Early childhood intervention in the community... makes sense, but does it really work?
Findings from our three-year evaluation of KidsFirst, the Saskatchewan government’s early intervention program

WHAT IS KidsFirst?

KidsFirst is a federally-funded, provincially-run intervention program launched in 2002 that provides support and services to vulnerable families with young children (aged 0-5) in Saskatchewan. It is offered in nine areas of the province that were identified as having high levels of need when the program was established. There are KidsFirst programs in Meadow Lake, Moose Jaw, Nipawin, Northern Saskatchewan, North Battleford, Yorkton and selected neighbourhoods in Prince Albert, Regina and Saskatoon.

KidsFirst has four goals:

- Children in very vulnerable situations are born healthy and remain so.
- Children living in very vulnerable circumstances are supported and nurtured by healthy, well-functioning families.
- Children living in very vulnerable situations are supported to maximize their ability to learn, thrive and problem-solve within their inherent capacity.
- Children living in very vulnerable situations are appropriately served by the KidsFirst program.

KidsFirst includes components such as identifying and assessing families that might be considered at-risk or vulnerable, and connecting them to existing community supports and programs. Clients enter the program during pregnancy or after the birth of their child. Factors determining their eligibility include low maternal education levels, mental health issues, financial instability, substance issues or other risk factors.

The most notable feature of the program is its home visitors. These are lay workers trained to support families in a number of ways, such as informally teaching parenting and life skills, helping them interact with their children and advocating for them with other agencies. They help establish trusting, nurturing relationships between parents and their children, and trusting relationships in their communities.

Home visitors share information with parents about programs and events in which they can participate, and help them access services in the community, such as early learning, child care, and specialized services for children,
and education, mental health and addictions services for parents. They also help parents access housing, transportation and food. They organize social and learning events where KidsFirst families can interact. Home visitors focus on the positive, building on each family’s strengths to build parents’ self-esteem and confidence. They are considered the link between KidsFirst parents and community services whose mandate is to support children and families.

This fact sheet is part of a series describing our three-year evaluation of KidsFirst, funded by the Canadian Population Health Initiative and the Government of Saskatchewan, with some additional support from MITACS, and the College of Medicine at the University of Saskatchewan. The evaluation was led by Nazeem Muhajarine, lead of the Healthy Children Research Team at the Saskatchewan Population Health and Evaluation Research Unit, in partnership with staff from the Early Childhood Development Unit in the Saskatchewan Ministry of Education, and KidsFirst program staff. A full list of team members is found in the reports.

The following reports were produced as part of this evaluation:

- Evaluation Framework;
- Community Profiles;
- Focused Literature Review;
- Using Theory to Plan and Evaluate KidsFirst (full and summary versions);
- Report of the Qualitative Study;
- Report of the Quantitative Study; and
- Summary of Findings and Recommendations.

Reports and fact sheets can all be read online or downloaded from www.kidSKAN.ca, the Saskatchewan Knowledge to Action Network for Early Childhood Development; visit www.kidSKAN.ca/KidsFirst, or click on “KidsFirst” under the Projects menu on the front page. For more information, contact Fleur Macqueen Smith, fleur.macqueensmith@usask.ca, 306-966-2957, Knowledge Transfer Manager of the Healthy Children Research Team in SPHERU.

“...A lot of our families, when they first come in, don’t know how to speak to a professional. They either get really angry, or they just don’t share their needs. By the time they’re done with the program, they have gained that skill.”

— home visitor

**EXAMPLES OF TYPICAL KidsFirst FAMILIES***

**Complex-Needs**
Sarah is an unemployed mother of two. She has FASD (Fetal Alcohol Spectrum Disorder), and her kids have FASD and developmental disorders. She has trouble with reading and writing. Her current boyfriend Dave is occasionally abusive. She has a history of drug addiction. Social Services has apprehended her children once before. She is usually short of money mid-month and relies on food banks.

**Medium/Intermediate-Needs**
Patricia is a single mother of three who has completed high school and works part-time. Two of her children are in school and one is in child care. She joined KidsFirst to help her manage her postpartum depression. She enjoys the contact with her home visitor as well as the program’s social gatherings.

