

FAMILY HOME VISITING

SERVICE OUTLINE



**Government
of South Australia**

Children, Youth and
Women's Health Service

Family Home Visiting aims to provide children with the best possible start in life and to assist families to provide the best possible support for their children. This will ensure that children, in the context of their families and communities, are provided with the foundation to develop to the best of their potential.

This document has been developed to give an overview of Children, Youth and Women's Health Service's Family Home Visiting across South Australia. Its aim is to provide a general guide to the philosophical basis, structure and content of Family Home Visiting while not going into the detail of content and strategies of the service or its evaluation.

Full acknowledgement is given to the staff of CYWHS for their contribution to this publication.

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June 2005

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INTRODUCTION

CHILDREN, YOUTH AND WOMEN'S HEALTH SERVICE

The Children, Youth and Women's Health Service (CYWHS) is South Australia's largest provider of health services for women, children and young people. CYWHS brings together the Women's and Children's Hospital and Child and Youth Health. Child and Youth Health has evolved from the School for Mothers, which was established in 1909. The organisation promotes the health, wellbeing and development of children, young people and families across South Australia by providing:

- > support to parents in areas of parenting
- > health services for infants, children and young people
- > support for families and children with additional needs
- > up to date health information for parents, children and young people.

POLICY CONTEXT

In recent years, an increasing amount of research evidence reveals that the right kind of support in the first few years of life can significantly improve long term outcomes for children (Karlo, Greenwood et al, 1998). The evidence around the achievement of these outcomes is strongest for some early childhood development programs, such as Perry Preschool (Schweinhart, 2005), and for home visiting by nurses in the first few years of life (Duggan, 2004). The South Australian Government's health and child protection reform programs (namely *First Steps Forward* and *Keeping Them Safe*) both endorse early intervention and prevention. These strategies provide the framework for investment in primary health care services and early intervention programs for children and their families. The Child Protection Review, *Our Best Investment: A State Plan to Protect and Advance the Interests of Children* (Layton, 2003), includes a recommendation that a statewide nurse home visiting service be implemented.

In November 2003, the South Australian Government's framework for early childhood services in South Australia 2003-2007, *Every Chance for Every Child: Making the Early Years Count* was launched. This initiative seeks to ensure that every child in the state is provided with the best possible start in life, in order that they develop to the best of their potential. It is through this initiative that CYWHS has implemented a Universal Contact service for every newborn (see page 5) and Family Home Visiting to further expand and strengthen current early intervention services in order to enhance the health and wellbeing of children and their families.

FAMILY HOME VISITING

Family Home Visiting is an effective, evidence-based strategy for improving outcomes for children through parental support and early intervention (Olds, 1998). The service aims to enhance the health, wellbeing and resilience of South Australian children. Family Home Visiting aims to provide better support for parents and carers and is expected to provide long term benefits for children, families and communities. Based on the evidence, outcomes that can be expected from this home visiting model include, in the short term, better parenting, better developmental experiences for children and enhanced child safety. Long term outcomes for children include better school retention and employment, less child abuse, less youth offending and enhanced social and emotional health (Olds, 1998).

Family Home Visiting is not a service that will be needed by all families in South Australia. Indeed, families with less need have been shown to benefit less from this intervention. It is estimated that 12-15% of all children born in South Australia (or some 2,100 to 2,600 newborns per annum) could benefit. In 2004-05, the rollout of Family Home Visiting commenced in four regions of the state: outer northern and southern metropolitan areas, the Riverland, Port Augusta and Whyalla.

BACKGROUND

THE IMPORTANCE OF EARLY CHILDHOOD

Policy makers and health professionals recognise the social and economic costs of poor health and wellbeing and of health inequalities in the Australian community. Poor health outcomes are the result of adverse environments (including social and community influences), genetic and relationship factors. Adverse environments predispose children and infants to a range of poor health outcomes such as injury, alcohol and drug abuse, social behaviour disorders, and poorer mental health, education and employment opportunities (Werner, 1992).

The work of Perry (1998), McCain and Mustard (1999) and Shore (1997) has shown important links between the early stress that infants and young children experience and their future developmental potential. The first year of an infant's life represents a critical period for brain development, as templates for future social relationships, personal self efficacy and resilience are laid down. Each year, about 100,000 Australian children and young people between 5 and 25 years of age develop serious emotional disorders, and about a million more young people are seriously affected by emotional problems (Zubrick et al, 1995). In many cases, symptoms persist and progress, leaving a burden of suffering and the need for ongoing care. Young people affected by such conditions have their future jeopardised and their families stressed, with ramifications into every level of society.

Strategies that support positive parenting and make family environments less stressful, including programs that enhance secure attachment between parent and infant in the first years of life, have been shown to produce sustainable positive outcomes for social and cognitive development. A growing body of research evidence continues to demonstrate that early childhood is key to improved long term outcomes for children (Karoly, Greenwood et al, 1998).

INTERNATIONAL AND AUSTRALIAN CONTEXT

Australia spends over \$2 billion each year on mental health services to address the needs of people who have mental health issues (O'Hanlon, 2000). In 1995, the economic cost of child abuse in South Australia was estimated to be \$303 million (McGurk, 1998). The direct cost of the criminal justice system to the South Australian community each year is approximately \$450 million (National Crime Prevention Branch, 2000). Health inequalities continue to be most

pronounced in the Aboriginal and Torres Strait Islander population, with unacceptably high levels of ill health and lack of wellbeing compared with the rest of Australia (Australian Institute of Health and Welfare, 2002).

The cost to the community of the outcomes of poor early childhood experiences is considerable. Overseas studies show that an investment in the early years can lead to significant savings to the community. The RAND Corporation, for example, estimated that for every \$1 invested in some specific early childhood development and parent support programs, in public savings in the health and criminal justice systems, at least \$7 was saved by the time these children were 27 years of age (Karoly, Greenwood et al, 1998) and almost \$13 by the time they turned 40 years of age (Schweinhart, 2005). The Nurse Home Visitation model (Olds, 1998), has also been shown to have a high benefit-cost ratio, of \$5 for every \$1 invested, after 15 years (Lynch, 2004).

