Home Visiting: *Promise and Peril*

by Jon Korfmacher, Ph.D.

In the United States, a popular form of intervention for young children at risk and their families is the "home visiting approach." As the name implies, the family receives assistance or support by a service provider not in an office or center, but in the family's home. Such support is designed to promote child health and development, improve parenting practices, and facilitate positive parent-child relationships. It also may attempt to improve the life course of parents themselves, such as in education, employment, and use of public welfare. It is unclear exactly how many families are being served by such an approach. A review of six popular home visiting programs in the United States estimated that

half a million families were enrolled in these programs alone (Gomby, Culross, & Behrman, 1999).

At the same time, the field of early childhood intervention is currently in a period of intense consternation over the issue of home visiting. Much of the consternation is due to this recent review by Gomby and colleagues (1999) of research of the major home visiting programs, which is fairly critical about their potential. The authors state that:

> Home visiting is a fragile intervention, dependent upon other community agencies for any success in case management, and dependent upon parents for any success with children. Home visiting programs struggle to change individual behavior and have limited success. (pg. 23).

The problem with such a generalization, one that the authors readily admit, is that there really is no such thing as a "home visiting approach." Home visiting is a place of service delivery, not a singular technique. There is no one way of delivering one type of service in the home, and the programs that are part of the review differ among many dimensions, from the professional identity of the visitor to the types of families served to the protocol to the outcomes targeted. Nevertheless, the authors do feel confident in summarizing the results of the reviewed programs:

> In most of the studies described, programs struggled to enroll, engage, and retain families. When program benefits were demonstrated, they usually accrued only to a subset of families originally enrolled in the programs, they rarely occurred for all of a program's goals, and the benefits were often quite modest in magnitude. (pg. 6).

It is not hard to believe that summary statements like this about a number of highly-regarded, well-studied programs will affect beliefs about the state of "home visiting" in the United States. In the following

pages I will provide an overview of the controversies of home visiting programs in the United States. I will focus in particular on a nurse home visiting program for first-time, low-income families developed and studied by David Olds and colleagues. I do this both because it is arguably the best-researched program that currently exists and because—in the interest of full disclosure—I have been involved as a member of the research team that has evaluated it.

A Non-System of Services

Home visiting emerged not from a particular profession or field, but as a response to a vexing service dilemma that afflicted many different fields: How does one assist families who, for whatever reason, do not make it to the center, office, or clinic where services are delivered? Families may lack transportation. Or they may be so chronically disorganized that they cannot pull themselves together to seek out important services. Or the services themselves may be so chronically disorganized that there is no obvious point of entry. Or families may distrust the system and not be willing to jump through bureaucratic hoops necessary to get assistance.

The simple and elegant solution (in theory) was to bring the services to the families instead. To meet them more than halfway, to reach out with a caring and supportive provider who would make the effort to connect families with what they need in the comfort and privacy of their own home. This is not a new concept, as home visiting has existed in different forms since the late 1800's (Weiss, 1993). Nor is it a concept unique to the United States, in that many other countries (e.g., Kamerman & Kahn, 1993; Bekman, 1998) have some form of services to families of young children

provided in the home.

Such a means of service provision is used by a multitude of professions. Support for young children and their families is fractured in the United States. There is no one place or one type of intervention. Nor is it mandated or available for all families. This is one primary way that home visiting in the US is different from home visiting in many European countries, where such an intervention exists within a system of universal care and services for families (Kamerman & Kahn, 1993).

Home visiting also may mean health or nursing services to medically fragile infants, family preservation services for families with active child maltreatment, various early intervention services for children showing developmental delay, or infant mental health services for cases where there is an identified problem in the parent-child dyad. It may also mean preventative services to statistically "at-risk" families of young children, risk being defined singularly or in combination by income, parent age, birth experience and outcome, first-time parenting, parent history of mental illness or substance use, or a number of other factors (it is these latter, preventative, models that were the focus of the recent review).

Home visiting may involve a one-visit newborn follow-up by a nurse after the family leaves the hospital, or it may involve a steady relationship with a home visitor that lasts years. Theories of change will also differ from program to program. Some models emphasize the simple transmission of information about a child's health and development, parenting practices, or services available in the community. Other models may work more directly with the child, modeling what the parent can do with the child

between visits. Still other models focus on the relationship that develops between visitor and caregiver, providing emotional support, a new model of relating, or regulation and organization to the parent that creates a corrective experience that ultimately benefits the relationship between parent and child. It is common for programs to mix a variety of approaches, so that visits may be more individualized to the needs of particular families.

