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BEST PRACTICE BRIEFS

PUTTING THE PIECES TOGETHER

OUTREACH PARTNERSHIPS

MICHIGAN STATE UNIVERSITY

EFFECTIVE HOME VISITING FOR VERY YOUNG CHILDREN—3

This is the fourth in a series of **BRIEFS** devoted to effective home visiting. This **BRIEF** explores staffing and logistical issues related to effectiveness.

THE IMPORTANCE OF STAFF

The relationship established by the home visitor with the parent and the content delivered by the home visitor are the mechanisms through which outcomes are achieved for the infant and for the parent.[1] Consequently, an exploration of effective home visiting must consider issues related to staffing:

- the decision to use professionals or paraprofessionals
- recruitment criteria
- provisions made for training and supervision
- agency policies and practices

Professional Versus Paraprofessional Staff

Professionals are persons who have specialized training in human services—nursing, social work, psychology, child development, early childhood education—that equips them to promote behavioral change. Paraprofessionals or lay helpers are persons whose primary competence is life experience and ability to work with families rather than specialized higher education. Characteristically, paraprofessionals are trained and supervised by professional staff.

The effectiveness of professional versus paraprofessional home visitors in accomplishing outcomes is a significant issue because the determination to use one or the other directly impacts costs.

1 See **BRIEF** No. 19.

Published analyses indicate that there are differences in the ways that professionals and paraprofessionals function.

- The Denver, Colorado, replication of the Nurse Home Visitation Program compared nurses and paraprofessionals within the same intervention model and parallel training.[2] The findings revealed that
  - nurses spent a greater proportion of time on parenting issues (46% vs. 32%)
  - paraprofessionals spent twice as much time on environmental health and safety issues (15% vs. 8%)
  - nurses completed more visits than paraprofessionals (average of 28 vs. 23 visits)
  - although one rationale for using paraprofessionals is their capacity to access low-income ethnic populations, paraprofessionals had a larger percent of families who passively refused service (20% vs. 14%)
  - paraprofessionals had more families drop out than did professionals (48% vs. 38%)
  - there was more turnover among paraprofessional staff
- The Ounce of Prevention Fund in Illinois,[3] assessing the performance of paraprofessionals in a variety of home visiting and family support programs, found that, despite training, characteristic modes of working with families constrained what paraprofessionals were accomplishing with families. Paraprofessionals generally
  - focused on child care practices rather than interpersonal aspects of parenting
  - avoided discussion of loaded topics such as family planning, child abuse, domestic violence, and adoption. This reticence was attributed to the paraprofessionals' unrecognized feelings related to their own life experiences that impaired their capacity to assist the parents and lowered expectations that persons in circumstances of poverty can change.

Recruitment Criteria

Whether professionals or paraprofessionals are recruited for staff, there are certain personal characteristics and attitudes that will enable individuals to work effectively with families.[4] These include

- warmth, understanding, and the ability to care for and relate to other human beings
- the ability to reflect about themselves and their work
- objectivity about their own parenting experiences and relationships
- emotional strength
- patience and realistic expectations about the pace and possibility for change
- a commitment to empowerment
- acceptance of cultural diversity

Training and Supervision

Training and supervision[5] are often overlooked necessary preconditions to effective home visiting. Regardless of staff competencies, an initial orientation and training and ongoing supervision must be essential components in the implementation of any service model. Professionals trained only in their discipline cannot be expected to come with all the knowledge and skills required to implement a home visiting service model.

2 J. Korfmacher, R. O'Brien, S. Hiatt, D. Olds, (1999), Differences in Program Implementation Between Nurses and Paraprofessionals Providing Home Visits During Pregnancy and Infancy: A Randomized Trial, *American Journal of Public Health,* Vol. 89(12), pp. 1847-1850. The comparison of outcome data for professionals vs. paraprofessionals had not been published as of December 2000.

3 J.S. Musik and F.M. Stott, (1990), Paraprofessionals, Parenting, and Child Development: Understanding the Problems and Seeking Solutions, In S.J. Meisels and J.P. Shonkoff (Eds.), *Handbook of Early Childhood Intervention,* Cambridge University Press, pp. 651-667.

4 Musick and Stott. See also M. Lerner, R. Halpern, and O. Harkavy (Eds.), (1992), *Fair Start for Children: Lessons Learned from Seven Demonstration Projects,* Yale University Press, ch. 9, pp. 179-197.

5 See E. Fenichel, (Ed.), (1992), *Learning through Supervision and Mentoring to Support the Development of Infants, Toddlers, and Their Families: A Source Book, Zero to Three*, Washington, DC: National Center for Infants, Toddlers, and Families.

