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Serving highly vulnerable families in home-visitation programs

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Abstract

Home-visitation programs for families with young children are growing in popularity in the US. These programs typically seek to prevent child abuse and neglect and/or promote optimal development for infants, toddlers, and/or preschool-age children. This paper focuses on improving the capacity of home-visitation programs to meet the complex needs of highly vulnerable families with young children. Poverty, maternal depression and substance abuse, and domestic violence are noted as factors that place young children at risk for poor outcomes. The challenges of providing home-visitation services to families in which these risk factors are present are discussed. Family engagement, matching services to families' needs, and staff capabilities are highlighted as areas in which improvements can be made to enhance home-visitation programs' capacity to serve highly vulnerable families. Recommendations are given for improving the effectiveness of home-visitation programs in serving these families, as well for addressing policy and research issues related to the further development and evaluation of these programs.

Key words: home visitation, home visiting, highly vulnerable families, family engagement, early childhood programs, family support

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Serving Highly Vulnerable Families in Home-Visitation Programs

With increasing recognition of the importance of intervening early in the lives of vulnerable children, programs that provide home-based services to young children and their families are receiving greater attention as mechanisms for promoting children's development and well-being. Several of these programs are undergoing significant expansion with the provision of substantial funding for home-visitation in the 2010 federal health care reform act (Health Resources and Services Administration, 2010). The potential benefits of home-visitation programs have been documented by the evaluation of various program models, several of which show modest, positive impacts for young children and their families. However, the degree to which prominent models of home-visitation have the capacity to meet the needs of young children at high levels of risk for poor outcomes and their families is unclear and warrants further examination.

This paper reviews the literature with a focus on improving the capacity of home-visitation programs to meet the complex and sometimes overwhelming needs of highly vulnerable families with young children. This discussion begins with a brief overview of the most widely replicated home-visitation programs followed by a description of key factors that threaten the optimal development and well-being of a significant portion of young children and families in the US. Three important aspects of home-visitation programs: family engagement, staff capabilities and characteristics, and matching services to families' needs, are discussed in the context of improving programs' capacity to meet the needs of highly vulnerable families. Recommendations are offered for improving the quality, effectiveness, and relevance of home-visitation programs in serving highly vulnerable families; as well as for addressing critical policy and research issues related to the further development, expansion, and evaluation of these programs.

An Overview of Home-visitation Programs

Support for home-visitation programs as a strategy for improving the well-being and life chances of vulnerable, young children has grown dramatically in recent years and continues to rise. Much of this support is driven by recent research findings that demonstrate the profound effects of early life experiences on the development and structure of the brain, as well as on children's social and emotional development and lifelong capacity for learning (Center on the Developing Child, 2007; Shonkoff & Meisels, 2000; Shonkoff & Phillips, 2000).

Recognition of the importance of intervening early in the lives of vulnerable children, along with compelling results from the evaluations of a few, prominent home-visitation programs has propelled these programs to share top-billing with expanded pre-kindergarten programs as strategies for improving school readiness as well as impacting other factors related to child well-being and future success (Killburn & Karoly, 2008; NGA Center for Best Practices, 2011; Rand Corporation, 2008). As a result, state and federal funding and support from private foundations for home-visitation programs have grown steadily. These programs will further expand over the next few years with the passage, in 2010, of the federal Patient Protection and Affordable Care Act (PL 111-148, 2010), which included approximately $1.5 billion over a five year period for significant expansion of home-visitation programs across the country (Children's Defense Fund, 2010; NGA Center for Best Practices, 2011).

A variety of intervention models fall into the category of home-visitation programs, although all deliver services through regularly scheduled visits to the homes of families with young children. Six programs are often singled out for being provided through multiple sites across the country and serving children from birth - or from the prenatal stage - to age three or five years. These programs are Healthy Families America (HFA), Nurse-Family Partnership (NFP), Early Head Start (EHS), Parents as Teachers (PAT), Home Instruction for Parents of Preschool Youngsters (HIPPY) and the Parent-Child Home Program (PCHP) (Gomby, 2005; Sweet & Appelbaum, 2004; Weiss & Klein, 2006).

Most home-visitation programs have some goals in common, including promoting early

learning and optimal development in young children, and improving parents' competence in caring for their child and stimulating his/her learning and development (Azzi-Lessing, 2011; Johnson, 2009). Moreover, reducing the risk of child abuse and neglect is a goal for several of these programs. Home-visitation programs typically educate parents regarding children's development and effective parenting skills. Most programs also work to connect families with additional resources in their communities, including child care and health care (Gomby, 2005; Gomby, Culross, & Behrman, 1999).

Despite their growing popularity, there is considerable uncertainty regarding the efficacy of home-visitation programs to produce meaningful and lasting outcomes for the children and families they serve. In analyzing evaluation results from these programs, some experts have noted that, overall, program effects are modest (Daro, 2006; Gomby, 2005; Sweet & Appelbaum, 2004); while others have pointed to modest program outcomes as encouraging indicators of the potential that these programs hold (Howard & Brooks-Gunn, 2009; Weiss and Klein, 2006). More-recent evaluation findings, especially those from Early Head Start, are more encouraging. The multi-site evaluation of Early Head Start identifies a number of benefits for participating children and their families (Administration for Children and Families, 2006; Love et al., 2005). The extent to which the benefits of EHS and other home-visitation programs are sustained is not yet clear (Sweet & Appelbaum, 2004).

There is consensus among researchers and policy experts regarding the need for more information about how home-visitation programs work and a clearer picture of the benefits they provide. Moreover, there is growing recognition that improvements must be made in the quality and types of services provided by home-visitation programs if they are to be effective in improving the life chances of young children at the highest levels of risk for poor outcomes (Astuto & Allen, 2009; Chaffin, 2004; Daro, 2006; Duggan et al., 2007; Gomby, 2007; Gomby, 2005; Jones Harden, 2010).