**Low-Needs**
Cecelia has a one-year-old baby. She is unemployed but is upgrading her high school diploma and wants to go to nursing school. She lives in a stable relationship with her boyfriend Kurt. They sometimes struggle with money but always pay bills and can buy groceries. They have a car so transportation is not a problem.

**Immigrant families**
Thiri is originally from Burma and came to Saskatchewan when she was first pregnant. Her home visitor took her to the hospital and stayed with her until her son was born. The home visitor has helped her register for English classes and has also arranged for translators when she needs them. Thiri has been able to make friends through a settlement agency, especially with the local Burmese community.
**Northern families**

June has lived in a northern Saskatchewan community her entire life. Her parents were in a residential school, and she had her first child at 16. She has had three more children since then. Her home visitor helped her leave an abusive relationship. She would like to go back to school but is staying home with her kids for now. She is learning parenting skills, and she notices her two youngest, her “KidsFirst” babies, seem more contented.

(*These descriptions are composite profiles, given as examples only, not descriptions of any one family in the program).

**HOW FAMILY RISK AND CHILDREN’S DEVELOPMENT IS TESTED**

Families in KidsFirst are assessed at different times using various tools. All babies born in Saskatchewan hospitals are screened to assess challenges faced by their families, and eligibility for KidsFirst services. If the family is deemed in need of KidsFirst services and they live in a community or neighbourhood targeted for KidsFirst, they are then offered these services.

Once families enter KidsFirst, an Initial Development Assessment (IDA) is conducted to determine their particular needs, and examine their baby’s development and environment. Ongoing Assessments (OGA) start when the baby is six months old, and are done every six months after that, up to age five (60 months). These assessments collect data on number of factors concerning KidsFirst families, with the degree of risk to the child noted according to eight categories: availability of social supports; food security; expectations of child; parent motivation; family identity and interactions; living conditions; housing suitability; and housing stability.

As well, children in KidsFirst families are assessed with Ages and Stages Questionnaires (ASQ), which are age-appropriate developmental screens for children that can be used from 4 to 60 months. They can help identify problems with a child’s gross motor, fine motor, communication, problem-solving, and personal/social skills. While these tests are crucial assessment tools for KidFirst, they also provided some of the data used for the three-year-long evaluation of the program.

**HOW IS KidsFirst DOING IN MEETING ITS GOALS?**

In 2007, a three-year evaluation process began, looking at how effective KidsFirst has been in the short term at meeting its four goals, as well as objectives specific to each goal. This evaluation was conducted as a partnership between the Early Childhood Development Unit at the Ministry of Education, which oversees the program, and the Saskatchewan Population Health and Evaluation Research Unit (SPHERU), a bi-university research unit at the Universities of Saskatchewan (in Saskatoon) and Regina (www.spheru.ca). SPHERU researcher Nazeem Muhajarine led the evaluation, which was funded primarily by the Canadian Population Health Initiative and the Government of Saskatchewan.

The evaluation team started by working with program managers of the KidsFirst sites to develop an evaluation framework, to guide how the evaluation would be

“My home visitor has helped me stand up for myself. Before I couldn’t do it because I wasn’t confident with myself and I figured I’d make the situation worse, but it’s different now. I can go up and talk for my children or for myself.”

—parent
conducted to determine if KidsFirst is meeting its goals and objectives (available at: www.kidskan.ca/node/174). Then they developed profiles of each of the nine KidsFirst communities, which describe each community (physical and social descriptions), its services, amenities and supports, its challenges, and a summary of its KidsFirst program’s operations (www.kidskan.ca/node/170).

They also conducted a review of literature on research in the US and Canada about home visiting programs similar to KidsFirst, to learn about what is and isn’t working in other programs (www.kidskan.ca/node/197), and developed a paper on the theories that explain how and why KidsFirst intervention activities bring about change, to better understand how the KidsFirst program works (www.kidskan.ca/node/172).

The evaluation included both quantitative and qualitative studies to determine how well KidsFirst has been working. The quantitative study measured the impact of KidsFirst on children’s health and wellbeing, and the qualitative study highlighted which practices and processes were most effective and which areas needed improvement.

