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SPECIAL ISSUE HOME VISITATION AND PREVENTING CHILD ABUSE

—by Deborah Daro
Guest Editor

The limited efficacy of treatment services for abused parents has long suggested that significant reductions in the rate of maltreatment can occur only through expanded prevention efforts (Cohn and Daro, 1988). Certainly no one has ever suggested that we diminish our efforts to provide high quality therapeutic services to all identified victims of maltreatment and their families. However, the sheer number of reports, over 2.9 million in 1992, is resulting in investigations being delayed and those families accepted for treatment not being properly monitored. Last year, only 60% of the families where abuse was confirmed received *any kind* of assistance (McCurdy and Daro, 1993). Even fewer receive what we would consider high quality interventions.

For many, the most promising approach to reducing the number of abuse and neglect cases is found in intervening *before* maltreatment occurs. Over the past ten years, a wide range of parenting education and support services has emerged providing new parents with an impressive array of assistance in meeting the physical and emotional needs of their children. Many of these models, including group-based educational programs, family resource centers, and ongoing family support groups, have produced notable changes in the mother's understanding of infant and child development, her capacity to access necessary services for herself and her children, and improved capacity to meet her child's needs (Daro, 1993; Kagan, Powell, Weissbourd and Zigler, 1987).

One of the most prolific and popular prevention strategies has been home visitation, particularly those programs targeting new parents. The literature is replete with examples of home visitation services provided under various auspices and designed within various theoretical frameworks (Daro, 1993; U.S. Government Accounting Office, 1990). While substantial debate continues over the most appropriate length of service, service content, and service provider, home visitation has been endorsed by the U.S. Advisory Board on Child Abuse and Neglect and the U.S. Government Accounting Office, among others, as the single most critical element in a comprehensive approach to preventing child maltreatment (U.S. Advisory Board, 1991; U.S. Government Accounting Office, 1992).

Achieving broad-based agreement on the desirability of a given social service intervention is both a blessing and a curse. Certainly the identification of a promising new initiative infuses the field

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NEWS 1993 an Excellent Year

—by Theresa Reid

What a year! APSAC began 1993 with a membership of 2,600, a staff of two and a half, and a gleam in the eye for a conference. As we near the close of 1993, APSAC's membership has grown to 4,000, its staff to five full-time and two part-time employees, and its conference to a major success and annual event. What will APSAC bring to the world—and the world to APSAC—in the next few years? APSAC's Board has articulated several ambitious plans for 1994 and beyond.

• **APSAC's Second National Colloquium.** In the next several weeks you will receive a brochure describing APSAC's Second National Colloquium, to be held in Cambridge, Massachusetts, May 4-7, 1994. As with its First, with its Second National Colloquium APSAC aims to provide the most advanced professional training in the field of child maltreatment. Designed with the aid of more than 40 experts volunteering generously as consultants, APSAC's Second National Colloquium offers seminars for professionals in mental health, medicine, law, law enforcement, child protective services, and allied fields. Seminars are designed specifically to address the ravages of physical abuse, sexual abuse, psychological abuse, and neglect.

In 1994, APSAC is broadening its program focus to include greater attention to ways in which communities and existing social systems can be mobilized to help resolve the problems of child abuse and neglect. While much of the program continues to focus on advanced skills required by professionals in their work with individual clients and families, several seminars focus on larger systems. APSAC's goal with this focus is to deepen participants' awareness of the global social factors that affect clients' lives before, during, and after professional intervention. We hope that participants will depart with the knowledge and skills to begin to adapt interventions to reflect social factors which may be far beyond the direct control of their clients.

Among the global social factors affecting a large proportion of participants' clients is America's response to racial and ethnic diversity. Given the

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LETTERS TO THE EDITOR

Dear Editor,

Richard Gelles fails to make his case for his opinion on the "doctrine of family reunification," published in *The APSAC Advisor*'s summer issue ("The Doctrine of Family Reunification: Child Protection or Risk?" V.6, n.2, 1993).

Gelles cites as one of the unfounded assumptions underlying family reunification that children do better with their parents. This assumption is questioned because "there is little rigorous scientific empirical support for the notion that children do better when raised by their birth parents." This may be true, but until randomly selected families begin to offer their children for controlled lifelong experiments, we will probably continue to lack the rigorous empirical scientific support called for. Is there evidence that children do better when they are *not* raised by their birth parents?

Gelles cites as another assumption that "children are harmed in foster placements," an assumption Gelles dismisses as "merely anecdotes and stories." However, the National Child Abuse and Neglect Data System reported 2,130 foster parent perpetrators in 1990 (revised) and 2,597 foster parent perpetrators in 1991. While these numbers reflect a very small proportion of the overall incidence of child maltreatment, they do seem more than anecdotal. And the considerable literature on traumatic effects of separation seem more than mere "stories."

Although Gelles presents only a weak case for family reunification, he acknowledges that it is probably appropriate for "between two-thirds and seventy percent of all the cases of abuse and neglect." Still, he calls for family reunification to be abandoned, but cites no evidence that the child-centered alternative would apply to any more, or even as many situations.

Gelles calls for some common-sense reforms: matching intervention to the needs of children, speedier court decisions, better risk assessment for serious cases, and educating the field on the importance of attachment between the ages of four and ten. But why must family reunification be abandoned to achieve any of these reforms?

Gelles's opinion needlessly divides our field into family reunification *or* child-centered practice. Can we not be child-centered *and* strive to preserve families? I wish Gelles would devote his considerable energies to researching how to make risk assessment predictive.

Sincerely,

David Cory, MSSW
Texas Department of Protective and Regulatory Services

Richard Gelles' response.

Dear Editor,

David Cory makes some good points in his response to my article, "The Doctrine of Family Reunification: Child Protection or Risk?" (*The APSAC Advisor*, Vol. 6, No. 2, 1993). However, he seems to miss the main point of my article. My main point in all my criticisms of the doctrine of family reunification is that the flaw of family preservation is not that the programs are ineffective, the flaw is that family preservation/family reunification *is not a generic panacea for child maltreatment and thus, should not be embraced as the single, generic solution to the problem of child maltreatment.*

Currently, on a national level and in many states and localities, family preservation/family reunification is *the* intervention or policy of choice. I am not the one who is dividing the field into family reunification vs. child-centered practice. This division is the result of the persistent and skilled marketing efforts of foundations, agency directors, and others who want family preservation to be the sole form of intervention for *all* cases of child maltreatment.

I do not advocate the abandonment of family reunification, I advocate the abandonment of family reunification as *the* generic intervention.

Mr. Cory asks why I do not turn my considerable energies to researching how to make risk assessment predictive. I have spent the better part of 20 years doing exactly that. However, there is precious little foundation or federal support for psychometrically sound research on risk assessment. Of the $1 billion in federal funds now being made available for family preservation, not one cent is to be invested in rigorous research on risk reassessment or even on assessing the effectiveness of family preservation programs. The reason for this is that family preservation "works" and thus, more research is believed to be unnecessary.

Mr. Cory points out that there is no research that children do better with their parents nor is there research that shows that children *do not* do better with their birth parents. I accept the truth of this statement. Given that neither assumption can, or probably will, be proven with scientific evidence, I would argue that the most prudent course of action is not to use the claim that children do better with their birth parents to support social policy. Since we cannot reject the null hypothesis (that is, that being raised by birth parents or non-birth parents makes little or no difference in child outcome), the proper course of action is to assume that there is indeed no major difference.

The case for children in foster families is a bit different. Although foster parents are reported for child maltreatment, the rate of reporting and the total number of reports is relatively low. My own examination of our Second National Family Violence Survey data reveals that foster parents are no more likely to physically abuse their children than are birth parents. The negative outcomes from foster placement probably have more to do with removal of children from their homes and the inconsistent policies of state agencies than with the actual performance of foster parents.

We can be child centered and use family preservation policies, but the chief goal must be child outcome. Those who advocate for family preservation rarely invoke child outcome as their main or core goal.

Sincerely,

Richard J. Gelles, PhD
Professor, Department of Sociology and Anthropology
University of Rhode Island

Letters to the Editor reflect the personal views of individual respondents and do not necessarily reflect the views of employers or of APSAC.

REVIEW OF RESEARCH on Home Visiting for Pregnant Women and Parents of Young Children

—by David Olds and Harriet Kitzman

This article has been drawn from an extensive literature review prepared by the authors for the Packard Foundation's The Future of Children, *Winter 1993.*

Home visiting to pregnant women and parents of young children is a strategy that has caught the imagination of policy and program planners concerned with the improvement of maternal and child health (National Commission to Prevent Infant Mortality, 1988, 1989; Olds, 1992; Public Health Service, 1989; U.S. Advisory Board on Child Abuse and Neglect, 1990, 1991; United States General Accounting Office, 1990). The National Commission to Prevent Infant Mortality has included home visiting as a central component of its strategy to improve the outcomes of pregnancy and reduce the rates of infant morbidity and mortality in the United States (National Commission to Prevent Infant Mortality, 1988; 1989). The Expert Panel on the Content of Prenatal Care has recommended that home visiting be included as part of an augmented set of services for low-income, at-risk women (Public Health Service, 1989). The U.S. Advisory Board on Child Abuse and Neglect has declared child maltreatment a national emergency, has identified home visiting as the most promising method of addressing this pernicious problem, and has called for the development of a national home visiting program for all new parents (Public Health Service, 1989; U.S. Advisory Board on Child Abuse and Neglect, 1991). In 1991 the General Accounting Office had issued a report encouraging Congress to increase its level of support for home visiting services through an expansion of Title XIX of the Social Security Act (United States General Accounting Office, 1990). In the meantime, many states have begun to increase their support of home visiting services through a variety of Medicaid service categories (United States General Accounting Office, 1990). To what extent does the evidence on the effectiveness of home visiting support this surge of interest?

In this article, we review randomized trials of home-visiting programs that were aimed at reducing the rates of preterm delivery and low birthweight, and promoting the health and development of parents and young children. The review is divided into four major sections: prenatal programs aimed at preventing preterm delivery and low birthweight; programs designed to improve the health and development of low-birthweight or preterm infants and their parents; programs established to enhance the well-being of children from families at social or economic risk; and those few studies that evaluated program costs and savings due to averted use of other services and increases in government tax revenues.

This review focuses on randomized trials because these studies, when adequately designed and conducted, produce substantially better estimates of program effects than do estimates derived from other types of research. By comparing the home-visited and control groups on the outcome of interest at the end of the study, the investigator can determine with a specified degree of statistical confidence the extent to which the differences observed between program and control groups are due to chance.

Prenatal Programs, Preterm Delivery, and Low Birthweight

None of the seven randomized trials of prenatal programs established to reduce the rates of preterm delivery and low birthweight found that home visiting reduced overall rates of preterm delivery or low birthweight (Oakley, Rajan, & Grant, 1990; Villar et al., 1992; Bryce, Stanley, & Garner, 1991; Dawson et al., 1989; Spencer, Thomas, & Morris, 1989; Graham et al., 1992; Olds, Henderson, Tatelbaum, et al., 1986). One study carried out in Elmira, New York, however, produced a significant reduction in the rates of preterm delivery among women who smoked cigarettes and an increase in birthweight among very young adolescents, two groups at increased risk for preterm delivery and low birthweight (Olds, Henderson, Tatelbaum, et al., 1986).

While none of the seven programs produced overall effects on the rates of preterm delivery and low birthweight, it should be emphasized that most of the trials failed to include program elements that are likely to improve pregnancy outcomes. To be effective, visitors must have detailed plans for not only teaching women about the risks and values of certain behaviors, but must be competent to help them devise individualized strategies for behavioral change. It is in these areas that standard prenatal care often fails, and home-visiting programs have the potential to make a difference. A corollary to this is that the positive effects of prenatal programs are likely to be focused on women with identifiable risks for preterm delivery or low birthweight. The failure of most trials carried out to date is, in our view, largely a reflection of inadequate causal models underlying the program design and a failure to concentrate the services on women with specific risks that are amenable to change.

With respect to improvement in maternal health outcomes, only two of the seven studies examined this issue and only one acheived success. Nurse-visited women in the Elmira trial reduced the number of cigarettes smoked and improved the quality of their diets over the course of pregnancy in contrast to women assigned to a comparison group (Olds, Henderson, Tatelbaum, et al., 1986). Comparable gains were not noted in a Latin American home visitation trial (Villar et al., 1992). The paucity of research on the improvement of health-related behaviors during pregnancy is lamentable because evidence suggests that at least certain types

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Home Visitation and Preventing

—Deborah Daro

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with new energy and new hope. It can mobilize new resources and invigorate those who have felt paralyzed by a lack of progress and significant change. In a period of increased reporting and more negative outcomes for children, practitioners and policy makers alike are seeking a new way to approach a seemingly intractable problem.

On the other hand, a new idea may result in an untimely and inappropriate retreat from existing programs, many of which have not been given the time or resources to mature fully. Different may be seen as better simply because it's new. Rather than adding the new idea to the existing pool of service resources, the new idea can become a replacement for current efforts. In the long run, such changes do not produce greater resources for children and, consequently, bring us no closer to reducing the scope of maltreatment in this country.

While not all home visitation programs are successful, those which are intensive, comprehensive, well integrated into other community services, and flexible in responding to a family's unique needs produce the most consistent and most impressive outcomes.

While such pendulum swings may be impossible to avoid, the dimensions can be narrowed through a careful and reasoned discussion about the merits of a given intervention and its anticipated impact on existing systems. This special issue of *The APSAC Advisor* has been designed to provide such a discussion of home visitation. This issue reviews the critical research findings with respect to home visitation (Olds and Kitzman), the policy context shaping current efforts in this area (Melton), the national and international programmatic experiences with this strategy (Breakey and Pratt, Mitchel and Donnelly, and Browne) and editorial comment on home visitation's strengths and limitations (Berliner).

Research findings have been particularly encouraging for home visitation programs. As summarized by David Olds, randomized trials of various home visitation strategies suggest that such services are successful in significantly reducing reported cases of child abuse, limiting the use of physical punishment, and enhancing the capacity of parents to care adequately for their children. While not all home visitation programs are successful, those which are intensive, comprehensive, well integrated into other community services, and flexible in responding to a family's unique needs produce the most consistent and most impressive outcomes.

Drawing upon this research base, the U.S. Advisory Board on Child Abuse and Neglect recommended that the nation move toward developing a voluntary, universal system of home visitation. Gary Melton, who served on the Board throughout its deliberations on this issue, outlines the broader context and vision which shaped this decision.

Gail Breakey and Betsy Pratt's article offers one state's experience in moving from a limited demonstration effort to a state-wide system. Under Hawaii's Healthy Start model, those new parents identified as being at risk for maltreatment are offered intensive home visitation services by a trained paraprofessional. As Breakey and Pratt note, establishing a statewide system requires a strong commitment to quality on the part of both administrators and staff.

While the U.S. Advisory Board identified the goal of universal home visitation, the National Committee to Prevent Child Abuse, in partnership with Ronald McDonald Children's Charities, launched a national initiative in 1992 to make this goal a reality. "Healthy Families America," as summarized in the article by Leslie Mitchel and Anne Cohn Donnelly, seeks to provide all new parents, particularly those at greatest risk for abuse, with access to intensive and comprehensive home visitation.

The concept of such a system may be new in the United States but is well established in many Western European countries. Kevin Browne reviews the experiences of health(home) visiting in Britain as it is conducted by the UK National Health System as well as various voluntary associations throughout the country. As noted by others, he reiterates the importance of developing a broader network of support services, such that the home visitor has a wide array of specific resources to offer families.

