Early intervention home visiting – evaluated and revisited!

Evaluation of a preventative model to strengthen isolated families

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This article is a follow-up of a paper describing a proposed 'best practice' model for a home visiting service for first-time parents (Drielsma, 1998). The results of three years implementation and evaluation of a pilot of that model in a geographically isolated semi-metropolitan high growth area on the Central Coast, NSW are presented and discussed. The service uses paid professionals within the context of a 'Family Centre' with a volunteer network to offer ongoing home visiting support to first-time parents who are facing social and geographical isolation and who have few supports and resources to meet their needs. Importantly, the service has relied on close collaboration with child health services and a partnership with other community agencies and the local community itself. The external evaluation used a mix of Action Research and quantitative tools. This showed that the pilot model effectively engaged 'high-risk' families in a non-stigmatising way. Further, these families were networked to an array of other mainstream child health and family support services. The essence of this model was described through an Action Profiling process and this correlated closely with the model's structural parameters of operation.

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In a previous paper, Drielsma (1998) described a model for early intervention home visiting to first-time parents in a geographically isolated community as a way to strengthen families and ultimately reduce child abuse and neglect. There has been unprecedented interest in early intervention and the early childhood years, following the exposure in Australia of the ideas and research of such prominent practitioners and academics as Bruce Perry (Perry et al, 1995), Deborah Phillips (Shonkoff & Phillips, 2000), David Barker (1997) and Fraser Mustard (Mustard & McCain, 1999). In response, we have seen the establishment of National Investment for the Early Years (NIFTEY); and the acceptance and adoption of the implications of this knowledge for early intervention by governments, both State and Federal. The latter is evidenced by the launch of the 'Families First' initiative in NSW in 1999 and the recent announcement of the Australian Government's 'Stronger Families and Communities Strategy'.

Effective home visitation models, while difficult to implement, are seen as tools that can ameliorate the risk of adverse health and welfare outcomes for disadvantaged families (Nicholson, Tually & Vimpani, 2000). Such programs are designed to assist at-risk families to strengthen parent-child interactions and improve family functioning skills (including effective access to other services) with the goal of promoting healthy family development. These programs seek to positively influence the development of 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 which have a component of regular support and education delivered through home visitation, are more successful than more narrowly focused programs (Olds, Henderson & Kitzman, 1994; Siegel et al, 1980).

This paper reviews the experience of three years of piloting the Northern Lakes Home Visiting (NLHV) service (Drielsma, 1998), profiling the families who used it and reporting on the external evaluation commissioned by Uniting*Care* Burnside (hereafter 'Burnside').

THE EXTERNAL EVALUATION PROJECT

Methodology

The audit of Home Visiting services in Australia undertaken by Vimpani, Frederico and Barclay (1996) found that there was little understanding of the generic qualities that made individual services a success. Essentially, what the industry lacked was an understanding of the 'essence' of home visiting. This knowledge gap is significant when considered in the context of changing attitudes to early intervention and preventive care services for families. Funding objectives put forward under the umbrella of the Families First Program in NSW demonstrate the importance for the industry as a whole to know what does constitute effective practice for professional home visiting.

The evaluation of NLHV sought to find this out. A small team of researchers from the University of Newcastle undertook a process and impact evaluation of NLHV. Burnside was funded for the evaluation by the Financial Markets Foundation for

Children. The researchers utilised a comprehensive and complementary range of selected psychometric tools and more innovative inquiry methods that bridge the qualitative/quantitative gap. Research activities followed a process of theory generation, testing and confirmation of what constituted effective practice for professional home visiting of first-time parents.

The evaluators were mindful of the importance of home visitor/family relationships and were particularly careful to ensure that evaluation activities did not take precedence over or impact negatively on the service provided by NLHV. As Jacob warns, 'evaluation activities should not detract from service delivery' (Jacobs, cited in Vimpani 1996, p.87). Consequently information was only collected when it was deemed suitable and where it did not detract from the main purpose of home visits. The methodology, therefore, emerged as a responsive and highly flexible approach to program evaluation.

Overall, the evaluators interviewed 81 families: 10 short-term recipients of the service, 34 long-term recipients and 5 participants of the Young Parents Group. In addition, the six months post-closure survey was conducted over the telephone with 32 families.

