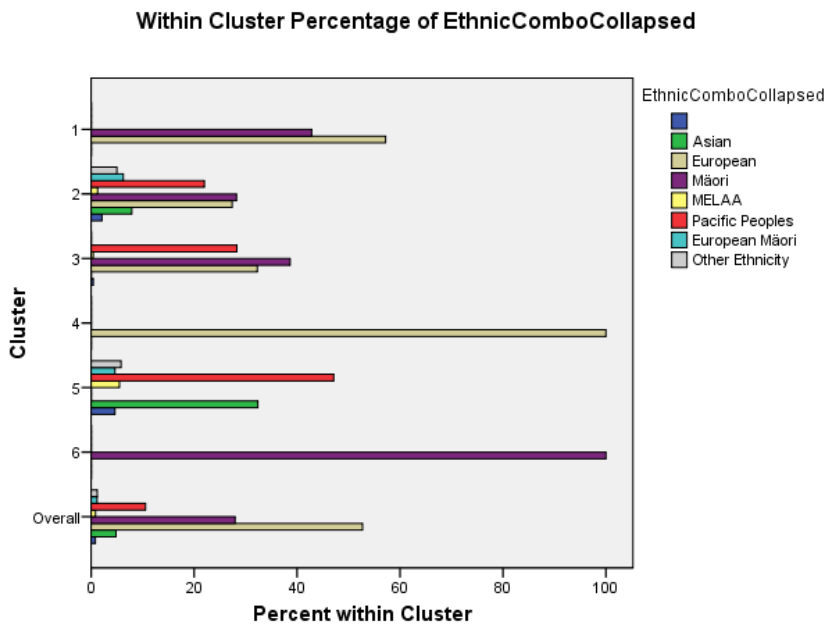


Figure 10. Ethnicity of mothers by cluster

Appendix 3: PAFT Results

Note this appendix is a fuller account of information provided in chapter three of the report.

How effective is PAFT in meeting its own goals and meeting the needs of parents? Is there variation in performance of PAFT across communities?

In this section we first examine child outcomes. We then work backwards through PAFT's programme logic examining evidence for each link in the logic chain. This examination is completed in section four following.

Summary

Analysis of outcomes for PAFT children at age 4, sourced from national screening of *child health and development* (B4School Checks), suggest increased amounts of PAFT are associated with:

- higher participation in B4School checks overall
- less need for referral or further assessment for hearing and conduct issues overall.

Analysis of sub-groups of PAFT families with similar characteristics suggests increased amounts of PAFT are associated with

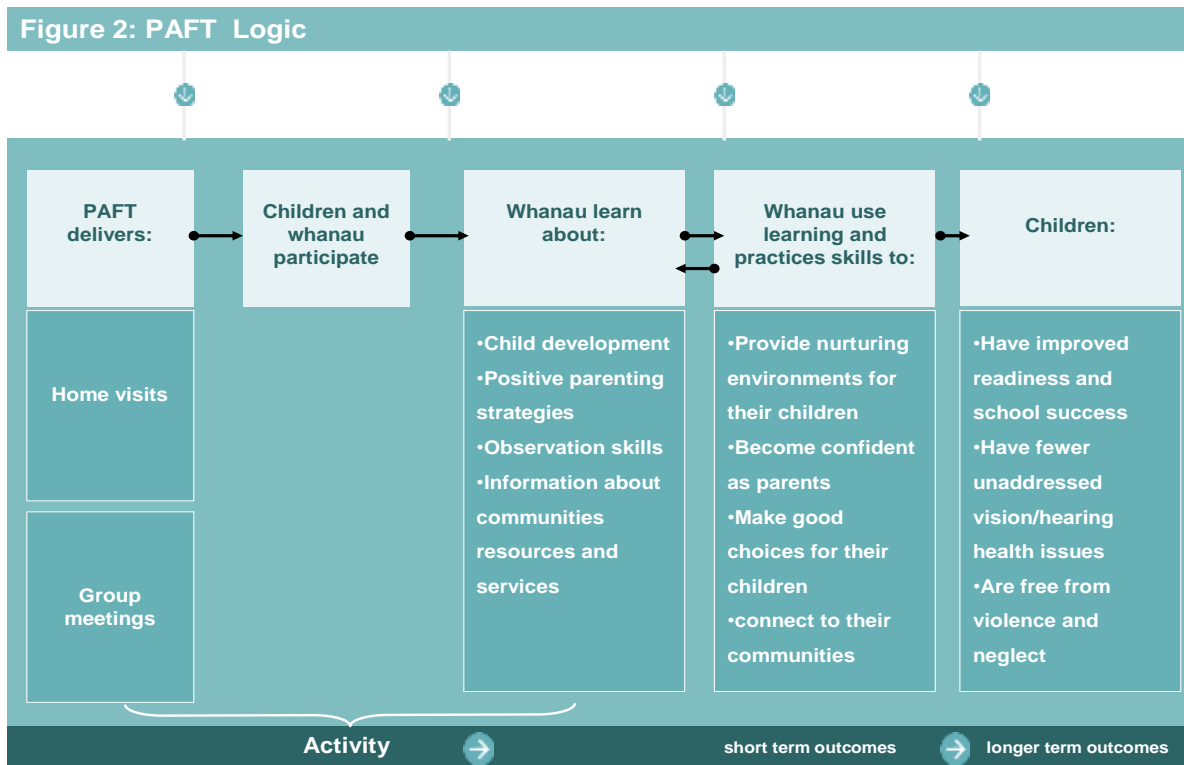
- better vision and conduct results for nuclear families with mothers who identify as Māori
- better conduct and developmental results for nuclear families with mothers identifying with 'other ethnicities' (that is, not European and not Māori)
- better hearing results for nuclear families with European mothers.

PAFT is a targeted programme, but it is not supposed to be for the most vulnerable families. Five out of the six positive associations between amount of PAFT and results of the checks were for clusters containing nuclear families (cluster four, five and six) who tended to be relatively better off. It could be that single-parents alone or in their extended families who are often younger and poorer compared with other PAFT families are not in a position to learn or implement parent education. Other circumstances in their lives overwhelm potential benefits of parent education. It could also be the case that 'education' is not the intervention needed for this group. Children associated with PAFT were more likely to be referred to CYFs than children in the general population. However they were just as likely to have a finding of maltreatment as children in the general population. PAFT children were just as *safe* as children in the general population.

Families report PAFT helps them with their *parenting* in range of ways clearly connected to the aims of the programme. The parenting survey as well as interview data suggest PAFT improves families knowledge, ability and confidence in parenting with little variation between sub-groups of the parenting sample. Families of all characteristics reported PAFT helped them develop in these areas of parenting.

PAFT outcomes

PAFT has evolved over the years. However its intentions, mechanisms and long-term goals have remained relatively stable. We have constructed a basic programme logic of PAFT from Te Whanau Harakeke Model for PAFT and the long-term goals and outcomes for PAFT written into the contracts with providers (Figure 2). We work backward through this programme logic assessing evidence of PAFT’s effectiveness against each step.



Outcomes for children

Measures and methods

We examined children’s health and development outcomes using the B4School Check (B4SC) data held by the Ministry of Health. B4SC are the last WellChild/Tamariki Ora visit for children at age 4 before they start school (<http://www.moh.govt.nz/moh.nsf/indexmh/b4-school-check-handbook-mar2010>).

B4SC is a relatively new screening regime for children in New Zealand and is still consolidating nationally. Our discussion highlights points of caution for interpreting findings. We were helped in this assessment by Dr Pat Touhy and Sue Dashfield at the Ministry of Health.

Our indicators from each measure as well as an assessment of our confidence in the measure are outlined in Table 2 below.