For the quantitative study, the team looked at program and provincial data gathered to conduct a family functioning and child development study and a child health study. As well as using the data from KidsFirst’s own assessment tools, the evaluation team created a comparison group of similar families who were not receiving KidsFirst services, and compared the two groups using provincial health data on babies’ birth weights, and rates of children’s physician visits for regular checkups, infectious diseases, respiratory diseases, perinatal conditions, injury and poisoning, and hospital visits for injury, poisoning, and respiratory illnesses.

For the qualitative study, researchers interviewed participants, program managers and home visitors, and other key stakeholders at each site to learn about parents’ experiences and the program as a whole: changes to parents’ confidence and knowledge; improvements of parent-child interactions; what practices, processes and policies helped the most; and what other factors contributed to or hindered the overall effectiveness of KidsFirst.

The team published reports on the quantitative study (www.kidskan.ca/node/280), qualitative study (www.kidskan.ca/node/279), and a report summarizing findings and recommendations (www.kidskan.ca/node/281).

**WHAT THE EVALUATION FOUND ABOUT KidsFirst**

- Within the first six months of enrolling in KidsFirst, families were at less risk in all eight assessment categories: availability of social supports, food security, expectations of child, parent motivation, family identity and interactions, living conditions, housing suitability, housing stability. While some families experienced improvements later in the program, most improvements were shown in the first six months.

- However, families with complex needs (experiencing challenges with domestic violence, maternal depression or mental illness, substance abuse, and extreme parenting stress) had decreased risk scores in only two categories: availability of social supports, and food security.

- Families were classified according to four stages of the program based on the need for home visits. Many did not progress past level 1 (weekly visits) to levels requiring less frequent visits.

- The percentage of woman who enrolled in the program during their prenatal period grew from 15% in the first years of the program (2002, 2003) to 35-40% in more recent years.
SUCCESS STORIES

The good news is that there were many success stories because of KidsFirst. The evaluation team found that the intervention program was able to help families in a number of important ways:

- **Improved prenatal/parenting knowledge and practices.** Many parents learned about the effects of drinking during pregnancy, the different stages of child development, and the importance of communicating and bonding with children.

- **Better parent-child interaction.** Parents learned about the importance of playing, singing and reading with children, the need for empathy, controlling their negative emotions, and understanding their baby’s cues.

- **Greater assertiveness and self-confidence.** Many felt that they were now able to disagree with people in positions of authority. Some left unhealthy and abusive relationships. Some felt they were better able to handle inter-generational conflicts about parenting practices.

- **Reaching out and accessing services.** More look for support now, especially when crises arise. Typically, they are also better able to communicate their problems and needs, although there can still be obstacles to reaching out for help such as negative experiences with or perception of community services.

- **Personal development.** Many parents expressed that they wanted to go back to school or become active in the labour market. They learned skills to help with this, such as study skills, writing a resume and preparing for a job interview.

- **Improved life skills.** Some parents reported that they learned skills such as cooking, making household budgets, completing paperwork, and applying for social housing. Other skills mentioned included problem-solving and coping, making and keeping appointments, and maintaining a stable home.

- **Other personal gains.** Many parents talked about how their social connections had improved or how they were more involved with their community. Another important benefit—and key to the role of home visitor—was the growth in parents’ abilities to form trusting relationships.

“Before KidsFirst, if I had a problem, I’d rather run away from it than deal with it. But now I just feel like, okay. Now I think, ‘How am I going to deal with it?’ I’ll kind of cool myself down, and then I’ll deal with it, or talk to this person about it, or talk to my kids about it.” — parent

- Eighty-four percent of children had at least one developmental screen (Ages and Stages Questionnaire, or ASQ) within the first year of life. Rates of screening ranged from 78 to 90 percent.

- According to the ASQ, most of the children appear to be developing normally. However, there was no relationship found between families’ length of enrolment in KidsFirst and their ASQ scores.

- Researchers did not have any information on what happened to children whose ASQ scores suggested that they needed further assessment; although it was believed that these children were referred for additional assistance, whether or not they received such assistance, and its outcome, was not recorded — information seen as necessary to be able to demonstrate support for children’s development.