Thirty-two long-term recipients, 5 volunteers and the 3 home visitors developed Action Profiles (Curtis 1996) of effective home visiting practice. This is an innovative Action Research tool which enabled respondents to indicate along a Lickert scale [score 5 = helpful through to score 1 = unhelpful] how effective NLHV's actions were for them. In sampling families for involvement in the Action Profiling process, the researchers were mindful to select evenly across the three home visitors, with an equal representation across the low, medium and high scoring groups of the Family Stress Checklist. Theories on what constituted effective practice that emerged through these Profiles were later tested in a survey to all key stakeholders.

The Key Stakeholder Survey was distributed to 165 stakeholders, including families, volunteers, home visitors, other agency staff and the Burnside Reference Group. Of these, 63 were returned (38.2% response rate), 45 of these from families. The Key Stakeholder Survey revealed how valuable various aspects of the program were to stakeholders.

In addition to these enquiry methods, 166 families also participated in assessment of their family functioning using five different standard scales:

1. the Family Stress Checklist (FSC) which assesses family risk of child abuse and neglect;
2. the Depression, Anxiety and Stress Scale (DASS) (Lovibond & Lovibond, 1998) and Parenting Stress Index (PSI) (Abidin, 1990) – two assessment tools for measuring depression, anxiety, stress in general and stress specifically related to the parenting role;
3. the HOME Inventory which measures the quality of life and degree of enrichment in a child's home environment; and
4. the Social Network Map which is a simple tool that enables respondents to identify the size and nature of relationships within their social network.

The home visitors administered each of these psychometric scales during their visits with families.

The evaluation findings are limited to the extent to which stakeholders were involved with various aspects of the evaluation. Psychometric scale involvement varied from 24.5% (PSI) to 60.6% (FSC) of NLHV clientele (n=274). The small representation within some of the psychometric scales makes extrapolation of the findings difficult. This is particularly important in the assessment of changes in family functioning over time. Scale data (set out in the full report of the external evaluation[1]) should, therefore, only be considered as indicative of trends occurring within the program and are not generalisable.

In undertaking this evaluation, the evaluators sought to incorporate as many key stakeholders as possible. The findings indicate what constitutes effective practice for preventative, early intervention home visiting and are transferable to the extent to which other services can emulate the practice environment evidenced in NLHV.

THE NORTHERN LAKES HOME VISITING (NLHV) PILOT

The model as described by Drielsma (1998) was established in May 1997 in the northern part of Wyong Shire, which together with the Gosford local government area makes up the Central Coast in NSW, one hour's drive north of Sydney. The population of Wyong Shire is estimated to be over 130,000 and 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, including 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% (compared to a state increase of 12%) between 1991/92 and 1994/95 (Department of Community Services, 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 experiencing the most rapid growth with many new housing block releases now occurring or planned.

NLHV set out to make a positive difference in the lives of children and their families by providing a home visiting service to first-time parents living in the northern Wyong shire with a baby up to 6 months of age at the time of intake. These families, by virtue of the area of operation, are generally socially and geographically isolated. The aim is to maximise the potential for positive outcomes through early intervention based on current research into the neuro-biology of brain development, and long term outcomes for children experiencing neglect during infancy. A detailed argument as to why this universal approach was taken is contained in the original article on the

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model (Drielsma, 1998).

The ability to successfully engage these families was premised on the more than usual openness that the birth of a first child presents. Paid professionals were employed to assess the developmental and social needs of infants while focusing on non-threatening and non-invasive practice. Ongoing uptake of the service is voluntary and based on mutually agreed assessment of need rather than through the application of formal risk assessment tools. Such ongoing intensive service is initially offered at least once a week for the first six months of the new-born's life, with the capacity for an extended home visiting service up to school age. Competence and independence are fostered in parents based on trust and social support (particularly supportive community networks and linkage to local early childhood and other more general services), using non-paternalistic approaches to empower parents in the provision of adequate care to their children and to facilitate parent-infant attachment. Issues relating to transition to the parenting role are a specific emphasis. Close collaborative links with the early childhood health care system in terms of program development and review, and the encouragement of families to maintain appropriate health care monitoring of their babies, are a paramount focus of practice. A volunteer network, offering practical supports such as transport and respite care of children in the home, was developed as an essential part of the overall service being offered. Close integration with other Burnside and community outreach services provides families with a range of appropriate parenting education options. Burnside places a high value on staff receiving adequate training, supervision and support and being given manageable and realistic caseloads, which maintain an early secondary prevention focus for their work.

