EVALUATING THE EFFECTIVENESS OF A PRE-FIVE FAMILY SERVICE

ABSTRACT

This article evaluates the effectiveness of a pre-five family service. An NHS primary care, community-based multidisciplinary team was set up to offer parenting support to families with children aged under five through group work. The evaluation found that families who attended the service experienced improvements in child well-being and parental mental health. The pre-five family service may therefore act as a model of effective community healthcare delivery within the NHS. This is a summary: the full paper and reference list can be accessed at nursingtimes.net.

The pre-five family service is a primary care community-based early intervention service operating in west Glasgow. The service aims to promote well-being in children under five and their carers, and particularly those in vulnerable and deprived families. The service is led by a health visitor and includes a team of health visitors, a staff nurse, a dietitian, a consultant clinical psychologist and an assistant psychologist.

The pre-five family service runs short-term and long-term groups for parents and carers that aim to promote child well-being through positive parenting practices. The service also provides similar support for parents on an individual basis whose specific needs cannot be met in a group setting.

It aims to promote child well-being through the provision of parenting guidance and to tackle parental mental health problems that are known to impinge negatively on children’s well-being. This is guided by evidence showing associations between parental mental health and child development. Goodman and Gotlib (1999) provided reviews of evidence linking parental depression and child psychological problems.

In addition, significant associations have been found between parental psychological health and child behaviour problems (Najman et al, 2000). For example, specific mental health problems such as parental stress have been associated with child behaviour problems (Cronic et al, 2005). The service intends to encourage social interaction among parents and engagement with professionals, and thereby reduce problems of social exclusion, depression and postnatal depression.

GROUP COURSES
The pre-five family service provides group-based interventions and is able to deliver healthcare to a large number of families, so it is very cost-effective. Between the inception of the service in July 2001 and March 2006 more than 970 families attended a group. In reality, this is an underestimate since it does not include families attending ‘baby bounce and rhyme time’ groups, which are run on a drop-in basis. However, it is estimated that around 50 families take up this service each week.

The group courses provided by the pre-five family service are as follows: ‘Infant massage’ (to promote healthy mother-infant bonding); ‘Managing children’s behaviour’; ‘First-time parent’ course; ‘Teenage mothers’ group’; and ‘Baby bounce and rhyme time’ (to help parents understand the benefits of reading and singing with children).

EVALUATION
To determine whether the service succeeds in improving child and parent/carer well-being, parents attending the service completed three different questionnaires. The total sample size was 406.

The questionnaires used were: the 12-question version of the General Health Questionnaire (GHQ-12), used to screen for mental health problems in parents/carers; the Strengths and Difficulties Questionnaire (SDQ), completed by parents to assess the general mental well-being of their children; and a parent satisfaction questionnaire, designed by the pre-five family service.

RESULTS
All the data was collected from parents attending ‘Managing children’s behaviour’, ‘Infant massage’ or ‘First-time parenting’ groups between the inception of the pre-five family service in July 2001 and March 2006.
PARENTAL MENTAL HEALTH
The pre-five family service has been able to evaluate changes in 406 parents attending one of the three groups that are mentioned above.

There was an average improvement in GHQ score associated with each type of group. The largest improvement was associated with the ‘Managing children’s behaviour’ group with average GHQ scores improving from 4.0 to 2.1, an improvement of 1.9 points. Average GHQ scores in ‘First-time parenting’ improved from 2.6 to 1.4, an improvement of 1.2. Average GHQ scores in ‘Infant massage’ improved from 1.8 to 1.0, an improvement of 0.8.

In the GHQ-12 a score of 4 or above may be used as a general indicator of likely mental health problems. Findings show that ‘Managing children’s behaviour’ groups may have helped to improve parents’ mental health from the cut-off point of 4 to below 4, that is, parents may have ceased experiencing mental health problems while attending the course. Although ‘First-time parenting’ and ‘Infant massage’ GHQ scores improved by less than ‘Managing children’s behaviour’ scores, this may be because scores started below the cut-off point and therefore had less room for improvement.

Child well-being
The service measured SDQ score changes for the children of 33 parents who attended ‘Managing children’s behaviour’ courses. This number is much less than the number of parents who attended these groups. This is mainly because parents must attend the first and last sessions of the course for the measurement of SDQ score changes, and attendance tends to decrease towards the end of a course.

The ‘total difficulties’ score changed from an average of 14.3 to an average of 11.6. The SDQ defines this as an improvement from a ‘borderline’ score to a score within the ‘normal’ range. When compared with norms from a large UK sample (Meltzer et al, 2000) this improvement represents a change from a ‘total difficulties’ score at the 85th percentile to the 78th percentile.

On average, this means children initially showed more difficulties than 85% of other UK children but improved by the end of a course to having more difficulties than 78% of other UK children. Given that these norms were based on all groups of UK children (whereas the pre-five family service engages with vulnerable and deprived children) this improvement may be significant.

Parent satisfaction
These findings are taken from questionnaires completed by 33 parents who attended a ‘Managing children’s behaviour’ course between 2003 and 2006.

All parents who completed questionnaires described the course as ‘very helpful’ or ‘helpful’. All 33 also rated the level of information given to be ‘about right’. Also, all respondents described the course as enjoyable, informative and sociable. Some 31 said the course had been a good way to meet other parents and to get extra support and advice from health professionals. A total of 16 parents said they learned about other local services for parents and children.

Other positive aspects were the benefits of social interaction with other parents; improvements in child behaviour (27 out of 33 parents thought there had been improvements since attending the course); improvements in parents’ ability to manage children’s behaviour (30 out of 33 said they now felt more confident about this); and improvements in parent-child relationships.

MULTI-AGENCY WORKING
The service seeks not only to deliver health benefits for families but also to develop effective ways of working in primary care. As the service is intended to meet the needs of vulnerable and deprived families, who often face various problems covering health, education and welfare, the service sought to develop an effective multidisciplinary team and strong links with other agencies.

The team has built alliances with Glasgow City Council Culture and Leisure Services. Culture and Leisure Services allows pre-five family groups to use local library premises free of charge to run ‘Baby bounce and rhyme time’ groups, making this group extremely cost-effective. The service works in partnership with ‘Buddies Club’, a local service that supports children with special needs and their families. It has also forged links with Sleep Scotland, which trains counsellors to support parents of children with special needs and poor sleep hygiene.

The service team includes a consultant clinical psychologist when working within the pre-five service area. The team includes an assistant psychologist who conducts audits under the supervision of the consultant clinical psychologist to assess the effectiveness of the service. The service also has a dietitian who offers a consultancy service to other health professionals in the team.

CONCLUSION
The range of professional relationships that the service has developed with health professionals and other agencies directly improves the interventions offered.

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REFERENCES

