

EVALUATION OF THE EARLYLINK PROJECT:

a pre-birth to eighteen months home visiting and parent support service in East Brighton

AN EVALUATION REPORT COVERING THE PERIOD JAN 2006 TO DEC 2006

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Evaluation summary

This evaluation which was carried out by researchers from the University of Brighton was commissioned by 'eb4u'.

The Earlylink project was evaluated against the objectives set for the East Brighton New Deal for Communities delivery plan as well as other nationally recognised areas of importance.

We used an outcome based evaluation approach which looked at the impact of the service on those who received it and the interrelationships between the service providers, clients and health care providers. We also used a stakeholder approach to ensure that the evaluation covered the things important to those who delivered and received the service.

We interviewed eighteen East Brighton families to get their view of the service. We also interviewed the Earlylink visitors and health care professionals who were supporting the families.

We found substantial evidence that the Earlylink service met local and national agendas for supporting families, parents and carers. It had a positive impact on the local community with many of the gains potentially influencing the future lives of children in Whitehawk and Mouslecoomb. In particular the service was most successful in reducing stress and isolation which often manifests in depression.

There was strong evidence to show that the support offered by the Earlylink visitors influenced child development and parent-child interaction. These are contributory factors to reducing the number of vulnerable children. Research studies show that the quality of the child parent relationship is 'a powerful determinant of child health and development and well being in adult life especially mental health' (DH 2005, p.38).

Whilst the move to Children's Centres will enable new services to be located within the community there is no doubt that without the flexibility and accessibility demonstrated by Earlylink service and its staff, the gains in engaging with some of the harder to reach families will be lost.

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Introduction

What is Earlylink and how does it operate?

Earlylink is a pre-birth to eighteen months weekly home visiting service in Moulsecoomb and Whitehawk which also offers group activities for babies and parents. It was funded through 'eb4u' in the absence of 'Sure Start' initiative monies which were allocated to the Central and Hollingdean areas of Brighton.

The Earlylink service started in September 2004 following consultation with the East Brighton Community which identified a strong request from families to extend the existing Playlink service (See Note). Although some Earlylink provision such as baby massage classes and other group activities were open to all young families living in the urban regeneration areas of Whitehawk and Moulsecoomb, initially the home visiting service was to be offered to mothers under twenty five; families new to the area and those families with identified needs.

The Earlylink team consist of an overall project director, a manager, visitors and domestic home support workers, and team admin support at each geographic site, plus a group support worker at Moulsecoomb (see Appendix 1 for full details). Earlylink visitors have a range of professional and vocational qualifications (see Appendix 1), with the majority having over 10 years experience of working within nursery/day care settings. The Earlylink team are all parents themselves although this is not a requirement of the job and four of the sixteen staff live locally. Earlylink Visitors all receive training: recent training includes awareness, emotional well-being, the importance of the first year of life, domestic violence, post natal depression, the Brazelton technique and positive parenting, food hygiene and nutrition. Earlylink Visitors receive training on child protection and are cleared to work with children.

Earlylink Visitors are employed to encourage and support families in enhancing their baby's emotional, physical, cognitive and social development as well as their health and nutrition. They do this through home visits and focused group activities. Visitors also provide counselling and support for the uptake of breast feeding. They play a part in recognising and supporting women with postnatal depression and enable them to get help from other services. The Visitors help the whole family to access additional support services and refer them to other services if necessary.

The Domestic Support Worker works alongside the Earlylink worker to give practical support to women who have had a caesarean section or those who need help with routine tasks because of post natal depression or other health or social issues. They help the parents to organise their home life and use routines that improve the well being of their children.

How does Earlylink relate to other family/parent support schemes?

Parent support schemes like Earlylink have been proven to be successful, and range from support for the normal stresses of parenthood to schemes that support families approaching crisis (Stratham 2000). Parent support schemes may be delivered in the home on a one to one basis or in groups, the time of the intervention also varies from pre-birth to post natal engagement. They can be offered in response to a battery of different required outcomes; health related, emotional and mental health related as well as social outcomes for both child and family. Barlow et al (2002) in their systematic review of the effectiveness of parenting programmes identify the positive benefits of 'population' based parent support groups to pregnant women with the aim of improving the children's' mental health. Engaging with parents in pregnancy succeeded in empowering them at an early point in their relationship with the child in advance of the postnatal period when life becomes more stressful.

Home visiting support can be offered by health professionals such as the US based Nurse Family Partnership described by Olds (2006), or via befriending or peer support schemes like the Community Mothers project in Ireland or Home Start in the UK. The Community Mothers scheme in Ireland showed mothers who were visited were less likely to be miserable and tired, babies more likely to have been breastfed for first six months and read to (Johnson and Molloy 1995).

Strathan (2000) indicates that there is evidence to show that family support offered by trained home visitors enhances mothers' wellbeing and leads to improved mother child relationship. However, one of the key aspects of the success of family support services is '*the way in which they are delivered and the nature of the relationship between the provider and user*' (2000:19). Strathan goes on to point out that service need to be attractive and accessible.

The drop out rates in family support schemes can be high: for instance a high proportion of families referred to Home-Start either did not take up the service or used it briefly (Oakley, Rajan and Turner 1998). However this may have been due to the status of the home visitor as a volunteer rather than paid employee.

The Earlylink scheme operates by employing staff who hold professional or vocational qualifications relating to the care of children. Earlylink staff work within strict guidelines and meet government requirements for protection of children Their previous work history within the community means that families see them as a trusted resource.

Earlylink offers a unique service in respect of the family/parenting support schemes described above i.e.

- ★ It is a pre-birth to 18 month scheme
- ★ It provides 'population' based access to group activities

- ★ It provides a home visiting service tailored to the needs of families identified (by Earlylink workers and Health Visitors) as requiring increased support
- ★ It is delivered by non health professional or non statutory agency staff who are trained specifically for the changing demands of an evolving service responsive to communities needs
- ★ It aims to meet a broad range of health related, emotional and mental health related outcomes as well as social outcomes for both child and family
- ★ It operates on the premise that supporting families (particularly the mother) will improve the quality of the child parent relationship, an important determinant of child health and development, and will impact on the quality of later adult life and mental health
- ★ It operates within and for the community, stimulating families' participation in the community and uptake of voluntary and statutory sector services

What is the relationship between Earlylink and other local voluntary and statutory services?

Earlylink was funded and set up in the absence of a Sure Start programme in East Brighton. Rather than providing a specific service Sure Start aimed to change existing services by reshaping, enhancing adding value and by increasing co-ordination across a partnership of statutory agencies, voluntary and community groups and parents, which will result in improved service delivery leading to enhanced child/family/community functioning (see methodology report executive summary, National Evaluation of Sure Start (NESS) at www.ness.bbk.ac.uk). This partnership, which is different in each programme, seems to be the unique factor in Sure Start's successes.

Although not part of a Sure Start partnership, the Earlylink service runs alongside the provision of midwifery, health visiting and social work services offered within the local health economy. Since the inception of the Earlylink scheme a raft of national initiatives has been introduced by government.

Every Child Matters together with the recommendations in the *National Service Framework for Children, Young People and Maternity Services* has highlighted the need to 'ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood' (Department of Health 2004a, page 8). Children's Centres were proposed through which to deliver services to families with children pre-birth to five meaning that future services will be co-located and work as part of multi-agency teams.

