

Home Visitation Programs in New Jersey: A Promising Approach for Preventing Child Abuse and Neglect

*Prepared by the Joint Workgroup of:
The NJ Task Force on Child Abuse and Neglect and
The Governor's Juvenile Justice and Delinquency Prevention Committee*

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Preventing child abuse and neglect before it occurs has often taken a back seat in funding and planning in New Jersey, to the more urgent and pressing needs of children who have already been abused. Many families with difficulties have had nowhere to turn. And, as stated by the director of the Division of Youth and Family Services' (DYFS), some families have been served by DYFS that don't belong in that system, but there was simply nothing else to offer them. There is increasing acknowledgement that the state can and should do more to intervene before harm occurs and that there should be more options for families. The new Division of Prevention and Community Partnerships, within the NJ Department of Human Services, is charged with this duty as part of the reform plan for the state's child protective services system.

The NJ Task Force on Child Abuse and Neglect (NJTFCAN) and the Governor's Juvenile Justice and Delinquency and Prevention Committee (JJJPC) jointly advocate for the adequate provision of home visitation programs. We strongly recommend to the NJ Legislature, and local government and planning bodies, that legitimate home visitation programs be funded and made available to every family who requests it, with means provided for outreach to at-risk families.

This brief discusses the research-based rationale for our recommendation, describes the qualities of a legitimate home visitation program, outlines the various programs existing in NJ meeting those criteria, and provides resource material for communities planning to include home visitation as a key strategy to preventing child abuse and neglect.

Introduction

Home visitation refers to programs that provide family-focused services prenatally through early childhood. Goals of these programs include: reducing the incidence of child maltreatment, delinquency, and maternal substance abuse and improving the health, social and developmental functioning of mothers and their babies. These programs are commonly targeted to specific population groups, such as: low-income; minority; young; less educated; first-time mothers; substance abusers; children at risk for abuse; low birth weight, or developmentally compromised infants.

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Research Findings

A report by the Centers for Disease Control and Prevention Task Force on Community Preventive Services (October 2003) concluded there is strong evidence to recommend early childhood home visitation for the prevention of child abuse and neglect based on their review of 22 studies focused on this outcome. Child maltreatment was reduced by a median of 39% (with a range of 24% to 74% reduction).

In Spring/Summer 1999, the *Future of Children* published a special issue on existing research of six key home visitation programs that have national implementation¹. Evaluations were based on program implementation at anywhere from 2 to 21 sites. The outcomes evaluated for the six programs tended to be multi-faceted, and in addition to the prevention of child abuse and neglect, included improving outcomes that might potentially have an indirect effect on abuse and neglect, such as: child health, child development, maternal life course (reduction of pregnancies/births; increased employment/education; independence from welfare) and parent child-rearing attitudes and practices. Some findings from this review regarding the impact on child abuse were:

- The Elmira site study of the Nurse-Family Partnership showed fewer substantiated cases of child abuse or neglect over a 15-year period following birth in comparison to a control group.
- In the Missouri PAT program, there were significantly fewer suspected cases of abuse and neglect (.34% annualized) than the 1.5% statewide average.

A study by Olds et al (1997) of the Nurse Visitation Model found that unmarried, low socioeconomic women who received nurse visits, in comparison to a control group: 1) received fewer months of public assistance (60.4 months of AFDC versus 90.3 months and 46.7 months of food stamps versus 83.5 months) and 2) had 43% fewer subsequent pregnancies. In the Olds model home visits begin during pregnancy and continue through the second year of the child's life; the home visitors are highly trained registered nurses.

An evaluation of nurse home visiting programs in Minnesota found that for families enrolled in the program 6 months or longer, rates of substantiated maltreatment were lower (9%) than the expected rate among high risk families not receiving home visits (20%).

A fact sheet released by Prevent Child Abuse America provides evidence from more than 20 evaluations that the Healthy Families model is effective in reducing child maltreatment and achieving other positive outcomes for children. Some findings were: 1) the child maltreatment rate among program participants in Pinellas County, Florida was 1.6% compared to 4.9% for the county, 2) In a Hawaii program, the rate of substantiated child maltreatment was less than half that found for a control group (3.3% vs. 6.8%) and 3) a program in Maryland had only two reports of child maltreatment among 254 families served in 4 years of program operation.