Challenges in Serving Highly Vulnerable Families

Conditions that Create High Levels of Vulnerability in Young Children

A growing body of research shows that a number of contextual factors can have harmful effects on children's cognitive, social, and emotional capabilities (Berger et al., 2009; Brooks-Gunn & Duncan, 1999). Researchers single-out three factors: maternal depression, maternal substance abuse, and domestic violence, as particularly harmful to the well-being and healthy development of young children (Carter et al., 2001; Corvo & Carpenter, 2000; Hans, Bernstein, & Henson, 1999; Huang & Freed, 2006; Westbrook & Jones Harden, 2010; Whitaker, Orzol, & Kahn, 2006). Although none of these risk factors are unique to families living in poverty, the stress of being poor combined with a lack of supports often conspire with these factors to increase harmful impacts on young children. (Berger, et al., 2009, Brooks-Gunn & Duncan, 1999; Chaffin, et al., 2001; Jones Harden, 2010; Petterson & Albers, 2001; Westbrook & Jones Harden, 2010; Whitaker et al., 2006). Poverty itself is widely recognized as a powerful risk factor; its threat to the healthy development of young children rising in proportion to the level of poverty and deprivation that children and their families experience. Moreover, there is evidence that extreme poverty has a greater negative impact on children's development when it occurs in the earliest years of life (Brooks-Gunn & Duncan, 1997; Ratcliffe & McKernan, 2010).

It has long been recognized that the presence of multiple risk factors, such as maternal depression and domestic violence, as well as the interactions between such risk factors, can create a cycle of extreme stress for affected families (Belsky & Jaffee, 2006; Chaffin et al., 2001; Halpern, 2000; Osofsky & Thompson, 2000; Whitaker et al., 2006). Young children who are continuously exposed to such stressors are at greater risk for child abuse and/or neglect and other forms of trauma, in addition to impaired cognitive development and mental health problems (Corvo & Carpenter, 2000; Osofsky & Thompson, 2000). The conditions that commonly occur in very low-income neighborhoods, such as frequent episodes of community violence, inadequate housing, and a shortage of social and recreational resources, heighten the levels of

isolation and stress experienced by the families who live there (Drake & Rank, 2009; Webb, 2003; Zeanah & Scheeringa, 1996).

Mediating and Moderating Effects of Family Risk

The degree to which the current cadre of well-known home-visitation programs has the capacity to achieve meaningful and lasting outcomes for children and families encountering multiple and significant challenges, particularly domestic violence, substance abuse, and maternal depression, is not yet clear. Various risk factors appear to mediate and moderate program impacts in complex ways that are not well understood.

Stevens et al., (2002), found that nearly 30% of mothers in a HFA program scored in the clinically significant range for depression and nearly 70% had experienced at least one violent trauma. Mothers in this study, who had a history of violent trauma, experienced more interruptions in service delivery, as reflected by fewer home visits. Similarly, Raikes et al. (2006) found that EHS families headed by mothers at higher levels of risk received fewer home visits and that visits to these families were less child focused than those received by lower-risk families. It is likely, as the authors speculate, that addressing various family risk factors diverts home visitors' attention from working with parents to promote optimal learning and social-emotional development in their children – an activity that appears to be critical to improving outcomes for children in home-visitation programs (Raikes et al., 2006). It is also likely that parents' capacity to focus on their children's learning and development is severely diminished when problems such as domestic violence, substance abuse, and depression are unaddressed and unresolved.

Home-visitation programs' impacts on families facing serious risk factors have been mixed. Tandon and colleagues (Tandon, Parillo, Jenkins, & Duggan, 2005) reported that over half of mothers participating in the home-visitation programs they studied were identified (by researchers) as affected by a mental health, substance abuse, or domestic violence problem. However, only one-quarter of the mothers received services to address these problems. Similarly,

Duggan et al. (2004) found that the HFA program they evaluated had little effect upon the serious risk factors, including domestic violence and substance abuse that the families in the program encountered. Evaluations of NFP found no effects on maternal depression (Gomby, 2005). Moreover, although the initial evaluation of NFP that took place in the late 1970's indicated that the program reduced some risk factors for child abuse and neglect, NFP was unsuccessful in ameliorating such risk for children in families affected by domestic violence (Eckenrode et al., 2000).

The much-larger, national evaluation of EHS showed encouraging but not significant results in reducing depressive symptoms in low-income mothers as their children reached age three (Lombardi & Bogle, 2004). Significant positive impacts on maternal depression did emerge, however, two years after EHS services ended, when participating children were age five (Chazan-Cohen et al., 2007). The national evaluation of EHS also found that, although families at highest levels of risk appeared not to benefit from EHS by the time the children turned three, some favorable impacts on parenting ability and home environment also emerged as the children in these families entered kindergarten (Administration for Children and Families, 2006).

The pathways through which EHS affects maternal depression and parent-child interaction appear to be complex. For instance, a small study of two EHS programs found strong, favorable impacts on dimensions of parent-child interaction, but only among depressed mothers and among mothers affected by both depression and insecure relationship attitudes. However, no significant impacts were found for the EHS programs, on levels of maternal depression and insecurity (Robinson & Emde, 2004). These findings indicate that EHS may improve parenting behaviors associated with depression even when the program does not appear to help alleviate parents' depression.

Although inconsistent definitions of risk across various home-visitation programs make it difficult to determine levels of risk experienced by participating families, it is apparent that these programs often fail to benefit families that are facing extreme and/or multiple risk factors

(Chaffin et al., 2001; Duggan et al., 2004; Guterman, 1999; Josten et al., 2002). Substance abuse and mental health problems, episodes of domestic violence, and frequent crises often reduce families' availability for and capacity to participate in home visitation programs (Brookes, Summers, Thornburg, Ispa, & Lane, 2006; McGuigan, Katzev, & Pratt, 2003; Raikes et al., 2006). Moreover, home-visitation programs often lack the resources, including qualified staff members, necessary to identify and effectively address these serious risk factors (Duggan et al., 2004; Hebbeler & Gerlach-Downie, 2002).

