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Preventing Physical Child Abuse and Neglect Through Home Visitation

In a growing number of nations the strategy of home visitation continues to be considered one of the primary ways of preventing physical child abuse and neglect. It is a sensible and straightforward strategy, and mounting scientific evidence points to home visitation as one of the most promising maltreatment prevention strategies available.

While it is a recently emerging strategy in many national and local contexts, home health visiting services date at least as far back as Florence Nightingale's pioneering work in the 1860's in Britain. It was a home visitor who was responsible for finding little Mary Ellen in a New York City tenement in 1874, which led to the establishment of the world's first child protection organization, the New York Society for the Prevention of Cruelty to Children (NYSPCC).

Today, most home visitation services designed to prevent physical child abuse and neglect are comprised of several characteristics that distinguish them from other service strategies.

First, as the name implies, service provision takes place primarily in the home, rather than in an agency, clinic, or hospital setting. As children do not grow up in professional offices, it makes imminent sense to provide services, including guidance around healthful parenting practices, in the real world settings where parents rear their children. Also, by traveling to the home environment, workers convey to families the importance of connecting with them "on their own turf" and are more able to overcome many common barriers to serving families where children are at risk of physical child abuse and neglect, such as geographic distances, transportation, financial or time difficulties. Home visitors often provide guidance on parenting practices, and they also often endeavor to

connect parents with other community supports, whether these be medically-, materially-, or psychosocially-oriented. Often home visitation services are lodged within larger programs and systems of care, whereby the home visitor serves a liaison function, helping families navigate their way to other available supports.

A second characteristic of home visitation is that families are typically initially identified from universal and therefore non-stigmatizing systems of care. Most commonly, these include health care systems in clinics or hospitals where mothers give birth. Most home visitation models initiate services very early, sometimes at the point of birth of a child, or even before birth during prenatal visits to a local health clinic. This is particularly critical from a prevention standpoint as a growing body of evidence indicates that the earliest years of life often hold the greatest risk for the most devastating manifestations of physical child abuse and neglect. At the same time, the early years are also the period during which the most fundamental building blocks for later psychosocial development are put in place, including the dynamic maturation and settling of the neurological system, the formation of primary emotional attachments, learning how to habituate to environmental stimuli, to self-regulate emotions, and to communicate. Given this, services provided during this "window of opportunity" have the greatest chance of preventing the most damaging incidents of maltreatment, and of promoting parent-child interactions that foster long-term developmental trajectories away from maltreatment toward more healthful child development and child rearing.

Thirdly, in contrast to traditional child protective services intervention, which is often

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This report follows the ISPCAN VID on Home Visitation, which took place on 23-27 May, 2005. Home visitation was selected because it is a widely available strategy and one which has shown strong promise when subject to rigorous evaluation. We recognize that home visitation is not the only way to support new parents but rather is one of a range of options being developed to support newborns and their parents.

The rapid expansion of home visitation over the past 20 years has not hinged exclusively on positive findings regarding a specific service model. Rather this movement has been fueled by a much broader body of research that highlights the first three years of life as an important intervention period for influencing a child's trajectory and the nature of the parent-child relationship. The empirical base for this assumption grew out of the early brain research, translated for popular consumption in the US by the Carnegie Foundation's Starting Points report (1974). In addition, longitudinal studies on US early intervention

efforts implemented in the 1960s, found marked improvements in educational outcomes and adult earnings among children exposed to high quality early intervention programs.

Collectively, these and other data sources supported what child abuse prevention advocates had believed for years - getting parents off to a good start in their relationship with their infant is important both for the infant's eventual development and the parent-child relationship. The key message from this body of research is not providing home visitation services to new parents but rather establishing a better system of support for new parents. None of the critiques of home visitation has contradicted these initial empirical findings - learning begins at birth and the first three years of a child's life has enormous influence on his or her development and world views.

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investigatory, authoritative, and even adversarial, home visitation programs typically provide services to families voluntarily and proactively. Home visitors focus on supporting and strengthening the family and the parent-child relationship, rather than on identifying and treating family deficits, or on decision-making about removing the child to another setting. Home visiting services, for example, may focus on educating parents around common health risk hazards, knowledge about normal developmental milestones to assist them in developing realistic expectations for their children, or support to deepen and improve the quality of the parent-child relationship.

Home visitation for the purpose of preventing physical child abuse and neglect before it occurs makes common sense; why wait to do something until after a child has been harmed if we can intervene earlier to prevent both the harm to a child and the need for a stigmatizing, coercive and more costly system response? Studies examining the effectiveness of home visitation report a picture of growing sophistication, and speak directly about the benefits of home visitation services. Although difficult to summarize briefly, the expanding evidence base allows us to discern at least these general trends:

1. If delivered in the right way and in the right context, home visitation programs can prevent significant numbers of incidents of physical child abuse and neglect before they ever occur. Five independently conducted meta-analyses, reviewing the full range of outcome studies on home visitation, have each reported a discernable positive impact on physical abuse and neglect and closely associated family factors. Among those meta-analyses, the U. S. Centers for Disease Control and Prevention recently concluded that up to 60% of cases of physical child abuse and neglect could be prevented before-the-fact by home visiting services (c. f. Bilukha et al., 2005; Guterman, 1999; Kendrick et al., 2000; MacLeod & Nelson, 2000; Sweet & Appelbaum, 2004).

