Home Visitation With Psychologically Vulnerable Families

Developments in the Profession and in the Professional

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Thirteen years ago, I wrote an article with the subtitle "Home Visitation With Psychologically Vulnerable Families" for *Zero To Three* (Jones, 1997). I was referring to providing home-based services to families from low socioeconomic backgrounds who were also characterized by child maltreatment, mental health difficulties, or other psychological risks. The field of home visiting was in a very different place at the time. Programs abounded but, with a few significant exceptions, they were locally designed and were not informed by research. Similarly, I was in a very different place professionally, and was seeking a career path in which I could marry the knowledge gained from more than two decades of practice with my recently acquired graduate degree. Working in the field of home visiting afforded me the opportunity to integrate these two sources of knowledge, and I embarked on a journey to enhance services to high-risk families through this service delivery mechanism.

The evidence on the value of home visiting programs has not been as compelling as those of us who had worked in these programs had hoped. The positive yet modest benefits of home visiting programs for young children and their families have been described in the articles in this issue (Boller, Strong, & Daro, this issue, p. 4; Paulsell, Boller, Hallgren, & Esposito, this issue, p. 16) and in other reviews of the research in this arena (Geeraert et al., 2004; Sweet & Appelbaum, 2004; Olds, Hill, Robinson, Song, & Little, 2000). These scholars summarize the consistent findings with respect to the impact of home visiting programs on parents and families, and they point to the limited effects of such programs on the outcomes for young children.

Although home visiting programs tend to serve the families at highest risk (Administration for Children and Families, 2006; Ammerman et al., 2006), researchers know little about how helpful these programs are for high-risk families. The available evidence is ambiguous at best. For example, for the children and families at highest risk who participated in Early Head Start center-based and mixed model programs, researchers found no benefits after 2 years of service. However, researchers found positive child and family outcomes for this population when children were approximately 5 years old, particularly for those in the home-based

Abstract

The evidence of the benefits of home visiting has revealed varying results and little is known about the elements that make programs of value to the families at highest risk for dysfunction. The variability in the effects of home visiting programs is linked to many factors, including program content and goals, the family and community context, the use of evaluation for program improvement, and how well the program is implemented. In this article, the author addresses how structural (dosage, target, and staffing) and process (relationships, theory of change, approach and activities) aspects of home visiting programs enhance their quality and, ultimately, their benefit to high-risk families and their young children.

model (Love, 2010). In an examination of the Nurse-Family Partnership program, family psychological risk (e.g., domestic violence) attenuated the effectiveness of home visiting interventions (Eckenrode et al., 2000). Further, a home visitor's inability to address these mental health issues can affect both family engagement in home-based programs and associated family and child outcomes (LeCroy & Whitaker, 2005; Tandon, Parillo, Jenkins, & Duggan, 2005).

The explanation for the varying effects of home visiting programs has been the subject of many policy, practice, and research discussions. As Gomby (2007) articulated, the benefits of home visiting programs are contingent upon program content, service alignment with program goals, the family and community context, the use of evaluation for program improvement, and how well the program is implemented. It is this last factor—implementation—that is the focus of this article. I will share the lessons I have garnered about implementing high-quality home visiting programs from my experiences in direct delivery of home visiting services, consulting with programs to enhance their service delivery, and conducting research on the implementation of these services. Specifically, I will address how structural (i.e., dosage, target, and staffing) and process (i.e., relationships, theory of change, approach and activities) aspects of home visiting programs enhance their quality and ultimately their benefit to high-risk families and their young children. (See Paulsell et al., this issue, p. 16, for further discussion of how research on dosage, content, and relationships is used to assess home visit quality across program models.)

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Home visiting programs experience major challenges with respect to engaging and retaining families.

Structural Factors

In the field of early childhood education, structural factors (e.g., group size, child–staff ratio, and staff credentials) are often linked to program quality (LoCasale-Crouch et al., 2007). Although these issues are not easily transferable to the field of home visitation, there are some factors that pertain to how home visits are structured that are relevant for a consideration of program quality, such as the dosage and target of home visits. In addition, there is a small body of evidence concerning the relation between staff background and program quality.