Lest we believe home visitation will "cure" child abuse, Lucy Berliner's essay offers a warning to those who would promote home visitation as panacea. The message all prevention planners, indeed all program planners, should glean from Berliner's discussion is the need to operate from a strong empirical base and promise no more than the data suggest you can achieve.

Reducing overall levels of maltreatment will be achieved not by promoting a single prevention strategy but rather by developing an integrated system in which each service is but one part of a coordinated service continuum. If such collaboration is to occur, those working with maltreating families and those seeking to avoid initial abuse need to understand each other's perspectives and initiatives. It is hoped that this issue of *The APSAC Advisor* has offered a platform for understanding the emerging interest in home visitation.

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INFANT HOME VISITATION:

One Step Toward Creation of Caring Communities

—by Gary B. Melton

In 1990, the U.S. Advisory Board on Child Abuse and Neglect (ABCAN) released its first report. With great media attention, ABCAN proclaimed a national emergency, because the problem of child maltreatment and the failure of the system charged with protecting children were of such enormous magnitude and such grave consequences. Although ABCAN issued 31 recommendations at that time, it described these recommmendations as merely "critical first steps" designed to respond to the national emergency, and it promised in the subsequent years to develop a new national strategy to replace a fundamentally flawed system.

The drafters of the report envisioned a new child-centered, neighborhood-based system. It would be based in part on the premise that "the thrust of a child-centered child protection system must be to move toward preventing child abuse and neglect before it happens" (U.S. Advisory Board on Child Abuse and Neglect, 1990, 81). ABCAN asserted further that such a function has been woefully underemphasized:

> The most serious shortcoming of the nation's system of intervention on behalf of children is that it depends upon a reporting and response process that has punitive connotations, and requires massive resources dedicated to the investigation of allegations. State and county child welfare programs have not been designed to get immediate help to families based on voluntary requests for assistance. As a result it has become far easier to pick up the telephone to report one's neighbor for child abuse than it is for that neighbor to request and receive help before the abuse happens. If the nation ultimately is to reduce the dollars and personnel needed for investigating reports, more resources must be allocated to establishing voluntary, non-punitive access to help (U.S. Advisory Board on Child Abuse and Neglect, 1990, 80).

The most serious shortcoming of the nation's system of intervention on behalf of children is that it depends upon a reporting and response process that has punitive connotations, and requires massive resources dedicated to the investigation of allegations.

ABCAN urged the federal Cabinet, especially the Secretary of Health and Human Services, and the nation's governors to ensure a "substantial" increase in efforts to prevent child maltreatment. Such efforts, ABCAN said, should include, "at a minimum...a significant expansion in the availability of home visitation and follow-up services for all families of newborns" (U.S. Advisory Board on Child Abuse and Neglect, 1990, 82, Recommendation 25).

In 1991, ABCAN began its elaboration of the new national strategy by publishing *Creating caring communities: Blueprint for an effective Federal policy on child abuse and neglect*. That report was "dedicated to the many thousands of American children and families trapped in the throes of abuse and neglect who are waiting for our society, and its governments, to respond to their plight with more than just a report, and more than just an investigation" (U.S. Advisory Board on Child Abuse and Neglect, 1991, Dedication).

Toward that end, ABCAN proposed the adoption of a National Child Protection Policy, declaring that "[t]he principle goal of governmental involvement in child protection should be to facilitate comprehensive efforts to ensure the safe and healthy development of children" (U.S. Advisory Board on Child Abuse and Neglect, 1991, 46). ABCAN further urged that relevant Federal agencies be mandated to "take all steps necessary to ensure that every community in the United States has the resources — fiscal, human, and technical — required to develop and implement a [comprehensive, child-centered, family-focused, and neighborhood based] child protection strategy" (U.S. Advisory Board on Child Abuse and Neglect, 1991, 48).

The top-priority recommendation in ABCAN's 1991 report (Recommendation G-1) provided for "a dramatic new Federal initiative aimed at preventing child maltreatment — piloting universal voluntary neonatal home visitation." The recommendation continues:

> The Federal government should begin planning for the sequential implementation of a universal voluntary home visitation system. The first step in the planning process should be the funding of a large series of coordinated pilot projects. Instead of reaffirming the efficacy of home visiting as a preventive measure — already well-established — these projects should aim at providing the Federal government with the information needed to establish and administer a national home visitation system (U.S. Advisory Board on Child Abuse and Neglect, 1991, 141).

ABCAN provided six options for Federal action to accomplish this recommendation:

- administrative decisions by the Administration for Children and Families, the Public Health Service, and the Health Care Financing Administration to direct child abuse and neglect demonstration grants, Maternal and Child Health block grants, and Medicaid funds toward the establishment of the necessary pilot programs;

- coordinated activities by the Department of Health and Human Services, ACTION (then the national volunteer agency), and the Points of Light Foundation to stimulate "Caring Community Programs" that would encompass community-wide home visitation programs staffed by volunteers;

- in concert with relevant professional associations, advocacy to persuade private insurors, including those serving Federal employees, to cover home visitation services;

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Infant Home Visitation

—Gary B. Melton

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• incorporation of home visitation services into the programs of the Indian Health Service;

• incorporation of home visitation services into the health services provided to military families;

• Congressional action to mandate the actions listed above.

In weighing the relative merits of this approach, it is important to bear in mind that the Board's emphasis on home visitation is embedded in a new sense of community involvement in and caring for children.

This community focus was derived from an assessment that child maltreatment both causes and results from an unraveling of the social fabric:

> Deterioration in the quality of urban neighborhoods and rural communities increases the isolation of families from their neighbors and, therefore, the rate of child abuse and neglect; child maltreatment itself tears the social fabric of the community and thus escalates the decline of neighborhoods and communities in crisis (U.S. Advisory Board on Child Abuse and Neglect, 1991, 44).

Neighborhood disintegration is accelerated by poverty. When economic resources are scarce or declining, the incentives to move are great; those who are left behind tend to be those with the fewest resources with which to help each other. The resulting combination of economic poverty and social isolation is especially pernicious; care for children becomes increasingly difficult, and the safety of the children is steadily reduced.

The U.S. Advisory Board on Child Abuse and Neglect recommendation for universal infant home visitation is consistent with its emphasis, elaborated in the 1993 report, on providing help to families when they need it (including during developmental transitions, like childbirth) and where they need it — making child protection a part of everyday life.

Although poverty poses dire risks for the safety of children, the sense of alienation and isolation expressed by many impoverished parents reflects broader social trends. With the extraordinary changes in family life and socioeconomic structure that have occurred in the past 30 years, informal, "natural" support networks have been disrupted and daily life has become more complex for most families, regardless of social class. Unfortunately, though, the service system has changed little in response.

The challenges at hand are expressed in ABCAN's recently released report, *Neighbors helping neighbors: A new national strategy for the protection of children*. That report, which presents a wide-ranging agenda for all sectors of society, ends with the following exhortation:

> To create a society in which children need not live in fear the nation must strive diligently to overcome th isolation created by the demands of modern life and exacerbated by the ravages of poverty. We must tear down the walls that divide us by race, class, and age, and we must create caring communities that support the families and shelter the children within them. We must take the time to see the need and to lend a hand.
>
> To achieve this simple vision, we must strenthen neighborhoods so that people are involved with each other as a community and that adults feel competent as parents, empowered to protect the safety of their own children, and responsible for supporting each other. A "quick fix" or "band-aid" is not enough. Programs must be constructed in a manner that they facilitate sustained development of neighborhoods that are safe environments for families. People must have sufficient resources and sense of control over their lives that they can help each other and that they can do so over the long term without feeling drained. Government at all levels can do much to facilitate such requisites for continuing safety for children and families; so too can private agencies, businesses, the religious community, and civic and philanthropic organizations. The nation's child protection system must be redesigned to support even the most troubled and impoverished neighborhoods and families — and to nurture and protect even the most vulnerable children within them.
>
> The Board challenges not just the new Federal leaders but also the leaders both inside and outside government in states and communities throughout the nation to consider the proposed strategy....[The Board] challenges all American adults to resolve to be good neighbors — to know, watch, and support their neighbors' children and to offer help when needed to their neighbors' families (U.S. Advisory Board, 1993, 82).

ABCAN's recommendation for universal infant home visitation is consistent with its emphasis, elaborated in the 1993 report, on providing help to families when they need it (including during developmental transitions, like childbirth) and where they need it — making child protection a part of everyday life.

The 1993 report also noted the potential of infant home visitation programs as structures on which to build support networks for families:

> Infant home visitation programs could serve as a base for organizing parents of children of the same age in clubs, groups, or activities in which they form a "natural" support network (U.S. Advisory Board, 1993, 20).

ABCAN's advocacy for universal infant home visitation programs thus is based on its recognition

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HEALTHY START HOME VISITING: HAWAII'S APPROACH

—by Gail Breakey and Betsy Pratt

In July, 1985, a three-year demonstration project to prevent child abuse and neglect began in Leeward, Oahu, a multi-ethnic, mixed urban and rural, fairly depressed community, with more than its share of problems—substandard housing, underemployed adults, substance abuse, mental illness, and child abuse and neglect. The initial funding level was $200,000 per year. By 1988, an evaluation of the program revealed that not a single case of abuse among the project's 241 high risk families had been reported since the demonstration began. There was also evidence of reduced family stress and improved functioning among the families served.

The success of the 1985-88 demonstration project was, of course, gratifying. But what is even more remarkable is the institutionalization of the Healthy Start program within the Maternal and Child Health Branch of Hawaii's Department of Health. By July, 1991, Healthy Start had expanded to 11 sites operated by seven community-based agencies throughout the state. The state legislature appropriated $7 million to support this effort and housed it within the State Health Department. At present, the program reaches approximately 52 percent of families with newborns throughout Hawaii. Healthy Start has evolved into a systematic and multi-purpose network of community-based maternal child health services.

Healthy Start has evolved into a systematic and multi-purpose network of community based maternal child health services....The wonder in Hawaii is the state legislature's willingness to support the expansion of a program without sacrificing quality.

The wonder in Hawaii is the state legislature's willingness to support the expansion of a program without sacrificing quality. In *Within our reach: Breaking the cycle of disadvantage*, Lisbeth Schorr (1990) reminds us that "The temptation to water down a proven model in order to distribute services more widely is ever present.... Especially when funds are scarce, there are powerful pressures to dissect a successful program and select some one part to be continued in isolation, losing sight of the fact that it was the sum of the parts that accounted for the demonstrated success."

Details of the Healthy Start program have been amply written about elsewhere (Breakey & Pratt, 1991). In this article, we want to explain how Hawaiians managed to gain support for a statewide expansion of the model program.

STATEWIDE EXPANSION OF A MODEL PROGRAM

Expansion of Healthy Start toward a statewide system might best be described as an achievement of "collaborative advocacy." Our efforts go back to 1976 and our excitement about results from our first early identification and home visiting program. We started a Statewide Council on Child Abuse and Neglect, with representation from committees from five neighboring islands. Federal and state funds supported a prevention project on each island, but when the federal grant ended in 1980, staffing was cut by half.

We realized that we needed another demonstration project. In 1984, during the Hawaii Family Stress Center's annual lobbying for prevention before the state legislature, we met with Senator Yamasaki, Chairman of the Ways and Means Committee of the Hawaii State Senate. He saw merit in the idea of a demonstration program with comprehensive coverage of one geographic area, a focus on child development and linkage to a medical home, and follow-up to age five. He supported funding for Healthy Start at $200,000 a year, with the intent to expand statewide if the model were successful.

Armed with data showing no abuse among project children during the first 18 months of Healthy Start, we went back to the legislature for support for an incremental approach to statewide expansion. Through quarterly statewide meetings, we had maintained a relationship with the five neighboring islands' Family Support Programs. They and the two other agencies on Oahu with home visiting experience joined us to develop a statewide plan.

Expansion of the Healthy Start model created no turf issues for the five Family Support Programs, since each served a distinct island community. On Oahu, home to 80 percent of Hawaii's population, there were turf issues to be resolved. The Hawaii Family Stress Center and the other home visiting agencies discussed the areas of Oahu that each was interested in serving. We also recognized that long-established programs did not have to adopt every detail of the Healthy Start model, as long as each program included essential features. Rather than attempting replication in a "cookie cutter" approach, we identified features which appeared essential to program success.

Legislative education and advocacy for prevention had begun in the mid-70's and continues to the present. In each legislative session, efforts are focused first upon early meetings with key legislators, chairs of subject and money committees, as well as with executive branch leadership. Next come several days of meetings with members of relevant committees in a constant effort to educate them to the great potential of prevention programs related to needs of children.

Several years ago, the Department of Health prepared a 10-year projection of target populations, staffing needs and costs for the program. The program is currently funded at about $7 million per year and costs to complete state-wide expansion would be about $12 million. Costs will increase by several million each year, as new cohorts of infants are added, until all sites begin to graduate children out of service. By the year 2003, the budget for the statewide program will be about $18 million.

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Healthy Start

—Gail Breakey
and Betsy Pratt

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A STATEWIDE PROGRAM: SURVIVING AND THRIVING

The situation of Healthy Start is unusual; the impetus for its establishment came from the private sector, but it is now institutionalized within the public sector. A statewide program must have a place within the established structure of state services in order to survive and thrive. Our program was placed in the mental health system from 1982-1988. The arrangement did not work well in our case, although it could conceivably work elsewhere. The Maternal Child Health Branch (MCHB), in contrast, has been a tremendous support to the development of Healthy Start as a statewide program. MCHB has provided a focus for coordination of all agencies, efficient contract management, monitoring, data collection, and advocacy for the program, both within the Department of Health and the larger community.

Members of the Healthy Start Network agree that the program needs to be completely statewide within a few years. Our current legislative effort is focusing upon providing existing programs with sufficient resources to maintain intake of newborns, which requires adding some staff each year, and to recruit and retain qualified staff. Next year or in the next biennium we will again pursue expansion, possibly bringing one or two new service agencies into our Network.

Programs like Healthy Start provide preventive services which cut across service categories including health, social services and early education services. Over time prevention services have the potential to reduce the costs of treatment in these areas as well as the costs of courts and corrections.

The issue of multiple sources of funding for a statewide program also deserves attention. Currently, state general funds comprise the major source of funds. It is a great deal to ask of a state legislature to fund a program as broadly based as Healthy Start from state revenues alone. Such a strategy would surely result in "dilution" eventually. It will be important to utilize all available funding streams as appropriate and available. These technically could include Medicaid reimbursement for targeted case management, possibly for risk assessments and developmental screening. Home visiting services could be covered with changes in the state's Medicaid plan. The federal carrot held out to states in developing Part H plans under P.L. 99-457 (IDEAS) has been potential federal funding of services to children enrolled in enrichment plans. In Hawaii, Healthy Start's environmentally at risk children would qualify. Programs like Healthy Start provide preventive services which cut across service categories including health, social services and early education services. Over time prevention services have the potential to reduce the costs of treatment in these areas as well as the costs of courts and corrections. It will be very important for states to look at developing funding streams for prevention and early intervention programs. These include innovative ideas such as setting aside a portion of federal Title IV and Medicaid reimbursements for treatment services, or a small percentage of departmental budgets in these areas for prevention. In this way, it will be possible to develop an infrastructure of prevention services which will likely reduce the demand for treatment services over the next decade.

