

\_\_\_\_\_. "Notes from Workshop on Placing Children." Workshop conducted in Natchitoches, LA, 1981.

Jones, M. L. "Preparing the School-Age Child for Adoption," *Child Welfare* LVIII (January 1979): 27-34.

Kearns, E., and Selmon, E. *I am Me*. New York, NY: Gosset and Dunlap, 1972.

Kubler-Ross, E. *On Death and Dying*. New York, NY: Macmillan, 1969.

(Address requests for a reprint to John W. McInturf, Shreveport Regional OHD/DCYFS, Room 801, 1525 Fairfield Ave., Shreveport, LA 71130.)

## CWLA T-SHIRTS

the children's campaign

On the Line for Children

child welfare league of america

**\$7.00 EACH**

NAVY WITH WHITE LOGO  
ADULT SIZES S-M-L-XL

\$1.50 POSTAGE AND HANDLING PER SHIRT  
FREE WITH ORDERS OF 5 SHIRTS OR MORE

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

SIZES AND QUANTITY \_\_\_\_\_

(ALLOW 3 WEEKS DELIVERY)

## PROGRAM DEVELOPMENT

# Home-Based Early Intervention: Dimensions of Current Practice

(CAREY ARTICLE)

ROBERT HALPERN

*Is home-based early intervention an invasion of the family that inadvertently undermines its self-confidence, or is it a life-saving service to families whose children are at risk of abuse and neglect?*

Home-based early intervention programs employ lay or professional home visitors to work with families whose infants or toddlers are at greater-than-average risk of developmental and/or health problems for any of a variety of reasons (e.g., constitutional vulnerability of the infant, extreme parental youth or isolation, parental mental illness, chronic poverty, etc.). These programs begin anywhere from the prenatal period through 24 months or so, and continue for at least a period of months.

Home-based early intervention programs embody a number of paradoxes. Although they have been undertaken for many years, they continue to appear as a fresh solution to meeting pressing social needs. Although lacking an agreed-upon theoretical basis and clear empirical justification, they continue to be recommended by prominent medical and behavioral scientists as a potentially effective means of preventing or ameliorating early childhood morbidity and developmental problems [Bronfenbrenner 1974; Kempe 1980; Select Panel for the Promotion of Child Health 1981]. Also, although lacking

Robert Halpern, Ph.D., is Senior Research Associate, High/Scope Educational Research Foundation, Ypsilanti, MI.

0009-4021/86/040387-12 \$1.50 © Child Welfare League of America

any permanent legal or institutional bases, they have continued to grow in number and in scope of action. Finally, in the face of numerous state-of-the-art reviews, we still know relatively little about the actual processes of intervention and change in home-visiting programs.

In this article the author enters into the world of practice in this field and attempts to describe its underlying dynamics, contradictions, ambiguities, and unique strengths. The reasons for the evident attractiveness of home-based intervention are examined, and implications for child welfare practice discussed.

### A Changing Context for the Practice of Home-Based Early Intervention

The practice of home-based early intervention in recent years has been influenced by four related factors. The first is changes in family composition and roles, particularly dramatic increases in the number and percent of single parent households, in births to unmarried mothers, and in births to very young mothers. The second is a growing knowledge of specific sources of health and developmental risk in infancy and early childhood, and growing attention to the prevalence of various risk factors. Complementing this specific knowledge has been the articulation of theoretical paradigms describing the complex interplay of biological, psychological, and social variables shaping child development. A third factor has been a growing interest among medical professionals, mental health professionals, and educators in problems not traditionally associated with their particular disciplines. (Pediatricians and neonatologists, for example, have become increasingly sensitive to the psycho-social consequences and family support implications of saving ever smaller and/or ever more damaged babies.) And, in ironic juxtaposition, a fourth factor has been a growing sense of the limitations of traditional professional roles in providing certain kinds of family support, and in dealing with certain persistent social problems.

These four factors have contributed to a social climate amenable to intervention in the home during the early months of the developing parent-child relationship, under certain circumstances. They have also made the potential efficacy of home-based early intervention seem plausible. Knowledge of sources of developmental risk in infancy, for example, has contributed to a more specific targeting of epidemiologically high-risk populations and to a better explanation of why these populations are high risk. The language of recently articulated child development theories—especially ecological and transactional theories—has been borrowed to describe program rationale, purposes,

and approaches. Pediatricians recognize a "new morbidity," whose causes are found in "the complex life situations of families" [Select Panel for the Promotion of Child Health 1981: 258].\* An emergent social movement promotes self-care, the rebuilding of social support networks, and the demystification of expertise, providing a philosophic basis for peer-oriented family support.

