EARLY CHILDHOOD HOME VISITATION: A Review of Research

Home visiting is a strategy to deliver a variety of services to a variety of populations. Home-visiting programs for infants and young children send individuals into the homes of families and seek to improve the lives of the children by encouraging changes in the attitudes, knowledge, and behaviors of the parents (Behrman, 1999).

For most infants, their cognitive, social and emotional development is stimulated by the enthusiasm and joy of their caretakers. However, too many infants—especially those with homes complicated by violence, maternal depression or mental illness, substance abuse, or poverty—experience compromised development.

A multidisciplinary group of experts convened by the U.S. Department of Health and Human Services on October 23-24, 2000 advised that it is essential that the nation find ways to support the emotional health of our youngest children and their families through a continuum of comprehensive, individualized, culturally competent services that focus on promotion, prevention and intervention.

This issue of VCPN focuses upon early childhood prevention programs. We will discuss some of the research findings and will spotlight effective and innovative program implementations. The challenges facing early prevention efforts will also be discussed. Virginia localities offer many early prevention programs. This issue of VCPN will feature Virginia Healthy Families and First Steps programs.

VCPN has already reported in detail on the Healthy Families America model (see VCPN, volume 52). Briefly, the program is voluntary and targets new or expectant parents at risk. That may mean the parents are young, single, and lacking social support, resources, or an understanding of child development. Some struggle with problems such as substance abuse, mental illness, or family violence, and some lack education or job skills.

Typically, home visitors work with parents to build strengths and minimize harmful behavior. Home visitors help parents to provide their children with experiences that stimulate healthy brain development. Home visitors also strive to help parents develop strong, nurturing bonds with their child. Children receive developmental screenings and referrals can be made, if needed. Families learn to use medical services and practice preventive medical care.

Parents can receive help with improving education, obtaining better housing, referrals for counseling, and finding jobs.

How effective are early prevention home-visiting programs? Let's consider some of the goals separately.

Reducing Child Maltreatment
A Centers for Disease Control and Prevention Task Force on Community Preventive Services reviewed 22 studies that evaluated effects of early childhood home visitation on child maltreatment. They found that programs resulted in a reduction of 40 percent in child abuse and neglect, regardless of whether incidents were assessed directly (reports to Child Protective Services) or indirectly (susicious injuries). A recently published meta-analysis of 40 evaluation studies of early prevention programs for at-risk families found that selected prevention programs produced a significant decrease in abusive and neglectful acts (Geeraert et al., 2004). A meta-analysis of 56 programs designed to promote family wellness and prevent child maltreatment demonstrated that most interventions were successful (MacLeod & Nelson, 2000).

One example of an early home visitation program is Healthy Families America. Over a dozen studies in nine states have demonstrated that Healthy Families America is effective in lowering rates of abuse and neglect. Two studies were completed in Virginia. Galano and Huntington (2001) found that all Virginia programs equaled or exceeded the statewide goal of having no child abuse or neglect reports for 95 percent of families who received services for at least 12 months. Barrett (1996) found that 2 percent of participating children had a substantiated report of child maltreatment, and all reports were for neglect. These results are similar to findings in other states (Prevent Child Abuse America, 2002).

Ensuring Healthy Child Development
Studies have examined health care utilization, insurance, emergency room use, and immunization rates. In a meta-analysis of 40 studies, Geeraert et al. (2004) found that early prevention programs, including...
Healthy Families America programs, had positive effects on child functioning. For example, among 633 Iowa Healthy Families participants, only 11 (1.3 percent) had no health care coverage. This compares to the average rate of 17 percent uninsured in Iowa (Berkenes, 2001). In New York, 75 percent of children in Healthy Families received the recommended number of well-baby visits the first 15 months compared to only 46 percent of children enrolled in New York State Medicaid. In New York City, the comparison was 78 percent of Healthy Families children completed all well-baby visits compared to only 36 percent of children in the Medicaid program (Greene et al., 2001).

In Maryland, 96 percent of participating Healthy Families mothers and 100 percent of babies had a “medical home” (regular doctor) (Klagholz et al., 2000). In Virginia, over a 3-year period, home-visited families required fewer emergency room visits than the control group (Galano & Huntington, 1997). Very high rates of immunization for children enrolled in Healthy Families are reported in 13 studies. All but three studies show rates of 90 percent or higher (as high as 100 percent!) with the lowest rate at 73 percent (HFA Website, 2002).

The Healthy Families America interventions boost rates of prenatal care as well. In Oregon, mothers enrolled in the program increased their care from 68 percent prior to enrollment to 88 percent while receiving services (Katzev, Pratt, & McGuigan, 2001). Prematurity rates improved in Virginia (40 percent in the control group compared to only 18 percent in enrolled families) (Galano & Huntington, 1997). In New Jersey, the birth weights of premature infants in Healthy Families were higher (average 6.3 lbs.) when compared to those who enrolled postnatally (average 5.5 lbs.) (Woodson, 2001).

Ensuring That Children are Ready to Learn

Brain research shows that early relationships and early stimulation are crucial not only for cognitive development, but for later emotional development (studies reviewed by Knitzer & Page, 1998). In addition to the developmental gains that have been documented to date, investing in infants, toddlers, and their families is likely to improve behavior and general adjustment in later years.

Families enrolled in Healthy Families interact more with their children in ways that stimulate healthy brain development. For example, in Oregon, 76 percent of participants read books with their children three or more times each week (Katzev et al., 2001). In Virginia, enrolled families maintained higher optimal stimulation levels than control families after both one and two years in the program (Galano & Huntington, 1997).

A program using nurses as home visitors (Olds et al., 2002) found children in the program exhibited superior mental development when compared to controls. Children in the program were less likely to exhibit language delays.

Children in Healthy Families receive early developmental screenings. Developmental screenings serve several purposes. First, and perhaps most important, developmental screening can detect problems early. According to a report from the Commonwealth Fund (2004), even though most children use their doctors regularly, common developmental problems such as learning disabilities, vision or hearing impairments, and behavioral disorders often go unrecognized. "Physicians lack the time and training to perform developmental assessments, health plans do not adequately reimburse physicians for the developmental health services they do provide, and current accountability systems do not measure the content and quality of such services" (Commonwealth Fund, 2004, p. 1). Thus, screenings by an in-home worker can be important in detecting problems.

Secondly, screenings provide information about the children's well-being and can be a measure of a program meeting goals. For example, children in Healthy Families score significantly better than control children: in Arizona, 95 percent were at age-appropriate developmental levels at 48 months of age (Davenport, 2001); in New York, 92 percent fell in the normal range (Greene et al., 2001). For children who were lagging, referrals for further service were made.

Promoting Self-Sufficiency

The meta-analysis by Geeraert et al. (2004) confirms improvements in families functioning for the 40 studies included in the analysis. Healthy Families America and similar programs assist parents in enrolling in school, finding employment, locating housing, obtaining counseling and help for serious problems, and decreasing stress. For example, a program with nurses as home visitors found participants had fewer subsequent pregnancies than controls (29 percent versus 41 percent) and subsequent pregnancies were delayed for longer intervals. Participants also worked more than the control group (6.83 versus 5.65 months) during the second year after the birth of their first child (Olds et al., 2002).

In Arizona, 17 percent of enrollees in Healthy Families were employed at the start of services. By the end of six months, 31 percent were employed and 40 percent were employed within a year. This trend lowered welfare payments, as Healthy Families participants spent fewer days receiving AFDC, Food Stamps and Medicaid than the control group (LeCroy & Milligan, 2001). Findings are similar in other states. For example, in Maryland, 88 percent of Healthy Families participants were enrolled in school or employed after year four of the program (Klagholz et al., 2000). In Florida, 35 percent ended dependence on public assistance within a year, 19 percent obtained a GED or job training, 64 percent obtained employment, and 41 percent moved to better housing (Nelson, Gordon, & Hoffman, 2000).

Healthy Families America helps enrollees delay or reduce subsequent pregnancies. In Florida, 95 percent of mothers did not become pregnant for at least two years after enrolling. In Hampton, Virginia, the repeat teen birth rate was substantially lower for enrolled mothers (9.4 percent) compared to the citywide rate of 35.8 percent and the state rate of 29.8 percent. In Maryland, 100 percent of teen mothers and 94 percent of adult mothers avoided a repeat pregnancy while enrolled in Healthy Families.

Promoting Positive Parenting

Healthy Families educates parents about positive discipline techniques, helps parents understand child development, and promotes positive attitudes and nurturing responses. Studies in seven states have found improvements in areas such as appropriate expectations for children, knowledge of child development, handling of stress, home safety, and social isolation. In Virginia, mothers in the program improved parent-child interaction scores, bonding, communication and care-giving while control group mothers showed lowered abilities and decreases in these areas (Galano & Huntington, 2003). The meta-analysis by Geeraert et al. (2004) of 40 studies also found positive effects on parent-child interaction.

Best Practices

One function of evaluation research is to identify best practices. A recent meta-analysis examined more than 900 research reports of a wide variety of family support programs, selecting 665 studies for coding that represented 260 programs (Layzer et al., 2001). Readers need to be aware that meta-analysis has limitations. The analysis includes diverse programs, varying in types of services offered and in method of service
delivery. The analysis can be accused of "mixing apples and oranges."

