

Australian Centre for Child Protection

A Pilot Exploration of a Family Home Visiting Program for Families of Aboriginal and Torres Strait Islander Children

Report and Recommendations: Perspectives of Parents
of Aboriginal Children and Organisational Considerations



University of
South Australia



Australian Government

**Department of Innovation
Industry, Science and Research**

February 2008

Leda Sivak, Research Associate
Fiona Arney, Senior Research Fellow
Kerry Lewig, Research Coordinator

Improving the lives of vulnerable children

We acknowledge this Land is the Traditional Lands for Kurna People and that we respect their spiritual relationship with their Country.

We also acknowledge the Kurna People as the custodians of the Adelaide Region and that their cultural and heritage beliefs are still as important to the living Kurna People today.



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Health Service



Aboriginal Health Council
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This evaluation of the Family Home Visiting program was auspiced by the Family Home Visiting Aboriginal Research Partnership. The Partnership included formal agreements between the Aboriginal Health Council of South Australia, the Australian Centre for Child Protection at the University of South Australia, the Children Youth and Women's Health Service (South Australia), and the Department of Families, Community Services, and Indigenous Affairs (Research & Analysis Branch). The Partnership also included representation from Nunkuwarrin Yunti - the Aboriginal Community Controlled Health Service for metropolitan Adelaide.

The Australian Centre for Child Protection is funded by the Department of Innovation, Industry, Science and Research.

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Table of Contents

Acknowledgements.....	4
Notes.....	4
Executive Summary.....	6
Purpose of Report.....	12
Background.....	12
Methodology.....	16
Findings of Focus Groups and Interviews with Parents.....	19
A. General Perceptions and Perceived Benefits of FHV – “It’s all good. I like the program”.....	21
B. Staff Characteristics – “She just has this thing about her”.....	24
C. The role of the ICCs – “We’re on the same level in the ways we think, and how we do things”.....	33
D. Program Structure – Engagement – “I wasn’t too sure what it was about”.....	38
E. Program Structure – Content of FHV – “You always welcome them. Because they’ve got that information”.....	46
F. Program Structure – Service Delivery.....	58
G. Program Structure – Cessation – “Have the home visits ‘til they’re eighteen!”.....	66
Discussion.....	69
References.....	77
Appendices.....	79
Appendix 1 – The Multidisciplinary Team.....	79
Appendix 2 – Home Visiting Aboriginal and Torres Strait Islander Families – Flow Chart.....	81
Appendix 3 – Research Tools.....	82

Acknowledgements

A number of people have contributed to this stage of the evaluation by providing important support and information to the research team.

Thank you to staff and managers at the Children, Youth and Women's Health Service who supported and participated in this research evaluation. A special thanks to all of the Indigenous Cultural Consultants whose expertise was invaluable in the design and process of this study. Particular thanks to staff in the metropolitan North and metropolitan South regions, especially Margaret Nelson, Rosemary Coveney, Honey Highfold, Rosie Smith, Marilyn Bingsapore-Lee, Cheryl Rothwell, Jill Hall and Sue Harrison, who were so helpful with inviting people to focus groups and interviews, and in assisting with transport, childcare and general support at the groups.

We would like to acknowledge the support and encouragement of the Adelaide Aboriginal Early Childhood Research and Evaluation Advisory Group (co-chaired and supported by FaCSIA (Melisah Feeney and Graham Brice, Longitudinal Study of Indigenous Children, Research & Analysis Branch)), which provided a forum for discussion and dissemination of ideas about this research, including a two-day symposium on Aboriginal Early Childhood at which this Evaluation was featured.

Our gratitude also goes to the Human Research Ethics Committee, University of South Australia; the Aboriginal Health Research Ethics Committee, Aboriginal Health Council of South Australia; Human Research Ethics Committee, Children Youth and Women's Health Service, for their prompt feedback and approval of this evaluative research.

Finally, our warmest thanks go to the many mothers, fathers, grandmothers, aunties, and children who took the time to attend interviews and focus groups and who shared their experiences and suggestions for the Family Home Visiting program as part of the evaluation and research process. It has been a privilege listening and speaking with each of you, and we hope to do justice to the experiences you have shared, both for your family and for other families who may encounter this service. Thank you for the generosity of attending our groups, and of inviting us into your homes to yarn about the health and wellbeing of your children.

Notes

1. Please note that within this document we have predominantly used the term 'Aboriginal' to refer to Aboriginal and Torres Strait Islander participants in this study, upon the recommendation of the Aboriginal Health Research and Ethics Committee. We have generally avoided the term 'Indigenous' as it is more often used for global representations of autochthonous peoples and lacks the specificity of identity within Australia.

2. The collective term “family” has been used at times to refer to the mothers, fathers and extended family members who took part in focus groups and interviews representing the views of those receiving Family Home Visiting and/or supporting recipients of the service.

3. For more information about the Family Home Visiting program please contact the Manager, Family Home Visiting on (08) 8303 1500.

Executive Summary

The South Australian Children, Youth and Women's Health Service has adopted and adapted a model of Family Home Visiting from the USA, using professional nurse home visitors and Indigenous Cultural Consultants (ICCs) in program delivery for Aboriginal clients in South Australia. The purpose of home visiting is to provide children with the best possible start in life and to assist families in providing the best support possible for their children. Home visits are provided by qualified child health nurses supported by a multidisciplinary team of psychologists, social workers, Aboriginal health workers and family brokers.

All families across South Australia now receive one home visit within the first few weeks of their child's life. Those families identified with additional needs for support, at this first visit, may be offered ongoing Family Home Visiting up to the child's second birthday. The program involves 34 visits focusing on child health and development and maternal-child attachment. The visits take place weekly for the first six weeks, then fortnightly for the next six months. Families receive monthly visits for the final twelve months of the program, and are supported in forming links with their local community. Currently Family Home Visiting is available across four rollout areas located in both metropolitan and rural South Australia. The Family Home Visiting program commenced rollout in April 2004.

The Family Home Visiting Aboriginal Research Partnership was formed in 2006 in order to explore two research aims:

1. To evaluate perceptions of Family Home Visiting program (FHV) with families of Aboriginal children;
2. To explore the suitability and acceptance of qualitative methodologies to involve urban families in a possible longitudinal study of Aboriginal children's development, *Footprints in Time*.

This report addresses the first aim by documenting the early stages of an evaluation of FHV delivered by the Children, Youth and Women's Health Service of South Australia. This Report outlines the findings of the first twelve months of the first stage of the evaluation process, which includes the experiences of the families of Aboriginal children and selected staff and management within the Family Home Visiting program. The report is intended to inform current and future roll out of the Family Home Visiting Program with Aboriginal families in South Australia and beyond.

The second aim of the project will be examined in detail in a report by Cate Jones for the Department for Families, Community Services and Indigenous Affairs.

The report includes findings from focus groups and interviews with family members, the vast majority of whom were currently enrolled in Family Home Visiting or who had graduated from the program. It also includes information from focus groups with the Indigenous Cultural Consultants who facilitate engagement and support for Aboriginal

clients in the program, and a focus group with the Family Home Visiting Implementation Team at the Children Youth and Women's Health Service.

Given there were very few participants in this first round of fieldwork who had either withdrawn from or refused the program, this report could be viewed as identifying what is working well for families who remain with the program rather than identifying barriers to engagement and retention. Further research with families who withdrew from or refused the program is needed to understand what other improvements could be made to the service.

Extremely positive feedback about the Program was given by almost all families who participated in focus groups and interviews. In general, FHV was seen as a convenient, responsive, positive approach to child health and development, delivered in an empowering and respectful way. For many participants, staff were seen as much more than professionals, often as family and friends of the families they were working with.

Participants identified a number of significant benefits from taking part in the program, although their perceptions of its impact varied. For some families, the benefits included practical assistance, information and referrals for health and other issues (eg, housing, playgroups), and for many it also included feeling more socially involved, more supported in their parenting decisions and generally more confident in themselves and their parenting. Although this evaluation is not designed to comment on health outcomes for these families, families reported an increase in their awareness of infant health and development.

Participants in both regions of the pilot were exceptionally positive about the qualities of the Family Home Visiting staff and the relationships they had built together, and the personal qualities and relational skills of the Family Home Visiting staff are very prominent themes that run throughout the findings. The Hilton Davis *Partnerships with Parents* model forms the backbone of specialized training for those Family Home Visiting staff who engage directly with clients, and many of the model's core components were reflected in participants' comments about the Family Home Visiting staff. The fact that participants spoke frequently of these indicates not only that many staff have embodied the model's values into their work with participants, but also that the qualities that are valued by the model were equally valued by clients.

The importance of providing families with the opportunity to have an Indigenous Cultural Consultant involved in Family Home Visiting was often highlighted. Aboriginal staff were seen as having an understanding of clients' contexts and culture and sometimes as having a different way of communicating with families. The involvement of ICCs was particularly valued when families were unlikely to have this kind of contact with Aboriginal people in the short term (eg, when families had just moved in to the area, or where a non-Aboriginal parent may not be confident about how to make connections with Aboriginal communities). The significance of Aboriginal staff as role

models for children and the community was highlighted, as well as the high level of accountability the ICCs have in the Aboriginal community regarding their role with FHV.

The passion and dedication of non-Aboriginal staff working with families was also highly valued. Partnered relationships between nurses and ICCs were especially important for individuals and communities who had had previous experiences in other settings in which they were less comfortable with professional staff.

Successful engagement in the FHV program was facilitated by staff following the established protocols for engaging families of Aboriginal children and participants' initial impressions of the staff. However, participants' perceptions of the eligibility criteria for Family Home Visiting were various and seemed to indicate that communication about the program has not been entirely consistent. Confusions about the purpose and eligibility criteria of the program may impact on the uptake of the service, and need to be addressed in a clear and consistent manner throughout local communities and health services within the roll-out regions. Furthermore, for potential clients who might encounter a clash between the population-health criteria and the program's exclusion criteria, both staff and family participants stressed the importance of providing responsive support.

The information, activities, services and referrals provided in the Family Home Visiting program were clearly valued by participants, as was the staff's responsiveness and flexibility around both what and how information was communicated to clients. Participants' experiences of the content of FHV cannot be easily separated from their relationships with the staff members, who in large part acted as significant mediators of clients' experiences.

The convenience of being visited within one's own home can be seen as one of the most prominent facilitators of continuing engagement with the program. Another factor that facilitated continuing involvement in the program was flexibility, which was frequently noted in terms of the negotiated scheduling appointments, but was also mentioned in terms of the location, duration, and frequency of visits, the responsiveness of particular information and activities, and staff's flexibility and responsiveness around the needs of other household members.

The dynamics of transition out of the service requires an awareness of the socially isolated context of many clients within the program, yet also raises questions about dependence and reliance that need to be explored in an outcomes-driven way. We need not only to document examples of supportive transitions out of the program, but also to begin to imagine and start developing sustainable, ongoing supports for families of young children.

A further research agenda incorporating qualitative methods is needed to explore a range of intersecting issues, including: the experiences of families who withdrew or refused the program; staff perceptions of FHV; comparisons between Aboriginal and

non-Aboriginal perceptions of the program; and investigating the potential clash between population health criteria and exclusion criteria for Family Home Visiting. It is also important to link this qualitative evaluation to outcomes and process evaluations in order to measure both the immediate impacts and long-term outcomes of the Family Home Visiting program.

Recommendations

The following recommendations are based on the interview data from respondents and from additional information obtained at the participant feedback sessions.

1. Acknowledge the importance of the role of ICCs in engaging and allocating families.
2. Ensure ICC involvement in all stages of the development of CYWHS programs that aim to engage Aboriginal clients.
3. Support the ICCs around allocation and eligibility of clients. For example, by ensuring ICCs have access to culturally appropriate reflective practice and are permitted informal peer support.
4. Promote and provide ongoing cultural awareness training throughout all levels of the Health Service.
5. Improve consistency and clarity of communication/information about the program, including population health and exclusion criteria.
For example:
 - Producing a DVD with “testimonials” to be presented at UCV and/or at maternal hospitals (consistent information, including about the role of the ICCs).
 - Television ads (like breastfeeding campaign) – with Aboriginal people and imagery
 - Linking name to earlier program ‘Mothers and Babies’
 - ‘Uniforms’ that delineate FHV staff from ‘welfare’ workers – eg. Women’s and Children’s Hospital logo on t-shirts?
 - Marking FHV cars with magnetic stick-on logos to differentiate from ‘welfare’ government cars – highlighting the mother-and-child-health focus
 - Nunga images, colours, designs as part of car logos
 - Posters – again with Nunga imagery and colours – in places where Aboriginal mothers might go
6. Retain “pending” category to give families plenty of time to decide whether to be involved in the program.
7. Model-up antenatal engagement for FHV clients.
8. Continue to develop program content in consultation with parents to suit their needs, desires and contexts, as well as the objectives of the program.

9. Support staff in continuing to respond to the whole-of-family by incorporating the whole-of-family approach into workforce modeling and case load allocation for ICCs and RNs.
10. Proactively explore options for better supporting fathers in their parenting role.
11. Ensure that clients who are not eligible for FHV have timely referral and access to the range of interventions appropriate for families with “high-risk” status. For example: fast-tracking into other services (eg, housing, domestic violence, drug and alcohol, Families SA); retaining options such as “access home visits’ or responsive home visiting, negotiated priority referral pathways to other primary health care services.
12. Retain and encourage options regarding other locations for the delivery of FHV (eg, clinic, children’s centres, other family members’ homes).
13. Encourage the utilisation of FHV psychologists and social workers for in-home support for FHV clients who may be experiencing more complex contextual challenges.
14. Acknowledge the role that ICCs and FHV nurses can play in liaising with other services (eg, Families SA) because they *know* a family, have been in the home and seen the parenting style.
15. Explore and model-up extending the program until transition to preschool. For example, by supporting FHV staff’s involvement in playgroups.
16. Embed qualitative methodologies into standard quality improvement practices, using as many approaches as is appropriate – ‘exit interview’ etc.
17. Link process, outcome and qualitative research to examine impact and acceptability of content and methods of delivery.
18. Continue a research agenda which examines FHV with a range of participants including Aboriginal families from other areas of roll-out, families who withdrew from, did not take up or were not offered FHV, non-Aboriginal families involved with FHV, and staff involved in the design, management and delivery of FHV.

Purpose of Report

The Family Home Visiting Aboriginal Research Partnership was formed in 2006 in order to explore two research aims:

1. To evaluate perceptions of Family Home Visiting program (FHV) with families of Aboriginal children;
2. To explore the suitability and acceptance of qualitative methodologies to involve urban families in a possible longitudinal study of Aboriginal children's development, *Footprints in Time*.¹

This report addresses the first aim by documenting the early stages of an evaluation of the Family Home Visiting program (FHV), delivered by the Children, Youth and Women's Health Service of South Australia. This Report outlines the findings of the first twelve months of the first stage of the evaluation process, which includes the experiences of the families of Aboriginal children and selected staff and management within the Family Home Visiting program. The report is intended to inform current and future roll out of the Family Home Visiting Program with Aboriginal families in South Australia and beyond. The second aim of the project is examined in detail in a report by Cate Jones for the Department for Families, Community Services and Indigenous Affairs.

Given there were very few participants in this first round of fieldwork who had either withdrawn from or refused the program, this report could be viewed as identifying what is working well for families who remain with the program rather than identifying barriers to engagement and retention. Similarly, given that it is families who have remained active within the program who have provided the information for this report, our findings are not necessarily representative of all clients' experiences of Family Home Visiting.

Background

"Home visiting" is a term used to describe a wide range of programs delivered to families in their homes. Recent reviews and meta-analyses of the home visiting literature have reported varying levels of effectiveness of such approaches in providing outcomes for child health and development, parenting practices and the prevention of child abuse and neglect (Bennett et al., 2007; Caldera et al., 2007; Duggan et al., 2007; Gomby, 2007; Holzer, Higgins, Bromfield, Richardson, & Higgins, 2006; Sweet & Appelbaum, 2004). The effectiveness of home visiting programs appears dependent on the characteristics of the intensity, duration, content and target group of the service (Bennett et al., 2007; Caldera et al., 2007; Duggan et al., 2007; Gomby, 2007).

There is quantitative evidence that Family Home Visiting programs, when delivered by trained professionals, can have substantial benefits for children and families. Much of the nurse home visiting literature is based on the pioneering work of David Olds and

¹ *Footprints in Time* will run from 2008 to 2011 in 11 sites (regional, urban and remote) across Australia. Adelaide has been selected as one of the urban sites. It will focus on babies and four-year olds initially.

colleagues, who have been implementing and evaluating home visiting programs for several decades. The findings from their recent follow-up studies demonstrate that prenatal and early childhood home visitation can produce long-term reductions in children's antisocial behaviour by reducing dysfunctional care of children and improving the maternal life course in at-risk populations (Olds et al., 1999; Olds et al., 1998), and can reduce child abuse and neglect in families with minimal incidents of domestic violence (Eckenrode et al., 2000).

The South Australian Children, Youth and Women's Health Service has adopted and adapted a model of Family Home Visiting from the US, with several significant modifications, including the removal of the antenatal component of Olds' model. A second modification is that, as well as nurses, Cultural Consultants are involved in program delivery for Aboriginal, Torres Strait Islander and African clients in South Australia. Although Olds promotes a nurse-led rather than paraprofessional-only delivery of home visiting interventions (Olds et al., 2002), there is a growing body of literature documenting the greater effectiveness of partnered approaches involving both nurses and community health workers (Barnes-Boyd, Norr, & Nacion, 2001; Roman et al., 2007). Furthermore, in one of the very few randomised trials of maternal-child home visiting in Indigenous populations (Apache and Navajo communities in the USA), a home visiting intervention for adolescent mothers was delivered solely by trained Indigenous paraprofessionals (due to a shortage of nurses on reservations) and shown to be well-received (Barlow et al., 2006; Harvey-Berino & Rourke, 2003).

Because the Family Home Visiting Program in South Australia has engaged a relatively high proportion of Aboriginal families in most areas in which it has been implemented, it is important to explore which aspects of the program have worked well for Aboriginal families and which have not, particularly given the dearth of literature around the effectiveness of nurse home visiting programs for clients in socially marginal or minority positions.

