No. 18, 1999-2000

BEST PRACTICE BRIEFS

PUTTING THE PIECES TOGETHER

OUTREACH PARTNERSHIPS

MICHIGAN STATE UNIVERSITY

SUMMARIES OF HOME VISITING MODELS FOR VERY YOUNG CHILDREN

The summaries of home visiting models contained in this **BRIEF** are the source material for **BRIEFS** No. 17, 19, and 20. The descriptions reflect the words used in the source material for each model. The main headings represent the primary intervention emphasis; comprehensive models use multiple approaches. Approaches to intervention are discussed in **BRIEF** No. 19.

RELATIONSHIP-BASED AND INFORMATION-BASED

NURSE HOME VISITATION PROGRAM

ELMIRA NY, MEMPHIS TN, DENVER CO

HIGH-RISK FAMILIES . . . . . .COMPREHENSIVE

Purpose. Improve physical and emotional care of children and reduce risks posed by limited intellectual functioning, lack of mastery, and poor mental health

Population Served. **Elmira:** primarily white (89%), first time pregnant women, the majority with at least one risk factor—poor (59%), single (62%), or adolescent (64%). **Memphis:** primarily African-American (92%), first time pregnant women with at least two risk factors—poor (85% at or below poverty level), single (98%), or less than 12 years of education (65% adolescent).

Service Delivery. Home visits.

The NHVP model, refined over the past 20 years, consists of the following elements:

- Home visitors are nurses who receive clinical supervision.
- Families are enrolled during pregnancy through end of second trimester.

- Visits: once a week beginning at enrollment for four weeks, then every other week through the birth of the baby; once a week for 6 weeks following delivery, then every other week through the 21st month; once a month for months 22 through 24.
- Guidelines provide outlines for visit content, resources for assessment and intervention, and specific curricula.[1] Nurse home visitor adapts content to individual needs of each family. Involves other family members.

Content. The nurse home visitor

- establishes a trusting relationship with the parent
- helps women improve prenatal care, health behavior, and nutrition during pregnancy
- teaches parents about factors influencing infant development
- promotes parent-infant interaction by facilitating understanding of child's communicative signals and enhancing interest in play
- teaches parents to manage health problems (observe signs of illness, take temperatures, and communicate with office staff before seeking care for illness or injury)
- promotes household safety
- links parents with needed services
- helps parents to build supportive relationships with family members and friends
- helps parents clarify their goals and develop problem-solving skills related to family planning, continuing education, and job search
- promotes self-confidence by helping parents set small achievable behavioral objectives between visits

Outcomes—assignment

Elmira: Children of all mothers who received services compared to controls over 15 years

- made fewer visits to emergency for injuries and ingestions

Poor unmarried adolescent mothers who received services compared to controls

- had more educationally stimulating toys in the home
- were less restrictive and punished children less frequently than controls (19% to 4%)

and over 15 years

- had fewer pregnancies (1.1 vs. 1.6) and increased time between first and second child (65 vs. 37 months)
- had more months in the work force and fewer months on welfare (60 vs. 90 months)
- experienced less disruption (e.g., work absence, accidents) from substance abuse
- had fewer arrests (.16 vs. .90)

Children of poor unmarried adolescents as compared to controls

- had fewer substantiated cases of child abuse and neglect during first two years (4% vs. 19%); verified cases over first four years were less serious
- had fewer verified cases of child abuse and neglect between age 4 and 15 (.11 vs. .53 reports over entire 15 years)

as adolescents (age 15), had fewer arrests (.20 vs. .45), fewer sex partners (.92 vs. 2.48), less use of tobacco and alcohol

Children of mothers with little sense of control over their life circumstances

- had fewer health care visits for injuries during age 1 to 4
- had improved mental development by 10 points at 12 and 24 months of age

Memphis: Mothers who received services compared to controls

- expressed greater empathy, less belief in physical punishment, fewer unrealistic expectations
- provided more stimulating environment
- had fewer second pregnancies by 24 months (36% vs. 47%)

No differences on completion of education or employment.

Children of mothers with low psychological resources

- had fewer physician or emergency room visits for injuries and ingestions
- had fewer days of hospitalization for injuries or ingestions
- were more communicative and more responsive to parents

No differences on immunization rates, cognitive development, or behavioral problems.