¹ These included: 1) Comprehensive Child Development Program (CCDP), 2) Hawaii Healthy Start, 3) Healthy Families America (HFA), 4) Home Instruction Program for Preschool Youngsters (HIPPI), 5) Nurse-Family Partnership (Nurse Home Visitation Program) and 6) Parents as Teachers (PAT).

Empirical research also demonstrates that the PAT model promotes school readiness as well as reduces the incidence of child abuse. Outcomes for families include: greater involvement in child's schooling, greater knowledge of child-rearing practices and child development, and higher performance in kindergarten through fourth grades.

Cost Analysis

There is evidence that home visitation programs are cost effective. In testimony provided by Sandra Alexander at the Child Abuse Prevention and Treatment Act (CAPTA) 2001 Reauthorization hearings, she noted that for every federal dollar spent on treating victims of child abuse, only one cent is spent on prevention. A study by Prevent Child Abuse America found that American families spend \$1,461.66 each year on child abuse and only \$1.06 for prevention.

There is evidence that home visitation programs are cost effective.

Cost data can be found for some programs. Healthy Families America costs range from \$1,500 to \$4,500 per family per year, Nurse-Family Partnership models are about \$3,200 in the first three years of start-up and \$2,800 thereafter, and the PAT model costs about \$580 per family.

A RAND cost-benefit analysis (Karoely et al., 1998) evaluated the Elmira trial through a 15-year follow-up. The Elmira studies focused on first-time, low-income mothers. The average program cost was \$6,083. Savings were found in four areas: 1) increased tax revenues due to increased employment, 2) decreased welfare outlays, 3) reduced expenditures for education, health and other services and 4) lower criminal justice system costs. The average total savings (\$24,694) were more than four times the program cost for high-risk families; they did not find a net savings for lower-risk families (\$3,775).

Qualities of a Legitimate Home Visiting Model

While home visiting is not a new concept, the techniques employed and the goals of the intervention continue to evolve and be refined. Research is currently underway by a number of objective institutions looking across programs to answer the multi-faceted question - under what circumstances do what kinds of interventions have what kinds of effects on what clients and at what cost. Preliminary information is available on this research and will be presented at a forum in New Jersey in the spring of 2005. As more is learned, recommendations regarding program usage in New Jersey may refine. However, there is strong evidence that a number of qualities present in a program design increases the overall effectiveness of the program and ensures that the program and staff are responsive to the needs of the community they are serving.

As a result, the members of the NJTFCAN and JJDPC recommend only investing in proven programs that meet these five criteria:

- **Research-based,**
- **Provide intensive training,**
- **Staff supervision,**
- **Quality assurance, and**
- **Outcomes research.**

What we mean by research-based:

A research-based program is developed based on a hypothesis so that every intervention (the independent variable) will have a specific effect on the client and presenting problem (the dependant variable). The hypothesis is derived from a specific established theory. Theoretical frameworks relevant to home visiting can include social systems, developmental psychology, physiology, ego psychology and others; a well-integrated program may have components that draw from several theoretical frameworks.

The importance of intensive training, supervision and quality assurance:

Training, supervision and quality assurance are all critical to ensure that the program model is being delivered to clients as the program was designed. Staff who understand the theoretical underpinnings of a program – e.g. why the intervention has specific components are more likely to deliver the intervention as designed.

Why outcomes research:

Along with the supervisory relationship, quantifying and recording interventions and client change provide the data necessary to generate information about the functioning of the program. By attending to characteristics of the clients, the agency, the community and the staff, documentation and qualitative analysis can help refine the program model to better serve specific types of clients.

Programs meeting those standards in New Jersey include:

- Family-Child Home Program
- Healthy Families
- HIPPY
- Nurse-Family Partnership
- Parents as Teachers
- POrSHe

Descriptions of these programs and sources for more information can be found in Appendix A. While other programs may meet these criteria, the programs listed above have infrastructure in place to provide the training, supervision and data collection for quality assurance and outcome research. None of these programs has been developed to scale, i.e. available throughout the state for the intended population.

Conclusion

Studies have demonstrated both the program and cost effectiveness of home visitation models. Leading experts in NJ, representing the fields of child abuse and neglect prevention and juvenile delinquency prevention on the NJ Task Force on Child Abuse and Neglect and the Governor's Juvenile Justice and Delinquency Prevention Committee, strongly recommend to the NJ Legislature, and local government and planning bodies, that appropriate², legitimate home visitation programs be funded and made available to every family who requests it, with means provided to outreach to at-risk families.

