# Assertive outreach care in Preventive Child Healthcare: an effectiveness study

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The goal of this study is to determine the effectiveness of Assertive outreach care in Preventive Child Healthcare. The research question is: what are the effects of this intervention (delivered as stipulated in the intervention guide) in an...

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| **Ethical review** | Approved WMO |
| **Status** | Recruitment stopped |
| **Health condition type** | Family issues |
| **Study type** | Interventional |

## Summary

### ID

NL-OMON36443

**Source**
ToetsingOnline

**Brief title**
Assertive outreach care in Preventive Child Healthcare

### Condition

- Family issues

**Synonym**
domestic problems, educational problems

**Research involving**
Human

### Sponsors and support

**Primary sponsor:** Universiteit van Tilburg
**Source(s) of monetary or material Support:** ZonMw;te Den Haag

## Intervention

**Keyword:** assertive outreach, effectiveness, families, prevention

## Outcome measures

### Primary outcome

The primary study parameters are the differences between intervention group and control group on the measures as mentioned below.

Registration of care consumption

The main outcome of the intervention is a successful linking between problem families and appropriate care. This means that agreements are made between the families and follow-up help, either from the family*s social network or from formal agencies. Subsequently, these agreements need to be kept by all persons involved. No standard measure is available that measures this outcome. Some measurements are available that include aspects of care consumption (like the Engagement Measure and client satisfaction questionnaires). With the help of these measurements a registration form will be developed to measure the family*s care consumption, distinguishing between parents, children and the family as a whole.

Family Questionnaire

The Family Questionnaire is a measure that assesses the core dimensions of family functioning and educational circumstances in families with 4 -18 year olds children. The psychometric properties are examined providing evidence of the psychometric qualitiy of the questionnaire. The COTAN has evaluated the

Family Questionnaire. All criteria were judged positively (*good*). The Family Questionnaire is divided in five subscales:

- responsiveness (educational relation of parents with the child)
- communication (communication of parents with the child)
- organisation (basic care, housekeeping)
- relationship (between mother and father)
- social network (connections between the family and its social environment)

Together, these scales cover the total performance of the family.

Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) is a standard instrument for early identification of psychosocial problems in 3-16 year olds children. The questionnaire is divided in five subscales:

- emotional symptoms
- conduct problems
- hyperactivity-inattention
- peer problems
- prosocial behaviour

A total difficulty score can also be calculated. The SDQ has an impact supplement that enquires further about chronicity, distress, social impairment, and burden to others. The psychometric properties are satisfactory. Since 2006, the SDQ is nationally implemented within the Preventive Child Healthcare system to trace psychosocial problem in children.

### Secondary outcome

not applicable

## Study description

### Background summary

Families who experience a chronic complex of socio-economic and psycho-social problems have impaired contact with healthcare and welfare services. Evidence exists that the core of this problem lies in a problematic interaction between this type of families and current systems of care and services. The adults and children involved have continues needs in multiple domains like finance, labour, housing and parenting. Their complex and interwoven difficulties do not fit in with the fragmented nature of care systems, highlighting well-defined, single problems and short-term services. Especially, the splitting of socio-economic and psycho-social support systems appears to be difficult for problem families. Psycho-social care often ignores socio-economic troubles, whereas these two fields are interrelated for this target group. From the practice of social workers and service providers it is known that they experience that problem families are one of the hardest populations to serve. It has been shown that the term *multi-problem families*, to point out the target group, mainly originates from the context of care and services facing difficulties in dealing with this group of clients. It is estimated that 2-5% of Dutch children (0-19) grow up in this type of families.
Assertive outreach care in Preventive Child Healthcare is an intervention that focuses on this target group. The aim of the intervention is to get in touch with care-avoiding problem families in the first place by using assertive outreach approaches. After that, the child health professionals help the family to accept care or support, and liaise between them and appropriate care. The intervention focuses on improving the situation of the children by means of a system-approach: the needs of all family members are taken into account. Earlier studies to this intervention were established to make a start with its scientific underpinning. These studies were aimed at getting detailed insight into characteristics of the target group and the content of the intervention. Furthermore, early outcomes were assessed on the level of direct intervention results and client satisfaction. It has been shown that the intervention deliverers were able to reach the target group. Linking to care and services was attained in the majority of the cases (79%-92%) and parents expressed satisfaction. Based on this research, the intervention has been stipulated in an intervention guide.

### Study objective

The goal of this study is to determine the effectiveness of Assertive outreach care in Preventive Child Healthcare. The research question is: what are the effects of this intervention (delivered as stipulated in the intervention guide) in an intervention group compared to a control group receiving *care as usual*?