2. Home visitation approaches, on the whole, show superior rates at which families at-risk for physical child abuse and neglect engage and participate in services, when compared against preventive services that are provided in agencies, centers, clinics, or hospitals (Guterman, 2001).

3. It is equally clear that home visitation should not be viewed in isolation, or as a panacea. Not all home visitation programs yield the same benefits in different

contexts, and indeed, it is critical to point out that some home visitation approaches have not been able to show any noticeable preventive benefit. One of the particularly important questions asked of the home visitation field is how to address the reality that many high-risk families either do not engage or drop out of such programs before the intended “dose” of services is delivered, watering down their potential family and community-wide benefit (Daro, et al., 2003). This is not to say that home visitation services only engage those who have relatively low risk for later maltreatment, and indeed several studies have reported that some families with greater specific risks engage and participate in services more than lower risk ones (e. g. Duggan, et al., 2000).

Overall, home visitation can be viewed as the most promising vehicle of choice in delivering necessary “ingredients” to prevent physical child abuse and neglect before it occurs. We still have a great deal to learn, however, about what specific preventive “ingredients” work best to reduce the risk of physical abuse and neglect in different contexts, as well as how best to ensure they are delivered to families that most need them.

Considerations in the Development of Home Visitation Programs

Professionals and policy makers have much to weigh when considering the development of home visitation services, including such fundamental questions as what the goals of home visitation should be, who should be served, and what services should be provided. In some contexts, the goals of home visitation services that target maltreatment prevention overlap with those of child protection, as well as with other allied health and developmental goals, such as assuring healthy baby outcomes, or preparing children to be ready to start school.

Some have noted that the blending of maltreatment prevention aims with other health and social goals helps reduce potential stigma that may accompany such services, and this may make families and the broader community more receptive to and supportive of services. In some contexts, home visitors targeting maltreatment prevention have specific dual objectives of both supportive outreach to at-risk families before maltreatment occurs and the early detection of specific cases of maltreatment when it does occur.

This melding of the aims of prevention with those of child protection appears sensible from an efficiency standpoint, as the same workers implement dual

objectives, and indeed home visitors often do uncover cases of maltreatment earlier than would otherwise have been the case, perhaps alerting child protection authorities to intervene to prevent more severe subsequent maltreatment.

It should be pointed out, however, that the evidence base in the home visitation field provides almost no guidance as to the advisability of coupling both maltreatment detection and maltreatment prevention together within the same home visitor role. Some have cautioned that the aims of prevention and those of protection should be segregated by design to ensure that authoritative pressure, stigma, and the urgent imperatives that accompany child protection work do not interfere with and overwhelm the need to engage families voluntarily, supportively and before maltreatment has occurred.

The idea that home visitation services, since they can prevent maltreatment before-the-fact, are also able to avert further physical child abuse and neglect after it has already occurred appears a questionable one, with little support in the existing research base (e. g. Macmillan, et al., 2005; Huxley & Warner, 1993).

A second key consideration in the development of home visitation services concerns the related question of whom to target and serve. Many home visiting programs, as they have multiple goals beyond merely child maltreatment prevention, serve families broadly. Some serve all families with a newborn universally, regardless of risk of abuse and neglect. Others are deployed to serve all families within targeted disadvantaged communities. Still others screen families, one-by-one, for specific risk. If the screen result is positive, home visiting services are offered only to these families.

The question of whom to serve is a complicated one and intertwined with the goals of home visitation. However, we can say that the evidence base for programs that screen in families on the basis of specific risk factors is not favorable, and indeed those programs that offer services to wide catchment areas seem to fare better in their capacity to demonstrate program effects (Guterman, 1999).

It is just as clear that regardless of the means by which families are identified for services, specific intervention strategies must match families’ needs, so the question of whom to serve is also interdependent with the question of what services will be provided. For example, if families struggling with substance abuse problems are specifically identified for home visitation services, programs must

configure intervention strategies that specifically address substance abuse issues in the context of child rearing. Similarly, if socially isolated families are specifically identified for home visiting services, specific strategies for assisting families to break down their isolation and improve their social supports should be offered, so that the criteria for program enrollment are closely fitted to program service strategies targeting specific risks.

Another related consideration is whom to deploy as home visitors, as well as the larger consideration about overall staffing patterns. Approaches on home visitation personnel vary widely, with some programs relying heavily or exclusively on nurses as home visitors, while others rely on social work professionals, paraprofessionals, or a blend of professional social workers, nurses and paraprofessionals.

Although some recent efforts have been made in the U. S. to discern whether one personnel configuration or another is superior, the evidence base remains divided about which personnel deliver the most effective services (Olds, et al., 1999; Olds, et al., 2002; Guterman Anisfeld & McCord, 2003; Bilukha, et al., 2005).

