Home visiting in South Western Sydney
An integrative literature review, description and development of a generic model

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Executive summary

Introduction

Families First is the key New South Wales government initiative for supporting families with children aged 0-8 and their communities. Home visiting is a key strategy of the initiative and professional, paraprofessional, paid non-professional and volunteer home visiting programs have been implemented. The purpose of this project is to assist in the planning of home visiting programs in South Western Sydney by describing the variety of home visiting programs internationally, describing home visiting programs in South Western Sydney, and developing a generic framework for planning and evaluating home visiting programs.

Three methods were employed: a review of home visiting studies published internationally; an empirical study of home visiting services in South Western Sydney; and the development of a generic framework through a grounded theory approach.

Literature analysis

An integrative review of the early childhood home visiting literature was undertaken to describe home visiting programs internationally and identify the characteristics of home visiting programs that were associated with positive outcomes for home visiting clients. Home visiting studies published in journals were sourced from electronic databases and by searching for references included in recent meta-analyses and systematic reviews. Full text articles that were accessible on-line were downloaded (n=43). Where full text was not available on-line, the abstract, together with additional information available from article citations was used (n=55). Limitations to the review included limiting the sourcing of articles and abstracts to those available in electronic academic literature, and limitations in publications including lack of detailed information on programs and potential publication bias.

Home visiting reported in the literature is undertaken by a range of professional and lay visitors. The single largest professional group was nurses. Very few studies of lay and/or volunteer home visiting were reported in the academic literature. Most home visiting studies were targeted at specific ‘at-risk’ individuals. Maternal and child related factors shown to place children at risk of poor health or developmental outcomes that have been targeted include mothers who were of low socioeconomic status, unmarried, being African American (in US trials), isolated or lacking social support, experiencing postnatal depression, or using drugs; infants who were pre-term, low birth weight or failing to thrive, or toddlers with difficult behaviour or sleep problems.

There is ongoing debate regarding the groups most likely to benefit from varying home visiting programs. The evidence from the literature analysis would suggest that, in the Australian context, low socioeconomic status women were the group most

1 Publication bias occurs when positive outcomes of research are published and less positive outcomes are not.
reported to benefit from the home visiting. Programs targeted to women with postnatal depression also reported benefits. The small number of studies of very complex needs families with drug use and children at risk of abuse and neglect showed few significant positive outcomes in the literature studied.

The content of the home visiting programs could be categorised into seven types: provision of resources/information, parenting skills, child development, counselling, problem solving, social support and parent-infant interaction. There was evidence of some program content being tailored to differing at risk groups. Most home visiting programs reported in the literature commenced postnatally.

The evidence in the literature indicates that interventions more likely to result in positive outcomes are those commencing antenatally, and those providing parenting skills, resourcing parents, and encouraging parent-infant interaction. Positive outcomes were also achieved from interventions focussing on child development, providing counselling and problem solving. Interventions focussed on social support were less likely to report positive outcomes.

The evidence from this literature analysis would suggest that, in the Australian context, positive outcomes are most likely to be gained from home visiting interventions with the following characteristics:

- Programs for mothers from low socioeconomic groups, some of which may be identified on the basis of membership of a population group such as teenaged or unmarried mothers, or by race.
- Home visiting by nurses where a broad range of outcomes is desired.
- Highly targeted interventions by psychologists/counsellors for mothers with postnatal depression.
- Programs commencing antenatally.
- Programs including child development, parenting skills, parent-infant interaction and direct and indirect provision of resources.

**Home visiting in South Western Sydney**

The aim of the empirical study is to increase our understanding of how early childhood home visiting services operate in the South Western Sydney (SWS) area. Data collection for this study occurred in three stages using three different data collection methods. A program audit was carried out in the first stage (n=45 programs that included some element of home visiting), followed by telephone interviews in the second stage (n=29 programs that regularly carry out home visiting), then focus groups in the final stage (n=3 programs\(^2\)).

In South Western Sydney, most home visiting programs offer a combination of home visiting, centre-based and other support activities, such as parenting groups and telephone assistance. The risk factor encountered and tackled by most of these programs is isolation experienced by women. Some programs experience difficulty in engaging with higher-risk client groups and non-parental care givers. Aboriginal and

\(^2\) The three programs participating in the focus groups were health home visiting, family support and intensive family support.
refugee groups conversely, are specifically targeted or captured by very few programs.

The majority of early childhood home visiting programs in South Western Sydney, aim to meet family needs through improving parenting skills, offering social support and linking families to resources. Problem solving and parent-child interaction were least mentioned as approaches to address needs. Strength and solution based models are used to guide all programs. These approaches and models are consistent with those considered to be of most benefit in the international literature.

By providing a service within the context of the families' homes, home visiting providers in South Western Sydney are able to identify need and implement interventions more appropriately. The provision of service is further facilitated by the development of a trusting visitor-client relationship. The level of trust and nature of relationships will be influenced by the skills of the visitor and aims of the program.

According to program managers and visitors, home visiting programs in South Western Sydney provide a variety of interventions. These interventions respond to, psychosocial, instrumental and educational needs. Psychosocial interventions include reflecting behaviour, goal setting, and empowering families. Instrumental interventions include practical help such as child minding or transport, information provision and linking families to community resources. Finally, educational interventions include parenting skills, child development and health promotion.

Based on the opinions of program managers and visitors, home visiting programs are affected by the capacity levels of clients, visitors and institutions, which are influenced by various factors. Entrenched problems such as substance abuse for instance, can limit a client’s ability to benefit from home visiting. Conversely, clients are seen as having the capacity to benefit when they have support, stable housing, and non-complex needs.

Visitor capacity is positively influenced by the support given by managers and can be negatively affected by high workload, burnout, and insufficient training in areas such as cultural sensitivity and boundary setting. Institutional capacity is adversely affected mostly by unstable funding, short contracts, resource constraints and staffing issues, particularly the retention of home visitors. Institutional capacity to deliver the program of home visiting is also impacted upon by the quality of the service network, particularly as this impacts on waiting lists for services.

Home visiting program managers and home visitors identified various non-specific outcomes of home visiting. These outcomes were not clearly articulated or defined however. The general feeling was that outcomes were more anecdotal than evidence based. Outcomes that were identified by participants did not easily relate to the types of outcomes measured in the international literature. Nonetheless, some identified outcomes could be viewed as direct impacts leading to outcomes in the literature, including:

- Increased confidence, improved problem solving, leading to improved maternal depression and self-esteem
- Improved networks and relationships, leading to improved social support
• Increased use of programs and services, including uptake of preventive services
• Health behaviours including breast feeding
• Improved control, leading to less risky behaviour
• Improved parenting skills, leading to improved environment, and improved child behaviour, health and mental development.

Few services in South Western Sydney, however, undertook systematic measurement of outcomes. Overall, service managers and home visitors experienced difficulty in identifying the outcomes of their programs, and relating them to their program strategies.

**Generic model of home visiting**

A generic model of home visiting has been developed based on the data from the literature analysis and empirical study, together with data from the concurrent evaluation of the Karitane volunteer home visiting program.

The analysis identified three co-dependent aspects of the home visiting intervention:
1. the context of home visiting, and
2. the trust relationship, which together create the conditions for home visiting, facilitating
3. psychosocial, instrumental and educational responses.

The ability of a home visiting program to create the conditions for home visiting and provide a response is effected by and in turn effects the clients', visitors' and institutions' capacity to deliver and respond to the intervention.

Five correlated outcomes of home visiting were identifiable in the literature and empirical data:
1. social resources, and
2. social well-being, arising from improved generalised and institutional trust;
3. demonstrated knowledge;
4. emotional well-being; and
5. adaptability.

The ability of home visiting programs to effectively achieve outcomes is mediated by client, visitor and institutional/programmatic capacity. Together the aspects of intervention, capacity to deliver/respond to the intervention and the outcomes of the intervention can be visually represented in the following model.
Generic model of home visiting (summary)

<table>
<thead>
<tr>
<th>3 CO-DEPENDENT ASPECTS OF INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create the conditions</td>
</tr>
<tr>
<td>1. CONTEXT</td>
</tr>
<tr>
<td>2. TRUST RELATIONSHIP</td>
</tr>
<tr>
<td>Psychosocial</td>
</tr>
<tr>
<td>Instrumental</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>3. RESPONSE</td>
</tr>
</tbody>
</table>

CAPACITY TO DELIVER/RESPOND TO INTERVENTION

| Client capacity | Visitor capacity | Institutional capacity |

5 CORRELATED OUTCOMES

<table>
<thead>
<tr>
<th>Generalised and institutional trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social resources</td>
</tr>
<tr>
<td>2. Social well-being</td>
</tr>
<tr>
<td>3. Demonstrated knowledge</td>
</tr>
<tr>
<td>4. Emotional well-being</td>
</tr>
<tr>
<td>5. Adaptability</td>
</tr>
</tbody>
</table>

This model presents the aspects of intervention, capacity and outcomes into a visual tool that accounts for program logic, capacity and outcomes and shows how these components relate to one another and influence program success. Benefits of the model include guidance and insight into:

- Planning and evaluating home visiting programs
- Identifying appropriate interventions and outcomes
- Linking outcomes to interventions offered
- Determining the best mix of interventions for each program (based on desired outcomes and available capacity)
- How program approach effects program capacity and vice versa
- Determining if capacity is available to carry out program aims

Further refinement of the model may occur through future use of the model as an evaluation and planning tool. In particular, identification of standardised tools for measurement of intervention, capacity and outcomes will facilitate the comparative and systematic evaluation of home visiting programs.

Conclusions

Home visiting programs in South Western Sydney are diverse, incorporating services directed at children and families with varying vulnerabilities ranging from isolation to existing child protection issues. Programs vary greatly in intensity and content. Few home visiting programs in South Western Sydney undertake systematic evaluation, and many lack a clear articulation of program logic linking intervention to outcomes. Nevertheless, through identification of the components of intervention, issues of capacity and the outcomes for clients in both the literature and empirical data, a model was developed upon which the program logic of home visiting programs in South Western Sydney can be mapped.
Based on the data and analyses undertaken in this project, two key areas of action can be identified relating to building capacity in South Western Sydney and the planning and evaluation of home visiting programs.

1) Building capacity in South Western Sydney

Key action areas regarding target groups
- Placing a greater emphasis on understanding how to best work with Aboriginal, refugee and non-English speaking groups via training of visitors, and improved collaboration with other Aboriginal and multicultural community services.
- Developing better strategies to reach clients with complex needs, and underserved groups such as grandparents and non-parental care givers.

Key action areas regarding capacity
- Ensuring funding reflects what home visiting services are expected to do, given the capacity available to them.
- Securing long-term funding to facilitate ongoing program planning and continuity.
- Training home visitors in areas such as; time management, boundary setting, expected service outcomes and cultural sensitivity.
- Developing more effective networks and pathways through increased collaboration with referral services (i.e. through joint visits or regular feedback) and other professionals (GPs, psychologists, therapists).
- Identifying ways to retain volunteer home visitors in home visiting programs.
- Maintaining motivation in home visitors and preventing 'burnout'.
- Offering ongoing training, support and supervision for home visitors to encourage staff/volunteer satisfaction and commitment.
- Developing better strategies to involve family members, such as fathers and grandparents, to improve client capacity to respond to intervention.

2) Planning and evaluation of home visiting programs

- Using the generic model of home visiting intervention and outcomes to evaluate and plan services.
- Establishing realistic outcomes taking into account the capacity of the client, home visitor and institution.
- Using evidence-based, best practices that have shown to achieve outcomes for families and children.
- Determining standardised ways to measure processes and outcomes.
- Using standardised tools such as those recommended in the NSW Families First Outcomes Framework and those used in the NSW Child Health Survey when appropriate.
- Sharing data from evaluations conducting among various services to develop evaluation capacity.
Introduction

Families First is the key New South Wales government initiative for supporting families with children aged 0-8 years, and their communities. The overall aim of the Families First initiative is to use a coordinated network of services to support parents, carers and communities raising children to solve problems early before those problems become entrenched (OCYP, 1999). The focus of Families First is on the promotion of health and well-being, and early identification and intervention for problems. The initiative is designed to achieve the outcomes of healthier children and parents, better functioning families, and child and family friendly communities.

Home visiting has become a standard approach for enhancing support and outcomes for families with babies and young children, and is a key strategy of the Families First initiative. As a strategy, home visiting is intended to support parents who are expecting or caring for a new baby (Field of Activity (FOA) 1), support parents who are caring for infants and young children (FOA 2), and assist families who need extra support (FOA 3).

The purpose of this project is to assist in the planning of home visiting programs in South Western Sydney (SWS). In this report, home visiting programs are defined as services which use the client's home as the main site for service delivery, and which may also include other elements such as telephone support and centre-based groups.

This project was funded by South Western Sydney Families First through the NSW Department of Community Services. The project was supported by an advisory group consisting of representatives of home visiting service providers in South Western Sydney (see Appendix A).

This report contains information:
- Describing the variety of home visiting programs and studies reported internationally.
- Identifying and describing the variety of home visiting models currently being used in SWS, including areas where home visiting may be expanded.
- Detailing a generic framework for understanding the program logic of home visiting upon which evaluation may be based.

In addition, resources to assist best practice in home visiting have been identified and are listed in Appendix B. These resources are available via a website (http://chetre.med.unsw.edu.au/earlychildhood/hvdirect.htm).

This report is based on three activities undertaken by the Centre for Health Equity Training Research and Evaluation during 2003-2004.
1. A review was undertaken of home visiting studies published internationally in academic literature to identify the characteristics of visitors, clients, and programs associated with positive outcomes for children and families.
2. An empirical study was undertaken of early childhood home visiting programs in SWS to describe home visiting program components, processes and outcomes in detail. This study was undertaken in three stages:
   a. An audit of services offering home visiting in SWS
b. A telephone survey with managers/coordinators of identified early childhood home visiting programs
c. Focus groups with home visitors.

3. Development of a generic framework for the planning and evaluation of home visiting services.

The report is presented in four sections.
Section 1 presents the analysis of the international literature
Section 2 presents the results of the empirical study of home visiting in SWS.
Section 3 presents a discussion of the findings and the development of a generic framework for home visiting.
Section 4 presents the conclusion and key areas for action.
Section 1: Literature analysis

1.1 Aim

A review of the early childhood home visiting literature was undertaken to:

- Describe home visiting programs internationally including
  - The types of home visitors
  - Target groups for home visiting
  - The content of home visiting programs
  - Schedules of home visiting (number and duration of visiting)
- Describe the outcomes of home visiting programs internationally.

Overall, the review aimed to identify the characteristics of home visiting programs that were associated with positive outcomes for home visiting clients.

1.2 Method

The method used was that of an integrative review. This integrative review was designed to answer the following research question:

- "What are the characteristics of home visiting programs that have been found to be effective for which groups of clients?"

Integrative reviews summarise past research and examine relationships between concepts of interest. Overall conclusions can then be drawn from the body of literature on a particular topic. The literature included in an integrative review may be broad. In this review, all quantitative and qualitative studies evaluating home visiting programs were included.

Home visiting studies published in peer-reviewed journals were sourced by the following means:

- Searching MedLine, CINAHL and Current Contents databases using the search term “home visiting” AND “child” OR “infant”

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Studies were read (full-text article where available (n=43)), abstract when full-text article not available through databases accessible to the investigators (n=55)). When the full-text article was not available, the abstract was used, and additional information about the study was sought from article citations in the systematic reviews. The analysis was inclusive of all published literature, and included experimental and non-experimental study designs: no assessment of methodological quality was undertaken.

The integrative review involved summarising the individual studies according to the following predefined concepts:

- risk factors for enrolment,
- profession of visitor
- program parameters
  - time of commencement
  - program content
  - intensity
  - duration
- program outcomes.

The information regarding the type of study, country of study, and the concepts of interest were coded and recorded in a spreadsheet (MS Excel). This information was then imported into statistical software (SPSS) for descriptive analysis, with the aim of describing the relationship between risk factors, program parameters and outcomes, rather than meta-analysis of the effects of home visiting.

Relationships in the data are described as patterns of differences rather than in terms of statistical significance for two reasons. Firstly, many of the data were multiple response and thus not amenable to statistical analysis, and, secondly, the limitations in the information provided in the articles makes statistical inference beyond the scope of this integrative analysis. Nevertheless, the analysis provided can usefully detect patterns in the characteristics of the home visiting programs reported in the literature that are useful for developing an understanding of the components of home visiting and their relationship with outcomes.

1.3 Limitations of the review

There are a number of limitations to be considered when interpreting the results of this review. Firstly, it was not possible to source every article. When the article was not available, coding was based on the information in the article abstract and/or on information about the article included in recent meta-analyses and systematic reviews. Furthermore, the information provided in the abstract/article rarely included an extensive description of the intervention undertaken, nor was evidence provided regarding the fidelity of the intervention. That is, there was no evidence that the program content was delivered to the participants.

Secondly, the review was limited to studies reported in the peer-reviewed academic literature. It is likely that many other home visiting programs have not published results in the academic literature. Thus, this review may not represent all types of home visiting programs. Indeed, other work undertaken at the Centre for Health Equity Training Research and Evaluation indicates that volunteer home visiting in particular is not often evaluated using standard quantitative outcome measures and rarely reported in the academic literature (Black and Kemp 2004).8

Finally, consideration must be given to publication bias, whereby positive results are more likely to be published than non-significant or negative results. Consequently, the programs and outcomes included in this review are unlikely to represent all outcomes of home visiting, but rather those measured quantitatively and where positive results are expected.

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1.4 Results
In total, 98 studies were reviewed, including 77 randomised controlled trials (RCT) and 21 non-RCT type studies. The studies included are detailed in Appendix B. Date of publication of the studies ranged from 1972 to 2003. The median number of clients in the study intervention groups was 78, with studies ranging from 9 to 1000 or more participants in the intervention group (Figure 1.4-1).

Figure 1.4-1 Number of participants in study intervention groups

1.4.1 Home visitors and their clients
This section describes the profession of the home visitors and the characteristics of their clients.

1.4.1.1 Who does home visiting
Home visiting was undertaken by a variety of professional and non-professional visitors (Table 1.4-1). The most common profession of the home visitor was nursing. Other professionals included teachers, psychologists, paediatric registrars and health visitors, or, in seven studies, a mix of professions. Studies of lay home visitors included volunteers and paid workers with no professional health/welfare/education training.

Table 1.4-1 Profession of home visitor

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>37</td>
<td>39.4</td>
</tr>
<tr>
<td>Other professional</td>
<td>45</td>
<td>47.9</td>
</tr>
<tr>
<td>Lay</td>
<td>12</td>
<td>12.8</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.0</td>
</tr>
</tbody>
</table>
1.4.1.2  Who gets visited

Differing studies recruited on the basis of differing criteria, or, in two thirds of the studies, multiple criteria. The most common entry criteria for a home visiting study was low socio-economic status (SES) (Table 1.4-2). In 22 of these studies, low SES was combined with race and/or teenaged mother and/or unmarried mother criteria. Few studies targeted those with drug use or families where the child was identified as at risk of abuse or neglect.

There was no pattern of difference in the types of families visited by nurse or other professionals. Although there were only a small number of studies that used lay visitors, lay visitors did not visit families at risk of abuse or neglect, mothers with postnatal depression or those with drug use.

Table 1.4-2 Entry criteria for clients in the studies

<table>
<thead>
<tr>
<th>Entry criteria</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal/family factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race (predominantly US African)</td>
<td>20</td>
<td>22.2</td>
</tr>
<tr>
<td>Low SES</td>
<td>42</td>
<td>46.7</td>
</tr>
<tr>
<td>Teenage mother</td>
<td>12</td>
<td>13.3</td>
</tr>
<tr>
<td>Unmarried mother</td>
<td>9</td>
<td>10.0</td>
</tr>
<tr>
<td>Primipara</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>At risk of abuse/neglect</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Postnatal depression</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Drug user</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Other maternal characteristic</td>
<td>9</td>
<td>10.0</td>
</tr>
<tr>
<td>Child factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-term or low birth weight</td>
<td>9</td>
<td>10.0</td>
</tr>
<tr>
<td>Failure to thrive</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>Other child characteristic</td>
<td>12</td>
<td>13.3</td>
</tr>
<tr>
<td>Other characteristic</td>
<td>16</td>
<td>17.8</td>
</tr>
<tr>
<td>Total*</td>
<td>150</td>
<td>166.7</td>
</tr>
</tbody>
</table>

*Adds to more than 100% as each study could have multiple entry criteria

1.4.2  Home visiting interventions

This section details the content, timing, intensity and duration of home visiting programs described in the literature.

1.4.2.1  What do they do

Generally, it was difficult to ascertain the content of the programs from the brief descriptions included in the published literature, and the specific content of the home visit was not often detailed. Nevertheless, where possible the content of the programs was classified into seven main type of intervention: counselling or psychological support; problem solving; child development; social support; parenting skills; parent-infant interaction; and provision of resources, including information, equipment (such as safety equipment or books), and linking into community resources.
The most common program content was providing resources (Table 1.4-3). Programs commonly included more than one content area. There was no pattern of difference in the content of programs undertaken by nurse, other professional or lay visitors.