Table 2: Measures and outcomes for PAFT evaluation from B4SC

Assessment domain	Tool	Indicator for evaluation	Confidence and comment
Hearing	Sweep audiometry followed by tympanometry	Number of children completing a check out of all PAFT children in the 2006 birth cohort. Number of children referred out of total children assessed.	High
Vision	Distance visual acuity Snellen and/or Parr letter-matching tests	Number of children completing a check out of all PAFT children in the 2006 birth cohort. Number of children referred out of total children assessed.	High
Developmental screen	Parental Evaluation of Developmental Status (PEDS)	Number of children completing a check out of all PAFT children in the 2006 birth cohort. Number of children with two or more 'significant predictive concerns' ²¹ out of total children assessed (ie channeled through pathway A).	Medium Developmental assessments are still 'bedding in' in New Zealand.
Behavioural screen	Strengths and Difficulties questionnaire (SDQ) Teacher and parent forms Relies on parent observation and reporting on their children's behaviour across a number of items in the last 6 months	Number of children completing a check out of all PAFT children in the 2006 birth cohort. Number of children with Total Difficulties score in the 'abnormal range' out of total children* Number of children scoring in the 'abnormal range' on the Conduct sub-scale out of total children assessed. * Total Difficulties scores adds together the results for the Conduct, Hyperactivity, Peer Problems and Emotional Scales of the Strengths and Difficulties Questionnaire.	Medium Low rates of return for the teacher questionnaire means we have not included it in our analysis. National trends suggest teachers are less likely to report behaviour concerns than parents (parent mean 6.9, teacher mean 3.9 on 'total difficulties'.) Behavioural assessments are still 'bedding in' in New Zealand.
Immunisation		Number of children completing a check for whom there is immunisation status out of all PAFT children in the 2006 birth cohort. Number of children fully immunised at the time of the check according to the National Immunisation Register (NIR) out of total children assessed.	Low. We found low agreement between parent reports and NIR. There is variability in providers to access NIR.

We looked at whether children with higher numbers of PAFT home visits had different outcomes to children who had lower numbers of home visits. We looked at the association between the number of home visits and whether children had a check (participation) and if the check showed a negative outcome or not²² (results).

We also grouped PAFT families sharing similar characteristics together.²³ Characteristics included income of the family, family structure, mother's ethnicity and mother's age at the birth of her child. This analysis produced six sub-groups of families (see Table 3 below). By doing this we were able to look

²¹ Parental Evaluation of Developmental Status: Parent Response Form. Significant predictors of difficulties for children between 48 months and 53 months on the PEDS are in the areas of: 'global/cognitive', 'expressive language and articulation', 'receptive language', 'gross motor' and 'other' areas of development.

²² We used logistic regression to estimate whether the amount of PAFT received was associated with child outcomes.

²³ We used SPSS two-step cluster function to cluster families. Some cases were excluded because of missing information – 90.5% of the 2006 birth cohort were clustered (2,722 families clustered out of 3,000).

at whether the association with PAFT's differed for different groups of families. We refer to family sub-groups as 'clusters'.

We have labelled clusters according to the family structure and ethnicity of the mother where this is salient. Names are given below after the cluster number. The size of the cluster follows the cluster name.

TABLE 3. Sub-groups of PAFT families used in the analysis								
Cluster number	Cluster name	Size of cluster (% of 2006 cohort)	Predominant Family structure	Ethnicity of mother	Income of household	Average age of mother (years)	Average No. home visits at exit	Completion rate
1	Single-parents	13%	Single-parents	European or Māori	lowest	24.1	13	32%
2	Single-parents with extended family	9%	Single-parents with extended family	All ethnicities	lowest	22.3	14	31%
3	Couples with extended family	9%	Couples with extended family	All ethnicities	low	24.5	13	27%
4	Nuclear European	40%	Nuclear	European	highest	27.9	19	52%
5	Nuclear 'other ethnicity'	13%	Nuclear	All ethnicities except European & Māori	medium	28.2	14	36%
6	Nuclear Māori	17%	Nuclear	Māori	medium	26.3	14	31%

CLUSTER ONE: EUROPEAN AND MĀORI SINGLE-PARENT FAMILIES (341 FAMILIES, 13% OF COHORT, 315 MATCHED)

Cluster one was made up of single parents whose mothers identified as European or Māori. Families in this cluster had the lowest incomes (along with cluster two). Mothers were in the middle of the age distribution for PAFT mothers (24 years at the birth of their child). Less than a third of these families completed the programme.

CLUSTER TWO: SINGLE-PARENTS IN EXTENDED FAMILIES (241 FAMILIES, 9% OF COHORT, 222 MATCHED)

Cluster two was made up predominantly of single parents living with extended families (70%). Some single-parent households were also represented in this group (21%). Mothers of all ethnic groups were represented here. Families in this cluster had the lowest incomes (along with cluster one) and the youngest mothers (22 years at the birth of their child). Less than a third of families completed the programme.

CLUSTER THREE: COUPLES IN EXTENDED FAMILIES (251 FAMILIES, 9% OF COHORT)

Cluster three was made predominantly of couples living with their extended family. Families whose household structure was 'unknown' were also represented here (about 20% of the cluster). All ethnicities were represented in this cluster. Mothers tended to be in the middle of the age distribution (24 years) and incomes were below average. This cluster had the lowest completion rate.

CLUSTER FOUR: NUCLEAR EUROPEAN (1093 FAMILIES, 40% OF COHORT)

Cluster four was made up of nuclear families only, with mothers who identified as European. This cluster had the highest incomes on average (though it is still not high)²⁴ and mothers were among the oldest in the birth cohort (28 years at the birth of their child). This cluster had the highest completion rate and the most number of visits at exit.

CLUSTER FIVE: NUCLEAR 'OTHER ETHNICITY' (346 FAMILIES, 13% OF COHORT)

Cluster five was made up of nuclear families, with mothers who identified with 'other ethnic' groups (not European and not Māori). The average age of mother at the birth of her child was 28 years with family incomes at the top of the range (alongside cluster four). Just over a third of families completed the programme.

CLUSTER SIX: NUCLEAR MĀORI (450 FAMILIES, 17% OF COHORT)

Cluster six was made up of nuclear families with mothers who identified as Māori. The average age of Mothers at the birth of their child in this cluster was close to 26 (25.6 years) which puts them in the middle of the age distribution for PAFT families. Incomes for families in this cluster were also in the middle of the income distribution. Just less than a third of these families completed the programme.

Provider variation

We also looked at whether there were differences in outcomes between PAFT providers. We know, for example, that some providers are better at engaging and retaining their families than others. And we also know that there is variation among providers on our indicators of provider performance from the Phase One report.

Findings for children

On average the amount of PAFT received was positively associated with participation in all checks and results for hearing and conduct results

Among children born in 2006 whose families were enrolled into PAFT:

- children in families with more PAFT visits were more likely to participate in all of the B4SC assessments
- children in families with more PAFT visits were equally as likely to be referred for further assessment or treatment for their vision or development
- children with more PAFT were less likely to be in the abnormal range on the conduct sub-scale on the SDPQ (part of the behavioural assessment). Overall behaviour scores on the SDPQ ('total difficulties') were not associated with amount of PAFT.
- children with more PAFT visits were less likely to be referred for hearing difficulties.

²⁴ 82% of PAFT families had incomes below \$50,000. This compares to a household median income In 2006/2007 of \$55,976 (HES, Statistics New Zealand)

We found provider variation in whether a check was done but not in the results of the checks once family characteristics were controlled for.

When we kept family characteristics constant, families of some providers looked like they were more likely to have a B4SC done than families from other providers.

When we kept family characteristics constant, we did not see a difference in the likelihood of children served by different providers being referred for further assessment or treatment following the B4SC.

The association with amount of PAFT received and B4SC participation and results varied for families living in different circumstances

PAFT was associated with better hearing or vision or conduct results for children in some family sub-groups. None of the groups showed any difference in overall behavioural scores according to whether they had had more PAFT or not. Figure 3 summarises the findings for the association between PAFT and family clusters. A dark outline indicates a positive and statistically significant association between amount of PAFT and the result. A light outline indicates some evidence of association (though not statistically significant). The dotted line represents the national average for the 2006 birth cohort at the time we extracted the data (March 2011). The curved lines summarise the difference in B4SC outcomes for families who received different amounts of PAFT. Number of home visits are on the horizontal axis and the likelihood of a result (between 0 and 1) is on the vertical axis.

Table 4 summarises the information but gives results for the B4School Checks with a comparison to the PAFT cohort and the general population.

PARTICIPATION IN CHECKS

Figure 3 shows the association between having a check done and more PAFT holds to some extent for families across all clusters except cluster two. We found no association between amount of PAFT and participation in B4SC for children living with single parents in their extended family.

RESULTS OF THE CHECKS BY DEVELOPMENTAL DOMAIN

Vision

- More PAFT was associated with a reduced rate or referral following a sight check for children living in nuclear Māori families (cluster six).
- We also found ‘some evidence’ that more PAFT was associated with a reduced rate or referral following a sight check for children living in extended family arrangements (with couples) (cluster two).

Table 4 shows single-parent families on their own or in extended families (clusters one and two) had the most room to improve when compared with national averages (12% compared with a national average of 8% referrals for sight difficulties).

