Prevention of Child Maltreatment through Home Visitation: A Review of Selected Literature

By

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Abstract

Child maltreatment is a significant problem in the United States with over 826,000 children maltreated yearly. Home visiting by registered nurses has been shown to decrease child maltreatment rates as well as improve the health and social functioning of families. This paper will examine home visitation programs, challenges of home visiting, effectiveness of registered nurses as home visitors and discuss areas for further research. A synopsis of local home visitation programs is also included.
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Introduction

Child maltreatment is a significant problem in the United States. In 1999 child protective services agencies received nearly three million reports of child maltreatment. “Of the 60.4 percent of these reports that were investigated, states found that there were an estimated 826,000 children who were victims of abuse and/or neglect.” (Carter, 2001). Compare this to 501,310, the total number of Auto Immune Deficiency Syndrome (AIDS) cases reported to the Centers of Disease Control (CDC) as of 1995, (Barker, Burton, & Zieve, 2000) or to 184,300 the number of newly diagnosed cases of breast cancer in 1996 (Varricchio, 1997) and you begin to wonder why the issue of child maltreatment does not have its own lapel ribbon.

The issues surrounding child maltreatment are complex with no easy answers. The National Institute of Health (NIH) may be able to find a vaccine for AIDS, or a cure for cancer but to remedy child maltreatment our society will have to deal with the issues of extreme poverty, teenage pregnancy, drug and alcohol abuse, and a large array of mental disturbances to name but a few. These multiple factors greatly compound the difficulty in finding solutions to child maltreatment.
Child Maltreatment

Definition

The four major types of abuse that comprise maltreatment include physical abuse, neglect, sexual abuse and emotional abuse. Physical abuse is most likely to occur when the parent is frustrated or angry and the injuries are frequently related to shaking and to unusually severe corporal punishment. Neglect is failure to provide for the basic needs of the child. It can be physical, such as not providing food, clothing or appropriate health care, educational, such as allowing chronic school truancy or emotional, such as not providing love and affection. Sexual abuse includes rape, incest, exhibitionism and commercial exploitation. This may be the most under-reported form of child maltreatment because of the secrecy that often accompanies the abuse. Emotional abuse includes extreme forms of punishment, constant belittling or rejection (Burns, Brady, Dunn & Starr, 2000).

Consequences

The consequences of maltreatment can be severe and long term. Maltreated infants often suffer from failure to thrive or experience attachment disorders. School age children are more likely to be aggressive toward their peers and perform poorly in school. As they get older maltreated children are more likely to suffer from depression, abuse alcohol and drugs and commit violent crime (English, 1998). Although maltreatment occurs in families of all income brackets, maltreatment is disproportionately found in large, single parent families living below the poverty level (Mohr & Tulman, 2000). Economically disadvantaged
children may also be exposed to other social toxins such as violent neighborhoods, substandard schools and illegal drugs. Children growing up in these environments are less likely to have healthy psychological and physical development, "yet in nursing they are an understudied population and a population for which few interventions have been developed and tested" (Mohr & Tulman, 2000 p. 59).

**Reporting Maltreatment**

In 1962 Dr. C. Henry Kempe and colleagues identified the phenomenon of "Battered Child Syndrome". Prior to this diagnosis, children with multiple fractures were given the diagnosis of "unrecognized trauma" (Kempe, 1962). Dr. Kempe was also greatly instrumental in the campaign for mandatory reporting of abuse by physicians (MD). At the request of the American Medical Association (AMA) the laws were expanded to include nurses, nurse practitioners (NP) social workers, teachers, counselors, and others (Kalichman, 1999). Filing a maltreatment report is a difficult step for most mandatory reporters, especially in cases of neglect where the maltreatment may not be clearly evident. The nurse, NP or MD may fear jeopardizing a relationship with the family or losing all contact with the child and family once the report is filed. The reporter also understands they will lose credibility if the report turns out to be unsubstantiated. The benefits to the child far out-weigh the risks. Once a report is filed the maltreating family may have access to services that previously were unavailable to them (Preis, Murphy & Tuttle, 2000). Mandatory reporting has been a positive step in the identification of maltreated children; however, to end the cycle of abuse,
prevention is necessary. Nursing, especially in the area of maternal-child is in a prime position to educate, intervene and prevent child maltreatment.