Healthy Start offers a systematic, highly effective and family-friendly approach to prevention of abuse and neglect and provision of health and early education services for the most vulnerable and needy infants and toddlers. It creates an excellent opportunity to reach and serve children and their families who have not been reached effectively by the EPDST program, immunization programs, health care programs, or prenatal services. Extending effective services to families of children at risk was a major recommendation of Lisbeth Schorr's book, *Within our reach: Breaking the cycle of disadvantage.*

Lisbeth Schorr defined six challenges to efforts designed to prevent "rotten outcomes" of childhood. Healthy Start offers a solution for the challenges of knowing what works, proving we can afford it, attracting and training skilled and committed personnel, resisting the lure of dilution in replication, "gentling the hand" of bureaucracy, and devising replication strategies. Schorr further challenges programs to develop methods of linking populations at risk with needed services. Healthy Start provides a mechanism for doing this. We look forward to collaborating with colleagues to serve our entire state and eventually our nation so that all of our children may have a safe and healthy start in life.

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HEALTHY FAMILIES AMERICA: Building A National System

—by Leslie Mitchel and Anne Cohn Donnelly

Introduction

For the past two decades, the National Committee to Prevent Child Abuse (NCPCA) has sought to identify programs and actions that reduce the risk for child maltreatment and promote healthy, positive outcomes for children. Since child abuse, like other childhood problems, is a complex issue with many underlying causes, prevention efforts must be comprehensive, addressing this diverse etiology. There is no single approach that can address the range of family needs, no single program that will prevent abuse in all families. Yet, if one is to start somewhere, a logical place to focus is with new parents, getting them off to a good start before destructive patterns are established.

While there are many impressive family support and early intervention models, the U.S. Advisory Board on Child Abuse and Neglect recommends a voluntary program of home visits to new parents and their babies as the desired approach (see Melton article in this issue). Grounded in the belief that all families need and deserve support, home visitation affords an opportunity to help families in their own environment, on their own terms. It is through these one-on-one exchanges that a relationship between a home visitor and a parent is formed — a relationship that can help keep even the most needy families engaged in services.

Though family needs and circumstances differ, Healthy Families America recognizes that all families need some level of support in the childrearing process. For many parents, this support comes from traditional sources - a spouse, a parent or a sibling - but for far too many others without such systems in place, outside assistance is necessary.

The public is very supportive of the concept. Public opinion polls conducted over the past few years by NCPCA show that over four-fifths of the respondents thought it appropriate to offer home visits and other supportive services to all first-time parents, including families like their own.

Recognizing the potential of home visitation for new parents, in January, 1992, NCPCA, in partnership with Ronald McDonald Children's Charities (RMCC) and in collaboration with the Hawaii Family Stress Center and the Hawaii Health Department, launched a national initiative entitled Healthy Families America (HFA). HFA, based on two decades of research on home visitor programs and modeled after a successful statewide system in Hawaii (see article by Breakey and Pratt in this issue), seeks to reach all first-time parents with intensive home visitor services. The goal of the initiative is to ensure that all new parents, particularly those at high risk for childhood maltreatment and other poor childhood outcomes, get off to a good start. The purpose of this article is to describe the approach NCPCA is taking to implement Healthy Families America.

The Healthy Families America Approach

The vision of Healthy Families America is that one day all new parents will receive the education and support they need through a voluntary home visitation system. Though family needs and circumstances differ, HFA recognizes that all families need some level of support in the childrearing process. For many parents, this support comes from traditional sources — a spouse, a parent or a sibling — but for far too many others without such systems in place, outside assistance is necessary. Just as this vision was both created and shared by the field, so too is the HFA effort to achieve the vision. From the beginning, NCPCA has worked with state Maternal and Child Health Programs, NCPCA state chapters and the state Children's Trust and Prevention Funds to help them sort out how to pursue their mission of supporting families.

Central to the Healthy Families America effort is the establishment of relationships with other organizations and programs whose goals, objectives and target populations are similar. To that end, NCPCA has established partnerships with over 40 national organizations such as the Cooperative Extension of the U.S. Department of Agriculture, the American Hospital Association, the American Nurses Association, and the National Association of Public Child Welfare Administrators. These partnerships have been instrumental at the state and community level in assuring that rather than duplicating existing efforts, HFA will build upon programs and enhance systems already in existence. In addition, they allow for a sharing of networks, the development of more collaborative approaches to linking services, and the creation of a more cooperative environment for knowledge and information exchange.

To date, statewide task forces have been established in nearly all fifty states. To help advance the efforts of these groups, HFA staff conduct "site visits" to these states. Depending upon the stage of development, a site visit may serve to clarify any issues or questions related to the approach, increase commitment of leadership, foster support from policy makers or assist in thorough implementation planning.

While some states are focusing broadly, using HFA as a vehicle to achieve systemic reform, others want to establish local HFA pilot sites which will grow into larger systems over time. With respect to the former, three states already have passed legislation supporting intensive home visitor services and many others are pursuing legislative initiatives. With respect to the latter, over twenty-seven HFA pilot sites already are operational. For those established pilot efforts, NCPCA, in collaboration with the Hawaii Family Stress Center, is providing training in how Hawaii operates its Healthy Start program and thus how pilot sites can effectively carry out the early identification and family support functions.

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Healthy Families America

—Leslie Mitchel and Anne Cohn Donnelly

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Grounded in the belief that all families need and deserve support, home visitation affords an opportunity to help families in their own environment, on their own terms. It is through these one-on-one exchanges that a relationship between a home visitor and a parent is formed — a relationship that can help keep even the most needy families engaged in services.

While the primary objective of Healthy Families America is to prevent child abuse and neglect, HFA also provides an infrastructure for identifying families' needs and empowering families to access a range of health and social services. By recognizing that children and families are individuals and entities unto themselves as well as part of a larger community, home visitors serve as a bridge to link parents to the resources they need to better care for themselves and their children.

Throughout the implementation process, NCPCA has been promoting flexibility in service delivery to facilitate HFA's integration into a wide range of communities, to encourage HFA's being built onto existing delivery systems in order to avoid duplication of efforts, to foster partnerships with existing service delivery systems, and to support opportunities for innovation. As HFA services are developed, they will be integrated as much as possible with existing community services.

Criteria Basic to the Healthy Families America Effort

Central to the HFA effort, however, are some basic criteria that repeated evaluations of early intervention programs have found to contribute to their effectiveness. These criteria fall into four categories: 1) initiation of services, 2) service intensity and duration, 3) content of services, and 4) selection and training of service providers. The critical elements and their relationship to existing family support services help to define how Healthy Families America activities will take shape across the country.

Initiation of Services

- Services are initiated prenatally or at birth.
- A universal intake service is provided for all new parents from a defined target area (e.g., educational hospital visit to all births in a given census tractor or zip code).
- Universal needs assessment using standardized protocol is utilized to systematically identify those new parents most in need of services due to the presence of various risk factors.
- All high risk parents are offered services in a positive, voluntary way.
- Home visitation is the core service offered.
- Creative outreach (e.g., persistent positive outreach for at least three months) is utilized to build client trust in accepting services.

Service Intensity and Duration

- The services offered are intensive (e.g., at least once a week).
- Services are offered over the long term (e.g., 3-5 years).

Content of Services

- Services are family-centered, addressing the needs of the child within the context of the family and recognizing that the adults in the family are the primary decision makers.
- Services focus both on supporting the parent as well as on supporting parent-child interaction and child development.
- Services include a focus on child health and linkages to the health care system (e.g., assurance of immunizations, visits to well baby clinics).
- Services include a focus on school readiness directly or by offering linkages to other school readiness services (e.g., Head Start, HIPPY).
- Service plans are tailored to needs of the individual family and problem solving to address service needs is foremost. The longer term focus of services is on self-sufficiency and empowerment.

Selection and Training of Service Providers

- Early identification and home visitation workers are selected based upon specific personal characteristics (e.g., non-judgmental, compassionate, able to establish a trusting relationship, etc.) rather than because of specific academic credentials or previous work experience.
- All workers complete intensive, standardized initial training program and periodic in-service training (e.g., every three months).
- All workers receive ongoing, intensive professional supervision to assure quality (e.g., two hours of supervision weekly for home visitors; no more than five or six home visitors for every supervisor).
- Worker caseloads are limited (e.g., no more than 15 of the highest risk families at any one time).

Underlying Principles of Healthy Families America

Healthy Families America calls upon states and communities to recognize programs already embracing many of these criteria and acknowledge their successes. But HFA also challenges us all to do better. NCPCA hopes to reform systems so that they comprehensively provide: access for all, coordinated services, and continuity of care.

Access for All: Since the public believes that all families deserve and could benefit from some form of enrichment, HFA hopes to create systems where this occurs. Systems in which all families receive a basic level of support and education, with additional assistance provided to those who are in need of and who request more. One way to reach this

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HOME VISITATION AND CHILD ABUSE: The British Experience

—by Kevin Browne

In the past twenty years there has been much debate on what services can be delivered to minimize the maltreatment of children. This debate has been limited by a poor understanding of intervention strategies for child abuse and neglect and of what constitutes a desirable outcome. Reviews on the causes of maltreatment (e.g., Browne, 1988) have emphasized a growing recognition that child abuse and neglect is a product of a poor parent/child relationship. This interactive perspective places less emphasis on individual problems of the parents. Therefore, interventions that strengthen the parent/child relationship are considered to be more promising for prevention than those aimed at parental psychopathology (Wolfe, 1993).

Wolfe (1993) observes that there have been promising developments in early interventions which address parental competency and family support to promote more positive parental knowledge, attitudes, skills, and behavior. He claims that personalized programs such as home visits over a period of one to three years stand out as the most successful interventions in achieving desired outcomes in terms of fewer child injuries, emergency room visits, and reports to protective agencies.

It has often been emphasized that such "health visiting services" could be used to prevent child abuse and neglect at a primary and secondary level. However, few countries have systematically used home visitation practices in this way, and even fewer countries have evaluated the effectiveness of home visits on the incidence and prevalence of child maltreatment.

A number of countries have statutory, government-sponsored home visitation programs, usually using health professionals such as community nurses. Most of these programs were set up with the aim of preventing ill health in families and reducing the rates of morbidity and mortality in young children. It has often been emphasized (e.g., Browne, 1989a) that such "health visiting services" could be used to prevent child abuse and neglect at a primary and secondary level. However, few countries have systematically used home visitation practices in this way, and even fewer countries have evaluated the effectiveness of home visits on the incidence and prevalence of child maltreatment.

Studies that evaluate the success of home visitation on reducing child abuse and neglect are mainly North American in origin with the exception of some investigations which have been carried out in the United Kingdom. In a previous article in this volume David Olds has extensively reviewed the North American literature. This paper will review the work carried out in Britian reflecting the experience of the health (home) visiting statutory services and voluntary agencies in the prevention of child maltreatment.

Historical perspective

Health visiting began in Britain in 1867 by the Manchester and Salford Ladies Sanatory Reform Association which employed "respectable" women to go from door to door giving advice on health and hygiene (Hale and Loveland, 1968). Formal training of health visitors followed soon after on a national basis. In 1946, the National Health Service was established in the U.K. and health visiting was incorporated into the Service. Since then, every British family with a newborn child has received home visits by a community nurse, free of charge, for the first five years of the child's life (see Luker and Orr, 1992).

During the past 126 years, there is little doubt that health visiting has limited the amount of physical neglect and malnutrition suffered by British children. Nevertheless, the reported incidence of child abuse in the U.K. is higher than most other countries in Western Europe. About 1% of U.K. children are seen by professionals for physical, psychological, and sexual abuse combined (Browne, 1989a;1993a). Some may argue that this amount reflects the success of health visitors at detecting children who are abused, or are likely to be abused. However, the number of child deaths from non accidental injury in the U.K. contradicts this viewpoint.

In 1991, British newspapers reported that 99 children under the age of 16 years of age died of non-accidental injury (Browne, 1993b). This figure represents 14% of all homicides and 33% of domestic homicides in 1991 (Browne, 1993b), and is consistent with claim that in England, Scotland and Wales, a fatal injury occurs to two to three children each week (NSPCC, 1985). The homicide rate in the U.S.A. (10 per 100,000 - FBI, 1991) is eight times that of the U.K. (1.3 per 100,000, - Home Office, 1991). The number of children who die of non-accidental injury in the U.S.A. is also much higher, but as a percentage of the overall and domestic homicide rates the percentage figures for the two countries remain remarkably similar (Gelles and Cornell, 1990). In both Britain and the U.S.A., child maltreatment is one of the top five most common causes of death to young children. The youngest children are the most vulnerable to fatal abuse, with 80 per cent of serious head injuries occuring to children under five years of age and 50 per cent to those under one (Crieghton, 1992). These horrific statistics demonstrate the need for early prediction and prevention and this article will address the successes as well as the failures of British home visitation schemes.

Home Visitation Schemes in the U.K.

Statutory

During pregnancy, birth and early childhood care, parents are by necessity in contact with the maternity and child health services of the U.K. National Health System. This offers health professionals the opportunity to prepare and support parents in the care of their children. The health visitor's

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Home Visitation and Child Abuse

—Kevin Browne

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role is unique because, as a fully qualified nurse and midwife, s/he offers unsolicited home visits. The work is concerned with health education and promotion of the family as a whole, with visits to families in need being made over a long period of time. Health visitors are trained to recognize health and relationship problems within families and are well placed to assess need and initiate action at an early stage. They encourage parents to take a responsible attitude to the care of their children and to seek appropriate help and support. It is suggested that this approach may reduce the chances of child maltreatment in the family (DOH, 1988a).

The U.K. Department of Health (DOH, 1988b) gives guidelines on the responsibilities of community nurses in relation to the recognition and referral of families under stress, and of families where child abuse and neglect is suspected. They are recommended to:

1. Set up a communication system with social work services and family practitioners about current concerns.
2. Review case loads regularly with colleagues and family practitioners to ensure all the information about the child and family is available.
3. Set up a system of formal notification and participate in case conferences.
4. Collect information about missing families and no-access visits, where there is cause for concern because a child has not been seen.
5. Ensure that there is effective communication with the hospital midwife involved with the family, especially during the hand-over of responsibility at approximately ten days after birth.
6. Take adequate legal advice when required to submit statements or appear as witnesses in court.
7. Prioritize the time necessary to assist in prevention work with families.
8. Establish appropriate systems of record keeping and reporting.
9. Give professional advice and information to other professionals and agencies about the detection and prevention role of health visitors in cases of child abuse.

The above guidelines are necessary as there is no mandatory reporting of child abuse and neglect in the U.K. and some health (home) visitors feel that their involvement in child protection threatens the ethical basis of their health promotion role in the family (e.g., Taylor and Tilly, 1989).

A study carried out by Gilardi (1991) shows that 97% of health visitors had been directly involved in a least one case of child abuse and neglect and over 70% in five cases or more. In 42% of cases the health visitor was the first to suspect abuse and 40% had been involved in the preparation of court proceedings. However, the study also found that a majority of health visitors felt their initial training in child protection was less than adequate.

Voluntary Agencies

Volunteers who visit families as a part of a organized plan for the prevention of family problems often have a close liaison with the statutory services. For example, the NEWPIN plan of home visiting and befriending in an inner-city community has shown this liaison to be effective in helping women who are unsupported in their task of motherhood (Pound and Mills, 1985).

The Home Start program (Harrison, 1981) offers the help of non-professional volunteers to intensively support families with small children in their own homes. The organizers claim this home help goes some way to prevent the possibility of child maltreatment. They give meticulous preparation and support for their volunteers in this work. However, the influence of such voluntary work on the prevalence and incidence of child maltreatment has yet to be established.