Overall, family support programs of all types in the meta-analysis produced modest but significant effects across a wide range of outcomes. However, not all programs were equally effective. Almost two-thirds of the programs studied had very small or no effects on parents’ understanding of child development, attitudes about child-rearing, or behaviors with their children. More than half of the programs had small or no effects on family functioning (Layzer et al., 2001). These findings emphasize a need to identify practices that result in change. The meta-analysis did identify some practices that produced stronger effects. These were:

- use of professional (rather than nonprofessional or paraprofessional) staff;
- offering group meetings and peer support;
- focus on specific types of families, such as teen mothers or those with a child with developmental disabilities and tailored interventions to that specific group;
- providing early intervention directly to the children (as opposed to only parent training);
- organized parent-child activities were important for teen mothers.

Others have also identified practices that are more effective. For example, Thompson (1995, cited in Fuddy & Thompson, 2001) found the following were effective practices:

- early and extended contact with the family;
- manageable case load size;
- greater training, supervision, and support for workers;
- an ecological perspective;
- paid staff, rather than volunteers;
- voluntary services;
- reliable funding.

Leventhal (1996) suggests nine factors of effective programs:

- early intervention;
- intensive service over a sustained time period;
- development of a therapeutic relationship between parent and home visitor;
- careful observation of the home;
- focus on parenting skills;
- child-centered services (focus on child);
- provision of concrete services such as shelter and health care;
- including fathers in services;
- ongoing review.

According to Mendoza et al. (2003), one component is most frequently cited as part of effective services. That component is trust. Relational trust is composed of social respect (genuine interest), personal regard (reducing another’s feelings of dependence and vulnerability), perceived competence (staff and parents able to depend upon each other and able to partner), and perception of basic integrity (people “keeping their word”). Relational trust is a key factor in change.

The meta-analysis by MacLeod and Nelson (2000) gave strong support to the idea that early intervention is more effective than later intervention. Gains made through proactive, early intervention were shown to be sustained, and in some cases, even increased, over time. In contrast, reactive interventions tended to fade. The authors felt that proactive interventions initiated a positive chain of events that broke the pattern of “downward spiral which may result in child maltreatment for those who are exposed to many adverse conditions” (p. 1141).

Likewise, intensive interventions (more than 6 months and more than 12 home visits) were effective whereas interventions lasting less than 6 months or less than 12 visits were not. Furthermore, MacLeod and Nelson found that longer follow-up intervals were required to detect reduced rates of child maltreatment. Reductions in problems had, in general, smaller effect sizes than measures of increases in competencies (such as increases in positive parent-child interaction or the creation and maintenance of secure and stimulating home environments).

One “best practice” question concerns the relative merit of a “strengths-based” empowerment approach versus a problem-focused approach. A strengths-based or family-centered approach emphasizes the family’s ability to make decisions and to use resources to their own benefit. In contrast, approaches emphasizing family deficiencies and needs consider the staff to be the “expert” and parent viewpoints and opinions are given little weight in the design of the curriculum, interventions, or activities (Mendoza, Katz, Robertson, & Rothenberg, 2003). The meta-analysis by MacLeod and Nelson (2000) provides strong support for an empowerment, strengths-focused and terms this orientation as “critical in interventions for vulnerable families” (p. 1142).

A strengths-based focus encourages parental involvement. Involvement is believed by some to be crucial to program success. “It is difficult for a program to serve parents who do not perceive that participating will be useful to them; those parents are clearly among the ‘hard-to-serve’ parents. Furthermore, parents who believe that the program will be useful may be unable to sustain their commitment because of Examples of Home Visiting Programs:

- The Nurse Home Visitation Program (NHVP) started as a university-based demonstration program in Elmhur, New York. It has been replicated in Memphis, Tennessee and Denver, Colorado.
- Hawaii’s Healthy Start is a home visiting program that serves families identified through screening as highly stressed or at risk for child abuse.
- Parents as Teachers (PAT) began in Missouri and now operates at more than 2000 sites across the country to promote the development of children from birth to age 3.
- The Home Instruction Program for Preschool Youngsters (HIPPY) seeks to prepare three to five year-olds for kindergarten and first grade.
- The Comprehensive Child Development Program (CCDP) is a five-year federal demonstration program that worked with families in poverty in 24 sites. CCDP aimed to promote children’s development, parent’s ability to parent, and family self-sufficiency.
- Healthy Families America (HFA) evolved from Hawaii’s Healthy Start. It has three broad goals: promoting positive parenting practices, improving child health and development, and preventing child abuse and neglect.

Innovative Ideas

Baby Massage Workshops:
Impaired attachment (insecure or disarranged) between parent and baby has been linked to poor development outcomes. Naughton and Heath (2001) report on baby massage workshops. The contact and physical nurturance promotes secure attachment.

Specialized Clinics:
Naughton and Heath (2001) report on the success of sleep clinics and feeding clinics. Sleep clinics assist parents in learning how to handle an infant or child with disturbed sleep. Feeding clinics combine the talents of a multidisciplinary team to address feeding difficulties of all sorts. For a more complete article about feeding problems and responses see VCPN, volume 54 (Fall, 1998).

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external factors in their lives” (Mendoza et al., 2003, p. 67).

It is imperative to continue to identify the “best practices” within programs. Programs with weaker effects can, theoretically, at least, adopt practices that have proven effectiveness and increase their impact. It is also important to recognize that effective practices are likely to differ between populations. Little was found in the research to guide program planners about how to adjust programs for specific populations such as a client who is deaf or one who is from a different culture. Cultural competence in service delivery is also crucial. For example, the Hispanic population is increasing rapidly in both the U.S.A. and in Virginia. Therefore, home visiting programs need to continue to identify and utilize practices that are effective with this subgroup of families. For a more complete discussion of cultural competence in service delivery, see VCPN, Volume 62.

It should be mentioned that not everyone agrees with the search for best practices. According to Naughton and Heath (2001), “efforts to isolate the most important ingredients of successful home visitation programs are thought to be misguided…as each appears to play a synergistic role” (p. 93). Rather, these authors believe that successful outcomes are due to “health visitors who establish a therapeutic alliance with families, recognize behavior change within the families’ social context as well as the individual beliefs and emotions…” (p. 93).

Recent Dissent

Several recently published studies have implications for home-visiting programs. These studies suggest that scrutiny of several aspects of home visiting is needed. The first area of question is the relationship between factors used in the screening and the outcome of child abuse or neglect. Many home visiting programs use a risk assessment based upon Kempe’s Family Stress Assessment (1976) or a similar measure. These checklists include factors such as parent substance abuse, poor mental health, presence of domestic violence, history of abuse as a child, unrealistic expectations for the child, and having an unwanted child. Other factors that have been used as risk indicators by some programs include young maternal age, limited education, poverty, and lack of social support. Such factors are commonly cited as associated with risk for child maltreatment, although their relationship may not be a causative one (U.S. Department of Health & Human Services, 2004).

Windham et al. (2004) used a sample of 595 mothers of newborns who were identified as at risk for child maltreatment. The researchers followed the mothers for three years, and used the mothers’ self-report of severe physical assault and assaults on the child’s self-esteem. A multivariable method for analyzing longitudinal data was employed to examine associations between risk factors and reported maltreatment.

Windham et al. (2004) found that maternal depression (especially higher levels of depression) and the mother being an active part of a violent relationship were potent indicators of risk for child physical assault. Low birth weight babies (those “small for gestational age”) and two-year-olds were at higher risk for physical assault. Demanding children and children of mothers who were abusing substances were at highest risk of verbal assault. They conclude “among high-risk families, parental psychopathology and other psychosocial risk factors are more strongly related to child maltreatment than demographic characteristics” (p. 658).

While Windham et al. did not examine all commonly cited risk factors, they did find that poverty, maternal age, education level and race were not associated with later child maltreatment. If other studies document this finding, then targeting families on the basis of demographic factors may be less valid than targeting families with maternal depression, substance abuse, and domestic violence. “The possibility needs to be considered that prevention programs may expend effort inefficiently by targeting far too many parents who will never maltreat their children anyway, while failing to provide sufficient focus and intensity for those who are truly at-risk” (Chaffin, 2004, p. 593).

Readers should note that early intervention programs such as Healthy Families programs have several goals other than prevention of maltreatment. Families who are not at specific risk for maltreatment can still be at risk for poor performance in areas of positive parenting, assisting their child in developing school readiness skills, and child health. Others argue that better general outcomes can reduce maltreatment risk over time (Leventhal, 1996).

The Windham et al. findings also have implications for service delivery. If the primary risk factors for child maltreatment are parent mental health, substance abuse, and partner violence, then interventions designed to alleviate these problems are also needed. Home visiting programs often focus their services on parenting education and case management (Duggan et al., 2004; Windham et al., 2004). Programs are typically targeting a broad range of goals related to child health and well-being rather than targeting parent psychopathology. Thus, home visiting early intervention services should continue to develop strong networks and partnerships with service providers who can address serious parent pathology.

