EVALUATION OF THE COTTAGE COMMUNITY CARE PILOT PROJECT

by

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A thesis
presented to the University of Western Sydney, Macarthur
in partial fulfillment of the requirements
for the degree of Master of Science Honours

March, 1999

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PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
Acknowledgements

Many individuals and organizations contributed to the ongoing evaluation of the Cottage community care pilot project. In particular my thanks to the Cottage Board of Management, staff of the South West Sydney Area Health Service and officers of the Department of Community Services, Campbelltown. Grateful thanks are also extended to members of the CCCP evaluation Advisory committee, John Russell, Diane Wagg, Dr Victor Nossar, Lina Fazzolari, Pauline Rockley, all of whom contributed considerable time and effort to various aspects of the evaluation. My gratitude is also extended to Margaret Armstrong and the volunteers and families who were generous in their efforts to provide information for this evaluation. Special thanks to Jacqie Leabeater, project co-ordinator of the CCCP, who while developing and managing the programme, enthusiastically collected information and drove this evaluation to its conclusion. Victoria Neville's contribution to completing this evaluation is also highly valued. Finally I would like to express gratitude to my supervisor, Dr Pat Bazeley, who, with great skill and thoroughness shepherded me through this project.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in whole or in part for a degree at this or any other institution.

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Abstract

The outcomes of a secondary level child protection/family support programme, the Cottage Community Care Pilot Project, were evaluated in this study. The evaluation employed a non-equivalent comparison group design of ‘at risk’ consenting first-time mothers in the perinatal period with babies up to 6 weeks of age. Ninety-three families were recruited from first time mothers presenting to the antenatal or postnatal services of the local hospital. Of these, 58 families were matched with a trained volunteer home visitor. Analysis of assessment items and questionnaires, reviews of hospital records and the Department of Community Services Child abuse and neglect notification register and focus groups with mothers and volunteers provided the information necessary to complete this study.

The CCCP had an impact on particular aspects of family function, certain infant and maternal health indices and the families’ use of community services. Its contribution to reducing the incidence of child abuse and neglect is less clear given the high levels of surveillance of intervention group families and the relative invisibility of the nature of the relationships within comparison group families.

Client feedback indicated unreserved support for the programme. Volunteers also expressed a high level of satisfaction regarding their involvement in the CCCP.

While home visitation by trained volunteers is not proposed as the total answer for effective child protection or family support, the findings of the evaluation of this programme suggest that there is a place for similar programmes, tailored to the needs of particular communities as one of a range of services established to promote family health.
Chapter 1

Introduction

Home visitation

Home visitation programmes involving volunteers or paid professionals in ongoing relationships with families have long been advocated as a strategy for improving maternal and infant health and as a child protection initiative. Home visitation is defined by Wasik et al. as “a process by which the professional or para professional provides help to a family in its own home. Such help typically focuses on social, emotional, cognitive or health needs and takes place over a sustained period of time” (Wasik, Bryant & Lyons, 1990, p. 13). Health workers visit the family at arranged times and depending on the goals of the programme provide a variety of services which may include education of parents, mentoring, advice, emotional and sometimes practical support and role modeling for parenting (Powell, 1993). In this study these activities are subsumed within the term family support. The increasing popularity of home visitation as a family support strategy has been linked with urbanisation and its associated social isolation, high infant mortality rates and the state of poverty (Barker & Anderson, 1988).

Home visitation programmes may be made available to all families (primary level prevention), or target vulnerable families only (secondary level prevention), and include home visitation services that commence pre or post-natally for varying lengths of time. Services may be delivered by a range of personnel including social workers, registered nurses, psychologists, trained lay workers and volunteers.

Home visitation and child abuse and neglect

In the United States of America, the United Kingdom and here in Australia reported incidents of child abuse and neglect increase each year. This may result from increased public and health professional awareness and the introduction of mandatory reporting. The increase in the incidents of child abuse and neglect reported in the media and to child protection agencies, increasing evidence of the adverse consequences of child maltreatment and rising public and professional awareness and concern have contributed to a renewal of interest in home visitation as a child abuse and neglect prevention and child protection strategy.

In the financial year 1996-1997 there were 29,985 reports of child abuse and neglect to the assessment units of the Department of Community Services, New South Wales
(DOCS). Of these, 13,002 (43%) were substantiated or confirmed as cases of child abuse and neglect. Forty four percent (44%) of these initial reports were requests for help or support as opposed to notifications of neglect. In the same period the Campbelltown office of DOCS received 1553 notifications, of which 41% were confirmed as child abuse and neglect incidents (Child Protection Summary Data Report, 1996/97). These figures represent a considerable degree of immediate and long term suffering to the families involved and ultimately a significant financial cost to the community through the various agencies that are or will be involved in dealing with the consequences of this abuse.

Background of Home visitation

Home visitation initiatives are considered to have originated in London in the 1850s, within a charitable initiative termed ‘friendly visiting’. The social reformers Octavia Hill and Louisa Twining organized middle class women to visit the poor in their homes and workhouses to offer support and spiritual guidance and advice on nutrition and hygiene (Scott, 1997). Ladies’ benevolent societies or missions were also often involved in this activity (Monteiro, 1985). In the late 19th century Florence Nightingale is credited with starting the first district nursing initiative, training and organizing nurses to visit and care for people (mainly the poor) in their own homes. At the time she stated “Money would be better spent in maintaining health in infancy and childhood than in building hospitals to cure diseases” (Nightingale, 1894, in Monteiro, 1985, p.184).

Over time home visitation continued to develop, in particular in the United Kingdom and Denmark where home visiting by registered nurses was incorporated into the national health service. Various organizations developed a range of services to families in their homes under the auspices of either a public health or education initiative or arising from the charter of a charitable institution. While some home visiting programmes targeted particular groups such as low income families, single mothers, young mothers, families with either developmentally delayed children or parent mental health problems, others were made available to all families (Barker, 1997). Many of these programmes include child protection as an aim.
Recent History

United States of America

The more recent history of the association of home visitation with child protection is considered to have commenced in the USA in 1962 with the work of Henry Kempe and his associates who coined the term ‘the battered child syndrome’ to describe the phenomenon of parents physically assaulting their children (Kempe, Silverman, Steele, Droegemueller & Silver, 1962, p. 17). Corby (1993, p. 26), describes this as the ‘rediscovery of child abuse’ and suggests that the physical abuse of children became a major social issue in no small part due to the enthusiasm and skill with which Kempe and others campaigned and promoted the idea that child abuse was a parental problem, that is a parent’s response to his/her own emotional and/or developmental deprivation. Corby contends that “Kempe’s ideas were in tune with the times in that the notion of parents abusing their children as a result of a psychological syndrome was more acceptable than attributing such cruelty to poverty or ignorance” (Corby, 1993, p. 27).

Kempe et al. (1976) also promoted the possibility that reported incidents of the battered child syndrome vastly underestimated the scope of the situation. They proposed an initiative that included taking a standard history and physically assessing children during periodic health assessments as well as undertaking standardized observations of parents and children during other pre, peri and post natal situations. The ideal promoted was that every child would have access to a trained lay health visitor who would ideally make contact with the family prior to the child’s birth and, based on an assessment of the degree of need of the family, be available to assist the family (Kempe, 1976).

However Wasik et al. (1990) contend that even earlier the impetus for the increase in the popularity of home visitation programmes was the de institutionalization of handicapped children to the care of their parents in the 1950s. The subsequent support needs of these parents coupled with the emerging recognition that children influence parental behaviour as much as parents influence children was the platform for the re-emergence of home visitation as a service strategy (Wasik et al., 1990). In relation to family health, Wasik et al. (1990) suggest home visitation to families is based on three major assumptions. These are, firstly, that parents are the key figures in the life of a child and that the home is the emotional, physical and cognitive setting in which all influential interactions that shape the infant occur. The second assumption is that all parents can learn to be positive and effective parents. Deficits in their own parenting, which may impede interaction with their own child, can be overcome with positive role modeling and support. Finally it is believed that the
degree to which the parents' needs are met is correlated to their effectiveness as parents. “...attention must be focused on helping parents address problems in their own lives that make it difficult for them to be responsive to their children” (Wasik et al., 1990, p. 15).

Whatever the impetus, home visitation in many forms was embraced as an effective and economical method of improving the health of families. Hawaii's Healthy Start programme (Waihee, 1992), the Baltimore programme (Hardy & Streett, 1989) and Project 12-Ways (Lutzker & Rice, 1984), are but a few of the over 4000 programmes identified by Roberts and Wasik in 1990 (cited in Vimpani et al., 1996) that provided services to families and children in the United States. The ongoing rigorous evaluations of the Elmira Project (Olds et al., 1986; 1992; 1994; 1997), which reported significant positive outcomes in child and maternal health, provided even more impetus for the adoption of home visitation as a strategy to assist families to constructively manage the challenges of parenting.

The United Kingdom

In United Kingdom a variety of home visitation programmes similarly developed, both influencing and being influenced by child protection and family support initiatives in the United States and increasing public and professional awareness of the prevalence of child abuse and neglect (Corby, 1993). One such programme, the Child Development Programme, started in 1980 and currently operates in collaboration with 25 health authorities in the United Kingdom involving 15,000 to 20,000 new families each year (Barker, Anderson & Chalmers, 1992). This programme has also been used as a model for the development of another programme, the Community Mothers' programme, developed in the University of Bristol and currently operating in five health authorities in England and Wales and one in Ireland (Johnson, Howell & Molloy, 1993, p. 1449). Similarly, other UK programmes commenced, such as Home-Start in Leicester in 1973, and Newpin (New Parent Infant Network) in South London in 1982. Both use volunteers and provide models of home visitation that have been widely adopted. In 1997 there were 206 Home-Start programmes in the UK, and 60 in seven other countries including at least three in Australia (Harrison, 1997).

Australia

The Department of Health and Family Services commissioned a recent audit of a sample of home visitation programmes in Australia under the auspices of the National Child Protection Council. Not all Australian programmes were surveyed but amongst those that were 280 identified themselves as including in their aims and
objectives the prevention of child abuse and neglect. Although operating under the
general heading of family support, the strategies these programmes employed were as
diverse as the programmes were numerous. Like their overseas counterparts they
were oriented towards different levels of prevention, employed various types of
workers, targeted a diverse range of groups, visited the participating families with
varying frequency, and used strategies that included various types of information
giving, direct assistance to parents, psychological counselling, parenting education
and child and family advocacy (Vimpani, Fredrico, Barclay & Davis, 1996).

This audit noted, there were however, few completed evaluations of preventative
home visitation programmes in Australia and none that measured the impact of such
programmes using comparison or control groups. Also noted in this audit and other
literature is the absence of published evaluation studies on programmes that focus on
non English speaking or Aboriginal or Torres Strait Islander populations (Vimpani et
al., 1996).

More recently (May 1998), the New South Wales Government Office of Children
and Young People announced the Families First initiative which aims to provide four
levels of family support service to all parents with children under eight years of age.
This service, which involves DOCS, New South Wales Health and Area Health
Services, the Department of Education and Training, the Ageing and Disability
Department and the Department of Housing, will be introduced initially in the South
Western suburbs of Sydney and two North Coast regions. The type of service the
initiative will offer includes: early childhood health visitors, volunteer home visitors,
early intervention teams and local development programmes. As well as helping
families to function more positively, Families First has been established to assist
neighbourhoods to develop informal support networks, reduce the conditions that
lead to child abuse and neglect, enhance the health of children and parents and foster
‘family friendly’ communities. Figures cited in the information supporting this
initiative state that one dollar spent on prevention efforts will save approximately
seven dollars on crisis and therapy services (New South Wales Government, Office
of Children and Young People, 1998).

Home visitation programmes represent a concerted effort to provide strategies that
will reduce the possibility that child abuse will occur. Many of these programmes
have reported positive outcomes including: improved parental (usually mothers) self
esteem, increased parenting competence, reduced social isolation of families,
 improved maternal and infant health and infant immunisation uptake and a reduced
incidence of child abuse and neglect amongst participating families (Barker, 1998;
Olds et al., 1986; 1994; 1997; Johnson et al., 1993; Cox, 1993; Hardy & Streett, 1989). Given the rich history of home visitation and the enthusiasm with which it is currently being adopted by various organizations in Australia, ongoing systematic evaluation of these programmes is critical to both justify the allocation of funding to this method rather than others, and to lend credibility and substance to the various claims made about the impact of home visitation as a child protection and family support strategy.
Chapter 2
Child abuse and neglect

The terms child abuse and neglect and child maltreatment are used interchangeably and for the purpose of this study are defined as incidents involving harm to children that have been investigated and confirmed by the Department of Community Services (DOCS). Angus and Woodward (1995) determined that the rates of child abuse and neglect in Australia for children aged between 0 and 16 years was 5.7 per 1000. Of the 1553 notifications (41% confirmed) of child abuse and neglect reported to the Campbelltown office of DOCS in the financial year 1996/97, 520 were cases of emotional abuse, 311 were confirmed as cases of neglect, 392 as physical abuse and 308 as sexual abuse. In 22 cases the nature of abuse was not specified. (Child summary data report 1996/97).

The impact of child abuse and neglect on these children and on the families in which they reside constitute not only pain and loss to those directly involved but also affect and diminish the broader community. Cox (1995) refers to this impact as a loss of social capital, the “social glue, the weft and warp of the social fabric which comprises the myriad of interactions that make up our public and private lives” (Cox, 1995, p.18). Social capital includes the relationships, networks and norms that bind, support and strengthen families and communities to each other and to the broader social context, all of which “facilitate co-ordination and co-operation for mutual benefit” (Cox, 1995, p. 19). Any act that diminishes this social capital diminishes us all. Equally any act that increases the inclusion and support of all families within the broader social context will ultimately add to the social capital of this society. Many family support and child protection programmes aimed at empowerment, education and inclusion could be viewed as endeavours to increase social capital.

Defining child abuse and neglect

Definitions of child abuse and neglect vary from country to country and state to state within Australia. In New South Wales the Children (Care and Protection) Act, 1987, No.54 (CCPA), defines abuse against children as follows:

Abuse, in relation to a child, means assault (including sexual assault) or ill treat the child or expose or subject the child to behaviour that psychologically harms the child, whether or not, in any case, with the consent of the child

However there is disagreement generally about exactly what constitutes harm and thus abuse and/or neglect to a child.

People do not always agree about what are or are not appropriate experiences for children...there may not be agreement about whether the circumstances that lead to the harm should be considered child abuse. The events may be seen as accidental or there may be circumstances mitigating responsibility for the behaviour that lead to the negative outcome for the child

(Vimpani et al., 1996, p. 6).

This lack of consensus regarding the definition of child abuse and neglect to some degree limits valid comparison of incidence and prevalence rates between and within countries (Fink & McCloskey, 1990; Corby, 1993). Also while formal and/or legal definitions of child abuse and neglect by child protection agencies enable categorisation, they do not necessarily present the complexities inherent in defining and determining the nature or extent of child maltreatment. For example, categorising sexual abuse as sexual abuse only in official data summaries or child abuse registers denies the likely emotional and sometimes physical abuse that frequently accompanies such an incident. Emotional abuse is equally difficult to define and probably even more difficult than other forms of abuse to measure, though it is considered to accompany all forms of abuse of children (Tomison & Tucci, 1997). Difficulties in defining and quantifying child maltreatment translate to difficulties in determining and planning relevant prevention and treatment services.

Aetiology of child abuse and neglect

An extensive body of research, mainly from the United States and the United Kingdom, has attempted to identify the factors involved in the aetiology of child maltreatment. A large proportion of this research concentrates on the attributes of mothers, most commonly from low socioeconomic backgrounds (Corby, 1993). There is little research on the role of fathers or stepfathers except in the area of sexual abuse.

There are a broad range of theoretical perspectives that have been used to explain the causation of child maltreatment. These derive from different disciplines and tend to emphasize either the parents’ or child’s psychological characteristics, patterns of family interaction, the nature of the relationship between the abuser, the child and the immediate environment, or the cultural, social and political conditions in which the family lives (Belsky, 1980; Corby, 1993). Until recently these diverse perspectives have contributed to disagreement and conflict regarding the causation of child abuse.
and neglect. Subsequent policy and practice initiatives sometimes reflected these disagreements.

Child abuse and neglect is now more commonly considered to be a multi-dimensional problem arising out of an array of complex interactions between environmental and cultural factors and family and individual dynamics.

The lives of individuals, families and societies are interdependent...in the case of maltreatment the intimate relationships between the child and the parents cannot be accounted for or understood without understanding how the conditions surrounding the family affect interaction between the child and parent.

(Garbarino & Gilliam, 1980, p. 21).

Based on the ecological perspective of human development outlined by Urie Brofenbrenner, Belsky developed a conceptual framework that integrated various theories of the aetiology of child maltreatment (Belsky, 1980). This ecological model proposes that child abuse and neglect is a product of the interaction of multiple forces at work across four different levels or spheres of influence. These four levels interact and influence each other and include the individual (ontogenic development), the family setting (the microsystem), the formal and informal social structures that influence the family (the exosystem), and the culture and belief systems in which the individual and family are embedded (the macrosystem).

The first of these levels or spheres of influence refers to “...what individual parents...bring with them to the family setting and the parenting role” (Belsky, 1980, p.321). Ontogenic development relates to such characteristics of the parents as their own parental history, developmental level, and feelings towards, attachment to and understanding of their infant. An unresolved, unhappy or abusive childhood (Gray, Cutler, Dean & Kempe, 1979; Helfer, 1982), a negative attitude towards the pregnancy (Murphy, Orkrow & Nicola, 1985; Orkrow, 1995), unrealistic expectations of children (Trickett, 1988; Weiss, 1988), social isolation and immaturity of the mother (Murphy, Orkrow and Nicola, 1985; Browne, 1988), and substance abuse and ill health (Wolfe, 1993) are some of the factors considered to be risk indicators for subsequent child abuse and neglect. While a history of abuse in a parent’s childhood increases the likelihood of child maltreatment not all abused children, however, become abusive parents (James, 1994b).

A further aspect of ontogenic development may be the the age of the parent. A number of studies have found that mothers less than 21 years of age are disproportionately implicated in child abuse notifications (Stier et al., 1993; Browne
& Saqi, 1988; Murphy et al., 1985). However in these studies close correlates of age are social class and the existence of surveillance through various forms of social and welfare agencies. These factors are difficult to separate out from the age itself and therefore the contribution of age to the aetiology of child maltreatment cannot be confidently stated.

The ‘micrsystem’ refers to the environment of the infant, the family setting, the child’s health and temperament (including prematurity, low birth weight and hyperactivity), family size and the emotional climate of the family. These factors may interact and increase or decrease the likelihood of child abuse and neglect occurring (Gray, Cutler, Deane & Kempe, 1977). Belsky (1980) suggests that the child interacts with its environment and in doing so can become “a causative agent in the abuse process” (Belsky, 1980, p. 324). A number of studies suggest a disproportionate number of maltreated children were born prematurely (Belsky, 1980; Lynch & Roberts 1982; Browne & Saqi, 1988). Various reasons are proposed to explain this phenomena including the relative unattractiveness of a premature baby and the perception of parents that the cry of a premature child is ‘aversive’ and more demanding, this in turn eliciting an aggressive response from the caregiver. Studies also indicate that a mentally or physically disabled child is more likely to be abused than the normal child (Belsky, 1980; White et al., 1987). In Spain, a recent investigation of the prevalence of maltreatment reported that approximately 12% of intellectually handicapped children in one area were maltreated compared to a prevalence rate of 1.5% in the non handicapped control group children (Verdugo, Bermejo & Fuertes, 1995).

Children in single parent families are over represented in child abuse and neglect statistics. Sack, Mason and Higgins (1985) found “the prevalence of physically abusive punishment to be twice as high in single parent households as in two parent households” (cited in Tominson, 1996, p. 3). A similar study reported that in one area of the United States over 40% of the cases of child abuse occurred in single parent families at a time when the national percentage for such families was 17% (Benedict, White & Cornely, 1985). Creighton and Noyes (1989) found that 25% of all children registered by the the National Society for the Care and Protection of Children (NSPCC) in England and Wales between 1983 and 1987 came from single parent households (cited in Corby, 1993, p. 72). The national percentage of single parent families was not reported in this study.

In relation to the correlation between gender and abusive behaviour, Creighton and Noyes analysed the data on all perpetrators of all forms of abuse reported to the
NSPCC in England and Wales in the period 1983-1987. Their findings revealed that mothers “were only slightly more frequently implicated as abusers than fathers in cases of physical abuse, much more frequently implicated as abusers in emotional abuse cases and considered to play a negligible part in sexual abuse” (1989, in Corby, 1993, p. 65). Corby (1993) also suggests that where there are male and female caretakers in the family it is not always determined who has abused the child, while in single parent families it is assumed that mothers are the abusers unless there is clear evidence to the contrary. In their research on this same issue Browne et al. (1988), note that 70% of child maltreatment was perpetrated by males. This can be partly explained by the fact that most sexual abuse is perpetrated by males and that children are notified as cases of emotional abuse in reported domestic violence incidents usually attributed to male violence. Girls are abused more often than boys though some of this difference in incidence could be due to the increased rates of reported sexual abuse in the female population.

Children are most at risk from physical abuse and neglect in their first year of life, this risk diminishing as they age (Corby, 1993). The vulnerability and dependence of a newborn child and the strain this places on families to some degree explains these findings. A recent report from the New South Wales Child Death Review Team states that “between July 1996 and June 1997 18 children and young persons died in circumstances indicative of homicide or ‘non accidental’ injury...11 of these deaths involved infants under 1 year of age” (NSW Child Death Review Team Report, 1998, p.63).

The ‘exosystem’ refers to the broader social context in which families exist and includes the economic status of the family and their degree of inclusion in the community network and working world. Holden et al., refer to the social context as “the factors in the community that support or strain family relationships” (Holden, Willis & Corcoran, 1992, p. 66). Among the factors that are identified as influences on the family are the availability and ease of access to the support of friends, other family and professional services and, equally important, the degree of exposure of the family to the monitoring and feedback functions of community support systems (Holden et al., 1992). It is suggested that if the parent(s) are socially isolated, do not have consistent access to friends and / or extended family for support, advice and relief they are less likely to effectively manage the normal stress of parenting. Holden et al. also correlate the increased risk of child maltreatment that occurs in lower socioeconomic groups with “the influence of an impoverished social context... [and]...the quality of the neighbourhood in providing family support through services...” (Holden et al., 1992, p. 67). Unemployment and its often subsequent loss
of self esteem and power, economic hardship, social isolation from family supports and housing difficulties are also considered to be factors that increase the family's vulnerability to child abuse and neglect (Johnson, Howell & Molloy, 1993; Gelles, 1992; Dubowitz, 1989; Browne, 1988; Wolfe et al., 1985; Green et al., 1980; Garbarino & Gilliam, 1980).

The "macrosystem" refers to the broader societal landscape and value system in which the family resides and which they reflect. It refers to the values and beliefs the society and community has about the place, worth and ownership of children, the nature, rights and responsibilities of parents and parenting and attitudes to child rearing and child discipline (Belsky, 1980; Gray et al., 1979). "What happens in the micro- and exosystems of child abuse and neglect is invariably influenced by prevailing cultural attitudes and values as well as historical changes which form the macrosystem of child maltreatment" (Belsky, 1980, p. 329).

While many factors including poverty, marital discord, unemployment, lack of supportive relationships, incomplete education, social isolation and the individual characteristics of parents and infants have been associated with various types of child abuse, no single factor adequately explains the phenomenon nor the conditions that are sufficient or necessary for child maltreatment to occur (Ammerman & Hersen, 1990; Belsky, 1988; Garbarino & Gilliam, 1980). All four spheres of influence are implicated in the genesis of child abuse. These change over time as the child and family develops and importantly illustrate the need to develop strategies that not only address individual families but also the broader social and cultural factors that shape the context in which families live. The ecological model emphasizes the interrelatedness of the four sub systems that influence the child’s and family’s development. In summary, the interaction and influence of conditions within these subsystems, particularly the combination of poverty, social isolation of the family from broader social and community networks, a premature or physically or mentally disabled infant and single parent status are considered to be major factors in the causation of child maltreatment (Corby, 1993; Murphy et al., 1985). Child abuse and neglect seems to be more likely to occur in families in which a number of these factors coexist and interact. However, the relative contribution of each to child abuse and the influence of environmental factors remains difficult to determine.
Consequences of child abuse and neglect

Research into the consequences of child abuse and neglect suffers from problems and limitations due to variations in definitions of child maltreatment, the problems inherent in establishing causal links between the abuse and later behaviour, and other methodological concerns. The adverse consequences of child maltreatment, immediate and long term, have been documented both in terms of the child’s response to the abuse and to a lesser extent the economic and social cost to the broader community (Seigel et al., 1980; Tomison & Tucci, 1997; Corby, 1993). Various studies suggest that children who have been maltreated demonstrate higher rates of criminal behaviour, are more likely to have spent time in prison or juvenile correction facilities and have higher rates of violent behaviour than children from non abusive homes (Tomison, 1996; The United States General Accounting Office, 1992). In one study of maltreated children it was found that 40% engaged in self destructive behaviour such as parasuicide, head banging and burning compared with 6.7% in the control group (Eckenrode et al., 1990, cited in The United States General Accounting Office, 1992, p. 13).

Erikson et al. (1989) investigated the effects of four different types of abuse on four groups of abused children in the first six years of their lives compared to a non abused control group of children (N=85) from a similar socio economic background.

Children from all the abused groups were generally rated as having less confidence and lower self esteem than those in the control group …at age four the neglected and emotionally abused children were the cause of great concern


These emotionally abused children showed a marked decline in intellectual functioning, disturbances in attachment and a lack of “social and emotional competence in a variety of situations” (Corby, 1993, p.109). These findings are similar to those reported by Lynch and Roberts (1982) in an earlier study of 39 physically abused children in Britain,“… generally the abused group were developmentally, emotionally, educationally and socially below the norms for children of their age” (Lynch and Roberts, 1982, cited in Corby, 1993, p. 109).

Corby also notes that maltreatment, though detrimental to the child, is not necessarily the major determinant of negative consequences. He concludes, “the ongoing climate in the family seems to be of prime importance in determining whether or not such consequences persist” (Corby, 1993, p.112). There is also evidence that the pattern of behaviour the child may develop to cope with its lack of protection and support can in turn cause further social and emotional isolation.
While various studies have posited a link between child maltreatment and long term consequences which include, in adulthood, higher rates of substance abuse, mental illness, depression, violence to self and others and general maladjustment, cause and effect is not proven (Briere, 1992; Browne & Finkelhor, 1986; Gelinas, 1983). Establishing links between abuse incidents and possible long term consequences is hampered and made more complex by the influence and interaction of a multitude of other factors including the child itself, the nature of the family, the community in which they live and the broader social context. Corby suggests that while the links between child abuse and neglect and later (adult) psychopathology are tenuous there is clear evidence that children who are abused “suffer considerable emotional and psychological problems in their early childhood, leading them to have problems in trusting people and to suffer from a sense of personal worthlessness...” (Corby, 1993, p. 116).

In 1984, Carmen, Rieker and Mills reported the findings of a study into the relationship between (childhood) physical and sexual abuse and adult psychiatric illness. These researchers undertook an in-depth retrospective examination of the in-patient records of 188 male and female psychiatric patients discharged over an 18 month period from a psychiatric in-patient unit in the United States (Carmen, Rieker & Mills, 1984). Sixty five percent of the non random sample were female, age range 12 - 88 years. Findings revealed that 43% of the sample had histories of physical or sexual abuse or both. Fifty three percent of the females and 23% of the males had been abused. On a number of indices the abused patients were significantly different from the non-abused patients. With regard to family characteristics abused patients were more likely than non abused patients to report excessive use of alcohol by their parent(s), and “… to have past histories that included suicidal and assaultive behaviour and criminal justice involvement” (Carmen et al., 1984, p.380). The abused group was likely to remain in hospital longer. Abused female clients were more likely to direct their anger and aggression inwards than non abused patients and to engage in behaviours ranging from passive resignation and helplessness to episodes of self mutilation and parasuicide. “This coping style was characterized by active suicidal intent and/or savage self hatred, with loss of control reflected in a variety of self destructive and self mutilating behaviours” (Carmen et al., 1984, p. 380). Male abused patients, mainly adolescent, were more likely than abused female patients to have been violent to others prior to their admission and while in-patients were more likely to direct their anger toward others.
Summary of issues

Child abuse and neglect arises out of the interaction of a range of individual, family and social circumstances, the exact contribution of each as yet unclear. What is known is that the duration and particular nature of the abuse, the age of the child at the time of the maltreatment, the manner in which the abuse is subsequently dealt with by the caretakers, the inherent adaptability of the child and finally the enduring emotional climate that the child is exposed to are among the many determinants of the sequelae of child maltreatment. Beyond the impact of child abuse on the individual, short and long term consequences of child maltreatment represent a loss to the community in terms of both social and economic capital. Not only is the child seemingly developmentally disadvantaged as a result of child abuse, as an adult their capacity to engage in adaptive adult experiences and responsibilities is sometimes also diminished.

In the absence of political will to alter the broader economic and social contexts of child rearing, home visitation offers an opportunity to develop strategies that attempt to address the nature and quality of family contexts, the family itself, and their inclusion in and access to existing social supports.
Chapter 3

Home visitation programmes
-a review of the evidence

This section will review the literature on home visitation programmes that attempt to address all or some of the factors considered to be implicated, within the ecological approach, in the cause of child abuse and neglect. Although the conceptual basis for the following perinatal home visitation programmes is shared, each programme differs in terms of the personnel that deliver the service and the context it operates in. All programmes attempt to address to some degree the factors associated with child maltreatment including the family’s lack of social support, inability to access health and welfare agencies and inadequate knowledge of parenting and child development. In all programmes the mother is the primary focus of the service, the needs of fathers or partners rarely mentioned.

In the United Kingdom and United States of America a number of programmes that focus on family support and child protection have been evaluated with varying degrees of rigour. All of these programmes have used variations of home visitation as the primary intervention or treatment. Evaluations of these programmes report varying levels of improvement in a range of variables including child abuse and neglect, changes in family functioning, the health status of mother and child, and parent-child interaction (Fink & McCloskey, 1990). Findings regarding the effectiveness of these programmes are, however somewhat equivocal due to overall differences between each programme in terms of the study populations, the nature of interventions, variable rigour and methods of the evaluation research, whether the outcomes measured were proximal or distal and not least of all, the variations in the definitions of child abuse and neglect.