² While legitimate home visiting programs have proven to be effective, emerging research referenced in this report seeks to identify the most appropriate interventions for specific populations.

Appendix A: Home Visitation Models

Family-Child Home Program

**Program Focus:
Families with children
from 18-36 months of age**

Description

The Family Child Home Program is a home-based parenting and family literacy program that promotes the educational success of socially and economically disadvantaged children by encouraging verbal interaction and play between parents and toddlers. The program improves parents' verbal responsiveness, child rearing competence and self-respect, minimizing the potential for child abuse and neglect. The parent obtains an understanding of the role as their child's first teacher while the child benefits in improved cognitive, social and emotional growth, which prepares them for school and future academic success.

The Family Child Home Program is a replication of the nationally acclaimed Parent-Child Home Program that has been operational since 1965. It is supported by the experience of over thirty-seven replications across seven states and three other nations. The Program was chosen as a model early intervention program by the National Institute of Mental Health. To recognize the flexible configuration of today's families, Family and Children's Services of Central New Jersey changed the name of its replication to the "Family Child Home Program."

Goals

Participating families with children aged 18 months to 36 months of age, are visited twice each week for two years by trained Home Visitors. In play sessions with the parent and the child, the Home Visitors demonstrate parenting techniques while emphasizing verbal interaction and learning through play using carefully chosen books and toys.

At the completion of the program, parents:

1. Increase use of alternatives to physical punishment as discipline.
2. Read more with their children and are more attentive to them
3. Plan and implement a daily 20 minute reading activity with their child
4. Increase understanding of age appropriate child cognitive skills and behavior.
5. Increase self-sufficiency through study, participating in ESL classes, and securing a job.
6. Increase participation in community activities of family literacy and child health.
7. Increase receptiveness to community involvement.

At the completion of the program, children:

1. Increase verbal interaction with their parents or primary caregivers.
2. Improve competency in expressive and receptive language.
3. Improve "attending behavior" by being able to listen to a story, ask and respond simple questions and to follow simple direction, e.g., putting a puzzle together.
4. Adjust easily to pre-school and/or school setting.

Core Values

Recent research and numerous articles have described the importance of providing nurturing positive, verbal interaction early in a child's life. This research also suggests the crucial role of the parent as a child's first and most important teacher, especially during the first few years of life. The Family-Child Home Program supports this research by igniting a child's thirst for learning within the first three years of life, which greatly reduces and/or eliminates the "at risk" category. Ensuring a child's thirst for learning assists in preparing children for pre-school, kindergarten and beyond. Fostering the development of conceptually rich language allows at risk children to compete with their peers academically.

Target Population

The Family Child Home Program works with "at risk" preschoolers 18 to 36 months old from families that are suffering from low incomes, limited education, or are isolated due to cultural and linguistic barriers. These families may be headed by a single or teen parent, dual career parents, grandparents or foster parents.

Duration and Frequency of Visits

The trained Home Visitors will visit the targeted parents and children in their homes twice a week for two years beginning when the child is between eighteen months and two years old.

Outcomes

1. Minimize potential for child abuse and neglect: Based on both self-reports and home visit observations, there have been no reports of child abuse and neglect. The mothers indicate overall that they are spending more time with their children and most are setting aside time, usually around their preschooler's bedtime for reading, playing and/or talking. For many families they have indicated that the toys and books have brought the family together. There are numerous reports of increased interaction and involvement by fathers, siblings and grandparents. The program has been successful in engaging the most isolated and often described as resistant populations who often are at risk of child abuse and neglect.
2. Reduce parental stress, which is often communicated to children around daily life situations: Such stress is often correlated with abuse; associated preoccupation with stressors is correlated with neglect. Parents report a growing sense of competency and consequent enhancement of effective stress management. The home visitors model many of the stress management techniques. Resulting in parents' report of a willingness to discuss issues surrounding their children and parenting as well as a receptiveness to engage in intervention and support services.
3. Parents are more giving of themselves as caregivers and teachers of their children: As mentioned earlier, parents report spending more time at home with their children in a way which both strengthens emotional bonds and stimulates children's intellectual development. Most of the parents attribute this directly to their involvement with the program.
4. Parents are more involved and interact more positively with their children. This was more than evident to us in the 100% participation in group outings and activities sponsored by the agency. On a number of occasions we had several generations of family members attend. All of the parents reported increased positive interaction with their children. On the average, two thirds of participant families had attended community activities involving family health and literacy.