This evaluation was conducted alongside the early implementation of Children's Centres in Brighton, with the Moulsecoomb Children's Centre opening in April 2006 and the Roundabout Children's Centre opening in October 2006. Additionally, nine gateway centres are planned to open across the city, with four centres opening in the east area during 2007/2008. The result of the planned introduction of these new initiatives is the current reorganisation of Health Visitors into geographic community teams and reallocation of case loads. At the same time the workers employed by the pre-existing Playlink scheme became integrated into the community teams. These workers are known as Early Years Visitors and there is some evidence to show that the Earlylink project has helped to define this new role which now incorporates earlier contact with the families. The Earlylink project has highlighted the benefits of early intervention, when parents can feel at their most vulnerable and babies are at their most susceptible to positive and negative experiences. Early Years Visitors will shadow Earlylink as part of their induction into their new role. The Early Years Visitors are accessed and supervised through the Health Visiting service following an assessment of the families need. Activities and groups are still open to all regardless of need.

Additionally, during the period of this evaluation the Earlylink service changed in response to ongoing feedback from stakeholders. Initially the home visiting service was offered on an open ended timescale basis but during the summer of 2006, it was agreed that the family's' needs would be reviewed regularly and visits focussed to achieve visitor and family negotiated outcomes. It was also agreed that when appropriate an earlier referral to the Playlink service would be made. Other new initiatives were set up and supported by Earlylink

staff during the evaluation period. An Earlylink manager together with a local Health Visitor identified and set up a Post Natal support group, run by a psychiatric nurse with crèche facilities funded by the Children's Centre. Breastfeeding support groups were established in response to women wanting to meet and share experiences with other breast-feeding women. It is hoped that the groups will encourage other mothers to start and continue breast-feeding. Parents took a key role in determining the name and the format of the Moulseccomb group.

What did we want to find out?

The Earlylink project was funded from New Deal for Communities monies so it was evaluated against the objectives for the East Brighton delivery plan which were to:

- ★ Reduce stress and isolation
- ★ Support families, parents and carers
- ★ Increase the percentage of women breastfeeding at birth
- ★ Reduce smoking in pregnancy
- ★ Reduce the number of vulnerable children

We also evaluated the Earlylink project against other nationally recognised areas of importance such as improved nutrition, identification of post natal depression and the quality of the child parent relationship (See Appendix 2).

In view of the changes proposed in services for children (*Every Child Matters and the National Service Framework for Children, Young People and Maternity Services*) we also wanted to look at Earlylink project in relation to the provision of midwifery, health visiting and social work services offered in the local health economy.

What method did we use to evaluate the Earlylink project?

The Earlylink study was planned as an outcome based evaluation which 'assess(es) the impact of the service on those who receive it' (Stratham 2000, p. 2). Stratham goes on to say that it is important to evaluate 'how' services are delivered in terms of the interrelationships between the service providers and clients as well as 'what' has been delivered.

We also took a stakeholder approach to the evaluation to ensure it covered the things that were important to those who delivered the service as well as the things that were important to those who received it.

The Earlylink project manager and the Earlylink manager for each of the geographic areas worked with the research team to produce the evaluation plan.

We then set up a steering group which included representatives from all the key stakeholders, plus parents who were members of the local community. The steering group consisted of three parents who had previously used the Earlylink service, a Sure Start manager, a Health Visiting practice manager, the Earlylink Project manager, two Earlylink managers and two Earlylink visitors (both geographic areas were represented). The steering group met two monthly and advised on and monitored the process of the evaluation, for example the interview questions were devised in consultation with the steering group. The stakeholder approach was expanded to include consulting the Earlylink workers on the interview questions for the families. In the last stages of the evaluation the steering group met monthly and at the final meeting more parents who had been involved in the evaluation were invited to help us validate the interpretation of data and the findings.

The university research team contributed a wide range of expertise to the evaluation. Professor Valerie Hall is a practising midwife and has research expertise with mothers and families and NHS workers; Dr Sue Virgo has extensive experience of interviewing and working with parents who are

vulnerable, and has worked in a child protection project for 10 years. Professor Angie Hart who has acted as advisor to the project has extensive practice and research experience in working with children with special needs and mental health difficulties, and disadvantaged families.

Who was chosen to participate in the evaluation and how was their view sought?

As the families were intended to be the key beneficiaries of the service we decided to put the main focus on their perceptions and experiences of the service. The views of the Earlylink visitors and health and social services workers supporting the families were sought to show how others perceived the benefits of the service to the families and see how they match with those of the families. We also wanted to get the views of health and social care workers on how Earlylink fitted into the existing network of statutory services. The evaluation was submitted to the NHS Local Research Ethics Committee for approval and registered for governance purposes with the Sussex NHS Research Consortium.

We interviewed 18 families (9 from Moulsecomb and 9 from Whitehawk), the Earlylink visitors supporting these families, and the health and social care workers involved with these families. In addition, it was agreed that we would draw upon the results of the 'before and after questionnaires' administered by the Earlylink Project Manager to families using the service at the time of the evaluation. These were not necessarily families that took part in our evaluation but the questionnaires gave more background information of how families perceived the service.

How were families recruited?

The families were recruited randomly rather than being selected for specific reasons. When the evaluation began a manager from each of the two

geographic areas approached new families as they began having support from the project. The families were given an information sheet about the evaluation and asked, by Earlylink managers, if they were willing to take part, and those that agreed completed a consent form. Approximately thirty families agreed to take part and those selected were the first nine from each area where an initial interview could be arranged.

The backgrounds of the families were varied which is important because it enabled us to get information about how the service was received by different types of families.

Eighteen families were consulted including six partners and two maternal grandmothers. Fifteen of the mothers were homemakers and three undertook part-time employment. Sixteen of the mothers were white British and English was the sole language in sixteen homes. Four families had children of mixed heritage. Fourteen families were tenants, two were owner-occupiers, one lodged with a parent and another was in emergency accommodation. Ten parents lived with a partner whilst seven parents lived alone with their child or children, and one parent lived alone with her child and her mother. Ten families relied solely on benefits for income.

There was a total number of 42 children in the families. Eight families had one child, three families had two children, three families had three children, one family had four children and three families had five children.

Most families were referred to Earlylink by their Health Visitor.

Earlylink managers assess all families by their need to determine what services will be provided for them. There are three levels of need:

Level one support proves an average input of one hour per week home visit or giving support with breastfeeding or access to groups.

Level two support provides an average input of one home visit a week with domestic home support or baby massage at home.

Level three support may provide more than one home visit a week or more intensive home support, domestic home support, breast-feeding support or baby massage.

Six of the families were provided with level one support, five families with level two support and seven families with level three support. The kinds of issues experienced by the families are given in Appendix 3.

How many families did we interview and what did we ask them?

We interviewed the mothers in eighteen families and asked them open ended questions about the Earlylink service when they first started receiving Earlylink support, and again after four to six months. Copies of the interview questions for both interviews are contained in Appendix 4. Originally we had hoped to conduct all the second interviews four months after the first but fitting in with families required flexibility and the timescale was extended in some cases. Even so we were unable to conduct a second interview with three of the mothers because two did not keep their appointments and the third couldn't be contacted. We also interviewed seven significant others such as partners or members of the extended family who gave us their view on the support to the whole family. A copy of the interview schedule for significant others is contained in Appendix 5.