Figure 3. Association between number of home visits and B4School Check results by cluster

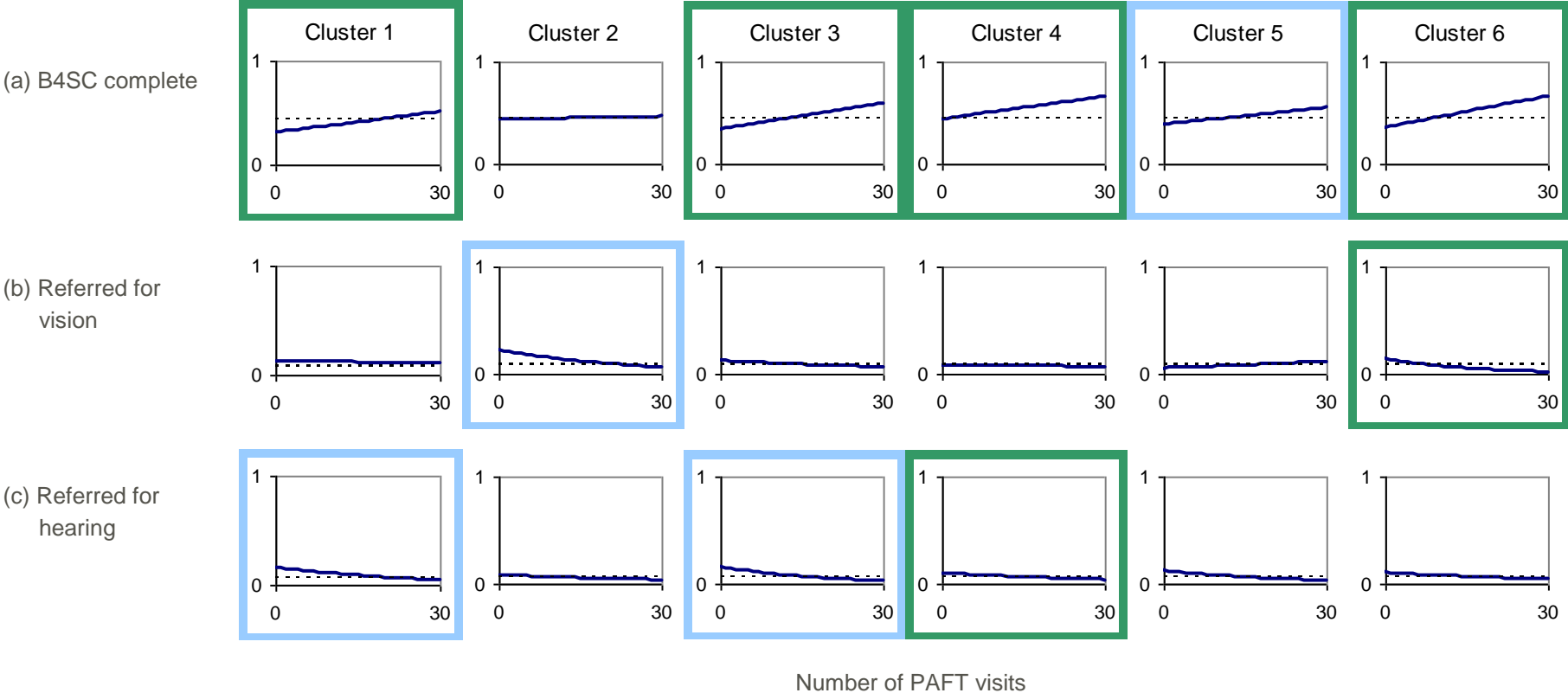


Figure 3 (cont). Association between number of home visits and B4School Check results by cluster

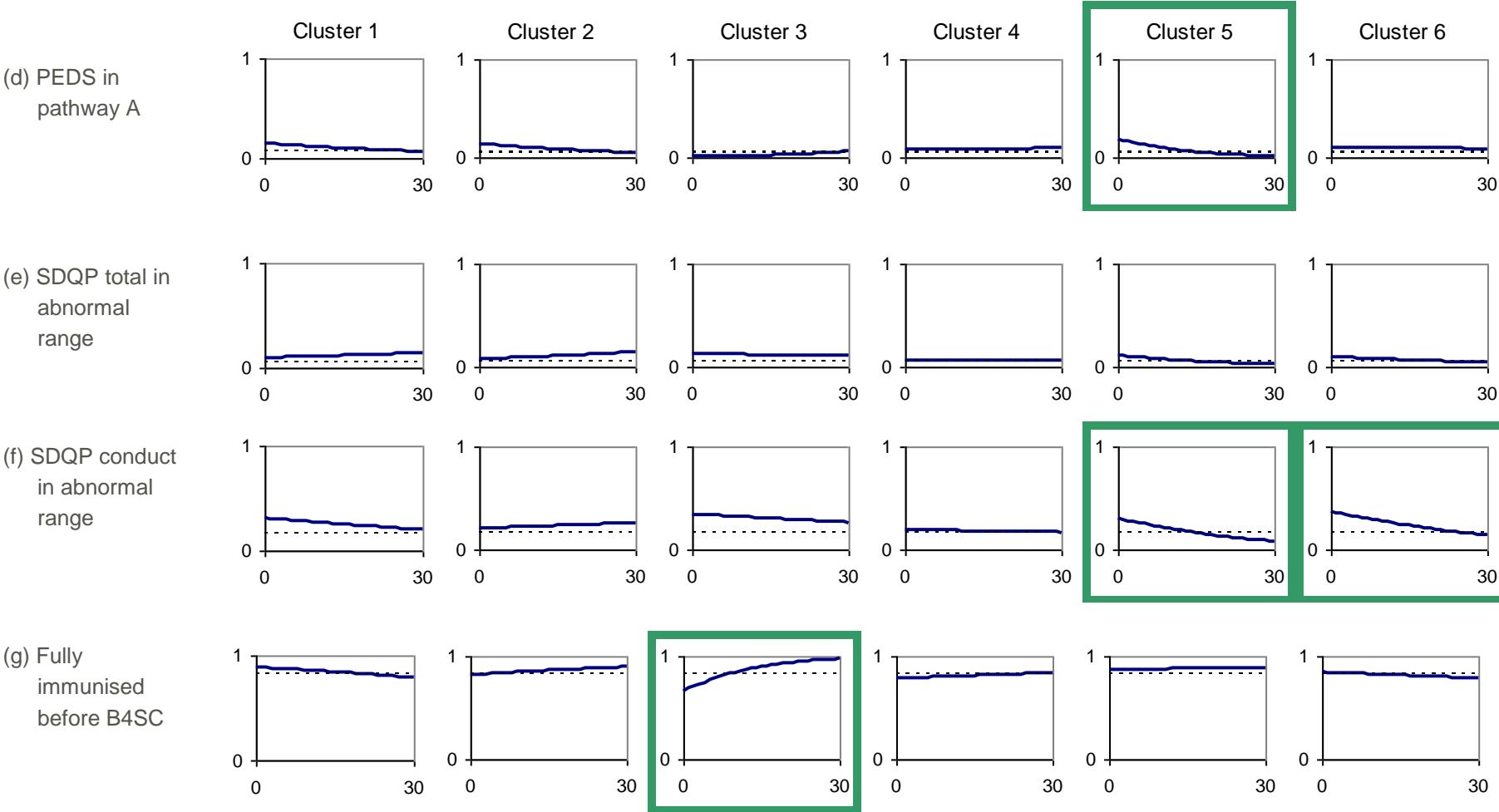


TABLE 4. Results of B4School Checks by family cluster

	Hearing			Vision			PEDS		SDPQ		Immunisation	
	No in cluster	Check done	Refer	Check done	Refer	Check done	Path A	Check done	Total Difficulties Abnorm.	Conduct Score Abnorm.	Check done	Complete
No cluster	275	62%	7%	62%	9%	56%	6%	56%	6%	16%	55%	74%
1	315	57%	9%	56%	12%	51%	11%	51%	13%	27%	51%	81%
2	222	55%	6%	55%	12%	50%	9%	50%	11%	23%	47%	84%
3	231	56%	8%	57%	9%	47%	3%	48%	11%	29%	48%	86%
4	1045	71%	6%	70%	7%	63%	9%	62%	7%	18%	61%	79%
5	324	53%	8%	53%	9%	48%	8%	48%	6%	17%	46%	91%
6	427	63%	7%	63%	7%	56%	10%	56%	8%	26%	55%	78%
All PAFT	2,839	63%	7%	62%	9%	56%	9%	56%	8%	21%	55%	80%
All B4SC	64,098	59%	6%	59%	8%	48%	6%	47%	5%	16%	47%	82%

Hearing

- More PAFT was associated with a reduced rate or referral following a hearing check for children living in nuclear families with European mothers (cluster four).