Because of their training, nurses may be better equipped to deliver information and services that address health-related aspects of maltreatment risk, such as teaching parents about poison hazards or accident prevention in the home. On the other hand, paraprofessionals may more easily overcome "social distances" of class and culture in engaging families. Further, programs that employ paraprofessionals, particularly when drawn from the same community as families receiving home visitation services, may contribute to developing local community capacity by equipping local residents to assist their own neighbors.

In reality, cost considerations often drive these personnel choices, so it is not surprising that many programs opt to rely heavily on lower paid paraprofessionals, who nonetheless, may require more intensive training overall. Interestingly, programs that have deployed

multidisciplinary teams in the home visiting context have not tended to fare well, at least in the reported outcome studies, so more comprehensive personnel strategies may not only be more expensive, but also bring unintended complications in delivering preventive benefit.

Across settings, home visitation programs vary substantially in the length and intensity of the services provided. These vary from one home visit after the birth of a child, to ongoing and regular visits until the child reaches kindergarten. Again, cost considerations will play a factor with regard to the level of service duration and intensity, and some programs will deliver several visits to families deemed lower risk for child maltreatment, and reserve more intensive services for those that appear to have a higher risk profile.

The evidence base seems to favor, not surprisingly, programs that provide at least

a moderate degree of service intensity (bi-weekly or weekly home visits), and perhaps length (Bilukha, 2005; Guterman, 2001).

It is important to emphasize that home visitation programs that strive to support families rearing children by providing tailored services within their own home settings are themselves lodged within a variety of community settings. Given this, while the vehicle of home visitation is one of the most promising strategies on the horizon to prevent physical abuse and neglect before it occurs, we must strive to deliver preventive "ingredients" with fidelity to benefit families, as well as to assure that these are best fitted to local contexts in which services are delivered.

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Home Visitation: Aspects of Practice in the UK

For over 60 years, universal children's services in the UK have included strategies based on home visitation. The original goals of the health visiting service were to improve the health of the nation's children. Wartime evacuation of children had revealed major health inequalities among children and provided a major impetus in the move towards universal

health care (Holman 1995; Parker 1995).

Health visiting remains central to child welfare in the UK and its evolution has both promoted and limited the development of home visitation on the American model. At a routine level, Health Visitors and Community Midwives make initial home visits to women during pregnancy, continuing after the birth of a

child.

Health visitors are nurses with additional training in community health, particularly relating to the families with children and they continue to monitor and advise on the well being of all children until they reach school age. They provide their services through both drop-in and appointment systems at clinic

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settings, as well as by home visits. Many mothers choose to visit clinics, in part, at least, because of the wider services they provide.

While there will always be home visits to a new born child, as children develop, home visits by health visitors tend to focus on the families in greatest need, either because of the child's health or for parenting reasons. Many health visitors now also provide, or support through training and supervision, group programmes around parenting and infant care. Some health visitors adapt these programmes for use in families where there is a pattern of regular home visiting although the concept of individual, home based delivery of parenting training is not widely applied. It is more likely to find health visitors or family support colleagues undertaking outreach work through home visits in order to build the confidence of parents to attend parenting support groups.

Health visitors will have particular responsibilities where a case is causing concern, either side of the child protection threshold. They will always form part of the core group of professionals involved in any case where maltreatment has been identified and a multi-agency plan is in place (substantiation is an approximate parallel) and may take lead responsibility in some cases. Health visitors are always a central point of referral in cases of concern about families with children under five years of age, and they, in turn, provide links into a range of other home visiting services.

In addition to health visiting, other child and family services use this approach to provide both routine monitoring and advice, and to deliver support to families who have specific needs. Many primary schools (5 to 11 years) have outreach programmes involving visits to families to help to prepare a child prior to starting nursery or school. Most localities additionally provide, either directly or through funding to NGOs and community groups, for a wide range of services to be delivered through a home visitation model.

These services usually involve spending time with families in planned, often programme led, or counselling-based work. The first of these approaches will include early literacy work, speech and language development, family learning, and play work, including toy library services. Here, a regular visitor will work with parents and children to promote the child's development through the activity concerned. Toy libraries, for example, often involve qualified nursery nurses or early years workers who introduce parents and children to developmentally appropriate toys on a monthly basis, ensuring that parents are able to support the child's early learning through play.

Many of the staff working in these services are called "support workers." Local policies have encouraged the recruitment and training of local people into all these services, reflecting diverse population groups so that the medium of communication can usually be in the parents' first language. These support staff are instrumental in referring families for other domiciliary support services where necessary. Different elements of children's services will provide support for particular needs, including children with disabilities or health problems, and parents with mental or physical health problems and psycho-social problems including substance use.

At an NGO level, a number of organisations have been established to support parents either as a primary focus or alongside other elements of family support, while all of the traditional providers of residential child care have moved into this area of work. While a number of these organisations include home visiting within their programmes, *Homestart* has home visitation as its main focus of work (Harrison 1981). Established in 1973, the scheme recruits parent volunteers to visit and support families requesting help. Their focus is on building a friendly relationship to support parents through practical help.

Homestart currently operates in over 300 communities in the UK and with military families serving abroad. It works alongside all the other children's services in the UK, including *Sure Start*, as a family support resource.