Prediction of Maltreating Caregivers

Twenty-two years ago the role of nursing in prevention of maltreatment was identified. Gray et al. (1979) conducted a study attempting to predict abnormal child rearing patterns. The investigators hoped that by accurately predicting abnormal child rearing patterns they would be in a "better position to initiate effective intervention before there has been significant damage" (p.128). Using interviews, a questionnaire and observations by labor and delivery nursing staff, participants were placed into high risk and low risk groups. The data gathered focused on the level of outside stress, parent coping mechanisms and family stability. Sample questions included in the survey were: Is the mother extremely depressed over the pregnancy?; Is there lack of support from the husband or father?; and Do the parents come from an abusive background?. The researchers found that a greater number of children in the high risk groups suffered from failure to thrive, had accidents that required medical attention and were more likely to have been reported to the Central Child Abuse Registry.

According to Gray, "nursing staff who work in the prenatal, labor and delivery area and postpartum units are ideally situated to make sensitive observations of a family's interactional behavior" (p.137). These assessments should be used to help guide interventions for families in need.

When studying high risk neighborhoods (Garbarino & Kostelny, 1992; Garbarino & Sherman, 1980) found that child maltreatment was not just a
symptom of individual family trouble but of neighborhood and community trouble as well. With research based on the theory of human ecology, the data indicates that among high risk mothers there is a decrease in social exchanges with the neighbors, underuse of formal support services, a higher incidence of major life crisis, and more neglect of the architecture of the neighborhood. “What emerges from the data is the conclusion that those who need the most tend to be clustered together in settings that must struggle to meet those needs” (Garbarino & Sherman, 1980 p.194). The researchers recommend a strong community focus with comprehensive sustained intervention in order to reverse “negative social momentum” and replace it with “positive momentum” Garbarino & Kostelny, 1992 p. 463)

The work by Gray, Garbarino, Kostelny and Sherman emphasize the need for a multidimensional approach to family nursing. If nursing is to prevent child maltreatment, we will have to identify at risk families early and work within the community to bring about change.

Strategies for Prevention

Currently a number of communities in the United States are utilizing home visitation as a means of improving the health and social functioning of families. It is hoped that frequent visits by registered nurses (RN's) or other mentors will educate new parents and assist them in developing appropriate child rearing skills. The purpose of this paper is to discuss the effectiveness of home visitation as a means of preventing child maltreatment as well as examining local home visitation programs.
Review of the Literature

Olds Model, Elmira Project

The Elmira project by Olds, Henderson, Chamberlin and Tatelbaum (1986) is the most often sited success story for home visitation. The researchers used a comprehensive nurse home visitation program "designed to prevent a wide range of childhood health and developmental problems including abuse and neglect" (Olds, et al. 1986 p. 66).

According to Olds et al. (1999), the study was grounded in "theories of human ecology, self-efficacy and human attachment" (p.47). The human ecology theory emphasizes the family and its intra and interdependence on its environment. The self-efficacy model suggests that "individuals choose those behaviors that they believe (1) will lead to a given outcome, and (2) they themselves can successfully carry out" (p. 48). This theory helps the visiting nurse understand how women make decisions regarding personal behavior, personal growth and the care of children. The attachment theory suggests that the degree of attachment the child feels toward its parent directly influences its ability to develop into a caring, responsive, empathic adult.

Utilizing a randomized clinical trial families were assigned to one of four treatment conditions. Those in treatment group one received no prenatal services from the research project. At ages one and two the children were screened for sensory and developmental problems. Families in the second treatment group were given free transportation for prenatal and well-child visits at
their local physician’s office. Their children were also screened for sensory and developmental problems. In treatment group three, in addition to screening and transportation a nurse visited the families every two weeks for an average of nine visits during pregnancy. Treatment group four received the same services as group three, however, the nurse visits continued until the child was two years of age. The study was conducted in rural New York, in a county of approximately 100,000 residents, with adequate health and social services as well as “consistently the highest rates of reported and confirmed cases of abuse and neglect in the state” (p.67). Women were recruited for the study if they met the following criteria: (1) less than age 19, (2) single parent status, and (3) low socioeconomic status. In order to heterogenize the program any woman who asked and who was bearing a first child was also allowed in the program. A total of 400 women were enrolled. Eighty five percent met a least one of the recruiting criteria and twenty three percent met all three. All non-white women were removed from the analysis because their sample size (46) was too small to cross-classify race.