Home visiting as a strategy is seen as a soft entry point for families who can then be introduced to an array of social contacts and access to other services. It provides a non-threatening environment for families, allowing them to maintain control over that contact and engagement. It also allows the NLHV team to access a wider range of families than can centre-based services.

The NLHV team consists of a co-ordinator and two home visitors who are based at the Northern Lakes Family Centre. The latter is a project that was the outcome of a partnership between Burnside, local business, the local Wyong Shire Council, other family support services in the area, and local residents, to service the 'service-infrastructure poor' far northern areas of Wyong Shire (Smyth & Drielsma, 1998). The Family Centre has its own co-ordinator, whose role includes establishing and maintaining volunteer networks. These may be utilised for practical home-based support for families engaged by the home visiting service as well as support for centre-based and community development activities.

The 'real' outcomes of the service are evidenced in the many positive stories that have emerged from the service and the positive affirmations by parents about the difference it has made to their parenting, and their ability to cope with challenges.

Significantly, a high level of integration of service is built into the partnership through the Family Centre. This was again a development of a research-based 'best practice' approach to the establishment of the program. Burnside saw the 'nesting' of NLHV within a Family Centre to be fundamental to an overall seamless array of service delivery to young families in the area. Indeed, it was this overall vision which catapulted efforts into reality when significant assistance was sought and gained from government and business to build and establish the centre, leading up to its opening in July 1997 (Smyth & Drielsma, 1998).

The NLHV coordinator carried a caseload of 10 families while the two home visitors carried a maximum caseload of 20 each (total of 50 families for the service at any one time). These workers are all tertiary trained, currently including a social worker, a welfare worker, and a child and family nurse. This mix was more fortuitous than by design as three generic 'home visitor' job descriptions (one to be coordinator) were used in the application and selection process. Home visitor contact includes modelling parenting strategies and behaviours; encouraging and supporting maternal and child health (eg, breastfeeding, management of smoking and other drug use, immunisation compliance); and exploring lifestyle/career development (including promoting longer intervals between pregnancies).

NLHV also uses volunteers to assist the service in the provision of practical support. These volunteers are carefully selected and trained jointly by the NLHV and the Family Centre coordinators, and are intrinsic to the development of a partnership model with the community. The main role that has emerged for the volunteers is to help with transport for clients who are socially isolated. They occasionally assume a friend-like 'visitor' role to take clients to the shops or just to give the parents a break and play with the child. Ongoing and lasting friendships have developed between volunteers and families, and while this is supervised in terms of families remaining empowered, it is not discouraged. Importantly, volunteers include those who have previously been receivers of direct services, or who (through NLHV needs assessment) have felt that they are in a good position to give as well as receive services. A number of parents who received a home visiting service in the first two years of operation were trained as volunteers to reciprocate the experience.

Contact with the home visitors is invited through a mixed promotional strategy. This includes targeting maternity wards in private and public hospitals; hospital midwives and their programs; ante-natal classes in the area; media promotion (including local newspapers and pamphlet/poster distribution and display); and inter-agency promotion (often resulting in more targeted referrals, eg, through the

NSW Department of Community Services and other family support services).

At the initial visit, the provision of follow-up with further visits is negotiated as part of a joint assessment of supports available and current needs. When considering continuation of the home visiting service beyond the initial first few weeks, a joint decision is arrived at between the family and the home visitor. This decision involves sitting down with the family and explaining how the service operates, assessing the situation and finding out what the family needs and is willing to accept. The quality of this first meeting has been crucial in terms of attracting the family's uptake of the service and ensuring voluntary acceptance free of any perceived pressure.

The home visitors focus on a number of issues in this mutual assessment. They consider the level of social isolation, the management of the baby, parent-child relationships and how these are progressing, and any other issues important for the family. The home visitors also take into account how well linked up to other services the families are, other agencies' views, the social support structure for the family, and how the family is coping.

The NLHV staff work closely with the existing Child and Family Nursing network servicing the northern Wyong Shire area. The Family Centre was successfully able to invite the local Health Service to hold a Child Health Clinic at the centre (the centre design specifically included a clinic room). This has proved to be extremely valuable to the integration of early childhood services in terms of home visiting and child health nursing. Other services held at the Family Centre include parenting courses, an early intervention language development group, playgroups, a 'Young Parents' support group, and local government immunisation clinics.