Table 1.4-3 Content of programs

<table>
<thead>
<tr>
<th>Program content</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling or psychological support</td>
<td>24</td>
<td>27.0</td>
</tr>
<tr>
<td>Problem solving</td>
<td>18</td>
<td>20.2</td>
</tr>
<tr>
<td>Child development</td>
<td>33</td>
<td>37.1</td>
</tr>
<tr>
<td>Social support</td>
<td>22</td>
<td>24.7</td>
</tr>
<tr>
<td>Parenting skills</td>
<td>40</td>
<td>44.9</td>
</tr>
<tr>
<td>Parent-infant interaction</td>
<td>13</td>
<td>14.6</td>
</tr>
<tr>
<td>Resource</td>
<td>73</td>
<td>82.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>223</td>
<td>250.6</td>
</tr>
</tbody>
</table>

* Total adds to more than 100% are could have more than one content area

1.4.2.2 What is done to whom

There were some patterns of differences in the content of programs provided for families with differing risk factors or vulnerabilities (Table 1.4-4). For example, teenaged mothers received programs with a greater concentration on parenting skills, whilst mothers with postnatal depression received programs concentrating on counselling or psychological support. There was no pattern of difference in the content of programs for differing child risk factors.
Table 1.4-4 Content of programs received by families with differing maternal risk factors or vulnerabilities (as determined by entry criteria)

<table>
<thead>
<tr>
<th>Program content</th>
<th>Race</th>
<th>Low SES</th>
<th>Teenage</th>
<th>Unmarried</th>
<th>Primipara</th>
<th>At risk of abuse</th>
<th>PND</th>
<th>Drug</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Counselling</td>
<td>7</td>
<td>36.8</td>
<td>10</td>
<td>27.8</td>
<td>2</td>
<td>18.2</td>
<td>1</td>
<td>12.5</td>
<td>1</td>
</tr>
<tr>
<td>Problem solving</td>
<td>7</td>
<td>36.8</td>
<td>6</td>
<td>16.7</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>12.5</td>
<td>1</td>
</tr>
<tr>
<td>Child development</td>
<td>7</td>
<td>36.8</td>
<td>11</td>
<td>30.6</td>
<td>4</td>
<td>36.4</td>
<td>3</td>
<td>37.5</td>
<td>1</td>
</tr>
<tr>
<td>Social support</td>
<td>7</td>
<td>36.8</td>
<td>15</td>
<td>41.7</td>
<td>3</td>
<td>27.3</td>
<td>4</td>
<td>50.0</td>
<td>2</td>
</tr>
<tr>
<td>Parenting skills</td>
<td>11</td>
<td>57.9</td>
<td>20</td>
<td>55.6</td>
<td>7</td>
<td>63.6</td>
<td>6</td>
<td>75.0</td>
<td>1</td>
</tr>
<tr>
<td>Parent infant interaction</td>
<td>7</td>
<td>36.8</td>
<td>8</td>
<td>22.2</td>
<td>3</td>
<td>27.3</td>
<td>2</td>
<td>25.0</td>
<td>1</td>
</tr>
<tr>
<td>Resource</td>
<td>14</td>
<td>73.7</td>
<td>30</td>
<td>83.3</td>
<td>9</td>
<td>81.8</td>
<td>8</td>
<td>100</td>
<td>2</td>
</tr>
</tbody>
</table>

*Adds to more than 100% as each study could have multiple entry criteria and multiple program content*
1.4.2.3 Antenatal and postnatal home visiting

Most (n=56, 74.7%) of programs in the literature commenced postnatally. Only 19 programs commenced antenatally. There was no pattern of difference in whether programs commenced ante- or postnatally according to the profession of the visitor (Table 1.4-5). Home visiting programs were more likely to commence antenatally for mothers/families where the entry criteria for the program was being a teen, unmarried or first-time mother (primipara) (Table 1.4-6). Programs containing social support intervention were more likely to commence in the antenatal period (Table 1.4-7).

Table 1.4-5 Ante- and postnatal home visiting by profession of visitor

<table>
<thead>
<tr>
<th>Commencement</th>
<th>Nurse</th>
<th>Other professional</th>
<th>Lay</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Antenatal</td>
<td>6</td>
<td>22.2</td>
<td>11</td>
<td>32.4</td>
</tr>
<tr>
<td>Postnatal</td>
<td>21</td>
<td>77.8</td>
<td>23</td>
<td>67.6</td>
</tr>
</tbody>
</table>

Table 1.4-6 Ante- and postnatal home visiting by maternal/family entry criteria

<table>
<thead>
<tr>
<th>Maternal/family entry criteria</th>
<th>Antenatal</th>
<th>Postnatal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%*</td>
</tr>
<tr>
<td>Race</td>
<td>4</td>
<td>40.0</td>
</tr>
<tr>
<td>Low SES</td>
<td>12</td>
<td>44.4</td>
</tr>
<tr>
<td>Teenage mother</td>
<td>6</td>
<td>54.5</td>
</tr>
<tr>
<td>Unmarried mother</td>
<td>7</td>
<td>87.5</td>
</tr>
<tr>
<td>Primipara</td>
<td>2</td>
<td>66.7</td>
</tr>
<tr>
<td>At risk of abuse/neglect</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td>Postnatal depression</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Drug user</td>
<td>1</td>
<td>100.0</td>
</tr>
<tr>
<td>Other maternal characteristic</td>
<td>4</td>
<td>57.1</td>
</tr>
</tbody>
</table>

*Row percentage

Table 1.4-7 Ante- and postnatal home visiting by content of program

<table>
<thead>
<tr>
<th>Program content</th>
<th>Antenatal</th>
<th>Postnatal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%*</td>
</tr>
<tr>
<td>Counselling</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>Problem solving</td>
<td>4</td>
<td>40.0</td>
</tr>
<tr>
<td>Child development</td>
<td>8</td>
<td>28.6</td>
</tr>
<tr>
<td>Social support</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td>Parenting skills</td>
<td>13</td>
<td>43.3</td>
</tr>
<tr>
<td>Parent infant interaction</td>
<td>3</td>
<td>42.9</td>
</tr>
<tr>
<td>Resource</td>
<td>16</td>
<td>25.8</td>
</tr>
</tbody>
</table>

*Row percentage
1.4.2.4 Intensity and duration of programs

The mean number of visits for the programs described in the literature was 20 visits (range 1-156 visits; Figure 1.4-2) over an average of 16 months (range 1-36 months; Figure 1.4-3). There was no pattern of difference in the number of visits or the duration of the program provided by nurse, other professional or lay visitors.

Figure 1.4-2 Number of visits

The intensity and duration of programs varied by the program content (Table 1.4-8). For example, counselling programs averaged monthly visits over a year, whereas problem solving interventions averaged weekly-fortnightly visits over 15-16 months.

Table 1.4-8 Intensity and duration of visiting by content of program

<table>
<thead>
<tr>
<th>Program content</th>
<th>Intensity (no of visits)</th>
<th>Duration (months of visiting)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Mean</td>
</tr>
<tr>
<td>Counselling</td>
<td>13.5</td>
<td>11.5</td>
</tr>
<tr>
<td>Problem solving</td>
<td>39.1</td>
<td>15.6</td>
</tr>
<tr>
<td>Child development</td>
<td>29.8</td>
<td>18.8</td>
</tr>
<tr>
<td>Social support</td>
<td>26.3</td>
<td>13.9</td>
</tr>
<tr>
<td>Parenting skills</td>
<td>19.2</td>
<td>14.2</td>
</tr>
<tr>
<td>Parent infant interaction</td>
<td>17.6</td>
<td>9.4</td>
</tr>
<tr>
<td>Resource</td>
<td>21.5</td>
<td>15.4</td>
</tr>
</tbody>
</table>
1.4.3 Outcomes of home visiting

This section describes the outcomes measures reported in the home visiting literature studied. It should be noted that these outcome measures may not represent all the outcomes measured in each published study, but rather, those that were reported. The impact of reporting bias, where positive results are more likely to be published than negative results, should be considered. It should also be noted that this section describes the quantitatively measured outcomes reported primarily in randomised controlled trials and other experimental designs, and not qualitative outcomes of home visiting.

1.4.3.1 What outcomes do they measure

The home visiting studies evaluated reported a number of different outcomes. Table 1.4-9 details the number of studies showing a significant positive outcome and those showing no significant positive outcomes for outcomes reported in at least five of the publications assessed. The most commonly reported outcome was the home environment (using the HOME inventory and other measures of environment including safety). Child behaviour was also commonly reported. Other less commonly reported outcomes included outcomes such as gap between pregnancies and introduction of solids. On average, each study reported 2-3 outcomes.

Outcomes more likely to be reported as significantly positive, rather than non-significant include the home environment, child behaviour, maternal depression/self-esteem, child health, breast feeding and less risky behaviour. On balance, non-significant results were more likely to be reported for child mental development, and uptake of preventive services.
Table 1.4-9 Home visiting outcomes

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Significant positive outcome (S)</th>
<th>No significant positive outcome (NS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment (HOME)</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Environment (other)</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>Child behaviour</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Child mental development</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Immunisation</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Uptake of preventive services</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Use of acute care</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Maternal depression/self-esteem</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Child health</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Social support</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Breast feeding</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Less risky behaviour</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Total*</td>
<td>117</td>
<td>81</td>
</tr>
</tbody>
</table>

* Total adds to more than 100% as each study could measure more than one outcome

Overall, on balance, studies of programs of visiting by other professionals reported a greater number of significant positive outcomes (n=50) versus non-significant outcomes (n=27) (Table 1.4-10). However, whilst there were no patterns of difference in the content of reported programs according to the profession of the visitor, nurse home visiting programs reported significant positive outcomes across a broader range of measures. In particular, significantly positive outcomes in use of acute care, child health and breastfeeding were more commonly reported for nurse home visiting. Positive outcomes in child behaviour and maternal depression/self-esteem were reported for home visiting by other professionals, specifically psychologists providing very targeted programs for children and families with mental health and child behavioural risk factors.

1.4.3.2 What benefit for what intensity and duration

The intensity and duration of visits varied greatly between studies. As a consequence there were no patterns of difference in the average intensity and duration of program related to the outcomes measured. Nevertheless, overall the trend was for studies showing significant positive outcomes to include a greater number of visits over a longer duration, with the exception of studies reporting significantly positive outcomes in the environment and maternal depression/self esteem (Table 1.4-11). These specific positive outcome studies tended to include fewer visits over a shorter duration.

There was no pattern of difference in the age of child at measurement of outcomes between studies showing significant positive outcomes and those that did not (Table 1.4-11).

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9 It should be noted that the studies of home visiting by lay persons were more likely to be qualitative or non-experimental in nature and thus did not report on many of the quantitative outcomes considered here.
However, studies showing significant positive outcomes for child behaviour, social support and less risky behaviour tended to measure these outcomes when children were older, whilst studies measuring maternal depression, home environment, child mental development and immunisation outcomes reported significant positive outcome when the child was younger.

Table 1.4-10 Significant positive and non-significant outcomes by profession of home visitor

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Nurse</th>
<th>Other professional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S*</td>
<td>NS*</td>
</tr>
<tr>
<td>Environment (HOME)</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Environment (other)</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Child behaviour</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Child mental development</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Immunisation</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Uptake of preventive services</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Use of acute care</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Maternal depression/self-esteem</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Child health</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Social support</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Breast feeding</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Less risky behaviour</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>42</td>
</tr>
</tbody>
</table>

* S = number of studies reporting significant positive outcome
* NS = number of studies reporting no significant positive outcome

Table 1.4-11 Significant positive and non-significant outcomes by intensity and duration of visiting, and child age at final measurement

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Intensity (no of visits)</th>
<th>Duration (months of visiting)</th>
<th>Evaluation (age of child in months)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S*</td>
<td>NS*</td>
<td>S*</td>
</tr>
<tr>
<td>Environment (HOME)</td>
<td>17.5</td>
<td>52.4</td>
<td>13.8</td>
</tr>
<tr>
<td>Environment (other)</td>
<td>20.8</td>
<td>35.3</td>
<td>15.7</td>
</tr>
<tr>
<td>Child behaviour</td>
<td>18.4</td>
<td>16.8</td>
<td>15.8</td>
</tr>
<tr>
<td>Child mental development</td>
<td>37.1</td>
<td>19.3</td>
<td>17.8</td>
</tr>
<tr>
<td>Immunisation</td>
<td>12.9</td>
<td>12.0</td>
<td>12.2</td>
</tr>
<tr>
<td>Uptake of preventive services</td>
<td>20.5</td>
<td>13.6</td>
<td>17.0</td>
</tr>
<tr>
<td>Use of acute care</td>
<td>18.2</td>
<td>17.6</td>
<td>19.2</td>
</tr>
<tr>
<td>Maternal depression/self-esteem</td>
<td>11.5</td>
<td>21.9</td>
<td>9.4</td>
</tr>
<tr>
<td>Child health</td>
<td>16.4</td>
<td>2.0</td>
<td>18.0</td>
</tr>
<tr>
<td>Social support</td>
<td>20.5</td>
<td>14.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Breast feeding</td>
<td>12.8</td>
<td>2.0</td>
<td>19.2</td>
</tr>
<tr>
<td>Less risky behaviour</td>
<td>23.8</td>
<td>15.7</td>
<td>21.9</td>
</tr>
</tbody>
</table>

* S = mean for studies reporting significant positive outcome
* NS = mean for studies reporting no significant positive outcome
1.4.3.3 What benefit for ante- versus postnatal commencement

On balance, programs that commenced antenatally reported a greater number of significant positive outcomes (n=39) versus non-significant outcomes (n=25), than did studies commencing postnatally (Table 1.4-12). In particular, studies of child behaviour and less risky behaviour showed positive outcomes when commencing antenatally, whilst studies of maternal depression/self esteem showed positive outcomes when commencing postnatally.

Table 1.4-12 Significant positive and non-significant outcomes by ante- and postnatal commencement

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Antenatal commencement</th>
<th>Postnatal commencement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S*</td>
<td>NS*</td>
</tr>
<tr>
<td>Environment (HOME)</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Environment (other)</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Child behaviour</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Child mental development</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Immunisation</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Uptake of preventive services</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Use of acute care</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Maternal depression/ self-esteem</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Child health</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Social support</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Breast feeding</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Less risky behaviour</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>25</td>
</tr>
</tbody>
</table>

* S = number of studies reporting significant positive outcome
* NS = number of studies reporting no significant positive outcome

1.4.3.4 What benefit for what mothers

Mothers recruited into the programs on the basis of race or low socio-economic status (SES) were likely to show significant positive outcomes, more-so than non-significant outcomes (65 reports of significant positive outcomes vs 36 reports of non-significant outcomes) particularly on measures of child behaviour, child health and the home environment (Table 1.4-13). Programs targeted to women with postnatal depression also showed positive outcomes specifically in maternal depression/self-esteem. The evidence for significant positive outcomes, rather than non-significant outcomes, is less clear for teenaged and unmarried mothers. The small number of studies of mothers/families at risk of abusing or neglecting their child and maternal drug users were unlikely to report significantly positive outcomes.
1.4.3.5 What benefit for what intervention

Programs that included child development, parenting skills, parent infant interaction and resource provision interventions were likely to report a higher number of significant positive, rather than non-significant results, on outcomes measures, particularly the home environment and maternal depression (for counselling interventions), child behaviour (for child development, parenting skill and resource interventions) (Table 1.4-14). There is less evidence of significant positive outcomes for problem solving, social support and parent-infant interaction interventions, except in the area of maternal depression/self esteem (for problem solving and parent-infant interaction interventions) and child health (for social support interventions).
Table 1.4-13 Significant positive and non-significant outcomes by maternal/family entry criteria

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Race</th>
<th>Low SES</th>
<th>Teenage</th>
<th>Unmarried</th>
<th>Primipara</th>
<th>At risk of abuse</th>
<th>PND</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S*</td>
<td>NS*</td>
<td>S*</td>
<td>NS*</td>
<td>S*</td>
<td>NS*</td>
<td>S</td>
<td>NS</td>
</tr>
<tr>
<td>Environment (HOME)</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Environment (other)</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
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* S = number of studies reporting significant positive outcome  
* NS = number of studies reporting no significant positive outcome
<table>
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<th>Outcome measure</th>
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<td>NS</td>
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<td>1</td>
<td>6</td>
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<td>2</td>
<td>1</td>
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<td>1</td>
</tr>
<tr>
<td>Breast feeding</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
</tr>
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<td>Less risky behaviour</td>
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<td>3</td>
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<td>30</td>
<td>22</td>
<td>19</td>
<td>43</td>
<td>32</td>
<td>20</td>
</tr>
</tbody>
</table>

* S = number of studies reporting significant positive outcome
* NS = number of studies reporting no significant positive outcome
1.5 Discussion

Home visiting was undertaken by a range of professional and lay visitors. The single largest professional group was nurses, however, there were more studies reporting visiting by other professionals, including social workers, psychologists, health educators, research assistants, and/or mixes of professional groups within the one program. Very few studies of lay and/or volunteer home visiting were reported in the academic literature.

Most home visiting studies were targeted at specific ‘at-risk’ individuals. Maternal and child related factors shown to place children at risk of poor health or developmental outcomes that have been targeted include mothers who were of low socioeconomic status, unmarried, being African American (in US trials), isolated or lacking social support, experiencing postnatal depression, or using drugs; infants who were pre-term, low birth weight or failing to thrive, or toddlers with difficult behaviour or sleep problems.

The content of the home visiting programs could be categorised into seven types. The most common content area was the provision of resources, which included direct provision of information or resources as well as indirect provision through referral and linking into other services. Parenting skills and child development were also common content areas. There was evidence of some program content being tailored to differing at risk groups, for example, young, unmarried women were more likely to receive a program that included parenting skills.

Most home visiting programs reported in the literature commenced postnatally. Programs were more likely to commence antenatally for mothers from clearly defined population subgroups, such as teen mothers, or first-time mothers. The average home visiting program reported in the literature provided 20 home visits over 16 months, however, there was great variation, from single visits to provide safety information, to long term (3 year) programs with over 50 visits.

There is ongoing debate regarding the groups most likely to benefit from varying home visiting programs. According to the draft NSW Health Home Visiting Guidelines, mothers who are young, lacking social support or experiencing financial stress, and child related risk factors make the family ‘vulnerable’, requiring a prevention and early intervention support response. Mothers with multiple risks, or those with more complex problems such as mental health problems, substance misuse, domestic violence or child abuse have ‘complex’ needs, requiring a specialist and continuing support response.

The evidence from the literature analysis would suggest that low socioeconomic status (SES) women were the group reported to have most benefit from the home visiting presented in the literature, particularly in child behaviour, and report the highest ratio of positive to non-significant outcomes. It should be noted, however, that multiple entry criteria were possible for each study, and half of the studies of low SES women included additional criteria for entry, most commonly race and/or teenage mother and/or unmarried mother: population groups more likely to be of low SES. Studies targeted at women with postnatal depression also showed positive outcomes.
specifically in maternal depression/self-esteem. The small number of studies of very complex needs families with drug use and children at risk of abuse and neglect showed few significant positive outcomes in these studies. The three groups showing the highest ratio of positive to non-significant outcomes were those entered into programs on the basis of race\textsuperscript{10}, low socioeconomic status and mothers with postnatal depression (Table 1.5-1).

Table 1.5-1 Ratio of significant positive to non-significant outcomes for differing at-risk groups

<table>
<thead>
<tr>
<th>Entry criteria</th>
<th>S*</th>
<th>NS*</th>
<th>Ratio*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postnatal depression</td>
<td>6</td>
<td>1</td>
<td>6.00:1</td>
</tr>
<tr>
<td>Race</td>
<td>31</td>
<td>17</td>
<td>1.82:1</td>
</tr>
<tr>
<td>Low SES</td>
<td>65</td>
<td>36</td>
<td>1.81:1</td>
</tr>
<tr>
<td>Teenaged</td>
<td>17</td>
<td>14</td>
<td>1.21:1</td>
</tr>
<tr>
<td>Primipara</td>
<td>7</td>
<td>6</td>
<td>1.17:1</td>
</tr>
<tr>
<td>Unmarried</td>
<td>16</td>
<td>15</td>
<td>1.07:1</td>
</tr>
<tr>
<td>Drug use</td>
<td>2</td>
<td>3</td>
<td>0.67:1</td>
</tr>
<tr>
<td>At risk of abuse</td>
<td>3</td>
<td>12</td>
<td>0.25:1</td>
</tr>
</tbody>
</table>

* S = number of studies reporting significant positive outcome
* NS = number of studies reporting no significant positive outcome
* Ratio of significant positive outcomes to non-significant outcomes. A higher ratio indicates a proportionally greater number of reports of positive outcomes.

Variations in impact of home visiting programs have been reported.\textsuperscript{11} Studies to date have varied in the timing of the commencement of home visiting and the content. Most studies analysed here commenced postnatally, however, the ratio of positive to non-significant outcomes was higher for those programs that commenced antenatally (1.56 significant positive n=39 : 1.00 non-significant outcomes n=25) compared with those commencing postnatally (1.15 significant positive n=52 : 1.00 non-significant outcomes n=45).

The interventions more likely to give positive outcomes are those commencing antenatally, and those providing parenting skills, resourcing parents, and encouraging parent-infant interaction. Positive outcomes were also achieved from interventions focussing on child development, providing counselling and problem solving. Interventions focussed on social support were less likely to report positive outcomes (Table 1.5-2).

The evidence from this literature analysis would suggest that, in the Australian context, positive outcomes are most likely to be gained from home visiting interventions with mothers from low socioeconomic groups, some of which may be identified on the basis of membership of a population group such as teenaged or unmarried mothers, or by race. Some benefit may also be gained from a focus on first-

\textsuperscript{10} Predominantly US studies of African American families
time mothers. Highly targeted programs for mothers with postnatal depression also achieve positive outcomes in maternal depression/self-esteem.