Dosage

In general, home visiting programs experience major challenges with respect to engaging and retaining families. This is an even more pernicious issue for those programs who target families at high psychological and socioeconomic risk. Some programs report attrition rates of as much as 50% and sharp declines in family participation after 2 years of service delivery (Raikes et al., 2006; Roggman, Boyce, Cook, & Jump, 2001). Thus, it is imperative to devise strategies to sustain these families in home visiting programs so that they receive the dosage of the service that potentially would promote positive outcomes for participant children and families.

For psychologically vulnerable families, home visiting should ideally begin during pregnancy. The initiation of services during the transition to parenthood may enhance the relationship that home visitors have with parents because they provide support during a time of extreme familial vulnerability. In addition, home visitors can potentially improve birth outcomes, which are significantly worse in high-risk families and lead to poorer outcomes throughout childhood (Crum, Hogan, Chapple, Browne, & Greene, 2005). Further, home visitors can scaffold families through the delivery and neonatal periods, which would allow them to address common challenges for high-risk families, such as postpartum depression and neurobehavioral difficulties in early infancy.

Although most home visiting programs aim to provide weekly visits, this goal is often not achieved. To ensure that home visitors have at least weekly contact with families, the planned frequency of visitation may need to be increased to two weekly visits. Moreover, more intensive intervention, such as home visits that occur twice weekly, may be necessary to engage and to promote behavioral change in high-risk families. High levels of intensity have been identified as an essential characteristic of effective prevention programs (Nation et al., 2003), and may be even more critical for home visiting programs serving high-risk families (Daro, McCurdy, Falconnier, & Stojanovic, 2003).

Reaearchers' knowledge about the appropriate length of service provision/enrollment for high-risk families is somewhat equivocal. For example, evaluations of interventions to promote attachment in high-risk families suggested that shorter interventions (i.e., less than 6 months) may be more beneficial (van IJzendoorn, Bakermans-Kranenburg, & Juffer, 2005). Similarly, home-based interventions geared to reducing behavior problems in young children (e.g., Family Check-Up) are often brief in duration. In contrast, long-term interventions, such as Early Head Start or the Nurse-Family Partnership, lead to strong outcomes after families have received 2 years of service (Love et al., 2005; Olds et al., 2004). It may be that home-based interventions with a very specific goal and expected outcome (e.g., change in attachment security or reduction of behavior problem) may be beneficial with brief service provision, whereas programs with a more comprehensive goal (e.g., to improve child and parent development across domains) may need to be longer in duration.

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Most home visiting programs target the parents as the mechanism by which family development will occur.

Target

Home visiting programs serve a vast array of families. The majority of these programs are designed for families with young children. Programs may address specific family structural characteristics (e.g., adolescent parents, foster parents, grandparents) or child or family risk factors (e.g., low birthweight children, families from low socioeconomic backgrounds). The type of families targeted by home-based programs is clearly connected to the program's goals. For example, a goal of home-based programs serving low-income adolescent parents is often to facilitate the parents' return to school.

Programs may also aim to affect a specific outcome, which is related to what member of the family is the target of the intervention. Sweet and Appelbaum (2004) identified two targets of home visiting programs—child development and support for the parent or family. The outcomes of these programs are in the expected direction and context, with child development programs benefiting children and family support programs benefiting parents. In addition to child- and parent-specific programs, some programs target the parent–child dyad. Often, these are infant mental health programs or programs that capitalize on parent–child interactions to improve parenting behaviors or reduce child behavior problems.

Programs that target the child often have a goal of improved child health, child development, or school readiness. To be effective, such programs must have an explicit child development focus within the home visit (Raikes et al., 2006; Roggman et al., 2001). This does not suggest that home visitors should interact exclusively with the child (e.g., providing speech or occupational therapy to the child while the parent is engaged in other activities in the home). In fact, such an approach may be detrimental to child outcomes. To achieve optimal child outcomes, home visitors should scaffold parents to interact with the child in a manner that addresses the developmental areas of concern. Moreover, it may be beneficial for programs to be connected to a more intensive child-directed service, such as center-based child care or early intervention.

