Early intervention home visiting

A preventative model to strengthen isolated families

Paul Drielsma

Burnside is an agency of the Uniting Church and has a role to facilitate the development of children and families most in need through quality services, research and advocacy. This article describes a home visiting model which was developed and approved for implementation as a three year pilot by Burnside on the Central Coast in NSW, beginning in 1997. The model is described and presented as a format that may be useful to stimulate similar program proposals elsewhere. The model uses paid professionals within the context of a 'Family Centre' with a volunteer network to offer ongoing home visiting support to first-time parents facing social and geographical isolation and who have few supports and resources to meet their needs. Importantly, the model relies on close collaboration with Child Health services and a partnership with other community agencies and the local community itself. The model accommodates current debate about the need to break cycles of abuse through positive preventative family support to strengthen families and communities.

***Paul Drielsma** is the Manager for Burnside, a non-government child and family welfare agency, in the rapid growth area of the Central Coast – one and a half hours north of Sydney, NSW.*
Address for correspondence:
Burnside Central Coast
PO Box 291, Bay Village, NSW 2261

In Australia as elsewhere, the past decade has seen alarming increases in notification rates of abuse and neglect of children (Angus et al 1994). New South Wales alone has seen an increase of 38% in notifications between 1991/92 and 1994/95 (DCS 1996). In response, there has been intense devotion of resources to a system that focuses on forensic approaches to child protection. These approaches have resulted in seemingly poor outcomes, with a consequent renewal of interest in models aimed at early preventative intervention.

Abuse of children is a major welfare and public health issue, contributing to significant social disadvantage related to physical injury, developmental disability and psychiatric disturbance plus increased morbidity rates in children. Research has shown that the greatest proportion of known perpetrators of all neglect, physical and emotional abuse are parents or those people that have a parental role.

In NSW, the Department of Community Services (DCS 1995) has identified the need for more emphasis on prevention initiatives and services as a response to the overwhelming demand placed on child protection resources. Such a view is based on findings that:

> Those who receive support in the role of caregiver have been shown to be better able to respond to children's needs and at the same time to meet their own needs. When parenting is a positive experience, the likelihood of abuse decreases. The availability of flexible local services and access to early intervention are ... important factors in preventing abuse. (DCS 1995, p.26)

Internationally, there has been a search for genuinely preventative programs for child abuse. There has consequently been great interest shown in the development and trial of home visitation models – early identification and family support programs which are designed to assist at-risk families to strengthen parent-child interactions and improve family functioning skills with the goal of promoting healthy family development. These programs seek to positively influence the development of the parent-child interaction before dysfunctional or abusive behaviours begin. While the literature shows various outcomes for different models of home visiting schemes in varied contexts, current evidence suggests that programs which link families with existing community services (such as early childhood and family support services) and have a component of regular support and education delivered through home visitation are more successful than more narrowly focused programs (Olds et al 1994; Siegal et al 1980).

Geographical context for the establishment of a Home Visiting Program

This paper describes a model for the provision of a home visiting program to first time parents in specific localities that are characterised by social and emotional isolation, particularly high growth areas in satellite communities which face geographical and social disadvantage. Problems of access to community services exacerbated by geographical isolation, lack of public transport and lower socio-economic

levels lead to social isolation – particularly for young families.

The model was developed with the Northern Wyong Shire of the Central Coast in NSW in mind – a high growth, under-serviced area characterised by social and geographical isolation. Wyong Shire is one of the two Local Government Areas (together with Gosford) that comprise the Central Coast in NSW. The population of Wyong Shire, presently estimated to be over 120,000, is projected to grow to near 200,000 by the year 2011. The area has a high proportion of young families and children; higher than state average single parent families; significant numbers of individuals and families on very low incomes; and most significantly, serious incidence of families in crisis, high domestic violence, and child abuse (Sheeley 1995). The latter is within the context of an overall Central Coast increase in substantiated reports of child abuse and neglect of 17% (as against a state increase of 12%) between 1991/92 and 1994/95 (DCS 1996). These indicators are as relevant for the northern end of the Shire as they are for the more service-rich southern area. The north is also poised for the most rapid growth with many new housing block releases now occurring or planned. 'Clearly, the next few years will reflect a steady increase in the number of young parents, children and adolescents living in the area' (Smyth 1995).

The links between income, occupation and education in producing regional inequalities within the Central Coast, and where the northern region of Wyong Shire is shown to be an area of reduced social and economic opportunities, is graphically illustrated in a recent Australian Centre for Equity through Education report (ACEE 1996).