Table 1.5-2 Ratio of significant positive to non-significant outcomes for differing program content

<table>
<thead>
<tr>
<th>Program content</th>
<th>S*</th>
<th>NS*</th>
<th>Ratio*</th>
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<tr>
<td>Parenting skills</td>
<td>58</td>
<td>33</td>
<td>1.76:1</td>
</tr>
<tr>
<td>Resource</td>
<td>100</td>
<td>63</td>
<td>1.59:1</td>
</tr>
<tr>
<td>Parent-infant interaction</td>
<td>20</td>
<td>13</td>
<td>1.54:1</td>
</tr>
<tr>
<td>Child development</td>
<td>43</td>
<td>32</td>
<td>1.34:1</td>
</tr>
<tr>
<td>Problem solving</td>
<td>22</td>
<td>19</td>
<td>1.15:1</td>
</tr>
<tr>
<td>Counselling</td>
<td>33</td>
<td>30</td>
<td>1.10:1</td>
</tr>
<tr>
<td>Social support</td>
<td>20</td>
<td>23</td>
<td>0.87:1</td>
</tr>
</tbody>
</table>

* S = number of studies reporting significant positive outcome
* NS = number of studies reporting no significant positive outcome
* Ratio of significant positive outcomes to non-significant outcomes. A higher ratio indicates a proportionally greater number of reports of positive outcomes.

Interventions reported in the literature have focused on up to 4 of the following elements: counselling; problem solving; child development; social support; parenting skills; parent-child interaction; and resource utilisation. Most of the studies reported in Elkan’s systematic review12 focused on just one element, for example, providing only counselling, or developing parenting skills. Some combined 2 elements, with a smaller number combining 3 or 4. Evidence from systematic reviews suggests that, whilst relationship building and social support are necessary for the success of home visiting, they are not sufficient to change parent behaviour.6 13 14

The evidence from the literature analysis undertaken here supports the assertion from the systematic reviews that social support is not sufficient. Indeed, the total number of studies reporting a non-significant result from social support was greater than those reporting significant positive outcomes for the outcomes studied here. Programs which included child development, parenting skills, parent-infant interaction and resource utilisation and provision had a higher ratio of significant positive to non-significant outcomes for the outcomes reviewed.

Section 2: Empirical study in South Western Sydney

2.1 Aim

The aim of the empirical study is to increase our understanding of how early childhood home visiting programs operate in the South Western Sydney (SWS) area by answering the following questions;

- What are the aims and approach to service of early childhood home visiting programs operating in SWS?
- What does home visiting offer as an early childhood intervention/prevention service?
- What influences the success of early childhood home visiting programs in SWS?
- What types of outcomes are achieved by early childhood home visiting services?

2.2 Methods

Data collection for this study occurred in three stages using three different data collection methods. A program audit was carried out in the first stage, followed by telephone interviews in the second stage, then focus groups in the final stage. This section outlines methods and response rates.

2.2.1 Stage One Audit

Using a snowballing technique, the audit was undertaken to identify and gather baseline data on early childhood home visiting programs operating in the South Western Sydney (SWS) area. A letter was devised to explain the purpose of the study and to request information on any other known home visiting programs in the area. This was attached to a short questionnaire of general service questions for program managers to complete and mail back (Appendix D). A total of forty-five programs were contacted.

Upon learning about various services that offer some component of home visiting, it was determined that only those services that maintain home visiting programs and regularly carry out home visiting to families with young children were to be included in the remainder of the study. Hence services that only carry out the occasional home visit were excluded from this study. Programs that were included did not have to exclusively target families with young children, but had to include them in their overall program scope.

2.2.2 Stage Two Telephone Interviews

In the second stage of data collection, we expected to gain an in-depth account of the various components of home visiting program service delivery. To do this, managers
(coordinators) of the 29 home visiting programs identified in Stage One, were mailed letters to gain their participation in Stage Two. Twenty-seven programs participated in Stage Two. We have incorporated the audit results obtained from the two programs that dropped out in Stage Two, in the results presented in Section 2.4.

The general areas that these programs work in include; health (5), family/parent support (14), intensive family/social support (5), drug rehabilitation (2), child disabilities (2), and education (2). Three of these programs carry out volunteer home visiting, one is an aboriginal service and three focus on non-English speaking populations.

Data collection involved a thirty-minute telephone interview and the completion of a target group checklist. Attached to the letter was a list of the questions to be covered during the interview, along with the checklist of groups and issues for managers to complete (Appendix E). The interview questionnaires were based on the results from the audit, analysis of literature and feedback from the working group. Notes were taken during the interview.

### 2.2.3 Stage Three Focus Groups

For the final stage, we were interested in delving into the intricacies of home visiting from the perspective of home visitors. Focus groups were held with visitors from three different types of home visiting services. These were health home visiting, family support and intensive family support. Each home visitor was asked in advanced to bring an interesting case (with no confidential details), which was used as a platform to probe for details about the nature of home visits. Questions asked during the focus group were also influenced by the data collected in Stage Two.

Due to a few difficulties encountered in arranging a focus group with a volunteer home visiting service, we were unable to include the type of service in the final data collection stage of our study. Nevertheless, a concurrent program evaluation being undertaken with Karitane’s home visiting program provided insights to assist the development of the generic evaluation and planning framework.

The focus groups were recorded on audiotape, and notes were taken during the session. The audiotape for the first focus group was transcribed verbatim. For the remaining focus groups, the notes taken during the session were enhanced by listening to the audiotape.

### 2.2.4 Analysis

Descriptive analysis (frequencies) was undertaken on the quantitative data collected in Stages One and Two, using the Statistical Package for the Social Sciences (SPSS). In addition, lists of service models, strategies, evaluation tools and supplementary activities were compiled. Qualitative data analysis software (QSR NVivo) was used to assist in compilation of the listings. Data were then analysed for each category of home visiting programs (see section 2.3).
Qualitative data gathered during Stages Two and Three were analysed using thematic analysis.\textsuperscript{15} Thematic analysis focuses on identifiable themes and patterns. Themes were listed from the transcribed telephone interviews and audiotapes of focus groups. Themes developed either from direct quotes or paraphrasing common ideas. The next step in the thematic analysis was to identify all data that related to the identified themes. Additional themes were identified as further interviews and focus groups were analysed. When new themes were identified, previously analysed interview notes and audiotapes were revisited to identify data relating to the new themes. The final step to the thematic analysis was to combine and catalogue related themes together into thematic groupings. A computerised spreadsheet (MS Excel) was used to assist in recording the themes in each interview and focus group, and identify groupings in the themes and patterns in the data.

\section*{2.3 Program categorisation}

In order to synthesise and describe the large number of home visiting programs in South Western Sydney it was necessary to categorise them. We developed our categories, by drawing on Guterman’s assertion that home visiting programs can be differentiated based on how clients are enrolled in programs and combined this with the public health prevention model.\textsuperscript{16} The three categories that programs in the study will fall under have been labelled, \textit{Primary}, \textit{Secondary} and \textit{Tertiary}.

\textbf{Primary}

Services that offer universal home visiting programs mostly focus on primary prevention/intervention, aiming to prevent individuals from falling into risk and to enhance existing protective factors. These programs identify and enrol individuals from defined geographical and demographic populations or subpopulations, providing universal access to specific populations, for example, all mothers of newborn children or aboriginal communities. Although there is a prevention focus, some of these programs will also provide early intervention through sustained home visiting if risk and vulnerability factors are identified. In such cases, the program could be considered to be offering both a primary and a secondary service.

\textbf{Secondary}

Programs that fall under this category have universal properties, in the sense that they work within defined populations. They are considered to be targeted however, as enrolment is based on specific individual demographic risk and vulnerability factors, that is, where a vulnerability to poor maternal and/or child outcomes has been identified (the ‘at-risk’), for example, teenage mothers, unsupported mothers or low socio-economic status. The aim of these programs is to intervene early to prevent and minimise risk through the provision of support and assistance. Volunteer home visiting and sustained nurse home visiting are types of programs that fall under this category.

\begin{flushleft}

\end{flushleft}
**Tertiary**
These programs actively screen and enrol individuals based on the presence of certain demographic risk markers and individual psychosocial risk and vulnerability factors, that is, working with groups with identified existing problems (the ‘in risk’), for example, substance abuse or child disability. Tertiary programs maintain a reactive approach to existing problems, aiming to reduce harm and the re-occurrence of problems.

### 2.4 What are the aims and approaches of early childhood home visiting programs operating in SWS?

The results in this section are based on the audit and telephone interviews, which were analysed using quantitative and descriptive approaches.

The results have been divided into two parts to illustrate the aims and approach of service for primary, secondary and tertiary early childhood home visiting programs. These two parts are:

- Target groups
- Service components

#### 2.4.1 Target groups

##### 2.4.1.1 Age of child

A number of programs focussed on the antenatal to 3 age range (29%). Overall it appears that children between the ages of 0 and 5 are serviced the most by home visiting programs (Figure 2.4-1). Only 15% of programs specifically target children beyond the early childhood ages. These children may however, be addressed by the 38% of services that provide home visiting programs up to or beyond 8 years of age.

Figure 2.4-1 Age Range of Children Targeted by Home Visiting Programs (n=27)
Primary

All primary home visiting programs offer antenatal home visiting (Figure 2.4-2). The majority of programs service children up until the age of 3 (66%). It’s important to keep in mind that those programs that indicated that they service children beyond this age, also offer sustained home visiting.

Figure 2.4-2 Age Range of Children Targeted by Primary Home Visiting Programs (n=6)

Secondary

The age range that is targeted most by secondary home visiting programs is between antenatal and 5 years old (28%) (Figure 2.4-3). Yet again, like primary programs, we can see that the age range most serviced is between 0-3 (46%).

Figure 2.4-3 Age Range of Children Targeted by Secondary Home Visiting Programs (n=15)
**Tertiary**

The majority of tertiary home visiting programs will service children at least up until the age of 8 (83%) (Figure 2.4-4).

![Figure 2.4-4 Age Range of Children Targeted by Tertiary Home Visiting Programs (n=6)](image)

2.4.1.2 **Risk and vulnerability factors**

We devised a checklist (see Appendix D) to inform us about the particular groups and risk and vulnerability factors that were targeted by home visiting programs. Managers were asked to disclose the degree to which these groups and issues were actually being addressed, rather than what was stipulated in the official mandate of the service. The checklist allowed them to place each item under the categories of, major focus, general focus, little focus and excluded.

Isolation (74%) was the most addressed factor. Adjustment to parenting, (55%), was also a fairly high area of focus amongst these programs. About 40% of home visiting programs targeted families involved with the Department of Community Services (DOCS) and experiencing child protection issues as a major focus.

We have presented the results by primary, secondary and tertiary services below.

**Primary**

Late antenatal care (80%) was considered by the majority of primary programs to be an area of major focus, along with isolation issues (80%), those with mental health problems (80%) and those experiencing child protection issues (80%). Mothers under 19 and substance misuse also ranked high among 60% of services.

The issues/groups that came under little focus by most programs were, refugees (20%), partner unemployed (20%) and grief and loss associated with death (20%).
Two programs indicated that indigenous populations are of little focus. No risk factors are excluded from primary programs, with the exception of refugees and non-English speaking groups on the part of the Aboriginal primary service. All other factors were mentioned as a general focus.

**Secondary**

The majority of managers of secondary home visiting programs strongly felt that isolation (73%) and adjustment to parenting (66%) were major factors targeted by their programs.

Substance misuse (40%) and late antenatal care (26%) were mentioned most frequently under the category *little focus*. Mothers with substance abuse were *excluded* by 20% of secondary programs. Indigenous groups (33%) and those with refugee status (26%) were also regarded as groups least targeted. Other issues such as mental health, domestic violence, were checked under the *excluded* category by one or two programs.

Overall, a relatively low number of secondary programs placed these risk factors and groups under the categories of *little focus* or *excluded*. For the most part, all groups and factors were considered to be of *general focus*.

**Tertiary**

The majority of managers from tertiary programs indicated that the type of clients that they focussed on addressing were families known to the Department of Community Services (63%), experiencing child protection problems (63%) isolation (63%) and those who maintain unstable housing (50%).

Individuals with refugee status (63%) belong to the group least addressed by tertiary programs. Overall, with the exception of one program that excludes late antenatal care, no groups or risk factors are excluded from tertiary programs and mostly fall under general focus.

### 2.4.2 Service components

Based on the Stage Two telephone interviews, this section looks at the various components of home visiting programs identified by program managers (coordinators). Primary, secondary and tertiary home visiting programs are described below by the following categories:

- Staffing
- Program workload
- Models
- Strategies
- Schedules
- Evaluation tools
- Supplementary activities
2.4.2.1 Staffing

The majority of home visiting programs in our study maintain 2-4 home visiting staff (34%). Twenty-one percent of programs have 5-8 staff, while only a few programs have more than 10. (Figure 2.4-5).

Figure 2.4-5 Number of Home Visiting Staff by Home Visiting Programs (n=29)

Primary

Thirty-two percents of primary home visiting programs have between 12 and 14 home visitors (Figure 2.4-6). There appears to be a great range in the number of staff among these programs as 17% have only one home visitor and another 17% have up 30.

Figure 2.4-6 Number of Home Visiting Staff by Primary Home Visiting Programs (n=6)
Secondary

For secondary programs, about half maintain less than 4 staff on board, while the other half maintain between 5 and 11. (Figure 2.4-7).

Figure 2.4-7 Number of Home Visiting Staff by Secondary Home Visiting Programs (n=15)

Tertiary

The majority of tertiary home visiting programs have a small number of staff, in comparison to primary and secondary programs, as 74% have between 2-4 home visiting staff (Figure 2.4-8).

Figure 2.4-8 Number of Home Visiting Staff by Tertiary Home Visiting Programs (n=8)
2.4.2.2 Program workload

The average number of visits per week by all staff among and within the three categories of programs varies significantly, with more than half of the programs undertaking a total of 20 or fewer visits per week (Figure 2.4-9).

Figure 2.4-9 Average Number of Visits per Week by Home Visiting Programs (n=26)

![Pie chart showing distribution of visits per week.](image)

* 3 missing

**Primary**

The average number of visits carried out per week by most primary programs ranges between 5 and 10 (Figure 2.4-10). There is a stark contrast between these services however, as the average number of visits per week for other programs was well beyond 20

Figure 2.4-10 Average Number of Visits per Week by Primary Home Visiting Programs (n=6)

![Pie chart showing distribution of visits per week.](image)
**Secondary**

The average range of home visits carried out in a week by the majority of secondary programs is also 5-10 (Figure 2.4-11). Unlike primary programs, a lower percentage of secondary programs will undertake more than a total of 20 visits a week.

Figure 2.4-11 Average Number of Visits per Week by Secondary Home Visiting Programs (n=14)

* 1 missing

**Tertiary**

The average range of number of visits carried out by most tertiary services per week is higher than both primary and secondary programs. Thirty-two percent carry out between 11 and 20 visits (Figure 2.4-12) and only 17% of tertiary services carry out fewer than 4 visits per week.

Figure 2.4-12 Average Number of Visits per Week by Tertiary Home Visiting Programs (n=6)
2.4.2.3 Models

The majority of home visiting programs in our study offer a combination of home visiting and centre based activities (54%). Only 21% strictly offer home visiting (Figure 2.4-13) and very few (3%) offer mostly centre based services supplemented with home visiting.\(^{17}\)

Figure 2.4-13 Level of Home Visiting by Home Visiting Programs (n=29)

![Pie chart showing the distribution of home visiting programs: 52% Combination, 24% Mostly Home Visiting, 21% Mostly Centre Based, 3% Entirely Home Visiting.]

**Primary**

Sixty-seven percent of primary programs are considered to be a combination of home visiting and centre based activities, while 33% mostly offer home visiting (Figure 2.4-14).

Figure 2.4-14 Level of Home Visiting by Primary Home Visiting Programs (n=6)

![Pie chart showing the distribution of primary home visiting programs: 67% Combination, 33% Mostly Home Visiting.]

\(^{17}\) Note that services who were mostly centre based and undertaking occasional or ad hoc home visiting were not included in the study.
The managers of primary home visiting programs believe various models, philosophies and theories are used to inform program interventions. As all of the primary programs identified in this study operate under the health services of their respective local government areas, they all identified common mandated home visiting guidelines and philosophies set out by the NSW Department of Health and the NSW Department of Community Services’ Families First Initiative. The manager of the Aboriginal universal home visiting service added that models and guidelines specific to aboriginal populations were also used by their service.

Models and guidelines used by primary home visiting programs include:
- Hilton Davis partnership model
- Families First Home Visiting guidelines (Department of Community Services)
- Home health visiting guidelines (Department of Health)
- Blue Book for growth and development guidelines
- The World Health Organization’s Guidelines on breastfeeding
- The Western Australian Aboriginal Home Visiting Program
- The South Australian Aboriginal Home Visiting Program
- The Victoria Aboriginal Health Services Booklet
- Bibi lung Knarneep
- Early intervention model

Secondary

Similar to primary home visiting programs, the majority of secondary programs are a combination of home visiting and centre based activities, while the other half are mostly or entirely home visiting (47%) (Figure 2.4-15).

Two managers of secondary home visiting programs said that their programs are based on specific models. One of these models is Parents as Teachers, which was based on brain development research in the United States and the second is the Sustained Nurse Home Visiting model.

Figure 2.4-15 Level of Home Visiting by Secondary Home Visiting Programs (n=15)
Like primary home visiting programs, many secondary programs are guided by philosophies founded by Families First as well as Family Support. With the exception of two, secondary home visiting programs managers didn’t feel that their programs and interventions were modeled on specific theories.

The general opinion was that home visitors don’t strictly adhere to any particular model or theory to shape interventions but instead draw on several to meet specific client needs. As one program manager of a volunteer home visiting service emphasised,

“I have a problem with models because each case is unique. It’s difficult to conform to models. We have some knowledge of theories, but interventions are based on needs not theories.”

That being said, there was overall consensus among managers over the use of strength and solution based models/strategies to guide home visiting.

“A solution focused approach is used to determine client needs and goals and a strength based approach is drawn on to build on the clients own strengths and knowledge to help meet their needs.” (Secondary Service Manager)

“Through the assessment we find out their needs and develop a plan specifically designed for them.” (Secondary Service Manager)

“We build on the knowledge they have.” (Secondary Service Manager)

Two program managers however, said that their programs are based on specific models which are, Parents as Teachers and Sustained Nurse Home Visiting

Tertiary

Only 13% of tertiary programs are mostly centre based. A high number of tertiary programs are considered to be a combination of home visiting and centre based activities (37%) while half were mostly or entirely home visiting (Figure 2.4-16).

Managers of tertiary programs were generally in agreement with managers of secondary programs, in that, models and theories are applied when in need, rather than being used to shape the intervention from the start. Most of these managers also emphasised the use of strength and solution based models.

“It’s building, as opposed to trying to cure the deficits.” (Tertiary Service Manager)

Only one program offers home visiting based on a specific model called the Home Builders model. This is an intensive family support model, originally from the United States.

Models and guidelines used by tertiary home visiting programs include:

- Child stimulation model
- Case management model
Clientele Centred theory
Families First
Attachment theory
Crisis theory
Bruce Perry brain development theory
Gabrino
Daniel/Russell
Broom-Brenan

Figure 2.4-16 Level of Home Visiting by Tertiary Home Visiting Programs (n=6)

2.4.2.4 Strategies

In the first stage of our study, home visiting program managers were asked to identify three key strategies used by their respective home visiting programs. These strategies have been grouped into the seven categories that were identified in the literature review.

Counselling or psychological support
- Emotional support
- Addiction counselling
- Postnatal depression

Problem Solving
- Reducing crisis
- Vital life skills

Child development
- Clinical and developmental check-ups and assessments
- Working towards milestone achievements
Social Support
- Parent/family social and play groups
- Practical assistance

Parenting Skills
- Infant/child skills
- Educating on milestone goals

Parent-infant interaction
- Encouraging parent-child interaction
- Talking to parent about child

Resources
a) Information
b) Material assistance
c) Linking to community resources

The figure below (Figure 2.4-17) shows that parenting skills is the main strategy used by most programs. The other two strategies used often are social support, and assistance with resources.

Similarly, the home visiting services that were investigated in the literature review, also focus on resources and parenting skills. To add, both problem solving and parent-infant interaction ranked as the least used strategies in both our study and in the literature review.

Figure 2.4-17 Program Priorities of Early Childhood Home Visiting Programs in SWS

**Primary**

Interventions used by primary home visiting programs principally address specific health issues and concerns of mothers and their children. It was emphasised however
that due to the limited number of visits of universal home visiting programs, there is a large reliance on referrals for clients that needs further assistance. Some of the health services that offer universal home visiting do have the resources to provide sustained home visiting when risk factors that require more attention are identified in the universal visit. In response these services employ additional strategies to intervene. Interventions used by primary home visitors include:

- Baby checks/assessments
- Information on child health and development
- Information on women’s health
- Information on child developmental milestones
- Referrals to other services

Interventions also offered by sustained home visitors include:

- Goal setting
- Problem solving
- Advocacy
- Chatting (especially among aboriginal groups)
- Offering some counselling

**Secondary**

Three interventions mentioned repeatedly by managers of secondary programs were information provision, linking to community services/agencies, and building a strength-based relationship with the client. Others intervention used include:

- Modelling parent-infant interaction
- Linking to services and play groups
- Goal setting
- Identifying needs and assets
- Building on strengths (i.e. using St. Luke’s Strength Cards)
- Life skills
- Triple P
- Being supportive
- Psychosocial support (empowerment, self-esteem)
- Advocacy
- Accompanying to appointments

**Tertiary**

Interventions cited by tertiary service managers were fairly similar to those used by secondary programs. Those specific to tertiary programs however, were psychological counselling, speech therapy and physiotherapy. Additional interventions and strategies used by tertiary home visitors include:

- Prevention programs
- Increase information
- Psychological counselling
- Play based interventions-delivered through play and modelling
- Speech path
- Physiotherapist
• Modelling parent-infant interaction
• Advocacy
• Accompanying
• Linking to services and agencies
• Employing flexibility and perseverance

2.4.2.5 Schedule

Overall, most clients that are offered home visiting will receive between 1-2 home visits (30%) (Figure 2.4-18). A number of programs (22%) will offer additional visits that can range between 11 and 15. Only a few programs offer home visits in the higher range of thirty or more visits.