These four factors also have served to broaden the purposes and expectations of home-based early intervention, a not totally welcome phenomenon, in light of a number of unanswered questions. The enormous body of knowledge about child development generated in recent years provides relatively little specific information about when and how to intervene in family life to prevent or ameliorate morbidity and developmental problems in early childhood. While recently articulated developmental theory identifies the conditions likely to threaten healthy development, it does not describe in practical terms how discrete interventions might help prevent or alter these conditions.

A number of social critics have argued for extreme caution in intervening in young family systems, albeit for different reasons. Lasch argues, for example, that the "invasion of the family by industry, the mass media, and the agencies of socialized parenthood has subtly altered the quality of the parent-child connection . . . destroying parents' confidence in their ability to perform the most elementary functions of childrearing" [1979: 292]. Schlossman [1978] argues that parent education programs of recent years have placed too much of the blame for unsuccessful child rearing on poor families themselves, especially mothers, and not enough on extrafamilial institutions. He suggests that the focus on the mother-infant dyad in much recent psychological research has inadvertently, if not consciously, implied that solutions to problems lie therein and nowhere else.

A number of authors have argued that the causes and even the consequences of incompetent childrearing remain incompletely understood [Escalona 1974; Wilson 1983]. Although we can identify populations statistically more likely than average to have problems, we do not adequately understand the causal dynamics of incompetent child rearing, nor can we reliably predict its sequelae. We have, further, few tools for "family diagnosis": to pinpoint incipient problems with clearly prescribed solutions [Newberger, Newberger and Richmond 1976]. More fundamentally, we are in far from complete societal agreement on the definition of inadequate child rearing.

There is agreement, nonetheless, that particular groups of infants and young

\* This "new morbidity" encompasses behavioral problems, nutritional problems, nonorganic failure to thrive, accidental injury and physical trauma, and psychosocial retardation, among other conditions.

children continue to suffer disproportionately high rates of preventable mortality, morbidity, and development problems. As such, until an era of fundamental social and institutional transformation arrives, discrete interventions into the family lives of high risk infants and children will be necessary. The practical implications of such a social commitment are discussed below.

### The Nature of Home-Based Early Intervention

Except where therapies are being administered to biologically handicapped infants and toddlers (or parents are being trained to do so), or in cases of obvious neglect or abuse, the reasons for intervention in home-based early intervention programs are usually ambiguous. That is, the home visitor is working with a less-than-fully defined diagnosis or problem and with less-than-fully developed techniques, to prevent the onset of a variety of possible health and developmental problems in infants. Related to the diagnostic ambiguity is an ambiguity in purpose. By entering into the home life of a young family the home visitor is opening a formerly closed system to scrutiny, as well as support. This scrutiny usually leads to certain prescriptions for change in behavior and coping patterns, even when the primary purpose for intervention is defined as family support.

#### *The Diagnostic Context*

The first step in planning a home-based early intervention effort is usually the selection of a target population, in some cases defined by parental characteristics, in some by infant characteristics, in some by neighborhood or community characteristics. The initial problem diagnosis is thus of the likely pattern of incompetence and/or stress associated with particular statuses—extreme parental youth, family social isolation, chronic poverty, a disorganized neighborhood, cultural difference, rearing of a constitutionally vulnerable child, and so forth. But simply knowing a family's history or current psychosocial status, or the nature of a child's constitutional vulnerability, does not provide adequate information for prediction of future child-rearing behavior, and especially does not immediately suggest how to intervene or what negative child outcomes would be prevented by intervention.

Improving the initial selection process would probably have an effect on the specificity of initial diagnosis and suggestions for treatment. But, as was noted earlier, we do not yet have adequately developed theories or tools based on such theories for prospective diagnosis of inadequate child-rearing behavior, especially theories and measurement strategies that would suggest prob-

able functional causes of child-rearing problems, and appropriate intervention procedures. Further, most available evidence suggests that relationships between discrete sets of antecedent risk factors and childhood outcomes are mediated by a variety of individual and environmental factors.

Greenspan [1983: 73] has suggested that functional criteria could be identified for selecting families for intervention, for example "demonstrated difficulty in rearing an older child who was manifesting severe psychological, social and cognitive problems." The development of other functional criteria (especially for first-time parents) is worth pursuing. But many families who might benefit from home-based early intervention are not obviously incompetent; for example, families with extremely fussy, unsettled infants. As Greenspan notes "in such instances even competent families may need guidance to figure out how to find just the right pattern of rocking, vocalization, and stroking to help their infants learn to be in calm, alert, attentive states" [p. 64].