The first interview focussed on attempting to capture a picture of how families were experiencing family life and their expectations of Earlylink when they first started receiving support from Earlylink. The interview questions were structured around the evaluation outcomes outlined in Appendix 2. These included issues of day-to-day life stresses, isolation, what support was available to the family, breastfeeding, smoking and how families anticipated Earlylink fitting in with other services to the family. Also we wanted to ask the health and social care professionals involved with the family for their views on the support Earlylink offered them, so we asked the family for the name of the person they were happy for us to contact.

The second interview focused more specifically on finding out whether, and to what extent, Earlylink support had met the specific evaluation objectives outlined above. We drew on the Parenting Daily Hassles Scale (Crnic 1990), to tease out issues that might inform how families were experiencing parenting.

How many Earlylink Visitors did we interview and what did we ask them?

We interviewed eleven Earlylink workers (nine Earlylink visitors and two domestic support workers) who were supporting the families in the study to find out how they thought Earlylink could support families, in general, and the families taking part in the research study, in particular. All nine Earlylink visitors were interviewed twice, once when they started visiting the family and then again approximately four months later. See Appendix 6 for interview questions which were structured around the evaluation objectives. In the first interview we wanted to find out why the family had been referred and what the Visitor thought the support would be. The second interview covered what support had been provided.

How many Health and Social Care Professionals did we interview and what did we ask them?

Seventeen families gave consent for us to interview a named health professional, which resulted in us interviewing thirteen Health Visitors, one Midwife and one Nursery Nurse. Some of the Health Visitors and the one midwife were named by more than one family but none of the families had an allocated social worker.

In the first interview we asked about pre-existing knowledge of the Earlylink service and what the health professional felt it could offer families in general but also what it could offer the specific family who had given us their name.

We were also asked how health professionals felt the Earlylink service fitted with their role and within the combined services network generally. In the second interview we focussed entirely on the health professionals' view of how well the service offered by early link matched their hopes and expectations for the family (see Appendix 7 for the interview schedules). We were unable to interview three of the Health Visitors for the second time because two had moved from the area and a third was on sick leave.

What did we find out?

The information we collected from the interviews has been analysed by picking out the things that illustrate the impact of Earlylink in respect of the specific evaluation objectives and the broader issues outlined in Appendix 2. The key headings that arose from the analysis of the information are stress, isolation, depression, healthy eating/weaning, child development, relationship with children, breastfeeding, smoking, benefits to family as a whole.

We have presented the information in three different ways. Firstly we have used the above headings to present detailed information about the families views, sometimes using their own words, which we feel gives weight to their views. Secondly we have presented two case studies which are examples of the type of support offered by Earlylink and show how the Earlylink Visitors and Health Professionals work together with the families. Some of the details of the case studies have been changed to protect the identities of the people involved but they are both based on actual situations. Thirdly we have compared the views of the families gathered through the interviews and questionnaire with those of the Earlylink Visitors and Health Professionals so that we can evaluate the impact of Earlylink and comment on the place of Earlylink in the combined services network. In this section we have also compared our findings with those of other researchers to show the impact of the Earlylink in meeting local and national agendas for supporting families.

What the families told us

Stress:

At the first interview parents were asked what kind of things they found stressful on a day-to-day basis. Mothers mentioned being stressed when they could not keep the house tidy or do things to look after themselves such as having a bath alone because the baby or children demanded their attention. Some mothers struggled with meeting the needs of several children. Some parents had a child with special needs and felt that made extra demands on them.

However, by the second interview most mothers felt that having Earlylink input made day-to-day life less stressful. A mother with a baby with special needs spoke of feeling less stressed now because she was able to go to baby groups, use the homeopath and baby massage and also because she was meeting new people.

One teenage mother who at the first interview had told us she that life was not stressful subsequently told us that it had become stressful due to a change in family circumstances. She felt that the Earlylink input had made life: *Very less stressful now. When they (EL) come round you can have a bath, wash up. Specially now I'm on my own.*

Families value knowing that Earlylink support is only a phone call away: *Even if I don't see her. Knowing she is there. If I had a really bad day I know I could phone and she'd come.*

Isolation:

At the first interview seven parents considered themselves to be isolated. At the second interview all of these parents felt supported by Earlylink in alleviating their isolation. The biggest issue is mothers who find it difficult to go out or who do not want to. One mother said at the first interview: *I don't mind sitting here on my own.* She now spends much more of her time out of the house.

Earlylink visitors have therefore been important in encouraging families to go out and in getting parents to understand the need for their children to socialise. The visitors have sometimes taken a strong role in being persistent and have often taken families to groups to overcome their resistance. Case Study 2 is a good example of the impact of Earlylink support on one family's isolation.

Two young mothers met through their Earlylink visitor and now feel less isolated as they do things together.

Depression:

Out of the eighteen mothers in the study twelve felt they had a form of depression. Some of these cases are from post natal depression, some from before the birth of their last child and some are exacerbated by their situation such as housing, ill health or relationship breakdown. These mothers have valued having someone to talk to: *(My visitor) was absolutely wonderful. Always a shoulder to cry on if I was feeling down. She would notice if I'm feeling down. I was very sceptical at the beginning about having a visitor.*

(I was depressed) way before I had the baby. It is more manageable (now).

That's why they are nagging me to go out. Most people believe I'm ok but they keep nagging me. Yeah. Manageable. Last couple of weeks has been a breakthrough. I've stopped panicking about so much to do. I'm doing a bit at a time. Just chipping away.

I still have it but because of housing. I can talk to (EL workers) because I'm so relaxed with them. I see them more as friends than workers. I can cry in front of them. They make me feel better for that day knowing it is out of my system by talking to them.

Healthy eating and weaning:

Many of the mothers welcomed advice on weaning their babies: *I used to make his own food. They helped with what things to mix with what. They gave me advice and things like that. He now has what I have.*

He was eating but not to the extent that I liked but now he is eating more.

She gave me advice. The recommendations have changed like the best time to start certain things. Basically they taught me all over again.

I was concerned with her puking and they suggested different ways of feeding her – different things.

Child development:

Much of the child development that takes place during home visits is through the visitor 'modelling' to the parents how to play and communicate with their babies.

She does things that I didn't do before because I didn't feel confident enough to do it. But now I don't leave him alone – only when he is asleep....I've got a little more understanding but I need a little bit more confidence on that side then I'll be fine.

She is really good. She shows us how to play more – communicate. The baby likes her. Her face lights up when she sees her. I think she knows there'll be different toys. She tries to bring in a different toy each week for her to explore.

She helped with the baby. He wouldn't sit by himself and she tried to encourage him.

My older child's speech is behind. Earlylink suggested the speech development group but he has started nursery (referred by Earlylink and Health Visitor) and his speech is coming along.

Relationship with children:

Most parents reported that they did not need support with their relationship with their children. However some did find the support helpful.

But with Earlylink that has helped I must admit. At first I was a bit 'ooh' but now I'm just...ok .

They can say things that I can do to stop the kids getting jealous of each other.

In two families Earlylink visitors have also helped parents get support for their relationship with their older children.

Breastfeeding:

Ten mothers breastfed within 48 hours of birth and six were still breastfeeding over four months later. Eight did not breastfeed for various reasons. Many of the families were referred after the baby was born and, therefore, too late for breastfeeding support from Earlylink. Several mothers felt unsupported by the hospital staff at the birth and wished they had persevered.

I would definitely want to breastfeed for my next baby. They don't help at the hospital. I didn't put him to the breast and they didn't suggest it..... I asked for a bottle and they gave me one.

Those mothers who were breastfeeding valued having Earlylink support if they needed it.

At the beginning I kept asking her (Earlylink visitor) for support. She reassured me when I got mastitis.