Tables 3.1 and 3.2 present an overview of the evaluations of five volunteer staffed, and four para professional/professional staffed family support/child protection programmes. These have been chosen because the implementation and evaluation of these programmes represents a range of issues that illustrate the complexities of comparing one programme and its outcomes to another. These differences continue to confound the findings of programme effectiveness. With these differences in mind the known qualities and limitations of each programme will be outlined.

Whilst programmes that employ professional or para professional health workers will be included, particular attention will be paid to programmes in which trained volunteers provided the service. Within this study professional and para professional staff are arbitrarily defined as paid employees of an organization and include
psychologists, registered nurses, social workers, health visitors, welfare workers and therapists. Volunteers are defined as those people who are do not receive financial reimbursement for their services (but may receive travel expenses), and who by definition volunteer their time to participate in a given programme. All volunteers referred to in this paper have undergone some formal training for their role and work under the supervision of a professional health worker. Such volunteers are variously referred to as ‘befrienders’ (Cox, Pound, Mills, Puckering & Owen, 1991), ‘community mothers’ (Johnson, Howell & Molloy, 1993), and ‘family aides’ (FOCUS, 1997, Campbelltown).

**Evaluations of Home visitation programmes employing trained volunteers**

Scientifically based evidence from randomised trials regarding the effectiveness of volunteer-based programmes in improving maternal and child health is limited. The “community mothers” study (Johnson et al., 1993), explored later in this paper is an exception. This is not to say volunteer-based programmes do not or cannot work, however few such programmes invest their scarce resources in formal, methodologically sound evaluation. This lack of positive evidence, however, has not diminished the enthusiasm for volunteer-based home visitation programmes, indeed self reports from volunteers and families alike universally support home visitation. Volunteer-based programmes can give service to many people as there are fewer employment and overhead costs. Also volunteers may be seen as less threatening, may have more time to spend with families in delivering practical help and while doing this lay down the foundations of a trusting and constructive relationship. Equally if the volunteer is from the same geographical area she may be experienced by the family as more accessible, trustworthy and acceptable (in all of the following studies the volunteer was female). Table 3.1 outlines the various aspects of the volunteer staffed home visitation programme that will be discussed in this section.
Table 3.1. Evaluations of home visitation programmes-volunteers

<table>
<thead>
<tr>
<th>Authors/year</th>
<th>Programme objectives</th>
<th>Nature of interventions</th>
<th>Study population</th>
<th>Control/comparison</th>
<th>Reliability/validity of data</th>
<th>Outcome measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Home-Start' Leicester Van Der Eyken. 1990 United Kingdom (UK)</td>
<td>Aim: to offer support friendship and practical assistance to families with children less than 5 years of age</td>
<td>Offers support and friendship and practical assistance to families with children under five years of age based on the establishment of a respectful relationship with a volunteer home visitor.</td>
<td>Mainly low income families with children under five years of age, 90% referred by social workers or health visitors.</td>
<td>Random sample of 20% (n=30) of 226 families</td>
<td>a) 0 b) + c) 0</td>
<td>Degree of change in family since involvement in Home Start as measured by volunteer, organiser, family, health visitor and social worker.</td>
<td>Of random sample of 30 families 85% of these families, thought there had been considerable change compared with 89% of health visitors, 55% by social worker, 67% by Home Start organiser and 47% by volunteer. Only 4% of families thought there had been no change.</td>
</tr>
</tbody>
</table>

Reliability and validity of data. – key;

a) Blinding: ++ = all outcome measures blind; + = majority of outcome measures blind; 0 = few or no outcome measures blind.
b) Extent of measurement: ++ = 2 or more measures of incidence of abuse or associated outcome; + = 1 measure only of incidence of abuse or associated outcome; 0 = no measure of abuse or associated outcome.
c) Reliability of measurement: ++ = reliability evident with data provided; + = reliability described without data provided; 0 = no measures of reliability.

(MacMillan et al., 1994)
Table 3.1 (cont). Evaluations of home visitation-volunteers

<table>
<thead>
<tr>
<th>Programme description</th>
<th>Research design</th>
<th>Outcomes</th>
<th>Findings</th>
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<tr>
<td><strong>Authors/year / programme objectives</strong></td>
<td><strong>Nature of interventions</strong></td>
<td><strong>Study population</strong></td>
<td><strong>Control/comparison</strong></td>
</tr>
<tr>
<td>'Newpin' South London Cox. 1991 UK</td>
<td>Offers help from a befriender, attendance at a drop-in centre, a client therapeutic group, individual counselling, or training to become a volunteer themselves</td>
<td>Parents or other main carers suffering from depression in deprived inner city area who are at risk of abusing, or who actually abuse their children.</td>
<td>Non random sample of 69 families</td>
</tr>
</tbody>
</table>

Reliability and validity of data. – key;

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<th>Outcomes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme objectives</td>
<td>Study population</td>
<td>Control/comparison</td>
<td>Outcome measures</td>
<td>1. Women in intervention group scored significantly better on 3 of 4 measures of self esteem.</td>
</tr>
<tr>
<td>'Community mothers'</td>
<td>Post natal non-professional support and encouragement to first time parents in rearing their children</td>
<td>Random assignment of eligible consenting mothers to either intervention (n=141) or control group (n=121).</td>
<td>a) 0 b) ++ c) +</td>
<td>2. Immunisation uptake significantly better in intervention group infants (p&lt;0.01)</td>
</tr>
<tr>
<td>Dublin Johnson et al., 1993</td>
<td>Disadvantaged first time mothers in a defined deprived area.</td>
<td></td>
<td>1. Mothers self esteem 2. Immunisation uptake 3. Infant hospital admissions 4. Infant diet 5. Developmental stimulation scores</td>
<td>3. Infants in control group had more accidents than intervention group infants (NS)</td>
</tr>
<tr>
<td>Ireland</td>
<td>Monthly visits by 'community mothers' for 1st year of infants life.</td>
<td></td>
<td></td>
<td>4. For duration of formula feeds and overall nutrition intervention group mothers performed significantly better than the controls.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. With the exception of motor games the differences between the two groups was highly significant in favour of the intervention group infants.</td>
</tr>
</tbody>
</table>

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(MacMillan et al., 1994)
### Table 3.1 (cont). Evaluations of home visitation-volunteers

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<th>Authors/ year programme country</th>
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<th>Nature of interventions</th>
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<th>Reliability/validity of data</th>
<th>Outcome measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Parent-aide&quot; Adelaide Australia Lines 1987</td>
<td>Aim: to prevent the re-abuse of children</td>
<td>Regular visits to allocated families to: a) provide nurture and mothering experiences for abusing mothers b) demonstrate flexibility about parenting c) be responsive to client whenever the client makes contact d) focus on mother not child e) meet regularly with primary care worker</td>
<td>Review of 36 abusing mothers referred to programme in 1st five years</td>
<td>Retrospective &amp; descriptive</td>
<td>a) 0 b) ++ c) 0</td>
<td>Successful resolution when parents, parent aide and primary care worker agreed that criteria for no further involvement of parent aides was met as follows 1. Child abuse had stopped 2. Mother viewed the child more favourably than before the intervention of child 3. Mother able to seek appropriate assistance 4. Mother had reasonable confidence she could deal with future crises</td>
<td>In more than 97% (35 of 36) cases when parent aide assigned to mother no re-abuse reported over a period of 8 years Ten cases met the criteria for successful resolutions.</td>
</tr>
</tbody>
</table>

Reliability and validity of data. – key;

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<tr>
<td>Benevolent Society Home-Start Redfern Australia Beardmore, 1996</td>
<td>Aim: to provide neighbourly support to normal families with additional needs. Goal: the reduction of child abuse and neglect and the reduction of other adverse health outcomes</td>
<td>Regular visits by trained volunteers to families with young children and additional needs to offer support, friendship and practical assistance</td>
<td>Families with young children (under five years of age, normal families with additional needs)</td>
<td>Retrospective and descriptive</td>
<td>a) 0 b) + c) +</td>
<td>Child abuse notifications State-trait anxiety Family function Maternal depression Locus of control of behaviour</td>
<td>No notifiable cases of child abuse and neglect. Significant improvements observed in family function, maternal anxiety and depression.</td>
</tr>
</tbody>
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(MacMillan et al., 1994)
Home-Start - Leicester

Margaret Harrison, a voluntary worker organiser, established Home-Start in Leicester (UK) in 1974 with 13 trained volunteers. It is perhaps the most well known and most replicated volunteer-based home visitation programme in the Western World. Home-Start has been described as a secondary level prevention programme (Scott, 1997). It targets families that are perceived as vulnerable and likely to experience a difficult transition to parenthood due to social, economic, personal and/or family difficulties. The programme offers support and friendship to families with children under five years of age and is based on values which include affording participating families respect and dignity within a sustained volunteer/mother/child relationship. Within this sustained relationship volunteers attempt to assist families to address their various difficulties through a range of activities that include practical help and facilitating access to other health, welfare and community agencies and social support systems. Volunteers are parents themselves and complete a 10 day training course which includes familiarisation with the objectives of Home-Start, an introduction to child development and community resources and relationship training. Once linked to their families volunteers receive at least fortnightly support and supervision. Over the past 24 years 266 Home-Start programmes have provided family support, friendship and practical assistance to over 500,000 families in the United Kingdom and elsewhere (Harrison, 1997).

In 1982 Van der Eyken undertook a retrospective descriptive evaluation of the Leicester Home-Start programme. In the first four years of the programme 226 families referred from a variety of statutory authorities were matched with trained volunteers. Most of these families (90%) were in the low income bracket, 40% were single parents and 25% of the children, (132 from 50 families) were on the child protection register. Van der Eyken characterised the participating families as being “...under many forms of stress...stress which in its severity has in many cases caused the family, either very temporarily, or over a longer period to lose control” (Van der Eyken, 1990, p.4). Families generally were considered to be isolated and disorganised.

Of the 156 families (70% of initial intake) who remained involved with Home-Start for the minimum period 45% maintained contact for 12 months, 42% remained linked to their volunteers for between 12 and 28 months and the remainder for up to four years. Eighteen children were placed in substitute care during the four years the programme was evaluated and this was at a lower rate than those of other similar socio-demographic areas. As there was no comparison or control group in this
evaluation it is impossible to determine whether even this incidence is a result of the surveillance these families were under. It is an indication that though valuable in other ways, Home-Start did not completely eliminate child maltreatment.

Of the 156 engaged families the Home-Start organiser rated 66% as having shown "considerable change", 27% as having shown "some change" and 7% as having not changed at all. Van der Eyken took a random sample of 20% (n=30) of these families and asked the involved social worker, health visitor, linked volunteer, Home-Start organiser and families themselves to rank the degree of change they observed or experienced. As indicated in Table 3.1, a large percentage of the families and their health visitors agreed there had been considerable change since their involvement in programme. However in this evaluation the details of the change are not outlined. The referring agents, social workers and health visitors were more optimistic and judged that all families had undergone some change during their contact with Home-Start. Notably, volunteers were the least positive about the degree of change in families. However the evaluation results are of limited value in that there was no control or comparison group, the evaluation was retrospective, lacked standardised outcome measures and there was no blind assessment (Cox, 1993; Goossens, 1995). Because of these limitations it is not possible to determine the extent to which this programme contributed to the prevention of child maltreatment. Despite these limitations Home-Start is highly valued by participants, is long lived and regarded as one of the pioneer home visitation programmes. It provides a service that is different from and complimentary to those offered by statutory bodies such as social work and the health visitors programme, and has served as a substantial model for the development of many other volunteer home visitation programmes.

**Newpin - South London**

'Newpin' (the new parent infant network), is an independent voluntary organization initially set up in 1982 in a deprived inner city area of South London. It was originally conceived as a family support scheme similar to Home-Start but in time changed its focus to target "...parents or other main carers suffering from depression or emotional distress, who are at risk of abusing, or who actually abuse their children, emotionally or physically" (Cox, 1993, p. 14). While Home-Start focused on providing a secondary level prevention programme to all families who were vulnerable due to social, economic, personal or family difficulties (ontogenic, microsystem and exosystem factors), Newpin, a secondary and tertiary level prevention programme, appeared to focus primarily on ontogenic factors, i.e.: the health and experience of the mother.
Families were self-referred or were referred from a variety of agencies, including health visitors and social workers, if they were thought to be depressed or at risk of abusing their children. Families were then assessed for their suitability for the Newpin approach. If deemed suitable and depending on need, families were then offered help from a befriender and/or the opportunity to attend a drop-in centre, client groups or individual counselling and therapy at the Newpin centre. There was a focused attempt to match client mothers with volunteers (befrienders) who lived in their neighbourhood or community with the intention of fostering empathy on the basis of their mutual experience and conditions.

Volunteers were trained for two half days per week over a six month period and participated in sessions such as child rearing, child play, relationships and parenting. They also participated in a self-development group over this time in which they were encouraged to explore and come to terms with events in their own past. At the end of training they were linked to clients and continued to receive weekly supervision. According to Cox (1993), after a period (unspecified) many clients went on to become befrienders within the scheme themselves.

In 1991 following a pilot evaluation, Cox, Pound, Mills, Puckering and Owen undertook a more substantive repeated measures evaluation contrasting four groups. The first group was comprised of potential volunteers (n=19), some of whom had already had extensive contact with Newpin. The second group comprised 21 new referrals to Newpin. The volunteer group then commenced Newpin training. The new referrals were linked to a befriender and “had the opportunity to attend the Newpin centre, mix with other referrals and in some cases attend a support group” (Cox et al., 1991, p.218). The comparison group of 24 mothers was drawn from a similar socio-demographic area of London and were similarly designated as comparable to either potential volunteers, that is those considered to benefit from volunteer training (n=15), or referral families (n=9). These two groups received assessment only.

The aim of this study was to evaluate the befriending scheme, in particular the effect of the scheme on the parent-child relationship. This design was intended to enable “the comparison of those within the scheme who had received volunteer training with those mothers who had been befriended” (Cox et al., 1991, p.218). Pre-assessment was undertaken at commencement in the programme and post assessment after 6 months. Interviews with mothers, developmental assessments of the children and videotaped observations of mother-child interactions provided the data for the evaluation.
While the study showed there were significant improvements in a mother's ability to anticipate her child's needs there were no significant differences in the six other dimensions of parenting measured including the promotion of autonomy in the child, the expression of warmth towards the child, stimulation of the child and mutual cooperation, the extent and nature of conflict and negotiation between the mother and child. (Cox, 1993). Equally, while some parent-child interactions improved dramatically, some showed no evidence of change at all. Mothers who sustained their contact with Newpin reported greater self-esteem and an improvement in their sense of control over their lives and reported great support for Newpin.

Although the focus of Newpin was the prevention of child abuse and neglect, no data on child abuse notifications was presented. Other major limitations of this study include the short time frame of the evaluation (6-8 months), the lack of randomisation or a comparable control group and the complexity and confusion created in the results by merging volunteers and referral mothers into the same group. Volunteer mothers were clearly different from those who were on entry designated as referral mothers and linked to a befriender. Despite this difference some results of these groups were pooled as though they were the same. Similarly the comparison group comprised both mothers who were deemed eligible to receive the service and mothers who would have been recruited as new volunteers. While no outcome data was presented for this group, comparisons were also made with a sample of depressed mothers of two year old children from the same area who had participated in an earlier study. This seems to further confound the results in that this third group is acknowledged by the investigators to be relatively disadvantaged and thus different from the treatment group. While there is ample evidence that participants in Newpin highly valued the emotional support they received in the programme there is no reliable evidence that it is an effective child protection programme.

**Community mothers - Dublin**

A more rigorous evaluation was completed on the 'community mothers' programme which commenced in Dublin, Ireland in 1983. This programme was based on the Child Development Programme (CDP) developed by the Early Childhood Development Unit of the University of Bristol which will be discussed in the next section. The Dublin programme differed from the original CDP programme in that, due to a lack of resources, it was forced to change from employing health professionals to recruiting successful experienced mothers to deliver the service (Johnson et al., 1993).
The programme aims were to use experienced mothers “in disadvantaged areas to give support and encouragement to first time parents in rearing their children using the child development programme” (Johnson et al., 1993, p.1449). Like the CDP it aimed to empower mothers to become self sufficient and competent to solve their own problems. In the main it addressed the health and welfare of the mother, her self esteem and her sense of control regarding her own life. In the Dublin programme, the local public health nurses identified the community mothers. If they consented and were judged suitable in a further interview with the regional family development nurse, they undertook a modularised training package over four weeks. During this time the recruited mothers met with other community mothers and were encouraged to exchange ideas and share their own experiences. Ongoing training support and supervision was provided by a family support nurse “who serves as a resource person, monitor and confidante” (Johnson et al., 1993, p.1449). By 1988 there were 90 community mothers and 490 families participating in this programme.

The objective of the evaluation of this programme was to see if non-professionals could deliver a child development programme to disadvantaged first time mothers with children up to one year of age. In a randomised control trial 262 first time mothers with children under six months of age were recruited and randomly assigned to either the control (n=121) or intervention group (n=141). Thirty experienced mothers from the same deprived area in Dublin were recruited to participate as community mothers. The intervention group mothers were linked to a community mother who was scheduled to visit monthly. Both the control and intervention group mothers continued to receive standard support from the public health nurse. Baseline demographic and developmental information was taken from all participants at the first interview and on the child’s first birthday an evaluation questionnaire was also administered. This questionnaire sought information on a range of outcomes including mother’s self esteem, levels of nutrition, infant immunisation completion and developmental stimulation methods. In keeping with the ethos of the CDP rates of child abuse and neglect were not included explicitly in the outcome criteria.

At the commencement of the trial there were no significant differences between the groups except for the employment status of mothers and fathers (i.e. 29% of intervention group mothers employed versus 17% of control group mothers: 51% of intervention group fathers employed versus 33% of control group fathers. p<0.05). The average age of the mothers was approximately 24 years. Two hundred and thirty two mother and infant pairs (89%) completed the evaluation at the child’s first birthday. As outlined in Table 3.1, mothers in the intervention group scored significantly better on three out of four measures of self esteem and more children in
this group had completed the required immunisations (p<0.01). Mothers in the intervention group kept their children on formula feeds significantly longer than those in the control group and provided their infants with better overall nutrition. Also the differences between the two groups in relation to a range of developmental stimulation variables were highly significant in favour of the intervention group.

The investigators pointed out the cost effectiveness of this approach. Throughout 1991, 130 community mothers, 11 family development nurses and a clerical assistant delivered the programme to between 900 and 1000 first time parents within a budget of 50,000 Irish pounds. Despite the fact that this study did not report on the incidence of child abuse and neglect these outcomes show that in the short term, trained volunteers can contribute in a cost effective way to positive health outcomes for both children and mothers within a structured and supportive programme.

Limitations of this study acknowledged by the authors were possible threats to the reliability and validity of the findings due to the use of new testing instruments and the lack of “blindness” of the family development nurses who administered the final evaluation questionnaire. Lack of details regarding the ‘risk status’ of mothers for subsequent child abuse and neglect also diminish the generalizability of the results. It would be helpful to know whether the improvements noted in the evaluation were sustained over time. One also wonders whether the higher rate of employment in the intervention group families may account for some of the differences noted in the evaluation, in particular measures of self esteem.

A home visitation service based on the community mothers’ programme has been established in Perth but is yet to be evaluated (Scott, 1997).

**Parent-aide programme - Adelaide**

As has been mentioned previously, there are few published evaluations of volunteer-based home visitation in Australia. One of the few reported, by David Lines in 1987, is of an outcome evaluation of the effectiveness of trained parent aides in preventing re-abuse of children in a programme that had been established in South Adelaide in 1978 (Lines, 1987). This tertiary level programme was modelled on that first described by Kempe (Kempe, 1973). Twelve parent aides and 36 “abusing mothers” participated in the programme.

The case notes of participating families were reviewed according to predetermined outcome measures (presented in Table 3.1). Outcomes were recorded for 31 of the 36 cases managed in the first five years. These indicate that in 10 cases the parent aide, primary care worker and parents judged the programme to be successful, 10 families
terminated from the programme, usually due to relocation, six families were maintaining their contact with the programme (and later terminated) and in four cases the parent aide withdrew at the parents request. Importantly in 35 of the 36 (97%) families no re-abuse was recorded on the state-wide child abuse register over a period of eight years.

**The Benevolent Society Home-Start - Redfern**

The Redfern Home-Start programme commenced in 1994, at the same time as the Cottage Community Care Pilot Programme began in Campbelltown. The programme aimed to provide neighbourly support to 'normal' families with additional needs and reduce child abuse and neglect. In keeping with the Home-Start protocol, volunteers needed to be parents themselves and if after interview they were deemed suitable, they were required to complete a 40 hour training programme.

External preliminary evaluation of both the Benevolent Society and the CCCP programmes was commissioned by the Department of Community Services in 1995 and involved a literature review, focus groups with volunteers and participating families, interviews with members of the respective programme Advisory committees and the project co-ordinators and analysis of the responses to questionnaires completed by participants in the review (Elix & Lambert, 1995). Though specific outcomes were not evaluated the report identified the following as particular strengths of the programmes:

- the trust developed between clients and their volunteers
- flexibility of the programmes to meet both client and volunteer needs
- the level of training and preparedness of volunteers
- the emphasis placed on matching of volunteers and clients
- the links available between the volunteer based programme and other programmes providing higher levels of professional care
- the commitment of each to ongoing evaluation

(Elix & Lambert, 1995, p.i)

In this preliminary evaluation, the main problems identified in these two programmes included the difficulties encountered in recruiting suitable families, and the heavy reliance placed on programme co-ordinators. The latter were expected to sustain the impetus of the programme, train, supervise and support volunteers, address the needs of evaluation in terms of data collection and continually ensure ongoing and adequate funding.
A further evaluation of the Benevolent Society’s programme was completed in July 1996. The aims of the programme, specified in the evaluation, included “the reduction of child abuse and neglect and other adverse health outcomes” (Beardmore, 1996, p. 20). As outlined in Table 3.1 the evaluation process involved reviewing quantitative data gathered from a range of assessments of clients at entry and exit points. These assessments included measures of anxiety, depression, perceived locus of control and, in common with the Cottage Community Care Pilot Programme, measures of family function and family stress. Qualitative data was gathered in interviews with programme co-ordinators and volunteers. The 38 families admitted to the programme were deemed to be at low risk for subsequent child abuse and neglect but in need of family support due to social isolation, socio-economic disadvantage, the presence of a chronically ill child in the family and/or parent(s) who experienced a persistent sense of low self worth. The average age of the mothers who participated was 32 years and the average number of children in the sample was two per family. Eleven were first time mothers, four were single parent families, 15 families had multiple births and four families required support because of disability of either the parent or child.

Of the 38 families who completed the initial assessments termination data was available for only 26 at the point of review. Of these not all completed all entry and exit assessments. While the report notes also there were no notified cases of child abuse and neglect among the sample reviewed, the basis for this assertion is not stated. At termination from the programme “significant improvements were observed in family functioning, and the level of maternal anxiety and maternal depression” (Beardmore, 1996, p. 3). Major limitations of this study include the lack of a control group, the small and heterogeneous sample, the incomplete data due to families terminating their involvement prior to the evaluation points or not returning the self report questionnaires and the failure to measure specific health outcomes. Perhaps also the evaluation was undertaken at too preliminary a stage. The nature and findings of this evaluation reflect the difficulties often encountered in programme evaluation that make comparisons between programmes difficult and diminish the authority of the results.

**Evaluations of Home visitation programmes employing para professional and professional health workers**

Table 3.2 outlines a range of professional or paraprofessional staffed home visitation programmes that will be further discussed in this section.
<table>
<thead>
<tr>
<th>Authors/year</th>
<th>Programme objectives</th>
<th>Nature of interventions</th>
<th>Study population</th>
<th>Sample</th>
<th>Reliability/validity of data</th>
<th>Outcome measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The Colorado study&quot; USA Gray, Cutler, Deane &amp; Kempe 1979</td>
<td>Aims: To identify women in prenatal period at high and low risk for subsequent child maltreatment. To prevent child abuse and neglect.</td>
<td>Regular post birth follow up by paediatrician. Weekly visits to family by public health nurse. Emotional support and co ordination of follow up done by lay persons.</td>
<td>Sample (150) drawn from 350 women who had their children in General Hospital between Nov. 1971 and March 1973</td>
<td>High and low risk mothers determined by prenatal questionnaire and nurse observations during delivery and post partum interview with mother Random assignment of 150 mothers to either; 1. High risk intervene (n=50) 2. Low risk intervene(n=50) 3. Low risk control group(n=50)</td>
<td>a) 0 b) ++ c) 0</td>
<td>Child abuse as indicated on Central Child abuse Registry. Number of accidents according to medical records Child immunisation uptake rates Denver developmental Screening tests. Number of observed indications of abnormal parenting.</td>
<td>No significant differences between intervention and control groups on all outcome measures though reported reduction in hospitalisation for serious injury of infants from high risk intervention group seen as an intervention effect.</td>
</tr>
</tbody>
</table>

**Reliability and validity of data. – key:**

- a) Blinding: ++ = all outcome measures blind; + = majority of outcome measures blind; 0 = few or no outcome measures blind.
- b) Extent of measurement: ++ = 2 or more measures of incidence of abuse or associated outcome; + = 1 measure only of incidence of abuse or associated outcome; 0 = no measure of abuse or associated outcome.
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(MacMillan et al., 1994)
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<tbody>
<tr>
<td>“The Elmira trial” USA</td>
<td>Aims: to prevent a wide range of health and developmental problems including abuse and neglect in children born to primiparas who were either teenagers, unmarried or of low socio-economic status</td>
<td>Nurse home visitation in pregnancy and the subsequent two years; involvement of family members and friends in child care; linking and free transportation of family to free health care and family services; parent education re infant development.</td>
<td>Prenatal contact with 1st time mothers in any one of the following conditions i) teenager ii) poor iii) single parent</td>
<td>Random assignment of 400 mothers to one of four groups Gp 1. (control gp) No services provided during pregnancy. Screening only. Gp 2. Free transportation for regular prenatal and well child care. Screening only. Gp 3. Nurse home visitor during pregnancy, screening and free transportation services Gp 4 Treatment group; Same as Gp 3 plus continued nurse visitation until child was two years of age</td>
<td>a) ++ b) ++ c) ++</td>
<td>1. Registered incidents of child abuse and neglect 2. Emergency room visits 3. Infant temperament and behavioural problems/maternal concern. conflict, scolding and spanking 4. Infant developmental quotients 5. Provision of appropriate play materials and avoidance of restriction and punishment</td>
<td>1. 19% of comparison group at high risk &amp; 4% of treatment group had abused or neglected their infant in first two years (p&lt;0.07) 2. Fewer treatment group infants presented to emergency rooms than infants of control group (p=0.01) 3. Treatment group mothers reported their babies had more positive mood, and that they had less conflict with or scolding of their infants. 4. Trends for nurse visited infants to have higher developmental quotients than babies in control group 5. Within high risk group nurse visited mothers punished and restricted their children less frequently than control group mothers and were more likely to provide appropriate play materials.</td>
</tr>
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Reliability and validity of data. — key:

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<tr>
<td>&quot;The Elmira trial&quot;</td>
<td>As in Olds et al., 1986</td>
<td>Nurse home visitation in pregnancy and the subsequent two years; involvement of family members and friends in child care; linking and free transportation of family to free health care and family services; parent education re infant development.</td>
<td>Follow up of families from 1986 trial during two year period after child's 2nd birthday</td>
<td>Gps 1 &amp; 2 (as above) combined and treated as control group (n=160)</td>
<td>1. Registered incidents of child abuse and neglect 2. Nurse visited children lived in homes where there were fewer hazards for children</td>
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<tr>
<td>USA Olds, Henderson, Kitzman 1994</td>
<td></td>
<td></td>
<td></td>
<td>Gp.3: (n=65) Gp.4: (n=93)</td>
<td>1. No enduring treatment effect in rates of child abuse and neglect 2. Nurse visited children lived in homes where there were fewer hazards for children</td>
<td></td>
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</tbody>
</table>

Reliability and validity of data. – key:

a) **Blinding:**
   
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<tr>
<td>&quot;The Elmira trial&quot; USA Olds, Eckenrode, Henderson, Kitzman, Powers, Cole, Sidora, Morris, Pettitt, &amp; Luckey 1997</td>
<td>See above: Olds et al., 1986</td>
<td>Nurse home visitation in pregnancy and the subsequent two years; involvement of family members and friends in child care; linking and free transportation of family to free health care and family services; parent education re infant development.</td>
<td>Follow up of 324 families from 1986 trial when their children were 15 years old.</td>
<td>Gps 1 &amp; 2 (as above) combined and treated as control group (n=184) Gp.3: (n=100) Gp.4: (n=116)</td>
<td>a) ++ b) ++ c) ++</td>
<td>Rates of subsequent births and use of welfare Substance abuse, criminal justice encounters, and child abuse and neglect</td>
<td>Significant results; Nurse visited children in contrast to control group had: a. 1.3 vs 1.6 subsequent children (p=0.02) b. 65 vs 37 months between birth of first and second child (p=0.001). c. 60 vs 90 months receiving welfare payments (p=0.005) d. 0.29 vs 0.54 verified reports of child abuse and neglect (p&lt;0.001). e. 0.41 vs 0.73 behavioural impairments due to alcohol or other drugs f. fewer arrests (p&lt;0.001)</td>
</tr>
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Reliability and validity of data. – key;  

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(MacMillan et al., 1994)
Table 3.2 (cont). Evaluations of home visitation-professional/para professional workers

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<th>Outcome measures</th>
<th>Findings</th>
</tr>
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<tbody>
<tr>
<td>“The Baltimore programme” USA Hardy &amp; Streett 1989</td>
<td>Aims: To provide inner city mothers with parenting education in the home as an extension of the existing federal Children and Youth programme; To prevent a wide range of health problems</td>
<td>Post natal monthly home visitation by trained para professional offering parenting education, support, referral and ongoing liaison with existing community health services</td>
<td>Black inner city economically disadvantaged 1st time mothers.</td>
<td>Random assignment of 290 consenting women to intervention or control group.</td>
<td>a) 0 b) ++ c) 0</td>
<td>Child abuse and neglect - suspected / verified infant health outcomes</td>
<td>Significantly fewer cases of suspected or verified cases of child abuse and neglect in intervention group. Intervention group significantly more compliant with immunisation completion and well child care; far fewer attendances at emergency departments or admissions to hospital.</td>
</tr>
</tbody>
</table>

Reliability and validity of data. – key;

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<th>Reliability/ validity of data*</th>
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<th>Findings</th>
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</thead>
<tbody>
<tr>
<td>“The Bristol Programme” (CDP) UK Barker, Anderson &amp; Chalmers 1992</td>
<td>Aims: To empower parents to and give them a sense of control over their lives; To improve every area of parent and child functioning including nutrition, health, language, social and cognitive goals, early education and emotional development.</td>
<td>Monthly support visits to new parents by specially trained health visitors who use semi structured methods to build parents self esteem, and empower them to become better parents. Sample consisted mainly of first time parents and their children, mothers generally younger than ages of district’s mothers as a whole, with children mostly aged less than 1 year residing mainly in district’s less advantaged areas.</td>
<td>Review of 31,791 records of participating families by health visitors compared to whole population of children in each area of each health authority involved in the study. Comparison samples highly dissimilar</td>
<td>a) 0 b) ++ c) ++</td>
<td>Proportion of programme children who had been placed on the Child Protection registers (CPR) within 1 year The proportion of programme children who had suffered physical abuse or who had died</td>
<td>Comparison of combined rates of placement of programme infants on the Child protection register (CPR) suggest that programme children can expect to have a 41% lower rate of registration on the CPR than non programme children (5.25 per 1000 vs 8.93 per 1000).</td>
<td></td>
</tr>
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(MacMillan et al., 1994)
The University of Colorado study

In the United States, Gray, Cutler, Dean, and Kempe were the first authors to report the results of an evaluation of a secondary level perinatal child maltreatment programme. They investigated the impact of a programme that combined a number of strategies directed toward predicting child maltreatment, improving child and maternal health and reducing the incidence of child abuse (Gray et al., 1979). As outlined in Table 3.2, a random sample of 150 mothers was drawn from 350 women who had their first or second child at the local hospital between 1971 and 1973. Pre and postnatal assessment was undertaken with each mother in an effort to identify those parents who “were most likely to exhibit abnormal parenting practices (i.e.; child abuse)” (Gray et al., 1979, p.128). Degree of risk was determined prenatally by the results of a questionnaire and postnatally by nursing staff rating mother-infant interaction on a standardised form. One hundred mothers determined to be at ‘high risk’ for subsequently maltreating their child were randomly allocated to either a “high risk intervene” or “high risk non intervene” group. Fifty mothers who were assessed as low risk were selected as controls. The high risk intervene group received weekly home visitation by lay health visitors, follow up visits by public health nurses and intensive bimonthly paediatric contact. The high risk non intervene group and the control group received standard services only.

