Who is vulnerable or hard-to-reach in the provision of maternity, Well Child and early parenting support services?

Addressing the Drivers of Crime: Maternity and Early Parenting Support

30 June 2010

Maternity and Early Parenting Support

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Drivers of Crime

Who is vulnerable or hard-to-reach in the provision of maternity, Well Child and early parenting support services?

1.   Executive Summary

1.1   This paper reviews the current data on the number of New Zealand children and families that could be considered to be 'vulnerable' or 'hard-to-reach'.

1.2   Families and children who are 'vulnerable' are those who are most at risk of adverse outcomes, such as poor health, low educational attainment, unemployment, economic disadvantage, or being a perpetrator or victim of crime. The term 'hard-to-reach' refers to those people who are less likely to engage in services that are aimed at them. There is substantial but not complete overlap between these two categories. An understanding of the former is useful for determining the groups and individuals that should be prioritised for services, while the latter helps us understand the challenges of engaging people in services and how these challenges can be addressed.

1.3   The research highlights that the most vulnerable children are those whom are born to young (primarily) teenage mothers, whose parents have few educational qualifications, who live in sole parent and/or low income families, who were small at birth or have suffered a birth or childhood injury, who have suffered neglect or maltreatment and who have been taken into statutory care for a period.

1.4   Māori children are over-represented in all these categories, and consequently are at far greater risk of adverse outcomes in adulthood than non-Māori children. New Zealand also has relatively high proportions of children in some of the categories identified above, such as those born to a teenage mother, living in a sole parent, and reported child abuse and injury.

1.5   Multiple disadvantage in childhood is a significant cause of poor outcomes in adulthood, and many of these factors identified above are co-occurring. For example, children in sole parent families more like than those in two-parent families have a parent with no qualifications and to be living in poverty. In general, however, we have poor information about the proportion of New Zealand children who experience multiple, sustained disadvantage. UK research suggests that about 4 to 7 percent of families experience multiple risks persistently, and New Zealand estimates are around 5 percent.

1.6   Hard-to-reach groups are harder to define but are likely to include: minority ethnic groups, sole parent families, those in low SES communities, those with mental health problems, those with complex needs and circumstances, people with drug or alcohol abuse problems, illegal immigrants, those engaged in criminal activities, and those who feel they might be at risk of statutory intervention if they engage with services.

1.7   Barriers to engagement in services by 'hard-to-reach' groups include service level or structural barriers (e.g. location, hours of operation, cost, lack of awareness about availability, lack of cultural responsiveness, and poor coordination between services), and barriers specific to families and their situations (e.g. transience, low literacy, physical or mental health issues, domestic violence, lack of transport, low income, negative perceptions of services, and generally chaotic lives). There is good evidence about how policy-makers and service providers can address these barriers and improve engagement by those who are hard-to-reach.

1.8   Limited New Zealand data is available about the extent to which vulnerable and hard-to-reach parents and children access services such as primary maternity services provided by Lead Maternity Carers (LMCs), and Well Child / Tamariki Ora services. Work is underway to improve data collection and reporting for these services. In addition, the comprehensive needs assessment process currently being developed by the Ministry of Health for use by LMCs and Well Child providers provides an important opportunity to identify our most vulnerable children and engage their families / whanau in services that can mitigate and address the underlying causes of adverse outcomes.

2.   Background

2.1   The social, economic and personal circumstances of some families place their children at risk of poor outcomes across a range of domains, including later criminal offending and victimisations. These children and families are often referred to as vulnerable. In addition, some children and their families are less likely to take part in services available to all families, including antenatal care, WellChild services, parent support services, and early childhood education.

2.2   This paper considers what is meant by the terms 'vulnerable' and 'hard-to-reach' and provides current data on the number of New Zealand children and families that fit within these broadly defined categories. It canvasses the available data on the extent to which vulnerable and hard-to-reach families engage in maternity, Well Child and early parenting support services. The paper also identifies the barriers to engagement in services by so-called 'hard-to-reach' groups. Subsequent report backs will identify strategies for addressing such barriers in order to better engage hard-to-reach families in positive services.

2.3   This report has been completed as part of the Maternity and Early Parenting Support workstream, which is being undertaken as part of the cross-government work programme for Addressing the Drivers of Crime. The focus is "improving engagement with vulnerable and hard-to-reach families".

2.4   The analysis undertaken for this report has revealed the limited data collected by central agencies on the participation of vulnerable and hard to reach parents and children in some services, including the primary maternity services provided by

Lead Maternity Carers, and Well Child / Tamariki Ora services. Data is more readily available about some MSD funded parenting support services such as Family Start and Early Start, which are targeted at families where children are at greater risk of adverse outcomes. As a consequence, other work within the Maternity and Early Parenting Support workstream of Addressing the Drivers of Crime has been re-focussed to identify challenges with the collection and sharing of high quality data on maternity, early parenting support and early childhood services, and identifying the further work required to improve the collection and sharing of high quality, current data in this area.

3. What do we mean by 'vulnerable'?

3.1 Families and children who are **'vulnerable'** are those who are most at risk of adverse outcomes, such as poor health, low educational attainment, unemployment, economic disadvantage, or being a perpetrator or victim of crime.

3.2 Accumulated evidence from research shows that a number of factors in early childhood are associated with a greater risk of adverse outcomes later in life, including offending and victimisation. These risk factors are often clustered and have a cumulative (and possibly exponential) effect, and children who face multiple risk factors can be considered particularly vulnerable.

3.3 The following table lists those risk factors for which there is good evidence across a number of studies. Early childhood risk factors that are particularly associated with a greater likelihood of future offending are highlighted in bold.