The estimated population for this northern area in 1996 was approximately 60,000. This is expected to reach 75,000 by the year 2001. The proportion of the population between 0 and 4 years of age is expected to remain in the range of 7-8% for the whole Shire over the next fifteen years. (Wyong Shire Council 1994). According to the ABS 1991 Census statistics, the actual proportion for this age range in 1991 was 8.3% for the northern shire.

In terms of income, 36.5% of the population in the northern shire earn less than $8,000. The average yearly income for males is $18,600 and for females is $10,600. The average household income is $26,600, 27% below the national average of $36,400 per year. 62.4% of the population have no qualifications, compared with 56.8% in Sydney, with 2.9% compared to 9.6% for Sydney having university degrees (Smyth 1995).

... current evidence suggests that programs which link families with existing community services ... and have a component of regular support and education delivered through home visitation are more successful than more narrowly focused programs.

SPECIFIC PARAMETERS OF THE PROPOSED MODEL

The mission of the Home Visiting Program is to make a positive difference in the lives of children and their families by providing a home visiting service driven by client needs. The service offers direct support to first-time parents as well as brokering effective and integrated access to a wide range of other early childhood and family and parenting support services.

The goals of the service are:

1. To access families who are isolated by distance and lack of transport in new growth and remote communities.
2. To maximise the opportunity that the birth of a new child presents in accessing families and offering them ongoing support appropriate to their needs and requests.
3. To assess, using qualified paid professionals, in non-threatening and non-invasive ways the developmental and social needs of young children in families.
4. To offer needs driven assessment in consultation with all new parent families, with voluntary uptake of ongoing home visiting support where a high degree of need is assessed.
5. To offer intensive services where appropriate – at least once a week for the first six months of the new-born's life, with a capacity for an extended home visiting service beyond that time.
6. To foster competence and independence in parents that is based on trust and social support.
7. To utilise non-paternalistic approaches that ultimately empower parents in the provision of adequate care to their children, and that facilitate parent-infant attachment.
8. To specifically address issues relating to transition to the parenting role.
9. To maintain close collaborative links with the Early Childhood health care system in terms of program development and review, and to encourage families to also maintain health care monitoring of their babies.
10. To enhance the development of supportive community networks for new parents through linkage to local services and the promotion of a volunteer network that offers practical supports such as transport and respite care of children in the home.
11. To provide, either directly or through close integration with other Burnside and community outreach services, a range of appropriate parent craft education to families.
12. To ensure that home visitors receive adequate training, supervision and support and are given manageable and realistic caseloads which maintain an early secondary prevention focus for their work.

PRINCIPLES OF THE MODEL

The following principles are fundamental to the model:

1. *The program utilises a non-punitive, self-help approach to reach out to families and encourage them to determine their own needs* (Thyen et al 1995). The use of screening tools to identify 'at risk' families is viewed as suspect in its efficacy (English & Pecora 1994). Such tools have been less successful than the research community had hoped, and are often resisted by targeted families. The low incidence of realised risk, plus the screening tools' high sensitivity but low specificity make for a high false positive rate that can stigmatise parents (FSSA 1994) and be potentially harmful. Further, the literature does not identify any sufficiently sensitive and specific indicator of child abuse to serve as a reliable risk factor (Thyen et al 1995; Leventhal 1982; Starr 1992; Starr 1982; Wald & Woolverton 1990). There is no standardised measure of child abuse and neglect (Olds & Kitzman 1993). Services which are offered universally to families with newborn children are deemed to have a higher likelihood, through uptake, acceptance, and self-selection for other supports, to actually target potential child abuse and neglect. Attempts to target 'at risk' children have been shown to often miss children with developmental delays or families with serious relationship problems who are supposedly in the 'non-risk' population (FSSA 1994). The proposed model would utilise a negotiated service offer through an initial informal home visit to assess needs and existing support and resources of each first-time parent(s) in the designated area.

2. *The use of volunteers is limited in this program to 'add-on' practical support within a service that utilises paid professional workers.*

   Volunteers and professionals are seen as capable of working together in creative combinations whereby the former offer practical support to families under the direction of the professional worker who is working with the family, and where the task performed by the volunteer is a clear part of the total support plan (FSSA 1995).

   In general, the literature supports the view that programs staffed by well-trained professionals are more likely to demonstrate success in terms of health and welfare outcomes of children (Olds & Kitzman 1993).