The two examples of voluntary work with families cited differ from the work of the National Society for the Prevention of Cruelty to Children (NSPCC) by offering support and help before any evidence of damage to the child can be seen. In contrast, the NSPCC works in a similar way to the statutory social services, intervening only after child abuse has occurred. This form of family intervention and treatment, at a tertiary level of prevention, is effective for approximately 60% of physical abuse and neglect cases involving a child under five (Hyman, 1978). Nevertheless, it may be too late for those children who die or who are crippled for life before the physical marks of child abuse and neglect are recognized. The aim for all those involved with child protection work must be secondary and primary prevention of violence to children, and not just inadequate control of the problem at a tertiary level of crisis intervention (Browne and Lynch, 1992).

Research on the Health Visitor Approach to Prevention

The successes and failures of the statutory health visiting service in detecting and preventing child abuse and neglect has been investigated only over the past five years. Research evaluating health visiting practices can be divided into studies of (1) health visitors detecting the possibility of child maltreatment with the view of secondary prevention; and (2) health visitors intervening to ameliorate parenting problems with the aim of primary prevention.

Detecting the possibility of child maltreatment

A number of articles have been written on the prediction of child abuse (see Leventhal, 1988), many of which have presented a list of characteris-

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OPINION
HOME VISITATION:
Let's Be Careful Out There

—by Lucy Berliner

Home visitation programs run the risk of becoming the child abuse fad of the 1990's. In my opinion they are being oversold as the virtual cure-all to the problem of child abuse and neglect. Influential organizations like the National Committee to Prevent Child Abuse(NCPCA) have undertaken national campaigns to promote widespread adoption of the model. The U.S. Advisory Board on Child Abuse and Neglect has embraced the concept of universal home visitation. State and local communities are clamoring to climb aboard. I am worried that, unless a more measured approach is taken, disillusion will set in and what might be an important contribution will be abandoned for failing to live up to the unrealistic claims which are being made for it.

Not even the most ardent adherents claim that home visitation itself will be sufficient. As a model it depends heavily on the availability of an array of community services to which families can be referred. Without the additional services, home visitation has little chance of making a significant difference for those families most in need. Even as a long-term strategy to reduce abuse in low risk families, there is not much basis for believing that it would prevent the more serious abuse situations. Arguably, these are the children for whom there should be the greatest concern.

There are a variety of driving forces behind this movement. One is enthusiasm for a promising intervention. Another is the mediocre record of success of other interventions. Others relate to the political climate. This is an era of reducing expectations for government support of expensive, high intensity programs. The idea of coercive state intervention in family life is increasingly challenged. Home visitation fits nicely with the current zeitgeist; it is universal, voluntary, and — because it occurs before parents are labeled as abusive or neglectful — prophylactic. It is not primarily the province of so-called do-gooder, child saving professionals. Who could be against it?

The lesson of the most recent cure *du jour*, family preservation programs, should alert us to the dangers of overstating the case. These brief, intensive, home-based interventions were hailed as the solution to the problem of out-of-home placement. It now turns out that in a majority of all cases children are not placed, and there are few significant differences in placement rates whether families get the intervention or not (Rossi, 1992). Unfortunately, the sole measure of success, until recently, was avoiding placement. Not only was placement usually regarded as a bad outcome per se, it was argued that there would be savings in foster care, a goal which has not been realized. Improvement in children's emotional status or in family functioning was only of secondary importance in selling the approach.

In no way am I suggesting that the goal of reducing placement or providing supportive services to families in crisis are bad ideas, or that the programs have no benefit. There are some positive findings, and family preservation programs are increasingly focusing on child and family functioning outcome measures (Pecora, 1993). But when the data start coming in, professionals are obliged to acknowledge it and respond. We might have been able to respond more constructively to family preservation data if home-based services advocates had not adopted such an ideological tone in addition to promising so much (Nelson, 1990). Far too often these programs were sold by arguing that caseworkers routinely placed children unnecessarily and were not committed to helping families, and by denigrating traditional professional services. This kind of "we care about families and you don't" subtext is revealed by calling a single limited intervention "family preservation," as if the myriad of other professional and non-professional approaches do not share the same goal: helping insure that children live in physically and psychologically safe families, with one or both parents whenever possible.

Any new approach which claims that it will reduce a social problem should be based on empirical knowledge and make a conceptually sound argument for why it might work. The advocates for home visitation have only partially met these requirements. For those cases of child abuse and neglect which may be caused by social isolation, lack of support, inadequate knowledge about child development, and deficits in parenting skills, it holds great promise. But many correlates of child abuse and neglect are not addressed by the approach. What about poverty and its associated features — substandard housing, no job prospects, inadequate health insurance and no day care? Home visitation cannot substitute for economic improvements. What about depression and substance abuse, which are frequently associated with child abuse and neglect? There are effective treatments for these disorders and they are not home visitation. How will home visitation affect those who will commit the more serious forms of physical child abuse which involve extreme, intentional violence and even sadistic acts? And no one has even suggested that it will be useful in preventing sexual abuse.

There is some evidence that certain types of home visitation programs may help reduce rates of child abuse and neglect (Olds & Kitzman, 1990). However, not all home visitation efforts are of equal intensity and quality and therefore produce varied outcomes. For example, a recent follow-up study of a randomized trial of paraprofessional-delivered home visitation services found no differences in rates of child abuse and neglect, nor on any of the other measures of child or parent well-being (Barth,1992). The author concluded that the intervention was not intensive or specific enough to resolve difficulties within its targeted high risk population. And even when such interventions produce improvements in knowledge and skills, they may not affect the more serious underlying problems, such as insecure attachment, which are widely thought to keep families at high risk for child abuse

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Home Visitation

—Lucy Berliner

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and other negative outcomes (Erickson, Korfmacher & Egeland, in press).

One argument made in support of home visitation is the relatively moderate success of interventions with high risk and child-abusing parents (Cohn & Daro, 1988). However, in many programs the interventions which were evaluated were of low magnitude and found to be more effective with low risk cases. Most authorities agree that certain types of abuse situations or characteristics of families decrease the likelihood of supportive/educational approaches working (see e.g., Wolfe, 1991). Parents with substance abuse disorders, psychopathology or criminality, and longstanding disturbances in functioning do not comply well with intervention efforts or succeed as often.

Perhaps the most important contribution of current interest in home visitation programs is the implicit recognition that providing social supports for new parents is a legitimate government activity. To ensure that this contribution is not made to the detriment of other prevention and treatment programs, other government and private organizations concerned with children and families' health and welfare should be enlisted in a broad social response designed to improve the lives of children.

Not even the most ardent adherents claim that home visitation itself will be sufficient. As a model it depends heavily on the availability of an array of community services to which families can be referred. Without the additional services, home visitation has little chance of making a significant difference for those families most in need. Even as a long-term strategy to reduce abuse in low risk families, there is not much basis for believing that it would prevent the more serious abuse situations. Arguably, these are the children for whom there should be the greatest concern.

There is general consensus that policy recommendations on child abuse and neglect should call for a comprehensive response which respects the contributions of different types of interventions. NCPCA and the U.S. Advisory Board strongly support a continuum of services. However, it is tempting, especially on the community level, to take the "do this instead of that" approach. Substituting one intervention for another brings attention to a new program, capitalizes on frustration with the limited success of other single interventions, and appeals to fickle government and private sources of funds which want a quick bang for a buck. There is no question that one result of this "substitute" mindset has been a certain amount of jumping on the nationwide home visitation bandwagon.

The problem with this effort in many communities is that these are times of cutbacks and downsizing in government and its support for social services. Everywhere, professionals and citizen groups are struggling just to maintain current programs. Advocates of home visitation programs will lose valuable allies among other child abuse professionals if they end up fighting over the same small pie. Not only other prevention programs, but treatment programs risk losing scarce funding to home visitation. It should not surprise anyone to find fairly serious resistance to this prospect.

One of the great fears of those of us who work with already abused children is that the shift of attention toward early intervention will result in erosions of the incremental advances in recent years toward recognizing the value of intervention with the children (Graziano & Mills, 1992). The lure of a prevention approach is strong, for obvious reasons. But no prevention strategy is going to eliminate child abuse and neglect. The causes of abuse in any given case are the result of a particular mix of societal, environmental and individual variables. Now that the public finally cares about abused and neglected children, government and private sources of funding should do what it takes to help them recover, and whenever possible help their parents as well. One important reason why so many intervention approaches have not had great success is because they have never been fully implemented. It takes time and resources to develop effective treatment services. Strategies and approaches must be tested and refined; programs must establish a track record. Treating those already maltreated and maltreating will cost a lot more money per case than providing home visitation to all new parents. These efforts are undermined or short circuited if funding sources prematurely or capriciously shift support with the blowing of political winds.

Giving up on trying to make a difference for the already damaged is dangerous and wrong. Unfortunately, it is all too common to hear social service and criminal justice professionals suggest that it is too late to even try with certain groups. For example, many community planners argue that services should be targeted only to the offspring of teenage mothers because there is little hope of significantly improving the functioning and prospects of the mothers — most of whom are abuse victims. There is no question that it is harder and more expensive to intervene later when problems are more ingrained, but it is still the right thing to do.

Proponents of new programs which will compete with the existing resources allocated for child abuse prevention and intervention have some obligation to consider the impact of their efforts. At the same time, established programs and funding sources cannot shut the door to new ideas and approaches. Communities can use various strategies to insure that one kind of service is not simply sacrificed for another. Legislators and local government officials are fond of saying to social service providers, "Don't just tell us to give you more money, tell us where to get it or who shouldn't get it." The cooperation we need requires the willingness to think more about the big picture and to be willing to sacrifice some of what we want.

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STATE CHAPTER NEWS

—by Claudia Soldano

A special welcome to all of our new CAPSAC members. Late this summer, the Boards of CAPSAC and APSAC agreed to merge the two organizations, which had been developing on parallel paths for many years. CAPSAC is now an affiliated chapter of APSAC. Congratulations!

Chapter Development

As 1993 draws to a close, we have an opportunity to review our goals and accomplishments. One of the more ambitious of APSAC's initiatives was the establishment of a successful chapter in every state by the year 2000, to address the local needs of our growing membership. Much of 1993 was spent working on the first step of this process: organizing the environment in which chapters operate. We gained the assistance of a *pro bono* attorney to sort out the legalities of the chapter-national relationship. A committee of experienced chapter organizers was formed to focus on state chapter development. Last, but by no means least, a full time staff person was hired to carry out the day to day operations of chapter relations.

Part of our goal is to keep chapters as independent as possible as they work toward APSAC's goals. To help with this, we are providing the necessary legal assistance for chapters to become independently incorporated and to gain non-profit status. This will allow chapters to be candidates for grants, federal and state tax exemptions, and tax-deductible donations.

The state chapter committee is charged with the responsibility of directing the environment in which chapters form, operate, and grow. All committee members have been part of organizing APSAC chapters, so they know of what they speak. Under their guidance, a variety of tools are being put in place to help groups with the organizational challenges of a chapter. Training materials on forming a chapter, establishing a committee system, and planning educational meetings have already been distributed to chapter coordinators and officers, and more materials are under preparation.

Having a staff director for state chapter development gives chapter organizers a central source for information and inspiration. Much of my time is spent finding out about the latest chapter needs and achievements and developing ways for the national to assist chapters. While I have met most of the chapter coordinators and officers by phone, I hope to meet all of them, along with other APSAC members, face-to-face at the Annual Meeting in San Diego in January or the Colloquium in Boston in May.

How do We Spell Success?

APSAC began 1993 with thirteen chartered chapters and many in the process of forming. We can now boast of twenty chartered chapters and active formation of at least eleven others. (Readers in Alaska, the District of Columbia, Louisiana, Nevada, New Jersey, North Dakota, South Dakota, West Virginia, and Wyoming: there's no chapter or identified coordinator in your state yet. If you are interested in forming a chapter, please call!) Obviously, the raw number of chapters listed play a part in reaching APSAC's goal of having a successful chapter in every state by the year 2000. But what are the other measures of "success"? The State Chapter Development and Oversight Committee outlined the criteria to define a successful chapter.

- A healthy percentage of APSAC members in the state are active in the chapter.
- The chapter's membership is large and diverse along disciplinary, racial, ethnic, and geographic lines.
- The chapter communicates regularly with its members.
- Active committees and task forces are producing measurable results.
- An annual meeting with program content is held.
- The chapter communicates regularly with APSAC's national office and Board.
- Chapter officers participate in organizational development training offered by the national office.

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Home Visitation

—Lucy Berliner

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Perhaps the most important contribution of current interest in home visitation programs is the implicit recognition that providing social supports for new parents is a legitimate government activity. To ensure that this contribution is not made to the detriment of other prevention and treatment programs, other government and private organizations concerned with children's and families' health and welfare should be enlisted in a broad social response designed to improve the lives of children.

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State Chapter News

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• The chapter meets the needs of members in its state, as articulated by the chapter in measurable and achievable goals.

I'm happy to be able to trumpet some of the specific achievements of our chapters.

• **Newsletters** - The goal of publishing a quarterly newsletter is well-represented by our Texas chapter. Regularly distributed to Texas members, the newsletter carries local and national announcements, articles, and conference summaries. It also lists members by discipline to encourage networking among and between groups. Other chapters with regular newsletters include Washington, Massachusetts, Arizona, North Carolina, Northern New England, Illinois, and California. More chapters are adding this benefit of membership every day.

• **Educational Meetings** - Our expectation of an annual meeting with program content is exemplified by the activities of chapters in Arizona,California, Colorado, Northern New England, Ohio, Massachusetts, North Carolina, Oregon, and Washington. Each of these chapters held meetings over the past year which highlighted a particular topic of interest permitting members to brainstorm and network. Many of the meetings have been centered on a keynote address by a prominent APSAC member.

• **Productive Committees** - Minimally, active Finance, Membership, Nominating, and Program committees which produce consistent results are crucial to chapter success. Many chapters, building on their strengths and interests, have created committees with special focuses. For instance, Washington has a Media committee, Texas has a Research/Network committee, North Carolina has an Awards committee, Arizona has an Advocacy group, and Massachusetts has a Research Committee. Much of the most meaningful work of these organizations is accomplished in these active committees.

APSAC's chapters continue to be a vital link in the effort to reach one of APSAC's major goals: ensuring that everyone affected by child maltreatment receives the best possible professional care. APSAC chapters give professionals a forum for regularly meeting to confront shared challenges, and pool resources to solve shared problems. I will look forward in the months to come to using this space to bring to everyone's attention the intelligence, creativity and energy constantly displayed by APSAC's burgeoning chapter system.

Claudia Soldano MSW, MBA is the Director of State Chapter Development at APSAC, Chicago, IL.

Where are APSAC's members?

Alaska	21	Kentucky	36	New York	136
Alabama	65	Louisiana	14	Ohio	125
Arkansas	30	Massachusetts	205	Oklahoma	94
Arizona	73	Maryland	70	Oregon	59
California	503	Maine	40	Pennsylvania	82
Colorado	85	Michigan	87	Rhode Island	26
Connecticut	48	Minnesota	78	South Carolina	37
DC	35	Missouri	86	South Dakota	5
Delaware	1	Mississippi	18	Tennessee	107
Florida	105	Montana	18	Texas	181
Georgia	52	North Carolina	147	Utah	34
Hawaii	34	North Dakota	10	Virginia	106
Iowa	34	Nebraska	20	Vermont	18
Idaho	13	New Hampshire	53	Washington	209
Illinois	221	New Jersey	64	Wisconsin	94
Indiana	69	New Mexico	34	West Virginia	6
Kansas	31	Nevada	34	Wyoming	5

Foreign/Territorial members: Australia (12); Bahamas (1); Belgium (1); Bermuda (2): Canada (42); England (6); Germany (6); Guam (1); Iceland (1); Ireland (2); Israel (2) Italy (2); Japan (6); The Netherlands (2); New Zealand (4); Puerto Rico (8); Scotland (2); South Africa (2); Switzerland (3); Taiwan (1); Unspecified Overseas Military (16); Virgin Islands (1); West Indies (1).

