JOINING FORCES Joining Families

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REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS

Home Visiting Revisited: One Spoke in the Wheel, Not the Silver Bullet

An Interview with John Eckenrode, Ph.D., Professor, Department of Human Development and Co-Director of the Family Life Development Center, Cornell University, Ithaca, NY. —*Conducted by James E. McCarroll, Ph.D.*

In This Issue

In this issue we expand upon some important topics previously presented— home visiting and Shaken Baby Syndrome. An in-depth interview on home visiting with John Eckenrode, Ph.D., Co-Director of the Family Life Development Center at Cornell University has implications for your research, clinical practice and marketing of services and programs. A review of an article on the economic costs associated with head trauma reinforces the importance of your prevention work around child abuse. Our feature on Parenting Capacity can enrich your work in conducting and creating new assessment modalities.

We hope you will enjoy our regular feature, Building Bridges to Research, that discusses the differences between prospective and retrospective approaches, and our column, Websites of Interest, with resources on parenting education and home visiting.

Join us in welcoming to our editorial staff David M. Benedek, M.D., Associate Professor and Scientist, Center for the Study of Traumatic Stress of Uniformed Services University of the Health Sciences. His expertise will be an invaluable addition to our newsletter.

Please continue to provide your feedback that enables us to serve your interests and growth.

— James. E. McCarroll, Ph.D., Editor-in-Chief

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The following interview with distinguished scholar and researcher, John Eckenrode of Cornell University, presents a provocative discussion of home visiting expanding upon the article, *Home Visiting: Research Review and FAP Implications,* which appeared in the Fall/Winter 2004 issue of *Joining Forces Joining Families* (available at: http://www.usuhs.mil/psy/traumaticstress/newcenter.html). Dr. Eckenrode raises important questions about home visiting. Should the program goal be prevention of child abuse or prevention of child neglect? Would it be more effective and engaging to reframe child abuse prevention as promotion of maternal and child health and development? What are the pros and cons of approaches that target parental risk factors versus an empowerment strategy? What are the differences in programs that use nurses versus paraprofessional home visitors? How can we better utilize fathers and other family members to increase the benefits of home visiting? What do we know about the cost-effectiveness of home visiting?

The purpose of this interview and our previous feature on home visiting is to stimulate research ideas and improved outcomes involving home visiting amongst Army family violence practitioners and programs.

Dr. McCarroll: In the Fall/Winter 2004 issue of Joining Forces Joining Families, we reviewed the Duggan et al. articles[1–3] and Mark Chaffin's commentary[4] in Child Abuse &

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The purpose of this interview and our previous feature on home visiting is to stimulate research ideas and improved outcomes involving home visiting amongst Army family violence practitioners and programs.

Neglect on home visiting to initiate dialogue and research ideas around the Army's experiences with this model. Please share your thoughts on those articles as well as your views on home visiting as a means of preventing child maltreatment.

Dr. Eckenrode: The Duggan articles are consistent with what some other research is showing, especially with regard to the particular home visiting model that was tested in Hawaii. The evidence coming out of the paraprofessional home visiting models is mixed, at best, and negative at worst. But, I thought the message was not entirely as discouraging as Dr. Chaffin's commentary suggested. In the Duggan articles there were at least some modest benefits of the program in terms of mothers' self-reported neglect behavior. There was little or no evidence that the program was preventing physical abuse, severe or minor.

This is an important point because when we think of these programs we tend to think of the prevention of abuse, physical or sexual abuse, rather than neglect. In fact, most of the issues that the home visitors are dealing with have to do with neglect given the population that they are working with, typically young mothers and fathers. Even in our Elmira trial[5,6] when there was some evidence for long-term effects, we were careful to say that what we were preventing was primarily neglect rather than abuse.

Chaffin touched on a number of important issues with regard to the quality of the evidence and the need for better research and the state of the art in terms of what the data is showing. In general, it was a timely and a well-written piece.

Dr. McCarroll: Is the primary prevention of child maltreatment still a reasonable goal of a home visiting program?