In Australia, home visiting programs based on the Olds methodology (Olds, 1998) have shown positive short term outcomes. Armstrong's research program has led to the implementation of a nurse home visiting service provided by the Queensland Government, which is now available to selected health regions in Queensland (Armstrong, 2000). Quinliven has conducted a randomised controlled trial of nurse home visiting in Western Australia that has shown significant benefits for the infant children of teenage mothers and has since been maintained as a service by the Western Australian Government (Quinliven, 2003). The New South Wales Government, in its Families First program, is conducting a controlled trial of nurse home visiting in south west Sydney. The NSW report *Realising Potential: Final Report of the Inquiry into Early Intervention for Children with Learning Difficulties* recommended general rollout of sustained home visiting by nurses for NSW (NSW Parliamentary Paper, 2003).

A significant amount of research evidence indicates that home visiting by nurses provides effective early intervention. Effective home visiting programs are intensive in the early months, linked to other resources where appropriate, initiated by nurse home visitors, sustained over the first two years, have strategies clearly linked to risk factors and expected outcomes, and have well trained and mentored staff. Home visiting services appear to be best delivered as part of a broad set of services for families and young children (Karoly, Greenwood et al, 1998).

A POPULATION HEALTH APPROACH

The overall goal of a population health approach is to maintain and improve the health of the entire population and to reduce inequalities in health between population groups.

A guiding principle of a population approach is “an increased focus on health outcomes (as opposed to inputs, processes and products) and on determining the degree of change that can actually be attributed to our work.” (Health Canada, 1998)

A population health approach is about delivering programs and services for whole communities, with particular emphasis on the preventive rather than the curative end of the health care continuum. It is an approach to health that emphasises equity, community participation, accessibility of services and the importance of addressing the determinants of health of both individuals and communities.

Approaches to clinical care that focus on people with higher levels of problems mainly serve a relatively small proportion of the population with more reactive interventions. A population health approach focuses on a much larger segment of the population where the level of risk may be somewhat lower but the reach and therefore impact is greater. Successful population approaches are capable of delivering greater health gains. A better balance between these two service strategies is desirable in order to deliver health gains for the whole community, as well as addressing the acute needs of individuals.

The CYWHS home visiting model has become a leader in Australia in delivering sustained home visiting (Family Home Visiting) from a universal platform (Universal Contact). This approach ensures that the service is more likely to be non-stigmatising and accessible to all families who may need it. Universal Contact ensures that every child will have the best possible chance of having families' need for appropriate support and assistance identified. For those for whom Family Home Visiting is not an appropriate intervention, other pathways, including referral to more appropriate services, are offered. The implementation of both Universal Contact and Family Home Visiting also provides opportunities to collect data that will inform both local and statewide planning to ensure greater service effectiveness. This data is also used to inform program development, service improvement and quality control, including relevance to local contexts.

UNIVERSAL CONTACT

Universal Contact offers an initial contact in the home by a nurse soon after birth for every child born in South Australia. It enables early identification of family and child development issues, leading to the possibility of earlier intervention and problem prevention. This service represents cutting edge practice in terms of national and international approaches to early intervention, because it is linked with Family Home Visiting.

Universal Contact and Family Home Visiting have the following elements:

- > A multitiered approach from the universal first contact to ongoing home visiting.
- > Appropriate early referral related to need.
- > The home visitor is a nurse.
- > Highly skilled multidisciplinary staff with specialist expertise.
- > Adequate support for staff who are involved in demanding and challenging work with very high need families.

There are four essential components to the Universal Contact:

- > Engaging parents in a positive partnership with health service providers.
- > Checking the health of the infant. This is an important aspect of the first visit that occurs in the family home and provides an excellent opportunity to engage mothers, fathers and other family members in getting to know their new infant.
- > Assessment of need. The *Pathways to Parenting* questionnaire has been designed to assist families, with the nurse, to identify any needs they currently have and which of those might be impacting on their ability to create a secure attachment with their infant.
- > Provision of appropriate information and making referrals.

The following areas are covered in the Universal Contact:

- > Building a positive relationship with the parent.
- > Registration of the client (completion of personal details sheet, provision of information about confidentiality, freedom of information and the mandatory notification obligation).

- > Information provision regarding relevant CYWHS services (for example, local child health clinic services, Families and Babies Program/Torrens House, Parent Helpline, web site, Getting to Know Your Baby Groups, Friends of Child and Youth Health).
- > Information provision regarding local area services (for example, immunisation, Australian Breastfeeding Association and others, as appropriate).
- > Discussion regarding any parent questions and a child health check at 1-4 weeks if it has not already been done.
- > Anticipatory guidance in respect to perceived need. (Written material can be offered after answering client's questions, for example, safety, SIDS, smoking, becoming a family, sleeping, crying, comforting, maternal health and wellbeing.)
- > Family needs assessment (*Pathways to Parenting* assessment).
- > Documentation in client-held record and completion of appropriate organisational documentation.
- > *Pathways to Parenting – the Indigenous Way* has been designed specifically for families with an Indigenous infant. In addition to engaging parents in a positive relationship with health service providers, this booklet provides information to parents, facilitates discussion around sensitive topics, and provides a more culturally sensitive environment in which to elicit information and enable completion of the *Pathways to Parenting* assessment.

If it is not possible to cover everything listed, and if it is convenient for the parent, the nurse may make another time to visit the family to finalise any outstanding issues.

Family Home Visiting aims to provide children with the best possible start in life and to assist families to provide the best possible support for their children. This will ensure that children, in the context of their families and communities, are provided with the foundation to develop to the best of their potential.

GOAL, OBJECTIVES, PRINCIPLES

GOAL

Family Home Visiting aims to provide children with the best possible start in life and to assist families to provide the best possible support for their children. This will ensure that children, in the context of their families and communities, are provided with the foundation to develop to the best of their potential.

OBJECTIVES

- > To enhance the mental and physical health of children and their families.
- > To enhance the cognitive, social and emotional wellbeing of children and their families.
- > To assist families to provide a safe and supportive environment for their children.
- > To better link families to available resources and networks within the community.
- > To offer an evidence-based, acceptable and culturally appropriate home visiting service.