Realities and tensions

The following reflections are made from a management perspective based on the three-year pilot of NLHV.

- There has been considerable effort to build a generic 'home visitor' role for all three workers. This has been difficult at times given the different professional backgrounds of each worker. For example, in building the skills of new parents, it is important for them to learn the benefits of (and how to successfully access) the local Child and Family Nursing Service. The home visitor who happens to be a child health nurse was supervised to refrain from acting as such, rather than adopt the generic role of home visitor (unless of course a critical health situation arose).
- Another tension has been in resisting the pressure to become a Family Support Service, ie, by not accepting crisis referrals to NLHV for parents who do not meet the eligibility criteria of the service. This has been very difficult in view of NLHV's and Burnside's philosophy to remain client-needs driven. Staff have needed constant encouragement not to attempt to be 'all things to all people', but rather to focus on the trialling of early intervention practice true to the aims and objectives of the service.
- Disappointing to date, there have not been many referrals from General Practitioners in the area, although there has been a good reception to the promotional visits made to these professionals. It remains to be seen whether this is a real problem in terms of first-time parents failing to be informed about the service at all.

While we were mindful early on that the service might struggle for acceptance by the Child and Family Nurse system (as a result of perceived threats to their territory), this has not been the case. On the contrary there has been an extremely healthy partnership formed in meeting the needs of families creatively. This partnership is a reflection of the efforts that were made to be inclusive from the formative stages of service planning. There has been continued representation of Child Health management and staff on the service's Reference Group (which meets quarterly), plus a spirit of collaboration and camaraderie fostered through the Family Centre and its use twice weekly as a Child Health Clinic venue.

Profile of the families and throughput data

This section describes the overall profile of all families who used the service during the three-year pilot and is taken from a Burnside internal dataset. In just about all cases, the respondent to qualitative questions is the mother on behalf of the whole family, although one of the guiding principles of practice was to engage and include fathers.

For the 32 months from May 1997 through to December 1999, a total of 258 families accessed NLHV and received a service. Tables 1, 2 and 3 show this sample in terms of family

Table 1: Family structure

Structure	Families	% of total
Both biological parents	213	83%
Biological mother, step-father	2	1%
Biological father, step-mother	0	0%
Biological mother only	40	16%
Biological father only	0	0%
(unknown)	3	1%
Total	**258**	**100%**

Table 2: Age at intake

Age at intake	Families	% of total
0-6 wks	171	66%
6wks-3mths	35	14%
3-6mths	24	9%
ante-natal	19	7%
(unknown)	9	3%
Total	**258**	**100%**
Average age at intake: 5.5 weeks		

Table 3: Ethnic background

Culture	Families	% of total	ABS (1996) rates
Anglo/Aust	202	78%	
NESB	13	5%	3.85%
Aborig/ATSI	4	2%	1.50%
(unknown)	39	15%	
Total	**258**	**100%**	

structure, age of the baby at intake to the service, and ethnic backgrounds.

For 66% of families, length of current residence was less than 2 years (20% less than 6 months).

For mothers, 43% of the 258 were less than 25 years of age (with 27% less than 20 years of age). For men (218 families with fathers), 24% were less than 25 years of age and 31% were unemployed, with 78% of the 40 single mother families also unemployed (not on maternity leave).

The local Health Service accounted for 71% of all referrals (which included 24% through hospital maternity wards, 35% through child and family nurses) with self-referrals accounting for 15% of the total.

As at 1 January 2000, 37% of families had received a service for in excess of 6 months with 18% still current client families. For the 13 families (5% of the total 258) referred by the Department of Community Services with child protection concerns, 38% had received a service in excess of 6 months with 15% still current.

The overall issue that home visitors saw themselves dealing with was 'transition to parenthood'. But more specifically, 'parenting' issues (which includes 'babycare') were by far the most prevalent identified concern dealt with through the home visiting interaction (common for 55% of families) with 'relationship' issues common for 9%; 'personal wellbeing' for 20%; and 'personal safety' for 8% of families.

For at least 29% of the families (12% unknown) there was no family car, with at least 38% of caregivers at home with the baby having no access to a car. Using a Financial Stress Checklist that was developed and trialled through NLHV, 80% of the total 258 families identified as experiencing 'moderate' to 'extreme' stress.