Dr. Eckenrode: It is. However most of the successful early intervention and family support programs would be labeled as comprehensive programs and do not focus exclusively on child abuse and neglect issues. They tend to be a bit broader – family support, parental support, and early education programs that deal with a range of issues. The program begun by David Olds in Elmira was not proposed to the community or to the parents initially as a child abuse and neglect prevention program. It focused more generally on maternal and child health; child abuse and neglect was one of a number of issues or outcomes that was the focus of that program. That is important. Some of these programs have become known as child abuse and neglect prevention programs because of who has picked up on what issues and what advocacy efforts have taken place. But, it is important to put it in the larger context, not only for the field, but also in terms of running these programs and in identifying families who will be in these programs. It is more effective when it is cast in terms of a program to promote maternal and child health and well-being and development of children, with child abuse and neglect being one of several program goals.

Dr. McCarroll: Duggan et al. point out that the vast majority of parents will not maltreat their children. Hence, having them participate in home visiting programs is essentially a waste of resources, whereas targeting already maltreating parents puts a different cast on it. Would you go for a targeted approach or a universal approach?

Dr. Eckenrode: The data are pretty clear at this point that these services are probably not having a very big impact on families where the

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Parenting Capacity: An Important Child and Family Assessment Component

James E. McCarroll, Ph.D., David M. Benedek, M.D. and Robert J. Ursano, M.D.

Parenting capacity describes the ability of parents to respond to and provide for their child's needs.

Parenting capacity describes the ability of parents to respond to and provide for their child's needs. The assessment of parenting capacity can be an important aspect of the Army Family Advocacy Program (FAP). This article reviews parenting capacity, one aspect of child and family assessment, that can be helpful in your work involving case substantiation, treatment decisions and potential research for improving the assessment process.

The *Framework for the Assessment of Children in Need and their Families* (hereafter referred to as "the Framework") is a program that was developed in the United Kingdom. Its objective is to accurately and sensitively identify children who may require social services and to ensure appropriate and timely services that can result in good outcomes.[1] The Framework identifies three domains of the assessment process: the child's developmental needs, the capacity of parents or caregivers to respond appropriately to those needs (parenting capacity), and family and environmental factors. The Framework's emphasis is holistic. It identifies children's developmental needs and circumstances and considers the children's and family's strengths as well as weaknesses. The assessment is done in collaboration with other relevant agencies and involves both parents and children, when possible.[2]

Donald and Jureidini, in Australia, argue that parenting capacity is the central concept in the assessment process.[3] In their view, parenting capacity is the parents' ability to empathically understand and give priority to their child's needs. Parents must be able to meet the challenges posed by their child's temperament and development and be able to accept and address their own personal characteristics that may impede their parenting capacity. It is seen as the product of the interaction of child, parent, and environmental factors. Thus, parenting capacity is more than the strengths and weaknesses of parents. Rather, the concept focuses our attention on parent-child resources and their match (or fit) and enhances the assessment.

An approach that identifies just strengths and weaknesses of parents, but does not relate the overall performance of the parents to the child they have harmed, will not enhance the decision-making process. Donald and Jureidini argue that assessment of parenting capacity should be attempted only after maltreatment has been substantiated. The reason for this is that the parents' reaction to and level of acceptance of the harm their child has suffered as a result of maltreatment becomes clear, and then becomes central to the assessment.

A further argument for the assessment of parenting capacity is that over-attribution of shortcomings in parenting to other causes (e.g., poverty or poor social support) limits thinking on interventions. In other words, if a problem is attributed to a social domain rather than inadequate parenting capacity, it will lead to the wrong intervention and expose the child to further harm. This error is seen when an agency devotes more resources to "scaffolding" (external factors such as social support and social agency assistance) without adequately assessing parenting capacity. However, interventions for scaffolding are often easier to apply than interventions to modify parenting capacity because it is more comfortable to blame circumstances than to confront shortcomings in the parents and their capacity to parent that particular child.[3]

Azar, Luaretti, and Loding [4] offer another approach to assessment of parenting in cases of already established child maltreatment. These authors provide extensive guidelines for the assessment of parenting in court cases for the termination of parental rights and other situations involving maltreatment, which encompass five parental skill areas: parenting skills, social cognitive skills, self-control skills, stress management, and social skills. In this approach, however, parenting capacity is one domain of the model and the factors are not related to the overall performance of the parents in the care of their child.

