Universal Home Visiting: A Recommendation from the U.S. Advisory Board on Child Abuse and Neglect

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Abstract

In 1991, the U.S. Advisory Board on Child Abuse and Neglect recommended that the federal government immediately begin phasing in a national universal home visiting program for children during the neonatal period. The Board believes that such home visiting can be an effective strategy in preventing child abuse and neglect.

In this article, Dr. Richard Krugman, chairman of the U.S. Advisory Board at the time, describes the development of this recommendation. As his article illustrates, initiatives for home visiting programs are often the result of a mix of political and social considerations and judgments, as well as knowledge gained from the experience and evaluation of such programs.

This article describes the deliberations of the U.S. Advisory Board on Child Abuse and Neglect leading to its September 1991 recommendation for universal home visiting. The Board was created by the 1988 Amendments to the Child Abuse Prevention and Treatment Act (CAPTA). The mission of the Board is to evaluate the nation’s efforts to accomplish the purposes of CAPTA and to make recommendations to the Secretary of Health and Human Services and the Congress on ways in which those efforts can be improved. The Board is a 15-member, multidisciplinary group with professional and lay members from public and private sectors.

In September 1991, the Board issued its second report. Among its recommendations was one calling for the federal government to implement a dramatic new initiative to phase in universal voluntary neonatal home visiting in the United States. This paper explores the development of that recommendation and discusses whether the Board’s approach has a future.

The Context for the Recommendation

To understand the Board’s recommendation for home visiting expansion, it is necessary to put that recommendation into the context of the history of the Board and its first two reports. When the Board had its first meeting in 1988, the Secretary
of Health and Human Services (HHS), Louis Sullivan, M.D., implored the Board not to be constrained by a narrow focus, but to advise him on what he and the new administration could do to reduce the toll of child maltreatment. The Board took this charge seriously and set about the task of developing major recommendations.

The sense of urgency felt by the Board was further heightened by news stories in 1988 that provoked a public outcry to “do something” about child abuse. Many of these stories focused on children who had died of abuse. These children were often known to the child protection system; some even had pending cases with protective service agencies. Adam Mann, Eli Creekmore, Michael Manning, Lisa Steinberg—their faces appeared on PBS; their stories were retold in newspapers across the country. The New York Times, Washington Post, Denver Post, Atlanta Constitution, and Miami Herald did stories about the failure of child protective services (CPS) to keep children safe.

At the same time, many other articles appeared in the media attacking child protective services for “gestapo-like tactics” in removing children from their homes precipitously. Dozens of false allegations of sexual abuse came into public view, and both the U.S. Congress and state legislatures were urged to curtail the activities of child protective service agencies. The situation was summarized by one CPS director who said, “We’re damned if we do and we’re damned if we don’t.”

After deliberating for a year, the Board issued its first report in June 1990. Taking a carefully crafted “no fault” approach, the Board declared the state of the child protection system in the United States “a national emergency.” The report traced the developments in child protection from Kempe’s 1962 “Battered Child Syndrome” paper (where it was estimated that there were 749 cases of abuse in the United States) to the 1989 estimate of 2.4 million reports, representing more than one million substantiated cases. The report pointed out that, with so many cases, the CPS system was overwhelmed, underfunded, and understaffed with undertrained and undersupported workers. The system was investigating reports but not treating children or families; prevention programs were sporadic at best. Further, the Board estimated that billions of dollars were being spent in health, corrections, education, and other services necessitated by the nation’s failure to prevent and treat child abuse and neglect adequately.

The Board’s first report, while global in nature, had 31 specific recommendations, generally urging increased recognition of the problem of child abuse and heightened resolve in making its solution one of the next decade’s priorities. The Board called for better data about child abuse, more emphasis on the generation and dissemination of knowledge, improved services, better training and support for CPS workers, and research about the current costs to our society of child abuse and the failure to prevent it. The Board also considered the present child protection system untenable and called for its replacement with “a new national comprehensive, child-centered, neighborhood-based child protection strategy.”