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No chapter in your state? Take the lead! Call APSAC's office, at 312-554-0166, and ask for information on how to start a state chapter.

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BOOK REVIEW

Evaluation of the sexually abused child: A medical textbook and photographic atlas edited by Astrid Heger and S. Jean Emans, Oxford, England, 1992, 244 pp. $60.

—Reviewed by A.P. Giardino and E.R. Giardino.

This book is directed to the health care provider who is called upon to evaluate children who may have been sexually abused. It represents a collaborative effort among two editors and eight contributors highly regarded in their respective areas of expertise. The ten chapters vary in length and content. The chapters range from brief general overview essays to more detailed text which outlines practical advice to the clinician performing an evaluation. The book has several unique features including a color photographic atlas of normal and abnormal genital and anal findings.

The book begins with a thoughtful essay dealing with the role of the physician in the evaluation of the sexually abused child and includes the recent American Academy of Pediatrics (AAP) guidelines for making decisions to report sexual abuse. An essay follows one child's navigation through the county child protection system. The complicated story of "JT" serves to highlight the bureaucracy and intrusiveness inherent in our current child protection services. Next, the text includes a detailed chapter on the psychological effects of sexual victimization. The discussion includes information on the prevalence of sexual abuse, its long-term impact on survivors, and factors believed to mediate the victimized child's future adjustment. The chapter concludes with a schema for the author's model of psychologic trauma on children.

The text shifts its focus to the components for the sexual abuse evaluation. The work-up is accurately described as beginning with the medical interview. Developmental issues relevant to the interview are described and practical advice is provided to the clinician. A description of the physical examination follows, including helpful details on the various exam positions. Another chapter describes genital embryology, physiologic changes, and female genital terminology. This chapter gives a synopsis of the changes that are expected during growth and development, especially pertaining to puberty.

The color atlas contains 116 photographs divided under the following headings with the number of photographs listed in parentheses: normal genitalia (18), developmental changes (8), variants (6), other variants (7) changes with technique and position (8), nonspecific changes (8), accidental trauma (5), acute genital trauma — sexual abuse (12), chronic changes — sexual abuse (8), sexually transmitted diseases (STDs) (13), normal ani or anal variants (2), anal changes (5), nonspecific anal changes (5), anal trauma (11). Photographs are high-quality and demonstrate subtle findings frequently encountered during the genital and anal examinations of children.

Following the atlas is a fairly comprehensive chapter dealing with STDs. General issues related to the sexual transmission of genital and anal infections in children are described. Then the text focuses on specific conditions and provides information on the biology of the infecting organism, its epidemiology, clinical signs and symptoms, and proposed treatments. The final chapter, written by a municipal court judge, deals with court testimony.

Additionally, the book contains a short glossary of anatomic terms and appendices containing five different sexual assault protocols from the authors' home institutions an an annotated bibliography describing 75 references.

In summary, *The Evaluation of the Sexually Abused Child* contains the insights and investigative expertise of notable experts in the field of sexual abuse. The strengths of the text are the atlas, the comprehensiveness of the STD chapter, the sample protocols, and the annotated bibliography. Health care providers will find valuable information in the pages of this textbook and photographic atlas.

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VIDEO REVIEW

Defending our lives. Cambridge Documentary Films, Inc. P.O. Box 385, Cambridge, MA 02139 (617) 354-3677. Available in film or video format. For rent ($45-50) or purchase ($150 for video; $375 for film).

—Reviewed by Kathy A. Kendall Tackett

Defending our lives is a gripping documentary about wife abuse. The film chronicles the stories of four women who are currently incarcerated because they killed their abusive partners. These women describe the effects of their abuse on them and on their children. Interwoven in these stories is the story of Assistant District Attorney Sara Buel. Ms. Buel is a former battered woman who was forced to flee her batterer with her infant son and foster children, and live on welfare. She was able to return to school, and become an attorney. She currently heads the Suffolk County (Massachusetts) Domestic Violence Unit.

For child abuse professionals, this film is especially helpful in understanding the environments of violent families. It would also be helpful for in-service training for law enforcement and social service agencies, as well as community groups. I enthusiastically recommend this film for all those interested in understanding the full scale of family violence and its effect on children.

Kathleen A. Kendall-Tackett, PhD is the Director of the Perinatal Education Group in Framingham, Massachusetts, and an Assistant Research Scientist at the Stone Center at Wellesley College. She is the Book Review Editor for the Advisor.

Review of Research

—David Olds
and Harriet Kitzman

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of health-related behaviors (such as maternal smoking) can be altered, with positive effects on birthweight (Sexton & Hebel, 1984).

All of the seven randomized trials of prenatal home visiting carried out to date included some psychosocial component in the home-visiting program (e.g., the provision of emotional support from the home visitor, the involvement of family members and friends), yet only three studies examined the influence of these components on outcomes. Investigators in the Elmira trial found that nurse-visited women, in contrast to comparison women, reported that their partners showed greater interest in their pregnancies at the end of gestation, and were more likely to be accompanied to the labor room by a support person (Olds, Henderson, Chamberlin et al., 1986). In the London trial, there was no program effect on depression at the end of pregnancy, but nurse-visited women reported fewer worries about the child in the newborn period (Field et al., 1982). In the Latin-American trial, the home-visited group reported more favorable expectations about delivery than did women in the control group (Villar et al., 1992). These results indicate that aspects of pregnant women's psychosocial functioning *can be* enhanced.

To be effective, programs must be clear about how they expect to improve the outcomes of pregnancy, and they must have sufficient contact with women to be able to achieve those objectives.

These types of mixed results can be found with respect to the ability of home visitation services to improve the mother's use of rountine prenatal care, reduce maternal hospitalization during pregnancy, and reduce newborn intensive care use. In the Elmira study, women visited by nurses made better use of the Supplemental Food and Nutrition Program for Women, Infants and Children (WIC) and attended childbirth education classes more frequently than did their counterparts in the comparison group (Olds, Henderson, Chamberlin et al., 1986). No other study reported on women's use of other health and human services in spite of considerable program emphasis on promoting this aspect of women's behavior.

In interpreting the general absence of program effects on preterm delivery and low birthweight, it is important to note that five of the trials were based on the assumption that preterm delivery and low birthweight could be reduced by reducing women's levels of psychosocial stress through the enhancement of their social support. In three of the trials, the home-visitors were even instructed to *avoid* teaching pregnant women about health-related behaviors (van Doorninck et al., 1980; Spencer, Thomas, & Morris, 1989; Oakley, Rajan, & Grant, 1990; Bryce, Stanley, & Garner, 1991). Only three of the tested programs systematically attempted to improve women's health-related behavior (Olds, Henderson, Chamberlin et al., 1986; Villar et al., 1992; Graham et al., 1992). To be effective, programs must be clear about how they expect to improve the outcomes of pregnancy, and they must have sufficient contact with women to be able to achieve those objectives.

Programs for Parents and their Preterm and Low Birthweight Newborns

Five randomized trials were identified which involved services for parents and their preterm or low birthweight babies (Scarr-Salapatek & Williams, 1973; Field et al., 1980; Barrera, Rosenbaum, & Cunningham, 1986; Resnick, Armstrong, & Carter, 1988; Resnick et al., 1987; Brooten et al., 1986). Four of the five focused on enhancing child development by improving some aspect of parental caregiving. All of these four studies are remarkably consistent in showing that home-visiting programs can increase the intellectual test performance of preterm and low birthweight newborns. In evaluating these studies, it is important to note that at least one (the Miami trial) employed infant test items in the home-visit protocol, so it is difficult to determine the extent to which the higher scores on the infant tests reflect superior cognitive development as opposed to the children's simply learning to solve the test items (Field et al., 1980).

Moreover, two of the studies had trouble maintaining contact with the families for assessments of program impact. In the first Philadelphia study, 93% of the intervention group, but only 60% of the control group were available for end-of-study assessments (Scarr-Salapatek & Williams, 1973). Similarly, the Florida trial was able to assess only 60% of the original sample at 12 months and 24% of the sample at 24 months (Resnick et al., 1987).

Two of the three studies which examined some aspect of the child's physical health as an outcome found postive service effects on the infant's weight gain and overall development. Among those three studies that examined program effects on various aspects of maternal caregiving, all found that at the end of the program, visited families provided homes that were more stimulating for the child's development. The teenaged parents of preterm babies visited in the Miami trial exhibited better interactive behavior with their infants, displayed more realistic attitudes towards child-rearing, and reported that their children had less difficult temperaments than did teenaged parents of preterm babies in the comparison group (Field et al., 1980). Investigators in the Ontario study composed two models of home-visiting programs and found that, compared to controls, parents enrolled in either type of home visiting program provided better home environments and better qualities of interaction with their children, with those enrolled in the parent-child interaction program functioning particularly well (Barrera, Rosenbaum, & Cunningham, 1986). Finally, investigators in the Florida trial found that parents visited at home provided more positive verbal interactions and fewer negative verbal interactions with their

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Review of Research

—David Olds
and Harriet Kitzman

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children (Resnick, Armstrong, & Carter, 1988).

Parents and Children at Social and Economic Risk

Nineteen randomized trials aimed at improving the health and wellbeing of children born to low-income families have been examined (Gutelius et al., 1977; Gutelius et al., 1972; Thompson et al., 1982; Field et al., 1982; Madden, O'Hara, & Levenstein, 1984; Olds, Henderson, Chamberlin et al., 1986; Olds, Henderson, & Kitzman, in press; Olds, Henderson, Tatelbaum, et. al., 1988; Scarr & McCartney, 1988; Booth et al., 1989; Powell & Grantham-McGregor, 1989; van Doorninck et al., 1980; Infante-Rivard et al., 1989; Wasik et al., 1990; Gray et al., 1979; Siegel et al., 1980; Barth, 1991; Barth, Hacking, & Ash, 1986; Hardy & Streett, 1989; Lambie, Bond, & Weikart, 1974; Jester & Guinagh, 1983; Osofsky, Culp, & Ware, 1988; Epstein & Weikart, 1979; Larson, 1980). We have divided these trials into two broad categories: studies aimed at improving children's intellectual functioning, and studies aimed at preventing maltreatment, enhancing child health, or mitigating behavioral problems.

The available evidence suggests that programs that employ nurses, are based on more comprehensive service models, and provide services to poor, unmarried teen parents stand a greater chance of influencing qualities of parental caregiving and the child's intellectual functioning than do narrowly focused programs staffed by paraprofessionals provided to a broad audience.

Fifteen trials placed significant emphasis on children's cognitive and language development by encouraging parents to be more actively involved in promoting their children's intellectual functioning. We have reviewed the studies that included an assessment of program impact on children's mental development and aspects of parental caregiving as a separate group, because the measures employed for these domains are either standardized or have acceptable reliability. Consequently, for this group of studies, we can begin to discuss what factors contribute to program success.

The results of those trials focusing on enhancing a child's mental development are mixed. Out of the 15 studies that examined program influence on children's mental development, six found significant overall program effects (Gutelius et al., 1977; Gutelius et al., 1972; Thompson et al., 1982; Field et al., 1980; Powell & Grantham-McGregor, 1989; Lambie, Bond, & Weikart, 1974; Jester & Guinagh, 1983). In at least one of these studies, however, the findings must be questioned because the final analysis was carried out on groups reconstituted from an extremely complex design in which there were high levels of attrition (Jester & Guinagh, 1983), leading us to question the equivalence of the groups on which the final analysis was performed.

In two of the studies there were modest indications that parental behavior was affected by the program, although there were no indications of program impact on children's intellectual functioning. In the New York City trial, the outcome measures for an increase in maternal teaching behaviors were tied directly to the content of the program materials. Since improved maternal teaching behaviors did not result in improved child intellectual functioning, the full meaning of the program effects is not clear (Madden, O'Hara, & Levenstein, 1984). The findings from the Colorado trial were limited to teens and Hispanics, and the authors offer no explanation as to why Hispanics should benefit more than other ethnic groups (Dawson et al., 1990; Dawson, van Doorninck, & Robinson, 1989). Because these isolated findings are not part of a coherent pattern of results, they are more likely to be chance findings that are not reflective of program impact. Moreover, this trial had substantial attrition. By the end of the 12th month of the child's life, 45% of the control group and 27% of the visited group were unavailable for assessments.

The evidence suggests that low-income, unmarried teenagers are particularly responsive to these types of programs. Three of the programs that produced positive effects on children's intellectual functioning served low-income, unmarried, Black teenaged mothers (Gutelius et al., 1977; Gutelius et al., 1972; Thompson et al., 1982; Field et al., 1982). The fourth served low-income mothers in Kingston, Jamaica (Powell & Grantham-McGregor, 1989). A fifth program carried out in Elmira, New York produced positive effects on the mental development of children whose mothers were primarily poor, white, unmarried teenagers (Olds, Henderson, Chamberlin et al., 1986; Olds, Henderson, Tatelbaum et al., 1986; Olds et. al., 1988). In contrast, of the studies that failed to produce positive effects, only one focused on low-income, unmarried teenagers (Kansas); it consisted of a narrowly defined program carried out by paraprofessionals (Field et al., 1980).

The available evidence suggests that programs that employ nurses, are based on more comprehensive service models, and provide services to poor, unmarried teen parents stand a greater chance of influencing qualities of parental caregiving and the child's intellectual functioning than do narrowly focused programs staffed by paraprofessionals provided to a broad audience. This is not to suggest that paraprofessional programs cannot produce positive effects. Rather, most paraprofessionally staffed programs examined in randomized trials have consisted of narrowly focused programs, which typically have been less successful.

Preventing Child Abuse

With respect to the prevention of child abuse, we now have six trials which have examined this outcome — Elmira (Olds, Henderson, Chamberlin, et al., 1986; Olds, Henderson, Tatelbaum et al.,

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1986; Olds et al., 1988); Colorado 1 (Dawson et al., 1990; Dawson, van Doorninck, & Robinson, 1989); Colorado 2 (Gray et al., 1979); Greensboro (Siegel et al., 1980); California (Barth, Hacking, & Ash, 1986); and Baltimore (Hardy & Streett, 1989). It is particularly difficult to determine whether programs have prevented child abuse and neglect, because there are no standardized measures of maltreatment (Leventhal, 1982) and definitions of maltreatment vary among studies. Most programs have relied upon a combination of reviews of state child protective service (CPS) records and children's medical records.

None of the studies produced overall reductions in the rates of child abuse and neglect derived from reviews of state CPS records. The absence of effect using CPS records should not be interpreted as an indication of program failure, however, because these data underestimate the frequency with which child maltreatment occurs and are prone to detection biases. Visitors in all states are required to report suspicion of maltreatment to the state child welfare agency, so families who receive home visiting are more likely to be detected as maltreating. While there are attractions in relying on the state-defined legal definition and corresponding state records, problems with ascertainment bias and underestimates of the rates make reliance on CPS records an insufficient basis for the determination of child maltreatment.