Improving Programs' Capacities to Serve Highly Vulnerable Families

Three aspects of home-visitation programs: family engagement, the characteristics and competencies of home visitors, and matching services to families' needs are frequently identified as critical to program success. Each of these aspects of home-visitation programs and their respective roles in improving the capacity of home-visitation programs to successfully serve highly vulnerable families are discussed below.

Engaging Highly Vulnerable Families

The importance of family engagement. Korfmacher et al. 2008 define family engagement as the "emotional quality of a family's interaction with a program" and distinguish it from participation, which they define as the quantity of involvement (i.e. number, duration, and frequency of visits). Levels of family engagement affect whether families will participate in a given program, the amount of time they will devote to participation, and the quality of their participation (Brookes et al., 2006; Damashek, Doughty, Ware, & Silovsky, 2011; Roggman, Boyce, Cook, & Jump, 2001).

Challenges in engaging highly vulnerable families. Researchers studying a variety of home-visitation programs note difficulties in engaging highly vulnerable families, although a few studies indicate exceptions. Several studies have found that families at higher levels of risk often participate in home-visitation programs at minimum levels and/or prematurely withdraw from

program services than families at lower levels of risk (Gomby, Culross, & Behrman, 1999; Hebbeler & Gerlach-Downie, 2002; McGuigan et al., 2003; Raikes et al., 2006; Robinson et al., 2002; Roggman et al., 2008; Wagner et al., 2003). Part of the reason for this may be the degree to which highly vulnerable families are overwhelmed by the stressful conditions under which they live; they may also be responding to a history of negative experiences with service providers, especially regarding child protective and other mandated services (Kerkorian, Bannon, & McKay, 2006; Madsen; 2007; McCurdy & Daro, 2001; Roberts, 1990; Webb, 2003). Families of color, which are more likely to be poor and therefore affected by the multiple risk factors associated with poverty, may be reluctant to engage in home visitation and other services, due to experiences with racism and/or oppression in past encounters with formal service systems (Huang & Isaacs, 2007; Slaughter-Defoe, 1993).

A few studies have reported levels of engagement that were somewhat higher for families facing significant risk factors, including maternal depression (Damashek et al., 2011; Girven et al., 2007), and domestic violence (Ammerman et al., 2006; Damashek et al., 2011; Daro et al., 2003; Duggan et al., 2000; McGuigan et al., 2003) than they were for families at lower levels of risk. These higher levels of engagement appear to be related to a number of variables including family, program, and home-visitor characteristics, as well as interactions between these variables. Brookes et al. (2006) found that inadequate resources and frequent relocations decreased levels of family participation in the EHS program they studied; however, families often participated at very high levels during periods of crisis. Further research is needed in order to better understand how variables such as parent motivation in the face of stressful situations and home visitors' level of expertise in addressing serious problems, impact family engagement.

Enhancing engagement strategies. Given the elevated levels of stress, social isolation, and negative encounters with service providers that highly vulnerable families often experience (Madsen, 2007; McGuigan et al., 2003; Slaughter-Defoe, 2003; Webb, 2003) it is important to develop strategies that motivate these families to fully participate in home-visitation services.

Such strategies should include increasing attention to the formation of close relationships between home visitors and families, employing engagement strategies that emphasize families' strengths and family empowerment, and incorporating culturally competent practices (Madsen, 2007; Wasik, 1993; Webb, 2003). Moreover, although most studies of home-visitation programs emphasize the engagement of mothers; there is increasing recognition of the importance of engaging fathers, mothers' partners, and extended family members, as well (Brookes et al., 2006; Johnson, 2004; Jones Harden, 2010; McGuigan et al., 2003). These additional participants can be important sources of support to mothers and their young children, and should be included in family engagement efforts.

The degree to which home visitors convey respect for parents' competence and acknowledge families' strengths is also a critical aspect of building relationships with parents and increasing their motivation to participate in programs. (Dunst, 2000; Wasik, 1993). Green, McAllister, and Tarte (2004) developed a parent-report tool, the Strengths-Based Practices Inventory (SBPI), for assessing the degree to which service providers employ practices that recognize and enhance family strengths and support family decision making. When used with a group of largely African-American EHS participants, families that reported higher scores on the SBPI participated in more home visits and scored higher on measures of parent empowerment than families reporting lower scores (Green et al., 2004). A study that compared various approaches to engaging and working with families found that parents were more likely to view staff members as effective helpers in programs that involved parents in decision making about various aspects of the program. (Dunst, Boyd, Trivette, & Hamby (2002).

Child FIRST, a home-visitation program serving families at higher levels of risk, employs strengths-based and shared decision-making approaches along with customized service planning and delivery. This program has demonstrated promising levels of engagement and outcomes for families affected by poverty and substance abuse, among other risk factors (Lowell, Paulicin, Carter, Godoy, & Briggs-Gowan, 2011). Damashek and colleagues (2011)

augmented SafeCare (SC), a home-visitation program designed to prevent the maltreatment of young children, with Motivational Interviewing (Miller & Rollnick, 2004), "an approach to therapy designed to strengthen motivation to change, build commitment, promote decisions for positive change and increase self-efficacy" (Damashek, Doughty, Ware, & Silovsky, 2010, p.10), in order to increase families' likelihood to enroll in and complete SC services. The combined home-visitation service, called SC+, was compared to Services as Usual in a randomized control trial that enrolled families affected by depression, substance abuse, and/or domestic violence. Families with one or more of these risk factors were more likely to enroll in and complete SC+ than those who participated in Services as Usual.

