Preventive Home Visiting

PROGRAM FOR FIRST TIME MOTHERS

Forty first-time mothers were randomly allocated to two groups, half who received the service of a home visitor and half who did not. The home visitor commenced visitation during the last month of pregnancy and continued until the baby was three months old, visiting or contacting the mother approximately once weekly. Pre and post measures of self-esteem, anxiety, locus of control and acceptance were taken, the only significant difference between the treated and the control group was a lower trait anxiety in the target group. However, the other results were in the predicted direction. While all of the mothers requested the service, those mothers who received the service stated they valued it highly. Three mothers in the target group were identified as being "at risk" and received appropriate treatment; they had not been located by any of the health services with whom they were in contact. The present study raised a number of issues associated with the delivery of such primary prevention services, particularly the need for more adequate program evaluation.

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INTRODUCTION

It has been claimed that many emotional problems have their aetiology in poor adaptation to particular developmental crises. Rappaport (1977) in discussing Gerald Caplan's (1964) conceptual model for prevention of mental disorder states, "depending on how such crises are handled, the person may emerge from them with either more or less adaptive skills. If a crisis is resolved with new insights and skills, the person emerges as stronger and better able to deal with future crises. If the crisis is handled poorly, the person may be less able to function well in the future. In short, crises are turning points in people's lives". (p. 67). Bernard Bloom (1963) in Parad (1965), maintains that, "Many workers who apply public health concepts to the field of mental health believe that good mental health is in large measure the result of a life history of successful crisis resolutions; and, therefore, by providing therapeutic interventions to people while they are in crisis, the incidence of subsequent mental disorder in these persons may be significantly reduced" (p. 303).

Caplan (1960) defines crisis in its simplest terms as "an upset in a steady state" (Parad, 1965, p. 24). Rappoport (1962) expands on this stating, "However in a state of crisis, by definition, it is postulated that the habitual problem solving activities are not adequate and do not lead rapidly to the previously achieved balanced state" (Parad, p. 24). The hazardous event itself requires a solution which is new in relation to the individuals' previous life experience. Caplan, (1961) emphasizes "The importance of periods of crisis in determining individual and group development" (p. 18). Many individuals are able to develop new solutions by means of the normal range of problem-solving mechanisms stemming from their general life experience and maturation and are thereby able to deal adequately with the potentially threatening event. Others are unable to respond with appropriate solutions, and the hazardous event and its sequelle continue to be a source of stress. Progress through eight stages of man discussed by Erickson (1950) is thought of as marked by a series of developmental crises. Such developmental crises are to be expected to occur at predictable times in the individual's life as he or she passes from birth to maturity

There are obvious normal critical transition points in the family life cycle; getting married, birth of the first child, children going to school, death of a spouse or children leaving home. As mentioned, it is postulated that the way these normal crises or status transitions are handled or coped with, will have long term effects both in terms of the mental health of the individual and in terms of the ensuing family relationships. LeMasters (1957) discusses a study which posed the hypothesis that the addition of the first child constitutes a crises event, forcing the married couple to move from an adult-centred pair type of organisation into a child-centred triad group system. To test this hypothesis, a group of young parents were interviewed, using a relatively unstructured interviewing technique. A number of socio economic variables were controlled. The definition of crisis used was that of Hill (1958) who defined it as "any sharp or decisive change for which old patterns are inadequate" (p. 51). A five-point scale was used in coding the interview data from (1) no crisis, to (5) severe crisis; the rating being arrived at jointly by the interviewer and the parents. Forty-six couples were studied and 38 (83%) confirmed the hypothesis.

There have been various programs designed to assist young parents in coping with their first child. One such program is recorded by Cyr & Wattenberg (1957) which described a clinic at Boston, U.S.A. which offered pre-natal, post-natal and well-child care to 116 families having babies. The Family Health Clinic functioned for 6 years under a special grant and had a multi-discipline staff consisting of obstetricians, pediatricians, nutritionists, public health nurse, social workers and consultant psychiatrist. Special emphasis was placed on the promotion of good mental and physical health through incorporation of preventive measures. The treatment focused on the reinforcement of capacities to handle crises or stress situations, and the development of healthy relationships during the period of pregnancy and infancy. Educational methods were used and included anticipatory guidance. This program unfortunately appears to have been poorly evaluated, and no precise indices of success such as using control group information were used. They claimed that "most mothers were able to approach parenthood with a healthy attitude and minimum of disorder". Also, "many of the women expressed a positive response and felt they had been much better 'prepared' for their experience than their friends who had not had a chance to discuss such matters" (Parad, 1965, p. 96). The authors commented that they though there was patient resistance, "even more unconscious than conscious, because of the common association of professionals with pathology" (p. 98), but unfortunately did not provide any specific data to substantiate this.