It is worth noting that this is not the first family home visiting program specifically tailored for Aboriginal Families to have been trialled in Adelaide. The Aboriginal Education Foundation Inc. (AEF), an Aboriginal-run, community-based agency, facilitated in-home support for mothers and families from 1972 until early in the 1990s. Its Aboriginal Senior Social Worker led a team from the very founding of the organisation (Brice et al., 1992), thus demonstrating a theme of staff continuity that similarly emerges in this report. Subsequently a research collaboration evolved resulting in a 3-year NHMRC-funded study of Adelaide Aboriginal families which ultimately focussed on Aboriginal and non-Aboriginal sole parents (Radford et al., 1999) and the understanding and alleviation of stressors associated with parenting. This multi-disciplinary project, incorporating sociological, public health and psychological perspectives, together with Aboriginal leadership, was the first such urban-based study of Indigenous families in Australia. Its methods included in-depth interviews and a comprehensive survey instrument, which was designed with ongoing Aboriginal input, joint planning and respectful listening (Brice, 1994). It is possible that community acceptance of family

home visiting and home-based, mixed-methods research in Adelaide may have been enhanced through the AEF's innovative service delivery model that operated until late last century.

About the Family Home Visiting program in South Australia

The FHV program operates within a policy context that includes the South Australian Government's 2003-2007 framework for early childhood services, *Every Chance for Every Child: Making the Early Years Count*, which was launched in November 2003 (Children Youth and Women's Health Service, 2005, p.2).

While scheduled for statewide rollout, Family Home Visiting is currently available across four regions of the state: Adelaide-metro North, Adelaide-metro South, Riverland, and Port Augusta/Whyalla. The present evaluation is incorporated within an Evaluation Framework developed by the Children, Youth and Women's Health Service, which includes: Input Evaluation (2004), Process Evaluation (2004), Outcome Evaluation (in progress), and Additional Research and Evaluation (present project).

The Family Home Visiting program in South Australia is the only maternal and child health home visiting service in the world which is delivered from a platform of universal service (at least one Universal Contact Visit for each child born in the State) and which uses population health criteria (mother less than 20 years; infant of Aboriginal descent; mother is socially isolated; poor attribution of mother toward infant) as well as targeted maternal assessment criteria (current or past treatment for mental health; alcohol or other drug related issues; family violence currently impacting on parenting; previous intervention from child protection services; child born with congenital abnormalities; and/or concern on the part of the assessing nurse at the Universal Contact Visit).

All families across South Australia now receive one home visit within the first few weeks of their child's life. Those families identified with additional needs for support, at this first visit, may be offered ongoing Family Home Visiting up to the child's second birthday. The program involves up to 34 visits focusing on child health and development and maternal-child attachment. The visits take place weekly for the first six weeks, then fortnightly for the next six months. Families receive monthly visits for the final twelve months of the program, and are supported in forming links with their local community.

The goal of Family Home Visiting is to build attachment between infants and primary caregivers in a non-judgmental manner and a non-threatening environment to meet the needs of parents and children in a responsive and predictive manner. A structure of the Family Home Visiting is outlined in the Family Home Visiting Service Outline (CYWHS, 2005), and the six modules that organise the sustained visiting include: Building Relationships; Your Social Baby; Becoming a Separate Being; Getting Mobile; The Who Am I Phase; and Toddling On.

A strengths-based approach – based on Hilton Davis’s Family Partnerships model (Davis, Day, & Bidmead, 2002), which focuses on the strengths of the individual to facilitate positive parenting, forms the backbone of staff interaction with families. The Family Home Visiting contact-staff (nurses and cultural consultants) are trained in developing secure attachment relationships, general child development, and socio-emotional issues facing families, including an intensive five day course in which participants reflect on and practice the characteristics of an effective helping relationship (Service Outline, p.12, 13). These staff are then supported by a multidisciplinary team, which includes social workers, psychologists, family support coordinators, bilingual community educators, and other health professionals. The role of the multidisciplinary team in Family Home Visiting is detailed in Appendix 1.

The role of the Indigenous Cultural Consultants (ICCs) is significant both to the families of Aboriginal children within the Family Home Visiting program and to the recruitment procedures for this initial phase of the evaluation. Furthermore, because of their ability to work in a mainstream service with Aboriginal clients, the ICCs embody an understanding of both cultures that they serve – the community of which they are a part of and at the same time work to support, and the organisation simultaneously defines the parameters of their service and seeks their expertise in the cultural specificities of their particular population. An outline of the protocols for engaging families of Aboriginal children is presented in Appendix 2.

Although generally delivered in clients’ homes, Family Home Visiting may be delivered in any setting in which the primary caregiver feels safe to explore the development of and attachment with their infant. In some circumstances this may include a women’s shelter, a grandmother’s home, or the local Child and Youth Health clinic.

Methodology

The methodology for this evaluation has been developed collaboratively, and will continue to receive ongoing input from those who will be affected by any changes that this research might recommend – for example, Children, Youth and Women’s Health Service management, ICCs, nurses, and families. In this way, it will be ensured that the research – including its aims, methods, questions, choice of locations, means of accessing data, analyses, interpretations, feedback and reporting, is best able to suit the needs of those who are involved with the program.

Research Questions

The aim of the first phase of the evaluation was to ascertain, from the perspectives of Aboriginal clients and Family Home Visiting staff, what a Family Home Visiting Program that successfully *engages* and *provides service* to the families of Aboriginal children would look like. The project sought to do this by addressing the following research questions:

1. What are clients’ and staff’s perceptions of Family Home Visiting?
2. What are the main benefits of Family Home Visiting?
3. What factors facilitated parental engagement within the program?
4. What were the perceived barriers to participation in the program?
5. What improvements could be made to the program’s methods of engagement and service delivery?

Design

The study used a cross-sectional qualitative design in two regions of metropolitan Adelaide: Northern (Salisbury/Elizabeth) and Southern (Noarlunga, Aldinga, Marion). These two regions were selected to pilot the methodology in sites in which the program was being delivered to a high number of clients with relatively good rates of uptake and retention.

Methods

Following three focus groups with selected staff in the Family Home Visiting program in April 2007, the recruitment of family participants took place in May and June 2007 after extensive interaction and consultation (for many months) with the Indigenous Cultural Consultants, who had been asked to assist with client recruitment. Family participants were initially contacted by FHV staff in the two regions and invited to participate in a focus group and/or interview. Informed consent was obtained from all participants. A total of five focus groups (three in the Southern region and two in the Northern region) and 23 interviews were conducted by the two Research Associates, Leda Sivak and Cate Jones.

Procedures

Potential participants were initially invited to a small group discussion, but were also given the option of only taking part in an individual interview if they preferred. Five

family focus groups were held in total: two at Kids & You, Elizabeth Grove in the North, and one each at Noarlunga Health Village, GP Plus Aldinga, and 'Hocus Pocus' café Marion in the South. With the participants' permission the majority of these discussions were audio-taped, although sound interference in two group settings in the South led to only notes being used for analysis. The focus groups with families were designed to allow for a broad discussion of the Family Home Visiting program. The interview guides for families and staff are included as Appendix 3.

Focus group participants were also invited to take part in a 1:1 interview with the researchers in the setting of their choice (eg, home, CYH clinic, other family member's house). The majority of the interviews took place in participants' homes. The purpose of the in depth interviews was to allow participants to discuss in more detail some of the themes and comments raised in the small group discussions, and to raise points that may not have been covered in the previous groups. Participants were able to have a support person with them during the interview (for example, an Indigenous Cultural Consultant, friend or family member); with the exception of the informal support of other members of their household, no participants chose this option.

Informed consent was received from all participants, and family participants received a cash acknowledgement of their time. All participants were given the opportunity to review and alter their transcripts (or interviewer's notes when participants expressed a desire not to be recorded).

Analysis

Data was independently coded by three researchers from the Australian Centre for Child Protection using content analysis as the coding methodology. The consistency of coding was at all times extremely high between the researchers and any discrepancies were resolved through discussion.

Participants

The first stage of fieldwork with families of Aboriginal children who were involved in FHV attracted 60 participants, including 47 focus group attendees (a total of 27 across three Southern focus groups; and a total of 20 across two Northern family focus groups) and 25 individual interviewees (17 in the southern region and eight in the northern region), and accounts for overlap between the two styles of involvement (12 individuals were involved in both settings and 13 chose to be interviewed but not take part in the group setting).

The majority of participants had either completed the Family Home Visiting program or were still active within it, and a number of extended family members participated also, as they were familiar with the program through supporting people who had been involved with FHV. As previously mentioned, the number of interview participants who had either withdrawn from, or refused to join the program are underrepresented in this interim report but will be included in future research.

Most participants were mothers who took part in FHV, although several fathers attended the focus groups and interviews, as well as extended family members.

The proportion of first-time parents represented in the research was approximately 50% while a number of participants have also received Family Home Visiting services for their older children. Several parents were also in a position to compare their experiences of parenting either with or without FHV, given that FHV was available for their youngest child, but not their older children.

Findings of Focus Groups and Interviews with Parents

Themes that emerged in the focus groups and interviews with families are reported below under the following headings:

- (A) General Perceptions and Perceived Benefits of FHV;
- (B) Staff Characteristics;
- (C) Role of the ICCs;
- (D) Program Structure – Engagement;
- (E) Program Structure – Content;
- (F) Program Structure – Service Delivery; and
- (G) Program Structure – Cessation.

There is a degree of overlap amongst all of these areas and many cannot be separated from each other. Two additional themes that frequently emerged and which thread through all of these sections were those of the contexts in which families were or had been living; and that the program, where possible, was able to include or address the needs of the whole family.

Challenging contextual issues that families had or were currently experiencing are shown in Figure 1.

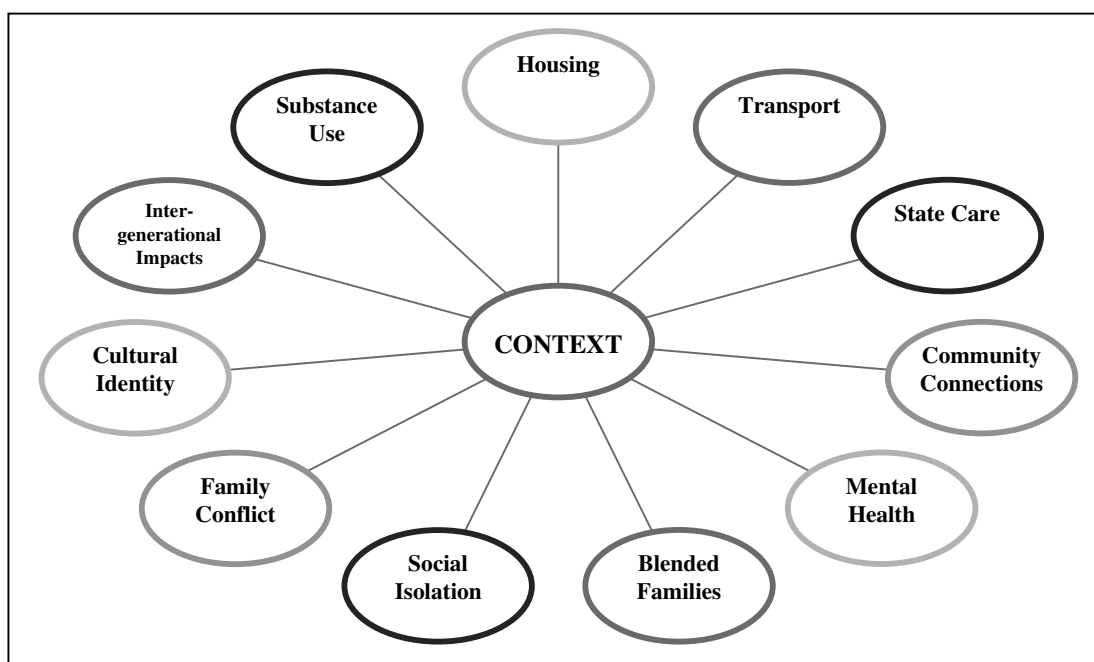


Figure 1. Contextual Challenges

It should be noted that this study was not designed to present a representative view of the experiences of Aboriginal families, and many families will have experienced positive

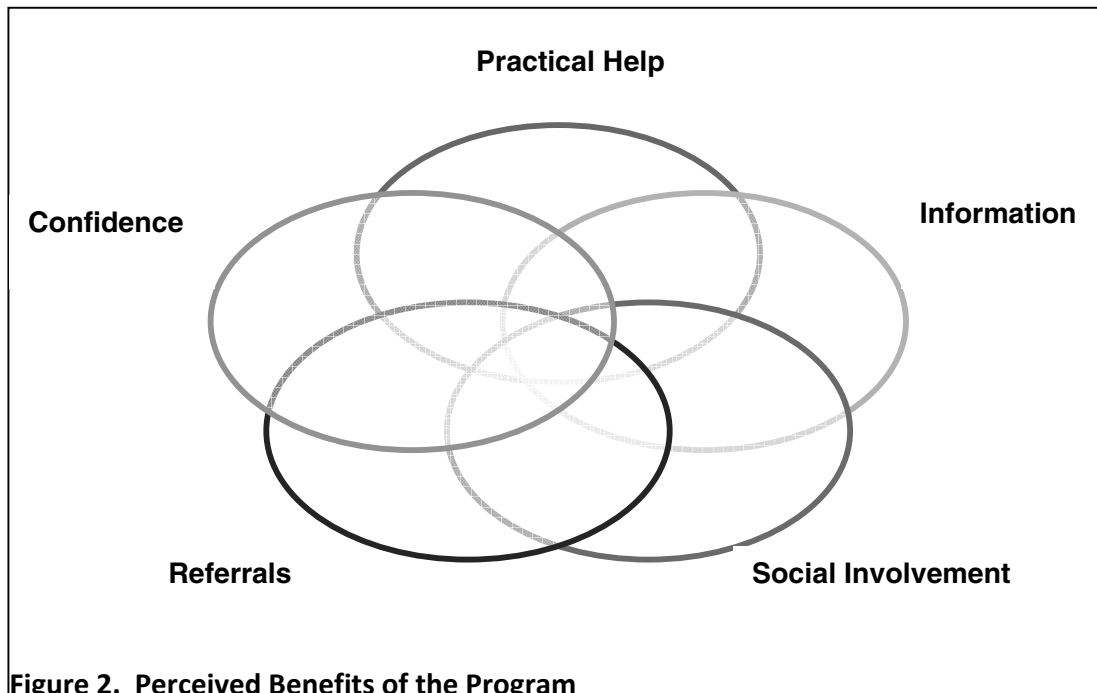
life circumstances as well as dealing with some or all of these challenges. Examples of how the program responds to the complexities in families' lives are included in many of the broader sections to illustrate the need for flexibility within the program to take into account, and where possible, to respond to individual family needs.

Regarding the second pervasive theme of incorporating "whole of family", although FHV is promoted as a maternal-child health service, the flexibility of the program means that at times staff could actively involve and be responsive to the needs of the whole family. This included providing services, information and referral for mothers, infants, fathers, grandparents, and other members of households. This is discussed in more detail in the following sections both in the approach of the staff, and in the content of the program.

It should be noted that for all sections, findings were generally consistent across both regions. Unprompted differences that arose in the North were mostly identified in focus groups and interviews that involved older Aboriginal women and the themes that were discussed may have been similarly found in the South with prompting. Where regional differences arose, these have been highlighted in the text. Unless otherwise indicated, quotes are from people who participated in the family focus groups and interviews. Selected quotes from a focus group with the Indigenous Cultural Consultants are included where they support or expand the comments made by family participants.

The analysis of themes for this project utilised all of the data available (ie, notes, transcripts and written responses from focus groups and interviews with family members and staff). The quotes used to illustrate these themes in the following sections are primarily from family participants whose interviews were audio-taped, and in some cases from the focus group conducted with the Indigenous Cultural Consultants. Where quotes could potentially identify the speakers they have not been used.

A. General Perceptions and Perceived Benefits of FHV – “It’s all good. I like the program”



Extremely positive feedback about the Program was given by almost all families who participated in focus groups and interviews.

Yeah, it (FHV) was definitely my saviour, and even my partner said, if he could be here, he'd even comment on how much we sort of got out of it.

- Mother

Where I find that I'm a better mother, being with [the nurse] than I was with my other two [children]. Because I've got this other support there for me, and all different information.

- Mother

One participant described the success of the program in the following way:

I'd say that if it stopped tomorrow, it was still beneficial. Which makes it successful. If you can learn one thing from one visit, you've succeeded with something, haven't you?

- Mother

In general, FHV was seen as a convenient, responsive, positive approach to child health and development, delivered in an empowering and respectful way. For many

participants, staff were seen as much more than professionals, often as family and friends of the families they were working with.

Yep, [the service has been 'successful']. Absolutely! One hundred percent. Sometimes the visits can be short – half an hour – and sometimes the visits can be an hour and a half. Because it's just – again, it's just like having a friend coming into your home, and giving you that support. But only, but only it's more professional. They know more, offer you more. Yeah. Just, yeah it's excellent. I know there's still time to come for this service to boom more. But I just wish it was sooner, rather than later, you know.

- Mother

Participants identified a number of significant benefits from taking part in the program (see Figure 2), although their perceptions of its impact varied. For some families, the benefits included practical assistance, information and referrals for health and other issues (eg, housing, playgroups), and for many it also included feeling more socially involved, more supported in their parenting decisions and generally more confident in themselves and their parenting.

I reckon it's opened me up to more talking. Because, when I first come to Adelaide I wouldn't go out or talk to hardly no one. And since [the nurse has] been coming and that, and [ICC 1] and [ICC 2] and that, I've been out in the open, and there are other areas for me to go to and all that.

- Mother

I think it just gives you more confidence, that you know what you're doing, you can get through the next week. And like, with all [my son's] changes, because he's growing and changing so much! Like, even when you have a hard week, just knowing that that's – you know, you can go back to your information chart, and go, "Oh yeah, he's supposed to be a bit unsettled this week". And you know, it makes you just feel a little bit more in control, I think.

- Mother

Thinking...maybe, "Am I doing the right thing?" and having that reassurance that, "Yeah, I am a tops mum, and I am doing the right thing." So, yeah. Having [the nurse] to say, "Yeah you are doing the right thing". It has definitely helped boost my confidence as a parent.

- Mother

Perceived benefits for families sometimes extended beyond the mother-infant dyad as participants reflected on how Family Home Visiting had enhanced their parenting of older children and their older children's interactions with the new baby as well.

I think I communicate now more with my oldest one, because she's twelve and thinks she's a real woman. (laughing) And she's real communicative with [the baby] now too. Since [the FHV nurse has] been coming she's been doing more programs with all of us. Yeah.

- Mother

The extent to which the program was perceived as helpful in relation to broader social factors appeared to reflect the degree of experience and support families had in their parenting roles.