In September 1990, Secretary Sullivan accepted the report and, in response, launched an initiative on child abuse. This initiative took 15 months to get under way. It consisted of 11 conferences (one national, 10 regional), a memorandum of understanding among cabinet secretaries which pledged cooperation and collaboration among relevant agencies within their jurisdiction, and Secretary Sullivan’s promise to talk about child abuse in his speeches. Congress was laudatory about the report and held hearings to prepare for amendments to CAPTA. Ultimately, however, the momentum was lost before any major changes were accomplished. Indeed, the legislative amendments to CAPTA in 1990-1991 involved no more than minor tinkering with the child welfare system.
The Recommendation

In September 1991, the Board released its second report, entitled, “Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Neglect.” In response to criticism that the first report was too broad, the Board acceded to congressional staff who wanted “something concrete, something we can write into legislation.” The second report offered 29 recommendations, all of which involved changes the federal government could make to lay the foundation for a new comprehensive child protection system. The recommendations fell into six specific areas: development and implementation of a national child protection policy (none is stated anywhere in federal or state statute); prevention and reduction of maltreatment by strengthening neighborhoods and families; provision of a new focus on child maltreatment in all relevant federal agencies; enhancement of federal efforts related to the generation, application, and dissemination of knowledge; and improvement in coordination among federal, state, tribal, and probate child protection efforts. Most important, the Board recommended a new federal initiative aimed at preventing child maltreatment: to begin immediately to phase in a universal voluntary neonatal home visiting system. The first step in this initiative would be funding a large series of coordinated pilot projects. The Board gave this recommendation for a home visiting system top priority over all other recommendations. It was supported by all 15 Board members.

As often occurs in policy development, the awareness of a notorious case triggered the Board’s interest in home visiting. The case, detailed in the report, concerned an infant who had been admitted to a Denver hospital earlier in the year. This baby had been born three months prematurely, had a lengthy, costly neonatal intensive care unit stay, was flagged as high risk by the nursing staff because the teenage parents fought with each other the few times they came to the nursery, but was sent home without CPS involvement because “nothing had happened yet.” Three weeks after going home, the baby was violently shaken by the father and readmitted with subdural hemorrhages, retinal hemorrhages, and several fractures. The infant lived but will be developmentally disabled and blind. The cost of the second hospitalization was $75,000; the cost of long-term care for the child will be at least $20,000 a year.

While recognizing that home visiting is not likely to prevent all potential abuse, the Board felt that, in cases such as this one, a home visitor might have prevented the incident. For example, a relative testified in court that the baby had been hit on the head by the father at 10 days of age leaving bruises, and no one had reported the incident. A home visitor might well have noted the bruises early or, perhaps, have helped the mother and relatives better protect the baby from the father.

The Board’s recommendation for home visiting, however, was shaped by more than this intuitive sense that a visitor to the home could, in many instances, identify and act upon risks for abuse. The Board and its staff consulted with Dr. David Olds about his research findings regarding home visiting. The Board also spoke with people who operated home visiting programs in Hawaii and elsewhere. (See Appendix, page 206, for description of Hawaii’s Healthy Start Program.)

Overall, the Board was encouraged by what it heard. As summarized by Olds in
his article in this journal issue, one formal evaluation has shown that home visiting can lead to at least a short-term reduction for poor, unmarried teens in the rates of state-verified cases of child abuse and neglect. In addition, in two studies, home visiting resulted in significant changes in children’s encounters with the health care system, such as hospitalization for serious injury—changes that are consistent with a decreasing need for services as a result of decreasing levels of malpractice. (See the article by Olds and Kitzman in this journal issue.)

In adopting its home visiting recommendation, the Board did not wish to oversell home visiting. The Board was aware that several studies also showed no effect from home visiting on child abuse (see the article by Olds and Kitzman in this journal issue). The Board was also aware that Olds found some evidence for mild increases in conflict when home visitors entered well-functioning middle class families. This latter effect, however, the Board felt would be mitigated by the voluntary nature of the program.

All in all, the Board’s recommendation was based on several considerations. Research results were promising; providers of home visiting services around the county were . . . optimistic about their effectiveness; and Board members believed intuitively that home visiting makes good sense.