3. *Families and children are best served at the preventative end of the child protection spectrum whereby parents are empowered and supported to achieve 'good enough' parenting outcomes.* Approaches which focus on forensic intervention tend, by themselves, to promote suspicion and alienation of parents who often feel disempowered and labelled as failures – the most dire outcome of which is the removal of children from families with mostly poor long-term outcomes and high risk of systems abuse.

4. *Fathers are integral to the ecology of a child and wherever possible need to be involved in interactions between home visiting workers and families.* While mothers are most often the primary carer for children, to alienate fathers from the process of empowerment in terms of parenting and infant attachment is to jeopardise the long-term outcomes of parenting support – 'each family member has a significant contribution in enabling and assisting change in a family system' (FSSA 1991). To this end, it is paramount that the service is able to access fathers by embracing flexible hours (including evening work).

5. *Services are best delivered within a multi-disciplinary and multi-faceted milieu.* Home visiting services should be integrated with early childhood nursing, and be a part of other outreach and centre-based opportunities for families to ask for and receive support from.

6. *To promote the service 'up front' as a child abuse/neglect preventative service would foster fear of stigmatisation for those families who would otherwise seek support at a stage of stress where they would never identify themselves as 'potentially abusive parents'.* There must always be an emphasis on positive outcomes in the support of the parent-infant relationship, plus a holistic approach to the needs of families and individuals in those families. This point is closely related to the principle of not attempting to identify 'at risk' parents through a screening tool. Further, even where a program is evaluated for its outcomes in reducing child abuse and neglect, care needs to be taken in allowing for detection bias which has been common in studies, as the incidence of reported abuse is often increased as a direct result of increased surveillance from home visiting when compared to control groups (Olds & Kitzman 1993).

7. *An important qualitative issue in how a home visiting service is offered is that there needs to be an 'up front' offer of long term involvement of the service with the family* (up to 4 years if necessary and accepted). At the same time, the family must be clearly aware that it remains in control in terms of if, how long and how often any home visiting is to occur.

8. *It is recognised that by partnering the program with the Child Health Nursing system, the likelihood of acceptance by parents and therefore uptake of the service and long-term outcomes is significantly increased.* Parents especially value nurses as home visitors 'because of nurses' abilities to address their concerns about health' (Olds & Kitzman 1993, p.87).

9. In line with Burnside's Access and Equity policy, *there is a clear intention to provide the service to families with children with disabilities and NESB families and to ensure that there are no barriers to access for those families.* Also, the involvement of such groups as Yarran and Coastlink (both Central Coast specialist services for families with children with developmental delays and disabilities), especially in the development of outreach opportunities with the establishment

of a Family Centre in the Northern Wyong Shire, will be strongly encouraged as the service attempts to integrate with other specialist support services.

10. *The service will strive to be family-focused*:

    (i) By providing a consistent key worker for each family who gets to know the family well, facilitate identification of family needs, and promote relevant supports. This role is dependent on a climate of inter-agency planning and co-operation;

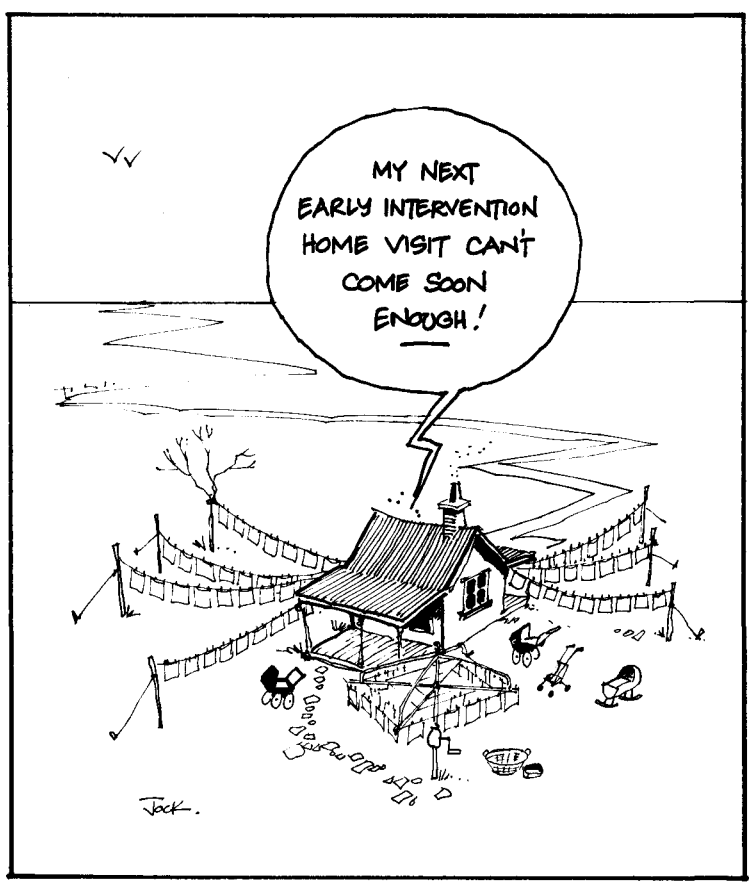
    (ii) Families will often themselves be an important information source for the ongoing professional development of the home visitors;

