Home Visiting Research, Training, and Infrastructure

A Literature Review

February 2007

Prepared by Tina Holden
on behalf of
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To all our home visitors who continue to support our children and their families – thank you.

A Special Note:

The BC Council *for* Families and the Home Visiting Advisory Committee are pleased to present the following report, "Home Visiting Research, Training and Infrastructure: A Literature Review". The BC Council *for* Families and the Home Visiting Advisory Committee are pleased to contribute to research in the area of home visiting.

While examining this report the Advisory Committee urges readers to keep in mind the complexity of language. In order to clarify some of the language that was used, a Glossary of Terms, developed by the Ministry of Children and Family Development Provincial Services for Children and Youth, which is compatible with the definitions of terms in this report, is attached in the Appendices. The Advisory Committee believes that while the terms used in this report were the best available at the time the Committee is also aware that language is constantly evolving and that newer terms may emerge. The Advisory Committee urges the family serving sector to continue to commit to on-going scrutiny of language in order to ensure that the words that we use convey respect.

For more information on the BC Council *for* Families or the Home Visiting Project please see the web site www.bccf.bc.ca or e-mail bccf@bccf.bc.ca.

Executive Summary

Purpose

The purpose of this literature review is to focus on three areas of home visiting programs for families with young children:

1. Review research on the impact of home visiting programs regarding families with young children.
2. Review training models for home visitors.
3. Investigate existing infrastructures throughout Canada that support home visiting programs.
4. Make recommendations for next steps.

Definitions

For the purposes of this review, home visiting will be defined as:

> *"the process by which a professional or paraprofessional provides help to a family in their own home."*[1]

The research on home visiting differentiates between "professional" home visitors and "paraprofessionals." The majority of studies referencing professional home visitors denote nurses; however social workers, teachers, doctors, psychologists, physical therapists, speech therapists, and religious organizations fall under this category. Para-professionals provide home based family support and often share common backgrounds and experiences with the families they visit but are not required to have post secondary education in a specific discipline.[2] For consistency, these definitions will be used throughout the review however, para-professionals will be referenced as peer/lay/para-professional.

Demographics

British Columbia is home to an estimated 247,000 children under six years of age.[3] It is estimated that over the next decade, that number will increase to more than 270,000 children under six years.

Consider this:

- Twenty-five percent of BC children are developmentally vulnerable when they enter school.[4]
- Aboriginal children account for approximately nine per cent of the child population, but make up 49 per cent of children-in-care.[5]
- Over the last 25 years, there has been a seventy-fold increase in the survival rate of low birth weight infants. Seventy-five per cent of infants born under 800g will have a disability diagnosis in their lifetime.[6]
- Seventy percent of parents with children under age six are employed outside the home.

- Mothers workforce participation increases as their children age:

Workforce participation of mothers by age of youngest child[4]:	
Age of Youngest Child	% of Mothers in Workforce
0–2	67.4%
3–5	73.5%
6–15	78.7%

Source: Ministry of Children and Family Development, November 2005

These trends, coupled with increased child population rates, will likely contribute to increased need for support that will lead to demand for programs and services for families with young children. Service providers report an increase in at-risk families who are able to keep their children with them and out of the system. Though positive, the implication is a higher need for support ot those families and prevention and early intervention services will be critical. Home visiting is believed to be one strategy, within a comprehensive system of programs and services, that can help address the systemic need for more resources and support families with young children.

Home Visiting in British Columbia

In British Columbia, home visiting programs exist in every region of the province but differ in program goals, populations served, staff delivering service, and types and lengths of service:

- Every newborn, for example, receives public health nurse contact, and depending on assessment outcomes, may receive home visits.
- The Infant Development Program (IDP) focuses on children up to three years old who are at risk for or have been diagnosed with a developmental disability.
- Home visiting programs under the Building Blocks initiative differ from each other; some are universal, some serve Fetal Alcohol Spectrum Disorder (FASD) prevention, and some serve Aboriginal communities.
- Finally, many community services across the province provide outreach and home visits to enhance their existing programs and services.

Numerous evaluations have been conducted to help practitioners and policy-makers understand the conditions under which home visiting strategies are most effective; for which families, by whom services are provided, and for which objectives. According to Gomby (1999), home visiting is one of the most scrutinized human service strategies.

There is enough evidence to support the existence of home visiting programs and their important role within a comprehensive system that supports families with young children. Gaps in the research, including effectiveness of home visiting, effective ingredients of home visiting, and the cost-effectiveness of home visiting still need to be addressed, however the recent studies provide policy-makers with important information regarding what to expect from home visiting programs.[7]

Implications for Policy and Practice

Studies report the mixed effects of home visiting programs on families with young children. In the research, important details emerge once results are no longer generalized across populations, goals, and services. These include:

- Programs targeting specific populations such as at-risk families, families with children with disabilities, teen parents, or specific ethnic groups. reportedly have better results than universal programs.
- Programs with highly trained home visitors produce greater outcomes with higher risk families.
- Programs with specific goals generate more positive outcomes.
- Programs that are a blended model of professionals and peer/lay/para-professionals, or that are entrenched within a multi-faceted, comprehensive program, produce better results for some populations.

Rigorously tested programs are not able to be tested within the context of the broader family, community, and service delivery system. This would require a great deal of funding for an extended length of time to capture outcomes decades later. Creating measurement tools to capture the complex ongoing influences on a child's life is next to impossible within a true randomized design. Unfortunately, government has to rely upon the research and its current challenges when making decisions.

Recent meta-analyses show that home visiting programs are not a panacea, nor should any program be. Instead, the analyses provide a more realistic level of expectation for home visiting programs and their outcomes.

Policy-makers need to continue dialogue with researchers and home visiting programs to ensure best practices are incorporated into programs. Existing policies should not get in the way of implementing such practices.

An analysis of government policies, and the continuum of services available in BC, that impact families with young children would assist in defining a more coordinated approach to home visiting programs in British Columbia.

Access to evaluation at a provincial level would allow BC the opportunity to study its own home visiting programs. Canadian provinces such as Alberta, Manitoba, and Ontario formed provincial coordination thus creating the ability to evaluate at a provincial level.

Training needs for home visitors are critical as acknowledged by home visiting experts and researchers alike.

Provinces supported by provincial coordination reported an ability to train core provincial trainers and provide broad evaluation.

Finally, in consideration of the cost effectiveness of home visiting programs:
"The relative costs and benefits of home visiting studied under optimal research conditions suggest that, in general, the benefits of home visiting outweigh the costs."[8]

Recommendations for Next Steps

Establish a coordinated provincial network for all home visiting programs across BC.

Provinces with coordinated home visiting networks reported the ability to address program development, training, and evaluation issues in comparison to provinces where provincial coordination is lacking. BC's home visiting programs need to build on the success of the existing BC infrastructures (IDP, Public Health, BC Council *for* Families, and Family Resource Programs) and create an opportunity for dialogue among home visiting programs across the province to develop a supportive infrastructure. An Advisory Committee is now in place. The group can establish a working group to begin the process. However, the Advisory Committee and/or Working Group will need the support of a coordinator. Provinces with such infrastructures as provincial networks are supported by a paid coordinator.

Develop provincial guidelines/standards for home visiting programs.

A provincial scan of existing home visiting programs is needed to fully understand the high variability in programs (goals, populations served, etc.) as well as the commonalities. Consistent guidelines or standards developed in partnership between home visiting programs, researchers, and policy-makers will lend a consistency to home visiting programs at a provincial level. Provinces with existing standards or guidelines have reportedly developed them through similar collaborative processes. The process for guideline or standard development will need to allow for variety of home visiting programs offered in communities and not compromise existing services, goals, and populations served.

Create opportunities for home visitors to access quality initial training.

Great Kids Inc. was the most preferred training program for high risk families discussed. Train the trainer models in other provinces reportedly are the most effective strategy for reducing training costs while providing home visiting programs with the opportunity to access quality training. Outcomes from this review indicate a strong preference for access to the Great Kids Inc. train the trainer model.

Establish a training implementation plan.

The need for a provincial scan of existing home visiting programs (as mentioned previously under the first recommendation for next steps) is critical for establishing training needs and capacities as well. A comprehensive list of existing home visiting programs across the province is the first step. Researchers consistently state that quality initial and on-going training are critical to the success of home visiting programs. The development and implementation of an implementation plan for home visitor training in British Columbia will effectively support home visitors' training needs across the province.

Coordinate advocacy activities, networking, and on-going training to energize the field.

Home visiting programs for high risk families that have been working in virtual isolation from other home visiting programs will benefit from networking and the opportunities they allow as demonstrated in other provinces. The established infrastructures in other provinces provide other opportunities as well. For example, a new federal home visiting initiative is currently developing in BC. At the writing of this report, consultation with existing home visiting programs has reportedly not yet occurred. The creation of a provincial infrastructure would enable such initiatives a specific contact point for such consultations and open communication and between all involved.

Build capacity for program evaluation at provincial and local levels.

Evaluation will offer accountability and demonstrate that home visiting programs make a difference in the lives of BC's children.

Connect with other Canadian home visiting networks

Canadian home visiting programs have much to offer each other and creating an opportunity to do so will benefit programs, families, communities, and governments.

Introduction

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Definitions

Florence Nightingale is often noted when discussing the beginning of home visiting in the late 1880's however; feminist research indicates that home visiting dates back as early as 200 A.D.[9] Women healers and wise women were valued and relied upon for centuries until medieval times when women healers, and later mid-wives, were criminalized as witches by Church and State: "No one does more harm to the Catholic Church than midwives." (Malleus Maleficarum)[10]

Female healers were empiricists, relying on cause and effect rather than passive faith of the male upper class healing under the auspices of the Church. Women were excluded from universities and eventually the Church legitimized the doctor's professionalism, denouncing non-professional healing as heresy: "If a woman dare to cure without having studied, she is a witch and must die."[11] Even Paracelsus, credited as the father of medicine, "burned his pharmaceuticals text, confessing that he 'has learned from the Sorceress all he knew'."[12] Ironically, the debate between professionals and non-professionals continues today and home visiting, still, is no exception.