Table 1: Risk factors in early childhood associated with adverse outcomes

Child Characteristics	Parents and their parenting style	Family factors and life events	Community factors
• Low birth weight • Birth injury • Disability • Chronic illness • Delayed development • Low intelligence • **Difficult temperament** • **Poor attachment** • **Poor social skills** • **Disruptive behaviour** • **Impulsivity**	• Single parent • Young maternal age • Depression or other mental illness • Drug or alcohol abuse • Harsh or inconsistent discipline • Lack of stimulation of child • **Lack of warmth & affection** • **Rejection of child** • **Abuse or neglect**	• **Family** instability, conflict or **violence** • Marital disharmony / divorce • Disorganised • Large family size / rapid successive pregnancies • Absence of father • **Very low level of parental education**	• **Socio-economic disadvantage** • Poor housing conditions

(From Foley et al, 2000)

3.4 Risk is a statistical concept and actual outcomes for people who are in a risk group, or exposed to risk, will vary. Many children who experience known risk factors for offending do not go on to commit crimes. It is also important to note that while risk factors may be correlated with particular outcomes, they are not necessarily causal, and may simply act as markers.

3.5 There is also growing evidence that the presence of some individual and family factors are protective, and can mitigate the effect of risk factors, reducing the likelihood of future offending. Thus, the likelihood of a child becoming an

offender or experiencing other negative outcomes, is influenced by a complex interaction of risk and protective factors over the life course. Nevertheless, the presence of multiple risk factors (and absence of protective factors) signals a greater likelihood of negative outcomes, enabling programmes and services to be targeted effectively.

4. What do we know about the number of vulnerable children / families in New Zealand?

4.1 Table 1 above identified a number of child, parent and community factors that make young children more vulnerable to negative outcomes. In this part of the report, we review the available New Zealand data on the prevalence of some of these indicators of vulnerability in New Zealand. This gives us a broad indication of the proportion of New Zealand children who could be considered to be vulnerable.

Young maternal age

4.2 New Zealand has relatively high teenage birth dates by international standards. In 2006, about seven to eight percent of all children born in New Zealand, and 17 percent of babies born to a Māori mother, were born to females aged under 20 years.

4.3 In 2007, the teenage birth rate for Māori women was more than four times that of the non-Māori rate and just over half (53 percent) of all females aged under 20 years who have children are Māori. The teenage birth rate for Māori increased by 27 percent between 2002 and 2007, driving an overall rise in the teenage birth rate during this period.

4.4 Linked to the higher teenage birth rate for Māori, there is also a strong link between low socio-economic status and teenage birth rates. In the period 2002 to 2006, the teenage birth rate for women aged 15 to 19 years living in the most deprived areas (NZDep Deciles 9 and 10) was 6.5 times higher than the rate for those living in the least deprived areas (NZDep Deciles 1 and 2).

The link between young maternal age and children's adverse outcomes

Evidence suggests that maternal age can have an impact on some aspects of parenting, such as mother-infant interaction and child outcomes, parenting skills and attitudes to child discipline. Pre-school age children of teenage mothers tend to show more behaviour problems, including higher levels of aggression and lower impulse control, than their peers born to older mothers and in adolescence experience higher rates of delinquency, grade failure, early school leaving and unemployment than their peers born to older mothers (Coley and Chase-Lansdale 1997).

However, a number of studies have found that found that once maternal characteristics and family circumstances are controlled for, the effect of teen childbearing per se on outcomes was statistically insignificant (Jaffee et al 2001). Overall, the evidence indicates that growing up with a mother who first gave birth as a teenager may not in and of itself be a risk factor for negative outcomes, but can act as a marker for the presence of other risk factors.

Living in a one parent family

4.5 Compared with other developed countries NZ has a relatively high proportion of children living in one-parent families (second only to the US). In 2006, 26 percent of NZ children aged under 18 years lived in sole parent families, with 42% for Māori children and 36 percent of Pacific children living with a sole parent.

4.6 Of infants aged under one year, data for 2006 identified that 19 percent were living with a sole mother. In the same year 36 percent of Māori infants and 32 percent of Pacific infants living with a sole mother.

The link between living in a one parent family and children's adverse outcomes

On average, children in lone parent families (regardless of the mother's age) have higher probabilities of a number of negative outcomes. They include psycho-social distress and behavioural disorders at all ages, academic underachievement and early school-leaving, health problems, early transitions into adult behaviour (such as childbearing) and low income and unemployment during adulthood (Baker, Pryor and Shirley 2000, Haveman and Wolfe 1993).

Just as with teenage parenthood, many of the negative outcomes associated with growing up in a sole parent family can be explained by other factors associated with single parenthood, such as low family income, poor maternal mental and physical health and low maternal education levels.

Low parental education

4.7 In 2006, 9 percent of Pākehā / European children 25 percent of Māori children were living with parents who had no formal qualifications. Children in sole parent families were five times more like than those in two-parent families to be living without a parent with qualifications (31 percent compared to 6 percent in 2006).

The link between low parental education and children's adverse outcomes

Research generally indicates that the mother's level of education has a stronger influence on children's outcomes in adulthood, than the father's level of education. However, recent research has found that the same sex parent's level of education (i.e. father's education for boys, mother's education for girls) has the greatest impact on New Zealand students' scores in the PISA assessments (Mare and Stillman, 2010, for the Families Commission).

There are a number of mechanisms by which parental education levels affect children's outcomes. Most likely is that low levels of parental education are linked to adverse outcomes via the lower levels of parental stimulation of children, which in turn contributes to poorer educational and social outcomes and the link between low parental education and lower family resources.

Socio-economic disadvantage (low income, living standards, neighbourhood deprivation)

4.8 In 2006, the median family income of dependent children in two-parent families was $69,900. The median family income of dependent children in sole-parent families was approximately a third of that for two-parent families ($23,800). Māori and Pacific children in sole-parent families headed by a mother had the lowest median family incomes: approximately $21,500 per annum.