A study of 171 adolescent mothers labeled high risk for child maltreatment in a comprehensive maternity program found no added benefits for youth who received home visits (Stevens-Simon et al., 2001). There were no significant treatment group differences in health utilization, rate of return to school postpartum, repeat pregnancies or child abuse and neglect. However, there was a significant difference in how young mothers complied with the intervention according to the support they received from their families and from the fathers of the babies. Thus, an ecological approach was supported.

Using Healthy Start programs in Hawai'i, Duggan et al. (2004) examined the question of service delivery and concluded that the programs accomplish little reduction in malleable parent risks for child abuse. They found that “high-dose” service was effective in reducing maternal alcohol use and instances of domestic violence but the more typical home visiting strategy resulted in no improvements in mental health of parents (depression, stress, or general functioning), substance use, partner psychological abuse, level of physical violence between the couple, or incidents to children resulting in injury.

Duggan et al. note that home visitors did not specifically target risk behaviors and related conditions. Rather, treatment plans contained broad goals that were not limited to the risk conditions that caused the family to be accepted into the program. Additionally, while workers rated themselves as very proficient in areas such as establishing relationships and promoting positive parenting, they rated themselves as less skilled in promoting natural support networks, helping families problem solve, goal setting, and addressing specific risks for child abuse such as substance use and partner violence.

Duggan et al. also found that in-home workers often were unaware of mental health, substance abuse and domestic violence problems in the families they served. Worker recognition rates for serious family problems ranged from 11 percent to 29 percent for “low dose” families and 8 percent to 50 percent for families with the most intensive service. Recognition rates were higher for partner physical violence.

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Virginia Beach’s Healthy Families program is one of Virginia’s larger programs. It was accredited in 2002. In 2003-04, workers received 1,260 referrals, screened 498 families, and served 984 families in the intervention program.

The program is divided into four components. Healthy Start provides support and education to first-time parents and at-risk parents who can benefit from in-depth assessment and ongoing home visitor services. A total of 388 families were enrolled. The Mother Baby Program provides short- and long-term home visiting to at-risk pregnant women. Public health nurses provided this service to 177 mothers-to-be. A Parent Support Program offers telephone information, referrals, and support to parents from the prenatal period until the baby’s third month. Trained volunteers and registered nurses responded to 253 families. The First Steps Program is similar to the Parent Support Program, but is limited to parents at Sentara Virginia Beach General Hospital (SVBGH). First Steps served 166 families in the last three quarters of 2003-04. (See page 12, this issue, for a description of First Steps.)

While much could be written about the Virginia Beach program, VCPN staff were most interested in the military families. Anna Pratt, Co-Coordinator of Healthy Families Virginia Beach, thinks military parents face special challenges. “There is the stress of coping with the frequent absence of one parent. This can be especially difficult if the parent is deployed,” she states. “Many members of the military are very young, very far from home, and have few sources of support in our locality.”

Amber Richey, one of the family support workers, is a military wife herself. Her husband has been in the Navy for 8 years. She agrees with Pratt. “Military families move frequently and don’t have support programs nearby. Also, their income is limited which makes mobility difficult. There may be only one car. Isolation can be a problem for a young mother with a new baby,” she notes. Richey says the Healthy Families program often provides transportation to doctor’s appointments or even to the park for an outing.

Virginia Beach Healthy Families collaborates with the Oceana Naval Family Services Center. “We can provide transportation for moms who have trouble getting to the base. Some do not even know the services are available on base. It is like a city and some moms are not familiar with where everything is located.”

The Oceana Naval Family Services Center does offer support groups for new parents and classes on a variety of topics. They offer referrals for problems such as substance abuse or domestic violence and direct assistance of various kinds. They also do home visits but don’t have sufficient staff for the need and refer families to Virginia Beach’s Healthy Family program.

Richey describes most military families as two-parent. She actively involves fathers in the program and times her visits so that both parents are home to benefit. This is in contrast to the majority of the participating families in the rest of the Virginia Beach program (80.2 percent of parents are single) and to most Virginia Healthy Family Programs where service is focused on single parents. Richey has served some single women who have become pregnant to enlisted men and do not plan to marry. The child is a dependent of a member of the military and eligible for some benefits, but the mother is not. In this situation, Richey says the program works only with mothers. They do not try to involve fathers if the mother is single.

One of the special services that are offered to military families is assistance with sending video tapes of the baby and pictures of the baby to deployed parents. Richey also invites military parents to field trips to area attractions. “It is something fun to do. We include a gift and lunch. Parents can meet other parents and make friends with someone in a similar situation,” she explains.

Pratt and Richey agree that a Healthy Families worker can make a large difference in the life of a young military family. Says Pratt, “Keeping a healthy mental attitude when you have a baby, no spouse, and are in a strange place is a large plateful.” Richey adds “It is an especially hard time to be alone if your spouse is deployed when you have a small baby.”

The program’s success is evident in the program outcome data. For FY 2003-04 the program participants achieved consistent prenatal care (92 percent), no founded reports of child maltreatment (95 percent), optimal home environments (96 percent), receipt of scheduled immunizations (93 percent) and a medical home for the child (100 percent).

Pratt attributes the program’s success to the staff’s belief in early intervention and to the way staff support each other. Pratt explains, “There are few staff changes because of the positive work experience. We are bonded as a staff and believe in what we do. The program makes a difference!”

More information is available from: Anna Pratt, RN, MSN, Co-ordinator, Healthy Families Virginia Beach, Virginia Beach Department of Public Health, Pembroke Corporate Center III, 4452 Corporation Lane, Virginia Beach, VA 23462 (757) 518-2700 or (757) 5188-2620 Fax: (757) 418-2643.
than for poor mental health and maternal substance use. The authors note that family
support workers seldom linked families to community resources to help with these
more serious problems.

Duggan et al. say that there has been a
philosophical shift in home visiting
programs in Hawaii. Early programs in the late
1980s and early 1990s were based on a risk
model and a delimited responsibility was
to make referrals to professionals for inter-
vention. In 1994, due to Early Intervention
Part C service requirements, the program
began “parent-driven” services where the
parent set the goals and defined strategies
to achieve them. Risk-reduction was replaced
by a “strengths-based perspective”. Inade-
quate skills training in risk recognition and
response further compromised the staﬀ's
ability to identify and address speciﬁc risks
for child abuse.

It is important to note that Duggan et
al.’s study measures reduction of risk fac-
tors rather than reduction of maltreatment.
No data is offered about whether or not the
program resulted in improvements in child
health and school readiness nor were rates of
founded child maltreatment reported.

Duggan et al.’s study does raise ques-
tions and may help explain some of the
discrepant ﬁndings. Improvements on
measures of child health (such as increased
immunization rates) does not necessarily
lower the risk for child abuse due to seri-
ous family problems. A recent study by
Bugental et al. (2002) illustrates this idea.
This study tested the beneﬁts of adding

a cognitive approach to the basic Hawaii
Healthy Start home-visiting model.

The study used 96 Latino families in
Santa Barbara County who were identiﬁed
as moderate risk for child abuse. Cogni-
tive-behavioral therapy has been relatively
successful. The cognitive appraisal com-
ponent was designed to enhance parents’
perceptions of power or competence within
parenting. Parents were assisted in making
a causal appraisal of the possible reasons for
an identiﬁed parenting problem and helped
to design a strategic plan. The success of
the strategy was then assessed at the next visit.
Parents were encouraged to ﬁnd new ways
to solve problems and to avoid self-blame
or child-blame.

Findings were interesting. Both condi-
tions (regular Healthy Start and the
enhanced condition- Healthy Start plus
cognitive-behavioral therapy) had similar
beneﬁts for child health and these were
signiﬁcant when compared to control chil-
dren. Only the enhanced group (the one
with cognitive-behavioral training) showed
reductions in harsh parenting and child
physical abuse. It was also interesting that
child variables were mediators for physical
abuse. For low-risk infants, only mothers
in the enhanced condition made low use
of harsh parenting practices. In contrast,
almost half of mothers in the other two
conditions (control and regular Healthy
Start) made use of harsh punishment with
high-risk infants.

Other research has stressed the impor-
tance of child variables. Naughton and
Heath (2001) examined medical records of
suspected non-accidental injury. The
majority of abusive incidents (77 percent)
were triggered by misbehavior or non-
compliance in the child. Speciﬁc triggers
(sleeping difﬁculties, feeding difﬁculties,
and inconsolable crying) have been identi-
fied as well (Showers, 1992).

Findings about the importance of child
components have implications for risk as-
essment. If selection criteria for home visit-
ing programs focus only on environmental
risk and risk due to parent characteristics
and do not include child medical risks and
child characteristics then some families at
risk may be overlooked.

Other variables have not been re-
searched. For example, intervention may
reduce risk of child abuse only temporarily.
A family may have a lower rate of abuse
while services are in place, yet the risk
factors remain and a reduction in service
can leave the child vulnerable. Further,
without agreement about how to measure
risk of abuse or risk of neglect, debates
about effectiveness of programs will likely
continue.

Targeting families most likely to beneﬁt
from services is important when resources
are scarce. For example, the Nurse Fam-
ily Partnership program (Glazner et al.,
2004) found that most of the “recovery” of
costs occurred in the low socio-economic
status group which had a ﬁve-fold return
compared to higher SES families where 150
percent of costs were recovered.