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> *"the process by which a professional or paraprofessional provides help to a family in their own home."*[13]

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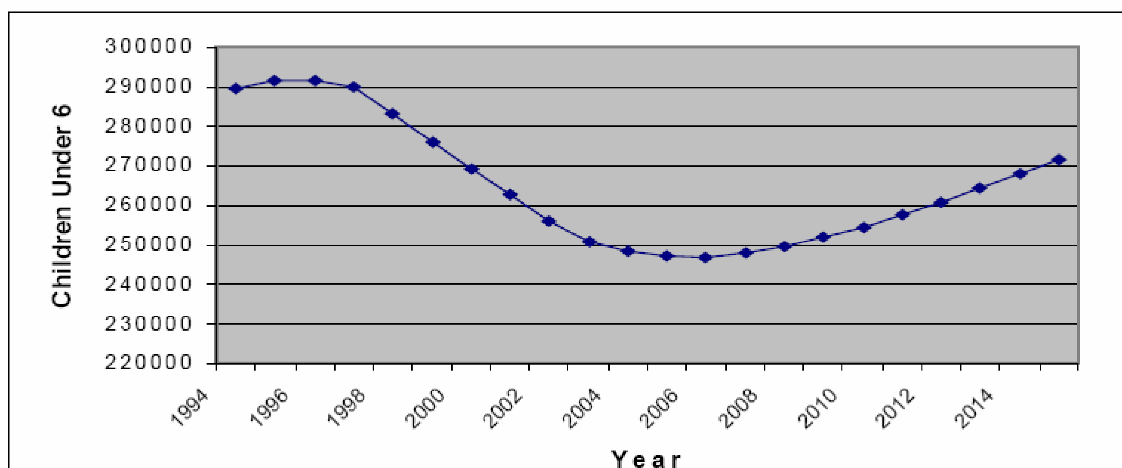
Projected Population of Children Under 6



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Section One: RESEARCH

The purpose of this section is to review home visiting research for high risk groups that examines the impact of home visitation on families with young children. An extensive body of high-quality literature on home visiting has already been subjected to several systematic reviews. It was not necessary, therefore, to conduct a full-scale systematic review of this literature, nor possible within the scope of this project. Results of existing systematic reviews were utilized and supplemented by an examination of more recent studies internationally (both academic and non-academic).

Home Visitation Research Faces Bias: A Commentary on Research in the Child Abuse Prevention Field

"It is understood in the scientific community that rigorous testing means a series of well-designed randomized controlled trials. Among scientific bodies whose business it is to evaluate research evidence, a small number of randomized trials, perhaps even a single large well-conducted randomized trial, is viewed as far more enlightening than a stack of studies using inferior methodologies.

When it comes to foods, drugs, or even veterinary treatments, randomized trials are required. When the stakes are high (e.g., childhood cancer treatments) large amounts of randomized trial data are amassed, each study building on the other, and that trial data is used to construct progressively and reliably more effective treatments.

Across much of the child abuse prevention field, there is no randomized trial data on whether home visiting interventions actually deliver their intended bottom-line benefits— namely, preventing future abuse or neglect. Too often, the field has grasped at anything new and hopeful, taking intervention models directly from prototype to large-scale implementation, without the difficult and time consuming intermediate steps involved in careful controlled field testing. Testing has simply not been a priority. This is not surprising given that child abuse prevention interventions developed primarily out of the advocacy community rather than the scientific community. It is important to note that the relationship with factual knowledge is quite different in advocacy circles than it is in science. Scientific ideals value skepticism and assert the primacy of facts over beliefs."

Is it time to rethink Healthy Start/Healthy Families?, Chaffin, M. Child Abuse & Neglect 28 (2004) 589-595
Department of Pediatrics,
University of Oklahoma Health Sciences Centre,
OK, USA

Challenges

Research on the efficacy and effectiveness of home visiting programs is as varied and complex as home visiting programs themselves. A challenge for researchers is to design appropriate evaluations that can effectively measure the complexity of home visiting programs that serve different populations with the existing methodologies available to them. Another challenge researchers face is proper funding to allow for rigorous longitudinal evaluation of home visiting programs and their outcomes. Adding to the complexity of home visiting programs is that often they are one component of a coordinated service system or a comprehensive approach to supporting families and their children making true randomized design and measuring direct outcomes a challenge. As demonstrated in the commentary on the left, if studies do not include true randomized design and measurement of direct outcomes, they can be dismissed by colleagues.

Despite these challenges, researchers have persevered and a host of studies have been published on home visiting. Studies differ with respect to populations served, outcomes measured, type of staff delivering the service, ages of children targeted, type of services

provided, length and intensity of services, theoretical bases for the services provided, methods of recruiting participants and methods of assigning families to experimental or control groups. These differences create yet another challenge. The research regarding the impact of home visiting programs on families with young children is not consistent.

A recent review of large scale at-risk home visiting programs in the United States (*Nurse Home Visitation Project, Hawaii Healthy Start, Parents as Teachers, Home Instruction Program for Preschool Youngsters, Infant Health and Development Program, and Chicago Parent-Child Centre; See Appendix for details*) concluded that research on these programs was not able to show that these programs have a strong and consistent effect on participating children and families. It was noted however, that modest effects have been repeatedly reported. Programs that are designed and implemented with greater rigor seem to provide better results.[20]

Generalizing home visiting research across all models is problematic; however, when specific aspects of the home visiting research are examined, outcomes are more significant. The following five categories below provide a more detailed exploration of those significant outcomes in the home visiting research. It should be noted that there are innumerable studies available on home visiting and not all aspects could be highlighted therefore topics significant to our purposes were chosen for the literature review.

Parent outcomes

Often home visiting programs approach the family as a whole however, outcome measurements are often reported separately as parental or child outcomes. The Sweet & Appelbaum (2004) meta-analysis of 60 home visiting programs found statistically significant increases in improved parenting behavior, better parenting attitudes, and increased maternal education. No treatment-produced differences were reported in employment/ wages, reliance on public assistance, or parents' self-reports of stress. Low-risk families showed greater improvements in parenting.[21]

Reportedly, the majority of studies have described only immediate post-treatment or short term effects. A notable exception has been the work of David Olds and his colleagues who have followed children into adolescence; their mothers received home visits from the prenatal period through the child's second birthday. Initial findings showed benefits for mothers and reductions in child maltreatment.[22]

More recent research indicates that home visiting programs can reduce negative parental affect and improve nurturing behaviours, knowledge of developmentally appropriate skills, and self-efficacy (Peterson, Tremblay, Ewigman & Saldan 2003).

In another study, home visitors who were behavioural consultants offered 1-2 hours a week of visits to families matched with controls on such variables as

parental stress, depression, social support, and existing parenting skills. Those receiving home visits were measured six months later and were found to have less parenting stress, children with fewer behavioural problems, and greater ability to teach children new behaviours that decreased problematic ones (Feldman & Werner 2002).

Child outcomes

Child outcomes for home visiting programs are most often reported as increased cognitive competence, increased social-emotional competence and decreased suffering of abuse. There were statistically significant but very modest increases in cognitive and social-emotional competence in the children from the Sweet & Appelbaum meta-analysis.[23]

Reportedly, treatment groups showed a significant but modest decrease in measures of child abuse potential, and overall there was no significant decrease in actual child abuse (*Note:* measured in only seven studies out of 60). [24] More recent studies of the effects of home visits have reported both positive and negative results. Home visits to high-risk, low income families begun before the child was 9 months of age and continued for up to 18 months were able to significantly reduce hostile-type behavior problems and increase positive play as measured when the children were age 5. Increased service duration was correlated with more positive behavioral outcomes.[25]

When examining findings for high- vs. low-risk families, high-risk families showed a greater reduction in child abuse potential and their children showed greater cognitive improvements. [26]

At the same time, even a modest improvement in parenting behavior and attitudes may yield, over time, improved child social-emotional functioning. The findings from the Olds et al study also suggest the potential for longer-term cost savings among high-risk youth. In adolescence, children of poor, single women who received the visiting program were less likely to be involved with the juvenile justice system (i.e., fewer arrests, convictions, and probation violations).[27]

Professionals vs. Peers/Lay/Para-Professionals

Many studies focus on comparing professional home visitors such as social workers, nurses, and nutritionists against trained home visitors - referred to by many titles but most commonly as *peer, lay* or *para-professionals.* The differential factor appears to be the level of education, training, and supervision required of home visitors. Individuals required to study a minimum of four years university in a particular discipline are referred to as professionals. In interviews with home visiting experts across Canada, the titles of "lay "or "para-professional" are not considered respectful. As stated earlier, peers/lay/para-professional will be used to describe the home visitors not required to have post secondary education in a specific discipline in an effort to respect all home visitors while maintaining consistency with terms used in the research.

Reportedly, child cognitive outcomes were better if the visitors were professionals as compared to peers/lay/para-professionals. In contrast, peers/lay/para-professionals produced the best outcomes in reducing child abuse. The Healthy Babies, Healthy Children (HBHC) program in Ontario provides a blended model for high-risk families that includes visits from both a public health nurse and peer/lay/para-professionals home visitors. Evaluation during the first two years of the program yielded higher infant development measures in children from high-risk situations who received services than children in high-risk situations who did not receive the services. [28]

Other programs recruited parents to train other parents and showed that parent-to-parent counselling was highly effective—but mostly for very targeted goals. Research showed that parents were able to help each other significantly to decrease excessive infant crying[29] (Wolke, Gray & Meyer 1994). A program at Michigan State University trained parents of children who had been in the neonatal intensive care unit (NICU) to model appropriate parenting behaviour and provide emotional and informational support to parents of babies in the NICU. This resulted in significant improvement on measures of maternal-infant relationships, home environment and maternal mood, as compared with a control group (Lindsay, Roman, DeWys et al. 1993).

