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Identifying a Solution to Early Childhood Inequality

WHY WE DID THIS STUDY

Research suggests family income is linked to a child's well-being and development, particularly during early childhood.[1] Research also indicates that offering high-quality parenting support, especially during the first three years of a child's life, is an effective and affordable way to address knowledge and resource inequalities for low-income families.[2] However, many low-income families with young children in New York City cannot access the support they need.

While there are programs that provide coaching and support for parents and there are policies that increase total income for families, Room to Grow is the only early childhood program we are aware of that combines the delivery of social support and material goods. These services are delivered in a warm, dignified environment through trusting relationships.

In March 2017, we launched a randomized controlled trial study of Room to Grow that followed a cohort of mothers and their children from pregnancy through age two. It is the first rigorous evaluation of a program that combines material goods, parenting education, and connections to community resources to promote the early health and development of young children. Although the impacts of financial support and parenting programs for low-income families are well-documented, this study offers a unique lens by examining whether the joint combination of these two supports leads to better outcomes for families and children.

We are following a cohort of mothers who received Room to Grow services (the "treatment group") alongside mothers who did not receive such services during babies' first two years of life (the "control group"). Our study is in its third year, and we anticipate releasing our initial findings in 2021. In total, we are following 317 mothers, who are divided equally between the treatment and control groups. As the babies approached age 1, we conducted our first follow-up with the mothers, with nearly 90 percent of both groups participating in the follow-up survey. Families in the treatment group participate in the three-year Room to Grow program, which provides quarterly 2-hour visits with a dedicated clinician focused on parent coaching, substantial material support (e.g. books, toys, clothing, baby equipment) at every visit, and warm referrals to additional resources and supports in their community (e.g. mental health, housing, job placement/GED). The control group does not receive these services.

We conducted baseline interviews in participants' homes and in public locations. When possible, the baseline interview also included an observational assessment of the home environment. Findings from these interviews provided a portrait of a mother's circumstances at intake (see Figure 1). The interviews covered a wide range of subjects, but included questions on mothers' health and mental health, material hardship and income, prenatal care and utilization, and knowledge of child development. For those interviewed in the home, the observational assessment focused on safety of the home environment and presence of material items and goods for the baby. As shown in Figure 1, compared to the average mother of a newborn in New York City, mothers in the study disproportionately face a host of disadvantages including housing instability, lower education levels, and material hardship.

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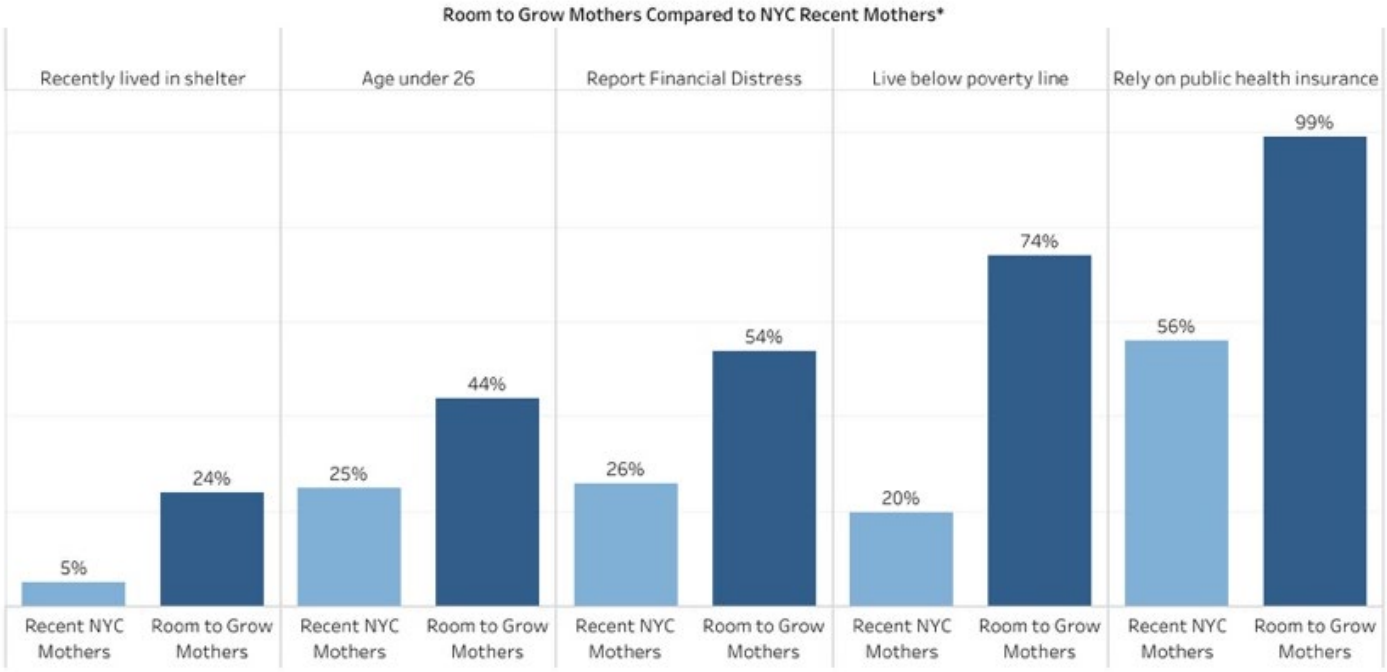
Figure 1. Room to Grow mothers are much more disadvantaged compared to mothers of newborns in New York City