- Some reports indicated mothers cut back on smoking, quit drinking or addressed addictions issues.

- Children in the program had fewer well-child physician visits (regular checkups) than children from a comparison group had during their first 13 months of life. The KidsFirst children had relatively fewer physician visits for perinatal conditions such as jaundice, but more hospital visits for respiratory conditions and more physician visits for infectious diseases than comparison children had. It was also observed that many KidsFirst families do not have a regular family physician.
“Some KidsFirst families that … have participated in different programs that I am involved in … have developed such good skills that they are networking away from here with each other. They provide transportation for each other; they help with child care for each other; they invite other families to their [kids’] birthday parties.” — program staff member

SOME CHALLENGES

While KidsFirst has accomplished much for many parents, it is still not reaching everyone it needs to. In fact, the evaluation determined that the families with the most complex needs were the ones least likely to stay with the program. Home visitors often found they were trying to help these families only in moments of crisis, rather than providing regular program support. Overall, home visitors felt they did not have the time they needed to give their attention to families. They also have a number of other obstacles, such as low pay, or, in extreme situations, safety concerns at some of the homes they visit. These factors make it hard for the program to retain home visitors, which in turn can undermine the effectiveness of KidsFirst and break down the trust built up between home visitors and families.

Another obstacle for the program is the computerized system used to keep track of data, the KidsFirst Information Management System (KIMS). Often, home visitors write their reports on paper and then need to enter them in the computer system, which uses up time that could be spent helping families.

Another concern is the policy limiting KidsFirst to families living in targeted areas, especially as the program can lose families when they have to move and cannot find new housing in the targeted area.

Occasionally there has been confusion about roles for people working with KidsFirst and whether their efforts overlap with those of Social Services. In certain cases, KidsFirst has had to establish services in some communities, as there are no existing services with which to connect.

Other challenges include cultural ones, such as skepticism from some in the Aboriginal community about the motives behind the KidsFirst program. There have been concerns as to whether this is a program aimed at taking children from homes, along the lines of the residential school system.

Finally, there are challenges with access to services, such as the need for more licensed child care, geographic challenges such as distance to services and lack of transportation, especially for families in the North, and challenges with family and community poverty.
RECOMMENDATIONS FROM THE EVALUATION

While KidsFirst has helped many families, there is room for improvement. Through the evaluation process and a final consultation with key stakeholders at which findings were presented, a series of recommendations was developed to address the major challenges for the KidsFirst program in order for it to help all families:

• intake should focus more on increasing prenatal recruitment, particularly in sites with relatively low prenatal recruitment
• parents should be encouraged to take their children for well-child visits within the first year, possibly through new partnerships with medical clinics or public health services
• families with complex needs should be offered a modified (specialized) program involving specialized home visitors
• working with appropriate agencies, increased effort should be made to help families find suitable, affordable and safe housing
• a thorough review of all existing data and collection procedures should be undertaken in order to enhance data quality, reliability, completeness, and relevance
• the database used to collect data should be reviewed and adjusted to reflect the needs of all user groups, and more training on its use provided
• the Growing Great Kids curriculum that home visitors use with families should be evaluated to see whether it was presented, received, learned, and implemented
• children screened and referred for additional psycho-educational assessment and/or interventions should be followed and their outcomes recorded
• the intensity of services provided in the first year should increase
• targeted area restrictions should be reviewed and updated or eliminated
• guidelines on the roles of various agencies and staff members who are involved in KidsFirst programming should be better defined
• community agencies should be encouraged to share information in an effort to streamline case management
• families should be encouraged to progress through the participation levels within the program, taking into consideration their particular situation
• efforts to retain home visitors should be increased

“Parents have more realistic expectations about what their children can do for their age, probably more awareness of health and safety, and more knowledge of child development.” —home visitor
SPHERU is a bi-university, interdisciplinary research unit committed to critical population health research. The SPHERU team consists of researchers from University of Saskatchewan and University of Regina who conduct research in three main areas - northern and aboriginal health, rural health, and healthy children.

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