There are therapeutic implications to the

A further argument for the assessment of parenting capacity is that over- attribution of shortcomings in parenting to other causes (e.g., poverty or poor social support) limits thinking on interventions. In other words, if a problem is attributed to a social domain rather than inadequate parenting capacity, it will lead to the wrong intervention and expose the child to further harm.

assessment of parenting capacity.[3] The most important of these is to give insight to parents into their relationship with the child and areas of needed change in empathy, skills, or management of stresses and resources that may affect their parenting. Therapy then revolves around the parents' acceptance of responsibility of past acts, any apparent damage done, resolution of previous trauma, management of the parents' own emotional feelings, and the ability to recognize and respond in a healthy way to their children's feelings and behaviors.

Parenting capacity is difficult to assess. Research that uses the concept of parenting capacity, in conjunction with traditional family and community scaffolding, can inform our understanding of family maltreatment in the Army and promote development of helpful intervention strategies. Parenting capacity assessment includes questions such as:

1) How well does the family function in an overall sense?
2) Do the parenting skills of the parents fit the needs of the child?
3) Where are the parents on the continuum of minimally effective to maximally effective parenting?
4) What evidence exists that the parents understand the problems between them and their child?
5) How willing and how able are the parents to make necessary changes?
6) Have class, race, or ethnic issues contributed to the family's problems and can they be part of the solutions?
7) Can the family be reasonably expected to achieve its goals and in what time frame?
8) How is parenting capacity affected by dynamic events such as the deployment of one or both parents, illnesses, separations, movement of family members in and out of the household and other family changes?

Much like Eckenrode's point in *Home Visiting Revisited: One Spoke in the Wheel, Not the Silver Bullet* that child abuse prevention goals in home visiting may be reframed as promotion of maternal and child health, parenting capacity as an assessment component can provide a positive lens for examining parental behavior, engaging parental involvement in its remediation and developing programs that reflect the changing nature of the parenting process in military life.

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Building Bridges to Research: Prospective and Retrospective Approaches to Child Maltreatment Research

James E. McCarroll, Ph.D., David M. Benedek, M.D. and Robert J. Ursano, M.D.

In a prospective study measures of exposure are taken before the outcome has occurred while in a retrospective study the measure of exposure is taken after the exposure.

The terms prospective and retrospective are used to describe two types of research design. This feature attempts to clarify the basic distinction between prospective and retrospective designs, and their relation to other research terms such as longitudinal, case-control, cross-sectional, and cohort. The views of two groups of researchers on the benefits and limitations of prospective and retrospective studies in child maltreatment research will then be presented.

Let's consider how we think about cause and effect. One way of thinking about the relation between cause and effect in child maltreatment research is to attempt to relate an event, which is called an *exposure,* such as childhood maltreatment, to an *outcome,* such as an adult illness or symptom. Research design requires that both the exposure and the outcome be measured, that their temporal sequence is reasonable (e.g., the outcome cannot occur before the exposure), that it is possible to analyze the relationship between the exposure and the outcome, and that the results are plausible (e.g., conform to a theory or fit in with previous findings).

The most important distinction between prospective and retrospective studies is that in a prospective study measures of exposure are taken before the outcome has occurred while in a retrospective study the measure of exposure is taken after the exposure has occurred; that is, retrospectively (e.g., looking backwards). In a prospective study, a group of children who have not been exposed to maltreatment are identified and followed over time. In a retrospective study, a group of children, some of whom have already been exposed, is identified and measures of exposure are taken after the outcome has occurred. For example, children who have been maltreated are assessed for their history to investigate variables that were associated with maltreatment such as low birth weight. Another way of stating this distinction is that the two methods differ in the timing of subject (case) identification. Prospective studies identify individuals or study groups and later determine the outcome. Retrospective studies take the outcome and then, looking back, determine what significant events occurred prior to the outcome.[1]

Other distinctions add complexity to the descriptions of both prospective and retrospective study methods. Two additional terms, *cohort* and *case-control,* are important. Frequently these are misidentified as describing prospective and retrospective designs, respectively. In cohort studies, participants are selected according to their exposure status (e.g., soldiers who have not yet deployed); in case-control studies, participants are selected based on their outcome status (e.g., all soldiers with posttraumatic stress symptoms after return from deployment).[1] However, both cohort and case-control studies can be prospective or retrospective.