Sources: D.L. Olds, et al., (1999), Prenatal and Infancy Home Visitation by Nurses: Recent Findings, *The Future of Children, Home Visiting: Recent Program Evaluations,* Vol. 9 (1), pp. 44-65. **Elmira:** D.L. Olds, et al., (1997), Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect, *Journal of the American Medical Association,* Vol. 278 (8), pp. 637-643. **Memphis:** H. Kitzman, et al., (1997), Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing, *Journal of the American Medical Association,* Vol. 278 (8), pp. 644-652. **For Information:** Dr. Narcisa Polonio, Replication and Program Strategies, 2005 Market Street, Suite 900, Philadelphia, PA 19103; **www.replication.org.**

[1] *NCAST Caregiver/Parent-Child Interaction Feeding Manual,* (1994), and *NCAST Keys to Caregiving*, (1990); University of Washington, School of Nursing; *Partners in Parenting Education*, three-volume curriculum (1999,1997,1997) published by How to Read Your Baby, Denver, CO.

RELATIONSHIP-BASED

INFANT MENTAL HEALTH SERVICES

MICHIGAN

HIGH RISK FAMILIES . . . . . COMPREHENSIVE

Purpose. Promote positive parent-infant interaction, healthy infant development, and parental competencies.

Population Served. Parent-infant dyads at risk for or exhibiting disrupted relationships, disorders of infancy, and/or delayed development of the child. Not limited to families with firstborns. Cross-site analysis indicated parents were 10% adolescents, 77% poor, 79% single, 37% had diagnosis of mental illness, developmental disability, or substance abuse. Infants were 44% first born, 28% low birth weight.

Service Delivery. Home visits.

- Home visitors are infant mental health specialists with background in social work, psychology, public health nursing, early childhood education, or child development and training in infant mental health intervention. Staff receive reflective supervision.
- Families are enrolled during pregnancy (24%), around the time of birth using screening tool, Borgess Interaction Assessment, or hospital referral (35%), or subsequently during first or second year.
- Weekly home visits, more frequent if family is in crisis, less frequent as family improves. Length of service varies by site: up to 3 years, contingent on status of the family. Service includes all young children in the family and mental health needs of mother. Involves other family members.

Infant mental health specialists may provide consultation to other programs working with infants and families. **Model Variations:** training in Parents as Teachers curriculum; volunteers plus infant mental health specialists (Doula Teen Parent Program).

Content. The infant mental health specialist

- establishes a trusting relationship with the parent
- facilitates access to community resources for basic needs, child care, parent's health and self-sufficiency; encourages parent to attend to health and safety issues
- focuses on the infant within the context of the parent-infant relationship
- provides guidance about the infant's growth and development
- assists parent to observe and interact appropriately with the infant; may use video tape; uses assessments to indicate infant's capabilities
- observes patterns of interaction and defines issues of clinical concern related to infant, past history, and current relationships
- encourages interaction and play to promote infant's development
- provides guidance and support in the resolution of crises; teaches problem-solving and decision-making skills
- uses clinical skills to enable parent to resolve own and familial conflicts
- assists parent to identify feelings, understand reactions, defenses, and coping strategies, and develop healthier patterns of interaction
- helps parent to understand need for social support and to connect to informal and formal sources

Outcomes—Random assignment (unpublished study)

Mothers receiving intervention, at one year

- scored significantly higher than control group on responsiveness of the mother, sensitivity to cues, and cognitive growth fostering
- had scores consistent with low-risk mothers with respect to responsiveness of the mother, sensitivity to the infant's cues, and cognitive growth fostering

Infants experienced half as many injuries as those in control group.

Pre/post analysis of *Objectives/Problems Checklist* across 5 programs indicated almost half of all families completed service according to plan, meeting service objectives related to parent-infant interaction, parent responsiveness, child care, material needs, mother's mental health and social support. All families made some progress.

Manual. Weatherston, D. and Tableman, B. (1989*). Infant Mental Health Services: Supporting Competencies/Reducing Risks.* Lansing, MI: Michigan Department of Mental Health.

Sources: Michigan Association for Infant Mental Health, (2000). *Guidelines for Infant Mental Health Programs; B. Wright,* (1986), An Approach to Infant-Parent Psychotherapy, *Infant Mental Health Journal,* Vol. 7(4), pp. 247-263.