Treatment groups one and two were combined when it was found they held no significant differences. Treatment groups one and two became known as the comparison group with treatment group three being labeled nurse-visited “pregnancy” and treatment group four labeled nurse visited “infancy”. Covariates for each group included age, education, marital status, maternal sense of control, husband or boyfriend support and socioeconomic status. Rates of child abuse and neglect were determined via interviews, review of medical records and
review of child abuse and neglect registries. "Reliability of the medical record review procedure was checked on a systematic and regular basis and found to be acceptable" (p. 68).

"During the first 2 years of the children's lives, 19% of the comparison group at greatest risk (poor, unmarried teens) and 4% of their nurse-visited counterparts had abused or neglected their children (p=.07)" (p. 71). As maternal sense of control declined, the incidence of maltreatment increased in the control group (p=.005), but in the nurse visited group, a "a decline in maternal sense of control did not lead to an increase in abuse and neglect" (p. 74). The nurse visited groups also had higher developmental quotients than the babies of their counterparts, provided their children with a larger number of appropriate play materials and made fewer trips to the emergency department for accidents and poisonings than the control group.

The authors discuss at length the need for caution when interpreting the findings. The nurse-visited women may have been "taught to give more socially desirable answers and to behave more appropriately in front of the interviewers" (Olds et al. 1986 p. 76). Because the analyzed population contained no non-white participants the findings cannot be generalized to all populations.

Fifteen years after the original study Olds et al returned to conduct a follow-up study. Three hundred twenty four of the original four hundred were interviewed and asked to complete a life-history calendar. The researchers also accessed child protective service records for incidents of abuse and the arrest and criminal conviction records of the mother. "The six covariates included in the final model
were maternal age, education, locus of control, husband or boyfriend support, mother's employment status and father's public-assistance status, all measured at registration" (Olds et al. 1997 p. 640). Looking specifically at the high risk group of low socioeconomic status (SES) unmarried women, Olds et al. found that the nurse visited infancy group had fewer subsequent pregnancies and greater spacing between first and second births (64.8 months Vs 37.3 months) when compared to the control group. They also had fewer arrests and convictions, were more likely to be employed, relied less on public assistance and had fewer substantiated reports of child maltreatment (0.11 vs 0.53 p<.001).

The Aid for Families with Dependent Children (AFDC) data were by self-report due to a number of lost or inaccessible records and the child abuse and neglect reports are from documented state records. When discussing the findings the researchers report that the costs of the program "from the standpoint of government spending, was recovered for low-SES families before the child reached four years of age" (p. 642).

**Olds Model, Memphis Project**

Seeking to replicate the Elmira results, Kitzman, et al (1997) tested the Olds model in an urban, (Memphis) primarily low-income unmarried African American population. As used previously in the Elmira study "the program protocols were based on theories of human ecology, human attachment and self efficacy"(p. 646). The authors "hypothesized that the program would produce outcomes similar to those in the original trial" (p.645). One thousand one hundred thirty nine unmarried low-income women with no known medical conditions and
experiencing their first pregnancy were recruited to the study. The participants were randomly assigned to one of the four treatment groups as explained in the Elmira project. "The nurses completed an average of seven home visits during pregnancy and 26 home visits during the first two years postpartum" (p. 646).

Following a detailed visit by visit protocol the nurses helped women improve their health-related behaviors and care of children. The protocols included drug and alcohol abuse and reduction of use, pregnancy complications, emotional care of children, signs of illness and child safety.

Prenatally, nurse visited women had fewer instances of pregnancy induced hypertension. They were also more likely to be using community services and to be employed (14% VS 8%). During the first two years of their lives "the nurse visited children were hospitalized at older ages and for substantially less serious reasons" (p. 649). Seven (54%) of the comparison group were hospitalized for fractures or head trauma, while none of the nurse-visited children were. The nurse visited mothers attempted breast-feeding more frequently than did women in the comparison group, although there were no differences in duration. "By the 24th month of the child’s life, in contrast to comparison-group counterparts, nurse-visited women held fewer beliefs about child-rearing associated with child abuse and neglect - lack of empathy, belief in physical punishment and unrealistic expectations for infants. Moreover, the homes of nurse-visited women were rated as more conductive to children’s development by utilizing the Home Observation for Measurement of the Environment scale" (p. 650).
Kitzman et al. (2000) returned to Memphis three years later for a follow-up study, looking specifically at maternal life course. Interviews were used to assess the participants educational achievements, number of months they participated in the workforce and number of months they were enrolled in public assistance from the child’s 24th to 54th months of life. Ninety one percent of the study members agreed to be interviewed. The researchers also accessed the Tennessee Department of Human Services records to obtain AFDC and food stamp information. These data were compared to the self report data with no significant differences found. “The nurse visited women had fewer subsequent pregnancies (1.15 VS 1.34)” (p.1987). They also had longer intervals between their first and second child, were enrolled in AFDC and food stamps for fewer months and had “partners who had been employed for longer durations” (p.1987). There were no significant program effects on maternal educational achievement, use of Medicaid or WIC, rates of spontaneous abortions or still births. This follow-up study did not specifically look at child maltreatment rates, however, the positive effects on maternal health, especially fewer subsequent pregnancies and longer spacing between pregnancies may improve the parents ability to become self sufficient. Further follow-up assessments of this study are planned.