For 121 mothers, breast-feeding information was collected. Of these, 76% were breastfeeding at the commencement of receiving a NLHV service, with 35% of those breastfeeding still doing so beyond the baby turning 6 months of age.

For 141 families, immunisation data was collected. Of these, 91% were up-to-date with immunisation regimes (90% of those who received a service in excess of 6 months duration were up-to-date).

Table 4: Goals achieved and usefulness

Goals achieved	Families	% of respondents	% of total
Wholly	74	86%	61%
Partially	12	14%	10%
Not at all	0	0%	0%
(not recorded)	35	n/a	29%
Total	**121**	**100%**	**100%**
Usefulness for parents			
Very	76	90%	63%
Somewhat	7	8%	6%
Not	1	1%	1%
(not recorded)	37	n/a	31%
Total	**121**	**100%**	**100%**

Of the 121 families who had 'exited' the service as at 1 January 2000, 31% had used services other than the Family Centre where NLHV is based, with 51% using a 'social support' type of service (the latter including through the Family Centre). NLHV had referred 42% of this group to Child and Family Health services with just 2% of families having to be 'reported' to the Department of Community Services for child protection concerns. All 23 families who agreed to and/or requested a volunteer for practical support were accommodated through a pool of selected and trained volunteers.

A 'feedback evaluation survey' was administered by staff to the 121 families who had 'exited' the service as at 1 January 2000 (see Table 4). The significance of the 35 and 37 families respectively who did not record a response to these questions is open to interpretation – although for some (and data was not collected on how many) it was not possible to contact them at the end of the service to 'put' the question.

Out of 111 of these families who responded to a question about whether in similar circumstances they would choose to use the service again, 97% said 'yes'. On whether they would recommend the service to other first-time parents, 95% of the 119 respondents said 'yes'.

Staff were asked to complete a survey on their perceptions of the outcomes achieved with families. As at 1 January 2000, this question was completed for 163 families with results shown in Table 5.

From 166 families rated, staff subjectively assigned a 'high complexity' rating to 60% of families worked with, and 'high urgency' to 33%.

A cohort of 59 families was explored to ascertain the reasons behind them only choosing to accept or negotiate a minimal home visiting service (defined as less than 3 visits in total). Due to difficulty of follow-up contact, only 29 could be contacted. Of these, 45%

Table 5: Staff perceptions of usefulness

Category	Families	% of total
Very useful	74	41%
Bandaid	6	3%
Significant life change	9	5%
Empowering	23	13%
Inappropriate	0	0%
No real outcome	13	7%
Somewhat useful	38	21%
(not recorded)	17	9%
Total	**180**	**100%**

simply cited 'no interest' as the reason for ceasing the service, with 28% citing that they had sufficient formal support systems in place.

For 160 families, it was possible to track the way in which the service contact ceased. For 18% of families, the cessation was at the parent(s) own instigation prior to what the worker would have thought to be 'completion' of goals or plans. For 69%, exit was via mutually negotiated completion of goals or plans. The average age of the baby at exit was 26½ weeks.

Overall, through a tracking and matching process of deliveries in hospitals which had the geographical area serviced by NLHV as part of their catchment, 41% of all first-time birth families in the area received a service during the 32 month period from May 1997 to December 1999.

THE ESSENCE OF HOME VISITING – THE NLHV MODEL IN ACTION

The external evaluation found that the staff and family Action Profiles, together with the results of the Key Stakeholder Survey and the standard scales of family functioning, revealed a service model based on four key elements:

1. partnerships;
2. culture of respect;
3. holistic multi-disciplinary approach;
4. flexible service delivery.

In effect, these four elements form the essence of the early intervention professional home visiting model employed through NLHV. This essence was co-created by the professional home visitors and the families they visited rather than being prescribed by policy and procedure alone. Home visitors, in their implementation of the model, developed partnerships with families and other agencies and accepted and respected the uniqueness of each. They provided a holistic multi-disciplinary approach to family support that was flexible and responsive to families' expressed needs. Feedback from other agency staff was positive and demonstrated the value of NLHV to families and services alike.

The service model developed by NLHV is conceptualised as two wheels working in unison (see Figure 1). The complementary nature of the 'family wheel' and the 'home visitor wheel' demonstrates how families and staff were empowered through their involvement with one another. This empowerment facilitated reciprocal learning and mutual benefit to both parties.

