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## Home visiting programs for the prevention of child abuse

### Introduction

The most widely recognised approach to child abuse prevention is a model that draws together the concepts surrounding primary, secondary and tertiary intervention.

**Primary prevention** refers to stopping abuse before it starts by targeting members of the community through broad-based programs directed at populations of people.

**Secondary prevention** programs are aimed at early intervention in high risk, vulnerable groups.

**Tertiary prevention** targets those individuals, families or groups where abuse has occurred, and attempts to prevent its recurrence.

### Primary prevention programs should include:

- support programs for new parents;
- education for parents;
- child care opportunities;
- programs for abused children and young adults;
- life skills training for children and young adults;
- self-help groups and other neighbourhood supports;
- family support services;
- community organisation activities; and
- public education of child abuse prevention.

### The overall objectives for the above approaches should be to:

- increase future parents' knowledge of child development and the demands of parenting;
- enhance parent-child bonding, emotional ties and communication;
- increase parents' skills in coping with the stresses of caring for children, including special needs children;
- increase parents' knowledge about home and child management;
- reduce the burden of child care;
- reduce family isolation and increase peer support;
- increase access to social and health services for all family members;
- reduce the long-term consequences of poor parenting.

The above objectives are intrinsic to many maternal and child health and community health nursing programs. Nevertheless, there is a significant gap in nursing research to demonstrate the contribution and effectiveness of practitioners in this area as well as the health outcomes for families involved in these programs.

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CENTRE FOR COMMUNITY CHILD HEALTH, ROYAL CHILDREN'S HOSPITAL, MELBOURNE



## Home visiting as an intervention for the prevention of child abuse

Preventative programs established over the past decade have had demonstrable effects such as a reduction in the incidence of child abuse, improved family functioning, increased utilisation of health resources and a reduction in the incidence of childhood accidents in the home for those families assisted by home visiting programs. Many of these programs have been directed towards specific groups within the community who have been identified as having the potential to abuse their children.

### Child abuse can be divided into four categories:

1. Physical abuse – non accidental injury inflicted on the child
2. Sexual abuse – an act which exposes the child to, or involves a child in, a sexual process beyond his or her understanding and contrary to accepted community standards
3. Emotional abuse – an act which results in the child suffering any kind of significant emotional deprivation or trauma
4. Neglect – serious omissions or commissions which, within the boundaries of cultural tradition, constitute a failure to provide conditions that are essential for the physical and emotional development of the child.

(Australian Institute of Health and Welfare. *Australia's children: Their health and wellbeing*. 1998. Canberra: AIHW)

The central aims of these programs are that child abuse can be prevented and reduced in families by providing home based care in relation to health education, parenting skills, social support and many other activities. Home visiting has long been used as a nursing strategy to assist families within their own environment. Nurses gain access to homes where many traditional 'welfare' services and agencies have been denied. Nurses are generally perceived as trusting, non-threatening and caring; therefore they are not perceived to be a threat by families identified as 'high risk'. The following are key examples of home visitation models.

### Elmira project (Upstate New York)

The premise of this program is that nurses can identify and help change factors in the family environment that interfere with parenting practices, employment, education and family planning, and thus reduce child abuse. Elmira was chosen because it had consistently shown the highest rates of child abuse in the State, despite the town being well resourced with health and human service facilities. The evaluation of this program reported that families who received home visiting had an abuse rate fifty percent lower than those who did not receive the service.

The Elmira project took the form of a clinical trial in which clients were randomly assigned to one of four treatment groups with:

- the most intensive service group received nurse home visits until their children were two.
- one group receiving home visits only before the child's birth,
- and the other two groups received no home visits.

As stated, the participants were randomly assigned to one of the four treatment groups. One group of one hundred and sixteen women received nurse home visits for the first two years of the child's life, as well as developmental screening at twelve months and two years for the child and free transportation to regular prenatal and well child clinics and nurse home visits during pregnancy. The other three groups received the above services, but they did not receive home visits after the birth of their child.

The nurses in this program had professional experience in maternal and child health and all had children of their own. The results and outcomes of this project were considered positive and successful.

Other outcomes of the Elmira program included:

- fewer subsequent pregnancies,
- mothers who were deemed to be 'high-risk' altered and restricted their discipline and punishment to their children.
- an eighty-two percent increase in employment for these women.
- health behaviours improved for this client group and they were more able and willing to access preventative health and human services than were the control group, who tended to use the crisis-focused services.

The cost benefits of this study were extensively evaluated. Olds, Henderson & Kitzman (1994) found that government expenditure could be reduced for low-income families if they were involved with a nurse home visitation program. The researchers also noted the importance of having nurses visit families from pregnancy through to the second year of the child's life. The nurses assisted and facilitated in the education and resolution of behavioural and psychosocial problems that had the potential to lead to less than adequate health outcomes for the family.

### **Hawaii's healthy start program**

Another successful program is 'Healthy Start', managed by the Maternal and Child Health Bureau in Hawaii. 'Healthy Start' is a statewide program that uses lay home visitors to implement services to families who are considered to be at high risk; that is, those families who have the highest potential to abuse their children. The service providers are seven non-profit organisations who have agreements with the Maternal and Child Health Bureau to provide specific services to families. The Maternal and Child Health Bureau has specific requirements and outcomes it expects from these service agreements. If these requirements and outcomes are not met then the service provider is at risk of losing ongoing funding and renewal of agreements.