One study (Elmira), nevertheless, showed a reduction in the rates of state-verified cases of child abuse or neglect among women at greatest risk for care-giving dysfunction, based on standard sociodemographic risk characteristics. In that study, four percent of the children born to nurse-visited poor unmarried teens had verified cases of child maltreatment during the first two years of the child's life compared to 19% of their counterparts in the comparison group. The reduction in state-verified cases of child abuse was corroborated by corresponding reductions in punishment and increases in the number of appropriate play materials observed in the children's homes at 10 and 22 months postpartum, and by reductions in emergency-room visits for injuries and ingestions during the second year of the child's life (Olds, Henderson, Chamberlin, et al., 1986). During a two-year period after the program ended, nurse-visited maltreated children lived in homes that were considerably more conducive to their intellectual social development, and they paid substantially fewer visits to the emergency room and physicians office for injuries and ingestions than did their counterparts in the comparison group (Olds, Henderson, & Kitzman, in press). However, no differences in reported child abuse were realized during the two-year period after the program ended (Olds, Henderson, & Kitzman, in press).

While data on program effectiveness for particular populations ranges from the spectacular to the disappointing, the potential value of home-visiting has only begun to be tapped with existing research designs, methods, and program models.

The absence of program effect on rates of child maltreatment derived from CPS records in other studies should not be viewed automatically as an indication that the program failed to reduce child maltreatment. Home visitors in all states are mandated reporters of suspected child maltreatment, so they are likely to identify emerging cases of child abuse and neglect at relatively early stages and report it to CPS, while the corresponding cases of maltreatment in the control groups are less likely to be detected until they become more serious and observable. There are indications that this type of detection bias may have operated in at least two of the programs (Dawson, van Doorninck, & Robinson, 1989; van Doorninck et al., 1980; Gray et al., 1979). Thus, maltreatment may be reduced by the provision of home-visiting, but its incidence may be detected unequally for the home-visited and control groups.

It is important, in this regard, to note that two of the six trials found significant changes in children's encounters with the health-care system that suggest reductions in either child abuse or neglect. The first Colorado trial found a significant reduction in hospitalization for serious injury, presumably due to abnormal parenting (Gray et al., 1979). The Baltimore trial of a single paraprofessional home-visitor found that the home-visited children made better use of preventive health services (well-child care), had fewer hospitalizations overall, and a lower proportion of cases with severe monilial diaper rash (which health-care providers believe is a reflection of parental caregiving) (Hardy & Streett, 1989). The Baltimore trial is particularly impressive because positive findings were observed for several outcomes that create a coherent picture of reduced caregiving dysfunction.

Studies of Costs and Benefits

Only a few of the randomized trials conducted on home visitation have examined the financial costs and benefits of home-visiting programs for pregnant women and parents of young children. The Philadelphia study of home-visiting following early discharge of low birthweight newborns showed that the visited group spent 11 fewer days in the hospital, weighed 200 grams less, and were 2 weeks younger at discharge than control infants. The mean hospital charge for the early-discharge group was $47,520 vs. $64,940 for the control group, and the mean physician's charge was $5,933 vs. $7,649. The mean cost of the home-visiting program was $576, which produced a mean net savings of $18,560 for each infant (Brooten et al., 1986).

A similar randomized trial was carried out to assess the safety and cost savings associated with the early discharge of full-term newborns. It showed

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that infants and parents who received a program of daily nurse-visiting could be discharged as early as 12 hours after delivery; the median age at discharge for the visited group was 26 hours, compared to 68 hours for the control group. The investigators estimated that the cost of the program (salaries of nurse practitioners, paramedical personnel, and medical consultants, as well as automobile expenses and home-care supplies) was approximately equaled by the hospital costs saved through early discharge (Yanover, Jones, & Miller, 1976). This study and the Philadelphia trial cited above were designed explicitly to reduce costs associated with the postpartum hospitalization of women and their newborns.

In the Elmira trial, the investigators assumed that, if institutionalized, the costs of the program would be covered by government. They therefore compared the cost of the program (nurses' salaries, benefits, supplies, travel, secretarial help, supervision, and agency indirect expenses) expressed in 1980 dollars to the cost of government services (also expressed in 1980 dollars) averted through the first four years of the child's life. Averted government-service costs were estimated by comparing the nurse-visited and comparison group with respect to the costs of Aid to Families with Dependent Children (AFDC), food stamps, Medicaid, child protective services and foster care, as well as increases in government revenues generated by income taxes from the women's participation in the work force. The savings that resulted from averted use of other government services and from increases in government tax revenues were discounted at 3% per year. On average, the prenatal and postpartum program cost about $3,200 for 2-1/2 years of home visiting, or about $1,280 per year. Low-income families (those most likely to use government services) used about $3,300 less in other government services (government service costs minus tax revenues) during each of the first four years of the index child's life than did low-income families in the comparison group. About 80% of the cost savings were concentrated in reductions in AFDC and food stamp payments, and about a third of the savings for low-income families overall were due to a reduction in unintended subsequent pregnancy. These cost savings may continue as the children grow older, but the families have not yet been followed beyond the children's fourth year of life (Olds et al., 1993).

The problems faced by vulnerable families in our society are so immense and the costs of failing to address these problems so great, that we cannot wait for a definitive body of research before we begin to take action. We must set such programs in motion, however, with full awareness that the way the way is not well marked, and that we must continue to invest in efforts to understand how to improve these preventive interventions.

The range of costs for home visiting is quite wide. In the paraprofessional program carried out in Denver by Dawson and colleagues (Dawson et al., 1990; Dawson, van Doorninck, & Robinson, 1989), the cost of the service was estimated at $1,224 per family per year, including salaries for the home visitors and project nurses, mileage, and indirect costs. This figure is similar to the costs of the Elmira program staffed by nurses at about the same time, and less than the cost of Home Start, which was estimated at $1,750 per year per family in 1974 dollars (Love et al., 1976).

Hardy and Streett calculated that their Baltimore program cost about only $60,000 to serve 131 families for a 24-month period (1989). These costs included salaries, fringe benefits, telephone, and administrative costs. The average total program cost was $458 per family for two years, or $229 per year. Although the total number of scheduled visits was only nine during the entire two-year period, the cost of the program was nevertheless remarkably low, especially since the program was carried out in the mid-1980s. Because the cost of this program is so dramatically different from the cost of others, it may not have included all of the same elements in the cost calculation.

Conclusions

Research on the effectiveness of home visiting is in its infancy. While data on program effectiveness for particular populations ranges from the spectacular to the disappointing, the potential value of home-visiting has only begun to be tapped with existing research designs, methods, and program models. In general, narrowly focused home visiting programs did not take advantage of many opportunities for the promotion of numerous aspects of maternal, child, and family health, and the evidence suggests that, at least for programs serving low-income, at-risk parents, those programs were less successful. Moreover, many of the studies failed to measure what the programs tried to affect, which has limited our ability to fully assess program impact and process. In addition, there is considerable room for learning more about the internal workings of such programs, including the impact of the home visitor-parent relationship, the role of program content, and the effects of frequency, timing, and duration of visitation on program success. The presence of so many variables that may affect the outcome of home visiting, of course, complicates the work of program evaluators. We should not be disheartened, however, in that the results from even these early trials can guide program and policy planners in their search for more effective preventive interventions.

Should government invest in home visiting? While there is some evidence that some home-visiting programs are at least revenue neutral from the standpoint of government spending, it must be remembered that program success varies considerably along the dimensions outlined in this review. The problems faced by vulnerable families in our society are so immense and the costs of failing to address these problems so great, that we cannot wait

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for a definitive body of research before we begin to take action. We must set such programs in motion, however, with full awareness that the way the way is not well marked, and that we must continue to invest in efforts to understand how to improve these preventive interventions.

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TOLL-FREE HELP: Nationwide Numbers for Child Abuse and Neglect Services

800-227-5242	American Association for Protecting Children
800-448-3000	Boystown National Hotline
800-I-AM-LOST	Child Find Hotline
800-422-4453	Child Help USA
800-999-9999	Covenant House Hotline
800-221-2681	Family Services of America
800-A-WAY-OUT	Hotline for parents considering abducting their children
800-272-0012	Kevin Collins Foundation
800-872-5437	Missing Children Help Center
800-843-5678	National Center for Missing and Exploited Children
800-222-1464	National Child Safety Council
800-222-2000	National Council on Child Abuse
800-333-SAFE	National Domestic Violence Hotline
800-999-5599	National Information Center for Children and Youth with Handicaps
800-KIDS-006	National Resource Center on Child Sexual Abuse
800-231-6946	National Runaway Hotline
800-621-4000	National Runaway Switchboard
800-442-HOPE	National Youth Crisis Hotline
800-782-SEEK	Operation Lookout, National Center for Missing Youth
800-421-0353	Parents Anonymous (except in California)
800-352-0386	Parents Anonymous (in California)
800-627-3675	Red Flag/Green Flag Resources (sexual abuse prevention materials for children and young women)
800-333-1069	Tough Love (problem teens)
800-236-1222	Tri-County Council on Domestic Violence and Sexual Assault
800-HIT-HOME	Youth Crisis Hotline (child abuse, runaways)

News

—Theresa Reid

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APSAC's mission is to improve society's response to the abuse abuse and neglect of its children by promoting effective interdisciplinary approaches to the identification, intervention, treatment, and prevention of child abuse and neglect.

diversity of the U.S. population and the disproportionate representation of people of color in the social service system, professionals in the field of child maltreatment must be sensitive to cultural differences and adapt their practice accordingly. All faculty for APSAC's 1994 Colloquium have been asked to address cultural issues at every relevant point. For faculty who do not feel adequately prepared, APSAC has identified several experts in cultural issues who will serve as consultants. In addition, nearly one-third of invited faculty are professionals of color, and many invited presentations specifically address cultural issues.

In addition to the two days of invited seminars, APSAC is devoting one of the three conference days to featuring the outstanding work being generated by professionals in the field. With research, skills-building, and poster presentations, APSAC's "Field Day" will present an extended opportunity for formal professional networking.

APSAC's aim for the future is to continue providing the most stimulating professional training in the field. With the thoughtful, sustained input of so many of our members, it will be hard for us to go far wrong.

• **APSAC's own journal.** APSAC's members speak with one voice when asked to name the single most valuable benefit of membership: *The APSAC Advisor*. A major vehicle for fulfilling APSAC's mission of professional education and training, *The APSAC Advisor* has grown far beyond a newsletter into a hybrid newsletter-journal. APSAC's Board of Directors has decided to separate the functions again, and produce both a freestanding quarterly journal and a shorter quarterly *Advisor*. Tentative plans are for the journal to contain the longer, refereed, heavily referenced articles now appearing frequently in *The APSAC Advisor*, plus review articles, some original research publications, and regular departments. According to the tentative plan, *The APSAC Advisor* will contain shorter, less heavily referenced articles, media reviews, Journal Highlights, association and state chapter news, and such features as regular legislative updates. Planning for the journal is now actively underway; publication is expected to begin no later than 1996. APSAC's Board is excited about crafting a second publication that is specifically tailored to the needs of APSAC's members.

• **Media conference.** Most APSAC members have been frustrated in recent months by one or another news broadcast or article that depicts professionals in the field of child maltreatment as at best well-meaning incompetents, at worst malicious ideologues. To a certain extent, the current "backlash" in the popular media reflects the predictable swing of the frenetic pendulum of a largely fad-driven medium. But some media vetting of professional practice in this field is valuable criticism of widespread practices which have not undergone sufficient professional scrutiny. Certainly one of our best defenses against any criticism is to be rigorously self-policing. APSAC's Board sees the task of increasing public awareness of the complex facts about child maltreatment as a clear part of its mission. Professional practice is directly affected when juries and lawmakers believe that children routinely lie about sexual abuse, or that overzealous mandated reporters ruin more lives than they save.

APSAC is trying to use limited funds to affect public awareness through a variety of means: by publicly responding to unbalanced media coverage (e.g., the letter to "Frontline" producer David Fanning, V.6, n.2), by producing press releases on important issues (e.g., press release on sexual abuse allegations in the context of divorce, V.6, n.2), and by writing Op-Ed pieces on important issues (e.g., children's reliability as witnesses, child abuse reporting) and submitting them for publication in major dailies.

In addition, APSAC is devoting resources to planning a media conference—a forum in which child abuse experts and media experts can come together to discuss the facts of child abuse and neglect, the costs of inaccurate, fad-based reporting on the problem, and the ways in which the two professions can work together to advance meaningful public discussion and understanding of the issues.

Significantly influencing public awareness takes a great deal of money and staff time—much more than APSAC currently has at its disposal. We will continue to devote to the effort the resources we can, however, and will keep members regularly informed of the efforts and outcomes.

APSAC's growth in the last few years has been dramatic, never more so than in 1993. Burgeoning state chapter development reflects and stimulates this growth, and provides a fruitful avenue for increasing input from APSAC's members (see story, p. 15-16). It is very exciting to be at the center of this increasingly vital, energetic, effective organization. As more and more professionals in the field of child maltreatment discover APSAC as their natural professional "home," the goals we achieve together are bound to delight us as much as 1993's growth has done. Please stay in contact with your professional society: the more APSAC hears from you, the stronger we all are.

MOVING?

Please notify the office in plenty of time so you don't miss any issues of *The APSAC Advisor* or the *Journal of Interpersonal Violence*.

Infant Home Visitation

—Gary B. Melton

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of the success of such programs in prevention of child maltreatment, better documented than for any other intervention; and such programs' conceptual consistency with the broad-scale social reform that ABCAN believes to be necessary for the protection of children.

In that vein, ABCAN has recommended home visitation as just one of a multitude of measures to increase community involvement in child protection. Indeed, the lengthy, heavily footnoted 1993 report is replete with actions that could be taken toward such an end, and it provides principles to guide child protection efforts in all sectors of society.

A general theme of the U.S. Advisory Board on Child Abuse and Neglect's reports has been that a matter so fundamental as the protection of children's security as persons demands much more careful planning than has typified child protection efforts thus far.

A general theme of ABCAN's reports has been that a matter so fundamental as the protection of children's security as persons demands much more careful planning than has typified child protection efforts thus far. Accordingly, ABCAN argued for incremental movement toward universal availability of home visitation for young families:

> The Board does not wish to oversell universal voluntary neonatal home visitation. It understands: (1) that there is evidence for negative side effects of home visitation programs among families that were already well-functioning; (2) that the positive effects are limited largely to "high-risk" families; (3) that some of the effect sizes are small; and (4) that the level of intervention that is necessary is substantial. (For example, the Hawaii Healthy Start Program, which is clearly the "star" among home visitation programs in the U.S., continues to the child's fifth year.)
>
> The Board also understands that a universal voluntary neonatal home visitation program will not be accomplished easily. The Hawaii program still screens substantially less than 100 percent of the births in that state and then provides a home visitor only to those who are determined to be at high risk. That program, which has taken a while to get off the ground in a small state with a geographically concentrated population, costs $6 million per year, with indigenous paraprofessionals (not public health nurses) as the home visitors.
>
> Moreover, the nations that have adopted home visitation typically have not had programs of the intensity of the [David] Olds approach. They also have national health services.
>
> Complex problems do not have simple solutions. While not a panacea, the Board believes that no other single intervention has the promise that home visitation has.
>
> That is why the 1991 report calls upon the Federal Government to begin the immediate planning for the sequential implementation of a universal voluntary system of neonatal home visitation services. The first step in the planning process should be a large series of coordinated pilot projects to provide information which the Federal Government would need in the establishment and administration of a system.
>
> Among the matters to be studied by the projects would be: costs; the level of program intensity required by families presenting various levels of risk; the optimal size of programs; data collection; staffing needs; training requirements; and differences in program design necessitated by various population groups and geographical locations. To ensure that the information obtained is accurate on a national scale, in the series should be state-wide, reservation-wide, county-wide, city-wide, and neighborhood-wide units (U.S. Advisory Board on Child Abuse and Neglect, 1991, 145).