In *longitudinal studies*, repeated measures are taken on the same persons and they are identified so they can be re-tested. A *cross-sectional study* is like a snap-shot in that measurement of exposure and outcome occurs only once and at the same time. A series of cross-sectional studies can be performed on a population to describe changes in the population over time, but usually the subject cannot be identified and linked to other information. An *experiment* is always a prospective cohort study because subjects are selected and assigned to groups and the investigator then waits for the outcome to occur.[1]

In a recent issue of *Child Abuse & Neglect* two groups of researchers offered comments on some advantages and disadvantages of both

Requirements of Research Design

- The exposure and the outcome both must be measured
- Their temporal sequence must be reasonable
- It must be possible to analyze the relationship between the exposure and the outcome
- The results must be plausible (e.g., conform to a theory or fit in with previous findings).

Prospective studies identify individuals or study groups and later determine the outcome. Retrospective studies take the outcome and then, looking back, determine what significant events occurred prior to the outcome.

prospective and retrospective studies in maltreatment research.[2–3] Each type of study (prospective and retrospective) has its advantages and one should not assume that prospective is necessarily better than retrospective.

Problems of retrospective studies in child maltreatment research

Accuracy of information

One of the problems of retrospective studies involving self-reports is whether the information provided is accurate. Why might such information be inaccurate? What a person remembers from childhood might be dependent on what the person has been told. There is a considerable body of maltreatment literature showing an unacceptable level of validity (accuracy) of self-reported (retrospective) childhood experience. Among the other reasons for such lack of validity are lack of rapport with the interviewer, a desire to protect parents or other persons, and a desire to forget or deny the past. Additionally, in retrospective reporting it is almost impossible to determine the extent of false positive responders (persons who say that an event happened when, in fact, it did not happen).[2]

Sources of bias in reporting

- *Recall bias* can cause errors in retrospective reports. Recall bias occurs when persons report exposure information after learning that they have the outcome in question.[1] Other examples of why people may be more likely to report early experiences in a negative way (recall bias) are poor health, negative mood, and other factors in the current life of the individual such as depression, substance abuse, and life satisfaction.[2]
- *Sampling bias* can occur in retrospective studies. It may be difficult to obtain a sample of the most representative population for the problem one wishes to study. For example, different data are usually obtained from persons visiting a doctor than from those in a women's shelter or from college students. Each of these will be biased in the direction of the problems presented by the respondents in each of these situations and can be representative only of that population.[2]
- *Investigating causality versus risk.* In retrospective reports there is little chance of examining causal relationships between exposure and outcome whereas this seems to be more likely in prospective studies. Whether outcomes are directly or indirectly related to the exposure will be difficult to tease out, but prospective studies at least allow the investigator to learn the temporal sequence of events following the exposure and other adverse events. While retrospective studies may not allow one to draw conclusions about causality, they can suggest possible risk factors for the outcomes.[2]

Problems of prospective studies in child maltreatment research

- *Identification of participants for the research.* There are many problems in identifying groups of children to follow in prospective studies. In one type of prospective study, an investigator would follow a group of children and later identify those children who are maltreated and those who are not. However, it is hard to identify maltreated children. Prospective designs will probably miss many victims of childhood maltreatment whose maltreatment was never reported to authorities. When victims are identified, reporting to authorities is mandatory. Investigators cannot simply identify and follow them without taking into account the effect of their identification and intervention or non-intervention. Finally, persons who were identified as maltreated children are probably not representative of maltreatment survivors as a whole. Thus, prospective and retrospective studies are likely to identify separate subgroups for study. [3]
- *Severity of abuse.* Unreported abuse may be more severe. Abuse may be more severe when unreported due to the belief that when abuse is identified it is more likely to stop; when it goes unreported it can continue and even escalate becoming more frequent and more severe. When maltreatment goes unreported, there can be other associated outcomes such as shame and isolation that can result in different outcomes such as more symptoms. [3]

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In fact, most of the issues that the home visitors are dealing with have to do with neglect given the population that they are working with, typically young mothers and fathers.

need is not very high: the well-functioning, two parent, middle income families with no identifiable risk factors such as substance abuse or mental health problems or domestic violence or those kinds of issues. While such families may have some minor benefits from participation, it is unlikely that 1) families would benefit greatly or, 2) they would remain in the programs very long.