Over recent years, the potential of home visitation as a specific service, following the US definition, has been explored and implemented in some areas. The concept of home visitation in the UK is, therefore, both a specific service, applying the US approach within the different welfare context; and a technique in which a range of services look to home visitation as the model for the delivery of services in particular circumstances.

Given the universal provision of health visiting and some other family services, the introduction of a home visitation model requires either the engagement, coordination and training of existing home visiting personnel around a common programme and ethos, or that it be superimposed on an existing programme of work. The combination of a different ecology of welfare and localised implementation means that there have been a number of different outcomes and consequences of home visitation initiatives within the UK, as illustrated in the following examples.

In Glasgow, Scotland, the *Starting Well* project, which ran between 2000 and 2004, was very closely based on the *Olds* approach, seeking to combine intensive home visiting with community supports. It was adjusted from the *Olds* model precisely because of the existing health visiting services and also in order to focus on communities of need, rather than individuals. The project as a whole had mixed results. To some extent this was attributed to the difficulty of integrating this kind of service with a pre-existing pattern of domiciliary practice; and to making changes among long established professionals. However the evaluators also acknowledged the difficulty of undertaking any accurate assessment of outcomes for children within a comparatively short time frame (Mackenzie, et al. 2004).

In 1998, the UK government introduced the **Sure Start** initiative through which more than 500 localities have been able to develop programmes of work designed to 'promote the physical, intellectual, social and emotional development of children – particularly those who are disadvantaged – to make sure they are ready to thrive when they get to school' (Glass 1999). Key principles of the initiative demonstrate the ways in which the government had listened to some of the messages from the US research on home visitation. Services were required to:

- coordinate, streamline and add value to existing services in the area;
- build on existing strengths in their work with parents and grandparents;
- provide universal services within their area;
- make links with services for older children;
- be culturally appropriate and sensitive; and
- promote participation in the design and working of the local area programme.

Local and national evaluations of *Sure Start* promote and share good practice but every local programme has unique elements in the selection and means of delivery of their services. In general, programme staff are made up of locally based professionals who transfer into the programme, or work alongside it and new staff, often recruited from within the local community. A pattern has emerged in a number of programmes of developing, for some people, a transition from service user to service volunteer to paid staff member. This links closely with the aspirations for the development of a children's services workforce in the UK, where the skills acquired during parenting can be harnessed and developed through training and practice

and utilised to the benefit of the community. It also provides ecological benefits to children and families through the development of social capital within disadvantaged communities.

One of *Sure Start*'s major areas of activity has been in the development of support to families where concerns are below the threshold of statutory social services interventions. An example typical of the approach used is of systematic, planned home visits by a range of professionals during the first year of a child's life. This draws together discrete, routine family visits and adds value by developing a coherent programme of contacts with regular links to the local *Sure Start* programme, for example in the following outline:

- Pre-birth: discussion with midwife or health visitor about local *Sure Start*
- At birth: information about local *Sure Start* provided to all new mothers in the target area while in hospital
- At 6 weeks: home visit by two *Sure Start* staff, with flowers, birth congratulations card and Parenting Pack. Information is provided about programme services. Early problems identified and help offered if appropriate. Contact with other services if required; local health visitor is part of the programme.
- At 12 weeks: visit to discuss weaning and offer practical support. Discuss early play and introduce the Toy Library. Baby is given a bib, bowl and spoon with the *Sure Start* logo. Discussion of plans to return to work to alert possible childcare provision.
- At 20 weeks: visit to address home safety. Information about safety gate/fire guard loan scheme. A home safety pack is provided. The 'treasure basket' approach to play is discussed and a basket is provided with a leaflet about suitable contents.
- At 28 weeks: visit by Health Visitor focussing on dental care and links with diet. The baby is given a dental pack with baby tooth brush and feeder cup.
- At 36/40 weeks: visit by Speech and Language therapist. Child assessed for need for early speech and language intervention and provided with an action rhymes book and a placemat.
- At 12 months: visit by *Sure Start* staff encouraging use of services and providing t-shirt and birthday card.

For some families living in the area covered by the programme this will be the only contact they have with services. For

others, a visit will trigger a period of short or longer-term involvement by the project. The visiting programme described above provides a range of family support activities ranging from parent training and counselling support to training for employment opportunities (Hollows, et al. 2005).

There has remained, however, a tension between developing a broad based, universal programme with encouragement of access to all, and operating as an arm of child maltreatment services. *Sure Start* programmes were not, initially, encouraged to keep detailed records as this was the province of the formal agencies. Most programmes do, in fact, maintain case notes on families where there is social work (i.e. child protection) involvement but aspects of early concerns are generally not noted. This tension between universality and openness and appropriate professional practice remain hard to resolve (Hollows, et al. 2006 (forthcoming)).

Some *Sure Start* programmes have developed specialist home visitation activities designed to target particular outcomes in child development. *Sure Start* programmes have focused on communities experiencing high levels of need, and one of the priorities has been to achieve improvements in speech and language of children. In one project a deliberate strategy involved the recruitment of speech and language support workers to help in language screening precisely because they provided "universal home visiting to minimize stigma and...contact the majority of families" (Pickstone 2005: 155). This was an area where, in spite of the high level of language delay among children, the previous level of referrals to speech and language services was only 10% of the expected level. The programme later introduced a dialogic reading programme.