    (iii) Informal supports such as extended family and neighbours will be recognised and encouraged wherever possible (Fyffe et al 1995).

TARGETING FAMILIES IN MOST NEED

Principle 1 above discussed the problems with targeting by way of screening tools. In striving to target the most socially disadvantaged in the community, it is often a concern of agencies to ensure that its programs do service the greatest need. The present proposal is that all first-time parents be accessed through the Health system and assessed with a view to offering some level of support. How does this target families most at risk? There are a number of points to make:

- We know that first time parents by definition do experience a certain amount of stress in adapting to parenthood and its related life-style changes – hence the model is not universally targeted in the true sense of the term as already we are talking about a targeted sub-set of the population.
- A designated 'high needs' community (as is the case for Northern Wyong Shire) in terms of its socio-economic indicators and its social/ geographical isolation represents a targeted *area*.
- The home visitors will initially assess in consultation with the parent(s) their perceived needs and the supports that they have available already to meet those needs. The home visitor will then, rather than automatically offer an ongoing home visiting service, assess with the parent(s) whether or not such a service best meets those identified needs, to what extent/intensity such a service should occur, or whether there are other more appropriate services available to meet those needs. Thus, for example, if a particular parent has the means to attend centre-based services and requires a play-group based on expressed needs to 'get out of the house' and 'make contact with other parents', such a service may be suggested (perhaps at the planned Family Centre in this case) which as a weekly event might fully meet the expressed needs of that parent(s). The home visitor (in consultation with the service co-ordinator and the Child Health Nurse) may feel very comfortable that this would be adequate for that family and would simply offer the home visiting service as a contact should any other needs/problems arise. This may then be followed up by one or two phone calls over the subsequent weeks as a matter of service protocol to ensure that the parent(s) has successfully 'plugged into' the desired centre-based service. This then is essentially a client-needs driven model. (See appendix for possible scenarios of families assessed).



How successful are 'risk assessment' tools at effectively resulting in highly targeted service delivery? The experience of 'The Cottage Community Care Project' (Kelleher 1996), a home visitation pilot project in Campbelltown that targets 'at risk' first-time parent families, is instructive here. The project used a hospital questionnaire to identify 'at risk' first-time mothers. Between March 1994 and December 1995, 388 first time mothers completed the questionnaire (from an expected 700 first time mothers per annum for the area), ie, a 'hit' rate of 32%. Two hundred and forty six (63% of the 388) were deemed to be eligible to participate in the pilot and were offered the service. Only 93 families (or 38% of the 246) took up the offer. This questions somewhat the capacity of a screening tool methodology to effectively achieve the desired service delivery outcome, albeit there are obviously many other factors to consider in assessing why a service is accepted or not. In view of other efficacy issues previously discussed, there does seem to be room to seriously question the use of such

a tool to achieve targeted service uptake. A 'low-key' client-needs driven approach may be at least as successful in accessing families in need, whilst also maintaining a truly preventative approach that meets needs through an integrated array of services.

PROGRAM BUDGET

Implementation of this model relies on the employment of paid professionals as home visitors. The actual budget approved to service the Northern Wyong Shire area for the Home Visiting Program alone is $185,000 recurrent – and this is for a service that will primarily target a more remote sub-area of that greater northern shire. Adaptation for use elsewhere would need to consider population (and expected birth rates), other available infrastructure and existing services. It is hoped to accommodate the workers at a proposed Family Centre in the area. This is a somewhat separate project in itself, with the Home Visiting Program costing including setting up an office within that centre (one room).

