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Long-term changes in parenting and child behavior after the Home-Start family support program

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ABSTRACT

Background: The intervention Home-Start is a wide spread program in a number of countries, among which the Netherlands. In Home-Start, trained volunteers visit families with young children in need of support once or twice a week to help them to deal with problems in family life and parenting. Little is known, however, about the effects of Home-Start. This study describes short-term and long term changes in families that participated in Home-Start.

Methods: Three groups of families with young children (at the start mean age 1 1/2 years) were followed over a period of four years. One of the groups of families participated in the Home-Start family support program in the first 6.6 months of this period. The two other groups were (1) a randomly selected community sample and (2) a group of families with elevated parenting stress and a need for support. Data were collected at the beginning of the study, (after median 1.4 months), directly after the intervention (median 6.6 months) and at two follow-up occasions (respectively, median 12.5 and 49.2 months after the first measurement). At the last measurement, data were available for 33, 45 and 34 families respectively.

Results: Multilevel analysis showed more positive changes in parental wellbeing, competence and behavior (more consistent behavior and less rejection) during the intervention period in the Home-Start group than in the two other groups. At the three year follow up, the Home-Start group showed, compared to the other groups, more improvements in parenting (more responsiveness), but also diminished child externalizing and internalizing behavior problems (less oppositional defiant behavior, affective problems and anxiety problems).

Conclusions: Home-Start seems a promising family support intervention that deserves to be studied more extensively.

1. Introduction

Home visiting is a widely applied mode of support for families with young children and attractive to professionals and policymakers because of its low-costs and easy accessibility. Various needs and problems are addressed by home visiting. Promoting positive and healthy parenting is however the primary goal of most programs (van Doesum, Riksen-Walraven, Hosman, & Hoefnagels, 2008; Gray, Spurway, & McClatchey, 2001; Niccols, 2008; Olds et al., 1999). Home visiting is usually provided to individually selected vulnerable families with specific needs or risks such as teenage motherhood, parental psychopathology or developmental or behavioral problems of children (indicated prevention e.g., Barlow et al., 2007; Eckenrode et al., 2000).

Effects of home visiting programs are generally small in magnitude and only few studies have found substantial effects on outcomes (Olds, Sadler, & Kitzman, 2007). A meta-analytic review of 60 programs (Sweet & Appelbaum, 2004) yielded weighted mean standardized effect sizes between −.043 and +.318. No specific characteristic of the programs discriminated between successful or less successful programs.

The present study contributes to the knowledge on home visiting programs by reporting short and long terms changes in families that were served by Home-Start, compared to changes in a comparison group of families at risk and a norm group: a community sample of families without known risks.

Home-Start serves families with young children (0–6 years) at risk. Individual families are referred by health care professionals or social workers. In Home-Start social support is the main component of the program. The home-visitors are volunteers that have no professional training in the field of parenting support, but are trained to offer need-oriented support to the families on an array of domains of family functioning such as: parenting, household management, building a social network, and referral to services. Volunteers are trained in a three-day program and booster sessions twice a year. Once a month they receive supervision of their local coordinator. Home visits are

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weekly for a minimum of 2 h. The length of the program is flexible and has an average of 10.5 months (Galama, 2012). The focus is on the reduction of stress levels within families, the enhancement of parental self-esteem, and the improvement of parents' social relations. The intervention theory is that by offering social support, a. The wellbeing of the mother improves b. Feelings of parental competence increase, c. Actual parenting behavior becomes more adaptive, and eventually d. Child behavior improves. No specific theoretical underpinning framework is available in the documents of Home-Start, but the departing points of the program seem to fit into the conceptual frameworks of risk accumulation, behavioral dysregulation and social support as protective factor (Hermanns, 1998; Sameroff & Fiese, 2000). In short: risk accumulation causes dysregulation of transactional family processes and an intervention that offers social support will mitigate the effect of risk accumulation and improve regulatory processes in the family. Home Start in the Netherlands is manualized and training is offered by a national organization (Stichting Home-Start Nederland) that is also responsible for the certification of local initiatives. In the Netherlands (population 16 million), Home-Start is implemented on a national scale. In 2010 a total number of 116 local sites were counted, serving a total of 2350 families by 2400 home visitors (Home Start Nederland, 2010).

English studies on the short-term effects of Home-Start in families showed mixed and modest results. Frost, Johnson, Stein, and Wallis (2000), conducting a pre-posttest design without control group, reported that Home-Start in England contributed to enhanced mother's emotional well-being, improvements of (both formal and informal) supportive relationships and increased confidence in parental capabilities. McAuley, Knapp, Beecham, McCurry, and Sleed (2004), using a quasi-experimental design, found positive changes in family functioning, parenting stress, maternal wellbeing, and child behavior in the Home-Start group. They however found the same changes in the comparison group. Barnes, Senior, and MacPherson (2009) found no effects of postnatally offered Home-Start on maternal depression at two and 12 months of age of the baby's in a study with three groups: a Home-Start supported group, case-matched controls and mothers offered, but not receiving support. In an additional report on this study Barnes, MacPherson, and Senior (2006) found a greater reduction in parent–child relationship difficulties for supported families compared to the case-matched controls, but mothers of the Home-Start group offered their children fewer healthy foods.