Table 4 shows referral rates for hearing for children in single-parent families (cluster one), couples with extended family (cluster three) and nuclear families with ‘other ethnicity’ mothers (cluster five) have some room for improvement for PAFT children to equal the national average of hearing referrals.

Behaviour (SDPQ)

‘Total Difficulties’

- We found no evidence of association between amount of PAFT and scores in the ‘abnormal range’ for total difficulties for any of our family clusters.

Table 4 shows assessments of behavioural concerns were higher overall in each of the PAFT clusters when compared with the national average on this scale. This indicates there was some room for improvement in the PAFT clusters.

Conduct scores

- More PAFT is associated with lower rates of abnormal conduct scores for nuclear families with Māori mothers (cluster six) and nuclear families with mothers of ‘other ethnicities’ (cluster five).

All children enrolled in PAFT had higher rates of conduct concerns than the national average (16%) indicating some room for improvement across all clusters.

Development

- More PAFT was associated with low rates of reported developmental difficulties for children in nuclear, 'other ethnicity' families (cluster five).

Children in single-parent families with or without extended family (cluster one and two) and nuclear families with European or Māori mothers had higher proportions of reported developmental concerns than the national average (6%). This indicates some room for improvement for these families.

This developmental assessment is still 'bedding in' in New Zealand, with some suggestions of differences in the way it is implemented across the country. This lowers the reliability of our indicator from this measurement tool. We don't know, for example, whether B4SC providers ask parents to fill in the PEDS screen where the child already has an identified disability.²⁵

The outcomes findings for the developmental screen which suggest that PAFT is not associated with better development outcomes for most families need to be tempered by a look at the range of specialist developmental services *already involved* in families assessed in PEDS outcomes pathway A (20% of families). This is a free text field in the general health questionnaire. A look at the services already received by families (where recorded) at the time of the B4SCheck where information was recorded for this group suggest:

- a level of need of the child beyond the scope of PAFT
- early identification of problems before the check for a small minority of families.

We do not know whether PAFT was the pathway into the help families were receiving at the time of their B4School Check. However it is certainly possible that association with PAFT may also at the least encourage families to seek support for their children.

Immunisation

- More PAFT was associated with higher rates of children being fully immunised for children living in extended families with two parents (cluster three).

Immunisation rates for families enrolled in PAFT for this cluster were 86% (compared with a national average of 82%).

However children in families of single-parents living in extended families (cluster two) and nuclear 'other ethnicity' families had better-than-average rates of immunisation (cluster five). Room for improvement was available to children in nuclear families with European (cluster four, 79%) or Māori mothers (cluster six, 78%).

We used provider checks of the National Immunisation Register (NIR) to determine whether immunisations had been completed at the time of the B4SC.

²⁵ For children needing further assessment or treatment following from the development screen, we looked at what was recorded against the question in the General Health Questionnaire for the 'Are you or your family receiving help or support from any other services?' We were interested in whether these children may already be under care for developmental issues. Of the 138 PAFT children needing further developmental assessment or treatment, 40 (29%) had comments recording help they were receiving. Of these 40 children, 70% (28% of all PAFT kids in PEDS pathway A) were already receiving support for one of their child's difficulties and/or, reported their child was disabled (eg autistic, global developmental delay, receiving child disability allowance). This means that these children had already been identified as having some developmental concerns before their B4School Check and were receiving support.

Officials at the Ministry of Health advised that not all providers of the B4SC had access to the National Immunisation Register (NIR) to check on immunisation status at the time of the B4SC assessment. For this reason, this immunisation indicator is not reliable. We checked the results of the NIR against parents reporting of immunisation and found parents under-reported their child's immunisation status compared with the NIR. That is parents whose children were fully immunised at the time of the check did not always report that to be the case.

How PAFT could be making a difference (or not)

This analysis suggests PAFT is associated with better results for some families in some domains. The mixed picture of results could be expected given the inconsistent results of home visitation programmes in the literature (see section one for a review).

The most reliable B4SC indicators are *vision and hearing*. Screening and referral for these outcomes follow well-established protocols in District Health Boards.

Problems with *vision* are not usually linked to structural determinants such as socio-economic status. Vision (for the most part) is biologically driven rather than being affected by environmental circumstances. Lower rates of referral for sight difficulties may reflect PAFT brokering access to vision specialists early on for children who need it. This could be the case for children living in nuclear families with Māori mothers and perhaps for children of single-parents living with their extended families.

Hearing problems are in part environmentally determined. The most direct solution offered by PAFT is early detection and referral. PAFT does not deal directly with changing the material living circumstances of family that are associated with illness leading to ear infections, for example. PAFT averages for hearing results were closer to national averages indicating less need for intervention across most of our clusters (one percentage point difference for cluster three, five and six).

PAFT was associated with a lower rate of hearing referrals for nuclear families. We have some evidence of association for better hearing results for single-parent families and couples with extended families— where the greatest disparity with national averages fell.

Taking the results of the hearing and vision results together (see Table 4) suggests a pattern where the association with amount of PAFT is strongest where the need was greatest (barring nuclear European families). We have some evidence that PAFT may be working well at monitoring and referring children for sight and hearing difficulties where there is a need, though the association is not so strong where families are in greater hardship.

Our discussion with child health experts at the Ministry of Health suggests that a family support intervention like PAFT would be expected to make some difference to children's developmental and behaviour results.

As we have noted above, we have less confidence in developmental and behavioural screens as indicators for PAFT outcomes because of potential variability in the way these checks have been implemented across the country. Given more time, results of these screens will become more reliable for evaluation purposes.

Monitoring *child development* and teaching families to observe and encourage their children's skills is a critical part of the PAFT programme. Our parent survey suggests that child development knowledge is the biggest growth area for parents on the programme. Families we talked to during the case studies felt reassured by having an expert monitoring their children.

However, amount of PAFT was not associated with better results from development screen for any families except for nuclear families with mother's of 'other ethnicity' (that is, not Māori and not European). Given the nature of PAFT, this is concerning.

Results of the *behaviour screen* are more promising with two clusters of families reporting lower levels of conduct concerns with more PAFT – nuclear families with mothers of 'other ethnicity' or Māori ethnicity. We note however, reports of conduct problems were higher among all clusters in the PAFT cohort than the national average – signaling room for improvement for all families.

Taking the results of the development and conduct together (Table 4), suggests PAFT is associated with better results for some families where the need is greater. But this is not the case for families in greater hardship (single-parents and couples with extended families) where PAFT is not associated with better conduct or development results.

How could we explain a lack of strong evidence associating PAFT with outcomes for children living with single-parents on their own or with extended families (clusters one and two)?

Families of single-parents living alone or with extended families had the lowest incomes of all the clusters and the youngest mothers. That is, they were parenting in more challenging situations (as far as we could tell with the data available). We suggest PAFT may not be enough to overcome the challenges facing single-parent families living in poverty, or with young mothers or both. This may especially be the case for single-parents living with their extended families, as PAFT was not associated with participation in B4SC for this group.

Five of six providers we visited suggested that PAFT worked best for families who had their basic needs met and were in a position to learn from the programme. Perhaps then, these families are not living in conditions that encourage learning or changes in parenting practice.²⁶

The literature provides reasonably strong evidence that poverty is a driver of child outcomes (Duncan, Ziollel-Guest and Kalieel, 2010). A recent internal review looking at the mechanisms linking poverty to child outcomes in the context of welfare receipt suggested the 'economic resources model' as playing the largest role (Mackay, 2010, unpublished). This model suggests 'welfare families have fewer economic resources and are more likely to be materially disadvantaged than families that are financially self-sufficient. Poor families not only have less money to invest in their children's schooling and to purchase other goods and services that promote healthy development, but are often preoccupied with managing economic crises and consequently have less time and energy to devote to their children.'