For Information: Deborah Weatherston, Graduate Certificate Program in Infant Mental Health, Merrill-Palmer Institute, Wayne State University; 313-872-1790; aa2233@ wayne.edu. Jeff Goldblatt, Michigan Department of Community Health; 517-335-8385; goldblatt@state.mi.us.

STEPS TOWARD EFFECTIVE ENJOYABLE PARENTING (STEEP)

MINNEAPOLIS, MINNESOTA

HIGH-RISK FAMILIES . . . . . COMPREHENSIVE

Purpose. Promote healthy parent-child relationships and prevent social-emotional problems among children.

Population Served. Poor, primarily single, young first time mothers; most reporting a history of abuse in childhood and/or recent relationships. No more than a high school education.

Service Delivery. Home visits plus parent-infant group.

- Facilitators are parents with bachelor's degrees in social science, and experience in working with low-income families. Training and weekly supervision are provided.
- Families are enrolled during second trimester of pregnancy. In evaluation project services continued until age 12 months. Replications are continuing service until age 3.
- The same facilitator conducts home visits and parent-infant groups on alternate weeks. Families in crisis receive more home visits.

Content. The facilitator

in home visits, empowers the mother through the trusting relationship, and

- promotes sensitive care giving and parent-infant interaction
- videotapes interaction to encourages process of self-observation and discovery
- assists mother to understand infant's behavior and meaning of developmental milestones
- problem solves with mother to adapt to everyday issues of parenting and concrete needs
- encourages mother to make positive choices regarding school, employment, and use of community services
- assists mother to understand her relationship to her child and his/her development
- assists mother to understand how her history and current life circumstances influence her interaction with infant
- problem solves with mother to build supportive relationships with family members and friends

in group sessions, undertakes structured activity with infants plus discussion and activities with the mothers.

Outcomes—Random assignment

Mothers receiving services, compared to a control group, when infant was 19 months,

- were less depressed and anxious
- more competent in managing daily life
- had fewer repeat pregnancies
- were more sensitive to child's cues and signals despite life stress
- provided a more stimulating environment

Biological fathers at five year follow up had a qualitatively better relationship with their children.

Children *did not improve in attachment status at 13 and 19 months.*

Manual. Erickson, M.F. and Simon, J. (1999). *Steps toward Effective Enjoyable Parenting: Facilitators Guide.* Minneapolis, MN: Irving B. Harris Training Center for Infant and Toddler Development, University of Minnesota.

Sources: M.F. Erickson and B. Egelund, (October/November 1999), The STEEP Program: Linking Theory and Research to Practice, *Zero to Three,* Washington, DC: The National Center for Infants, Toddlers and Families, pp. 11-16. J. Korfmacher, (1997), Adult Attachment: Implications for the Therapeutic Process in a Home Visitation Intervention, *Applied Developmental Science,* Vol. 1(1), pp. 43-52.

UCLA FAMILY DEVELOPMENT PROJECT

LOS ANGELES, CALIFORNIA

HIGH-RISK FAMILIES . . . . . COMPREHENSIVE

Purpose. Improve child's development and parent's functioning and relationships

Population Served. First time mothers, poor, lacking support, plus other risk factors; 93% single. Hispanic 42%, Caucasian 36%, African-American 19%.

Service Delivery. Home visits plus weekly mother-infant group.

- Home visitors are mental health professionals with experience in child development and family systems who received training and weekly individual/group supervision.
- Families are enrolled in late pregnancy.
- Weekly home visits every week through age 12 months; every other week through age 24 months. Telephone and follow up contacts in years three and four. Father and other family members are involved.

Content. The home visitor

- builds a trusting relationship with the parent
- addresses all aspects of the family's functioning, using a family systems approach

- promotes mother's adaptation; listens, expresses empathy, and helps mother to focus her concerns and to problem solve
- guides mother in assessing her relationship to her family of origin and keeping a connection while defining and asserting her autonomy
- assists mother to develop a continuing positive contact with partner, define and resolve emotionally charged difficulties
- aids mother to understand and effectively respond to the needs of infant
- helps mother to encourage child's autonomy, involvement in tasks, and self-control
- jointly observe the child, provides information and models alternative solutions
- assists mother in setting and pursuing a goal
- assists mother to obtain concrete assistance; advocates with health care, child care, job training, etc.

Outcomes—Random assignment

Mothers receiving home visits compared with control group, at 12 months

- had developed a positive relationship with partner; continued in contact
- increased family support while control group declined
- were more responsive to the infant
- were less intrusive in child's play
- were more likely to avoid restriction and punishment

There were no significant differences in the mother's level of depression or anxiety.