While there are increasing opportunities for professionals to be exposed in their university training to the knowledge/strategies/techniques expected to be incorporated into home visits, there is still a need for acquisition or upgrading of information, skills, and practices for the intervention model selected. This orientation is even more important for paraprofessionals.

Training, in many ways, must parallel the interaction between home visitor and parent where didactic transfer of information is less effective than a "mental health" approach. To overcome the limitations outlined in the previous section, home visiting programs should

- use instruments to assess infant capabilities and parent-infant interaction as training tools
- provide opportunities in training and supervision for staff to reflect on their own history, feelings, and conflicts that may influence their reactions to, and their capacity to work with, families[6]

Ongoing supervision must be much more than an administrative review of performance. Ongoing case supervision can be undertaken by a knowledgeable professionally trained supervisor or provided as consultation by an external expert. It provides an opportunity for individual staff members, or the home visitors as a group, to reinforce training, problem solve around the issues presented by individual families, and reflect on their own capabilities, vulnerabilities, and life experiences that may be framing their responses to families. These opportunities for reflection and support enable staff to be more effective with families and reduce burnout and staff turnover.

Agency Policy and Practice

Agency policy and expectations can affect job performance and outcome.

- Attrition will be greater if the agency's expectations and implicit or explicit policy allow for case closing after one failed visit, as was noted in **BEST PRACTICE BRIEF** No. 16.
- Availability of agency cars or insurance coverage for staff who drive their own cars can facilitate access to services.
- Periodic monitoring of expected inputs and outcomes, together with appropriate supervision, can improve performance.

Agency issues that impact the continuity of leadership and staff are closely related to staffing concerns. Noncompetitive pay scales and the uncertainty of future grant funding make offers from more established agencies attractive. Whenever possible, programs should be integrated into the agency's ongoing structure and funding sources.

The Logistics of Intervention

When Should the Intervention Start

Parents are most open to guidance and support during pregnancy or around the time of birth. Preventive early intervention programs initiate their contacts at one or another of these points, using a systematic review of women in prenatal clinics or maternity units.

- Strongest outcomes are obtained when **enrollment occurs during pregnancy** and services are continued during infancy.[7] The relationship with the home visitor can be consolidated during pregnancy and a start made on resolution of issues that will impact the infant.

Because families may not be identified at initial screenings, may refuse service, or may experience changes in life circumstances, there should always be the opportunity within a community for families to be identified and referred at a **later point in time.** Families who are having substantial difficulty in caring for an infant are also more open to intervention, provided it is offered in a nonjudgmental, supportive way.

6 Musick and Stott.

7 Nurse Home Visitation Program. The Montreal Home Visitation Program found better results for families enrolled during pregnancy versus those for whom services started when the infant was 6 weeks of age.

Dosage

The amount of contact between the home visitor and the parent is the matrix within which the trusting relationship is forged and the interactions that may lead to change take place. Consequently, how often and for what period of time the home visitor visits are significant design issues. The amount of contact may be insufficient if (1) there is too large an interval between visits (frequency), or (2) termination occurs too early in the infant's development.

The amount of contact between the home visitor and the parent is also related to the way the model is implemented. Inevitably, appointments are missed; if makeup visits are not feasible, the interval between contacts is always greater—and the number of contacts is always less—than that anticipated in the model's design.

Implications for Practice. The number of visits actually received by each family should be documented and analyzed in relation to the outcomes accomplished and the characteristics of the parent.

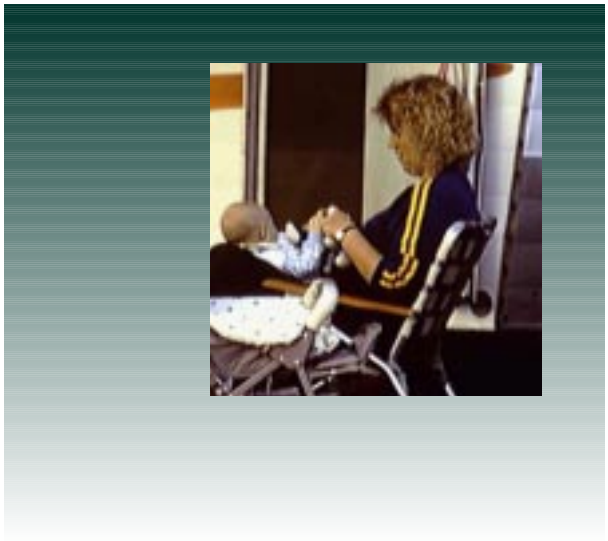
How Often To Visit

Models providing ongoing home visiting are designed with all manner of permutations:

- **a consistent pattern:** once a week, three weeks out of four, every 10 days, every other week,[8] once a month
- **a declining pattern,** starting out with once a week during the first months and shifting to longer periods as the child reaches a developmental plateau or as the family stabilizes[9]
- **a consistent pattern but more frequent visits as needed,** justified by the initial need to establish a relationship, the health and child care issues around very young infants, and/or the severity of issues presented by the family. Programs that recruit high-risk families and attend to situational issues typically will make more frequent visits when the family is in crisis. Where home visitors have the flexibility to schedule the frequency of visits, they will reasonably allocate a greater number of visits to those families perceived to be in the greatest need for services.