Most of these programs have high attrition rates, and the attrition rate will be higher among families that do not feel they have the need. So, given how difficult it is to fund these programs at the level of communities, even for the high-risk parents, it is unlikely that we would be able to justify a universal approach. Now, that may be different in the military where there is a different structure and different funding options and so forth, but at least in the civilian community, I don't think we will see a push at the policy level for universal approaches just because the data do not support it at the moment.

Dr. McCarroll: Do you see benefits of targeted services toward such groups as first time mothers and already maltreating parents?

Dr. Eckenrode: I am most familiar with the program that selected primarily first time mothers. The data are less strong in terms of the effectiveness of these programs with parents that have already had one or two children. Some fair consideration should be given as to whether first-time parents are an important sub-population who would be open to health messages, open to change, and may have questions about the health of their children, and therefore may be more amenable to those kinds of interventions. Plus, they tend to be higher risk, as teen parents for example. There is room for more research on whether other populations of parents can benefit as much. Regarding maltreating parents, I have not seen strong data indicating the effectiveness of these programs for preventing recidivism of maltreatment among already identified maltreating parents. I am not sure that I would target a home visiting program on already maltreating parents, especially if one were interested in prevention rather than remediation.

Dr. McCarroll: What has been your experience on the use of screening tools? I know that the Duggan articles used the Kempe family checklist and the military has its own risk assessment instrument.

Dr. Eckenrode: I am not an expert on what particular measures can be used as screening tools. We targeted low income, single parent status, and age as risk factors. Other programs such as ours have taken a broader demographic approach and recruited mothers who have met certain demographic criteria. There are other risk factors for maltreatment, as cited in some of the literature such as in the Duggan papers and the Chaffin article and work by Neil Guterman[7] that point to the need to target and customize our approaches to parents who have risk factors that are known to be associated with child abuse and neglect, such as substance use, psychological problems or the presence of domestic violence.

It is precisely these kinds of risks that home visitors, particularly paraprofessional home visitors, are not very well trained to tackle. They are difficult problems to deal with and may require some combination of approaches, home visiting and other kinds of therapeutic approaches for some of the more serious issues such as substance abuse and mental health problems. You cannot really expect home visitors in a modest intervention such as this to deal with very significant family problems such as those.

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John Eckenrode

John Eckenrode is a social psychologist (Tufts, 1979) whose research interests are the effects of preventive interventions, and the stress and coping processes involved in child abuse and neglect. Author of numerous journal articles and chapters, Dr. Eckenrode is the editor of *Stress Between Work and Family* (with Susan Gore); *The Social Context of Coping;* and *Understanding Abusive Families* (with James Garbarino). Dr. Eckenrode received the Robert Chin Memorial Award from the Society for the Psychological Study of Social Issues (SPSSI) in 1995 for the year's finest paper on child abuse and neglect. In 1997 he received the annual research award from the National Institute for Health Care Management in the maternal and child health care category. He is a fellow of the American Psychological Association (Div. 7).

…these services are probably not having a very big impact on families where the need is not very high: the well-functioning, two parent, middle income families with no identifiable risk factors such as substance abuse or mental health problems or domestic violence or those kinds of issues.

Dr. McCarroll: Would you give us your thoughts on differences between programs that attempt to correct the risk factors that brought the family into the program in the first place, as Duggan et al. and Chaffin advocated, versus those that use an empowerment model emphasizing parental strengths?

Dr. Eckenrode: It is not an either-or situation. I have a lot of respect for the empowerment model and the work of my colleagues at Cornell, Urie Bronfenbrenner[8] and Mon Cochran[9, 10] who use and promote it. We have developed programs at Cornell that try to build on those insights in working with families and family support workers. But, there are certain, straightforward risk factors that are present in families. For example, if you start working with mothers pre-natally there are some obvious risk factors impacting child development such as maternal smoking or alcohol use. I don't think anyone would argue that focusing on those risk factors in the young pregnant woman would be a mistake. Completely letting a mother engage in such behaviors that define her own goals in a home visiting program would be a misguided effort.