I think it did help a lot. The information, and even these playgroups. Just to know what's out and happening Because there's no way to get information. But they'll [nurse and ICC] bring us, just things like, when to start feeding them, and toilet training. And when to start doing it – when's too late or too early? And they always know the right answers. And pamphlets and moral support, mentally support.... I speak to [nurse's name] more than I speak to my mum, and ask her for help. Even when my son was in hospital, I'd ring [the nurse] crying, and just that support.

- Mother

Oh yeah, because I didn't really have any idea about what to do with a baby. Like I had my instincts but [nurse's name] has just helped me with stuff like, she says things like, "That's normal, this is normal", like, "Don't worry about that"...helping me which is good. It's good to have her just one-on-one because my family aren't around

- Mother

It's not going to change the way he [my son] is. It might change us as being able to interact with him better, which I suppose in the long run would benefit him. But. Yeah, there's nothing really that we'd be doing that's the wrong thing to do. Which comes from experience, and maturing and whatever.

- Mother

Although this evaluation is not designed to comment on health outcomes for these families, it is possible to indicate an apparent increase in families' awareness of infant health. Families' comments are consistent with several of the key objectives of the program – including health and safety, child development, parent/child interaction, and community connections. It will be important to link this qualitative evaluation to an outcomes evaluation in order to measure both the immediate impacts and long-term outcomes of the Family Home Visiting program.

B. Staff Characteristics – “She just has this thing about her” -

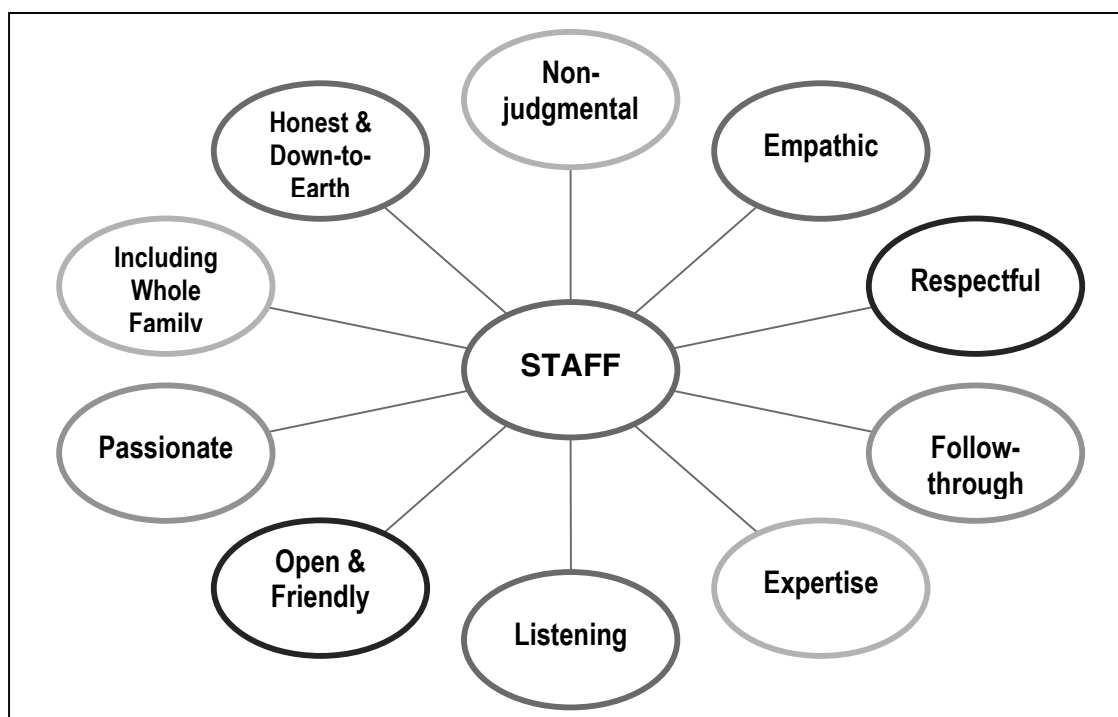


Figure 3. Characteristics of the FHV Staff

Participants in both regions of the pilot were exceptionally positive about the qualities of the Family Home Visiting staff and the relationships they had built together (see Figure 3).

I've got nothing [bad to say about the staff], I think they're wonderful.

- Participant in Focus Group

I think she's lovely. (laughing)

- Mother

Yep. Yep [the nurse is] really good and a heaps nice lady too.

- Mother

Oh she's a goody! All the kids like her, you know what I mean, even though she's here to give you the needles.

- Mother

The personal qualities and relational skills of the Family Home Visiting staff are very prominent themes that run throughout the findings.

But these three [ICCs] go out of their way. These three are good. You know what I mean, they're excellent. They go out of their way, they'll ring up. But if we could get

other workers like them. Because [inaudible because a baby is crying] Both black and white – you’ve got good whitefellas there, they know the family. You’ve got other whitefellas that make you feel very out-of-place and uncomfortable. You know. Same with the Nungas – you get the good and you get the bad. You know, ones that will bend over backwards to help you, and the other ones just won’t bother. You know. But you know, if you get that good white person, no problem! You know, “Come in”. Because you get a feeling from the person straight away, “Good person”.

- Extended Family Member

I reckon [FHV staff] have to...love what they do and they would have to love being involved with the families...and to put up with how some families are...because they can’t be too judgmental. All families are probably a bit rude to start off with because they don’t know who you are, how you are, what’s going on in your head...and you are going to be with their child...so...like all of them are going to love the program...they love the program now and they love the people who work for them. It’s about respect and earning that respect to start off with.

- Mother

The Hilton Davis *Partnerships with Parents* model forms the backbone of specialized training for those Family Home Visiting staff who engage directly with clients. Many of the model’s core components were reflected in participants’ comments about the Family Home Visiting staff. These included personal qualities such as respect, genuineness, empathy, humility, quiet enthusiasm, personal integrity, intellectual and emotional attunement, and technical expertise, as well as interpersonal skills such as listening, enthusing and encouraging, and enabling (change).

One of the key objectives of the Family Home Visiting program is the building of relationships and ‘partnerships’ with those in the parenting role. The fact that participants spoke frequently of these indicates not only that many staff have embodied the model’s values into their work with participants, but also that the qualities that are valued by the model were equally valued by clients.

Components of the *Partnership with Parents* model have been woven throughout the following exploration of participants’ perceptions of staff and the relationships that they developed throughout the program.

Interpersonal Skills & Strengths-based Approach

Well [the FHV nurses] have good interpersonal skills, so you feel comfortable with them all the time. And when they call they always ask, “How are you?”

- Mother

In alignment with the *Partnership with Parents* model, one cluster of interpersonal skills that families resoundingly appreciated in the staff was the strengths-based approach of their partnership-building with families. This was described in relation to staff’s ability to empower, enable and support clients in their parenting decisions, and has resulted in

many participants feeling that their choices and opinions were respected. It was also supported by staff's consistent positivity, and the absence of negativity and doubt, which was significant in the lives of many participants who had had less-than-ideal experiences in other service relationships and social settings.

Families described how advice was given in such a way that they did not feel forced to accept it, and that alternatives were given rather than advice. This enabled families to make changes without feeling disempowered or that they were "bad parents".

She's [nurse] really placid. And so she's not really, "Do this and do that" overbearing. She's just – I suppose she just lets me do the talking! (laughing) And so, whatever I've got, she'll just listen and then start giving information and stuff. And yeah, I think that's what I like about her the most. Because a lot of people just tell you what to do. And they might be right or it might be wrong, but they just don't let you come to that place by yourself. But she's good like that.

- Mother

But they never say anything negatively. Or anything like that. It's always very, very positive. ... And no one's tried that like that before.

- Mother

Similarly, another participant described how the nurse conveyed that clients' opinions were valuable by discussing – even potentially divisive issues such as child discipline – in a neutral and informed manner.

And yeah, but she doesn't say well, "You should never smack your child! And if I ever see you, I'll report you to the Child Services!" Something like that. It's more like, "This is one of the things that happens with smacking children, and this is another way of approaching it, if you don't want to do it that way."

- Mother

This was also true of staff's behaviour in relation to referrals for external services.

They let you know [about other services], but they don't force you to do it, you know. Like, "If you've got all these questions, you need to go there". They don't do that. They're like, "Well we know of this group here that deals with this here", you know, "If you like, if you want us to..." They'll sort of ask, but they leave the decision up to you, you know.

- Extended Family Member

The positive comments and feedback provided by the FHV staff were a key way in which the strengths-based approach was demonstrated, and participants expressed the value of this not only for young mothers, but also for those with more parenting experience.

And the main thing is that she is always positive, finds positives. Especially when things are... You know, young girls are very vulnerable to negativity, hugely vulnerable, and [the nurse] will just find things all the time with them that are positives. And [the nurse]

will just talk to them. And you see [the young mums] once they have lifted themselves up [the nurse is] like, "Well maybe you can try this now".

- Extended Family Member

Having had other kids, anything that gives you positive feedback in the way you're bringing up your child is good. Because you're just so – it doesn't matter how many children you've had, you're still learning things. And things change, from what they say is okay ten years ago, to what they say now.

- Mother

Yeah, but when they [FHV staff] left they always made you feel like you was doing a good job, sort a thing. They are just so good I can't think of anything that would make them better.

- Mother

No. I've never experienced [the FHV staff having 'attitudes']. They've always been really nice, really outgoing. Speaking to you all the time. Yeah, and not when – and if I do something wrong, they're not doubting me about it. They're telling me a right way that I can understand.

- Mother

Empowering parents was one key to the positive, strengths-based approach taken with clients. However, this occasionally contrasted with participants' experiences; for example, on one occasion a younger mother was not treated as the primary decision maker for her child, as the staff member (now no longer working with this family) bypassed the parent and spoke more directly to the client's mother-in-law.

Well, the other [nurse], yeah. (laughing) Yeah, that was really annoying, because she was there to talk to me because it's my child. Not, you know – you don't talk to the grandmother, because she's had four kids. She knows what she's doing! (laughing) But it's better that like, yeah, I could've asked her [mother-in-law] for advice. But everyone's different and it's better to hear it from my nurse, than from, you know, the mother-in-law.

- Mother

Focus groups and interviews also highlighted the importance of feeling listened to, another interpersonal skill highlighted by the *Partnership with Parents* model. Participants valued the fact that FHV staff took the time to 'sit and listen' and clarify any client concerns.

Yeah, but they sit down, and they've got the time for you, and they sit there. [inaudible] They don't cut you short or nothing. [Mother: That's true for the Aboriginal workers too.]

Extended Family Member

Personal Qualities – Enthusiasm & Involvement

Like their interpersonal skills, the personal qualities displayed by the staff often reflected the Hilton Davis Partnership model's ideals, which include 'helper qualities' such as respect, genuineness, empathy, humility, quiet enthusiasm, personal integrity,

intellectual and emotional attunement, and technical expertise. In particular, staff's genuine enthusiasm and involvement in clients' lives was amply demonstrated by the examples that participants described. Furthermore, staff very often performed roles and services that extended well beyond the expectations of clients, and sometimes beyond the original intentions of the model. The fact that staff were perceived as friends/family members was a dynamic that many participants valued.

Respect was demonstrated in a number of ways including clarifying details around appointments, and having a non-judgmental approach to families and their decisions including valuing parents' input and opinions.

No, because when they come to visit, they'll ask, "Is it okay if I come back next time?" And they'll ask "What day is good for you?", and that. They'll ask. They don't say, "Well, we're going to be back next week at ten o'clock and..."

- Extended Family Member

And only my worker's there and myself, and when she's rang me up and asked me, "Is it alright if I come by myself, because they (Aboriginal worker) can't come?" and all that. And, yeah. It doesn't worry me if they don't come or not, but.

- Mother

She's really friendly, and outgoing and open. And she doesn't – like if you have an opinion that's different to hers, she values that opinion, doesn't sort of say, "Oh, no, you're wrong" or whatever.

- Mother

Evidence of genuineness and empathy included a demonstrated understanding of families' circumstances and an authentic interest in supporting Aboriginal people's health as well as sharing their own parenting experiences.

To me they're more like family, interested in you like family. They're not just in a job, but they're interested in your child. And really, really – and I've seen people doing their job, it's their job and they've got to do it, early childcare workers – but these [FHV staff] are like genuinely concerned about our children, and they love them like they're their own family. So it's...might be the empathy thing, I don't know.

- Mother

They can see that where we're coming from. They know what the situation has been. And they do things to inform us, so we can do things about it.

- Mother

That's why [inaudible], you get somebody who knows what your life is like, and they want to support Nungas. You know what I mean.

- Extended Family Member

Sometimes we get off on a tangent because her children have similar abilities to my older ones...and we've talked to her about that. We were having a good discussion about that, and how it's got good points and bad points, and what those good points

and bad things are. And how she handles it, because she's got kids that are similar. So, that's quite good. She's not just the nurse, she's a mum. And she has trials and stuff with her own children, like everybody, which is good because sometimes professionals come across as though their children are perfect and she doesn't do that. (laughing) Because no kids are perfect.

- Mother

Staff enthusiasm for their role was a prominent theme, and the staff were often seen as going beyond parents' and staff expectations of their role, and sometimes beyond the service model.

She sometimes even offers to take me shopping, and all that. She even – if she's got a car seat, she'll often take me and the kids in, if she's got time and everything, yeah.

- Mother

Oh yeah, for sure. They just go out of their way for anything. I even rung [nurse] up one night 'cause I couldn't get home down this way and she stopped on her way, I think she was going home from work, and she stopped on the way and picked us up, and these kids and took us home like.

- Mother

She [nurse] goes out of her way. And even out of working hours, she's so good. She'll call you or you can call her. She'll always just sit there.

- Mother

I didn't expect they'd be so nice! (laughing) And I didn't expect her to drive me to my playgroups and everything, and help me out that way. And like, answer my phone call at 7:30 at night or something.

- Mother

Yeah, [my baby] still has to go to hospital now [...] have appointments at 9.00am. Sometimes we don't get home 'til 4.30pm and they [FHV staff] pick me up at 8.30am and we get to the hospital and they are with me all day. There's nothing else they'd get done 'cause they are with me all day. They're [FHV staff] good, excellent.

- Mother

This is contrasted with a nurse initially assigned to a family, who did not have these qualities.

Well the other one, she – I don't know – sort of had the attitude like she didn't really care about her job; she just wanted to get it over and done with, and she's more in it for the money, I thought. Because she had no heart in it. And. As opposed to this one now: she thinks the world of her job. She loves it.

- Mother

The passion and dedication of non-Aboriginal staff working with families was very highly valued, as well as adding to the strength of the partnered relationships between nurses and ICCs. This was particularly important for individuals (and indirectly, communities)

who had had previous experiences in other settings in which they were less comfortable with professional staff. As one Aboriginal staff member commented:

For Family Home Visiting to happen, you need to have ...the nurses. Because there are nurses out there who are really passionate about Aboriginal people and Aboriginal health. And they really put every effort into it! And that's why it's worked...Because we've had a couple of nurses that have really pushed. Without those nurses, it wouldn't be working like it is today. It would be hard. ...You've got that support, they go that little bit further...

- Indigenous Cultural Consultant

And it makes a big difference with this Nunga community, with the lot of them. Because if you get someone that's stone-faced, no smile, no nothing, well they're [the community] going to back off, you know, "I don't want nothing to do with this". But the nurses they've got are real down to earth, and easy going, you know. Yeah, great.

- Mother

I mean I try to get involved [in FHV] – well I do, I'm there [at the visits]. And she's [nurse] very nice, she's very personable. And I've had occasions where people aren't and it can be really awful, you know, if they're telling you what to do.

- Mother

[Our nurse] could almost pass for a Nunga! (laughing)

- Mother

She's down to earth and easy going, and connected to the community. And people pick up on that. But I mentioned the white people, who are very – I don't know the word...

- Extended Family Member

Some participants commented on how they appreciated both the extra assistance from staff and their own independence. This is an important point as the program does not aim create a dependent relationship between families and FHV staff.

I thought [having a baby] was going to be so difficult – like to try to get around on public transport and like, "What if something happened?" Because I don't want to call [my partner's] mum. Because I'm really independent, and I don't want to have to be relying on someone. But it's good to have someone coming here. But I haven't really become reliant on [the nurse] – to do everything all the time – but it just makes life a lot easier. Than having to get to the doctor, and get to the doctor's surgery, every fortnight or whatever. (laughing) [...] But she does give me other services. And I wouldn't call her like, really late – because she's given me this 24-hour parent-line and...

- Mother

There's not really anything more they can do, in capacity of what the job is. You get what you would expect to get from a travelling, or a visiting nurse. You wouldn't expect them to come over and do your housework or something. (laughing) You know, what else can she do? She's here to help you and your relationship with your baby. And to reassure you with his development. She can't really do anything else. (laughing)

- Mother

Staff were also seen as being attuned to parents' emotional needs, particularly in the absence of other supports, and families valued the knowledge they brought with them to the role.

Because some girls have nobody. But I'm more isolated than them. I only rely on my foster mum – I don't have aunties, uncles, cousins, so. They did a lot for me, you know. And most of my girlfriends don't even know half the things that are around in the community for them. If it's depression, or if it's malnutrition – all sorts of things. Just lots of information, you don't even have to ask, they'll offer. You know what I mean? If you're shy or you can't, you don't even have to think about asking. They know, they're aware, and they'll offer it.

- Mother

Other personal qualities that both the nurses and the ICCs in partnership exhibited, and which facilitated clients' feelings of comfort, included a cheerful disposition, openness, honesty, and being friendly and outgoing.

Yeah. She's very open, and honest.

- Extended Family Member

Yeah, they just come out and you have a laugh. And you can just talk to them like when they ask you how you feel today, you can say, "I feel like shit today". They're just...

- Mother

They're not intrusive...

- Mother

Yeah, they make me feel really comfortable, you know.

- Mother

They are always happy, laughing and you just feel comfortable. Yeah, I don't know, you couldn't improve anything on it I reckon. Nah, it's good, it's excellent.

- Mother

Additional staff characteristics that were seen as important to parents included a love of children, a lack of prejudice about race or age, approachability, connections with the community, and a friendly, outgoing and down-to-earth demeanour.

The nurse just loves [my child], you can tell.

- Mother

I got a good one....Some people don't want to touch us.

- Mother

Yeah, the nurses are really down to earth. They don't – they sort of bring you out of their shell too, you know. Because over the years as parents we've had – well I've had people

that [inaudible] face, and, "I'm not going back to them", you know, and "I'm not taking my kids to them". Well these ones here – well I sit there right through the whole visit, you know.

