
Home Visitation as a Domestic Violence Prevention Strategy: A Discussion Paper for the Government of Alberta



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1.0 Introduction

Shift: The Project to End Domestic Violence was initiated by the Brenda Strafford Chair in the Prevention of Domestic Violence, in the Faculty of Social Work, at the University of Calgary. Shift is aimed at significantly reducing domestic violence in Alberta using a primary prevention approach to stop first-time victimization and perpetration. In short, primary prevention means taking action to build resilience and prevent problems before they occur.

Shift is committed to enhance the capacity of policy makers, systems leaders, clinicians, service providers and the community at large, to reduce the rates of domestic violence in Alberta. We are committed to making our research accessible and working collaboratively with a diverse range of stakeholders, to inform and influence current and future domestic violence prevention efforts, through the perspective of primary prevention.

In November 2011, the Government of Alberta requested support for the redesign of their family violence prevention framework. The intention was to ensure the framework included primary prevention strategies and recommendations, demonstrating a full continuum of support and services. Through this process, Shift was asked to research existing government programs and initiatives that could be enhanced or modified to support a significant reduction in family violence rates. As a result of this research, the home visitation program was identified as a key tactic in the prevention of family violence.

The purpose of this report is threefold: 1) To briefly examine the relationship between home visitation and family violence prevention; 2) To provide a synopsis of two specific home visitation programs relevant to the Alberta context; and 3) To identify steps to support the inclusion of home visitation as part of the Government of Alberta's family violence prevention framework. Considerations for the Government of Alberta are at the end of the report.

2.0 Methods

This review focused on literature—primarily documents, research reports and academic literature—overviewing two specific home visitation models: the Healthy Families America model (currently used in Alberta), and the Nurse-Family Partnership, which is being adopted by many other jurisdictions in Canada.

The main search strategy used was:

- Searches of government, non-government and academic literature on the topic of home visitation.
- Search terms included “home visitation and domestic violence,” “Healthy Families America and home visitation,” “Nurse-Family Partnership and home visitation,” and “child maltreatment and home visitation.”

It should be noted that this review does not include information on the many other home visitation programs available. Given the context of home visitation in Alberta, attention was directed towards the model currently in place in the province and the one other model where both reduction of child maltreatment and domestic violence has been reported.

3.0 Findings and Implications

3.1 Home Visitation: An Overview

Home visitation is a method of service delivery that has been rapidly growing in popularity, both internationally and nationally. Historically, home visiting has been an essential component of public health practices (Sharps, Campbell, Baty, Walker, & Bair-Merritt, 2008). In the past decade, it has been increasingly used as a strategy to meet a wide range of objectives, such as improvements in home environments, family development, healthy child development and the prevention of child behaviour problems (Bilukha et al., 2005).

In many countries, home visitation programs are offered universally to all families with children, regardless of the estimated risk of child-related health or social problems. In the United States and Canada, these kinds of programs have been offered to specific population groups, such as low-income, young, less-educated, first-time mothers, and children at risk of abuse or neglect (Bilukha et al., 2005; Sharps et al., 2008). Research has demonstrated the effectiveness of home visitation in the prevention of child abuse and neglect (Bilukha et al., 2005; Donelan-McCall, Eckenrode, & Olds, 2009; Howard & Brooks-Gunn, 2009).

3.1.1 *What is Home Visitation?*

While there is a great deal of variation between home-based interventions, common activities include personal relationship building, strengthening parental coping skills, information sharing, case management and advocacy. Also common to such programs is the underlying belief that services delivered in the home will have some sort of positive impact on the families they serve, and that positive changes in parenting practices have long-term benefits for children's immediate and future development.

These types of programs are intended to impact a wide range of outcomes, such as:

- Child abuse and neglect;
- Parent-child attachment;
- Parenting behaviours;
- Parent self-efficacy;
- Self-sufficiency;
- Child development;
- School readiness (Donelan-McCall et al., 2009).

There is a wide variation on the nature and type of home visitation programs available, with individual programs differing dramatically, specifically in regards to:

- Age of children targeted;
- Risk status of the family;
- Range of services offered;
- Intensity of the home visits;
- Content of the curriculum used;
- Who provides the service (Howard & Brooks-Gunn, 2009).

3.1.2 Home Visitation and Domestic Violence Prevention

Research has demonstrated a pervasive link between child maltreatment and domestic violence (Osofsky, 2003). Studies consistently show that child maltreatment, neglect and abuse (particularly physical and sexual) are significant risk factors for future abuse of and/or victimization by dating and marriage partners (World Health Organization and London School of Hygiene and Tropical Medicine, 2010). Exposure to violence as a child, whether through experiencing maltreatment or by witnessing domestic violence, is related to being in a future abusive relationship as an adult as well as affecting parenting skills (MacMillan & Wathen, 2005). Childhood maltreatment and abuse is consistently cited as a risk factor for both perpetration and victimization of domestic violence as an adult (World Health Organization and London School of Hygiene and Tropical Medicine, 2010).