Program Costs

Personal / Supplies	% Time	Salary	Cost
Coordinator	100	28k-40k	28-40k
Home Visitors	Varies	0-\$13/hr	?
Curriculum materials (books/toys)		\$150-200/family	\$6-8k
Support Staff	50	\$15k+	\$7k
Staff Travel			\$200-1k
Office Costs			\$3-5k
Total			Approx. 60k

Program Evaluation

Throughout the two-year program, at every six-month interval, the family's progress is evaluated using the Parents and Children Together (PACT) assessment tool. Also, the participating parents' interactive behavior will be evaluated at the end and beginning of the program by the Maternal Interactive Behavior videotape measure. Finally, we also use the developmental tool, Ages and Stages, to assess where the child is developmentally up to par. Psychologists are not needed to administer any of these measures.

*Please see Psychometric Assessment done on the Family Child Home Program.

**Description provided by Family and Children's Services of Central New Jersey.*

Healthy Families- New Jersey

Program Focus:
Pregnant and newly parenting families with moderate stress/risk factors; service may be maintained until child reaches age 5

Description

The Healthy Families America (HFA) is a research-based, highly proscribed home visiting program model that provides education and supportive services to new and expectant parents, targeting families who are overburdened by specific stressors known to contribute to risk of child abuse and neglect. Families who may be at risk of maltreatment are identified through a systematic assessment process that targets pregnant women and new births in the target community.

Home visitors who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.

Goals

- To prevent abuse and neglect of children under five years of age by providing early identification and intervention services to families at risk;
- To ensure that families at risk for child abuse and neglect receive appropriate health and supportive services;
- To assist at-risk parents in promoting positive child development among infants and children at risk and;
- To identify and build on family strengths and to support parents as the primary care givers and nurturers of their children.

Duration and Frequency of Visits

Initially, the frequency of visits is once a week; this intensity lasts a minimum of 6 months. As the family progresses through the program, the intensity of visits may decrease depending on the reduction of stressors.

Referrals

Referrals to the Healthy Families Programs are made if results from a standardized screening tool indicate that risk factors might be present. The tool includes fifteen (15) standard questions. The screen has to be positive in order for the family to receive an assessment.

There are twenty-four (24) Healthy Families programs in the state of New Jersey. These sites cover seventeen (17) of the states twenty-one (21) counties. Each site has agreements with hospitals, clinics, and social service agencies in their communities for which they receive referrals.

Tools for Assessment and Program Evaluation

There is a 15-point screen, as described above. Families who screen positive for risk are assessed using the Kempe Family Stress Checklist. The Kempe assesses stressors that include isolation, drug abuse, childhood history of child abuse and neglect, mental illness, criminal history, and/or lack of knowledge about child development. Those families who have a history or a presence of these factors are offered intensive, long-term home visitation services.

The Home Observation for the Measurement of the Environment (HOME) is administered every six (6) months to assess the environment of the home and use the results to direct interventions with the family.

The Home Visitors also administer the Adult/Adolescent Parenting Inventory (AAPI) when the family is enrolled and then annually to measure the mother/fathers attitudes toward parenting.

The Ages and Stages Developmental Screen is completed at a minimum of every six months to ensure that the target child is developing appropriately. If a delay is suspected, the home visitor will make a referral for additional screening and/or intervention.

Data

All of the Healthy Families New Jersey Programs collect client level data and compile it using the Program Information Management System (PIMS). Some of the data collected includes: demographic information, number of screens conducted, number of assessments conducted, number of families enrolled, immunization records, medical home information, referrals, home visit information, etc.

Agency/Organization Administering

Prevent Child Abuse-New Jersey manages the Healthy Families New Jersey sites through contracts with the Department of Human Services and Children's Futures.