Figure 2.4-18 Average Number of Visits per Client by Home Visiting Programs (n=23)

* 6 missing

**Primary**

Primary services that provide the universal visits will attempt to see all mothers within the first two weeks a baby is born. One manager admitted however, that it sometimes takes 3-4 weeks before the mother and baby are seen due to low resources.

The universal visit is used as an opportunity to assist mothers and encourage them to regularly visit the clinic to monitor the health and development of their child within the clinic setting. Most managers felt that many mothers are generally compliant and on average take their children to clinic for two years.

If risk and vulnerability factors are identified in the client’s home during the universal visit(s), some of these services have the resources to offer sustained home visiting to these clients as well. This generally involves offering additional home visits that are frequently made initially and then are gradually spaced over a two-year period.
Managers made it clear that this schedule is only a guide and that the number and frequency of visits over time will vary according to the need of the client.

Forty-nine percent of primary home visiting programs will offer between 1-2 home visits per client on average (Figure 2.4-19). As mentioned, those programs that offer a higher average of visits per client, also offer sustained home visiting. Although there are some programs that can offer more than 3 visits, these programs do not offer sustained home visiting, but will offer a few visits beyond the universal if need be and resources are available.

Figure 2.4-19 Average Number of Visits per Client by Primary Home Visiting Programs (n=6)

![Pie chart showing 17% for each category: 1-2, 3-5, 6-10, 11-15 visits per client.]

**Secondary**

With the exception of one program that maintains a two-year sustained home visiting schedule, secondary programs are not generally guided by visiting schedules. The attitude towards schedules was that the frequency of visits will depend on each client’s own needs, circumstances and characteristics, which are clearly unknown at the start.

A few managers asserted that they don’t introduce set schedules because it is important that clients don’t feel locked into a program and so that the client is involved in decisions over the number and frequency of visits they receive.

Like primary home visiting programs, a number of secondary programs provide an average of 1-2 visits (28%) (Figure 2.4-20). More than half of secondary programs however, offer beyond 10 visits per client on average (54%).

In general, although there is no minimum number of visits, due to limited resources, these home visiting programs are not always able to offer the service over a long-term period. The maximum amount of time spent with clients ranged from three months to one year, and on average 4 months.

In describing the types of schedules used managers said,
“Don’t have a set program- don’t want to lock them in or make them feel obligated.” (Volunteer Secondary Service Manager)

“We try to individualize the service according to need.” (Secondary Service Manager)

“We tackle different issues depending on the stage the child has reached and what they need at that point.” (Secondary Service Manager)

Figure 2.4-20 Average Number of Visits per Client by Secondary Home Visiting Programs (n=11)

<table>
<thead>
<tr>
<th>Number of Visits</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>27%</td>
</tr>
<tr>
<td>3-5</td>
<td>28%</td>
</tr>
<tr>
<td>6-10</td>
<td>9%</td>
</tr>
<tr>
<td>11-15</td>
<td>9%</td>
</tr>
<tr>
<td>16-30</td>
<td>27%</td>
</tr>
</tbody>
</table>

* 4 missing

**Tertiary**

As mentioned earlier, one tertiary service is based on the Home Builders Model. This model maintains a relatively intensive schedule of six visits a week over six 6 weeks. The other services, offer individualised schedules based on client needs and goals for the same reasons given by the managers of secondary services. The maximum amount of time spent with clients ranges from three months to about a year, and on average these tertiary services will spend 6- 8 months with clients. Managers gave the impression that the overall intensity and frequency of visits provided by tertiary programs was higher than secondary programs. The average number of visits per client for most tertiary programs is higher than those of primary and secondary, with almost half (49%) over more than 30 visits per client (Figure 2.4-21).
2.4.2.6 Evaluation Tools

Primary

Home visiting nurses use standard clinical assessment tools and measurements to ensure specific child health and development goals are met. Nurses tend to rely on community feedback and other informal mechanisms such as observation to reveal if clients are benefiting from the service, particularly socially and emotionally. A client satisfaction survey was carried out previously to indicate levels of satisfaction with all health services offered, however, no health service has undergone an exclusive evaluation of the home visiting component of their service. Tools that primary home visiting programs use include:

- Community feedback
- Referral by word of mouth
- Client satisfaction survey
- Developmental milestones (Blue book)
- Growth/weight charts
- Observation
- EPDS (monthly statistics)

Secondary

There is a heavy reliance on client feedback to inform home visitors and managers on how well the service is meeting client needs. Both formal feedback via periodic and end of service surveys/questionnaires, and informal feedback from the client, the client’s family and other participating agencies are used. Supervisors of volunteer home visitors also gain feedback from clients to help assess the volunteers performance as a visitor. To date, only three secondary programs have either undergone or are presently undergoing program evaluations. Tools used by secondary home visiting programs include:
• Observation
• Regular case reviews
• Formal clinical and developmental assessments
• Questionnaires
• Four Colour Approach
• Miracle Question
• Scale of Family Functioning
• Feedback from outside consultant
• Feedback from managers/supervisors

**Tertiary**

Tertiary services resort to a number of formal tools to evaluate programs. Measuring and documenting the progress of tertiary level clients is often mandatory for referring agencies such as DOCS.

A few managers emphasised the importance of carrying out regular case reviews (often every 3 months) to track progress, re-assess needs and make any necessary changes to goals. Formal and informal feedback from clients is also taken advantage of to determine level of progress. Despite the use of such feedback tools however, one manager expressed that she saw little value in their end of service feedback form, because she didn’t believe that clients offered much constructive feedback to help improve service. Tools used by tertiary programs to evaluate client progress include:

- Family risk checklist
- Observation
- Developmental assessment tools
- North Carolina Family Assessment Scale
- Strength based tools
- Formal service feedback forms/ questionnaires
- Feedback from other services and agencies
- HOME
- Speech assessment
- Supervisor interviews with clients

Only two intensive services have undergone formal program evaluations.

**2.4.2.7 Supplementary activities**

**Primary**

Various supplementary support activities are offered to clients through nurse home visitors. Managers saw the most value in parenting support groups, as address several issues/needs identified in the visit. Benefits of groups include; the provision of a forum for clients to exchange information with each other; knowledge and skill building and; the formation of strong social networks. Activities offered that supplement home visiting include:

- Outreach clinics
- Parent support groups
- Toddler groups
Education committees
• Sleep and settling groups
• Pram walking
• Preschool programs
• Health promotion
• Phone calls

Secondary

The two main forms of supplementary support offered by secondary home visitors are telephone support and centre based activities. Telephone support takes the form of follow-up phone calls to check up on client progress and provision of information. Some programs also permit clients to call the home visitor for support and assistance outside of home visiting hours. Centre based activities that clients are encouraged to take part in include; parent support groups, child play groups and information sessions. Other home visiting related activities that visitors are involved with include administrative support and involvement with community based committees. Only one manager stated that her program did not offer supplementary home visiting activities due to lack of funds and resources.

Tertiary

Supplementary activities offered by home visitors of tertiary programs are quite similar to those of secondary services. One activity exclusive to tertiary home visiting however is what was referred to as ‘sensitivity training’. This training is offered to referral agencies so that they may gain an adequate understanding of how to handle high need clients. Supplementary activities for tertiary home visiting programs include:

• Phone calls
• Parent groups
• Supportive playgroups
• Outreach groups
• On-call 24-7
• Information sessions
• Sensitivity Training

2.4.3 Summary

Isolation is the greatest area of focus for all home visiting programs. Both primary and tertiary programs maintain a high focus on DOCS, child protection and isolation related issues--primary programs within the context of universal assessment and prevention of risk, and tertiary services within the context of management of identified risk. Secondary programs primarily focus on adjustment to parenting and isolation issues. These programs focus least on substance abuse, late antenatal care, indigenous and refugee issues and groups. Overall the more intensive services are inclusive of the widest range of issues.
The category, Indigenous groups was indicated the most times under *little focus* or *excluded*. It appears that 26% of home visiting programs give little or no attention to indigenous groups, while for 19% of programs this group is a major focus. Overall, refugees get the least attention from all three types of service.

Most home visiting programs offer a combination of home visiting, centre-based and other support activities. The majority of early childhood home visiting programs aim to improve parenting skills, offer social support to families and link them to resources. The least used strategies of home visiting programs overall are problem solving and parent-child interaction.

With the exception of universal home visiting, secondary and tertiary programs are generally not based on specific models or theories, but a combination of family support and child development theories. Strength and solution based models however guide all programs in their approach to intervention. Multiple interventions are offered by all services to meet specific, social, educational, psychological, physical, material and support needs. The level and intensity however will vary among, primary, secondary and tertiary programs. Some programs that offer universal home visiting will also offer targeted home visits to clients with needs, similar to secondary programs.

The evaluation tools most used by all services are formal and informal client feedback. Primary and tertiary programs are often mandated to use specific formal tools as well. The most noted supplementary activities offered by home visiting programs are support groups and telephone support.

### 2.5 What does home visiting offer as an early childhood intervention/prevention service?

Although home visiting is generally believed to be a good approach to service provision for young children and their families, differences in program aims and goals, have contributed to a nebulous understanding of what home visiting services actually have to offer and how they offer it.

Through our analysis of the data collected, we have attempted to shed some light on this area. Thematic analysis was used to analyse the interviews and focus groups, which drew out key themes and concepts within the data (see section 2.2.4 for details of thematic analysis method). The identified themes allowed us to uncover 3 key co-dependant aspects to approaching home visiting.

These three aspects involve;

1) Attempting to identify both surface and underlying needs and problems of clients, that is their, ‘real needs’

2) Creating the conditions to meet the ‘real needs’ of clients, that is by, reaching out to them, working in their homes and building a trusting relationship and;

3) Implementing a multi-faceted integrated intervention that meets psychosocial, instrumental/practical and educational client needs.

These are discussed in more detail below.
2.5.1 Home visiting approach to identifying ‘real needs’

Based on our analysis, early childhood home visiting programs operate under different assumptions about clients than do other prevention/intervention services. Normally, health and social services expect client needs to be recognised and brought to their attention, by the clients themselves or by others such as family, friends, police, general practitioners or social workers.

Unlike other services however, home visiting programs do not assume that clients can identify their own needs or will go to the appropriate service for assistance. Furthermore, even if individuals can identify their problems/concerns, home visiting managers insisted that they still will not necessarily make the effort to take up services. This is often because they do not know who to go to, do not feel comfortable discussing their concerns or maintain a general lack of trust in services.

Lastly, some of the participants believe that it is naïve to assume that client needs can be fully understood based solely on what clients choose to disclose. Hence practitioners need to make an effort to identify the various surface level problems, as well as the underlying needs and causes of these problems that the client may or may not reveal or recognise.

To do this, home visitors attempt to create the conditions that will allow them to identify these needs. The first condition is to work with the clients in their own home and environment, and the second is to build a trusting relationship with them. The conditions can then facilitate the multifaceted integrated response offered by the home visitor to meet the client’s needs. The example below intends to demonstrate how a home visitor learns more about a client’s needs through the established conditions, and how this facilitates the help offered.

A home visitor meets a client who asserts that her only concern is the frustration that she experiences because her child doesn’t to listen to her. By observing the mother and child in their home environment, the home visitor notices the client speaks to the child in a negative tone of voice whenever she asks the child to do something and determines that this has contributed to her difficulty in getting her child to listen to her. In response, the home visitor aims to help the client learn how to interact more positively with her child. By gaining the trust of the client and by further observation however, the home visitor also learns that the mother has little support, few resources and low self-esteem, all of which can hinder her ability to interact well with her child, even if she is taught how to. Thus the home visitor responds in various ways, which can directly and indirectly help the mother and her child with the problem that was presented and the problem at its core. Strategies that may be employed include, modelling proper parent-child interaction, normalising, building on strengths and linking her to social support groups. The implementation of these strategies is also facilitated by the trust and confidence gained by the client.

The example above clearly illustrates that the one concern disclosed by the client isn’t often the only area in her life that needs to be addressed. It also shows that the insight
into the client is gained by the home visitor through time, effort and trust. Finally, it makes clear that a number of responses are needed to tackle the various issues learned about. In accordance with what managers emphasised, home visitors do not offer one intervention, but, ‘a parcel of services and interventions’ that tackle the various interrelated issues in a client’s life.

Based on our analysis of participant perceptions, we further clarify how home visitors create the appropriate conditions to identify ‘real needs’, and the nature of the multifaceted integrated response.

2.5.2 The context for home visiting

Context relates to the ‘place’ where home visiting takes place. That is, in the client’s home and environment, as opposed to a clinic or centre, where family and child services are traditionally offered. Home visitors and managers were convinced that observing and working with clients in their home rather than a clinic, gave them much greater access to understanding their client’s needs, challenges and capacity to change. Another important advantage of visits in the home is that home visitors can reach those families who are in need but who do not take advantage of mainstream, centre-based services. Specific characteristics of home visiting in context became clear through analysis of the data. These are described below.

2.5.2.1 Integrated with family

Home visitors often attempt to integrate and involve family members during their visits. Integration of family members was said to encourage some level of interest and support, to further assist the client in benefiting from the home visiting service. According to a few home visitors, engaging well with a client’s child is a means to capture the interest of parents, who are not necessarily open to the service at first. Engaging and mobilising the support from other influential family members, such as a spouse or in-laws was also said to greatly influence client progress.

“We take the opportunity to look at the whole family-because some don’t take up services on their own.” (Primary Service Manager)

"When we home visit we provide drug counselling, home counselling and family counselling. That’s a really good reason to do home visiting, because you can talk to the other family members. Sometimes that’s really useful. Having a chat and help family members get information they need to support someone with a chronic drug problem." (Tertiary Service Home Visitor)

By working in a client’s home environment, home visitors have the opportunity to see what support and resources are or are not at the clients’ disposal. Taking these into consideration, the home visitor can introduce strategies that are appropriate and can be integrated into normal household activities without conflicting with other priorities or interests.
2.5.2.2 Predictable

All new mothers can expect to receive at least one home visit from a child and family nurse to check up on the well being of their babies. Once a client is enrolled in a secondary or tertiary service they can also rely on routine home visits to assist with and monitor client and child progress.

Managers of programs that carry out more than 1 to 2 visits stressed that it is the consistent effort put forth by the home visitors to follow-up and check on clients that contributes to their success. This appeared to be particularly beneficial for clients that have been neglected by services in the past.

“Parents get excited about you turning up and planning next visit.” (Secondary Service Home Visitor)

“They generally don’t think we’re going to come back, they are vulnerable people, and are used to people leaving them.” (Secondary Service Home Visitor)

2.5.2.3 Opportunistic needs identification

Working in the context of a client’s home allows for a home visitor to discover needs as they arise and unveil over the time they are there. Through keen observation, home visitors can pick up on personal or family needs that the client themself may not recognise or share with the home visitor.

“Sometimes we need to wait for the opportunity to come up before we can address something.” (Secondary Service Home Visitor)

“Can’t plan a visit, need to go along with how the parent feels and needs.” (Tertiary Service Home Visitor)

“Someone can tell me they are doing well and everything is honky dory, but then you go into the house, it’s a different story.” (Primary Service Home Visitor)

2.5.2.4 Flexibility

An important characteristic of the context that home visitors work in is the flexibility of the service provided, even after goals, strategies and visiting schedules have been agreed on. By avoiding a rigid program structure, the home visitor can account for unanticipated events and situations that come into play during the course of the service and change the scope of the program as needed.

“You may plan something- but that goes out and something else comes in.” (Secondary Service Home Visitor)

2.5.2.5 Accessible

Home visiting is a readily accessible service available to clients. The accessibility of home visitors particularly caters to clients who are not in a position to seek out
assistance or information on their own, despite the need. These clients face obstacles that prevent them from getting themselves to a clinic or centre. Such obstacles might include; isolation from services, cost of transport, disorganisation, too many children, poor health and other pressing priorities.

“Most of what we do is home visiting because clients don't come to us. They are too disorganised to get themselves to the centre to see us. Its very important for intensive cases, involved with DOCS and drugs.” *(Tertiary Service Home Visitor)*

“Its good for new mothers to have someone around when they need support, she goes through an emotional roller coaster after having a baby and can’t always get herself to the clinic” *(Secondary Service Home Visitor)*

“We make sure we are timely and accessible.” *(Primary Service Manager)*

### 2.5.2.6 Acceptable

A few participants feel that some clients will more readily accept home visitors from similar cultural backgrounds, as common cultural issues and experiences can be related and understood. Some of the home visiting programs in this study have recognised this and have made efforts to cross this barrier. Efforts include; employing staff from specific language and cultural groups, using interpreters and offering cultural sensitive training to home visitors.

The reputation of home visiting services is also an important factor, which can influence the acceptability of programs. A few managers attributed their acceptability in communities to their reputation of being a non-intrusive service or to the general word/opinion about their service based on the experiences of other clients and services.

“They are more accepting of a service like ours that is low key.” *(Tertiary Service Manager)*

“There are strong ties between the cultural groups so things get passed through word of mouth and it brings interest in what we do.” *(Secondary Service Manager)*

### 2.5.3 The visitor-client relationship

There as overwhelming agreement among the participants emphasised that a trusting relationship is the principal means to gain insight into client needs and to facilitate the intervention. As expressed by two home visitors of a secondary program,

“They will keep you at a distance until they feel they can trust you.”

“We need to form a trusting relationship first- they won’t invite you into their lives before that.”

Although relationship building is pursued by home visitors, it differs in form depending on the background and skills of the home visitor and the type of service.
being provided. For volunteer home visiting, managers concentrate on appropriately matching the client to the visitor to increase the chances of building a trusting relationship. On the other hand, other services that employ professional and paraprofessionals rely mostly on professional skills and expertise to assist them.

The relationship is also influenced by the type of trust the home visitor intends to gain. Participants identified two types of trust to facilitate relationship building. These are Institutional Trust and Familiar Trust, which are further discussed below.

2.5.3.1 Institutional Trust

Universal home visiting nurses seem to have an advantage when going out to see clients. Despite the low number of visits (1-2), nurses are able to establish rapport and work with the clients more readily because of the institutional trust clients have in health services. Universal home visiting nurses conveyed that most mothers accept them as knowledgeable public servants, who have the child’s well being in interest and therefore can be trusted.

““The blue bag18 gets you anywhere. That’s a way to build trust too if you do the baby checks and use the blue book to acknowledge the fact that the baby is doing well.” (Primary Service Home Visitor)

However for some high needs clients who have had negative experiences with services and agencies, institutional trust may not be present. Participants recognised that in this case a greater effort has to be put forth in order to re-establish relations between these clients and institutions.

2.5.3.2 Familiar Trust

Secondary and tertiary home visitors don’t often have the advantage of institutional trust. For this reason, they will seek to gain a familiar level of trust to build relationships which facilitate their work. The various approaches to gain familiar trust are related below.

Persistence

Home visitors continually go back to work with clients, regardless if they are receptive to them or not. Some participants believe that this gives clients the message that home visitors are trustworthy and reliable—because they always come back. Participants felt that persistence not only helps them gain trust but can dispel mistrust on the part of vulnerable clients who have reason to mistrust services for various reasons.

“It’s an experience they’ve never had before, being heard, so they don’t know if they should trust us. We recognise this and continue to be persistent.” (Tertiary Service Manager)

“We make sure they are attended to so they don't lose confidence [in services] again.” (Secondary Service Home Visitor)

18 The blue bag is the home visiting kit used by nurses to carry scales and other equipment.
“Hanging in there even though they challenge you, keep going back. After a period of time they see you’re not going to judge them.” *(Primary Service Manager)*

**Time**

Home visitors take time when they work with clients so that the client opens up to them at their own pace, when they feel comfortable enough to do so.

"Because of culture she would not disclose problems with her marriage. But as time went by and by giving her information, she began to open up. After that she and her husband went for family mediating.” *(Secondary Service Home Visitor)*

“At first everyone says they are fine, but after 15 minutes or half an hour they start to open up to you.” *(Primary Service Home Visitor)*

**Continuity**

Continuity was described as another key element in establishing a trusting relationship with clients. One home visitor believed that is was important because the client is relieved from the daunting task of constantly opening and establishing new relationships with services and workers. Instead, the one main service provider—the home visitor—can be relied on to respond to their various issues and concerns, which is encouraging for clients to open up and trust them.

“It’s successful because the mother has the same person to help them move through the early childhood period smoother, as opposed to going to various services to get the same support that we give them.” *(Secondary Service Home Visitor)*

**Support**

Several forms of support offered by home visitors were believed to add to the visitor’s ability to gain the trust and confidence of clients. Among them are chatting, giving client time, helping the client out with random things around the home and after hours support via telephone. The opinion was that these forms of support reassure clients that home visitors are there for them, further strengthening their relationship.