As numerous studies have demonstrated the effectiveness of home visitation in the prevention of child maltreatment (Bilukha et al., 2005; Donelan-McCall et al., 2009; Howard & Brooks-Gunn, 2009), it is now becoming recognized as a promising domestic violence prevention strategy because it targets a significant risk factor for future perpetration and victimization of domestic violence (World Health Organization and London School of Hygiene and Tropical Medicine, 2010; Olds et al., 2011).

3.2 Home Visitation Models

While there are many types of home visitation programs, two that warrant specific attention are Healthy Families America (HFA) and the Nurse-Family Partnership (NFP). The home visitation programs funded by Alberta's Children and Youth Services are based on the HFA model, while many other jurisdictions in Canada are adopting the NFP model. Both have undergone significant evaluations in order to determine their effectiveness in the prevention of child maltreatment.

3.2.1 Healthy Families America

This model of home visitation, based on the Hawaii Healthy Start initiative, began in 1993 in the continental United States (Howard & Brooks-Gunn, 2009). Healthy Families America (HFA) provides voluntary home-based support for disadvantaged mothers beginning prenatally or just after the child's birth and continuing for a period of three to five years.

Trained paraprofessionals are used to provide the in-home support. Paraprofessionals are those who possess training and credentials in a relevant subject area but who do not have a "professional" designation (i.e., nurse, social worker, psychologist).

Specific goals of the program include:

- Promoting positive parenting skills;
- Enhancing child health and development;
- Preventing child abuse and neglect (LeCroy & Krysik, 2011).

The program is built around a set of "critical elements" that provide a benchmark against which quality is assessed (LeCroy & Krysik, 2011). In order to become accredited as a bona fide Healthy Families America program, documentation regarding program implementation needs to be reviewed and site visits conducted (Healthy Families America, 2003; LeCroy & Krysik, 2011).

This program has been evaluated many times, with the most recent being a 2011 evaluation of the Healthy Families Arizona Home Visiting program (LeCroy & Krysik, 2011). Results from earlier evaluations have been disappointing, with most showing no effects on measures of childhood injuries or other objectively measured outcomes consistent with the prevention of maltreatment (Donelan-McCall et al., 2009). One of the possible reasons given for the lack of clear outcomes was in the quality (or lack thereof) of the program implementation (LeCroy & Krysik, 2011). Concerns over duration of program enrolment and home-visit frequency were also raised in other evaluations of the HFA model (Caldera et al., 2007).

More recent evaluations, specifically those conducted in New York and Arizona, show more promising results, including modest impacts on physical abuse, increased safety practices, increased use of community resources, and increased participation in school and training programs for parents (DuMont et al., 2008). The New York study included women prior to the birth of their child. Program effects were most pronounced for this subgroup who received services prenatally.

Cost savings were also calculated in the New York evaluation. The average total cost of the program was approximately US\$3,074 per family per year (costs ranged from US\$2,645 at one site to US\$3,836 at another) (DuMont et al., 2010). The evaluation showed different rates of savings, depending on which study group was used to do the calculations. Overall, the program returned 15 per cent of the cost to provide the intervention (i.e., a return of \$1.15 for every dollar spent). However, when looking at particular sub-samples within the study—specifically women receiving the intervention who had at least one previous substantiated child services report—investment in the program returned \$3.16 for every dollar spent by the time the target child was seven years old. This data is in contrast to other studies that have calculated net losses of the HFA model of 4.8 cents for every dollar spent and overall net losses of US\$1,830 per family (Lee, Aos, & Miller, 2008).

3.2.2 Nurse-Family Partnership

The Nurse-Family Partnership program began in New York in 1977 (Donelan-McCall et al., 2009). It is considered to be the most well-developed home visiting program in the United States (Howard & Brooks-Gunn, 2009). This is a voluntary program for pregnant, low-income women having first births, enrolled before the 28th week of gestation. Home visits continue through the child's second birthday. Nurses are used to provide the services, due to their formal training in health care and their corresponding ability to address mothers' and family members' concerns about the complications of pregnancy, labour and delivery, as well as the physical health of the infant (Donelan-McCall et al., 2009).

The NFP has three goals:

- Improve outcomes of pregnancy;
- Improve the child's subsequent health and development (in part by preventing child abuse and neglect);
- Improve families' economic self-sufficiency (Donelan-McCall et al., 2009).

This program is grounded in epidemiology, theories of human ecology and attachment (Donelan-McCall et al., 2009). In fact, this program is based on a strict replication process, with a structure to help ensure the program is conducted with fidelity to the model tested in the clinical trials (Nurse Family Partnership, 2011). In other words, there is no room for "picking and choosing" which elements are focused on.