The rims of the wheels contain the same four key elements.

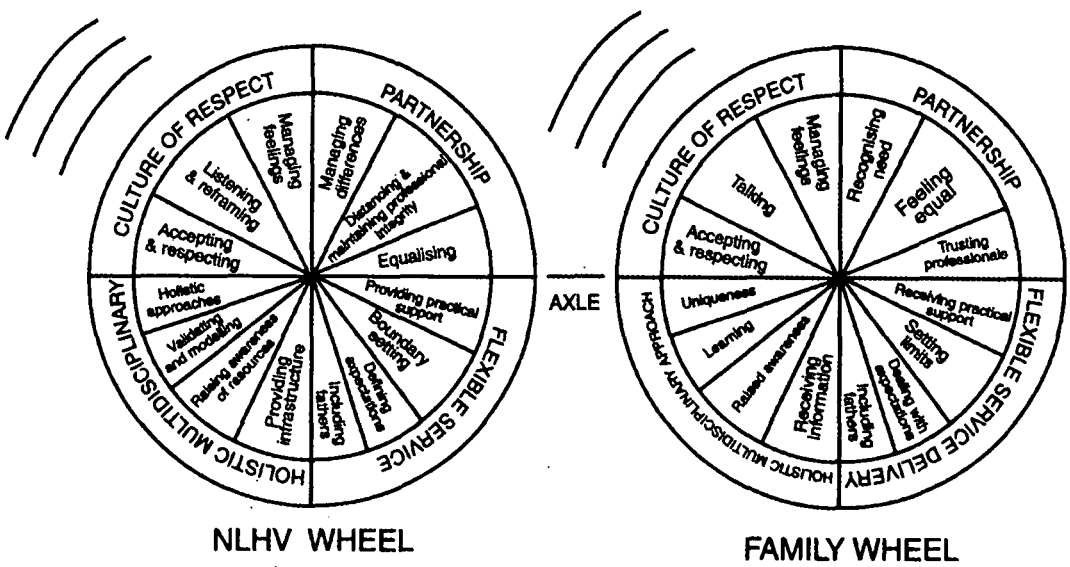
1. Partnerships

The partnerships that developed were non-hierarchical and enabled families to receive support while at the same time maintain control over the decision-making processes affecting their lives.

2. Culture of respect

This refers to the non-judgemental nature of the service. For home visitors, this meant respecting the lifestyle choices made by families regardless of whether they personally approved of such choices or not, and also recognising that families are unique. This created an environment where families felt comfortable with home visitors and were able to relate openly to them without fear of criticism or judgement.

Figure 1: Twin Wheels of Empowerment: the essence of home visiting mutually shaped by families and staff



3. Holistic multi-disciplinary approach

The NLHV staff drew on a varied array of disciplines in order to achieve NLHV's aims. This enabled home visitors to deal holistically with the complexities of family life rather than focusing on one aspect only (ie, health or welfare).

4. Flexible service delivery

Home visitors were not constrained by rigid protocols and were able to address the needs of individual families in ways that were deemed relevant and appropriate for each family.

Inside the rims are the spokes that strengthen the wheels. These spokes are the action strategies that underpin the essence of home visiting. The strategies undertaken by the home visitors and the families differ, yet are complementary. They developed out of the language used by both groups to describe the program in action. For example, on the home visitor wheel 'Listening and Reframing' appears in the Culture of Respect segment. 'Reframing' refers to the home visitor re-phrasing what she thinks she has heard both to check her understanding as well as to affirm what the parent has said. This is one way home visitors described their interactions with families. Complementary to this strategy is the families' strategy, which they simply called 'talking'. The language on the two wheels differs slightly, but the actions are always complementary. These wheels demonstrate the importance of home visitor actions which complement family actions.

The twin wheels are capable of moving forward in unison. This forward movement is what builds the capacity of both families and home visitors to maximise family functioning and minimise risk to children. The most valued home visitor practice, which facilitated this forward movement, was the non-judgemental attitude of staff towards families. This was closely followed by the reassurance and praise offered to families by home visitors and the trust families in turn placed in their home visitor.

Services which intend to follow a similar model, and education providers considering the educational needs of home visitors, may find it useful to bear in mind the experience of NLHV and the findings of this evaluation. The key elements and the associated action strategies identified through the evaluation provide some useful suggestions for those in the industry.