Although the primary purpose was to improve literacy, because of its base within a programme with broader outcome measures, the criteria for success recognised the holistic nature of the intervention, for example the reports of parent-child enjoyment of the shared activities (Morgan 2005).

The *Sure Start* programmes have, therefore, demonstrated ways of creating a multi professional base for delivering home-based services. Co-training has been of considerable advantage in building an integrated workforce – particularly among those who have come without any particular professional allegiance. It is important to recognise that there are few formal protocols for this kind of work and

much depends on the knowledge and creativity of individual workers, along with the quality of inter-professional relationships.

The high priority attached to staff development has meant that training has been made available to others working in the wider community and this has had a notable 'spin off' effect where the messages of *Sure Start* have spread to wider groups of professionals. These programmes are the subject of intensive local and national evaluation and one of the key messages to date is that those who make most use of the services are those with greater human capital (NESS, 2005).

A further finding was that health-led projects were most successful, perhaps because they are experienced in universal service delivery, but also because their capacity for and experience of data sharing and service integration may be stronger. These findings clearly relate to the UK context, but may indicate the importance of developing services that build on and enhance existing cultures. Again, there are concerns that the outcomes for children will not be clear for some years to come. As *Sure Start* programmes begin to merge with mainstream services it will be interesting to see the longer-term impact on workforce values and practices. Further information about *Sure Start* can be found at <http://www.surestart.gov.uk> and about the National Evaluation of *Sure Start* at <http://www.ness.bbk.ac.uk/>

A recent development in the UK is the CARE programme (Browne et al. 2006; in press), a home visiting programme that aims to assess infants' growth, development and psycho-social transitions in their first year of life. It provides an Index of Need checklist for use by professionals together with parents in the process of risk assessment. The programme takes a partnership with parents approach and sets realistic targets and goals, bearing in mind the practical workload issues that practitioners face. The programme has recently been the subject of a detailed evaluation (see reference above), which will be published later this year.

One of the features common of much of the work described here is the creation of 'paraprofessionals' who, in the early stages at least, operate rather like 'Mentor Moms' (Guterman 2001). As noted above, this not only harnesses community expertise but also generates social capital within communities. This approach to workforce development is a key strategy within current UK governmental thinking

relating to children's outcomes (see <http://www.everychildmatters.gov.uk/delivering-services/workforcereform/>) and includes common elements of training for all who work with children as well as introducing an approach to shared assessments of need at early intervention stages with children and families. At the same time it raises questions about the relationship between professional evaluations of parenting and community values about parenting if coherent messages are to be conveyed to parents.

In conclusion, the experience within the UK suggests that while we can learn considerably from home visitation models, our own developments need to be grounded in local professional cultures and histories, whether the intention is to build on those cultures or to transform them. It is clear, however, that home visitation programmes can be adapted to deliver a range of home-based services for children and their families in situations where this is more appropriate than centre-based

work. How far these services will change outcomes for children, and particularly outcomes related to maltreatment, remains to be seen as detailed evaluation and scrutiny continue in the years to come.

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Linking Home and Community with Child Protection Services: A Professional/Paraprofessional Partnership Model

Applying models of home visitation to protect children and families in difficult circumstances in developing countries, where systems of community-based social services are just now emerging, presents many challenges. Policy frameworks guided by the Convention on the Rights of the Child (CRC) outline standards for protecting and preventing abuse and neglect of children, especially the most vulnerable. Implementation of these home-based practice models requires innovative program structures and approaches to meet the human resource needs. In Romania, the pressure to deinstitutionalize children in residential care stimulated the exploration of innovative ways to provide services in homes and communities, particularly for children and families living in small, isolated rural communities. The lack of a pool of skilled staff in the newly emerging human services professions, most particularly social work, coupled with limited or non-existent transportation and communication services, were critical barriers to facilitating home-based models of child and family protection. Successful implementation of these new models of service that depend on home visitation also requires a system for monitoring services, and those children and families being served in the system.

Approaching home visitation as a

"strategy for service delivery to create change" (Whipple, et. al., 2005, p. 71), as opposed to an intervention method supports the development of models that expand program outcomes where major reforms are being implemented (Gray, et. al., 2001). Determining who is most qualified to provide a service- the professional or paraprofessional (Guterman, 1999) - becomes a critical part of the planning process when the required human, financial and technical (i.e., transportation and communication) resources are limited or non-existent. In Romania, the development of a network of community care social workers emerged as a practical strategy for meeting the government's goal of reversing the trend of institutionalization of children in need of protection. The new social policies obliged local governments to reunify children with their biological families and implement a system of family-based care (foster care, group homes, and national adoption), as well as prevent the separation of children from their families through a range of family support and family education programs. These were new words and new approaches for a government with decreasing resources and increasing levels of economic and social deprivation.