4.9   In 2006, six percent of children living in two-parent families in 2006 had neither parent employed. In contrast, the percentage of children in sole-parent families in which the parent was not employed was 49 percent (59 percent for Māori children in sole-parent families and 60 percent for Pacific children).

4.10   The 2009 Household Incomes Report provides information on the material wellbeing on New Zealanders from 1982 to 2009[1]. It showed that 22 percent of children were living in poverty (i.e. below 60 percent of the median income before housing costs) in 2008. Taking into account housing costs, 28% of all children and 60% of children in families with no full-time workers, were determined to be living in poverty.

4.11   In relation to the age of dependent children, child poverty rates are highest amongst the 0-6 age group, with 20 percent of children living in household below 60 the percent threshold, compared to 16 percent for those aged 7-11 years, and 14 percent for those aged 12 – 17 years.

4.12   Sole-parent households with dependent children have the highest income poverty rates (49 percent) of all household types, although the level of poverty in sole parent families was strongly determined by the type of household. For example, 53 percent of sole parent families with dependent children living in their own household were in poverty, compared to 11 percent of sole parent families with dependent children living in a wider household.

4.13   Unfortunately measures of household income are not reported by ethnicity. However, the New Zealand Deprivation Index (NZDep) also provides a measure of social and economic disadvantage. Nine factors make up the NZDep Index measure, including income, benefit dependence, employment, housing, sole parent status, qualifications, communication and transport.

4.14   Māori children are significantly more likely to live in geographical areas of higher deprivation (NZDep2006 deciles 9 and 10). Forty-two percent of Māori children aged 0-14 living in these two deciles, compared to 18.8 percent of non-Māori children.

4.15   The 2004 Ministry of Health Report on Maternity Maternal and Newborn Information identifies that a noticeably higher concentration of mothers with newborns live in more deprived areas (NZDep areas 9 and 10). While these deciles contain 20 percent of the New Zealand population overall, just under 30 percent of women who gave birth in 2004 lived in these areas. This reflects the fact that Māori and Pacific women are over-represented in the more deprived deciles and that these ethnic groups have younger age structures and higher birth rates than the national average.

4.16   Measures of living standards recognise that a family's ability to meet its needs is affected by more than just income. In New Zealand, the Ministry of Social Development has developed a multi-dimensional measure of living standards called ELSI (Economic Living Standard Index).   ELSI includes 40 distinct indicator items across four categories: economising items; ownership restrictions, social participation restrictions, and self-assessments of standard of living.

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[1] An updated Household Incomes Report, drawing on the 2008-09 Household Economic Survey, is due in June 2010.

4.17   Using ELSI, Jensen et al (2007) conclude that while a sufficiently high income provides a complete buffer against the risk of hardship, a low income does not indicate the inevitability of hardship. Other factors, such as the low level of assets living in rented housing, low educational qualifications, the presence of children, and being a beneficiary are all associated with lower living standards. ELSI data for 2004 indicates that 31 percent of sole parent beneficiaries live in conditions of severe hardship, and a further 25 percent face significant hardship (Jensen et al, 2007).

The link between socio-economic disadvantage and adverse outcomes

A number of studies have found a link between indicators of socio-economic disadvantage and antisocial or criminal behaviour and other negative outcomes. For example, the Christchurch Health and Development Study ((Fergusson, et al, 1996) identified that 22 percent of children from the 5 percent of the most disadvantaged families went on to experience multiple problems in their teenage years. This compared with only 0.2% of children the least disadvantaged families.

A wide range of causal and linking mechanisms between socio-economic deprivation and crime have been identified. These include family socialisation processes and the higher levels of family stress and dysfunction often present. A number of studies highlight the mediating effect that child factors (temperament, personality and IQ) have on the interaction between socio-economic and family factors, and youth and adult offending.

Birth injury, low birth weight and childhood injury

4.18   Although good reporting systems are in place for birth events resulting in child and maternal deaths, there is very limited data available in New Zealand on the incidence of birth injuries which result in subsequent health and development issues for children.

4.19   We do, however, have reasonable data on low birth weight, which is a risk factor for adverse outcomes. Low birth weight can occur for a range of reasons, including chronic health problems in the mother (e.g. diabetes), infections in the mother or foetus, inadequate maternal weight gain, and the use of alcohol, tobacco or other drugs by the mother during pregnancy.

4.20   Of full-term babies born in 2005, 2.1 percent had a low birthweight. Although Asian babies had the highest proportion of small-for-date at term, Pacific and Māori babies had the lowest birthweights and tended to be small-for-date at term. Mothers aged under 20 years, aged 40 years and over, or who lived in the most deprived areas (NZDep quintile 5) were more likely to have full-term babies with a low birthweight (3.2 percent, 2.7 percent and 2.8 percent respectively).

4.21   Plunket reporting data for the last quarter of 2009 indicates that 21 percent of infants under one year of age living in NZDep decile 10 (the most deprived) areas who were seen by Plunket were exposed to tobacco smoke in the home. This compares to 9.7 percent of all children, and 2 percent of infants aged under one year who live in NZDep decile 1 areas. 24 percent of Māori children aged under one year who were seen by Plunket were exposed to tobacco smoke.

Multiple and Persistent Disadvantage

4.22   Many families face multiple disadvantages, including poverty, family violence, mental and physical ill-health and unemployment. These various disadvantages are often inter-related and have a compounding effect. The complex and co-occurring nature of multiple disadvantage means it often persists over time, including across generations.

4.23   Measures of multiple disadvantage attempt to capture a wide range of factors that impact on family living standards and wellbeing, including material resources (e.g. income, assets), human capital (e.g. literacy levels, qualifications, skills), physical and mental wellbeing (e.g. illness, addictions), and institutional and interpersonal connections.