- Extended Family Member

[The nurse] has an interest in children and she has a passion for what she does. She was just meant to be. How she treats the children her passion shows through.

- Mother

C. The role of the ICCs

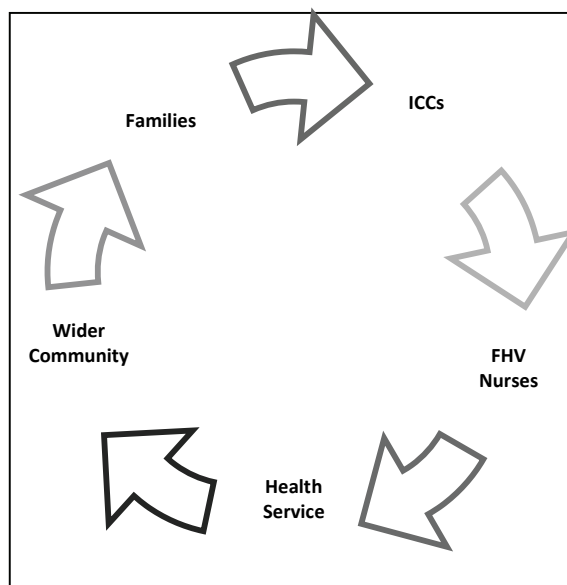


Figure 4. The Role of the ICCs

The importance of providing families with the opportunity to have a Cultural Consultant involved in Family Home Visiting was often highlighted (see Figure 4). Being presented with the choice was important to participants. In fact, having a prior relationship with the particular Aboriginal staff member was generally less important than their ability to mediate the building of a relationship between the Family Home Visiting nurse and the family.

I might not necessarily get on well with that particular person [ICC], but they're a lot more likely to get in my home [than a non-Aboriginal nurse on her/his own], you know what I mean, because we're on the same level. We're on the same level in the ways we think, and how we do things. They know what lines to draw and we know what lines to draw, so it's very much needed that you have an Aboriginal worker with anyone that come to do that [in your home].

- Extended Family Member

The importance of having Aboriginal staff available was frequently mentioned by participants in the north (first in the focus groups, but repeated in the interviews), often in a way that contrasted the perceived abilities of Aboriginal workers and non-Aboriginal staff, while recognising that the combination of both sets of strengths was important.

I like it more when the Aboriginal workers come in with the health workers. You feel more at ease with an Aboriginal worker coming in, yeah.

- Mother

And even a well-intended non-Aboriginal worker can sometimes unknowingly be insensitive to your needs or to your culture, you know, your ways.

- Mother

Some participants highlighted the importance of Aboriginal staff in the engagement process, sometimes noting that without the presence of an Aboriginal worker, potential clients might not be receptive to the service.

Having the Aboriginal workers is really important. Because you wouldn't get into my house without them....Why is that? Well, I think for me, as an older woman, you've had to put up with racism for so long, and it's in all aspects of life – you go into a shop, you go into the pub, they all look at you, and they expect you to have done something. It's very [inaudible], they follow you, and, "What have I done?" And I haven't done anything. So it doesn't matter what organisation, it's about getting the right [inaudible] services for you as a person. So that's why I say that.

- Extended Family Member

Aboriginal staff were also seen as having an understanding of clients' context and culture and sometimes as having a different way of communicating with families.

Well with the Aboriginal workers, I like how you can talk about your culture more with the Aboriginal workers around, and how you feel – like, with the non-Aboriginals you can, but with the Aboriginal ones, how you're feeling. Yeah.

- Mother

They are more understanding.

- Mother

[Aboriginal workers] don't talk down to you. It's like, they're not saying that "This is the way to do things, this is the right way" all the time. Like Aboriginal people just say, "It's your way of doin' it so it's alright", you know. It's friendlier. They've got a different way of explaining stuff.

- Extended Family Member

At times the ICCs provided a mediating role in the communication between the FHV nurse and their clients, as one participant noted:

Yeah, [the FHV nurse] the midwife lady, she explains everything, and she's really good, yeah. If I ask questions that I'm not too sure about she either lets me know, or if I'm not sure, Auntie [ICC] will put it in the terms I understand. But yeah. [...] Because sometimes if [the nurse] doesn't understand what I'm saying, Auntie [ICC] will put it into the perspective so [the nurse] knows, so yeah. [...] Oh, I just look at [the ICC], she just... I'm not sure how she does it, but yeah.

- Mother

A number of participants indicated that they would have liked more contact with the ICCs for this reason, although many attributed the lack of involvement to the ICCs busy schedules and competing commitments. The involvement of ICCs was particularly valued when families were unlikely to have this kind of contact with Aboriginal people in the short term (eg, when families had just moved in to the area, or where a non-

Aboriginal parent may not be confident about how to make connections with Aboriginal communities).

I'm Aboriginal [but not from Adelaide], and I don't know much about the Aboriginal people here. So, if they're going to give us an Aboriginal worker, it's good for her to come. Because I don't know much about what I can do here. I mean, she told me about the dads' group, but that's about all. But other things, like the things that are going to happen around here, like important things, meetings or get-togethers with other families and that.

- Father

You know, I hardly ever actually get an Aboriginal worker coming to my home. [...] No, I want [the Aboriginal staff] to come, because the only Aboriginal people my child gets to see is from the Early Learning Program. That's a playgroup, where they come out and play with him once a fortnight. But that's it. I think [the ICC] has come out, I think two or three times maybe? But that's about it. So my baby sees no blackfellas at all. It sucks. (laughing)

- Mother

Yeah, and it's the community links, and so maintaining that community through the [Aboriginal] workers.

- Mother

One participant highlighted the significance of Aboriginal staff as role models for children and the community.

[Children] need people in the community that they identify with as role models. For example, like I know that my kids look at Auntie [ICC] and [our FHV nurse] as a source of – like they talk to them, tell them about, “I did this deadly” or like, “We're doing this in the weekend”. My thing is, being a single parent, and I had five generations [in my family], but then my great-grandmother passed away, then the next year my mother passed away. So like my whole line went in those two years. And so, what I have is – but you know, like there was women's business, and all the aunties and all the cousins, everyone, all the nanas there, and all of that is gone? And so I absolutely – I sort of look to [the ICCs] and the AEWs [Aboriginal Education Workers] for that identity. That's their purpose. And so, the kids need that too.

- Mother

There were many levels of ICC involvement with families as dictated by participants' needs, but also to some extent by competing demands for ICCs' time. Some clients wanted ongoing ICC participation while others were happy with less contact.

They [ICC] come to every visit I've been having, yeah. [...] There've been a few times that the Aboriginal worker hasn't come, and it's been that I feel alright.

- Mother

I only saw [the ICC] a couple of times and when [the nurse] went away and stuff and she said I can ring her, um, but I loved [ICC's name]. [My child] loved her and I wished I

could've got to see her more because she just has this thing about her, you just feel comfortable with her and you can talk to her about anything. Yeah, but unfortunately I didn't get to see her as much. But I loved her, she's great.

- Mother

As well as Cultural Consultant being a 24-hour, 7-day a week role, the ICCs have a high level of accountability to the community particularly with regards to the eligibility of families for FHV.

And the other thing too, is you get people coming up to you saying, "Oh, well, how come my cousin is doing that Family Home Visiting Program, but I've got twice as much kids as her, and I need more and more help, and how come I can't be a part of it?" And then you have to explain. [...] Just that "Due to too many crises that keep occurring, you don't really fit into the Family Home Visiting program, but what we can do is offer you other supports." And I always say, "We're not giving up on you! If you ever need to call me, give me a call".

- Indigenous Cultural Consultant

Now, we [ICCs] actually know our role. And we know who would fit into Family Home Visiting. But then it's our credibility in the community as well. That we have to still meet with them, and give them... If we know for a fact that, in our heart, that they're not going to fit the Family Home Visiting Program, we still have to give them the resources. To refer them on, too.

- Indigenous Cultural Consultant

Although deeply important, close community connections create precarious negotiations and potential repercussions for the ICCs in that their roles as workers and community members are never separable.

And with me, like how I work, is I need to make sure I do my best, that I don't offend anyone. Because once your credibility is ruined in the community, and the word of mouth gets around the community, you mightn't get any other people looking to do Family Home Visiting. Because you're that worker that mucked up that family. That's why you have to do your best.

- Indigenous Cultural Consultant

Staff members commented on the potential for misunderstandings, particularly around the contrast between population health criteria and the exclusion criteria in cases of family complexity. Furthermore, staff discussed the process and purpose of case reviews and the obligation to provide support to families who do not meet the criteria.

Now just because you're Aboriginal doesn't actually automatically mean that you go into that program, because it's not.

- Indigenous Cultural Consultant

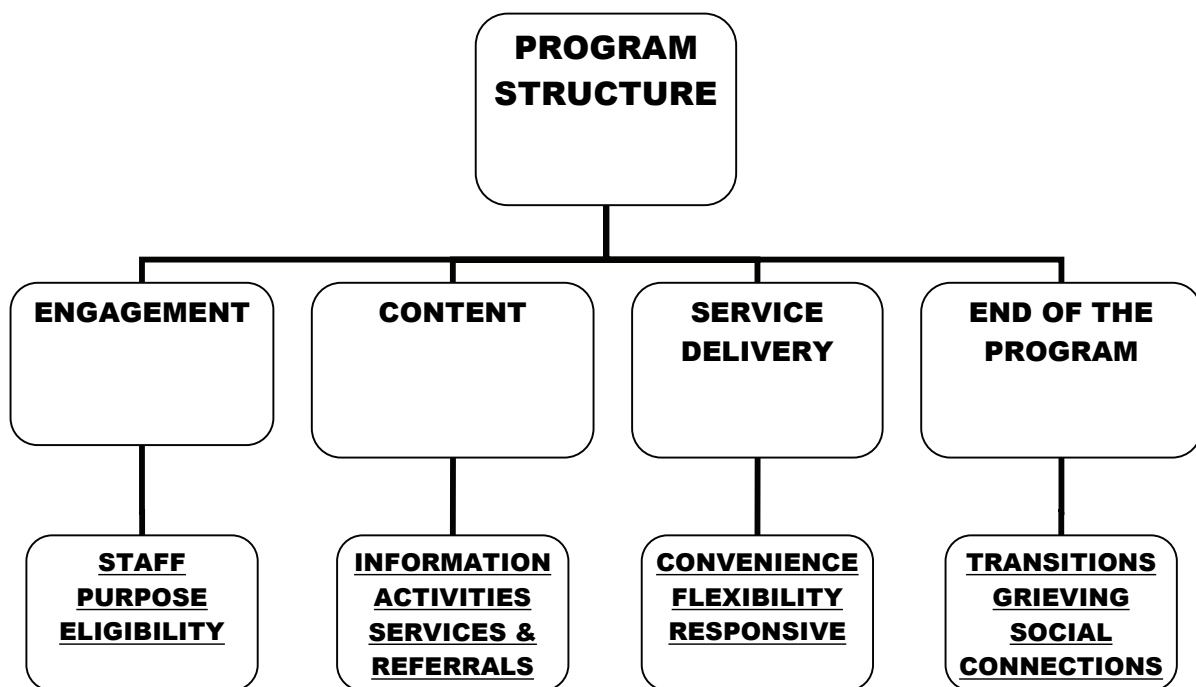
But the Program, Family Home Visiting, is not for those hard cases. The criteria for Family Home Visiting is Aboriginal, young mums, and isolation. And they are the criteria. But then there's things that come in there as well. But that's when you bring it back to

the case discussion, to actually discuss, “will that family get something out of it?” You need to look at will that family get something out of it. Because you can’t put them in, because they’re actually taking up space where somebody will actually get something from it. And then you need to look at, well, if they’re not giving that family Home Visiting, you need to look at what other resources there are for them. Then you do your case planning, to refer them on to whatever.

- Indigenous Cultural Consultant

RECOMMENDATIONS

- 1. Acknowledge the importance of the role of ICCs in engaging and allocating families at all levels of the Organisation**
- 2. Ensure ICC involvement in all stages of the development of CYWHS programs that aim to engage Aboriginal clients.**
- 3. Support the ICCs around allocation and eligibility of clients. For example, by ensuring ICCs have access to culturally appropriate reflective practice and are permitted informal peer support.**
- 4. Promote and provide ongoing cultural awareness training throughout all levels of the Health Service.**



D. Program Structure – Engagement – “I wasn’t too sure what it was about”

Successful engagement in the FHV program was facilitated by staff following the established protocols for engaging families of Aboriginal children and participants’ initial impressions of the staff. However, participants’ expressed varying perceptions of the purpose of the program and the criteria for eligibility, both of which could be improved with more consistent and timely communication about the program in a number of settings.

Successful Engagement & Significance of Staff

Although not all participants could remember how the initial engagement began, many described experiences that closely matched the program’s engagement protocols (see Appendix 3). This particularly includes that potential clients be assured of their *choice* regarding whether to continue the visits.

Yeah, how did I find out about it....Oh that’s right, [the FHV nurse] came around when you leave hospital and you have the visit, the initial visit. [The nurse] and [ICC] came around and just told me about it. That it was something happening and it was here and would I be interested and that I could even see how it goes and then stop doing it if I wanted. So I said, “Yeah for sure. I’ll give it a try definitely” and I liked it so much I ended up calling them initiating it and saying can you come back, you know, I’ve got some questions or can you give us some pamphlets...yeah I just really went with it.

- Mother

Because I don’t really know anything about babies. (laughing) Like I thought it would be really helpful, and I just thought... I was told you can stop at any time if you feel like it’s

too imposing or anything like that. So I thought, "Okay, we'll just see how we go", but it's really enjoyable. Yeah. Because I suppose I think, "What would I do without it?!" He's gets weighed every week and every fortnight now, and you know. You can just ask any questions. So, whatever's gone on in that week – if I didn't have somebody coming, I don't know how I would find out this information!

- Mother

Interestingly, one participant commented that she had first heard about the program antenatally, which will be discussed further below.

Well, when I had [my daughter], an Aboriginal worker told me, in the hospital. 'Cause I was having like a little antenatal class, like just an Aboriginal class in the hospital.

- Mother

Other participants spoke of their relationships with the Family Home Visiting staff prior to their involvement in the program, and they noted the value of these relationships by pointing out the ease with which FHV was accepted because of their experiences of Access Visits or Responsive Home Visiting in the past.

No, I'm not fussed about them [home visits] at all. Because I had them with my other two [children], so.

- Mother

Well [the nurse] has been close to the family for about... 'cause of my little brother who's five now, so I knew her beforehand, but straightaway when [my daughter] was born [the nurse] phoned the hospital after I'd had her and then she just turned up on my doorstep when [my daughter] was 2 days old. Yeah, she followed up on what I was doing and...yeah.

- Mother

An important factor in engaging clients within the Family Home Visiting program was the initial perceptions of staff. As identified in Section C, this included the role of the Indigenous Cultural Consultants in facilitating engagement.

Oh, I think if they had workers that rubbed you up the wrong way, I think it would be the last time they'd ever get near the gate again, inna? You know, you probably wouldn't have a program running.

- Extended Family Member

And they're approachable, and introduce who they are. The way they approach you is really good.

- Mother

And if I don't like them [people who visit professionally] I just go into the kitchen. And when these ones [ICC and FHV nurse] came I think what happened was she [nurse] said, "Oh hello, are you the nana?" And we started having a good old yarn, you know. And I felt that good vibe off them straightaway.

- Extended Family Member

For me it's kind of unspoken, if there's not that Nunga worker there, I won't be in that program. So for me, like for me, I want that Nunga worker there. Or if I can't have the Nunga worker, I access the mainstream service.

- Mother

Yeah, it's a good service when you get the right people. Like, you need Aboriginal people to come out. When you get the right people it's more friendlier, more comfortable and relaxed. When you've got your own kind, things are more relaxed, more better. I can't pick it out loud, like really explain it.

- Extended Family Member

Eligibility Criteria and Access to the Program

Participants' perceptions of the eligibility criteria for Family Home Visiting were various and seemed to indicate that communication about the program has not been entirely consistent. For potential clients who might encounter a clash between the population-health criteria and the program's exclusion criteria, both staff and family participants stressed the importance of providing responsive support.

Although many families were recruited into the program in direct accordance with the program's engagement protocols, there was also evidence of confusions. Participants expressed perceptions of their own and others' eligibility for Family Home Visiting, which were not always aligned with the program's eligibility criteria; for example attributing their involvement in the program with their child's health status (eg. premature birth).

I just knew that a nurse was coming to weigh every fortnight or something, and I just thought, "Oh, that's good. I'll know her [my baby's] progress." Because she [my daughter] was premature as well? That's why I think they offered it to me? To keep checking, because if her birth-weight dropped, she would have to go back in. Yeah. So that's why I think they offered it to me at first.

- Mother

Well I had [my youngest child], she was premature, at the [...] Hospital, and they thought because she was so premature I would need support on-and-off while she was in hospital, and when she came home.

- Mother

Another perception regarding the eligibility criteria was the assumption that the service was universal and available to all parents.

They [FHV] would definitely be the best [service] 'cause you don't need an appointment or to be a certain category...you just need to be having a child.

- Mother

Similarly, even within the population criteria there may be an assumption of universality, which can cause confusion in relation to clients' friends and the types of services that their friends can expect.

She just came around it must have been put through [the hospital] 'cause I'd never heard of it, and all through my pregnancy no one ever said anything and then they came around to have that first visit that you get when you come out of hospital and then she made an appointment that day to come back. I still wasn't kind of aware, I just thought that every mum got it and then I realised after a while that it was because [my daughter] was Aboriginal that I got it. So I was like, "Okay".

- Mother

Because, like even one of my friends, she had one [nurse] come out to her, and then the nurse stopped coming. And she's like, "I really want this nurse to keep coming out". And I was like, "Call them. They're meant to keep coming out." Because what I heard, it's compulsory for a few nurses to come out. Because she was meant to be in the home visiting program and, yeah, the nurse just stopped coming out, because she said, "Yeah, your baby's fine." ...And I said, "You're in the program. You're meant to be having someone come out like, whether it's fortnightly or what", you know. Because she can't find the time to get her baby out, and go to the doctor's and get it weighed all the time.

- Mother

The importance of maintaining supportive contact with families who do not meet the Family Home Visiting eligibility criteria was discussed by staff members who emphasized the continuing necessity of other forms of home visiting, such as Access Visits or Responsive Home Visiting.

And this is where the other thing is, we have 'Access' and all those other visits. It's just about, you know, there's some that go into the Family Home Visiting and do well. But there's some there that don't. But what happens to them?