The National Government's plan was to build a *network of community social workers* in each county that linked

professionally trained social workers with paraprofessionals who lived in small communities and towns where access to professional child protection services was limited. The community social workers, recruited from local villages and towns through the local mayor's offices, were screened and interviewed jointly by local village representatives and county child protection representatives. The community social workers were employed by the local mayor's office which was responsible for paying their salaries and providing administrative support. The community social workers provided home-based case management services under the direct supervision of professionally trained social workers. The aim was to have a community care social worker in each of the villages or collection of villages (commune) who would work with a "network" of community workers that supported each other through a series of on-going training programs and supervisory meetings. The community care coordinator, a professionally trained social worker, can supervise up to ten (10) community social workers.

A. Model of Home Visitation:

In this model, the community social worker becomes the local representative for the village government who advocates for access to home-based models of prevention and protection programs.

Home visitation is one method used by the community social worker to help families access services. The model uses a *strengths-based, educational approach* to assist families with stress-reduction, job loss, housing issues, basic problem solving, household management, child care and help with specific problems such as alcoholism, domestic violence, and economic problems.

Goal: To reduce dependency on institutional care and expand citizen commitment for support and care of children at risk of maltreatment in their community.

Objectives:

- Family reintegration for children living in institutional care and foster care;
- Prevention of maltreatment and placement of children in out-of-home care;
- Recruitment of foster parents through a neighborhood/community foster care model;
- Increased permanency for children through local adoption, long-term fostering, and family reunification services;
- Monitoring of children reunited with their own families and children placed in foster and adoptive care within the rural community.

B. Home-Based Intervention Strategies:

The model is based on a professional-paraprofessional community partnership delivering case management services in remote, underserved areas. The process is as follows. The Community Care Social Worker receives a file on a child in his/her community through the mayor's office. The community care social worker locates and visits the family for an assessment using an assessment protocol developed by the child protection authorities. The assessment report is written and submitted to the child protection commission through the Community Care coordinator or directly through the mayor's office. Other referrals are received directly through the mayor's office for services to children and families in risk situations. The request could be for financial assistance for example, for food, medicine or school supplies. The community worker's interventions link families with other services when necessary, including health, employment, child care, and educational services.

The *Community Care Coordinator* has the responsibility for coordinating and supervising the activities of Community Care Social Workers. The Coordinator works with the community social worker

to do community-based assessments to identify the community resources which are required to improve home-based services. The *Community Care Social Worker's* functions include a range of home and community visitation services aimed at engaging parents in problem-solving, motivating parents, and providing information and support. They also include working with teachers and health professionals in identifying and assessing potential risk of harm cases. A community reintegration program expands the home-based services to include community-building efforts. The Community Social Worker and Coordinator partner :

Do a comprehensive needs assessment of their assigned location including strengths and weaknesses;
Identify interested citizens and citizen groups in the identification and resolution of local problems of children and families;
Identify local NGOs and government resources with potential for developing additional community resources aimed at increasing in-home services.

C. Overview of Training:

Implementation of home-based community services requires a continuing process of education and training for the coordinators, paraprofessionals, rural mayors and their staff. *Community Care Coordinators*, although professionally trained, develop competencies in supervision, team-building, community assessment and community work with particular emphasis on in-home family education and family support prevention services. *The Community Care Coordinator* facilitates and coordinates the training of the network of community care social workers that he/she supervises. The community social work training is provided at a central location and includes guest speakers from NGOs, public child protection services as well as education, health, social services, and mayors' offices. Training for community care social workers includes knowledge of child protection legislation and procedures, basic case management skills with emphasis on home-visitation, interviewing and problem identification, assessment, referral and follow-up. The national and local authorities provide the on-going training for mayors and staff from rural villages. The mayors' training includes information on legislation and strategies related to the implementation of child welfare services, budgeting, national, county and local responsibilities, and the philosophy and practice of case management including home-based

intervention models.

D. Financial and Administrative Costs:

Shared financial and administrative costs can provide incentives for local governments and communities in emerging democracies to support vulnerable children and families in their communities and homes. The shared cost structure between the village (supporting the community social worker) and the county (supporting the coordinator, including training and transportation costs) is critical, given the limited human and financial resources. Other donor groups and NGOs are more likely to support demonstration projects that build community and home-based care. The monitoring function for children in protective care must have financial and administrative support from the county and national child protection authorities.

E. Key Components for Success:

Principles of community-building, collaboration, outreach, and a strengths-based, educational approach are critical to implementing home-based, community development models of child protection and prevention. The system for managing and monitoring at the local level depends on a collaborative relationship between the local village authority, the county child protection representatives and the national authority. Outcomes can only be measured by what happens in the homes and communities of the most vulnerable citizens.

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Home Visiting as a Strategy to Prevent Child Abuse in Australia

Home visiting programs have increasingly been recognised as a key element of early intervention strategies designed to improve a broad range of health, development and well-being outcomes of children and young people in Australia over the past decade.