* Data on NYC Recent Mothers pulled from the Robinhood Poverty Tracker developed by Columbia University's Columbia Population Research Center. Available at: http://povertytracker.robinhood.org

The Year One Follow-Up RCT retention rate for the 317 mothers who completed baseline surveys was approximately 89 percent, and was almost identical across the treatment and control groups. As their children approached age one, we conducted a telephone survey with the mothers. This survey focused on things like maternal depressive symptoms, stress, provision of cognitive stimulation to the child, parents' sense of competence in their parenting role, and other interim measures that participation in the program could potentially improve.

We are now in the process of conducting follow-up with mothers after two years, where we capture a similar set of outcomes as during the age one survey. After the mothers graduate from the program when their babies turn 3 years old, we will once again visit with the mothers and their babies in person. This visit will collect "gold standard" measures of parenting and child development through structured observations and direct assessments of child development. Given the innovative nature of the Room to Grow intervention, we expect that many mothers will benefit from their experiences in the program. For example, in our qualitative research, one mother in the treatment group described how this unique combination of support from Room to Grow has increased her capacity to bond with her child and improve her circumstances:

"Parenting with my other children was a struggle. I was always worrying about where I'm gonna get, and when I'm gonna get, the next thing… Now, I have time to focus on bettering myself. I have the support for my child, which is what's gonna put my life into place."

Within her baby's first year, this mother obtained her GED and moved her family from a domestic violence shelter into a single-family apartment. Quotes like these highlight the power of social support in combination with material goods to promote positive parenting and stability in this critical window of 0-3.

WHAT THESE FINDINGS WILL MEAN

It is our hope that initial outcomes from this study could increase public sector support for interventions that combine parenting and material supports. Validation of Room to Grow's program model is an important step forward to helping the program go to scale so that it can reach more families. These study findings can also help to provide supporting evidence funding other early childhood programs such as the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), or policy changes such as those made by the U.S. Preventative Services Task Force (USPSTF), who in 2019 recommended that insurers cover mental health counseling without copayments.

These findings will be critical for informing continuous improvement in the Room to Grow program model with its emphasis on addressing parenting knowledge and the daily material hardships of parents raising newborns in poverty. Ultimately, we hope that these study findings will influence the policy space in a way that yields long-term systems change.

MORE ABOUT THIS STUDY

The randomized control trial in this study included sample of 317 mothers, with 158 in the treatment group and 159 in the control group. Participants recruited into the study were referred by either Room to Grow community members, program participants, or partner organizations. Randomization was successful, with treatment and control groups showing statistical balance across a variety of demographic indicators. These indicators included race/ethnicity, maternal age and education, poverty status, material hardship levels, and living arrangements (e.g., presence of a spouse or partner, presence of one or more of the mother's parents, etc.). Results will be forthcoming.

SOURCES

[1] Chaudry, Ajay, and Christopher Wimer (2016). "Poverty is Not Just an Indicator: The Relationship between Income, Poverty, and Child Well-being." *Academic Pediatrics*, 16(3), Supplement, S23-S29.

[2] Britto, Pia R., et al. "Nurturing care: promoting early childhood development." The Lancet 389.10064 (2017): 91-102.

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