PRINCIPLES

Family Home Visiting is based on the following principles:

- > The best interests of the child are paramount.
- > Parents have the primary responsibility for bringing up their children, and others in the community can make a valuable contribution.
- > Fairness and equity require that the same access to and quality of support is available to all parents.
- > Diverse family patterns are to be respected within the framework of children's rights and Australia's legal obligations, with recognition that there is no one right way of parenting.
- > Effective services to children require collaborative partnerships with parents, governments, community organisations and the corporate sector and are holistic in that they acknowledge the critical importance of societal, cultural, community, family and individual aspects.
- > In order to respond appropriately to parents, home visiting staff and other professionals need to understand their own attitudes, values and feelings in relation to parenting, and services need to be based on the development of positive and respectful relationships.

RELATIONSHIP WITH PARENTS

FAMILY PARTNERSHIPS MODEL

It cannot be stated strongly enough that Family Home Visiting is based on the building of a respectful and supportive partnership relationship between the nurse home visitor and the parents and family. This means that nursing and child development information, expertise and any other supports will be provided within the context of a partnership relationship with the family.

The underlying model for this is Family Partnerships (Davis, Day and Bidmead, 2002).

FAMILY PARTNERSHIPS MODEL

The Family Partnerships model (called the Parent Adviser model in Europe) has been developed over many years. Application of this model is supported by a widely reported usefulness to practitioners and by research evidence. These studies strongly suggest that the Family Partnerships model training program enables professionals to be more confident and competent in their relationships with parents. The research includes two randomised controlled trials and shows the psychosocial functioning of both parents and their children who may be experiencing childhood disability and mental health problems improves when they work with practitioners trained in this approach (Davis, Day and Bidmead, 2002).

RELATIONSHIP WITH INFANT

THE ATTACHMENT RELATIONSHIP

Human infants are predisposed to form attachment relationships to the adults who care for them in the first few months of life. Babies come into the world with behaviour that serves to build that connection with others, including sucking, clinging, grasping and crying. Initially closeness with adult caregivers is essential for the physical survival of the totally dependent young baby. But secure infant-caregiver attachment also serves an important function in creating the context in which the infant's learning and development unfolds. Although the attachment to the caregiver begins to develop from the first moment of the infant's life, it is not an instant experience. This relationship develops gradually over weeks and months, as the infant and parent engage in repeated interactions, adapting to each other's unique ways. The attachment typically has become well established by the time the child is about one year of age and a secure attachment has been found to be a protective factor in resilience research (Werner, 1992).

Because of the crucial learning and development that takes place in the infant in these early stages it is important that all children have the possibility to learn and grow in a nurturing environment that facilitates this growth.

Supporting the development of a secure and safe relationship for the infant with the primary caregivers is an important focus of home visiting. Elements of the STEEP Model (Steps Toward Effective Enjoyable Parenting – Erickson et al, 2002), the Circle of Security Model (Marvin, Hoffman, Cooper and Powell, 2002) and *Keys to Caregiving and Parent-Child Interaction*, two of the NCAST programs (Barnard, 1994) also inform the work of home visitors.

STEEP

(Steps Towards Effective Enjoyable Parenting)

The STEEP program is an attachment-based home visiting and group support program that promotes good parent-infant relationships and personal growth for parents. Developed at the University of Minnesota, USA, it is based on over twenty five years of longitudinal research and its philosophy is endorsed by Family Home Visiting.

The STEEP program recognises that:

- > the parent-infant relationship is central to positive child development and is enhanced by a supportive family and community, on the basis that stronger families lead to stronger communities and strong communities support strong families
- > every family is unique and demands an individual approach
- > everyone has strengths and abilities.

Family Home Visiting incorporates aspects of the STEEP model that have been shown to enhance parent-infant relationships.

CIRCLE OF SECURITY

The Circle of Security was developed at the Marycliff Institute in Spokane, Washington, USA. The model explores the idea that relationship difficulties arise when the infant is restricted in the development of a separate and competent sense of self. The parent's best gift to their infant is to be with them, without impinging. The core attachment concept explained by the Circle of Security is that children are born with an innate drive to form a relationship with their parents and a need for them to provide a secure base from which to explore, support and encouragement for their exploration and a safe haven to which the infant can return.

Family Home Visiting incorporates attachment theory and practice from the Circle of Security model.

KEYS TO CAREGIVING AND PARENT-CHILD INTERACTION (NCAST)

These programs were developed by NCAST-AVENUE at the University of Washington, Seattle, USA. In Family Home Visiting the nurses will use the *Parent-Child Interaction* model and concepts to objectively look at what is happening in the parent-child interaction. This will enable them to provide positive feedback to parents about what is going well in their interactions with their infant, and ideas to assist the parents where there may some area of difficulty. Nurses will also use some of the material relating to infant cues and teaching loops. Teaching loops encourage children's self efficacy and self confidence. In the *Keys to Caregiving* program, infant cues are explained in detail. Helping parents recognise the cues their infant is giving builds their confidence in knowing what their infant needs and helps them to provide sensitive care.

STAFFING

NURSE HOME VISITORS

Family Home Visiting relies particularly on the skills of nurses with formal training and experience in the health of infants and children. All Family Home Visiting nurses are registered general nurses with a post basic qualification in community child health nursing and skills in managing complex clinical situations often presented by high risk families. All Family Home Visiting nurses are classified as Clinical Nurses due to the complexity of their role.

Attributes of nurse home visitors

In addition to their clinical skills, it is critical that Family Home Visiting nurses also have appropriate personal qualities. As well as being non-judgmental and having warmth, flexibility, self awareness and the ability to contain strong emotions, Family Home Visiting nurses also require the following skills, qualities and knowledge:

- > non judgemental respect for others
- > the ability to develop helpful and caring relationships
- > the ability to use a client focused approach in decision making
- > assessment of the parents' situation and personal strengths and issues
- > case management skills
- > the ability to engage in collaborative practice
- > the ability to provide a supportive environment for colleagues
- > the ability to engage in activities to improve practice.

These standards are taken from the Nursing Standards Handbook and are reiterated in the Family Partnership and STEEP approaches that are used in Family Home Visiting.