- Indigenous Cultural Consultant

But that ... keeps coming back to the Responsive Home Visiting. And if you could go out there, and they didn't fit into the Family Home Visiting, that's okay because "We could offer you this, this, this". It's not a 'Family Home Visiting' because Family Home Visiting talks about different modules, about attachment to the baby. "But we can offer you this..." But at the moment we can't do that. And that's why it's so different in different areas. Because we're all doing different things. But if we were able to do that, it would be a different thing.

- Indigenous Cultural Consultant

Families were also concerned for those who did not choose to join the program, and advised that support be made available for parents with young children, particularly those who might feel isolated or lonely.

Regardless of whether you want to go into the program or not, it should be ok for them to still come out on the odd occasion that you just feel like crap and don't want to go in. If you still want your baby checked or you don't have petrol...whatever, whatever reason.

'Cause, I mean, I've just had such a good relationship with them [FHV staff] and just think they're lovely. But it's still good, if you don't want to be in the program to have that access to a home visit now and again, for whatever reasons. 'Cause it's just good to have them. They are great people to have around, and you can talk to them and they can offer you a lot of advice on this or that or whatever, or just to sit and talk to. Sometimes it can be lonely being at home with a baby.

- Mother

This was also reinforced by a participant in a feedback session who described a need for follow-up after the Universal Contact Visit regarding mental health and other contextual challenges that may emerge after the assessment for eligibility for the program has taken place.

Perceptions of the Purpose of FHV

Initial perceptions of the purpose of FHV were also varied, and may be seen to link closely with perceptions of eligibility. Clearly communicating the purpose of the Family Home Visiting program to potential clients is very important, both for initial engagement and for continuing satisfaction with the program. At times, participants were very clear about the program's purpose.

I think the main focus of the home visitation is building that secure relationship, because babies, if they get that secure bond, it sets them up for their healthy relationships right through the rest of their life. So if you don't have that good bond, it's detrimental in the other way. So it's showing people how to interact with their babies, if they don't know what to do, or if they haven't been around little ones.

- Mother

However, there were several significant confusions regarding the purpose of the visits that emerged.

I wasn't too sure what it was about. [But the ICC] explained everything to me like, "Oh no, it's not that. You've got a choice to be in the program or not," and that made me feel good. And she came out and that was really good.

- Mother

A related facet of this lack of clarity is the fact that some hospital staff – even in birthing hospitals that service roll-out sites for FHV – appeared to be unaware of the Family Home Visiting program.

And even when I got out of hospital this time – 'cause they were like asking me if I wanted a couple of visits 'cause they [my twins] were in the neo-natal ward – I said, "No it's alright I have these other people come around", and they'd never even heard of it (FHV) at the hospital. They said, "What's it called?", and I said "I've got no idea. I think it's because they are Aboriginal." And they said, "What's it called?" and I said, "I don't know; it's just the home nurse". (laughing)

- Mother

A second concern regarding participants' perceptions of the purpose of the Family Home Visiting program relates to the possibility of perceived overlap between this health service and other government services such as those relating to child protection.

One participant commented on her initial fear that the purpose of Family Home Visiting might be related to child protection surveillance. In the following example, the participant's post-natal depression became related to her fear insofar as she associated being watched closely with her 'crying', as well as a more general fear of having 'done something wrong'.

First I was scared [of FHV visits] – no, I was. “What are these people here for? I’m just crying, I’m not like...” And then that eased up. But I was scared at first. ... They were pretty casual when they were asking if they could sign him [my son] up for the program. And stuff like that. I was still nervous, because I didn’t know – I thought I’d done something wrong. Or they might take my baby, I didn’t know. You know what I mean? Like I thought I’d done something wrong or, “Why are they coming here?” [...] Oh, that [removing my child] was my worst nightmare.

- Mother

The necessity of clarifying the purpose and value of the program is heightened by the effects of this particular misunderstanding on *potential* clients, who may have refused the service out of fear. For example, as the same participant described, she herself has been reassuring friends about the purpose and personal value of Family Home Visiting, with particular reference to the qualities of the staff.

It [FHV] needs to be more easily approached. Because all of my other girlfriends relate it with their child gets taken from them. So they’re like, “We don’t want them coming around our house.” So that’s what happens. So you need to get that wiped off. Somehow. Because I only get a positive experience, that’s what I get out of it. And I tell everyone, “No, they’re so good. You can open up. You can tell them anything, and they’re there for you. They’re going to help you. And don’t get scared and all that.” Yeah.

- Mother

One participant described the manner in which misunderstandings arose. This participant commented on unclear communication by multiple staff and the implication that FHV was compulsory.

At the start they were changing the nurses around so I was a bit confused. I didn’t know what was going on until [the ICC] came out one day and she explained everything to me. I just thought the nurses were coming out to check up on me. [...] I had about 5 nurses who came out in the first month or 2 months. It was changing all the time and it made me feel a bit strange. It being my first child I thought, “Are they checking up on me or what?” That’s how I felt. No, it was good after a while when [the current nurse] came out. She’s been really good. [...] Maybe if at the hospital they had explained to me that I had a choice to have home visiting it would have been better. Yeah, I didn’t know what was going on if they were making sure that I was a good mum or... [...] Yeah at first I did

feel a bit uncomfortable. Yeah, like, "What's going on?" But once [the ICC] came out and said, "We're not checking up on you. We're here to help you if you need anything."

- Mother

Another confusion that could be alleviated with better communication – or even adherence to the designated protocols – related to the role of the cultural consultant.

Because 'Aboriginal' was ticked on the form, they just gave [the ICC's service] to us anyway. But I didn't know that was happening. So it would've been nice if they had've told me. [The ICC] sort of just came with the nurse? And it was sort of like a shock, like "I didn't know you were coming as well".

- Mother

Confusions about the purpose and eligibility criteria of Family Home Visiting may impact on the uptake of the service, and need to be addressed in a clear and consistent manner throughout local communities and health services within the roll-out regions.

When prompted by the researchers, several participants commented that earlier or more timely awareness of the service would have been helpful and that meeting the home visiting staff before the program began would have helped to build trust, although all of these participants came to appreciate the service.

Yeah, but it would've been nice, like to know this while you were pregnant, and you know, to have a choice who was coming, and meet the person that's going to be coming to your house, and you know? But, it turned out to be good.

- Mother

I would've liked to have met them – not before the baby was born, but the hospital was a good part for her to come in and to introduce herself to each family. (184) [...] Before you left the hospital. So that way, you could – you got to know her a little bit, and she got to know her, before she came to visit.

- Father

Because you want to trust them before you have your baby. Yeah, because I started late – like I was three months after, you know. I'd moved from [a different region]. So I don't know how they normally do it, but it would be good to know them [staff] before.

- Mother

RECOMMENDATIONS

5. Improve consistency and clarity of communication/information about the program, including population health and exclusion criteria.

For example:

- Producing a DVD with “testimonials” to be presented at UCV and/or at maternal hospitals (consistent information, including about the role of the ICCs).
- Television ads (like breastfeeding campaign) – with Aboriginal

people and imagery

- **Linking name to earlier program 'Mothers and Babies'**
- **'Uniforms' that delineate FHV staff from 'welfare' workers – eg. Women's and Children's Hospital logo on t-shirts?**
- **Marking FHV cars with magnetic stick-on logos to differentiate from 'welfare' government cars – highlighting the mother-and-child-health focus**
- **Nunga images, colours, designs as part of car logos**
- **Posters – again with Nunga imagery and colours – in places where Aboriginal mothers might go**

- 6. Retain "pending" category to give families plenty of time to decide whether to be involved in the program.**
- 7. Model-up antenatal engagement for FHV clients.**

E. Program Structure – Content of FHV – “You always welcome them. Because they’ve got that information.”

The developmental stuff. They’re always up to what they should be, and how they’re interacting, and what you can be doing to stimulate them, and what they’re seeing – you know, like when they can only see 30cm in front, and then they can see further – so what you can be doing, and what activities. And they did like a video, they did a little video, and they give you the DVD, with a little picture of [our son] on the cover. And then they make you a little folder, and you’ve got all your information that you need. And it’s good.

- Father

The information, activities, services and referrals provided in the Family Home Visiting program were clearly valued by participants, as was the staff’s responsiveness and flexibility around both what and how information was communicated to clients. Participants’ experiences of the content of FHV cannot be easily separated from their relationships with the staff members, who in large part acted as significant mediators of clients’ experiences. This is reflected in the findings below, in which the staff’s responsiveness, flexibility and availability often facilitated participants’ positive perceptions of the information, activities and referrals that comprise the content of the Family Home Visiting program.

Further, Family Home Visiting’s ability to incorporate a whole-of-family approach within the program might also be seen as particularly important in the context of Aboriginal families, many of whom have experienced disruptions to the continuity of family, culture and community.

The whole family, the whole family. Because it’s ridiculous if you’re just over there to do a health check, and the baby is okay and the mother’s okay. But she’s worried she doesn’t have anywhere to live, and she’s busted up, and they’re starving, and – you know?

- Indigenous Cultural Consultant

Information

The information provided in the Family Home Visiting was clearly valued by participants, as was the staff’s responsiveness and flexibility around both what and how information was communicated to clients.

Ah, just all of the information. They just – they’re just really supportive, and they’re always telling you about other things. Or giving you – whatever you ask about, they’ll come back with all the information on that next time, and it’s just... And the fact that you get weighed and measured and stuff, ongoing. Because your feeding and that can change, week to week, depending on growth spurts and things like that. So it’s good to know that you’re still – and they chart it for you, so you can see if he’s going up or down. Yeah, it just gives you that idea.

- Mother

The information made available to parents was seen as helpful both by first-time parents and by those parents who had not had a baby in several years.

Well, I find that all the information that they give you – because this is my first [baby], they come with – like, they made me up a little folder, with his name on it. And they put in all this development stuff, with what he should be doing, and so then like – and what games he can be playing and music, and stuff like that.

- Mother

Oh, knowing that I've got support, and if I needed any questions for my baby, I'm doing it alright. [It's doing it] all over again, because it's been four years since I had one! (laughing)

- Mother

Importantly, the parents appreciated the fact that the content of the visits generally targeted the child-rearing issues that they were concerned with on a day to day basis.

She sort of does what we want to do. So if we have something we need to talk about, or if we want the baby to be weighed or something, then she's happy to do that, or whatever we want. So she sort of takes the lead from us, and what our needs are.

- Father

If the visiting was to stop now, I don't know what I'd do – like I'm glad that it goes for two years, because you know, you just get through one bit, and then there's the next bit. And, "When do solids come in?" And, "When does this come in?" And when he starts walking, and "When do I toilet train?" And they'll be around for all of that? I think is really good.

- Mother

Yeah, you always look forward to what they're going to bring next. Because it's keeping up with your baby, your baby's [development].

- Mother

As noted above, information for the whole family regarding child development was seen as particularly useful by a number of participants. For some, Family Home Visiting was reported to be the only context in which they learned certain types of information, particularly around child development and the developmental value of play.

And Nungas have a lot of kids but we don't always get taught [about 'development']. Like one of the exercises for my son is throwing a ball from one hand to the other, and the reason why they're doing that is that it kind of links up both sides of the brain – and I never knew anything like that until now. Because I hadn't done anything like that, you know what I mean.

- Mother

I think for me and [my baby] it's been good, because like I'll know that what I'm doing is not just – it's actually stimulating him, and he's actually growing and learning because of the things I'm doing. And not just, "Oh, I feel like playing with you, now I don't feel like playing with you." It's knowing that that is actually his stimulation and everything, because he'd be getting more out of it than just – like, if I thought it was just play, and didn't realise that he thrives on that for his development! So he's getting more from that, I suppose.

- Mother

Being able to talk with staff about the information was seen as helpful for some, while others liked that handouts could be referred to between visits, and by other members of the family.

And like talking, you get way more information out of that than reading pamphlets. Because reading something, you know, you can take it in whatever context you think, and it might not be the right context. And if you don't get something, she's there to explain it to you.

- Mother

Every time they [FHV staff] come [the nurse has] always got an information booklet there. And that's good yeah. Because it's not only good for me, it's good for the kids to read it as well – I've got an eleven and a ten year old.

- Mother

Participants also mentioned learning about child nutrition, including breast/bottle-feeding, and how the information could support their choices, as well as providing practical support.

With the other two, I didn't breastfeed them. So with this one here, [the nurse] has helped me along, with the first few visits, about breastfeeding. So it's really good that way, with her. So she's helped me along with the breastfeeding part. And I'm starting to understand a lot more now with it.

- Mother

But the handouts they give out are good too. I do often go to them, and – especially when it comes to feeding advice, because you forget what age they're supposed to be having which foods. And having a little check-list there is good, "Oh, yeah, they can have that at this age."

- Mother

And with the first couple of home visits from the female nurses, they showed me a couple of ways how to get [my son] attached [for breastfeeding]. And in particular, the second nurse showed the best way, and I stuck with that for a long while. And now he just jumps on and off when he wants.

- Mother

Much of the information was immediately known to staff, reflecting their expertise. However, when this was not the case, many participants commented on how the staff immediately followed up in obtaining information.

And it's good ... if you don't know something, and you ask, she'll tell you. So [you] learn as well. It's not just a good nurse that comes to weigh him and all that, she's good at other stuff.

- Father

Like if I've got lots to talk about, or lots of questions, then we might be a couple of hours. You know, like it might be – it's just as long as I need, so some weeks are short and some weeks are long. So I feel like, if I ever wanted more information – and sometimes I'm just asking a question and I don't even know that there could be more information, but she'll come with it next week!

- Mother

Participants also highlighted the value of the activities that were included in the handouts.

They give you lots of handouts of like, how to feed a baby, how to interact. At each age level, you get a new sheet with different games to play and different songs to sing, and that sort of thing. So you can build up quite a good supply of information. And also stuff for dads, not just for mums.

- Mother

Activities – “I was surprised by the video – that was a good surprise.”

One of the most commonly mentioned activities in this fieldwork was the filming of parents and children interacting. While some parents were initially nervous about being videotaped, all families who commented on the filming were positive about the experience. It was seen as a good opportunity to reflect on parenting behaviour as well as providing a record of children's development. Being offered the choice to participate in the filming was important to all participants, whether they chose to be videoed or not.

And like that video, that was heaps unexpected! And that was fun!

- Mother

Well, at first I didn't want the movie, the video – at first I didn't. (laughing) Only because of my own – I don't know, feeling a bit shame about being on video, but that was my own stuff. ...Yeah. I was like, “Mm, I don't know about being on video, it's a bit scary.” (laughing) And then I just snapped out of it, and let her do it.

- Mother

They do DVDs with the families, and they do a lot of stuff showing how you're interacting with your baby, and things. Like you can learn from what the baby's doing, and see things that, when you're doing it, you don't notice. That probably is one of the really good things.

- Mother

The video activity was also seen as useful for providing a record of child development for those did not have access to recording equipment, and for sharing with other members of the household. Participants noted the staff's conscious efforts to include older children in the filming. This also was seen as something that could be used to encourage older children to reflect on interactions with their younger sibling.

Yeah, because a lot of families don't have access to a DVD recorder, and it's something that you can't get back. I mean, they're only going to be small for such a short time. And to have that record, if you're not in a position to buy the equipment, it's really good. And they do – at the end, they give you the individual ones, and at the end they put it all on one whole tape. So yeah. It's really good.

- Mother

Yeah, I've got two older ones, eleven and nine. And they're [FHV staff] really good with them, and even included them in the video camera, the filming and everything. And the whole family, and it's real good. I never done that with my other ones, my other children.

- Mother

Health supports and services

In terms of infants' health, participants in the research highly valued the services and health supports FHV provided for their babies, including tracking their child's growth by weighing, measuring, and (sometimes) in-home immunisation (more about this is included in Section F).

'Cause she comes to the house, and does her shots and everything. And does her weighs and her checks and everything, so that's really good. You don't have to go to a hospital or a doctor. And if there's anything wrong with [my baby], I just ring [the nurse] and ask her, and she'll come over. And yeah. It's like a doctor on-call. So it's good. (laughing) Yeah, I know. It's so good! (laughing)

- Mother

As well as routine health checks, FHV clients appreciated the fact that because the staff knew families so well, they could identify significant but subtle changes in children's health.

...And like they've known you. Like I had a baby who was sick, and because of my home visits, I found out that he had really bad gastro that was going around not long ago. [...] And that's how, because she's keeping track of my baby all the time, like she [nurse] rang me up straight away when she got to the office that afternoon, and said, "I'll make sure you've got some extra food so he can put the weight back on"

- Mother

Examples of the staff's attention to health concerns for other members of the household include maternal health, and the health of older children and grandmothers.

Maternal health

Well, they used to check me over. Like, when I first came out of hospital. But yeah, because it was just me and my daughter. Yeah, so we was both getting help.

- Mother

Older children’s health

Well, my daughter’s only just had surgery, on her hips, and I found that when she had that, they [FHV staff] were there to help me with her as well.

- Mother

Serving nanas

And with these workers here, what happened is, they came one day, at one visit, and we were talking, something about my diabetes, and the nurse said she’d bring one of the diabetes health workers down, to have a talk with me when they came on their next visit, you know. Which I just thought was great. Because, they could’ve said, “We’ll make an appointment for you”, and I’d say, “Yeah, I’ll go to it”, and I probably wouldn’t end up going to it, you know? But they brought the worker to me. You know?

- Extended Family Member

Referrals, Context and Community Connections

One of the main objectives of the Family Home Visiting program is to provide clients with referrals for both health and social support, in order to assist clients in developing sustained community connections that endure beyond their involvement in the program. Participants spoke of many examples of referrals and introductions to community supports, including physical and mental health care, housing, child protection, higher education, and children’s playgroups (see Figure 6).