Five outcomes were measured at follow up, occurring between 17 and 35 months postnatally as outlined in Table 3.2. Results indicated there were no significant differences between the control and intervention groups on the five outcomes measured, one of which was child abuse incidence recorded in the Central Child Abuse Registry. There was a greater though statistically insignificant number of reported incidents of child maltreatment involving intervention group infants. As noted in later similar studies this could be explained by the increased surveillance of these infants (Gray, Cutler, Dean & Kempe, 1979). Analysis of the nature and severity of the child abuse incidents revealed that the control and intervention groups differed significantly in the severity of child maltreatment. Less severe episodes of child maltreatment were reported for high risk mothers who had received enhanced contact with health professionals. High risk non-intervention infants were significantly more likely to require in-patient treatment for serious injuries (trauma and poisoning) at a younger age than those children in the low risk group. Gray et al. (1979), observed also that, despite these injuries none of the families involved were reported by medical staff to other helping agencies or notified as possible abuse and neglect incidents. No hospitalisations occurred in the high risk intervention or low risk groups. This was seen as an intervention effect. This initial evaluation data was
encouraging and paved the way for further development of programmes to prevent child maltreatment through enhanced involvement between families and professional and para professional helpers in the pre natal and perinatal period (Holden, Willis & Corcoran, 1992).

Criticisms of this study include that the outcome evaluation was conducted on approximately 50% of the participants only, there was no reliability or validity data presented for the instruments used to determine risk, and inclusion and exclusion criteria were not clearly defined (Goossens, 1996; MacMillan, Offord, Griffith & MacMillan, 1994).

**The Elmira prenatal/early infancy project**

The often cited Elmira study was a randomised trial of nurse home visitation carried out in the late 1970’s and early 1980’s in a small semirural city (population 40,000), in upstate New York. The theoretical foundations of the Elmira project reflected the growing recognition of the ecological model of child maltreatment, that is, that child maltreatment is most likely the product of the interaction between the parents abilities, experiences and resources, the child’s emerging emotional and behavioural characteristics and the social environment in which the family exists (Olds et al., 1986, Wolfe, 1993). The project’s interventions included parent education regarding pre-natal health and infant care, enhancement of social support and extensive linkage of families to health and human service organizations. This programme was evaluated in 1986, 1994 and finally in a fifteen year follow up, in 1997. The programme took place in a community the investigators described as being:

...beset with extremely difficult economic conditions...in 1980 rated the worst Standard Statistical area in the United States in terms of its economic conditions...and from the early 1970’s through the mid 1980’s the community had the highest rates of reported and verified cases of child abuse and neglect in New York State. (Olds, 1992, p. 2).

Women were deemed eligible for the study if they were first time mothers, up to 26 weeks pregnant, and at risk for poor pregnancy outcomes due to being poor, unmarried or less than 19 years of age. Over two years 400 women were deemed eligible, consented to participate and were randomly assigned to one of four treatment conditions as detailed below.
<table>
<thead>
<tr>
<th>Group</th>
<th>Condition</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-</td>
<td>Control</td>
<td>No formal intervention</td>
</tr>
<tr>
<td>2-</td>
<td>Control</td>
<td>No formal intervention</td>
</tr>
<tr>
<td>3</td>
<td>Treatment</td>
<td>Fortnightly antenatal home visitation until delivery of infant, thereafter screening and free transportation</td>
</tr>
</tbody>
</table>
| 4     | Treatment | Antenatal and postnatal visitation  
For six weeks post delivery visited weekly  
Six weeks-four months visited fortnightly  
Four-14 months visited three weekly  
14-20 months visited monthly  
20-24 months visited every six weeks |

All outcome data were collected blind. Infants in all four groups were screened for sensory and developmental problems with a variety of validated instruments. All participants were screened at recruitment to the programme (prior to the 30th week of pregnancy) and at 6, 10, 12, 22, and 24 months of age. Medical records, child abuse and neglect notification registries, emergency room and immunisation records were reviewed for all participants. Groups 1 and 2 were combined for the purpose of analysis and treated as the control group as it was determined there was no difference in their use of prenatal and well child care (Olds et al., 1986).

In the initial evaluation, undertaken after the first two years of the programme, it was found that women assigned to Group 4 who were visited by a nurse both pre- and post-natally, had fewer incidences of verified child abuse and neglect (at 4%) than women in the control group (at 19%; p<0.07). Also the babies of the women in group 4 who received extended regular visitation by nurses and other support were seen less often in the local hospital's emergency room, and visited their physicians for accidents and poisoning less frequently than those in other groups. Nurse visited adolescents in groups 3 and 4 had babies who were nearly one pound heavier at birth than those born to mothers in the control group, probably due to better attendance at antenatal classes, improved nutrition, decreased exposure to smoking and fewer urinary tract infections. Beyond these outcomes there were no other significant advantages demonstrated in group 3 mothers. In this initial study Olds et al., concluded that "the pattern of results from this investigation provides evidence that nurse home visitors are capable of preventing a number of care giving dysfunctions, including child abuse and neglect" (Olds et al., 1986, p.76)
The focus of a four year follow up study of this programme to test for lasting treatment effects included an examination of the health, development, rates of child abuse and neglect and living conditions of children that had participated in the original programme (Olds, Henderson and Kitzman, 1994). The ensuing report states:

There were no treatment differences in rates of child abuse and neglect or the children's intellectual functioning from 25 to 48 months of age. Nurse visited children, nevertheless, lived in homes where there were fewer hazards for children; they had 40% fewer injuries and ingestions and 45% fewer behavioural and parental coping problems noted in the physicians record; and they made 35% fewer visits to the emergency department than did children of the comparison group

(Olds et al., 1994, p.89).

Amongst other longer term benefits, nurse-visited women were less likely to punish or restrict their children, had 43% fewer pregnancies, delayed the birth of a second child an average of 12 months longer than those in the comparison group and were more likely to have completed their child’s primary immunisations. It was also reported that the adolescent mothers of group 4 were more likely to engage in activities that stimulated their children’s language skills and provided more age appropriate toys, games and reading materials to their infants. The authors of this follow up report concluded that “it may be necessary to extend the length of the programme for families at highest risk to produce lasting reductions in child abuse and neglect” (Olds et al., 1994, p.89)

Unlike most other evaluations of home visitation the investigators in this study also paid attention to the cost benefits of this programme and concluded that the programme had paid for itself by the time the children were four years of age. In testimony prepared for the United States of America’s House Senate Committee on Children and Families, Olds stated that;

...on average, the prenatal and post partum nurse visitation programme cost about $3200 for two-and-half years of home visitation. Low income women (those most likely to use government services) used $3,300 less in other government services during the first four years after delivery than did their low-income counterparts in the comparison group. About one third of the cost savings for low-income families came from the reduction in unintended subsequent pregnancies, and about 80% of the cost savings were concentrated in reduction in Aid to Families with Dependent Children (AFDC) and Food Stamp payments

(Olds, 1992, p.4).

A more recent 15 year follow up of 324 of the original sample of 400 families was conducted to “determine the extent to which the beneficial effects of the
programme...altered the life course trajectories of the mothers through the child's 15th birthday” (Olds et al., 1997, p. 638). As outlined in Table 3.2, it was found that those women who were visited by nurses during pregnancy and the first two years of their infant's life, in contrast to those families in the control group, had fewer subsequent pregnancies, a longer time between the birth of their first and second child, reduced incidence of child abuse and neglect, fewer behavioural impairments due to alcohol and other drugs, less criminal behaviour and less use of welfare aid. In particular unmarried women of low socio economic status seemed to benefit most from the programme. In essence many of the benefits reported in the first evaluation of this randomised trial programme were sustained in the long term evaluation.

The authors of this study identify a range of limitations that effect the generalizability of the findings. The Elmira study was conducted under favorable circumstances in the late 1970s and early 1980s. Five nurses were recruited and specifically trained for the programme and assigned a manageable caseload (20-25 families). The programme was based on an ecological model of child and maternal health, had a broad health and social service orientation and was well supported by existing social and health services. The small semi rural county selected for the programme, well served by health and human services, is not necessarily representative of either inner city or other rural communities as they are in the late 1990s. Equally, the families enrolled in the programme, mainly white, young, first time mothers, presenting at less than 30 weeks gestation are not totally representative of all ‘at risk’ families in the United States. Despite these limitations this study is considered to be the most methodologically sound evaluation of home visitation thus far, the findings often cited to support the effectiveness of home visitation by professional workers.

According to the United States General Accounting Office (GAO) report on home visiting (1990) when the demonstration project was finished in 1983 the programme was absorbed by the local health authority. Due to financial constraints and a different philosophy the programme was significantly altered in terms of its focus, the extent of service offered, the target population and the nurses’ caseload. As a result of these changes all of the original home visitors left within a few months. One director of county services reported to the GAO committee that the revised programme “was no longer achieving the same reductions in low birthweight as the original programme” (GAO, 1990, p. 42). This illustrates the possibility that the broad ecological approach of the original programme and the regularity of visits by specifically trained nurses with a manageable caseload contributed significantly to its success in comparison to other home visiting programmes.
The Baltimore programme

In another randomised control trial Hardy and Streett (1989) evaluated a home visitation programme made available to black, inner city, economically disadvantaged primiparous mothers, an entirely different population than those participating in the Elmira trial. Like the Elmira trial the programme was based on an ecological framework and emphasized parenting education geared to the age of the baby and mother, emotional support and increasing parents’ access to existing health and social services, including well babies clinics and other preventative health services as necessary. As table 3.2 indicates a total of 290 women who consented soon after delivery were randomly assigned to either the intervention or control group. Intervention group mothers were visited monthly (over 24 months) by a middle aged black woman with a Bachelor of Arts degree who had previously lived in the community and who was specifically recruited and trained for the programme.

The outcomes of this programme were generally positive. The intervention group had significantly fewer cases of suspected child abuse and neglect (1.5% versus 9.8%) and verified abuse and neglect (0.08% versus 9.1%) than the control group. The intervention group mothers were more compliant with well child care and immunisation completion and their infants had fewer admissions to hospitals for accidents or health problems. Cost analysis revealed that the average cost of medical care per intervention group child was $1301 compared with $1899 per control child. This appears to be a relatively successful programme in that it was delivered by a woman who was familiar with the particular context and language of these mothers’ lives, it was extended over a long period of time and it included a range of interventions, not least of which was improving parents access to a wide range of health services.

The Child Development Programme - Bristol

The Child Development Programme, started in 1980 by the Early Childhood Development Unit of the University of Bristol, was initially an experimental project. It now operates in collaboration with 25 health authorities and one health board across England, Wales and Northern Ireland. An estimated 15,000 to 20,000 new families are involved in this programme each year. “In essence the programme offers monthly support visits to new parents antenatally and for the first year or more of life...most visits are undertaken by specially trained health visitors...” (Barker, Anderson & Chalmers, 1992, p. 4). The programme is described as “a general support programme which focuses on improving every area of parent and child functioning, including nutrition, health, language, social and cognitive goals, early
education and emotional development” (Barker et al., 1992, p. 6). Barker and his associates are adamant in refusing to label their programme as a child abuse prevention initiative or to target ‘vulnerable’ families stating:

...it is not a programme to combat child abuse; such an aim would be seen as gratuitous if not deeply offensive by all parents who willingly take part in the programme...statistical evidence and a wealth of anecdotal details about the effects of the programme in reducing child abuse have been seen as a by-product, however important in itself, of a general support programme...

(Barker et al., 1992, p. 6).

The most recent evaluation of selected outcomes of this programme included a review of the records of over 30,000 participating families. The rates of placement of children on the Child Protection register were up to 41% lower than the estimated levels for the health authorities as a whole with rates of physical abuse reduced by up to 50%. While these results are encouraging they are described by the authors as “tentative” due to the difficulties in analysing and extrapolating a wide range of data from a variety of sources (Barker et al., 1992, p. 41).

**Brisbane Programme - Australia**

In Australia a randomised control trial of nurse home visitation has been commenced in Brisbane. ‘Vulnerable’ families (N=181) were recruited immediately after the birth of their child. Of these, 91 were randomly assigned to the intervention group and received home visits from a child health nurse (weekly till six weeks, fortnightly till three months, three weekly till six months, monthly till one year and three monthly till two years). Ninety families were assigned to the control group and encouraged to access the local Community Child Health services. Outcome evaluation is being undertaken by an independent researcher blinded to the families’ intervention status. Preliminary findings from this project indicate that the intervention group rated more positively on the indices used to evaluate maternal and infant attachment and maternal distress/depression (Armstrong, Fraser, Dadds & Morris, 1997).
Summary

Child abuse is a complex and multifaceted phenomenon. It is thought to arise out of the family’s response to and interaction with the ever changing and often adverse and complex contexts and situations within which they live (Belsky, 1988). Since the mid 1960s home visitation involving volunteers or professional workers in ongoing relationships with families has been strongly advocated as a strategy for improving maternal and child health and as a child protection measure. Primary and secondary level home visitation programmes generally aim to prevent child abuse and neglect by assisting families to establish behaviours and a lifestyle that will assist them to cope constructively with these contexts and situations and subsequently reduce the likelihood that child abuse will occur.

Those programmes that took a broad ecological approach including, linking the family with existing services such as well baby clinics, paediatricians and other community services, as well as providing regular support and education visits by the worker, (Olds et al., 1994; Johnson et al., 1993; Barker et al., 1992; Hardy & Streett, 1989) seemed to be more successful than those programmes that offered a narrower service (Cox et al., 1991). All but one programme addressed services to mothers who, due to a variety of negative life circumstances including youth, poverty, and social isolation or previous child abuse were considered to be ‘vulnerable’ or ‘at risk’ of subsequent child maltreatment with the other targeting mothers experiencing intrapersonal difficulties such as depression (Cox et al., 1991). None of the programmes reviewed reported on issues related to including fathers or partners in the programme.

Programmes that commenced prenatally and extended into the second year of the infants life (Olds et al., 1994; Hardy and Streett, 1989) seemed to be more beneficial than those initiated after the birth of the child (Gray et al., 1979), or those that ceased within 6-8 months (Beardmore, 1996; Cox et al., 1991). There is evidence that desired outcomes such as more positive parenting knowledge attitudes and skills, as well as fewer child injuries, emergency room visits and reports to protective agencies are linked not only to the duration of home visitation but also the breadth of services available. (Olds et al., 1986; 1994; 1997). While some home visitation programmes, in particular the Elmira trial (Olds et al., 1986; 1994; 1997), the Dublin Community Mothers scheme (Johnson et al., 1993), the Bristol programme, (Barker, Anderson & Chalmers, 1992) and the Baltimore programme (Hardy & Streett, 1989) appear to demonstrate significant and desirable outcomes in relation to a reduced incidence of
child abuse and neglect and improvements in child and maternal health, the findings of other programmes are less reliable.

It is difficult to assess the relative effectiveness of para professionals, professionals and volunteers as home visitors. Volunteer based programmes are rarely evaluated, or if they are, the studies have major methodological flaws (Van der Eyken, 1990; Cox et al., 1991; Beardmore, 1996). While evaluations of volunteer based programmes show they can offer valued emotional and social support, there is little evidence, as yet, that they prevent child abuse and neglect. The advantages of volunteer based home visitation, however, clearly include low cost, enabling service agencies to reach a greater number of parents. Equally the volunteer may be perceived as more accessible and trustworthy by the client population, especially if she comes from the same geographical area and has experiences in common with the client.

Disadvantages of volunteer based programmes identified by Hardy and Streett (1989) and Cox et al. (1991) include the possibility that some families have extraordinary needs beyond the capabilities of even a trained volunteer. These families often require professional intervention, illustrating the necessity for volunteers to know how to work within their capacity and for home visitation programmes to ensure that volunteers have access to well structured accessible support and regular supervision. Whether volunteer or professionally staffed, programmes that had a well constructed curriculum for their home visitors seemed to produce the most dramatic results (Olds et al., 1986; 1994; 1997; Hardy & Streett, 1989; Johnson et al., 1993). Differences in programme and research design and the size and nature of samples further contribute to the difficulties in judging the relative effectiveness of various home visitation programmes as child protection and family support strategies. In the next chapter a more detailed examination of the issues that complicate evaluation of home visitation will be conducted.
Chapter 4

Issues in evaluation of home visitation programmes

While evaluations of home visitation have increased both in quantity and quality in the past ten years, debate continues about what constitutes an effective family support/child protection programme and equally the most effective way of determining a programme’s effectiveness. The review in the previous chapter indicated numerous difficulties that limited the validity and generaliseability of findings of evaluations of home visitation programmes. It is not always clear what works with whom and under what circumstances, to prevent the occurrence of child abuse and neglect. The differences between programmes, the varying contexts they operate in, their duration, the models and nature of service offered and the varying populations they target confine both comparisons and judgements about their relative effectiveness.

In this chapter these issues and their impact on the evaluation of home visitation programmes will be examined further. While the issues have been categorized as either methodological, conceptual or ethical/practical/political this division is somewhat arbitrary. In reality it is the combination of issues that contributes to the ongoing difficulties in judging the effectiveness and efficiency of home visitation as a child protection and family support strategy.

The purpose of evaluation

According to Smith and Glass “…evaluation is the process of establishing value judgements based on evidence about a product or programme” (1995). In a more comprehensive definition, Rossi and Freeman conclude that “evaluation research is...activity directed at collecting, analysing and interpreting information on the need for, implementation of, and effectiveness and efficiency of intervention efforts to better the lot of humankind” (Rossi and Freeman, 1989, p. 61). Owen (1993) proposes that evaluation can be carried out for one or more of the following reasons:

- Enlightenment
- Accountability
- Programme improvement
- Programme clarification
- Programme development
- Symbolic reasons

In terms of Owen’s model all of the evaluations in Chapter 3 were undertaken to provide enlightenment, to meet accountability requirements and/or to inform and influence others regarding the impact of the programme on a particular client population. In the main, all endeavored to assess the impact of the programme on various aspects of the mother or child’s experience or behaviour as part of an ongoing effort to influence the development of policies and strategies that would serve to support families and through this reduce the incidence of child abuse and neglect.

Methodological issues

The term methodology refers to the different designs, techniques, procedures and strategies employed in research activities to test hypotheses or examine or measure various phenomena. It may include the use of surveys, direct observations, testing and audits (Pietrzak, Ramler, Renner, Ford & Gilbert, 1990). Evaluation research can be summative or formative, involving input, process and/or outcome/impact evaluation and can be undertaken using experimental, quasi-experimental or non experimental research methods. The evaluation method chosen depends on the purpose of the evaluation, the availability of resources and what Owen (1993) terms the “state of the programme...the degree to which the programme under review has been implemented at the time of the proposed evaluation” (p. 22). Impact or outcome evaluations are most commonly done with programmes that Owen refers to as “settled” (1993, p. 21), that is established. Process evaluations, concerned with what actually happens in the delivery of a programme, are usually undertaken in the developmental stages.

Design considerations

*Formative vs summative - the focus of evaluation*

It is apparent that the vast majority of evaluations of home visitation are primarily summative in nature. That is, the evaluations are in the main concerned with assessing outcomes, or the impact of the programme on given populations. Most also have undertaken a degree of input evaluation, identifying and evaluating in varying degrees such elements as the background rationale for the programme, the programme goals and resources, target populations, interventions and details of other health and social services and personnel involved in the programme. However few studies have undertaken a detailed process evaluation which is defined by Pietrzak et al. (1990, p. 111) as “an assessment of the internal dynamics and operation of the programme...it focuses on programme activities that involve direct interactions
between clients and line staff and are central to the accomplishment of the programmes objectives". While the nature of interventions are outlined for each programme, there is little research detailing the nature of the relationships between visitor and client, or what factors within this relationship operate as protective factors against child maltreatment. The detail of these interactions and the identification of possible protective factors remain largely unknown. Questions that remain unanswered include: What constitutes effective emotional support, practical assistance and friendship? How can these attributes be fostered and assessed? What elements of the relationship between the client family, the visitor and the supervisor are essential to positive outcomes? These are largely the process elements of a programme and given they are essential to programme outcomes, they require further and detailed examination (Owen, 1993). These questions would need to be addressed by non experimental or qualitative research methods. Such methods could reveal significant aspects of the care giver's and client's experience of home visitation that could contribute to the further development of effective child protection and family support programmes.

Perhaps the seeming preoccupation with outcome studies reflects a need to first establish home visitation as an effective child protection strategy before undertaking detailed examination of why and how it works. The focus on outcomes may also reflect a need to demonstrate the impact of a programme in order to secure ongoing funding or to meet the demands of other stakeholders. The current emphasis in the health and human services domain on the need for evidence based practice might also contribute to the prevalence of outcome evaluations. However while outcome studies are important, in particular to justify home visitation as a family support and child protection strategy, process evaluations are equally essential to clarify and inform future practice.

**Experimental designs**

A review of the literature reveals that randomized control trials, the ‘gold standard’ experimental design, are the exception rather than the rule in home visitation evaluation. MacMillan and her colleagues (1994) undertook a critical review of studies of perinatal and early childhood programmes. A literature search yielded 1522 citations published in the journal literature between 1979 and 1993. Of these 33 studies met the inclusion criteria of a randomized control trial. Eleven studies, of which six were evaluations of home visitation programmes, were finally included in the review as they also met the criteria of targeting physical abuse and/or neglect.
MacMillan and her associates scored these 11 trials on the following five criteria which are considered to be key elements of a rigorous randomized control trial:

1. method of sample allocation  
2. baseline comparison of experimental and control groups  
3. inclusion and exclusion criteria  
4. follow up  
5. outcome assessment  

(MacMillan et al., 1994, p. 837).

The total available score was 25, the range of scores of the 11 trials was 8-23. Only the Elmira study (Olds et al., 1986) scored above 20 (23). True randomization of subjects occurred in six of the 11 studies. Sample sizes ranged from 100 to 400 participants and sample attrition from 8-43%. Inadequate sample size and high attrition rates are commonly problematic in home visitation trials (Helfer, 1982).

The difficulties in using randomized control trials to evaluate home visitation programmes are similar to those that complicate the evaluation of most community based health initiatives. Often it is difficult if not impossible to carry out true experimental research in a natural setting, that is within the community or family context. The multitude of variables that shift and change in both these contexts defy the level of control demanded in a true experiment. Populations served by these programmes are sometimes highly mobile, making access, retention and follow up difficult. The ethical dilemmas posed by knowingly withholding apparently helpful treatments to vulnerable or high risk groups are often unacceptable to service providers. This makes random allocation of families to either the experimental or control group difficult or impossible and in some evaluations inappropriate.

**Quasi experimental designs**

Other methods used to evaluate the effectiveness of home visitation are quasi experimental in nature, including non-equivalent comparison group designs. The significant difference between these and true experiments is that clients are not randomly allocated to the control group. Instead, a comparison group is selected on the basis of particular characteristics thought to be important, for example, age, gender, socio economic status, risk factors or marital status. Given the possible differences between the groups prior to and during the intervention, any changes observed may well be the result of influences other than the intervention. This reduces the capacity to make the kinds of cause and effect inferences that researchers often seek and to some degree limits significantly the generalizability of the results (Polit and Hungler, 1993). Despite these limitations it is sometimes more feasible, ethical and practical to conduct quasi experimental research when evaluating home
visitation programmes. Cox et al.'s. (1991) study of the Newpin programme is an example of the difficulties inherent in quasi experimental designs in that the comparison group comprised mothers who, though chosen by health visitors from another similar inner city area, may have been subject to different influences from those in the intervention group.

*Non experimental designs*

Non experimental designs have also been used to evaluate home visitation, for example single group studies (Beardmore, 1996), and correlational research (Van der Eyken, 1990; Lines, 1987). While there is value in this type of design, in particular where it is considered unethical or impossible to manipulate the independent variable, the major disadvantage is that, "relative to experimental or quasi experimental research, it is weak in its ability to reveal causal relationships (Polit and Hungler, 1993, p. 142). In this design it is difficult to separate the effect of measurement, maturation and history from the effect of intervention. However if numerous similar studies have produced similar results, or if experimental studies exist featuring similar procedures and approaches then it is possible to have more confidence in the results (Vimpani et al., 1996).

*One off vs. longitudinal design*

Another issue that arises in evaluating the impact of a programme concerns the desirable timing of evaluation, whether the evaluation of outcomes is proximal or distal. Long term evaluation such as that carried out by Olds et al. (1986; 1990; 1997), at 25 months, four years and 14 years revealed long term positive gains on a range of outcomes for the families involved. Interestingly in mapping the long term impact of the programme this study revealed greater differences between the groups on a number of outcome measures at two and 14 years than was apparent at four years (Olds, 1997). Long term evaluation is valuable in that it demonstrates the enduring positive impact of a home visitation programme on the life experience of the participants. These long term positive outcomes also serve to illustrate the cost benefits of this particular home visitation programme. More commonly, as indicated in Table 4.1 evaluations measure relatively short term effects and these once only.
<table>
<thead>
<tr>
<th>Authors / year</th>
<th>Timing of visits</th>
<th>Duration of intervention</th>
<th>Nature of Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beardmore. 1996</td>
<td>Post natal: not specified</td>
<td>Average follow up period between initial assessments and termination data = 5 months.</td>
<td>Visits by trained volunteers to families with young children and additional needs to offer support, friendship and practical assistance</td>
</tr>
<tr>
<td>Johnson et al., 1993</td>
<td>Post natal: monthly visits</td>
<td>Visits during the first year of the infants life</td>
<td>Post natal non professional support and encouragement in child rearing by community mother using the Bristol Child development programme</td>
</tr>
<tr>
<td>Cox. 1991</td>
<td>Post natal: as arranged with mothers</td>
<td>2 - 8mths</td>
<td>Depending on initial assessment of need client may be offered help from a befriender, and/or attendance at a ‘drop in’ centre, a client group, or individual counselling and therapy or volunteer training.</td>
</tr>
<tr>
<td>Van Der Eyken. 1990</td>
<td>Post natal: as arranged with mothers</td>
<td>45% of families in contact for between 3 weeks and 12 months. 42% in contact for 12-28 months</td>
<td>Emotional and practical support of mother by designated volunteer. Mothers able to join discussion groups, play groups, toy library, and participate in social outings.</td>
</tr>
</tbody>
</table>
| Lines. 1987 | Post abuse: Up to twice per week early in the relationship, less often as the risk of abuse lessened. The mean time spent by parent aide with client was 20 hours per month. | Not specified | Regular visits to allocated families to:  
a) provide nurture and mothering experiences for abusing mothers  
b) demonstrate flexibility about parenting  
c) be responsive to client whenever the client makes contact  
d) focus on mother not child  
e) meet regularly with primary care worker |
<table>
<thead>
<tr>
<th>Authors / year</th>
<th>Timing of visits</th>
<th>Duration of intervention</th>
<th>Nature of Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gray, Cutler, Deane &amp; Kempe 1979</td>
<td>Post natal: Weekly visits by public health nurse for six weeks after delivery;</td>
<td>17-35 months</td>
<td>Weekly visits by public health nurse offering practical support and parental training. Regular follow up by paediatrician. Emotional support and co-ordination of follow up done by lay person.</td>
</tr>
<tr>
<td>(a)Olds, Henderson, Chamberlin &amp; Tatelbaum 1986</td>
<td>During pregnancy: an average of nine visits per client. Post-natally: 0-6 weeks: Nurse visitation approximately every 2 weeks. 6 weeks - four months: visits every two weeks. 4-14 months: visits every 3 weeks. 14-20 months: visits every 4 weeks 20-24 months: visits every 6 weeks.</td>
<td>Two years</td>
<td>Antenatal and post natal parenting education in infant development; involvement of family and friends in child care, linkage of family members with health and human services.</td>
</tr>
<tr>
<td>Hardy &amp; Streett 1989</td>
<td>Post natal: Routine home visits made to coincide with visits to the well child clinic at 7-10 days post nataly and at months 2, 4, 6, 9, 12, 15, 18, 21, and 24. Additional visits as needed. Overall mean no. of visits = 15.5.</td>
<td>Mean duration of follow up of: Study infants: 23.4 months Control group: 22.9 months.</td>
<td>Home visitation by a trained para professional offering parenting education, child care, information, support, referral and ongoing liaison with existing community health services.</td>
</tr>
<tr>
<td>Barker, Anderson &amp; Chalmers 1992</td>
<td>At least one visit in antenatal period and 8 or more visits in post natal period (first year or more of infants life).</td>
<td>Not specified</td>
<td>Monthly support visits to new parents by specially trained health visitors who use semi structured methods to build parents self esteem, and empower them to become better parents. (Bristol Child development programme)</td>
</tr>
</tbody>
</table>
Reliability and validity issues

Evaluating home visitation programmes is further complicated by “variations in the range, relevance and reliability of outcome measures used...” (Vimpani et al., 1996, p.36). These variations are evident in the range of outcome measures used to evaluate impact in the studies reviewed previously. This variability in outcome measures coupled with the range of interventions being evaluated inhibit the further development of knowledge regarding the nature and respective value of protective factors in home visitation programmes, that is, providing the information needed to determine exactly what does work with whom.