Most home visiting programs target the parents as the mechanism by which family development will occur. Consistent with this focus, the benefits of home visiting programs for parents are greater than they are for children in the family (Gomby, 2007; Sweet & Appelbaum, 2004). Positive outcomes for parents are particularly robust in programs which move beyond a focus on parental support to a focus on parenting skill. Although researchers know that home-based programs result in positive outcomes for mothers, they know very little about home visiting effects on fathers, siblings, and other relatives of target children. Given the relation between the functioning of these other family members, particularly fathers, and child outcomes, programs should be devised which target parents and caregivers beyond mothers.

Interventions grounded in the mental health field can be delivered in the home, and as such promote positive outcomes for high-risk parents and children. For example, Fisher and Stoolmiller (2008) reported reductions in stress for foster mothers participating in a home-based intervention to improve their parenting skills. Similarly, Beeber et al. (2007) integrated a cognitive–behavioral approach to reducing maternal depression in their home visiting model. Both of these programs delivered a very detailed intervention that was designed to improve a specific parent characteristic or skill.

It is increasingly common for interventions for young children and their families to target the dyad and work toward enhancing parent–child interaction. There is emerging evidence that programs that target the dyad lead to improved parent, child, and dyadic outcomes. For example, parent–child interaction therapy delivered in the home to families of young children resulted in reductions in child maltreatment (Chaffin et al., 2004). Similarly, the delivery of parent–infant psychotherapy, an infant mental health approach which promotes positive parent–child interaction, also led to reduced child maltreatment (Cicchetti, Rogosch, & Toth, 2006). In addition, distinct iterations of programs to promote positive parenting and management of child behavior, which have used parents' interactions with the children as the focus on the intervention, have resulted in improved parenting skills (Dishion et al., 2008).

Staffing

The role of staff in the delivery of high-quality home visiting programs is obviously critical. Which staff characteristics are linked to quality is not as transparent. For example, there is ambiguity in the field as to whether home visitors need to have college degrees to deliver high-quality services. In a direct examination of this question, Olds and colleagues (Korfmacher, O'Brien, Hiatt, & Olds, 1999; Olds et al., 2004; Olds et al., 2002) found that although paraprofessional-delivered services do have a positive impact on families, these effects are not of the same magnitude and type as those resulting from professional home visitation (i.e., with nurses). The smaller impact of the paraprofessional intervention has been attributed to the differences in the content covered by the two groups, specifically the tendency of paraprofessionals to focus on environmental health and concrete service issues such as food and shelter (Hiatt, Sampson, & Baird, 1997). Although no other study has explicitly compared types of home visitors, many programs using paraprofessional home visitors have documented benefits for families (Black, Dubowitz, & Starr, 2007; Diaz, Oshana, & Harding, 2004; Wagner & Clayton, 1999).

Notably, there has been no research about the benefit to families of that compares paraprofessionals with other types of professional home visitors, such as social workers or child development specialists.

Staff competence, particularly in regard to addressing the issues that high-risk families face (e.g., mental illness, substance use, and family violence), also influences program quality. For example, in a qualitative examination of Early Head Start staff, home visitors reported being uncomfortable and ill-prepared in identifying and addressing mental health issues (Jones Harden, Denmark, & Saul, 2010). On the basis of their study of home visitors in the Healthy Families program, LeCroy and Whitaker (2005) identified five home visitor characteristics that were linked to competence in working with high-risk families: having clinical skill, addressing family difficulties, addressing parenting difficulties, resolving personal difficulties, and having experience.

In an examination of Healthy Families home visiting programs, more than half of participating mothers were in need of mental health, domestic violence, or substance abuse services, yet only about a quarter of them received those services (Tandon et al., 2005). This service gap was attributed to the lack of training and support home visitors received with respect to assessing, communicating, and collaborating in regard to family risk. In a subsequent qualitative study, home visitors reported that they had knowledge about family risks, but they needed more training and supervision regarding how to intervene with families around issues such as substance abuse, mental illness, and domestic violence (Tandon, Mercer, Saylor, & Duggan, 2008).

