Factsheet

Door-to-Door Social Inclusion in a multi-ethnic problem neighbourhood

Final results of an effectiveness study

Introduction Social inclusion of people who are long-term unemployed is a major challenge, in particular in densely populated large city neighbourhoods such as the Schilderswijk in The Hague (Netherlands). Many of those citizens feel trapped in a cycle of unemployment, stigma, poverty and complex social problems. The Hague developed a social case management intervention to increase participation and employment of long-term unemployed parents: the Door-to-Door approach (DTD). The Trimbos Institute conducted an effectiveness study to evaluate the impact of this approach.

Main findings Occupational participation including voluntary work increased in 40% of 111 persons in the DTD programme compared to 27% in 85 persons in the control group whom had been offered a minimum of support. Also 5% of DTD participants gained and kept paid competitive or supported employment during follow-up, against none of the control participants. These differences are relatively small but significant.

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The Door-to-Door intervention

The Door-to-Door (DTD) intervention is a case management approach using specialised counsellors to support people in the target group individually to optimise the degree of participation in the society and employment possibilities.

DTD focused on long-term unemployed parents living in the target neighbourhood, aged between 27 and 65, who received social welfare benefits for at least three years and lived together with at least one child under 18 years old. People who were already receiving a social intervention were excluded.

The Hague aimed at maximizing the participation level and chances of employment of citizens in the target group. The specific ambitions were: to help 50% of the participants to get more active in society and to help 15% of the participants find supported or regular employment.

Key elements of DTD are:

- Close cooperation with third parties operating in the neighbourhood;
- Long-term support: 12 -(if needed) 18 months;
- Special designed tools to improve communication, for example through incentive, barrier and interest cards;
- Frequent contact and quick follow-up;
- Outreaching, through home visits and active approach of consultants towards participants;
- Tailor-made support;
- The commitment of the participant to the project by signing a contract;
- Obligation to participate ('make the most of it');
- Specially trained counsellors:
    - Use of Motivational Interviewing
    - Cross-cultural communication
    - Positive and flexible attitude
    - Thorough supervision and peer support.

Research method

To evaluate the effectiveness and workings of DTD the Trimbos Institute conducted a mixed method effectiveness study. A cluster randomized controlled trial was carried out to evaluate whether DTD was effective compared with the results of a control group. The control group received a minimum of social care as is usually provided by the city. The experimental group received DTD. Those two groups each represented a sub-quarter of the Schilderswijk neighbourhood that was randomly chosen out of five comparable sub-quarters the Schilderswijk was divided in for this purpose.

Of 142 experimental participants 111 were included in both measurements, as were 85 from the 117 control participants. Baseline measurements were conducted between December 2012 and May 2013; follow-up measurement took place one year later.

Participation was measured with the Dutch Participation scale This scale has six levels:

1) Socially excluded
2) Social contact outside own household
3) Participating in organised activities
4) Voluntary work
5) Supported employment
6) Regular employment

To get an in-depth picture of experiences with the DTD approach a qualitative research was carried out at baseline and at follow-up. For this purpose semi-structured interviews were held with 25 participants and 13 professionals and staff members involved with DTD (including those from surrounding organisations).

Participants

The majority of the participants was female (74%) and between 40 and 49 years old (48%). Almost half of them were unmarried (46%). Most of them had Dutch citizenship, while born in another country (92%), mainly Turkey (31%) and Morocco (30%). The average duration of receiving social welfare benefits was ten years.

At baseline the control and experimental group participants had similar social participation levels (Mann-Whitney U, p=.63). A quarter of the participants was neither engaged in any activity nor had contact with others outside the household (level 1: 26%). Almost one third had no organised activities, but had social relationships outside the direct environment (level 2 : 31%). Almost one third took part in organised activities (level 3: 31%). Involvement in voluntary work, supported employment and competitive employment was seen in 11% (respective levels: 5%, 2%, and 4%).

Characteristics of the Door-to-Door intervention

The Door-to-Door intervention lasted on average 12.5 months (N=123, SD=1.5); the shortest trajectory took eight months and the longest 16 months. On average the participants had an initial home visit and seven additional meetings with their counsellor (N=113). The time between subsequent contact moments was on average six weeks (N=111, M=6.3, SD=3.5).

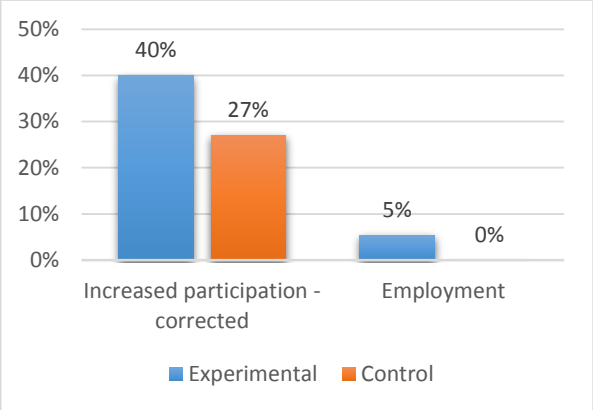
Effects on main outcomes

At twelve months follow-up the two groups differed in participation level (Mann-Whitney; p=.04). This overall difference seems to be the consequence of a higher number of experimental respondents who participated in the three higher levels of the scale: 31% compared to 17% in control participants (combined outcomes of voluntary, supported and paid employment)

Thus, the participation levels of experimental respondents are more favourable *at* follow-up than in the control group. However, the main question is whether the situation was more (strongly) *improved in time* in experimental respondents compared to the control group.