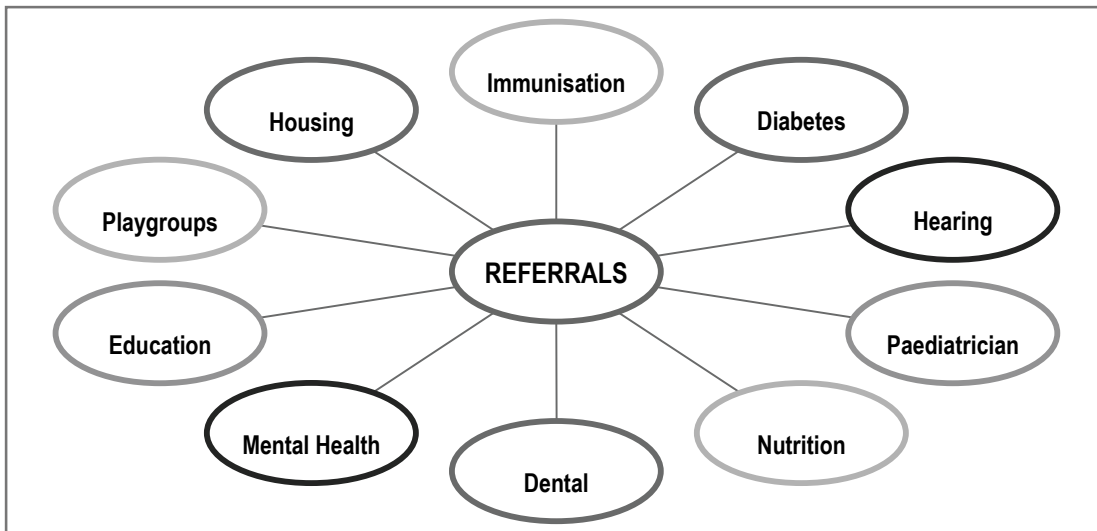


Figure 6. Referrals

Health-related referrals were often oriented around children's health needs, such as dental care, maternal nutrition, hearing assessments, allied health and medical specialists.

Yeah, because when I got stuck – because [my daughter's] teeth are starting to go funny, at the front, and like yeah they were the first people that I could think of – to go to them. Yeah, and they looked up – it took them a while to look up, but they ended up ringing me back and giving me a place and giving me a referral to go for [my daughter] to get her teeth checked. So yeah, that was good.

- Mother

Yeah, well, other services that I had to engage in – and [the nurse] helped me with this – were the nutritionist, dietician side. The Child and Youth Health hearing assessments, I had to get a couple of those done, for my daughters. Yeah. But [the nurse], he also points out other community centres that run playgroups and things like that.

- Mother

[The nurse has] referred us to the physio before, and we also had to get referred to get his hearing done, because it didn't get done in the hospital. So yeah, she has referred us. And she's going to refer us to see a paediatrician, just before he turns one, because he's small for his age, and just to make sure they're all happy.

- Mother

Information and referral was not limited solely to child health and development but also addressed issues such as housing, higher education, children's playgroups, and other services.

Housing, they done like a support letter for me. Yeah, just to say that I was one of their clients, and that I was on my own and just had a newborn baby. But yeah, that was good like that way, to help me push for housing, so.

- Mother

But they [ICC and FHV nurse] have done support letters for the education department around behaviour, and what they've seen in the home.

- Mother

Yeah, she's told me about SACE that they do on Thursdays at [the local] primary school. You do your Year 12 equivalent, and there's a crèche there and everything, and you do it every Thursday. So she's told me about that and everything.

- Mother

Yeah other agencies. And that's what I'd like you to hear. They've plugged us into sports, kindies, health, [...] hospitals, specialists...wherever the women in program are, and I've met most of the women in the program, whenever they hear of a good idea, doesn't matter where or what it is, they [the nurse and ICC] will pass that information onto you because they care about you and your child.

- Mother

Once again it is important to note how the staff frequently played a significant mediating role in participants' experiences of external referrals. Staff assisted with out-of-home services in a number of ways, including arranging appointments, assisting with transport, accompanying clients into new settings, and visiting their FHV clients in hospitals.

Yeah, he's [the nurse] very good with that, because if I ask him to put me in touch with a service, like, for instance the hearing service, he said, "Yep. Leave it with me and I will call you back with some more information." But what he [nurse] does, is he goes off and makes the appointment! (laughing) And gets back to me with the time and everything, so I don't really have to worry about any of that stuff, you know. Yeah, he's really – he's real helpful. You know, he'll go out of his way to do those things, so. And not just that, he offers transportation to different services, you know.

- Mother

[The nurse] drives me to my playgroup, and then drops me at my mums' groups. So. So that's worked out really good.

- Mother

Maybe I would've got back on my feet and back out in the world, maybe later on – I don't know. It probably would've taken me a bit longer, if it wasn't for [the nurse] to sort of like, you know. And because – I think it helped me get there quicker, because [she] said, "I'll go there with you. Come on, you know, I'll be there, so..." So that helped that initial ice-breaker.

- Mother

Parenting support for fathers and grandmothers

As well as providing responsive health supports for whole families, Family Home Visiting also supported other members of the household in their parenting role especially fathers and grandmothers. While sometimes unexpected, the importance of fathering was also expressed by participants, and the staff's ability to support fathering within the Family Home Visiting program was very much appreciated.

Yeah, it's not just children, youth and women – there's men involved. You can't just have children without men! (laughing) ...It's families! And dads should be encouraged to participate with their children.

- Mother

I was really quite surprised at seeing a flyer like that [specifically for fathers]. I don't think I've ever seen one before in my life, you know.

- Mother

I would like to see more support for the dads.

- Extended Family Member

Although there were pragmatic limitations to the extent to which a program such as FHV (eg. fathers' work commitments clashing with the timing of visits), which has a maternal-infant focus, could engage fathers, the importance of the program in supporting dads was emphasised by both mothers and fathers involved in the evaluation. Support for fathers included providing information for them and including them in visits where possible. Although some men were unavailable or unwilling to engage in some instances, for those fathers who were available for the visits, contact with the FHV staff was generally well received.

We've had lots of information given to us about the Dads' Group... They ran, late last year, or last school term of last year – they ran a Nunga Fathers' Group, and they do – and they ran like excursions, and dads' barbeque lunches, and things like that. And yeah, it was at a time when [my partner] had just got into full-time work, and unfortunately he couldn't participate with the kids, you know.

- Mother

A couple of times [my partner attended the visits], in our old house. Yeah, only a couple of times. And they've [nurse and participant's partner] just – like bonded – over those couple of times, they've bonded, you know. Just like how me and [the nurse] have, all this time, for the past ten months. Yeah, and [my partner] really, really enjoys – well, even though he's not here most of the time...

- Mother

She's [nurse] full trying to get [my partner] to go into the dads' groups and things, and yeah, when he's here, she talks to him and everything, and tells him like, you know "You should do this" and everything. Because he's got some queries on how he can bond with her [our daughter], instead of it just being the mother all the time. Because he full tries to get into it. And she's yeah, telling him, "There's swimming lessons on the weekends that you can go to." Because he works all the time, and so the weekend's his only time with her [our daughter]. And so she's [nurse] given us a couple of pamphlets on the swimming lessons and everything. And rung up for us and yeah. Getting him involved as well. And she talks to him when he's got some queries.

- Mother

Mothers also took a role in facilitating their partners' involvement in parenting by discussing the visits with their children's fathers, and relaying dads' questions to the FHV staff.

Mother: *But I tell you everything anyway.*

Father: *Yeah, [she] tells me everything, she fills me in. (laughing)*

Yeah, the [children's] father likes to know about it, so I tell him on the side later. (laughing) [...] Well I always tell him everything anyway, so yeah.

- Mother

Yeah, 'cause, a lot of it for him [my partner] was difficult as well. Um, like a lot of the information we got and the questions that we asked [the nurse] were from him as well. So it was a great help for him and he, like, the amount that [the nurse] helped us, he's

just as thankful as I am. Every time she came around and he was home she'd really encourage him to join in and... [...] Yeah, 'cause he felt a bit out of the picture and she would always include him. With all the sleep stuff she's encouraged him to come and help, like, "This is what you do." And [our daughter] is a full daddy's girl now, like he really got in there and...

- Mother

Fathers also supported mothers' in their parenting.

My partner [supports my parenting]. It's just the things he does. He doesn't make me feel incompetent. Because at first I was like, "I can't do it. I can't do it", you know, "I'm hopeless". And he was like, "No you're not. I mean, look at her [our daughter]." You know, "You can just tell. Everyone compliments her and everything". [...] Yeah, in the weekends is like his time. Like, he gets up for her bottles in the weekend, and...

- Mother

A suggestion for staffing arose when the researchers asked how the Family Home Visiting service could better support fathers and engage men in parenting. The two participants in the following dialogue commented on the need for more male staff – both in the nursing role and in the role of cultural consultant.

Mother 5: *I reckon if they get a male in. [to help men be more involved with their kids]*

Mother 6: *A male nurse.*

Mother 5: *And even a male Aboriginal worker, because I think the men would come out more, and be open, if they've got male workers. Because I notice if they have females, a males are not going to come out and talk. Because not all carers are female either. [...] And I know a lot of men who are out there caring for their kids, and I don't think they would like for females to come in.*

This recognition of the role of fathers and the need for organisational support for men's parenting was also noted by staff.

What I was getting at is, we've got an organisation, it's the mother and the child? But we've had a couple of families, like the husband does everything! And it's the mother that bashes the husband. And the husband is saying, "Um, I'm really the caregiver of the child. And I need help around relationships, you know counselling, for both of us, to make it change". You know? So it's how you look at the scenario. But sometimes when you listen to nurses and managers, it's all focused on the mother and child, the mother and child. And the father is sort of like pushed right back? And you've got fathers out there that are screaming out for help.

- Indigenous Cultural Consultant

Family Home Visiting also supported grandmothers in their parenting and care-giving of children. Both mothers and grandmothers commented on their experiences of Family Home Visiting's engagement with grandparents. Participants expressed that as well as accepting grandmothers' participation in the visits, Family Home Visiting often supported grandmothers in their parenting roles.

We have four generations here, and that's got to be very rare in Aboriginal communities. So he [baby] is just spoiled rotten, but he's a really good child. And I think, being an older mother, and I'm sure the other grandmothers agree, that you can be a better mum with your grandchildren than you were with your children. [...] So, it's about you [grandmother] too, learning to be a good parent. I've not always been a good parent.

- Extended Family Member

Well for the first year of my daughter's life, I lived with my mum. So my mum was there most of the time for the visits. And what was helpful was my mum hearing this information from [the nurse], and taking that on board as well. So she had more of an understanding. Because it's been a long time. And I mean, she's got grandkids – but she didn't live with them like she did with my little one. So yeah, it was helpful, as a family, for Mum to absorb information and stuff. [...] Well, I don't know if it [nana's being present at the visits] stopped her [from giving advice]. (laughing) But she had more of an open mind with things, just with how things are done differently than they were twenty or thirty years ago. [...] My mum just sat there basically [during the FHV visits], and just listened, and made cups of tea. (laughing)

- Mother

Our findings suggest that the potential impacts of programs such as Family Home Visiting might sometimes extend to the rest of the household, especially when staff are permitted to take a holistic approach, recognising the complicated contexts of some families in the program.

And just another thing, before they [FHV staff] came, I felt like there was just no room for baby. Like families really seemed to be worrying about themselves, and so having the workers coming to the home, they gave the message that new baby was a very important part of the family as well. That's a big thing for me, because they [people in the household] didn't really care about babies' routines. I mean people would just rock up when they want, and especially after the money and that, baby bonus, you know. Everybody would come around, humbugging... It's good having them [Aboriginal FHV staff] there, because your neighbours don't...and the community, you've got that backup, "Yeah babies are really important".

- Mother

RECOMMENDATIONS

- 8. Continue to develop program content in consultation with parents to suit their needs, desires and contexts, as well as the objectives of the program.**
- 9. Support staff in continuing to respond to the whole-of-family by incorporating the whole-of-family approach into workforce modeling and case load allocation for ICCs and RNs.**

10. Proactively explore options for better supporting fathers in their parenting role.

F. Program Structure – Service Delivery

“Well, having them come out to your home, that makes everything so easy.”

Research participants were overwhelmingly positive about the dynamics of service delivery within FHV, and commented on the convenience, flexibility, continuity and responsiveness of the ‘process aspects’ of this program. It is worth noting that many of the positive examples that participants described indicate the importance of the respectful, supportive and understanding behaviour of Family Home Visiting staff.

No, I thought they [frequency of visits] were just perfect. Like [the nurse] always, always stressed that, “Am I coming too often, or is it not enough?” And he always, every visit, he still says, “If, [Mother 4], I’m overloading you, or you know, if there is ever a time that you want to cancel, just because you want to, just ring me and we will reschedule for another time.” Um. He’s um, overall he’s always got time, you know. And he’s not too fussed about the cancellations – I’ve never ever cancelled because I wanted to, it’s always because I’ve had something else on. Because I always look forward to [the nurse] coming. Because I’ve always got questions. And because he’s the – because [my baby] doesn’t weigh as much as what my girls did, they were bigger babies, and he’s a breastfed baby – I’m always keen to see on what his weight progression is. And you know, yeah, just little niggly concerns I have, little questions. Yeah, so. And again, if [the nurse] has his holidays, he always tells me, and we sometimes don’t see each other for a couple of months, you know, and um. Yep. But again, he always tells me if he’s going away or if he can’t make it or, you know, things like if he needs to bring other, additional information to give me. Yeah, everything. He’s very – yeah, he remembers a lot of things. (laughing)

- Mother

Convenience

The convenience of being visited within one’s own home was a strong theme, and can be seen as one of the most prominent facilitators of continuing engagement with the program. The fact that staff visited within the home was valued for a number of reasons, including: parents’ and children’s comfort in their own home, removing transportation pressures, alleviating the challenges of negotiating several small children at once and the time it takes to get babies ready, not having to change other children’s routines, and accommodating other family commitments when staff have the ability to develop relationships with other children in the home.

Overall it’s good having a nurse come out to your home because you don’t have to go out and have these things done. It’s – everything can be told to you at home, for instance, what you need to know about your baby. You know, you’re comfortable in your own home. They basically do everything for you – give you information about the baby and yourself, immunisations – although I haven’t had them at-home done yet – um, and just little things that they do for you. Videotaping, so I’ve heard – I haven’t had that done yet. And also, it’s sort of – what I didn’t mention before was like, you have this little bond with this particular person. Like, if you want to call it a friend, as well as a

professional that comes into your home and checks you and the baby out. Yeah, it's very – it's excellent. For me it's a good thing. Because I don't get out very much.

- Mother

And so I found that joining the program meant that I didn't have to change the other children's routine. I felt like I could – you could feed the baby, and give him a feed, and do all of that, and you didn't have to get the nappy-bag ready, get the baby ready, get yourself ready, work out how you're going to get to, say, Child and Youth Health. And you didn't have any of those problems. You stayed in your own routine. And that's like the immunisation, and weighing and everything.

- Mother

Well, it's been really good because I haven't – I've got a license but I don't have a vehicle. So it just enables me to – because someone comes here, and rather than me get to their clinic.

- Mother

Because I had two other children, and it was hard. And I just came from [a different region] and it was hard learning my way around. And it was real easy to get them to come home, and me not to muck around on buses.

- Mother

As well as the program being conducted in the home, the significance of transportation difficulties and clients' common reliance on public transport emerged in relation Family Home Visiting staff's awareness and assistance with transportation issues not only in relation to children's health but also to clients' involvement in social interactions.

Family Home Visiting gives families a lot more opportunities to get to places, to groups, and interact with other children more. And especially when the baby is little, it's really good for immunisations and advice when you don't want to be travelling on buses all day...it's just really, really handy.

- Mother

The convenience and comfort of home visits was contrasted with previous experiences of clinic visits.

Yeah. Having the other two children – they're eleven and thirteen – I had to take them to visit the CAFHS nurse, and I had to – well, at the time we only had one car, which my husband-at-time drove to work. So I had to walk to visit the lady. And yeah. The first one was a prem baby, and so she was absolutely tiny when she came home. And juggling a little baby, and all the health and stuff that goes with that, was hard. But then when the second one came along, there was a toddler and a baby, so juggling that, and trying to get to the nurse... And you've got to keep them occupied while you're waiting for your appointment, and if she was running late, you know. And the place we went to, the room they had the appointments in was really, really small. And it's easier in your own home, because the baby can continue to play, and do what it does. And you can freely talk. Whereas, if you go into someone else's environment, they [children] want to touch everything, and inevitably touch everything they're not allowed to. And

you try and occupy them. And it makes you rush through the visit – and they're [health staff] probably on a restricted timeframe, whereas with the visiting nurse, she stays for a long time. So you can talk about lots of issues that you wouldn't normally talk about. So that's really good, I think.

- Mother

And you can do that in your own environment. Like not – like with my older two I had to go to Women's and Children's or you know, and it's a really ratty environment. I'd feel like I was already wound up like a top, before I even went. But when you're at home in your own environment it just makes it easier.

- Mother

Flexibility

Another factor that facilitated continuing involvement in the program was flexibility, which was frequently noted in terms of the negotiated scheduling appointments, but was also mentioned in terms of the location, duration, and frequency of visits, the responsiveness of particular information and activities, and staff's flexibility and responsiveness around the needs of other household members.

Flexibility in the timing and scheduling was important to participants, especially given their often complex schedules.

I'm a very organised person. I try to organise with [the nurse] the most convenient times – and again, he [the nurse] does too. Because he says, "Anytime you need to reschedule, just ring me up and we'll do it." But no, I'm very satisfied with this service. It's really good.

- Mother

And she rings you first and organises a time that suits you. So not just, "Oh, yeah, I can only come at this time". She contacts me and lets me know what time, so it suits me. Or if I want to see her again that week, or whether I just leave it to the Tuesday when I see her. So.

- Mother

I think that it's good that they [FHV staff] call before they come as well. Obviously if you've forgot the appointment, or something's gone wrong. Or she let's us know if she's running late. And sometimes people don't do that, but that's really important because you might be waiting and, "Where is she?" She always sends a text.

- Mother

The duration of visits was another way in which flexibility was expressed, insofar as the length of home visits seemed to vary to an extent as determined by the needs of the family.

And they never rush you. Like, "You've got an appointment and we've got an hour". Sometimes it's an hour and sometimes it's shorter, whatever you need.

- Mother

She's been here two to three hours sometimes, if she has no visits, nothing to follow on, and we've been talking about something. Yeah, we get on a roll. (laughing)

- Mother

When they [ICC and nurse] come here, like over the last fortnight I was a bit tired. Yeah. Because I didn't have much sleep the night before, and when I was feeding I just dozed off. And they didn't stay very long because they knew I was tired. So they go, "Well, since you're tired, we'll just do a little bit and then we'll leave." So they know when... So, if I'm not feeling too good when they come, because they – what time – they come about 9:30, and they don't leave until like eleven. So they're here for awhile with you. But if I'm tired or something, I'll just say, "Yeah, I think we should just catch up another time." Yeah, so it's good like that. So I just stop at any time.

- Mother

Another expression of the program's flexibility was evident in participants' descriptions of staff's responsive approach to the content of the visits, as described earlier.