OPERATIONAL PLAN

The co-ordinator and two other home visitors will work closely with the existing Child Health Nursing network servicing the northern Wyong Shire area. Within this area, Child Health services are offered under two distinct service delivery models in two geographical sectors. In the far northern Shire, where geographical isolation is more pronounced, there are no Area Health baby health clinics. A Child Health Nurse provides limited home visiting (one-off plus an extra visit where deemed necessary) and mobile outreach clinics beyond that. In the southern sector of northern Wyong Shire, where the local Area Health Service does operate centres, baby health clinics are the primary mode of service (with very occasional home visits in special cases).

Home visiting will be open to all first time parents in the greater northern Wyong Shire. However, in the more remote far northern Shire, there will be greater energy devoted to proactively engaging these families. This will occur through hospital midwives and other health professionals (during the 36th week of pregnancy 'booking in' session or soon after birth while at hospital or at home) promoting the home visiting service to prospective parents to gain consent for initial ante-natal contact by the home visitor. At the initial visit, the provision of follow-up with further visits will be negotiated as part of a joint assessment of supports available and current needs. An opportunity may arise for joint home visits with the Child Health Nurse where the nurse has deemed a second visit necessary, or where there are specific health issues that warrant collaborative intervention. Otherwise, once consent has occurred, the home visitor may visit alone following the initial nurse visit.

In the southern sector of the northern Wyong Shire, Child Health Nurses will promote the home visiting service through clinic contact with first time parents, plus act as triage agents for families they consider may be facing particular adjustment difficulties and who would particularly benefit from home visiting support. General Practitioners will also be an important source of information to first time parents about the service, as well as being referral agents.

It is hoped that initial home visits to families, in the context of access through the health system, will provide a non-threatening approach to these families whereby their needs and current support systems can be identified, and they can be offered options to meet those needs, including the *possibility* of ongoing visits by the home visitor where both the parent(s) and worker deem that to be appropriate (see appendix for scenarios). The quality of this first meeting will be crucial in terms of attracting the family's uptake of the service and ensuring voluntary acceptance free of any perceived pressure. Protocols have been developed by a Reference Group set up for the service that includes child health, other community service and local resident representation. To increase the access to first time parents from the target area, a degree of promotion of the service has been undertaken through maternity units, ante-natal classes and local GP practices. The Child Health Nurse will promote the service directly to prospective and new parents.

The home visitors will clearly not be providing health checks that are the domain of Child Health Nurses. However, it will be important that, either through existing knowledge or through inservice training, the workers develop skills in assessing when referral back to the Child Health Nurse (either to clinics or if deemed necessary through nurse home visits) is indicated.

The Home Visiting Program is not set up to be interventionist for families in terms of targeting pre-existent pathologies – rather it is an early secondary prevention program aiming to support families in order to avert the development of crises in facing the stresses of adjusting to the addition of a new baby. A comprehensive approach to families that addresses a multitude of family needs simultaneously, following families from birth (and even pregnancy) through to at least the child's first birthday and ideally to school age where needed, is most likely to provide tangible outcomes (Olds & Kitzman 1993).

The model accepts findings in the literature which suggest that maximum uptake and impact for families who may otherwise proceed to have major problems leading to child abuse and neglect is to be found in offering a home visiting service to first-time parents (see Vimpani et al 1996). There are obvious tensions here in terms of families with high needs who have two or more children including the new-born that may exceed those of first-time parents – and the service will need to remain focused on its early preventative mission and adhere to the criteria of first time parents if it is to avoid becoming a tertiary prevention service.

THE FAMILY CENTRE 'CONTEXT'

The Home Visiting Program will be based at a newly established 'Family Centre' in the area. This base will also be where a proposed Family Centre Co-ordinator will work from, and one role of this person will be to explore and establish volunteer networks that may be utilised for practical home-based support for families utilising the Home Visiting Service. The overall concept of a Family Centre is proposed along the lines of a Family Resource Project - which provides universal access for

services at the primary level of prevention of child abuse and neglect (FSSA 1994). The elements of such a centre (which would need to evolve over time) would include:

- social support
- universal access
- a focus not on problems but on strengths of families
- emphasis on prevention rather than treatment or remediation
- involvement of local community members in design and provision of services
- staff working non-hierarchically and in partnership with parents.

The volunteer network will be intrinsic to the development of a partnership model with the community – volunteers may include those who have previously been receivers of direct services, or who in needs assessment have felt that they are in a good position to give as well as receive services.

In integrating existing parenting groups (currently offered by Burnside on the Central Coast) and the proposed Home Visiting Program plus a range of existing services on an 'outreach' and 'as needed' basis into such a centre, the aim is to develop family supports 'on a continuum from prevention through early intervention to crisis management and long-term supportive measures' (FSSA 1994 p.3) The centre will also serve as a base for outreach clinical services such as Child Health Clinics, and other community support groups to access the area and link in with the Home Visiting Program.