Preventing child maltreatment is only one of the goals being tackled in a society that has become increasingly concerned at the impact of social and family change on children's well-being. These concerns are about rising rates of child abuse and the resultant placement of children in various forms of out-of-home care, an increase in youth suicide rates, rising rates of disruptive behaviour accompanied by poor academic outcomes, violence and bullying in schools and communities, and evidence of the deterioration in some aspects of physical health status such as rising rates of overweight and obesity, Type I and II diabetes and asthma (1). Broad social changes in the last 30 years have created challenges which are beyond the adaptive capacity of some families. These changes include:

- the penetration of the electronic media into every nook and cranny of community life;
- the increasing rates of dissolution of extended and nuclear families;
- the diversity of values being voiced about what constitutes a moral life;
- the growth of individualism and materialism at the expense of a sense of community and the social isolation and decline in happiness (2) that may accompany them;
- and concerns about the loss of the human capital affecting capacity of some families with young children, particularly those challenged by the demands of single parenthood or experiencing difficulties balancing work-family commitments.

Whilst Hoghughi (3) identifies poor parenting as a common causal factor for many of these woes, Bronfenbrenner's ecological analysis (4) demands that we look beyond each issue (or symptom) to the context in which these concerns have emerged.

It is into the space marked by increasing social isolation, lack of support of parents in their parenting role and concerns about the impact of parental behaviours on children's outcomes that home visiting has been introduced as a potentially helpful strategy in Australia. But it is important that those providing home visiting are clear about which parents they are trying to help, what changes they are seeking to bring about and that they ensure there is a clear "theory of change" with supporting evidence that underpins what they are doing. Sometimes elements of evidence that have been crucial to the success of a particular program are glossed over or ignored.

For example, in the well-documented series of trials and replications by David Olds and his colleagues of pre-and postnatal home visiting by nurses over the past 20 years (5), the importance of the antenatal component (and its seamless transition into the infancy program) in achieving some of the benefits recorded over the subsequent 15 years – and the judgement of the program's worth as an economic investment – are not appreciated.

It was the antenatal component that led to a reduction in smoking (6), itself now recognised as a brain-damaging (or

nervous system damaging) risk factor increasing the likelihood of disruptive behaviour in children born to mothers who smoke nicotine.

In Australia, the possibility of introducing a nurse home visiting service that spans the period between early pregnancy and late infancy can only be realised if existing barriers between midwifery/obstetrics and child and family health nursing systems that obstruct the continuity of care are overcome. In Australia, many midwifery service systems have responsibility for "preparation for parenthood" groups which address some of the elements covered by nurses in the Nurse Family Partnership program: and some nurses engage in targeted home visiting during pregnancy and for the first 6 weeks after birth, but don't have the funding to continue beyond that. Newly established home visiting programs have struggled to bridge that divide.

In South Australia (population 1.6 million), Family Home Visiting, a component of that state's Every Chance for Every Child initiative now being rolled out across the state (7), only begins after a universal nurse post-natal home visit is undertaken to screen mothers for eligibility for services.

In an evaluation of a sustained home visiting program in western Sydney, which attempted to enrol women antenatally, only 1.5 home visits on average were achieved (8). Not surprisingly, no impact on maternal smoking rates has been found. However, there was an improvement in knowledge about the risk factors for Sudden Infant Deaths, and mothers in the intervention group felt more able to cope with their baby and life in general and access help for themselves.

Across the Tasman, in Christchurch, New Zealand, Fergusson has recently reported (9) that whilst small to moderate effect sizes were found in child outcomes, no impact on parental outcomes of a sustained post-natal home visiting program compared to non-visited controls was observed.

Second, Olds and colleagues' program was only offered to first time mothers on the grounds that the life-transition to first-time parenthood was likely to create unique opportunities for learning that would not be present in subsequent pregnancies. Whilst cost-benefit analyses have shown marginal benefits to all first-time mothers, it was amongst those who were single, teenage and disadvantaged that the greatest benefits were found (10).

This evidence points to several other conclusions:

- First, it is unlikely that someone without a health background would be able to convince mothers of the need for change in areas like smoking behaviour – hence Olds' use of nurses and their demonstrable superiority to paraprofessionals. As Guterman points out there has been little attempt to compare outcomes that use different groups of professionals. This has been evidenced by Fergusson's recent report (9) that used both social workers and nurses for sustained home visiting with no analysis so far of any differences between them.

Generally, comparisons in studies have most often been between nurses and paraprofessionals or volunteers, not between nurses and social workers. If the issues being addressed are more about family relationships and parenting, perhaps an Early Childhood Support Worker, Family Services social worker or a social worker from a non-government organisation might be just as effective, but there is no evidence at this stage to support this one way or the other.

- Second, being able to persuade women to change their behaviour requires a clear understanding of motivational

interviewing and the stages of behavioural change (11). Providing women with expert information about harms and the theory of how they might quit smoking in the absence of a supportive relationship with someone who is prepared to come alongside them in a respectful partnership that acknowledges their strengths and the challenges they face, is unlikely to be successful.

Whilst volunteer or paraprofessional home visitors may be able to provide practical or emotional support for mothers during and after pregnancy, it is improbable that even with the short-term training provided for these visitors, they would have the knowledge, skills or experience to facilitate such significant changes in health-related behaviours. Indeed, most nurses require additional training to develop these capabilities.