Yeah. She [nurse] didn't come in and say, "Okay, we're going to be discussing this today, this and this and this". She would just go with the flow. Whatever I wanted, whatever issues I had. It was all about me.

- Mother

One other dimension of the program's flexibility was described in relation to the location of home visits. Although rare, staff sometimes conducted the Family Home Visiting program in a location other than the parents' home. In one example, the visits were held in the client's mother's home due to staff safety issues in the client's household.

Yeah, they [FHV staff] were really good, especially because of the situation at the time, they weren't allowed to come into the violence so... If you knew how hard it was for me to get out at the time... so I just used to say [to my partner], "I'm going over to Mum's house". And I ended up telling him – I was really honest with him in the end: "They're not allowed to come here anymore because of you. Now to get my daughter weighed or checked I've got to go over to my mum's house."

- Mother

Flexibility around the frequency of visits in the Home Visiting program may be viewed as another factor that facilitates continuing involvement in the program. Examples of variations in the frequency indicate that parents' feelings of confidence impacted on their desire for visits.

Sometimes they come once a week, and sometimes every two weeks. I find every two weeks works better, but sometimes I've had weekly visits, and I like that. And sometimes I'll miss a week, and then once a fortnight.

- Mother

Yeah, yeah, I think it was like twice a week and then once a week and then once a month and so on from there, but definitely I think for the first six months it was once a week. [...] And then I started missing a visit one week or so and building up confidence. So I'd say, "It's alright this week, everything is good", to a point where I sort of said, "It's all good now".

- Mother

Some participants were aware of the scheduled frequency of visits, and several commented that the timing of the transition from weekly to fortnightly, or fortnightly to monthly occurred at just the right time. However, it appeared that many participants were less aware of the program format in this regard, and what emerged as most important to clients was that the timing and scheduling was a shared negotiation.

No, I think they're [frequency of visits] right-on.

- Mother

I think they have a little plan where it's once a week for some weeks, and then they go fortnightly for awhile, and then it's... And I found that when they went fortnightly I was just ready for fortnightly visits. It was just good timing.

- Mother

It's – at the point where you start thinking, "I don't need you to come every time", that's sort of when it transitions over to monthly anyway. So it's probably a good balance. I'd say.

- Mother

Continuity of Staff

Participants noted the importance of staff continuity, but also identified situations in which change had beneficial outcomes. Furthermore, they highlighted the need for well-managed transitions between staff members, both when changes are instigated by staff and by clients.

Some participants contrasted Family Home Visiting with other home visiting services they had had in the past.

Because I know years ago you used to have CAFHS nurses, and they used to come around, and sometimes you know, you don't get the same person all the time. One would be, "Get the baby weighed, yeah, everything's right" [in somber tone], you know? Yeah, but what they do in this program [FHV], you know? I think it's great. It's excellent. Yeah.

- Extended Family Member

Other participants reinforced the importance of having the same staff member, often highlighting that continuity of staff permits a deeper and broader 'knowing' of the clients (both parents and children) and their context and history.

I think, like, you could have any nurse come and do it, but it's nice to have the same person coming to your house all the time, and they get to know your baby a bit, and know your family, and know your background. Like some families have bigger problems than others, and some have personal issues – and we all have financial issues! (laughing)

- Mother

This was considered not only for the parents' comfort, but was also seen to be important for children.

Because [FHV] was an ongoing thing, and it was a regular visit, [my daughter] built trust and a relationship [with the nurse]. And like I said before, [the FHV nurse] was like an auntie. So it was like, "[Nurse's name]!" [My daughter] just loves her. So she has become part of [my daughter's] world.

- Mother

So even when the kids are in school, they'll know... And like the Nunga workers in the community, we do it in the community where the Nunga worker says, "I remember when you was a little bubba. I was the mean lady that gave you needles", you know. And that gives children a sense of connectedness, from when they were a baby, and reaching out to, "I'm a big kid".

- Mother

One reason that continuity of staff was noted as important to participants was the simple fact of being known to the staff. Although noted in relation to not having to repeatedly tell the same history to different staff, being known appeared to be particularly important to participants who navigated periods of unstable mental health.

At [the hospital] they send out nurses to come and see you, but you get different people all the time so you're saying the same shit over and over, whereas [the nurse and ICC] already know everything about me. They're good.

- Mother

If a new one [nurse] came, she wouldn't know, if I'm not well that day. Mentally or physically. And [my nurse] knows me even mentally, if I'm depressed. She'll know what's happening. You know, "Are you alright?" And she knows how serious it is by the way I talk, and... And that's what I like. Because with a different one...

- Mother

Changes in staff were sometimes seen as discomfoting and required time and energy to build new relationships for parents and for children.

Mother: *No, they're all good. The only thing I didn't like was like you get to know one worker and what they're like and then [...] And she left. [...] She moved somewhere else. [...] I think [the second nurse] felt it too.*

Extended Family Member: *Oh that's right. And that's why you were upset. Because you see, you build that relationship with the person [FHV staff member]. You know. [...] That*

one person. And then, like I said, when they leave, you know, it's like, "Now I've got to build this all up again."

Some participants described experiences in which a change in staff had a beneficial outcome. In the first of the two examples below, in fact, the participant later mentioned that she had considered leaving the program before becoming involved with her current nurse.

But I've had a couple of different nurses. ...Um, one of them got sick and I don't know, she just kind of disappeared, so. (laughing) So somebody else turned up, and I was like, "Oh, okay". And [the second nurse] is really good.

- Mother

Well, I had one stage where I had one worker, she used to ring up all the time, and used to just ring, ring, ring all the time. And it used to just annoy me sometimes. But I said to her once, and that was it, and I never heard from her again. But then she changed areas, and I got this other lady now, and she's really good. She's really good.

- Mother

Smooth transitions between workers were seen as possible, as highlighted by this participant:

Somebody with the same goals, the same principles, the same, you know, on the same wavelength. Because I moved from [a different site of roll-out] where I had [ICC] – as my worker she was deadly [...] in her role as the Nunga worker, she was fantastic! And [the nurse], the non-Aboriginal worker, she was deadly too. And then moving here, it was just a really smooth transition. Like they had rung Auntie [ICC] and [the nurse], and said, "She's on her way!" (laughing)

- Mother

Responsiveness to Contextual Factors

As described above, maintaining clients' involvement within this program was greatly enhanced by staff's flexibility and responsiveness around contextual factors such as changes of residence (and region), shifts in clients' relationships with partners and other family members, and changes in clients' mental health status.

Staff responsiveness to clients' mental health in a supportive and accepting way was deeply appreciated by participants, who also commented on the fact that they did not always need to describe their mood for staff to know that they required extra support.

Because, and they've seen my parenting, they [nurse and ICC] know that if I'm not well and when I'm well. Because I've got depression, if I'm well, I'm going to my appointments, and everything's deadly, then all good. But they know too that when I'm sick, that I won't make appointments, I'll cut it, I won't be home. So they'll keep coming back. They won't worry about being disappointed with you, "She wasn't there". (laughing) They understand that I've got...

- Mother

I think the only time they come frequently is when you are very depressed, and they need to come back the next week. Without making it very subtle, just, "I'll come out next week". Because they're really not doing – they've seen a lot, and you don't even have to open your mouth, they know it. They know you even generally, if you're not well.

- Mother

RECOMMENDATIONS

- 11. Ensure that clients who are not eligible for FHV have timely referral and access to the range of interventions appropriate for families with "high-risk" status. For example: fast-tracking into other services (eg, housing, domestic violence, drug and alcohol, Families SA); retaining options such as "access home visits" or responsive home visiting, negotiated priority referral pathways to other primary health care services.**
- 12. Retain and encourage options regarding other locations for the delivery of FHV (eg, clinic, children's centres, other family members' homes).**
- 13. Encourage the utilisation of FHV psychologists and social workers for in-home support for FHV clients who may be experiencing more complex contextual challenges.**
- 14. Acknowledge the role that ICCs and FHV nurses can play in liaising with other services (eg, Families SA) because they *know* a family, have been in the home and seen the parenting style.**

G. Program Structure – Cessation – “Have the home visits ‘til they’re eighteen!”

Although participants rarely found fault with the program, one improvement that was suggested a number of times related to the duration of the program and the transition from regular home visits to “boom, nothing”.

The final module of the FHV program explicitly encourages staff to work with parents around goal setting, confidence, transition planning, and links with local services, and many participants [particularly in the southern region] spoke of the extent to which Family Home Visiting staff were actively involved in linking them to community groups throughout the program. Playgroups and early learning groups in particular became valued social supports for several participants at the end of the Family Home Visiting program.

Well, through [our nurse] we went to the Nunga playgroup, we started ‘Learning Together’, and [the nurse] decided to come along one day and visit us there and she liked the program ‘cause it’s all about literacy and children learning to read and how they first develop reading and writing skills, so after she came twice she started bringing other people and she linked everyone together and it was lovely, you know...more groups that we could go to together...and we do book making now...

- Mother

It [FHV] has put me onto the Early Learning Program, which is a program that I like.

- Mother

Like, I think [my nurse has] been really helpful in the fact that she introduced me to playgroup, and stuff like that, the Nunga playgroup – and I didn’t know they existed.

- Mother

Yep. She’s helped me go to other things other than just playgroup. Like she’s offered me all different playgroups to go to. Um. Like the young mums’ group, where it’s not about the babies – they have a crèche there, and it’s about you. And talking with other people, and getting to know other people and everything. And there’s drop-in centres you can go to, to get immunisations, if you don’t want it done by her. And yeah. She’s offered things, you know, other than her. So yeah.

- Mother

While the program aims to create a smooth transition out of Family Home Visiting by increasing clients’ social connections within the local community, there is evidence of significant variation in clients’ experiences of the cessation of the program. Several participants commented that the transition from the program was made easier by assurances from staff that they would still be available for the families in their care.

Well they said, “You can call me whenever you want.” I’ll feel lonely [when the visits finish]. But they said, “Call me whenever you want.” And I will, because they know me and they know [my son], and also, I have to grow up.

- Mother

Also, participants who had strong familial support found the transition reasonably smooth.

I don't know [how I felt when FHV finished]. Uh. Not too bad, because I had my mum there. So, and she's like really good. And that's my step-mum. And my dad – that's my real dad. (laughing) Yeah, and um. Yeah, so. They helped. Yeah, it's still... I don't know. I didn't really feel anything, because I had them there.

- Mother

However, other participants found the transition more difficult, with some feeling a sense of loss for the whole family at the end of the program. Often this was associated with social isolation.

I won't know what's happening now 'cause nobody will tell me, unless she [FHV staff member] tells me. Informing me about it, like, she's always informing me about everything. Maybe I'll have to go out and find out on my own. (laughing)

- Mother

Yeah, it was like, "This is our last visit." And we got a little certificate for [my daughter]. Yeah, but it was just like, "This is our last visit." And I don't know. Some people might handle it better than me. I can only speak for myself, but I found it really hard to break free from that. [...] Really I don't think there would've been anything [they could do at the end of FHV to make it easier], because inevitably it would've ended. ...Yeah, so whether or not it was the last meeting, or if it was a whole day spent together doing activities and the video, yeah. I think it still would've been the process of it ending anyway – that grieving process. Mm.

- Mother

I know [my daughter] misses [the nurse]. She still says, "Are we going to see [nurse's name] today?" Or, "Is [nurse's name] coming over?" She does. And I know she would have been grieving. She would've gone through a grieving process, and missing her. She had a birthday and, "Is [nurse's name] coming to my party?" So, she's [nurse] made a huge impact in her life. And mine as well. And she's like an auntie, like my auntie as well. A dear friend that I have a lot of respect for, and really do look up to, and admire. Mm.

- Mother

Several participants and staff noted the gap in services and support between the end of Family Home Visiting and the beginning of school or pre-school.

At 2 years old...after having [my daughter] and having FHV so regularly and then having it just stop is not right, it's a bit of a fright. So I reckon it could be like once a month or something, after the child is two. Like just checking in to see that you are doing okay. Because you always need that extra support for parents.

- Mother

I like that they're in it 'til they're two years old. Because there's nothing else out there for them. ...I think it should be up to three! There's nothing there for them from three to five, school-age. So basically from birth to three would be good.

- Indigenous Cultural Consultant

This was seen as particularly important for those parents who might be more isolated than the majority.

Everyone loves it [Family Home Visiting]. They think it's wonderful. All the women I talk to are excited about the program. The only thing is that, for those women who haven't plugged into other services like the Nunga playgroup – for maybe social isolation reasons or for any reason – the program doesn't close down. Maybe they [FHV staff] could pop in once a month until their child is four, at least. So maybe if they can't get them to kindy the service could continue until school. The only thing I'd think about is having continued support for families, for those who really, really need it.

- Mother

The dynamics of transition (into *and* out of the Family Home Visiting program) require further research, both with families and with staff. Awareness of the socially isolated context of many clients within the program raises questions about dependence and reliance that need to be explored in an outcomes-driven way. We need not only to document examples of supportive transitions out of the program, but also to begin to imagine and start developing sustainable, ongoing supports for families of young children.

RECOMMENDATIONS

- 15. Explore and model-up extending the program until transition to preschool. For example, by supporting FHV staff's involvement in playgroups.**

Discussion

Summary of Findings

The findings of this pilot study were overwhelmingly positive toward the Family Home Visiting program, indicating that families of Aboriginal children who remained in the program highly valued its staff, content, and mode of delivery.

Staff Characteristics

By far the most common finding in this research was that the qualities and characteristics of the Family Home Visiting staff contributed greatly to the success of the program. Exceedingly positive and complimentary, families' comments also reflected the personal qualities that the service seeks when employing home visitors. The Family Home Visiting Service Outline (2005) notes that the program relies on the skills of the staff, and states that, "As well as being non-judgemental and having warmth, flexibility, self awareness and the ability to contain strong emotions" (CYWHS, 2005: 10), other abilities and qualities are also needed. In direct alignment with our findings, the Service Outline lists qualities such as: having non judgemental respect for others, an ability to develop health and caring relationships, being client focused in decision making, and effectively assessing families' strengths and needs, as well as more structural abilities such as being able to work collaboratively with other colleagues. It is heartening to see such a close resonance between the qualities valued by clients and those valued by the organisation that employs sustained home visiting staff.

Furthermore, our findings parallel studies from the US and the UK exploring clients' perceptions of home visiting programs, analysed within the framework of Hilton Davis's *Partnerships with Parents* approach (Barlow et al., 2006; Kirkpatrick, Barloe, Stewart-Brown, & Davis, 2007). The fact that non-Aboriginal clients in the UK and Native American clients in the US valued qualities such as the honesty, friendliness, willingness to listen and warmth of the staff, as well as their non-judgmental attitudes, partnership approach, sharing of control, valuing of opinions, and building of genuine relationships indicates that our findings are unlikely to be limited to the Aboriginal families involved in Family Home Visiting in South Australia. Similarly, the fact that many participants in the UK study had had prior experiences with health and referral services that were less than positive, yet came to feel more confident as parents from their involvement with the home visiting service also resonates with the experiences documented in this report.

Cross-cultural Staffing

As well as general compliments for the Family Home Visiting staff – both nurses and ICCs – our findings highlighted the value that families placed upon being provided a service in cross-cultural partnership. Although some families built a rapid rapport with the nurses and were comfortable having home visits without the Aboriginal workers present at every visit, all valued the availability of culturally informed contact – if only to maintain their connection with the local Aboriginal community through their association with the

Indigenous Cultural Consultants. Other families stressed their preference for having regular contact with the ICCs in tandem with the nurse, expressing the ways in which communication could be facilitated in this manner. The significance of involving Aboriginal staff in the very first contact with families cannot be overstated as perceptions of the program are so strongly mediated by initial impressions of the staff.

The complexity of the role of Indigenous Cultural Consultants – particularly in terms of their accountability to the community – gives rise to a number of recommendations regarding acknowledgment and support for the ICCs' role. The fact that families valued the partnered involvement of Aboriginal staff and FHV nurses lends weight to facilitating effective partnerships. As identified by the participants in one of the participant feedback sessions for this project, in some ways a Nurse-ICC partnership may be viewed as an active model of Reconciliation in Australia. Ongoing cultural awareness training for all staff throughout the organisation can help to develop a genuinely culturally-safe health service.

Structure of the Program

Although the Structure of the Program has been presented somewhat chronologically within the findings, there is a significant overlap between service content, delivery, and the more relational aspects of the service. Not surprisingly, families' perceptions of and relationships with the staff strongly mediated their perceptions of the program itself. In this sense, comments about the content of the program were often difficult to distinguish from the manner in which the information, activities and health services were delivered, and of course service delivery was embodied in staff's behaviours and manners of communication.

Content and Delivery

The convenience of being visited within one's own home was one of the most prominent facilitators of continuing engagement with the program, as was the flexibility of the program – the mutually negotiated scheduling, location, duration, and frequency of visits, the provision of family-specific information and activities, and staff's flexibility and responsiveness around the needs of other family members. Continuity of staff also facilitated families' ongoing involvement with the program, although situations in which a change of staff gave rise to beneficial outcomes were also described. Families highlighted the need for well-managed transitions between staff members, both when changes are instigated by staff and by clients, but also pointed out the time needed for their children to develop relationships with new staff.

One very significant aspect of the program's structure is its flexibility – the fact that families were always offered choice in relation to their involvement in the various facets of program, and the ability of staff to respond to families' self-defined needs as they arose. Because of this flexible approach we rarely heard examples of inappropriate program content or delivery. Instead, families felt entitled to make their own decisions about when and if they wanted to engage in particular activities, as well as about the frequency and duration of visits. In a similar way, the potential inappropriateness (or

being 'too come-forward') of some questions, such as those within the Pathways to Parenting questionnaire, was averted by staff who reminded families that they could choose to not respond to questions that made them feel uncomfortable. Although this may be seen to threaten program integrity, such adaptive and responsive flexibility may also be one of the most fundamental facilitators of successful engagement and retention of clients. Evaluations of the Family Home Visiting program, including the Process and Outcomes evaluations, may wish to map successful or effective adaptations of the program as well as monitoring staff adherence to the defined service model.

Engagement and Cessation

Of great importance in this study, was the need to clarify the purpose and eligibility criteria for the Family Home Visiting program and to address these in a clear and consistent manner throughout local communities and health services within the roll-out regions. Confusions about the purpose and eligibility criteria of Family Home Visiting may impact on the uptake of the service, and need to be proactively rectified by the Children, Youth and Women's Health Service in order to reduce the burden of explanation that otherwise falls to contact staff or even clients themselves in discussions with their peers. As this recommendation was fielded with participants in the dynamic feedback sessions, families and staff suggested several ways in which the service could communicate the purpose and value of the program, some of which included visually 'branding' the service in a way that clearly distinguishes it from child protection and other stigmatised government services. We have included these suggestions from participants as part of our recommendations.