In a more well known study in the United States, Olds et al. (2002) randomized families to peer/lay/para-professional home visitors versus nurses and showed that mothers in the peer/lay/para-professionals group interacted more often with their infants. The nurse-visited group had more gains on a range of measures including lower subsequent birth-rates, decreased smoking rates, and greater sense of well-being, and their children were less likely to exhibit language delays and had superior mental development.

Culture

Studies reporting on culture and ethnicity within home visiting are difficult to find however, a program designed to reduce infant mortality examined this aspect.

Working with low-income, inner-city pregnant women of African-American or Mexican-American background, a team of trained community residents acted as advocates to offer a culturally sensitive home visiting program. Like the HBHC program in Ontario, this was a blended model as home visitors were accompanied by a nurse. The teaming was designed to combine the health knowledge of the nurse and the advocate's understanding of the social context of the local community, with the advocates conducting the majority of the program.

Outcome results at 12 month follow up for the African-American group included more developmentally appropriate parenting expectations and higher infant mental development scores. For the Mexican-Americans, there were smaller gains such as positive effects on maternal daily living skills, but the program was reportedly culturally more biased toward the African-American women (Norr, Crittenden, Lehrer, Reyes, Boyd, Nacion & Watanabe 2003).

Services
Longer programs were associated with better cognitive outcomes for children; otherwise length of program was reportedly unrelated to program benefits. The average age of the child was not related to any of the outcome measures (Sweet & Appelbaum, 2004). There is not a consistent answer with respect to frequency across literature reviews however, a study in Jamaica that compared health and cognitive outcomes achieved through weekly, twice a month, and monthly visits found that as the frequency of visits increased, the developmental measures of children improved. The group that was visited monthly showed no difference in outcomes from controls. It is believed that frequent home visits provided families with the consistency needed to build trusting relationships with a home visitor over time (Ounce of Prevention Fund, 2003). Further, this allowed information and guidance to be presented in a non-threatening way that was more likely to be accepted.[30]

A Finnish study found that as few as 10 visits a year during the first five years of life, with a focus on child-rearing and family issues, had a long-term benefit in reducing mental health problems by the time children reached adolescence. These positive outcomes were observed in families with, as well as without, high levels of psychosocial risk (Aronen & Kurkela 1996).

Another study in the West Indies provided weekly home visits across three years to the familles of malnourished children. The visits focused on teaching parents how to stimulate their children intellectually and linguistically. The children performed significantly better on measures of intelligence administered 14 years later than did a control group (Gratham-McGregor, Powell, Walker et al. 1994).

Criteria for successful behaviour change in home visiting programs are less clear. According to reviews, they include some information, opportunities to observe role models and to practice the skills, participatory problem solving, focused goals, use of peer educators, and a minimum of 14 hours (Kirby, 2000; Sweet & Appelbaum, 2004).

David Olds (1992, 2002), in a review of his research on the efficacy of home visiting programs, characterized the following as the most successful for high-risk pregnant women:

1. a focus on families at greater need for the service
2. the use of nurses who begin during pregnancy and follow the family at least through the second year of the child's life
3. the promotion of positive health -related behaviours and qualities of infant care giving
4. efforts to reduce family stress by improving the social and physical environments in which families live (Olds et al. 1999).

Hegland & Hughes from the Department of Human Development and Family

Studies at Iowa State University recommend ten evidence-based practices for home visiting programs:

Ten Evidence-Based Practices for Home Visiting Programs

Susan Hegland & Kere Hughes
Department of Human Development & Family Studies
Iowa State University

Strategy	Recommendation	Research Support
1. Program Match	a) Match program goals to family needs and program resources.	Families with high levels of need make gains only with more intensive services from more highly trained professionals (Gomby, 2005).
2. Home Visitor Qualifications	a) Match qualifications of home visitor (e.g., paraprofessional, professional) to that demonstrated in model.	Paraprofessionals do best in programs with limited goals and a prescriptive curriculum; highly qualified home visitors needed for families with multiple, complex issues (Gomby, 2005).
3. Preservice & Inservice Training	a) Provide the same intensity (i.e., hours, group size) of pre-service training by qualified instructors as specified in the evidence-based model. b) Provide the same frequency and intensity of inservice training as specified in the model. c) Assess home visitors' understanding of adult learning styles as well as program goals and strategies through activities such as role plays and case studies.	Most effective training is spaced in time and includes on-site consultation and assessment of learning (Epstein, 1993). In less effective home visiting programs, staff receive less training—both pre-service and on-going; these changes have been linked to weaker outcomes (Gomby, 2005; Schorr, 1977; Yoshikawa, Rosman, & Hsueh, J., 2002).
4. Supervision	a) Ensure program fidelity by providing ongoing review of home visits by both supervisor and home visitor using written documentation, on-site observations, or videotapes.	Home visits tend to drift from a focus on parent-child interactions to pleasant, chatty, visits between host and guest (Peterson, 2002; Roggman, Boyce, Cook, & Jump, 2001).
5. Home Visitor Retention	a) Minimize turnover of home visitors through competitive salary and benefits packages.	High turnover, due to low wages for home visitors, is linked to negative program outcomes (Gomby, 2005).

Strategy	Recommendation	Research Support
6. Family Recruitment	a) Recruit families in need of services.	Up to 40% of families recruited fail to enroll (Gomby, 2005), limiting generalization of results.
7. Cultural Sensitivity	a) Ensure that home visitors use strategies and activities consistent with cultural values of family, not just parent, especially if the parent lives with an extended family.	Strategies and activities that are inconsistent with the cultural beliefs and values of the family are less likely to be implemented, and more likely to lead to drop outs (Cowan, Powell, & Cowan, 1998; National Research Council, 2000)
8. Family Engagement	a) Maintain family engagement during visits. b) Jointly plan for parent follow-up activities. c) Review parent follow-up at next meeting.	Less effective home visitors praise the parent, and demonstrate activities, rather than jointly planning, implementing, and reviewing activities (Hebbeler et al. 2002).
9. Parenting Focus	a) Address needs recognized bv the parent. b) Ensure that children in families with high needs participate in a high quality early care and education program.	Home visiting program are more successful at changing self-reported parenting attitudes, beliefs, and behaviors; child programs are more successful at changing child outcomes (Gomby, 2005; Love et al., 2002; Sweet & Appelbaum, 2004)
10. Program Intensity and Duration	a) Monitor frequency and duration of home visits. b) Minimize attrition by scheduling home visits at family's convenience. c) Monitor who is dropping out and why.	Families who stay with home visiting programs tend to be ones who least need the program, while highest need families drop out at rates above 50% (Gomby, Colross, Behrman, 1999; Innocenti, 2002; Wagner, Spiker, & Linn, 2002). High attrition limits generalization of results.

A Final Word on Research

There is enough evidence to support the existence of home visiting programs and their important role within a comprehensive system that supports families with young children. Gaps in the research, including effectiveness of home visiting, effective ingredients of home visiting, and the cost-effectiveness of home visiting still need to be addressed, however the recent efficacy studies provide policy-makers with important information regarding what to expect from home visiting programs.[31]

Section Two: TRAINING

Section two summarizes expert opinions and training experiences of home visiting authorities across British Columbia and other Canadian provinces on home visitor training for peer/lay/para-professionals.

"The availability of appropriate and high-quality training is one of the most critical issues facing home visiting."

Wasik & Bryant, 2001

The available research on home visitor training focuses on training issues rather than model and curriculum comparisons. Researchers state that home visitors could benefit from more intensive training in the formal assessment of risks and the protocols for communication about those risks with their families. Home visitors could also receive support from and work in collaboration with professionals in addressing family risks. Gomby (1999) stresses that no matter what their skill level, close supervision is needed to help home visitors deal with the emotional stresses of the job and maintain objectivity, prevent drift from program protocols, and provide an opportunity for reflection and professional growth[32].

Format

Approximately 16 interviews were conducted across BC and Canada during this review with the following groups: home visiting front line staff, home visiting coordinators, executive directors, provincial coordinators and directors, public health representatives, Aboriginal representatives, researchers, home visitor trainers, government representatives, and home visiting advisory committee members. Training documentation was reviewed as well as research literature discussing home visitor training issues.

Results

There were four main training needs discussed by those interviewed: initial training for new home visitors, wrap around training or continuous training for home visitors, the need for supervision of home visitors as it relates to training, and train the trainer. Home visiting experts across Canada agreed that training is a key element in the success of programs and researchers concur (Gomby 2005). Access to quality training is a challenge for most programs as funding is often an issue.

Another issue regarding training is staff turnover rates. From a research perspective, turnover rates can interfere with family attrition[33] and more research is needed to determine if higher levels of training and supervision to reduce emotional burn-out and higher wages would reduce turnover rates (Gomby et al., 1999). Compared to the child care field where staff turnover rates are high, home visiting programs simply cannot afford to fly expert trainers in from other

provinces or the US for one new home visitor. Most consulted believed that a cost effective solution is the train the trainer model. Many provinces have core trainers already in place (e.g. Newfoundland, Ontario, Manitoba and Alberta).

Four comprehensive home visitor training models were highlighted by interviewees:

1. Healthy Families America,
2. Great Kids, Inc, (US model),
3. Invest in Kids (Canadian model), and
4. Reaching Out to Families by Nzen'man Child & Family Development Centre Society/Sterling Consulting (British Columbia, Canada).

Great Kids Inc. and Invest in Kids were the two most discussed training programs for high risk families by those interviewed. Both models offer "train the trainer" certification. Many programs across Canada have taken both training and described their current programs as a "hybrid" of both training models. Still, there was a 60% preference for Great Kids, Inc. among those consulted. Consistently, home visiting experts reported there is a greater practical application of what was taught during the Great Kids Inc. sessions to the realities of day-to-day work as a home visitor. Reportedly, the Great Kids Inc. integrated model of core training and curriculum is the only model that provides a weekly step-by-step guide for home visitors. The comprehensive model provides home visitors with the skills required to achieve positive outcomes with families. It was noted that resources dealing with high-risk families from Invest in Kids was a useful resource and supporting a Canadian model was appreciated by those consulted.