** Description provided by Healthy Families – New Jersey, Prevent Child Abuse – New Jersey.*

HIPPY – Home Instruction for Parents of Preschool Youngsters

<p>Program Focus: Parents of preschool children, 3-5 years old and economically disadvantaged</p>
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Description

HIPPY offers a structured three-year curriculum available in both English and Spanish for children ages three thru five. The curriculum contains 30 weeks of activity packets, 9 storybooks, and 20 manipulative shapes for each child. The program focuses on visual and sensory discrimination, language development, problem solving, story comprehension, logical thinking and perceptual discrimination skills. Many activities leave room for creative and joint exploration. The curriculum is delivered and modeled each week by a trained HIPPY Home Instructor. During the visit, the home instructor role-plays the upcoming packet with the parent. The home instructor and parent each have an opportunity to act as the parent and child. Through this modeling, parents learn in a non-judgmental way to work with their child, gaining confidence in their own abilities. Through the process of role-play, the parent is then ready to deliver the lesson to their child with ease. By guaranteeing success and offering immediate gratification for teaching efforts, this structured approach gives parents the confidence to take on increased responsibility in their roles as educators.

Another unique component integral to the HIPPY program is the monthly group meetings. Group meetings enable parents to network and support each other. Additionally, group meetings provide a wonderful opportunity for parents to receive information on parenting, school related topics, and health awareness by professionals in a variety of fields.

Goals

- Empower each parent to take an active role in their child’s learning while reinforcing basic skills.
- Build readiness skills for preschool children bringing their school entry levels closer to those of the norm.
- Foster an appreciation for learning in the children through success with sensorial based activities.
- Encourage parents to return to school to pursue their own academic goals or seek job training.

Tools for Assessment and Program Evaluation

Client specific and service utilization is collected through the HIPPY MIS (Management Information System). On an annual basis, HIPPY USA gathers basic demographic and process data from all local HIPPY sites. The data is collected mid-year (week 15) and end of the year (week 30). HIPPY USA evaluates annual data to facilitate efforts to support programs through training and technical assistance. It also allows HIPPY USA to determine important trends within the communities/population where HIPPY is implemented. The HIPPY MIS program generates the following local information:

1. **National Demographics**

2. **Children**

- a. Total # of children by HIPPY curriculum age group.

- b. Race/Ethnicity of HIPPY children.
- c. Primary languages of HIPPY children.
- 3. Families**
 - a. Total
 - b. Where do HIPPY families live.
 - c. Attrition Rate.
 - d. Why families left HIPPY.
- 4. Home Instructors**
 - a. Total
 - b. Highest Education level achieved
 - c. Prior work experience.
 - d. Home instructors currently enrolled in an educational program.
 - e. Attrition rate
 - f. Why home instructors left HIPPY.
- 5. Coordinator**
 - a. Total
 - b. Professional specialization.
- 6. Funding**
 - a. Federal
 - b. State
 - c. Local
- 7. Group Meetings**
 - a. Average number of group meetings.
 - b. Average attendance rate.

Beginning in October, the program plans to implement pre/post testing of our HIPPY 3 & 4 year olds using the Dial 3 screening instrument. The Dial 3 assesses five developmental areas: Motor, Concepts, Language, Self Help and Social skills. The program is also in partnership with the Englewood school system to determine a proper screening tool for measuring children's success in the later years.

Agency/Organization Administering

HIPPY was developed in 1969 at the National Council of Jewish Women, Research Institute for Innovation in Education at the Hebrew University of Jerusalem, Israel. It has grown into a worldwide movement. The first U.S. program was founded in 1984 in Tulsa, Oklahoma. There are currently 132 program sites here in the United States.

The local HIPPY program began in 1994 and is co-sponsored by Bergen Family Center and NCJW, Greater Teaneck Section. It serves the communities of Englewood, Teaneck, Bergenfield and Hackensack. The program ended the 2003-2004 HIPPY year with 118 children and 112 families. It is the only HIPPY site in New Jersey.

** Description provided by HIPPY – New Jersey, Bergen Family Center and the National Council of Jewish Women.*

Nurse-Family Partnership

Program Focus:
Low-income, first time pregnant mom, no later than the 28th week until the child is two years old

Program Summary

Nurse-Family Partnership (Formerly Prenatal and Infancy Home Visitation by Nurses), guided by a strong theoretical orientation, consists of intensive and comprehensive home visitation by nurses during a woman's pregnancy and the first two years after birth of the woman's first child. While the primary mode of service delivery is home visitation, the program depends upon a variety of other health and human services in order to achieve its positive effects.

Program Targets

The program is designed to serve low-income, at-risk pregnant women bearing their first child.

Program Content

Nurse home visitors work with families in their homes during pregnancy and the first two years of the child's life. The program is designed to help women improve their prenatal health and the outcomes of pregnancy; improve the care provided to infants and toddlers in an effort to improve the children's health and development; and improve women's own personal development, giving particular attention to the planning of future pregnancies, women's educational achievement, and parents' participation in the work force. Typically, a nurse visitor is assigned to a family and works with that family through the duration of the program.