The problem of differential surveillance for child abuse between intervention and control groups also poses problems in determining the validity of findings regarding the incidence of child abuse and neglect. The parenting practice of clients receiving home visitation is regularly observed by the home visitor. This scrutiny may reveal behavioural incidents that are judged as abusive or neglectful and as such are likely to be registered or reported to the authorities. In contrast, comparison or control group clients are not under similar scrutiny. This may lead to a bias in the recorded incidence of child abuse and neglect.

The findings of a recent review of randomized control trials using similar inclusion criteria to those of MacMillan and her colleagues (1994) was undertaken by Roberts, Kramer and Suissa (1996). The overall findings regarding methodology were similar to the earlier review. An additional focus of this review was that it included in its findings a meta analysis of the results from eight randomized trials that examined the effectiveness of home visitation in the prevention of child injury. The researchers concluded that while ‘home visitation programmes have the potential to reduce significantly the rates of childhood injury....the problem of differential surveillance for child abuse between intervention and control groups precludes the use of reported abuse as a valid outcome measure in control trials of home visiting” (Roberts, Kramer and Suissa, 1996, p.29). In summary, questions remain about the lack of uniformity in definitions of child maltreatment, what constitutes valid and reliable measurements of this variable, the impact of increased surveillance and the validity of officially reported cases (Garbarino, 1986).

Other measures used to assess the impact of home visitation are infant and maternal health outcomes. A range of infant health outcomes were measured in five studies (Johnson, 1993; Gray et al., 1979; Olds et al., 1986, 1994, 1997; Hardy and Streett, 1989). Various maternal health outcomes were measured in three studies (Olds et al.,
1986; 1994; 1997; Beardmore, 1996; Johnson, 1993). Measures of family function, state-trait anxiety, locus of control of behaviour, and the quality of mother-child interaction were amongst the other outcomes studied. All of these variables are linked theoretically to the aetiology of child abuse and neglect. Given other methodological difficulties, including small and diverse samples and difficulties in recruitment and retention, this variation further confounds comparisons of programme effectiveness.

With reference to outcome variables such as attachment behaviour and infant health and family function, a recent audit of home visitation programmes concluded “In order to establish the effectiveness of a child abuse prevention programme concerned with these variables, direct evidence on the incidence of abuse is needed” (Vimpani et al., 1996, p.38). For example, the posited link between desirable outcomes such as improved maternal and or infant health, or maternal-infant attachment and reduced rates of child abuse, needs to be more firmly established. While improvements in maternal and child health or maternal infant attachment are desirable outcomes, one must be cautious in concluding that these improvements lead directly to a reduction in child maltreatment (Fink and McCloskey, 1990). Garbarino states that:

> Evaluation efforts must use multiple measures...A complete approach will include efforts to assess changes in the incidence of child death and serious injury, costs and outcomes of treatment [on the assumption that prevention programmes may affect the ‘treatability’ of cases that do occur], hospital emergency room treatment, standards for disciplinary practices...and knowledge and attitudes concerning the range of behaviours that constitute or increase the risk for abuse. Measures of behaviour are the bottom line...

(Garbarino, 1986, p.155)

**Cost effectiveness and cost benefit**

There is little information regarding the cost of preventing child abuse and neglect, or in the longer term, the social and economic costs of failing to prevent it (James 1994). In the United States the General Accounting Office identified three studies that suggested that “although prevention can be costly, it can pay for itself in the long run” (1992, p.23). These three studies, the Hawaii Healthy Start programme, the Elmirna Project and the Michigan Children’s Trust programme all demonstrated significant economic benefits associated with preventing child abuse and neglect and improving maternal and infant health status. The costs of these prevention initiatives were shown to be far less than the social and economic costs associated with providing the necessary range of health and social services after abuse had occurred.

Few of the programmes reviewed here completed an analysis of either the cost effectiveness or cost benefit of home visitation. Olds et al. (1994) concluded that the
Elmira project had paid for itself in terms of savings in government spending by the time the children were four years of age. While it is more difficult to quantify the social costs of child maltreatment, the findings of the cost benefit analysis conducted by Olds et al. (1997) suggests that social capital can be enhanced by prevention initiatives. Given the economic constraints and the competitive arena within which all health and social programmes operate, the failure to undertake efficiency assessments, that is cost benefit and cost effectiveness analysis of all programmes, is a significant omission (Rossi and Freeman, 1989). This omission might be addressed if economic expertise was added to evaluation efforts (Owen, 1993; Fink and McCloskey, 1990).

**Implementation**

**Recruitment and retention**

The practical difficulty of recruiting suitable clients in sufficient numbers, establishing matched control and intervention groups and retaining participants for a sufficient length of time within the programme are issues that challenge evaluations of home visitation programmes. In the studies reviewed in this paper sample size varied from 30-400 participants. As child abuse and neglect is a low incidence variable, large samples are needed to generate significant statistical analysis for this variable (Vinpani et al., 1996; Helfer, 1982). Equally samples need to be representative of the larger population in order that the findings can be generalized.

Apart from the Child Development Programme (Barker et al., 1992) and Home-Start (Van der Eyken, 1990), all programmes reviewed here were directed towards families considered to be ‘at risk’ or ‘vulnerable’ for subsequent adverse child health outcomes (Beardmore, 1996; Johnson, 1993; Cox et al., 1991; Hardy and Streett, 1989; Olds et al., 1986; Gray, et al., 1979), or to families who had already abused their child (Cox et al., 1991; Lines, 1987). How vulnerability or risk was determined varied from programme to programme. The Newpin programme (Cox et al., 1991), accepted referrals from health visitors, social workers and other health agencies of parents or other care givers suffering from depression who were considered at risk or who had actually abused their children. In contrast another programme used a checklist or questionnaire administered by trained nurses to assess risk for later child maltreatment (Gray et al., 1979). In contrast again, the Elmira project (Olds et al., 1986) had strict inclusion and exclusion criteria and randomly selected first time mothers who met specific demographic criteria. If risk or vulnerability is to be used to determine access to home visitation there seems to be a need for the further development of valid and reliable screening instruments.
Sample attrition seems also to be a problem in evaluation of home visitation programmes. Olds et al. (1986) reported that between 15-21% of the participants did not complete their study. Similar rates of attrition were reported in other studies (Hardy and Streett, 1989; Johnson et al., 1993; Beardmore, 1996). There are high levels of mobility among some of the high risk or vulnerable families that comprise the target populations of home visitation programmes. Whatever the reasons for this attrition, it would seem important that evaluation studies find some way to identify the reasons that vulnerable families withdraw from home visitation programmes. This would enable the development of strategies that might enhance their retention within future programmes.

Conceptual and theoretical issues

**Defining child abuse and neglect (a summative issue)**

The major focus of all but three of the home visitation programmes reviewed in Chapter 3 was the prevention of child abuse and neglect. An ongoing difficulty in evaluating family support/child protection programmes and their impact is the variation in definition of child abuse and neglect. “The lack of a standardized definition of child abuse has a dramatic impact on incidence data because statistics reflect phenomena ranging from the number of children killed each year to the number spanked” (Zigler, 1983, p. 333). It is likely that the agencies responsible for recording incidents of child abuse and neglect not only have different reporting standards but also markedly different concerns and agendas than the community based family support/child protection programmes or programme evaluators. This variability sharpens the need for researchers to define child abuse and neglect beyond the definitions used by reporting agencies. Clear descriptions of what is meant by child abuse are necessary so that one can understand what the programme was designed to achieve. Garbarino points out that there is a need for precision in stating prevention goals and to acknowledge and measure in evaluations of home visitation “the distinction between reducing severity and reducing incidence of child abuse and neglect” (1986, p.153). These are not distinctions that are readily available from most reporting agencies’ child abuse registers, nor are they evident in the studies reviewed.

Both under reporting and over reporting of child maltreatment contribute to the difficulties inherent in determining incidence. Reliable baseline data regarding the true incidence of child maltreatment is often not available. The discrepancy between reported and unreported cases is not precisely known, may vary over time and to some degree is dependent on reporting standards (Garbarino, 1986; Fink and McCloskey, 1990; Gelles, 1992). Given that the incidence of child abuse and neglect
depends entirely on how it is defined and how extensively it is searched for, lack of a uniform definition and valid measures of this key outcome adds to the complexity of evaluating the impact of home visitation programmes.

**The aetiology of child abuse and neglect (a formative issue)**

Another major difficulty in evaluating the worth or effectiveness of family support/child protection programmes is centred in the complex nature of the aetiology of child abuse and neglect. Dingwall (1985) is critical of the existing knowledge base regarding child abuse and neglect, stating “the amount of scientifically validated research on child abuse and neglect is vanishingly small...” (p.51). Within the ecological model, child abuse and neglect is considered to be a consequence of the interaction between and the accumulation of various factors both within and external to the family environment. The effects and interactions of various factors such as the parents’ experience of abuse (ontogenetic development), the child’s abuse eliciting behaviour, patterns of family interaction and spousal relations (the microsystem), neighbourhood resources and levels of social support (the ecosystem) and tolerance of violence, definitions of parenthood and methods of disciplining children (the macrosystem) are believed to interact and contribute to child abuse and neglect (Vinson, Baldry, Hargreaves, 1992). However the contribution of each of these various factors to child abuse and neglect is as yet unclear, as is the way they interactively combine to shape a care giver’s actions towards a child (Belsky, 1980). Many vulnerable families do not abuse their children and families that appear secure, do. What are less clear are the conditions that cause this vulnerability to be translated into child maltreatment (Vinson et al., 1992). As stated in a recent review of evaluations of home visitation programmes

...it is worth reiterating that one of the reasons rigorous studies are needed, is that our understanding of the factors which contribute to child abuse and neglect is more limited than we usually care to think. There is not one factor associated with this multi-deficit phenomenon that is not also prevalent among families who do not abuse their children


The lack of certainty which surrounds the causes of child maltreatment illustrates the need for more research evidence for theories or models which explain the links between the risk factor(s) and the outcome(s) to better inform and guide family support and child protection practice. Just as risk factors are identified, it would seem to be equally important to more clearly identify and articulate those factors that operate as protective within seemingly vulnerable or high risk families. Process evaluations that examine how and why home visitation programs work could
contribute to a fuller understanding of the essential elements of these risk and protective factors and what operates within home visitation to alter them.

There is a need therefore for evaluations to more clearly articulate hypothesised links between the conceptual framework of their programmes, their goals and interventions and the outcomes selected for measurement. Suggested correlates of subsequent child maltreatment which have been included in the rationales of home visitation programmes to date are low levels of available social support and single marital status, low socio economic status, young age at pregnancy, low levels of mother-infant attachment, high state-trait anxiety, high levels of intra family violence and insufficient knowledge regarding parenting and child development (Garbarino, 1986). While the goals of family support programmes target and intend to alter some of these factors, such as low levels of social support and insufficient knowledge regarding parenting and child development, other risk factors such as young age of mother cannot be altered and more clearly identify the target groups for home visitation. One of the tasks for future evaluation research is to identify those components of social supports that were most effective, for different populations in different contexts.

**Practical/ethical/political issues**

Programme evaluations usually occur in natural settings, are subject to the influence of multiple and sometimes competing groups, and pose various political, ethical and practical challenges. The relative influence of the various factors that shape and determine the process, impact and utilization of evaluation will now be considered.

**Stakeholders in evaluation**

Evaluation of social programmes is influenced to a greater or lesser degree by the sometimes competing interests and needs of the various stakeholders involved in the programme. Stakeholders may include the programme staff and managers, funding organizations or program sponsors, programme competitors, target participants, policy and decision makers, the evaluator(s) and contextual stakeholders, that is, organizations or groups in the immediate environment of a programme (Rossi and Freeman, 1989). While it is not suggested that all of these potential stakeholders will be involved at all times, the interests and needs of each will need to be addressed if the evaluation is to have maximum utility. They are the potential audience for the evaluation. They can also influence the evaluation process. For example contextual stakeholders may help or hinder an evaluation when data collection depends on access to an organization’s records or registers.
Not all stakeholders in this debate have an equal voice. It could be argued that the primary stakeholders, the at risk or vulnerable families and children, have the weakest voice of all in this debate. They must depend on more powerful and articulate individuals and groups to represent their interests, and to utilize evaluation findings in the ongoing development of policy and practice. This political dimension adds weight to the need for evaluation to measure more than outcomes and apply similar zeal to qualifying the clients’ experience and reactions to home visitation.

**Insider vs. outsider relationships**

In reviewing the literature of evaluations of home visitation it is sometimes difficult to discern whether the evaluators were also involved in the design and implementation of the programme, in Owen’s (1993) terms, whether they were insiders or outsiders. According to Owen (1993), the relationship between the evaluators and the programme should be explicit.

> [An insider is] an entity [individual or group] directly associated with the conduct and/or impact of the programme... an outsider is an entity external to the programme who, for one reason or another, has a vested interest in the conduct and/or impact of the programme

(Owen 1993 p. 33).

The greatest difference between insider as compared to external evaluators is in the degree of objectivity and credibility considered to accompany these roles. Although there are advantages inherent in insider evaluation such as reduced cost and familiarity with the organization or programme, there are also possible disadvantages. An insider’s objectivity may be compromised or influenced as a result of their existing relationships within the organization. For example, the evaluation may be undertaken as an accountability exercise to a funding or sponsoring organization or to ensure ongoing funding. According to Owen (1993, p. 37), “it would be a brave organization which gave heavy emphasis to negative findings”. This is not to say that, given adequate resources, insiders cannot or do not complete effective evaluations.

The major advantages of an outsider undertaking an evaluation is the perception that they are free from bias regarding the outcomes and that they are employed because they have special expertise in conducting evaluations of programmes. The disadvantages include the cost of employing an outside evaluator and the possibility that they may be seen as a threat by programme staff, especially if programme staff are not included in the evaluation planning, or if there is a perception that the evaluation may produce adverse findings. This occurs most commonly when evaluation is being undertaken as an accountability exercise for outside funding.
organizations. In this circumstance programme staff may not fully co-operate with
the evaluator and thereby impede the evaluation. The possible influence of these
relationships on the evaluations reviewed in this paper are impossible to ascertain as
they are rarely identified or commented upon.

**Utilization of evaluation**

How evaluation information is used or valued in shaping policy or practice is beyond
the control of individual evaluators. This lies within the political domain which is
sometimes subject to the competing and shifting demands and interests of multiple
stakeholders. According to Rossi and Freeman “evaluation is...undertaken to affect
policy development, to shape the design and implementation of social interventions
and to improve the management of social programmes” (1989, p. 417). Evaluation of
home visitation programmes is, to some degree, a political activity. However, even if
an evaluation demonstrates the effectiveness of a programme, it does not necessarily
follow that the programme will be continued or replicated in other contexts, or that
ensuing policy or practice will reflect the findings of the evaluation. For example, the
Elmira trial was considered to be an effective family support/child protection
programme (Olds et al., 1986). Despite this, at the end of the demonstration period
(1983), the programme was absorbed by the local health authority and, due to
financial constraints, significantly altered. Not surprisingly, the revised programme
no longer achieved the same results (United States General Accounting Office, 1990).
Other than being highly valued by participants, the evaluation findings of both the
Newpin and Home-Start programmes were equivocal and yet both programmes have
been widely emulated (Cox, 1991; Van der Eyken, 1990).

Time and funding constraints also contribute to the process and utility of evaluations.
Studies that measure distal outcomes are rare because of policy imperatives, funding
difficulties and methodological problems including sample attrition. According to
Rossi and Freeman “political and programme worlds often move at a much faster
pace...policy makers and project sponsors are usually impatient to know whether a
programme is achieving its goals, and often their time frame is in months, not years”
(1989, p. 434). The long term follow up (14 years) of participants in the Elmira trial
by Olds and his colleague is an exception in home visitation evaluation (Olds, 1997).
The findings of this ongoing study have however contributed substantially to the
knowledge base on the effects of sustained home visitation in a particular context.
The Hawthorne effect

Regardless of whether the evaluator is an insider or outsider the principles that underpin effective and credible evaluation are similar to those that are the foundations of all valid and reliable research. According to Rossi and Freeman (1989, p. 248) "the act of research itself is an intervention" and as such possibly contributes to outcomes. The outcomes of those programmes that are resourced and established as experimental (e.g.: Olds et al., 1986), may well be influenced by their relative intensity (Garbarino 1986). This may make replication of these pilot or experimental programmes in others contexts disappointing. Fiske et al. (1972) recommend adding experimental and control groups with post test measures only to control for the effects of pre testing.

Ethical issues and evaluation

The ethical issues inherent in assigning high risk or vulnerable families to a no treatment condition remains a major challenge in the evaluation of home visitation programmes. In a well designed experiment great care is taken to allocate families to either a control or experimental group in an unbiased fashion. (Rossi, 1972). Withholding apparently helpful treatments from high risk families, however, is often an impossible choice for service providers, for both ethical and political reasons (Beardmore, 1996; Olds et al., 1986). Fairweather (1967) and Rossi & Freeman (1989) recommend comparison of several alternative treatments (that have the same purpose) as was undertaken in the Elmira trial (1986). Olds et al. (1986) offered a partial solution to this issue by including a group that received a modified treatment (Group 3). This gives relative standards for evaluation rather than pass-fail and may provide more detailed information regarding the programme.

Another ethical concern that arises in the evaluation of home visitation programmes relates to the possible stigmatization inherent in associating child protection or child abuse and neglect with home visitation and the effect this has on the availability of participants. It has been suggested that many families deemed to be 'high risk' do not abuse their children. Ethical guidelines for research suggest that potential subjects are fully informed about the nature of the research they are being invited to participate in and should be able to accept or decline the offer to participate without jeopardy. Many vulnerable families may refuse to participate in the programme or its evaluation to avoid further stigmatization and alienation. As Vimpani et al., comment:

There is an Australian experience of a community refuting home visiting as a strategy for supporting families if it is publicised in terms of
preventing child abuse which has the effect of labelling all programme recipients as potential child abusers

(Vimpani et al., 1996, p. 85).

A more fundamental philosophical issue in the debate regarding child abuse prevention efforts lies in the difference and relationship between the “patchwork prevention” approach within which home visitation as a child protection strategy resides and the “total reform prevention” approach which refers to the changes needed to the broader social, economic, cultural and political context. The latter approach represents a view that total social reform is a necessary prerequisite for the prevention of child maltreatment (Garbarino, 1986). It seems though that while the total reform approach might be ideal, it is more practical within the current political climate to continue with patchwork prevention efforts. According to Garbarino,

Existing research appears to demonstrate that patchwork prevention is possible...neighborhoods equally characterized by economic deprivation differ in their rates of child maltreatment...altering families without fundamental community change is possible to some degree. And yet we should not too readily discard the hypothesis that sustained, widespread prevention will only come as a feature of efforts (such as reducing poverty, improving health care, and improving the political climate for children's issues) that are more in keeping with total reform prevention.

(Garbarino, 1986, p.155)

Conclusion

It seems evident that while there is an essential need to continue to conduct timely and rigorous evaluations of home visitation, the endeavor itself is an inherently complex enterprise. The concerns addressed in this section reflect these complexities. A recent national audit of home visitation programmes in Australia (Vimpani et al., 1996), included a comprehensive set of recommendations and an outline of an integrated evaluation model that could address many of the concerns raised in this chapter. The report suggests the adoption of the five tiered approach to evaluation initially developed by Jacobs (1988). Within this approach evaluation activities are organized at specific levels or tiers according to the state of the programme. Jacobs (1988, p.40) suggests the following five levels could serve to organize the activities of the evaluation:

- Level 1-pre-implementation
- Level 2-accountability level
- Level 3-programme clarification
- Level 4-programme improvement
- Level 5-programme impact
Each successive tier or level of evaluation activity requires more sophisticated and complex data collection and analysis. The most complex and demanding level of evaluation occurs at the programme impact or outcome level. Using Jacobs’ (1988) model Vimpani et al., (1996) suggest the integrated approach comprise:

1. The ongoing development of guidelines for monitoring of best practice (or input and process evaluation). Applying Jacobs’ (1988) model this incorporates levels 1, 2, 3 and 4, that is, those tiers concerned with pre-implementation, accountability, programme clarification and programme improvement.

2. A case study approach to better understand the “essence” of home visitation and to provide theory generating data. Again if Jacobs (1988) model is applied this fits with levels 3 and 4, that is, programme clarification and programme management

3. A research strategy for outcome evaluation. This function fits with what Jacobs (1988) described as levels/tiers 4 and 5, that is programme improvement and programme impact

(Vimpani et al., 1996, p. 88).

The major utility of this proposed integrated model is “that it is applicable to all types of home visitation programmes” (Vimpani et al., 1996, p. 88). It is suggested in this audit and its recommendations that the application of this model of evaluation would greatly enhance the development of theory and more clearly elucidate the inputs, processes and outcomes that constitute effective and efficient home visitation. Given the enthusiasm demonstrated for, and increases in the funding of home visitation as a child protection measure, it seems essential that further attention is given to assessing the nature and relative value of various interventions, the processes and structures that support these and in particular to identify and examine the protective factors and the conditions in which these operate. In summary;

The quality of care cannot be fully comprehended or successfully assured without understanding how structure influences process, and process influences outcome. No matter where one starts in this chain, one must ultimately deal with it as a whole

Chapter 5

The Current Study

The Cottage Community Care Pilot Programme

Background

The Cottage Family Care Centre (CFC) is sponsored by the Uniting Church of Campbelltown. It was established in 1981 and is primarily funded by the Department of Community Services, Burnside and community donations. Since then it has provided a community based specialized service for families with children 0 - 5 years of age who have been notified / registered with the Department of Community Services as “children at risk” (The Cottage Family Care Centre, Annual Report, 1993). The CFC is a tertiary level service as all the families enrolled in this programme include a child or children who have been abused or neglected.

In March 1992 the Cottage Family Care Centre (CFC) sponsored an International Child Protection Conference. At this conference a guest speaker, Professor Richard Krugman, outlined the success of the home visitation programmes operating in Denver and Hawaii in reducing the incidence of child abuse and neglect. Following this conference a member of the CFC attended the 9th International Congress for Child Abuse and Neglect in Chicago, to investigate home visitation models of child abuse/neglect prevention. Subsequently the Cottage Family Care Centre management committee established a steering committee to explore the possibility of establishing a programme in the local government area modeled on similar projects trialed in the USA. The steering committee comprised invited representatives from various health and welfare agencies including the Department of Community Services (DOCS) at both area and district level, the South West Sydney Area Health Service (SWSAHS), the Department of School Education and Training, the local City Council, Family Support Services, Department of Community Paediatrics (SWSAHS) and Macarthur Temporary Family Care. These agencies became the key stakeholders in the programme and collaborated in the development of the Cottage Community Care Programme.

In October 1993 The Cottage Family Care Centre received funding of $16,500 from the Department of Community Services to develop and establish a one year pilot programme, The Cottage Community Care Pilot Project (CCCP). In November 1993 an Advisory committee was formed to oversee the ongoing implementation of the CCCP. Membership comprised invited representatives of the organizations that comprised the steering committee. Though individual membership changed over the
next three years each of the initial stakeholders maintained their representation on the Advisory committee and the evaluation Advisory committee. A project co-ordinator was seconded from DOCS to establish the programme. Following a period of extensive planning and the development of policy and procedures, liaison with the local hospital antenatal and post natal staff and other service organizations and the recruitment and training of volunteers in the area, the programme commenced in March 1994. Subsequent funding $16,500 (per annum) and the ongoing secondment of the project co-ordinator maintained the programme throughout 1995/96. Out of the experience of developing and maintaining this pilot project the CCCP underwent significant changes and from July 1997 was offered in a revised form as the programme FOCUS on New Families with ongoing funding from DOCS.

The community context

The CCCP was piloted in a local government area (LGA) in the Macarthur region on the south west fringe of the Sydney Metropolitan area. The LGA in which the CCCP commenced has experienced population growth in excess of 15% per annum over the past 20 years. In 1994 it was the most rapidly growing area in Australia (Department of Planning and Community Development, 1994). Over this time the rapid growth of the population throughout the region, and in the LGA in particular, has placed a significant demand on the social, community and health infrastructures. The population of this LGA is predominantly young. In 1994 approximately 40% of the population were aged between 0-14 years, 17% were aged 15-24 years and 33% of the population were aged between 25-44 years. The region has a high fertility rate with approximately 4000 births per year in 1994 and 1995 (South West Sydney Area Health Service, 1997).

In 1994 Macarthur had a higher percentage of single parents than the State average (15.2% versus 9.6%), a higher than State average of people unemployed (13.3% versus 8.4%) and approximately 15% of the population earned less than $16,000 per annum. The region also has above average rates of child abuse notifications when compared to the rest of NSW (Department of Planning and Community Development, 1994; South West Sydney Area Health Service, 1997).

The programme

The CCCP was established to initiate contact with vulnerable first time parents during the perinatal period and to maintain contact with these families during the first three years of the child’s life, as necessary. The programme was designed to directly address factors that are associated with child maltreatment. These factors include lack of parenting skills, little or no knowledge about child development, the isolation
many new families experience due to loss or absence of extended family support, single parent status, and the inability or reluctance of some new families to access available community supports and resources. In weekly contact/visits with their allocated family trained volunteers offered emotional support, parenting education, referrals to community services, and follow up contacts to these new parents. It was hoped that these interventions would promote the health status of the families involved. Additional support was available to the family through 24 hour on-call pager access to the project co-ordinator. Weekly volunteer contact was available for the first year. After the first year a phasing out period commenced, and depending on the family’s autonomy and stability the volunteer visits reduced to fortnightly, monthly and quarterly until the child was three years of age.

Programme goals

The specific goals of the CCCP were to:

- Identify families with potential parenting problems;
- Provide personal support for new families adjusting to new parenting;
- Reduce the isolation of the new family;
- Educate families in infant/family growth and attachment;
- Promote parent-infant attachment;
- Role model healthy parent-child interaction;
- Promote parent child interaction;
- Help new parents to develop their own positive parenting style;
- Reinforce skills and strengths needed for quality parenting;
- Involve fathers/significant others in visitor-client interaction;
- Help new families identify and utilize community resources to meet new and changing needs;
- Empower families to recognize and solve their own problems with appropriate supports;
- Enhance the function of families in the programme;
- Reduce the incidence of child abuse and neglect;
- Enhance the health of the mother and infant.

Staffing

Since October 1993 the project co-ordinator, seconded from The Department of Community Services has developed and maintained the CCCP. In June 1994 she was permanently appointed to the position. Support and guidance were available from the Director and Management Committee of CFC and the advisory and evaluation committees of the CCCP.
Volunteer recruitment and training

Volunteers were recruited from a variety of sources including the media, word of mouth, brochures describing the project distributed at doctors’ offices, schools, community health centres, TAFE colleges, universities, local churches and through speaking engagements at local volunteer and service organizations. Volunteers were accepted for the service if they were deemed suitable by the project co-ordinator and the Director of the Cottage, were willing to complete the 20 hours training and participate in ongoing training, support and supervision, were able to commit themselves to the project for a minimum of six months and agreed to all terms and conditions laid down in the following policies and procedures:

1. Job description
2. Volunteer contract
3. Statement of volunteer rights and relationships
4. Parameters of the volunteer client relationship
5. Confidentiality agreement
6. Occupational health and safety provisions
7. Protocol for community service referrals
8. Reimbursement for car usage
9. Telephone cost repayment
10. Client volunteer termination protocol
11. Domestic violence procedures


Between February 1994 and May 1995 the project co-ordinator organized and ran six volunteer training groups of 20 hours, each group containing 10 volunteers. Each training programme consisted of five four hourly sessions over a five week period. Details of the training programme are contained in Appendix 1.