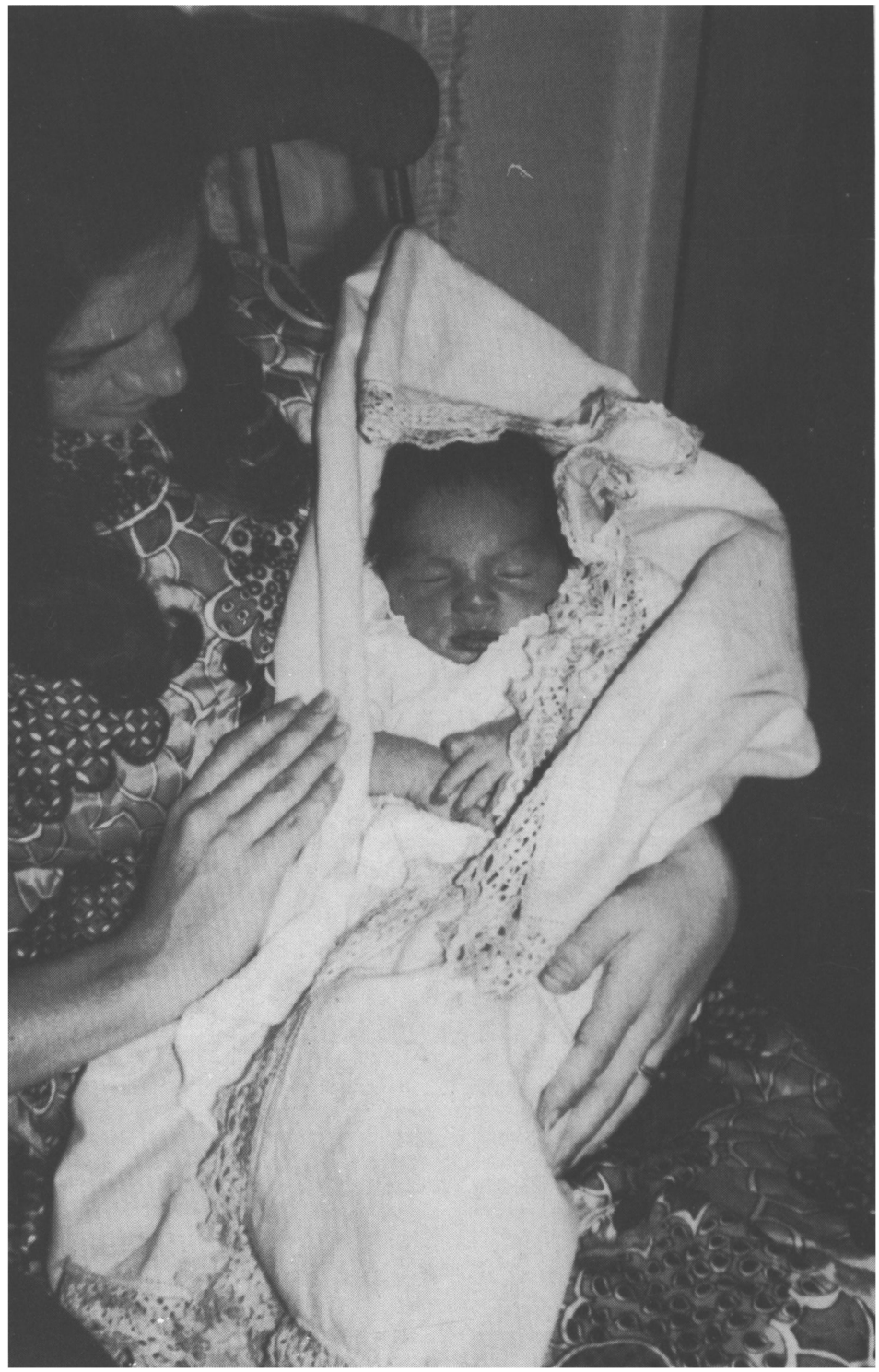
It could be argued that such a study as this could have been extended and also been more effective with the use of non-professional home visitors. The failure of the traditional health professionals to meet the needs of large numbers of target groups has been well documented (see Rappaport 1977, p. 374). The non-professional movement is based partly on the above, not only because of too small numbers of professionals, but some studies which have shown that traditional approaches have not been altogether effective (Cowen, Gardner & Zax, 1967). It has also been suggested by Rioch (1966) that the perception of non-professionals by some target people as being closer to themselves, make it easier for them to identify with them and use them as models. The work of Bandura (1969) demonstrates that the characteristics of a model do influence his or her effectiveness as a change agent. The implications of this would seem very important, when we are considering the role of non-professionals in fostering growth and change in the community.