Some mothers felt they did not need support as they were breastfeeding successfully without it. However, Earlylink Visitors did support breastfeeding

in less direct ways like passing on advice from the breastfeeding counsellor, offering support when a baby had thrush and supporting couples with relationship issues due to breastfeeding. In this way they helped mothers maintain breastfeeding.

Two of the mothers who received breastfeeding support from Earlylink have gone on to be involved in supporting other breastfeeding mothers within their community.

Smoking:

Eleven mothers were smokers, although most had reduced the amount after pregnancy or the birth. All said they had been offered support and encouragement via Earlylink. Some families had taken up the support although many felt they are too stressed to give up completely. Seven mothers did not smoke at all.

Benefit to the family as a whole:

Two families consisted of a mother and one child. Those mothers who had supportive families did not all feel that the family had benefited as a whole (four families): *If I hadn't had a supportive family it would have helped more. I can certainly see the benefits for those without a husband.*

Most families did feel that their family benefited as a whole: *It gives us the option to go out. Information on days out to go on. Domestic help to let me spend time with the kids. That helps with all of them. Instead of wasting time when I could be spending time with them.*

Yes, particularly the day they come up. I'll be in a better mood with my partner and the kids are better behaved that day. When I'm overtired I see the kids as a chore. Then I can think I'm here to enjoy my kids.

We had baby massage to fit in with us. Literally more support for me although the children get to play with other children.

When one mother was hospitalized for 6 weeks Earlylink supported the maternal grandmother and great-grandmother to care for the child.

Case studies

The following case studies are examples of the type of support offered by Earlylink and show how the Earlylink Visitors and Health Professionals work together with the families. Some of the details of the case studies have been changed to protect the identities of the people involved but they are both based on actual situations.

Louise and her baby who are receiving level three support

Louise is in her early twenties and lives with her baby and her mother in her mother's rented accommodation. Louise's income is provided by benefits. Louise has one hourly visit per week from her visitor. She is also collected and supported through group sessions. She has baby massage at home and in the group. She has been supported with a structured weaning programme and the visitor has taken food and prepared it with Louise. Louise has been encouraged to eat food with her baby. She has also been taken out to a day's parenting session with other families.

At her first interview Louise talked of sometimes feeling stressed and crying and that when her visitor came she talked about how she was coping. Louise hoped, through Earlylink, to meet a lot of people and open herself up. At that time she felt unable to go to groups and wanted home visits. Her expectations of having Earlylink were to have some support with development for her baby. She had tried breastfeeding but was unsuccessful as her baby was poorly before and after the birth. Louise had been offered support with giving up smoking but had not yet followed it up because she found it a struggle to do it. At the time of the first interview Louise had received support from her Health Visitor and previously from a Social Worker. Louise felt the support from her Earlylink visitor was different to that of the Health Visitor in that the Earlylink visitor could stay longer and give her time to talk.

At her second interview Louise was asked if having Earlylink support had made daily life less stressful. Louise felt that the support had helped a lot. She felt it had given her a lot of confidence enabling her to go out and meet other people. Now that Louise has more confidence she also goes to another playgroup in the neighbourhood on her own. Louise was asked if the expectation she had that Earlylink would provide help with development for her baby had been met. She felt that she had received a lot of support in helping her baby to sit up and to play with her baby. She learned things to do with her baby that she had not done before because she had not felt confident to do them. At the end of the interview Louise stated that she would be lost without Earlylink support because she would not feel as good without that help as she now does.

When interviewed, Louise's Earlylink visitor reported that decreasing isolation and supporting Louise with child development had been a big part of her work with this family. The visitor had enabled Louise to access a lot of groups and was aware that Louise was now able to attend new groups on her own. Child development was an issue as the baby was delayed in all areas having been born prematurely and been poorly at birth. The visitor had spent a lot of time supporting Louise to stimulate her baby and had encouraged her to do things with the baby. The visitor had lots of telephone contact with the Health Visitor and the Health Visitor had referred the baby to the children's hospital for additional developmental support. The visitor felt Earlylink had filled a gap in services by offering a lot of support to Louise and her baby.

When first interviewed, Louise's Health Visitor viewed this family's specific need as being continuing social support with lots of advice about play, stimulation and child development for the baby. She knew that the Earlylink visitor encouraged Louise to play with her baby in a way that developed the baby's muscles. She added that it was important that this work with the mother and baby was carried out between her visits and without that support there could potentially be more developmental delay. At the second interview, the Health Visitor reported that Louise is interested in her baby's development

but that the baby is still delayed. She felt that this might have been worse if Earlylink had not been involved. The Health Visitor also felt that getting Louise out had been important for the family.

Jenny and her family who are receiving level one support

Jenny is in her mid-twenties and lives with her husband and five children in a two-bedroomed rented flat without a garden. The family's income is provided by Jenny's husband's fulltime work. Jenny has one hourly home visit per week and she now attends two Earlylink groups and her husband attends the weekly Dad's group.

At her first interview Jenny talked about the stresses of getting her children organised for school and playgroup in the mornings. The only support she had before Earlylink support was her mother who was now incapacitated through ill health. Jenny was finding Earlylink support reassuring as she spent most of her time at home on her own. She initially had anxieties about having a home visitor as she thought they would be strict and tell her what to do. She hoped that having an Earlylink visitor would give her someone to talk to if she was unsure about anything. Jenny did not breastfeed her youngest child as she did not produce enough milk. The midwives had encouraged her and she tried but she gave up. She had breastfed her older children. Jenny does not smoke and therefore did not need support in this area. Jenny felt that Earlylink and the Health Visiting service offered the same sort of advice. She saw the role of the Health Visitor to do developmental checks and for Earlylink to give support rather than checking up on the family.

At her second interview Jenny was asked if having Earlylink support had made life less stressful. Jenny felt that the support had helped her get out and about. If she had not had that support she would have stayed in and not attended groups. Jenny's Earlylink visitor had introduced Jenny to the groups by initially having their meetings during the group. Jenny also felt she had benefited from support with weaning as the recommendations had changed since her last child. She felt she had been taught all over again. She also felt

she had benefited from child development support as her baby would not sit by himself and she was shown how to encourage the baby. Jenny felt strongly that her whole family had benefited from Earlylink support. She felt this was mostly from being given the confidence to go and do things. She saw her children as much more sociable now that she was able to take them out to mix with other people. She felt that her children now settle in anywhere. Jenny was now having joint visits from her Health Visitor and Earlylink visitor and she felt that everybody was talking to each other and that the Health Visitor was now offering more than just checkups.

When first interviewed, Jenny's Earlylink visitor saw her main aim was to get Jenny and her husband out of the house so that the children could socialise. She wanted to give Jenny the opportunity to meet other women of her age and for the children to meet other children. The children had difficulties with separation at that time and the worker had concerns for when they started nursery or school. At the second interview Jenny's visitor commented on how Jenny's confidence had grown from going out and how this had been better for her relationship with her children as she was not as quiet as she had been.

Jenny's Health Visitor, at the first interview, saw the role of Earlylink as a means to getting Jenny and her family out into the community. She thought that without that support Jenny would be a traditional stay-at-home mother who would not go to groups or get involved in trying to improve her life. At the second interview she saw that Jenny and her husband were both going to groups and that Jenny was actively accessing services and campaigning for better housing for her family. The Health Visitor felt that Earlylink support had given Jenny the confidence to take this on.

What difference did Earlylink make?