Nursing structure and support

It is acknowledged that no materials can provide unequivocal guidance for all situations that Family Home Visiting nurses will face, and because of this, Family Home Visiting exists within a structure of peer and team support. Nurses are encouraged to consult with their peers and other members of their multidisciplinary team to more effectively assist families and to better respond to difficult situations. This work requires personal mentoring and debriefing through processes such as case review and reflective consultation

with other nursing staff and a social worker or psychologist from the Centre for Parenting. Nurses are also members of their regional team, consisting of all staff members providing services in a particular region. The Regional Managers are the line managers of nurses who provide services to families, and are involved in case allocation and workload management. Support is also provided to nurses by the Clinical Nurse Consultants, whose role is to support and improve clinical practice by developing and providing policies and guidelines. In conjunction with the Clinical Nurse Consultants, Regional Managers also support staff in and assess the clinical nursing components of the program.

MULTIDISCIPLINARY TEAM

Social Workers/Psychologists

The social workers and psychologists working in Family Home Visiting are all senior practitioners from the Centre for Parenting, CYWHS. They are infant and family specialists who provide training and support to the nurse home visitors in psychosocial aspects of the service, in personal mentoring and debriefing, in skills development and in case planning. They also deliver some parent-infant assessment and counselling as appropriate. The social workers and psychologists complement the work of the nurses by bringing a psychosocial approach to family issues. This, in conjunction with the health focus of the nurse, provides a more holistic service and ensures that the needs of families are addressed at several different levels.

Centre for Parenting

The Centre for Parenting is a multidisciplinary centre that is playing a key role in developing the content of the home visiting service and which also provides training for nurse home visitors and other staff involved in Family Home Visiting. The Centre for Parenting is contributing expertise to the program evaluation and has developed quality standards for the psychosocial aspects of the service. It offers a consultancy service for professionals who work with parents and provides other programs which support home visiting such as parenting groups.

Family Support Coordinators

Family Support Coordinators play a key role in the multidisciplinary team by brokering services for families. The Family Support Coordinators are the link with other external agencies that work in partnership with CYWHS. The Family Support Coordinators can also increase the efficiency of the nurse home visitors, by allowing them more time for building relationships with the family. Family Support Coordinators work on three levels: the systems level – developing more effective service systems, the agency level – improving access for families to service agencies, and the local level – developing effective links between families and service providers.

Indigenous Cultural Consultants

Indigenous Cultural Consultants work with nurses where an infant has been identified as being of Aboriginal or Torres Strait Islander descent. Their role is to facilitate access for individual families to the Family Home Visiting service, help build a relationship between other Family Home Visiting staff and the family, provide families with information and advice on support services and agencies in their local area and help link families to local community support networks. They also provide invaluable insight into cultural issues and into family dynamics that can assist other Family Home Visiting staff to provide a better service and build and maintain important networks with local area services that support families within their own communities.

Bilingual Community Educators

A number of cultural groups have settled in South Australia over many years and more recently families from Africa, Iraq and Afghanistan have been resettled in regions across South Australia. Due to the often traumatic circumstances in which these families have fled their homes, it is essential to use interpreters and to utilise the services of a Bilingual Community Educator to ensure that the family understands what is happening and that the family's cultural context and experiences inform the service they are provided.

Other health professionals

In working with families, the knowledge of other health professionals may be required and again this can enhance the work undertaken by the nurse visiting the family. In addition to the professionals listed above, others who might be consulted include doctors, paediatricians, community health workers, psychiatrists, physiotherapists, audiologists and speech pathologists.

PROGRAM SUPPORT

Major Projects Unit

Staff of the Major Projects Unit provide project assistance and support to staff involved in the delivery of Family Home Visiting. Major Projects staff facilitate program planning and implementation, research, reporting and consultation with other key stakeholders, including other government departments and local and regional bodies. The Major Projects Unit also manages the resources for the development and delivery of the service.

TRAINING

Family Home Visiting nurses are already clinical nurses with additional qualifications in community child health nursing. This understanding underpins their ability to support and assist parents in caring for their newborn and other children. On this foundation, however, other training has been provided for all staff involved in Family Home Visiting.

This includes:

Preparatory training program

The initial five day preparatory training program is prepared and delivered by the Centre for Parenting for nursing, social work and other staff who are involved in Family Home Visiting.

This training involves the following components:

> **Training in developing secure attachment relationships**

Staff receive training in the theoretical underpinnings of the development of secure attachment relationships. The training involves seminars, learning to interpret new relationships from video tape, case discussion, and planning. A number of models have informed the training:

- > STEEP (Steps Towards Effective Enjoyable Parenting) (Erickson et al, 2002). This is an attachment based home visiting and group support program that promotes good parent-infant relationships and personal growth for parents.

It includes many simple and developmentally appropriate tools and handouts for use with families. Particular use is made of the *Seeing is Believing* process from the STEEP program. Nurse home visitors are trained in the use of video tape with families, in which parents enjoy and learn from being able to take a step outside the immediate action and observe and learn from their interactions with their infant.

- > Circle of Security (Marvin et al, 2002), a simple conceptualisation of attachment theory which parents find understandable and a helpful guide to interpreting their infant's needs and behaviour. Nurse home visitors learn how to explain and use this model with parents.

- > *Keys to Caregiving and Parent-Child Interaction* (NCAST), two models looking at infant cues and the parent-infant interaction. Nurses will learn the theoretical framework underpinning *Parent-Child Interaction* assessment tools to objectively look at what is happening in the parent-child interaction. Nurses will also learn how to use some of the material relating to infant cues, in particular how to identify engaging cues (cues that communicate the infant's desire to interact) and disengaging cues (cues that communicate the infant's need that they have had enough or they need a break) and how to help parents to recognise these cues.

> **Training in general child development**

Building on their existing knowledge, nurse home visitors are introduced to and contribute ideas on a variety of other tools and resources to assist infant and child development from all perspectives (cognitive, physical, emotional and social).

> **Training in socio-emotional issues facing families**

Staff receive training in a range of socio-emotional issues facing families. The training involves specialist presenters addressing issues including the mental health of parents, best responses to domestic and family violence and its effect on children, drug and alcohol use and misuse, cultural and indigenous issues, and child protection.

Ongoing training program

In addition to the five days of preparatory training, there are also regular three monthly recall days of additional training for all staff involved in Family Home Visiting. These ongoing training days provide the opportunity for staff to reflect on practice and to receive additional training.