Zax & Specter (1974) quote many examples of using non-professionals in helping roles in the community. They define a non-professional as, "any individual who is recruited to provide mental health services without having completed customary professional training in one of the traditional mental health disciplines. As such, the non-professional may be paid or unpaid, and may be a trained practicing professional in some other field" (p. 368). Within the traditional mental hospital setting, college student volunteers have served as companions to hospitalized mental patients (Holzberg, 1967; Klein & Zax, 1965; Umbarger, Dalsimer, Morrison & Breggin, 1962), and high school students have served as companions for adolescent and pre-adolescent hospitalized patients, (Fellows & Wolpin, 1969). There are several examples of the use of non-professionals in an activity reserved heretofore for only the most skilled professionals. For example, Poser (1966) and Rappaport, Chimsky & Cowen (1971) have employed college undergraduates as group therapists in mental hospitals. Kreitzer (1969) has trained college students to participate in a hospital behaviour therapy program for emotionally disturbed children.

Johnston (1967) has reported the successful use of retired people as "Foster Grandparents" for children suffering from emotional disturbance, at the Summit County Child Welfare Clinic in Ohio, U.S.A. More recently in Melbourne, Australia, McGregor (1978) introduced a pilot project to ascertain the effectiveness of using foster grandparents with mentally and physically handicapped children. The addition of the foster grandparent to the helping team appeared to have many benefits for the children, the staff and the grandparent. McGregor claims that "on the whole, children are making better progress as a result of having foster grandparents" (p. 19) Volunteers are also being used extensively in other areas, for example, in family oriented counselling agencies, such as Southern Family Life Service Association, Sandringham, Victoria, where they undertake various jobs such as family aides, drivers, child minders, visitation of the aged.

The diversity both in the types of roles being filled by non-professionals (or volunteers) as well as the types of professionals who are serving as non-professionals, is impressive. But as Zax & Specter (1974) maintain, though it appears that programs making use of non-professionals are increasing, we lack much basic data on them.

A handbook for volunteers published by McGregor, James Gerrand and Cater (1982), containing some histories to illustrate problems that may arise in volunteer work, is a much needed



practical guide. While this fulfills a real need, there remains a paucity of material with an evaluative focus.

In modern industrialized nations, such as Australia, various models for delivery of maternal services have been developed. The traditional model is private obstetrician with general practitioner. In Victoria, Australia, the normal model, following the birth, is the provision for an infant welfare nursing sister to make a home visit initially, and then for the mother to visit the infant health centre at her own volition. Some mothers do not use this option and often these are the mothers who isolate themselves from support and who need it most. One alternative intervention which has potential for use with these mothers, is the regular home visits by non-professionals. (Gray, Cutler, Deans & Kempe, 1977; Dawe, 1973; Court, 1969).

A recent Canadian study by Larson (1980) attempted to assess the efficacy of home visits by two inexperienced psychology undergraduates, in promoting better child health and development. The study was designed to answer two broad questions: (i) whether home visitors could influence infant health and early environmental experiences, and (ii) whether the timing of such home visits also contribute to these outcomes. The results of this study provide encouraging evidence that in part answers both questions affirmatively. It was ably demonstrated that home visitors can enhance the quality of early environmental experiences and thereby improve specific infant health outcomes. In addition, the results suggest that the timing of these visits may be a critical factor in the efficacy of a home visiting program. Specifically, mother-infant pairs who received home visits beginning during pregnancy, clearly benefited. Those who received the home visits beginning only in the infants' sixth week, seem to have gained little when compared to control pairs.