“Many are isolated and don’t have friends, we just talk.” *(Secondary Service Home Visitor)*

“Stayed with her for a while as she experienced numerous problems with her baby-then linked her to a group, helped her form networks, which helped with her confidence.” *(Primary Service Home Visitor)*

**Non-authoritarian manner**

As mentioned earlier, participants felt that many clients are wary about accepting services because they’ve lost trust in services through past negative experiences. A few home visitors attributed this to the authoritarian nature of some services when dealing with clients—particularly those mandated by government agencies.
Participants also expressed that migrants that have come from countries under strict political regimes will often hesitate to work with home visitors due to suspicion about the service’s intentions. Thus home visitors try hard to approach clients with a very open, friendly non-authoritarian attitude and demeanour.

“We align ourselves with community activities. We are viewed as the people from ‘paint and play’.” (Tertiary Service Manager)

"We explain to them that the service is their choice and they can say no.” (Secondary Service Home Visitor)

Agreed boundaries and expectations

Because home visiting is a flexible and open approach to service provision that many vulnerable clients are not accustomed to, the need to set boundaries and limits was stressed as an important part of establishing a relationship. This is to avoid, creating dependencies and unrealistic expectations on clients or visitors.

One manager stated that there is a fine line when it comes to the consistent follow-up through home visits. Although she recognised it as a beneficial intervention, she stress that visitors need to be careful not to be too pushy or persistent.

“Had a case where client didn’t want file closed. But the nurse saw the service as providing a social support/dependency- as opposed to working on the actual issues.” (Secondary Service Manager)

“As a worker from the same background they ask for extra favours like money. So I need to be professional.” (Primary Service Home Visitor)

“Need to make sure that although persistent, can’t be too pushy. It’s important for the home visitor to recognise boundaries and not to take it too personally.” (Primary Service Manager)

2.5.4 Interventions to respond to need

Based on what the home visitor can learn about the client’s needs, they respond by using a variety of interventions that are deemed suitable. Aspects of this response are guided by the programs goals, limitations and length of intervention. As mentioned, these responses address psychological, instrumental and educational needs and are described in detail below.

2.5.4.1 Psychological

Reflecting behaviour

By talking to clients and sharing life experiences home visitors learn about client belief systems that either foster or inhibit positive outcomes. Drawing on experiences of their own and others can also be used to subtly show clients how changes can actually be made in the lives.
One visitor from a secondary program conveyed that she learned about one of her client’s destructive beliefs by using this technique,

“Some women accept their lives with complacency. One woman that was abused by her husband said, ‘Don’t all men hit their wives?’”

**Goal Setting**

Participants recognised that many clients are not in a position to set and reach goals for themselves. Accordingly home visitors will work with clients to set short and long-term goals that address the various needs identified and also reflect the client’s values. They conveyed that the goals and strategies determined are used as guidelines, to help the client and visitor monitor and assess progress. They can however, be modified if the need arises as time goes by.

“See what her values are and what she wants to address”

“Facilitate them to identify their own goals. Map out what they need to do to reach their goals in the given timeframe.” *(Tertiary Service Manager)*

**Different perspective**

The participants assert that many clients do not maintain realistic expectations of themselves, their children and life in general. By offering a different perspective however, visitors are able to normalise situations and help clients achieve a more realistic outlook. Examples of how home visitors attempt this, include suggesting different solutions to re-occurring problems, sharing experiences and discussing success stories of individuals in similar situations.

“Sometimes they feel that a family problem is closed to the outside. As parents, they think that they should know what to do. Women are expected to know about mothering even if it’s their first time.” *(Secondary Service Home Visitor)*

**Empowering**

Home visitors empower clients by helping them recognise their qualities, skills and potential to change, which raises their self-esteem and confidence. Techniques used to accomplish this include, affirmation of positive beliefs and behaviours and encouragement to choose different life options. A few programs make use of ‘strength cards’, which are meant to help clients who find difficulty in talking about themselves to identify and verbalise their own strengths and assets.

“Helping her see what decisions can be made by showing her that she can have that control.” *(Secondary Service Home Visitor)*

“Help them see that they’re survivors.” *(Secondary Service Home Visitor)*
2.5.4.2 Instrumental

Linking

In order to reduce isolation and increase client resources, home visitors attempt to introduce clients to community groups and amenities. The participants suggested that clients are either unaware of services or do not feel comfortable in taking them up. In response home visitors provide the necessary information to help increase client access. Parent support groups and playgroups for instance, were mentioned repeatedly by participants, as a good means to connect clients with other community members and develop social and practical skills.

Assisting clients enrol with services helps ease the transition, so that clients become more familiar and comfortable with the process. Many visitors will also advocate on the client’s behalf in situations when clients encounter difficulty in negotiating with agencies.

“Linking a parent to child care itself, frees up time for the parent to spend time on themselves.” (Secondary Service Home Visitor)

Practical help

Participants said that they will offer practical help as needed, such as accompanying clients who don’t have transport, organising the house and playing with the child(ren). The degree to which practical help is offered however varies considerably by the type of home visiting and program guidelines. Volunteer home visiting services for instance appear to place a much larger emphasis on practical home assistance, than other types of home visiting programs. While volunteers will take on child minding, professional visitors will attempt to keep it at a minimum.

"We are working with very vulnerable groups. They are not stable enough to get to appointments. So we need to help them at first.” (Tertiary Service Manager)

Information made accessible

Information provision can take on many forms. These include showing clients how various amenities in the community work, such as public transport, explaining what resources are available to them such as child care and teaching them skills related to parenting such as child development games. Some participants expressed that many clients have very little information about resources that are available to them or are misinformed about important issues, such as proper child health and development.

“Some people don't know their entitlements with Centerlink either. It’s amazing how people don't know about their rights because they are isolated physically and because of language.” (Secondary Service Home Visitor)
2.5.4.3 Educational

Parenting skills

Helping parents develop and enhance parenting skills and crafts is carried out in a variety of ways. Role modelling was mentioned a number of times, to help parents see how to positively interact with their child. Information is provided in response to questions and concerns about parenting, for example how to bathe and feed the baby or how the child is developing.

“We can see what happens in the home, and provide key points that parents can pick up on. We can provide opportunities for mum to see our interaction with children.”
(Secondary Service Home Visitor)

Child development

Programs looked to enhance child development skills, but varied in how intently they did so. Most visitors will introduce strategies to parents to help their child(ren) reach developmental milestones. A few of the tertiary services in our study also look to support families with children who have developmental delays and disabilities, by providing support, normalising and imparting skills that specifically target the development of these children.

Health Promotion

Home visitors take part in promoting and encouraging healthy behaviours, to prevent and reduce risk behaviours. Nurses particularly play a large role in this area. Visitors explained that information about women's and child health is often conveyed verbally, through written material and through visual aids such as a video used by one targeted program for expecting mothers. One home visiting nurse expressed that she can’t always stop a client from risky behaviours such as smoking, but will still attempt to introduce and promote ways that they can still reduce harm to the baby for instance.

2.5.5 Summary

The managers and providers of home visiting services in South Western Sydney were clear in articulating the type of service offered by home visiting, particularly as this differed from other, clinic or centre-based services.

By providing a service within the context of the families' homes, home visiting providers are able to identify need and implement interventions more appropriately. Within this context, opportunistically identifying need and providing appropriate interventions was facilitated by integrating with the family. Home visiting provides a predictable, flexible, accessible and acceptable service.

The provision of service is further facilitated by the development of a trusting visitor-client relationship. Two types of trust that home visitors maintain are Institutional Trust and Familiar trust. Institutional trust is particularly important for universal, primary home visiting services. For secondary and tertiary services, institutional trust
may form the basis for initial acceptance of the service however, the service work to gain familiar trust. Home visitors attempt various ways to achieve familiar trust with clients. Familiar trust is built through persistence, continuity, providing support, visitors having a non-authoritarian approach, and establishing agreed boundaries and expectations. The level of trust and nature of relationships will be influenced by skills of the visitor and aims of the program.

The home visiting service will provide a variety of interventions to respond to need. These could be grouped into psychological, instrumental and educational interventions. Psychological interventions included reflecting behaviour, goal setting, empowering families and providing a different perspective. Instrumental interventions included practical help such as child minding or transport, as well as providing information and linking families into community resources. Educational interventions mentioned by service managers and home visitors included parenting skills, child development and health promotion.

2.6 What influences the success of home visiting programs in SWS?

This section provides further insight into how home visiting programs operate in SWS, or more specifically how they operate successfully. Using the same approach to analysis as we did in the previous section, we used a thematic analysis to analyse the interviews and focus groups to see what themes and concepts emerged from the data.

This sections looks at an important issue raised by the participants. They made clear that despite offering an effective early prevention/intervention approach to service, the effectiveness of service is influenced by varying levels of capacity. These levels relate to client, visitor and institutional capacity. The participants' description of how these three areas of capacity can affect their ability to provide effective service is detailed below.

2.6.1 Client Capacity

The participants identified a range of factors that they felt influenced a client’s ability to engage with and respond to home visiting. These are discussed below.

2.6.1.1 Motivation

Home visitors felt that some clients have a willingness and desire to change, which facilitates their ability to benefit from the service. It was in the opinion of the participants that these clients most easily accept home visitors and demonstrate that they are keen to learn from the service to improve the lives of their children. Some participants also conveyed that clients who undergo serious child protection problems and fear that their children will be taken away, also display a willingness to co-operate with home visitors, in order to prevent the removal of their child(ren).

“They have a willingness to change.” (Secondary Service Manager)
“[Stable families] accept the service more voluntarily than others.” (Secondary Service Manager)

“It’s when clients are ready and open to recognise the problem. Then they start to benefit more.” (Tertiary Service Manager)

2.6.1.2 Entrenched problems

Participants agreed that those clients living in fairly entrenched conditions involving low socio-economic status, substance abuse or domestic violence, don’t have the time or desire for home visiting services and are generally unresponsiveness to home visitors. This is particularly an issue when home visiting is mandated and forced upon clients. One service manager expressed her opinion that the fact that these clients haven’t taken up services voluntarily is, in itself, an indication of their lack of interest in home visits.

Some of the participants also attributed particular characteristic to these clients which they felt placed them in these situations and also make it even more difficult to escape. These include few life opportunities, little education and minimal survival skills. As many of these clients are forced to take up the service, participants believe that it is like a chore, because they don’t have a choice in the matter: “Because these clients have so many other issues to deal with, they can’t often benefit from the home visit.”

“Once a family is in crisis it is more difficult to change behaviour.” (Secondary Service Manager)

“Families that have other pressing issues to deal with such as getting food on the table.” (Secondary Service Manager)

2.6.1.3 System Fear

Fear of services and institutions is believed to hinder a client’s ability to engage with home visiting services. Migrant groups who come from countries with strict political regimes were said to question the intentions of services. Participants from mainstream services also found that Aboriginal groups question the service and the purpose of data collection. It was generally felt that this is a consequence of the misuse of surveillance data collected from aboriginal populations in the past.

“Many Asian cultures have a fear of authority, so worker tries to reassure them.” (Tertiary Service Manager)

“Need to keep in mind the mistrust and problems in the past with the government.” (Primary Service Manager)

2.6.1.4 Stability

Stable women/families are considered to be those who have support (family, spousal, friends), have few financial needs and maintain secure housing. In the opinion of most of the participants, these clients gain the most benefit from home visiting.
“We find the pattern intriguing, we hoped mothers with social and financial needs would benefit most, but it’s the mothers with good homes, perhaps isolated and who are more mature that do.” *(Volunteer Secondary Service Manager)*

2.6.1.5 System Abuse

Some home visitors have encountered clients that they believed were abusing the service offered. It appeared to the visitors that certain clients took up numerous services expecting to receive incentives or expecting the home visitor to over extend her/his responsibilities. One home visitor expressed frustration over a client that left her to child mind, while the client went out to carry out her own errands.

2.6.1.6 Health

*Mental health*

Poor mental health is believed to be another factor that affects the ability to benefit from the home visiting. Certain mental health issues that visitors find difficult and time consuming are personality disorders, intellectual disabilities and to a lesser extent postnatal depression. One secondary service manager expressed that this group of people are subject to neglect, because home visiting services generally don’t have the capacity to deal with mental health issues.

*Dependencies*

Addictions, such as drug, alcohol and gambling were addressed as dependencies that can severely impact a client’s ability to engage in home visiting or any other service. This is not only a result of the physical and cognitive limitations of a client, but as well as the social stigmatisation, which makes it difficult for clients engage and openly discuss their problems.

2.6.1.7 Culture

*Multicultural groups*

Some visitors said that they have found themselves confronted with cultural traditions that have conflicted with interventions. For instance, as some women only leave their homes with their husbands, isolation reduction strategies, which encourage women to get out of the home, cannot be introduced.

Another setback raised was that home visitors could be viewed as being intrusive. It seemed that some clients felt that home visitors were trying to impose their values on them. One participant spoke of an encounter with a client from a cultural tradition that maintains that all women with children should instinctively know how to raise children appropriately. Thus the client found great difficulty in accepting the advice of the visitor—particularly since the client belonged to another cultural group.
**Aboriginal women/families**

More than half of the service managers felt that although aboriginal populations are not excluded from their scope of service, they don’t often reach this population. Difficulties these services encounter include misunderstood cultural beliefs and a general mistrust of mainstream services. One manager of a mainstream service said that even with an Aboriginal home visitor on board, they have had difficulty engaging the Aboriginal community with their service.

Customs, such as ‘walkabouts’, were perceived as additional barriers to receiving service. The manager of the Aboriginal home visiting program included in this study asserted that because the Aboriginal population is so transient, it can be difficult to keep up with home visits. Another issue raised that has made it difficult for the Aboriginal universal service to reach Aboriginal children antenatally is the difficulty in identifying non-Aboriginal women pregnant with Aboriginal men.

2.6.1.8 **Resources**

Lack of transportation was regarded as an obstacle preventing clients from getting to services and groups that home visitors attempt to link them into. According to the participants, even when public transport is available, many clients who have too many children and don’t have access to a sitter find it difficult to get to a service and therefore won’t take up a referral.

Clients who don’t have resources such as telephones are also limited in their ability to contact services and set up appointments. In fact, because many home visiting programs will confirm enrolment into the program by telephone, clients who don’t have a contact number may miss out on receiving the service. A few managers recognised this limitation in service though and conveyed that they will go out and visit clients to capture those who don’t have phone access.

2.6.1.9 **Support**

Some of the participants acknowledged the importance of client support from spouses, friends and relatives, and how it can influence involvement and responsiveness to the home visitor and service. Thus visitors attempt to mobilise the support of such individuals by talking to them and getting them involved, so that clients can achieve their goals more effectively.

"Can see what’s happening in the house. For example domestic violence on the part of in-laws, from husband or older siblings, so we try to talk to them too.” *(Secondary Service Home Visitor)*

The participants admitted however, that for the most part, attempting to integrate the father is difficult. This is either because they are busy at work or because they don’t recognise the value in their involvement, particularly because raising the children is viewed as the mother’s responsibility.

“Raising children is seen as women’s work.” *(Secondary Service Home Visitor)*
2.6.2 Visitor Capacity

The participants expressed that certain factors related to the attributes and resources of the home visitor facilitated or inhibited the ability to carry out home visit adequately. These factors are discussed below.

2.6.2.1 Support and Supervision

The overall supervision and management of home visitors is considered to be quite good by the participants involved in our study. Good working relationships and communication between different levels of management and staff was emphasised by managers and home visitors alike.

Managers accomplish this by creating supportive environments for home visitors, which encourages regular feedback, on-going training, input in management decisions, open-lines of communication and a strong emphasis on teamwork. The team work component was stressed as a particularly effective form of support, as home visitors had opportunities to regularly consult and work with their colleagues and managers.

“Supervision is really important. We feel we can offload some of the burden we carry from difficult home visits.” (Primary Service Home Visitor)

“Everyone feels they’ve been listened to and are informed.” (Secondary Service Manager)

“Management and clinical level staff involved in decision making.” (Secondary Service Manager)

Managers felt that in addition to the level of commitment of their staff, staff retention can be attributed to good managerial support, flexibility and program philosophy.

“We use a strength based approach to management of staff also. A celebration of skills and successes.” (Tertiary Service Manager)

“We are flexible, staff can come and go if they need to take breaks, and are welcome back.” (Volunteer Secondary Home Visitor)

2.6.2.2 Motivation

Perseverance

Despite the workload and challenges in engaging some clients, home visitors remain highly motivated and determined to see the clients through. Home visitors generally attribute their perseverance to a genuine desire to work with children and families and to help them achieve positive outcome. Many home visitors also stressed that there is a reciprocal effect and the clients themselves have a significant impact on their lives in a positive way as well.
“Need to have a sense of humour—can’t take it to heart, although not always easy.” *(Primary Service Home Visitor)*

“We kind of become like family, we learn a lot for our lives too. They give us as much as we give them.” *(Primary Service Home Visitor)*

“Can be very frustrating, but it’s a privilege to be involved in peoples lives.” *(Primary Service Home Visitor)*

‘Burnout’

There was some discussion of ‘burnout’, experienced after home visitors had been working in the area for an extended period of time or when the workload becomes overwhelming. As a result some move on, while others learn how to deal with it. One nurse home visitor admitted,

“We are only human, my motivation isn’t what it should be—but there are some ways of dealing with it. If I’m in bad mood and tired from the last visit, I can still pull it off at the next visit. You perform.”

Managers acknowledged that the workload given to home visitors was quite demanding at times, due to increased clientele and the low number of staff and resources. In response, volunteer home visitors are given the opportunity to take a break from the service when they feel overwhelmed and are welcomed back when they are ready. Other programs offer flexibility in work schedules and short breaks in order to give home visitors some relief. In spite of these efforts however, it was still considered to be major issue.

**2.6.2.3 Experience**

Life experience, particularly as a mother, was said to assist the participants in their work tremendously.

“Need to have compassion and understanding of the emotional and physical impact of being a parent.” *(Secondary Service Home Visitor)*

“There is a certain amount of training you need to approach home visiting, but it’s mostly experience—you can’t beat that.” *(Primary Service Home Visitor)*

A few visitors felt that clients will generally have more confidence in those who can draw on their own experiences as a parent, as opposed to a young person who has little or no parenting experience. Some even felt that their experiences are an even stronger asset than their training. One home visitor however was opposed to the idea that more experience is better and even implied that a younger person might even have an advantage over those older due to the assets they bring with them.

“The longer you’ve been doing something the more you can overlook things. Maybe someone with fresh eyes can recognise something you’d miss” *(Primary Service Home Visitor)*
2.6.2.4 Training

Overall, home visitors were considered to be adequately prepared to conduct home visits, whether they were offered specific home visiting training or not. Managers of programs that didn’t offer specific training argued that this didn’t pose a major threat, because their visitors were either professionals or had good experience in family support and welfare.

That being said, all managers felt that training could be enhanced in specific areas. For instance, one area training is needed in is cultural sensitivity and awareness about both migrant and aboriginal cultures, as misunderstandings have caused difficulties in the past.

Another aspect of home visiting managers felt visitors need to improve in is ‘setting boundaries’. Participants expressed concern over the difficulty in avoiding client dependency, despite attempts made to do so. Reasons given to explain this phenomenon relate to home visitors personally becoming important people in the lives of clients, difficulties encountered when working with other services, and the comfort in disclosing needs to one person. This often results in an expectation for home visitors to overextend their service. Another consequence is difficulty that clients experience in exiting the program.

"Because we are the first contact and we have this rapport with the client-they don't really want to go to somebody else." (Secondary Service Home Visitor)

“We are usually the first person to show an interest in them.” (Secondary Service Home Visitor)

“People would rather talk to educator because familiar with them, but we are trained teachers not counsellors.” (Secondary Service Manager)

The manager of a volunteer home visiting service raised another concern related to boundaries, on the part of visitor. She stated that volunteers themselves don’t always know their boundaries and there have been incidences when volunteers themselves become overpowering, demanding or become dependent on the client themselves.

2.6.3 Institutional Capacity

Participants spoke of capacity issues within their programs and institutions that impacted on their ability to undertake effective home visiting. These are described below.

2.6.3.1 Agency/Service Partnerships

Overall, the participants felt that they had good referral networks. They based this on their knowledge of agencies and services, which they call on when referrals are to be made. Some managers felt that their networks were particularly effective and said that in addition to being connected with community services and agencies in their areas they also had regular case reviews, workshops and open-lines of communication.
Overall however, the participants did feel that networks could improve through better communication and collaboration. For instance, despite arrangements to have services and agencies report back, home visitors voiced that they rarely receive verbal or formal reports on client progress and thus couldn’t ensure that clients had taken up services post referral.

Participants also expressed frustration over the reluctance on behalf of some agencies to work with home visitors who are advocating on the client’s behalf when they are unable to do it for themselves. This makes it difficult for home visitors who are attempting to link clients and meet their needs.

Another important issue related to network capacity was that clients, particularly those most vulnerable, are constantly referred to countless services. One universal home visiting nurse said that after referring her client to a support service, the service referred the client back to the universal home visiting program. She and other participants stressed that handling cases in such a manner can have a highly negative impact on a client’s ability to benefit from any service.

To avoid this situation arising, managers and home visitors of tertiary services made clear that they only refer clients when absolutely necessary, for instance when they are not equipped to deal with specific issues, such as drug addiction. They stressed that they attempt to take care of all of their client needs themselves, as they recognise there is a high risk that these clients will be neglected otherwise. They base this opinion on a number of factors that relate to the difficulty in re-establishing relationships with other services, long waiting lists and the inability and reluctance to take on high need clients on the part of the other services. It appeared that several services will refuse to take on these clients because they often misunderstand and judge clients with complex needs.