Challenges of Home Visits

Although the idea of visiting families in the home who would otherwise not receive services may be intuitively appealing, this mode of service has turned out to be anything but simple. There are many challenges to conducting home visiting effectively (see Kitzman, Cole, Yoos, & Olds, 1997; Hiatt, Sampson, & Baird, 1997; Musick & Stott, 1990; Bryant, Lyons, & Wasik, 1990). The reasons often boil down to these:
1) Home visiting removes the veneer or status of professionalism since there is not a professional office or work environment where services take place;
2) Families may not see offers for help as helpful, but rather as an intrusion on their privacy and a way for the government to monitor their household activities;
3) Families have difficulty accommodating home visitors into a schedule filled with competing demands from work, school, family, and friends.
4) Adding travel time will reduce the daily caseload of each interventionist compared to a center-based program;
5) Supervision and quality control may be harder with home visiting. It may feel more private to the home

visitor and family, so that sharing experiences with a supervisor becomes more difficult;
6) Household distractions, such as the television, the telephone, and other family members, compete for the caregiver's attention during visits;
7) Welfare reform is increasingly forcing mothers out of the house during prime hours that home visitors work;
8) Safety issues impact visits when they occur in dangerous neighborhoods;
9) Difficult-to-engage families, a main target for home visiting programs, are so classified because they are very difficult to work with, so that any positive outcomes seen will likely be attenuated;
10) The combination of difficult families, stressful working conditions, and low pay leads to frequent staff turn-over in many programs.

Despite these challenges, home visiting remains a very popular mechanism for service delivery, both practically and idealistically. Practically, home visiting may be the only way of providing services to some families. Idealistically, it seems a noble effort to help families who may start out resistant but ultimately be appreciative and value the outreach. Unfortunately, well-intentioned and idealized inclinations of "rescuing" families from difficult circumstances (internal and external) often are not realized under objective randomized trials that are empirically rigorous, as Gomby and colleagues ultimately concluded.

Reviewing six prevention programs, five of which were subjected to randomized trials[1], one can see that they were not overwhelmingly and universally successful in facilitating child development, reducing child

maltreatment, improving the situation of families, or promoting secure relationships between parents and children. All of the programs did find some positive effects, for at least some of the families, at some of the sites. Overall, however, the reader may feel that the results from these studies are not consistent enough nor of sufficient magnitude to arouse much optimism for these models.

But are these home visiting programs really ineffective? Randomized trials, although often considered a "gold standard" for evaluating interventions, provide conservative estimates of program effects. For example, an "unsuccessful" randomized trial of a large-scale home visiting case management initiative, the Comprehensive Child Development Program (CCDP; St. Pierre, Layzer, Goodson, & Bernstein, 1997; St. Pierre & Layzer, 1999) showed that families with a home visitor were no different after 5 years from a group of families who received typical community services. Both groups, however, showed improvement over time in child language and achievement scores, maternal employment, welfare use, and depression. Instead of being simply ineffective (see Gomby et al., 1999, p. 19), it may be that the CCDP was not more effective in bringing about the measured outcomes than typical community services. The nature of a randomized trial, however, does not allow for a good examination of this issue. By default, the lack of differences between the treatment and control group leads to the conclusion that the treatment was not useful.

I am not advocating for the elimination of randomized trials in home visiting research, but simply that they be seen as only one evaluation tool. Randomized trials are an important source of information about the value of an intervention, but they by

themselves cannot determine that value. Other forms of data—qualitative, clinical, quasi-experimental—also inform public and professional opinion. They are subject to different forms of confounds and bias than randomized trials, but if used carefully, reasonable (even if not absolute) conclusions can be drawn about a program's value and effectiveness. As Halpern (1984) has noted, many case studies exist that suggest home visiting programs can offer valuable support to some of the vulnerable families they serve.