HOME VISITING PROGRAM

Staffing

1. **Co-ordinator/Home Visitor**: The co-ordinator is responsible for the supervision and support of home visitors, and the development and implementation of specific protocols for the day-to-day operation of the service. The co-ordinator is an experienced, university qualified, social welfare professional with advanced communication and organisational skills, and has a background in early childhood services. The co-ordinator will also work actively and collaboratively to develop a practical support volunteer system to complement the professionally-based home visitors. The role will also include some direct home visitation work.
2. **Home Visitors**: Once protocols were developed, two home visitors were employed. Home visitors should be: experienced welfare practitioners with at least diploma/ certificate qualifications; selected from a range of possible professional backgrounds including nursing, social work, psychology and family support; have an in-depth knowledge of babycraft, early childhood development and the range of resources available for the local community that may be called upon (both locally or called in from the wider region); ideally have a demonstrated commitment to the local community. The actual workers employed were an experienced Child Health Nurse and a Family Support Worker (Welfare Certificate).
3. **Client and community participation:** The service will strive to involve clients in a partnering relationship and to create links within communities. To this end, it is envisaged that clients of the program will be given every opportunity to participate in voluntary peer support networks with other parents.

Services which are offered universally to families with newborn children are deemed to have a higher likelihood, through uptake, acceptance, and self-selection for other supports, to actually target potential child abuse and neglect.

Caseloads

A caseload of 10 families for the co-ordinator and 20 each for the home visitors should not be exceeded in terms of feasible workload at any one time. Like other services, there will possibly be frustrations in waiting lists arising if the service is well utilised, and this will be a management and strategic issue for the service in future resource planning and efforts to fund the program externally.

The development of a volunteer program should always be maintained at the level of practical support only and not change to more than that for economic or logistic reasons. However, well run, practical, volunteer home help support can offer much to families short of more intensive intervention and support.

Referral Protocols

The service will attempt to maintain an early intervention preventative/support focus and not duplicate existing tertiary prevention services. This will mean that families will normally self-refer through consent given to hospital midwives ante-natally or after the service is offered at or soon after the point of contact with post-natal Child Health Nurse home visits and/or post-natal attendance at Early Childhood Centres.

An upper age limit for the new baby for intake into the service has been set at 6 months (the maximum preventative impact is predicated on 'as near to birth as possible' engagement). Also, 'first-time parents' has been defined to include situations where at least one of the parents is first time *and* there are either no children currently living with those parents *or* the children are over 12 years of age. Whilst perhaps an arbitrary distinction, the issue of maintaining the early preventative impact of the service is again paramount.

Clients of the Department of Community Services (DCS) would also be eligible for referral into the program for supportive home visiting provided that those families are first time parents. Obviously, protocols will need to be developed to ensure that, where such DCS clients are involved in child protection intervention, there is a clear distinction between the preventative support offered by the home visitors and

the ongoing intervention of *other* agencies. A family being offered home visiting and which has current child protection issues would be referred to the DCS for further support options and possible intervention. Therefore it is important that the home visiting service is not seen by the DCS as a program to which such families are referred other than for preventative support or support beyond the resolution of acute child protection needs. It is also paramount to the home visiting service that participation of families remain voluntary and not mandated by the DCS.

Evaluation

As previously stated, child abuse figures for the Wyong Shire are alarmingly high when compared to NSW as a whole. While it would be hoped that such statistics could be shown to decline as a result of home visiting, it is unrealistic to show this outcome through evaluation (a full discussion of this point occurs in Vimpani et al 1996). Among other points, it has been noted that home visiting can actually show increased notification outcomes due to a reporting bias flowing from the increased surveillance that home visiting presents.

Importantly, the program will strive to collate narrative qualitative outcomes for families who use the service, plus register measurable positive outcomes for children and use validated tools to assess program goal attainment. While not lending itself to traditionally 'hard' outcome data, the collection of this material reflects the program's focus on positive outcomes for families. There will not be an over-reliance on quantifiable measures that require huge investments of resources in order to come close to clinical research standards of validity. However, funding has been sought for a specific external evaluation project over the first three years of the service. To this end, links through the University of Newcastle have been established. An 'action research' model would be best suited to assessing outcomes, with reference to the kinds of tools highlighted in the recent audit of Home Visitor Programs conducted under the auspice of the National Child Protection Council (Vimpani et al 1996).