Infants were more securely attached, compliant, autonomous, and task involved.

There were no significant differences in the child's cognitive development.

Manuals (3). C.M. Heinike, (1989), *UCLA Family Development Project: Operational Manuals for Prevention Intervention Plan,* Los Angeles, CA: University of California, Department of Psychiatry and Biobehavioral Sciences, 760 Westwood Plaza, Los Angeles, CA 90024-1759.

Source: C.M. Heinike, N.R. Fineman, G. Ruth, S.L. Recchia, D. Guthrie, C. Rodning, (1999), Relationship-based Intervention with At-risk Mothers: Outcome in the First Year of Life, *Infant Mental Health Journal,* Vol. 20 (4), pp. 339-374.

INFORMATION-BASED AND ACCESS TO SERVICES

HEALTHY FAMILIES AMERICA

HIGH-RISK FAMILIES . . . . . COMPREHENSIVE

Purpose. Promote positive parenting and prevent child abuse and neglect.

Population Served. Families with risk factors related to lack of support; low income; less than high school education; history of substance abuse, mental illness, abortions, marital or family problems; plus high score in interview using Kempe's Family Stress Checklist.

Service Delivery. Home visits.

- Home visitors, generally paraprofessional, are selected for personal characteristics rather than education. Staff receive training and ongoing supervision.
- Recruitment process depends on site, but model proposes systematic assessment prenatally or within two weeks of birth and enrollment within three months.
- Frequency of visits is related to family's level of functioning based on criteria for meeting specific goals. Visits are undertaken initially every week and progress by stages to quarterly. Families can stay in service for three to five years.
- Visits involve other family members.

National organization, Prevent Child Abuse America, provides materials for training and information system. **Model Variations in Michigan.** Infant mental health specialists serve as supervisor, some staff. Cross training with Parents as Teachers.

Content. The home visitor

- refers to child care, job training, financial, food and housing assistance, family support centers, substance abuse treatment, domestic violence shelters
- links families to a medical provider
- provides information on child development and age-appropriate behavior; uses a formal curriculum
- discusses appropriate child behavior management
- provides education/modeling on positive parent-infant interaction
- provides information on health, infant feeding, nutrition, and food preparation

- teaches crisis management and problem-solving/decision-making skills

Outcomes—Random assignment in Virginia and Hawaii; **comparison groups** in Arizona and Wisconsin; many **pre-post** studies

Parents

- exhibited greater responsiveness to child's cues (Hawaii, Wisconsin)
- provided more stimulating home environment (Virginia)
- reduction in child abuse potential score (Hawaii)
- had fewer second births (Virginia)
- used less welfare (Arizona, Florida)

No increase in level of social support (Virginia, Hawaii)

Children

- reduction in substantiated reports of child abuse and neglect (3.3% vs. 6.8%—Hawaii; families with more than one child: 3.3% vs. 8.5%—Arizona). *No difference (Virginia); not reported (Wisconsin)*
- 90+% of participants up to date on immunizations across all sites

No differences in measures of child's cognitive development (Virginia, Hawaii)

Manual. Family Services Workers Manual.

Source: D. Daro & K. Harding, (1999), Healthy Families America: Using Research to Enhance Practice. *The Future of Children, Home Visiting: Recent Program Evaluations,* Vol. 9 (1), pp. 159-167, 177. Los Altos, CA: David and Lucille Packard Foundation. **For Information:** Prevent Child Abuse (PCA) America, 200 South Michigan Avenue, 17th floor, Chicago, IL 60604-2404; 312-663-3520; www.preventchildabuse.org. **In Michigan:** Mike Foley and Kay Loftus, Children's Charter of the Courts of Michigan; 517-482-7533; childcrt@aol.com.

INFORMATION-BASED: EDUCATION AND GUIDANCE

PARENTS AS TEACHERS (PAT)

LOW TO MEDIUM RISK FAMILIES . . . . . TARGETED

Purpose. Educate and empower parents to become active participants in their child's education.

Population Served. Infants no older than six months up to age four. Intended for any parent. Characteristics of families recruited will vary by site.

Service Delivery. Home visit and parent support meetings.

- Home visitors are selected for life experience but generally have some college education. Must be credentialed through a 5-day training and one follow-up session.