On the other hand, there is a lot that can be learned from empowerment approaches in terms of how we work with families, how they are approached, the collaborative efforts that are used in these programs with parents, respect for parents, respect for diversity and training cultural competence of our visitors. These are all very positive things and they speak more to the approach that is used by the visitors than the content of what is being attempted. There needs to be some balance between this approach of targeting risk factors including what we know from epidemiological literature about certain risks that are present for mothers and children in the population. Some families have more of those risk factors, whether it is poverty or substance use or domestic violence, and we certainly cannot ignore those when it comes to these types of prevention programs. But, it does raise some questions. How do you do that while preserving the dignity of the enrolled family? How do you recruit them as partners in the process? How do you build upon the supportive element of the home visitor-family relationship? The key to the success of any of these programs is the quality of that relationship between the home visitor and the mothers.

Dr. McCarroll: How would you assess the quality of the relationship between the mother and the home visitor?

Dr. Eckenrode: There have been attempts to do that. Some of the more recent work that David Olds and his group have been doing in Denver has explicitly tried to measure the quality of that relationship between nurses and mothers.[10] Typically this is done through self-report measures of the mother as a part of the evaluation design. It asks them not only about what happened, but also the qualitative aspects of that relationship. Jon Korfmacher[11] looked at some of that when he worked in Denver with David Olds. But, there are other approaches. You can also probably get good, reliable data from looking at that relationship from the mother's point of view. But, you can also get assessments from the visitor's point of view as well in terms of how well that relationship is going.

Dr. McCarroll: What have been the differences in outcomes using nurse home visitors compared to paraprofessionals?

Dr. Eckenrode: There have probably been more evaluations of paraprofessional models than nurse models at this point. The Duggan studies examined a paraprofessional model. The only trial that I know of that has explicitly tried to compare randomly assigned families to a nurse or paraprofessional home visitor is David Olds' Denver trial, [12] which is now completed, and those kids are now in elementary school. Most of the paraprofessionals were from the community and did not have a college degree. The data clearly show the superiority of the nurse home visiting condition across several child and maternal outcomes. Typically, the pattern of results shows small gains for the paraprofessional-visited families, which were not statistically different from the control group families, and larger gains for the nurse-visited families that were statistically different from the control group. The paraprofessional approach seems to have very limited, modest effects. With large scale dissemination of the paraprofessional model, I would presume that there are some benefits for some families, but across the board and across these studies we are just not seeing very big effects at this point.

On the other hand, there is a lot that can be learned from empowerment approaches in terms of how we work with families, how they are approached, the collaborative efforts that are used in these programs with parents, respect for parents, respect for diversity and training cultural competence of our visitors.

Dr. McCarroll: I wonder if that is due to educational background of the nurses or whether the paraprofessionals are not getting adequate training and supervision.

*Dr. Eckenrode:*It's kind of a mix. In David Olds' trial in Denver they got basically the same level of training and supervision.[12] So, it wasn't program implementation differences that could explain that. When I hear David talk about it, it is a combination of things including their level of education and ability to respond to issues in a family. There are also legitimacy issues and the sense of respect that people accord nurses in the community. First time pregnant women may be more open to the kind of relationship with a nurse and the kind of information that a nurse can provide because of questions around health issues. Nurses may be in a better position to provide this kind of information. It is harder for a paraprofessional to come into a family and achieve that same comfort level around these kinds of issues.

There are also programmatic issues. We know there is more turnover among paraprofessional home visitors than there is with the nurses due to the inability, understandably, of many community agencies to pay their paraprofessionals very well. We know that the continuity of that relationship over the time with the home visited parents is an important program component that could be linked to success. So, there are other structural reasons that might work against the effectiveness of the paraprofessional model.