Differential Response in Home Visiting

Rather than assuming these programs to be monolithic entities, with everybody receiving the same "dose" of services and responding (or not responding) in the same way, there is increasing acknowledgment of multiple pathways for families in programs. Families will respond in different ways to different aspects of the program. Although it is a cliché to talk about a "paradigm shift" in home visiting research, there is a movement developing to change the nature of the question of examinations of home visiting programs and other aspects of early childhood intervention (Emde, Korfmacher, & Kubicek, in press). Instead of asking "Does it work?" (the primary question of randomized trials), researchers and evaluators are increasingly more likely to ask "How does it work, for whom, under what circumstances?"

This involves more complicated analyses, examining factors within participants, factors within the programs themselves, factors within the larger ecosystem where families and programs operate, and the gray area where client, program, and contextual factors intersect, in order to

understand the differential response families show to home visiting programs. Some of this research can be done within randomized trials, where different types of families may be randomly assigned to different levels of program implementation. But much of it can only be done through intensive study of individual cases, so that we can begin to understand the experience of families with home visiting services and the meaning and value families place (or do not place) on these services. These studies will be "messy": exploratory and filled with possible confounds and biases. Trying to understand the ebb and flow of an intervention program can at times seem akin to nailing water to a wall.

Here is an example. One of the most fully researched preventive home visiting programs is the Nurse Home Visitation Program developed by David Olds and his colleagues (Olds, Kitzman, Cole & Robinson, 1997). It has been subject to three separate randomized trials over three different regions of the United States, using three different populations of young, low-income first-time mothers and their infants, and two different types of home visitors. There is a consistent thread in the findings to suggest the program's effectiveness in improving parenting, child health, reduction in child maltreatment, and improving the life course development of the mothers (see Olds, Henderson et al., 1999).

In two of these sites, an interesting finding was discovered about program implementation in a study that I co-authored (Olds & Korfmacher, 1998). Although not instructed to, nurse home visitors conducted a greater number of visits with mothers who were more psychologically vulnerable, conducted slightly fewer visits for mothers who were the least vulnerable, and completed the fewest number of visits with mothers in a

middle level of vulnerability. Depending on their levels of psychological resources, then, mothers received a different level of program intensity.

What does this finding mean? I believe that nurses perceived a greater need in these more vulnerable families (who were not, incidentally, labeled as more vulnerable to the nurses) and consequently increased their level of visitation. The slight increase in visiting seen with the mothers with greater psychological resources (compared to those mothers with only an average level) was attributed to these mothers being competent enough to make an effort to keep their scheduled appointments with their home visitor. In one case, it may be that nurses made the effort to find and connect with the families. In the other case, the mothers made the effort to be available for visits with their nurse.

These are reasonable interpretations, and they fit with a pattern of differential response seen across a variety of outcome domains, including child maltreatment rates, caregiving environment, and parenting attitudes: Intervention effects were often concentrated in mothers with lower levels of psychological resources. In other words, nurses perceived an increased need in these families and made an extra effort to connect with them, an effort that paid off in particularly strong intervention effects with this sub-group.

Are these the correct interpretations? We can not be sure. It may be that some other factor is influencing the pattern of results seen. For example, maybe lower-resource mothers were just more likely to be home, since more competent mothers may be working and, therefore, harder to visit. The authors did statistically control for employment in the analyses for this reason. But it is impossible to control for all measured and unmea-

sured possible confounding factors. And the results may not always be consistent. This relationship between psychological resources and amount of contact was not replicated in the third and most recent program site. Even with data emerging from rigorous empirical research, a certain amount of subjective interpretation of the results is necessary.

Also crucial to realize is that randomized trials need a large number of subjects, necessary for adequate statistical power. This means that measures used are often fairly broad-stroked. In this case, number of visits

stood for the entire nebulous concept of the intervention implementation. It is hard to fully understand the meaning of the intervention to families using number of visits as the sole determination of intervention process. It is here that a more in-depth under-standing of the families as they went through the program would be helpful. Such an investigation would provide more information of how parents interacted with their nurse home visitors and responded to the visits and would be an important comple-ment to the quantitative study, providing context to the empirical findings. At one site of the Nurse Home Visitation Program, such a qualitative study was undertaken (Kitzman et al., 1998), although it did not address the hypothesis of nurses increasing visits to mothers in whom they perceived a greater need.

Questions to Ask

Along with studying program outcomes, then, there are equally (if not more) valid questions that need to be asked of home visiting programs. All of these questions need to be examined using multiple research methods, with empirically-driven research sitting alongside alternative methods of study.