Olds Model, Nurse Family Partnership

Evaluation of the Olds model is on going. Titled the “Nurse Family Partnership Program”, the model is currently operating in 150 communities nationwide. Oklahoma and Wyoming are operating the program statewide. The Nurse Family Partnership program is based at the National Center for Children,
Families and Communities (NCCFC), an interdisciplinary center located at the University of Colorado Health Sciences Center. The NCCFC provides training of staff, agency planning and evaluation services. In Washington, the program is titled "Best Beginnings" and is implemented in four counties: Snohomish, Chelan-Douglas, Seattle-King and Jefferson. The program is still in its early phase with no outcome data available; however, they have met their goal of enrolling 150 participants (NCCFC, 2001).

Hawaii Healthy Start

The success of the Elmira project has been partly responsible for a proliferation of home visitation programs. Another nationally recognized model of home visitation is Hawaii's Healthy Start Program (HSP). Originally piloted in a single community in 1985 the program now involves almost two-thirds the state. The HSP model was seen as a very promising strategy in the prevention of child maltreatment and in 1993 the National Committee to Prevent Child Abuse recommended establishment of similar home visitation programs. By 1997 programs were established in 38 states and the District of Columbia. The HSP model differs from the Olds model in a number of ways. Participants are identified via at risk assessments of newborns, therefore eliminating prenatal visits and the visitors are trained paraprofessionals rather than RN's. They also will visit any at risk family, without regard to the age of the mother or previous births. The goals are similar, "to improve family functioning, promote child health and development and prevent child abuse and neglect". (Duggan et al. 2000, p. 250).
The goal of this research was to assess the effectiveness of service delivery of the HSP program once taken to scale. Looking at data from six HSP sites in Hawaii (n=373) the researchers found attrition to be a large factor with only 50% of participants active after one year of service. They found that program acceptance was greatest among teenage mothers still in high school and among families of infants at biological risk. Unfortunately, mothers with a history of violence toward their partner, and thus with children at great risk for maltreatment were also most likely to receive less than 12 visits from the program. The researchers found little differences in reported incidences of child maltreatment after one year of intervention. They stress utilizing child protective service (CPS) reports as a measure of maltreatment can be misleading for two reasons: 1) reports of maltreatment are rare events and therefore extremely large sample sizes are needed for meaningful data. 2) Visited families are subject to increased surveillance, which may result in a maltreatment report bias. Also, CPS may be less likely to investigate an HSP family believing the family is already receiving intervention and reasoning their services can best be directed elsewhere. The researchers found after two years of intervention the HSP mothers reported greater use of nonviolent discipline, experienced less stress and believed themselves to be more competent in their parenting skills (Duggan et al. 1999).

A wide variation in referral rates to other agencies was also found among the program sites. This was attributed to at least four factors. Home visitors cannot refer to services that do not exist or are in short supply. The visitors were unwilling to refer to services of unknown quality. The visitor may not have the
skills to appropriately assess and identify needs and even with the visitors best efforts, the family may refuse service.

When compared to the Olds model, the researchers note the initial costs are less due to savings in paraprofessional salaries as compared to nurses. However, these savings were partially offset due to increased supervisory and training costs. The HSP model also allows inclusion of all at risk families regardless of previous births, whereas in the Olds model only first time mothers are included in the study. Additionally, the Olds model is run under small scale, tight research control, whereas, the HSP is full scale, state wide, with much less research control. Duggan et al. note that “paraprofessional home visiting has not been evaluated as extensively, but has been endorsed widely because of the potential, but untested advantages it offers” (Duggan et al. 2000 p. 257).