Evaluation of the programme

In December 1993 an evaluation Advisory committee was formed by the Cottage Centre management committee to plan and oversee the evaluation of the CCCP. This group comprised members of the organizations represented on the Advisory committee (often the same person). An evaluation method was developed by the evaluation Advisory committee at the same time as the programme was being planned and developed. At this time it was decided that the evaluation would adopt a two group experimental design with random assignment of 100 consenting families to either the intervention or control group. Various screening and measurement instruments were selected to screen families for eligibility for the programme and to assess particular aspects of family health and behaviour at entry to the programme and after one year. These instruments had all been validated in previous home visitation programme evaluations in the United States of America.
In February 1994 the Dean of the Faculty of Health, University of Western Sydney, Macarthur was consulted by the Advisory committee regarding the possibility of a member of the Faculty becoming involved in the evaluation. After discussion with the Dean and members of the Advisory committee I accepted the invitation to undertake the evaluation. After consultation with the members of the evaluation Advisory committee, in particular the Director of the Cottage Family Care Centre and the project co-ordinator of the CCCP, further details of the evaluation were explored and established including:

- the purpose of the evaluation;
- identification of key stakeholders and audiences;
- the focus of the evaluation; i.e.: the questions to be addressed;
- development of data management strategies;
- development of reporting formats and times lines;
- gaining ethical approval from the SWSAHS and DOCS.

**Aims and objectives of the evaluation**

The aim of the evaluation was:

To provide information to decision makers regarding the effectiveness of the CCCP.

In order to achieve this aim the following specific objectives were established:

- To review the effectiveness of the CCCP in relation to its established goals;
- To identify areas of strength in the programme;
- To identify areas of concern in the programme;
- To report the progress of the evaluation to the CCCP evaluation Advisory committee each month;
- To prepare annual reports on the progress of the evaluation for consideration of the management committee of the Cottage Family Care Centre;
- To prepare a final evaluation report at the end of the pilot programme in March 1997.

Although the evaluation design had been decided prior to my involvement there was as yet neither a formal completed research proposal nor approval from the ethics committee of SWSAHS for the evaluation research to proceed. Also, although the instruments for data collection had been chosen the data collection itself was not formally or completely organized, nor was the means for collating the collected data.

**Research questions**

In consultation with the Advisory committee and based on the CCCP’s goals the following research questions were generated:

What is the difference between the children and mothers in the comparison and intervention groups in relation to the following:
1. the incidence of child abuse and neglect in the sampled population.
2. the health status of the mother and her child as measured by specific indicators.
3. family function in the participating families as measured by the Scale of Family Functioning

In May 1994 it became apparent that a two group experimental design posed particular problems which, it was believed, contributed to the slowness in recruiting participants for the CCCP. Despite extensive recruitment efforts, which revealed large numbers of eligible participants, only 12 families had agreed to participate in the programme at this stage. This refusal of families to participate will be discussed in more detail in a later section. A further three factors combined to cause reconsideration of the evaluation design. Firstly a major ethical difficulty arose for the recruiters centred on the random assignment of high risk families to either the intervention or control group. The project co-ordinator and the social worker involved in recruitment were less than enthusiastic about high risk families being denied the opportunity of volunteer contact. Their dilemma mirrors one of the difficulties inherent in carrying out true experimental designs in a natural or family setting. In particular the dilemma of knowingly withholding apparently helpful treatments to vulnerable populations was unacceptable, as it has been in other similar programmes (Beardmore, 1996). The second factor that contributed to the reconsideration of the evaluation design concerned securing ongoing funding. In March 1994 funding was only secure until October 1994. The then current slowness of recruitment indicated that a full sample would not be available in order to report adequate progress to the funding organization and thus secure ongoing funding for the programme. Finally the slowness in recruiting client families was thought to have some impact on the retention of volunteers who, once trained, were impatient to be linked to their client. The evaluation committee was asked by the steering committee to reconsider the evaluation design. It was then decided to adopt a non-equivalent comparison group design, recruiting intervention group families first, thus engaging the already trained volunteers and then families for the comparison group.
Methodology

Research Design

The study employed a non-equivalent comparison group design of "at risk" consenting first-time mothers in the perinatal period with babies up to six weeks of age. Ninety three families were recruited from first time mothers presenting to the antenatal or post natal services of the local hospital. Families who were recruited to the comparison group tended to be at lower risk or less vulnerable, than mothers who were recruited to the intervention group and subsequently linked to a volunteer. Like most other evaluations of home visitation, reviewed in the previous chapter, the evaluation was summative in nature and focused on measuring selected outcomes as evidence of the programme's effectiveness. The families in the intervention group received all assessments and were linked to volunteers at commencement in the CCCP, the families in the comparison group received assessment only. Both groups were reassessed after 12 months.

Measures used to gather information

Quantitative and qualitative data was gained from a variety of strategies and measures including initial screening of prospective participants, entry and exit questionnaires and assessments, and interviews and focus groups with participants and volunteers. Various screening and measurement instruments had been chosen to screen families for eligibility for the programme and to assess particular aspects of family health and behaviour at entry to the programme and after one year. These instruments had all been validated in previous home visitation evaluations in the United States of America. Hospital admission records and the Department of Community Services Central Information System (CIS) were examined twice during the CCCP to identify admissions to hospital and notifications of child abuse and neglect of infants involved in the study. Table 5.1 outlines screening and data collection methods used during this evaluation.

A description of each of these measures and their contribution to the evaluation is outlined below.
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* See Appendices 2 - 6 for screening and assessment items.
Screening

The following measures were used to determine the family’s eligibility to participate in the CCCP

The SWSAHS Hospital Questionnaire (First Time Parent Survey)

All first time mothers presenting to the prenatal or postnatal areas were asked to complete the SWSAHS Hospital Questionnaire with either the CCCP project co-ordinator or the Unit Social Worker. This fourteen item questionnaire was derived from the Parenting Readiness checklist and provided demographic data and information regarding the availability of social and family support, the client and family’s health history and whether the pregnancy was planned or unplanned. Completion of this questionnaire enabled the project co-ordinator to complete the Parenting Readiness checklist.

The Parenting Readiness Checklist (PRC)

This was completed by the project co-ordinator based solely on information gathered in the SWSAHS Hospital Questionnaire. The PRC is used in other similar programmes to identify families at risk of later child abuse and neglect (Breakey & Pratt 1991). Completion of the PRC enables limited assessment of various aspects of the mothers ontogenic development and the exosystem and macrosystem into which the child will be born. Thus problems that are considered to be associated with difficulties in parenting and later child abuse and neglect can be identified. If two or more items of this 15 item checklist, or any of Questions 1, 10 or 11 were scored positive (yes) the family was considered to be at risk of abusive or neglectful behaviour and was eligible for inclusion in the Cottage Community Care Pilot Project. If the client consented to participate, the following assessments were undertaken.

Risk assessment

The Family Stress Checklist (Schmitt and Carroll, 1978)

The project co-ordinator visited all available families in the project within 4 weeks of their agreement to participate and completed the Family Stress Checklist (FSC). This checklist, developed at the E. Henry Kempe Centre (1976), has been validated and widely used as a screening tool for child abuse and neglect in a number of family support programmes including the Colorado programme and Healthy Start in Hawaii (Murphy, et al., 1985; Breakey & Pratt, 1991). The FSC enables more detailed appraisal of the family’s life experience and social context than the PRC and more
clearly identifies the family's vulnerability or the existence of risk factors that, within the ecological model, increase the likelihood of later child maltreatment.

This checklist rates the responses to 10 items, each containing sub-sections, as either low risk, mild risk or high risk, and scores 0 - 5 - 10 for each question respectively. Higher scores indicate higher risk. Three of the items (Questions 3, 8 and 9) were not used in the CCCP as they related to families who already had children. The remaining questions address the parents' own childhood experience (including whether the parent was beaten or abused as a child), the degree of stress the family is currently experiencing, and the parents' perception of the impact of the pregnancy on their lives. Also included are questions that determine the presence or absence of a psychiatric or criminal history, social isolation, rigid or unrealistic expectations of the child and the propensity of the parent(s) for violent temper outbursts (Ayoub & Jacewitz, 1982; Murphy, et al., 1985).

A total score of 0 - 20 is indicative of low risk; a score of 25 and over indicates mild risk; a score of 40 + has been correlated with a high potential for child abuse. In The Cottage Community Care Pilot Project any parent who received a score of 40 or more was considered at high risk.

Assessment of family function

The Scale of Family Function

The Scale of Family Functioning (SFF) was used to evaluate particular aspects of family function, and was specifically designed for use in family support programmes in the United States (Dean & Robinson, 1984). Unfortunately the validity and reliability of this instrument is unknown as the authors were not available for discussion. However information that arose out of these assessments was used to assess a family's function over a period of time and to further inform the CCCP staff regarding the nature and particular difficulties (if any) participating families were experiencing. This rating at entry and after one year, or at exit from the programme, served to indicate the degree of change in various aspects of family function. Each family, usually the mother only, was interviewed to allow completion of this scale. The interviews were undertaken by the same assessor at entry and at exit or after 12 months participation. This assessor had no other contact with participants in the CCCP though due to the recruiting pattern (intervention group recruited first and then comparison group) she may have been aware of which group subjects were in.
The eight dimensions on which the family were rated on a five point scale ranging from adequate (score of 1) to critically impaired (score of 5) were:

- Social supports
- Family conflict, stress and coping
- Self esteem
- Confidence as a parent
- Stability and meeting basic needs
- Expectations
- Affective relationships
- Sensitivity to caretaking functions.

**Health assessment**

*The CCCP self administered health questionnaire*

This self-completion mail-out questionnaire was constructed to gather data from participants at twelve monthly intervals. It contained 18 questions that sought information on the health and immunisation status of the mother and her infant, the type of community services the family visited during their participation in the CCCP and whether and for how long the baby was breastfed. The questionnaire also sought information regarding current contraception methods used by the mother and whether any member of the family used any health service in the previous 12 months.

**SWSAHS hospital clinical records**

Hospital admission records of all infants were examined twice during the programme to identify admissions and diagnosis of all infants in the CCCP.

*The Department of Community Services central information system (CIS)*.

All infants participating in the study were cross-checked twice during the CCCP against DOCS central information system to identify notifications of child abuse and neglect in the study population. In order to preserve the confidentiality of the participants in the CCCP the cross-checking was undertaken by a DOCS Officer.
Qualitative data

Focus groups with volunteers

Two focus groups of approximately two hours each were held with volunteers in August 1995 (N=13), and May 1996 (N=8). Volunteers were informed that each group’s discussion would contribute to the evaluation of the CCCP and was intended to gather information on their experience as volunteers. Volunteers were also informed that the focus groups were voluntary and that their anonymity would be assured. Volunteers were asked to respond to two questions that were placed on a whiteboard. These questions were 1) What is it like to be a volunteer in the CCCP?, and 2) What sustains you as a volunteer? These issues were discussed and explored by the volunteers with minimal prompting by the facilitator.

Focus groups with participating mothers

Two focus groups were held with mothers who had been linked to volunteers for varying lengths of time, average 12 months. Each focus group was approximately 2 hours long. Focus group 1 was held with three mothers who were in the older age group (mean age 26 yrs), and married, characteristics that were not highly representative of the study population. Focus group 2 was held with three mothers who were more representative of the study population in that the average age of this group was 20.2 years, two were single and two had left school at Year 11 or before. Participants in both groups were asked to address the question “What is your experience of being linked to a volunteer in the Cottage Community Care Pilot Project?” and explored this issue with prompting by the facilitator.

Exit discussions with volunteers withdrawing from the CCCP

The Project co-ordinator interviewed 11 volunteers who, after training, withdrew from the CCCP prior to being linked to a client. The purpose of this exit interview was to explore the volunteers’ reasons for declining to participate further in the CCCP.
Recruitment and Sample

Recruitment of families

Families were not invited to participate in the CCCP if any of the following conditions existed:

1. The baby was over 6 weeks of age
2. The family was currently involved with the Department of Community Services
3. The parent/s were in treatment for ongoing substance abuse.
4. The family was currently involved in mental health treatment
5. The family lived outside the geographic boundary, i.e. The Campbelltown Local Government Area.
6. The family situation was determined to be outside the realm of the CCCP’s capabilities.

Between March 1994 and December 1995, 388 first time mothers completed the SWSAHS Hospital Questionnaire. Two hundred and forty six (63%) were deemed eligible to participate in the CCCP and were offered the service. There was no significant difference in age, marital status and education between those who were eligible for inclusion but declined to participate (N=153) and those who consented to participate in the CCCP.

Ninety three families agreed to participate (38% of the total deemed eligible). Fifty eight were placed in the intervention or treatment group and then 35 families were recruited for the comparison group. In the intervention group 44 families were recruited and assigned their volunteers before the birth of their babies and 14 families were recruited and assigned their volunteer post natally.

Constraints on recruitment of families

The development of an effective recruitment process within the constraints of funding and staffing resources was an ongoing and difficult process. Recruitment proceeded slowly. Although a great deal of time was spent on recruitment by the project co-ordinator and hospital social worker, the number of women finally consenting to participate in the programme was relatively small. Difficulties that arose in recruitment included the limited availability of the project co-ordinator (available 1 day a week since March 1994) or hospital social worker to administer the Hospital Questionnaire or explain the CCCP. Although the antenatal service attempted to book appointments for first time mothers on the days that either the project co-ordinator or hospital social worker was available, this was not always possible. The SWSAHS Hospital Questionnaire was an addition to other hospital admission requirements and completed voluntarily by staff and prospective clients. A
number of mothers indicated reluctance to complete the form, often due to time constraints such as the need to return to work. Already busy staff, in particular in the post natal wards and other health facilities, found it difficult to administer yet another form, although they seemed less reluctant to refer mothers to the programme verbally.

A further difficulty was to engage those individuals in the CCCP who did complete the screening process and were deemed eligible. Only 38% of those deemed eligible for inclusion in the CCCP agreed to accept the service. One hundred and fifty three mothers, all eligible, declined to participate in the programme. In a report to the Advisory committee in December 1994 the hospital social worker responsible for interviewing all first time mothers (possible recruits for the CCCP) offered the following interpretation as to why some eligible families declined to accept the CCCP. She believed that some young pregnant women believed they had the requisite skills for parenting due to caring for younger siblings, or felt they had supports in their own family. Other reasons potential participants gave when declining the service included that “others needed the service more than they did”, or they “didn’t want help from outsiders” (CCCP Advisory Committee minutes, 2/12/95). These difficulties illustrate the need to make future family support programmes accessible and attractive to families. One way of achieving this might be to make these programmes available to all families, rather than by selecting or attempting to recruit only those families deemed to be vulnerable or in need of extra support.

**Sociodemographic profile of participants**

All sociodemographic data was derived from the completed SWSAHS Hospital Questionnaire. The majority of clients participating in the CCCP were young, single and had left school at Year 11 or below. The mothers’ ages ranged between 14 and 42 years, average age 21 years. The median age for the whole sample was 20 years. Mothers aged 22 years or less comprised 74% of the intervention group and 72% of the comparison group. Sixty-seven percent of the participating mothers cited their marital status as single. Fifty-four percent of those in the CCCP received benefits or pensions. Seventeen percent of the intervention group and six percent of the comparison group were in Housing Department accommodation.

Two of the participants identified themselves as Aboriginal or Torres Strait Islanders, 12 indicated they were born outside Australia and the remainder (81) were Australian born. There was no significant difference in marital status, age, education or income between the women in the intervention and comparison groups.
Assessment of vulnerability and level of risk of participating families

The results from the screening and entry assessments indicate that the screening method was effective in identifying vulnerable families. The majority of families participating in the CCCP, particularly intervention group families, were experiencing multiple stresses, social isolation, low self esteem and had few available social supports.

Table 5.2 outlines the data derived from the completed Parenting Readiness Checklist of participants. The most commonly indicated risk indicators for all groups are marital status (single), and education (less than Year 12). A significant number of mothers in the intervention group also scored positively on the item, low self esteem/depression. Marital or family problems refers to any indication of discord among family members who are relevant to the client and includes a boyfriend or the father of the baby. Discord refers to arguments and violence within the family (Waihee & Lewin, 1992). This indicator is ranked 5th in both groups. Over 50% of the families in the intervention group were likely to score positively on 3 or more risk indicators. The comparison group families more commonly scored positively on only two risk factors.
Table 5.2.  Parent Readiness Checklist (PRC) - Identified Risk Indicators
(intervention and comparison groups)

<table>
<thead>
<tr>
<th>PRC Risk Indicator</th>
<th>Intervention group (N = 58)</th>
<th>Comparison group (N = 35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Partner unemployed</td>
<td>71</td>
<td>69</td>
</tr>
<tr>
<td>Financial stress</td>
<td>38</td>
<td>11</td>
</tr>
<tr>
<td>Unstable Housing</td>
<td>26</td>
<td>17</td>
</tr>
<tr>
<td>No Telephone</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Education &lt; Year 12</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Lack of support</td>
<td>69</td>
<td>80</td>
</tr>
<tr>
<td>History of substance abuse</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Unwanted pregnancy</td>
<td>34</td>
<td>37</td>
</tr>
<tr>
<td>History of terminations</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Late or no prenatal care *</td>
<td>36</td>
<td>43</td>
</tr>
<tr>
<td>History of psychiatric care</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Marital or family problems</td>
<td>40</td>
<td>29</td>
</tr>
<tr>
<td>Low self esteem/ depression</td>
<td>50</td>
<td>17</td>
</tr>
<tr>
<td>Mother 19 ≤ yrs</td>
<td>47</td>
<td>43</td>
</tr>
</tbody>
</table>

*NB Item 11: Late or no prenatal care: In the United States where this instrument was initially trialed as a screening device 'Late prenatal care' included all mothers who contacted antenatal services after 12 weeks gestation. The antenatal clinic, Campbelltown Hospital do not encourage mothers to present before 12 weeks gestation and defines 'late prenatal care' as the pregnant women presenting for antenatal care later than 20 weeks gestation. This instrument was not modified for the Australian context, therefore the percentage of CCCP mothers presenting with this risk indicator cannot be considered particularly informative.
The results of the FSC assessments for each group are shown in Table 5.3. These results indicate that significantly more families in the intervention group were rated as experiencing multiple family stresses. Forty percent of the intervention group was rated as 'high risk' for later child abuse on this assessment. In the comparison group eleven percent of families were within the 'high risk' category. It is apparent that the comparison group overall were significantly less vulnerable than those families in the intervention group.

**Table 5.3. Family Stress Checklist (FSC) - Level of Risk (intervention & comparison groups)**

<table>
<thead>
<tr>
<th>FSC Risk level</th>
<th>Intervention group</th>
<th>Comparison group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Low (0-20)</td>
<td>15</td>
<td>32</td>
</tr>
<tr>
<td>Mild (25-35)</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>High (40+)</td>
<td>19</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>47</td>
<td>100</td>
</tr>
</tbody>
</table>

Further breakdown of the participants’ responses indicate that a significant number of families from the intervention group scored positively (score =10) on Question 1 (n=20, 43%), Question 4 (n=23, 49%), and Question 5 (n=24, 51%) of the FSC. These questions related to the participants acknowledging maltreatment themselves as children (Question 1), experiencing themselves as being socially isolated, depressed and/or having low self esteem (Question 4), and the existence of multiple stresses or crises in their lives (Question 5). Eleven (39%) of the comparison group also scored positively on Question 5. The results of this screening indicate that the intervention group families were experiencing more stresses at entry to the CCCP and therefore would be deemed to be at higher risk for subsequent child maltreatment than families from the comparison group. This result suggests that the goal of targeting vulnerable families was met in the CCCP. However the numerous discussions in the evaluation advisory group regarding the ethics of recruiting high risk families for the comparison group may well have resulted in an unconscious tendency to avoid placing these families in the comparison group.
Recruitment of volunteers

In the first year of the CCCP sixty women were recruited through local newspaper advertisements and trained as volunteers. The average age of these volunteers, all of whom were women, was 41 years. Sixty one percent were married (one defacto relationship included), 27% were separated, divorced or widowed and 15% were single. The vast majority were Australian born (87%), the remaining six volunteers describing themselves as New Zealanders or British. Ninety percent of all volunteers were parents themselves. Following the 20 hour training programme 11 volunteers withdrew before being linked to a client. The project co-ordinator held interviews with five of these volunteers who indicated they were withdrawing from the CCCP because they considered the programme inappropriate. These volunteers were asked to elaborate on their decision to terminate their involvement. A summary of these discussions is contained in Appendix 7. Eleven volunteers left the programme while still linked to their client. All of these clients were offered and accepted another volunteer. A further 16 volunteers ceased to be involved in the CCCP after completing their first client match which averaged eight months. Table 5.4 outlines the reasons given by these volunteers when they terminated their involvement with the CCCP.

<table>
<thead>
<tr>
<th>Stated reason for withdrawal</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 27)</td>
<td></td>
</tr>
<tr>
<td>Employment opportunity</td>
<td>8</td>
</tr>
<tr>
<td>Family commitments</td>
<td>6</td>
</tr>
<tr>
<td>CCCP not appropriate</td>
<td>5</td>
</tr>
<tr>
<td>Time out needed</td>
<td>5</td>
</tr>
<tr>
<td>Health reasons</td>
<td>1</td>
</tr>
<tr>
<td>Study</td>
<td>1</td>
</tr>
<tr>
<td>Left LGA</td>
<td>1</td>
</tr>
</tbody>
</table>
Constraints on recruitment and retention of volunteers

Coordinating the availability of volunteers with entry of families to the CCCP added to the complexity encountered in establishment of this project. The slowness with which recruitment of clients proceeded affected the retention of volunteers. At the completion of their training volunteers were keen to be linked with a client. This was often delayed due to slowness of recruitment of families. In ongoing training sessions some volunteers expressed frustration at the delay in being linked with clients. However once linked to their clients, they rated their experience as volunteers very positively.

Data analysis

All data retrieved from completed questionnaires and from cross checking all participants against SWSAHS hospital records and the Department of Community Services CIS register were summarized using descriptive statistics. Data from the Scale of Family Function, completed by families at entry to and and exit from the CCCP (or after one year), were further analyzed using t tests for independent samples to assess the significance of the levels of changes in family function between entry and exit to the programme.

Summary

The initial screening and risk assessments of participants revealed a group of first time mothers who were mainly young and single and who had left school at Year 11 or below. Intervention group families were assessed as experiencing a greater number of stressors at entry to the programme than comparison group mothers and therefore were deemed at higher risk of subsequent child abuse and neglect. The goal of targeting vulnerable families was clearly met by the CCCP. However a major issue remains in that many equally vulnerable families refused to participate in the programme.

Though some of the problems encountered in recruiting sufficient client families for the CCCP can be explained by the limited amount of time available for this to be undertaken, the reasons why many eligible families refused to participate is more puzzling. When asking eligible clients if they would consent to participate care was taken to present the programme as a family support initiative. Over the recruitment period one hundred and fifty three families who were eligible to participate in the programme refused to do so. They were similar in every way to those who comprised the intervention group. The unwillingness of these families to become involved lends support to the argument for making family support programmes available to all.
parents, thus reducing the possible stigmatization effect sometimes associated with needing extra services. Equally, co-ordinating the recruitment and training of a sufficient number of volunteers with the recruitment of clients is an issue that needs to be addressed in similar projects.

The evaluation of the CCCP was completed over a three year period guided by the Management Committee of the Cottage Family Centre and the Evaluation Advisory committee of the CCCP. Resource constraints, including funding and the availability of personnel, coupled with the realities associated with conducting research in a natural environment also influenced the nature and conduct of the evaluation.
Chapter 6

Results

Between March 1994 and March 1997 quantitative and qualitative data regarding the impact of the CCCP on the participating families were gained from a range of sources as outlined in Table 5.1 in the previous chapter. An analysis of this data follows. It should be noted however that due to sample attrition and the relatively small number of participants completing all assessment items, the findings of this evaluation are indicative only.

Retention of families and assessment completion

Table 6.1 indicates the length of time intervention group families remained in the CCCP. Of the 58 families recruited to the intervention group 27 families left the programme within six months of joining. Thirty-one families remained linked to their volunteers for seven months or longer.

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>No of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N=58)</td>
<td></td>
</tr>
<tr>
<td>Less than 3 months</td>
<td>13</td>
</tr>
<tr>
<td>4 - 6 months</td>
<td>14</td>
</tr>
<tr>
<td>7 - 12 months</td>
<td>12</td>
</tr>
<tr>
<td>13- 18 months</td>
<td>16</td>
</tr>
<tr>
<td>19 - 24 months</td>
<td>3*</td>
</tr>
</tbody>
</table>

* Two of these families transferred to FOCUS when the CCCP finished

Information regarding the 27 families who withdrew from the CCCP prior to seven months is presented in Table 6.2. Six of the 27 families had scored in the high risk category after completing the Family Stress Checklist compared with 13 of the 31 who remained in the programme. Approximately 50% of the 27 clients who left the CCCP within six months of joining had left the local government area (LGA). This perhaps illustrates the transitory lifestyles of some of these young families and poses particular challenges to family support programmes. The remaining 50% who withdrew within six months terminated their contact with the CCCP for a range of reasons including returning to work or school, family no longer eligible for CCCP
due to involvement with Family Support Services or DOCS for more intense support, or families indicating they did not require the support offered by the CCCP.

Table 6.2  Reasons for withdrawal of clients from CCCP (intervention group)

<table>
<thead>
<tr>
<th>Reason for withdrawal</th>
<th>(n=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicated they did not require CCCP</td>
<td>9</td>
</tr>
<tr>
<td>Left LGA</td>
<td>12</td>
</tr>
<tr>
<td>Returned to work</td>
<td>2</td>
</tr>
<tr>
<td>Client referred to family support</td>
<td>1</td>
</tr>
<tr>
<td>Client came under DOCS supervision</td>
<td>2</td>
</tr>
<tr>
<td>Returned to school</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6.3 outlines the completion rates of the various screening and assessment measures used to select eligible families and subsequently, to assess the impact of the CCCP on these families. At entry to the programme three attempts were made to contact consenting families to complete the entry assessments (the Scale of Family Function and the Family Stress Checklist). If these attempts were unsuccessful these families were deemed to have terminated their involvement with the CCCP. These families had not as yet been linked with a volunteer and in later discussion are described as the ‘withdrawn’ group. The project co-ordinator was unable to contact 11 of the 58 intervention group families and seven of the 35 comparison group families to complete the Family Stress Checklist (FSC), and the Scale of Family function (SFF). Thus of the 58 families recruited for the intervention group, 47 completed all of the required assessments at entry to the programme. Twenty-six of the 35 families recruited for the comparison group completed all entry assessments. After one year or at exit from the CCCP 26 intervention group families and 14 comparison group families were available to complete the Scale of Family Function. As with the entry assessments three attempts were made to contact all families to complete this item.
Table 6.3.  Completion rate for screening and assessment items of families participating in the CCCP.

<table>
<thead>
<tr>
<th>Assessment item</th>
<th>Number of families completing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention group</td>
</tr>
<tr>
<td>SWSAHS Hospital Questionnaire</td>
<td>58</td>
</tr>
<tr>
<td>Parenting Readiness Checklist</td>
<td>58</td>
</tr>
<tr>
<td>Family Stress Checklist</td>
<td>47</td>
</tr>
<tr>
<td>Scale of Family Function (Entry)</td>
<td>47</td>
</tr>
<tr>
<td>Scale of Family Function (at 12mths)</td>
<td>26</td>
</tr>
<tr>
<td>CCCP Health questionnaire</td>
<td>17</td>
</tr>
<tr>
<td>Hospital admission records cross checked</td>
<td>58</td>
</tr>
<tr>
<td>DOCS central information service cross checked</td>
<td>58</td>
</tr>
</tbody>
</table>
Evaluation outcomes

Notifications of child abuse and neglect

After 12 months participation in the CCCP all infants were cross checked with the DOCS Central Information Services (CIS) records. The CIS collates child abuse and neglect notifications throughout NSW. Over the three years of the programme there were 17 notifications alleging incidents of child abuse and neglect involving ten families associated with the CCCP. After investigation by DOCS officers ten of these notifications were confirmed as child abuse and neglect incidents. Six of these confirmed incidents involved intervention group families and four involved families who had withdrawn from the CCCP prior to the notification. The outcomes of the remaining seven notifications are unknown (3), not yet investigated (1), or not confirmed/closed (3).

All confirmed notifications involving intervention group families were by the Director of the Cottage Centre or the CCCP project co-ordinator. Five of these were incidents of alleged abuse due to exposure to domestic violence. The nature of the remaining confirmed incident is unknown.

The four other confirmed incidents of child abuse and neglect involved three families who had withdrawn from the intervention group prior to the notification. One incident was categorized as ‘other physical abuse’ and two incidents as ‘abuse involving the parent(s) emotional state constituting a threat to the child’. All of these families had terminated their involvement with the CCCP within 3 months of joining.

Fifty percent of all notifications occurred when the baby was between 0-4 months of age. Eighty percent of the total notifications occurred when the child was aged between 2 and 12 months. The average age of the mothers whose infants were notified to DOCS and later confirmed as incidents of child abuse and neglect was 19 years (age range 15-22yrs; median age 18 years).

All infants who were notified to DOCS came from families who scored positively on multiple Parenting Readiness Checklist risk indicators and were were rated as marginally adequate or less on the initial Scale of Family Function. These families also rated as either high or mild risk on the Family Stress checklist at entry to the programme. Curiously none of the infants of families rated at entry as moderate risk on this measure(n=13), were subsequently notified as abused.

While there was a slightly higher percentage of withdrawn group families involved in confirmed incidents of child abuse and neglect than intervention group families, the findings are statistically insignificant. It is important however, to reiterate that in all
of the confirmed incidents of child abuse and neglect involving intervention group families, either the Director or project co-ordinator of the CCCP made the notification to DOCS. This supports the contention suggested in other studies (Gray et al., 1979; Barth, Hacking, Ash, 1988; Barth, 1991), that there is positive relationship between increased surveillance and higher rates of notification. Whilst child abuse and neglect notifications have been used as a measurable outcome in this evaluation the effect of the incident on the child’s health is not known.

Details of these notifications are outlined in Table 6.4.
Table 6.4  Department of Community Services notifications, status in CCCP, PRC risk indicators, FSC level of risk and outcomes-all groups as at 2nd March 1997.