A recent document, *Establishment of Provincial Home Visiting Coordination and Training,* was submitted by Mary Packham, Lisa Mills, Kathy Currier, and Nadine Johnson to the Province of British Columbia. In it, the home visiting experts from the Building Blocks initiative identified Great Kids Inc. as the preferred model based on their own professional training and experience and their consultation with other home visiting experts across BC and Canada.

In provinces such as Manitoba and Alberta, the provincial governments chose the train the trainer model. Manitoba preferred Great Kids Inc, while Alberta opted for Invest in Kids, however, since the original training; Calgary has had training from Great Kids Inc. in addition to the original core training from Invest in Kids.

Cultural context is an important issue among home visiting programs. Currently, a literature review is underway for home visitor training specifically for urban Aboriginal homes. Unfortunately the results of this literature review were not available in time to include in this report however initial results reportedly show that the Nzen'man model (designed around the components of Head Start) is a more culturally appropriate model for Aboriginal home visitors. BC will need to consider how to merge the needs of all home visiting programs when choosing an appropriate training model in the future (e.g. high risk, special needs, Aboriginal, teen parents, etc.).

Section Three: Infrastructure

Section three summarizes existing home visiting infrastructures across British Columbia and within other Canadian provinces.

British Columbia

The Infant Development Program (IDP) first began in 1972. IDP specifically targets prevention and intervention for children birth – three years who are at risk for or have developmental disabilities. The provincial Ministry of Children and Family Development (MCFD) funds the IDP and they are sponsored by various local community services. In more recent years, Aboriginal IDP's (AIDP) have emerged. Both the IDP and the AIDP, separartely funded, have full time Provincial Advisors and they collaborate in their roles to advise, train, monitor local staff and encourage standard practices.[34] The Advisors are supported by 1FTE administrative staff. Five Regional Advisors across the province (matched to MCFD's five regions) are funded for three days/month. Emphasis is put on high quality training, maintaining standards such as family-centered services and other evidence-based practices. IDP has developed its own program manual (including best practice standards and assessment tools) and training on local, regional, and provincial levels. There is an online certificate and diploma in infant development available through the University of British Columbia. These courses and other training are open to other community service providers.

In a recent document submitted to the Province of British Columbia, entitled *Establishment of Provincial Home Visiting Coordination and Training*, BC home visiting experts from the Building Blocks initiative recommended the Province establish coordination of home visiting programs at provincial and regional levels as well as provincial core trainers. The infrastructure recommended was very similar to IDP's structure which is reportedly very cost effective for that high level of coordination.

In the late 1990's, home visiting programs within the Building Blocks initiative did experience a certain level of provincial coordination from the Ministry of Children and Family Development including teleconferences, annual network meetings, and addressing critical topics such as training and program evaluation. Coordinators valued the ability to share information across programs including program development, program outcomes, and family successes. In the absence of such coordination provincially, supports are dependent on the energy and skills of a few individuals who have limited resources to address home visiting issues at this level.

The BC Council *for* Families has also acted in a coordinating capacity for home visiting programs including the coordination of Building Blocks teleconferences (once the initiative expanded beyond home visiting programs). Still, IDP remains the most consistently coordinated home visiting program outside of public health in BC.

Alberta

“The Alberta Home Visitation Network Association was formed in 1998-99 after two "Creating Healthy Families" conferences were held in the province. Participants at these conferences wanted to provide a forum to encourage the development and integrity of voluntary, long-term home visitation programs as a way of assisting families with children aged zero to six years. This would be accomplished through the establishment of a provincial resource center that would link all home visitation programs in the province.

In 1999, a group of interested representatives, from community-based agencies and home visitation programs, met on a regular basis to share information about the home visitation programs in their communities and to discuss concerns about program development and delivery. It was felt that, while the meetings provide valuable networking, a provincial association and an information resource centre would better meet the needs of home visitation programs across the province. The group decided to formalize the provincial association structure, develop key areas of work, establish a provincial resource centre and hire a coordinator.”

AHVNA website, accessed November 2006

There are 35 provincially funded contracts for home visiting in Alberta and 32 are members of the Alberta Home Visitation Network Association (AHVNA). In total, 72 members, at an annual fee of $75.00, are supported by the Association.

Currently the AHVNA holds 3-4 network meetings annually in Red Deer, a geographically central location for home visitors across the province. The AHVNA is governed by an elected board which meets annually approximately 8-10 times.

Funding for the AHVNA is provided by the provincial government’s Alberta Children’s Services and a local foundation. The provincial government’s funding commitment for five years was matched by the foundation. Once the five years expires, all funding will be provided on a year-to-year basis.

The province created standards/guidelines for home visiting programs in consultation with the AHVNA. Home visiting programs were expected to comply with those new standards as of November 2005.

Refer to the Appendix for a copy of the AHVNA’s brochure.

Manitoba

Families First offers home visiting supports to families with children, from pregnancy to school entry. Families First is delivered across the province by community public health. A peer/lay/para-professional home visitor can meet with families on a regular basis for up to three years.

Originally the program was a Family Centre model and was piloted in 1999. They received provincial funding and rolled out the program across the province converting to the now public health model. The peer/lay/para-professional home visitors, who work in partnership with the public health nurses, received training from Great Kids Inc. Every health region across the province has a trainer. Families First is currently creating a training plan.

Families First has a Provincial Coordinator and operates under the province's Health Child Manitoba. The coordinator is supported by administrative staff, a program manager, and a researcher who is responsible for developing evaluation outcomes, measurements, and tools. The Provincial Coordinator reports to the Director of Public Health. The program regularly collects data for evaluation though reportedly experiences typical home visiting evaluation challenges by relying on self reporting, and need larger numbers and longer term visits for more significant statistical results. All aspects of the program are funded provincially.

Each regional health authority in the province is funded for supervision and coordination. Depending on geographic location, some are funded for 1-2 days a week and some are funded for 5 days a week. In the north, the coordinator role and supervisor roles are combined.

Families First is the largest home visiting program in Manitoba. There are other home visiting programs in the province through organizations such as Aboriginal Head Start and through Child Welfare. Currently there is a home visiting program piloted for First Nations on reserve that is federally funded through First Nations Inuit Health.

Ontario

Like Manitoba's blended model, Ontario's Healthy Babies, Healthy Children combines the home visiting services of a public health nurse and a peer/lay/para-professional:

"Public-health programming in Ontario is provincially mandated. Some public-health programs are 100% provincially funded, while others are cost-shared between the province and the municipality. The Healthy Babies, Healthy Children (HBHC) program is a 100% provincially mandated and funded prevention/early intervention initiative. The HBHC program provides a blended model of home visiting services for high-risk families that includes visits from public-health nurses as well as supervised and trained peer or lay home visitors. The lay home visitor is the main contact with the family and the province has stipulated that the ratio of lay visits to professional visits should range between 3:1 to 6:1, with a minimum ratio of 3:1 lay visits to professional visits. The program does not employ a standardized curriculum or identify specific interventions."

Voices from the Field: Prenatal and Postnatal Home Visiting

The province has also funded a two year evaluation of the HBHC program. Outcomes from the initial evaluation identified several issues common to home visiting programs including who should be providing the home visits, what is the optimal duration for service, should the program target specific populations, how to reach and engage most at-risk families, is family attrition dependent on family-hone visitor relationship, and what is the impact of cultural diversity on such programs.

Unfortunately further details on the infrastructure of the HBHC program were not available to include in this report.

Nova Scotia

Healthy Beginnings is a province-wide enhancement initiative of the work public health nurses do pre and post-natal. Like many programs across Canada, it is a blended model of professionals and peer/lay/para-professionals.

There are four regions in the province of Nova Scotia. All four regions decided to develop Healthy Beginnings in 2001. Jointly they developed 13 common standards for home visiting programs across the province (see Appendix for details). A Provincial Steering Committee was established. Ten per cent of the provincial budget goes to the Steering Committee to assist with the following:

- Initial training of home visitors
- Research and report writing such as:
    - Literature review on the effectiveness of home visiting programs (2002)
    - Province-wide program scan on home visiting programs (2003)

    - Literature review on evaluation of home visiting programs (2004)
    - Creation of an evaluation framework (2004)
    - Review of resources for parents (2005)
- Establishing a standard data collection process across programs as well as a provincial database for evaluation

The Steering committee Continues to develop the initiative including evaluation and governance structure.

Prince Edward Island (PEI)

PEI has a five year provincial strategy for healthy child development. Best Start PEI is a home visiting program initially piloted through National Crime Prevention for five years. It was piloted in 1999. Every baby was screened at birth by a public health nurse at which time an assessment was completed. Should the family receive a certain score, then Best Start was offered and the family was matched to a peer/lay/para-professional. The program worked with the family until the baby reached 18 months.

Two Coordinators cover the entire Island and they are supported by Supervisors who provide direct supervision to the home visitors. The program is now funded by the Public Health Agency and it is run out of Family Resource Centres in the province.

Newfoundland & Labrador

The Healthy Baby Club is yet another blended model implemented across the province. Public Health nurses, nutritionists, and Resource Mothers (peer/lay/para-professionals) work together to support pregnant women pre and post natal.

In St. John's, the home visitors, trained by a comprehensive resource developed locally in the 1990's, are local volunteers from the community. However, throughout the rest of the province, the Resource Mothers are paid staff who also coordinate the program.

There is a Provincial Advisory Committee which developed standards and facilitates networking. The program is funded by the federal CPNP program.