These findings indicate that further experimentation with strengths-based and empowerment-oriented approaches (which include shared decision making) should occur, particularly in home-visitation programs seeking to improve parents' motivation in families at higher levels of risk. Assessment protocols, such as the SBPI that inventory the unique strengths and assets of individual families in addition to the challenges and problems they encounter, and intervention strategies such as MI, which promote commitment and self-efficacy, should be incorporated and evaluated. Parents' roles in determining the goals and objectives of the services they receive should be amplified, and programs should assist parents in developing problem-solving and self-advocacy skills. (Eamon, 2008; Madsen, 2007; Saleebey, 2008).

It is important to note that a strengths-based, empowerment-oriented approach to working with families does not preclude confronting parents about significant risk factors such as domestic violence and substance abuse, and working to obtain their commitment to addressing these risks (Dunst & Deal, 1994). It is often necessary for service providers to educate parents regarding the implications that such risk factors have for the healthy development and overall well-being of their children (Duggan et al., 2007; Tandon, Mercer, Saylor, & Duggan, 2008). Doing so in way that conveys respect for parents, acknowledges their strengths, and elicits their agreement to address challenging issues, such as domestic violence and substance abuse, requires

a specific set of skills including strong communication skills, the use of non-judgmental language, and high levels of interpersonal warmth (Dunst & Deal, 1994). Greater attention should be focused on this complex aspect of family engagement, in order to develop specific strategies for improving the capacity of home-visitation programs to effectively serve highly vulnerable families. Moreover, programs should provide home visitors with appropriate training and adequate supervision in order for them to develop the skills necessary to achieve and maintain the engagement of families affected by serious psychosocial challenges (Madsen, 2007).

Characteristics, Preparation, and Support of Home Visitors

Home visitors' characteristics. The experiences, personality characteristics, and competencies (type and amount of education and training) of home visitors contribute to their effectiveness, especially with highly vulnerable families (Astuto & Allen, 2009; Jones Harden, 2011; Roggman et al., 2001). A few studies suggest that similarities in home visitors' and mothers' personalities and personal histories help promote mothers' engagement in home-visitation services (Brookes et al., 2006); and that similarities in racial/ethnic backgrounds may increase levels of engagement for African-American and non-English speaking Latino mothers (McCurdy, Gannon, & Daro, 2003; Raikes et al., 2006). Further research is needed to identify essential traits and/or experiences of home visitors that may increase their capacity to engage certain types of families. Additional study is also needed on the role of racial, ethnic, and socioeconomic similarities between home visitors and the families they serve, in promoting parents' engagement.

It is important to point out that such similarities comprise just one aspect of what it takes to deliver effective services to families, especially those at higher levels of risk. Although parents may easily relate to home visitors with whom they share some similar characteristics, such as being a parent; they typically want and need providers who have the capacity to help them address their problems and stressors, and mentor them in promoting their child's healthy

development (Dunst, Trivette, & Deal, 1994; Hebbeler & Gerlach-Downie, 2002; Korfmacher et al., 2008; McCurdy et al., 2003; Tandon et al., 2008).

Most of the prominent models of home visitation rely heavily on paraprofessionals, with the expectation that families will relate best to service providers with whom they share similarities. EHS programs employ large numbers of paraprofessionals; these programs also utilize multidisciplinary teams that may include early childhood, health, and mental health professionals (Mann, Bogle, & Parlakian, 2004). NFP utilizes only registered nurses. Paraprofessionals typically lack college degrees or have degrees in fields other than human services (Korfmacher, et al., 2008). In a study of NFP that compared the use of registered nurses and paraprofessional home visitors, most impacts had larger effect sizes for families visited by nurses than for those with a paraprofessional home visitor (Hiatt, Sampson, & Baird, 1997; Korfmacher, O'Brien, Hiatt, & Olds, 1999; Olds et. al., 2002).

A few studies suggest that the needs of highly vulnerable families may exceed the capacity of registered nurses, as well as paraprofessionals, to identify and address risk factors such as maternal depression and domestic violence (Chaffin, 2004; Eckenrode et al., 2000; Tandon et al., 2008). Social workers, with their grounding in an ecological, holistic perspective, expertise in working with low-income and minority families, and especially at the Masters level, expertise in family systems and mental health, appear to be particularly well equipped to serve such families (Ammerman, et al., 2005; Azzi-Lessing, 2010). For instance, the randomized, controlled evaluation of Child FIRST demonstrated a number of significant, positive effects for both children and parents in families at high levels of risk, utilizing bachelors and masters-level social workers as home visitors (Lowell et al., 2011).

Unfortunately, social work education programs typically offer limited content on early childhood development and the ranks of professional social workers in early childhood programs appear to be relatively thin (Azzi-Lessing, 2010); however, professional social workers are increasingly utilized in early-childhood mental health programs (Gilliam, 2007; Lowell et al.,

2011). In order to better prepare social workers to staff home-visitation programs, social work education programs, both at the bachelors and masters levels, should incorporate additional opportunities for learning about providing services to very young children and their families. This would include adding relevant coursework, including content on early childhood development, providing internships in early-childhood settings, and forming partnerships with faculty in early-childhood education and other related fields (Azzi-Lessing, 2010; Block & Block, 2002).

Training and supervision of home visitors. Adequate training is necessary for home visitors to be able to identify and address difficult problems such as substance abuse, domestic violence, and depression in the families they serve (Damashek et al., 2011; Duggan et al., 2004), as well as to identify symptoms of trauma and other factors that increase risk among young children. Possessing skill in identifying and assessing these conditions is essential for home visitors to ensure that family members receive services critical to their well being. Moreover, developing positive relationships with families at higher levels of risk, especially those who are difficult to engage, requires special skills, as does working with families from various cultures and socio-economic levels (Astuto & Allen, 2009; Azzi-Lessing, 2011; Brooks-Gunn, Berlin, & Fuligni, 2000; Johnson, 2009; Lynch & Hanson, 2004). Home-visitor training should go beyond providing information on these topics, and utilize case studies, role plays, and other tools to equip home visitors with the skills necessary to provide effective intervention (Boris et al., 2006; Tandon et al., 2008). Home visitors must be aware of the resources available in the communities they serve and have the skills necessary to navigate complex systems and regulations, in order to assist families in accessing these resources (Gomby, 2007). Achieving these levels of expertise is likely to require programs to devote more time and financial resources than are currently allocated for staff training in home-visitation programs (Chaffin, 2004; Duggan et al., 2007).