Policy Options

Universal versus Targeted

Having opted to recommend home visiting, the Board debated several policy options. The first was whether the approach should be universal or targeted. Although aware that most of the programs showing reductions in abuse and neglect targeted high-risk populations, the Board felt it was important to offer home visiting services on a universal basis. The major reasons for this decision were as follows:

1. A universal approach avoids stigmatization. There was the feeling by some Board members that, unless home visiting was perceived by the public as “mainstream, necessary and for everyone,” it would fail. In fact, several hundred home visitor programs to prevent child abuse were federally funded in the late 1970s. Nearly all died after the 1981-82 budget reductions. Many Board members perceived this history as evidence that, unlike Head Start, programs for those at risk of physical abuse were not considered mainstream and, therefore, were not worthy of funding. Further, the Board expected that a universal program could still target some subgroups for special focus and more intensive services.

2. The literature supports other health, educational, and welfare benefits of home visiting besides reduction of child maltreatment. (See the article by Olds and Kitzman in this journal issue.) In the Board’s view, all young families could benefit from some good help with a new baby.

David Olds and other advisors cautioned the Board that a universal approach might be too expensive to be practical. However, the Board was aware of models that used unpaid volunteers exclusively or used volunteers for low-risk families and paid professionals to serve high-risk families. The Board believed that this approach should, in many instances, be less costly than using professionals to visit everyone. In addition, the Board anticipated that routine visits to newborns at least once after birth would be increasingly funded by private and public sources as the length of stay in hospitals postpartum dropped below 24 hours. These visits, generally covered as part of a health plan and/or hospital risk management effort, could identify which families need professional (high-risk) or volunteer (low-risk) support, thereby making more appropriate use of the higher-paid professionals.

Voluntary versus Mandatory

The Board also considered whether the national home visiting program should be voluntary or mandatory. With little discussion, the Board agreed home visiting should be voluntary for the following reasons:

1. No one believed that acceptance of mandatory home visiting was likely in the United States. Because some of the pilot
programs would probably have federal support, the sense that “Big Brother” was coming into people’s homes was already real to some people and the program might become completely unacceptable if it were a mandatory federal (or state) intervention.

The Board agreed that the overriding goal of the proposed national home visiting program was to ensure that someone would always be available to the family.

2. A voluntary approach fit more comfortably with the Board’s evolving idea of a child-centered, family-focused, neighborhood-based, child protection strategy.

3. A voluntary approach might create an atmosphere in which new parents who received services would later become volunteer home visitors in their own neighborhoods.

Duration and Frequency of Visits
The third policy option discussed by the Board concerned the length of time during which visits should be provided. From the perspective of child abuse prevention, the important time period is the first two years of a child’s life. Two-thirds of the mortality and much of the morbidity of physical abuse occur during this period. Most of the home visiting programs run for one year. For example, in the Denver Community Caring Program (a home visiting program using volunteers for low-risk families and paid paraprofessionals for high-risk parents), the need for home visitor support wanes for low-risk families by eight months and often ends formally at one year. Informal links among volunteers and families often continue. High-risk families may need home visits for more than a year, at least until children are enrolled in preschool or Head Start, and sometimes later. Thus, by recommending neonatal home visiting, the Board set a minimum standard for home visiting: weekly visits during the first month of a baby’s life and, for some families, daily contact. It was the Board’s assumption, however, that visiting would, in many instances, continue substantially longer than the neonatal period.

Staffing
Research literature does not yet answer the question of whether home visiting should be done by professionals or paraprofessionals. Many of the formally evaluated programs have used professionals, especially public health nurses, as home visitors. (See the article by Olds and Kitzman in this journal issue.) However, many private nonprofit agencies throughout the United States—some of whom are affiliated with the National Committee for the Prevention of Child Abuse (NCPCA) or the National Parent Aide Association (NPAA)—provide home visiting services using paraprofessionals. The question of the benefits of professional versus paraprofessional visitors is currently being investigated by Olds in a study in Denver. (See the articles by Olds and Kitzman and by Wasik in this journal issue.)

For reasons primarily of cost, the Board believed that, at this time, programs should use a mix of professional and paraprofessional visitors. The Board expressed no preference about whether professionals should come from the public or private sectors except that, if the public sector were involved in the pilot programs, the Board believed these programs should be based in public health departments, not child protective services. The reason for this belief was that public health nurses still have a generally positive reputation in communities as “helpers,” whereas child welfare and even mental health professionals are often not seen positively. This point was exemplified when the Rocky Mountain News editorialized after the second report was released that the Board had gone too far in violating the privacy of families when it suggested that “social workers” be sent into homes of every new parent. This misreading of the recommendation was not uncommon and reflects the mistrust society now has of child welfare.