Dr. McCarroll: Due to the wide dispersal of forces, the military is often only able to use volunteers or paraprofessionals, and not nurses. Can you envision a mixed model for the military in which a nurse or an experienced person acts as a supervisor of volunteers or paraprofessionals and alternates visits with them?

*Dr. Eckenrode:*Yes. It is possible these kinds of hybrid models might be successful in some cases and contexts with some families. I don't think we have the data, at least in the randomized trials, to know. Those are probably forthcoming as people experiment with different combinations such as the level of education and level of supervision. We may reach a day where there are data to support something like what you describe.

Whoever the visitors are, there are some program elements that need to be in place in terms of adequate training, supervision, caseloads, and length of follow-up to ensure success. I certainly don't think you can go in with a paraprofessional model even if they are supervised by higher level people, do it for six weeks with a narrow focus on one or two issues, and expect to see much by way of long-term effects. I'd rather see a more comprehensive, long-term approach with a smaller number of families than a watered-down approach that tried to reach all the families and is unlikely to be successful.

Dr. McCarroll: At what stage in a woman's pregnancy would you start such a program?

*Dr. Eckenrode:*That is a good question. As the pregnancy progresses, mothers become more and more focused on it. But, you don't want to wait too long into the third trimester to recruit women because if there are risky health behaviors or nutrition problems, then you really need to get to them earlier. It is certainly better to recruit in the second trimester than the third. You might just not realistically be able to pick up families much earlier than that. I do not know what the standards are for pre-natal visits, but that's probably a good set of guidelines that can be used as to when these programs should start. Often that is how these families are recruited through the pre-natal programs.

Dr. McCarroll: Also, in terms of developing models, the military may have an advantage over civilian communities in the opportunity to recruit fathers into home visiting programs.

Dr. Eckenrode: I think there is a lot of interesting work that could be done in terms of father involvement and how that might help keep mothers in the program longer. Such an approach might help to deal with some of these attrition issues. Father involvement could act as a multiplier reinforcing what the nurses are doing. We also know that family members can have a negative effect. If the young mother is living with family members that are not on the same page as the nurses or other home visitors their effects can be detrimental to the program's effectiveness. But, the opposite is also true. One of the original goals of the program was having the involvement of either a husband, a grandmother or a partner present during the pregnancy, at the birth of the child, and around the house enough to help with child care activities. There is a lot of room for work and improvement there. *Continued on p. 10*

An important point to make is that home visiting programs by themselves are kind of modest interventions requiring us to have modest expectations and goals. They need to be seen in the context of the whole web of services available to families and to children.

Dr. McCarroll: What information is available on program costs?

Dr. Eckenrode: There is a new study that has come out of Washington State that examines the costs and benefits of several early intervention and family support programs. In terms of the nurse visiting program, the data show that it is cost-effective over the long term, and that a Healthy Families approach actually does not recover the costs of the program. The information is available on the web.

The summary report is at: www.wsipp.wa.gov/rptfiles/04-07-3901.pdf. *The technical appendix is at* www.wsipp.wa.gov/rptfiles/04-07-3901a.pdf and *references* at www.wsipp.wa.gov/rptfiles/04-07-3901b.pdf.

The Washington State project provides a more comprehensive view of outcomes than earlier cost-benefit studies allowed. A monetary value was put on education outcomes, substance abuse outcomes, teen pregnancy outcomes, and child abuse and neglect outcomes, in addition to criminal outcomes. We hope this effort produces a more complete accounting of policy options that can increase the efficiency with which taxpayer dollars are spent.

Dr. McCarroll: Any final thoughts that I have not asked you about?

Dr. Eckenrode: An important point to make is that home visiting programs by themselves are kind of modest interventions requiring us to have modest expectations and goals. They need to be seen in the context of the whole web of services available to families and to children. I think the most effective long-term approaches will be those in which home visiting is a part of a network of services such as combining home visiting with other high quality programs like center-based child care.

The other challenge is how to bridge between these programs once families leave the home visiting programs. How do you continue working with these families through the pre-school years until the children reach school age and beyond? As stand alone programs, they are not likely to have great impact on families. They really need to be thought of as one component of a more comprehensive approach to something like preventing child abuse and neglect, which would include other kinds of approaches to already maltreating families, community-based prevention efforts, and school-based prevention efforts. Home visiting is one spoke in the wheel and it might be an important one and an interesting one, but it is not the silver bullet that has come along that is going to solve all these problems.