The present study was conducted at Southern Family Life Service Association Sandringham, Victoria, Australia, which is primarily a family counselling agency, with a wide range of volunteer services. Recently, the organization initiated some preventive community based programs using the team approach of professionals and volunteers (Begg & Swartz, 1980). The present study was undertaken to ascertain whether home visits by volunteers for a limited period, both prior to baby's birth and after, had any significant effect on various indices of mothers' adjustment and well being. The hypothesis formulated, was that early introduction of support to first time mothers, aid them in coping with the event of their first babes. More specifically, that those mothers who received regular volunteer visits, would have higher self esteem, lower anxiety, would be more in control and would display more appropriate mothering behaviour generally.

METHOD

Setting. Southern Family Life Service Association is staffed by seven social workers, one of these being in charge of the volunteer service and training program. It is basically a counselling agency; a wide range of people are seen, the majority requiring marital therapy or child guidance. Volunteers undertake a wide variety of tasks, including regular visitation to families who need special support, working together with the social worker within a team framework, the social worker being the leader of the team.

Subjects. Forty pregnant women from the south-eastern suburbs of Melbourne, who were expecting a first child and attending pre-natal physiotherapy groups, volunteered to participate in the study.

Design. The forty were randomly allocated to two groups. The research design used was the "post-test only control group design", in the terminology of Campbell & Standly (1963).

Home Visitors. The four home visitors who were involved were experienced family-aides and were selected from a large pool of voluntary workers who had already undergone the usual twelve week training course provided at the Centre. This was a fairly general course, and some of the topics were, for example, confidentiality, grief, ethical issues, "smothering" versus "mothering". These four unpaid workers had all experienced motherhood and child rearing; two of them were grandmothers, and the third became one towards the end of the project. They were particularly interested in this area, had shown themselves to be sensible, resourceful mothers.

Additionally and importantly, they demonstrated an ability to empathize, to relate warmly and were confident of their mothering and feminine attitudes. They were also able to verbalize their experiences. All lived at home with their husbands, and two had teenage children still sharing the home. One had a double certificate in nursing but had not worked in that capacity for four years. One had a Bachelor of Arts Degree, plus a Librarian diploma and had not been in paid employment for twenty-nine years. One had office training, and had worked as a volunteer co-ordinator for Southern Family Life Service until five years ago. One was currently employed as a part-time business woman.

The volunteer was introduced to the mother as a friendly visitor who was available to offer support, as a person who had had children herself. It was also stated that a social worker was organising the project, and that the volunteer had a continuing close contact with her, which was confidential to the two.

Discussions at the Centre initially were help approximately once fortnightly, later once per month. The content varied, and covered in the main, practical situations and alternatives for handling these, special concerns about particular mothers, roles, topics for conversation and confidentiality issues.

SERVICE / PROGRAM

Group A received the service which was the focus of this study. They were visited either once or twice prior to the birth (in some instances in hospital), and then a once weekly contact was maintained generally by home visit but sometimes by telephone, for three months, Group B, the control, received no service. The frequency of the volunteer visits and time sequence including the administration of the questionnaire was explained by telephone to members of Group A. Group B mothers were also telephoned but the only information given to them was that they would receive a questionnaire at three months. Those mothers visited were told that the visitor was not there to take the place of the infant welfare sister. Two social workers, one who focused more on the research aspects and the other mainly on the practical service, were involved, both meeting together regularly with the four volunteers.

INSTRUMENTS

(i) Four self report paper and pencil tests were administered to Group A and Group B at the end of 3 months program operation. The tests used were—

(a) *State Trait Anxiety Inventory (Speilberger, 1970).* This instrument is designed to measure a level of anxiety as well as the present state of anxiety.

(b) *Self Esteem Inventory)Coopersmith, 1975)* This set is designed to measure an individual's feelings of self-worth.

(c) *Locus of Control (Rotter, 1966)* This scale purports to measure an individual's generalized expentancy about the locus of control, whether it is external or internal.