For example, there has been extensive training of child health nurses in New South Wales, Australia (population of nearly 7 million), as universal post-natal nurse home visiting has been rolled out as part of that state government's *Families First* early intervention strategy. As funding becomes available, the goal is to introduce sustained nurse home visiting. This training uses a previously trialled communication and engagement skills training package developed by Hilton Davis and colleagues (12) and implemented in several European countries (13). It is interesting to note that the evolution in the name of Olds and colleagues program over the past two decades is a cogent reflection of this reality – from the Prenatal and Infancy Nurse Home Visitation program (14) to the Nurse Family Partnership (5).

- Third, there are other reasons why using nurses may be preferable to other groups of professionals. Sensitive nurses are arguably less threatening than social workers who are often associated in people's minds with coercive interventions by statutory child protection and other government agencies. Women for whom sustained home visiting has been found to be successful include many whose own parenting experience has been troubled. Insecure or disorganised attachment may have been a feature of their earlier life; and they are at risk of reproducing similar patterns of attachment in their own children unless they can acquire skills in being responsive to their baby's signals and taking their lead from the baby.

It is clear that in the Nurse Family Partnership the visitor aims to model a secure responsive attachment relationship with the mother she is visiting, and use this as a scaffold that provides a supportive framework for the mother to adopt the same behavioural characteristics with her new baby. Drawing inferences from the attachment literature, the caring qualities of nurses can be seen as manifesting a capacity to "hold" mothers while they explore new ways of being (15). Cann and others (16) in some brilliant conceptual work, have recently construed the challenge of parenting as a key transition point in adult development that requires a high level of adaptability, something that sustained home visiting can clearly facilitate.

- Fourth, the Nurse Family Partnership strategy is not a panacea for families confronting all forms of vulnerability. Its effectiveness in the presence of significant domestic violence is limited (17). Its capacity to reduce re-abuse when the parents have older children who have been subjected to abuse is doubtful (18). Its effectiveness for women facing major substance-abuse problems (e.g. cocaine, amphetamines, heroin, or indeed even alcohol) has not been convincingly demonstrated. Whilst there are some reports of successful lay (19) or paraprofessional home visiting programs (20) using reformed addicts for this population, some are in the non-peer reviewed literature (21).

Logic would suggest that these women may require supplementary strategies to bring about change; the *Parents*

Under Pressure model developed by Queensland researcher Sharon Dawe & colleagues (22) may be helpful in this context. In the light of these findings, agencies need to be cautious about offering home visiting to broader populations of vulnerable families without first gathering convincing research evidence of its effectiveness.

In New South Wales, a new early intervention initiative by the statutory child protection agency (Department of Community Services (DoCS)) aims to contract with a range of other agencies to provide sustained home visiting and other early intervention strategies to families with children under eight years exhibiting a range of vulnerabilities including:

- Domestic Violence
- Parental Drug and Alcohol Misuse
- Parental Mental Health Issues
- A lack of extended family or social supports
- Parents with significant learning difficulties or intellectual disability
- Child behaviour management problems (e.g.: parent/child conflict, school problems, parenting difficulties)

Other strategies being offered include child care or preschool education and group parenting programs (23).

Furthermore, the aim of home visiting services is to provide support and skill development to parents at the earliest possible opportunity, before serious difficulties arise. The key elements of home visiting under the Early Intervention Program include:

- Providing information, practical support and advice to parents on the care of babies and children
- Modelling good parenting practice, and
- Assisting families develop supportive networks.

At the beginning of the program, the criteria for entry (80% of participants) will be children who have been mandatorily notified to the Department's Child Protection Helpline as being at risk of harm for abuse, but for whom it is deemed a child protection intervention is not warranted. Early intervention workers employed by the statutory agency will screen families for eligibility before offering them a place in the early intervention program to be offered by an external agency. Rigorous controlled evaluation of this program will be essential. This is necessary because of:

- the range of vulnerabilities being addressed
- the stage of family formation at which sustained home visiting is being offered
- the possible impact of the continuing involvement of DoCS staff as case managers on the capacity of program recipients to develop and maintain a trusting relationship with staff providing the early intervention.

Where to from here? The Economics...

Recent media and political responses to 2000 Nobel Laureate in Economics Jim Heckman's case arguing for the economic efficiency of investing in very young children during a visit to Australia in February 2006 indicated his message struck a chord with many in the community (24). Early intervention has been recently identified by the state of New South Wales (NSW) Minister for Health as one of his top five priorities for the NSW public health system. The time is right to roll out sustained home visiting to those for whom its greatest efficacy in improving maternal and child health and well-being outcomes, including child maltreatment, has been demonstrated (i.e. first-time, pregnant, single, socio-economically disadvantaged, teenage

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mothers) whilst exploring through funded research and development programs its capacity to reduce the risks of abuse and other adverse outcomes in other vulnerable groups where its potential has yet to be confirmed with the same degree of certainty.

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We are especially grateful to each of the authors for making the time in their busy lives to contribute to this Report. Home visitation is the subject of much international interest and these perspectives will serve to stimulate our thinking and future practice.

Jenny Gray, Special Report Editor
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