Program Outcomes

This program has been tested with both White and African American families in rural and urban settings. Nurse-visited women and children fared better than those assigned to control groups in each of the outcome domains established as goals for the program. In a 15-year follow-up study of primarily White families in Elmira, New York, findings showed that low-income and unmarried women and their children provided a nurse home visitor had, in contrast to those in a comparison group:

- 79% fewer verified reports of child abuse or neglect;
- 31% fewer subsequent births;
- An average of over two years' greater interval between the birth of their first and second child;
- 30 months less receipt of Aid to Families with Dependent Children;
- 44% fewer maternal behavioral problems due to alcohol and drug abuse;
- 69% fewer maternal arrests;
- 60% fewer instances of running away on the part of the 15-year-old children;
- 56% fewer arrests on the part of the 15-year-old children; and
- 56% fewer days of alcohol consumption on the part of the 15-year-old children.

Program Costs

The cost of the program was recovered by the first child's fourth birthday. Substantial savings to government and society were calculated over the children's lifetimes. In 1997, the two-and-a-half-year program was estimated to cost \$3,200 per year per family during the start-up phase (the first three years of program operation) and \$2,800 per family per year once the nurses are completely trained and working at full capacity. Actual cost of the program will vary depending primarily upon the salaries of local community-health nurses. Communities have used a variety of local, state, and federal funding sources to support the program, including Medicaid, welfare-reform, maternal and child health, and child abuse prevention dollars.

The information for this fact sheet was excerpted from:

Olds, D., Hill, P., Mihalic, S., & O'Brien, R. (1998). Blueprints for Violence Prevention, Book Seven: Prenatal and Infancy Home Visitation by Nurses. Boulder, CO: Center for the Study and Prevention of Violence.

Parents as Teachers (PAT)

Program Focus:
Families with children,
from pregnancy until
the child enters
kindergarten

Description

Parents as Teachers (PAT) is an international early childhood parent education and family support program serving families throughout pregnancy until their child enters kindergarten, usually age 5. The program utilizes a comprehensive neuroscience-based curriculum that links the latest brain research with the care and education of young children. Thus through parent education and guided developmentally appropriate parent/child interactions, PAT is designed to foster attachment and to enhance both child development and school achievement.

The PAT program was developed as a universal access model. Recognizing that all families can benefit from support, Parents as Teachers families come in all configurations, from all socio-economic levels, and from rural, urban and suburban communities. Though an international model, PAT serves as a local program, adaptable to fit family and community needs. Family participation is voluntary.

Core Values

- The early years of a child's life are critical for optimal development and provide the foundation for success in school and in life.
- Parents are their children's first and most influential teachers.
- Established and emerging research should be the foundation of parent education and family support curricula, training, materials and services.
- All young children and their families deserve the same opportunities to succeed, regardless of any demographic, geographic or economic considerations.
- An understanding and appreciation of the history and traditions of diverse cultures is essential in serving families.

Goals

- Increase parent knowledge of early childhood development and improve parenting practices
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

Program Components

- **Personal visits** — Personal visits (weekly, bi-weekly or monthly as needed) are the major service delivery component. During these visits, parent educators share age-appropriate child development information, help parents learn to observe their own child, address their

parenting concerns, and engage the family in developmentally appropriate activities that provide meaningful parent/child interaction.

- **Group meetings** — Parent group meetings provide opportunities to share information about parenting issues and child development. Parents learn from and support each other, observe their children with other children, practice parenting skills and interact with their children through developmentally appropriate learning activities.
- **Screening** — Periodic developmental, health, vision and hearing screening provides for early identification of developmental delays and health, vision and hearing problems. Regular review of each child's developmental progress identifies strengths and abilities as well as areas of concern that require referral for follow-up services, and increases parents' understanding of their child's development.
- **Resource network** — Parent educators help families identify and connect with needed resources and overcome barriers to accessing services. Programs take an active role in establishing ongoing collaborative relationships with other organizations that serve families.