Unfortunately, neither the Bush Administration, the Clinton Administration, nor the Congress has taken the initiative for such a planned, comprehensive infant home visitation program. It is gratifying to note, however, that many of the states have joined with the National Committee to Prevent Child Abuse (NCPCA) and the Ronald McDonald Children's Charities to initiate home visitation programs, and that the National Center on Child Abuse and Neglect has provided NCPCA with additional support for related evaluation research.

If home visitation is to be universally available to young American families, concerted action by the federal government is likely to be a necessary component. I hope that such involvement will come soon, although I fear that it will not. When it does occur, federal, state, and local governments and the private sector should join to make infant home visitation one step in a broader plan for the creation of caring communities respectful of children and supporting of families. Such an approach is critical to the building and rebuilding of safe environments for children.

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Healthy Families America

—Leslie Mitchel and Anne Cohn Donnelly

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goal is through partnerships among new parent programs. For example, merging a program like First Steps with HFA. First Steps, created by the Georgia Council on Child Abuse is an example of a model already providing short-term educational and support services to all families with newborns (e.g., one or two visits around the time of birth). Since the program is hospital-based and primarily short-term, it provides a solid foundation for identifying families in need of more comprehensive services. In at least two states with First Steps programs, Arizona and Georgia, efforts are underway to introduce a systematic needs assessment and expand the model to incorporate the components of a Healthy Families America system. This type of partnership makes effective use of limited dollars by combining program efforts, which achieves the goal of offering general support and information to all parents and supplementing this with more intensive services to families most in need.

By recognizing that children and families are individuals and entities unto themselves as well as part of a larger community, home visitors serve as a bridge to link parents to the resources they need to better care for themselves and their children.

Coordinated Services: No single prevention or intervention program can address the entire range of families' needs. HFA in and of itself is not a panacea, but is effective as part of a comprehensive effort to link parents and children to care that meets their specific needs. NCPCA's training and technical assistance to HFA planning teams emphasizes and promotes such coordination. For example, the Cooperative Extension System of the U.S. Department of Agriculture, currently trains paraprofessional home visitors to provide guidance on nutrition and household management issues. To avoid wasteful duplication by creating new HFA sites or training new paraprofessionals, communities are being encouraged to build on the Extension's existing system.

No single prevention or intervention program can address the entire range of families' needs. Healthy Families America in and of itself is not a panacea, but is effective as part of a comprehensive effort to link parents and children to care that meets their specific needs.

Similarly, HFA sites seeking to offer parent support groups in addition to home visits are being encouraged to connect with programs already well-established in their community. For example, programs such as MELD (Minnesota Early Learning Design), which has been serving families since 1973, give parents another vehicle for gaining support, through a peer group format with "parents helping parents." And, in addition to providing direct services to families, staff at MELD and other programs can help with ongoing training for HFA paraprofessionals.

Continuity of Care: The home visitor services provided under the Healthy Families America banner are designed to begin intensively and taper off as families grow more stable, autonomous, and responsive to their children's needs. Since families participate in HFA for up to five years, the services are the least intensive just prior to school entry. As a result, a critical element in the HFA criteria is to help enroll families in Head Start or establish program linkages with other school readiness programs. Models such as HIPPY, the Home Instruction Program for Preschool Youngsters, utilize paraprofessional home visitors to work with parents of four- or five-years-olds during the critical transition between preschool and kindergarten. NCPCA and HIPPY hope to build the HIPPY program into one or more existing HFA sites to demonstrate how the two efforts can work together. Finally, there are a multitude of center-based family resource and support programs, often with multiple foci, that can be important resource for families. In addition to general support, these centers offer services such as English as a Second Language classes, clothing exchanges, child care, and literacy education; they are an integral component to the comprehensive array of family support services. And, these centers remain accessible to families following their participation with an HFA site.

Conclusion

The vision of Healthy Families America is to help all adults develop their capacity as parents so that their children can in turn achieve their fullest potential. It is a vision shared and created by the field. But it will only be realized if all HFA efforts are done collaboratively. Only through a coordinated system can we assure that families will receive all of the services they need (with a secure funding base).

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Infant Home Visitation

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(U.S. Advisory Board Reports can be obtained from either the U.S. Government Printing Office or by contacting the Board's office, 200 Independence Ave., SW, Washington, DC 20201; 202-690-8137.)

APSAC FACTS:

Twenty-three states are home to approved APSAC chapters. Professionals are actively forming chapters in 18 additional states and in Puerto Rico. Professionals in Australia, Canada, and the U.S. Armed Forces stationed overseas have expressed interest in developing APSAC chapters as well.

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tics common to abusing parents and to abused children. Community nurses have been significantly influenced in their work by such articles, using the characteristics as "early warning signs" ever since they were first published on a British sample (Lynch, 1975; Lynch et al, 1976; Lynch and Roberts, 1977).

However, recent reviews of the relative value of these characteristics for the practical and routine monitoring of risk in potential child abusing families has emphasized a need for caution (Barker, 1990; Howitt, 1992). Nevertheless, health visitors commonly use checklists of risk characteristics both officially and unofficially. The aim of this risk strategy is to give special attention to those in greatest need of help in parenting before child maltreatment occurs and to distribute the now scarce community resources to their maximal effect. This approach could be regarded as secondary prevention.

Unlike the large number of assessment tools available in North America which have been assessed for reliability and validity for the detection of child maltreatment (see review by Ammerman, 1993), the checklists used by health professionals in the U.K. have not been systematically evaluated. Recently, however, Browne (1993a) prospectively evaluated a typical checklist completed by midwives and health visitors around the time of birth. The checklist was developed from a number of demographic and epidemiological studies carried out in the U.K. with special reference to nonaccidental injury to children in Surrey, England (Browne and Saqi, 1988a).

At a primary preventive level, health visitors have the unique position of being in contact with all families with a newborn. Thus they can offer help and support to parents without stigmatizing the family as a problem family. They may intervene to halt the progression of underlying family processes that lead to the physical and emotional abuse and neglect of children.

To facilitate ease of administration, no more than twelve items of information were selected on the basis that they could be routinely and easily obtained by the health visitor and her nursing colleagues. Items included age of mother, time period between pregnancies, post-delivery separation, evidence of prematurity/low birth weight/handicap, family with separated or single parent, socio-economic problems, history of violence, record of psychological problems or socialization difficulties. Characteristics that were more difficult to assess, such as prenatal experiences, were omitted from the checklist to enhance reliability, and not because they were unimportant.

The concept of the checklist was that, when applied to all families with a newborn child in a given locality, exceptional families with a high number of adverse characteristics (risk factors) were identified as "high risk" and offered intervention. It was assumed that the higher the number of factors present, the greater the intervention required and the more "at risk" the child. Evidence for the predominance in abusing families of the characteristics used for screening had been already well established (Browne and Saqi, 1988a).

Health visitors in conjunction with professional colleagues completed the twelve item checklist outlined above on all children born in 1985 and 1986 in three health districts of Surrey, England. In total, 14,252 births were screened for the potential of child abuse and neglect and seven per cent (964) were indentified as "high risk." The full population of 14,452 children was then followed up for five years and in 1991, 106 families had attended a case conference for suspected or actual maltreatment of their newborn child, giving an incidence rate of 7 children in every thousand. This figure is slightly higher than the national estimate of 5 per 1000 for children under five years (DOH, 1992). Table 1 presents the percentage of abusing and non-abusing families that possessed the checklist characteristics (risk factors), in order of relative importance for prediction.

TABLE 1: *Relative importance of screening characteristics for child abuse (as determined by discriminate function analysis)*

Checklist Characteristics	% Abusing families (n=106)	% Non-abusing families (n=14,146)
History of family violence	30.2	1.6
Parent indifferent, intolerant or over-anxious towards child	31.1	3.1
Single or separated parent	48.1	6.94
Socio-economic problems such as unemployment	70.8	12.9
History of mental illness, drug or alcohol addiction	34.9	4.8
Parent abused or neglected as a child	19.8	1.8
Infant premature, low birth weight	21.7	6.9
Infant separated from mother for greater than 24 hours post delivery	12.3	3.2
Mother less than 21 years old at the time of birth	29.2	7.7
Step parent or cohabittee present	27.4	6.2
Less than 18 months between birth of children	16.0	7.5
Infant mentally or physically handicapped	2.8	1.1

(From Browne 1993a.)

It was found that fully completed checklists, with the relative weighting for each factor taken into account, could correctly classify 86% of potential

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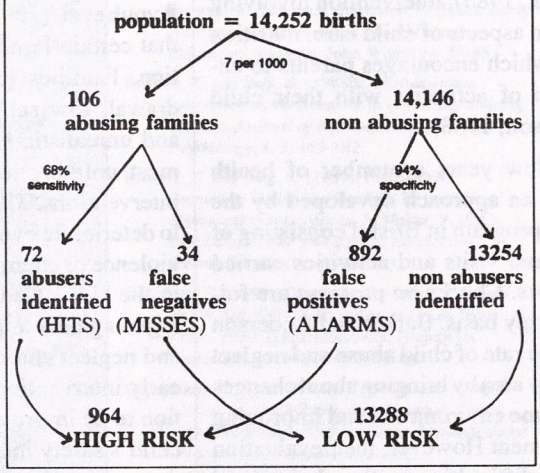
cases. The screening procedure was sensitive to 68% of abusing families and correctly specified 94% of the non-abusing families. Surprisingly, nearly a third of the abusing families had few risk factor characteristics of any weight and were incorrectly indentified as "low risk" around the time of birth. The most worrying aspect of the checklist is that 6% of the non-abusing families were incorrectly identified as high risk for potential child abuse as they were found to have a number of heavy weighted risk factors. Figure 1 shows the grave implications of

FIGURE 1: *Screening effects on a population*



these statistics in terms of the number of families affected in the population studied.

The low prevalence of child abuse combined with even the most optimistic estimates of screening effectiveness implies that a screening program would yield large numbers of false positives (Daniel et al, 1978). The checklist detection rate would mean that for every 14,252 births screened it would be necessary to distinguish between 72 true risk cases and 892 false positives in the 964 cases identified as high risk. This would indicate the requirement of a second screening procedure to be carried out with high risk families based on the significant differences found between abusing and non-abusing parent — child relationships (Browne and Saqi, 1987;1988b). Thus, health visitors might be trained to assess the following characteristics of violent parent — child relationships:

- An evaluation of caretaker's knowledge and attitudes to parenting the child.
- Parental perceptions of the child's behaviour and the child's perceptions of the parent.
- Parental emotions and responses to stress.
- The observation of parent/child interaction and behavior.
- The quality of the child's attachment to his or her parents.

A more difficult problem would be to distinguish the 34 missed cases from the 13,254 correctly identified non abusers as they would be mixed up in a population of 13,288 low risk families.

Therefore, when the checklist is applied prospectively to a large population of births, seven per cent of English families with a newborn child show a high number of "predisposing" factors of child abuse. On follow-up, only 1 in 13 of these "high risk" families went on to abuse their children within five years of birth (Browne, 1993a). On the basis that approximately half of all abused children are under five years of age (Creighton, 1992) this figure should have been considerably higher in order to prevent child maltreatment. However, it must be recognized that risk factors, which are thought to predispose families to child abuse, are not a sufficient causal explanation (Browne, 1989b). The chances of these situational stressors resulting in child abuse and other forms of family violence are mediated by and depend on the interactive relationships within the family and other compensatory factors such as social support.

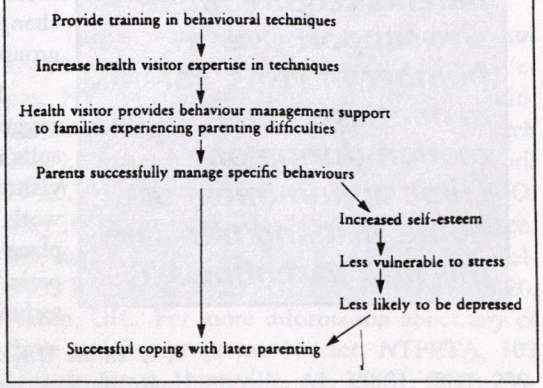
For systematic screening for child abuse and neglect to be successful the health visitors require significant resources to develop reliable and valid methods for detecting risk factors, receive training in methods of screening and the interpretation of risk characteristics, and to implement intervention strategies to prevent or ameliorate undesired outcomes.

Indeed, is it ethical to identify families as high risk without the resources to offer them help and support in reducing their problems?

Intervening to ameliorate parenting problems

At a primary preventive level, health visitors have the unique position of being in contact with all families with a newborn. Thus they can offer help and support to parents without stigmatizing the family as a problem family. They may intervene to halt the progression of underlying family processes that lead to the physical and emotional abuse and neglect of children. It is argued by Stevenson et al. (1988) that interventions which develop parenting behavior will help directly with coping skills and

FIGURE 2: *Intervening to ameliorate parenting problems*



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indirectly by improving the parents' self esteem (see Figure 2).

It is not surprising that parents require intensive support over a number of visits. Parents cannot assimilate information during one clinic appointment or home visit and translate this into parenting skills. Hence, a number of systematic programs of home visiting by trained nurse health visitors in conjunction with other professionals has been used in the U.K. for the following behavioral interventions: treatment of severe and persistent crime in young children (Pritchard, 1986); treatment of severe feeding problems and non-organic failure to thrive (Iwaniec et al., 1985); intervention involving a set of materials on aspects of child care, nutrition and development which encourages parents to engage in a program of activities with their child (Barker and Anderson, 1988).

In the last few years a number of health districts have used an approach developed by the child development program in Bristol consisting of semi-structured home visits and activities carried out by health visitors. Checks on progress are followed up on a monthly basis. Barker and Anderson (1988) claim that the rate of child abuse and neglect can be reduced in any area by bringing about changes in aspects of the home environment and improving the child's development However, their evaluation is undermined by difficulties in the design and analysis of their data (Stevenson, 1989a).

Evaluating Health Visitor Interventions

There have been few studies on the outcome of health visitor interventions. Unfortunately the studies that have been carried out (Stevenson et al, 1988; Weir and Dinnick, 1988; and Nicol et al, 1984) have failed to identify significant effects of health visitor interventions. Weir and Dinnick (1988) give the following possible reasons for this failure:

(1) The possibility that behavior modification is not effective in treating the problem they were concerned with, namely sleep disturbance.

(2) The health visitors were insufficiently trained in behavioral techniques.

It is not surprising that parents require intensive support over a number of visits. Parents cannot assimilate information during one clinic appointment or home visit and translate this into parenting skills.

(3) The rate of spontaneous remission was too high and the sample size too small to show a significant difference in changes between the treated and control groups.

In addition Stevenson et al. (1988) suggest that their lack of significant results may have been due to the health visitors not being supported during their work, and to the evaluation's taking place too soon after the initial training period, before the nurses could use the techniques effectively.

In the U.K. researchers have yet to convincingly demonstrate that nurse health visitors can work effectively by themselves using behavioural management techniques with a wide range of children (Stevenson, 1989b). However, in conjunction with other professional colleagues they show more success (e.g., Pritchard, 1986).