Earlier studies in the Netherlands showed positive changes in families that were served by Home-Start. Hermanns, Venne-van-de, and Leseman (1997) followed 43 families through the Home-Start intervention. Pre- and posttest comparisons revealed that mothers experienced a decrease in parenting stress, an increase in feelings of parental competence and well-being. In addition mothers reported progress in specific family matters (e.g., improved child contact, more self-confidence or strengthened family relationships). In a recent quasi experimental study by Asscher, Hermanns, and Deković (2008) positive effects were reported by mothers: improvements in maternal competence, less depressive feelings, more consistent parenting behavior and decreased negative controlling behavior. Moreover, Asscher, Dekovic, Prinzie, and Hermanns (2008) showed that results were of clinical significance, since at post-test a substantial number (39% to 84%) of the Home-Start mothers functioned in the domains of maternal well-being, parenting behavior and child behavior at a level equivalent to that of a community sample. Dekovic et al. (2010) tested the mechanisms of change of the Home-Start and found that intervention results were consistent with the hypothesized intervention model: Home-Start induced changes in feelings of parental competence which in turn predicted changes in parenting.

In short, Home-Start seems to be able to provide help to families with young children that experience difficulties in daily life. An important question is, however, if the reported changes will endure over a longer period of time. A second question has to do with child behavior. The intervention theory of Home-Start hypothesizes that effective family support changes transactional processes in child rearing and creates new, positive cycles of interactions (as a mirror-image of Patterson's coercive cycles) that will, in time, further promote a positive parent–child relationship. In the course of this process child behavior problems should diminish.

Hence, we elaborated on the study of Asscher, Dekovic, Prinzie, and Hermanns (2008), and Asscher, Hermanns, and Deković (2008). In their study two measurement occasions (prior and after intervention) were described. For the present study, additional measurements were included: one at one month after the start of the program and at two follow-up occasions, more specifically, 12 and 49 months after the first measurement. The outcome measures include indicators of maternal well-being, maternal behavior and child problem behavior. The focus of child outcome is on externalizing as well as on internalizing child behavior. So, next to hyperactive and oppositional child behavior, we also examined the development of anxious and affective child problems. Parent and child data of the five measurement occasions will be modeled simultaneously by using longitudinal multilevel models.

2. Method

2.1. Participants

Three groups were distinguished: a Home-Start group, a comparison group with elevated levels of parenting stress and a reported need for support and a community sample that reported no stresses or need for support. The three-group design allows us to describe changes in the intervention group and compare them to the developmental course of family functioning and childhood problem behaviors within a group of families with elevated stress and a need for support.

The Home-Start families were recruited through the coordinators of various Home-Start programs. Every family that was serviced was asked to participate. The comparison group was acquired from the files of well-baby-offices that are situated in regions where the Home-Start program was not available. The well-baby-office is a service offered by the Dutch preventive child health care (CHC) in which children and parents are seen at regular intervals to check physical growth and to provide vaccinations. The service reaches more than 95% of children between 0 and 4 years old. From this large pool of families, a comparison group in the relevant age group was selected. In an earlier study (Hermanns et al., 1997) it was found that parents that receive Home-Start services have above average level of parenting stress as measured with the Daily Hassles Scale of Crnic and Greenberg (1990), (more than 1 SD above the average of non-clinical groups as well for frequency of daily hassles as their impact). One of the criteria for the comparison group was therefore an elevated level of parenting stress. A second criterion was the need for support, the perception of children as more difficult than other children, and the willingness to accept support by a volunteer, as by definition this was expressed by the Home-Start group also. One thousand questionnaires were sent by mail regarding parental stress (Dutch version of the Parenting Stress Index— short form, De Brock, Vermulst, Gerris, & Abidin, 1992) together with three additional questions: 1. Do you need support regarding parenting every now and then? (*Yes*/*No*), 2. If this support were from a volunteer, coming three hours each week to support you, would you want to use this service? (*Yes*/*No*), and 3. How often do you find your child to be more difficult than other children (1 '*hardly ever*' to 4 '*almost always*'). A total of 373 questionnaires were returned. Inclusion criteria for the comparison group were: (1) self-reported parental stress levels are above the standardized mean for non-clinical groups ($M \geq 2.48$), or, (2) at least two out of the three additional questions were answered positive. A community sample with average levels of stress and no extra need for support was randomly selected from the rest of the families.

Consent to participate in the study of the comparison group and the community sample was asked in a letter sent out by the well-baby-