Tools for Assessment and Program Evaluation

The Parents as Teachers standards and quality indicators establish a blueprint for quality implementation of PAT, based on best practices in the field of early childhood home visitation. The standards are intended to provide programs and parent educators with clear guidelines for implementing the PAT model. PAT national funds empirical outcome evaluations which have demonstrated that ‘the causal model, which postulates both direct and indirect effects of PAT on school readiness (is) strongly supported by the data’ (*Pfannenstiel, Seitz, and Zigler, NHSA Dialog;6,1, 71-78, 2002*).

Agency/Organization Administering

The Parents as Teachers National Center, Inc. (PATNC) has developed a strong logic model and research-based curricula. PATNC also monitors program evaluations, as well as the training, certification, and support of parent educators in their work to assist parents in becoming their children's first and best teachers.

Prevent Child Abuse-New Jersey is the PAT state affiliate responsible for NJ training, coordination and curricula distribution.

**Descriptions provided by NJ PAT Affiliate Office, Prevent Child Abuse – New Jersey.*

POrSCHe Home Visiting Program

<p>Program Focus: High-risk families with infant/child under six years old</p>
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Description

Prevention Oriented System for Child Health (POrSCHe) home visiting is a relationship-based service that considers health holistically and requires assessment, intervention and evaluation that is based on the specific needs of children and their families over a period of time. It implies voluntary participation, mutual respect and a desire and willingness to enhance the parent-child relationship. The POrSCHe home visitor has many roles in the provision of services to families—advocate, supporter, educator, resource, health promoter and friend.

The approach of the POrSCHe nurse home visitor is based on the principles and practices of infant mental health that offer support and guidance to families as they form their earliest attachments with their infants and young children. Since the outset of this project, the services of Gerard Costa, Ph.D., Director of the YCS Institute and an Infant Mental Health Trainer have been utilized to provide ongoing education and support to the supervisors and case managers providing services to families. Children/Families referred to POrSCHe receive a systematic assessment of their health, nutrition, safety, growth and development, parent-child interaction and social support status by a registered nurse with experience in public health and/or pediatric care. Home visit services include ongoing assessment, evaluation, parenting education and support, social support and case management that promote age-appropriate immunization, lead screening, WIC enrollment, well-child check-ups, and other related preventive child care services.

Goals

1. Promote the physical and psychosocial health of low-income children and their families through education and parenting support.
2. Integrate aspects of existing state and local programs to ensure that appropriate coordination and follow-up are provided for children needing immunizations, developmental assessment, lead screening, nutritional support, and related health and social services.
3. Develop public health linkages with Medicaid Managed Care and other primary care providers to maximize healthy outcomes.
4. Promote appropriate utilization of primary care providers and decrease use of hospital emergency departments for non-urgent care.

Duration and Frequency of Visits

Home visits ranged from a single visit to intermittent visits for several years. Generally, those families that have only recorded one visit has been to those who chose not to participate in the program.

When POrSCHe Home Visiting was established, the expectation that the number of visits and the length of time visits would continue was to be determined by the needs of the family and their willingness and desire to continue the relationship with the nurse home visitor. There had been a conscious decision not to be too prescriptive with the frequency of visits.

Referrals

Referrals include issues related to prenatal care, early newborn and early childhood, and children who have been identified with elevated blood lead levels. The standardized tools will help better identify primary problem issues and have more objective measures to guide interventions including discharge based on met needs.

Referrals to the POrSCHe home visiting projects are made through community linkages with pediatric primary care providers, NJ FamilyCare, Medicaid Managed Care, WIC, Child Health Clinics, Federally Qualified Health Centers, hospital discharge planners, and other established linkages specific to each project catchment area.

Tools for Assessment and Program Evaluation

A family and child(ren) demographics form is completed on admission to the program and updated as needed; Family/Caregiver and Child assessment is completed and updated quarterly (includes 13 categories of issues ranging from housing and educational needs to psychological well-being and changes that may occur relative to residence, employment, or individuals in the home)—this tool serves as the basis for developing an intervention plan with the family; Community Life Skills Scale and Difficult Life Circumstances, if indicated, completed every 6 months or more frequently according to the needs of the family; Ages and Stages Questionnaire recorded at least every 6 months or more frequently as indicated by the needs of the child and family; Infant/Toddler or Early Childhood Home Observation for the Measurement of the Environment (HOME) inventories completed age-appropriately at least every 6 months; and the completion of the Universal Child Health Record either by the child's primary care provider or nurse home visitor, at least every 6 months; and safety and lead risk assessments are also completed.