Overall there is good evidence to show that Earlylink has made a positive difference to families in terms of objectives outlined in the East Brighton New Deal for Communities delivery plan. It has also had a positive impact in supporting health professionals in their role. We make this statement based

on the evidence below which consists of comparing the views of the families gathered through the interviews and questionnaire with those of the Earlylink Visitors and health professionals. We have also compared our findings with those of other researchers to show the impact of the Earlylink in meeting local and national agendas for supporting families.

Stress:

Although the impact of stress and isolation is combined in the specific objectives of the evaluation it was decided to separate the two issues when interviewing families, because experiencing stress on a day-to-day basis need not be connected with isolation. Whereas when first receiving Earlylink support all but one mother found some aspect of parenting or running a home stressful there was strong evidence later that receiving Earlylink support made day-to-day life less stressful. The number of mothers reporting the usefulness of having someone to talk to increased significantly over the period of visiting. Health Visitors talked about the potential for the Earlylink service to help mothers relieve anxiety, improve their self-esteem and to empower themselves through community support and action. They reported that the relationship between the Earlylink visitor and the family was key to achieving these aims.

Isolation:

Jack and Gordon (1999) argue that the building of social capital in poor communities has more positive impact on child welfare than formal child protection and family support services. Research has identified that disadvantaged groups have smaller social networks than the general population (Jack 2005). Jack claims that 'Social networks that provide reliable sources of information and advice, or practical and emotional support, have consistently been found to be associated with positive influences on families, parents and children'. He points out 'that social isolation has been identified as potentially harmful to satisfactory parenting' (Jack 2005, p.296).

There was strong evidence that Earlylink made a difference to mothers and families although they did not always recognise their isolation until they

started to mix with others. Reducing isolation was viewed as an important part of what Earlylink visitors thought they ought to be doing. Case Study 2 illustrates this finding. Isolation was also one of the key areas that Health Visitors reported as problematic for mothers and they valued the success that Earlylink visitors had achieved. Overcoming isolation was defined as needing to get into a network of other mothers for social reasons but also to access other mothers who reinforced good parenting models. The impact on isolation was shown in the quantitative data from the Earlylink questionnaire where the number of families attending groups increased significantly by the end of the visiting period.

Depression:

The majority of mothers felt that they had a form of depression and they valued having someone to talk to which they felt alleviated their depression. Although not all mothers were diagnosed as clinically depressed or suffering from post natal depression it is important that their reports of feeling depressed are acted upon in some way. There is a growing evidence to show that the first few months of a child's life are an important time when they form attachments and learn about emotional and social interactions (NSF Chapter 2). This process is compromised when the child parent interaction is poor due to depressed mood. It must also be borne in mind that the first three months after birth is a critical time for maternal mental health. Suicide has been identified as the highest cause of maternal death in the UK with the rates of suicide being highest in the first three months after birth at a time when there is most risk of postnatal depression (CEMACH 2004).

The Earlylink visitors recognised that the great majority of families needed emotional support and offered it. Health Visitors felt the Earlylink service did reduce depression mainly in terms of increasing self esteem and reducing isolation although a small number felt that work specifically on post natal depression should be carried out only by qualified workers. However, Earlylink visitors engaged with mothers in a way that enabled them to speak openly about their depressed state and this was something that mothers were not always prepared to do with health professionals. Therefore we would

conclude that Earlylink had a strong impact by supporting mothers who felt they were depressed.

Healthy eating and weaning:

While many people eat well some groups, particularly the disadvantaged and vulnerable in society, do not (Department of Health 2004b). It has been acknowledged that good maternal and child nutrition favourably affects long term health outcomes (Department of Health 2002).

Many mothers valued the practical ideas and support as well as the advice offered by Earlylink visitors and they felt it made a difference. Earlylink visitors saw this as an important area of work and reported giving advice and practical support to thirteen families. A number of Health Visitors welcomed the Earlylink visitors' reinforcement of their advice but others who were not fully aware of Earlylink visitor skills and training questioned the involvement in this area of their practice. Quantitative data supports the families' value of the support. The number of respondents who thought feeding was going well increased significantly by the end of the visiting period. There is, therefore, strong evidence to suggest that Earlylink makes a valuable contribution in this area.

Child Development:

The recognition that all children from birth have a need to develop is highlighted in *Birth to three matters* (see DfES 2002) and that this is achieved 'through interaction with people and exploration of the world around them'. The National Service Framework adds that there is a need for services to support families to focus on the young child's early needs (Department of Health 2004a). The Framework suggests that 'support focused on enhancing sensitivity needs to be provided for parents in high risk groups for the first six months of the child's life to improve attachment'.

Much of the work taking place during home visits happens by the Earlylink visitor 'modelling' how to play and communicate with babies. Earlylink visitors reported working on child development with most families. Support ranged

from giving ideas and encouraging play to intensive support to families who had babies with developmental delay. This was well evaluated by parents. The majority of Health Visitors saw this as an area in which Earlylink took an active part in reinforcing their advice and role modelling play with beneficial outcomes. Overall, the quantitative data supported the benefits of the work but whilst parents did not always recognise that support was offered specifically to enhance child development, health professionals fully recognised and valued the potential and actual benefits. In view of this we conclude that Earlylink made a significant contribution to enhancing child development.

Relationship with children:

The first few months and years of a child's life are important in establishing the patterns of emotional cognitive and social functioning of the child and there is evidence to show that the quality of the parent-infant relationship creates the conditions for establishing healthy patterns of functioning (Barlow et al 2002).

Most families in the study felt that they did not need support in their relationship with their child. The researchers consider that although parents' relationship with their child had been discussed during the interview their response was likely to be influenced by societal expectations that mothers would naturally have a warm and loving relationship with their child. To admit to a poor relationship with their child is likely to be difficult. This is an interesting finding as Earlylink visitors felt there were issues to work with even when mothers felt they had a good relationship with their child. Earlylink visitors undertook this work because they felt that maintaining good relationships can be difficult when mothers feel low.

The effects of parental stress and poor parent child interactions are various but include impact on the infant and toddler sleep patterns (Barlow et al 2002) and early behavioural problems (Shaw 2001), both of which are likely to further disrupt the parent child relationship. Positive proactive parenting is

associated with high self esteem and protection against later disruptive behaviour (Cohen (1994); Baumrind (1985) quoted in Barlow et al (2002).

Health Visitors felt that Earlylink did enable better relationships with children using a variety of mechanisms from providing alternative child minding arrangements to positive parenting role modelling which resulted in the actual reduction in the amount of violent language in a family. This is an important finding because it is recognised that populations using excessive verbal and corporal punishment from an early age are strongly associated with increased child behaviour problems (Brenner and Fox 1998).

Breastfeeding:

It is difficult to compare breastfeeding rates from this evaluation with local figures as pressures on those collecting the data often means that local data returns are often incomplete. However, it is accepted that the culture in East Brighton is towards bottle feeding and therefore the figure of 55% mothers initiating breast feeding within 48 hours is favourable. However, the more important figure is that of mothers who continued to breast feed. The millennium cohort study (Kelly 2005) indicated that across all social classes although breast feeding was initiated for 71% of babies, by 6 months of age the proportions being exclusively breast-fed declined considerably. By four months of age only 3% of babies were exclusively breast fed. Although the Earlylink data does not exclude supplementary forms of feeding it is encouraging to note that 33% of the mothers in the study had breast fed for at least four months. These figures also compare favourably with those of Hamlyn et al (2002) who found that 50% of women in lower occupation groups gave up breast feeding by six weeks.