Conclusion

The research of Olds et al. (1986) in the U.S.A. provides a good example of effective interventions in promotioning parental competence and self confidence in dealing with the care and the management of the child. These interventions improve mother/child play and reduce physical punishment and the incidence of child abuse and neglect. However, Ayoub et al. (1993) claim from their work in Boston that certain families do not benefit from intervention. Families presenting with depression, withdrawal, low self-esteem, limited parenting skills and unrealistic expectations of their children, are most unlikely to show change with home-based interventions. There is a tendency for these families to deteriorate even further in the presence of family violence or chemical dependency. Like researchers in the U.K., Catherine Ayoub and her colleagues argue against a quick fix approach to child abuse and neglect and suggest that continuous long-term early intervention is the only way for family function to be improved, and that in some families, the child's safety must be carefully monitored.

Child maltreatment is a complex problem, but the majority of facets appear to respond better to prevention rather than treatment. In the U.K. at present, resources are not available to implement prevention ideas in a way that will maximize their success. Indeed Wolfe (1993) states that "the transition from a reactive to a proactive child protection strategy will be gradual and no doubt expensive in the short term." Unfortunately, the current British Government has chosen to place less emphasis on health visiting, rather than to develop the service further and provide more appropriate training in child protection for community nurses. In future, written and visual information may be provided to parents to compensate for the decreasing contact with families (e.g., Percy and Barker, 1986).

The author wishes to thank Dr. Margaret Lynch for her help with the historical perspectives in this article.

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The homicide rate in the U.S.A. (10 per 100,000 - FBI, 1991) is eight times that of the U.K. (1.3 per 100,000, - Home Office, 1991). The number of children who die of non accidental injury in the U.S.A. is also much higher, but as a percentage of the overall and domestic homicide rates the percentage figures for the two countries remain remarkably similar (Gelles and Cornell, 1990). In both Britain and the U.S.A., child maltreatment is one of the top five most common causes of death to young children.

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NTPETA Begins Model Program with Sites Throughout the Nation

The National Training Program on Effective Treatment Approaches in Child Sexual Abuse (NTPETA) has developed and will be presenting a state-of-the-art curriculum for therapists who treat sexually abused children. Twenty sites from across the country have been chosen as training sites for this model program

Topics covered during the training include language skills to enhance communication with children and adolescents; expressive techniques; assessment and treatment planning; specific treatment provider issues, such as needs and approaches for self-care and assuring culturally sensitive practices; working with sexually reactive children; appropriate termination of treatment; and serving non-offending parents and siblings.

The dates and sites for the programs are January 10-12, Syracuse, NY; February 15-17, Las Vegas, NV; March 7-9, Boise, ID; March 14-16, LaPlata, MD; March 22-24, Swainsboro GA; March 28-30, Sacramento, CA; April 4-6, Plano, TX; April 18-20, Arvada, CO; May 12-14, St. Louis, MO; May 16-18, Spokane, WA; May 23-25, Kalamazoo, MI; June 6-8, Houston, TX; June 20-22, Philadelphia, PA; June 27-29, Ogden, UT; July 18-20, Akron, OH. For more information about any of these training programs contact: NTPETA, 107 Lincoln Street, Huntsville, AL 35801; (800) 239-9939.

U.S. DEPARTMENT OF JUSTICE

Office of Justice Programs

The OVC sponsors many events to focus public attention on crime victim needs and to advance crime victim rights, including hosting an event during the annual National Crime Victims' Rights Week which honors the accomplishments of outstanding victim advocates.

Office For Victims of Crime

The Office for Victims of Crime (OVC), created in 1985, is one of five agencies within the Office of Justice Programs, U.S. Department of Justice has served as the Federal government's focal point for all issues affecting crime victims. The Crime Victims Fund, which is the responsibility of the OVC, is the primary financial resource for all federally supported victim programs. The fund is supported, not by tax dollars, but through the fines paid by persons convicted of federal crimes. It supports rape crisis hotlines, shelters for battered women, therapy for abused children, as well as direct costs, such as medical expenses not covered by insurance.

Grant Programs

Formula Grant Program

OVC's State Compensation and Assistance Division is responsible for awarding the following formula grants:

• *The Crime Victim Compensation Program* helps victims cope with financial problems left in the wake of crime. Each state is awarded forty percent of the amount it distributes in compensation per year, so that Federal dollars reinforce the state's commitment to its own compensation programs.

• The *Crime Victim Assistance Program* helps provide services like shelters for victims of domestic violence, childcare for victims who appear in court, and counseling for abused children.

Discretionary Grant Programs

Federal Crimes Victims Division

These programs are directed at undeserved or isolated victim populations, and also provide training and technical assistance to improve the quality of service to these populations. They include:

• *The Emergency Service Fund* provides funding for emergency situations where victims and witnesses do not have access to local resources.

• *Assistance for Federal Victims of Crime in Indian Country Grant Program* provides culturally competent victim assistance for Native American communities on Federal lands.

• *Children's Justice Act Discretionary Grant Program for Native Americans* improves the investigation and prosecution of child abuse in Native American communities on Federal land.

• *Training and Technical Assistance for Federal Officials* is available to federal prosecutors, law enforcement officers, victim witness coordinators, and corrections officials.

Special Projects Division

This division designs discretionary grant programs to facilitate victim assistance provision nationwide. Grants have provided assistance to exploited children transported across state lines, supported investigation and prosecution of child abuse, advanced victim awareness of civil legal remedies against perpetrators. Another aspect of this division is to implement the recommendations set forth in the President's Task Force on Victims of Crime, 1982 Final Report, by working to institutionalize an awareness of victim rights among criminal justice system professionals. This is done through OVC-sponsored training and technical assistance for these professionals.

Non-grant related leadership efforts

The OVC sponsors many events to focus public attention on crime victim needs and to advance crime victim rights, including hosting an event during the annual National Crime Victims' Rights Week which honors the accomplishments of outstanding victim advocates. In addition, the OVC plays a key role in monitoring and facilitating Federal agency compliance with stationary mandates affecting victims. Typical statutes that the OVC monitors includes The Victim Witness Protection Act of 1982, The 1990 Crime Control Act, The Victims Rights and Resolution Act of 1990, and The Victims of Child Abuse Act of 1990.

The Office for Victims of Crime embraces a multi-dimensional role at the Federal level as an advocate for crime victims. The goal of the OVC is to draw public attention to crime victim needs and to promote victim rights through legislation and public policy. For additional information please contact: Office of Victims of Crime, 633 Indiana Avenue, NW, Washington, DC 20531; (202) 514-6444.

HELP APSAC GROW

Do you belong to another professional organization—national or local—which shares APSAC's interest in child maltreatment? Would those colleagues benefit from knowing more about APSAC and the work we do? Contact the national office for information that can be distributed to other groups. Phone 312-554-0166 or Fax 312-554-0919

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CONFERENCE NEWS

The San Diego Conference on Responding to Child Maltreatment: January 24-28, 1994

APSAC is proud to be a cooperating organization for the San Diego Conference on Responding to Child Maltreatment, sponsored by the San Diego Children's Hospital Center for Child Protection. For years, David Chadwick, MD, Director of the Center, has presented one of the premier conferences in the field; his 1994 conference will be no exception.

The San Diego conference features general sessions on "The role of prosecutors in a national agenda for children" (Patricia Toth), "The international response to the abuse and neglect of children" (Richard Krugman), "Programs, policies, and directions for preventive services" (David Olds), "Futurecasting: Child welfare at a crossroads" (Charles Wilson), "Children in cults: A law enforcement perspective" (Ken Lanning), and "The 'backlash' in historical perspective" (Erna Olafson).

Workshops and forums will be presented on such topics as culturally competent interviews with Native American offenders, victims, and families; recent Federal and State legislation in child protection; accommodating child witnesses v. defendants' rights; child abuse in the military; case management in remote areas; and how not to interview young children. An intensive series of workshops on head injuries will be offered for medical professionals, as will a forum for investigators.

Additional activities will include all-day APSAC Advanced Training Institutes on January 24, a general APSAC meeting on January 25, an annual CAPSAC meeting and luncheon on January 27, and APSAC task force meetings every afternoon. Continuing education credits are available for all sessions.

Attorney General Janet Reno has been invited to give the Conference's keynote address.

A partial list of conference offerings cannot do justice to the richness and variety of the program. We hope that you are able to join us in San Diego to experience that for yourself. For more information please contact Robbie Webb at the Center for Child Protection, 619-495-4940.

ANNOUNCEMENTS

National Teleconference on Child Death Review Teams. February 16-17, 1994. Sponsored by the U.S. Department of Justice in conjunction with South Carolina Educational Television.

This national teleconference will provide top-quality training at no charge to jurisdictions developing or operating multi-agency child death review teams. A video telecourse and instructional guides will be prepared from the teleconference and will be available at low cost. To participate, you should identify a "satellite downlink site" in your area, such as a local public television station or some local universities. To take advantage of this remarkable free training please contact: Kathryn Turman, M/CAP Project, 8301 Greensboro Drive, Suite 420, McLean, VA, 22102; phone 703-734-8970; FAX 703-734-4965.

POSITION ANNOUNCEMENTS

LICENSED CLINICAL SOCIAL WORKER. Full-time with benefits. Various duties in hospital setting and new child advocacy center. Assessments/interviews of alleged child abuse victims.

Qualifications: Interviewing and assessment skills, knowledge of childhood trauma and sexual abuse. Ability to work with children.

Contact: Barbara Cohen, LCSW; Manager, Soc. Svces. Dept.; St. Charles Medical Center, 2500 NE Neff Rd., Bend, OR 97701. 1-800-446-2177.

CLINICAL COORDINATOR. provide management & supervision of clinical program for nonprofit; Masters in social work or psych. license eligible or current TN license as social worker/psych. examiner; min. 2 yrs. supervisory clin. experience post licensure; 2 yrs. prof. experience w/ sexually abused children & families; 2 yrs. supervisory or administrative role.

CLINICAL SPECIALIST. PT; conduct extensive assessment & crisis counseling; Masters social work or psych.; license eligible or current TN license as social worker/psych. examiner; 2 yrs. supervisory clin. experience post licensure; 2 yrs. prof. experience w/ sexually abused children & families pref.

CLINICAL SPECIALIST. FT; conduct extensive assessments & crisis counseling; Masters social work or psych.; license eligible or current TN license as clinical social worker/psych. examiner; min. 2 yrs. supervised clin. experience post licensure w/ sexually abused children & families pref; multicultural experience.

Contact: Children's Advocacy Center, PO Box 6186, Chattanooga, TN 37401-6186; EOE.

CONFERENCES

APSAC Discounts

January 24-28, 1994. ***The San Diego Conference on Responding to Child Maltreatment.*** Cosponsored by San Diego Children's Hospital Center for Child Protection and APSAC. Call Robbie or Diane at 619-576-5814.

February 18-20, 1994. ***Children, Mental Health and the Law.*** Miami, FL. Topics include: sexual abuse, child abuse, competency, deliquency, expert testimony, custody, hospitalization, dangerousness, and ethical issues. Sponsored by Forensic and Clinical Psychology Associates and the University of Miami School of Law. Contact, Dr. Bruce Frumkin, 305-666-0068, FAX 305-666-8283.

May 4-7, 1994. ***APSAC's Second National Colloquium.*** Cambridge, MA. Call Latrice Woods at the APSAC national office, 312-554-0166.

Other Conferences

January 24-28, 1994 or February 7-11, 1994. ***National Community Crisis Response Team Training Institutes.*** Washington, DC. Contact, Director of Training, National Organization for Victim Assistance, 1757 Park Road, NW, Washington, DC, 202-232-6682.

February 11, 1994. ***Evaluation & Intervention with Juvenile Sex Offenders: Putting the Pieces Together.*** Columbus, OH. Sponsored by Children's Hospital and the Governor's Office of Criminal Justice, State of Ohio. Featuring John Hunter, PhD.

February 20-22, 1994. ***Theory to Practice...& Beyond: Delivering Restorative Justice to Sexually Abusive Youth.*** Denver, CO. Sponsored by Kempe National Center, University of Colorado, Health Sciences Center. Contact Kempe National Center, NAPN CONF., 1205 Oneida St., Denver, CO, 80220-2944.

February 22-26, 1994. ***National Symposium on Child Sexual Abuse.*** Huntsville, AL. Sponsored by National Children's Advocacy Center. Contact Marilyn Grundy, 205-533-6129.

February 27- March 2, 1994. ***21st National Conference on Juvenile Justice.*** Boston, MA. Sponsored by the National Council of Juvenile & Family Court Judges and National District Attorneys Association. Contact, National District Attorneys Association, 703-549-9222.

March 20-26, 1994. ***The 15th Anniversary Children and Hospitals Week.*** Bethseda, MD. Sponsored by The Association for the Care of Children's Health. A major public awareness campaign. Contact, Trish McClean, CHW Coordinator, 301-654-6549.

April 13-14, 1994. ***Prevention Works Wonders Conference.*** Austin, TX. Sponsored by Children's Trust Fund of Texas Council. Contact, Children's Trust Fund of Texas Council, 512-458-1281.

April 21-23, 1994. ***Seventh National Conference on Children and the Law.*** Washington, DC. Sponsored by the ABA Center. Contact, ABA Center on Children and the Law, 202-331-2250.

May 22-25, 1994. ***29th Annual Conference: Dreams, Schemes, & Flying Machines: Tools for Pediatric Health Care in the '90's...and beyond.*** Bethseda, MD. Sponsored by Association for the Care of Children's Health. Contact, Conference Administrative Coordinator, 301-654-1205.

July 31-August 2, 1994. ***National Symposium on Child Fatalities: The Missouri Experience.*** Sponsored by Missouri Dept. of Social Services State Technical Assistance Team (STAT), the Missouri Institute of Mental health, and the University of Missouri-Columbia School of Nursing and School of Health Related Professions. Call Karen Phodes 314-644-8803

August 4-7, 1994. ***12th Annual VOICES In Action Conference.*** Chicago, IL. Sponsored by VOICES. **Workshop proposals due January 30, 1994.** Contact, Nina Corwin, VOICES; Box 148309, Chicago, IL 60614, 800-7VOICE8.

APSAC members represent a broad diversity of professional disciplines, geographic locations, and conceptual orientations. Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence.

Announcing!

Second National Colloquium

The American Professional Society on The Abuse of Children

●

May 4–7, 1994

●

Hyatt Regency Cambridge, Massachusettes

MARK YOUR CALENDAR NOW!

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$50,000 annual income and above.	$85
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Under $50,000 annual income	$100

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(004) Education	(005) Judiciary	(006) Law
(007) Law Enforcement	(008) Medicine	(009) Ministry
(010) Nursing	(011) Offender Treatment	(012) Probation
(013) Psychiatry	(014) Psychology	(016) Social Work

Method Of Payment

Payment must be made in US funds, by check, charge, money order, or New York draft.
Visa or MasterCard payments may be FAXed to 312-554-0919.

$ _____ is enclosed for membership dues.

$ _____ *Please also accept this voluntary tax-free gift for APSAC's Endowment Fund.*

$ _____ **Total amount enclosed.**

Check # _____ ❑ Visa ❑ MasterCard

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Please note: *In renewing a membership, APSAC members certify their continuing compliance with the standards of conduct appropriate for APSAC members, including, but not limited to, the professional and ethical standards of, and all laws and regulations relating to, their respective professions.*

APSAC is pleased to participating in **"Child Abuse and Neglect: The People of Color Leadership Institute" (POCLI).** The goal of POCLI is to promote the leadership of people of color in child protective systems and to improve the cultural competence and sensitivity of those systems that affect families of color. As part of the effort to evaluate the effectiveness of POCLI, APSAC would like to gather information on the cultural diversity of its membership. Your participation is strictly voluntary.

I consider my cultural group identification to be: _____ (please specify)

American Professional Society on the Abuse of Children
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