The family-level diagnostic process in most home-based early intervention programs is thus gradual and incremental. Home visitors modify their initial assessments as they learn about family history, and observe actual interactions among parents, the infant, the physical and social environment of the home, and the family's formal and informal support systems. It would seem to be a somewhat inefficient diagnostic process, except that it allows for naturalistic observation of emerging transactional patterns, difficult to acquire in clinical settings. The keys to the success of the process are the quality of observations of family functioning, the quality of inferences drawn about intervention and support needs, and the periodic updating of the family assessment and thus the plan of action. Generally, the incremental diagnostic process in home-based early intervention fits well the long-term nature of the intervention and the fluidity of a context characterized by continuously changing participants.

#### *The Treatment Process*

There are no standard procedures for home-based early intervention, although certain types of processes are identifiable in most programs. These processes include personal relationship-building (principally with the mother), work to strengthen parental coping skills, information sharing, observation/surveillance, and in some instances case management and advocacy. Within the framework of the diagnostic ambiguity and causal uncertainty discussed above, these processes are usually employed to influence a number of parental attributes; dimensions of parent-infant interaction, and contextual factors.

The technical work of home visiting usually is undertaken in the context of a gradually nurtured personal relationship with the mother. Because there

are no socially defined rules for interaction between home visitor and parent—as there are, for example, between physician and patient, or teacher and pupil—and because home visitors are often undertaking their role for the first time, each home visitor must to some extent invent her role as she goes along.\* Because personal relationships are less stereotyped than professional-client relationships, the same home visitor will often develop a different type of “working alliance” with each mother. The program’s purposes, duration, and curriculum define the parameters of the home visiting role, but not the specific treatment process for each family.

In some programs multifaceted work with the family is conceptualized from the outset to be necessary to influence the multiple factors that contribute to early childhood or later developmental outcomes. More commonly, the home visitor is often impelled by circumstances to address the personal neediness of the parent and/or lack of material resources to meet family needs. (This is especially true when programs seek out or accept referrals of multiproblem families.) A parent who cannot successfully meet her own primary needs is going to have a very difficult time meeting her infant’s physical and psychosocial needs. Economic insecurity, inadequate housing, lack of access to medical care, and related problems may seem more tangible and immediate to a parent than the nurturance of an optimal psychosocial relationship with the infant.

The case management demands on the home visitor can feel overwhelming, especially with parents chronically unable to cope with the variety of demands of daily family life or in community contexts severely lacking in formal medical, social welfare, and related services. Home visitors sometimes find they have to struggle to focus their own and the parents’ attention on the more mundane but still crucial skill-building that converts a tentative but growing sense of parental confidence to actual competence.

Ironically, such skill-building—in appropriately interpreting the infant’s behavioral and verbal cues and responding contingently, in providing developmentally appropriate toys and materials, in taking the infant’s temperature, in bathing the infant, and in dozens of other activities—is itself embedded in the affective climate of the parent-infant relationship, formed in part by the mother’s sense of her own personal resources and social support. Thus, the work to strengthen specific infant care and stimulation skills and the work to remove obstacles to a focus on those skills are linked. The home visitor must find the balance that moves the work forward in each area.

Establishing an appropriate role for home visitors—especially lay home

\* Home visitors in this article are considered to be female and, hence, are referred to by the feminine pronouns

visitors who must address a variety of medical, mental health, educational, social, and material needs of young families—is a subject of continuing concern to those practicing in this field. It is in the nature of home-based early intervention to fill unique service and family support voids in communities. The home visiting role usually contains elements of both professional intervention and informal social support. But lay home-visitors sometimes find themselves assuming traditional professional roles—making medical diagnoses, providing counseling to potentially abusive parents, analyzing dietary adequacy—especially when there are few formal services nearby (as in rural areas), when there have been cutbacks in local human service programs, or when there are significant cultural and linguistic barriers to overcome.

Do families in these situations receive second-class service? Equally important, is too much being asked of the lay home-visitor and the program itself? When the service and support voids being filled locally include inaccessible or poor quality medical care for certain groups of pregnant women, infants and children, or insensitive or underfunded social service agencies, home-based early intervention programs may assume responsibilities incommensurate with their technical and fiscal resources. Compounding the problem here is the fact that home visiting programs frequently increase demands on the formal service by referring families to services, and expediting the service acquisition process.