'Negative social support' may also be a factor in some families. Educator interviews as well as those with families in our case studies suggest that PAFT helped parents by supporting their decisions sometimes in the face of 'negative social support'. That is, parenting in situations where family's support networks discouraged them from parenting in the way they thought best. It could be that case that delivering PAFT to young single-parents or couples without changing the context of potential 'negative social support' (for example, by also working with extended families) negates its usefulness. The lack of findings for single-parents in extended families could also be explained by young mothers

²⁶ The sixth provider had a strong policy of holding on to their families especially young mothers who did not have established living arrangements (moved around) as they felt they could still get some benefit from PAFT. We note also a tendency for providers to try and help families to the extent that they could in areas where no other help was available – at least as an interim measure. This drive to help extended to families who PAFT might not be the best solution for but for whom there were no alternatives.

not being ready to step into the parenting role. Educators also gave examples where this was the case particularly in discussing challenges in engaging families.

To sum up health and development: PAFT is a targeted programme, but it is not supposed to be for the most vulnerable families. Five out of the six positive associations between amount of PAFT and results of the checks were for clusters containing nuclear families (cluster four, five and six) who tended to be relatively better off. It could be that single-parents alone or in their extended families who are often younger and poorer compared with other PAFT families are not in a position to learn or implement parent education. Other circumstances in their lives overwhelm potential benefits of parent education. It could also be the case that ‘education’ is not the intervention needed for this group.

Child safety

To examine the contribution PAFT might make to reducing child maltreatment we compared rates of notification and substantiation of a random sample of PAFT children born in 2006 (n=100) to the general population born in 2006. PAFT children differ from the general population because they join PAFT on the basis of some risk factors associated with poor child outcomes being present. PAFT children are a more vulnerable group than the general population.

TABLE 5. PAFT and general population rates of notification and abuse for 2006 Birth cohort		
	General population	PAFT sample
Rate of notifications per 100 families	20.2	32 (±9)
Rate of findings per 100 families	6.6	6 (±4.6)

PAFT children are more likely to be notified to CYF than children in the general population²⁷.

Table 5 shows that at age 4, 32 of the 100 PAFT children in the sample had been notified to CYFs. The confidence interval suggests the actual rate of notification for PAFT children in the 2006 birth cohort would fall between 23 and 41 children per 100.

The general population rate was 20.2 notifications per 100 children born in 2006.

PAFT children are more likely to be notified to CYF than children in the general population.

PAFT children are no more likely to have substantiated findings of abuse than children in the general population.

At age 4, six of the 100 PAFT children in our sample had a substantiated finding. The confidence interval suggests the actual rate of substantiation for PAFT children would fall between 1 and 11 substantiations per 100 children.

The general population rate of substantiations was 6.6 children per 100 children born in 2006

PAFT children are no more likely to have substantiated findings of abuse than children in the general population.

²⁷ Notifications can be seen as a indication of community sensitivity or responsiveness to child abuse.

Of the PAFT families notified to CYF in our sample, we did not find any cases where PAFT, or PAFT host organisations notified families. We know from our fieldwork that educators do not make the decision to notify a family on their own. Concerns are discussed with the PAFT co-ordinator and a manager of the host agency (often not involved directly in PAFT). PAFT educators also may talk to other agencies involved with families to check family safety. The decision on WHO notifies is negotiated in different ways and with different parties.

We also note that in the five of the six cases where a substantiation was made, family violence was present. Intervening in family violence is beyond the scope of PAFT to influence except by referral.

To sum up child safety: Children associated with PAFT are more likely to be referred to CYFs than children in the general population. However they are no more likely to have substantiated findings of abuse than children in the general population.

Outcomes for parents

Results so far suggest PAFT is associated with some results for some children. In this section we look at results for families.

Summary

Families report PAFT helps them with their parenting in a range of ways clearly connected to the aims of the programme. The parenting survey as well as interview data suggest PAFT improves families' knowledge, ability and confidence in parenting with little variation between sub-groups of the family sample. Families of all characteristics reported PAFT helped them develop in these areas of parenting.

Measures and methods

We examined outcomes for parents and families in three ways.

In Phase One we analysed outcome stories provided by PAFT staff in their biannual reports. We also used this source of information to help us understand the mechanisms through which PAFT helped families.

In Phase Two we surveyed all parents who had been on PAFT for a year or more as at 31 January 2011. We also interviewed educators and parents in our case studies about what they saw changing as a result of PAFT.

We begin this section with a summary of how educators know they are making a difference before looking at results of the parent survey.

Indicators of change – educator and family accounts

For our case studies, we asked staff and families how they knew PAFT was making a difference. Educators described a range of ways that PAFT was making a difference to families including changes they were able to observe directly.

At the simplest level educator reported families were home (routinely at the time of the visit) and present during the visit. This indicates parents are appreciative of the visit and **wanting to participate**.

Other indicators that PAFT was making a difference were **environmental changes** in the home. This included moving dangerous objects out of the reach of children, making the floor (which is the babies primary playspace) cleaner, not using props that may delay the child's physical development such as jolly jumpers and excersaucers, and evidence of PAFT resources, designed to promote the child's learning, around the home.

Educators also observed **changes in parenting behaviour**. Notable differences were in the way parents interacted with their babies- such as talking to them more, recognising and responding to the child's cues. Educators also observed parents making resources or doing activities with the child, and parents being able to share observations of their child's development.

Educators observed parents getting out and **socialising more** as well joining playgroups and attending parent classes.

Educators also gave examples of changes in **family functioning**. These included moving out of violent relationships and members of the wider family engaging with their child's learning.

Our parent survey captures changes to parenting primarily for behaviour. These results are linked to the sorts of outcomes observed by families and their educators above. However, interview data suggest a wider range of outcomes for PAFT than are captured in our survey.

Parenting Survey

We examined change in parenting outcomes on a standardised psychometric tool developed for Parents as Teachers – the University of Idaho Survey of Parenting Practice (UISPP, Shaklee and Demarest, 2005). Families currently on PAFT assessed their growth in:

- knowledge of child development
- confidence in parenting skills
- their ability to respond to their child
- the amount of activities they did with their child

Using the same format as the UISPP we also asked about their:

- enjoyment of being a parent
- connection to other families with children.

This tool asked parents to rate their parenting on a number of items now and then think back to before PAFT and rate themselves on the items then²⁸. We also developed a number of statements about how PAFT helped based on our analysis of outcome stories in Phase One. Our instruments were

²⁸ The approach to assessment is called a 'retrospective pre-test' methodology. The assumption is that pre-test and post-test programme responses to any question may not be comparable because learning about parenting will cause parents to think about survey items in a new way. This was demonstrated by parents in a pre-post test evaluation of HFA that ran the retrospective pre-test methodology alongside (Pratt et al, 2000). Before you start a programme, 'you don't know what you don't know.' You might think you know a lot then realise how much there is to know as you learn more throughout the programme. So by the end, you rate your knowledge as less than you know at the pre-test before undertaking the programme. The retrospective design gets around this problem by parents rating themselves from the same reference point.

commented on by the PAFT contract management team and tested cognitively with parents and parent educators.

Sample

We surveyed all families who were enrolled on PAFT as at 31 January 2011 and had been on PAFT for a year at least. Children's ages ranged from 1 – 3 years. Nine-hundred people returned surveys yielding an estimated response rate of 38%.

Compared with all families surveyed, survey respondents were more likely to be from:

- nuclear families than other family types
- families earning above \$35,000 a year compared to families on lower incomes
- families with mothers aged over 26 years than families with younger mothers at the birth of their child
- families with a European mother than other families

Table 6. Parent Survey Response sClass		Family's surveyed	Families surveyed	Families Responding	Families responding	Families responding
		(n=2343)	(% in each demographic category)	(n=900)	Response rate of each group (%)	% of families responding from each demog group
Family structure	nuclear family	1565	66.8	652	41.7	72.4
	single-parent	242	10.3	72	29.8	8.0
	extended (with partner)	216	9.2	73	33.8	8.1
	extended (without partner)	123	5.2	35	28.5	3.9
	unknown	197	8.4	68	34.5	7.6
	Total	2343	100.0	900	38.4	100.0
Family income	below \$20,000	581	24.8	159	27.4	17.7
	\$20,000 to \$25,000	258	11.0	75	29.1	8.3
	\$25,000 to \$35,000	319	13.6	109	34.2	12.1
	\$35,001 to \$50,000	489	20.9	210	42.9	23.3
	over \$50,000	567	24.2	305	53.8	33.9
	unknown/missing	129	5.5	42	32.6	4.7
	Total	2343	100.0	900	38.4	100.0
Mothers' age	Under 20	383	16.3	87	22.7	9.7
	20 to 25	713	30.4	222	31.1	24.7
	26 to 35	944	40.3	433	45.9	48.1
	Over 35	270	11.5	145	53.7	16.1
	unknown/missing	33	1.4	13	39.4	1.4
	Total	2343	100.0	900	38.4	100.0
Ethnicity	European	1430	61.0	644	45.0	71.6
	Māori	282	12.0	81	28.7	9.0
	European Māori	233	9.9	79	33.9	8.8
	Pacific Peoples	179	7.6	23	12.8	2.6
	Asian	105	4.5	49	46.7	5.4
	Māori Pacific Peoples	19	0.8	1	5.3	0.1
	MELAA	19	0.8	7	36.8	0.8