(d) *The mother-child Relationship Evaluation Scale (Roth, 1961)* This experimental device is designed to measure a mother's attitudes to her child. It contains four sub-scales; Acceptance, Over-Protection, Over-indulgence, Rejection.

(ii) Following completion of the questionnaires, the mothers in both Groups A & B were asked the questions contained in Appendix A. These questions focussed on how the mothers experienced the first three months after the birth and attempted to identify from whom they sought help.

RESULTS

Table 1 measured standard deviations for Target (T) and Control (C) groups on dependent variables.

An additional measure was taken of subjects' attitudes to the visiting service. Results suggest that most found it helpful in the target group, and most in the control would have liked a visitor. A summary of results of questions can be seen in Appendix A.

DISCUSSION

The present results indicated the target group had significantly less trait anxiety than the control. This was unexpected as it was hypothesized that state, not trait, anxiety would be lowered by the use of the visiting servicing during the critical period surrounding the birth of the first baby. An explanation could be that the birth of a first baby is such a major and powerful experience, that it alters the basic trait anxiety of the individual. However, Spielberger states that the individual's level of trait anxiety should be stable over a relatively long period of time.

Perhaps during the first few months following the birth of a baby, a mother is so physically exhausted, that this, combined with hormonal changes, confounds the separate measurement of state and trait anxiety. The state anxiety may be masked by depression – it is interesting to note that most mothers in both groups commented on feeling "depressed" during the three months following the birth, not on being anxious.

While the state anxiety difference was not significant between the target and the control groups it was in the expected direction – the target group mean score was lower than that of the control group. Perhaps the difference between the two groups in state anxiety was not as large as expected because of the limited nature of the service. In many ways this was a minimal service and perhaps if more intensive service had been provided over a longer time span or the same service with a larger sample and utilising a more representative group of mothers, the difference may have been significant. On the other measures, there were no significant differences between the scores of mothers in the two groups. However, the acceptance measure of the target group was higher than that of the controls. Larson (1980) maintains there is a need for additional studies of mother/child health home visit programs on a community wide scale, with such areas of visit timing, content, style and number in need of further examination. Larson believes that such controlled studies would broaden our understanding of home visit programs and improve their effectiveness.

The feed-back from the mothers in response to the five questions asked verbally was important (Appendix A) in suggesting that the target group found the service overwhelmingly helpful (only one did not), and the control group, save for three, said they would have appreciated the service. Most of the target group saw the advantage in having the visitor as someone from outside their friends and family to talk to. who was "neutral" and "understood". The control group expressed similar sentiments. The term "someone with experience" was used several times by the control group

The content of the visits was, in the main, verbal, supportive discussion, the visitor being especially careful to direct the mother to the local infant welfare sister if she felt questions to be more appropriate for professional attention. Discussion with the visitors by the supervising social worker, suggested that the visitors needed support in being their natural, neighbourly selves, as there was a tendence to "go the other way", and feel nervous about giving any advice at all. It was difficult for the visitors to differentiate between a "no trespass area", and where they could speak freely from their experience. The overlap between themselves and professionals in the field may have been emphasised in their preliminary instruction too much, and their contribution to the mother stifled as a result. The effects of the visiting service may have been more significant if the volunteers' level of assistance had been more like that of a friend who gave advice.

It is interesting to note that while early identification of "at risk" individuals was not the focus of the pilot project, three of the target group mothers needed to be referred to the agency for extra counselling help. It did not appear that they had been identified by any of the health service professional personnel they were in contact with; they had not been given any extra support or service. These three mothers exhibited factors which indicated serious mothering difficulties. With extra surveillance and support, they became able to cope better. One of these mothers 9 months later, still requires the regular visits and support of a volunteer visitor. This is an example of secondary prevention in the terminology of Caplan (1964).