> **In the Elmira and Memphis Nurse Home Visitation Programs,** families with the lowest psychological resources[10] received a higher number of visits. However, home visitors also recorded a higher number of visits to those parents with the highest psychological resources who were more successful in scheduling appointments and more assertive in taking advantage of what the home visitor had to offer.

Data from evaluated projects do not provide a consistent answer with respect to frequency. The most definitive information comes from a study in Jamaica, focused on health and cognitive outcomes, that compared weekly, twice a month visits, and monthly visits. As the frequency of visits increased, the developmental measures improved. The group that was visited monthly showed no difference in outcomes from controls.[11]



8 Models using a combination of home visits and parent groups provide for each in an alternate week. For parents who do not attend the parent group, the frequency of contact is every other week.

9 Healthy Families America.

10 Psychological resources were measured by a sense of mastery measure in the Elmira project and by an index composed of measures of intelligence, mental health, coping skills, and self-efficacy in the Memphis project. D.L Olds and J. Korfmacher, (1998), Maternal Psychological Characteristics as Influences on Home Visitation Contact, *Journal of Community Psychology,* Vol. 26(1), pp. 23-36.

11 C. Powell and S. Grantham-McGregor, (1989), Home Visiting of Varying Frequency and Child Development, *Pediatrics,* Vol. 4, pp.157-164. The project used paraprofessionals with extensive training.

Dispersed Visit Health-Sponsored Alternative Models. Two models linked to health care had positive results with substantially longer intervals between visits:

- Linking home visits and clinic visits for an inner city high-risk population, the Johns Hopkins Children and Youth Program achieved good health outcomes, operating with as much as 2 to 3 months between home visits and 1 1/2 to 2 1/2 months between the clinic visit and the next home visit. See summary in **BRIEF** No. 18.
- The Montreal Home Visitation Study had positive results with prenatal enrollment, one prenatal and one postpartum hospital visit, visits at approximately ten-day intervals during the infant's first six weeks, and visits at developmental change points, approximately 3 months apart, between the ages of six weeks and 15 months. See summary in **BRIEF** No. 18.

How Long To Visit

Most early intervention home visiting models vary in maximum length of service that is expected to be provided, from 1 year up to the entire preschool period of 5 years. In fact, attrition rates guarantee a shorter period of involvement for most families. Termination when the child is age 3 is a realistic maximum expectation with transfer at that point to center-based programming.

Analyses of outcomes by length of service for infant mental health programs in Michigan indicate greater effectiveness for those families who remain in service for longer periods (see **BEST PRACTICE BRIEF** No. 16). The Nurse Home Visitation Program has served families for a period of two years with documented outcomes into adolescence.

Some outcomes may be more easily accomplished than others. For example, changing attachment status for infant/toddlers in high-risk families seems to require a longer period of intervention. Erickson found no significant difference in the quality of attachment for infants in families receiving services for only one year and attributed this outcome to the limited period of service.[12]

However, **Brief Intervention Models** that use a behavior-based approach with defined populations have been effective in accomplishing objectives.

- **The Interaction Guidance Model,** using videotapes of parent-infant interactions with families resistant to health professional direction, makes a contractual agreement for 10-12 sessions with a possibility for future re-engagement. See summary in **BRIEF** No. 18. This is consistent with Brazelton's conceptualization of "touchpoints"—that families will be more responsive to intermittent intensive contacts timed to coincide with the cycle of behavioral reorganization and consolidation as the infant shifts to the next developmental stage.[13]
- **A Brief Behavioral Intervention with Irritable Infants** in low income families, identified at birth, involves 3 two-hour sessions between the ages of 6 and 9 months.

How Many Families Per Home Visitor

Caseloads per home visitor vary from 10 to 25 in reported projects. This is a cost versus quality issue. Larger caseloads can mean

- less frequent visits per family
- higher attrition of families
- higher turnover of staff

The number of families served by the home visitor should be smaller when all families on the caseload are in the beginning stages. The number of families can be larger when the caseload contains a mix of newly enrolled families and those who are in the phase out stages. The size of the caseload determines the frequency and length of visits. There is a continuing tension between the administrative concerns for cost containment and the service concerns for delivering optimal dosage and quality.

12 STEEP. Lieberman, et al. (see footnote 4, **BRIEF** No. 17) similarly found changes in behavioral precursors but no change in attachment status after one year of intervention.