Another question concerns the deﬁnition
of which families are “high-risk”. Programs
can serve persons of questionable risk such
as “ﬁrst-time parents” or single parents
who, without the presence of other risk
factors, may be at only average risk for seri-
ous child maltreatment. Such parents may
be unskilled and may beneﬁt greatly from
services. Their infants and children may
develop much better than control groups.
However, since these parents are unlikeli-
ly to engage in serious child maltreatment,
some authors argue that services to this
population are not “cost-effective” (Chaf-
ﬁn, 2004).

Oshana et al. (2004) maintain that
Healthy Families America is aware of
limitations of programs in addressing and
ameliorating serious family problems.
“Healthy Families America State Leaders
in a national network, raised concern about
program capacity to address domestic violence,
substance abuse, and mental health issues
as early as 1998. Local efforts in many com-
munities have sought to augment Healthy
Families America accordingly” (Oshana
et al., 2004, p. 2).

It is likely that families compromised by
mental illness, substance abuse or addiction
and/or domestic violence need interventions
that are supplemental to what Healthy
Families and similar programs offer in
order to address these serious problems
and lower the risk of child maltreatment
or poor child outcomes for these families.
A positive relationship with an in-home
worker could be a ﬁrst step in achieving
the needed referrals.

Training speciﬁc to detecting problems
such as mental illness or domestic violence
might improve worker sophistication in
detecting problems early. Formal links with

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and successes. Commentary will address the next steps for
Healthy Families America. The lead article is by Joseph
Galano, Ph.D., Department of Psychology, College of William
and Mary. The issue can be ordered through the Haworth
Press at (800) 429-6784 or on the web at www.haworthpress.com/store. Don’t miss this important publication!

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Page County is a rural county nestled in the Blue Ridge Mountains in west central Virginia. Its 23,177 citizens are lower on socioeconomic variables than residents of adjacent counties and when compared to the average population in Virginia. Nearly 80 percent of the county’s population reside in rural areas.

In 2001, the health workforce of Page County included 20 physicians, 5 dentists, 5 nurse practitioners, and 13 retail pharmacists. There is one full-time physician per 1,150 people. A community hospital provides acute care, employs eleven of the county’s physicians, and provides significant transportation, therapy and allied health services. The county is listed as a Health Professional Shortage Area as calculated by the federal government formula.

Over a third of the births in Page County are non-marital births, about 8 percent higher than the rate in the Commonwealth. The county’s teen birth rate is 200 percent of the regional rate for teen mothers less than 15 years of age; 115 percent of the regional rate for mothers 15 to 17 years of age, and; 120 percent for mothers ages 18 to 19.

“We are not a crisis management entity,” explains Emily Akerson, RN, MN, C-FNP, Program Manager for Healthy Families Page County. “We are about education and skill development.”

The Page County Healthy Families program is an example of how a rural program can develop creative partnerships and offer assistance to new parents. The program just started in 2000 as a four-month pilot. “A needs assessment had determined that the demand for parent support services was very strong,” says Akerson. “So we wrote a grant to the Family and Children Trust Fund.”

The Health Place, a community outreach program in Stanley sponsored by the Blue Ridge Area Health Education Center, undertook a comprehensive health needs assessment of Page County. The unmet health care needs divided into two broad themes: a) a need to increase availability and access to health care and supportive services, and b) modifying unhealthy behaviors leading to poor health outcomes.

While there were many findings of interest, pertinent to Healthy Families was the need for family support. The area’s traditional strong extended family orientation was found to be fragmenting, causing stress and poor outcomes. Due to limited employment options, one parent might be working in a distant location and there were also a large number of single-parent families. These findings and others supported the establishment of Healthy Families.

A hallmark of the Page County program is the partnerships with other community initiatives. The Program receives assistance and direction from Akerson and others at JMU’s Institute for Innovation for Health and Human Services. Staff and students from departments of nursing, psychology, and social work assist with the program. A second partnership is with The Health Place in Stanley, Virginia. The Health Place provides speech therapy, physical therapy, case management, occupational therapy, and case management services. It also houses the Healthy Families Program. Other partnerships are with the Reading Road Show (see separate Spotlight, next issue) and with a Freddie-Mac-funded book sharing program that provides books for prenatal use. Nutrition education is provided. The community has a program for Parent-Infant Education (PIE). The Page Pregnancy Center is available to clients. Transportation to doctors/dentists/mental health is provided by CART, a local program.

“Our typical client is a single parent who is not attending school and does not have resources or skills. If clients are employed, they are likely doing shift work with uncertain hours,” explains Akerson. “Some clients have a history of substance abuse and must have multiple areas of vulnerability,” she continues.

The Page County Healthy Families program provides home visiting services through a Family Support Worker. Bonnie Sullivan, RN. Ms. Sullivan has experience with patient education and was excited about the opportunity to develop a new program.

“Anyone can benefit from supportive services,” explains Sullivan, “but we try to target those families with the greatest need.” A wide range of agencies and private providers offer prenatal women the chance to complete a self-screening scale. The scales are forwarded to Sullivan who scores them and then invites those meeting criteria to do an assessment.

“The hardest part is getting the family to allow you to come to see them,” says Sullivan. “The assessment is a time to try to engage the family and to set goals. Services and goal-setting is individualized. The greater the support in the home, the less intense the services are,” she explains.

Sullivan’s caseload of up to 15 families is generally young. Scheduling can be difficult. Some teenage mothers are still in high school, working part-time, and trying to care for a baby. Many are unaware of services that they qualify for and Sullivan helps the moms apply. She also tries to educate them, which may mean dispelling years of myths. “For example, my clients’ mothers and grandmothers will caution them against ‘spoiling’ a baby by picking the infant up when crying,” notes Sullivan.

Services can be provided until the child is 5 years old. Generally, services decrease and are less intense as clients learn new skills. Speaking of a current client, Sullivan says, “This first time I made transportation arrangements for her, next time I will instruct her and help her do it while I’m there, after that she will be expected to do it herself.”

Sullivan sees advantages to working in a small rural area. “When I’m trying to find resources for a client, I generally get answers eventually. If my call is not returned I know I’ll see the person I called somewhere in my travels!” Sullivan says that services are more stable in small, rural areas, and that turnover rates of staff are lower. Urban areas do have more specialized services, but utilization rates may be similar to smaller programs.

What is the future for Page County Healthy Families? “We need a stable base for funding the program,” says Sullivan. “Currently we are funded by a grant (from the Virginia Department of Social Services) and grants always end,” she adds. Sullivan would like to seek support from businesses but recognizes the challenges as there are few businesses in Page County and they are approached by many groups for support. If the program continues, Sullivan hopes to develop more specialized services for teen mothers and greater collaboration with schools.

More information is available from: Bonnie Sullivan, RN, Family Support Worker, Healthy Families Page County at the Health Place, P.O. Box 12, Stanley, VA 22851 (540) 778-4061 or Emily Akerson, RN, MN, C-FNP, Program Manager, Institute for Innovation, MSC 9010, James Madison University, Harrisonburg, VA 22807 (540) 568-6120, E-mail: akersoek@jmu.edu.
Healthy Families Virginia
FY 2002-2003
Statewide Evaluation Report

The Statewide Evaluation Report was prepared by researchers Joseph Galano, Ph.D., College of William and Mary and Lee Huntington, Ph.D., Huntington Associates, LTD.

Healthy Families Virginia (HFV) has been providing home-visited services to Virginia’s most overburdened families for nearly a decade. What started as pilot projects has grown into a statewide initiative. HFV embraces the four goals endorsed by Healthy Families America:
- improving pregnancy outcomes and child health,
- promoting positive parenting practices,
- promoting child development, and
- preventing child abuse and neglect.

In order to reach these goals, HFV helps parents provide a safe and supportive home environment. They use a variety of educational methods to help parents gain a better understanding about child development. Staff assists families in identifying and connecting with health care and supportive services. Staff teach and model positive forms of discipline and teach parents how to nurture and bond with children.

**Statistical Profile of HFV**

There were 26 HFV sites participating in the statewide evaluation during FY 2003. The 26 programs served 73 Virginia localities. All programs perform risk assessment and target home visiting towards high-risk families. Eighteen programs served only first-time parents, four served first-time parents as well as teen and unwed mothers, and four programs had sufficient resources to serve all pregnant women. Programs were hosted most frequently in health departments and hospitals, followed by family support agencies, mental health centers, and social services agencies.

The proportion of non-state funding for Healthy Families Programs as a percentage of total funding has continually increased and now accounts for more than half of grant funds. Sites have continued to diversify their sources of funding.

Healthy Families staff have a variety of qualifications. About 56 percent graduated from college and 88 percent have some college education. Staff describe themselves as Caucasian (49 percent), African-American (32 percent), and Hispanic (16 percent). Staff members are family support workers providing home visits (54 percent), family resource workers (23 percent), and program managers or clinical supervisors (14 percent).

**Participators**

During FY 2000-2003, the 26 HFV programs conducted 23,000 screenings and provided in-depth assessment to 7,000 women. (Readers should note that 8 sites not included in the evaluation study served an additional 25 percent of families.) Ninety percent of women received assessments prenatally or within two weeks of delivery.