Blair & Justice (1976) advocate a health visitor program as a primary preventive measure against child abuse. "Although opposition to health visitors is likely – even if families are not required by law to admit them to their homes – a truly comprehensive primary prevention program may well require this extensive measure. The home is the only place where all the critical points of the triad of host, agent, and environment can be observed. If children are followed up beyond infancy, early warning signs of other problems can also be detected, including those we have identified elsewhere as warning signals of later violent behaviour". (p. 234)

A study by Gray, Cutler, Dean and Kempe (1977) indicates that, it is possible both during the pre and post natal periods to predict the potential for some abnormal child-rearing practices, of which child abuse and neglect is one extreme. "These perinatal and early neonatal periods offer an excellent opportunity to make assessments of a new born infant's behaviour, observe the mothers and fathers responses to their child, and to study the interaction between them. The perinatal period also provides easy accessibility to individuals as they become a family, permits observation of the mother and child during a critically sensitive time, and allows pediatric intervention to begin early whenever there is indication that potentially harmful child-rearing patterns may occur. Intervention at this time can be aimed at increasing strength within the family so that a child may have the opportunity to reach his physical, emotional and intellectual potential". (p. 2). The view is widely supported by those who have studied child abuse; Dawe (1973), Court (1969), Kempe & Helfer (1971).

During the group discussions with the visitors, they were alerted to early signs of mothering problems, including child abuse. In retrospect, however, from some comments made by them, it seems that some of them did not fully grasp the implications of the behaviour of some of their mothers. It would appear very important that more time be alloted to this critical area in any future similar programs.

Blair & Justice (1976) state, "if the health visitor is to make effective preventive interventions, she must be trained to recognise the signs of potential abuse . . . what the health visitor should be trained to detect are signs of 'abnormal rearing',

the parent's isolation, suspicion and distrust, lack of friends, inability to reach out to others, marital conflict, excessive expectations of the child. Early detection of potential child abuse requires the recognition of signs of symbiotic relationships between parents and parent and child". (p. 233).

The visitors frequently commented that the mothers they visited needed re-assurance from them concerning the "why" of their babies crying. The visitors found the mothers generally became unsettled when their baby cried for a long period and needed suggestions for handling this. Silock (1979) comments on a longitudinal study of individuality in behavioural development by Thomas, Jess & Birch (1968), who identified a number of problem behaviour patterns which, they believe, were fostered by a mismatch between the behavioural characteristics of the children and the expectations of their parents, who had misread and misjudged the infant's cries. When their parents were given guidance in recognising and responding to the signals of their infants, the children developed into "well functioning" individuals. It would appear from our experience and that of this latter study that mothers often need special support in learning to understand their first baby's signals; a home visitor, herself a "well seasoned" mother, could have an important role in this area.

When considering future use of visitors to first time mothers, the modelling aspects cannot be ignored. Careful selection would therefore be critical, so that the volunteer is modelling those characteristics of mothering which would be important for the mother to learn. Bandura (1976) has contributed a great deal of knowledge about the modelling process. As he states "most of the behaviours that people display are learned either deliberately or inadvertently, through the influence of example". (p.5). According to Chamberlain & Szumowski (1980) the modelling of warmth and affection may be more important than anything else. They suggested that physicians should focus their teaching efforts on showing mothers how they could interact with their children in more affectionate and cognitively stimulating ways. Their research indicated that the most important predictor of the child's development status at 18 months was the amount of positive contact between the mother and child at one year of age. They quoted Gordon (1969) as having shown that lay persons can be trained to teach mothers how to increase positive interaction with their child.

Bandura's (1969) work on modelling suggests that the characteristics of a model do influence his or her effectiveness as a change agent. It has been noted by Rioch (1966) and Cowen (1967) in Rappaport (1977) that the perception of non-professionals by some target people as closer to themselves may lead to an increased willingness to identify and model after the helper. Chinsky & Rappaport (1970) in Rappaport (1977) supply some specific evidence that at least among chronic hospitalized patients, non-professionals are viewed as more similar to themselves than are professional helpers.

The present study attempted to evaluate the effect of a pilot primary prevention service for first time mothers. The area of primary prevention is a sadly neglected one. Most professionals have a problem-oriented approach, with services aimed at helping the client after a problem becomes manifest. An Australian paper written by Clarke & Viney (1979), explores the concept of primary prevention, and the question of why primary prevention is not being practised more extensively is also examined. Some of their answers include the lack of immediate rewards it provides for professionals, its low visibility preventing adequate government funding and the lack of descriptive research results on which to base it. They also comment on the importance of a community oriented team approach " . . . which is not yet applied in educational practice nor is it the normal occurrence in professional practice" (p. 17). They cite the report of the Australian Royal Commission on Human Relationships (Evatt, Arnott & Deveson, 1977) which has recommended research concerned with the primary prevention of illness.