The psychological characteristics of home visitors also affect their performance. For example, home visitors in one Early Head Start program had physical and mental health difficulties that affected their capacity to work with families (Jones Harden et al., 2010). Home visitors may also experience the secondary trauma and burn-out that is common among many human service providers, particularly those serving high-risk families (Jones Harden et al., 2010). Gill and colleagues (Gill, Greenberg, Moon, & Margraf, 2007) documented high levels of emotional exhaustion and depression in home visiting staff. To address home visitors' limitations in intervening with high-risk families and their own vulnerability, a higher level of supervision and support is necessary (Scott Heller & Gilkerson, 2009; Saul & Jones Harden, 2009). Reflective supervision, with the consistency and continuity of support it offers, would provide home visitors with the opportunity to improve their skills in a neutral, reflective context. Supervision also should entail "in-vivo" observation and feedback of home visitors' work. Supervisors can accompany staff on home visits, or observe and provide feedback through reviewing a videotape of a home visit.

Unless the home visitor supervisor is an expert in intervening with psychologically at-risk families, consultation from a mental health professional is critical. The strategies for incorporating mental health consultation in early childhood programs are applicable to home visiting programs (Donahue, Falk, & Provet, 2000; Jones Harden & Lythcott, 2005; Perry, Kaufmann, & Knitzer, 2007). Mental health consultants can participate in reflective supervision sessions and accompany staff on home visits. They can also participate in case conferences (i.e., explicit discussions about how to intervene with specific families) and provide training on select topics (e.g., postpartum depression). In addition, they can observe children, families, and staff and can also deliver mental health services in the context of the home visit.

As part of their supervision and consultation experiences, staff who work with vulnerable families may require support to specifically address the emotional exhaustion that often accompanies this work (Jones Harden, 2009). Home visitors could keep a journal about the experience of service provision and could formally and regularly share their feelings and experiences with peers who are also home visitors. Programs can provide home visitors with mental wellness activities, such as meditation and exercise sessions and mental health days/fairs. Home visitors should also be trained and scaffolded to manage loss, to prioritize their activities (so as not to become overwhelmed with the enormity of families' needs), and to improve their coping strategies.

Home visitor well-being and competence are also affected by the health of the home visiting program. In other organizations, elevated job stress has been linked to excessive work demands and worker perception of a lack of organizational support (Carayon & Zijlstra, 1999; Jones, Flynn, & Kelloway, 1995; Sauter & Murphy, 1995). In a qualitative study of staff in a specific Early Head Start program, home visitors reported having excessive work responsibilities without sufficient structural and emotional support to meet the demands of their jobs (Jones Harden, et al., 2010). Such experiences have the potential to adversely affect the well-being and performance of the home visitors in early childhood intervention programs.

Process Factors

There are myriad process factors that have been linked to high-quality early childhood intervention, including teacher–child relationships, the content of the intervention, and the mechanisms by which the intervention is provided (Pianta

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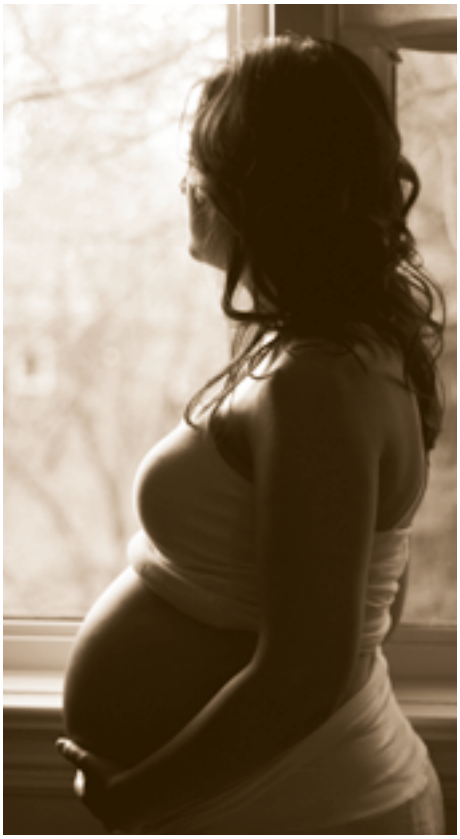
The majority of home visiting programs are designed for families with young children.



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For psychologically vulnerable families, home visiting should ideally begin during pregnancy.

et al., 2005). Parallel processes in home visiting programs include the staff–family relationship, the program's theory of change, and the approach, content, and activities that characterize the program.

Staff–Family Relationship

The critical nature of the relationship between individuals and their service providers is perceived as key to behavioral change. Relationship-based approaches have gained some traction in the early childhood field, such as the use of primary caregivers in center-based programs (Owen, Klauski, & Mata-Otero, 2008). In relationship-based home visiting programs, relationships—among staff and between staff and families—are based on trust, empathy, and responsiveness (Saul & Jones Harden, 2009).