Data

The tools listed above with the exception of the safety and lead risk assessment, have been introduced with specified periodicity during this past year; therefore, data from these tools is not yet available. A data system has been developed and all of data from these tools including all demographic information are being entered for each client/family. Summary data related to the grant objective is available from 1998 through 2002. Approximately 800 families are currently receiving nurse home visits from this project. POrSCHe clients are served in Camden, East Orange, Irvington, Jersey City, Paterson, Plainfield, and Trenton as well as in Burlington, Gloucester, Middlesex, Monmouth and Warren Counties. The projects in East Orange, Irvington and Paterson are primarily serving children who are lead burdened.

Agency/Organization Administering

NJ Department of Health and Senior Services

** Description provided by the Department of Health and Senior Services.*

Appendix B:

Home Visiting Elements of NJ Model Programs

Name of Program	Family-Child Home Program
Program Focus	Families with children from 18 – 36 months of age
Intensity of Service	Home visits Minimum of 2 x/week for 2 years
Provider of Service	Trained home visitors (parents)
Training & Supervision	Intensive training & ongoing supervision
Core Elements of Visit	<ul style="list-style-type: none"> * Standardized assessment tools * Support verbal interaction and play between parents and toddlers * Understand role of parent as first teacher to encourage future school and academic success
Location of Program	Middlesex County

Name of Program	Healthy Families
Program Focus	Pregnant mom and family after birth of infant
Intensity of Service	Home visits At least 1 x/week
Provider of Service	Paraprofessional
Training & Supervision	Intensive training & ongoing supervision
Core Elements of Visit	<ul style="list-style-type: none"> * Standardized assessment tool * Support parent and parent-child interaction * Link parent to community resources as well as health care resources
Location of Program	Different sponsoring agencies

Name of Program	HIPPY (<u>H</u> ome <u>I</u> nstruction for <u>P</u> arents of <u>P</u> reschool <u>Y</u> oungsters)
Program Focus	Parents of preschool children, 3-5 years old Economically disadvantaged
Intensity of Service	3 year program, Weekly for 30 weeks each year (October – June)
Provider of Service	BA level professional with advanced degree in: Early Childhood, Elementary, Parent/Adult Education, Social Work, Community Development, or Family Literacy and Family Support.
Training & Supervision	Intense week of training & annual HIPPY conference as well as annual site visits from HIPPY USA
Core Elements of Visit	<ul style="list-style-type: none"> * Specific to working w/parents....not child... * Review child's preschool curriculum...roleplay * Parent literacy * Personal issues
Location of Program	Bergen Family Center and NCJW, Greater Teaneck Section (Englewood, Teaneck, Bergenfield and Hackensack)

Name of Program	Nurse Family Partnership (NFP)
Program Focus	* Low income parent(s) * First time pregnant mom (by 16 th week , not later than 28 th week of pregnancy) through first two years of child's life
Intensity of Service	Intensive visit schedule
Provider of Service	RN
Training & Supervision	Well prepared nursing supervisor for nurse visitors
Core Elements of Visit	* Use NFP Clinical Information System * Developmental sequence to visits * Mom's personal health and life course * Community resource assessment * Quality of caregiving for the child"
Location of Program	Trenton and Atlantic City ³

Name of Program	Parents As Teachers (PAT)
Program Focus	Family Throughout pregnancy and until child enters kindergarten
Intensity of Service	Personal visits (weekly-monthly) and group meetings to match family needs and program goals
Provider of Service	Certified Parent Educators
Training & Supervision	PAT Parent Educators must maintain annual certification.
Core Elements of Visit	*Parent education through interactive neuroscience based activities *Standardized assessments and screenings *Family Support through linkage with Community Resources. *Parent/child educational Group Meetings
Location of Program	* Different sponsoring agencies * Abbott preschool sites ⁴ and other sites

Name of Program	POrSCHe (Prevention Oriented System for Child Health)
Program Focus	High risk family with infant /child under age six
Intensity of Service	1-3x/week based on need Average duration of visits - 3 years
Provider of Service	RN
Training & Supervision	Reflective supervision and case conferences
Core Elements of Visit	* Home assessment * Developmental assessment * Link to health care and community resources * Parent education
Location of Program	Different grant funded agencies

³ Not an officially replicated site.

⁴ Family Outreach Program (FOP) provides PAT services to 3 and 4 year olds through the Abbott contracted child care centers. Home visits may occur at the child's home or the child care center.

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