2009-01-01

Family-Centered Early Intervention in North America: Have Home-based Programmes Lived up to their Promise for High-risk Families?

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Abstract

While early intervention programming is not new in North America, such programs have gone through a rapid expansion in recent years. This has been motivated by the recognition of the need for timely intervention, the development of a family rather than a child focused practice philosophy and the desire on the part of funding organizations to save money by promoting less expensive programming. This article reviews the various components of early intervention programmes in North America while also questioning aspects of current practice. There is a clear need for family-centered intervention. This should not be in question. However, the fundamental question should not be whether family centered intervention is necessary but rather how can empirical research inform best practices? It is the conclusion of the authors that this will be the key challenge in the coming years.

Keywords: Early Intervention, Family Centered Practice

Introduction

Early intervention programs have existed in North America for well over thirty years. However, there has been a rapid expansion of programmes in Canada and the United States in the past decade. This expansion has been driven by a number of factors. The first, and most significant factor is based on the supposition that interventions with children have to begin as early as possible in order to be effective (Karoly, Greenwood, Everingham, Hoube, Kilburn, Rydell, Sanders, & Chiesa, 1998; MacLeod & Nelson, 2000; Marshall, Charles, Hare, & Ponzetti, 2005; McCain & Mustard, 1999). Historically, North American practice was based upon interventions for school age children in all but exceptional cases. Services were provided in either residential or child guidance settings and tended to be professionally driven and quite intrusive (Charles & Gabor, 2006). Growing dissatisfaction both in the lay and professional communities with the degree of intrusiveness and the questionable efficacy of these services resulted in the development of a service philosophy that called for the least intrusive interventions to be used with children and families (Chaffin, Bonner & Hill, 2001; Charles & Gabor, 2006).

A second reason for program expansion is related to the gradual change in how high-risk children and families in need were viewed in the North American social service arena. This change was the result of a philosophical shift from a child focused to a family-centered service delivery model. Children were no longer seen as being independent of the family system in which they were raised (Charles & Gabor, 2006). Change could not occur in the child if there was not a corresponding change in the family.

The third reason for the growth in early intervention programs was an attempt to save money. The provincial and state governments in Canada and the United States respectively and the federal governments in both countries have grown increasingly worried over the past two decades regarding bellowing children and family services budgets (Besharov, 1994; Fraser, Armstrong, Morris & Dadds, 2000; Walton, 2001). As a result there has been a concerted effort in recent years to gain control over what many have come to believe is an out-of-control expense. This is not to say that the only reason that governments began to provide increased funding for this type of intervention was the need to save money. It was also motivated by the desire to transfer monies to where they could most effectively be spent. This shift followed the advice of numerous researchers and practitioners who contributed to the increasing body of knowledge regarding the importance of a nurturing and stimulating family environment for optimal child development (McCain & Mustard, 1999).

The philosophical shift in service delivery on the part of professional services providers combined with a desire of governments to save money prompted an explosive expansion in the number and type of early intervention programs in North America. Early intervention programs became firmly established as a critical component of the child and family service continuum. The purpose of this article is to review the various aspects of early intervention programs in North America.

Early intervention involves planned action that is directed toward optimal growth and development in infants and young children (McCain & Mustard, 1999). It includes an enormous range of programs and services mostly with a parent education and/or child stimulation focus. These efforts are being used increasingly with children at-risk. Families at greatest risk for disruption and/or child placement are typically those with young children (from birth to three years old) living in poverty with a young, unmarried mother who has mental or substance abuse problems and lacks a reliable social support network (Gray, Spurway, & McClatchey, 2001; Marcenko & Spence, 1995).

There is compelling evidence that early intervention results in a positive immediate effect across a range of outcome variables for many different types of children (MacLeod & Nelson, 2000). Evidence for long-term impact is less compelling (Casto & Mastropieri, 1986; Fraser, Armstrong, Morris, & Dadds, 2000; White & Casto, 1984). Meta-analysis has been used to provide a comprehensive review of extant early intervention studies (Casto & White, 1985; Casto & Mastropieri, 1986; Mentore, 1999; White & Casto, 1984), which found that the most important

indicators of program effectiveness were the use of professionals and a highly structured program. Interestingly, the type of intervention (that is, educational, medical, psychological, and mixed), the location of programs or services (that is, home-based, center-based, or mixed), the intensity of programs, the timing of intervention or age of entry into programs or the level of parental involvement were not found to enhance efficacy.