<table>
<thead>
<tr>
<th>Family</th>
<th>Parent Readiness Checklist (risk factors)</th>
<th>Family Stress Checklist (level of risk)</th>
<th>Status in CCCP at time notified</th>
<th>Outcome **</th>
</tr>
</thead>
</table>
| 1*     | Single.  
1. Single.  
4. Unstable housing  
5. No phone.  
15. Mother 19yrs or less. | Not completed | Intervention | Withdrawn | Not confirmed/closed  
Not confirmed/closed  
Confirmed/closed |
13. Marital/family problems | High | Intervention | Confirmed  
Confirmed/ registered |
| Baby 1 | 14. Low self esteem/depressed.  
15. Mother 19yrs or less. | | | Confirmed  
Confirmed/ registered |
| Baby 2 | | | | |
| 3      | 1. Single.  
2. Partner unemployed  
13. Marital/family problems | High | Withdrawn | Confirmed/closed  
Confirmed/closed |
3. Financial stress  
8. History of substance abuse  
13. Marital/family problems  
15. Mother 19yrs or less. | High | Withdrawn | Unknown |
| 5*     | 1. Single.  
2. Partner unemployed  
13. Marital/family problems  
9. Unwanted pregnancy  
15. Mother 19yrs or less. | High | Intervention | Confirmed/closed |

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Table 6.4 (cont). Department of Community Services notifications, status in CCCP, PRC risk indicators, FSC level of risk and outcomes - all groups as at 2nd March 1997.

<table>
<thead>
<tr>
<th>Family</th>
<th>Parent Readiness Checklist (risk factors)</th>
<th>Family Stress Checklist (level of risk)</th>
<th>Status in CCCP at time notified</th>
<th>Outcome **</th>
</tr>
</thead>
<tbody>
<tr>
<td>6*</td>
<td>1. Single.</td>
<td>High</td>
<td>Intervention</td>
<td>Confirmed/registered</td>
</tr>
<tr>
<td></td>
<td>2. Partner unemployed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15. Mother 19yrs or less.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1. Single.</td>
<td>Mild</td>
<td>Withdrawn</td>
<td>Not yet investigated</td>
</tr>
<tr>
<td></td>
<td>2. Partner unemployed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. Marital/family problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>1. Single.</td>
<td>Mild</td>
<td>Withdrawn</td>
<td>Confirmed/ closed</td>
</tr>
<tr>
<td></td>
<td>4. Unstable housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. Marital/family problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Low self esteem/depressed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>6. Education &lt;Yr 12</td>
<td>Mild</td>
<td>Comparison</td>
<td>Unknown</td>
</tr>
<tr>
<td></td>
<td>9. Unwanted pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. History of abortions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>6. Education &lt;Yr 12</td>
<td>Not completed</td>
<td>Withdrawn</td>
<td>Unknown</td>
</tr>
<tr>
<td></td>
<td>7. Lack of support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Low self esteem/depressed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total notifications = 17
Total confirmed = 10

* Notification made by CCCP project co-ordinator or the director of the Cottage Centre.
** Terms used in the Outcomes column of Table 9 are defined by the NSW Department of Community Services (1994) as follows: "Notification is the official recording of the allegation of abuse or neglect of the child...this starts the process of investigation and decision making about possible investigation...The grounds for registration are that abuse or neglect has been confirmed and that the child is in need of ongoing protection to ensure his or her safety. To confirm the notification requires that it be very highly probable (sic) that abuse or neglect has occurred. Confirmed / closed...no further action by Dept. necessary" (NSW Department of Community Services, 1994)
Maternal health

After 12 months in the programme CCCP health questionnaires were sent out to all families who had completed the entry SFF (n=73), and the FSC (n=75). Twenty seven of these were completed and returned, 17 from intervention group mothers and ten from comparison group mothers, representing a completion rate of 36%.

There were no significant differences between families who were linked to volunteers and comparison group families on a range of outcome variables including completion rates for post natal checks and PAP smears, nor were there any substantial differences in the rate or degree of post natal problems reported by mothers in the two groups.

There was no significant difference between the numbers of intervention and comparison group mothers who breast fed their infants.

Twelve of the 17 intervention group mothers who responded to the CCCP health questionnaire were taking oral contraception (71%), and just one (6%) of the 17 was again pregnant. Six of the ten comparison group mothers who responded were taking some form of oral contraception (60%), and three (30%), were currently expecting their second child. The questionnaire did not address the issue of whether these pregnancies were planned. While the small sample and low response rate to the questionnaire act as cautions against any firm conclusions, similar patterns of delaying a second pregnancy were found in the four year follow up of the Elmira project mothers (Olds et al., 1994).

Infant health

Immunisation

Information regarding the immunisation status of their infants was also sought from participating families. Of those who responded from the intervention group (n=17), all but one infant had received the recommended immunisations at 2 and 4 months of age. Fifteen of these infants also completed the polio vaccine and triple antigen at 6 months of age. One set of twins is included in this data. The initial pattern of immunisation completion (up to 4 months of age) was similar in the comparison group families though fewer of this group (n=5), reported completion of the immunisations required when their infant was 6 months of age.

Immunisation for measles, mumps and rubella occurs when the infant is 12 months old. Seven of the 17 families in the intervention group had completed this immunisation and only one of the ten comparison group families had done so. It would appear that the intervention group were more likely to complete immunisation on time than the comparison group. These findings are similar to those found in the
two year follow up of families in both the Elmira (Olds et al., 1986) and Baltimore trials (Hardy & Streett, 1989).

While immunisation for Hepatitis B is not a universal requirement, almost all of those families in the comparison group who responded reported having had their infants immunized for this disease (n=8) whereas in families with volunteers only six infants were similarly immunized. Most families completed their immunisations at their General Practitioners as is common throughout New South Wales. Only four of the respondents indicated they had attended the Immunisation Clinic.

**Hospital Admissions**

After 12 months participation, the hospital records of all infants involved in the CCCP were examined to identify admissions and diagnoses. In total there were 41 admissions to Accident and Emergency departments in the SWSAHS involving 25 infants. Fifteen of the 41 admissions occurred when the infants were aged 0-3 months. As indicated in Table 6.5, babies from the intervention group were more likely to be admitted to hospital more often than those from the withdrawn or comparison groups. Whether this was due to volunteers actively encouraging families to present their infants for hospital treatment or a reflection of the higher risk status of intervention group families is unknown. In later focus groups volunteers did comment on encouraging mothers to seek medical assistance if their infants were unwell.

**Table 6.5**  
**SWSAHS admissions to accident and emergency department and number of babies involved (intervention, withdrawn & comparison group babies, as at 12th January 1997).**

<table>
<thead>
<tr>
<th></th>
<th>Intervention (N=47)</th>
<th>Withdrawn (N=11)</th>
<th>Comparison (N=35)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of hospital admissions</td>
<td>27</td>
<td>5</td>
<td>9</td>
<td>41</td>
</tr>
<tr>
<td>Total number of babies involved</td>
<td>15</td>
<td>3</td>
<td>7</td>
<td>25</td>
</tr>
</tbody>
</table>
As noted in studies reviewed earlier, frequent use of accident and emergency services could be associated with either increased awareness or anxiety of mothers regarding their baby’s health or inability to access other services. Table 6.6 shows the diagnosis (taken from clinical admission notes), of all infants admitted to Accident and Emergency services between March 1994 and January 1997. Only one of these hospital admissions was associated with a subsequent DOCS notification. However three infants who were notified to DOCS also each had more than two admissions to the accident and emergency department (A&E) in their first year of life. One child from the intervention group (Family 2, Baby 1 in Table 6.4) had three admissions to A&E for accidental injury which is frequently associated with the quality of parental care (Olds et al, 1986). This same child was also the subject of two later DOCS notifications which were both confirmed and one of which was registered. Both of these notifications occurred while the family was involved in the CCCP and resulted from the project co-ordinator notifying DOCS that the infant was exposed to domestic violence. Another child (Family 3 in Table 6.4) had three admissions to hospital for failure to thrive in the first three months of life. While on the first admission failure to thrive was determined to be due to organic factors (severe reflux), later admissions were deemed to be due to neglect of non organic origin. As far as can be assessed from hospital admission records and the CIS register these later admissions to hospital were investigated by DOCS and confirmed and closed before this infant was six months of age. This family, assessed as high risk at entry to the programme, terminated their involvement within 3 weeks of joining the programme and before being linked to a volunteer. The third child (Family 1 in Table 6.4) had three admissions to A&E and also four notifications to DOCS in the first year of life. This family also withdrew within six weeks of joining the CCCP. In the hospital case notes of the five infants where irritability was the diagnosis, comment was also made about the mother’s anxiety or anger with the child.
Table 6.6.  Diagnostic categories of illness/injury when examined at SWSAHS Accident and Emergency Department, (intervention & comparison groups), as at 12th January 1997

<table>
<thead>
<tr>
<th>Diagnostic category</th>
<th>Included in diagnostic category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N=41)</td>
<td></td>
</tr>
<tr>
<td>Respiratory Infection</td>
<td>Bronchitis (2)</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Respiratory distress (8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory infection (6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumonia (1)</td>
<td></td>
</tr>
<tr>
<td>Gastro intestinal symptoms</td>
<td>Oesophageal reflux (1)</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Colic (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diarrhoea &amp; vomiting (6)</td>
<td></td>
</tr>
<tr>
<td>Accidental injury</td>
<td>Infant 1:</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Bruising as a result of fall (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lacerations, grazes, play injury (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infant 2: Head abrasions (1)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Conjunctivitis (1)</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Oral Thrush (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lactose intolerance (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teething (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Irritability (5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Failure to thrive (1 infant = 3 admissions)</td>
<td></td>
</tr>
</tbody>
</table>
Level of family function at entry to the CCCP and after 12 months

At entry to the CCCP a higher percentage of intervention group families rated as marginally adequate or less than the comparison group on all eight SFF items. These results reflect the multiple stresses identified by families during their assessment and tend to support the attainment of the goal of the CCCP to target ‘vulnerable’ first time families. Also the analysis, at entry to the CCCP, reveals a group of mainly young mothers, many with less than adequate self esteem experiencing a high level of family conflict and less than adequate available social support.

There were no significant differences between the whole sample at entry and those who completed both entry and exit SFF assessments in any of the items measured in the SFF. Table 6.7 shows the percentage of CCCP families who rated as marginally adequate or less on all SFF items at entry to the programme and after 12 months or at exit. After one year it seems that while those who remained in both groups changed, the degree of change in the intervention group families was most marked across all items except the family’s stability in meeting basic needs. This item assesses the stability of income and housing adequacy. Neither group demonstrated significant change in this item between entry and exit.
Table 6.7. Percentage of families rated as marginally adequate or less on SFF items at entry to CCCP, and those completing SFF both at entry and at exit or after 12 months.

<table>
<thead>
<tr>
<th>SFF item</th>
<th>Intervention group (%)</th>
<th>Comparison group (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At entry</td>
<td>Available at entry &amp; exit</td>
</tr>
<tr>
<td></td>
<td>(Total=47)</td>
<td>(n=26)</td>
</tr>
<tr>
<td></td>
<td>At entry</td>
<td>At exit</td>
</tr>
<tr>
<td>Social supports</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>Family conflict/stress &amp; coping</td>
<td>89</td>
<td>85</td>
</tr>
<tr>
<td>Self esteem</td>
<td>93</td>
<td>88</td>
</tr>
<tr>
<td>Confidence as a parent</td>
<td>95</td>
<td>92</td>
</tr>
<tr>
<td>Stability/meeting basic needs</td>
<td>83</td>
<td>77</td>
</tr>
<tr>
<td>Expectations</td>
<td>95</td>
<td>97</td>
</tr>
<tr>
<td>Affective relationships*</td>
<td>95</td>
<td>92</td>
</tr>
<tr>
<td>Sensitivity to caretaking functions*</td>
<td>86</td>
<td>81</td>
</tr>
</tbody>
</table>

* The items 'Affective relationships' and 'Sensitivity to Caretaking Function' mainly relate to the parent(s) relationship with their infant. As only 17% of mothers had given birth at the time of the entry assessment, the rating of these items are not reliable indicators on the entry SFF.
At the second assessment a higher percentage of families rated as adequate on all items, the intervention group families showing the most marked improvement and the most change, tending to ‘catch up’ to the level of function of those in the comparison group. Whilst the intervention group improved in all areas of family function, when compared to change in the comparison group the improvement was statistically significant in the items ‘Social Supports’, ‘Expectations’ and ‘Family stress and Coping’. Table 6.8 details the significance of the changes that occurred between entry and exit in those for whom both measures were available. These findings suggest that the presence of a volunteer may have contributed in some way to assist families to mobilize their social support networks, develop realistic expectations regarding their infant and manage stress and family conflict in a more constructive manner.

Table 6.8.  **Average change between individual pre and post test means on Scale of Family Function (SFF).**

<table>
<thead>
<tr>
<th>SFF Variable</th>
<th>Intervention group (Mean) (n=26)</th>
<th>Comparison group (Mean) (n=14)</th>
<th>Significance of change between groups (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Supports</td>
<td>0.61</td>
<td>0.00</td>
<td>0.02</td>
</tr>
<tr>
<td>Family conflict/stress &amp; coping</td>
<td>0.34</td>
<td>0.07</td>
<td>0.04</td>
</tr>
<tr>
<td>Self esteem</td>
<td>0.38</td>
<td>0.14</td>
<td>NS</td>
</tr>
<tr>
<td>Confidence as parent</td>
<td>0.92</td>
<td>0.57</td>
<td>NS</td>
</tr>
<tr>
<td>Stability &amp; meeting basic needs</td>
<td>0.19</td>
<td>0.35</td>
<td>NS</td>
</tr>
<tr>
<td>Expectations</td>
<td>0.92</td>
<td>0.28</td>
<td>0.02</td>
</tr>
<tr>
<td>Affective relationships**</td>
<td>0.88</td>
<td>0.57</td>
<td>NS</td>
</tr>
<tr>
<td>Sensitivity to caretaking functions**</td>
<td>0.53</td>
<td>0.35</td>
<td>NS</td>
</tr>
</tbody>
</table>

(a) Determined by independent sample t-test. NS = not significant at the <0.05 level
* Negative sign indicates improvement
** Note previous cautions

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Use of Community Services

The CCCP health questionnaire (completed by 27 families after 12 months participation) also asked families to indicate the number of Community Services they had visited in the past twelve months. The results from this questionnaire are presented in Table 6.9. Mothers from the comparison group, who were rated as at less risk than intervention group families at entry to the CCCP were more likely to have attended antenatal clinics, antenatal classes and their General Practitioner prior to the birth of their baby. However after the birth of their babies, families from the intervention group used a greater variety of Community Services more frequently than those in the comparison group. One could speculate however that the intervention group, who at entry to the programme tended to be rated as a higher risk group, had a greater need to access these services. Equally, perhaps, these families received more encouragement and direction from volunteers to attend relevant services. Six mothers of the intervention group attended the local Community Area Health Service facility for treatment of post natal depression more than twice.

Table 6.9. Percentage of CCCP health questionnaire respondents indicating use of selected Community services during 12 months participation in the CCCP

<table>
<thead>
<tr>
<th>Community service</th>
<th>Intervention group (%)</th>
<th>Comparison group (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=17)</td>
<td>(n=10)</td>
</tr>
<tr>
<td>Antenatal clinic</td>
<td>53</td>
<td>90</td>
</tr>
<tr>
<td>Antenatal classes</td>
<td>53</td>
<td>56</td>
</tr>
<tr>
<td>Community Health Baby clinic</td>
<td>82</td>
<td>56</td>
</tr>
<tr>
<td>Immunisation clinics</td>
<td>56</td>
<td>20</td>
</tr>
<tr>
<td>Karitane/Tresillian (Residential units)</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Department of Housing</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>64</td>
<td>100</td>
</tr>
<tr>
<td>Counselling Services</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>35</td>
<td>0</td>
</tr>
</tbody>
</table>
Summary of quantitative results

While it should be noted that the findings of this evaluation are indicative only, due to sample attrition and the relatively small number of participants completing all assessment items, there are indications that the presence of a volunteer seemed to have an impact on the wellbeing of some families. At entry to the CCCP a high percentage of the total group were rated as marginally adequate or less on eight items assessing adequacy in family function. After one year, families with volunteers had improved on all but one item in the assessment of family function. In particular, families linked to volunteers showed statistically significant improvements in the following three areas;

1. A belief they had developed a positive social network, were aware of and used available community supports and had access to support.
2. An increased and adequate ability to cope with and resolve family difficulties.
3. They were found to be more mature and to have developed age appropriate expectations regarding their infant.

Families without volunteers however, showed no significant change in any of the eight measures of family adequacy. This result suggests that the presence of a volunteer over a period of one year made a significant difference to families cohesion and adequacy.

In relation to mother and infant health, mothers with volunteers seemed to be a little more likely to be using some form of contraception and fewer were again pregnant when compared to mothers in the comparison group. Infants of these families were also more likely than comparison group infants to have completed the recommended infant immunisations beyond four months of age.

Over the three years of the pilot there were ten confirmed child abuse and neglect incidents. Six of these involved families with volunteers, and were the result of notifications made by the staff of the programme. The majority of these notifications were related to domestic violence incidents involving adults. The remaining four confirmed incidents of child abuse and neglect occurred in three families who had withdrawn from the CCCP within three months of joining. The notifications occurred after they had left the programme and illustrate the difficulties sometimes encountered in providing a service to this mainly young and highly mobile group, while further emphasizing the need to do so.
Volunteer linked families reported visiting a wider range of Community Services more often than comparison group families. This could be an outcome of greater need, or indicate that they received more encouragement from volunteers to access these services.

**Qualitative data**

**Client Perception of the CCCP**

Two small focus groups were held with mothers who had been linked to volunteers for varying lengths of time (average 12 months). Focus group one was held with three mothers who were in the older age group (mean age 26 yrs), and married, characteristics that were not highly representative of the study population. These mothers had been in full time employment prior to the birth of their baby and all commented on the changes that occurred in their lives when they became full time mothers. In particular they commented on the social isolation they experienced when they left paid work, and equally difficult, their loss of independence in terms of available money and time alone or with their partners. These mothers had participated in a fortnightly support group established by the project co-ordinator for older women. All found this very helpful in reducing their social isolation and their comments regarding this support group are also included below.

Focus group two was held with three mothers who were more representative of the study population. The average age of this group was 20.2 years, two were single and two had left school at Year 11 or before. The major issues these women expressed regarding their transition to motherhood were difficulties regarding relationships with their families who generally expressed anxiety about their single mother status and how they would manage. Like the older mothers from focus group 1 these mothers also commented on their social isolation and that often their families expressed ambivalence about baby sitting when the new mother wanted to go out with friends. Both groups commented positively on their participation in the CCCP and were unreserved in praising their volunteers and the project co-ordinator. The dissatisfaction expressed by one mother centred on the unreliability of the first volunteer she was linked with. This volunteer was often late for the pre arranged visit or on one occasion failed to arrive at all. Fortunately the mother was able to discuss this with the project co-ordinator who, after discussion with the volunteer and the mother, assigned another volunteer. The first volunteer left the programme commenting that her expectations about her volunteer role were not met.

The CCCP Health and Community Services questionnaire completed by 17 families of the intervention group after 12 months in the programme also included two items
that asked mothers to comment on sources of satisfaction and dissatisfaction regarding their involvement with their volunteer and the CCCP. These responses have been included in the comments below. Further comments from these women regarding their experience in the CCCP include:

**Regarding Volunteers:**
- Once I felt she wasn't there to judge me I trusted her...that took about 4 visits;
- Helped me find my feet in the community, knew where to go for cheap things;
- My volunteer became like a mother, just guided me, she knew how to do things that made me anxious;
- Just knowing there was always someone or somewhere (The Cottage Centre) to go when I felt I wasn’t coping helped me through a lot of situations;
- When I desperately needed help she was there immediately;
- She included my husband and he wasn’t that keen at the beginning;
- There should be a similar programme for new fathers;
- Helped me with practical things, became part of my life. I looked forward to her visit every week... it helped me get through;
- Having a person who had raised her own family was great...I knew she was talking from her own experience and she’d had tough times;
- She only gave me what I needed, didn’t lecture or come on with the ‘shoulds’. It was like she wanted me to figure it out and most times I did;
- At the beginning I felt I had to be the ‘perfect’ mother and that I had to prove I could do it. She made it OK to be less than perfect and I began to enjoy my baby more;
- She helped make it OK with my parents who loved the baby but were angry with me for having it. She gave me confidence that I could manage by just being there.

**Regarding CCCP support group:**
- I could see I was not the only person feeling down...other mothers were going through the same things I was and doing OK...that helped me...;
- It was good to share resentment towards husbands regarding the sense that only our lives had changed - our husband’s lives hadn't changed at all...;
- Made new friends that have lasted;
- Shared weekly recreation activities with these new friends...good to see other mothers were sometimes struggling with their new baby;
- Helped me become confident that I was doing OK with my baby...lessened my sense that I was alone.

_Dissatisfactions_

- "My first volunteer didn't come when she said she would...she wasn't always reliable;
- ...found myself avoiding the visits but the second volunteer was great;
- ...we just hit it off...she was much older than me and seemed to know what it was like with my baby".

Clients commented that it was helpful to have someone with them who was not anxious about their baby, and who could address their concerns without judgement. Three commented that the volunteer helped them deal with the occasional resentment or anger they felt at the changes imposed on them by the demands of motherhood, suggesting that in the absence of a volunteer this anger would have been directed at their partners. One mother who experienced post natal depression suggested that without the constant availability of her volunteer and the CCCP project co-ordinator she would probably have been unable to successfully negotiate treatment through the existing Mental Health Services. Some mothers expressed a desire that their partners were more involved in the CCCP, though they were at a loss as to how this might happen. They did not believe that the CCCP excluded their partners but rather those partners were unsure as to how they could be involved. All of these clients supported the CCCP unreservedly and suggested the programme should be available to all mothers.

_Volunteers' perception of the CCCP_

Volunteers also were asked to complete a questionnaire after 12 months participation in the CCCP. Issues addressed in this questionnaire included time linked with families, number and duration of visits, telephone links, participation in supervision and ongoing training and sources of satisfaction and dissatisfaction in being a volunteer. Twenty-six completed questionnaires were returned (return rate = 55%). On average volunteers were linked to their families for approximately eight months (maximum 18mths) and during that time made 24 visits (maximum 108 visits), each visit on average two hours long. Seven volunteers were linked to two families in succession. Eighty-seven percent of the volunteers visited their family weekly the remainder 13% visited fortnightly. Half of those who responded had been linked to their families from the antenatal period.
When recruited to the CCCP volunteers were advised of the requirement to attend monthly volunteer group support meetings, which included ongoing training sessions, and separate monthly individual supervision meetings with the project co-ordinator. Times for the monthly support meeting were varied each month in an effort to accommodate the schedules of volunteers. Table 6.10 outlines the volunteers’ responses when asked how often they attended these meetings. Comments regarding these meetings were further elaborated in the volunteer focus groups.

Table 6.10. Volunteer attendance at monthly individual supervision and volunteer support group meetings (N=26).

<table>
<thead>
<tr>
<th>Meetings attended</th>
<th>Volunteer Support Group (%)</th>
<th>Individual Supervision (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended all</td>
<td>31</td>
<td>46</td>
</tr>
<tr>
<td>Attended 50%&gt;</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Attended 50%&lt;</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>

One of the goals of the CCCP was to ‘Help new families identify and utilize community resources to meet new and changing needs’. Responses received in the Volunteer Questionnaire indicate that volunteers supported their family’s attendance at a range of community services. Twelve volunteers indicated they went with their mothers to the antenatal clinic or antenatal classes (a total of 47 visits), five volunteers accompanied their mothers on nine visits to Immunisation Clinics, two volunteers assisted their family to access Financial Service assistance 10 times, and 10 volunteers accompanied their mothers on 17 visits to the Early Childhood Clinic. Other Community Services that volunteers helped their clients to access included Jasmine Cottage (four volunteers), General Practitioners (five volunteers), the local hospital, The Sydney City Mission, Family Support Services, Cottage Project Coffee mornings, The Cottage Family Care Centre, and Young Mothers’ groups run by the CCCP. Volunteers assisted mothers/families to attend these Community Services in a range of ways, including helping the family to identify the problem and the Community Service that could assist, and frequently by attending the Community Service with the family.

Volunteers were also asked to identify what was the most and least satisfying aspect of their volunteer experience. The responses of the 18 volunteers who completed this section include the following:
Most satisfying part of being a volunteer

- Helping and supporting people/families (n=6);
- Seeing increases in self esteem/confidence/competency of mother (n=4);
- Being able to support and guide, share own experience, listen and support as friend (n=4);
- Seeing baby thrive, building trust with mother; (n=2).
- A sense of belonging and being supported/enjoy visits and support as volunteer (n=2).

Least satisfying part of being a volunteer:

Nine volunteers did not complete the section of the questionnaire asking them to identify the least satisfying aspects of being a volunteer. The comments of those who did complete this section are outlined below.

- Difficulty in getting regular access to family (n=5);
- Experiencing the ambivalence of mother (n=1), mother’s restlessness (n=1), interference by client’s mother (n=1);
- Slow development of relationship (n=1), not always an easy relationship (n=1).

Sources of satisfaction and dissatisfaction expressed by volunteers in this self administered questionnaire were similar to responses to the same question given by volunteers participating in the focus groups.

Volunteers’ experience - Focus groups.

Within the two focus groups a range of issues were discussed and explored by the volunteers with minimal prompting by the facilitator. Volunteers in both focus groups discussed the reasons they joined the CCCP. Although each volunteer expressed slightly different motivation, all supported the belief that when first time mothers themselves, they would have greatly benefited from the presence of a volunteer and that this experience was important in deciding to join the CCCP. Other reasons given for joining included the need to be busy and if possible to help others, or for some who were isolated themselves through the loss of a loved one, becoming a volunteer offered the opportunity to meet others, feel useful and participate in a larger endeavor. The idea of giving something back to the community by being part of this programme was firmly supported by participants. Other recurring themes and issues that arose in the volunteers’ discussion have been grouped under various headings and are summarized in point form below:
**Sustaining factors**
- volunteer training benefited them in their own lives;
- being part of the success and achievement of these families;
- seeing the potential in these families;
- more awareness of own good fortune;
- more aware of own teenage children and able to relate to them better;
- learning to become more tolerant, less judgmental;
- someone believing in me made me feel so good;
- being accepted and appreciated by families;
- constant and available support from project co-ordinator.

**Sources of frustration/dissatisfaction/concern**
- delay in being linked to client after training
- sense of helplessness due to:
  a) unable to be with client alone...always in the presence of the local tribe'
  b) clients frequently canceling visits
  c) having a family that was coping very well gave me a feeling of uselessness
- worrying about finally separating from the family - what will happen to these families;
- sometimes feel like a 'spy' or intruder especially at the beginning;
- culture shock when someone else's version of normal was 'so different from my own';
- learning to draw the line between my problems and theirs.

**Problems faced by ‘our’ families**
- isolation, no partner or immediate support;
- no role models to teach them different ways of doing things;
- fear of labor or pain;
- fear of how the their family would react to the child;
- intellectual and social difficulties;
- low self esteem/helplessness;
- the immaturity of some mothers.

Discussion about the nature of their interactions with their families revealed that while each client-volunteer relationship is unique, there were more similarities than
differences in the process of forming these relationships. Most volunteers stated that developing trust with their families and thus gaining access to their lives was the most difficult aspect of the relationship. All told anecdotes about trust building with their families, in most cases initially with the mothers.

One volunteer recounted the difficulty she experienced in visiting and engaging her young mother and infant alone. At each visit this volunteer was engaged in searching discussions with the neighbors, mainly women, who seemed to be the support group in residence for the single mother. They not only constantly sought information about the CCCP but also often spoke for the mother. The volunteer resolved this situation by changing her expectations about the nature of family, thereafter including these women in her visits. In families where there was a husband or boyfriend, they seemed to act as observers until some incident occurred that engaged or involved them (e.g.: volunteer car breakdown/incident of domestic violence). These incidents seemingly provided a medium or opportunity to engage the partner in the process.

Other issues regarding client-family relationships related to the volunteers’ beliefs about their need to be clear about the responsibilities and rights of their role. Volunteers deemed it important to be able to assert limits or boundaries in their relationship if necessary. They spoke of having to establish with clients that they were not only babysitters, or always there to provide transport to shopping centres or similar places. One volunteer spoke of having to gently confront her client’s boyfriend who was being verbally aggressive to her when she was working with the mother and child.

**Challenges and changes as a result of being a volunteer**

- An eye opening experience on how teenagers think and how different their priorities are to ours;

- It was a lesson in the reality of other peoples lives...an education on another side of life...makes you evaluate your own morals, ideals and teachings;

- You learn to appreciate your own life and the people in it.

**Feedback on Supervision and Support**

In both focus group discussions the volunteers talked of the value of the volunteer support groups. These groups seemingly were valued as an opportunity to get support for their own issues and doubts and equally importantly, not only listen to the doubts and concerns of others, but also contribute to solutions. These groups also seemed to satisfy the need expressed by many volunteers of feeling they were engaged in
something useful. Hearing other volunteers talk about their successes was also valued highly by those in the discussions.

Monthly individual supervision sessions with the project co-ordinator were seen as an essential and necessary part of being a volunteer. Volunteers asserted that these sessions helped them clarify situations, plan different approaches, separate their lives from those of their clients and keep a realistic perspective on the limits of their role. Some believed these sessions helped them to maintain their optimism when their families had often lost theirs and to deal with their disappointment when their families failed to meet some expectation. Volunteers also commented that support and advice was available at all times, not just within the monthly supervision meetings. In general volunteers spoke positively of their experience with their clients and were equally positive about their participation in the CCCP.
Chapter 7

Discussion

Child abuse and neglect is a major problem affecting many thousands of families each year in Australia. While there is apparent agreement about the need to confront this issue, debate continues about what constitutes effective child protection policy and practice. The delivery of support and education and fostering the inclusion of families in the community through the medium of volunteer based home visitation programmes is proposed as one of a range of strategies that enable and assist families to develop safe and constructive relationships both within the family unit and between the family and the wider community. The Cottage Community Care Pilot Project was one such programme. The findings of the evaluation of the CCCP suggest that volunteer based home visitation can make a significant contribution as one of a range of support services available to families. In this section the findings of the evaluation and their implications will be discussed.