This program has been well-evaluated, with three large randomized controlled trials conducted in addition to a 15-year follow-up to the original 1977 group of participants. In all studies, the program was found to positively affect a range of risk factors associated for child maltreatment, children's general health and well-being. In the 15

year follow-up study, a 48 per cent decline in rates of child abuse and neglect was found. Additionally, in a 2011 study, rates of domestic violence were found to be reduced by 37 per cent as compared to the control group (Olds et al., 2011).

Evaluation of the cost of implementing the Nurse Family Partnership indicates that nurse visitation costs range from US\$2,914 to US\$6,463 per family, with the average cost being US\$4,500 per family per year (Nurse Family Partnership, 2011). Further research on the cost benefits of the program revealed that cost savings and benefits derived from implementing Nurse Family Partnership yielded a cost benefit ratio of 5.7:1 (Karoly, Kilburn, & Canon, 2005). In other words, for every dollar spent on programming that has been shown to reduce domestic violence as well as contributing to a wide range of health, education and employment outcomes for women and children, there is more than five dollars in cost savings and benefits generated for both the government and society at large.

3.2.3 Differences between the HFA and NFP models

There are several important differences between the two models of home visitation. While both programs seek to lower rates of child abuse and maltreatment, they differ in terms of how they go about it. Table 1 demonstrates some of the key differences and similarities between the models:

Table 1. Elements of HFA and NFP

Program Elements	Program	
	<i>Nurse Family Partnership</i>	<i>Healthy Families America</i>
<i>Who delivers the program</i>	Nurses	Paraprofessionals
<i>Recruitment</i>	Voluntary participation	Voluntary participation
<i>Program Curriculum</i>	Rigid curriculum	Guiding principles
<i>Initiation of Program</i>	Prenatally before 28 weeks gestation	Prenatally or just after child's birth (in Alberta, families can enter program up until child is 2.5 years old)
<i>Evaluations conducted</i>	Yes, large-scale randomized controlled trials	Yes, randomized controlled trials
<i>Findings</i>	All three studies conducted demonstrated positive impacts on intended program objectives. Of interest, NFP showed results around decreasing the rate of subsequent births of first-time parents. This can have ripple	Mixed results. First three studies found issues in program implementation affected results. Two other studies showed modest positive benefits. The New York evaluation found that while there were no differences noted for confirmed child service reports (physical abuse, neglect and foster care) by

	effects on both the children and mother.	the child's 7th birthday, less serious physical abuse was found, in addition to more frequent use of non-violent discipline strategies.
<i>Reported outcomes in DV</i>	37 per cent reduction found in one study	No
<i>Cost effectiveness</i>	Range of cost savings from as low as \$1.26 in low-risk groups to \$5.71 in higher risk groups (all groups are first-time mothers).	Mixed findings. Some studies show net losses of HFA model of 4.8 cents for every dollar spent. Other studies have demonstrated an overall net loss of \$1,830 per family (Lee, Aos, & Miller, 2008). New York evaluation showed a positive return of US\$.25 for first-time, low-income mothers, and demonstrated a significant \$3.16 return for those women who had at least one prior substantiated child services report (DuMont et al., 2010).
<i>Range of populations</i>	African American, Hispanic and low-income Caucasian.	2010 report by DuMont et al. indicates white (non-Latina,) Latina, and African American (Non-Latina.)

3.3 Home Visitation and Alberta

While the home visitation programs used in Alberta are *based* on the Healthy Families America (2003) model, it is unclear from the literature review as to whether they are accredited, bona fide models of HFA (as per the HFA accreditation process) or variations. As Healthy Family America evaluations have pointed out, lack of appropriate program implementation has reduced the program's ability to demonstrate desired outcomes. This evaluation result needs to be considered in light of the current form of flexible implementation across Alberta.

There have been several evaluations conducted in the province on the home visitation programs available. The evaluations suggest the programs were achieving positive outcomes, although it is unclear which design of home visitation these programs are following and which ones produce the greatest effects. The Calgary evaluation (completed in 2004) discusses the tools and screening used for domestic violence, while other available evaluations (i.e., Edmonton, 2005 and provincial outcome monitoring, 2007-2011) do not mention any domestic violence screening protocols.

In all cases of home visitation in Alberta, the program serves a wide range of families, not only those who are first-time parents or who have been recruited prenatally. In fact, families may enter the program with a child as old as 2.5 years of age. This may pose limitations to the potential success of a home visitation program, as parents who

already have children may already have engaged in child maltreatment and child abuse patterns, therefore making those behaviours very resistant to change (DuMont et al., 2010). In Healthy Families America, families may or may not be first-time parents.