4.24   Research in New Zealand (Jensen et al, 2007) has found that 63 percent of those with nine or more disadvantages (adversities and economic impediments) experienced severe or significant hardship. The research found that the major part of the association between living standards and disadvantage remained after controlling for income.

4.25   Recent research in the United Kingdom by Oroyemi et al (2009) identified that just under half (45%) of families in the UK Families and Children's Study were exposed to multiple risk markers (two or more) but fewer than 2% experienced ten risks or more. Oroyemi et al (2009) also found that more families experienced singular and multiple forms of risk over a six-year period than the cross-sectional data indicated. For example, about 19% families were income poor at any one time, but over a six-year period 41% families were affected. A small proportion of families (4-7%) experienced multiple risks persistently. These families were more likely to be lone parents, to have four or more children, to have young mothers or mothers from Black ethnic groups, to be social tenants and to live in urban areas.

4.26   The New Zealand Child Health Strategy estimated that children in around 5 percent of New Zealand families (about 25,000 families) could be considered to be experiencing multiple disadvantage and at high risk of adverse outcomes (Fergusson et al 1990; Yoshikawa 1994).

Child maltreatment and neglect

4.27   Four percent of respondents in the Christchurch Health and Development Study reported experiencing overly frequent, harsh or abusive punishment by parents. In the Dunedin Multidisciplinary Health and Development Study, 6 percent of the cohort reported to have been subject to severe physical punishment in childhood (Infometrics, 2008).

4.28   New Zealand has relatively high rates of reported child abuse and injury compared to other OECD countries, although there is a need for caution in making international comparisons in this area because of different definitions and reporting rates.

4.29   In New Zealand during the period 2004 to 2008, hospital admissions for injuries arising from the assault, neglect or maltreatment of children exhibited a J-shaped distribution with age, with rates being higher for infants under 1 year of age, and those aged 11 years and over. Hospital admissions for injuries arising from the assault, neglect or maltreatment of children were significantly higher for males, Māori and Pacific children, and for those living in the most deprived areas of the country (The Children's Social Health Monitor). Non-accidental injury and neglect deaths for children aged 0-4 years occur at a higher rate in low socio-economic status groups, and perpetrators are characterised by poverty, instability and unemployment (Duncanson et al, 2009).

4.30   Overseas research indicates that children with mothers aged under 15 years, or aged under 17 years with two or more children, are significantly more likely to be fatally abused or experience serious injury as a result than children with mothers aged 25 years or over. Risk is also higher if the child's mother had less than 12 years of education (Duncanson et al, 2009).

4.31   Research also indicates that the likelihood a serious assault of a child under five years of age increases tenfold for a child whose mother did not receive pre-natal care or dropped out of antenatal classes. Risk is also increased if the mother of the child is uncooperative with social service or health agencies (Duncanson et al, 2009).

> **The link between child maltreatment and adverse outcomes**
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> Child maltreatment has adverse effects on brain development by over-activating the stress response system, leaving the child with an impaired ability to regulate their emotions. Child maltreatment is sometimes defined as including witnessing violence against other family members.
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> Research studies have shown that children who have been physically abused are at higher risk of subsequent violent offending. Children who have been subject to neglect are also at higher risk of subsequent violent offending, but to a lesser degree than those who have been physically abused.

Children in statutory care

4.32 As at 31 May 2010, there were 5,619 children under the statutory care of Child Youth and Family, of whom 29 percent were aged between 0 and 5 years of age[2].

4.33 There is fairly clear evidence that children who are taken into state care are one the most vulnerable and disadvantaged groups in society. Longitudinal research from the UK (Viner and Taylor, 2005) found that, controlling for socioeconomic status, both male and female children who had been in state care were more than twice as likely to have a conviction by 30 years of age. Both men and women with a history of public care were also more likely to have been homeless, have psychological morbidity, and be in poor general health. Men but not women with a history of care were more likely to be unemployed and less likely to attain a higher degree. Women with a history of care were more likely to be permanently expelled from school.

> **The link between being in statutory care and adverse outcomes**
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> Overseas studies indicate that a greater proportion of prisoners have spent time in statutory care as a child, compared to the general population. For example, almost one third (30%) of prisoners in an Australian study reported having been placed in care before the age of 16 years (Indig et al (2010)
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> Being taken into statutory care is an indicator of risk of poor outcomes. Children are taken into statutory care for a range of reasons (abuse or neglect, family dysfunction, severe behavioural problems in children; parental imprisonment). While it is difficult to generalise, it is likely that a child who is removed from their family and placed in statutory care will be from a family facing significant complex issues and multiple disadvantage. These factors are likely to lead to poor outcomes, irrespective of whether a child is taken into care, and any adverse effects of poor quality care.

Parental abuse of alcohol and other drugs

4.34 A 2006–07 survey by the Ministry of Health estimated 21.1% of drinkers aged 15 years and older met the diagnostic criterion of hazardous drinking3. Rates of hazardous consumption among the young, Māori, Pacific and lower socio-economic groups were all significantly higher, with 39.2% of Māori and Pacific peoples drinking hazardously; and higher rates of hazardous drinking amongst

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[2] Statistics provided by MSD by email on 8 July 2010.

[3] Defined as "an established pattern of alcohol consumption that carries a high risk of future damage to physical or mental health, but may not yet have resulted in significant adverse effects"

those living in the country's more deprived areas (New Zealand Law Commission, 2010).