Of the 7,274 individuals who received an assessment, 78 percent assessed positive. Of the 4,538 positively assessed families offered services, approximately 85 percent accepted. A total of 3,327 participants enrolled. Based on the risk assessment interview, 50 percent of the enrolled participants were considered moderate-risk and 45 percent were thought to be high-risk.

Most of the mothers enrolled in HFV were unmarried (85 percent). Approximately 40 percent had graduated from high school and 2 percent had a college degree. The average age was 21 years. Ethnic background was 44 percent African-American, 31 percent Caucasian and 22 percent Hispanic.

During the most recent year, 93 percent of HFV participants were engaged successfully. This is a very promising finding, since engaging families frequently poses a major hurdle for prevention programs.

**Outcomes**

Galano and Huntington organized the findings within the framework of the Statewide Goals and Objectives adopted in June 1999.

**Improving Pregnancy Outcomes and Child Health:**
- Healthy Birth Weight – 88 percent of Healthy Families children were born with healthy birth weights (2,500 grams or more).
- Connection to Medical Care Providers

- Nearly 88 percent had a primary medical care provider within two months of enrollment and 80 percent of participating children continued to receive services from that provider. After six months of participation, 87 percent had a care provider.
- Immunizations – 85 percent of enrolled children received 100 percent of their 16 scheduled immunizations. This compares to a national rate of 66 percent, to the Virginia base rate of 64.8 percent and to the Virginia Health Department rate of 57.34 percent.

The authors note that these positive child and maternal health findings complement the national results emerging from other Healthy Families America programs, which have demonstrated improved health status, improved service utilization, and high rates of immunization. Virginia’s evaluation, however, is the only one to date to have documented impacts on pregnancy risks and birth complications.

**Maternal Health Outcomes:**

Of the 2,756 mothers enrolled in the HFV programs, 47 percent (386 teens and 912 non-teens) were enrolled long enough to be included in this component of the evaluation. After 24 months, findings were:
- Subsequent Births for Teens: 91.4 percent of teen mothers had no subsequent births and 2.3 percent had a subsequent birth after the targeted 24-month interval, representing a 94 percent success rate.
- Subsequent Births for Non-Teens: 92 percent of non-teens mothers had no subsequent births and 4 percent had a subsequent birth after the targeted 24-month interval, representing a 96 percent success rate statewide.

The data suggest that HFV effectively helped women reduce closely-spaced and unintended pregnancies. Delays in subsequent childbirth are associated with higher educational attainment, improved child health, increased future job status, and decreased infant homicide.

**Child Development Outcomes:**

- Screening for Development – Many programs experienced difficulty attaining the goal of semi-annual screenings. Eleven sites (42 percent) surpassed the state criterion and four sites (15 percent) were within 10 percent of criterion.
- Referred – 100 percent of programs surpassed the criterion of referring 90 percent of children with suspected developmental delay.
- Monitoring – Twenty-three of the 25 sites (92 percent) met the criterion of monitoring 100 percent of children with developmental delay.

Programs were extremely successful in executing referrals of children with suspected delays and in follow-up to ensure receipt of services. Many programs, however, are not meeting criteria for conducting the semi-annual screenings of all children.
Parent-Child Interaction and the Home Environment:

This important domain is a cornerstone for examining the effects of HFV. Virginia sites have adopted instruments to measure these objectives in this domain. Evaluation requires at least a 1-year interval and most programs began to implement the measures in FY 2000. By FY 2003, 12 programs conducted the assessments necessary to evaluate the parent-child interaction objective and 14 sites had followed families for long enough to evaluate the home environment.

* Positive Parent-Child Interaction (or Improvements) - Ten of 12 sites (83 percent) surpassed the criterion.
* Optimizing Home Environments - Thirteen of 14 sites (93 percent) surpassed the criterion.

HFV was successful in helping parents display greater sensitivity to their children’s cues, show greater understanding of child development, demonstrate greater knowledge of discipline methods, lessen scores on personal distress, and lower rigidity scores.

Child Abuse and Neglect:

* A 6-year random-assignment study of Hampton Healthy Start in FY 1993 showed that the annual rate of founded cases never exceeded 1.5 percent.
* Northern Virginia Family Services programs have consistently had rates of 3 percent or less for founded cases of child maltreatment.
* Across 21 sites and 1747 cases, the rate of founded cases for FY 2000-03 was 0.97 percent.

Given that families served by HFV are chosen by the presence of factors that make them high risk for child maltreatment, the rate of founded cases is extremely low. A report by the Federal Interagency Forum on Child and Family Statistics (1997) indicated that the national child abuse and neglect rate for families with similar incomes is 4.7 percent. HFV sites have clearly outperformed the comparison standard.

Hampton Healthy Start, Hampton VA

This section of the report includes summaries of two evaluations. The first is a six-year random assignment study of Hampton Healthy Start conducted between 1992 and 1998 (Galano & Huntington, 1997). This is followed by a summary of a 2002 Benchmark study of community-wide health.

Child and Family Outcomes

During a three-year recruitment period 614 women were determined to be at risk of child abuse and neglect. Of these, 417 were invited to participate in Healthy Start and 197 were assigned to a control group that received the full array of services normally provided by the Hampton Health Department. The participants were predominantly unmarried (67 percent) and African-American (72 percent).

The evaluation findings document strong positive program outcomes:

* Reduced Pregnancy Risk Status and Birth Complications. In general, about 85 percent of all intervention mothers had no pregnancy risk factors, compared with about 50 percent of the control group mothers. In addition, 18 percent of the intervention mothers had infants born with one or two birth complications, compared with 40 percent of the control group mothers.
* Improved Parent-Child Interaction. Intervention families showed moderate and statistically significant improvement in parent-child interaction, bonding and communication skills, and maternal caregiving after participating in the program for two years.
* Increased Child Immunization Rates. An average of 93 percent of the children born to women enrolled in Healthy Start were appropriately immunized. This rate far exceeds the state average.
* Improved Home Environment. The developmental stimulation provided by families in the intervention group was more appropriate after one year in the program than that provided by families in the control group.
* Improved Child Health and Physical Development. A follow-up of children at age three found consistent data favoring the physical development, medical care, and health of target children participating in Healthy Start.
* Reduced Repeat Teen Births. The overall repeat teen birth rate for the city of Hampton (35.8 percent) was four times higher than the rate for Healthy Start participants (9.4 percent).
* Child Abuse and Neglect. Although the program enrolls a high-risk population, the annual rates for child abuse and neglect for Healthy Start families were low, ranging from 0.6 percent to 1.5 percent in each of the five years examined.

Hampton is the only Virginia program to conduct a randomized study and the only program that had sufficient resources to evaluate pregnancy risks/birth complications and repeat teen births. Participants experienced one-third of the pregnancy risks and less than half of the birth complications compared to women receiving the standard health department services but not participating in Healthy Families. These outcomes, in comparison to the performance of the control group, are impressive and instructive.

Community-Wide Impact:

Hampton Healthy Families Partnership (HFP) is one of the most comprehensive and well-established programs in the Commonwealth. (For a description of this program, see VCPN, volume 52). After repeatedly demonstrating the program’s efficacy at the participant level, partnership leaders wondered if the HFP had produced results at the community level. As a result, the city of Hampton commissioned a Benchmark study to determine if the Partnership was creating an ecology that nurtured children and families.

The Benchmark study examined Hampton’s performance between 1984-2000 on eight community-wide benchmarks of child and family health. The study compared Hampton to similar communities, examining the 8-year period prior to HFP and the 8-year period after the initiative.

The study found that Hampton outperformed all comparison regions/cities in both reducing rates of infant mortality and lowering rates of child abuse and neglect. These two outcomes best represent the Partnership’s objectives. Moreover, Hampton experienced progress in five of the eight domains: a decline in adequate birth weights (increase in low birth weights) followed a national trend. Additional analyses of socio-demographic indicators such as unemployment, children receiving TANF, median income, and out-of-wedlock births indicated that Hampton was becoming poorer on these factors known to have negative effects on health outcomes. Given these trends, the city’s progress is even more dramatic. Since the program in Hampton is just now moving to a community-wide level, the full impact will not occur until

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Healthy Families America

VCPN has reported on Healthy Families America (HFA) in prior issues (see volume 52). Since then, the initiative has continued to grow. This voluntary in-home program has proved to be a flexible, effective prevention technique.

In 1991, the U.S. Advisory Board on CAN reported that home visiting similar to Hawaii’s Healthy Start model was the most promising strategy for child abuse prevention (U.S. Advisory Board on Child Abuse and Neglect, 1991). The Healthy Families America initiative was launched in 1992 by Prevent Child Abuse America, in conjunction with Ronald McDonald House Charities and with ongoing support from the Freddie Mac Foundation. The program addresses three equally important goals:

- to promote positive parenting;
- to enhance child health and development; and
- to prevent child abuse and neglect.

Shortly after Healthy Families America began its initiative, the National Research Council (1993) released a report recommending home visiting as a way to prevent child maltreatment. It is important to note that the National Research Council is a panel of scientists, not advocates (Oshana et al., 2004). While the NRC report was specific to Healthy Families America, it was encouragement for efforts that were underway.

Prevent Child Abuse America took the role of assisting communities across America in implementing home visiting programs (Oshana et al., 2004). Over the last 12 years, Healthy Families America has grown to over 430 sites in North America, assessing more than 72,000 parents in 2003 and providing comprehensive home visiting to over 47,000 families each year.