Better improvement in social participation?
Participants receiving the Door-to-Door intervention more often went up one level or more on the Dutch Scale for Participation than control participants did (See figure 1). The success rate of the experimental group appeared to be 40%, compared to 27% in the control group.

Figure 1 Improvement in Participation level – Comparison of DTD with control group



This difference was significant if all correction variables were taken into account (β=0.97, p=0.02). However, the sensitivity analysis without self-sufficiency as a control variable yielded a non-significant difference (β=.443, p=.19). An analysis into the 'crude' effect of the intervention (i.e.: without all control variables) revealed that the difference came close to significance; or a 'tendency towards an effect' (β=0.59, p=0.06).

Better improvement in paid employment?
The study revealed that DTD participants more often improved their situation regarding paid employment than those in the control group did. At twelve months follow-up 5% of experimental participants (n=6) were engaged in paid employment regardless whether this concerned supported or unsupported work, compared to none of the control participants (Figure 1). This is a significant difference (p=.04, Fisher's Exact test).

Improvement in Self-Sufficiency

To explore possible secondary effects we examined whether DTD had a positive effect on the self-sufficiency in participants. This outcome was measured with the Self-Sufficiency Matrix (SSM). The participants' level of self-sufficiency is rated by a professional assessor on eleven dimensions on a 5-point scale ranging from: 1) acute problems (much support needed) to 5) fully self-sufficient. The dimensions represent the major life domains, for instance: financial situation, daily activities (including employment, mental health, physical health, and social participation.

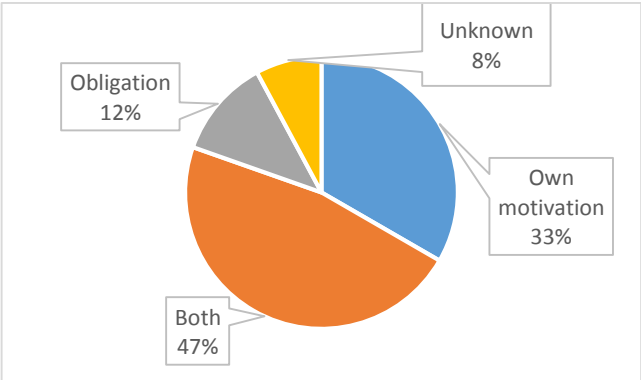
Regression analyses showed that the experimental group improved significantly stronger in self-sufficiency than the control group did (overall measure of self-sufficiency; β=.474, p=.00)

Who benefits most?

Positive outcomes in participation in the DTD group were associated with a higher number of contacts between participant and counsellor (β=.258, p=.002, N=96).

Also related to successful outcomes was the participant's self-reported motivation at follow-up. Participants who were least partially personally motivated to get active, were more successful than participants who merely felt obliged to participate.

Figure 2 Motivation of participants after receiving DTD



Barriers to improve participation: participants' view

Several barriers hindered reaching the project's goals for more participants. The qualitative study yielded that barriers participants faced to increase social participation, were, to their own judgment: 1) mental and/or physical health problems; 2) social role aspects, such as being a single mother, the demands of which would limit time to spend on work; 3) problems with the Dutch language; 4) a lack of basic education or qualifications; and 5) problems and restrictions related to a low income, e.g. not having enough money to travel or pay a fee for sports lessons.

Colophon

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Barriers to improve participation: view of professionals

First of all, the professionals mentioned the same barriers as participants did, especially the language and financial problems. One of the most often additionally mentioned impediments was that there seems to be a larger supply of activities and occupational possibilities for women than for men. Secondly, professionals and respondents themselves often had troubles understanding the requirements for joining certain activities and found it difficult to properly assess the abilities in participants to fulfil these requirements. Finally, appealing to citizens to participate in the community can also be hindered by cultural differences. For example in Turkish or Moroccan cultures voluntary work especially by men is often not seen as a full-fledged occupation; only regular paid work counts.

To conclude

The study provides first evidence that the Door-to-door approach is useful in improving social participation in people who are long-term unemployed. This is in particular the case for improving the working situation, regardless whether this concerns paid or unpaid work and regardless whether it involves supported or competitive work.

The Door-to-door approach seems to be a promising intervention model yielding hope that participation improvements in people who are long-term unemployed are possible.

The study has several strong features, such as the adequate power and the randomisation. Nevertheless, some weaknesses should be taken into account for a proper interpretation and weighting of the findings. Not elaborated here is the finding that at baseline the two study groups differed on several characteristics, indicating a better social functioning of participants in the control group at baseline. Secondly, during the first months of the follow-up period, the DTD-team was still working to incorporate the different methodical elements of the approach. Improvements were made during the study and currently new groups of participants already profit from the DTD '2.0' version. This means that we studied the effects of the approach while the content and implementation of it were not yet comprehensively established.

Further research should focus on the effectiveness of a well-implemented DTD model, that incorporates adjustments based on this study findings and future sources to be consulted, such as (potential) clients themselves.

References / further reading:

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