4.35   The incidence of FASD in New Zealand is unknown because there is no nationally consistent definition or diagnostic criteria for FASD in New Zealand. based on overseas incidence rates of 3 per 1000 live births, Alcohol Healthwatch has estimated that at least 173 babies are born with FASD every year in New Zealand, although others give higher estimates (Elliott et al, 2008)

The link between parental alcohol and drug abuse and adverse outcomes

Excessive use of alcohol in pregnancy can result in children being born with Foetal Alcohol Syndrome (FAS) which results in life-long effects on brain functioning, growth and behaviour, or with foetal alcohol effects (FAE) which influence their mental development and behaviour. A study of New Zealand caregivers raising children with FASD (Symes, 2004) reported that approximately percent of the children had problems with theft and / or were violent (cited Elliott et al, 2008).

Children of heavy drinking parents and caregivers are more at risk of early sexual behaviour, pregnancy, hospital admission, substance abuse and eating disorders depression and anxiety, attention deficit hyperactivity disorder, and conduct disorder (Barwick, 2007). Research has also shown that children of mothers who drink heavily during pregnancy may have their childhood further affected by neglect, deprivation and other behaviours associated with heavy alcohol use by their caregivers.

Families with parental substance misuse have high rates of child maltreatment. A 2009 MSD research report concluding the three most common factors associated with child homicides were drug and alcohol use and abuse, physical punishment and extreme response to intimate partner separation (cited New Zealand Law Commission, 2010).

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5.   What do we mean by hard-to-reach?

5.1   The term 'hard-to-reach' refers to those people who are less likely to engage in services that are aimed at them. It should be noted, however, that the term is used inconsistently and is subject to criticism.

5.2   Within the broad category of hard-to-reach, some authors have identified several sub-categories, as shown in the following table:

Table 2: Sub-categories of hard-to-reach

Type	Definition	Examples
Minority groups	Groups who are traditionally under-represented as users of services, who may feel excluded from services, may not see services as relevant to their needs, or who may face practical barriers to engagement	Minority ethnic groups, sole parent families, refugee and migrant populations, those in low SES communities
'Slipping through the net'	The overlooked and invisible (hidden populations) and those unable to articulate their needs	Those with mental health problems, those who fall just outside the criteria for eligibility or entitlement to services, those with complex needs and circumstances
'The service resistant'	Those who are wary, distrustful and generally unwilling to engage with service providers, the 'over-targeted' and the disaffected.	Examples might be people with drug or alcohol abuse problems, illegal immigrants, those engaged in criminal activities, those who feel they might be at risk of statutory intervention if they engage with services.

(Adapted from: Doherty, Stott, Kinder and Harradine (ed) (2004)

5.3   As noted above, the term hard-to-reach has its critics. Some writers (e.g. Smith 2006, Murphy 2006, both cited Brackertz 2007) take issue with some people being labelled as 'hard-to-reach', noting that the term is potentially stigmatising and defines the problem as being with the individual or group being referred to, not with a service's approach to them. It also implies a homogeneity within broadly defined groups, which does not necessarily exist.

5.4   Those critical of the term hard-to-reach argue that service providers must assume responsibility for their failure to engage some groups, and take action to ensure their services are more inclusive and attractive to those who may not respond to traditional approaches to engaging clients. Some services are taking these criticisms on board and a recent Australian study on engaging hard to reach families and children, referred to a parenting programme which identified hard-to-reach groups as any sections of the population who were under-represented as users of their service.

5.5   The terms 'vulnerable' and 'hard-to-reach' are not inter-changeable: not all vulnerable families are hard-to-reach, and not all hard-to-reach families will be vulnerable. For example, many vulnerable families will be receiving a wide range of services, but may continue to be at risk of negative outcomes because of the complex and multi-faceted nature of the issues they face, or because services may not be available or designed in such as way to address these issues effectively.

5.6   Similarly, there will be some families who do not engage in services, but who may not be at significant risk of negative outcomes (e.g. members of closed religious groups). Nevertheless, there is likely to be a reasonable degree of overlap between those who are vulnerable, and those who do not engage or participate in core health, welfare and education services.

6. What do we know about the number of hard-to-reach families in New Zealand?

6.1 Determining the number of hard-to-each families is a difficult task. While we have some data about the people who participate in services, we know very little about those who does not. We also have very limited knowledge about the size of some hard-to-reach groups, particularly 'hidden populations' (for example, gang members and their families, and illegal migrants) who often live at the margins of society, and have little engagement in the mainstream economy or with social and health services. Moreover, as noted above, it is likely that the broad categories of hard-to-reach are actually quite heterogeneous, with some people being quite happy to engage with some types of services and others completely disengaged. This point is reinforced in the findings of a New Zealand evaluation of 35 'reducing inequalities' projects aimed at improving access to primary health care in New Zeland, which noted:

> "The 'hard to reach groups' within a population are not homogeneous. Projects identified Māori clients, Pacific clients and the poor as 'hard to reach'. Some projects also identified people with chronic illness and the socially isolated, especially the elderly, as also being difficult to deliver services to. There are of course many people in these groups that are perfectly happy to use existing services, and do so successfully. People are also not always uniformly disengaged from primary care. They may have no difficulty in attending for trauma, but are terrified of seeing a health service for preventative care."   (Gribben, 2007)

Examples of some categories of hard-to-reach in NZ

6.2 The following table sets out possible categories of hard-to-reach families in New Zealand and where possible, provides information about the likely numbers of people in these categories.

Table 3: Possible categories and prevalence of hard-to-reach groups

Under-served / hard to reach groups	Information about prevalence in NZ
Highly mobile / transient families	No data available
Families with gang associations	Total number of patched gang members and associates is estimated to be between 3,000 and 3,500[4]
Families where one or more parent is involved in serious or multiple or low-level offending	The 2003 prison population census identified that 35 percent of female and 12 percent of male sentenced inmates had dependent children at the time of their imprisonment.
Parents with drug or alcohol abuse problems	No data available
People who feel they might be at risk of statutory intervention if they engage with services (e.g. families with repeat CYF notifications; illegal immigrants;).	In 2007/08, CYF received 89,461 notifications of child abuse nationally. 67 percent of notifications to CYF are repeat notifications. No data available on the estimated size of illegal immigrant population in NZ.
Families with high housing needs	304 people were on Housing New Zealand's Priority A waiting list (i.e. classified as having severe housing need) in December 2009.