Home Visit Challenges

The Olds model demonstrates many positive outcomes when needy families are home visited. However, home visit programs have a number of challenges to overcome. Included in these obstacles are attrition, social stigma and adequate staffing.

Attrition

Gomby, Culross and Behrman (1999) compared six home visit models including the Olds model and Hawaii Healthy Start and identified challenges for the home visitor (RN or paraprofessional). A primary concern is attrition, with between 27-67% of families leaving the studies. The issue of attrition has been researched very little, but is thought to be the result of a number of different
factors. Letourneau, (2001) researched the issue of attrition among home visited first time adolescent mothers. In this pilot study (n=24), fifty percent of participants left prior to completion. Reasons for leaving included “not enough time” and lack of flexibility on the part of the nurse when scheduling visits. Those that remained in the program reported they found the program helpful, the material interesting, and appreciated having someone to talk to. Letourneau concludes that attrition rates may be reduced if “families believe that they are gaining something valuable from their ongoing participation” (p.186).

According to Peggy Hill, Deputy Director of NCCFC (e-mail correspondence, August 15,2001) the causes of attrition are variable, “ranging from welfare reform policies to movement of the migrant labor force to agency policies”. She emphasizes that agencies with a “three strikes you are out rule” meaning after three “no shows” the client is dropped from the program, are not applicable to a program that serves a high-risk population. Hill also stressed that attrition may be due to failure on the part of the nurse to develop a strong relationship with the family and adapt the program to both the needs and strengths of the family.

Social Stigma

The nurse/family relationship can be further complicated by social stigma. In Great Britain and Scandinavia home visitors exist on a national level, with nearly every delivery followed by a home visit. In America, only the “at risk” are visited and the family may not want the stigma that comes with the visitor, especially when the visitor is mandated by law to report any child abuse or neglect (Moffit 1997). One response to this issue would be to send a visitor to every new
parent. Unfortunately agencies involved in at risk families are struggling to meet budgets. Olds et al. (1999) cautions that universal visiting may cause dilution of services with the end result being the families most in need not receiving adequate services.

**Adequate Staffing**

Adequate staffing also impacts attrition and overall effectiveness of the program. The Memphis study experienced a 50% staff turnover rate due to a community wide nursing shortage. Olds and colleagues felt this may have been a factor in the limited results of the Memphis study when compared to Elmira (Gomby, Culross & Behrman, 1999). According to Peggy Hill (2001) the current nursing shortage has not impacted retention of nursing staff in current studies being run at the NCCFC. This is most likely due to the attractiveness of the work. Nurses unhappy with long hospital hours and heavy patient loads may find family nursing to be both satisfying and a challenge.

**RN or Paraprofessional**

**Effectiveness of RN**

The research by Olds indicates positive family outcomes when an RN is home visiting; however, little data are available demonstrating greater effectiveness when compared to paraprofessional visitors. Because labor is the most significant cost of a home visitor program, it is tempting to use less highly trained and thus less expensive workers. Preliminary results of a trial comparing program effects of home visitor paraprofessionals to home visitor RN's show the
turnover was higher among paraprofessional visitors. "Seventeen paraprofessionals were hired over the course of the study, whereas there was no turnover among the 10 nurses" (Olds, et al 1999, p.62). According to Gomby, Culross and Behrman (1999) "Home visitors must have the personal skills to establish rapport with families, the organizational skills to deliver the home visiting curriculum while still responding to family crises that may arise, the problem-solving skills to address issues that families present in the moment when they are presented, and the cognitive skills to do the paperwork that is required"(p.18). High staff turnover rates greatly affect the ability to establish rapport with a parent, and lesser trained staff may not have the problem solving abilities required to work with high risk families. Olds et al. (1999) explain that they chose to use RNs in the original studies because of the nurses formal training in women’s and children’s health and their ability to manage complex clinical situations. Nurses also have "increased credibility and persuasive power in the eyes of family members"(p.49).

Kearney, York and Deatrick (2000), agree that the visitor should be a professional nurse. "The skills found in effective home visiting, including relationship-building and therapeutic use of self and resources to promote family health and child development, are squarely within the province of professional nursing and less likely to be developed in lay community visitors or paraprofessionals" (p.375). The authors stress the importance of continued research comparing nurse and non-nurse delivery systems in order to gain support for effective nurse-delivered home visitation programs.
Role of Advanced Practice Nurse

The role of the advanced practice nurse (APN) in detecting and treating maltreated children has been well defined in the area of primary care; however, in the area of actual home visits the role is less clear. Kang, Barnard and Oshio (1994) investigated the role of the (APN) in home visitation of at risk and disabled young children. Although the findings were limited due to small sample size, the data show that the APN utilized the entire scope of their nursing practice including “planning treatment, referring to other services, giving information to parents and prescribing treatment to foster development” (p.383). The researchers stress the APN can be an effective adjunct to early intervention programs especially in rural areas.