The Case for Action

As with many programs that are clearly aiming at prevention, there is immense difficulty in building a case for their implementation based on proven 'beyond doubt' outcomes. Much has been done in attempts to evaluate Home Visiting Programs, and it would be irresponsible to say the verdict is definitely in. Having said this, there are strong intuitive indicators that home visiting works and can be an effective circuit breaker for the cycle of child abuse (Leventhal 1996). While home visiting cannot be regarded as a panacea for all the problems that confront families in the nurturing of children, it can be claimed to be at least a necessary if not sufficient ingredient from a services point of view (Weiss 1993). Quoting the words of Professor Graham Vimpani (speaking at a National Forum on Home Visiting Programs in Canberra, April, 1996) home visiting is an idea whose time has come, which connects the axle of family to the wheel of services. The failure of investigative approaches in the area of child protection and the continued isolation and breakdown of the family model to cope alone, together with the opportunity that home visiting provides in accessing families who don't themselves access centre-based services, provides a commonsense rationale for well managed Home Visiting Programs. Home Visiting Programs need to be viewed as an investment in the building of 'social capital' (see Cox 1995) rather than a bandaid approach to family support – whereby the capacity of parents to provide a physical presence and nurturing attention for their children is enhanced and increased.

> The problems faced by vulnerable families in our society are so immense and the costs of failing to address these problems so great that we cannot wait for a definitive body of research before we begin to take action. We must set such programs in motion, however, with full awareness that the way is not well marked and that we must continue to invest in research to improve these types of preventive interventions (Olds & Kitzman 1993, p.89). □

References

Australian Centre for Equity through Education (1996), 'Regional Inequalities - Income, Occupation and Education' (Central Coast section).

Angus, G., Wilkinson, K., & Zabar, P. (1994), *Child Abuse and Neglect Australia 1991-92*, Australian Institute of Child Health and Welfare, Child Welfare Series, (5), AGPS, Canberra. Cox, E. 1995, *A truly civil society*, ABC Books, Sydney.

Department of Community Services (NSW) (1995), *Strategic Directions in Child Protection*, Draft for Comment - Care & Protection Directorate, October.

Department of Community Services (NSW) (1996), *Trends in Child Protection: Profiles for financial Years 1991/92 - 1994/95*, Information and Planning Group, Child & Family Services Directorate, May.

English D.J., Pecora P.J. (1994), 'Risk Assessment as a Practice Method in Child Protective Services', *Child Welfare* 73(5), September - October, pp. 451-473.

FSSA of NSW Inc (1991), *Working with Men in Family Support*, Discussion Paper.

FSSA of NSW Inc. (1994), *Primary Prevention Family Resource Projects for NSW*, Discussion Paper - March.

FSSA of NSW Inc. (1995), *Volunteers in Home Visiting Programs*, Discussion Paper - May.

Fyffe C., Gavidia-Payne S.T., McCubbery J. (1995), 'Early Intervention and families in rural Victoria' *Australian Journal of Early Childhood* 20(4), December.

Kelleher, L. (1996), *Progress Report - Evaluation of the Cottage Community Care Pilot Project*, Faculty of Health, UWS Macarthur for The Cottage Family Care Centre.

Leventhal, J.M. (1982), 'Research strategies and methodologic standards in studies of risk factors for child abuse' *Child Abuse and Neglect* 6, pp. 113-123.

Leventhal, J.M. (1996), 'Twenty years later: we do know how to prevent child abuse and neglect' *Child Abuse and Neglect* 20(8), pp 647-653.

Olds, D.L. & Kitzman, H. (1993), 'Review of Research on Home Visiting for Pregnant Women and Parents of Young Children' *The Future of Children:* Home Visiting 3(3), Winter.

Olds, D.L., Henderson, C.R. & Kitzman, H. (1994), 'Does Parental and Infancy Nurse Home Visitation Have Enduring Effects on Qualities of Parental Caregiving and Child Health at 25 to 50 Months of Life?' *Paediatrics* 93(1), pp 89-98.

Sheeley, C. (1995), *Justice for Central Coast Residents*, Research Project - ITRAC Wyong Shire Inc.

Siegal, E., Bauman, K.A., Schaefer, E.S. et al. (1980), 'Hospital and home support during infancy: impact on maternal attachment, child abuse and neglect, and health care utilisation' *Paediatrics* 66. pp 176-182.