Primary preventive programs often seek to generate more positive community involvement in health care, compared to the problem or disease approach which tends to encourage clients to regard themselves as passive recipients of treatment. The use of non-professionals in primary prevention programs would seem to be an effective and economical way of mobilising these valuable community resources. It is unfortunate that there is a paucity of research concerning the effectiveness of the above. Rappaport's (1977) comment is particularly relevant, "however, although it is true that 'hard nosed' empirical data are relatively scarce, the same is also true for evaluation of the effectiveness of the professionals. Most service delivery programs be they professional or non-professional, traditional or innovative, are simply not well evaluated. They are usually not evaluated at all". (p. 375). Rappaport further maintains that "the base line for comparison of non-professional services must be selected by asking 'what would happen to these target people in the absence of this program'. In some cases the appropriate comparison will be to a non-treatment 'treatment as usual' control group, because many times the non-professional services are offered not as a substitute for professional care but as a substitute for no attention at all". (p. 375). Rappaport also makes the observation that although professional services may be theoretically available they are not necessarily easily accessible. In the case of the particular area under discussion, it could be concluded that without early identification and subsequent intervention, it is unlikely that the problems the three "at risk" mothers exhibited (15% of target group), would have simply "gone away", but would likely have become more established, serious and difficult to treat and required longer term, more expensive professional care as time progressed.

Although there is a wealth of written material and research on the crucial importance of support for new mothers, services in this area do not seem to be adequate in our community. Silcock (1979) observes, "although western societies believe themselves to be child centered, families are left to carry out the major tasks and responsibilities of child rearing largely without prior training, emotional support or adequate physical and economic assistance". (p. 295). He also contends that families are often separated from the extended family due to increasing mobility and that the only persons the mother can turn to are often her peers, who, too, are equally inexperienced and ill-prepared for parenting.

It seems that those professionals who have direct contacts with mothers prior to and when the child is young, are in a particularly strategic position to ensure that each mother is receiving adequate support. As professional awareness of the problems of first time mothers increases, there may be more co-operation and enthusiasm for appropriate support programs. It was unfortunate when setting up this study that when medical personnel were located, few could see a need for such a program and fewer supported it. One remarked that his mothers were middle class and educated and that they did not have any problems. The longitudinal study by Chamberlain & Szumowski (1980), which evaluated the relationship between the physicians' efforts to educate mothers of first born children about child behaviour and development and various outcome measures of mother and child functioning over a 2½ year period, concluded that pediatric contacts were not as effective as they could be. The authors stated, "whatever the solution, it is time to rethink our total approach to providing preventive services to mothers and young children. If periodic well-child

visits with physicians are too expensive, or not as effective as they could be in terms of providing education and emotional support, other alternatives should be explored before we retreat from our goals of comprehensive care and once again become preoccupied with only the physical aspects of child development". (p. 884). They concluded that trained lay persons could provide education and emotional support, complementing the physician service by home visits thereby decreasing the number of office visits.

True prevention must 'nip problems in the bud' and strengthen capabilities so that future problems are less likely to occur. Programs should begin as early as possible, for example in the schools and maternity hospitals. The research by Gray, Cutler, Dean & Kempe (1977) already cited, provides valuable guidelines for all those who have contact with mothers pre-natally and post-natally, for early detection of those who are likely to have mothering problems in the future. These mothers can then be followed up more closely with the possibility of referral to a suitable program. Involvement of a home visitor could be very appropriate.