Although the Earlylink project was set up to work with mothers pre-birth the majority of the Earlylink visitors began working with the families after the baby was born and therefore were not in a position to influence the decision to breastfeed. However, when they had provided support in the pregnancy some mothers reported the lack of support in the hospital as the reason they gave up.

It is impossible to say how much Earlylink influenced the initiation and maintenance of breast feeding particularly in view of the low numbers of pre-birth families recruited to the project. However, it is important to note that as Fairbank et al 2000 report, a combination of interventions is the most effective way to encourage initiation of breastfeeding and that as our own data show continued effective support is necessary to maintain breastfeeding.

Smoking:

The CityStats of Brighton and Hove 2004 (see www.citystats.org), indicate that the percentage of women smoking during pregnancy in Brighton and Hove during 2003-04 was highest in the two geographical areas covered by this study with 46 – 52.99% of mothers smoking.

Our study found that eleven of the mothers smoke (61.11%) but all have reduced the amount they smoke since pregnancy or the birth of their baby. All but one had also changed the place of smoking so that it was not near the baby. All families had been offered support to cease smoking but many felt too stressed to give up completely. All Earlylink visitors offered support and referral to smoking cessation services and reported that parents who had not wanted to give up completely had reduced their intake or stopped for short periods. Quantitative data suggests that although families did not consider support particularly useful the respondents evaluated the advice on where to get help slightly more positively by the end of the visiting period. Although mothers might not have ceased smoking they appear to have adopted a more health orientated approach to smoking habits.

Benefit to families as a whole:

One of the four key themes of *Every Child Matters* is the need to increase the focus on supporting families and carers as they are the 'most critical influence on children's lives'. It is therefore significant to look at the benefit that programmes may have to families as a whole.

In our study we found that most families felt there were benefits to their family. Those mentioned included domestic support, outings and reducing isolation for the whole family including the involvement of fathers in Dad's groups. The opportunity to access services like homeopathy and cranio-sacral therapy, usually available only to those who can afford the fee, plays some part in reducing health inequalities. Returning to the theme of social capital (Jack and Gordon 1999) discussed previously, it is important to mention that Health Visitors report benefits such as encouraging the families to access other services, developing social networks within the community and encouraging participation in the community.

Does Earlylink play an important role within the combined local health and social care services?

Stratham (2000) tells us that evaluation needs to look not only at outcomes of a service but 'how' services are delivered in terms of the interrelationships between the service providers and clients. This was particularly important within this evaluation as the service ran alongside other services which would be incorporated into the new Children's Centres. It was hoped that the evaluation findings would throw light on the part that Earlylink played within services for children and highlight those aspects that were not currently delivered by the other services. The following areas came from the information gained from interviews with the health professionals and is compared with the views expressed by mothers and families.

Overall, health professionals saw the Earlylink service as complementary to the other services although most Health Visitors thought it should be Health Visitor led. They believed that this would reduce duplication of assessment which when undertaken by a Health Visitor would be more comprehensive and enable a clearer focus on the action needed to support a family. Health professionals highly valued the input of Earlylink visitors to reinforce parenting advice and role modelling play activities, thus enhancing child development. Many commented that it was not currently possible to provide the regularity of

visiting required to reinforce advice and relied on Earlylink to carry out this function. Health professionals particularly valued the service in terms of reducing isolation by encouraging and escorting mothers to join group activities and meet other mothers. Many felt the service helped improve the family's relationship with their children. One Health Visitor comments *'its been really good – we've worked together to try and complement what each other does for this family what was offered was ... seemed really successful and is working really well.'*

Work in the areas of breastfeeding support, smoking cessation and postnatal depression were less well accepted as it was thought that they should be undertaken by qualified professionals. In this circumstance and in other situations where Health Visitors reported overlap it was often because there was a lack of awareness of the role, training and qualification of the Earlylink visitors.

Health professionals generally felt that the service should be offered across the whole of Brighton and that it would inevitably be offered only to those in greatest need. This would not result in it being seen as a stigmatising service and the uptake would continue to be good because families valued it. However there is evidence to suggest that a 'population' based approach to parent support as a primary intervention before the stresses of the postnatal period take effect enable an improved parent child relationship (Barlow et al 2002).

Health professionals felt the move of all services to the Children's Centres would enable families to see the service as whole and not separate parts. Although the move would enable improved communication, there is much evidence to suggest that some families would be unable/or unwilling to access groups run from the centres without a worker accompanying them and helping to integrate into the groups. Dixon-Woods et al (2005) in their review of vulnerable groups' access to care found that if services were not made easily accessible socially excluded groups were disadvantaged in using them. This

is cause for concern as some of the most vulnerable families fit into this category.

Many Health Visitors commented on the importance of a regular and frequent visiting service between their own visits. The benefits of this were to reinforce the Health Visitor messages through action but also as a monitoring activity to ensure that things were going well. However, they also commented that in the case of difficult to engage families it was important to identify a person that the family felt comfortable with to enable acceptance and trust, and therefore continuity of personnel was important. This view was reinforced by the families when in a small number of cases they had reported difficulties in their relationship with some health professionals. One other important aspect of the difference between the Health Visiting service and the Earlylink service offered was the focus on the mother. Mothers felt the Health Visitor focussed on the baby and monitoring the baby's development whereas they valued the attention Earlylink gave to them as mothers as well as their need to support the baby.

A number of Health Visitors commented on the value of the flexibility of the service in response to families' needs both in terms of the timing of visits but also in what actually is offered. However, some Health Visitors believed that the work done with families should be reassessed regularly to ensure it was still needed. This was something that was later introduced by Earlylink during the period of evaluation.

What if Earlylink did not exist?

Throughout the evaluation process, families and health professionals were sharing with us their concern regarding the future of the Earlylink service. We decided to include this section because it illuminates the areas that cannot be covered by existing support and services either because resources are insufficient or the services were not set up in a way that would meet their needs.

Seven families felt that they would have support from family or friends if Earlylink was not there. Of these, two families felt they would have less social contact or literally just have the family as support. The rest of the families felt that the loss of Earlylink would have a significant impact on their lives:

I'd be sitting at home depressed.

I'm friendly with a few neighbours but not a close friend and the family is a bit distant.

I would have groups but nobody for me – to pour it out while she holds the baby. Nobody else can do that for me.

I know I'd never go out. I can't imagine not having them – too lonely – no one is interested.

If I have another baby I don't know what I'd do without Earlylink.

Health Visitors had all recommended or referred families to the service and although some saw it primarily as a befriending service, their hopes and expectations of the service indicated that they anticipated a broader range of support. The Health Visitors saw the service as valuable with many reporting it as invaluable. Some Health Visitors felt that the Earlylink intervention had prevented individual families going on to be referred to the statutory service. The majority of Health Visitors were adamant that elements of Earlylink's service should be retained although more closely linked to the Health Visiting service. The loss of this service would have a significant effect on their role and their work with vulnerable families.

Did we miss anything?

The evaluation was planned to be 'outcomes based', using stakeholder and community involvement. The membership and operation of the steering group ensured good stakeholder and community involvement. The number of people interviewed and the sources of information we drew upon show that we gathered sufficient and appropriate evidence to evaluate the impact of Earlylink in terms of the specific objectives outlined in Appendix 2.