The largest number of sites, 56, is in Indiana. Florida has 39 and Illinois has 36; Oregon has 15 sites; Virginia has 37 sites; Massachusetts has 33 sites; and New York has 28. There are 7 states with 10 to 20 programs, 10 states have 5 to 9 programs; 5 states currently have one program and 5 states have none (Harding, Daz, & Oshana, forthcoming).

The basic model for Healthy Families America is to offer strong support, available at or before birth, for every parent and child who wants and needs the support (Dazo & Harding, 1999). Prevention services such as parent support groups, early childhood programs, and parent education are integrated into the base of support. It is important to note that Healthy Families America, while based on the Hawaii Healthy Start program model and other major family support initiatives, is not a strict replication model. Rather, community partners are independent and flexibility is essential to allow implementation to match community characteristics and needs (Oshana et al., 2004). To ensure quality, Healthy Families America’s home visitation programs adhere to 12 critical elements (see side bar). These 12 elements are based upon over two decades of research on best practice standards. In partnership with the Council on Accreditation of Services to Families and Children (COA), Prevent Child Abuse America has developed and implemented a credentialing process. Only programs that commit to the quality standards can be affiliated with the national initiative.

While programs may differ, the typical Healthy Families America home visitation program provides systematic assessment to all new or first-time parents in a given community either prenatally or at the time the baby is born. Families at greater risk of parenting difficulties (including child maltreatment) are encouraged to enroll in the home visiting program, beginning with weekly visits. The frequency of visits is adjusted according to the family’s needs. In most communities, services can continue until the child is five years of age.

Participants in Healthy Families America are a diverse group of parents who face many different challenges. Most are single parents and many are teen mothers. Some live in relative isolation with little social support. Others may be referred due to struggles with substance abuse, mental illness, current or past family violence, poverty, unstable housing, unemployment, and limited skills.

Healthy Families America endorses community collaboration (see VCPN, Volume 70 for an article about the basis for collaborative approaches). Staff are drawn from many disciplines including social work, child development, public health, psychology and nursing. Programs are located in a wide variety of settings, including public and private agencies, local non-profit organizations, and private institutions. Training is available from national, state, and regional offices. Quality control measures and ongoing evaluation research help refine programs.

Healthy Families America offers services to families based upon their stated needs and personal goals. Each family helps to craft their own action plan to improve their own lives and the outcomes for their children. In this way, families take ownership of their participation and progress.

Prevent Child Abuse America provides a variety of different mechanisms to foster dialogue about best practices. They continually “rethink” and refine the model. The Healthy Families America Research Network includes over 50 researchers conducting 35 evaluations of Healthy Families America home visiting programs throughout the nation. In 2000, with support from the Packard Foundation and the Gerber Foundation, the network was expanded to include program administrators and practitioners. The intent is to promote the exchange of knowledge between the scientists and the practitioners.

From its inception, Healthy Families America has been a field-driven initiative, refining the model on the basis of empirical evidence. At the national level, Healthy Families America continuously engages in assessment and efforts to improve the quality of services (Oshana et al., 2004). Healthy Families America supports a research network and a research-practice council of independent evaluators. Research is used to improve program practice. Research studies have documented the effectiveness of Healthy Families America in several areas (Prevent Child Abuse America, 2002):

- Promoting Positive Parenting Practices – Staff work with parents to expand existing strengths and minimize harmful behaviors. They help parents understand their child’s developmental capabilities, learn positive methods of discipline, and develop skills for interacting with children. Home visitors help strengthen parent-child bonds and assist parents in learning greater sensitivity and responsiveness towards children.

- Improving Family Health – Families enrolled in Healthy Families America use medical services more appropriately (when compared to control groups or to the general population), improve access to preventive health care, and achieve higher immunization rates. As a result, the enrolled families show improvements in health. Furthermore, participants are more likely to seek prenatal care, resulting in fewer birth complications and fewer low weight babies when compared to families that did not receive services.

- Enhancing School Readiness – Many factors influence a child’s readiness to benefit from school. These include health status, nutrition, stimulation, and ability to concentrate, among others. An undetected developmental delay might limit a child’s learning readiness. Children whose families
participate in Healthy Families America receive early developmental screenings
and, if needed, referral to appropriate services. Staff helps families learn activities
that stimulate the infant’s brain growth and development. Thus, children from
Healthy Families America families show greater readiness than do compari-
sion children.

* Increasing Self-Sufficiency: More stable home environments are correlated
with better child development. Healthy Families America program staff provides
referrals. They help link parents to educational resources, counseling, and agencies
that can assist with stable employment and housing. Some programs work with fami-
lies to space children and delay pregnancy until the parents are able to handle an
additional child.

Furthermore, Healthy Families America has developed partnerships with specialized
service providers in most communities. National data indicate that 96 percent of
Healthy Families America programs partner with domestic violence agencies, and
89 percent with substance abuse treatment centers (Harding et al., forthcoming as cited
in O’Shauna et al., 2004). Plus, on average, Healthy Families America Programs part-
ner with 17 local agencies per site.

The strategy of home visiting for first-time or young families has been endorsed
by reputable groups. These include the Centers for Disease Control and Prevention,
the Office of Juvenile Justice and Delinquency Prevention, and the National Center
for Children in Poverty. These endorse-
ments provide strong support for Healthy Families America and similar programs.
The Healthy Families America model will continue to evolve based on experience and
research findings.

Further information about Healthy Families America is available from:
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dent, National Center on Child Abuse Preven-
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(312) 334-6805, Fax (312) 939-8962
E-mail: doshana@preventchildabuse.org
Web site: http://www.preventchildabuse.org

Critical Elements of Healthy Families America’s Intensive Home Visitation Program

Service Initiation
• Prevention services need to be initiated prenatally or at the
time a baby is born.
• To ensure the efficient allocation of resources, programs need
to implement a standardized process of assessing the needs of
all new parents in their target communities.
• Services need to be offered on a voluntary basis and use posi-
tive, persistent outreach efforts to build family trust.

Service Content
• Services for those families facing the greatest challenges need
to be intensive (at least once a week), with well-defined criteria
for increasing or decreasing the service intensity.
• Services must be made available for an extended period (three
to five years) to achieve lasting behavioral change.
• Services should be culturally competent such that the staff
understands, acknowledges, and respects cultural differences
among participants. Materials used should reflect the cul-
tural, linguistic, racial, and ethnic diversity of the population
served.
• Services should be comprehensive, focusing on supporting the
parents as well as supporting parent-child interaction and the
child’s development.

• At a minimum, each family should be linked to a medical
provider to ensure timely immunizations and well-child care. Depending
upon the families’ needs, they may also be linked to additional services such as school readiness programs,
child care; job training programs; financial, food, and housing assistance programs; family support centers; substance-abuse treatment programs; and domestic violence shelters.
• Staff should have limited caseloads to ensure that home visitors have an adequate amount of time to spend with each family to meet varying needs and to plan for future activities.

Service Provider Selection and Training
• Service providers should be selected on the basis of their ability
to demonstrate a combination of the requisite personal character-
istics (for example, compassion, ability to establish a trusting
relationship, and empathy) and knowledge base as represented
by specific academic degrees or employment portfolios.
• All service providers must receive intensive, didactic train-
ing specific to their roles within the HFA service structure as
defined by the critical elements and related standards of best
practice.
• Program staff should receive ongoing, effective supervision so
that they are able to assist families in realizing their service ob-
jectives and protect themselves from stress-related burnout.

healthy families america
regional resource centers.

HFA began the planning for re-
gional resource centers in 2002. The
Centers are intended to provide a
central point of contact for state sys-
tems within each region. The hope is
to expand capacity and to improve
the quality of training and technical
assistance.

Two regional centers have been
established:
HFA Midwest RRC
Kathleen Strader, Director
4405 Woodward Ave., H-700
Pontiac, MI 48314
(248) 988-8990
Fax: (248) 644-6747
www.hfamidwest.org
strader@trinity-health.org

HFA Western RRC
Kate Wathaker, Director
620 N. Country Club, Suite #B
Tuscon, AZ 85716
(520) 323-5022
Fax: (520) 328-5155
www.hfa-wrrc.org
hfa2date@earthlink.net
VCNP surveyed 20 of Virginia’s Healthy Families programs. They were a varied group—some small (14 families) and some large (nearly 200 families); some very rural and others urban or suburban; some just starting and others with 6 or 7 years of experience.

In general the clients of each program reflect the area the program serves. Some programs (Loudoun County; Arlington) serve mainly Spanish-speaking families. A number of programs noted a rising Hispanic population. Even in rural areas such as Culpeper or the Blue Ridge, a third to half of families served speak mainly Spanish. In the Southwest program, almost all families were white, rural, Appalachian. Programs in Richmond and Portsmouth serve mainly African-American, inner-city families.

Programs often serve high numbers of teenage mothers (60 to 60 percent in many programs). The size of programs varies. Of the 20 programs interviewed, six serve 50 or fewer families per year, six serve over a hundred families a year, and most (eight programs) serve between 50 and 100 families.

Some of the programs are described in separate spotlights. Some interesting and innovative ideas are described below.