Areas for Further Research

Clearly, continued research is needed to establish effective programs most notably finding solutions to high attrition rates. Programs with attrition rates of fifty percent cannot effectively address the problems of needy families and communities. Continued research is necessary to find solutions and approaches to address this complex problem. Secondly, continued research determining the effectiveness of nurse home visit programs is needed. If nursing is to take a leadership role in the care of needy children, families and communities, competent, effectual and cost effective service must be provided and documented through research. Lastly, continued investigation into successful community programs as well as successful methods of community collaboration is necessary. The multiple problems of at risk families will require multiple
interventions with an interdisciplinary and collaborative focus for nursing. If communities are to help needy families, a wide base of support programs will be required. As stated earlier, home visitors cannot refer to programs that do not exist. Nurse home visit programs will be of no help if additional family services such as day care, drug abuse rehabilitation, and educational assistance are not available and if these agencies do not collaborate to meet the needs of families.

Established Local Programs

Funding cuts over the past two decades severely decreased the home visit public health programs that were at one time a staple of many communities. In order to meet the needs of high risk families many communities have formed a patchwork or programs (Kearney, 2000). This patchwork of home visiting can be demonstrated by looking at programs available locally. These programs are not research based, however they give a glimpse of what is available on the local level. The visitors may be volunteers, trained paraprofessionals or professional RN's. While these local programs do not specifically state prevention of child maltreatment as a goal, each program does focus on improving maternal-child health, child development and parenting skills.

First Steps Program

Washington State First Steps program began in 1989 as part of the Maternity Care Access Act. Its purpose was to reduce maternal and infant illness and death and to increase access to maternity and infant care for low-income families. This program is jointly administered by the Department of Social
Services and the Department of Health and consists of interdisciplinary teams of OB and pediatric care providers, public health departments, nutritional support and chemical dependency treatment providers. The two primary programs of First Steps are Maternity Support Services (MSS) and Maternity Case Management (MCM) (1989 Maternity Care Access Act, 1999).

Maternity support services is available to all women eligible for Medicaid and provides support early in pregnancy via an interdisciplinary team of public health nurses, nutritionists, and social workers. With the combined services the women may receive up to ten visits during pregnancy and the following 2 months postpartum (Maternity Support Services, 1999). In the Longview-Kelso area, the public health department along with DSHS, Parents Place and the Family Health Center are responsible for providing the services. According to Sue Grinnell (PHN supervisor, personal communication, July 17, 2001) the limited number of visits can be problematic with each service vying for visits. If a public health nurse feels the mom needs nursing visits twice a month, it greatly decreases the number of times she can see a nutritionist or social worker. The patient may also develop a rapport with a staff member and refuse visits from other services. Because four different agencies provide service, proper communication and coordination of service can be a challenge.

Maternity Case management (MCM) is available for women who meet high-risk criteria, which includes age 17 or younger or drug or alcohol use. As long as the criteria are met, the patient can receive an additional 10 visits under MSS and receive case management services until the child is two years old. In the
Longview-Kelso area MCM is provided through the Family Health Center. The providers are paraprofessional caseworkers who have been trained in MCM case management. This includes identification of client needs and linking the client to appropriate services (Maternity Case Management, 1999). According to Lisa Loeb, program coordinator, case managers are required to see the patient monthly, but often see them more frequently (personal communication, July 17, 2001). According to Diane Tiffany, state program manager of MCM (personal communication, Oct. 8, 2001), the caseworkers develop specific goals and objectives for each client and success in meeting these goals is monitored by each individual agency. State wide goals of the MCM program include smoking cessation and a decreased repeat pregnancy rate.