Regular updates and professional development sessions are also held in relation to the clinical nursing skills used by Family Home Visiting nurses, including regular updates in child protection mandatory notification.

Ongoing mentoring

This is provided to Family Home Visiting nurses by social workers and psychologists from the Centre for Parenting in conjunction with Clinical Nurse Consultants and Regional Managers. Social workers and psychologists are mentored by senior Centre for Parenting staff. Training workshops create a consistency of approach to the work being undertaken in the field. Ongoing training and the time to practice skills is essential in the role of a Family Home Visitor.

Family Partnerships model training

All staff involved in Family Home Visiting are trained in the Family Partnerships model (Davis, Day and Bidmead, 2002). This approach (called the Parent Adviser model in Europe) has been implemented across Europe as part of the European Early Promotion Program. Families First in NSW and Best Beginnings in WA have also incorporated it into their programs.

The training program in the Family Partnerships model involves a five day ten module intensive course in which participants reflect on and practice the characteristics of an effective helping relationship – a partnership relationship with parents. It includes a focus on the qualities and skills needed to enable families to identify and work on their own issues and on the process of helping which is most effective. The emphasis of the course is on participants actually putting the ideas and skills into practice, not just talking about them. An essential aspect of the training is reflection on practice in between sessions and also ongoing opportunities for reflective consultation/supervision after completion of the course. In this way learning from the course is maintained and integrated into practice.

Two groups of Facilitators for Family Partnerships and two Facilitator Trainers have been trained and accredited by Hilton Davis on behalf of his Centre for Parenting, London. This means that the training is sustainable within CYWHS, so that future staff can be trained in using this approach.

CASE REVIEW AND REFLECTIVE CONSULTATION

CASE REVIEW

Case review is a core component of Family Home Visiting. For effective case review a multidisciplinary approach is recommended as this allows for an open and broad discussion of both clinical and psychosocial aspects. Consideration of family issues draws on a number of professionals and is therefore more likely to lead to decisions that will be consistent, useful and of good quality. Case review also provides support to nurses around difficult decisions and cases. It helps build a team and fulfils an educative function to all staff by sharing knowledge about how to deal with challenging family situations. In Family Home Visiting, a case review involves a discussion about individual families between the home visiting team of nurses and a social worker or psychologist from the Centre for Parenting. Sometimes it includes an Indigenous Cultural Consultant, a Family Support Co-ordinator, staff from other relevant disciplines or invited agency representatives. The purpose of the discussion is to identify and clarify what help the family might need and how to best assist them access appropriate referrals.

Functions of case review:

- > Supporting home visiting staff, including peer support and support from case review facilitator
- > Facilitating discussion about clients to make collaborative decisions about referral pathways and ongoing family support in Family Home Visiting
- > Debriefing as needed
- > Family Home Visiting case allocation
- > Training and development
- > Issues discussion
- > Reflection on practice.

REFLECTIVE CONSULTATION

The key to effective home visiting is the skill of the nurses working in the service. It is important to recognise that home visiting may challenge the values, skills and self perception of those nurses. It is therefore important to support staff to develop as reflective practitioners and to recognise the meaning of their own and their clients' actions and experiences. Family Home Visiting nurses are involved in reflective consultation to reflect on their work with families so that they can better assist them in nurturing, problem solving, evaluating, interpreting and clarifying their own role. This ensures that the nurse home visitors are supported in helping parents respond sensitively to their infants so that their infants can develop more secure attachments.

ENTRY CRITERIA

Entry to Family Home Visiting is generally through assessment provided by the Universal Contact case review. Entry to Family Home Visiting is voluntary and is based on the presence of certain criteria or risk factors. Based on available evidence of efficacy, the cut off for entry into Family Home Visiting is infants aged three months. However, if special circumstances exist, such as if an infant is born prematurely and has an extended hospital stay or is adopted from overseas, the criteria can be adjusted. In such situations, the decision about entry will be made at the multidisciplinary case review.

Population level assessment criteria

In most cases families entering Family Home Visiting do so as the result of population level assessment criteria:

- > Mother is less than 20 years of age
- > Infant is identified as being of Aboriginal or Torres Strait Islander descent
- > Mother is socially isolated
- > Mother expresses poor attribution towards her infant.

In areas of rollout, families that meet these population-based criteria are automatically offered entry into Family Home Visiting, unless it is clear at the case review that for particular circumstances it is unlikely the infant will benefit from the service.

Maternal assessment criteria

Some families enter Family Home Visiting based on individual maternal assessment criteria:

- > Current or past treatment for a mental health issue
- > Drug and alcohol related issues
- > Domestic violence currently impacting on parenting
- > Previous intervention from CYFS
- > Child born with congenital abnormalities
- > Concern on the part of the assessing nurse.

Families that meet one or some of the individual maternal assessment criteria are reviewed at the multidisciplinary case review. If it is felt that the infant may benefit from the service, the nurse recontacts the family to offer entry into Family Home Visiting. Considerable effort is made to contact families and help them access the service, with up to six visits being made to families who have not been able to be contacted.

In a few particular instances it is clear that the infant will not benefit from Family Home Visiting. The service may not be suitable for families in the following situations:

- > After every attempt had been made the family remains unwilling to respond to the service or the family is unable to do so because of issues affecting their perception or ability to use the service
- > The needs of the infant or the family require a different type of service
- > There is a lack of safety for the nurse in visiting the home.

In instances where Family Home Visiting is not appropriate:

- > Relevant issues are discussed at the case review and referrals made to appropriate agencies. Reasonable follow up is provided to promote effective referral
- > The family is offered all other services provided by CYWHS in clinics or centres
- > Families are also referred to CYFS if there is a risk of abuse to (or neglect of) the infant.