Innovations

VCNP staff asked the Healthy Families Programs interviewed if there were any innovations in their program or anything they felt they did especially well. Here are some of the responses:

- Healthy Families of Richmond works hard to involve fathers in the program. They have three male staff members (two family support workers and one family resource specialist).
- Piedmont Healthy Families has developed a great teamwork which allows them to serve seven rural counties—a huge area.
- Healthy Families of the Eastern Shore is able to identify eligible families very early by working with staff at prenatal clinics. Early contact with families allows them to establish good relationships with parents prior to the baby’s birth.
- By aligning themselves with a Children’s Advocacy Center, Healthy Families of the Southwest is able to partner with 50 agencies involved in prevention, intervention and treatment.
- MotherNet/Healthy Families Loudoun requires all staff to be bilingual in English and Spanish. Their service population is 90 percent Spanish-speaking.
- Healthy Families Prince William/Northern Virginia combined with Early Head Start to offer comprehensive services. They also have “boundary free” services. Families who move can transfer automatically to a new site.
- In Hopewell/Prince George Healthy Families, an infant intervention specialist from the CSB accompanies the Healthy Families staff when doing assessments.
- Newport News Healthy Families works closely with the Infant-Toddler Connection (see separate article, this issue on the Infant-Toddler Connection). They also have a father-involvement component and a special outreach for Hispanic families.

FIRST STEPS

First Steps teaches parents how to care for newborns. It was created in 1984 by a five-organization coalition in Georgia. Since then, it has expanded to include 44 program sites in Georgia, 55 sites in 20 other states (including at least two sites in Virginia) and 5 sites in military installations in Europe. A number of First Steps sites have expanded to include prenatal care and specialized services to families of neonatal intensive care babies.

Each parent receives a parenting package which includes information about Fatherhood Syndrome, Sudden Infant Death Syndrome, Shaken Baby Syndrome, postpartum care and early childhood development. A colorful developmental record calendar with stickers includes immunization reminders and parenting tips such as how to cope with a crying infant. A local community resource guide outlines referral sources and community support programs.

There is an initial face-to-face visit to parents of newborns by specially trained staff or volunteers. The visit usually occurs in the hospital and is for all families without regard to risk factors, social status, support systems, age, or race. As a result, there is no stigma or labeling attached to the program and parents participate because they want to provide their newborn with the best possible care. Each family receives the information packet. There are follow up contacts by telephone and mailings for a minimum of three months. A 24-hour warmline/parent helpline is available.

In Virginia, two hospitals have implemented the program. They are Obici Hospital in Suffolk, and Sentara Virginia Beach General Hospital. DePaul Hospital in Norfolk is in the developing stage and plans to implement the program in January.

Mary Russo, First Steps Virginia Coordinator, comments, “Babies don’t come with instructions. We offer our services to any parent. We call once a week to answer questions and give information. We follow up with telephone calls for a minimum of three months to give support, education, and referrals. The first three months are crucial.”

Russo explains that prior to implementing First Steps, much research was done to locate the most effective program that utilized volunteers. Virginia’s programs retain strong connections to the Georgia program, using their trainers to train Virginia volunteers so the award-winning program is an exact replication.

First Steps has been recognized by the U.S. Department of Health and Human Services Office of Child Abuse and Neglect as a Program with Noteworthy Aspects.

More information is available from:

**Georgia headquarters**

- Heather Murray-Charles, LMSW, First Steps Program Specialist, Prevent Child Abuse Georgia, 1720 Peachtree Street, NW, Suite 600, Atlanta, GA 30309, 1-800-CHILDREN or (404) 870-6583, Fax: (404) 870-6541
- E-mail: heatherm@preventchildabusega.org
- Web site: www.preventchildabusega.org

**Virginia’s headquarters**

- Mary Russo, Virginia First Steps Coordinator, 525 Cedar Lane, Virginia Beach, VA 23452 (757) 340-3841, E-mail: maryrusso1@cox.net

**Hospital Coordinators**

- Lori White, OBICI Hospital, 2800 Godwin Blvd., Suffolk, VA 23434, (757) 934-4405, fax: (757) 934-4536, e-mail: jwhite@obici.com
- Kathie Gore, Virginia Beach Health Department, 4452 Corporation Lane, Virginia Beach, VA 23462, (757) 578-2633, e-mail: Kathie.Gore@udh.virginia.gov

**Virginia Beach Healthy Families** (see separate article, page 5).
The Infant & Toddler Connection is Virginia's early intervention system for children birth to two years who are not developing as expected. They provide supports and services to children and their families.

Children who are eligible for early intervention services will have one or more of the following: 25 percent delay in any area of development; a diagnosed physical or mental condition such as Down's Syndrome, cerebral palsy, or seizure disorder; atypical development such as unusual muscle tone; or parent/child attachment difficulties. An evaluation, provided free of charge, determines eligibility.

Service coordination is provided at no cost to the family. If the team (which includes the parent) believes the eligible child will benefit from early intervention services, an Individualized Family Service Plan (IFSP) is developed.

Early intervention services may include:
* assistive technology
* audiology
* family training and home visits
* health services
* medical services (for diagnosis and evaluation only)
* nursing services
* nutrition services
* occupational therapy
* physical therapy
* psychological services
* social work services
* special instruction
* speech-language pathology
* transportation
* vision services

In accordance with federal requirements, early intervention services must be provided in natural environments, including home and community settings in which children without disabilities participate, to the extent that is possible. Families pay for early intervention services through Medicaid, private insurance, and family fees. However, no child is denied services due to inability to pay.

David Mills, state technical assistance consultant, comments, "The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services is the state lead agency for the Infant & Toddler Connection of Virginia. There are 40 local lead agencies that coordinate early intervention services in Virginia. In each of these 40 areas, a local interagency coordinating council provides advice and assistance to the local lead agency. Participation includes families, social services, education, health and private providers among others."

The federal government laid the groundwork for the Infant & Toddler Connection in 1986. Congress enacted early intervention legislation as an amendment to the Education of Handicapped Children's Act (1975) to ensure that all children with disabilities from birth through age three could receive appropriate early intervention services.

In 1992, The Virginia General Assembly passed the state legislation which codified an infrastructure for Virginia's early intervention system. Responsibility for implementation is shared at state and local levels and the legislation encourages interagency collaboration.

In Virginia, more than 4204 children and families were receiving services from the Infant & Toddler Connection as of December 1, 2003. This was a 30 percent increase over 2000. About 89 percent of services were provided in the child's natural environment.

The Infant & Toddler Connection of Virginia has set goals for continued system improvement:

- The percentage of children identified and served in the Commonwealth is still below comparable national data. There is a goal to identify an increased percentage of eligible children and to identify them earlier.
- Financial stability is a critical issue during times of limited funding.
- Continued training and guidance to localities to ensure that federal time lines are met and that services are provided in the child's natural environment.
- Enhancing a web-based data system to facilitate monitoring and evaluation.

More information is available from: Infant & Toddler Connection of Virginia, DMHR SAS, 1220 Bank Street, 9th Floor, PO Box 1797, Richmond, VA 23218-1797 (804) 786-3710 TTY/TDD 1-804-771-5877 Fax: (804) 371-7959 Website: www.infantva.org To locate services in Virginia call (800) 234-1448.
Virginia’s Healthy Families Alexandria program is established and strong. VCOPN reported on the program in 1997 (volume 52) as one of Virginia’s model efforts. VCOPN recently interviewed program staff and learned that the program has continued to grow and modify to meet Alexandria’s needs.

“What distinguishes Northern Virginia,” explains Carol Freeman, Program Manager, “is that 84 percent of our clients are immigrants.” Freeman is new to Healthy Families Alexandria. She is a longtime resident of Alexandria, and she has also lived and worked in West Africa and Asia. She joins a multinational and multilingual staff. Seven workers are bilingual and come from Mexico, El Salvador, Guatemala, and Peru. Two others are African-American.

“Many of our families are in crisis,” says Freeman, “and their needs are very immediate. We have hired a bilingual therapist to assist. It is hard for a family to focus on parent-child relationships and the lessons we bring if they are dealing with crisis.” Freeman says that 65 percent of enrolled families are Spanish-speaking and 10 percent are African-American. Another 13 percent are African.

Rosario Le Blanc has a dual perspective on service to immigrants. She is a support worker for Healthy Families today, but five years ago she was new to this country and also a new mother, participating in Healthy Families services. Le Blanc was a social worker in her native country (Peru) and worked for over 10 years before coming to the U.S.A. and meeting her husband. She had been in this country over a year when her child was born. She says a year is “a short time” to acclimate.

“The play group was so friendly,” says Le Blanc. “I found friends from many countries. It was a beginning for me.” Le Blanc says that immigrants face special challenges. “First, the language is a barrier. Second, it is hard to understand the social rules,” she explains. “The social adjustment is very hard. If you encounter a rude person, it is easy to be afraid and to feel incompetent. Then you step back and become more isolated.”

Le Blanc says, as a worker, she has found many immigrant moms isolated and depressed. This can have negative effects on the baby. Those new to this country may have friends and family here, but more often, they leave significant family members behind. “We visit every single week and support the family,” says Le Blanc.