Outcomes

Child abuse and neglect

It is difficult to determine whether the incidence of child abuse and neglect in the intervention group families is a feature of the indicator used to measure child abuse and neglect, or the close observation of these families by project staff. In this study this indicator was confirmed incidents of child abuse and neglect recorded by the NSW Department of Community Services. Other studies, (Olds, 1992; Roberts et al, 1996) suggest that the lack of standardised measures of child abuse and neglect, and the fact that families linked to volunteers are more likely to have abuse incidents noticed, make it difficult to determine whether the programme is effective in reducing the incidence of child abuse and neglect. Certainly all seven notifications involving intervention group families were made by the Director of the Cottage Centre or the CCCP project co-ordinator, supporting the assertion that the close surveillance of families in programmes such as the CCCP is likely to increase the number of reports of abuse. This potential for bias in reporting the outcome child abuse and neglect is considered a serious threat to validity (Roberts et al., 1996). The fact that the sample was small and child maltreatment is a low incidence variable further weakens the validity of these findings (Fink & McCloskey, 1990).

The nature and severity of each incident of child abuse and neglect was rarely reported in the studies reviewed for this paper. Of the six confirmed incidents of child
abuse and neglect involving infants in the intervention group of the CCCP, five involved the infant being exposed to an incident of domestic violence. In New South Wales infant involvement in this type of incident is labelled as emotional abuse. As in other studies (Hardy & Streett, 1989; Olds et al., 1986; 1994; 1997), further information regarding the severity and sequelae of these and other types of confirmed incidents was not available, in this instance due to the privacy and confidentiality provisions of the Department of Community Services. This outcome reinforces the need for future research to define child abuse and neglect beyond official definitions and to clearly distinguish between reducing the severity and reducing the incidence of child abuse and neglect (Garbarino, 1986).

**Maternal and infant health**

Intervention group mothers were less likely to be again pregnant and were slightly more likely to be using some form of contraception. Infant immunisation completion was higher among intervention group families, in particular among those families who remained linked to the CCCP for seven months or more. These positive outcomes are similar to those found in the Elmira study (Olds et al., 1986; 1994; 1997). In the absence of more detail one can speculate this may well have been a function of the attention the volunteer gave to both the mother’s as well as the infant’s health and well being. Examination of other infant and maternal health indicators show little significant difference between intervention and comparison group families, although on the negative side, more infants from intervention group families were admitted to hospital more often. Whether this was due to volunteers actively encouraging families to present their infants for hospital treatment, or a reflection of the high risk status of these families at entry to the CCCP is unknown.

**Family Function**

Family function improved significantly on a range of indicators in families in the intervention group. At entry to the programme a higher percentage of intervention group families than comparison group families rated as marginally adequate or less on the eight items measuring family function. After one year the families that were linked to volunteers showed the most marked improvement and the most change on all items, and within this, statistically significant improvement on the items assessing availability of social supports, expectations of self and child and the ability to cope with family stress when compared to families in the comparison group. In a sense the intervention group families caught up to the level of function of the families in the comparison group. Given that, at entry to the programme, intervention group families were more often of single parent status and indicated they had few available social
supports, these results are positive and suggest that the presence of a volunteer over a period of one year benefited the participating families.

**Use of community services**

Intervention group mothers used a range of community services more often than did comparison group mothers. Whether this outcome was an expression of greater need, or the result of volunteers’ encouragement and facilitating access to these services is not known. A review of the CCCP goals indicates that generally the role of the volunteers included the requirement that they assist and support their assigned family to enhance their existing coping skills, develop positive parenting skills, use community services and establish and maintain supportive relationships within their community. While the unique nature of volunteer interactions with families was beyond the remit of this study, as was the detail of the strategies they employed to assist these mainly young families, an examination of the clients’ and volunteers’ perceptions of their relationships indicate that volunteers became a significant support person who was highly valued, in particular for non judgemental support and a willingness to appropriately share their own ‘parenting’ experience. While relating to their assigned families, volunteers worked to reduce the social isolation of these new families and encouraged families to develop positive coping mechanisms to deal with the inevitable stresses of parenting. Volunteers were active in supporting their families to access available community services and generally expressed sensitivity to the particular circumstances of their families, even though some of these were outside their own experience.

It is also evident that those intervention group mothers who attended the mothers’ support group at the Cottage Centre formed friendships with other mothers that were long term and supportive. These mothers agreed that they valued these social occasions and went on to organise social and recreational events with their new found friends independently of the programme. The mothers’ support group seemed not only to offer a structure in which new mothers could share the joys, doubts and concerns associated with new parenting, but also the opportunity for participants to expand their social network and to be more exposed to and included in the broader social context of their community. It could be argued that these positive outcomes served to reduce the impact of social isolation as a contributing factor to family stress and conflict and ultimately child abuse and neglect.
**Client satisfaction**

As in other studies (Beardmore 1996; Johnson et al., 1993; Cox et al., 1991; Hardy & Streett, 1989), client feedback indicated unreserved support for the services of the programme. Mothers highly valued their relationship with their volunteers, and commented positively on the availability of support and the generally non-judgemental assistance they received. The mothers group support meetings held at the Cottage Family Care Centre were also highly valued. These outcomes also reflect attainment of the CCCP’s goals related to reducing the isolation of the new family and helping the new family to identify and use community services. Involving partners was a further goal of the CCCP and although volunteers reportedly made every effort to include partners this was seldom achieved. Timing of volunteer visits, usually during the day, may have contributed to this failure to involve partners, though volunteers indicated that partners who were there often disappeared when the volunteer arrived. Some mothers strongly expressed the view however that their partners also needed some sort of support in making the transition to parenthood. No other research reviewed for this study commented on the inclusion or exclusion of partners. This suggests that if the goal of involving both parents, or mothers and partners, is to be realised, this aspect of home visitation to families requires further research and innovative trials in order to develop strategies that would be more inclusive of fathers or partners.

**Issues arising out of the evaluation**

Child abuse is a complex and multifaceted phenomenon. It is thought to arise out of a family’s response to and interaction with the ever changing and often adverse contexts and situations within which it resides (Belsky, 1988). In the absence of fundamental and comprehensive economic, cultural and social change, child abuse prevention efforts have focused on changing, at a variety of levels, specific factors thought to be associated with child maltreatment (Garbarino, 1986). Secondary level home visitation programmes generally aim to prevent child abuse and neglect by assisting families to establish behaviours and a lifestyle that will allow them to cope constructively with adverse contexts and situations and subsequently reduce the likelihood that child abuse will occur. Some authors argue that home visitation to families is essentially an investment in the social capital of a community in that it has the potential to enhance relationships between and within families and communities (Cox, 1995; Coleman, 1988). While there are those who advocate that home visitation should be available to all parents (Barker et al., 1988, 1992; Harrison, 1991), more commonly home visitation programmes target families who are considered to be ‘vulnerable’, or ‘at risk’ of later child maltreatment due to a variety
of negative life circumstances (Olds et al., 1986; 1994; 1997; Hardy & Streett, 1989; Johnson et al., 1993; Cox et al., 1991). This latter perspective of the role of home visitation as a preventative strategy for vulnerable families was reflected in the goals and strategies of the CCCP.

The CCCP was piloted with a sample of first time mothers who met specific predetermined inclusion criteria. Given it was a volunteer based service, care was taken to exclude first time parents whose needs or level of risk might require more expert intervention. In the CCCP, the age, marital status, socio economic status and degree of social isolation, especially of families in the intervention group, significantly reflected the risk indicators thought to be associated with child abuse. At entry to the programme, as indicated on all three entry assessments, the majority of families were experiencing multiple stresses, social isolation, low self esteem and had few social supports - clearly vulnerable families. All of these factors reflected the desired recruitment profile of the CCCP.

However during the recruitment phase there were a further 153 families who also demonstrated these risk indicators, had a similar demographic profile and were eligible but refused to participate in the CCCP. Ethical constraints made it impossible to follow up these families and compare them with the intervention group families on the various outcome indicators. The unwillingness of these similarly vulnerable families to become involved lends support to the need to make family support programmes available to all families thus reducing the possible stigmatisation effect sometimes associated with needing extra services. Making family support services available to all mothers, as advocated by Barker et al. (1992), and thus reducing any possible stigma, might increase the likelihood that these families would accept a programme such as the CCCP. Equally, the transitory lifestyles of some of the young families who withdrew early from the CCCP pose a challenge to any family support programme and indicate that future programmes may need to tailor these services more specifically to this group. As in the evaluations of the Elmira trial (Olds, 1986; 1994; 1997) these findings do suggest that the longer families stayed with the CCCP the more they benefited.

There are further limitations in this evaluation that require consideration. The majority of families were recruited through the local hospital antenatal service thus excluding women who did not attend antenatal services. This nature of this latter group is unknown but it may have included those who were most in need of support and almost certainly, those with private health insurance, thus limiting the diversity of the sampled population. Also as noted previously, though many families were accepting of home visitation there were also many eligible families who refused to
participate or who commenced in the CCCP and then terminated their involvement early. It may be that some of the positive outcomes in families of the intervention group may be as much a function of initial acceptance and willingness to participate in the CCCP as it is a result of the programme's effectiveness. The limited number of families who remained in the CCCP and who were available for the completion of all evaluation items, and the non-random assignment of families to either the intervention or comparison group were further significant limitations.

Generalising the findings of this study to other similar volunteer based services is further limited by the design of the study, the nature and size of the sample and the particular social milieu in which it occurred. The interventions were delivered to a small high risk group of first time parents who lived in a relatively new, rapidly developing community on the edge of a large city. The programme arose out of the interest and enthusiasm of various stakeholders who then, in important and diverse ways, supported its ongoing development and implementation. Collaboration between health, community and family service organizations and the sponsoring agency was critical in ensuring that the programme became known and accepted and that the participating families received access as necessary to the many agencies involved. The caution is that the characteristics of the recruited families in a particular community context, and intensity of the programme, shaped by the unique partnerships involved and the enthusiasm and particular skills of the key stakeholders, may have significantly influenced the outcomes of the CCCP. While researchers point to the need for any home visitation programme to be nested in a comprehensive health service (Olds et al., 1986; Johnson et al., 1993; Hardy & Streett 1989), these unique aspects of the development and operation of the CCCP restrict the extent to which the results are generalizable to programmes of universal home visitation. (Roberts et al., 1996). Equally while programme benefits are suggested in the difference in the measures of family function and some maternal and infant health indicators, the non-equivalence of the groups at entry to the programme somewhat weakens the result.

Whether any of the benefits observed in this evaluation is enduring is another issue that requires further research. Helfer notes the propensity of evaluations to measure proximal rather than distal outcomes and asks "should one accept the absence of abuse/neglect in the first year of life as the criteria for demonstrating the benefit, later in life, of a given manoeuvre or programme?" (Helfer, 1982, p. 258). Measuring distal outcomes, as Olds and colleagues have done over a 15 year period in the Elmira trial (Olds et al., 1997), would address the question of the durability of changes in infant and maternal experiences. This would enable assessment of the accumulative impact of prevention programmes over a period of time on a range of
issues affecting families, including child abuse and neglect. Studies of this kind, in keeping with the ecological perspective, could provide tangible evidence of the health, social and economic benefits of family support/child protection home visitation programmes. Only long term follow up of both groups participating in the CCCP can produce any certainty regarding the durability of treatment effects.

The processes that operate within home visitation to produce benefits are not addressed in this study. Explanations may lie in the examination of the qualities and attributes of the ongoing relationship between the volunteer and mother. For example one mother described the relationship in the following manner “…she only gave me what I needed, didn’t lecture or come on with the ‘shoulds’. It was like she wanted me to figure it out and most times I did…”. In their discussion of the Elmira project, Olds et al. (1994), raise this issue and argue the need to more closely examine the nature and process of the ‘therapeutic alliance’ formed between visitor and client that seems critical to positive outcomes in home visitation (Olds et al., 1994). Other researchers have also identified the need for more research in this area (Vimpani et al., 1996; Johnson et al., 1993; Cox et al., 1991; Hardy & Streett, 1989).

Practical/political issues

The evaluation process was planned and initiated at the same time that the CCCP service was developed. This involved the project co-ordinator in developing structures and processes to meet the demands of the evaluation at the same time as she was developing the protocols of the CCCP service. The latter included preparation of manuals, recruitment and training of volunteers and extensive liaison with other services, in particular the SWSAHS and DOCS. She was responsible for supervision of volunteers, monitoring of families’ progress, promoting the programme within the community, facilitating the mothers’ support groups and responding to any crisis that might occur with participating families. She also was involved in preparing submissions to ensure ongoing funding. The project co-ordinator was heavily involved in screening clients for inclusion in the pilot, completing the SWSAHS Hospital Questionnaire, the Parenting Readiness Checklist, and the Family Stress Checklist assessment interviews with prospective families, all of which contributed to the data included in the evaluation.

It is clear that the project co-ordinator’s role was central to both the success of the programme and the completion of the evaluation. The CCCP was a new programme and was promoted with great enthusiasm by the various stakeholders. As an insider (Owen, 1993) the project co-ordinator was familiar with the policies and structures of the programme and its management committee, and was responsible to the various
stakeholders for all aspects of the programme. The inevitable tensions that arose out of the parallel demands of developing and running the service while also meeting the demands of evaluation placed an extra burden on the project co-ordinator. While she capably met these demands it seemed that sometimes this was more a feature of her determination and personal skills than existing supportive structures and processes.

When I, the outsider, became involved in the evaluation, the methodology was essentially established. The first tasks were to establish the limits and responsibilities of the respective roles of the project co-ordinator and myself and the structures and processes that would enable these to be accomplished. The screening and initial assessment instruments formed an essential data source for evaluation. As the outsider, I was totally dependent upon the project co-ordinator and the Director of the Cottage Family Care Centre for access to this information. To allow the development of an extensive data base required the project co-ordinator keeping meticulous records of all assessments. It also required regular meetings between the project co-ordinator and myself to deal with any difficulties that arose in gathering and recording data and responding to the needs of various stakeholders for information. These activities further eroded the time the project co-ordinator had for the ongoing development of the programme.

Whilst the need for evaluation was unequivocally accepted, it could be argued the evaluation could have been more efficiently carried out if it was funded and developed separately from the development of the CCCP. Not least, the project co-ordinator would have been less involved in maintaining the necessary data collection and more available for the establishment and maintenance of the CCCP. In particular the need for the project co-ordinator to meet the requirements for evaluation whilst undertaking the various tasks of establishing the CCCP and ensuring ongoing funding may have made her less available for the vital initial contacts with some intervention group families. This may have contributed to the early termination of some of these families who on initial screening demonstrated they had few available social supports, were in the main young and single and who may have benefited from ongoing participation in the CCCP. These issues reflect the concerns expressed by Owen (1993) regarding the extra effort required when insiders are extensively involved in the evaluation and could also be factors that contribute to the paucity of evaluations of community based home visitation.
Cost

The overall budget for this preventative programme was approximately $190,500 over three years, $6145 for each of the 31 families who remained with their volunteer for six months or more. This amount includes salaries and the $16500 (per year) running costs granted by DOCS. Though some of these costs were associated with the ongoing assessment of comparison group families it is evident that this is a relatively inexpensive programme to operate. There is however little information regarding the overall economic and social cost of managing child abuse and neglect, or of failing to prevent it. This, coupled with the lack of information regarding the costs of similar volunteer based home visitation programmes in Australia, makes it impossible to offer any firm conclusions regarding the cost effectiveness of this programme.

Broader implications

Though volunteer based family support programmes are numerous, rigorous and systematic evaluations are relatively few, often due to lack of resources such as money and expertise. The evaluation of the CCCP reflects the complexities inherent in designing evaluation in a natural setting and of determining the general effectiveness and value of home visitation as a child protection and family support measure. Further research into the nature, qualities and limitations of volunteer based home visitation family support programmes is clearly warranted. While home visitation by trained volunteers is not proposed as the total answer for effective child protection or family support, the findings of the evaluation of this programme suggest that there is a place for similar programmes, tailored to the needs of particular communities as one of a range of services established to promote family health and well being. The development of similar programmes offers opportunities to further nurture and enhance positive relationships within and between families and the broader community. Programmes that serve to foster these relationships could serve to ameliorate the impact of social isolation and aloneness experienced by many families, and in this would clearly contribute to the social capital of our communities. This enhancement could contribute to minimising the effects of the suggested multiple correlates of child abuse and neglect. Programmes that promote family cohesion and inclusion in the broader society could surely contribute to a reduction in the long term misery and suffering that accompany child abuse and neglect.
References


Olds, D. L. (1992). *What do we know about home visitation as a means of preventing child abuse and neglect (Testimony prepared for The House Select Committee on Children and Families): Department of Paediatrics, University of Rochester, School of Medicine and Dentistry. Rochester.*


Appendices
Appendix 1.

Overview of training, support and supervision of volunteers
1. Volunteer training programme (four hours per week over five weeks)

<table>
<thead>
<tr>
<th>Aims/objectives of session</th>
<th>Content</th>
<th>Delivered by</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Week 1:</strong></td>
<td>Goals and services of the CCCP</td>
<td>Project co-ordinator</td>
</tr>
<tr>
<td>To understand the CCCP goals</td>
<td>Volunteers roles and responsibilities</td>
<td></td>
</tr>
<tr>
<td>To understand the role and responsibilities of a volunteer</td>
<td>Orientation to CCCP procedures</td>
<td></td>
</tr>
<tr>
<td>To clarify their interest and commitment to the CCCP</td>
<td>Co-ordinator's role</td>
<td></td>
</tr>
<tr>
<td><strong>Week 2:</strong></td>
<td>Child abuse and Families at risk</td>
<td>Project co-ordinator</td>
</tr>
<tr>
<td>To begin to understand the dynamics of child abuse</td>
<td></td>
<td>Director of Cottage Centre</td>
</tr>
<tr>
<td>To understand the role of the Cottage Centre</td>
<td></td>
<td></td>
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<tr>
<td>as an intervention programme and the role of the CCCP as a prevention programme in breaking the cycle of child abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Week 3:</strong></td>
<td>Overview of child development</td>
<td>Project co-ordinator</td>
</tr>
<tr>
<td>To have a basic understanding of the needs of parents and the child antenatally and post natally</td>
<td>Infant development, bonding and attachment.</td>
<td>Project co-ordinator</td>
</tr>
<tr>
<td>Labour and delivery</td>
<td></td>
<td>Macarthur Area Health Community</td>
</tr>
<tr>
<td>Infant stimulation</td>
<td></td>
<td>educators</td>
</tr>
<tr>
<td>Infant routines</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Week 4:</strong></td>
<td>Communication skills</td>
<td>Project co-ordinator</td>
</tr>
<tr>
<td>To understand the components of communication in order for the volunteer to communicate effectively with parents in person or by telephone</td>
<td></td>
<td>Director of Cottage Centre</td>
</tr>
</tbody>
</table>

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Week 5:
To have knowledge of community resources and what to offer that may be helpful to parents services

- Community networking
- The CCCP referral policies and procedures
- Closure and evaluation
- Project co-ordinator
- Exit agencies

2. Subsequent training:
Follow up training to further develop volunteer skills and knowledge and to respond to volunteers needs organised within monthly four-hour sessions, which included the following topics:

- Antenatal issues
- Post natal depression
- Post partum issues
- First Aid
- Fostering self esteem
- Child development - the first 12 months
- The importance of language and play for infants
- Injury prevention
- Domestic violence
- Grief and loss
- Babies born with disabilities
- Personal development a). Conflict resolution b). Stress management

3. Support and supervision of volunteers

All volunteers had access to the project co-ordinator at all times and in particular had monthly supervision (debriefing, family management, planning and resourcing) on a 1-1 basis and in monthly large group meetings/ get togethers.
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Appendix 2

South West Sydney Area Health Service questionnaire
(first time parent survey)
INFORMATION SHEET

FIRST TIME PARENT SURVEY

We are surveying first time parents who present to . Hospital, with the aim of working towards better service provision for these families.

We hope to interview all families that are expecting their first child, but for those families we are not able to interview we ask that you fill in the following questionnaire.

From the results of this survey we will be offering a selected number of families the opportunity to be part of a local pilot service:

"The Cottage Community Care Project"

Please Note

* If it is difficult to answer some of the following questions we will respect your right to leave them unanswered.

* None of the information from this survey will be used in an identifiable way for purposes other than this survey without your written consent.

FURTHER ENQUIRIES OR COMMENTS:

* Please contact . at Hospital on (Tuesdays, Wednesdays & Fridays).
Date: __________

NAME: __________________________________________

ADDRESS: ______________________________________

PHONE: ________________________________________

AGE: _______ WHEN IS YOUR BABY DUE __/__/____

QUESTIONNAIRE

Please [ ] appropriate box.

1. Marital Status:
   - Married [ ]
   - Single [ ]
   - Divorced [ ]
   - Separated [ ]
   - De Facto [ ]
     (How long have you been living together?) ______

2. Partner:
   - Employed [ ]
   - Unemployed [ ]

3. Income: What type of income do you or your partner receive?
   - Wages [ ]
   - Benefits [ ]
   - Pension [ ]
   - Other [ ]

4. Housing:
   - Purchasing own home [ ]
   - Private Rental [ ]
   - Dept. of Housing [ ]
   - Sharing with friends or other family [ ]
4. Housing (Cont.):
   How long have you been at your current address? ____________________
   How many people live in your house? ____________________

5. Do you have the telephone connected? [ ] Yes [ ] No

6. At what level did you leave school? ____________________
   Any further studies since? [ ] Yes [ ] No
   If yes, please outline. ____________________

7. Supports Available:
   a) Closest Family (excluding partner) (e.g. Mother, Father, Sister, Aunty, etc)
      ____________________
      * Are they available to support you following the birth of your baby? [ ] Yes [ ] No
   b) Do you have other support people available following delivery? [ ] Yes [ ] No

8. How often would you consume? Please circle.
   Alcohol: Daily Weekly Not Often Never
   Cigarettes: Daily Weekly Not Often Never
   Other drugs: Daily Weekly Not Often Never

9. Was your pregnancy Planned [ ]
    Unplanned [ ]

   How did you feel about being pregnant?
   ____________________
   ____________________
   ____________________

10. Have you had any terminations of pregnancy? [ ] Yes [ ] No
11. How many weeks pregnant were you when you made your first appointment with the clinic or doctor? 

12. Have you or your partner ever had treatment for a psychiatric illness? [ ] Yes [ ] No

13. Are there any problems in your family that particularly worry you?
   a) Relationship problems with:
      - partner [ ] Yes [ ] No
      - parents [ ] Yes [ ] No
      - other family members [ ] Yes [ ] No
   b) Constant argument: [ ] Yes [ ] No
   c) Violence in family: [ ] Yes [ ] No
   d) Financial problems: [ ] Yes [ ] No

14. a) Circle those words which best describe you:
    content loved powerless anxious
    unhappy valued confident
    frustrated helpless worthless coping
    depressed scared excited angry

   b) How do you feel about yourself at the moment?
    Mark on the scale below where you feel you are at:

    0 5 10
    very 0.K very
    negative positive
15. For the family of a newborn, the rewards and demands of parenthood are endless! There will be ups and downs and many unanswered questions.

There is an opportunity for some first time parents to become involved in a pilot project, The Cottage Community Care Project, that is looking at various ways of helping new parents.

If you are lucky enough to be selected would you be agreeable to us forwarding your name, address and telephone number to the project coordinator who will contact you with further information.

[ ] Yes

[ ] No

Signed: ...........................................

..............................................

Thank you for participating in this survey.
Appendix 3
Parenting Readiness Checklist
Parenting: Readiness Checklist - Parenting Feedback Risk Assessment

The following factors form part of a list of factors, adapted from Dean & Robinson's (1984) Scale of Family Functioning.

For a first-time mother presenting at Campbelltown Hospital, or at Campbelltown Community Health Centres.

Please complete referral to Project Co-ordinator if:

a) 2 or more factors are checked

and b) if any of the following numbers are checked: (1), (10), or (11).

1. Marital status; single/divorced/separated: ____________________________

2. Husband Unemployed ____________________________

   (Husband means spouse, partner, or any male to be involved with mother and baby in such capacity.)

3. Inadequate Income/financial Stress: ____________________________

4. Unstable Housing: ____________________________

   (No home or uncertain of having home or questionable address.)

5. No Telephone: ____________________________

6. Education under 12 years: ____________________________

7. Inadequate Emergency Contacts ____________________________

   (Means no immediate family, parents or sibling listed for emergency contact.)

8. History of Substance Abuse ____________________________

   (Means excessive use of drugs or alcohol)

9. Unwanted Pregnancy ____________________________

10. History of Abortions ____________________________

    (Means more than one ITOP within twelve months of current pregnancy or more than two ITOPs ever.)

11. Late Prenatal Care or No Prenatal Care ____________________________

    (Late prenatal care is after 12 weeks of pregnancy.)

12. History of Psychiatric Care ____________________________

13. Marital or family problems ____________________________

    (Refers to any indication of discord among family members as relevant to the patient to include boyfriend or father of the baby; history of family violence; include arguments.)

14. Low self-esteem ____________________________

    History of/or currently depressed ____________________________

15. Mother 19 Years and under ____________________________
Appendix 4

Family Stress Checklist
# Implementation of a Family Stress Checklist

(Questions are not asked in any order, nor are all questions necessarily asked of each client.)

**1. Parent beaten or deprived as a child.**

- How did your parents treat you when you were a child? 

- How did your parents get you to behave when growing up? 

- Did both parents treat you the same? 

- Was the treatment fair? 

- Who are you living with now? When a child? 

- Do you want to raise you child differently than you were raised? 

- Were your brothers and sisters treated the same as you were? 

- Did your parents treat you differently when you became a teenager? 

**2. Parent has criminal or mental illness history (category used for mental breakdown as well as transient situational stresses).**

- Have you ever seen a counsellor before? 

- Did you have any problems in school? (Did you see a school counsellor?) 

- Have you had any contact with other agencies, eg: mental health, welfare, legal? 

- Tell me about your partner - are you together? What type of work does he do? (Pay particular attention to issue of how he gets to work, driver's license? police involvement? If wife/girlfriend describes her partner's behaviour as weird, ask if he has ever had any treatment for that.) 

- Was there anyone who took a particular interest in you when you were growing up? 

- Do you/your partner drink? Is that a problem?
3. Parent suspected of abuse in the past.
- How do you discipline a child? ____________________________________________
- Do you have any problems getting a child to co-operate? __________
- Does your partner agree with you that "Johnnie" has/does not have a problem? __________________________
- Have you ever seen a social worker/been to a social agency about the behaviour problem (give egs: School social worker, mental health, welfare)? __________
- How do you handle the situation when you get mad at a child? _______________
- Did you baby-sit when you were younger? _________________________
- (If patient is a step-parent) How was it to become a "parent" overnight? _____________

4. Parent with low self-esteem, social isolation, or depression.
- If you were not talking to me about your concerns, who would you be talking to? (Observe general appearance: Does client look sad or at a loss to talk?) ____________________________________________
- With whom do you spend most of your time? ____________________________
- What do you do for fun? _____________________________________________
- Do you like the way life is going for you? _____________________________
- What is a typical day like for you? ____________________________________
- Do you think you/your partner will be a good mother/father? Do you think you/your partner is a good father/mother? __________________________
5. **Multiple crises or stresses.**

- Who is in the home? Does everyone get along? How are things going for you? (Observe client's interaction in the clinic with child / other parents/professional staff.)

- How does your partner feel about this pregnancy?

- Does your living situation work for you? (Observe types of requests client makes of staff, eg. emergency food order, housing emergencies, clinic walk-in with sick child.)

- What is most stressful in your home?

6. **Violent temper outbursts.**

- When you/your partner get angry, what do you do?

- What does your partner do when you get angry?

- What do you do when he gets angry?

- Do you have a bad temper? And your partner?

- Do you find you and your partner hitting each other when you get angry?

- What happens in your home when you/your partner drink too much?
   - How is co-operation handled in your home? ____________________________
   - If interviewing while children in playroom or office are screaming, ask client what the screaming of kids does to her. ____________________________
   - Do you feel you know enough about how children grow and develop? ____________________________
   - Would you like to know more about raising children? (It is difficult to imagine what it will be like caring for a newborn if one has never had the experience.) ____________________________
   - Who has talked to you about raising children? ____________________________
   - What would you do if a child you were caring for began to cry? ____________________________

8. Harsh punishment of child.
   - How do you discipline your child? ____________________________
   - Do you or your partner use the same methods to get your child to co-operate? ____________________________
   - Are you satisfied with the discipline methods you use? ______
   - What is the most important thing in raising a child? ____________________________
   - Do you want to raise your child differently than you were raised? What changes have you made? ____________________________
9. Child difficult/provocative, or perceived to be by parents.
   - Is your child difficult to handle? (Observe mother’s interaction with the child.)
   - What does your child do that irritates you? Do you think he does that on purpose?
   - In what ways is your partner involved with your child (children)?

10. Child unwanted or at risk for bonding.
   - Was this pregnancy planned?
   - Do you want to be a mother/father?
   - How is life going to be different once this baby is born? Are you making plans for those changes?
   - Have you baby clothes? Thought of names?
   - Do you own maternity clothes?
   - When did your partner/family find out you were pregnant?
   - If you were not pregnant now, what would you be doing?
   - What had you been planning for yourself for next year?
Rating Scale
for
Family Stress Checklist

# 1: Parent beaten or deprived as a child.

NORMAL:

a. No corporal punishment.

b. Infrequent spankings (less than 6 times ever with hand, belt, stick, etc. which left no marks or only lasting up to an hour or so.

c. Received consistent nurturing.

Rate as MILD if one or more applies.

MILD:

a. Frequent spankings with or without some bruises.

b. Received intermittent nurturing.

c. Sibling with history of (a) or (b).

d. Witnessed spouse abuse of parents.

Rate as SEVERE if one or more applies.

SEVERE:

a. Severe beatings, including bruising if lasting for days.

b. Raised by more than 2 families.

c. Raised by one or more families but with no nurturing parent model.

d. Bizarre psychological abuse, eg made to eat in garage or doghouse.

e. Hx of running away from home.

f. Constantly scapegoated as "black sheep" of family.

g. Hx of sexual abuse.

h. Removed from home or abandoned.
# 2: Parent with criminal / mental illness / substance abuse.