1) What is the value of the helping relationship between caregiver and home visitor?

It is often assumed that the

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alliance that develops between visitor and caregiver is important, particularly for programs that last one or more years. There is much about this alliance that we do not know. As in psychotherapy research, the concept of the helping relationship has been measured mostly in terms of contribu-tions by the participating client/parent, measuring, for example, program "taking" (Osofsky, Culp, & Ware, 1988), achievement of treatment goals (Barnard et al., 1988), or commitment (Korfmacher, Adam, Ogawa, & Egeland, 1997). However, individuals within the helping relationship—the client and the provider—construct psychological meanings of the relationship that are based upon their own personal history and interpreta-tion of events, and they will perceive the relationship in ways different from each other or from an outside ob-server. There are also features specific

to a given individual helping relation-ship; that is, the match between therapist and patient is frequently shown to be an important program element in adult psychotherapy (see Beutler, Machado, & Neufeldt, 1994), and is assumed to be so in early childhood interventions as well (Korfmacher, 1998).

And since the relationship is dynamic, the quality of the match and the meanings individuals attach to the relationship will change over time. Even in higher-functioning helping relationships there will be periods of disruption and repair. How the home visitor and the family member negotiate these times in an important area of study. This dynamic aspect of the alliance makes it difficult to study. Although our theory and our practice highlight how crucial it is to attend to the helping relationship, in an evaluation context, the helping relationship is a moving target. This aspect of home visiting research needs increased attention.

2) Should intervention be universal or targeted?

Treatment-oriented home visiting programs (such as infant mental health, family preservation, early intervention programs) are targeted towards particular populations manifesting difficulties in family functioning or the child's develop-ment. Many preventive home visiting models, however, are universal. That is, within a geographic area they aim to assist all families with infants or young children (this seems to be a common feature of most home visiting programs in Europe as well). Based upon his research, Olds has often advocated for targeting services to more vulnerable families (Olds & Kitzman, 1993; Olds, Henderson et al., 1999). His model,

however, is the only one that has consistently shown sub-group effects with this more vulnerable population.

What is apparent, however, is that most home visiting programs do not know what groups to target or even the best way to identify them. For example, an evaluation of Hawaii's Healthy Start, a popular paraprofessional home visiting model, found that the screening process developed to target families at higher risk did not do a very good job and identifying those who really were at higher risk (Center on Child Abuse Prevention Research, 1996).

There are political considerations as well. Universal home visiting within a community may reduce the stigma that can be associated with targeted home visiting programs, where caregivers may feel that they are being labeled as "bad parents" who are being scrutinized by authorities. Most likely, however, a universal approach to home visiting services would need to offer different levels or intensities of services for families depending on their need. Some families may need a much more intensive intervention, while other low-risk families would need considerably fewer visits. This leads to the next major question about home visiting.

3) How much intervention is needed to show program effects?

A curious feature of many of the studied home visiting programs is their seeming inability to maintain the prescribed visitation schedule. It is common for programs to complete only somewhere around half the expected number of visits, and many have fairly large drop-out rates. This is true of the "unsuccessful" programs (such as CCDP) as well as the empirically-validated approaches (such as the Nurse Home Visitation Program).

Although results from this research would seem to suggest cutting down the visitation schedule, such a move may very well further reduce the amount of visiting that happens, since this phenomenon seems to occur whether programs are weekly, bi-weekly, or less than that. Visitation schedules provide a goal for home visitors and a message of commitment to the families, and may have value for these reasons, despite difficulties reaching the required level. And since these are averages, there are families who are receiving many more visits, as well as families receiving much less.

Some universal programs perform just a few visits, while others expect the visits to last much longer. We do not really know how much visiting is "enough" for program effects to be seen. That is, although there is great interest in discovering a dose-response curve in these intervention programs, no one seems to have done that yet. And it may be simply because it is very hard to do. Home visiting, as noted above, is more than just the number of home visits. It involves a complicated dance between family and visitor as they attempt to find ways to work together toward shared goals. Finding the average "dosage" of a home visiting program for an average family within that program may not be a very meaningful statistic.

4) What should we look for in home visitors?