Her dedication is evident. She concludes, “Every time I receive a new case, I recall what it is like to be in a new country. I know how they feel.”

One resource that crosses the language barrier is the “Bonding with Baby” books. Families receive a new book every three months. The attractive, square, wordless, cardboard book is shared between parent and baby. The parent “reads” the book to his baby, creating a story line. The pictures show parent-infant interaction. Moms and dads are encouraged to imitate the pictures and to observe their child’s reaction.

“Bonding with Baby” books are available through the Freddie Mac Foundation. More information is at www.bonding-withbaby.org

Another resource is videotaping. Videotaping is used to support the Mutual Competence Model. According to Lynn Kosanovich, M.A., Program Supervisor, it is a strengths-based model that allows families to discover for themselves what is effective. “We assume that our parents want to be the best that they can be,” says Kosanovich. “The videotape is a tool to help identify what the child responds to and what cues the child gives.” The tape allows parents to “step back” and see their baby or toddler in a different way. Parents are given a copy of the tape as a memento.

Kosanovich says that most parents are excited about being videotaped. “This is a concrete way to focus on parent-child interaction. It’s a new idea and part of teaching mutual competence. We have shifted from case management and a focus on problems to an interest in child development,” says Kosanovich.

The Mutual Competence Model is grounded in the idea that parents are experts about their own children and all parents want to be good parents. Using a “strengths” model, the professional relies upon the parent to be the change agent and to design plans for change. The Mutual Competence Model builds upon the work of Victor Bernstein, cofounder of the Ounce of Prevention Fund in Chicago.

To measure the quality of the parent-child interaction, the Alexandria Healthy Families uses the Nursing Child Assessment Satellite Training (NCAST). The scales allow observers to rate parent-child interaction on predictability of behavior, social responsiveness, and readability of cues. Kosanovich is enthusiastic about the assessment and has attended two week-long trainings to become proficient in the ratings.

Healthy Families Alexandria uses the Parents as Teachers (PAT) curriculum in work with families. PAT provides information on child development and activities to support that information. The Parents as Teachers program is one that was evaluated by the Washington State Institute for Public Policy (2004) and found to be cost-effective (although it was judged as less effective than some other programs).

Finally, Healthy Families Alexandria has been proactive in maintaining communications with local child protective services units. Joint cases are discussed at quarterly meetings between the two agency supervisors, the Healthy Families Program manager and a representative CPS worker. “It has helped immensely”, says Kosanovich, “to keep us on the same page and to allow us to collaborate as we serve each family.”

To learn more about the Alexandria Healthy Families, contact Carol Freeman or Lynn Kosanovich at Northern Virginia Family Service, 5249 Duke Street, Suite 308, Alexandria, VA 22304 (703) 212-1702, Fax: 703-751-5197, E-mail: cfreeman@nvfs.org
Web site: www.nvfs.org
Healthy Families Virginia

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2005 or later. However, the preliminary results are encouraging.

More Can Be Done!

While HFV continues to build on its strong record of success, more can be done. Galano and Huntington offer several recommendations to help translate research findings into improved policy and practice.

- Strengthen HFV capacity:
  a) Initiate a plan to help individual sites better identify and assess the factors contributing to school readiness;
  b) Identify specific strategies that are effective; and
  c) Promote formal agreements among stakeholders.

- Increase the number of HFV programs that enroll mothers prenatally.

- Develop a 5-year plan to expand local capacity so that all HFV sites may serve at least 80 percent of eligible families. (The Center for Disease Control and Prevention’s Task Force on Community Preventive Services estimates that 40 percent of all maltreatment could be prevented if this recommendation were followed.)

- Implement the new curriculum developed by Prevent Child Abuse America in all Virginia sites currently enrolling women prenatally.

More information is available from: Joseph Galano, Ph.D. Psychology Department, College of William and Mary, P.O. Box 8795, Williamsburg, VA 23187-8795, (757) 221-3878, Fax (757) 221-3896, E-mail: jgala@wm.edu
Web Site: http://www.hamptonva.us/healthyfamilies

Recommended Resources

Available from: Brookes Publishing Company, PO Box 10524, Baltimore, MD 21205-0624, 800-638-3775 (U.S.A. & Canada) or 1-410-337-9580 (worldwide), Fax: (410) 337-8539, website: http://www.brookespublishing.com/asq

These parent-completed questionnaires enable identification of developmental delays between the ages of four months and five years. The questionnaires are written at a fourth-to-sixth grade reading level, allowing for easy administration. Parents can complete a questionnaire in less than twenty minutes. Subsequent professional scoring requires less than five minutes.

The boxed set of questionnaires contains nineteen illustrated and color-coded photocopiable questionnaires. They are given at timed intervals in a child's life. These questionnaires check progress in communication, gross motor skills, fine motor skills, problem-solving, personal-social skills, and overall development. Other ASQ components that are available include a user's guide ($45) and a twenty-two minute videotape ($44). This system is flexible and culturally sensitive, available in English, Spanish, French, Korean, and other languages. The developers of the ASQ have also created the ASQ: SE for tracking the social-emotional development of young children.
The Ages and Stages Questionnaire has been adopted by Virginia Healthy Families programs as the recommended instrument for screening participating children.

Available from: Center for Prevention and Early Intervention Policy, 1339 E. Lafayette Street, Tallahassee, Florida 32301 (850) 922-1300, Fax: (850) 922-1352

These materials are so attractive! There are three curricula – one for prenatal; one for infancy 0-6 months; and one for infancy 7-12 months.
The prenatal curriculum is organized chronologically and has a total of 92 selections of topics. The other two curricula are similar, with over a dozen selections of topics for each month.
In total, each set of handouts contains over 90 glossy colorful sheets. Each sheet covers a different topic. Topics range from car seat safety to soothing a fussy baby. Information on each developmental stage is included. The handouts correspond to the curriculum topic.

These materials are truly exceptional!

Available from: Circulation Department, The David and Lucile Packard Foundation, 300 Second Street, Suite 200, Los Altos, CA 94022 Fax: (650) 948-6408, E-mail: circulation@futureofchildren.org
Web Site: http://www.futureofchildren.org (Note: All issues of The Future of Children are now available online.)

In 1993 The Future of Children published an issue focused on home visiting programs for families with young children. Since then, the number of home visiting programs has grown and research has identified effective models. This issue of The Future of Children reports on specific programs: Parents as Teachers; the Home Instruction Program for Preschool Youngsters; Hawaii's Healthy Start: Healthy Families America; the Nurse Home Visitation Program; the Comprehensive Child Development Program. These programs are described in detail, along with evaluation results.

Early Childhood Mental Health Consultation by Elena Cohen & Roxane Kaufmann, no date, 44 pages, free of charge.
Available from: Georgetown University Child Development Center, 3307 M. Street, N.W., Suite 401, Washington, D.C. 20007 (202) 687-8635, Fax: (202) 687-1954, e-mail: Kaufmann@gunet.georgetown.edu

Child care providers who work with society's youngest members are encountering an increasing number with serious behavioral problems. In response to this challenge, the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS) brought together key mental health professionals to discuss the process of mental health consultation in early childhood settings. The resulting monograph examines the roles of a consultant, the essential features of childhood mental health consultation, and the knowledge and skills needed by consultants. Sections at the end contain model programs and resources for training.
specialized service providers could ease the
process of engaging families in additional
services. Service availability and payment
for mental health treatment might be issues
that could be addressed at the community
level.

Healthy Families America has respond-
ed to the concerns raised by mixed research
findings. They already had a Research
Network comprised of over 50 scientists.
The network was expanded to include
practitioners. A subset of individuals,
representing both evaluation research and
practice in 14 states, formed the Research
Practice Council. The aim was to examine
program implementation and quality. The
group started by examining enrollment and
retention. An initial study identified sub-
stantial variation across sites on indicators
of retention and frequency of home visitors.
There was also substantial variation in the
risk level of the families served. This is con-
sistent with the mixed findings of outcome
studies to date. The study (Harding et al.,
2004) also established that certain sites have
developed highly successful strategies for
engaging and retaining families, retaining
staff, and providing intensive services.

The next research goal for Healthy Fami-
lies America is to examine family outcomes
across sites and consider how differences in
family risk might contribute to differences
in outcome. Other areas for future research
include content of home visits, supervision
of staff, indices of community risk, and ser-
vice through community resources.

Summary of Challenges

Home visiting early intervention pro-
grams focus upon healthy child develop-
ment and promoting positive interactions
between parents and children. Research
has identified some successes in reaching
these goals. Research has also identified
challenges.

- Programs may not adequately assess
and address serious risk factors for child
maltreatment. These include parent mental
health, parent substance abuse, and domes-
tic violence. Referrals to treatment provid-
ers and others who can address these risk
factors are few in some programs.
- In-home paraprofessional workers
may not be adequately trained to detect
serious problems such as substance abuse,
depression, and domestic violence. Pro-
grams have trouble attracting and keeping
highly qualified trained workers.
- Fathers are rarely seen in some pro-
grams, yet serious risk factors can be as-

References Available Upon Request

VCPN is on the web — Visit us at:
http://psychweb.cisat.jmu.edu/graysojh

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School of Psychology
MSC 7401
800 S. Main Street
Harrisonburg, VA 22807
Attn: J. Grayson

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