## Study design

The present study has a quasi-experimental design. The intervention condition consists of Assertive outreach care as stipulated in the intervention guide. The control condition consists of *care as usual* as routinely delivered by Preventive Child Healthcare. This condition is delivered to families eligible for Assertive outreach care as identified by Preventive Child Healthcare. In this study, no random assignment of families takes place. For ethical and practical reasons randomisation is deemed unfeasible.
A power calculation has shown that both study groups should encompass 40 families. Drop out of families could happen at several moments during the study. Therefore, the intervention group as well as the control group should consist of 66 families.
In both the intervention group and the control group three assessments take place: baseline, post-intervention and half-year follow-up. Three measures are used: a registration to assess care consumption, the Family Questionnaire and the Strengths and Difficulties Questionnaire. All measures are used at baseline, post-intervention and half-year follow-up.

## Intervention

Assertive outreach care originates in public mental healthcare settings for marginalised persons with severe and complex problems not receiving help they objectively need, like homeless people and persons with complex addiction problems. Nowadays, these types of interventions are entering the field of child care, and are applied to marginalised problem families as well. Assertive outreach care in Preventive Child Healthcare focuses on:
- problem families
- their social network and
- services and healthcare providers that could provide help or support.

The intervention consists of an active approach of problem families in their own environments to get in touch with them, motivate them to accept suitable care and liaise between them and appropriate support or care. The intervention primarily focuses on the parent(s) aimed at so-called *shared care*, i.e. parent(s) and Preventive Child Healthcare reach a shared understanding that the development of the child(ren) is severely threatened. The ultimate goal is to improve the situation of the child.
The family*s social network and formal agencies can provide help or support. The intervention aims that this is actively and coherently done. Within existing models of assertive outreach care, this is the so-called *broker*s

model*. The broker*s model is the form of assertive outreach where care is *brokered* between clients and agencies. Clients are typically transferred to regular care facilities after an assessment and development of a plan. This means that Assertive outreach care in Preventive Child Healthcare provides no treatment for specific underlying problems, like relationship or psychiatric problems of the parents. Assertive outreach care is voluntary, using gentle pressure motivated from the child being threatened.
Assertive outreach care in Preventive Child Healthcare temporarily provides practical support (i.e. apply for social benefit, seeking solutions for transportation of children to school/nursery) as a tool in building rapport and to make room for follow-up help. The intervention takes approximately 6 months and consists of 5 main steps (i.e. 1. case finding, 2. making contact, 3. sustaining contact, 4. developing a family plan, 5. linking (arranging for services to be delivered)).
Several components seem to contribute to the results of the intervention, including the outreach approach, family empowerment, the system approach, practical support, and building bridges between the family and (in)formal support and assistance.

**Study burden and risks**

Families who participate in this study are asked to complete two questionnaires and to answer some questions on care consumption. This takes place three times during the study. Total time to be invested is 2,5 hours within a period of one year. Some questions could be perceived as an incursion on one's privacy, specifically the questions from the Family Questionnaire concerning partnership.

# Contacts

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# Trial sites

## Listed location countries

Netherlands

# Eligibility criteria

**Age**
Adults (18-64 years)
Elderly (65 years and older)

## Inclusion criteria

- a family with at least one child under age;
- the family has multiple socio-economic and psycho-social problems; these problems are chronic and interrelated;
- the development of the child is severely threatened;
- the family is not accessing, or no longer accessing, mainstream services and there is no case manager available yet;
- Preventive child healthcare professionals suspect that it takes extra efforts to get in touch with the family and to establish a working relation; when Preventive Child Healthcare refrain form intervention, they suspect that the development of the child worsened or that a crises will arise.

## Exclusion criteria

None

# Study design

## Design

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| Study type: | Interventional |
| Intervention model: | Other |
| Allocation: | Non-randomized controlled trial |

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| Masking: | Open (masking not used) |
| Control: | Active |
| Primary purpose: | Health services research |

### Recruitment

NL

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| Recruitment status: | Recruitment stopped |
| Start date (anticipated): | 01-10-2011 |
| Enrollment: | 132 |
| Type: | Actual |

## Ethics review

Approved WMO

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| Date: | 17-05-2011 |
| Application type: | First submission |
| Review commission: | METC Brabant (Tilburg) |

Approved WMO

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|---|---|
| Date: | 06-12-2012 |
| Application type: | Amendment |
| Review commission: | METC Brabant (Tilburg) |

## Study registrations

### Followed up by the following (possibly more current) registration

No registrations found.

### Other (possibly less up-to-date) registrations in this register

No registrations found.

## In other registers

| Register | ID |
| --- | --- |
| CCMO | NL34498.008.11 |