However, we should acknowledge that because we could not tell whether the information from the questionnaire, administered by Earlylink managers, included the views of all 18 families, we were not able to set our evidence against the full background picture as we had hoped. Also it was difficult to find recent and accurate information about local rates for cessation of smoking and breast feeding. This lack of background information meant that we could not compare our findings against a broader local picture but it did not undermine our findings of the impact of the Earlylink on the individual families we interviewed.

Our evidence enabled us to comment on the impact of the Earlylink service across all families but it was not possible to determine whether the benefits perceived by the recipients and health professionals had been achieved by the Earlylink Service alone. In order to evaluate the service in this way a 'control' group of families who were not using the service would have been necessary. Similarly we were not able to provide detailed information on what worked for individual families and under what circumstances as to do this would require manipulation of variables which would have reduced the richness of the data. The requirements of this commissioned study to evaluate the impact of Earlylink against the objectives of the delivery plan made this type of approach inappropriate and the use of a control group, unethical.

Our evidence was gathered over a period of four months which represents a brief snapshot in time so therefore we are not able to comment on the sustainability of the effect over time. However the importance of this critical

early period in establishing positive parenting has been recognised throughout the National Service Framework for Children, Young People and Maternity Services as fundamental to reducing the number of vulnerable children throughout childhood.

The evaluation also looked at 'how' services were delivered in terms of the interrelationships between the service providers and clients and the service providers and health professionals. We were given the names of a sufficient number of health professionals who we interviewed but none of the families had an allocated social worker and so we were unable to evaluate the relationship between the service providers and the Social Services. We feel this is an area for further research as health professionals commented that they felt the Earlylink service may well have provided a 'safety net' that prevented families going on to be referred to the statutory services.

Conclusion

There is substantial evidence that the Earlylink service met local and national agendas for supporting families, parents and carers. In particular the service was most successful in reducing stress and isolation which often manifests in depression. Earlylink visitors play a key part in recognising and offering well evaluated support to mothers who were depressed or feeling low. There was strong evidence to show that the support offered by the Earlylink visitors influenced child development and parent-child interaction. These are contributory factors to reducing the number of vulnerable children.

Data on healthy eating and weaning demonstrates that Earlylink makes a valuable contribution in this area. It is difficult to accurately evaluate the impact Earlylink has had on increasing the number of women breast feeding at birth, however it is encouraging to note the above average percentage of mothers in low income groups who have maintained breastfeeding for over four months. Although there is no apparent increase in smoking cessation

again it is encouraging to note that the vast majority of mothers who smoke appear to have adopted a more health orientated approach to smoking habits.

The exploration of the role of Earlylink within the combined services illustrates its complementary affect on other services. Importantly, mothers have told us that because the service operates in a social mode as well as a health model and works by supporting the mother to meet her own needs as well as her child's needs, it is particularly beneficial. It has enabled mothers to feel cared for and therefore relate better to their children. This is an important finding as research studies show that the quality of the child parent relationship is 'a powerful determinant of child health and development and well being in adult life especially mental health' (DH 2005, p.38).

The positive impact that the Earlylink project has had on the local community is significant with many of the gains potentially influencing the future lives of children in Whitehawk and Mouslecoomb. Its role in reducing stress and isolation and its effect on enhancing early parent child interaction will make an important contribution to reducing the number of vulnerable children in the locality. This is due to Earlylink's unique role in supporting mothers by helping them meet their own needs rather than focussing on the child as in the health led services. This important finding should be taken into account when redesigning and reallocating services.

Whilst the move to Children's Centres will enable new services to be located within the community there is no doubt that without the flexibility and accessibility demonstrated by Earlylink service and its staff, the gains in engaging with some of the harder to reach families will be lost.

Acknowledgements

The authors would like to give particular thanks to Sylvia Wilkinson, Earlylink Project Manager, for her unwavering help and support throughout the evaluation. Thanks also go to the steering group and all the families, Earlylink Visitors and Health Professionals who gave up their time to be interviewed. Finally thanks to Professor Angie Hart for acting as advisor and to Rachael Lockey for her helpful comments and Chloe Gerhardt who helped us produce the final report.

Note

The Playlink scheme

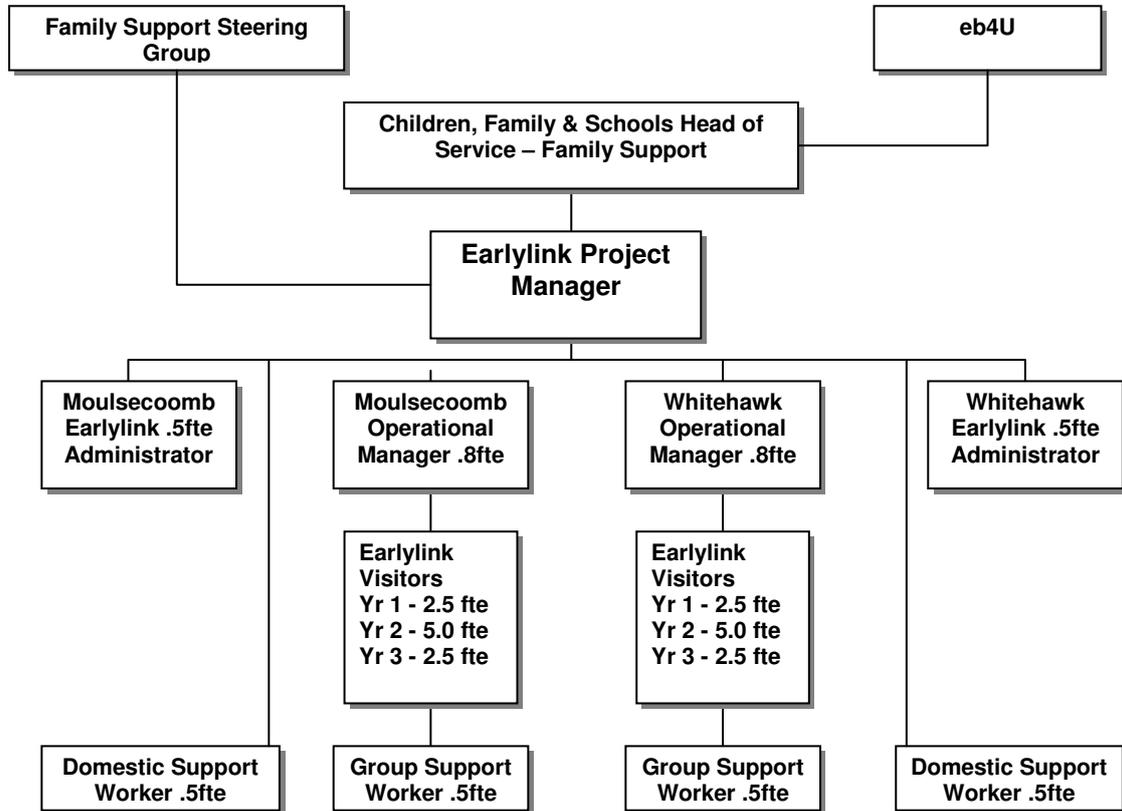
The Playlink scheme was set up in Mouluscoomb in 1986 and Whitehawk in 1990. It was developed as a result of concerns that within certain areas there were limited opportunities and a lack of resources for families with young children. It recognised the need to enhance opportunities for young children and their families during the crucial pre-school years. It was designed to promote language development, concentration, social skills and independent activity, and also to strengthen family life and prevent breakdown. There is evidence to show that Playlink children showed significantly greater concentration during table play and had fewer speech and language problems on starting at nursery. They also showed greater ability, skill and self-confidence in talking to other children and to adults (Daines et al 1989).