A related issue was whether home visitors should be salaried professionals or unpaid volunteers. Both approaches have advantages and disadvantages. The potential gain in cost-effectiveness in programs using volunteers may be outweighed by turnover and lack of continuity. In addition, volunteers may “get in over their heads” with high-risk families. On the other hand, a disadvantage of professionals such as public health nurses is their relatively high salary. In addition, the Board was concerned that most public health agencies are evolving into home health agencies driven by insurance reimbursement. As discussed above, in the Board’s vision, a universal
voluntary system of home visiting needs both paid (for high-risk) and volunteer (for low-risk) visitors.

Purpose of Visit
A critical issue also discussed by the Board was the purpose of the home visit. Is it to prevent something bad (child abuse) or to enhance something good (positive family interaction)? In keeping with its overall strategy for child abuse prevention, the Board agreed that the main thrust of any universal voluntary home visiting program should be to provide services to enhance family interactions.

In fact, as the Board reviewed home visiting program models throughout the United States and the world, it was clear that home visitors filled many roles. Some were health oriented; others were focused on parent education and child development; and others were targeted toward child abuse prevention. In reality, no single model and no single type of home visitor—parent interaction is likely to meet all the needs of parents over time. Parental needs for health and education advice or for emotional support or respite in times of stress are unpredictable. The Board agreed that the overriding goal of the proposed national home visiting program was to ensure that someone would always be available to the family so that it would be as easy for a parent to pick up the telephone and get help before abusing a child as it is now for a neighbor or professional to pick up the telephone and report a case of maltreatment after it happens.

Options for Action
With these policy issues in mind, the Board decided specifically to recommend that the federal government begin planning for the sequential implementation of a universal voluntary neonatal home visitation system. The first step in this planning process would be to fund a series of coordinated pilot projects. The purpose of these projects would be to provide information the federal government would need to establish and administer a system. Although the Board believed that there was already sufficient information to show home visiting as an effective strategy in preventing child abuse, at least in some instances, it also believed that more information was needed about the costs of these programs, the level of program intensity required by families presenting various levels of risk, the optimal size of programs, staffing needs, training requirements, and differences in program design necessitated by various population groups and geographic locations.

The Board envisioned a series of up to 10 projects which would involve entire communities, counties, or states. Staffing in these pilots would be varied, involving public/private, professional/paraprofessional, volunteer/paid. All pilots would build on existing smaller programs. The Board estimated that programs could reach 500 high-risk families for every $1,000,000 in direct costs when using paid visitors and serve 5,000 low-risk families per every $1,000,000 in direct costs when using volunteers. If these estimates are accurate, in Colorado, with approximately 50,000 births annually and approximately 10% high-risk families (defined according to Gray and colleagues’), a statewide program might cost $18 million annually if it reached all infants. Ten million dollars annually would be spent to reach the 5,000 high-risk families, and $8 million would be spent for program costs coordinating volunteers in reaching the 40,000 low-risk families. If only 25% of low-risk families were served, the cost would drop to $12.5 million. Some of this cost could be offset by savings in government expenditures. As Olds has shown, up to 60% of the costs of a public health nurse home visitor to certain high-risk families are saved in reduced Aid to Families with Dependent Children and Medicaid costs. (See the article by Olds and Kitzman in this journal issue.)

Finally, the Board suggested five Options for Action by the Secretary of HHS and/or Congress to implement this recommendation. The Secretary of HHS could do the following:

1. Direct the Administration for Children, Youth and Families (ACYF), the Public Health Service (PHS), and the Health Care Financing Administration (HCFA) to launch the pilot projects. Possible
sources of funding might be the National Center on Child Abuse and Neglect (NCCAN) Demonstration Grants program, the Maternal and Child Health (MCH) Block Grant program, and the Medicaid program.

2. Direct appropriate components of HHS, in collaboration with American Council to Improve Our Neighborhoods (ACTION) and the Points of Light Foundation, to stimulate the development of volunteer programs.

3. Direct appropriate components of the Department, in collaboration with the American Academy of Pediatrics and the National Child Abuse Coalition to attempt to persuade insurers, including those serving federal employees, to cover the costs of home visiting.