The home visitor is one of the least understood elements of a home visiting program. In the United States, the greatest debate appears to be the value of professional home visitors (typically nurses) versus paraprofessional, or lay, home visitors, who do not have formal training in the helping professions but likely have had similar experiences to the families receiving

services. David Olds and colleagues explicitly studied this issue in a trial comparing program outcomes for families visited by nurses or paraprofessionals. In general, although both types of visitors produced effects in maternal life course (employment and subsequent pregnancies) and parent-child interaction measures, outcomes were often stronger for the nurse program (Olds, Robinson et al., 1999). The nurse program also showed effects in some child outcomes, such as language development and emotional regulation where the paraprofessionals did not. These findings may be because nurse home visitors completed more visits on average, and focused on perhaps more crucial pieces of the program protocol, namely physical health concerns and parenting issues (Korfmacher, O'Brien, Hiatt, & Olds, in press).

Both sets of visitors, however, were trained in the model originally developed for nurses, with only slight modifications for the paraprofessionals. It is unclear what the outcomes would be if paraprofessionals were trained in a program model more uniquely suited to their abilities and background, although it is worth noting that most models that are explicitly paraprofessionally-focused do not show as strong empirical outcomes as the Nurse Home Visitation Program (see Olds & Kitzman, 1993; Gomby et al., 1999).

Professional background and status, however, is only one of many different dimensions upon which home visitors will vary, including previous experience, age, ethnicity, personality and interaction styles (Korfmacher, 1998). It is surprising, given how obviously crucial they are to any home visiting program, how little we know about what goes into a good home visitor besides clinical intuitions of needing to be sensitive to others and

having good people skills.

5) How can home visiting be integrated into a continuum of services?

It is clear that a one-size-fits-all approach that was implicit in the early enthusiasm for this method of service delivery is not viable. Not every family (and maybe only a minority of families, as the empirical reviews have noted) will respond to services offered in the home by a friendly and compassionate helper. As Gomby and colleagues (1999) rightly point out, other services may be more meaningful and helpful to families. As more and more low-income families have working parents due to welfare reform in the United

by the federal government as a downward extension of the Head Start school readiness program) have been allowed to offer combinations of center-based and home-visiting services, depending on family needs and preferences. It will be interesting to see how such service combinations play out.

Conclusion

No matter what one's professional opinion of the value of home visiting programs, they are an important aspect of delivering services to young children and their families in the United States. In the last two decades, there

ate reactions about this opinion passes, programs and home visitors will most likely go back to work and continue with their mission. After all, most have considerable experience operating in underfunded and under-valued conditions.

The peril of home visiting is that these programs will return to business as usual, not taking seriously the criticisms and the recommendations that emerge from these latest empirical findings. It is clear that considerable effort needs to be made in program improvement and in understanding whom can best be helped by what sorts of services. This is something upon which all interested parties— program staff, researchers, and policy people—need to work together. Home visiting programs are not going to provide the magic bullet to assist all families. No one sort of intervention can. But through careful and more complex study, we may begin to understand why there is success for some families and how there can be success for others.

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States, for example, the availability of enriched or high-quality child care takes on added significance.

But home visiting programs likely have an important role as part of a continuum or package of services offered to families. Some families will respond to a home visiting program, and may, in fact, only respond to such a way of delivering services. Perhaps if families were offered the "luxury" of choosing which services make the most sense to them, home visiting programs would start showing greater effectiveness with the families who most desire it. This is, however, easier said than done, especially given the propensity of home visiting programs to reach out to families who do not necessarily believe they need services in the first place. Recently, Early Head Start programs (programs for low-income children birth to three funded

has been a tremendous amount of optimism about their promise in making a difference in the lives of these families. This optimism is followed now by a sense of unfulfilled expectations and disappointment that the societal ills home visiting programs seemed so set to battle still remain.

But the promise of home visiting still remains, in the empirical results that are uncovered (even if smaller and more idiosyncratic than hoped for), in the families that offer testimonials to their home visitor and to the difference this person made, and in the quest in which the home visitors themselves engage, trying to connect with families whom the visitors suspect need a lifeline of help and support. The current critical opinion of home visiting programs may very well have far-reaching implications in policy and funding circles. But once the immedi-

Note
[1.] The five programs subjected to randomized trial were Parents As Teachers, Nurse Home Visitation Program, Comprehensive Child Development Program, Home Instruction Program for Preschool Youngsters, and Hawaii's Healthy Start. The sixth model, Healthy Families America, was studied by a network of local researchers using a variety of empirical methods.