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[4] Minister of Police Hon Annette King, June 2008, cited Parliamentary Library Research Paper 09/02. 3 April 2009

Māori living in areas of high socioeconomic deprivation, with relatively low participation in services (e.g. PHOs, ECE)	Forty-two percent of Māori children aged 0-14 live in NZDep deciles 9 and 10 (compared to 18.8 percent of non-Māori children).
'Early starter' sole parent beneficiaries (i.e. young when had first child and young when they first received a main benefit)	In 2008, there were 41,000 'Early Starters' (36% of all sole parent beneficiaries), with 91,000 children (45% of all children of all sole parent beneficiaries). Māori are over-represented in the Early Starter group (53%); 48% of Early Starters live in highly deprived areas; and Early Starters are more likely than other sole parent beneficiaries to have three children (22% compared to 13%) or four children (13% compared to 7%). Available data also indicates higher levels of financial hardship amongst this group compared to other sole parent beneficiaries.
Families experiencing multiple disadvantage	New Zealand Child Health Strategy identifies that an estimated 5 percent of New Zealand families (about 25,000 families) are at a high risk of adverse outcomes. UK research indicates that between 4-7% of families experience persistent multiple risk factors. A higher concentration of mothers with newborns live in more NZDep 9 and 10 areas, and 42 percent of Māori children aged 0-14 live in these two deciles, compared to 19 percent of non-Māori children. Needs assessment processes likely to be required to assess multiple disadvantage on a family-by-family basis.

7.   What are the barriers to participation in services by hard-to-reach families?

7.1   Rather than attempting to comprehensively describe and measure the number of people who are hard to reach, it can be more useful to identify the barriers that can lead to non-engagement with services, and then consider how these barriers can be addressed.

7.2   There are many reasons that parents may be resistant to engaging with health, social and educational services, even when the support and intervention provided may lead to positive change in their lives. They may fear judgement and consequences, have chaotic lives, be overwhelmed by multiple and intractable difficulties, and feel unable to develop trusting relationships with practitioners.

7.3   In general terms, there are two broad categories of barriers to inclusive services that engage vulnerable and hard to reach families: service level (or structural) barriers, and barriers specific to children, their parents and their situations. Examples of the types of barriers that fall within these two categories are outlined in the following table:

Table 4: Barriers to engagement in services

Service level (structural) barriers	Barriers specific to children, their parents and their situations
• Lack of publicity about services • Cost of services • Service availability and eligibility • Inaccessible location • Lack of public transport • Limited opening hours • Inflexible appointment systems and overcrowded clinics • Poor coordination between services • Lack of cultural sensitivity / attention to cultural needs • Insensitive or judgemental attitudes and behaviours of staff or of other parents • Services do not meet needs or seem directly relevant or beneficial to parents	• Limited income, financial stress • Lack of family and social support • Lack of private transport • Residential mobility, unstable housing or homelessness • Low literacy levels • Large family size • Ambivalence about pregnancy / parenthood • Personal preferences, beliefs about the service • Fear of child protection services • Disabilities, physical or mental health issues (including addictions) • Domestic violence • Day to day stress

(Adapted from: Carbone et al (2004))

7.4   As suggested by the information presented in Table 4 above, many barriers to engagement by families are low-level, practical matters that could easily be addressed by services. It is interesting to note that research suggests that a perception of fewer practical barriers, even where a high number of such barriers is actually present, is related to increased participation in services by parents.

7.5   A New Zealand study (Gribben, 2007) reported the following views offered by primary health providers as to why some Māori clients might not access services:

- Reception staff being unwelcoming to Māori patients because of bad debts and/or appearance

- Even low cost fees being unaffordable to the poorest sections of the population

- Individuals having more immediate priorities for survival than primary health care needs.

7.6   There is mixed evidence on the impact of some factors on engagement. For example, ethnicity and age of parents, single parenthood, age of children, severity of child's problem behaviour and previous parental antisocial behaviour have been found in different studies to exert a variable influence on engagement with services (MacQueen et al (2007).

7.7   A final group of barriers to participation in services aimed at parents are those associated with gender, and the participation of fathers in particular. Barriers to father's engagement in parenting support services (cited in MacQueen et al, 2007) include:

- Practical difficulties relating to male employment patterns

- The focus of staff on mothers and children rather than the whole family

- Negative staff attitudes and child protection anxieties

- The overwhelmingly female environment, lack of other men participating and lack of 'male' activities

- A lack of recognition amongst practitioners / providers of the differences in how men and women communicate and the coping mechanisms they employ under stress (e.g. men often prefer instrumental coping strategies and task-focused communication).

8. To what extent do vulnerable and hard to reach families participate in maternity, early parenting support and other early years services?

8.1 Unfortunately, the adequacy of data available to determine the extent to which vulnerable and hard to reach groups engage in maternity, Well Child and family support services is highly variable, and in some cases almost absent.

8.2 Using the data that is available about the level of participation in some services, we can that we might expect to see, versus actual participation, as a basis for identifying who could be considered under-served by current services.

8.3 What we do know is that:

- In the 1 July to 31 December 2009 quarter, 21 percent of Plunket new baby cases (children who received their first Well Child contact while aged under 1 year) were Māori. Just under 23 percent of all babies born annually between 2005 to 2007 were Māori, indicating that Māori babies are well represented amongst Plunket's new baby cases.