Other Ethnicity	49	2.1	9	0.0	1.0
unknown	27	1.2	7	0.0	0.8
Total	2343	100.0	900	38.4	100.0

Families rate their parenting knowledge, confidence and ability more highly after their time on PAFT

Fig 4 shows that respondents rated their parenting knowledge, confidence, ability and amount of time spent with their children significantly more highly at the time of the survey than before they started PAFT. The largest changes occurred where respondents showed the most room to move. The biggest changes in descending order were reported for knowledge, confidence, ability and amount items. At the time of survey respondents rated their parenting abilities most strongly followed by the amount of activities they did with their child, their confidence and knowledge of child development (in descending order).

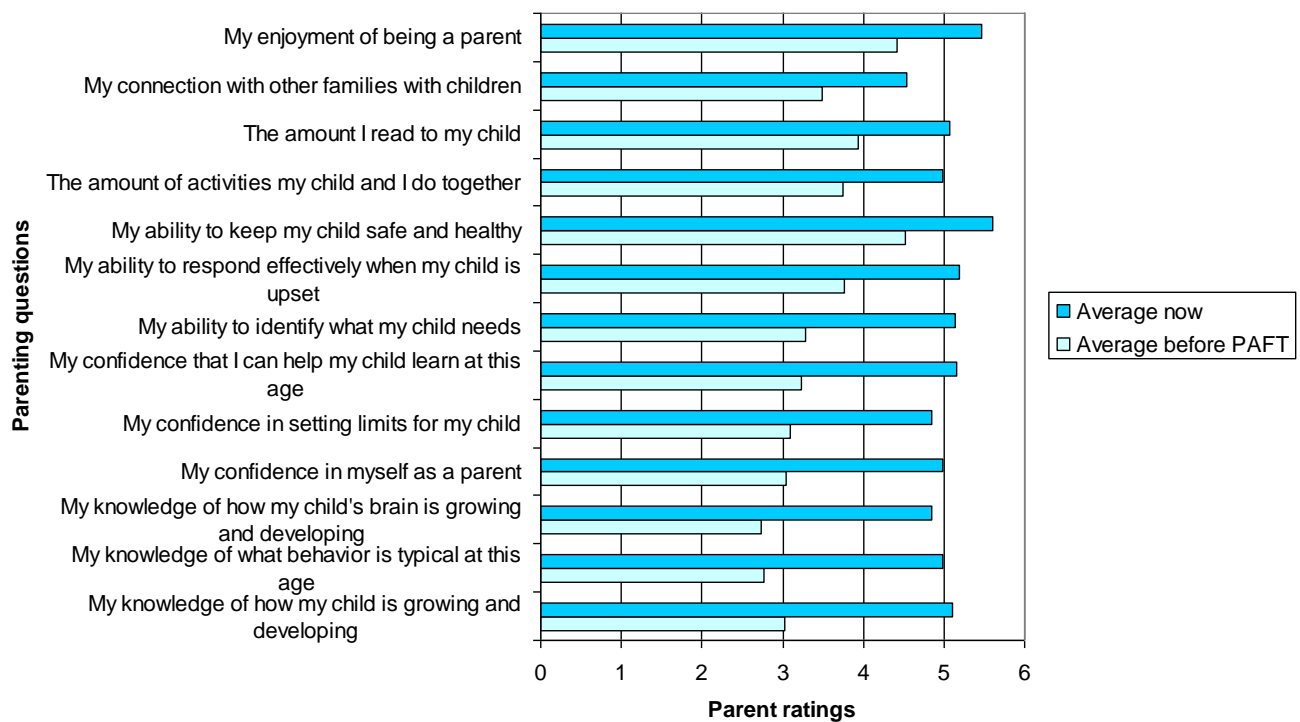


Figure 4. Change in parenting pre and post PAFT

Our analysis found changes in parenting outcomes were consistent across families from different income levels, ethnicities, household structures and with young and old mothers.

Both first-time parents and parents on PAFT with their second or further child, reported positive changes in their parenting after their time on PAFT. First-time parents reported bigger changes than second time parents. This is what you would expect given that first-time parents will grow in their parenting practice from the experience of having a child (compared to not having a child).

Because parenting is influenced by multiple factors we asked how much PAFT helped with parenting.

Figure 5 shows 85% of respondents thought PAFT helped them with their parenting ‘quite a lot’ or ‘a great deal’. Reports of how much PAFT helped were consistent across families from different income levels, ethnicities, household structures and with young and old mothers.

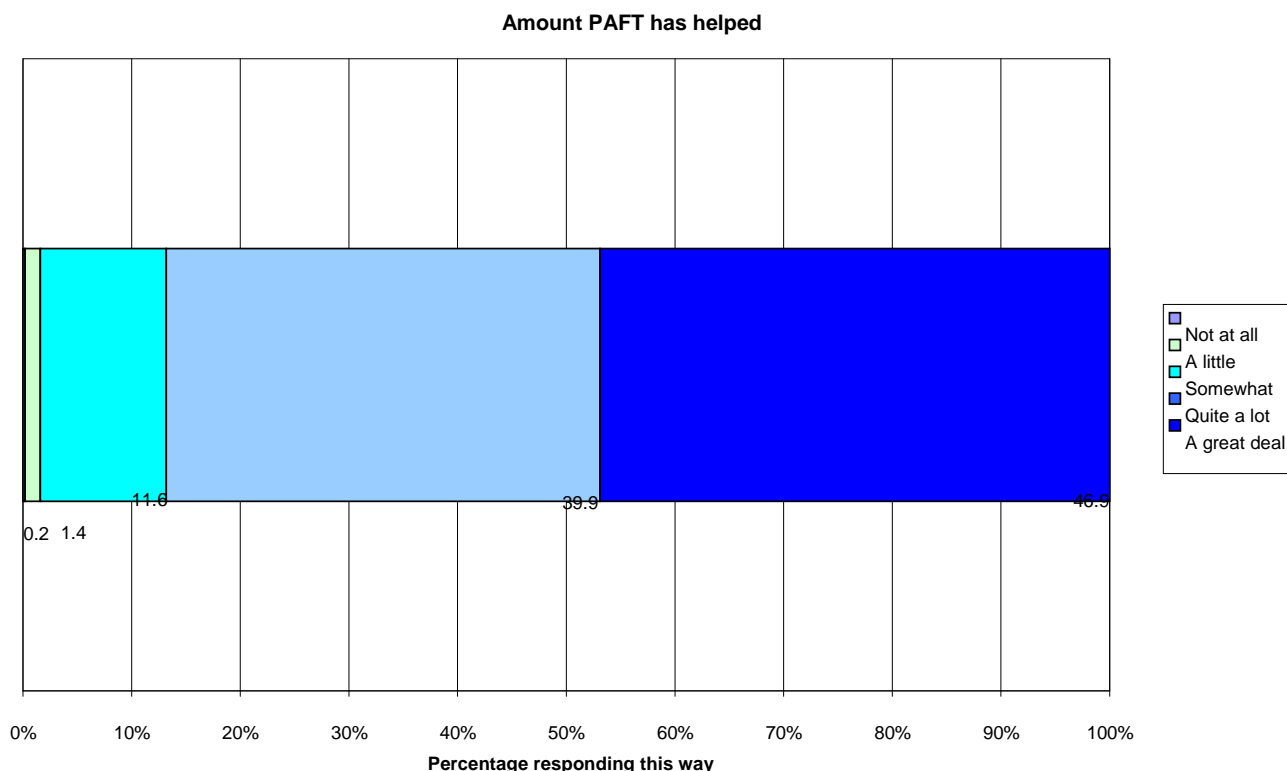


Figure 5. How much PAFT helped parenting

Those families who more strongly agreed that they had access to community resources and help in their parenting also reported that PAFT helped to a greater degree than other families. It could be that PAFT encouraged families to be connected with parenting resources so they were more aware of them. Or access to resources augmented the training received with PAFT. Or happier parents were more likely to respond positively to this question.