Frequently the families who participated in this research valued the manner in which they were approached and offered the program. However, the number and multiple roles of initial staff was sometimes confusing, and two suggestions arose from this. First, that FHV nurses conduct the Universal Contact Visit with all population-criteria clients when these criteria are known in order to provide immediate continuity with the Family Home Visiting program. Second, that ICCs be involved in all Universal Contact Visits with Aboriginal children when the child's ethnicity is known, and that a subsequent appointment with ICC and FHV nurse be arranged for those whose ethnicity is not known until the Universal Contact Visit.

The socially isolated context of many clients within the program raises questions about dependence and reliance that need to be explored in an outcomes-driven way in order to imagine and start developing sustainable, ongoing supports for families of young children. This became particularly evident as families described the cessation of the program and their transition to more community based supports. The value of Nunga playgroups that involve families who have experienced Family Home Visiting was repeatedly emphasised, and the occasional attendance of FHV staff at these playgroups was highly valued as well. Although we recommend exploring options around extending the program to preschool, there may be ways in which the Health Service can co-sponsor playgroups in collaboration with DECS in order to bridge the gap between the ages of two and five.

Context and Whole-of-Family Approach

Two recurrent themes that emerged in discussions with families were the importance of the extended family and the existence of complex social pressures. The significance of the Family Home Visiting program's interface with the contextual challenges that many Aboriginal families experience was made very apparent in the dynamic feedback sessions with research participants that followed our initial analysis of the interview and focus group data. Although wholly supportive of the recommendations that we had suggested and the ways that we chose to organise the report, families frequently reiterated the importance of continuing to provide and facilitate support around broader contextual issues. Participants' feedback has led us to develop some more specific recommendations around how the Family Home Visiting service can support families in accessing broader social supports throughout the duration of the program.

The importance of addressing contextual factors within the Family Home Visiting program is of particular significance because of the potential for contradiction between the program's population health approach and the rate of exclusion criteria in some of the populations being served. For example, in some regions of Family Home Visiting rollout, the prevalence of exclusion criteria in Aboriginal families (due to overcrowding, domestic violence, substance use and/or mental health issues within the household, for example) has been as high as 25-30%, which causes difficulties in providing a consistent service for 90% of a population in order to produce population health effects.

It may be possible for the government to prioritise the population health objectives by modelling a more intensive strategy for facilitating complex contextual support for families whose needs may be greater due to the complexity of their social contexts. Home visiting programs that do not specifically address contextual issues such as maternal depression, parental drug and alcohol use and family violence are greatly limited in their ability to impact upon child abuse and neglect (Duggan et al., 2007). Such strategies could also be examined for non-Aboriginal families who are experiencing difficulty in accessing mainstream, out-of-home support services. Further research is needed to explore the most effective ways of linking services for families with complex needs in order to retain the integrity of the population health approach of Family Home Visiting in South Australia.

Whole-of-Family Approach

The significance of extended family and kinship connections is well documented in literature regarding more-traditional Aboriginal childrearing and childcare practices (Warrki Jarrinjaku ACRS Project Team, 2002) as well as in earlier research in Adelaide (Radford et al., 1990). Our findings similarly indicated that this significance often extends to urban Aboriginal families. The frequent involvement of grandparents, aunties, uncles, cousins and siblings in some form of shared childrearing indicates that accommodating a whole-of-family approach to parenting might be an appropriate way of providing child health services for Aboriginal families. Although the Family Home Visiting program is based around the mother-child dyad and is structured to develop the

attachment primarily between these two, we heard examples of ways in which fathers and grandparents, and even siblings, were supported not only in terms of their access to health services, but also in their childcare skills and attachment practices.

The whole-of-family approach that some staff felt able to provide was highly valued by clients, which has led us to recommend overt and ongoing support for staff in engaging and serving all members of the household. However, there are resource implications and accountability requirements associated with providing a program that address the health and relational needs of a whole family or household. One strategy to accommodate these concerns might be to facilitate the utilising of non-nursing staff, such as specialist healthcare staff and psychologists and social workers, in an in-home capacity.

Contextual Challenges

In a similar manner, the contextual challenges that many families spoke of may also benefit from an in-home strategy and an awareness of whole-of-family dynamics. While housing instability and maternal depression and anxiety were the most commonly mentioned contextual challenges, FHV staff were often able to facilitate change and greater stability for families. When FHV staff wrote support letters to Housing SA, for example, families who had been on waiting lists for months were often moved to a higher priority category for subsidised housing. The ability of FHV staff to act in a liaising capacity with services such as housing – but also those such as the state child protection service, Families SA – because of their awareness of the more intimate dynamics and pressures within a household offers significant potential for families to feel better supported while accessing and engaging with these organisations.

The utilisation of CYWHS social workers and psychologists in an in-home capacity for mothers experiencing depression and anxiety was another seemingly innovative strategy facilitated by some FHV staff. Given that this expertise does dwell within the service, encouraging such professionals to become involved with families directly, rather than solely in a case conferencing capacity, might be a very beneficial supplement to the more physical health focus of the nursing staff.

Other innovative approaches to supporting parents who were experiencing difficulties such as family conflict or domestic violence included staff offering to provide the Family Home Visiting program in a setting other than the maternal home, for example by conducting the visits in a grandparent's home. This innovation opens the possibility of similarly conducting the program in more neutral settings (such as child health clinics) for families who may benefit from the child development and attachment aspects of the program, which are not as heavily emphasised when parents bring their children to a clinic for standard health checks and immunisations. To some extent, this asks for a broadening of the definition of the terms 'home' and 'visiting', giving rise to ideological questions as well as resource implications. Nevertheless, we recommend that alternative strategies be imagined, considered and modelled where possible.

Limitations

Although our recruitment strategy and range of participation choices made it possible for a gratifyingly high number of family members to contribute to this research, there were more individuals willing to be involved than time permitted us to include. In some cases people who had expressed interest in participating found themselves unable to attend focus groups on the scheduled day, yet we were unfortunately unable to reschedule as often as hoped. Furthermore, several people who provided contact details in order to be interviewed individually were unable to be included due to the time limitations of the research process.

More significantly, although we had hoped to explore the experiences of a range of families by speaking with equal proportions of people who had completed, remained active in, withdrawn from and refused the program, our recruitment strategy attracted far more people who were either actively involved or who had completed Family Home Visiting. This limits the generalisability of these findings to families who were not involved with or who withdrew from the program.

Although our data would suggest that positive experiences of the program have been experienced in similar proportions across the Northern and Southern rollout regions, other background information suggests that further research is needed to tease out regional differences and local dynamics. In a similar vein, because we did not ask all participants to state the names of the staff who visit them, we are unsure what proportion of staff are represented by the comments that we have heard thus far. Further, we had hoped to speak with staff throughout the organisation about their experiences of working with Aboriginal families in order to build a more comprehensive picture of the various facilitators and barriers to quality service provision. Due to time constraints in the pilot phase of this research, we were unable to complete this aspect of the investigation, and further research is needed in this area.

We feel able to provide solid examples of what works for families of Aboriginal children who chose to engage with and remain involved in the Family Home Visiting program, yet further research is needed to explore the experiences of families who either withdrew early or were not interested in the program. By investigating these experiences, more improvements regarding the content and delivery of the service may emerge, providing more thorough feedback to the Children, Youth and Women's Health Service regarding the quality of this program.

Finally, because this research is not intended as an outcome evaluation, the results need to be considered with the results of other evaluation projects being coordinated by the Children, Youth and Women's Health Service Family Home Visiting Evaluation Committee, led by Professor Michael Sawyer.

Further Research

As noted above, a research project specifically exploring the experiences of families who refused and withdrew from the program is needed. Given the success of this first phase of the pilot, and the fact that the research tools have been generally well received by participants, it may be prudent to begin this research promptly. A slightly different recruitment approach and interview technique may be required both for expediency and for more anonymous participation; for example, conducting telephone interviews, rather than face-to-face meetings.

Similarly, as noted in the discussion of contextual factors and the contrast between the Population Health approach and the prevalence of exclusion criteria in some populations, research is needed to explore what supports are available for families who are not currently deemed to be eligible for Family Home Visiting. This style of research may also be enhanced by a research design that involves telephone interviews rather than face-to-face participation.

The importance of the characteristics of FHV staff highlighted in this project, emphasises the need for a more comprehensive exploration of the experiences of service-delivery staff (nurses) and support staff. In speaking with Family Home Visiting staff, it could be possible to pilot questions arising from family participants; to look for regional variations in issues arising for families; to ask for perceptions of differences between working with non-Aboriginal and Aboriginal families, etc. Another important strand of further research would be to compare the experiences of Aboriginal families with those of non-Aboriginal families' experiences in order to ascertain the extent to which the views reported here are universal as opposed to culturally specific.

The dynamics of transition (into *and* out of the Family Home Visiting program) require further research, both with families and with staff. Awareness of the socially isolated context of many clients within the program raises questions about dependence and reliance that need to be explored in an outcomes-driven way. We need not only to document examples of supportive transitions out of the program, but also to begin to imagine and start developing sustainable, ongoing supports for families of young children.

In all research it will be important to link qualitative investigations to process and outcomes evaluations in order to measure both the immediate impacts and long-term outcomes of the Family Home Visiting program.

Support for an ongoing qualitative research agenda was evident in a comment by one participant in the pilot investigation who highlighted how the current evaluation of FHV with families of Aboriginal children was able to document the success of the program so that this success could be shared with others.

I think it's really good that you are actually looking into the program, and assessing it. Sometimes things just go running. And I think the worthiness of the

program needs – it's good that it's being shown that it's worthwhile. And the only way you can find that out is by doing what you're doing now, and that's good. To research into that is good, and I'm sure that it will benefit people in the future.

- Mother

RECOMMENDATIONS

- 16. Embed qualitative methodologies into standard quality improvement practices, using as many approaches as is appropriate – 'exit interview' etc.**
- 17. Link process, outcome and qualitative research to examine impact and acceptability of content and methods of delivery.**
- 18. Continue a research agenda which examines FHV with a range of participants including Aboriginal families from other areas of roll-out, families who withdrew from, did not take up or were not offered FHV, non-Aboriginal families involved with FHV, and staff involved in the design, management and delivery of FHV.**

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Appendices

Appendix 1 – The Multidisciplinary Team

Excerpt from CYWHS (2005) Family Home Visiting Service Outline, pp.10-11

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.

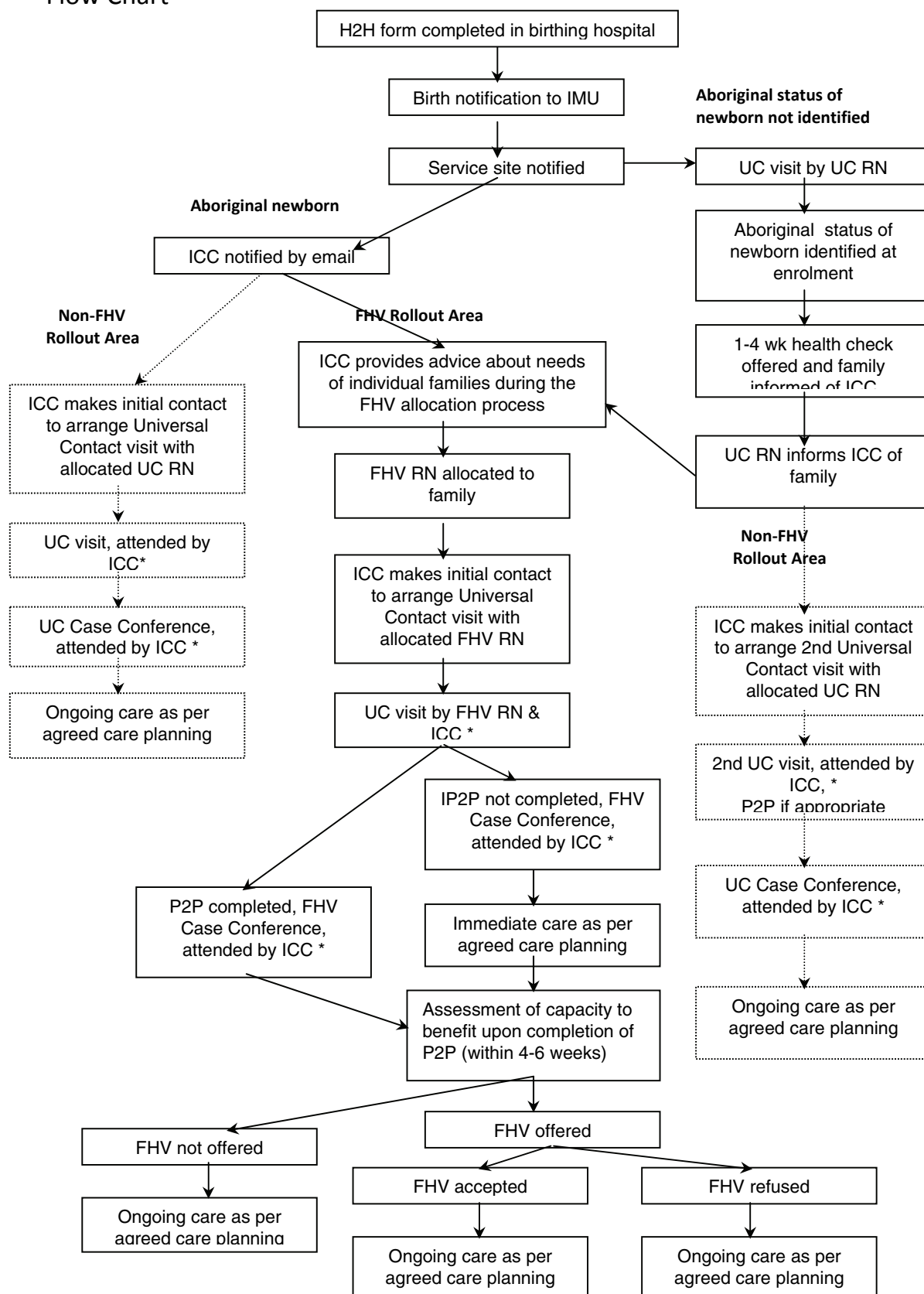
Bilingual Community Educators

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.

Appendix 2 – Home Visiting Aboriginal and Torres Strait Islander Families – Flow Chart



Appendix 3 – Research Tools

Semi-structured focus groups and interviews

The focus groups and interviews with staff and parents will be semi-structured. The interviewer will ask broad, open-ended questions, and then depending on the type and level of participants' involvement with the Program, a range of graded prompts will be used. Please note – the prompts will not be asked as a list of questions – it is anticipated that they will be used if the participant does not mention these topics in their narrative about the program.

The following broad questions and prompts will be used for all staff and parents:

We are interested in finding out about what you think about the Family Home Visiting Program (having the nurse come and visit you after your baby was born) generally. We'd also like to find out about how you became involved with the Program, and why you thought it might be useful or not....

Can you tell me about how you became involved with the Program? (staff, caregivers who enrolled in FHV). Or for those caregivers not involved – Can you tell me a bit about why you didn't want to take part in the Program? And/or for those caregivers no longer involved – Can you tell me about why you stopped being involved with the Program?

Specific prompts (for caregivers) – Who helped you become involved? When did you become involved? Why did you become involved? Was there something about the program that appealed/did not appeal to you?

What do you think about the Program?

Specific prompts - What has worked well? What has not worked so well? Types of activities – information and education, mentoring, referral processes, linkages to other services, support for families, relationships with staff and families.

Do you think the program is successful? Why/not?

Specific prompts - What type of things do you think helped or didn't help the success of the program? Specific prompts around practical barriers and facilitators eg frequency of visits, people involved, content of the sessions – What would a successful program look like for you? What kind of changes (if any) for yourself or your organisation/clients/family did your involvement in the Program lead to? If, unsure – Give examples Changes to social supports, parent-child interaction, parental mood and emotions, parenting behaviour.

What could have been done differently? How?

Specific prompts - What other services have you used/been involved with and how do they compare with FHV? Are there good things that FHV learn from services/ groups that you've liked? What could FHV do to be of more use to your friends and your community?

Are there any other supports or services you/your community/your clients need?

Additional questions for staff

What modifications to the FHV model have you made? How successful were these changes? Why?

Are there 'fundamentals' of the FHV model that should not be changed? Why?

Additional questions for caregivers

*What do you reckon/think this program is helping you to achieve with your kids?
(prompts to open the field for discussion)*

Family Home Visiting aside, I really would like to just talk about your child for a bit...

Looking ahead say, over the next 5 years, I'd really like you to dream and ponder for a moment about your future ... what would you want that future to look like? That is, when you think about [name of child] .

Prompt: Maybe, you might like to picture yourself having a cuppa and talking with a close friend or relative that you hadn't seen in a while. Picture yourself telling them your story. What sort of story would you really want to be able to tell to them if [name of child] at 5 years of age was showing signs of 'growing up strong' as they say. What might be the really important bits of your story about [name of child] be about? What would those signs of 'growing up strong' look like to you? What might your story be? Just think it over a bit if you like.

As a caregiver of an Aboriginal child, how do you think government organizations can support and show respect for your family?

Finally, and on a different note altogether. If you and your child were invited to take part in a national study hopefully beginning next year - that would 'track' your child's development and changes in your family and so forth (say, 'until [name of child] was xx years old', ie 4 years later). I'll just tell you a bit about it - it's a study that is looking at how to raise Aboriginal kids (babies and 4 year olds) strong and healthy and how governments can do better to give kids a better future. It's called Footprints in Time you may have heard about it. How would you feel about that? Do you reckon you might like to be involved? A key part of it would be that an Aboriginal woman (a member of the Footprints in Time team) would call on you at least twice a year to find out how your child is growing up and developing – and to just chat about how it is all going over a cuppa. And you would get to name the 'right' time for that person to call and whether it was in your house or at the local community centre. Would you like think that over a bit or can you say now if you'd be interested or not? {Give Footprints brochure} By saying "Yes" now won't in any way stop you from saying "No" later on, and the first thing that Aboriginal woman would do, would be to tell you a lot more about the study and ask you for permission which you would have to give in writing. Would you be interested in taking part?

Australian Centre for Child Protection

University of South Australia
St Bernards Road
Magill SA 5072

www.unisa.edu.au/childprotection/

The Australian Centre for Child Protection is funded by the Department of Innovation, Industry, Science and Research