- 24 percent of Plunket new baby cases were in NZDep deciles 9 and 10 (the most disadvantaged deciles). In 2004, just under 30 percent of women who gave birth in 2004 lived in these areas. This indicates that families with infants may under-utilise Plunket Well Child services in low decile areas. About 15 percent of Well Child services are delivered by 56 independent providers contracted by DHBs, and its possible that people in low decile areas may be more likely to access Well Child services from non-Plunket providers. This cannot be confirmed, however, as the information collected by DHB-contracted providers about the families who uses their services is inconsistent and not routinely provided to the Ministry of Health.

- The 2007 Maternity Consumer Satisfaction Survey indicated that only a very small proportion of respondents (1.6 percent) did not receive any antenatal care, and 2.9 percent received their antenatal care from a GP who was not a Lead Maternity Carer (LMC). However, the data does not disclose the composition of the small group of women who did not receive antenatal care, and does not indicate how many and what groups of women do not access antenatal care until very late in their pregnancy. Moreover, young and Māori women are under-represented in the Maternity Consumer Satisfaction Survey and as such it may under-represent the proportion of women who do not access antenatal care.

- Māori and Pacific women are significantly less likely to attend antenatal or childbirth education classes, with only 24% of pregnant Māori and Pacific women attending such classes, compared to 58.4 percent of all mothers.

- Family Start is targeted to families who are vulnerable to adverse outcomes, and this is reflected in the data on who participates in these intensive support

programmes. Of the 3,591 families that joined Family Start in the 12 months to October 2009, the following proportions of families met particular referral criteria, with most families meeting more than one: 81% low income; 24% young parents; 32% unsupported parents; 19% no or minimal antenatal care; 21% mental health problems; 15% substance abuse; 40% relationship problems; 26% family history of abuse; and 19% involvement with CYF. These findings suggest that Family Start is engaging vulnerable families.

- Of the children active with Family Start in April 2009, 60 percent identified Māori as one of their ethnic groups, and 27 percent identified as Pacific (identification of multiple ethnic groups was common).

- Māori and Pacific children and those living in low decile areas are less likely to participate in early childhood education (ECE). Overall 95 percent of New Zealand children participate in ECE before beginning schools, but only 91 percent of Māori and 85 percent of Pacifika children will have participated in ECE prior to starting school. In the least advantaged 30 percent of communities, only 88 percent of children attend ECE. In the most vulnerable local communities such as Randwick Park in Otara, as few as 60 percent of children will attend E immediately before beginning school.

9. Conclusions

9.1   There is a high but not complete overlap between the concepts of vulnerable and the hard to reach. Vulnerability relates to the level of risk of adverse outcomes. It is important to understand who and how many people are vulnerable, as this assists effective targeting of services. We know a reasonable amount about who is vulnerable in NZ, but very little about the extent to which these groups use maternity, Well Child, parenting support and early childhood education services. We also have few robust measures of the proportion of families who face multiple disadvantage and are therefore at greatest risk of adverse outcomes.

9.2   The concept of hard-to-reach relates to engagement with services. We have a very limited knowledge in central government about the groups within the population who miss out on services. We can identify some broad categories of hard to reach but these likely to be indicative only. It is probably more useful to understand barriers to engagement so that action can be taken to address them. However, we also need to collect better information about the broad categories and more fine-grained sub-categories of people who do and don't use services.

9.3   It is clear from the available data, however, that Māori children and their whanau are particularly vulnerable to negative outcomes, and have lower levels of engagement in some types of services. Improving the responsiveness of maternity, Well Child, parenting and family support, and early childhood education   services to Māori, and increasing the participation of Māori families in these services should be a key priorities that are reflected in the policy settings, contracting arrangements and specifications for these services.

References

Barwick, Helena (2007) **An uphill struggle: The challenges of accumulated adversity.** A report commissioned by the Ministry of Social Development. Unpublished (Copy provided by MSD)

Brackertz, Nicola (2007) **Who is hard to reach and why?** ISR Working Paper. January 2007.

Carbone Stephen, Alex Fraser Rasika Ramburuth and Lucy Nelms (2004) **Breaking Cycles, Building Futures. Promoting Inclusion of vulnerable families in antenatal and universal early childhood services. A report on the first three stages of the project.** Published by the Victorian Government Department of Human Services, Melbourne, Victoria. Australia. December 2004

Gribben B (2007) **Improving Access to Primary health care: An evaluation of 35 reducing inequalities projects.** Wellington: Ministry of Health. January 2007

CBG Health Research (2005)

Cortis, Natasha, Ilan Katz and Roger Patulny (2009) **Engaging Hard-to-reach families and children.** Australian Government Department of Families, Housing, Community Services and Indigenous Affairs, Occasional Paper No. 26.

Dawe, S, P Harnett, and S Frye (2008) Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do, **Child Abuse Prevention Issues** No 29, 2008.

Department for Children, Schools and Families and Ministry of Justice (2007) **Children of Offenders Review.** A joint Department for Children, Schools and Families / Ministry of Justice review to consider how to support children of prisoners to achieve better outcomes. June 2007.

Doherty Paul, Alison Stott and Kay Kinder (NFER) and Harradine, Sally (ed) **Delivering services to hard to reach families in On Track areas: definition, consultation and needs assessment.** Home Office Development and Practice Report No. 15, 2004.

Duncanson Mavis, Don Smith and Emma Davies. **Death and Serious Injury from Assault of Children aged under 5 years in Aotearoa: A Review of international literature and recent findings.** A publication commissioned by the Office of the Children's Commissioner. June 2009

Early Childhood Consortium, Faculty of Education and Project Evaluation Unit, School of Population Health (2005) **Evaluation Report: Breaking Cycles Building Futures.** University of Melbourne. May 2005.