“Won’t want to deal with them because they think they are too feral.” (Tertiary Service Manager)

Many services however, do not have the resources to keep their clients for too long and consequently will need to refer to other services that can meet specific needs. Strategies used to minimise the negative effect of referrals include joint visits and offering training to other services and agencies. The joint visits are encouraged so that the home visitors referring the case works with the referral service/agency to introduce the client to the new case worker and ease the transition to the second service.

Sensitivity training is also offered by some tertiary services to help agencies and services overcome stereotypes and challenges encountered when working with certain clients. Although this was viewed as a positive step forward, it was emphasised that much more work needs to be done before services will appropriately take on high needs clients.

“Home visiting is part of the jigsaw puzzle and need to link in if it’s going to work. Mental health and DOCS cases are too complex, can't be resolved just by home visiting. Need families and other agencies to engage.” (Tertiary Service Home Visitor)
2.6.3.2 Waiting lists

A major challenge also encountered when attempting to refer clients is long waiting lists. In general, waiting lists were said to range from 1 month to 2 years. This is a concern because clients whose needs are not taken up fairly quickly can potentially lose interest in addressing their problem(s), feel neglected or lose trust in services altogether.

Consequently, this has also contributed to the high workload of home visitors and client dependency. Home visitors felt that they have had to take on roles meant for specialists to ensure client needs are not neglected, even if they lack the appropriate skills. They also felt strongly about the risk that clients will become more dependent on them, which is difficult to avoid when home visitors appear to be the only service provider responsive to their needs.

“Although we can identify all these problems, we can't refer to a social worker after the baby is born. Generally there’s a 6 week wait, so we end up being social workers.” (Primary Service Home Visitor)

“There are so long, by the time they are accepted, we have already put everything in place.” (Primary Service Home Visitor)

2.6.3.3 Relationship with General Practitioners

The beliefs and attitudes that general practitioners (GPs) hold toward home visiting were said to potentially affect a client’s willingness to take up home visiting and visiting the health clinic. One universal home visiting manager said that it was like a competition between the GPs and home visitors at times. She added that, GP’s in the past have influenced how clients respond to home visitors and their advice, feeling like they actually deterred clients from continuing with home visits. In general, managers of universal home visiting services felt that relationships between the two professionals needed to be improved.

2.6.3.4 Funding

The overall opinion regarding funding was that an accurate understanding of the existing profiles of home visiting programs and how they have had to evolve over the years hasn’t been reviewed. Consequently managers think that there is an unrealistic expectation of what can be achieved, given the limited funds available and the increasing workload. They felt that programs are not carried out to their best ability as the funding is simply not sufficient.

“Funded in 1994, no increase in funding for 10 years, yet service has increased 100 fold.” (Volunteer Secondary Service Manager)

There was evident frustration in relation to the instability in funding as well. The main complaints concerned the short length of the period that funding is allocated for (usually one year) and the late notification regarding funding approval and renewal. These obstacles have made it difficult to sustain staff due to the lack of job security, and to plan and implement changes for the subsequent year.
One manager said that what adds to the frustration is the time and effort expended on continually applying to renew funding. This is considered to be a challenge when there are other pressing administrative responsibilities pending and no guarantee that funding will be received.

“We are seeking more funding—but it’s difficult. The whole process is incredibly frustrating—we push to get applications in on time and don’t hear from them for months.” (Secondary Service Manager)

Despite grievances over funding, it was generally viewed as an “age old issue” that managers have accepted as an ongoing challenge. For that reason, managers put forth that they will do their best to work within constraints to offer the service as adequately as possible. They recognized however, that this often adds to the burden placed on home visitors and reduces the number of clients accepted to their programs.

“We try to work within the budget— we know we won’t get more money, so we’re trying to find other ways to best meet the needs of clients.” (Secondary Service Manager)

2.6.3.5 Staffing

Low staffing is an issue for nearly all services, except for those who offer volunteer home visiting. Managers expressed that obtaining more staff would be a key means to improve home visiting programs. The inability to do so however, relates to inadequacies in funding. One secondary service manager said that because of recent cut backs in funding they’ve been forced to reduce the number of staff from seven home visitors to one and that the existence of the program itself is not for certain. Overall, low staffing has also led to increased workload, waiting lists and even refusal of service.

The participants found that the workload of home visitors far surpasses the number of home visitors available to manage it. Universal service managers complained that they often have to borrow nurses from other programs who are not funded to carry out home visiting, to assist with the workload.

On the occasions when demand far exceeds supply, secondary home visiting services refer cases to support groups or other home visiting services (usually volunteer). These managers said that it is important to link people into some service even if they can’t take them in themselves since, ‘they have the need now’. Often as a last resort, secondary home visiting services will maintain waiting lists, which range from 3-6 months. For ethical reasons, most tertiary services refuse to take on cases altogether if they don’t have enough staff.

Volunteer home visiting programs expressed a slightly different concern with regards to staffing. Despite having a number of visitors, because volunteers are under no obligation to stay with the service, stability can suffer. The manager of one volunteer home visiting services expressed that their turnover rate is quite high, which can have negative consequences on clients and the program, as training is resource and energy intensive: “We lose them almost as fast as they train them!”
Although recruiting staff was not considered to be a major obstacle for most services, a few services have encountered major obstacles in this area. One of these is the Aboriginal universal home visiting service, which finds it difficult to recruit among the Aboriginal community. The other is a tertiary service, which attributes the difficulty to the challenging nature of the work and the low pay.

### 2.6.3.6 Resources

Home visiting is believed to be a resource intensive service, yet most services expressed the view that they maintain low levels of resources, which can pose a serious problem. Besides staff and time, which are the basic essentials to carry out home visits, resources such as interpreters and cars needed to facilitate the work, are rather scarce. Many services for instance will cater to migrant groups, yet few have home visitors that possess the language skills needed to communicate with all non-English speaking populations. Interpreters are an alternative, yet were said to be very expensive and often unavailable. An additional challenge in working with interpreters is that it’s much more difficult to build a relationship and assess needs with a third person.

### 2.6.3.7 O H & S Issues

The majority of home visiting programs do not accept clients when it conflicts with OH & S issues. Issues home visitors will avoid include violence in homes, serious substance abuse, dangerous pets or unsafe environment. Secondary services will more often than not refer these cases to tertiary home visiting programs or other appropriate services. Depending on the risk involved, tertiary services will spend more time to determine if they can work with these cases before deciding if they need to be referred. A few of the universal and intensive service managers said that in face of this issue they will send two visitors on a visit instead of one, in order to ensure the safety of the home visitors and to avoid refusing service.

### 2.6.3.8 Policy

Some participants felt that particular policies will prevent certain individuals from being reached. For example, programs in which visitors act as mandatory notifiers can potentially deter clients from taking up service out of fear. A second concern raised by some was that because services target parents with young children, grandparents and other caretakers may be a group that are neglected.

### 2.6.4 Summary

Service managers and home visitors considered that home visiting programs will be influenced by the capacity of the client, visitor and institution.

Those clients with entrenched problems (substance abuse problems, domestic violence) maintain the least capacity to engage in home visiting, which negatively effects their ability to benefit. It was felt that Aboriginal populations are difficult to reach because of cultural differences and service mistrust. Clients who have good
support, stable housing, and non-complex needs were felt to have the capacity to benefit most from home visiting.

Most service managers and home visitors considered that home visitors are well supported by supervisors and teams. Burnout was an issues guarded against. The areas of most concern were in the need for further staff capacity building through training in cultural sensitivity and awareness, as well as training to assist home visitors in setting boundaries with clients.

Major obstacles for home visiting programs include heavy workload, unstable funding, short contracts and resource constraints. Stability and continuity of visitors is a concern for volunteer home visitors. Service managers and home visitors were concerned that vulnerable groups can be subject to further marginalisation when services don’t respond to them due to O H & S issues or lack of visitor skills and client capacity. In addition, non-English speaking families may not be receiving adequate home visiting due to lack of language skills amongst home visitors, difficulties in using interpreters (who may effect the ability of the home visitor to establish a familiar trusting relationship) and cultural misunderstandings.

At a program level, participants considered their services to have good service networks however, the effectiveness of home visiting could be impacted by waiting lists. An area for improvement was in relationships with general practitioners.

2.7 What types of outcomes are achieved by early childhood home visiting services?

For the most part, the participants in the study did not clearly articulate the outcomes of their home visiting service, particularly relating to aspects of the intervention. Overall they seemed to portray general anecdotal outcomes related to the overall service. Those outcomes raised by the participants are highlighted below.

**Increased use of services and programs**

This appeared to be an important expected outcome for the participants. Universal nurse home visitors for instance looked to increase attendance at the clinic for regular check-ups, whereas secondary and tertiary services emphasised increased use and uptake of other support services and groups. When asked how they knew interventions were working, the following were some of the responses given;

“`When they come into the clinic.” (Primary Service Home Visitor)`

“`Once they have accessed services we know it’s been effective.” (Secondary Service Manager)`

“`Observation and feedback from other services.” (Primary Service Manager)`
A few participants stated that they know that they are reaching clients when clients react positively to future visits and show more interest to engage in the visit.

“Parents get excited about you turning up and planning next visit” (Secondary Service Home Visitor)

**Improved networks**

Improved social networks for clients is an outcome that was mentioned by a few participants. This is achieved either through support groups or more involvement within the community.

**Improved relationships**

The participants regarded improved relationships as an ideal outcome with respect to the client and service provider, child, family and other social networks.

**Parenting skills**

Some participants mentioned that by observing how the mother interacts and handles her child over time, they could see how she utilises the parenting skills taught to her, which is an important outcome.

“By watching parent over the month, watching for parents to do things differently.” (Secondary Service Home Visitor)

**Health behaviours**

Uptake of appropriate feeding practices was said to indicate to nurse home visitors that mothers had benefited from their guidance.

**Increased confidence**

Increased client confidence was an outcome mentioned many times. This confidence relates to a client’s ability to undertake certain tasks and steps for the betterment of themselves and children.

“More confident, able to get babies and themselves organised.” (Tertiary Service Home Visitor)

“Easier for person when going out.” (Secondary Service Manager)

**Improved problem solving**

Witnessing clients draw on their strengths to solve problems was viewed as a key outcome for clients.

“Because they are doing the right thing.” (Secondary Service Manager)
“It enables the family to be able to use strength to solve issues.” (Primary Service Manager)

**Control**

Exerting more control in life was another important outcome for clients. According to the home visitor of an intensive service, this control does not necessarily imply that the client is 100% well, but that they are able to at least take the steps to make changes in parts of their lives, working towards a higher goal.

“Where people are at the end of the program-some may not be completely off drugs-but may not be in prison in the last 12 months or have reconnected with families. Success is an individual thing-not necessarily reflected in abstinence from drugs.” (Tertiary Service Home Visitor)

### 2.7.1 Summary

Outcomes are mostly anecdotal based on observation, rather than systematic measurement. Key outcomes were increased client confidence, increased use of services and programs, recognition of strengths and improved problem solving, and greater client control over their lives. These outcomes however, were spoken about in general terms, rather than being linked to interventions used or the goals of the service.

### 2.8 Discussion

Using several approaches to our analysis, we have been able to comment on several key aspects of how services in SWS approach and deliver home visiting. Notably on,

- The aims and approach to service of early childhood home visiting programs operating in SWS
- What home visiting offers as an early childhood intervention/prevention service
- The influence of capacity on the success in carrying out early childhood home visiting programs
- The outcomes of early childhood home visiting programs.

In section 2.4 we discovered that there is great variety in the groups targeted by home visiting programs in South Western Sydney however, Aboriginal and refugee families were groups participants felt were not targeted by current services. Families who were isolated were the major focus for most services.

All participants described their programs as strengths-based and solution focussed and offered a variety of interventions to meet clients’ social, educational, psychological, physical, material and support needs. Few programs however, had a specific model or theory guiding their services. In addition, few programs undertook systematic evaluation activities using standardised tools, but rather, relied on more informal feedback and client satisfaction surveys.
The interventions offered by home visiting programs in South Western Sydney were consistent with the findings of the literature analysis. Programs in South Western Sydney, like those internationally, focussed on strategies to improve parenting skills and child development and on providing resources. The strategies employed by home visiting programs in South Western Sydney were, therefore, consistent with those strategies shown to be more likely to produce significant positive outcomes: parenting skills, resources, and child development (see Table 1.5-2).

We investigated the strategies used in home visiting services further in section 2.5. Home visiting services establishing the context for home visiting through integrating with the family, opportunistically identifying need, and providing a predictable, flexible, accessible and acceptable service. The importance of the trust relationship between the visitor and the client was highlighted by participants. As listed by participants in Stage Two, the programs in South Western Sydney focussed on social support, more so than those reported in the international literature. This however, may be due to under-reporting of the relationship building activities in the academic literature, as the social support afforded by the visitor may not be identified as such. The social support described by the participants in this study included the support provided by the familiar trust relationship between the visitor and the client, which is a facilitator of the home visiting intervention. Further, services offer multifaceted, integrated interventions to address the needs of the clients. These approaches by the home visiting programs in South Western Sydney is generally consistent with best practice in home visiting as described by Gombley, as shown in Table 2.8-1.

In section 2.6 we looked at client, visitor and institutional capacity and how participants felt their programs were effected by them. We learned that essentially, the right level of capacity needs to be injected into a program for it to work effectively. Client, visitor and institutional capacity could all impact on the home visiting programs' ability to provide their services optimally. The observation by participants that those clients with very complex needs were less likely to benefit from home visiting is consistent with the international literature analysis which showed few studies reporting positive outcomes for families at risk of abuse and neglect or where there is drug use.

Generally, participants were positive about the visitors' capacity to provide services. Participants also recognised some limitation in institutional capacity, particularly relating to waiting lists, funding, staffing and resourcing of home visiting activities. The capacity of programs to deliver the home visiting intervention is an area under-reported in the international literature. Only recently have commentators sought to understand the variability in success of home visiting programs reported in the literature, and are identifying variable program capacity and fidelity as contributing factors.

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Table 2.8-1 Best practice criteria for home visiting interventions\(^{21}\) compared with programs in South Western Sydney

<table>
<thead>
<tr>
<th>Best practice criteria</th>
<th>Programs in South Western Sydney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal systems should be offered to everyone so that it is not stigmatising – but it does not have to be uniform.</td>
<td>A range of services is available focusing on differing population groups and sub-groups however, difficulty experienced in providing mainstream services to Aboriginal and refugee families.</td>
</tr>
<tr>
<td>Must go beyond visit to reach goals.</td>
<td>Most services offer supplementary activities including centre-based activities and telephone support.</td>
</tr>
<tr>
<td>Address need of parent and child.</td>
<td>Services focus on social support, parenting skills and resources as well as child development. Services provide psychological, instrumental and educational interventions.</td>
</tr>
<tr>
<td>Flexibility in intensity and duration.</td>
<td>Primary, secondary and tertiary services all offer some flexibility in service schedule. Secondary and tertiary services in particular, are guided by the needs, circumstances and characteristics of their clients.</td>
</tr>
<tr>
<td>Staff should be employed in their ability to meet program goals and population served, rather than degree. Careful matching (client-visitor).</td>
<td>The creation of a trust relationship is crucial to home visiting. Institutional trust in nurses is the basis of universal services. The ability of staff to engender familiar trust is the basis of secondary and tertiary services.</td>
</tr>
</tbody>
</table>

Finally in section 2.7, we were able to identify various outcomes of home visiting from the data. These outcomes however, were not clearly articulated or defined by the participants. The general impression was that outcomes were more anecdotal than evidence based. The outcomes identified by participants did not easily relate to the types of outcomes measured in the international literature (see Table 1.4-9).

Nevertheless, some identified outcomes could be viewed as direct impacts leading to outcomes in the literature, including:

- Increased confidence, improved problem solving, leading to improved maternal depression and self-esteem
- Improved networks and relationships, leading to improved social support
- Increased use of programs and services, including uptake of preventive services
- Health behaviours including breast feeding
- Improved control, leading to less risky behaviour.
- Improved parenting skills, leading to improved environment, and improved child behaviour, health and mental development.

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Few services in South Western Sydney undertook systematic measurement of outcomes.

A final finding from the empirical study reported here was that although managers and home visitors were able to comment on the various components, approaches and processes of their home visiting services, they lacked a clear understanding of how the pieces actually fit together. For example, despite the fact that participants acknowledged that institutional capacity is not always present, there was no indication on the part of program managers that this changed or will effect overall program goals, aims or strategies. Further, service managers and home visitors experienced difficulty in identifying the outcomes of their programs, and attempting to relate the to the program strategies. Such ambiguity in understanding may indicate that home visiting programs participating in this study lack an adequate conceptual framework of service provision to guide program execution (as was reflected in section 2.4). This could be expected as, to date, home visiting programs have received little guidance from the literature or elsewhere to assist program managers balance priorities and limitations, while monitoring the achievement of expected outcomes.
Section 3: A generic framework for early childhood home visiting

3.1 Aim

The final stage in this project was to utilise all the available data to develop a generic framework for early childhood home visiting which would facilitate the planning and evaluation of home visiting programs in South Western Sydney.

3.2 Method

The data were analysed using the grounded theory method of analysis. Grounded theory method is particularly useful where there is little research in the subject area, and where existing understandings of a concept fail to be useful in resolving persistent problems. The grounded theory method is particularly useful in developing an understanding of the conditions and outcomes of processes and interactions.

3.2.1 Data

Data from all components of the study were used. These included:

- International literature analysis reported in Section 1:
- Qualitative data from the empirical study reported in Section 2:
- Qualitative data from the concurrent evaluation of the Karitane volunteer home visiting program, being undertaken at the Centre for Health Equity Training Research and Evaluation.

3.2.2 Analysis

In the first step of the grounded theory analysis, the coding undertaken in the analyses in Section 1 and 2 were reviewed. Codes were then grouped together according to their conceptual similarities. Constant comparative analysis was then undertaken to develop the model. Constant comparative analysis is the process of developing concepts which are then refined by reviewing and comparing other data. On the basis of these comparisons concepts may be confirmed, discarded, refined or elaborated, and their relationships to one another are explored. Ultimately the concepts are integrated into a coherent model which includes an awareness of the context and the conditions under which processes occur, and considers the consequences of these processes, contexts and conditions. Such a model should both 'fit' and 'work', that is, it should be applicable to the data examined and be meaningfully relevant.

Whilst the program managers and home visitors in South Western Sydney experienced difficulty in articulating the relationship between interventions and

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outcomes, and the impact of capacity, by looking at patterns within all the data, it was possible to identify such relationships and impacts.

### 3.3 Results

#### 3.3.1 Three co-dependent aspects of intervention

It was clear from our analyses that the best practice approach to home visiting involved working in context, establishing a trusting relationship and intervening with a multifaceted, integrated response. The emerging evidence in the international literature suggests that the establishing the context and trust relationship create the conditions for home visiting. These conditions are necessary for the success of home visiting, but are not sufficient to change parent behaviour. In order to do so, home visiting programs provide a response to identified needs. The literature and empirical study suggest that the response could be classified under three types: psychosocial, instrumental and educational.

The literature and patterns identified in the empirical data indicate that the conditions for home visiting (context and trust relationship) and the response (psychosocial, instrumental and educational interventions) are co-dependent. That is, providing a response is dependent on the context and relationships integral to home visiting, and these conditions are in turn dependent on the home visiting response. For example, home visitors providing secondary and tertiary services described the process of developing the familiar trust relationship as reliant on the home visitor providing prompt instrumental response to identified need early in the relationship. This included such things are providing promised information or organising transport, which facilitated the development of the client's trust.

The literature and empirical data also indicate that different types of services (primary, secondary, tertiary) provided by different types of home visitors (nurses, other professionals, lay/volunteer) will provide differing responses. These relate to the needs and capacity of the client group and the skills, training and capacity of the visitor and the program. Further, these responses by home visiting programs may occur during the home visit, but may also occur during supplementary activities. For example, education about child development may occur within the home and also in a parenting group.

#### 3.3.2 Capacity to deliver and respond to intervention

By exploring the interactions and patterns in the data between the identified aspects of home visiting intervention and the capacity or clients, visitors and institutions, the mediating effect of capacity was evident. In both the literature analysis and empirical study, clients with complex and entrenched problems were less likely to be able to respond to the home visiting intervention in ways that demonstrated outcomes. Emerging literature (for example, Olds recent comparative trial of nurse and
paraprofessional home visiting\(^{25}\) has highlighted the varying capacities of differing professional groups to deliver varying home visiting programs. Respondents in the empirical study also identified visitor capacity issues. Institutional capacity, whilst under-reported in the literature, was clearly identified as a mediating factor in the delivery of home visiting programs in South Western Sydney.

The capacity to deliver or respond to the intervention and the three co-dependent aspects of the intervention have an interactive effect on each other. For example, the training, skills, and experience of the home visitor will effect their ability to deliver responses and establish a trust relationship. Conversely, the type of response required may impact upon the support and supervision needed by the visitor. The reputation of the institution providing the home visiting program will impact on the likelihood of an institutional trust relationship. Conversely, the required response will be mediated by the staffing, funding, resources and program capacity. There is also an interactive relationship between the types of responses needed and the client's present and future capacities.

### 3.3.3 Five correlated outcomes

The outcomes identified in the literature and the empirical study were able to be clustered into five conceptual groups: social resources, social well-being, demonstrated knowledge, emotional well-being and adaptability.