Home-based intervention whereby professional or lay visitors intervene in the family residence has become common mode of service delivery. Mahoney et al. (1998) suggested that intervention effectiveness is fundamentally dependent on the manner in which parents interact with their children. A number of researchers (Olds & Kitzman, 1993; Wasik, Bryant, & Lyons, 1990; Weiss, 1993) have suggested that effective home-based programs are characterized by being comprehensive, family-centered, voluntary and continuous in nature (being offered once a week for the first six months and up to five years, if possible). The same studies also found that the home visitors involved in the program needed to have received intensive training and ongoing professional supervision. In addition, community services needed to be readily available and of high quality in order to enhance the capacity of families to utilize the services.

Family-centered intervention efforts focus on the quality of the parent and child relationship. Parents are encouraged and supported to engage in highly responsive interactions with their children. The primary goal of family-centered programs is to assist families through direct support services aimed at strengthening families and enhancing the nurturing environments that promote children's health and development. Many models have been developed; most include some form of home visitation. The focus of home visitors' involvement with families has been for emotional support, parenting information, and referral and liaison with health care providers and other community agencies.

The family-centered approach appears particularly salient to successful home-based intervention. Heinicke et al. (1999) noted that such an approach resulted in at-risk mothers exhibiting greater emotional availability and responsiveness to their infants. The presence of optimal mother-child interaction can be understood in light of the attachment between mother and child. Korfmacher, Adam, Ogawa, & Egeland (1997) found that mothers who had secure attachment representations were more involved and accepting of intervention than insecure mothers who were more likely to hold a crisis orientation to intervention and exhibit more emotionally unengaged involvement. Children whose mothers were more relationship-focused were more securely attached, autonomous, and task oriented at 12 to 14 months (Heinicke, Fineman, Ruth, Recchia, Guthrie, & Rodning, 1999). Yet, Kelly, Buehlman & Caldwell (2000) stressed that most home visitors lack necessary training to attend to the parent-child relationship and improve interaction.

Home visitation as an intervention strategy for at-risk families is not a new idea. Yet, despite significant human and fiscal investment in home-based early intervention, a number of paradoxes remain. There is enormous variation in the basic assumptions, goals, content, intensity, and

duration of these programs. Home visitation practices lack an agreed-upon theoretical basis or clear empirical justification. The reasons for home visitation are often ambiguous both diagnostically and in purpose. Further, the process of home-based intervention is open-ended and idiosyncratic (Halpern, 1986). Further, home-based intervention refers to a wide range of services and includes a broad array of practitioners who may not share the same practice model. In some instances, the models are often contradictory. It is not uncommon for some home visitors to adhere to a stabilization/crisis intervention model while others in the same program follow a prevention/health promotion model. The problem with this scenario is that the time frames of these various models are widely different (Drummond, Weir, & Kysela, 2002).

Empirical evidence for the effectiveness of home visitation is limited. Although many home-based programs have anecdotally documented success, early research was not done systematically or rigorously enough to be definitive about its efficacy (American Academy of Pediatrics, 1998; Chapman, Siegal, & Cross, 1990; Musick & Stott, 1990). It appears that the attractiveness of home-based early intervention is intuitive and reinforced by a social climate that promotes self-care and the demystification of expertise.

Evaluation studies of home-based programs are equivocal. On the one hand, research has documented that at-risk pregnant and postpartum women who were in need of greater support services utilized more services when they were involved in home-based intervention. In fact, home visitors were considered to be the most helpful service. The increased use of services was related to overall satisfaction with intervention (Marcenko & Spence, 1994; Sherman, Sanders, & Yearde, 1998). Barquest & Martin (1984) reported that the Kansas Healthy Start-Home Visitor Program led to an increase in postpartum visits, contact with infants, number of children examined, immunization contacts, and family planning contacts. On the other hand, St. Pierre and Layzer (1999), in an evaluation of the Comprehensive Child Development Program, concluded that home visiting was not an effective means of service delivery for low-income families. McCurdy (2001) found that home visiting did not significantly enhance social support among parents in the Hawaii Healthy Start program. These contradictory findings may be explained by the consideration of the intensity of support services rather than simply its presence. Navaie-Waliser, Martin, Campbell, Tessaro, Kotelchuck, & Cross (2000) followed high-risk mothers for one year postpartum and found that participants provided with more intensive home visitor support had higher self-esteem and lower depressive symptoms. Scheduling conflicts, participation compliance, and limited number of home visitors can influence the intensity.