PAFT helps families through improving child development knowledge, affirming families and giving practical parenting strategies

We asked families to indicate their agreement with a number of statements about how PAFT helped them. These items were developed from our analysis of outcome stories contained in provider biannual reports, responses to parent surveys conducted six-monthly with PAFT parents, and our reading of PAFT’s design (the ‘intended programme’). One is strongly disagree and 5 is strongly agree. Ratings are show in Fig 6 below.

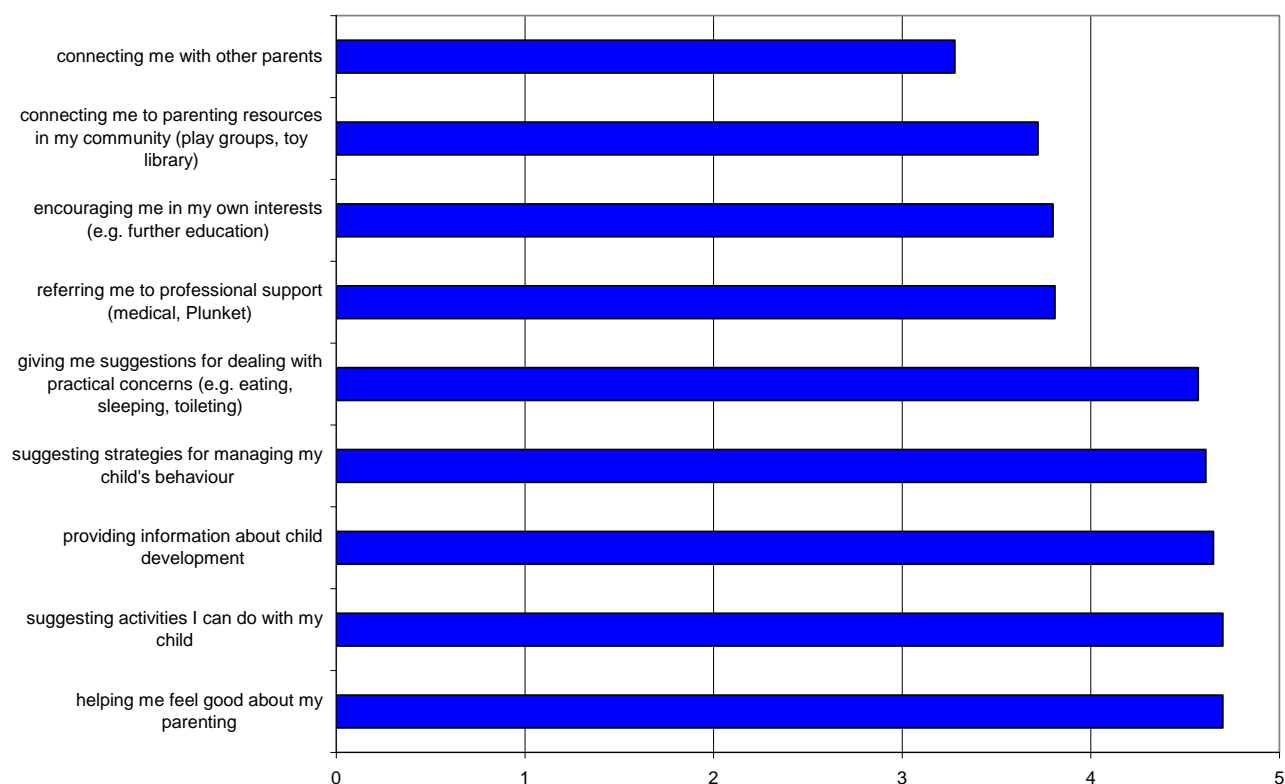


Figure 6. Family agreement with how PAFT helped them

On a scale of 1-5 where 5 is strongly agree and 1 is strongly disagree we found strongest agreement for:

- Helping me feel good about my parenting (affirmation)
- Suggesting activities I can do with my child (things to do)
- Providing information about child development (information)
- Suggesting strategies for managing my child's behaviour (strategies)
- Given me suggestions for dealing with practical concerns (eg eating, sleeping, toileting) (strategies)

On the basis of common support, we suggest these are the core mechanisms by which families are helped in PAFT. These items were also strong themes in the free text comments from parents in the survey (n=600). Parents appreciated the knowledge, activities and advice received from educators and their improved feeling of confidence.

The 'referring' and 'connecting' mechanisms did not garner such high agreement nor 'encouraging me in my own interests'²⁹ as other items. We found a tendency for families with European mothers or in the highest income brackets to agree less strongly with these items. However differences between groups of families where they existed were very small and did not account for much variance in parent responses. That is, there are a lot of *other things* determining parents ratings of how PAFT helped them compared with the demographic variables we could measure.

²⁹ Note 'encouraging me in my own interests' is not part of the design of PAFT but is one of the outcomes parents and educators attribute to the programme according to the biannual report outcome stories and biannual parent surveys.

We also found an association between people more strongly agreeing that they had access to community and parenting resources also more strongly agreeing that PAFT helped them in each of the ways. Again this association could be explained in several ways including:

- people feeling they have good support being more likely to make the most of PAFT
- the ways that PAFT helps being facilitated by good access to resources and parenting help
- a happy response bias where some families are inclined to respond positively to all questions asked.

Provider variation

For 14 providers who had enough respondents (n=30) to put into a regression model, we found 'provider' accounted for a very small amount of variance in the parent change scores. That is, the 14 providers were all doing a reasonable job in helping parents change in positive directions with their parenting. Differences among the 14 providers were even smaller for the 'amount PAFT helped', accounting for only 1% of the variance in the model.

The story so far

PAFT is associated with better participation in child health and development monitoring (B4SC) for all families except for single-parents living with extended family (that is five of six clusters we looked at). PAFT educators actively monitor children's health and development. They also encourage family members to observe their children and take action where it is needed. PAFT may be a mechanism for assisting families to better monitor and look after their children's health. Or it could be, that families who seek reassurance about their children's health are more likely to enrol in PAFT and also more likely to participation in health and development monitoring (B4SC). Our current analysis can not rule out the latter possibility.

The association between higher participation in PAFT and better child monitoring does not translate to better results for children across all these groups.

The largest cluster of families in PAFT (40% in 2006) were nuclear families with relatively higher levels of incomes than other family types, older mothers and mothers identifying as European. PAFT secures highest engagement from this group. However, PAFT is not associated with better results for children in three of four domains we looked at. Only hearing results were associated with PAFT. A comparison of the results for children in this group with national averages indicates some small room for improvement in behaviour and development domains – that is, there is a need but it is small compared with other PAFT clusters.

Single-parents living alone or with their extended family are more likely to drop out of PAFT early. Even where they stay, we could not find much evidence of apparent benefits for their children. These families have the lowest income of all PAFT groups and the youngest mothers. We observed a similar pattern of results for couples with extended families in the behaviour assessment. Our findings so far suggest that even if these families could be better engaged in PAFT, outcomes for their children would not necessarily be improved.

Nuclear families with Māori mothers and mothers of 'other ethnicity' are also lost from PAFT at higher rates than their European counterparts. However, where they stay on the programme they report better outcomes for their children in two of four domains. Children in both groups have better conduct screening results at age 4. Nuclear families with 'other ethnicity' mothers also report better

developmental outcomes for their children. Children in nuclear families with Māori mothers have better sight outcomes. In sum, for nuclear families with 'non-European mothers', increased participation in PAFT is associated with better results for their children.

We have also observed that substantiated child abuse findings are similar for the PAFT 2006 cohort and the general population at age 4. PAFT children are just as safe as children in the general population.

Families report PAFT helps them with their parenting in a range of ways clearly connected to the aims of the programme. We found that families who completed parenting surveys (around 40%) rated themselves highly in their ability to look after their children, the amount they interacted with their children, their confidence in their skills, and their knowledge in child development (in descending order). The parenting survey as well as interview data suggest PAFT improves families' knowledge, ability and confidence in parenting with little variation between sub-groups of the parenting sample. We don't know the extent to which these positive results are true of all families on PAFT. If we assumed they were, it would seem that for a majority of families on PAFT (with the exception of nuclear families with non-European mothers) self-assessed knowledge and ability to parent while on the programme does not necessarily translate into positive child health and development outcomes at age 4.