Positive relationships between families and program staff are essential for the quality of home visiting services. For example, family engagement with home visiting programs is related to the home visitors' capacity to develop a positive helping relationship with families (Korfmacher, Green, Spellman, & Thornburg, 2007), and to home visitor conscientiousness and persistence with families (Brookes, Summers, Thornburg, Ispa & Lane, 2006). Family engagement and relationships with home visitors are promoted by the high levels of empathy on the part of home-based service providers, particularly paraprofessionals, with high-risk families (Hiatt et al., 1997; Jones Harden et al., 2010; Wasik & Roberts, 1994). Home visitors' nonjudgmental, optimistic attitude about parents is more likely to lead to increased family participation and positive family outcomes (Beeber et al., 2007). Thus, home visitors who display empathy, acceptance, and other positive responses to families can provide high-risk families with positive experiences with service providers that they may have not experienced, and that are more likely to lead to positive outcomes.

The cultural match between families and home visitors may also have some bearing on their relationships, particularly for immigrant families (Daro et al., 2003; Suleiman, 2003). Whereas there is some literature showing that these families use and potentially benefit more from home-based programs when compared to other demographic groups (Administration for Children and Families, 2002, 2006), the language barriers must be addressed. Some home-based programs have resolved this issue by hiring bilingual staff, but many do not have the financial or staff resources to linguistically match all families with appropriate home visitors. Other programs rely on interpreters to support interventionists to deliver services. The evidence on the use of interpreters in intervention programs is mixed. Some scholars and practitioners underscore challenges related to interpreter subjectivity and the lack of connectedness between the clinician and family (Jackson, Zatzick, & Harris, 2008; Suleiman, 2003). Others have found that interpreters do not adversely affect program effectiveness, and allow previously inaccessible interventions to be delivered to broader ranges of families (Beeber et al., 2007). In whatever manner programs address this issue, it is essential that home visitors be able to communicate with their families, a process which is fundamental to the success of any human service delivery strategy, particularly those aimed at high-risk families.

Thus, researchers know that relationships between families and service providers are powerful influencers of participants' engagement in home visiting programs as well as of their outcomes. These relationships may be particularly important for high-risk families, who may have had negative encounters with service providers in the past. Building relationships with such families may require more patience, creativity, and persistence than with other families (e.g., returning to the home multiple and varying times to catch the family at home). Providing concrete reminders that they have been "held in the mind" of home visiting staff may be necessary, such as when staff brings tangible resources to the home visiting session (e.g., diapers). Often after these intensive attempts at initial engagement, the relationships can be sustained over time. It is important to note that because of the intensity of these relationships, home visitors may need assistance in maintaining their professional boundaries and nonjudgmental attitudes toward families (Musick & Stott, 2000).

Theory of Change

All intervention programs must have a clearly articulated theory of change which identifies the mechanisms by which home visiting staff achieve programmatic goals. For example, enhancing parent–child interaction is a key strategy for home visitors to use to achieve positive child outcomes (Barnard, 1998; Jones Harden, 2002; Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007). However, it may be challenging for home visitors to implement activities which promote parent–child interaction, particularly when families are in crisis (Jones Harden et al., 2010; Peterson et al., 2007; Roggman et al., 2001). Hebbeler and Gerlach-Downie (2002) found that home visitors' perceptions and practices were to some extent in direct contradiction to the child development goals of the programs in which they were employed. Specifically, the home visitors emphasized their roles as providers of family support more than as providers of parenting information; they did not address the connection between child development information and parenting behaviors; and they did not directly facilitate parent–child interaction.

To reach program goals, home visitors must implement activities in accordance with the programs' theory of change, despite the challenges they encounter. This is no easy task when services need to be aligned with families' needs, matched to the developmental level of the child and family, and linked directly to the goals and desired outcomes of the program. Formal collaborations with other service providers are often required to meet the multiple needs of high-risk families. For example, child-directed services may be essential for child outcomes (e.g., high quality child care) and may compensate in some way for the compromised contexts in which these children are reared. In addition, linkages to therapeutic interventions for parents, such as substance abuse and mental health treatment, are critical for promoting the development of high-risk parents.