Implications for Policy and Practice

Studies report the mixed effects of home visiting programs on families with young children. In the research, important details emerge once results are no longer generalized across populations, goals, and services. These include:

- Programs targeting specific populations such as at-risk families, families with children with disabilities, teen parents, or specific ethnic groups. reportedly have better results than universal programs.
- Programs with highly trained home visitors produce greater outcomes with higher risk families.
- Programs with specific goals generate more positive outcomes.
- Programs that are a blended model of professionals and peer/lay/para-professionals, or that are entrenched within a multi-faceted, comprehensive program, produce better results for some populations.

Rigorously tested programs are not able to be tested within the context of the broader family, community, and service delivery system. This would require a great deal of funding for an extended length of time to capture outcomes decades later. Creating measurement tools to capture the complex ongoing influences on a child's life is next to impossible within a true randomized design. Unfortunately, government has to rely upon the research and its current challenges when making decisions.

Recent meta-analyses show that home visiting programs are not a panacea, nor should any program be. Instead, the analyses provide a more realistic level of expectation for home visiting programs and their outcomes.

Policy-makers need to continue dialogue with researchers and home visiting programs to ensure best practices are incorporated into programs. Existing policies should not get in the way of implementing such practices.

An analysis of government policies, and the continuum of services available in BC, that impact families with young children would assist in defining a more coordinated approach to home visiting programs in British Columbia.

Access to evaluation at a provincial level would allow BC the opportunity to study its own home visiting programs. Canadian provinces such as Alberta, Manitoba, and Ontario formed provincial coordination thus creating the ability to evaluate at a provincial level.

Training needs for home visitors are critical as acknowledged by home visiting experts and researchers alike.

Provinces supported by provincial coordination reported an ability to train core provincial trainers and provide broad evaluation.

Finally, in consideration of the cost effectiveness of home visiting programs:
"The relative costs and benefits of home visiting studied under optimal research conditions suggest that, in general, the benefits of home visiting outweigh the costs."[xxxv]

Recommendations for Next Steps

Establish a coordinated provincial network for all home visiting programs across BC.

Provinces with coordinated home visiting networks reported the ability to address program development, training, and evaluation issues in comparison to provinces where provincial coordination is lacking. BC's home visiting programs need to build on the success of the existing BC infrastructures (IDP, Public Health, BC Council *for* Families, and Family Resource Programs) and create an opportunity for dialogue among home visiting programs across the province to develop a supportive infrastructure. An Advisory Committee is now in place. The group can establish a working group to begin the process. However, the Advisory Committee and/or Working Group will need the support of a coordinator. Provinces with such infrastructures as provincial networks are supported by a paid coordinator.

Develop provincial guidelines/standards for home visiting programs.

A provincial scan of existing home visiting programs is needed to fully understand the high variability in programs (goals, populations served, etc.) as well as the commonalities. Consistent guidelines or standards developed in partnership between home visiting programs, researchers, and policy-makers will lend a consistency to home visiting programs at a provincial level. Provinces with existing standards or guidelines have reportedly developed them through similar collaborative processes. The process for guideline or standard development will need to allow for variety of home visiting programs offered in communities and not compromise existing services, goals, and populations served.

Create opportunities for home visitors to access quality initial training.

Great Kids Inc. was the most preferred training program discussed. Train the trainer models in other provinces reportedly are the most effective strategy for reducing training costs while providing home visiting programs with the opportunity to access quality training. Outcomes from this review indicate a strong preference for access to the Great Kids Inc. train the trainer model.

Establish a training implementation plan.

The need for a provincial scan of existing home visiting programs (as mentioned previously under the first recommendation for next steps) is critical for establishing training needs and capacities as well. A comprehensive list of existing home visiting programs across the province is the first step. Researchers consistently state that quality initial and on-going training are critical to the success of home visiting programs. The development and implementation of an implementation plan for home visitor training in British Columbia will effectively support home visitors' training needs across the province.

Coordinate advocacy activities, networking, and on-going training to energize the field.

Home visiting programs for high risk families that have been working in virtual isolation from other home visiting programs will benefit from networking and the opportunities they allow as demonstrated in other provinces. The established infrastructures in other provinces provide other opportunities as well. For example, a new federal home visiting initiative is currently developing in BC. At the writing of this report, consultation with existing home visiting programs has reportedly not yet occurred. The creation of a provincial infrastructure would enable such initiatives a specific contact point for such consultations and open communication and between all involved.

Build capacity for program evaluation at provincial and local levels.

Evaluation will offer accountability and demonstrate that home visiting programs make a difference in the lives of BC's children.

Connect with other Canadian home visiting networks

Canadian home visiting programs have much to offer each other and creating an opportunity to do so will benefit programs, families, communities, and governments.

APPENDIX

Children and Youth with Special Needs: A Glossary of Terms

Version One
December 2006

Introduction

The purpose of this glossary is to provide a common understanding of the terms pertaining to the services and service delivery of programs offered to children and youth with special needs (CYSN) and their families. It is directed to service providers, government staff and community members seeking clarification of these terms.

As a number of individuals and organizations are involved in the delivery of services to CYSN and their families, various understandings of the relevant terms exist. This glossary is intended as a point of reference to:

- Support effective coordination of services and systems across all service sectors; and,
- Promote clarity in discussions regarding these terms.

It is an evolving document that may be revised in order to acknowledge the dynamic nature of the terms.

The glossary was developed by gathering definitions from a variety of governmental and non-governmental sources, including the International Classification of Functioning, Disability and Health, and documents from the Ministries of Education, Health and Children and Family Development.

Feedback may be sent to Provincial Services for Children and Youth with Special Needs, Ministry of Children and Family Development (250 952-6044).

1 of 14 pages

Children and Youth with Special Needs: A Glossary of Terms
Version One
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Access to Services
The ability of individuals or groups to reach or use services provided in the most appropriate setting, at the right time, and based on individual or group needs. Access may apply at the level of the individual persons served (timeliness or other barriers) or the target population for the organization.

Accessibility
The provision of specific equipment or techniques that enable those with special needs to gain knowledge and information about community integration opportunities.

Activity (from a therapeutic perspective)
The execution of a task or action by an individual.

Activity Limitations
Difficulties an individual may have in executing activities. An activity limitation may range from a slight to a severe deviation, in terms of quality or quantity, in executing the activity in a manner or to the extent that is expected of people without the health condition.[1]

Activities (from a service perspective)
Services or functions carried out by a program.

Advocate
An individual who is not an attorney, but who assists parents and children in their dealings with service providers, service units, and relevant personnel.

Advocacy
Participating in efforts to strengthen and improve services. This may include speaking for, writing in favour of, supporting, and/or acting on behalf of oneself, another person, or a cause in order to influence systems, decision-makers, and other community resources.

Assessment
Appraising the level or magnitude of a child's development, as well as his/her family's strengths, resources, concerns, priorities and needs related to his/her development, and providing recommendations regarding intervention and its desired outcomes. A comprehensive assessment synthesizes past records, evaluations, interviews with significant people, observations of current behaviour, results of standardized tests, and other special procedures. Assessment differs from testing in that testing reflects performance at a particular time, whereas assessment requires

[1] A related term is participation restrictions. Activity limitations differ from participation restrictions in that the latter denotes difficulties faced in experiencing life situations, while the former suggests difficulties faced in actively executing activities.

clinical judgment to give meaning to the overall pattern and interrelationships among various results.[2]

At-Risk Child or Youth
A child or youth who, while currently healthy, is at risk of developing learning, emotional, behavioural or physical disabilities in the future.

Best Practice
Activities or guidelines that produce a specific outcome and that are supported by research, experience with a particular intervention, and/or expert opinion.[3]

Best Practice Evidence
A broad range of research evidence used to evaluate the merits of a given practice, including evidence based on multiple research designs.[4]

Case Conferencing
A planned and formal meeting of team members, usually including the family and/or client, to work collaboratively in developing, reviewing, and/or updating short- and long range plans for service delivery.

Child- and Youth-Centred
Children and youth with special needs are active participants in the planning and implementation of services to ensure that their needs are met in a functionally-based, accessible manner. This approach focuses on the child or youth's choices and interests; the organization of the environment is a key element in providing choices that will facilitate development.

Child or Youth with Special Needs
A child or youth between birth and 19 years of age who has significant impairments in one or more of the following areas: health, cognition, communication, sensory processing, movement, social/emotional/behavioural, and self-help (adaptive); and requires specialized supports to enhance or improve his/her health, development, or participation in daily activities at home, in school and in his/her community.

Collaboration
A process in which professionals from various disciplines work together to achieve a common goal. The collaborative model fosters the development and implementation of comprehensive, coherent programs, as it involves professionals learning from each other.

[2] A related term is screening. Assessment follows screening, as screening is a preliminary step used to determine the presence of special needs, while assessment establishes the level of services required.
[3] Related terms are best practice evidence, evidence-based practice, and promising practice. While a best practice is the actual practice that has been verified as a best practice by best practice evidence, evidence based practice is the act of using best practices. Conversely, a promising practice is one that has not yet received the same level of validation as a best practice.
[4] See footnote 3.

Community Development
The process of involving a community in the identification and reinforcement of those aspects of community life, culture, and political activity conducive to health. This increases the positive outcomes possible within a community by linking together individuals and organizations working in pursuit of common goals.

Comprehensive
An approach that supports all children and youth by providing a cohesive set of services that includes universal and specialized services addressing multiple needs. A comprehensive approach incorporates specialized and natural community programs and resources. The intended outcomes of providing universal services to all children include early identification, prevention, and elimination of stigma for receiving services. By offering services to all children within the natural community setting, those with special needs are less likely to be stigmatized for receiving services and their respective abilities to access local resources and activities are facilitated.

Consultation
A process in which a service provider uses his/her expertise to assist other adults in meeting a child's or youth's special needs. This often takes the form of advice regarding the child, youth or family, the establishment of programs to be carried out by the other adults, and monitoring the implementation of intervention programs.