- Monthly, biweekly, or weekly home visits, depending on needs of family and resources available, plus one group meeting per month.
- National organization provides training and materials through state sites. Materials are available at two reading levels and in Spanish.

Content. The home visitor

- presents lessons from a structured curriculum, *Born to Learn,* that models appropriate ways of interacting
- leaves handout materials that reinforce or supplement sessions
- conducts or arranges for periodic screenings of children's hearing, vision, general development
- refers to other community agencies

Outcomes—Random assignment

Children of teen mothers receiving both PAT and case management (but not PAT alone) had gains of 1.3 to 1.5 months in cognitive development and fewer opened cases of child abuse.

Children of Spanish speaking (but not English-speaking) **Latina mothers** had positive results in cognitive development and 2+months gains in self help and social development.

There was little effect on parents' knowledge, attitude, or behaviors or on child health

Comparison studies with general populations (those participating versus those not participating) have generally shown positive results in cognitive development.

Source: M.M. Wagner and S.L. Clayton, (1999), The Parents as Teachers Program: Results from Two Demonstrations, *The Future of Children, Home Visiting: Recent Program Evaluations,* Vol. 9 (1), pp. 91-115. Los Altos, CA: The David and Lucille Packard Foundation. **For Information:** Parents as Teachers National Center, 10176 Corporate Square Drive, Suite 230, St. Louis, MO 63132; 314-432-4330; www.patnc.org. **In Michigan:** Deanna DePree, Ottawa County Life Services, 160 South Waverly, Holland, MI 49423; 616-396-7566, ext.116.

BUILDING STRONG FAMILIES/ PARENTING YOUNG CHILDREN

MICHIGAN STATE UNIVERSITY EXTENSION

MEDIUM TO LOW -RISK FAMILIES . . . . . TARGETED

Purpose. Provide parents and caregivers the knowledge and skills needed to help their children reach their potential.

Population Served. Parents with limited resources, who may or may not have limited literacy, and children age 0 to 3.

Service Delivery. Home visits or parent groups.

- Home visitors or group facilitators are volunteers, paraprofessionals, or professionals who may receive training if desired.
- Minimum of 10-12 sessions.

Content. The home visitor or facilitator

- presents a four unit curriculum through multicultural, cartoon-style flip charts, real-life videotapes, and experiential activities that cover:
  - How Kids Develop: an overview of developmental stages
  - Helping Kids Behave: positive discipline alternatives to match the stages of development
  - Playing to Learn: positive interactions to enhance development
  - Smart Living: identifying personal and family strengths and setting realistic goals.
- prompts discussion of behavioral choices that parents can make

Outcomes—Comparison group

Women participating in Building Strong Families reported

- a greater increase in satisfaction with their level of social support from neighbors and physician
- more positive change in parenting behaviors
- a greater increase in locus of control

For Information: Jodi Spicer, MSUE, 103 Human Ecology Building. East Lansing, MI 48824; 517- 353-9359; http://www.msue.msu.edu/msue/cyf/family/bsfone.html.

BEHAVIOR-BASED

BRIEF INTERVENTION WITH IRRITABLE INFANTS

NETHERLANDS

HIGH-RISK FAMILIES . . . . . TARGETED

Purpose: Promote secure attachment by enhancing the mother's sense of efficacy in relating with her child.

Population Served. Normal first born infants, from well functioning low-income families, who were irritable (17% of all births to low-income families) and therefore difficult to care for; at risk of insecure attachment because of irritability and low level of maternal responsiveness characteristic of low-income families. Concrete needs were not an issue.

Service Delivery. Home visits.

- Home visitor was a health professional.
- Three 2-hour visits were made during infant's 6th to 9th month of age (the point in development where mothers lose confidence in their mothering capacity).
- Infants were selected on basis of score on Brazelton Neonatal Assessment Scale administered at 10 and 15 days after birth.

Content was based on prior observational study of interaction between mothers and irritable infants. The home visitor, using skill training and reinforcement to influence mother-infant interaction,

- assisted the mother to perceive the infant's signals and interpret them correctly
- encouraged mother to respond to the infant's gaze and verbalizations, maintain silence when the infant's gaze was averted
- provided feedback to assist the mother to adjust her behavior to her infant's unique cues; promoted soothing and alternative responses depending on the infant's behavior
- encouraged play
- emphasized maternal strengths

Outcomes—Random assignment

Mothers were

- more responsive, visually attentive, and stimulating at 9 months
- more responsive, accepting, and accessible at 24 months
- more responsive, assisting child more during peer play at 42 months
- more encouraging of child's task involvement and autonomy

Fathers were more responsive to children.