13 T.B. Brazelton, (1992), *Touchpoints,* New York: Guildford Press. Stern has suggested that such serial brief treatments can be an appropriate model for parent-infant psychotherapy when the same relationship-risk issue may resurface in different forms as the infant develops. D.N. Stern, (1995), *The Motherhood Constellation,* New York: Basic Books, ch. 10.

THE COMMUNITY SYSTEM

Home visiting programs no longer exist in isolation. For better or for worse, the widespread interest in improving outcomes for very young children has resulted in funding availability from various categorical agencies; as a result, communities have developed multiple program models. From the community standpoint, effective home visiting at this time requires systematic development of a referral process that identifies families at early stages in the health care system and offers them the service that is most appropriate for their level of risk. See **BEST PRACTICE BRIEF** No. 10 on *A Community System Of Care for Very Young Children* where systems issues are discussed in detail.

Can Home Visiting Accomplish Cognitive Outcomes?

While home visiting models initially targeted health outcomes and the prevention of child abuse and neglect, more recent policy concerns have targeted outcomes related to the prevention of violence[14] and readiness to succeed in school. Home visiting has been shown to impact the health, behavioral, and emotional components of readiness to succeed but appears to be less effective with cognitive development. What the child actually receives in the way of stimulation after each home visit is dependent on the available time and motivation of the parent between home visits.

In comparison, center-based models directed at optimal development can be intensive (daily), and often start during early infancy. As a result, center-based models are more likely to have an impact on language and short-term cognitive development.

Project Care, using Ramey's Abecderian center-based model, found that children receiving center-based child care plus home visiting, starting with infants between 1 1/2 and 5 months of age, achieved significantly higher levels on cognitive indices from 18 to 54 months than a control group or a home visiting only group. Children in the home visiting only group and in the control group who were enrolled in community (non-research) child care also scored higher than their peers.[15]

The Cost, Quality, and Outcomes Study, sampling classrooms in child care centers across 4 states and following children through second grade, found that high quality child care had long-term effects on children:

- classroom practices (the quality of the child care environment, teacher sensitivity and responsiveness, and teaching style) were related to better performance in school on measures of basic cognitive skills (language and math)
- strong teacher-child relationships resulted in children's behavioral competence in the elementary classroom (attention skills, sociability, fewer problem behaviors, and better peer relations)

Children of mothers with lower levels of education benefited most with respect to math skills and problem behaviors, and gains were sustained through second grade.[16]

The evidence on improvement in school performance for high-risk children in quality child care would argue for a clear linkage with quality child care, concurrently or sequentially, for those high-risk children served through home visiting.

14 See R. Karr-Morse and M.S. Wiley, (1997), *Ghosts from the Nursery: Tracing the Roots of Violence,* New York: Atlantic Monthly Press.

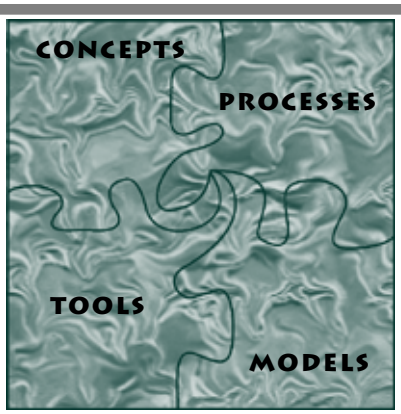
15 B.H. Wasik., C.T. Ramey, D.M. Bryant, J.J. Sparling, (1990), A Longitudinal Study of Two Early Intervention Strategies: Project CARE, *Child Development,* Vol. 61, pp. 1682-1696.

16 U.S. Department of Education, Office of Educational Research and Improvement, (June 1999), *The Children of the Cost, Quality, and Outcomes Study Go to School, Executive Summary.* The data came from 826 children in 170 full day child care centers in California, Colorado, Connecticut, and North Carolina.

CONCLUSIONS

One can conclude from this series of **BRIEFS** that the effective home visiting intervention

- uses a **model appropriate to** the population's **level of risk**
  - uses a mental health relationship-based approach with high-risk families
- is clear about **objectives and content**
  - implements the core components of the model
- has **well trained staff** who
  - recognize their own values, vulnerabilities, and life experiences that may affect their work with families
  - understand and can communicate the various components that impact infant development
- supports staff through **reflective supervision and agency policies**
- emphasizes the home visitor's **development of a trusting relationship**
- focuses on **both infant and parent**
- uses a **systematic process to enroll families** during pregnancy or around the time of birth
- **visits frequently and long enough** to accomplish desired objectives
- is **comprehensive** in addressing situational stresses, social supports, psychological issues, and parental behaviors as needed by the particular family
- links families to **quality child care**
- is **realistic** about what can be accomplished



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