Continuum of care
A system of services addressing the ongoing and/or intermittent needs of persons at risk or with functional limitations resulting from disease, trauma, aging, congenital and/or developmental conditions. Such a system may be achieved by accessing a single provider, multiple providers, and/or a network of providers. The intensity and diversity of services may vary depending on the functional and psychosocial needs of the persons served.

Coordination
Establishing and maintaining links among the resources, supports, and multi-disciplinary or multi-sectoral services necessary to meet family-identified goals or to streamline services in the community.

Counseling
The service provided by a trained professional, within the context of a therapeutic relationship, which facilitates the exploration and resolution of a client's self-identified personal/family concerns and issues.

Cultural Competence
An organization's ability to acknowledge, respect and incorporate, at all levels, racial, ethnic, linguistic, religious and social diversity.[5]

Cultural Sensitivity
Knowledge of cultural differences and the corresponding usage of verbal and nonverbal behaviour to optimize interactions with individuals from various cultural backgrounds.[6]

Culturally Responsive Services
Services that meet the changing cultural needs of the communities they are intended to serve, rather than expecting clients and consumers to adapt to prescribed services as they exist.[7]

Disability
An umbrella term for impairments, activity limitations and participation restrictions including environmental and personal factors. A disability may be temporary or permanent, reversible or irreversible, and progressive or regressive.

Early Identification
Referrals and assessments to identify children with developmental delays or at risk of developing delays as early in life as possible.

Early Intervention
Specific services provided to infants and toddlers who show signs of, or are at risk of having, a developmental delay. These services are often tailored to the specific needs of each child with the goal of furthering development and enhancing the child's potential for growth and development. Early and prompt intervention programs can prevent or reduce the consequences of disabling conditions, particularly in young children.

Education (from a service perspective)
The provision of information and/or training to develop the knowledge, skills, and/or awareness of resources of a third party in order to enhance the environmental supports available to individuals with disabilities. It might be provided to a person either singularly or in a group situation and differs from consultation in that the content of educational information is not specifically developed for an individual client.

[5] Related terms are cultural sensitivity and culturally responsive systems. Cultural sensitivity is a prerequisite for the development of cultural competence, as knowledge of cultural differences informs an organization's ability to acknowledge, respect, and incorporate those differences. Culturally responsive systems may result from the existence of cultural sensitivity and cultural competence.
[6]See footnote 5.
[7] See footnote 5.

Evidence-Based Practice
The use of current best practice evidence, obtained through systematic research on the effects of intervention, and individual expertise in decision-making about the provision of services.[8]

Family
The persons who play a significant role in an individual's life and act as his/her support network. It may include the person's parents, spouse, siblings, extended family, guardians, legally authorized representatives, or significant others as identified by the person served. Due to the diversity of family structures, it may include people who are not legally related to the client.

Family Support
Services intended to promote family wellness, preserve family integrity and enhance family functioning by assisting families to acquire parenting, child development, and advocacy skills and addressing factors which affect their capacity to parent.

Family-Centred
An approach to assessment and intervention that assigns significance to the family's concerns, abilities and priorities. A professional and family partnership is formed, under which professionals are guided by an understanding of the centrality of families in meeting the needs of children and youth with special needs.

Functioning
An umbrella term for body functions, body structures, activities and participation, including environmental and personal factors.

Impairment
A temporary or permanent loss or disability of psychological, physiological or anatomical structure or function.

Inclusion
The processes supporting the meaningful participation of children and youth with special needs in all aspects of home, school and community life; this involves full participation in programs designed for typically developing children. Within an educational context, inclusion refers to the belief that one educational system for all students is ideal and that every student is entitled to an instructional program which meets his/her individual needs and learning characteristics. The practice of inclusion goes beyond placement to include meaningful participation and the promotion of interaction with others.[9]

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[8] Related terms are best practice, best practice evidence, and promising practice. While a best practice is the actual practice that has been verified as a best practice by best practice evidence, evidence-based practice is the act of using best practices. Conversely, a promising practice is one that has not yet received the same level of validation as a best practice.
[9] A related term is integration of children and youth with special needs. Inclusion differs from integration of children and youth with special needs in that integration is a strategy aimed at achieving inclusion.

Individual plan
An organized statement of the proposed service/treatment process to guide a provider and a person served throughout the duration of service/treatment. It identifies goals and objectives, services to be provided, persons responsible for providing services, and input from the person served.

Inputs
Resources dedicated to, or consumed by, a particular program or activity. This often includes money, staff and staff time, facilities, and equipment.

Intake Consultation
The initial contact with the client and/or caregiver following referral, designed to obtain informal descriptive information about a client's performance in order to estimate further needs. It is also aimed at determining the caregiver's priorities regarding the client's needs and at providing immediate assistance. This service may require more than one contact.

Integrated Case Management
A team approach to coordinating various services for a specific child and/or family through a cohesive and sensible plan; all members of the team work together to provide assessment, planning, monitoring and evaluation. The team should include all service providers who have a role in implementing the plan, and whenever possible, the child or youth's family.

Integrated Service Delivery
A process that delivers a wide range of educational, health and social services in a coordinated manner to improve the outcomes for children and families and is considered more than cooperation or coordination. It involves joint planning and decision-making, and service providers offering services under a unified mandate.

Integration of services between disciplines is described as occurring at the following four levels:

- early identification and assessment to establish support and service needs;
- service planning, including attention to the informal as well as formal supports; and, services to the child and family
- delivery of informal and formal supports and services at the system level governing the various agencies and professionals involved

Integration of Children and Youth with Special Needs
A strategy for inclusion that involves physically placing children and youth with special needs with their peers without special needs. Necessary support in educational, vocational, residential, community and employment settings is provided in order to enable children and youth with special needs to succeed.[10]

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[10] A related term is inclusion. Inclusion differs from integration of children and youth with special needs in that integration is a strategy aimed at achieving inclusion.

Interdisciplinary
The integration of professionals representing two or more disciplines into a distinct discipline. Team members participate in the assessment, planning, and/or implementation of a program. The final case formulation reflects the conclusions of a staffing conference at which professional disagreements are discussed and resolved in a manner that respects each individual's contribution.[11]

Intervention
A specific treatment action or set of actions by a treatment team (or any of its members) that, as a component of a treatment plan, is directed at improving the well-being of the client by facilitating a change in the behaviour, condition or functioning of the child, youth and/or family.

Key Worker
A 'guide' who helps families maneuver through a complex array of systems by offering support and facilitating collaborative working relationships among service providers across agencies and sectors. This differs from traditional case management in that it involves coordination across all systems and the empowerment of parents.

Logic Model
Describes how a program should work and presents the planned activities for the program, focusing on the logical linkages between the inputs, activities, outputs, and outcomes. While a logic model presents a theory about the expected program outcome, it does not demonstrate whether the program caused the observed outcome.

Monitoring and Supervision
Entails the service provider conducting an assessment to identify strengths and changing needs of the individual client (child and/or family). The service provider designs an intervention plan to meet individual needs and trains another person within the client's natural environment to carry it out. As the service provider remains responsible for the plan, he/she ensures that procedures are implemented on a consistent basis and remains in regular contact with the person carrying out the plan. Monitoring and supervision may include occasional hands-on interaction between the service provider and the child in order to assess the child's status and update recommendations accordingly.

Multidisciplinary
The involvement of professionals from two or more disciplines in the provision of integrated and coordinated services, including evaluation and assessment activities. Each professional addresses the issues from the perspective of his/her own discipline.[12]
professionals crossing traditional discipline-specific boundaries.

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[11]Related terms are multidisciplinary and transdisciplinary. While the interdisciplinary model focuses on the creation of a 'new discipline,' the multidisciplinary model involves each professional approaching an issue from the perspective of his/her discipline. Conversely, the transdisciplinary model entails professionals crossing traditional discipline-specific boundaries.
[12]Related terms are interdisciplinary and transdisciplinary. While the interdisciplinary model focuses on the creation of a 'new discipline,' the multidisciplinary model involves each professional approaching an issue from the perspective of his/her discipline. Conversely, the transdisciplinary model entails

Needs-Based Assessment
The needs of the child/youth and family are measured through a comprehensive assessment of the child/youth's development and stressors for the family.

Outcomes
The results experienced by individuals or populations during or after participation in program activities. Outcomes may relate to behaviour, skills, knowledge, values, condition, status, or other attributes and may be positive or negative, intended or unintended and direct or indirect.

Outputs
The direct products of program activities, which are usually measured in terms of the volume of work accomplished.

Parent/Guardian
The guardian(s) of the child or youth, the person(s) legally entitled to custody of the child or youth, or the person(s) who has the care and control of the child or youth; this includes natural, foster and adoptive adult caregivers. Guardian, when used in reference to a child or youth, means the guardian as defined in the *Family Relations Act.*

Participation
A person's involvement in a life situation.

Participation Restrictions
Difficulties an individual may experience in involvement in life situations. The presence of a participation restriction is determined by comparing an individual's participation to that which is expected of an individual without a disability in that culture or society.[13]

Performance Measure
Sometimes referred to as an indicator, this is a tool for objectively measuring the degree of success a program has had in achieving its objectives, goals and planned program activities.

Person-Centred Planning
A concept that places the individual with special needs in a respected leadership role during the transition planning and service delivery processes, thereby encouraging him/her to participate in planning for his/her future. The approach is consistent with the principles of self-determination.

[13] A related term is activity limitations. Activity limitations differ from participation restrictions in that the latter denotes difficulties faced in experiencing life situations, while the former suggests difficulties faced in actively executing activities.