An alternative service for first time mothers has been developed in Minnesota (Belbas, 1979), where MELD groups are run by young parents who have training and commence during the mother's first pregnancy continuing until the child is 2 years of age. These groups seem to provide a valued service for parents who have the confidence to join such groups and the ability to continue attendance over a long period of time. An important feature of MELD groups is the involvement of the father. A father's understanding of the care of a young child, together with his support of the mother, can render her more effective in her mothering role, even if he is with the child less than the mother. Additionally for some children, the father is the primary attachment figure (Schaffer & Emerson, 1964) in Silcock (1979), and some studies, also in Silcock, suggest that fathers are as influential on child development as the mother✕ (Radin, (1973), Rode (1971)). However, the above groups would not attract or cater for the hard to reach deprived mother or parents who do not have confidence in coping in a group situation. "Mums Chums" (Begg & Swartz, 1980) shcemes which utilize young mothers, following a short training course, as visitors to new young mothers under the auspices of an infant welfare centre, may be effective. However, if conducted in areas with a high density of deprivation, mothers may not have the emotional resources to support each other and could, in fact, reinforce poor parenting. Also if a mother is having difficulty she requires a long-term commitment from the volunteer visitor. Although "Mums Chums" are valuable supports on a short term basis, it is wondered whether an older woman, having completed her child rearing, may be more appropriate in some instances.

Evaluation of such programs is very important. At times the assumptions that they are resting on have been researched and found to be wrong: One example of an adverse result from a program with a primary prevention goal was reported by Webb, (1973) in Clarke & Viney (1979), who noted the increased usage that followed warnings given through mass media outlets in the U.S.A. about the hazards of glue sniffing and the use of LSD. Unfortunately, few human services professionals have the resources to evaluate programs. If health professionals are to be encouraged to do this and to practice primary prevention after graduation, then a change in emphasis will be necessary in their education, and a re-allocation of priorities established within service organisations.

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New Grants for 43 Children's Service Projects

The Minister for Social Security, Senator Don Grimes, recently announced that he had approved grants for 43 children's services projects under the Children's Services Program.

Senator Grimes referred to the announcement in the Budget that the Government would be providing $10 million in 1983/84 for high priority new and expanded projects and initiatives under the Porgram. "A large number of projects has been identified", the Minister said, "and today's approval of projects rated as being of the highest priority will be the forerunner of other approvals to be announced progressively".

The Minister then gave details of the number of services in each State and estimated costs. "The 43 grants will cost in excess of $2.175 million in a full year. Additional day care places for some 1,465 children will be provided", he said. Although only one grant has been provided for N.S.W. further grants are presently being considered and will be announced shortly.

The Minister continued: "There are not yet sufficient day care places available in Australia, nor are there sufficient services related to the needs of low income families.

"The Government will therefore be seeking added flexibility under the Children's Services Program so that these needs can be met more effectively. We shall be encouraging new and existing service sponsors to extend the range of services they provide so that by their multi-functional nature they might more adequately meet the needs of families.

"To this end, I have decided to abandon the use of the terms, 'mainstream' and 'non-mainstream', as adopted by the previous Government in determining its priorities under the Children's Services Program. I believe 'non-mainstream' in particular has a negative connotation and has served to inhibit the development of a flexible range of children's services which the present Government considers to be so vital".

The Minister added that work was proceeding in his Department on a planning approach to funding under the Children's Services Program. "The 'submission model' approach, which has tended to favour the articulate and those with the resources to devote to submission writing, is to evolve into a 'planning model' approach which will allow areas of greatest need to be identified", he said. "Data relating to the supply of and demand for day care services are being collected and analysed and the process of associated consultations with State, Local government and community organisations has commenced."

BACKGROUND NOTES ON CHILDREN'S SERVICES PROGRAM 1983/84.

* The 1983/84 Budget allocation for the Children's Services Program for services other than pre-schools is $85.86 million, an increase of $20.91 million or about 33% over the previous year's expenditure.
* An amount of $10 million has been allocated for high priority new and expanded projects and initiatives.
* The implementation of revised funding arrangements for day care services aimed at ensuring that economically needy families are not denied access to care because of costs is continuing. A new fee rebating arrangement for economically needy users, known as Special Economic Need Subsidy (SENS), was introduced in January 1983.
* Upon taking office the Government decided that the guidelines for day care fee relief developed by the former Government should continue subject to:—
  * the deletion of a minimum fee provision; and
  * an extensive review during 1983.

The fee relief review process has taken the form of an interdepartmental committee and extensive community consultation.

* As a focus for the community consultation the Minister recently approved a grant of up to $22,000 to the National Association of Community Based Children's Services to mount a forum in Canberra from 19-21 September, 1983. The forum will be attended by individuals from the day care field throughout Australia representing a range of views and service types.

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