Smyth, N. (1995), 'Northern Exposure', *The ITRAC Advocate* 3(3), September.

Starr, R.H. (1992), *Understanding child maltreatment: Thoughts on risk assessment from a middle-aged researcher.* Paper presented at the 7th National Roundtable on Risk Assessment, San Francisco, CA, June.

Starr, R.H. (Ed.). (1982), *Child abuse prediction: Policy implications.* Cambridge, MA: Ballinger Publishing Co.

Strategic Planning Department (1994), *Population Statistics*, Wyong Shire Council, June.

Thyen, U., Thiessen, R. & Heinsohn-Krug, M. (1995) 'Secondary Prevention - Serving Families at Risk' *Child Abuse & Neglect* 19(11), pp. 1337-1347.

Vimpani, G., Frederico, M. & Barclay, L. (Consultants) (1996), 'An Audit of Home Visiting Programs and the Development of an Evaluation Framework' commissioned under the auspices of the National Child Protection Council by the Department of Health and Community Services, AGPS, Canberra.

Wald, M.S. & Woolverton, M. (1990), 'Risk assessment: The emperor's new clothes?' *Child Welfare* 69, pp. 483-511.

Weiss, H.B. (1993), 'Home Visits: necessary but not sufficient' *The Future of Children*: Home Visiting 3(3), pp. 113-127.

Appendix

FAMILY CAREER SCENARIOS

The following are example scenarios to illustrate the possible pathways of family assessments that would occur in consultation with first time parents. The scenarios also particularly attempt to illustrate the integration of the proposed service with the planned Family Centre.

SCENARIO 1.

Parents agree to see home visitor to discuss service, although the Child Health Nurse had to arrange as a co-visit to follow-up on her usual one-off home visit following return home. Living in far northern Shire, father is long-term unemployed. No immediate extended family reside on the Central Coast, with mother's parents estranged and interstate. The family moved into a housing department house 2 months prior to the birth. There is no family car. The parents exhibit signs of stress and relationship disharmony. With some gentle encouragement, it is agreed that the home visitor will visit twice weekly (at the Child Health Nurse's suggestion) for the first 2 months (and then to review frequency). After 2 weeks, mother exhibits severe depression and is referred to GP and Family Care Cottage for more thorough assessment and intervention with continued contact by home visitor as well. Father is offered voluntary involvement at Family Centre 2 days a week to assist with centre maintenance, with explorations made re: job training opportunities. Mother has 'time out' arranged with the provision of voluntary respite child care in the home. Possibility of Home Care and Family Support Services are explored. Probable notification is averted through ongoing supports.

SCENARIO 2.

Parents agree to see home visitor to discuss service. Living in southern sector of northern Wyong Shire. Father commutes with only car and is away from 6.00am to 5.30pm Monday to Friday; mother and new-born isolated by very poor public transport (3 buses per day, taking up to 3 hours to travel to Wyong, the closest major centre), and is new to the area (parents live in Sydney). First visit by home visitor involves joint assessment of needs where mother expresses her fears of isolation both in terms of baby's developmental needs and her own lack of mothering confidence. She also talks about the shock of being alone with a baby after previously being in the work force. Home visitor and mother propose plan to maintain a weekly visit plus explore playgroups in the area and networks that could assist with transport to them (eg, a new playgroup at the Family Centre). Possibility of involvement of a local volunteer to assist mother with shopping and other tasks are discussed with home visitor to explore options.

SCENARIO 3.

Parents agree to see home visitor to discuss service. Family lives in far northern Shire. Father works in Wyong and gets a lift with a friend, leaving a family car at home. Mother does express some desire to have further assistance – but is most interested in health checks and is able and willing to arrange attendance at an Early Childhood Centre (in southern sector of the northern Wyong Shire) for checks and advice from the Child & Family Health Team (Area Health). The home visitor invites further contact if required and rings during the next fortnight to see how things are going.

SCENARIO 4.

Parent agrees to see home visitor to discuss service. Single mother lives far northern Shire and receives supporting parent benefit. Her parents live in Wyong and are regular visitors. Mother expresses some interest in support, but feels that own parents provide adequate support in terms of visiting. Mother does talk about a need to socialise and is very interested in a women's survival course being run by Burnside at local Family Centre (as part of Parenting Groups Program) as a way to both connect with other women and gain skills for own preservation. Parents of mother agree to assist with transport to group and mind baby during this time. Group develops some strong linkages and participants agree, at suggestion of Family Centre co-ordinator, to continue meeting as a support/social group at the centre. □