Children

- were more self soothing, more sociable, and cried less at 9 months
- were more securely attached at 12 months (62% vs. 22%), 18 months (72% vs. 26%), and 42 months
- were more autonomous; explored more; exhibited more sophisticated play with toys and more engagement in meaningful action and verbal interaction at 24 months
- were more cooperative, more imitative of mother's actions at 24 months
- had more positive relationship with peers at 42 months
- exhibited fewer behavior problems at 42 months

There were no differences on cognitive measures.

Sources: D.C.van den Boom, (1994), The Influence of Temperament and Mothering on Attachment and Exploration: An Experimental Manipulation of Sensitive Responsiveness among Lower Class Mothers with Irritable Infants, *Child Development,* Vol. 65, pp. 1457-1477. D.C.van den Boom, (1995), Do First Year Intervention Efforts Endure? Follow-up during Toddlerhood of a Sample of Dutch Irritable Infants, *Child Development,* Vol. 66, pp.1798-1816.

INTERACTION GUIDANCE

MICHIGAN

HIGH-RISK FAMILIES . . . . . TARGETED

Purpose. Promote infant's well-being through positive change in parent-infant interaction.

Population Served. Difficult to engage families: resistant to other forms of psychotherapy; young, inexperienced, cognitively limited, and infants with failure to thrive, regulation disorders, and organic problems.

Service Delivery. Office sessions plus home visits.

- Interaction guidance therapist is a mental health professional with special training.
- Families are referred by other professionals.
- Initial meeting of family household members at referral site is followed by home visit(s), for all family members to establish goals. Ten to twelve weekly sessions are held at center playroom with one or more follow up home visits.
- Sessions are videotaped.

Content. The interaction guidance therapist

- highlights existing family strengths
- explores history of family relationship with the infant
- assists family to establish treatment goals
- invites parent(s) to play with infant and videotapes 6 minutes of interaction
- reviews videotape with parent(s), soliciting their perceptions and feelings
- highlights specific positive interactive behaviors
- discusses issues of concern to parents or identified by therapist
- requests family to reflect on treatment progress
- prepares an edited videotape for the family documenting the changes in parent-infant interaction

Outcomes—Random assignment to two intervention models.

Mothers receiving interaction guidance improved on relationship measures, presenting symptoms, and mother's representation of her infant. No differences in results compared with a brief parent-infant psychotherapy model but mothers receiving interaction guidance were less intrusively controlling.

Pre-post data with failure to thrive infants found **infants** gained weight and avoided subsequent hospitalizations; **parents** achieved more responsive caregving and obtained more social support; gains continued at 12 month follow up after intervention.

Source: S.C. McDonough, (1993), Interaction Guidance: Understanding and Treating Early Infant-Caregiver Relationship Disturbances, In C.Zeanah (Ed.), *Handbook of Infant Mental Health,* chapter 27, pp. 414-426.

ADJUNCT TO HEALTH CARE

JOHNS HOPKINS CHILDREN AND YOUTH PROGRAM

BALTIMORE

HIGH-RISK FAMILIES . . . . . TARGETED

Purpose. Promote child's health and development.

Population Served. African-American inner city infants weighing more than 2000 grams. Of the parents, 79% were single, for 23% this was the first-born child.

Service Delivery. Home visits.

- Families were enrolled in the pediatric clinic.
- Home visitor was a middle-aged, college-educated community resident.
- Visits were scheduled when the infant was 7-10 days old just before the initial clinic visit,

and subsequently at 2-3 weeks before the scheduled clinic visits at 2, 4, 6, 9, 12, 15, 18, 21, 24 months. Additional visits could be made as needed, and families could access the home visitor or other staff by telephone.