The 'Healthy Start' experience has been referred to as the 'model for the nation' in the prevention of child abuse. This program is voluntary and is offered as a service until children are five years old. The families are accessed and screened through hospitals. The program began in 1985 (a three year demonstration project) and is currently able to service about fifty-two percent of families with newborns across Hawaii. Clients who are pregnant and or those who have an infant under three months of age are eligible for this program.

The screening of the hospital records is carried out by early identification staff (EID) who screen for these factors:

1. marital status: single (lone), separated, or divorced mother;
2. partner unemployed;
3. inadequate income or no information regarding source of income;
4. unstable housing;
5. no phone;

6. education under twelve years;
7. inadequate emergency contacts;
8. history of substance abuse;
9. late or no prenatal care;
10. history of abortions;
11. history of psychiatric care;
12. abortion unsuccessfully sought or attempted;
13. relinquishment for adoption sought or attempted;
14. marital or family problems and,
15. history of, or current depression.

Once this screening is complete the EID staff follow through with an interview with the mother if:

- seven of the fifteen factors cannot be answered from the information in the medical charts;
- at least two of the factors are present; and,
- if any one of the following factors exists (lone mother, no prenatal care (or late care) or abortion sought or attempted).

If none of these factors are met, the women are not considered to be at risk and are not followed through. Home visiting is the central focus of the 'Healthy Start' program. The services offered are similar to many preventative programs. The visitors offer counseling and provide information regarding the resources available to the clients, such as financial assistance, nursing and medical care, respite care and much more. The home visitors check the children for developmental delays and measure the parent-child interaction. The frequency of visits varies from weekly to quarterly, depending on the needs and the assessment of the family functioning. The home visitors provide support to families and help identify and reduce stress in the family that can lead to child abuse. If the home visitor identifies a problem with a child's development they refer the child to a health or educational professional.

The client group targeted by 'Healthy Start' is similar to that involved in the Elmira project, being predominantly women who are single (lone), under twenty-four years of age and with minimal education. Many of the clients have histories of drug abuse, spouse abuse, are unemployed and have some prior involvement with protective services. These families are offered visits for up to five years and according to

Wallach and Lister (1995) approximately ninety percent of families who are screened as 'high risk' accept the home visiting service.

From past evaluations, the 'Healthy Start' program has reduced the incidence of child abuse. In fact, one study suggested that less than one percent of the clients were confirmed as abusive. There are other 'ripple effect' benefits to these programs as well. For example, a study performed from 1987 to 1990 found that two-year-old clients enrolled with 'Healthy Start' had an immunisation completion rate of ninety percent, compared to sixty percent for the overall two-year-old population in the United States.

One of the major differences between 'Healthy Start' and the Elmira project is the staff profile. The Elmira project utilises the skills and experience of professional nurses for direct client service delivery, whereas 'Healthy Start' has a mixed staff profile. The service providers determine their own requirements for staff qualifications. The managers and directors of the programs have nursing degrees and most are Masters prepared. The home visitors vary in their educational and professional backgrounds. The home visitors have high school diplomas, some have college degrees and some have Bachelors degrees. The home visitors are given a five-week course focusing on topics such as child abuse and crisis intervention, and they also learn about developmental assessment. They cover areas such as interpersonal communication and cultural sensitivity.

'Healthy Start' provides services to families for a period of five years compared with the Elmira project that serviced families for a maximum of two years. The 'Healthy Start' program has a reported child abuse rate of less than one percent in its client population, and according to Plotnick (1994) this is commendable when compared with other projects working with at-risk families, where abuse rates of eighteen to twenty percent are reported.

## Health visitors (England)

England too has a model of health delivery to families in the home. This model is based on the intention to improve the health of the overall population. The role of health visitors (nurses) is to promote health through home visiting and community action and although they work with clients of all ages the majority of their work is with families and young children. However, health visitors are becoming increasingly involved with child protection. But like so many other nursing programs there has been minimal research on what they do their effectiveness, and their ability to reduce the incidence of child abuse and neglect.

## In conclusion

The problem lies with evaluating these types of preventative programs and then being able to access health care funding to sustain these programs.

It is difficult to find comprehensive studies that relate to a cost-benefit analysis of preventative programs. It is even more difficult to generalise, because of the nature and disparity of so many preventative programs. However, one point of agreement generally found in the literature is the enormous cost of tertiary interventions. The United States Government General Accounting Office (1992) acknowledged that primary and secondary prevention programs, like the Elmira project, are expensive to implement but they pay for themselves in the long term in the savings accrued from reduced treatment and the social costs. However, in Australia, we have minimal evidence to support the effectiveness of home visiting programs. Further research and longitudinal evaluations are required to demonstrate the effectiveness of such programs in this country.

## AUTHOR

Jane Redden-Hoare

Senior Lecturer, School of Postgraduate Nursing

The University of Melbourne

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