Prevention
Actions aimed at eradicating or minimizing the impact of disease and/or disability, maintaining and enhancing resiliency factors and decreasing risk factors that threaten a person's healthy optimal functioning. There are five levels of prevention:

- Primordial Prevention: Actions and measures that inhibit the emergence and establishment of environmental, economic, social and behavioural conditions known to increase the risk of disease and/or disability. These include such factors as improving housing availability and reducing child poverty.[14]
- Primary Prevention: Protection of health by personal and communal efforts, such as enhancing nutritional status, immunizing against communicable diseases, and eliminating environmental risks such as contaminated drinking water.[15]
- Secondary Prevention: A set of measures, such as screening programs, available to individuals and communities for early detection and prompt intervention to control disease and minimize disability.
- Tertiary Prevention: Measures aimed at softening the impact of long-term disease and disability by eliminating suffering and maximizing potential years of functional life.
- Quarternary Prevention: Measures that ease suffering without curing the symptoms of terminal disease.

Program
A system of activities with clearly defined, dedicated resources and coherent, consistent, measurable objectives, performed for the benefit of persons served**.**

Promising Practice
A practice that does not have the same level of validation as a best practice, but has an empirical basis, including an evaluation component/plan, for predicting that further research could demonstrate its effectiveness.[16]

Promotion
Activities that develop, enhance or increase the awareness of, or maintain capacities for, healthy, optimal functioning.[17]

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[14] Related terms are primary prevention and promotion. While primordial and primary prevention include activities that promote optimal healthy functioning by preventing disease and/or disability, promotion seeks to disseminate knowledge of successful preventative techniques.
[15] See footnote 14.
[16]Related terms are best practice, best practice evidence, and evidence-based practice. While a best practice is the actual practice that has been verified as a best practice by best practice evidence, evidence-based practice is the act of using best practices. Conversely, a promising practice is one that has not yet received the same level of validation as a best practice.
17 Related terms are primordial prevention and primary prevention. While primordial and primary prevention include activities that promote optimal healthy functioning by preventing disease and/or disability, promotion seeks to disseminate knowledge of successful preventative techniques.

Rehabilitation
The provision of medical, psychological, educational and family services to people with special needs in order to maximize their vocational, mental, physical and social abilities and facilitate functioning as independently as possible. Although the term *adult rehabilitation* refers to the recovery of abilities lost, *pediatric rehabilitation* connotes the development of abilities not previously mastered. There is consequently a difference in instructional techniques and individual motivation dealing with an adult who may remember having achieved a particular goal in the past, compared with a child who likely has no such experiences on which to rely.[18]

Respite
Supports and services that provide parents with a short-term break from the demands of caring for a child or youth with special needs. This allows the parent(s) to attend to needs away from the child or youth, such as their own needs or those of other children in the family. Respite is used to decrease stress in the homes of children and youth with special needs, thereby ultimately increasing caregivers' effectiveness. There are three types of respite:

- In-Home Respite: Consists of an individual coming into the home to care for the child or youth.
- Out-of-Home Respite: May include a short-term out-of-home placement, family care with a surrogate foster family, group homes or residential respite centres.
- Homemaking Supports: Assist families in day-to-day care and provide a wide range of services, including counselling and instruction in parenting skills.

Results-Based Approach
A service delivery method involving the collection and use of performance information to evaluate the outcomes of the service provided, with the intention of strengthening decision-making, learning, improving programs, and ensuring accountability.

Screening
A face-to-face, computer-assisted, or telephone interview to identify a person's potential special needs. A first step in diagnosis, screening is a form of secondary prevention that requires diagnosis prior to the initiation of therapy or other intervention. Screening is applied only to asymptomatic (without symptoms) populations. Thus, when a parent has concerns about a child's development, the child is not asymptomatic and should be assessed, not screened.[19]

Service Providers
Individuals who assist children and youth who have special needs, or are at risk of developing special needs, and their families. Assistance may be in the form of information, referral, consultation, facilitation, or direct service. Service providers may be ministry staff, contracted staff, or informal family supports such as volunteers.

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[18] Pediatric rehabilitation is often referred to as habilitation, which denotes the mastery of skills not previously learned.
[19] A related term is assessment. Assessment follows screening, as screening is a preliminary step used to determine the presence of special needs, while assessment establishes the level of services required.

Service Referral
Arranging for a person to receive the services provided by the appropriate agent or service unit.

Single Point Access
A single point of access to a full range of services, coordinated assessment and planning, and case management for children and youth with special needs. This approach facilitates the sharing of physical and staff resources and simplifies access for children and youth with special needs and their families.

Special Educational Needs
Those characteristics which make it necessary to provide a student undertaking an educational program with resources different from those which are needed by most students. Special educational needs are identified during assessment of a student and form the basis for determining an appropriate educational program, including necessary resources, for that student.

Standard
An established, measurable, achievable statement that describes a minimum acceptable level of performance against which actual performance can be compared. Service providers use standards to attain and maintain quality of care or service delivery.

Therapy
Intervention activities that are individually designed for a client. The use of therapy requires that the services provider conduct an assessment to identify strengths and changing needs of the individual client. The service provider is required to monitor changes that occur and alter the treatment accordingly. Direct therapy is provided either individually or in small groups and requires personal interaction between the therapist and the child. The focus of direct therapy is to meet the client's needs through very specialized therapeutic strategies, while indirect therapy involves the therapist suggesting ways that parents, teachers and other service providers can integrate intervention strategies. As part of consultation, a therapist may provide training to staff and parents, recommend equipment and/or inform parents and service providers of appropriate readings and other resources. The types of therapies often utilized by children and youth with special needs include the following:

- Occupational Therapy: The use of adaptive work and play activities to increase independent functioning, enhance development and prevent disability. This may include a program to improve the child's ability to perform daily activities (feeding, washing, toileting and dressing) and school activities (such as printing). Adaptive equipment recommendations and usage training may be provided, as well as suggestions regarding the adaptation of a task or environment in order to achieve maximum independence.[20]

[20] Occupational Therapy (OT) and Physical Therapy (PT) offer complementary services. However, OT mainly focuses on a person's ability to function independently within his/her environment, while PT mainly focuses on the body's physical functions.

- Physical Therapy: A discipline concerned with the evaluation, monitoring and restoration of physical function. This may be achieved through handling and relaxation techniques, electrotherapeutic techniques, exercises, and the provision of adaptive equipment to enhance movement and independent functioning.[21]
- Speech-Language Therapy: Therapeutic measures aimed at the remediation and amelioration of speech and language disorders through prevention, identification, assessment, diagnosis and intervention strategies.

Tiers of Service
Currently there are four tiers of service within ministries and authorities. The responsibility assigned to each tier is as follows:

- Tier One: Universal services, such as those provided by physicians and teachers.
- Tier Two: Community services, such as the Infant Development Program, Early Intervention Therapy, and School-Aged Therapy.
- Tier Three: Specialized regional health services, including assessment and diagnosis services relating to Autism Spectrum Disorder and/or Fetal Alcohol Spectrum Disorder.
- Tier Four: Provincial services, such as those provided by tertiary rehabilitation centres.

Transdisciplinary
A team approach to the diagnosis and treatment of developmental disabilities. Such a team goes beyond the interdisciplinary model, in that one or more of the professionals on the team crosses traditional discipline-specific boundaries. Thus, with the transdisciplinary approach, an individual professional can incorporate components of the interdisciplinary team interaction.[22]

Transition Planning
A partnership involving the individual with special needs, his/her family, local service providers, school personnel, and government staff who support transitions. The purpose of transition planning is to identify opportunities and experiences that will prepare the individual for his/her post-school activities. It is an interactive, dynamic process that involves preparation and implementation of an Individual Transition Program (ITP), which may be incorporated into the Individual Education Plan (IEP).

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[21] See footnote 20.
[22] Related terms are interdisciplinary and multidisciplinary. While the interdisciplinary model focuses on the creation of a 'new discipline,' the multidisciplinary model involves each professional approaching an issue from the perspective of his/her discipline. Conversely, the transdisciplinary model entails professionals crossing traditional discipline-specific boundaries.

Treatment
A professionally recognized approach that applies accepted theories, principles, and techniques designed to achieve recovery and rehabilitative outcomes for the persons served.

Wait Time
The time elapsing between when a procedure, support or service is formally requested and when it is carried out.

Waitlist
A list of people waiting to receive a specific support or service that is unavailable at the time that the need for the support or service is identified.

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Popular U.S.-Based Home Visiting Programs Reported in Several Rigorous Studies

Descriptions of the Home Visiting Program Models Included in the Evaluations Reported in This Journal Issue[a]

Program	Program Goals	Scheduled Onset, Duration, and Frequency of Home Visits	Population Served	Background of Home Visitors	Training Requirements for Home Visitors
The Comprehensive Child Development Program (CCDP)	• Enhance the physical, social, emotional, and intellectual development of children • Provide support to parents and other family members • Assist families in becoming economically self-sufficient	Birth to one year old through fifth birthday Biweekly	Low-income families, all ethnicities, at 24 sites in the United States	Paraprofessionals and those with associate's degrees or other forms of post–high school training	Extensive in-service training
Hawaii Healthy Start	• Advance optimal child development • Promote positive parenting • Enhance parent-child interaction and parenting skills • Assure a regular physician and "medical home" • Prevent child abuse and neglect	Birth through fifth birthday Weekly, fading to quarterly	All parents of newborns in Hawaii, all income levels and ethnicities, who were identified at the time of children's birth as at risk for abuse and neglect	Paraprofessionals and those with bachelor's degrees	One week of preservice training plus 30 additional hours of in-service training
Healthy Families America (HFA)	• Promote positive parenting • Prevent child abuse and neglect	Birth through fifth birthday Weekly, fading to quarterly	Parents in the mainland United States and Canada, all income levels and ethnicities, who were identified at the time of children's birth as at risk for abuse	Paraprofessionals and those with bachelor's degrees	One week of preservice training; one day of continuing training quarterly; and 80 hours of additional training in the first 6 months of service are recommended by Prevent Child Abuse America.
The Home Instruction Program for Preschool Youngsters (HIPPY)	• Empower parents as primary educators of their children • Foster parent involvement in school and community life • Maximize children's chances for successful early school experiences	Academic year, or two years before, through the end of kindergarten Biweekly, that is, at least 15 times over 30 weeks during the school year	Families in the United States and Guam, all income levels and ethnicities	Paraprofessionals; most work part time (20 to 25 hours per week)	Intensive preservice training in the HIPPY program model plus weekly ongoing training
Nurse Home Visitation Program	• Improve pregnancy outcomes • Improve child health and development • Improve families' economic self-sufficiency	Prenatal through second birthday Weekly, fading to monthly	Low-income, first-time mothers, all ethnicities	Public health nurses	Two weeks of training in the program model over the first year of service. Forty-six hours of continuing education in assessing parent-infant interaction, plus additional continuing education as needed.
Parents as Teachers (PAT)	• Empower parents to give their children the best possible start in life • Give children a solid foundation for school success • Prevent and reduce child abuse • Increase parents' feelings of competence and confidence • Develop home-school-community partnerships on behalf of children	Prenatal through third birthday Monthly, biweekly, or weekly, depending upon family needs and funding levels	Families in the United States and six other countries, all income levels and ethnicities	Paraprofessionals and those with associate's, bachelor's, and advanced degrees	One week of preservice training plus one additional day in first six months; 20 hours of in-service training required in the first year; additional in-service hours required annually for credentialing by the Parents as Teachers National Center; specialized PATNC trainings strongly recommended.