Dr. McCarroll: Thank you for this information. I am sure our readers will appreciate your thoughts on home visiting. We look forward to your input in the future. Thanks again.

Dr. Eckenrode: You are welcome. My pleasure.

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Health Care Burden of Head Trauma in Young Children

James E. McCarroll, Ph.D.

A recent article in *Child Abuse & Neglect*[1] looked at the presenting characteristics, hospital course, and hospital costs associated with head trauma in young children and whether these factors were different for abused compared to non-abused children. We summarize the findings from this article that follows up a past feature on Shaken Baby Syndrome (*Joining Forces Joining Families*, Spring 2004), and hope it may enrich the interactions between FAP personnel and emergency room and primary care providers who are often "on the front lines" of these traumas. Data on the morbidity and mortality of abusive head trauma in children, including causes and rates of injuries and outcomes, are also provided.

The study was based on a retrospective record review of 377 (89 abused and 288 non-abused) children less than 3 years of age who were admitted to Children's Hospital of Pittsburgh between January 1995 and December 1999. The findings presented below underscore the differences between these two groups of children.

Caretakers of abused children were more likely to give a history of no trauma or minor trauma compared to the caretakers of non-abused children.

- The length of hospital stay was longer for abused children (mean=9.25 days) compared to non-abused children (mean=3.03 days).
- Hospital charges were significantly higher for abused children (mean=$40,082) compared to non-abused children (mean=$15,671).
- Abused children were more likely to:
  - ❑ Be under one year of age
  - ❑ Covered by Medicaid than by commercial insurance
  - ❑ Admitted to ICU
  - ❑ Die from their injuries

Among the 15 children who died while in the hospital, 9 had been abused. About half of the abused children (55%) were discharged to foster care. The early economic costs of hospitalization secondary to abusive head injury are high. The costs of long-term care for abused children in this study are likely to be significant given that injuries sustained at a young age can have developmental consequences with long-term implications. The authors emphasize the importance of focusing greater resources on decreasing the incidence of abusive head trauma, which is a primary goal of the FAP.

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- *Costs.* Prospective studies are very expensive when the investigator seeks to identify for studying low frequency events. For example, one must follow 100 subjects to find one case if the rate of occurrence is 1%.

The statistical issues involved in the distinctions presented here are more complex than our presentation here. However, our purpose is to present the broad outlines of prospective and retrospective research designs and to apply them to child maltreatment research and practice.

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Websites of Interest

The following websites provide information on home visiting and parenting:

National Center for Children, Families, and Communities

www.nccfc.org/nursefamilypartnership.

This website, produced by the University of Colorado Health Sciences Center, provides information about nurse home visiting programs, specifically, the nurse-family partnership. The site describes the basic requirements of the nurse-family partnership program: how to become a site; training resources; costs and evaluations.
Also on the site, David Olds, PhD, the Director of the Prevention Research Center for Family and Child Health, describes results of research providing evidence of the nurse-family partnership's effects.

Healthy Families America

www.healthyfamiliesamerica.org.

Healthy Families America is a national program model designed to help expectant and new parents. The organization fosters positive parenting, enhanced child health and development, and prevention of child abuse and neglect. This website provides network resources, advocacy information, and research information.

Parents as Teachers (PAT)

www.patnc.org.

PAT is an international early childhood parent education and family support program serving families throughout pregnancy until their child enters kindergarten, usually age 5. Its goal is to enhance child development and school achievement through parent education for all families

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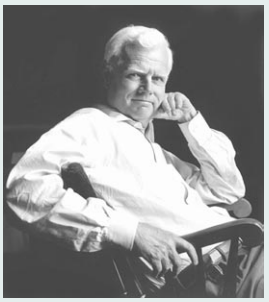

Coming Next Issue

An Interview with ***William R. Beardslee,*** Psychiatrist-in-Chief, Children's Hospital Boston; Gardner Monks Professor of Child Psychiatry, Harvard Medical School, on the effects of depression on children and families, and an evidence-based treatment approach.