Parents Place: Mentor of Mother Program

In an interview, Virginia Janke, of Parents Place in Longview, WA (June 27, 2001) discussed the Mentor of Mother program. The mentors are volunteers from the community, usually women with grown children. After two days of inservice helping them deal with the particular problems they may encounter, the mentors are partnered with a new mother. The mentors help guide the mother to proper health care and available community services. The goal is to have mentors visit at least one hour weekly, however they often spend much more time with the mother. The mentorship lasts from six months to two years. The mentors are recruited through word of mouth, radio and newspaper ads. The mothers are referred by physicians, the hospital or from other family members. The MOM program works hand in hand with First Steps MCM, giving intensive
visits to those at highest risk. According to Janke, evaluation of the program has been difficult due to the varying needs and circumstances of the mothers. Some mothers have few needs and only want a mentor for occasional advice, others need intensive guidance in all areas of child care.

**Progress Center**

The Progress Center provides evaluation and education to children with special needs from birth to age three. The center provides neurodevelopmental therapy, communication therapy, education and family support services. One aspect of the family support service is the Outreach Program. Participants of this program are visited at the hospital by an outreach staff person. They are given information on child development, infant safety, and medical support. This visit is followed-up by an at home visit where the information is reviewed and questions are answered. If all is well, continued follow-up is done via the Tracking Learning Children (TLC) program which sends out monthly questionnaires to parents. If the responses indicate concern, the child is formally evaluated by trained Progress Center staff and referred to appropriate services (personal communication, Kristine Langley, June 6, 2001).

**Lower Columbia College Home Intervention**

The Progress Center works hand in hand with Lower Columbia College (LCC) Home Intervention Program. If the screening process indicates further home visits are necessary, LCC home intervention takes over for weekly visits. LCC Home Intervention is designed specifically for parents experiencing extreme poverty, substance abuse, have a history of domestic violence, teen parent, or
large numbers of children in the home. As an adjunct of the Home and Family life program at LCC, the Home Intervention program is designed to allow visits to at risk families who may otherwise fall through the cracks. According to program director Diane Bagley, (personal communication, July 19, 2001) the visitors help with everything from teaching appropriate parenting skills to assisting in cleaning the home. Referrals have come from the Progress Center, physicians, and Head Start. The director, Diane Bagley and an assistant staff person are responsible for making all the visits. They are also responsible for evaluating and referring clients to additional appropriate services.

Community Need

The need for community services in the Longview-Kelso area is great. Poverty rates are high with 18% of all children living below the poverty line. Arrests for drug and alcohol use are twice the state average, as is the general arrest rate for young adults. In the year 2000 the Kelso Department of Child and Family Services (DCFS) had 172 dependency hearings (recommending a child be removed from the home due to extreme maltreatment) which was a 50% increase from the previous year (Kelso DCFS, Child Protective Service Program, 2001). The poverty rates along with the high maltreatment rates indicate a need for further, intense intervention. Because outcome data of the present programs are limited, it is difficult to determine their effectiveness. Additionally, of the available programs in Longview-Kelso only one, Maternity Support Services, utilizes RN's for care delivery, and only for 10 visits. The Olds model has demonstrated the positive effects of a nurse delivered program in prevention of
child maltreatment and at the same time proving to be cost effective. Adding a nurse delivered home visitation program following the Olds model to the existing mix of programs could be an asset to the community and may improve child maltreatment statistics.

Conclusion

It is important to remember the issue of child maltreatment will not be easily remedied. There is no silver bullet and one program will not solve years of entrenched human behavior. We know how difficult it is to change behavior even when the individual desires change. It’s far more difficult to change behavior in an individual who does not believe they need changing. "When mothers see all the children in their neighborhoods at about the same developmental level as their own children, when they see their relatives rearing their children the same way they do, and when they see their neighbors struggling with the same work, husband, boyfriend and money issues they have, they may not see the need or have the motivation to change." (Gomby Culross, & Behrman, 1999 p.23) In order to break the cycle we need to offer sound, well supported child and family programs including day care, educational assistance, drug treatment, and parenting classes.

Child maltreatment prevention has often been thought of as a role for social workers and Child Protective Services (CPS). However, these agencies do not get involved until after maltreatment has occurred and a report has been filed. Nurses have the education, credibility and evidence supporting their role in child
maltreatment prevention. Working within each individual home, RN's and APN's can help build healthy families which in turn will build healthy communities. Twenty-two years ago Gray stated "Families identified as being in need of extra services must have access to intensive, continuous supportive intervention. It makes little sense to provide excellent prenatal, obstetrical and neonatal pediatric care in our hospitals, only to abandon the most needy young families at the hospital door" (1979,p. 38). What was true then is still true today.
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