[a] The program descriptions in this table reflect the home visiting models as of December 1998. The program evaluations reported in this journal issue were undertaken in earlier years and therefore may contain program descriptions different from those presented in this table.

Alberta Home Visitation Network Association (AHVNA) brochure (page 1)

ensuring that every child has a healthy beginning

An Ounce of Prevention

In Alberta, community home visitation programs are offered to parents and parent-to-be as a support in raising children to be healthy, safe and secure from infancy on to adulthood. The health and well-being of Alberta families with children ages 0-6 is promoted through voluntary long-term home visitation services. Home visits allow services to be tailored to best meet the needs of all family members.

About AHVNA

The Alberta Home Visitation Network Association (AHVNA) is a provincial non-profit society aimed at promoting quality home visitation programs. AHVNA is a member-driven organization comprised of interested individuals, community-based agencies, home visitation programs, Child and Family Services Authorities and Regional Health Authorities

The Association promotes best practices and standards in home visitation through

- Centralized research and evaluation resources
- Sharing of information on training opportunities
- Providing networking opportunities
- Creating forums for members to have input on relevant issues

12 Key Factors for Success

AHVNA supports the following key elements as best practice in a home visitation program:

Start Early – Initiate services prenatally or as soon as possible after birth

Set the Standard – Use a standardized assessment tool to identify families who are most in need of services

Voluntary Participation – Offer services using positive and creative efforts to build family trust

Consistency – Offer intensive services with well defined criteria for increasing or decreasing frequency of home visits over the long term

Cultural Consideration – Acknowledge and respect cultural, linguistic, geographic, racial and ethnic diversity of the population served

Parental Support – Focus on enhancing parent competencies, parent-child interaction and child development

Medical Links – Connect families to a medical provider to ensure optimal parent and child health and development. Assistance programs, school reading programs, AADAC programs and domestic violence shelters may also be considered at this time

Manageable Caseloads – Limit staff case loads to assure that home visitors have adequate time to spend with each family

Selecting Service Providers – Service providers are selected because of their personal characteristic (non-judgmental, compassionate) their experience and skill sets

Basic Training – Service Providers have a framework based on education or experience for handling the variety of experiences they may encounter when working with families who may be facing multiple challenges. Ongoing training should be provided

Intensive Training – Service providers receive intensive training to understand the essential components of family assessment and home visitation

Supervision – All service providers receive ongoing reflective supervision to support effective home visitation interventions, to promote families goal attainment and to avoid stress-related burnout

"AHVNA provides and instant connection with home visitation programs all over the province."
– an AHVNA member

Alberta Home Visitation Network Association (AHVNA) brochure (page 2)

Benefits of AHVNA Membership

- A voice in the support and coordination of home visitation programs throughout the province
- Policy advisory role with the provincial government regarding childrens initiatives
- A national presence regarding home visitation programs
- Regular provincial meetings
- Outstanding networking opportunities
- Knowledge of, and access to, available curriculum
- Up to date current information on training opportunities
- Knowledge of accepted best practices
- Participation in developing provincial standards

AHVNA supports Home Visitation that:

focuses on strengths, and supports families by building trusting relationships, teaching problem solving skills, encouraging positive parent-child relationships, and supporting healthy child growth and development.

"It's rewarding to have families let us into their lives, to see the trust develop and then evolve so that the family can then participate fully in their community, giving back, as well as receiving services."
– a family visitor

Be a Part of the Family

To find out more about AHVNA and how you can participate, either as a member organization, or as an individual, please contact:

Alberta Home Visitation Network Association
9321 Jasper Avenue
Edmonton, Alberta
T5H 3T7

Phone: (780) 429.4787
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Website: www.ahvna.org

supporting quality home visiting programs across Alberta for children and families

Funding for AHVNA is provided by Alberta Children's Services and the Muttart Foundation.

Alberta Home Visitation Network Association

supporting quality home visiting programs across Alberta for children and families

Nova Scotia Health Beginnings Home Visiting Program Standards

Healthy Beginnings: Enhanced Home Visiting Initiative is an enhancement to current public health programs for young families In Nova Scotia. The following program standards for Healthy Beginnings were developed within the framework of "*Public Health Services - Who we are and What we do*" and build on existing standards and targets outlined in the Nova Scotia Health Standards.[23]

Program Standards

Public Health Services, through its governance structure:

1. Ensures that the implementation and evaluation of 'Healthy Beginnings' is grounded within the public health functions of population health assessment, health surveillance (part of assessing the health of populations e.g. tracking injuries, conducting health surveys), population health advocacy, health promotion, disease/injury prevention, and health protection.

2. Supports the establishment of multi-partner Local Implementation Teams to implement the Healthy Beginnings: Enhanced Home Visiting Initiative using agreed upon program guidelines, targets and standards, and building on existing programs.

3. Supports a family-centred, strengths-based approach to the implementation and evaluation of 'Healthy Beginnings'.

4. With partners, establishes and maintains effective processes (i.e. policies and procedures) for communication and referral/linkages among community and other health system resources for families.

5. With community partners (e.g. Canada Prenatal Nutrition Program), continues to offer prenatal services and supports to families 'at risk'[24], using a family-centred, strengths-based approach.

6. Through the local implementation team, in collaboration with Healthy Beginnings Provincial Steering Committee, supports the development of the prenatal component [25] of 'Healthy Beginnings'.

7. Offers universal postpartum screening[26], using a standardized approach, according to the guidelines established by the Healthy Beginnings Provincial Steering Committee.

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[23] Nova Scotia Department of Health. *Nova Scotia Health Standards.* 1997.
[24] Nova Scotia Health Standards Document, April 1997
[25] Prenatal component will also be informed by the work of the Prenatal Education & Support Program Review Working Group
[26] As a result of (1) the considerable variation that exists in current PHS early childhood development 'practice' across the province, (2) the time required to transition to new program standards and targets, and (3) the phased-in budget allocation for 'Healthy Beginnings', it is recognized and accepted that DHAs/SSAs may have to phase-in screening and assessment processes.

8. Contacts all postpartum families to provide health information/ postpartum support and home visiting as needed for identified short-term maternal and infant health concerns, using a family-centred, strengths-based approach.

9. Offers an in-depth family assessment[27], using a standardized, family-centred, strengths-based approach, to families identified through the screening process as potentially benefiting from enhanced home visiting or other community supports.

10. Offers enhanced home visiting to families identified through the assessment process, as potentially benefiting from enhanced home visiting, for the first three years of their child's life, using a family-centred, strengths-based approach. Enhanced home visiting will be offered to families by public health professional staff and/or trained community home visitors. Together, with the home visitor, parents determine the frequency and duration of enhanced home visiting. The assessment process and known evidence/best practice will also guide the frequency and duration of home visiting.

11. Supports 'Healthy Beginnings' professional staff competencies to support the expected outcomes for this program. The Healthy Beginnings Provincial Steering Committee has identified the following *priority training areas* for professional staff. Priority training areas include but are not limited to:

    - Screening/ assessment
    - Parent-child attachment
    - Breastfeeding
    - Mental Health
    - Working knowledge of Children & Family Services Act
    - Program evaluation
    - Growth and development
    - Family planning
    - Family violence
    - Addictions

12. a) Supports the following role of community home visitor[28]: emotional and practical family support, provision of parent information, provision of general health information, referrals to partner organizations, assistance with family goal setting and achievement, and parent role modeling.

    b) Supports *priority core* training opportunities, which have been identified for community home visitors and their supervisors, to support the role of the home visitor. These include but are not limited to:[29]
    - Parenting skills
    - Family goal setting
    - Professional boundaries & limits
    - Healthy child development
    - Family-centred, strengths-based approach
    - Documentation

[27] As above
[28] Lilley, S. & Price, P. (2003) Home Visiting to Support Young Families in Nova Scotia: Report of a Province-Wide Program Scan. Report written for the Healthy Beginnings: Enhanced Home Visiting Initiative Provincial Steering Committee
[29] Lilley,S., Price, P. (2003). Home Visiting to Support Young Families in Nova Scotia. Report written for the Healthy Beginnings: Enhanced Home Visiting Initiative Provincial Steering Committee

- Knowledge of local resources/referral processes.

c) Supports community home visitors to acquire a 'working knowledge' of the priority training areas identified for professional staff (as identified in Standard 11).

d) Supports the dimensions of effective support, supervision and coordination to support the community home visitor role (based on best and current[30] practice). These include: use of a strengths-based approach, trained supervisors, low home visitor to supervisor ratios[31], frequent and regular communication between supervisors and home visitors, regular opportunities for collective home visitor debriefing.

13. Participates, as leaders, in the development and implementation of a data collection and monitoring system to support evaluation and program planning.

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