4. Direct the Assistant Secretary for Health to ensure that home visiting services are provided through the health care programs of the Indian Health Service.

5. Direct the Assistant Secretary for Health to attempt to persuade the Department of Defense to provide home visiting services to military families.

The Board urged that Congress use the next (1992) CAPTA reauthorization to authorize the sequential implementation of home visiting programs and to require the Secretary to take the above actions if the Secretary had not done so. The Board strongly believed that federal involvement was crucial both to launch and to evaluate the pilot programs.

The Response from Public and Private Sectors

The response from HHS varied by division but was nowhere positive. Secretary Sullivan never publicly discussed the home visiting recommendation. No directives went forth. In fact, most of the response from the National Center on Child Abuse and Neglect within HHS was that the recommendation was too prescriptive and unrealistic in that the Board had no authority to decide upon such a major recommendation and that the recommendation was much too costly in tough budget times.

Congress was equally disappointing in its response. While a year earlier many members of Congress had been enthusiastic about the Board’s first report and had urged the Board to “give us something specific,” the 1992 CAPTA reauthorization passed without authorization for home visiting pilots (or any other substantive measures). Congress did incorporate a $30 million home visiting initiative in the Children of Substance Abusers Act. Although no appropriation has been made for that program as yet, an RFP has gone out from MCH to fund some pilots (Appendix, page 214). Thus, the 18-year pattern of tinkering with CAPTA and passing cosmetic changes to assuage the public and trumpet passage of a child abuse bill continued.

In contrast to the Washington response, several groups in the field, such as the National Committee for the Prevention of Child Abuse (NCPCA) and the National Parent Aide Association, were ecstatic about the recommendation. These organizations were already involved in encouraging the development or maintenance of home visiting services, and the national recognition was a boost to their efforts. As a result of the Board recommendation, NCPCA was able to obtain a $1,000,000 grant from the Ronald McDonald Foundation to launch Healthy Families America, which has as its goal replicating in other states the Hawaii Healthy Start home visiting program. This effort is well under way with an evaluation component in place. (See Appendix, page 207, and the article by Powell in this journal issue.)

The Board’s 1993 report, to be released in late 1993, describes in detail the Board’s vision of what a new comprehensive, child-centered, family-focused, and neighborhood-based child protection strategy should look like. Home visiting must be a part of that strategy. Whether the new administration will be responsive remains to be seen. Louis Sullivan was the only Secretary of HHS in the past 18 years to speak publicly about the problem of child abuse. Although his initiative suffered from a failure to thrive in many ways, it gave more visibility at
the federal level to this issue than ever given before, regardless of the political party in power.

**Conclusion**

Now is the time to implement home visiting programs. The need for effective strategies to address child abuse is greater than ever. If and when the new administration implements home visiting, it should be flexible rather than prescriptive on such matters as how home visiting programs should be run, who should be on their boards, who should be selected, and what their training should be.

During the development of a national home visiting strategy, additional information must be gathered about how best to meet the needs of the children and parents served through home visiting; no single model should be chosen as the starting point. It is essential to explore combinations of volunteer and paid visitors for low- and high-risk families. If neighborhoods, religious organizations, corporations, hospitals, and other large groups that have access to families can be induced to develop voluntary home visitor networks, many goals would be accomplished. Home visiting would be destigmatized, professionals would be freed to work with higher-risk families, and by the end of the decade in some of the pilot programs, one might begin to see a reduction in the incidence of child abuse. That, in fact, is the priority goal, and efforts toward achieving it must get under way now.

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3. The Board spoke with Ray Helfer, M.D., about perinatal coaching programs in Michigan; Gail Breakey, R.N., and Betsy Pratt about the Hawaii Healthy Start Program; and Susan Hiatt, Ph.D., and Sally Holloway, M.S.W., about the Community Caring and Family Focus direct home visitor programs in Denver, which are staffed by volunteers.


7. This estimate assumes 25 visitors at an annual salary of $25,000 serving 20 families per year, plus $375,000 in program costs. These visitors would be lay therapists. The costs would be higher if public health nurses were used.

8. Low-risk families are served by volunteers who receive no salary, but training and organizational costs are estimated at $50 per volunteer. This estimate assumes 2,000 volunteers serving 2.5 low-risk families each year.