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APPENDIX 1

EARLYLINK TEAM/STRUCTURE



APPENDIX 2

Evaluation objectives

Overall Evaluation objectives	Evaluation objectives relating to the East Brighton New Deal for Communities delivery plan	Evaluation objectives relating to 'Every Child Matters' and the 'National Service Framework for Children, Young People and Maternity Services'
Examine the extent to which Earlylink impacts on the reduction of stress and isolation	Reduce stress and isolation	Quality of the child parent relationship
Examine the extent to which Earlylink supports families, parents and carers	Support families, parents and carers	Identification of post natal depression
Examine the impact of the scheme on breastfeeding at birth and afterwards	Increase percentage of women breastfeeding at birth	Improved nutrition
Examine the impact of the scheme on the reduction of smoking in pregnancy and afterwards	Reduce smoking in pregnancy	
Examine the extent to which the combined services of Earlylink and health and social care workers meet the families' needs	Reduce the number of vulnerable children	Co-located services within multi-agency working
Explore the role of Earlylink within the combined services network		Co-located services within multi-agency working

APPENDIX 3

Issues experienced by the families interviewed

History of depression

Post-natal depression

Domestic violence

Poor accommodation

Parent with an anti-social behaviour order (ASBO)

Traumatic birth experience

History of childhood abuse to the mother

Mother with a learning difficulty

Mother with obsessive/compulsive disorder

Mother with hearing impairment

Mother with Multiple Sclerosis

Family with baby with vision impairment

Family with toddler with vision impairment

APPENDIX 4

First and second Interview Schedules for families

First Interview:

1. Life Stresses

Parenting is one of the hardest jobs in the world and is certainly one of the most stressful.

What kind of things do you find stressful on a day-to-day basis?

How isolating is it being at home with a child/children?

Have you had any support before being involved with Earlylink?

Who has been the most support to you in the past?

2. Earlylink Support

How did you first get involved with Earlylink?

How did it feel getting involved in a support service?

Do you feel you should be able to cope on your own?

What are your expectations of being involved with Earlylink?

What do you hope to get from the Earlylink visitor?

3. Breastfeeding

Are you going to/are you breastfeeding?

Did you change your mind about breastfeeding?

What has influenced your decision to breastfeed/not breastfeed?

4. Smoking

Do you smoke?

Has anyone tried to support you to give up smoking during pregnancy and afterwards?

5. Support of combined services

Do you have other services such as health or social care workers supporting your family?

How do you think Earlylink will fit in with other services such as the midwife, health visitor or social care workers?

What do you think will be different in the support that Earlylink gives?

What do you hope will be different in the support that Earlylink gives?

Would it be ok for us to talk to other workers/people in your family who are supporting you?

Second Interview for families:

Has having Earlylink input made day-to-day life less stressful? Give examples.

Do you now feel less isolated? Give examples.

Who is now the most support to you?

(Using notes from first interview with parent: Look at what parent hoped and expected to get from Earlylink)

What do you think you have got from Earlylink? How did it meet or not meet your hopes and expectations?

Has it helped with the following areas:

- Healthy Eating? Weaning? How do you find feeding or meal times now?
- Depression? Are you finding everyday life more manageable now? In what ways?
- Child development? Do you have more understanding of your child or children's development? In what ways?
- Relationship with your child/children? How demanding of your time or attention do you find your child or children now? Have you discovered any ways to make the relationship easier?

Have you had home domestic support from Earlylink?

Has there been benefit to your family as a whole? In what ways?

If breastfeeding, how supportive has Earlylink been? Do you think Earlylink support might help with breastfeeding in a future pregnancy?

If smoking, how supportive has Earlylink been in trying to give up?

What things would help you?

How has Earlylink worked in with other services that you use? How has the support from Earlylink been different from other services?

What support would you have if Earlylink was not there?

What would you want to tell another parent who was thinking of having Earlylink support?

Are there any things that you would like to add about your experience of Earlylink support?

APPENDIX 5

Interview for Significant Others

1. Life Stresses

Parenting is one of the hardest jobs in the world and is certainly one of the most stressful. What do you think are the stresses on a day-to-day basis?

Do you think it is isolating being at home with a child/children?

Do you know of any support that your family has had before being involved with Earlylink?

Who do you think has been the most support in the past?

2. Earlylink Support

How do you feel about your family having Earlylink support?

Do you feel that your family should be able to cope on their own?

How do you think Earlylink support might help parents?

What are your expectations of Earlylink support for your family?

What do you hope your family will get from the Earlylink visitor?

3. Breastfeeding

The Earlylink service hopes to support mothers to breastfeed. Do you think this support would be helpful for your family?

4. Smoking

Earlylink also supports mothers to give up smoking during pregnancy and afterwards. Do you think this support would be helpful for your family?

5. Support of Combined Services

Do you know of other services such as health or social care workers supporting your family?

How do you think Earlylink will fit in with other services such as the midwife, health visitor or social care workers?

What do you think will be different in the support that Earlylink gives?

What do you hope will be different in the support that Earlylink gives?

APPENDIX 6

Interview Schedules for Earlylink visitors

First Interview:

1. What was the original referral for?
2. How did you see Earlylink helping this family in general?

More specifically:

Isolation

Depression

Child Development

Nutrition/Weaning

Relationship with child/children

Breastfeeding

Smoking

3. What was the family offered in the way of Earlylink support?
4. What was the reason for this?
5. When the family was first referred how long did you think they would need Earlylink support for?
6. What were your hopes and expectations of the Earlylink service for clients in general terms?
7. and for this family in particular?
8. How did you think Earlylink support would fit with the service health and social workers might offer this family? Have you had any communication with the health and social workers regarding this family? How do you think the Earlylink service fits with the combined health and social care services more generally?
9. To what extent do you think Earlylink workers might have access to families that other services find difficult to access? Why and how?

Second Interview:

1. How do you think the work with this family compares to the original referral?
2. How long have this family made use of Earlylink support?
3. How do you think Earlylink has helped this family? Please give examples.

More specifically:

Isolation

Depression

Child Development

Nutrition/Weaning

Relationship with child/children

Breastfeeding

Smoking

4. Has the length of input from the Earlylink worker matched the expectation at referral?
5. Have you referred them to other services?
6. Have health and social care professionals been involved with this family as far as you know and if so how has your role interacted with theirs? Please give examples e.g. joint visits, case conferences, communication issues. How do you think support to this family has fitted in with the combined services?

APPENDIX 7

Interview Schedules for Health and Social Care Workers

Interview 1

Knowledge of the service

Are you aware of the Earlylink home visiting service if so please describe any previous involvement with the service?

Views on the acceptability of the service

Would you recommend the Earlylink service to your clients and if you have recommended clients do you know how many of them have gone on to register?

Would you consider referring clients to the service and have you done this in the past?

Currently the Earlylink service is only offered in the Whitehawk and Moulsecoomb areas do you think it should be more widely available?

Hopes and expectations of the service

What are your views on the impact of the Earlylink service on your role and your targets? Please give examples of any such targets.

What are your hopes and expectations of the Earlylink service for your clients in general terms and for XXX in particular?

What is your view of how the Earlylink service fits in with the combined network of services offered within the locality?

Interview 2

The second interview was based on Health Professionals' views on their hopes and expectations of the Earlylink service for the client who gave us their name.

This section of the previous interview was read to them and they were asked to comment on the extent to which the hopes and expectations have been realised and the impact on the family.

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