Elliott, Elizabeth J and Carol Bower (2008) Alcohol and pregnancy: The pivotal role of the obstetrician. **Australian and New Zealand Journal of Obstetrics and Gynaecology** 2008; 48: 236–239

Elliott, Lisa, Kristina Coleman, Arsupol Suebwongpat and Sarah Norris (2008) **Fetal Alcohol Spectrum Disorders (FASD): Systematic reviews of prevention, diagnosis and management.** Health Services Assessment Collaboration Report 2008.

Foley Debra, Sharon Goldfield, June McLoughlin, Jeanette Nagorcka, Frank Oberklaid, Melissa Wake (2000) **A Review of the Early Childhood Literature.** Prepared for the Department of Family and Community Services as a background paper for the National Families Strategy by the Centre for Community Child Health. February 2000.

Girling Melissa, John Huakau, Sally Casswell and Kim Conway (2006) **Families and Heavy Drinking: Impacts on Children's Wellbeing. Systematic Review.** Centre for Social and Health Outcomes Research and Evaluation and Te Rōpū Whāriki Massey University. Families Commission. Blue Skies Report No. 6/06. June 2006.

Ghate, Deborah and Neal Hazel (2004) **Parenting in Poor Environments: Stress Support and Coping. A summary of key messages for policy and practice from a major international study.** Policy Research Bureau. United Kingdom

Hannon, Celia, Claudia Wood and Louise Bazalgette (2010) **In Loco Parentis**. A Demos report commissioned by Barnardos. June 2010. United Kingdom. http://www.barnardos.org.uk/in_loco_parentis_-_web.pdf

Indig, D, L Topp, B Ross, H Mamoon, B Border, S Kumar, and M McNamara (2010) **2009 New South Wales Inmate Health Survey: Key Findings Report.** Justice Health. Sydney.

Infometrics (2008) **The Nature of Economic Costs from Child Abuse and Neglect in New Zealand.** A report prepared for Every Child Counts. August 2008.

Jensen, John, Sathi Sathyandra and Morna Matangi-Want (2007) The 2004 New Zealand Living Standards Survey: What does it signal about the importance of multiple disadvantage? **Social Policy Journal of New Zealand**. Issue 30, March 2007.

Lievore Denise and Pat Mayhew (2007) **The scale and nature of family violence in New Zealand: A review and evaluation of knowledge.** Report prepared for the Centre for Social Research and Evaluation, Ministry of Social Development. April 2007.

McCarthy Peter, Karen Laing and Janet Walker (2004) **Offenders of the Future? Assessing the Risk of Children and Young People Becoming Involved in Criminal or Antisocial Behaviour.** Research Report RR545. Department for Education and Skills

MacQueen Sarah, Joe Curran, Linda Hutton, and Bill Whyte (2007) **Support and Services for Parents: A Review f the literature in Engaging and Supporting Parents.** Scottish Government Social Research.

McKeown, Kieran (2000) **A Guide to What Works in Family Support Services for Vulnerable   Familes.** http://www.omc.gov.ie/documents/publications/A_Guide_to_what_Works_in_Family_Support_Serviecs_for_Vunerable_Families.pdf

Ministry of Health (1998) **Child Health Strategy**. Wellington, New Zealand. June 1998.

Ministry of Health (2009) **A Focus on the Health of Māori and Pacific Children: Key findings of the 2006/07 New Zealand Health Survey.** Ministry of Health. Wellington, New Zealand. December 2009. http://www.moh.govt.nz/moh.nsf/pagesmh/9834/$File/focus-on-health-maori-pacific-children.pdf

Ministry of Justice (2009) **Risk Factors and Causal Mechanisms for Offending.** Strategic Policy Brief. March 2009. http://www.justice.govt.nz/policy-and-consultation/drivers-of-crime/resources#strategic-policy-briefs

Ministry of Social Development (2008) **Children and Young People: Indicators of Wellbeing in New Zealand 2008**. Wellington

Moran, Patricia, Deborah Gate, Amelia van der Merwe (2004) **What works in Parenting Support? A Review of the International Evidence.** Department for Education and Skills. Research Report RR574

New Zealand Law Commission (2010) **Alcohol In Our Lives: Curbing the Harm.** NZLC R 114. Published 27 Apr 2010.

Oroyemi Paul, Giacomo Damioli, Matt Barnes and Tim Crosier (2009) **Understanding the risks of social exclusion across the life course: Families with Children. A Research Report for the Social Excusion Task Force, Cabinet Office.** UK Cabinet Office and the National Centre for Social Research.

Parliamentary Library (2009) **Young People and Gangs in New Zealand**. Parliamentary Library Research Paper. Research Paper 09/02. 3 April 2009

Perry, Bryan (2009) **Household incomes in New Zealand: trends in indicators of inequality and hardship 1982 to 2008.** Ministry of Social Development. Wellington. June 2009

Rucklidge, Julia, Anthony McLean and Paula Bateup (2009) Criminal Offending and Learning Disabilities in New Zealand Youth: Does Reading Comprehension Predict Recidivism? **Crime and Delinquency OnlineFirst,** published May 27, 2009.

Sarij-Blatchford Iram and John Sarij-Blatchford (2009) **Improving Children's Attainment Through a Better Quality of Family-Based Support for Early Learning**. Early Years Research Review 2. Centre for Excellence in Outcomes in Children and Young People's Services (C4EO) London UK. January 2009. www.c4eo.org.uk

Sutton, Carole, David Utting and David Farrington (eds) (2004) **Support from the Start: working with young children and their families to reduce the risks of crime and anti-social behaviour.** Department for Education and Skills. Research Report 524. www.dfes.gov.uk/research

The Children's Social Health Monitor New Zealand (undated) **Injuries Arising from the Assault, Neglect or Maltreatment of Children** http://www.nzchildren.co.nz/injuries.php