Why is it, that higher involvement with PAFT is not consistently associated with a range of better health and development outcomes for children across the board? We suspect the effects of a parenting programme may not be enough for families living in hardship. In the following section we discuss what we have learned about PAFT design and implementation to begin to answer this question.

Appendix 4: Home Visit Record Recording Sheet

Home Visit Observation Form - Revised

Date:	
Family present (write all names, roles, ages of focal child and siblings)	
Provider:	
Parent educator:	
Observer:	
Home Visit Number:	

Observation Interval: 30 second intervals in blocks of 10 minutes. Have your watch ready.

Instructions:

Partial Interval Record for Home Visit

- Begin observing 5 minutes after the start of the visit
- Observe for 10 minutes, break for 2 minutes, then start next 10 minute observation period. Continue this cycle until the visit is finished or you have coded 60 minutes of data.
- For each interval observed, code what participants spend the **most time** doing.
- Put an X in the box when you make an observation for that interval.

Note: This schedule of observation works best if you observe at the start of the interval and capture your observations in the last few seconds of the interval.

Parental engagement: record at the end of the period on 6 point scale.

1 = parent uninterested in material or activities; didn't initiate topics with child or educator; displayed flat affect, appeared distracted, was physically distant or was involved in another activity.

6 = mother displayed much interest in or initiated activities and discussion related to issues meaningful for the child and family, elaborated discussion, asked questions or provided information, was in close proximity to the educator or child and appeared to enjoy interactions.

Note:

- An appendix with definitions for each category is appended to this observation record
- Use the last page of the record to make notes about your impressions of the visit and the environment of the family.

Reference: Peterson, C., Luze, G., Eshbaugh, E., Jeon, H., Ross Kantz, K. (2007). Enhancing Parent-Child Interactions through Home Visiting: Promising Practice or Unfulfilled Promise? Journal of Early Intervention, 29 (2), 119 -140.

Observation Period 1

Definition	1	2	3	4	5	6	7	8	9	10	Total intervals
Primary Interaction Partners											
Educator - Parent											
Educator – Parent – Focal child											
Educator - Child											
Educator - other											
Parent - Child											
Parent - other											
Child - other											
Joint Other interaction with child											
Nature of Educator interaction											
Child focused											
Direct teaching with child											
Modelling for parent											
Coaching/support parent/child interaction											
Facilitates child play											
Adult focused											
Provides information											
Asks for information											
Listening											
Positive affirmation											
Effort to engage other family members											
Self-disclosure											
Other											
Observe interaction											
General conversation											
Other											
Paper work											
Interacts with other child											
Content											
Child development											
Child health and safety											
Parenting issues											
Family functioning											
Family phys. health											
Basic needs											
Employment or Ed. of parents											
Community resource or referral											
Admin/scheduling											
Other											
PE											

Parent engagement: on scale of 1 to 6 1 = parent uninterested in material or activities; didn't initiate topics with child or educator; displayed flat affect, appeared distracted, was physically distant or was involved in another activity. 6 = mother displayed much interest in or initiated activities and discussion related to issues meaningful for the child and family, elaborated discussion, asked questions or provided information, was in close proximity to the educator or child and appeared to enjoy interactions.

Appendix: Home Visit Observation Form: Definitions for Observational Categories

Definition	Definitions
Primary Interaction Partners	Who
Educator – Parent (EP)	Interaction between educator and parent (child present but not the focus)
Educator – Parent – Focal child (EPC)	Interaction between educator, another adult (parent) and focal child
Educator – Child (EC)	Interaction between educator and focal child
Educator-other (EO)	Educator interaction with other adult or non-focal child (eg sibling or visitor)
Parent-Child (PC)	Interaction between parent and focal child (educator present but not interacting)
Parent-other (PO)	Parent Interaction with person other than interventionist or focal child
Child-other (CO)	Focal child interacts with Other adult (not parent or educator identified as leading the visit: eg a grandmother visiting interacts with child during a visit)
Other joint interaction with child (OI)	Two or more individuals (adults or non-focal child) involved in joint interaction with focal child
Nature of Educator Interaction	How
Child focused	
Direct teaching with child	Educator 'plays' with focal child to elicit responses, initiate activities, and control materials in small group activities (EC)
Modelling for parent	Demonstration of interaction with focal child while parent is attending to intervention and child (EPC)
Coaching/support parent/child interaction	Educator interprets focal child's behaviour for parent, provides suggestions regarding interaction with child, encourages or reinforces parent interaction with focal child while they are interacting (EPC)
Facilitates child play	Educator joins in focal child's play
Adult focused	
Provides information	Relaying information verbally or in writing regarding the child, family or household, including demonstration or support of reflection for parents (may be keeping child amused, but is not reflecting on what child is doing, talking to parent about something other than what the child is currently doing).
Asks for information	Educator poses questions or probes and listens to parent response, including reflections on what other has said
Listening	Other adult or child initiates exchange and most of the interval educators attention is focused on what is said
Positive affirmation	Educator acknowledges accomplishments, reinforces parent competence, 'celebrates', hugs – parent and child are not interacting at the time
Effort to engage other fam members	Educator directly refocuses parent attention to child or tries to involve sibling or others to be involved in the interaction
Self-disclosure	Educator relays relevant personal experience or feeling to demonstrate empathy and/or relationship building
Other	
Observe interaction	Educator is focused on the verbal and nonverbal interactions of others. This includes looking on with no vocalisation or physical support, such as watching a child play with toys (do not code Educator as a primary interaction partner if they're observing. Eg if educator is observing parent and child play – code PC)
General conversation	Discussion that is not described elsewhere

Other	Getting organised, transition activities
Paper work	Educator completes forms or documentation related to the services provided (including home visit record, milestone summary?)
Interacts with other child	Educator interacts with non-focal child (eg sibling or visitor)
Content	What
Child development	Related to focal child's cognitive, social-emotional, language, motor and behaviour development including provision of an environment to support development (includes observation of child playing)
Child health and safety	Related to physical health and illness of the focal child (eg immunisations, dental care, nutrition, car safety, special needs)
Parenting issues	Discussions of issues such as behavioural guidance, sleeping, eating, child-care needs that do not fall into above two categories (includes toileting)
Family functioning	Discussion of patterns of stress and coping, family interactions and relationships of family members other than the focal child
Family phys. health	Discussions of illness, preventive health care, nutrition, substance use/abuse and safety of family members other than the focal child
Basic needs	Discussions regarding food, housing, finances, transportation, child support, immigration or other issues regarding meeting families basic needs
Employment or ed. of parents	Discussion of status of employment or education or opportunities or resources for employment or education
Community resource or referral	Discussion about or referral to service available other than those being provided by educator (eg transportation, mental health, toy library, GP)
Admin/scheduling	Reference to documentation of services, scheduling of visits or other meetings, policies and services available through the educator and their agency
Other	Discussions of topic not addressed in another category

Appendix 5: Parents As Teachers Old and New Approaches



Parents as Teachers

Parents as Teachers Approach

	2005	2011
Philosophy and Theoretical Framework	Strengths Model	Human Ecology and Family Systems Developmental Parenting Attribution Theory Empowerment and Self-Efficacy
Personal Visit Approach and Content	Instructional Focus on Child Development	Parent educators facilitate, reflect, and partner with families. Focus on healthy pregnancies, parent-child interaction, development-centered parenting and family well-being.
Structure of the Personal Visit	5 elements rapport, observation, parent-child activity, discussion, summary	Opening Parent-Child Interaction Development-Centered Parenting Family Well-Being Closing
Screening	Child Screening	Family-Centered Assessment Child Screening
Relationship between parenting and child development	Parenting Issues	7 Developmental Topics addressed throughout the child's development using key messages: Sleep, Attachment, Nutrition, Discipline, Routines/Transitions, Safety, Health
Parenting Behavior	No specific behaviors: Designer, Authority, Consultant	Parenting Behaviors (nurturing, designing/guiding, responding, communicating, supporting learning)
Curriculum Structure	Specialized Visits And Personal Visit Plans by month	Foundational Visits (First Visit, Child Development, Parenting Behaviors, Developmental Topics, Brain Development, Family Dynamics & Culture, Family Supports, Planning as Partners) and Guided Planning Tools

In addition, the 2011 Parents as Teachers Foundational and Model Implementation curriculum and training will focus on evidence-based practices, family well-being factors, parent-child activity pages, parent educator tool kit, intentional reflection, parent educator core competencies, strengthening families protective factors, parent goal setting, and an enhanced prenatal section.

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