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"Is there something like that?"

Building awareness for parenting support programs

*by Lauren Barton, Lee Anne
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Parenting support, empower-
ment, and education are at the core of
the infant mental health profession.
We develop therapeutic relationships
to help clients overcome personal and
situational obstacles that prevent
them from fully engaging in nurturant
parenting practices. We listen and
inform to help parents observe,
interpret, and respond to their
children's actions. We try to prevent
future problems by shaping the
expectations and interactions that
form the core of the child's interper-
sonal experiences. But, in the United
States we do not reach every parent
who has concerns. We do not reach
every parent at risk. Our impact
extends only as far as our programs

successfully identify and engage
individuals within our communities.

Although early intervention,
parent education, and parent support
services are available in most commu-
nities, underutilization of those
services remains a problem (Honig,
1984; Huber, Holditch-Davis, &
Brandon, 1993; Meisels, 1989). One
study found that only one-sixth of
parents of preterm infants were
receiving adequate early intervention
services when their children were three
years old (Huber et al., 1993). More-
over, individuals with low incomes and
people of color are particularly likely to
underutilize the services available
within their communities (Palfrey,
Walker, Butler, & Singer, 1989; Powell,
1988; Weiss & Halpern, 1991; Pottick,
Lerman, & Micchelli, 1992). Often
those with the greatest need do not

receive the services designed to help
them (Ayers, 1989; Seybold, Fritz, &
MacPhee, 1991).

Many obstacles have been
identified as barriers to successful
health and social service utilization.
They include cost, transportation
difficulties and geographic inaccessi-
bility, lack of child care, programmatic
bias or discrimination, cultural barriers,
programmatic obstacles such as
language barriers and hours of
operation, poor psychological
functioning including depression, lack
of awareness of services, and lack of
perceived appropriateness of the
services to individual needs (Huber et
al., 1993; Leatherman, Blackburn, &
Davidhizar, 1990; Lia-Hoagberg et al.,
1990; Sisk et al., 1996; Rhodes, 1993).

Much work has discussed best
practices for implementing services
and the importance of engaging
families (Carter & Harvey, 1996;
Musick & Stott, 1990; Roman, Lindsay,
Moore, & Shoemaker, 1999;
Simeonsson & Bailey, 1990). Indeed,
the provision of accessible, perhaps
home-based, services by culturally
competent staff can appeal to and
increase service use among hard to
reach populations (Berlin, O'Neal, &
Brooks-Gunn, 1998; Downs & Walker,
1996; Lieberman, 1990; Polk, 1994).
Yet, often programs do not receive
referrals to initiate contact with each
family who might benefit and parents
either are not aware of or do not seek
assistance from parenting support
services in their communities. Im-
proved understanding of the issues
involved in parenting service utiliza-
tion is needed.

As part of a qualitative study to
explore factors related to preterm birth,
forty Medicaid-eligible, African-
American mothers of preterm infants
under 18 months of age were inter-
viewed by African-American women
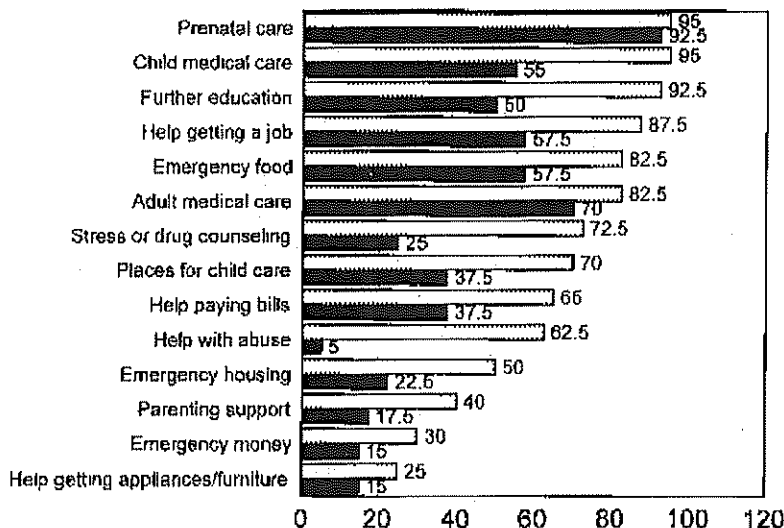living in their community. All of the