DETAILS OF THE HOME VISITS

CONTENT OF VISITS

Family Home Visiting has been divided into modules, or clusters of visits, to allow for flexibility in the delivery of the service. These modules are as follows:

- > Module 1: Infant 3 - 8 weeks
- > Module 2: Infant 10 weeks - 5 months
- > Module 3: Infant 5½ - 8 months
- > Module 4: Infant 9 - 12 months
- > Module 5: Infant 13 - 18 months
- > Module 6: Infant 18 - 24 months

Each module includes a description of the material and activities staff should aim to cover in each visit. However, as the model is based on the building of a relationship between the nurse home visitor and the family, and on the development of the infant and the parent-infant relationship, it is recognised that it is important to be flexible with the service so that it suits the family and follows the parent's lead, addressing the issues they raise. Therefore, the content of the modules are suggestions of what can be accomplished. If unable to include an activity in the suggested week, nurses are asked to attempt to include it somewhere in the module, and in relation to the infant, as near to the developmentally appropriate stage as possible.

If a family does not begin Family Home Visiting until the infant is older (for example, six weeks) it is important that the nurse visits weekly for the first six weeks of contact in order to develop a relationship with the family and address their issues and needs. More regular visits are also needed if the family transfers to a different nurse for any reason, for example, when moving house.

SERVICE APPROACHES

Partnership

The visits occur in the family's home and therefore it is anticipated that parents may feel more confident in their own space. Home visiting staff respect their role as visitors in another person's home and develop with parents a partnership approach to working together.

Parental input

Parents and home visitors need to have some expectations of the process and outcomes of Family Home Visiting. The Family Home Visiting service has some universal components that will be part of the service for every family, such as anticipatory guidance, attachment-based interactions and skills development. Building on this, the service reflects the specific needs and strengths of each individual family. In the discussion of expectations, home visitors clarify the boundaries and opportunities of their role and work with the parents to develop their personal goals for the program and for themselves and their children. Parents' expectations for their children are clarified to provide a sounder basis for supporting appropriate attributions.

Developing secure attachments

The parenting that children receive is the cornerstone of the development of their emotional, interpersonal and social wellbeing. The quality of relationships they form with others, including their own children when they become parents, will be shaped by their own care-taking experiences. Home visitors supporting families must understand adult attachment issues and work in partnership with parents to develop secure attachments for infants as the foundation for future development.

Trust and relationship building

It is recognised that some parents have not had the opportunity to develop the foundations for trusting relationships in their own early years and this can present difficulties for them in relating to other adults and to their own children. Staff need to have an understanding of adult attachment issues and training in developing trusting, supportive and respectful relationships with clients as well as skills in supporting the development of secure attachments with children. Family Home Visiting is relationship based and includes:

- > Developing a relationship of trust with clients that facilitates a 'holding' environment to enable change to occur
- > Assisting parents in developing supportive relationships in their family and positive connections in their community
- > Assisting parents to develop positive attachment relationships with their children.

Strengths-based approach

Family Home Visiting uses a strengths-based approach, building parents' confidence and encouraging their strengths, supporting them to do things where they can, assisting them where needed and offering greater support in cases of illness and special need.

Modelling

Modelling is done with care so that the home visitor does not take the role of an expert showing the parent what to do and how to do it. The relationship should not be, or be seen to be, one of demonstration. However, in terms of helping parents to feel safe to try different ways of relating to children (for example, talking or singing to infants), it can assist parents to feel free to try new things.

Reframing

Parents will be given information and assistance to develop realistic expectations and more positive understanding of their children's behaviour and developmental needs.

Social connectedness/social capital

The development of sustainable communities is critical for supportive structural networks that enhance the health and welfare of families and children. External support assists in building resilience in parents and children. Family Home Visiting assists parents to make stronger and more supportive links within their communities.

Cultural inclusion

Families from different cultures have different values and beliefs. Home visitors respond to the uniqueness of each family in the context of their culture. Staff listen to and respect families' cultural beliefs and values and work within them, except where the safety or wellbeing of the children is of concern. In particular, home visitors respect and are sensitive to the needs of Aboriginal and Torres Strait Islander families and adjust their activities appropriately.

Collaboration with community agencies

Effective and ongoing collaboration between the many community agencies that can assist families is imperative for more effective intervention with families. (Linke, 2001)

The visiting schedule for Family Home Visiting is for 34 visits to be made to the family home during the first two years of the infant's life. While there will be some universal elements of the service based on child development and needs, the program is flexible and responsive to family and parental needs and issues. The following schedule may need to be adapted to ensure age appropriate intervention if there are any gaps in service due to sickness, transfer or where there is delayed entry of an infant into the service.

SCHEDULE OF VISITS

DESCRIPTION	AGE OF INFANT	FREQUENCY OF VISITS
Universal Contact	Within 14 days of the infant's birth	weekly

MODULE 1		
3 - 8 WEEKS		
Visit 1	3 weeks	weekly
Visit 2	4 weeks	weekly
Visit 3	5 weeks	weekly
Visit 4	6 weeks	weekly
Visit 5	7 weeks	weekly
Visit 6	8 weeks	weekly
MODULE 2		
10 WEEKS - 5 MONTHS		
Visit 7	10 weeks	fortnightly
Visit 8	3 months	fortnightly
Visit 9	3½ months	fortnightly
Visit 10	4 months	fortnightly
Visit 11	4½ months	fortnightly
Visit 12	5 months	fortnightly
MODULE 3		
5½ - 8 MONTHS		
Visit 13	5½ months	fortnightly
Visit 14	6 months	fortnightly
Visit 15	6½ months	fortnightly
Visit 16	7 months	fortnightly
Visit 17	7½ months	fortnightly
Visit 18	8 months	fortnightly
MODULE 4		
9 - 12 MONTHS		
Visit 19	9 months	monthly
Visit 20	10 months	monthly
Visit 21	11 months	monthly
Visit 22	12 months	monthly
MODULE 5		
13 - 18 MONTHS		
Visit 23	13 months	monthly
Visit 24	14 months	monthly
Visit 25	15 months	monthly
Visit 26	16 months	monthly
Visit 27	17 months	monthly
Visit 28	18 months	monthly
MODULE 6		
19 - 24 MONTHS		
Visit 29	19 months	monthly
Visit 30	20 months	monthly
Visit 31	21 months	monthly
Visit 32	22 months	monthly
Visit 33	23 months	monthly
Visit 34	24 months	monthly

Infant 3 - 8 weeks
Building Relationships

module **1**

AIM

- > To build a relationship with the family
- > To promote parents'/caregivers' getting to know and understand their infant
- > To ensure the family has suitable social supports (both formal and informal) to meet their needs