Approaches and Activities

The approaches to service delivery undertaken by home visiting programs are as variable as their goals and outcomes. Some programs are didactic and designed

to influence families through directive, educational intervention strategies. Others have a more supportive approach, in which home visitors use empathy and the provision of concrete resources to intervene with families. Recently, evaluations of interventions which use an active, experiential approach that focuses explicitly on parent skill-building and behavior change have suggested that such programs have the potential to benefit high-risk families more than do generic parent education programs (Barth, 2009). These programs have purposeful, planned content and activities which are linked to the program's theory of change and are designed to modify specific behaviors on the part of a targeted group of parents or children.

In the home visiting arena, programs that use strategies that are explicitly articulated and linked to the theory of change have been found to be beneficial. For example, home visitors in the Nurse-Family Partnership program use specific strategies that are devised to change maternal and child health behaviors and to promote self-efficacy in mothers of young infants (Olds et al., 2004). The Family Check-Up program focuses home visits on helping parents practice positive strategies for the reduction of behavior problems in young children (Dishion et al., 2008). Home visitors in the Parent Child Interaction Therapy program (Chaffin et al., 2004) coach parents to respond to their young children more appropriately while they are interacting with them. In Project SafeCare (Gershater-Molko, Lutzker, & Wesch, 2002), home visitors scaffold parents in their interactions with their young children and also intervene directly with parenting behaviors relative to child safety, health, and bonding.

Although some flexibility and individualization are allowed in these programs, the delivery of specifically articulated strategies and approaches is paramount. Often, the content and activities are delineated in formal curricula or intervention manuals in order to increase the likelihood that the services are delivered with consistency and fidelity. Supervision and observation of home visitors can also be used to ensure that they are delivering the home-based interventions with fidelity. This should be accompanied by monitoring of how well the intervention is delivered, such as home visitor logs and family questionnaires. Such strategies are particularly important for home visits with high-risk families, which can easily be consumed by addressing the myriad crises that they encounter at the expense of the intervention.

Recommendations and Conclusions

The primary lesson that I have learned over the last decade is that home visiting during the early childhood years is an effective service delivery mechanism, *when implemented in a quality manner.* Arguably, it is even more important to attend to the quality implementation of home-based interventions when they are delivered to psychologically vulnerable families. These services must have an explicit goal, a specific target population, and an associated theory of change. In particular, parent–child interaction intervention should be a key component of home-based services that are designed to promote child and parent development. Home-based interventions that focus on enhancing skills and behaviors among parents show particular promise.

Ensuring that families receive an appropriate dosage of home visits is also critical, which may be achieved through increasing the number of home visit attempts that are made by programs, increasing the frequency of home visits for high-risk populations, or both. The development of sustained relationships with families is paramount, with a particular emphasis on providing the affective and concrete supports that may increase the engagement of vulnerable populations. Matching home visitors and families who share a similar background, particularly in regard to language, is another implementation strategy that may improve program quality and family engagement.

An essential component of quality home visiting programs is staff who are trained, monitored, and supported to intervene with the particular risk factors that psychologically vulnerable families present. Because home visitors in most programs address the needs of the "whole" child and family, their knowledge and skill regarding child and parent physical and mental health must be enhanced. Further, each home visitor should have regular access to supportive supervision and mental health consultation through which they can reflect upon personal issues that affect their work, improve their knowledge and skill in working with high-risk families, and address any organizational or other barriers to their effectiveness. This concrete and instrumental support for working with high-risk families, as well as ongoing, active monitoring and guidance of home visitors in the direct context of their visits to families, can facilitate their delivery of high quality, intended services.

Gomby (2007) asserted that "the aspects of (home visiting) program implementation that are especially important are those such as staffing and service intensity that facilitate the creation of a trusting relationship and/or delivery of program content" (p. 794). Through my now decades of involvement in home-based work with families, I have learned the value of attending carefully to the what, who, and how of delivering services to children and families in the home. In other words, home visiting programs cannot positively influence the developmental trajectories of children and families at psychological and socioeconomic risk unless their services are based on explicit theory, are designed to convey specific content, are delivered by well-trained and supported staff, and are comprised of goal-directed strategies that focus on behavioral change.

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