A number of developments in the field of early childhood mental health hold promise for developing a home-visitation workforce that is adequately prepared to effectively serve families

with a wide range of needs and those at various levels of risk. Led by Michigan, several states are developing credentialing programs for paraprofessionals as well as service providers with bachelors and masters degrees (Weatherston, Kaplan-Estrin, & Goldberg, 2009). These programs are based on agreed-upon, research-based, core competencies for working with families with young children. In a number of states, early-childhood mental-health service providers are credentialed at various levels of competency that correspond to levels of education, work experience, in-service training, and supervised practice (Korfmacher & Hilado, 2008; Weatherston et al., 2009).

Not only does the early childhood mental health movement provide frameworks for developing a home-visitation workforce that is credentialed at various levels of skill and expertise, the content of the training and credentialing process could be adapted for use in preparing home visitors (Meyers, 2007). Many of the values, skills, and areas of expertise that are recognized as necessary to the provision of high-quality, early-childhood mental health services, are identical to those required to deliver high-quality home-visitation services, especially when targeted toward families at high levels of risk (Chazan-Cohen, Stark, Mann, & Fitzgerald, 2007). Moreover, like many home-visitation programs, early-childhood mental health programs seek to promote the healthy development of both children and their parents, as well as to support the parent-child relationship (Lieberman & Van Horn, 2009; Lowell, et al. 2011; McAllister & Thomas, 2007). Those seeking to improve the skills and expertise of home visitors should look to the early-childhood mental health field for training content, as well as for frameworks for delivering training and credentialing program staff members. The state of Vermont, for instance, has a well-articulated training program targeted toward developing service providers' knowledge of child development, as well as competencies in service coordination, working with families, integrating families into their communities, and working with child care providers (Bean, Biss & Hepburn, 2007).

Collaboration between home visitation and early-childhood mental health entities has

begun to take place at the federal level. The federal Early Promotion and Intervention Research Consortium (E-PIRC) seeks to strengthen EHS programs by integrating early childhood mental health approaches and evaluating impacts on child development, behavior, and parent-child interactions (Beeber et al., 2007; Solchany & Barnard, 2004).

Frequent, high-quality supervision is also necessary in order for home visitors to work effectively with highly vulnerable families (McGuigan et al., 2003; Tandon et al., 2008). Supervisors should have the advanced education and skills necessary to assist home visitors in identifying, assessing, and intervening in areas such as substance abuse, depression, and domestic violence (Boris et al., 2006; Duggan et al., 2007; Tandon et al., 2008) They should also be skilled in providing reflective supervision, the process by which supervisors spend individual time with staff members, building a trusting, empathic relationship. This relationship serves as a catalyst for staff members to build similarly supportive relationships with parents and to foster the development of optimal relationships between parents and their infants. In addition to facilitating this parallel relationship-building process, this type of supervision encourages self-awareness and self-reflection to promote better understanding of the families that staff members serve (McAllister & Thomas, 2007; Weatherston, 2007). Particularly in the infant mental health field, reflective supervision is well recognized as necessary to support high-quality work with vulnerable, young children and their families (Gilkerson, 2004; Perry & Kaufman, 2009; Solchany & Barnard, 2004). The application of reflective supervision to home-visitation programs has shown promise (Chazan-Cohen et al., 2007; McAllister & Thomas, 2007) and should be further explored and evaluated.

Supervisors should also have expertise in culturally competent service delivery in order to support home visitors in working through conflicts and/or misunderstandings that may arise regarding families' cultural traditions, values, and beliefs. Roberts defines cultural competence as "a program's ability to honor and respect those beliefs, interpersonal styles, attitudes and behaviors both of families who are clients and the multicultural staff who are providing services"

(1990, p. 4). Moreover, it is important that supervisory staff members are immediately available to home visitors in the event that consultation is required to address incidents of family violence, parents' intoxication, and other crises that are likely to occur within highly vulnerable families. The support and guidance that supervisors provide is important for the provision of effective services as well for retention of home visitors. Keeping home-visitor turnover to a minimum is critical to maintaining effective relationships with families and ensuring continuity of services (Brookes et al., 2006; Daro, 2007).

The promise of multi-disciplinary teams. It is apparent that no single discipline fully equips professionals to address the complex and diverse range of challenges faced by highly vulnerable families with young children. The use of multidisciplinary teams could better equip home-visitation programs to address many of the challenges that highly vulnerable families encounter, while recognizing the differences in families' needs and strengths (McAllister & Thomas, 2007). This approach would enable programs to tailor interventions based on each individual family's needs and strengths, providing the health care expertise of a nurse to families with medically fragile, young children, and the expertise of social workers or mental health counselors to families that are struggling with parental addiction and/or depression (Azzi-Lessing, 2011). Paraprofessionals, when teamed with health, mental health, and/or early childhood professionals, could play valuable roles in mentoring young, inexperienced parents, as well as in helping families meet basic needs (Azzi-Lessing, 2011; Korfmacher et al., 1999; Tandon et al., 2008).