KEY CONCLUSIONS FROM THE EXTERNAL EVALUATION REPORT

A full report of the external evaluation was produced which contains detailed statistical and qualitative data analysis.

NLHV's universal approach to family recruitment resulted in high, medium and low-risk groups of families using the service and de-stigmatised the perception of professional home visiting for families who utilised the service. These families reported feeling more confident in their parenting ability and better able to deal with issues related to the transition to parenthood as a direct result of their involvement with NLVH. Access to other services to address specific needs was further enhanced by the provision of information and transportation.

Recruitment and retention of families with children considered being at high risk of abuse and neglect was favourable. The retention of high-risk families beyond 12 months was greater than the retention of low risk families. Similar trends occurred in the retention of families where parents experienced high levels of depression and anxiety. On average, these families were retained for longer periods than those experiencing lower levels of depression and anxiety. There were also significant decreases in the proportion of families suffering depression and anxiety with improvement of the home environment for child development over time. The Social Network Map proved to be an effective tool for engaging families in discussion about the nature of their relationships, while insufficient families participated in the PSI to make sound conclusions about its use. Changes in general stress levels did not on average improve over time, and research needs to be conducted to explore this

CASE STUDY – MANDY

Mandy is a 19-year-old Filipino mother who was referred to the service by the hospital when Mandy's baby was 2 days old. There were some major concerns about Mandy's maturity and her ability to care for her baby. Mandy had a history of sexual abuse and lived with her two brothers, who both used heroin, and her mother, who struggled to work full time and had little time to support her daughter. Mandy was also the victim of domestic violence involving an aunty.

A home visitor visited a few days after Mandy came home with the baby. It took a long time for trust to develop and a relationship to occur between Mandy and the Home Visitor. Most of the visits were spent giving general support, baby knowledge and dealing with the domestic violence and other extended family issues.

Mandy was linked up to the Young Parents group which, two years later, she continues to attend weekly. She particularly likes to learn songs and activities she can do with her baby. Mandy also visits the Child Health Nurse when she is at the centre.

The Home Visitor still visits monthly and spends a lot of time helping Mandy deal with issues around the baby. The baby is thriving and there are no issues of child safety.

phenomenon further. Again, these findings are detailed in the full evaluation report.

The nesting of NLHV within the Northern Lakes Family Centre added value to the service. Coordination of early childhood clinics and parenting groups enabled a seamless flow of clients from one service to the other. A significant outcome of NLHV has been the highly successful Young Parents group. This group operated at the Family Centre as a Home Visiting activity and grew from client need. Teenagers, especially teenagers who are parents, have traditionally been notoriously difficult to engage. This group has run each week with up to 20 parents a week, for the better part of the 3 year pilot and has been a significant way to impart information, model good parenting and establish peer support. Families attending the Young Parents group also had improved access to immunisation clinics and developed links with local early childhood services.

The multi-disciplinary team of professional home visitors employed by NLHV readily addressed a diverse range of families' needs. The expertise of the social worker, welfare worker and early childhood nurse were combined in the delivery of the NLHV service. Staff felt comfortable seeking additional support and advice when working in unfamiliar areas and regularly undertook group supervision to resolve problems. NLHV's ability to continue to deal with the range of issues presented by families is dependent upon these two key characteristics.

The small yet dedicated group of trained volunteers extended the range of service provided by NLHV. These volunteers provided low-profile assistance to families who required additional support. Invariably, this support took the form of transportation and respite care. Personal gratification of volunteers was generally high, but there were times when the full potential of volunteers was not fully utilised. In these instances, poor understanding of the role of volunteers and limited resources were significant issues.

The action strategies and associated indicators of effective practice developed through this evaluation typify the essence of home visiting as implemented through NLHV. They demonstrate how home visiting is described and justified as well as the interaction of relationships between key stakeholder groups. For home visiting in general, these findings point to a need for consideration of a curriculum for home visiting which might consider these strategies and devise training modules that facilitate learning outcomes based on those indicators of effective practice most valued by key stakeholders.

The 'real' outcomes of the service are evidenced in the many positive stories that have emerged from the service and the positive affirmations by parents about the difference it has made to their parenting, and their ability to cope with challenges. For many families who are in longer term contact with the service, the occurrence of abuse and neglect seems to have been averted by enhancing strong bonds between parents and babies and providing support through critical times. ♦

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