CORE ACTIVITIES FOR THE MODULE

Infant Health and Safety

- > Respond to parents' queries and needs regarding their infant
- > Growth assessment and responsive health surveillance
- > Anticipatory guidance - settling, normalise infant crying, feeding, infant safety

Child Development

- > Child development including the *Developmental Play Activities* 0–3 months
- > Introduce *Wonder Weeks* concept (infant cognitive and emotional development) and discuss any signs
- > Introduce and explain infant cues and their importance in understanding infant needs. Encourage parents to become observers of their infant's cues

Relationships

- > Introduce the service and discuss and explore parents' goal for program involvement
- > Explore the parents' feelings about parenthood, the meaning of their infant to them and their dreams for their infant
- > Support parents' feeling of connection to their infant through activities and resources
- > Encourage parents to focus on infant communication cues to understand their infant's perspective and nurture a responsive relationship between parents and infant
- > Video tape the parent-infant interaction
- > Talk with parents about any specific cultural issues that might be necessary for the family home visitor to know about to ensure a sensitive relationship develops

Social/Environmental

- > Respond to needs identified in *Pathways to Parenting* assessment – for example, housing, finances
- > Responsive health surveillance for parents – maternal and paternal health and wellbeing, contraception, postnatal depression
- > Support connection to community supports and agencies for the family
- > Introduce parents to *Getting to Know Your Baby* groups and book them in as appropriate
- > Focus on dads and their needs

Infant 10 weeks - 5 months
Your Social Baby

module

2

AIM

- > To introduce activities to promote child development
- > To promote the developing interaction between the parents and the infant
- > To promote the parents'/caregivers' sensitive behavioural and emotional regulation of the infant
- > To support and enable the family to deal with issues and needs

Relationships

- > Family Home Visiting nurse to continue to build relationship with family using the *Family Partnerships* model
- > Video tape the parent-infant interaction and watch this with the parents to make discoveries and increase parents' awareness of what is happening in their interactions
- > Introduce the *Circle of Security* and relate this model to observations of the infant's behaviour

Social/Environmental

- > Connect parents to a community group – or develop a special group for Family Home Visiting parents as needed
- > Complete negotiation around any issues identified through *Pathways to Parenting* assessment
- > Check if support and referral is needed for budgeting
- > Parental health review: smoking, alcohol and drugs, how they are coping?

CORE ACTIVITIES FOR THE MODULE

Infant Health and Safety

- > Responsive health surveillance
- > Anticipatory guidance - developmental tips and safety, mobility, when to call the doctor, nutrition, immunisation

Child Development

- > Child development including sharing activities from the *Developmental Play Activities* 3-6 months
- > Promote growth and developmental changes, including discussing *Wonder Weeks* at around 12 and 17 weeks
- > Promote infant communication through games and books
- > Support with establishment of patterns (for example, settling) with developmental changes

Infant 5¹/₂ - 8 months

Becoming a Separate Being

module

3

AIM

- > To support and enable the family
- > To help parents/caregivers anticipate and enjoy the infant growing to become a separate being

CORE ACTIVITIES FOR THE MODULE

Infant Health and Safety

- > Responsive health surveillance - 6 month health check
- > Anticipatory guidance - solids, food preparation, chewing, growth of teeth, immunisation, safety tips regarding mobility, crawling

Child Development

- > Separation anxiety 7-8 months - review sleep and settling
- > Child development including sharing activities from the *Developmental Play Activities* 6-9 months - including communication games, books
- > Promote growth and developmental changes including discussing *Wonder Weeks* at around 26 weeks and 36 weeks

Relationships

- > Review parents' dreams for their infant/goals for home visiting
- > Promote parents' understanding of their infant's perspective
- > 6 months - video tape the parent-infant interaction and watch this with the parents to make discoveries
- > Discuss the idea of parents as teachers
- > Encourage and reinforce the strengths and successes on video or in actual situations
- > Wonder with parents about any areas of difficulty - where they might come from
- > Respond to separation anxiety and stranger fears - benefits of secure attachment, self esteem
- > Begin discussions regarding discipline - discipline being a way of teaching and learning

Social/Environmental

- > Parental health review - sleeping, rest, stresses, strains
- > Relationship review, provide information and refer as required
- > Review and promote family contacts with community - could organise get together for Family Home Visiting participants
- > Promote family strengths and family esteem, for example, cultural identity, decision making, problem solving

Infant 9 - 12 months
Getting Mobile

module

4

AIM

- > To support and enable parents/caregivers with general issues and needs
- > To support parents as the infant gets mobile

CORE ACTIVITIES FOR THE MODULE

Infant Health and Safety

- > Responsive health surveillance
- > Anticipatory guidance - crawling, pulling to stand, cruising, outdoor play, revisit passive smoking, dental - teeth and gum care
- > Advise about immunisation coming up at 12 months

Child Development

- > Child development including sharing activities from the *Developmental Play Activities* 9-12 months - including communication and language games, books
- > Promote growth and developmental changes including *Wonder Weeks* at around 44 weeks and 53 weeks

Relationships

- > Review dreams for infant and self
- > 10 months - video tape the parent-infant interaction and watch this with the parents to make discoveries
- > Encourage and reinforce the strengths and successes - using *Circle of Security* language:
 - > Wonder with parents about any areas of difficulty
 - > Listen to and explore any emotions behind such difficulties
 - > Plan activities to address any areas in which parent struggles
- > Focus on dad's relationship with infant
- > Revisit infant's perspective of parents - letter from infant at 12 months

Social/Environmental

- > Review and enable family goals
- > Social supports – playgroups, child care options
- > Celebrate the infant's first year

Infant 13 - 18 months
The Who Am I? Phase

module

5

AIM

- > Help parents/caregivers support their toddler as they move towards more independence
- > To enable the family to address needs

CORE ACTIVITIES FOR THE MODULE

Infant Health and Safety

- > Responsive health surveillance
- > Anticipatory guidance - learning to walk – home and away safety, discuss toilet training - *Don't Rush Me*
- > Advise about immunisation coming up at 18 months
- > Advise about 18 month health check