Ammerman et al., (2005) reported promising results for families participating in NFP and HFA programs in which the staff was augmented by a Masters-level social worker, who provided several sessions of In-Home Cognitive Behavior Therapy to mothers with depression. Results were similarly encouraging in a study that used specially trained mental health professionals to provide consultation to nurses in an NFP program (Boris et al., 2006). The efficacy of utilizing highly trained (usually Masters level) mental health professionals to provide

consultation to staff members working with children and families in early childhood settings is also documented in the research on early childhood mental health services (Brennan, Bradley, Allen, Dallas, & Perry, 2008; Gilliam, 2007). Careful coordination of services and close collaboration among team members are essential to the effectiveness of multi-disciplinary teams, especially when working with families with complex needs and challenges. The inclusion of more highly trained and skilled personnel, especially those qualified to address serious problems such as family violence and substance abuse, in home-visitation programs, should be further utilized and evaluated.

Matching Services to Families' Needs

The focus of home visits. Several studies have documented the interrelatedness of family engagement and the types of services provided in home-visitation programs. For instance, a study of EHS (2006) found that both levels of family engagement and the delivery of child-focused interventions predicted gains in children's cognitive and language development and parents' ability to provide home environments that supported and stimulated language and literacy (Raikes et al., 2006). Moreover, families were less likely to drop out of EHS when more time was spent working with parents on child-development activities during home visits (Roggman, Cook, Peterson, and Raikes, 2008). Peterson, Luze, Eshbaugh, Jeon, & Kantz (2007) found that home visitors' coaching and modeling positive parent-child interactions increased levels of engagement for mothers participating in EHS or early intervention (Part C) services. These findings suggest that involving parents in child-development activities fosters parent engagement and that higher levels of parent engagement increase the degree to which home visits are focused on child-development activities. They also demonstrate what appears to be complex interplay and reciprocal relationships between family engagement, the types of services provided, and outcomes, for home-visitation programs.

Results from these studies illustrate the need to carefully consider how time should be spent during home visits, particularly for highly vulnerable families. They suggest that engaging

parents in activities that focus on supporting their children's development is critical to both achieving gains in children's cognitive and language abilities (Raikes et al., 2006) and reducing family drop-out rates (Roggman et al., 2008). As previously noted, however, families at higher levels of risk may drop out of home-visitation programs at higher rates due, at least in part, to extreme stress and multiple distractions related to poverty, domestic violence, substance abuse, and other serious problems. Families are also likely to withdraw from services that do not meet their expectations for addressing some of their most pressing needs (Green & McAllister, 2000; Korfmacher et al., 2008; McCurdy & Daro, 2001; Roggman et al., 2008). This raises questions about what the focus of home visits targeted toward highly vulnerable families should be. Should visits address stressors such as maternal depression and domestic violence that threaten the well-being of family members and divert parents' energy and attention away from child development concerns? And if alleviating sources of severe family stress becomes the focus of home visits, will there be time for adequate attention to important child development-focused activities as well?

Increased flexibility and customization of services. These questions are difficult to answer, given the limited number of studies on home-visitation programs with highly vulnerable families, inconsistent definitions of child and family risk, and limited information about the "black box" of what takes place during home visits (Daro, 2006; Gomby, 2005; Jones Harden, 2010; Korfmacher et al., 2008). Research findings so far indicate the need for increased flexibility in the frequency and duration of visits and in the type and amount of services that are provided (Duggan, et al., 2007; McCurdy & Daro, 2001; O'Reilly, Wilkes, Luck, & Jackson, 2010).

Korfmacher et al. point out that improved family engagement strategies, by themselves, are insufficient; given that "…the most dedicated families will not be involved in services that are unresponsive to their needs, beliefs and interests"(2008, p. 191). This speaks to the importance of ensuring that home-visitation program goals are aligned with the goals of the

families they serve (Gomby, 2007). Service contracts, such as the Family Partnership Agreements used in EHS, can be powerful tools for ensuring such alignment, especially for families facing multiple challenges that threaten to overwhelm them as well as their home visitors. Negotiating with parents to select the specific needs and goals to be addressed helps to ensure that the services provided align with families' priorities and concerns, which, as previously noted, is an important factor in family engagement and retention (Korfmacher et al., 2008; Madsen, 2007; McCurdy & Daro, 2001).

Meeting the needs of highly vulnerable families requires increased flexibility in home-visitation programs, so that the number, frequency and duration, and focus of the visits correspond to the needs of each family served (Daro, 2006; Johnson, 2009; McCurdy & Daro, 2001; McGuigan et al., 2003). While families with relatively minor needs may benefit from monthly home visits, those with multiple needs and at higher levels of risk are likely to require more-frequent visits or visits that last longer than what programs typically provide (Azzi-Lessing, 2011). Flexibility in the frequency and duration of home visits would provide time to address sources of family stress and risk as well as to engage parents in promoting their children's well-being and early learning, both critical activities when serving higher-risk families.

Expanding programs' capacities. In addition to increased flexibility in the amount of time that home visitors spend with families, programs serving highly vulnerable families should increase their capacity to address factors that pose high levels of risk to young children. This means equipping program staff to identify and address maternal depression, child and adult trauma, substance abuse, domestic violence, and other concerns likely to have negative impacts on young children. Strategies to achieve this, as discussed above, include training home visitors to develop advanced skills, adding staff with advanced degrees and expertise in mental health, family violence, substance abuse, and other key areas, and improving the supervision that home visitors receive (Azzi-Lessing, 2011; Duggan et al., 2007; Tandon et al., 2008). Moreover,

programs could be enhanced by adding supplemental services and increasing the intensity of certain services to respond to the specific needs of targeted families. For instance, Bugental et al. (2002) demonstrated the promise of using enhanced training in parenting skills to improve outcomes for families participating in a Healthy Families America (HFA) program.