In general, even when there is a specific infant stimulation or health education curriculum and a shared sense of the appropriate scope and limits of the home visitor’s role, the process of home-based early intervention is open-ended and idiosyncratic. The key challenge for supervisor and home visitor is to strive constantly for better definition of the nature of the work with each family—priorities, emphases, parental responses indicative of progress—and at the same time, manage the host of support needs evoked by the home visitor’s presence.

### The Effects of Home-Based Early Intervention

We know less than we should about the effects of home-based early intervention, given the amount of human and fiscal investment already made and likely to be made in the future, in this field of practice. And we know even less still about the underlying change processes set in motion by interventions of this type. The history of program evaluation in this field has been characterized by a focus on average effects, especially infant I.Q. effects, and by a host of problems related to inadequate theory, research design, and methodology. Most of these problems have been discussed in detail elsewhere,

by the author [Halpern 1984] and by others [Gray and Wandersman 1980; White and Casto 1984]. As should be apparent from the discussion earlier on, the nature of the typical selection and treatment processes further constrain valid and reliable estimation of program effects, especially in quantitative-statistical terms.

Only a very small percentage of programs in this field have undertaken attempted summative evaluation. These programs probably represent the most carefully implemented work in the field, if for no other reason than because of the quality control effect of evaluation activities. The modest available evidence from individual program reports, literature reviews, and meta-analyses [see in particular Gray and Wandersman 1980; Chamberlain 1980; Hev-erly, Newman and Forquer 1982; Simmeonson, Cooper and Scheiner 1982; Anderson, Fox and Lewin 1983; Halpern 1984; White and Casto 1984; Ram-ey, Bryant and Suarez in press] suggests the following magnitude and nature of effects of home-based early intervention:

1. A modest, overall pattern of absolute differences favoring treat-ment over control families;
2. Significant effects reported in widely differing parent, infant, and parent-infant outcome domains; in some cases because mea-surement occurred in different domains, in others because effects were found in different domains;
3. No evidence that any particular subgroup of high-risk families benefits more than another, or that focusing on one kind of problem is more appropriate than focusing on others; but modest evidence that secondary prevention in this area is generally more effective than primary prevention;
4. Significant within-program differences in magnitude and nature of effects (not surprising given the individualized nature of treat-ments in many cases); and
5. Little evidence of medium- or long-term maintenance of changes in parental behavior and support systems, or in infant health and development, in part because only a handful of programs have attempted any follow-up.

No identifiable set of evaluation procedures has yet emerged to address the constraints to estimation of program effects peculiar to this intervention tech-nology, or common to quasi-experimental work in the general field of early intervention. At a minimum, such work would have a focus on: formulation of procedures for obtaining unbiased estimates of program effects in situations where comparison groups cannot be assumed to have been drawn from the

same population as the treatment group because of non-random assignment and/or non-random attrition; selection of indicators and development of mea-surement procedures for a number of important outcomes—maternal self-care during pregnancy, physical care of the infant at home, infant feeding practices, maternal social support, family coping ability, utilization of pre-ventive and episodic medical care, infant health status (including morbidity, non-organic failure-to-thrive, growth, and so forth); and development of data analysis procedures sensitive to family-specific patterns of change attributable to the intervention. These problems are not fully resolveable, but deserve more attention from developmental researchers, evaluators, and social science methodologists than they have received up to now.

For example, threats to valid inference due to inability or unwillingness to employ random assignment to treatments can be partially offset by use of multiple comparison standards (e.g., community baselines, recent historical controls, and non-equivalent contemporary controls) for each of a number of key outcomes. If findings are confirmed across different comparisons, sig-nificant post-treatment differences can be attributed to the treatment more confidently. Greater use can be made of existing data bases to construct community or population baselines or recent historical controls. These data bases could include medical and other human service records, data from other early intervention programs, or even data from research studies conducted with populations similar to the target population.

Formulation of evaluation procedures responsive to the research design and measurement problems in this field would be facilitated by better models of the change processes set in motion by home-based early intervention. Such models would facilitate choice of measurement domains and specific variables for measurement, suggest data analytic strategies, and assist investigators in explaining patterns of effects found. A causal map describing variable rela-tionships has been developed by James T. Bond, a colleague of the author presenting a partial model of change in a multisite home-based early inter-vention effort with which the author is affiliated.\* The partial model links the intervention as a whole to a series of intermediate objectives—enhanced maternal knowledge and attitudes—that would in turn affect maternal behavior and eventually infant health and developmental status. A more complete model would specify also community and family characteristics and the exact nature of the treatment in relation to intermediate objectives.

Model building would assist not only specification of variables for mea-surement and causal relationships to be analyzed, but would also encourage evaluators to address a number of questions virtually unexplored at this time.