Content. The home visitor

- discussed age-appropriate issues related to parenting and child care skills, including well and sick care, feeding, clothing, safety
- gave anticipatory guidance and discussed developmental milestones
- assisted families to resolve crises through referral and support
- referred psychosocial issues to the social worker or educator
- provided a calendar that included clinic visits, names and telephone numbers of staff, and information on child development and safety
- provided pamphlets, at a fourth grade reading level, covering areas discussed

Outcomes—Random assignment

Infants receiving home visits, as compared to controls

- completed immunizations on time (88% vs. 69%)
- had fewer chronic ear infections (21% vs. 55%)
- had fewer head injuries resulting in a clinic visit (6% vs. 11%)
- had fewer clinic and emergency room visits and fewer hospital admissions (6% vs.15%)
- reduced suspected child abuse and neglect (1.5% vs. 9.8%)

Source: J. B. Hardy and R. Street, (December, 1989), Family Support and Parenting Education in the Home: An Effective Extension of Clinic-based Preventive Health Care Services for Poor Children, *Pediatrics,* pp. 927-931.

MONTREAL HOME VISITATION STUDY

MODERATE-RISK FAMILIES . . . . . COMPREHENSIVE

Purpose: Promote child's health and development

Population Served. Working class women between 18 and 35 years, no more than high school education, first born full term infants.

Service Delivery. Home visits.

- Home visitors were persons with undergraduate degrees in child psychology who received extensive training from a pediatrician.

- Group A received one prenatal visit, one postpartum hospital visit, and 4 visits during first six weeks and 5 visits during the period 1 1/2 months to 15 months (at approximately 3 month intervals). Group B received 10 home visits from 1 1/2 months to 15 months.

Content

Group A. The home visitor

- at prenatal visit, introduced herself, reviewed schedule of future visits, reviewed preparations for infant, reviewed what might be anticipated during delivery and hospitalization
- at hospital visit, encouraged interaction and active care of the infant.

Groups A and B. The home visitor, using a prearranged protocol, but allowing for mother's needs to structure the visit

- provided counseling and advice on caretaking, e.g., feeding, sleep and scheduling, bathing and clothing; injury prevention; appropriate well-child care
- encouraged mothers to interact frequently with their infants, e.g., talking during feedings and responding to vocalizations
- reviewed mother's support system, her relationship with the infant's father, areas of exceptional stress or concern
- reviewed the infant's developmental competence with the mother and suggested types of activities to promote capability

Outcomes—Randomized assignment to Group B and control; time lagged recruitment for Group A

Mothers in Group A

- were more responsive, particularly at 6 weeks and 6 months
- provided a more stimulating home environment
- had fewer mother-child interaction problems than Group B mothers

Fathers in Group A were more likely to participate in the care of the child than Group B fathers (96% vs. 78%).

Children in Group A compared to controls

- had more immunizations at 12 and 18 months
- had significantly fewer accidents—accident rate for control children was 4 times greater at 6 months and 2 times greater at 12 months. *There was no significant difference in the rate of emergency room visits.*
- had fewer feeding and sleeping problems than children in Group B

Source: C. Larson, (1980), Efficacy of Prenatal and Postpartum Home Visits on Child Health and Development, *Pediatrics,* Vol. 66, pp. 191-197.

HEALTHY STEPS FOR YOUNG CHILDREN PROGRAM

15 SITES

ALL FAMILIES . . . . . TARGETED

Purpose. Promote child health and development.

Population Served. All families receiving pediatric services from group practices, hospital-based clinics, or health maintenance organizations. Across all sites, close to 33% of parents are poor, 10% adolescents, 36% single, 18% have not completed high school, 27% completed college. Low birth weight infants, 7%. 18% African-American, 20% Hispanic.

Service Delivery. Home visits, office visits, and parent groups.

- Two Healthy Steps specialists work as a team with 4 to 8 pediatricians and pediatric nurse practitioners.
- The Healthy Steps specialist may be an early childhood educator, nurse, nurse practitioner, social worker who has expertise in early childhood development. Each specialist serves 50 children.
- Seven home visits over three years are timed to predictable junctures in parent-child relationship.

Boston University and Commonwealth Fund provide training and protocols.

Content. The specialist

- **in office visits,** answers questions about child development, identifies family health risks, takes advantage of teachable moments
- **in home visits,** informs parents about fostering cognitive and emotional development
- **in parent groups,** promotes social support, interactive learning, and practice in problem solving.
- responds to **telephone information line** to address parents' concerns
- assesses development to identify early signs of problems and to provide teachable moments
- provides written information in handouts and in bulletin sent out before visits
- provides information about community resources and parent-to-parent connections

Outcomes—Randomized assignment. Results across 6 sites will be available in 2002.