Social resources includes the appropriate use of services and programs as well as increased community participation, including such activities as getting out of the house to go shopping, to the child's school, or to sporting or other community activities. Social well-being includes improved social networks (such as through parenting or play groups), and improved friendship and family relationships. From the patterns of data in the empirical study, these outcomes were achieved where the trust relationship with the home visitor impacted on the development of broader generalised community, personal and institutional trust, through affirming and empowering clients and providing instrumental assistance.

Demonstrated knowledge includes demonstrating and enacting knowledge of parentcraft, adaptive parenting skills (that is, the skills to respond appropriately to the child's needs) and life skills, appropriate developmental expectations and health behaviours, primarily resulting from educational responses. Emotional well-being includes reduced anxiety and stress, reduce negative feelings, increased confidence and increased self-esteem primarily resulting from psychosocial responses. Adaptability includes improved problem solving, resourcefulness and control, resulting from psychosocial, instrumental and educational responses.

The five outcomes are highly correlated. For example, reduced stress may result in improved family relationships, which conversely could contribute to reduced stress.

Improved problem solving, and appropriate developmental expectations may result in improved adaptive parenting skills, and vice versa.

The quality and quantity of outcomes achieved is dependent on the aspects of intervention implemented within each home visiting program, the capacity of the program to deliver the intervention, and the capacity of the client to respond to the intervention.

### 3.4 Model

Through our findings, we have developed a generic model of home visiting interventions and outcomes (Figure 3.4-1). This model re-iterates our findings into a visual tool that accounts for program logic, capacity and outcomes, directly related to the home visiting program. The model functions within a broader context of categorisation of programs described in Section 2.3, relating to the universal or targeted focus of the program, identification of needs and risk for the individual or the population, and proactive versus reactive approaches.

Once the needs and/or risks of the individuals and population, and approach of the program has been determined, this model can be used to show how the components of the home visiting program (intervention, capacity and outcomes) relate to one another and influence program success. This model can also be used as a valuable program planning and evaluation tool for primary, secondary and tertiary home visiting services.
### 3 CO-DEPENDENT ASPECTS OF INTERVENTION

<table>
<thead>
<tr>
<th>Create the conditions</th>
<th>3. RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CONTEXT</td>
<td>2. TRUST RELATIONSHIP</td>
</tr>
<tr>
<td>Integrated into normal activities</td>
<td>(institutional ↔ familiar)</td>
</tr>
<tr>
<td>Integrated in environment</td>
<td>Reliable</td>
</tr>
<tr>
<td>Predictable</td>
<td>Non-authoritarian</td>
</tr>
<tr>
<td>Opportunistically identifying needs</td>
<td>Back-up, safety net</td>
</tr>
<tr>
<td>Flexible</td>
<td>Agreed boundaries/expectations</td>
</tr>
<tr>
<td>Accessible</td>
<td>Persistence, continuity</td>
</tr>
<tr>
<td></td>
<td>Support</td>
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<tr>
<td></td>
<td>Shared experiences</td>
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<tr>
<td></td>
<td>Confidante</td>
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<tr>
<td></td>
<td>Psychosocial</td>
</tr>
<tr>
<td></td>
<td>- Affirmation</td>
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<td></td>
<td>- Normalising</td>
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<td></td>
<td>- Empowerment</td>
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<td>- Reflecting behaviour</td>
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<td>- Different perspective</td>
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<td>- Problem solving</td>
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<td>- Goal setting</td>
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<td></td>
<td>Instrumental</td>
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<td>- Information made accessible</td>
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<td>- Resources</td>
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<td>- Linking</td>
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<td>- Practical help (transport, child minding)</td>
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<td>- Advocacy</td>
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<td>- Accompanying</td>
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<td>Education</td>
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<td></td>
<td>- Adaptive parenting/attachment skills</td>
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<td></td>
<td>- Parentcraft skills</td>
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<td></td>
<td>- Child development</td>
</tr>
<tr>
<td></td>
<td>- Life skills</td>
</tr>
<tr>
<td></td>
<td>- Health promotion</td>
</tr>
</tbody>
</table>

### CAPACITY TO DELIVER/RESPOND TO INTERVENTION (mediating layer)

<table>
<thead>
<tr>
<th>CLIENT (mother/family)</th>
<th>VISITOR</th>
<th>INSTITUTIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience</td>
<td>Training</td>
<td>Staffing</td>
</tr>
<tr>
<td>Skills</td>
<td>Experience</td>
<td>Programmatic</td>
</tr>
<tr>
<td>Support</td>
<td>Support/supervision</td>
<td>Networks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Funding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>number, length,</td>
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<tr>
<td></td>
<td></td>
<td>duration of visits)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals/values</td>
</tr>
</tbody>
</table>

### 5 CORRELATED OUTCOMES

<table>
<thead>
<tr>
<th>1. SOCIAL RESOURCES</th>
<th>2. SOCIAL WELL-BEING</th>
<th>3. DEMONSTRATED KNOWLEDGE</th>
<th>4. EMOTIONAL WELL-BEING</th>
<th>5. ADAPTABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased appropriate use of services and programs</td>
<td>Improved networks</td>
<td>Parentcraft</td>
<td>Reduced anxiety/stress</td>
<td>Improved problem solving</td>
</tr>
<tr>
<td>Increased community participation</td>
<td>Improved friendship relationships</td>
<td>Adaptive parenting</td>
<td>Reduced negative feelings</td>
<td>Resourcefulness</td>
</tr>
<tr>
<td></td>
<td>Improved family relationships</td>
<td>Appropriate developmental expectations</td>
<td>Increased confidence</td>
<td>Control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Life skills</td>
<td>Increased self esteem</td>
<td></td>
</tr>
</tbody>
</table>
3.4.1 How to use the model

The model is divided into three parts, ‘Three Co-Dependant Aspects of Intervention’, ‘Capacity to Respond and Deliver’ and ‘Five Correlated Outcomes’. All of these have been discussed in some detail in sections 3.3 and 3.4. The model functions within a broader framework of decisions regarding the parameters of the program to be introduced, such as the focus of the program (universal/targeted), the approach to be taken (proactive/reactive) as detailed in section 2.3, and the identification of the needs of both the population to be served by the intervention and the individual clients participating in the service.

To assist in effectively planning or evaluating home visiting programs, five questions can then be asked based on the model within the broader framework of program design and need identification (Figure 3.4-2).

Figure 3.4-2 Evaluation and planning questions

1) What are the desired outcomes of the home visiting program?
2) Does this program establish the conditions for the home visiting?
3) Are interventions offered evidence-based, realistic and related to the desired outcomes?
4) Is there mediating capacity to carry out the program adequately and achieve outcomes?
5) Are the desired outcomes achieved?
We will demonstrate how the model can be used as both an evaluation and planning tool, using the examples of evaluating a universal health home visiting program and planning a sustained home visiting service.

### 3.4.1.1 Example of evaluating a universal health home visiting program

The first example is of an evaluation of a primary, universal health home visiting program, based on the description of these services provided in section 2.4 and the NSW Home Health Visiting Guidelines. As described earlier, universal health home visiting aims to provide 1-2 visits to all new mothers two weeks after delivery.

Although some health services will also offer sustained home visits if needs are identified in the universal visit, that component of the service must be considered to be a secondary program and evaluated separately based on outcomes expected for sustained home visiting, rather than a primary, universal service.

1) **What are the desired outcomes of the home visiting program?**

The first stage in evaluating any program is to establish the desired outcomes for the home visiting program. These outcomes should be realistic taking into account the program parameters, population and individual client need, the capacity of the program and the aspects of intervention implemented. It is important to be circumspect regarding what can realistically be achieved.

For example, in a universal home visiting program, with capacity to offer 1 or 2 home visits to new mothers, focussing on affirming and normalising mothers at home could, realistically, be expected to have an impact on reducing anxiety and increasing the mothers' confidence. Providing accessible information about parenting and play groups may (if the information is acted upon) result in improved networks. Referrals to other service providers and information about the centre-based child health clinics may (if the referral and links are acted upon) result in increased appropriate use of services and programs. Similarly, providing information and education about child development, parentcraft (such as sterilisation and sleep and settling), and immunisation could be expected to result in demonstrated knowledge of parentcraft, appropriate developmental expectations and health behaviours such as breastfeeding and immunisation.

2) **Does this program establish the conditions for home visiting?**

The first step in evaluating this program is to determine if the conditions for the intervention are being met. Universal home visiting programs are no different than others in terms of the place they will work and identify needs.

Referring to the section ‘Context’ in the model, the program manager carrying out the evaluation can determine if this condition is met adequately by checking against all the items listed in this section. These include;
For instance as a universal program to all mothers, the service is considered to be *predictable*. To maintain predictability, the appropriate measures need to be implemented to ensure that all mothers are reached after delivery. In that, managers need to ensure that mothers have not fallen through the cracks, and should investigate any known cases that have, to determine why it happened and how to avoid future occurrences.

With respect to creating the second condition, ‘Trust Relationship’, we have highlighted that nurse home visitors have an advantage over other types of visitors because they maintain *institutional trust*. This is important as they do not have the time to build familiar trust.

Guided by the model, other characteristics of the trusting relationship maintained by the universal home visitor include:

<table>
<thead>
<tr>
<th>2. TRUST RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>(institutional ↔ familiar)</td>
</tr>
<tr>
<td>✓ Reliable</td>
</tr>
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<td>- Support</td>
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<tr>
<td>- Shared experiences</td>
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</tbody>
</table>

Other areas such as, *continuity*, are not included in the list for universal services, due to the few visits that are carried out. Sustained home visiting on the other hand, would maintain this characteristic in their approach.

Once it has been determined that the program is creating the appropriate context for home visiting, the second question can be asked.
3) Are interventions offered evidence-based, realistic and related to outcomes?

Some of the goals of universal home visiting cited in the NSW Health Home Visiting Guidelines include;

- Provide an opportunity to respond to issues or concerns the parent may have regarding the health and development of the baby, to monitor the baby’s growth and general progress, and provide information as required;
- Provide an opportunity to identify with each family, condition and experiences that will promote their baby’s health and well-being and to promote parent infant bonding and attachment
- Link the family with other appropriate service and supports, including centre based early childhood health services

To ensure that an effective intervention response is offered, it is important to ensure that these goals are reached using valid theories that are linked to the desired outcomes. In general, nurse home visitors in a universal program have the capacity to offer several evidence-based responses/interventions, which will fall under the categories outlined in the model under ‘Response’

Given however, that only one or two universal home visits will be carried out by this service, only a select few can realistically and effectively be offered to reach these aims. These could include;

<table>
<thead>
<tr>
<th>Psychosocial</th>
<th>Instrumental</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Affirmation</td>
<td>✓ Information made accessible</td>
<td>✓ Adaptive parenting/ attachment skills</td>
</tr>
<tr>
<td>✓ Normalising</td>
<td>✓ Resources</td>
<td>✓ Parentcraft skills</td>
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<tr>
<td>✓ Empowerment</td>
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<td>- Different perspective</td>
<td>- Advocacy</td>
<td>✓ Health promotion</td>
</tr>
<tr>
<td>- Problem solving</td>
<td>- Accompanying</td>
<td></td>
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<tr>
<td>- Goal setting</td>
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</tbody>
</table>

To address attachment issues for instance, universal home visitors will aim to promote this behaviour, as opposed to ensure that it has been taken up, which can take time. Thus, care must be taken in determining and measuring outcomes based on what is offered. For instance, whereas a sustained nurse home visitor can expect a client to develop child interaction skills, and monitor that development, a universal home visitor can only really expect that the client is aware of its importance and seeks out help if necessary—thus these should be the outcomes measured for this type of service.

Despite the few visits and interventions however, it should be said that, universal home visitors can still make a big impact on clients. Normalising for instance can greatly help new mothers who are stressed by behaviours in their children that they don’t understand. Based on the nurse home visitors health knowledge, they should be able to explain and normalise the situation fairly quickly and adequately reduce anxiety levels in the mother.
It is important to note that any intervention provided as a response will be taken up more easily if the visitor has established an appropriate level of trust with the client. Thus highlighting the co-dependent aspects of the intervention.

After going through each response and ensuring that they are appropriate, realistic and achievable, the next question that can be asked is,

4) **Is there mediating capacity to carryout the program adequately and achieve outcomes?**

Managers need to look at the various levels of capacity, to determine if outcomes can be achieved. Essentially, ensuring capacity of the client, visitor and institution are areas that home visiting services need to strive to achieve. For the purposes of evaluation, the model can be used to signal if a program is not reaching program goals and outcomes due to a lack of capacity in any of these areas.

For example, if a home visitor identifies that a client has psychological needs, the visitor can intervene by linking them with a counsellor in the community. The ability to link the client however, will depend on the effectiveness of the network of services the program has established. As linking is a major component of universal home visiting, ensuring that effective referral pathways are established is essential and should be an area of capacity to focus on.

Another area of capacity refers to visitor skills and training. For this service, all home visitors would need to have a nursing background and preferably experience in family welfare or social support. Additional expertise that nurses should have can be determined by the population served. For instance, if the majority of the population to be provided services are non-English speakers, then nurses with specific language skills may be preferred. If this is not possible, then mobilising interpreters to go along to visits would be the next alternative. If there is inability to gain capacity in this area however, a large proportion of mothers may be under serviced, which would ultimately effect the universality of the program.

Overall by using this model, home visiting programs that target families with young children, can gain insight into the right mix of the various components needed to achieve goals most effectively, in light of the capacity of their clients, visitors and institution.

5) **Are the desired outcomes achieved?**

Whilst many of the outcomes desired from a universal home visiting program require that the client act upon the information, education and resources provided, measurement of the desired outcomes will provide evidence of the effectiveness of delivery of the interventions and the conditions of the home visit. For example, measuring subsequent use of centre-based child health services (increased use of services and programs), would be indicative of the effectiveness of the conditions of the home visit and the response – where the visitor was reliable and engaged with the client in a non-authoritarian manner, and provided accessible, useful and relevant
information and resources, the client may feel there was value in using the centre-based service.


3.4.1.2 Example of planning a sustained home visiting program

The second example is of the use of the framework to assist in planning a sustained home visiting program, based on the description of these services provided by service managers and visitors and the NSW Health Home Visiting guidelines. Sustained home visiting programs aim to provide an intensive and long-term (2-3 years) intervention for defined population or subpopulation with vulnerabilities.

In using the model for planning of services it is particularly important that the broader framework for the home visiting program be established. That is, decisions need to be made regarding:

a) program parameters, including, universal versus targeted and proactive versus reactive approaches; and
b) identification of the needs and risks of the individuals and population to be served will need be undertaken.

What are the desired outcomes of the home visiting program?

In planning a sustained home visiting service an initial task is to identify the desired outcomes of the service. This should be done with reference to knowledge of the needs of the defined population. For example, the literature analysis suggests that women with low socioeconomic status are likely to show positive outcomes from home visiting in the areas of emotional well-being (maternal depression/self-esteem) and health behaviours (child health, and breastfeeding (see Table 1.4-13)).

Does this program establish the conditions for the home visiting?

Next, the program should establish the conditions for sustained home visiting. Sustained home visiting is based on establishing a familiar trust relationship between the visitor and the client. The desired aspects of the trusting relationship should be established. For example, a professional sustained home visiting program could plan to establish a relationship based on reliability, persistence and continuity, non-authoritarian approaches, and providing a back-up and a safety net, within clearly defined boundaries of practice. A volunteer sustained home visiting program could plan to be reliable and non-authoritarian but have less clearly defined boundaries, and base the trust relationship on shared experiences (by carefully matching client and visitor) and visitors being clients' confidante. These two examples are illustrated in the following sections taken from the model.
**Example of sustained professional home visiting program**

1. CONTEXT
   ✓ Integrated into normal activities
   ✓ Integrated in environment
   ✓ Predictable
   ✓ Opportunistically identifying needs
   ✓ Flexible
   ✓ Accessible

2. TRUST RELATIONSHIP
   (institutional ↔ familiar)
   ✓ Reliable
   ✓ Non-authoritarian
   ✓ Back-up, safety net
   ✓ Agreed boundaries/expectations
   ✓ Persistence, continuity
   - Support
   - Shared experiences
   - Confidante

**Example of sustained volunteer home visiting program**

1. CONTEXT
   ✓ Integrated into normal activities
   ✓ Integrated in environment
   ✓ Predictable
   ✓ Opportunistically identifying needs
   ✓ Flexible
   ✓ Accessible

2. TRUST RELATIONSHIP
   (institutional ↔ familiar)
   ✓ Reliable
   ✓ Non-authoritarian
   - Back-up, safety net
   - Agreed boundaries/expectations
   - Persistence, continuity
   ✓ Support
   ✓ Shared experiences
   ✓ Confidante

*Are interventions offered evidence-based, realistic and related to the desired outcomes?*

It is essential that the service planner determine the responses to be included in the program. The responses should be based on evidence of effectiveness for the particular population group to be served. For example, there is evidence of effectiveness of psychosocial interventions improving emotional well-being for mothers with postnatal depression. Conversely, for example, there is little evidence that the provision of practical help will result in improved problem solving (see Table 1.4-14). The program planner would therefore determine the interventions most likely to produce positive outcomes for the program participants, as illustrated in the following examples.
Is there mediating capacity to carry out the program adequately and achieve outcomes?

Next, planners should determine the client, visitor and institutional capacity needed to deliver and respond to the chosen interventions in order to achieve the desired outcomes. For example, a professional sustained home visiting program addressing emotional well-being for mothers with postnatal depression may consider a staffing mix of appropriately trained nurses, social workers and psychologists, and resource the staff team with access to a perinatal psychiatrist. A volunteer sustained home visiting program aiming to achieve increased client community participation by providing instrumental interventions such as practical help with transport, would need to consider the transport resources (cars) available for use by the program.

Are the desired outcomes achieved?

Once established, the program should undertake evaluation to determine whether the desired outcomes are being achieved. Issues relating to the context, response and capacity of the program can then be identified and addressed.
3.5 Discussion

A generic model of home visiting has been developed based on the data from the literature analysis and empirical study. The model demonstrates that there are three co-dependent aspects of home visiting intervention – the context of home visiting and the trust relationship which together create the conditions for home visiting facilitating psychosocial, instrumental and educational responses.

The ability of a home visiting program to create the conditions for home visiting and provide a response is effected by and in turn effects the clients', visitors' and institutions' capacity to deliver and respond to the intervention.

Five correlated outcomes of home visiting were identifiable in the literature and empirical data: social resources and social well-being, arising from improved generalised and institutional trust; demonstrated knowledge; emotional well-being; and adaptability. The ability of home visiting programs to effectively achieve outcomes is mediated by client, visitor and institutional/programmatic capacity.

This model presents these aspects of intervention, capacity and outcomes into a visual tool that accounts for program logic, capacity and outcomes and shows how these components relate to one another and influence program success. Benefits of the model include:

- Offers guidance to plan and evaluate home visiting programs
- Assists in identify desired interventions and outcomes
- Helps link outcomes to interventions offered
- Helps determine the best mix of interventions for each program (based on desired outcomes and capacity)
- Reveals how program approach can effect program capacity and vice versa
- Assists in determining if capacity is available to carry out program aims

Further refinement of the model may occur through future use of the model as an evaluation and planning tool. In particular, identification of standardised tools for measurement of intervention, capacity and outcomes will facilitate the comparative and systematic evaluation of home visiting programs.26

26 This work is currently being undertaken by the Home Visiting subgroup of the NSW Families First Research and Evaluation Expert Advisory Committee.
Section 4: Conclusion and key areas for future action

Home visiting as an intervention to improve outcomes for families with young children has been implemented extensively, particularly in the USA and also in the UK. The evidence from the evaluations of these interventions suggests that low socioeconomic families (including families living in low socioeconomic areas, as well as population groups of lower socioeconomic status such as teenaged and unmarried mothers) are most likely to benefit from home visiting programs. Targeted psychological interventions for women with postnatal depression are also effective in improving maternal depression and self-esteem. The programs reported included a range of content including provision of resources and information, parenting skills, child development, counselling, problem solving, social support and parent-infant interaction, according to the needs of the population and/or clients served.

The evidence in the literature indicates that interventions more likely to give positive outcomes are those commencing antenatally, and those providing parenting skills, resourcing parents, and encouraging parent-infant interaction. Positive outcomes were also achieved from interventions focussing on child development, providing counselling and problem solving. Interventions focussed on social support were less likely to report positive outcomes.

In South Western Sydney (SWS) there is a range of home visiting services including services directed at children and families with varying vulnerabilities ranging from isolation to existing child protection issues. Most commonly, home visiting programs in SWS target women experiencing isolation. Indigenous and refugee groups are not a main focus for most SWS home visiting services. Unlike the programs reported in the literature, families in lower socioeconomic groups are not a primary focus for most home visiting services, with the exception that primary services did maintain some focus on teenaged mothers.

The content of home visiting programs in SWS is consistent with the approaches shown to be of most benefit in the international literature. All SWS home visiting programs are based on strengths and solution based models. Most SWS programs focus on providing parenting skills, offering social support to families and linking families to resources. Contrary to the international evidence regarding the best outcomes, however, most home visiting programs in SWS commence postnatally.

SWS home visiting program managers and visitors identified the importance of home visiting as a means of creating the conditions for effective intervention. By providing a service within the context of the families' homes, home visiting providers are able to identify need and implement interventions more appropriately. Service provision is further facilitated by the development of a trusting visitor-client relationship. Creating the optimal conditions facilitates a range of psychological, instrumental and educational responses to the needs of families.