**NORMAL:**

- a. No arrests or ONE TIME mild offence, eg teenaged shoplifting or stealing a car. DO NOT include any crime against a person.
- b. No drug use.
- c. ONE TIME experimental use of any drug.
- d. No alcohol use or occasional use up to 1 drink / day if this is not seen as a problem by family (if seen as a problem, rate as MILD).
- e. Occasional drunkenness up to 1/month if NOT seen as problem by family (if seen as problem, rate as MILD).
- f. Never required psychiatric care.

Rate as MILD if one or more applies.

**MILD:**

- a. More than one minor traffic violation or record of minor juvenile or adult crime (speeding, minor theft).
- b. Any drug use more than 1x (rate as SEVERE any drug use during pregnancy.
- c. Drinking regularly with more than 1 drink/day or drunkenness more than once a month (if seen as problem, rate as SEVERE).
- d. Hx of or currently seeing psychiatrist / psychologist for minor life crisis, eg. counselling to improve life, rather than therapy for psychiatric problem.
- e. Parent demonstrates ongoing rehabilitation (for more than 2 years) but with history of:
  - * Severe mild offences / arrests
  - * Crime against a person, eg assault and battery, armed robbery
  - * Prison term
  - * Heavy drug use
  - * Alcoholism or heavy drinking
  - * Mental hospitalisation or long-term psychiatric care.
# 2: Parent with criminal/mental illness/substance abuse (Cont'd)

Rate as SEVERE

if one or more applies.

SEVERE:

a. Chronic pattern of criminal activity.

b. Current or recent prison term (within last 2 years), driving under influence of alcohol or hx of theft, burglary, felonies, prostitution.

c. Chronic/heavy use of any drug, including marijuana.

d. History of recurrent episodes of heavy drug use, even if not currently using, eg, heroin addict, now reformed and returned to heroin in the past.

e. Any drug use at any time during pregnancy, whether know about pregnancy or not.

f. Current chronic heavy drinking / alcoholism.

g. History of recurrent episodes of alcoholism, even if presently "dry".

h. ANY drinking/drug use, regular or occasional, which results in violent episodes.

i. Current indications and/or diagnosis of psychosis, eg, medication prescribed by psychiatrist or hx of hospitalisation.

j. Chronic pattern of psychiatric problems.

k. History of diagnosed schizophrenia or sociopathic behaviour.
# 3: Parent suspected of abuse in the past.


MILD: a. Official report of mild abuse; children not placed in foster care or removed from home.
b. Chronic use of illicit drugs with children present but not where parents are "out of it".
c. Abuse suspected, but not confirmed.

b. Mysterious death of sibling.
c. Children placed in foster care / removed from home.
d. Child allowed to use any illicit drugs (ever).
e. Child present with adult use of any substance where parent is unable to care for child due to intoxication.
f. Child abuse suspected in previous marriage for either parent.

Rate as SEVERE if one or more applies.
# 4: Parent with low self-esteem, social isolation, depression, no lifelines.

**NORMAL:**

a. Close to at least 1 family member, ie: sees regularly and/or can and does call on them for serious problems.
b. Happy and content with life at present.
c. Sees and enjoys other people regularly.
d. Parent can name more than one lifeline and will actually use them.
e. Parent has phone and transportation.

**MILD:**

Rate as MILD if **two or more apply.**

a. Not close to family with no hostility.
b. Discontent with life but sees this as temporary.
c. Sees and enjoys other people at least once a week.
d. Parent can name one lifeline only and will actually use it.
e. Parent has no phone w/hone available and/or no transportation.
f. Not high school graduate.
g. Parent expresses difficulty in coping with life stresses.
h. Late Prenatal care.

**SEVERE**

Rate as SEVERE if **one or more applies.**

a. Not close to family with hostility.
b. Very unhappy or depressed with life and sees this as permanent, or does not see immediate end to situation.
c. Rarely sees other people or no enjoyment.
d. Parent can name no lifeline.
e. Parent can name a lifeline but will not actually use it.
f. Parent will not "burden" anyone with problems, feels has to handle by self.
g. Parent unable to cope with life stresses.
h. Hx abuse of childhood abuse/neglect without resolution.
i. Hx of lifestyle (eg, prostitution) or expressions of low self-esteem.
j. No prenatal care.
# 5: Multiple crises or stresses.

**NORMAL:**
- a. Parent can name nothing that is stressful.
- b. Parents argue occasionally but soon resolve without violence and do not see this as a problem (if seen as problem rate as MILD).
- c. Finances are not a big problem for family, although they may not have "enough" money.

**Rate as MILD if two or more apply or if one listed under SEVERE applies.**

**MILD**
- a. Parents argue frequently without violence and do not see this as problem (if seen as a problem rate as SEVERE).
- b. Parents argue occasionally without violence but see this as stressful.
- c. Finances are "tight" but parent feels (s)he can "manage".
- d. Recent loss of loved one who did not serve as lifeline.
- e. Recent change of job, with history of good work stability.
- f. Recent move, but previously in one place more than 1 year.
- g. Living situation seen as inadequate but not stressful by family.
- h. One separation with no current threat of divorce.
- i. Multiple crises with which parent demonstrates good coping and does not feel overwhelmed.

**Rate as SEVERE if two or more apply.**

**SEVERE**
- a. Parents constantly in conflict with or without violence.
- b. One parent very afraid of other parent.
- c. Finances cause too much stress to parent.
- d. Chaotic lifestyle with continual crises which parent feels unable to handle.
- e. Multiple separations and/or threat of divorce.
- f. Recent loss of loved one who served as lifeline.
- g. Frequent job changes.
- h. Frequent moves.
- i. Living situation seen as stressful by parents (eg. temporary, overcrowded, conflicts).
- j. Any other stress parent mentions which is constantly present in his/her life and with which (s)he is unable to cope or doesn’t see hope of escape.
# 6: Violent Temper Outbursts.

**NORMAL:**
- a. No violence.
- b. Yelling / screaming / leaving when angry.

Rate as MILD if **one or more** applies.

**MILD:**
- a. Parent throws things when angry, but not at people.
- b. Parent pushes or gives slaps when angry, (not more than once in past 2 years).

Rate as SEVERE if **one or more** apply.

**SEVERE:**
- a. Parent hits, kicks when angry to leave lasting marks, eg. bruises, black eye.
- b. Parent has history of violent behaviour to others, eg. assault/murder.
- c. Parent throws things at people.
- d. Parent breaks up house in uncontrollable rage.
- e. One parent is afraid of violence in spouse, though no hx of violence.
RATING (Cont'd)

# 7: Rigid and unrealistic expectations of child.

NORMAL:

a. No information, but shows concern, eg: has books, plans to ask doctor.
b. Expects walking between 9-15 months but will not worry until 15 months or later.
c. Expects toilet training between 1 - 1 1/2 but will not worry until 2 years.
d. Will pick up crying baby or expresses concern regarding possible illness.
e. Shows concern for physical and emotional needs of baby.

Rate as MILD if one or more applies.

MILD

a. Any expectation of walking earlier than above but without rigidity, ie: this is not essential to parent.
b. Any expectations of toilet training earlier than above but without rigidity, as in "a".
c. Any expectations of walking/toilet training unreasonably beyond normal, eg: walking at 4 years (may be indications of parent unwilling to or unable to detect serious development lags).
d. Worries about spoiling the baby but tolerant of normal annoying behaviour.
e. Will let baby cry for up to 1/2 hour but expresses concern for needs of baby.
f. Fear of being unsuccessful parent.

Rate as SEVERE if one or more applies.

SEVERE:

a. Any RIGID expectation of walking/toilet training earlier than above, ie: this is VERY important to parent.
b. Intolerance of normal annoying behaviour or excessively concerned about spoiling.
c. Parent says (s)he or spouse cannot stand crying baby and will become angry with same.
d. Parent expresses NO concern for needs of baby.
e. Parent will not check on or be concerned regarding baby crying longer than 1/2 hour.
f. Parent was abused as child and sees this as justified or as right way to discipline.
g. Parent feels that infants and children intentionally misbehave out of malice and must be dominated to ensure "respect".
h. Parent has no information, and has no plans, to acquire information.
# 8: Harsh Punishment of Child.

A. For Early Identification purposes, baby up to 2 months:

NORMAL: a. None.

MILD: a. Yelling at baby under 2 months.

Rate as SEVERE if one or more applies.

SEVERE: a. Physical punishment of baby prior to crawling.
b. Shaking of baby.
c. Other dangerous punishment of older children.

B. For discharge purposes or respite intake child under 5 years.

NORMAL: a. Physical punishment not used, or used as secondary strategy to withdrawal of privileges and 'time out'. When child is punished physically, no implements (spoon, paddle, stick) used.

Rate as MILD if one or more applies.

MILD: a. Occasional use of physical punishment. Implements used but not in the head or spinal column area and with no bruises or lasting marks.

Rate as SEVERE if one or more applies.

SEVERE: a. Physical punishment alone used for infants, with no restraints as to implement used or duration or severity of blows, bruises or lasting marks.
RATING (Cont'd)

# 9: Child difficult and/or provocative or perceived to be by parents.

**NORMAL:**

a. Not present.

b. Child's behaviour viewed as normal part of growth process.

**MILD:**

a. Baby is wakeful, colicky, irritable or so perceived by parents.

b. Baby seen as sometimes difficult but positives also mentioned.

**SEVERE:**

a. Baby behaviour seen by parents as provocative, eg. "he wants to make me angry so he cries".

b. Baby seen as having no good points.

c. Baby is constantly difficult, or so perceived by parents.

d. Baby seen as deserving of physical punishment.

Rate as MILD if one or more applies.

Rate as SEVERE if one or more applies.
# 10: Child unwanted or at risk for poor bonding.

**NORMAL:**
- a. baby is very much wanted, whether planned or unplanned.
- b. Parent displays warmth when talking about baby.
- c. Childrearing looked upon as positive life change.

**MILD:**
- a. Baby is wanted but is premature.
- b. Parent initially wanted an abortion or adoption but now feels positive with changes being made in lifestyle to accommodate new addition to family.
- c. Single parent family.
- d. Prolonged separation of parents (eg longer than one week).

**SEVERE:**
- a. Baby is unwanted, eg, not coming at a good time in parent's life and parents unsure if able to handle situation.
- b. Parent is ambivalent about baby.
- c. Baby MUST have certain characteristics if parent is going to love it, eg, certain sex, looks, personality, etc.
- d. Parent is not natural father of baby, whether or not he states that he wants a baby.
- e. Baby seen as a burden on lifestyle.
- f. No positive statements made about pregnancy or child rearing.
The Cottage Community Care Programme

(Based on the family Stress Checklist Health Start Reporting Form.)

* Grade questions 1 - 10 for mother and father (or significant other):

- Not Present (Normal) = 0
- Mild = 5
- Severe = 10

Place number selected in blank space provided.
The numeric maximum high risk raw score a parent can receive is 100. Only one high risk parent is required to put a family at high risk.

If a category is not applicable then place 'N/A'.
If a category is not known then place 'U'.

At completion of checklist add total score.
Appendix 5  Scale of Family Function
# The Cottage Community Care Project
## Scale of Family Functioning
*(J. Dean & C. Robinson, 1984)*

<table>
<thead>
<tr>
<th>Interpersonal Issues</th>
<th>Adequate</th>
<th>Marginally Adequate</th>
<th>Moderately Impaired</th>
<th>Seriously Impaired</th>
<th>Critically Impaired</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Supports</strong></td>
<td>-positive social network available and utilised by family</td>
<td>-need help in identifying increased support. -ability to utilise available help. -new to community and need information on community resources.</td>
<td>-has need for help in learning how to use supports. -the supports available are used sporadically or are unpredictable. -inadequate number of supports.</td>
<td>-not able to identify any consistent helping person. -contacts are often critical. -family has very diminished capacity to establish relationships that can offer help.</td>
<td>-contacts with others practically nonexistent. -contacts are abusive in nature. -need remedial work in learning how to reach out. -minimal capacity to establish relationships.</td>
</tr>
<tr>
<td><strong>Family Conflict/Stress and Coping</strong></td>
<td>-conflicts are met with positive coping style; talking, ability to express feelings constructively. -no concern for safety of individuals.</td>
<td>-conflicts met with confusion. -uncertainty in how to express feelings. -some difficulty in identifying alternatives. -in general, conflict does not impact problem solving capacity. -good ability to anticipate crisis. -no concern for safety of individuals.</td>
<td>-conflicts met with inadequate/negative coping; withdrawal, denial, yelling, flight, somatic complaint. -family members are unpredictable in ability to communicate and identify alternatives. -problem solving is sporadic; not a reliable channel in anticipation of crisis. -some concern for safety of individuals.</td>
<td>-conflicts met with more extreme negative coping behaviours; drug/alcohol dependency, throwing things, little impulse control. -little meaningful communication between family members, either very distant or enmeshed situation. -little ability to solve problems or anticipate crisis. -great concern for safety of individuals.</td>
<td>-conflicts met with extreme violent outbursts, severe regression. -coping primarily by being physically abusive or sexually acting out. -no ability to anticipate crisis; family moves from one crisis to another. -grave concern for safety.</td>
</tr>
<tr>
<td><strong>Self Esteem</strong></td>
<td>-exhibits pride in accomplishments, past and present. -little self doubt, able to accept praise.</td>
<td>-acknowledges past accomplishments, reluctant to take pride in present. -has some self doubt around abilities but responds to praise</td>
<td>-reluctant to take pride in past or present accomplishments. -has self doubt and difficulty accepting praise</td>
<td>-unable to identify positive qualities in self. -cannot accept positive statements or empathy</td>
<td>-sees self as bad, evil. -signs of major depression /suicidal impulses.</td>
</tr>
<tr>
<td>Confidence</td>
<td>Adequate</td>
<td>Marginally Adequate</td>
<td>Moderately Impaired</td>
<td>Seriously Impaired</td>
<td>Critically Impaired</td>
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<tr>
<td>rent-Infant</td>
<td>-positive aspects in infant identified with self.</td>
<td>-ability to identify some positive self aspects of infant.</td>
<td>-identifies some negative things in self with infant.</td>
<td>-sees many of own negative qualities in infant.</td>
<td>-no ability to tolerate ones own negative qualities in infant.</td>
</tr>
<tr>
<td></td>
<td>-no role confusion.</td>
<td>-clear role definition.</td>
<td>-under stress demonstrates need to have infant become care giver.</td>
<td>-often distorts role of infant and parent.</td>
<td>-extreme distortion of roles.</td>
</tr>
<tr>
<td></td>
<td>-has basic sense of confidence; knows what to do in most situations.</td>
<td>-experience some awkwardness and has many questions and concerns.</td>
<td>-anxiety leads to frequent calling of professionals.</td>
<td>-highly anxious about parenting abilities, which blocks ability to follow past solutions.</td>
<td>-experiences severe inadequacy manifested by apathy, depression, abusive behaviour of infant or withdrawal.</td>
</tr>
<tr>
<td>Meeting basic needs</td>
<td>basic needs met with stable income and adequate housing.</td>
<td>-income stable but family feels it is stretched with the demands of having infant.</td>
<td>-income not stable or adequate.</td>
<td>-income has been unstable and inadequate for prolonged</td>
<td>-no predictable income.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-basic needs are met with some difficulty.</td>
<td>-inadequate housing, considering need to move.</td>
<td>-family has frequent moves.</td>
<td>-may lead vagrant life with no established residence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-housing adequate.</td>
<td>-demonstrate poor judgement around decisions with money, food, housing - however this is available.</td>
<td>-numerous back bills.</td>
<td>-food often unavailable for parent and baby.</td>
</tr>
<tr>
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<td>-utilities threatened: heat, electricity, etc.</td>
<td>-may exhibit long term pattern of severe instability.</td>
</tr>
<tr>
<td>Expectations</td>
<td>-parents demonstrate age-appropriate expectations.</td>
<td>-unsure of age-appropriate expectations.</td>
<td>-expectations for infant are inappropriate for age; somewhat high or too low.</td>
<td>unrealistic expectations; too high or too low.</td>
<td>-highly unrealistic expectations, distorted view of infant.</td>
</tr>
<tr>
<td></td>
<td>-demonstrate flexible thinking in relation to infant.</td>
<td>-flexibility in thinking.</td>
<td>-has somewhat rigid image of what infant will be like.</td>
<td>-rigid thinking.</td>
<td>-may experience delusional thought in relation to infant.</td>
</tr>
<tr>
<td>Parent-Infant Issues</td>
<td>Adequate</td>
<td>Marginally Adequate</td>
<td>Moderately Impaired</td>
<td>Seriously Impaired</td>
<td>Critically Impaired</td>
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<tr>
<td><strong>Affective Relationship</strong></td>
<td>-mother/father infant enjoy each other.</td>
<td>-enjoyment of infant.</td>
<td>-sporadic enjoyment of infant.</td>
<td>-very poor timing observed.</td>
<td>-no enjoyment of infant.</td>
</tr>
<tr>
<td></td>
<td>-smooth, rhythmical style present- create a social &quot;dance&quot;.</td>
<td>-unsure of how to engage with baby.</td>
<td>-mother inconsistent, not in sync, at times intrusive.</td>
<td>-little fit between the two.</td>
<td>-highly intrusive, interaction sadistic.</td>
</tr>
<tr>
<td></td>
<td>-playful interaction pervades relationship with contributions from both.</td>
<td>-there exists periods of time where rhythm of interaction is present, but is at times sporadic.</td>
<td>weak cues given by infant or cues given are missed,</td>
<td>-at times, a &quot;teasing&quot; quality to interaction.</td>
<td>-parents exhibit extreme hostility or rage with infant.</td>
</tr>
<tr>
<td></td>
<td>-soothing occurs predictably and effectively.</td>
<td>-soothing of baby is sometimes difficult.</td>
<td>-success with soothing is unpredictable and creates concern.</td>
<td>-cues missed on a consistent basis.</td>
<td>-infant may be impaired or exhibiting withdrawal, lack of weight gain.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-infant may be impaired or playtime with infant.</td>
<td>-soothing not attempted.</td>
</tr>
<tr>
<td><strong>Sensitivity to Care-taking Functions</strong></td>
<td>-awareness of basic needs of infant re: food, comfort, etc - anticipates needs beforehand.</td>
<td>-uncertainty in responding to infants cues, but consistently responds.</td>
<td>-inappropriate delays in caring of infant.</td>
<td>serious avoiding of caretaking role, relinquishes this to inappropriate others.</td>
<td>relinquishment of all caretaking so that infant is in grave danger.</td>
</tr>
<tr>
<td></td>
<td>-reads cues of infant and responds appropriately in feeding.</td>
<td>-becomes flustered around demands but is able to meet demands of infant in timely way.</td>
<td>-response to needs disorganised, sporadic, often does not know what to do.</td>
<td>-often does not respond, or response is highly unpredictable.</td>
<td>-infant experiences little or no response to needs - gross insensitivity to needs.</td>
</tr>
<tr>
<td></td>
<td>-displays empathy for infant's discomfort and has ability to delay own needs.</td>
<td>-anticipates needs beforehand.</td>
<td>-poor anticipation of infants needs.</td>
<td>-allows infant to go unchanged or crying for hours.</td>
<td>-response is physically abusive.</td>
</tr>
<tr>
<td></td>
<td>-no concern for safety of infant.</td>
<td>-no concern for safety of infant.</td>
<td>-some infant hazards and concerns felt.</td>
<td>-sees infant demands as punishing - has impulse to abuse.</td>
<td>-professional experiences grave concern for infant safety.</td>
</tr>
</tbody>
</table>
THE COTTAGE FAMILY CARE CENTRE

The Cottage Community Care Project
POST OFFICE BOX 357, CAMPBELLTOWN N.S.W. 2560 • TELEPHONE (046) 281855

A Community Programme working to enhance and enrich the parenting experience.

THE COTTAGE COMMUNITY CARE PROJECT

CLIENT QUESTIONNAIRE

Date: ..................................

The following information is required as part of the Cottage Community Care Project Evaluation, and we would really appreciate if you would answer the following questions. For some of you who have not yet had your babies, please answer only those questions that are applicable to you. Your participation and co-operation is highly regarded with this valuable project.

At all times we respect your privacy and therefore the information will not be used in any way that identifies you.

Please return this questionnaire in the self-addressed stamped envelope, as soon as possible.

If you have any queries do not hesitate to contact me on telephone no. 281855.

Regards,

Jacquie Leabeater
Project Co-ordinator

An activity sponsored by the Campbelltown Uniting Church.
1. Client ID
   Baby’s Date of Birth (i) (ii)

2. Schooling:
   At what age did you leave school? ........................................
   Did you require assistance in any of the following areas at school?

<table>
<thead>
<tr>
<th></th>
<th>Level at School</th>
<th>Duration (in months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remedial Classes</td>
<td></td>
<td></td>
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<tr>
<td>English as a Second Language</td>
<td></td>
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<tr>
<td>Special School</td>
<td></td>
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<tr>
<td>Other: Please specify below:</td>
<td></td>
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</tr>
</tbody>
</table>

3. Throughout your pregnancy did you:

   Smoke
   Drink

   Yes/No
   Yes/No

   If yes to either please give the following information:

   Alcohol: No. of glasses  ..... Daily  ..... Weekly  Not Often
   Cigarettes: No.  ..... Daily  ..... Weekly  Not Often
   Other Drugs  ..... Daily  ..... Weekly  Not Often
4. Were there any problems during your pregnancy including gestational diabetes, iron deficiency, high blood? Please indicate.

5. Since the birth of your baby have you:
   - Smoked
   - Drank
   - Yes/No
   - Yes/No

   If yes to either, how often would you consume?
   - Alcohol: No. of glasses
   - Daily
   - Weekly
   - Not Often
   - Cigarettes: No.
   - Daily
   - Weekly
   - Not Often
   - Other Drugs
   - Daily
   - Weekly
   - Not Often

6. Did you have your six week check-up after the birth of your baby? Yes/No

7. Breast feeding:
   a. Did you plan to breastfeed? Yes/No
   b. Did you breastfeed? Yes/No
   c. For how long did you breastfeed (in weeks)?

8. Were there any health problems for you after the birth, including post natal depression, baby blues, excessive bleeding, colds, flu, etc?
   If yes please comment?

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Duration</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
9. Since the birth of your baby have you been on any form of contraception? Yes/No
If yes, please comment.

10. In the last twelve months have you had a
    Pap smear? Yes/No
    Breast check? Yes/No

11. Since the birth of your first baby have you had another baby? Yes/No

12. Are you pregnant now? Yes/No

13. Have there been any significant changes in your life since your involvement with the Cottage Community Care Project including:
    marital status/relationships
    housing
    financial status etc

    Please outline these changes below:
    ........................................................................................................
    ........................................................................................................
    ........................................................................................................
    ........................................................................................................
    ........................................................................................................

14. Please tick the appropriate columns below to indicate which of the following immunisations your baby has had, and who gave it.
<table>
<thead>
<tr>
<th>By G.P.</th>
<th>Immunisation Clinic</th>
<th>Age of baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Polio Vaccine (Sabin) Triple Antigen</td>
<td></td>
<td></td>
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<tr>
<td>☐ Polio Vaccine (Sabin) Triple Antigen</td>
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<tr>
<td>☐ Polio Vaccine (Sabin) Triple Antigen</td>
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<tr>
<td>☐ Measles/Mumps/ Rubella</td>
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<tr>
<td>☐ Triple Antigen</td>
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<tr>
<td>☐ C.D.T. and Polio Vaccine (Sabin)</td>
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<tr>
<td>☐ Hepatitis B</td>
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</tbody>
</table>

15. At what age in months did your baby commence pureed food?

16. Please indicate below, whether you and/or family (including baby) have attended any of the following services. For the columns "Who" and "Referral Type" please use the keys below:

<table>
<thead>
<tr>
<th>WHO</th>
<th>REFERRAL TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S = Self</td>
<td>S = Self</td>
</tr>
<tr>
<td>P = Partner</td>
<td>C = Cottage Project</td>
</tr>
<tr>
<td>B = Baby</td>
<td>A = Other Agency</td>
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<tr>
<td>F = Family</td>
<td></td>
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</tbody>
</table>

Referral No of

<table>
<thead>
<tr>
<th>Antenatal Clinic</th>
<th>Yes</th>
<th>No</th>
<th>Who?</th>
<th>Type</th>
<th>Visits</th>
<th>Issue</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Classes</td>
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<td>Financial Services</td>
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<td>Housing</td>
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<tr>
<td>Respite Care</td>
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<td>Family Support Services</td>
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<tr>
<td>Specialised Counselling</td>
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<tr>
<td>Young Mothers Groups</td>
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<tr>
<td>Cottage Project Coffee Mornings</td>
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<td>Immunisation Clinic</td>
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<tr>
<td>Early Childhood Clinic</td>
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<td>G.P's</td>
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<td>Obstetrician/ Gynaecologist</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>Who?</td>
<td>Type</td>
<td>Visits</td>
<td>Issue</td>
<td>Outcomes</td>
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<td>Paediatrician</td>
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<td>Cottage Family Care Centre</td>
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<td>Jasmine Cottage</td>
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<td>Sydney City Mission</td>
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<td>Occupational Therapy</td>
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<td>Physiotherapy</td>
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<tr>
<td>Other (please specify below):</td>
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</table>

17. Would you please indicate whether you or any member of your family attended any of the following since the birth of your baby:

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Who Attended</th>
<th>Length of Stay in Days</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S=Self P=Partner B=Baby</td>
<td>Why</td>
<td></td>
</tr>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>Kartane/ Tressilian</td>
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<td>2.</td>
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</table>
18. Department of Community Services - Has this Department been involved with the family since participating in this programme?
   Yes/No

   If yes, in what way?

Thank you very much for completing this form. Your attention to this will help to complete this part of the Programme's evaluation.
Appendix 7

Exit interviews with volunteers
EXIT DISCUSSIONS WITH VOLUNTEERS

Discussions were held between the Coordinator and the five volunteers who chose to withdraw their involvement as a Volunteer support person in the CCCP, and whose reasons were pertaining to the CCCP not being appropriate.

The focus of these discussions was to ascertain from each volunteer, their perception as to why the CCCP was not appropriate in meeting their needs.

Whilst the reasons for the remaining volunteers who left the programme were in large self explanatory it was considered that clarification be sought from these five volunteers.

VOLUNTEER 1:

The volunteer was matched with her client and very quickly an appropriate supportive role was established, to help this mother in the early stages of parenthood. Due to the fact the mother was presenting with some Post Natal Depression symptoms the volunteer spent a significantly more amount of time with the mother and baby to essentially provide the much needed emotional support and practical assistance. However the mother was also experiencing some interpersonal relationship problems with her partner and his family and after only a couple of months involvement with the CCCP, she made a choice to leave the Local Government Area, to move closer to the support of her own mother.

It was very disappointing for the volunteer who obviously felt that she had invested a lot of time and energy with this young mother. However both the volunteer and the mother parted knowing that the mother could always contact the volunteer if needed.

Shortly afterwards the Coordinator made arrangements for the volunteer to be matched to another mother but at this point the volunteer made a decision to withdraw her involvement. She said she felt that she could not be assured that a similar relationship would not develop where as a result it consumed a lot of her emotional wellbeing. Whilst the Coordinator did spend some time with the volunteer helping the volunteer through some of these issues her decision to withdraw remained the same.
Through circumstances, some followup with this volunteer was achieved and she was able to report that, to this present day the relationship between the volunteer, the mother and her infant, have remained solidly intact. Whilst the mother remained out of the LGA phone contact was established and then later on when the mother returned to the Campbelltown area, home visits resumed and a close supportive relationship was reestablished.

VOLUNTEER 2:

This particular volunteer who was matched with her family for just under three months, had difficulty maintaining the CCCP protocols around boundary setting. There had been considerable emphasis placed on this issue in the CCCP Core training. Some further discussions were held between the Coordinator, Cottage Director and the volunteer and given the concerns raised with this volunteer it was considered that she would benefit from some more direct supervision. The volunteer became a volunteer in the Cottage Child Care programme where the Child Care workers were able to support her more closely in her role as volunteer. This volunteer has remained in the Child Care programme for around 12 months and has consistently developed her skills and on occasions has gained employment as relief staff in the capacity of an untrained assistant.

VOLUNTEER 3:

The third volunteer had completed her training and appeared very enthusiastic about becoming a CCCP volunteer. During the Core training she presented as having developed a very positive approach in working with the families and was able to demonstrate a very non judgemental approach.

The Coordinator believed she had the skills necessary in working with a "High Risk" family. Consequently the Coordinator discussed with the volunteer a proposed family. At this point the volunteer became increasingly anxious about becoming a Home Support person and made a very quick decision to withdraw. The Coordinator made several efforts to encourage her to stay on, and be linked to a lower risk family. However despite these efforts the volunteer chose to exit, and said her family situation had changed and she would need to give the matter due consideration. No further contact was made.
VOLUNTEER 4:

This volunteer was introduced to a mother in the antenatal period and given that the mother continued to work throughout her pregnancy the establishment of this relationship relied heavily on phone contact. However given the lack of availability of this mother this was very frustrating for the volunteer, but she did persevere. By the time the infant was born the volunteer had become very disallusioned about her role and in fact had lost heart. Additionally, at this stage, the mother was saying she did not feel that she required the support of a volunteer and that it would be difficult anyway as she would be returning to work.

The Coordinator was able to empathise with the Volunteer as to her feelings of rejection, not being needed etc but encouraged her to believe in the programme's aims to support families.

Clearly the mother initially believed that she would require lots of added support given that the pregnancy was more like a miracle due to gynaecological problems. However as time progressed she was able to come to terms with the pregnancy and was obviously getting the support she needed from family, partner and friends.

Following this experience the Volunteer appeared to lack the confidence needed to go ahead with another mother at this stage. She suggested that if she reconsidered she would advise the Coordinator.

No further contact was made.

VOLUNTEER 5:

This last volunteer was matched for a short period but due to time constraints and transport limitations found the match to be unsuitable. Adding to these difficulties this particular mother had no telephone which made it difficult for the volunteer to confirm appointments. Consequently the volunteer would become angry when she would arrive for a visit and the mother was not there.

She was willing to be placed with a mother in a location close to a bus route. This transport limitation made it very difficult for the Coordinator to find a mother to suit the needs of the volunteer. The volunteer understood this and accepted that the CCCP was not suitable for her.