The use of paraprofessional rather than professional staff (that is, public health nurses, counselors, and social workers) in home-based intervention is a contested issue. Research has documented that programs employing professionals are effective (Fraser, Armstrong, Morris, & Dadds, 2000; Letourneau, Drummond, Fleming, Kysela, McDonald, & Stewart, 2001; Olds & Kitzman, 1993; Olds, Robinson, O'Brien, Luckey, Pettit, Henderson, Ng, Sheff, Korfmacher, Hiatt, & Talmi, 2001). Some research has found that professional home visitors promote more constructive parent-child interaction. Gray, Spurway, & McClatchey (2001) noted that parents' self-esteem,

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confidence, social support, and the quality of parent-child interaction improved as a result of home visitations. Letourneau et al. (2001) also reported that professional nurse home visitors enhanced parent-child relationships. Yet, Kelly, Buehlman, & Caldwell (2000) noted that most professional providers lack the necessary training to ameliorate the parent-child relationship. Other studies have noted that paraprofessionals were as effective as professionals in the delivery of services (Durlak, 1979; Musick & Stott, 1990).

The use of paraprofessionals represents a viable non-threatening approach with at-risk women. Marcenko & Spence (1994) noted that paraprofessionals did provide formal support for at-risk pregnant women but were less successful at connecting them with informal support networks. Although these women increased access to services, and decreased psychological distress, no differences were found on home environment, self-esteem, or preventing placement. High-risk pregnant women with greater social support needs and healthier behavior were more receptive to long-term home visitation than others.

High risk families pose a unique challenge for early intervention programs because their lives are often characterized not only by serious substance abuse, but also by multiple and chronic life problems, chaotic living conditions, poverty, violence, insufficient supports, poor coping skills, and alienation from community health and social service providers. Maternal substance abuse further damages already strained relationships with children resulting from repetitive patterns of interaction based upon traumatic life experiences. These mothers are often unable to provide the stable, consistent, nurturing environments necessary for children's growth and development. Although children may supply the impetus for mothers to seek complete treatment, they continue to show impairments in their parenting skills. Despite relatively intensive home visitation, no effects on observed maternal competence or child responsiveness during mother-child interactions at 18 months postpartum were found. However, ongoing drug use and poor parenting attitudes were associated with less optimal maternal behaviors during mother-child interaction (Schuler, Nair, & Black, 2002).

The importance of recovery from substance abuse and relational support to high-risk mothers has been noted in previous studies. Ernst, Grant, Streissguth, & Sampson (1999) noted that high-risk mothers in the Seattle Birth-to-Three Program, which included intensive long-term home visits, spent more time with their paraprofessional home visitors and therefore became more involved in the relationship aspect of the intervention and were more likely to enter treatment, remain abstinent, deliver fewer subsequent children, and retain custody of their children.
Parenting outcomes may be improved through comprehensive family-centered programs that address the unique multitude of problems these parents experience. Treating one problem alone is insufficient to correct family deficits and dysfunction. Intervention must consist of services directed toward both substance abuse recovery and relapse prevention as well as family support and preservation (Gruber, Fleetwood, & Herring, 2001; Mejta & Lavin, 1996).

Parenting skills programs offer an important supplement to comprehensive programs. These skills can be taught by home visitors or in group settings. Recent studies have reported promising results from the inclusion of parenting information in home visitation programs. Culp, Culp, Blankenmeyer, and Passmark (1998) reported significant improvement in adolescent mothers who participated in weekly home visits with a parenting skills component in their knowledge of infant development, empathic responsiveness, and family roles when compared with mothers who were not at-risk. Similarly, Aktan, Kumpfer, & Turner, (1996) reported that parenting skills training with families of older children did lower illegal drug use in the family, the parent's own drug use and depression, and increase the time spent with children and perceived program efficacy. Cowen (2001) showed that at-risk parents could increase nurturing parenting attitudes. Nicholson, Anderson, Fox, (2002) noted that at-risk parents who participated in parenting programs reported significantly decreased levels of verbal or corporal punishment, anger, stress, and reported child behavior problems. And, Bugental et al. (2002) reported that intervention in which home visitors addressed parents' erroneous thoughts about parenting were more effective than typical home visiting as evident in decreased harsh parenting and physical abuse.

Conclusion

Overall, this review of family-centered early intervention offers three recommendations for future programming efforts. First, the recognition of contradictory practice models must be considered. The crisis intervention/stabilization model may prove useful during the initial stages of intervention; however, concerted effort to move toward a prevention/health promotion model must be made, especially if personal change through education is an intended outcome. Implicit in this move from crisis intervention to health promotion is the notion of time. Significant life changes such as those required in the lives of at-risk families cannot be accomplished in several months or even one year. Accordingly, home visitation once initiated should be construed as a long-term intervention that probably will last over an extended period of time (that is, the first three years of life). Second, the need for thorough training and ongoing education and support of paraprofessional staff is critical. Finally, the salience of professional supervision of paraprofessionals and the delineation of a well-organized developmental program are emphasized.

The need for family-centered intervention is undeniable especially for vulnerable families. The fundamental question is not whether family-centered intervention is necessary but rather how empirical research can inform anecdotal and ideological premises upon which many of these programs are currently based. This will be the challenge in the coming years.

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