Service managers and home visitors in SWS identified a number of issues relating to the capacity of services to deliver home visiting programs, and the capacity of families to benefit from such programs. For families, there were capacity issues relating to clients with entrenched and complex issues, as well as issues in delivering
culturally appropriate services to non-English speaking, refugee and Aboriginal families. Service capacity issues included instability of funding, staff capacity and training, and resource constraints.

Although home visiting program managers and visitors in SWS were able to detail the elements of the intervention, and capacity issues they were not able to clearly articulate the outcomes of home visiting for families. Few home visiting services in SWS undertake systematic measurements of outcomes for their clients. Managers and home visitors were able to comment on the various components, approaches and processes of their home visiting services, however, they lacked a clear understanding of how the pieces actually fit together. Further, service managers and home visitors experienced difficulty in identifying the outcomes of their programs, and attempting to relate the to the program strategies.

Such ambiguity in understanding may indicate that home visiting programs participating in this study lack an adequate conceptual framework of service provision to guide program execution. This could be expected as, to date, home visiting programs have received little guidance from the literature or elsewhere to assist program managers balance priorities and limitations, while monitoring the achievement of expected outcomes. The generic model of home visiting developed here can assist in:

a) articulation of the intervention, capacity and outcomes for home visiting programs; and
b) evaluation and planning of home visiting programs.

**Key action areas**

Based on the integrative review of the literature, data and analyses undertaken, issues relating to the capacity of home visiting programs in SWS have been identified in the areas of ensuring adequate coverage of all target groups within the region, and the capacity of the programs to deliver home visiting services. In addition, areas for action in planning and evaluation of home visiting programs have been identified.

Key areas for future action can be made in two areas:

1) Building capacity in South Western Sydney
2) Planning and evaluation of home visiting programs.

**1) Building capacity in South Western Sydney**

Recommendations regarding target groups

- Programs need to place a greater emphasis on understanding how to best work with Aboriginal, refugee and non-English speaking groups via training of visitors, and improved collaboration with other Aboriginal and multicultural community services.
- There is a need to develop better strategies to reach clients with complex needs, and under-served groups such as grandparents and non-parental care givers.

Recommendations regarding capacity

- Funding should reflect what home visiting services are expected to do, given the capacity available to them.
• Greater security of funding would facilitate ongoing program planning and continuity.
• Training for home visitors should cover topics such as time management, boundary setting, expected service outcomes and cultural sensitivity.
• There is a need to focus on developing more effective networks and pathways through better collaboration with referral services (joint visits, feedback) and other professionals (GPs, psychologists, therapists).
• There is a need to investigate ways to retain volunteer home visitors in home visiting programs.
• Maintaining motivation in home visitors and preventing 'burnout' are paramount to the success of home visiting programs.
• Ongoing training, support and supervision for home visitors are important for ongoing staff and volunteer commitment.
• Home visiting programs should aim to develop better strategies for involving family members, such as fathers and grandparents, to improve maternal capacity to respond to intervention.

2) Planning and evaluation of home visiting programs
• Home visiting programs should consider use of the generic model of home visiting intervention and outcomes to evaluate and plan services.
• Outcomes should be realistic and consider the capacity of the client, home visitor and institution.
• Interventions should articulate the underlying models, be evidence-based, and use best practices that have been proven to reach and achieve outcomes for families and children.
• There is a need to determine standardised ways to measure processes and outcomes.
• Standardised tools such as recommended in the NSW Families First Outcomes Framework and those used in the NSW Child Health Survey should be used wherever appropriate.
• Data from evaluations should be shared among services, to facilitate comparability of measures and develop evaluation capacity.
### Appendix A: Advisory group membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
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<tr>
<td>Trish Clark</td>
<td>South Western Sydney Area Health Service</td>
</tr>
<tr>
<td>Joan Cummins</td>
<td>Campbelltown Family Support Service</td>
</tr>
<tr>
<td>Hannah Dow</td>
<td>Campbelltown Family Support Service</td>
</tr>
<tr>
<td>John Eastwood</td>
<td>South Western Sydney Area Health Service</td>
</tr>
<tr>
<td>Anne King</td>
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</tr>
<tr>
<td>Tracey Popham</td>
<td>South Western Sydney Area Health Service</td>
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<tr>
<td>Wies Schuringa</td>
<td>Benevolent Society</td>
</tr>
<tr>
<td>Deborah Ryan</td>
<td>Families First, Department of Community Services</td>
</tr>
</tbody>
</table>
Appendix B: Home visiting resources

B.1 Australian Reports

Review of the Early Intervention Parenting Program and Good Beginnings Prototypes Report

The Early Intervention Parenting (EIP) program and Good Beginnings Prototypes (GBP) were reviewed in 2003 to determine if the focus continues to be relevant to and consistent with future policy direction and program priorities. The review identified that EIP and Good Beginnings projects are broadly consistent with research on good practice.

The projects are using responsive approaches to their target groups that work from parents’ strengths. Most projects use holistic and multi-faceted approaches. Where a single focus intervention is used parents are, in the main, linked with other services. Projects demonstrate the use of a mix of individual support, skills education and community development approaches


Parenting Australia, Jesuit Social Services: Solemates

Solemates was a successful innovative early intervention program for young, isolated sole parents with babies and/or young children. The program matched these families with carefully selected and trained volunteers, who then provided intensive support and friendship through regular home visits and informal outings. Male volunteers were matched with male parents and female volunteers with female parents.

The Solemates program targeted sole parents who were socially isolated and at-risk, in that they were struggling to parent alone, and had limited local friendship or family networks, minimal knowledge of or engagement in local community activities, networks and services, and a lack of transport or support to get out into the community. Their at-risk status also often arose or was compounded by an insecure housing situation, unstable personal relationships and emotional health, dysfunctional or abusive family relationships, being very young and/or vulnerable or lacking experience, knowledge or support around parenting.


Northern Lakes Home Visiting evaluation report

A pilot project by UnitingCare Burnside, evaluated by the University of Newcastle
This summary outlines the origins, implementation and results of a three year external evaluation of the Northern Lakes Home Visiting service pilot in the Northern Wyong Shire of New South Wales.


**FACS Parenting Information Project**

This project evaluated parenting information and parenting information needs.


### B.2 International publications and reports

**Systematic review of international studies (Elkan et al, UK)**


This report is an extensive review of the general effectiveness and cost effectiveness of home visiting by health visitors in both early childhood and adults – including (for childhood home visiting) meta-analysis of effects for many outcomes including child development, maternal depression, parenting and the quality of the home environment.

http://www.hta.nhsweb.nhs.uk/fullmono/mon413.pdf

**From pregnancy to early childhood: early interventions to enhance the mental health of children and families (UK)**

Dr. Jacqueline Barnes, Annemarie Freude-Lagevardi
Leopold Muller Centre, Department of Paediatrics and Child Health
Royal Free and University College Medical School
University College London
Sponsored and funded by the Mental Health Foundation
January 2003
ISBN 1 903645 31 X
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The Mental Health Foundation commissioned this report on the basis of its National Enquiry into the Mental Health of Children and Young People, ‘Bright Futures’. It aims to summarise a variety of interventions designed to improve parenting, family functioning and young children’s mental health and to promote thinking about future work rather a definitive summary of existing knowledge. This summary defines the key points from the full report, which comprises two volumes. Volume 1 is a written report and Volume 2 summarises the research in a number of tables. Both the
executive summary and the full report are available on the Mental Health Foundation website: http://www.mentalhealth.org.uk


The Future of Children (USA)

The David And Lucile Packard Foundation
Volume 9 • Number 1 Spring/Summer 1999

This edition of the web-based journal, The Future of Children, is dedicated to home visiting.

http://www.futureofchildren.org/pubs-info3133/pubs-info.htm?doc_id=78926

The Role of Home-Visitation Programs in Improving Health Outcomes for Children and Families (USA)

American Academy Of Pediatrics, Council on Child and Adolescent Health
Policy statement

This document reports the policy of the American Academy of Pediatrics regarding interventions in childhood and adolescent, including recommendations for home visiting in early childhood.

http://aappolicy.aappublications.org/cgi/reprint/pediatrics;101/3/486.pdf

B.3 Service models

BestStart (Victoria)

Best Start aims to improve the health, development, learning and well-being of all children across Victoria from pregnancy through transition to school (taken to be children 0-8 years of age). Best Start will achieve this aim through supporting communities, parents, families and service providers to improve universal local early years service systems. These improvements will: result in better access to child and family support, health services and early education improve the capacity and confidence of parents to be, parents and families to care for children and help them to enjoy parenting assist communities to become more child friendly. This means that together we can give children the best possible start for their future health, education and social well-being. Best Start is auspiced by the Department of Human Services and the Department of Education and Training and assisted by the Community Support Fund.

This report was commissioned from the Centre for Community Child Health to provide the Best Start project with a clear understanding of international and Australian programs, interventions and services which have been tested and evaluated to demonstrate benefits to young children or their families. The report is a key resource for Best Start local partnerships
Parents as Teachers

This document details the program model for Parents as Teachers.


Nurse-Family Partnership (David Olds, USA)

This document from the National Center for Children, Families and Communities provides details of the Nurse-Family Partnership model designed by David Olds and partners and implemented in various locations across the USA.

http://www.nursefamilypartnership.org/pdfs/descriptionNFP.pdf

National Health Service, Community Child Mental Health Services (UK)

This document details the framework utilised by the National Health Service in the UK for the development of parenting initiatives to improve child mental health outcomes, including the Parent Advisor Model (Hilton Davis).


NSW Families First

This document details a model for development of service networks to support families with young children in NSW.


Home Instruction Program for Preschool Youngsters (HIPPY)

This document provides details of the HIPPY program, a program of home visiting by home tutors aimed at improve early education outcomes.


B.4 Evaluation frameworks and performance indicators

NSW Families First Outcomes Evaluation Framework

This report details the outcomes framework for the NSW Families First initiative.

Best Start Indicators (Victoria)

This report was commissioned from the Centre for Community Child Health to inform the Best Start Project in the development of a small set of indicators of child health, development, learning and well-being for use in the Best Start demonstration projects - which can be monitored at a local level as part of the project evaluation.


Irish Program of Action for Children

This report details the child health indicators for the Irish program Action for Children.

http://www.hebe.ie/ProgrammesProjects/ProgrammeofActionforChildren/Documentation/HealthIndicators/FiletoUpload,1146,en.pdf

B.5 Evaluation tools

Family Support Services Australia, Measuring Outcomes in Family Support : Practitioners' Guide

The following tools may be useful to family support services. There are many other tools required for other players. These tools have been developed on the basis that they will be used and modified by individual family support services to meet their needs. They have been developed on the following principles:

- The tool will be holistic
- The tool will be designed to monitor changes in individual clients and their circumstances - the point of comparison will be the client not a population standard
- The data from using the tool will also be able to show changes in groups of clients (eg clients participating in a new service model)
- The client should be involved in using the tools and reflecting on the information gathered.

Tool 1 Snapshot of Life - Client’s picture
This can be used early in service delivery, later in service delivery and on completion.

Tool 2 Snapshot of life - Worker’s picture
This can be used early in service delivery, later in service delivery and on completion.

Tool 3 Goals - Joint client and worker picture
This can be used jointly by the client and the worker during service delivery

Tool 4 Service facts and figures
This is data gathered about the client (eg age, gender, type of family) and services provided (eg amount and frequency of service).
**Tool 5 Snapshot of life (Long Version)**
This can be used early in service delivery, later in service delivery and on completion. The data is much more detailed than Tool 1.

**Tool 6 Service facts and figures (Long Version)**
This is data gathered about the client (eg age, gender, type of family) and services provided (eg amount and frequency of service). The data is more detailed than Tool 4.

**Tool 7 Specific topics in service delivery or research**
These tools could be used if a service wishes to explore a particular topic with a group of clients.

- Topic 1 - Social capital
- Topic 2 - Life's practicalities
- Topic 3 - Life experiences and outlook
- Topic 4 - Feelings about parenting
- Topic 5 - Relationship with spouse
- Topic 6 - Storybook reading
- Topic 7 - Children
- Topic 8 - Practical parenting
- Topic 9 - Building strengths
- Topic 10 - Significant life events
- Topic 11 - Stress
- Topic 12 - Participation in community organisations
- Topic 13 - Information
- Topic 14 - Beliefs about others
- Topic 15 - Young person's experience (12 year old or older)
- Topic 16 - Groups
- Topic 17 - Family worker services


**Indicators of Social and Family Functioning (Aust)**


This report proposes a framework for indicators of social and family functioning centred on outcomes for child health and wellbeing. It introduces a new instrument for the measurement of indicators comprising a set of items and scales to derive indicators.


**NSW Child Health Survey**

This supplementary edition of the NSW Public Health Bulletin provides the results of the first NSW Child Health Survey conducted in 2001. Also included is the survey instrument.


B.6 Links

NSW Families First


Parents as Teachers

http://www.patnc.org/

National Child Protection Clearinghouse (Australia)


UK Sure Start

http://www.surestart.gov.uk/

US Department of Health and Human Service – Early Head Start program

http://www.ehsnrc.org/

National Center for Children, Families and Communities (David Olds, USA)

http://www.nursefamilypartnership.org/

US Department of Health Promotion and Education - Strengthening Families

http://www.strengtheningfamilies.org

Healthy Families America

http://www.healthyfamiliesamerica.org/home/index.shtml

US Zero to Three

http://www.zerotothree.org
### Appendix C: Home visiting literature

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<td>Duration of program</td>
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<td>Duration of program</td>
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<td>Commencement</td>
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<td>RCT</td>
<td>USA</td>
<td>mixed professional</td>
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<td>at risk</td>
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<td>156</td>
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<td>120</td>
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<td>non-RCT</td>
<td>Norway</td>
<td>nurses</td>
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<td>postnatal</td>
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</table>


## Appendix D: Program audit questionnaire

### Overview of Services

1. **Name of your team/unit of service**

2. **Your Name and Position**

3. **Name all forms of services your centre/clinic provides**

4. **Total number of staff (including management)**

5. **Total number of HV staff**

6. **Average number of HV volunteers**

7. **Average number of home visits in a typical week**

8. **Number of clients registered with your HV program**

9. **Average number of visits per client**

10. **List 3 main priorities to your home visiting program**

11. **How long has your unit provided early childhood/family services?**

12. **How long has your unit provided HV services?**

13. **Check the general description that best describes the type of HV you carry out**

   - [ ] Entirely centre/clinic based
   - [ ] Predominantly centre/clinic based with occasional home visits
   - [ ] Combination of centre/clinic and home visiting program
   - [ ] Predominantly home visiting with occasional centre/clinic based services
   - [ ] Entirely home visiting
14. What age group do you target your home visiting program?

- Antenatal
- 0-3
- 3-5
- 5-8
- 0-8
- >8
Appendix E: Telephone interview questions and checklist

Home Visiting Services in SWS

Program

a. List the program goals of your home visiting (HV) program from highest to lowest priority

1. _________________
2. _________________
3. _________________
4. _________________
5. _________________

b. List the top 5 expected outcomes by implementing HV?

1. _________________
2. _________________
3. _________________
4. _________________
5. _________________

c. Identify those factors that have assisted the implementation of HV, as well those that have been obstacles.

<table>
<thead>
<tr>
<th>Assisted</th>
<th>Obstacle</th>
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</thead>
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<tr>
<td>Adequate resources</td>
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<td>Support from state level</td>
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<tr>
<td>Strong leadership</td>
<td>□</td>
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<tr>
<td>Strong local networks</td>
<td>□</td>
</tr>
<tr>
<td>Commitment of agencies within network</td>
<td>□</td>
</tr>
<tr>
<td>Capacity within community</td>
<td>□</td>
</tr>
<tr>
<td>Other _________________</td>
<td>□</td>
</tr>
<tr>
<td>Other _________________</td>
<td>□</td>
</tr>
</tbody>
</table>
d. What aspects of your HV program could be improved or strengthened? What do you need to achieve this?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Models/theories

a. Are any particular models or theories used to guide your program aims and/or program, activities?

Yes ☐ No ☐ If yes, please specify and explain why.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

b. Please specify any sources of information used to assist in the planning and implementation of your HV activities?

☐ Manuals
☐ Guides
☐ Websites
☐ Organizations
☐ Templates
☐ Community
☐ Other

Evaluation

a. Who carries out the evaluation at each stage, how often and by what means?

<table>
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<th>Evaluator</th>
<th>Frequency</th>
<th>Means</th>
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<td>Impact</td>
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<tr>
<td>Outcome</td>
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</tbody>
</table>
b. If an evaluation has been carried out, please indicate the aspects of your HV program that need improvement, from most needed to least needed. (and why?)

1. _________________________________________________________________
2. _________________________________________________________________
3. _________________________________________________________________
4. _________________________________________________________________

**Intake**

a. Where are most of the clients enrolled in your HV program referred from?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

b. Check the form(s) of referral accepted by your HV program.

☐ Written (professional)
☐ Phone call
☐ Drop-in
☐ Other _____________

c. Please describe any referrals that have been refused in the past and on what basis.
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Networks**

g. List other groups/services involved in your HV program and the extent of their involvement.

<table>
<thead>
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<th>Level of involvement</th>
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<tbody>
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<td>4.</td>
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<td>5.</td>
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</tbody>
</table>
h. What are the major challenges faced in collaboration. Briefly explain why.

- Community receptiveness ______________________________
- Time ______________________________
- Service Network ______________________________
- Client relations ______________________________
- Other ______________________________

i. Specify those relationships that have been the most effective and indicate why this might be.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Activities

a. Please name the main activities carried out by your HV program under each category listed below, along with the time of intervention. Tick more than one box for each activity if it applies (i.e. if parental counseling is offered before a problem arises and as soon as there is some indication it has become a problem, check ‘Early prevention’ and ‘Early response’).

<table>
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</table>
b. Please list the top 5 activities that are carried out to meet your HV program goals. Also indicate how often these activities are carried out in a month and the rational/evidence for the particular activity. (i.e.)

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</table>

c. Please indicate the level of difficulty in implementing each of the 5 mentioned activities.

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<th>Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very</td>
</tr>
<tr>
<td>1. ________</td>
<td>□</td>
</tr>
<tr>
<td>2. ________</td>
<td>□</td>
</tr>
<tr>
<td>3. ________</td>
<td>□</td>
</tr>
<tr>
<td>4. ________</td>
<td>□</td>
</tr>
<tr>
<td>5. ________</td>
<td>□</td>
</tr>
</tbody>
</table>

d. What are the major obstacles encountered while attempting to carry out the moderate to difficult activities mentioned above?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Obstacle</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ________</td>
<td>______</td>
</tr>
<tr>
<td>2. ________</td>
<td>______</td>
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<tr>
<td>3. ________</td>
<td>______</td>
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<tr>
<td>4. ________</td>
<td>______</td>
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<tr>
<td>5. ________</td>
<td>______</td>
</tr>
</tbody>
</table>
e. Have any changes in activities been made from the original plan after implementing HV?

No ☐ Yes ☐ If yes, what and why?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

f. Explain the mechanisms that have been put in place to encourage community input?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Referral System

a. Please describe the type of referral system in place for your HV program.
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

b. Please list any challenges encountered that have delayed effective referral.
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Target Group

a. Who are the specific target groups for your HV services and why?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
b. Rate your HV program’s capacity to reach each target group from the easiest to the most difficult and indicate what the challenges are in reaching them.

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
<td></td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

Indicate the level at which your HV program focuses on the issues/groups listed below. Also indicate in the last column, whether certain issues/groups are explicitly excluded from your HV program.

<table>
<thead>
<tr>
<th>Vulnerability/risk factor</th>
<th>Major focus</th>
<th>General focus</th>
<th>Little or no focus</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother under 19 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Single, unsupported parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late antenatal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(after 20 weeks gestation)</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Financial stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic complicated delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Adjustment to parenting issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child with disability/chronic illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstable housing</td>
<td></td>
<td></td>
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<tr>
<td>Partner unemployed</td>
<td></td>
<td></td>
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<tr>
<td>Isolated (eg. geographic, no telephone, lack of support)</td>
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<tr>
<td>Refugee status, recent migrant</td>
<td></td>
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<td></td>
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<tr>
<td>Single, low income, young, unsupported parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Current substance misuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Current history of mental health problems and disorders</td>
<td></td>
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</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
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<tr>
<td>Relationship issues with parents/partner</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Parent with developmental disability</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>History of domestic violence</td>
<td></td>
<td></td>
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<tr>
<td>Grief/loss associated with the death of a child or other significant family member</td>
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<tr>
<td>Family known to DoCS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current child protection issues</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Population groups</td>
<td>Major focus</td>
<td>General focus</td>
<td>Little or no focus</td>
<td>Excluded</td>
</tr>
<tr>
<td>----------------------------------------</td>
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<td>-------------------</td>
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</tr>
<tr>
<td>Indigenous</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-English speaking</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>First-time parents</td>
<td></td>
<td></td>
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<tr>
<td>Non-resident status</td>
<td></td>
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<tr>
<td>Refugees</td>
<td></td>
<td></td>
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<tr>
<td>Specific geographic locality</td>
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</tbody>
</table>

**Service Provision**

a. Who is responsible for carrying out HV? (i.e. Nurse, teacher, volunteer)

**Type of home visitor**

1. _________
2. _________
3. _________

b. Please describe the schedule for HV by specifying the frequency and duration of visits (i.e. fortnightly until a child’s second birth). Please be as precise as possible.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

b. What type and level of training do the service providers have?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

b. Have skills been updated? If so, how frequently?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

d. Describe a typical home visit.