Source: B. Guyer, et al., Assessing the Impact of Pediatric-Based Developmental Services on Infants, Families, and Clinicians: Challenges to Evaluating the Healthy Steps Program, *Pediatrics,* Vol.105 (3).

For Information: www.healthysteps.org.

ACCESS TO SERVICES

COMPREHENSIVE CHILD DEVELOPMENT PROGRAM

HIGH-RISK FAMILIES . . . . . COMPREHENSIVE

Purpose. Promote child development and family self-sufficiency.

Population Served (21 sites). Low-income families; other risk factors varied by site.

Service Delivery. Home visits, parent classes and support groups, child care after age 3, developmental screening.

- Sites could develop services that were not available.
- Home visitors were paraprofessionals and professional case managers. Time of enrollment was determined by sites.
- Home visits occurred every one or two weeks. Families were expected to receive services until child was 5 years old.

Content. U.S. Administration on Children and Families guidelines specified providing parenting education, early childhood education, counseling, and crisis intervention services; and assessing family needs, developing a family service plan, making referrals for service, and keeping a record of the services received. The home visitor

- made referrals to improve economic self-sufficiency, to adult education (38%), vocational and job training (18%)
- made referrals and facilitated access to prenatal care, substance abuse services, family planning, child care, income support, and housing
- provided information about life skills
- trained parents in infant and child development and parenting skills (home visitor suggested an approach, the parent conducted the activity with the child, and the home visitor reinforced or modeled)
- provided cognitive stimulation

Outcomes—Random assignment

Only one site (Brattleboro, VT) out of 21 had positive results. Site was characterized by community support and interagency linkages, strong leadership from sponsoring school with focus on children and education, continuity in staff, and low attrition of families *(personal communication from Judith Jerald).*

Parents at Brattleboro receiving services as compared to controls

- decreased percent of mothers on welfare (46% vs. 65%)
- increased average amount of time employed (69% vs. 47%)
- were assessed as not at risk for abuse (67% vs. 46%)

Children at Brattleboro showed increased cognitive development.

Source: R.G. St. Pierre, et al., (1997). *National Impact Evaluation of the Comprehensive Child Development Program: Final Report,* Cambridge: MA: Abt Associates Inc., Description of Services, section 2, pp. 2-7 and Executive Summary, pp. 9-10. Projects have been terminated.

INFORMATION-BASED, REFERRAL, RELATIONSHIP-BASED

EARLY HEAD START

HIGH TO LOW RISK FAMILIES . . . . COMPREHENSIVE

Purpose. Enhance children's cognitive, social, emotional, and physical development; assist parents in fulfilling their parental roles; and help parents move toward self- sufficiency.

Population Served. Infants and toddlers from low income families as defined by federal poverty guidelines; 10% of enrollees are children with disabilities; 10% may have higher incomes.

Service Delivery. May be through weekly home visits and twice monthly group socialization activities, a combination of home visits and center-based program, or a center-based program. Some programs are now being approved to provide services to the child care provider in family child care.

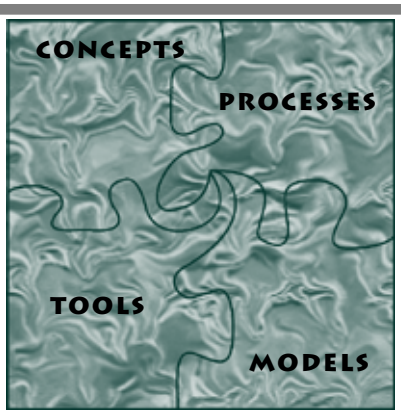
- Home visitors are generally paraprofessionals. Many programs in Michigan are hiring persons with bachelor's degrees. Ongoing staff development is required.
- Approach to intervention will vary by site. **Model Variation:** One site in Michigan is using master's level infant mental health specialists.
- Training and technical assistance is provided through federally funded regional centers.

Content. Home visitors provide services in accordance with Head Start Performance Standards.

Outcomes. A national evaluation involving 17 sites and nearly 3000 families is underway; results will be available in 2001.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, 45 CFR Part 1306, Head Start Staffing Requirements and Program Options.

For Information: www.ehsnrc,org/ehs.html. **In Michigan:** Brooke Foulds, Great Lakes Quality Network, Room 22, Kellogg Center, East Lansing, MI 48824. 517-353-5194. fouldsdo@msu.edu.



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