\* Available on request to the author

For example: Are treatment effects found in maternal behavior and attitudes linked to the ongoing presence or support of the home visitor in such a way that they are not likely to be sustained once home visiting terminates? Does the mother's perception of social support provided by the home visitor mediate receptivity to the information shared? To what extent does identification with the home visitor contribute to change? Which changes in parental behavior seem most significantly to influence infant health and development? How do availability and accessibility of formal medical and other human services affect patterns of effects found in home-based early intervention programs? Conversely, how does home-based early intervention influence the efficiency and effectiveness of formal services? Answers to these and other questions will be crucial to building future work in this field.

#### Home-Based Early Intervention and Preventive Child Welfare Practice

Home-based early intervention programs stand at the prevention periphery of child welfare practice, as both part of a continuum and as something of a departure. The goals and techniques of home-based early intervention are consonant with a growing consensus in the child welfare community that every effort should be made to meet children's needs in the home and family context, and that these needs are best understood in the framework of the family as a social system [Kadushin 1978; Belsky, Lerner and Spanier 1982]. Early-intervention home visitors, like other child welfare practitioners, often work in a mediating role between child and parents, and between family and larger society. The work of home-based early intervention is consistent with a cautious but persistent effort to expand the role of less interruptive protective services, for example, the use of parent aides for open protective service cases. It is consistent also with a long history in child welfare practice—dating back to the nineteenth century—of home-based education, surveillance, and more recently, respite [Davoren 1982]. To the extent that home-based early intervention programs differ from other preventive child welfare strategies, it is, perhaps, in their relatively greater emphasis on promotion of child and family development than on child protection. It is tempting to argue that child welfare practitioners should devote more attention to actively promoting family and community development.

If there is a child welfare target population particularly suited to intervention and support through home-based early intervention, it is those families at unusual risk of neglecting their infants and toddlers. Child neglect, though three to five times more common than child abuse, receives significantly less attention and fewer child welfare resources than the latter problem [Wolock

and Horowitz 1984]. Although child neglect seems to be due in part to unequal access to societal resources, other contributing factors include parental isolation, inappropriate use of available resources, inadequate understanding of children's developmental needs, and lack of social support. Home-based early intervention is well suited to addressing these causal factors, if adequate early identification can be made.

In general, though, this author believes that no single societal purpose or discrete set of purposes will emerge as most appropriate for home-based early intervention. Rather, this field will continue to evolve from multiple institutional roots, in response to felt needs of particular communities and institutions, and changing social and scientific priorities. Effective practice in this field will be found in the fit among community structure, implementing organization capacity, client needs, and program design. The generic elements of practice—personal relationship building, sustained support for the mother, work to strengthen parental coping skills, information sharing, observation-surveillance, case management—will and should continue to receive differential emphasis in different programs. ♦

#### References

- Anderson, M., Fox, H., and Lewin, L. "Reducing Infant Death and Disability: Effective Interventions and State Strategies for Implementation." Washington, DC: Lewin and Associates, September 1983. Photocopy.
- Belsky, J., Lerner, R., and Spanier, G. *The Child in the Family*. Reading, MA: Addison-Wesley, 1982.
- Bronfenbrenner, U. "Is Early Intervention Effective?" *Teacher's College Record* 76 (December 1974): 279–303.
- Chamberlain, R. "Conference Exploring the Use of Home Visitors to Improve the Delivery of Preventive Services to Mothers with Young Children." Evanston, IL: American Academy of Pediatrics, June 1980.
- Davoren, E. "The Profession of Social Work and the Protection of Children," in *Child Abuse*, edited by E. Newberger. Boston, MA: Little, Brown, 1982.
- Escalona, S. "Intervention Programs for Children at Psychiatric Risk: The Contribution of Child Psychology and Developmental Theory," in *The Child in His Family: Children at Psychiatric Risk*, edited by E. J. Anthony and C. Koupernik. Vol. 3. New York, NY: Wiley, 1974.
- Gray, S., and Wandersman, L. "The Methodology of Home-Based Intervention Studies: Problems and Strategies," *Child Development* 51 (December 1980): 993–1009.
- Greenspan, S. Testimony Prepared for the Select Committee on Children, Youth and Families. "Hearing on Prevention Strategies for Healthy Babies and Healthy Children." Washington, DC: U.S. Government Printing Office, June 30, 1983.
- Halpern, R. "Lack of Effects for Home-Based Early Intervention? Some Possible Explanations." *American Journal of Orthopsychiatry* 54 (January 1984): 33–42.