Child Development

- > Child development including sharing activities from the *Developmental Play Activities* 15-18 months – including developing gross and fine motor skills, communication
- > Promote growth and developmental changes including discussing *Wonder Weeks* at around 61-63 and 72-73 weeks
- > Separation anxiety applied to the toddling child and longer separations. Strategies including preparation, transition objects, recognising cues
- > Boys and girls *Discovering Me* - body parts awareness and touching, explore parental understanding of gender and sexuality

Relationships

- > Promote understanding of the toddler
- > Explore and plan - setting limits for the toddler, encouraging development, managing feelings
- > 15 months - video tape the parent-infant interaction, a play session, and watch this with the parents to make discoveries
- > Encourage and reinforce the strengths and successes on video or in actual or planned situations - using *Circle of Security* language - present the toddler *Circle of Security* magnet:
 - > Wonder with parents about any areas of difficulty
 - > Provide listening and exploration
- > 18 months - begin awareness of termination of home visits in 6 months

Social/Environmental

- > Parental health/relationship review input as needed, for example, dealing with conflict
- > Review family contacts - local Family Home Visiting families get together?
- > Promote family strengths and family esteem, for example, cultural identity, decision making, problem solving
- > 18 months - focus on dads - how is it going?

Infant 18 - 24 months
Toddling On

module

6

AIM

- > To review parenting goals and changes
- > To build knowledge and confidence in the parents/caregivers for the parenting role ahead
- > To prepare for and celebrate the end of Family Home Visiting. Transition planning for future options. Dealing with separation and ending
- > Ensure family connections through links with local services

CORE ACTIVITIES FOR THE MODULE:

Infant Health and Safety

- > Responsive health surveillance
- > Anticipatory guidance – toddlerhood and safety (falls, poisons, cars), nutrition and diet
- > Pneumovax immunisation for Aboriginal families
- > Advise about 2½ year health check

Child Development

- > Child development including discussing and drawing on Developmental Play Activities 18-24 months and beyond:
 - > Learning to socialise
 - > Play and appropriate toys
 - > Behaviour - setting limits, positive encouragement
 - > Toilet Training - *Am I ready?* review

Relationships

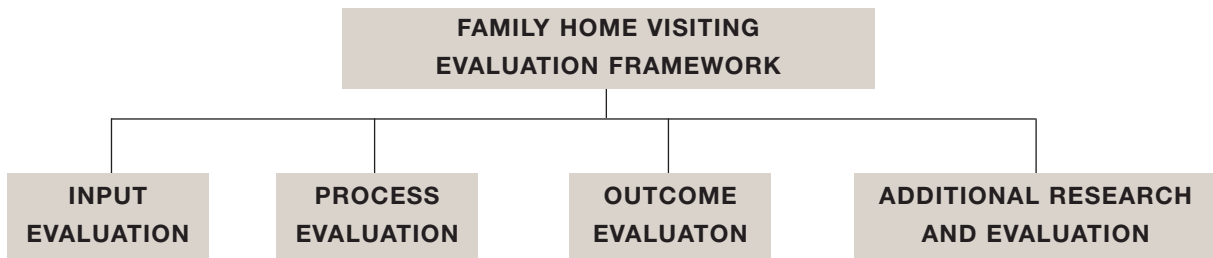
- > Anticipation of and preparation for the end of home visiting – explore and acknowledge the change that will occur in the relationship of Family Home Visiting to family
- > Review dreams for infant and parents – letter from the toddler at 19 months
- > 21 months - video tape the parent-infant interaction - preparation of a summary tape to leave with family
- > Present the summary tape. Review together the journey of discovery and growth that has been taken
- > Mementos to leave at end of Family Home Visiting

Social/Environmental

- > Transition and connect to other social supports and programs - local Family Home Visiting families farewell?
- > Focus on dads – where to from here?
- > Celebrate the child's second birthday

EVALUATION

The Family Home Visiting Evaluation Framework is based on the systems evaluation model, which is widely used in program evaluation. The evaluation focuses on three primary areas: input evaluation, process evaluation and outcome evaluation. In addition to the three primary areas a number of additional research and evaluation activities looking at specific aspects of the service may also be undertaken.



The input evaluation documents the key elements of the service such as staff selection criteria, training modules, client entry criteria and assessment tools.

The process evaluation is designed to investigate program integrity by determining the extent to which the service is operating and being rolled out as intended and the extent to which the client population is being served. The process evaluation also identifies the key barriers and facilitators impacting on program implementation.

The outcome evaluation is designed to assess the extent to which Family Home Visiting affects the client population in the short and medium term. The outcome evaluation focuses specifically on those indicators that home visiting programs have been shown within Australian and internationally to positively impact such as childhood injury, immunisation coverage, hospital admission, primary caregiver-child interaction, contraceptive practices and parental support networks.

The key data sources for the evaluation includes client information collected as part of routine service delivery, program documentation, client and staff completed questionnaires, staff focus groups and in-depth interviews. All data used for the purpose of the evaluation will be aggregated and deidentified to ensure the confidentiality of clients and staff.

The emphasis for the initial twelve months of the Family Home Visiting evaluation will be on the input and process evaluation, incorporating all of the work being undertaken in relation to the program planning, development and implementation. During the subsequent twelve month period the process evaluation indicators will continue to be monitored in addition to the commencement of the outcome evaluation.

HOME VISITING EVALUATION AND RESEARCH REFERENCE GROUP

A high-level external Home Visiting Evaluation and Research Reference Group has been convened to provide rigour to this evaluation process. This group includes representatives from SA, NSW, VIC and the Commonwealth. The main role of this group is to provide advice and guidance to CYWHS on the development of the evaluation framework, on methodological issues, on the selection of assessment tools and outcome measures and on data collection and analysis. It is envisaged that this group will provide an independent perspective to the work that CYWHS is undertaking and provide a high level of rigour to the evaluation process.

HOME VISITING EVALUATION AND RESEARCH REFERENCE GROUP (AS AT MAY 2005)

External members

Professor Kevin Forsyth (Chair)	<i>Head of Paediatrics and Child Health</i> Flinders Medical Centre, SA
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Rod Squires	<i>Children, Youth and Family Services</i> Department for Families and Communities, SA
Ben Wallace	<i>Director, Stronger Families</i> Family and Community Services, (Commonwealth)

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