Recommendations from the evaluation of Healthy Families New York include screening for all at-risk pregnant women in a community rather than just new mothers (i.e., mothers with newborns), although the evaluation goes on to show the greatest cost-benefits for populations that already have children (i.e., those with a prior child services report).

4.0 Conclusion

Currently, the Government of Alberta invests \$8.5 million into home visitation throughout Alberta. Based on research in this area, the following options are considerations to enhance the effectiveness of home visitation services in Alberta and to use the home visitation programs to reduce future rates of domestic violence.

4.1 Prioritize child welfare cases in the current home visitation model

Based on the research described above, those home visitation programs that demonstrate the greatest effect are those that are rigorously implemented and target the right population. As Table 1 demonstrates, cost savings from home visitation also varies depending on the model implemented. Based on the most recent large-scale evaluation, results vary according to who is offered home visitation services (DuMont et al., 2010).

The Healthy Families America model (currently in place in Alberta) is most cost-effective when directed towards women with children who have already had at least one substantiated child services report (as a non-victim). Therefore, it is recommended that:

- The Government of Alberta maintain the \$8.5 million in funding for the current model in place (Healthy Families America model), but ensure that priority is given to ***families with children who have already had at least one substantiated child services report***. This process will align with research evidence demonstrating that the Healthy Families America model is most cost-effective with this population.

4.2 Screen all at-risk pregnant women in a community and prioritize prenatal service initiation in the current home visitation model

In the same 2010 evaluation, DuMont et al. recommend that services also be prioritized for those entering the program during the prenatal period. Based on their findings, it is recommended that:

- The Government of Alberta maintains the \$8.5 million in funding for the current model in place (Healthy Families America model), but prioritizes prenatal service initiation by working with primary care physicians to focus screening efforts on all at-risk pregnant women in a community. Putting this priority on prenatal service initiation would also support mothers to achieve better birth outcomes (Lee et al., 2009).

4.3 Develop domestic violence training and screening protocols to be embedded into the current service delivery model

Research on home visitation programs has demonstrated its limited effectiveness when domestic violence is occurring and not being addressed (Sharps, Campbell, Baty, Walker & Bair-Merritt, 2008). In fact, home visitation programs usually do not include a formal domestic violence protocol (Bullock, 2010). Studies in this area have shown that home visitors often are unaware of the importance of screening for domestic violence, lack the knowledge and skills to handle the information once domestic violence has been disclosed, and are unaware of how their own experiences impact the way they handle domestic violence disclosures (Bullock & Sharps, 2011). Given this, the following recommendations are:

- Invest \$100,000 new dollars in developing and implementing domestic violence training for home visitation workers.

This would ensure that Home Visitation workers:

- Have training in the dynamics of domestic violence
 - Have training in how to assess and appropriately refer families experiencing domestic violence
 - Have training in how to assess what is happening with the violence in follow-up visits
- Develop a domestic violence assessment protocol in consultation with domestic violence experts and the Alberta Home Visitation Network (AHVNA) so that all home visitors routinely assess for domestic violence at program entry.
 - For those women who enter the program prenatally, develop assessment protocols in consultation with domestic violence experts and AHVNA to ensure women are assessed for domestic violence at entry to the program, at one other time during the prenatal period, and at postpartum, when abuse is known to restart (Saltzman, Johnson, Gilbert & Goodwin, 2003).

4.4 Pilot Nurse-Family Partnership (NFP) in three distinct communities

As demonstrated through the literature, the NFP program has been well-evaluated, demonstrating significant outcomes in a range of risk factors associated for child maltreatment, children's general health and well-being (Donelan-McCall et al., 2009; Howard & Brooks-Gunn, 2009; Olds et al., 2011). Research has also demonstrated that this program is cost-effective, with benefits ranging from US\$1.26 in low-risk populations to US\$5.71 in high-risk populations. This program is strictly targeted to first-time, low-income women before 28 weeks of gestation, and is therefore a primary prevention strategy for child maltreatment, as it targets those soon-to-be parents *who do not already have children*. Therefore, no child abuse or maltreatment has ever occurred. Given this, the following recommendations are:

- Invest \$9.6 million new dollars from the health portfolio to support the pilot of NFP in three distinct communities where 1,500 first-time, low-income mothers are referred into the program.
- Ensure that the subsequent evaluation of the pilot sites includes training and measures for domestic violence, as NFP is the only home visitation program to demonstrate reductions in domestic violence (Olds et al., 2011). As this result has only been demonstrated in one trial, more research is required to understand if the program can directly support the reduction of domestic violence rates. Connecting with the British Columbia pilot project that is in the process of creating a protocol, training and evaluation strategy with the nurses may be a great starting point for making the connections between the NFP program and reducing rates of family violence.

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VIOLENCE
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