In addition to collaborating with children's mental health programs, developers of home-visitation programs should look to family preservation and other child protective programs for tools, resources, and strategies for working with families that are affected by substance abuse, domestic violence, and other serious risk factors. Professionals working in child protective systems have long recognized the threat that these factors pose to the well-being of children and have developed an array of strategies and tools for identifying, assessing and intervening with affected families (Clyman, Harden, & Little, 2002; Doueck, Bronson, & Levine, 1992; Korfmacher, 2000; Olsen, Allen, & Azzi-Lessing, 1996). Some of these resources could be utilized and/or adapted by home-visitation programs for assessing the needs of highly vulnerable families, planning services that are responsive to the multiple challenges these families face, and for evaluating service impacts. Moreover, integration of evidence-based models of child abuse prevention, such as Parent-Child Interaction Therapy, would likely enhance programs' capacity to reduce risk for child abuse, a key goal of a number of home-visitation programs (Chaffin & Friedrich, 2004; O'Reilly et al., 2010; Thomas & Zimmer-Gembeck, 2011).

Expanding partnerships. Meeting the needs of families that are struggling with maternal depression, substance abuse, domestic violence, and similar challenges requires a high level of collaboration among service providers from various types of agencies. Home-visitation programs should build strong partnerships with local providers of services that address these challenges (Gomby, 2007). Jointly developed procedures for referral, case planning, and frequent information sharing can facilitate smooth and effective coordination of services. Moreover, professionals with expertise in mental health, substance abuse, and domestic violence can provide critical training and consultation to staff in home-visitation programs (Azzi-Lessing,

2011).

Collaboration with Early Intervention (Part C) programs and with child protective services is especially important, as young children in families affected by maternal depression, substance abuse, and similar risk factors are more likely to be diagnosed with or at risk for developmental disabilities and/or child abuse and neglect (Brookes et al., 2006; Knitzer & Lefkowitz, 2006; Raikes, 2006.). Home visitors should work closely with the providers of Early Intervention and child protective services, along with those providing other services, to ensure that families receive relevant, well-coordinated services (Waldfogel, 2009).

Those planning home-visitation programs should inventory and assess the services and resources available in a given community as well as develop an understanding of the challenges, such as community violence and a lack of supports and resources available to the families that live there (McGuigan et al., 2003). Although a single program, such as home visitation, cannot compensate for a dearth of critical resources in a given community, program leaders may be able to bridge some gaps by forming partnerships with the health and human service agencies that are available, as well as with churches, schools, and social and cultural organizations. Moreover, home-visitation program planners should work with other, local service providers in low-resource and/or high-need communities, to advocate for funding and the development of additional services to meet families' needs.

Given the powerful role that poverty plays in creating risk for young children and their families (Chaffin et al., 2001), it is important that home-visitation programs work effectively with public and private organizations that administer Temporary Assistance for Needy Families (TANF) and other income supports (known as welfare programs). Low-income parents of young children often struggle to meet the work, education, and/or job training requirements for receiving assistance through TANF while ensuring that their children receive adequate care (Abramowitz, 2005; Knitzer, 2000). Many of the these families need assistance in understanding the often-confusing rules of public-assistance programs and in accessing the transportation, child

care, and other resources necessary to comply with program rules and move towards self-sufficiency (Lindsey, 2009; Shields & Behrman, 2002). Home visitors – in programs that are sufficiently flexible – could assist families in accessing TANF and other benefits and in addressing the wide range of barriers to employment that low-income parents often face.

Research and Policy Issues

More-Comprehensive Program Evaluation

Rigorous evaluation that compares the efficacy of increased flexibility, comprehensiveness, and customization of services, with what is typically provided by prominent models of home visitation in serving families at higher levels of risk is needed. Studies of this type, which document the specific services that are provided, the credentials of service providers, and the specific strategies through which services are provided, would inform efforts to improve outcomes for highly vulnerable families (Bradley et al., 2009; Korfmacher et al., 2008; Raikes et al., 2006).

There is growing consensus that in order to meet the needs of highly vulnerable families, various types of programs must utilize effective engagement strategies, strive for cultural competence, offer comprehensive services, and be flexible and responsive to the extended families, communities and other systems that surround participating families (Duggan et al., 2007; Gomby, 2007; Knitzer & Lefkowitz, 2006). Such individualized, multi-faceted programs require a more-complex evaluation than do those that are highly-standardized; and call for the use of qualitative methods and a variety of quantitative methods, along with experimental design (McCall & Green, 2004; Smyth & Schorr, 2009).

Experimental design, in which families are randomly assigned to participate in services or to a control group, is widely viewed as the gold standard for program evaluation. However, this method alone is insufficient to capture the complexity of both the lives of highly vulnerable families and the services that families require; and should be augmented by evaluation tools that assess a wide range of family and program variables (Azzi-Lessing, 2011; McCall & Green,

2004; Smyth & Schorr, 2009). Such an approach has been taken in the 17-site evaluation of EHS, which incorporates within-treatment analyses of variables such as levels of program participation and types of service delivery, along with the use of experimental design, to provide a detailed and nuanced picture of how this program serves a wide range of low-income families with young children (Brookes et al., 2006; McCall & Green, 2004; Raikes et al., 2004). On a much smaller scale, the randomized, controlled trial of Child FIRST (Lowell, et al., 2011) utilized a wide variety of measures, standardized and self-developed, to assess numerous variables related to participating children, parents, and families, as well as indicators of risk. These methods enabled the evaluation of Child FIRST to assess variables such as service dosage, parent satisfaction, and services accessed, as well as child and parent outcomes. Although this study did not provide information on which components of the program influenced which specific outcomes, it provides a more-nuanced picture of the program's impacts and the program inputs required to achieve them.

Future evaluations of home-visitation programs should be designed to take into account the availability of critical resources as well as the challenges experienced by families living in a given community. This requires going beyond counting the number and/ or types of referrals made, to examining the effectiveness of the referral process and the quality of the services to which families are linked. Examining the role that the availability of other resources plays in outcomes for home-visitation programs would provide important information about the types of community resources that are necessary for producing desired outcomes (Azzi-Lessing, 2011; Gomby, 2007; McCall & Green, 2004; Smyth & Schorr, 2009), particularly with families at higher levels of risk. Moreover, the cost of these additional resources should be accounted for in cost-benefit analyses of home-visitation programs, so that program developers and policymakers have a fuller understanding of what it takes to effectively to serve families with multiple needs.

Developing More-Responsive Program Models

A number of home-visitation programs are developing and testing strategies designed to

improve their capacity to address serious risk factors in the families they serve (Johnson, 2009; Roggman, Boyce, & Cook, 2009; Weiss & Klein, 2006). This raises the question of whether the best approach is enhancing existing models of home visitation so that they are better equipped to assist highly vulnerable families or developing new models that are sufficiently comprehensive and responsive to the challenges these families face (Chaffin, 2004; Duggan et al., 2007; O'Reilly et al., 2010). The former approach poses many challenges, given that the theoretical frameworks on which prominent models of home-visitation programs are based are not reflective of the numerous and extreme risk factors that many vulnerable families face. On the other hand, the latter approach would require a significant commitment of new funding to develop, evaluate, and replicate new models.

Of the prominent models of home-visitation, Early Head Start (EHS) may offer the most suitable foundation for developing home-visitation services that are more responsive to the needs of highly vulnerable families. Based on its original, four "building blocks" of child development, family development, community building, and staff development, EHS emphasizes attention to the various systems (i.e. extended family, neighborhoods, and childcare programs) that contain participating children and families (Raikes et al., 2004; Robinson, et al., 2009). EHS, like the other widely replicated models of home-visitation, has yet to demonstrate its ability to achieve significant, long-term impacts for highly vulnerable children and families, although it did demonstrate long-term impacts for subgroups of children and families (see Vogel, Xue, Moiduddin, Carlson, & Kisker, 2010). Its capacity to deliver comprehensive and customizable services, its capacity to utilize multidisciplinary teams, and its emphasis on full family engagement, cultural competence, and community building provide a promising framework for enhancing and improving efforts to serve these families. Moreover, as noted above, the evaluation of EHS provides a useful framework for capturing the complexity of variables that must be measured in order to provide an accurate picture of what it really takes to meet the multiple needs of highly vulnerable families.

Addressing program fidelity. Proposing the development of programs that are highly customizable in order to best meet the diverse needs and build upon the unique strengths of highly vulnerable families inevitably raises questions about maintaining program fidelity. That is: how to ensure that a program is delivered in a way that maintains its integrity across various service providers and families and, if the program is to be replicated, across various program sites. EHS addresses model fidelity by requiring that programs adhere to a set of performance standards, and periodically monitoring programs to ensure that such standards are met. Improving upon this approach, Child FIRST utilizes an Assessment and Intervention Fidelity Checklist to ensure that the core elements of the model are consistently addressed, as a diverse array of services is provided to families. Home visitors complete the checklist after each visit and review it during supervision sessions (Lowell et al. 2011). These are promising approaches; however, methods to ensure program fidelity in delivering comprehensive and customized services to highly vulnerable families are in need of further development and evaluation (Azzi-Lessing, 2011).

Home-visitation Programs as a Part of a Comprehensive System

Policymakers would do well to support efforts to ensure that home-visitation programs are truly responsive to the needs of highly vulnerable families; as children in these families are at significant risk for poor outcomes (Chaffin et al., 2001, Jones Harden, 2010; Knitzer & Lefkowitz, 2006). Equally important is recognizing that even the most well-designed home-visitation programs, by themselves, will be insufficient to counter the cumulative, harmful impacts of poverty, family and community violence, impaired parenting, and other serious risk factors that threaten the optimal development of millions of young children (Chaffin, 2004; Daro, 2006; Gomby, 2005; Howard & Brooks-Gunn, 2009).

There is growing consensus among researchers and policymakers that a carefully coordinated, comprehensive service system holds the greatest promise for improving the life chances of our nation's most vulnerable, young children. Such a system would encompass

home-visitation programs, in addition to high-quality early care and education, early childhood mental health services, and parent education and support groups (Austin et al., 2007; Knitzer & Lefkowitz, 2006; Perry, Kaufman & Knitzer, 2007; Weiss & Klein, 2006). It would also include adult mental health and substance abuse services, and programs and supports, such as work readiness and job training, to help lift vulnerable families from poverty.

Along with some private foundations and several state initiatives, the federal government is promoting improvements in systems that serve young children through its Early Childhood Comprehensive Systems project (Johnson & Theberge, 2007; National Center for Children in Poverty, 2007). This project seeks to eliminate barriers between child-serving systems in order to improve service coordination and comprehensiveness. It is important that these and other system-building efforts incorporate adult-serving programs, including those that offer income and employment supports for parents, along with services oriented toward young children, in order to facilitate the comprehensive service coordination that highly vulnerable families need.

Conclusion

The parent support and education, as well as encouragement for early learning, that widely replicated models of home-visitation provide, are likely to be helpful to many families at low-to-moderate levels of risk. However, it can be argued that it is in society's best interest to do whatever it takes to improve the well-being and prospects of children in highly vulnerable families: children who are at greatest risk for poor outcomes. From an economic standpoint, these are the children who – without adequate intervention early in life – are likely to cost taxpayers in substantial expenditures for special education, juvenile crime and adolescent parenthood. From a social justice perspective, young children in families affected by poverty, maternal impairment, domestic violence, and/or other serious risk factors are most in need of intervention and support.

It would be unfortunate if the substantial, new investments of public funds in home-visitation programs failed to reach and improve the life chances of these most vulnerable

children. It is time to focus attention and significant resources in building, testing, and bringing to scale programs that are specifically targeted towards meeting the multiple and complex needs of these children and their families. The recommendations presented in this paper are offered as the beginnings of a blueprint for helping to move this important work forward.

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