Figure 1: Knowledge and use of formal community services.
[ ] *Percent with knowledge of services* ▇ *Percent having ever used*
services

mothers were living in a mid-size urban community that provides free maternal support services to low-income pregnant women and to parents with low incomes during their infants' first year of life. A variety of other parenting support services are also available to these parents as both supplemental program components and independent missions of other non-profit agencies in the community. Ninety percent of the women sampled had lived in the community for five years or more and most of them had lived there for their entire lives. When interviewed, each of the women was asked to name places available to seek help for different kinds of concerns and if she had ever used each identified agency for that type of assistance.

The results described in Figure 1 reveal an important message for individuals delivering parenting services. In a sample where 27% of the women reported having a child with special needs and all of the participants were mothers of high-risk infants, only 40 percent of those interviewed were even aware of places to seek formal parenting support. In maternal awareness of availability, parenting support services ranked twelfth out of the fourteen types of assistance investigated. Most individuals were knowledgeable about where to access basic health care services and how to find assistance for employment, furthering their education, and locating emergency food, but they had not learned about the availability of parenting support services. Moreover, only half of those participants who could identify a place to access formal parenting support had ever used them, resulting in less than 18% of these parents of high-risk infants ever having contact with any parenting support services.

Despite the specificity of the sample and its size limitations, these findings raise important questions for parenting support programs. Are existing services reaching their intended populations? What mechanisms might be most effective at increasing awareness of parenting services?

The widespread knowledge about health care facilities in the sample points to the benefits of integrating health and parenting support services and of promoting efforts to create a service delivery system that families can easily access through one point of entry. Within the existing system,

> *The widespread knowledge about health care facilities in the sample points to the benefits of integrating health and parenting support services and of promoting efforts to create a service delivery system that families can easily access through one point of entry.*

expanding recruitment might begin by including staff in health care settings to personally enroll individuals into parenting support services as well as providing posters, displays, or brochures to reach out to parents in the waiting rooms. Working closely with receptionists, nurses, and physicians in these settings to help them understand the variety of supports provided by agencies and how to incorporate discussion of these into their routine interactions with clients might also increase participation in the services. However, these approaches can only be successful

with the subset of the population that uses health care services. Alternative approaches must be considered to engage the truly hard to reach, high risk populations that do not routinely connect with formal services or do so only in crisis situations.

Increased attention to publicizing parenting support programs through places of worship, laundromats, parks, shopping centers, food banks, word of mouth networks, and the mass media might begin to reach some of the individuals with significant needs who never even seek formal assistance. Incorporating messages that underscore the benefits of participation into centers of daily life may be a first step toward conveying the relevance of and establishing both awareness of and acceptance for parenting programs in the community.

In addition to attending to where we focus our outreach efforts, we must also re-examine how our marketing messages and missions relate to the diverse families within our communities. Parents vary considerably in their personal and social resources, including income, social support, and education. Influences like substance abuse, mental illness, physical and mental disabilities, and intrafamily violence also impact families, contributing to highly varied needs and experiences. Moreover, families in the United States represent over 250 ethnic/racial groups from nearly every country and region of the world. These unique cultural traditions, values, beliefs, and attitudes shape parents' interpretations of and responses to their situations and to services in their communities. Using messages that are sensitive to situational and cultural differences can help build positive perceptions about parenting services as widespread, acceptable resources rather than as programs perceived to provide training

for incompetent parents.

An essential component of quality service delivery is attracting and engaging the intended families. To succeed in this, we must creatively market our programs and meet the individual needs of the diverse populations we serve. After all, establishing excellence in implementing parenting support services can only have maximal benefits within U.S. society if we also excel at attracting and engaging the parents in our midst.

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President's Perspective

Yvon Gauthier

I wish again to discuss social policy. You may remember that in my last Perspectives column, I had expressed my distress and helplessness over the tragic events in Kosovo and wondered what and how WAIMH could participate in the repair that will be necessary. Since then, we have seen the ending of the more acute events and the beginning of families returning to their country to find the destruction of their homes and villages.

We may think that the problem has been solved. We no longer see the excruciating images on our television screens; but we know the reality is different. These families have to mourn the loss of their husbands, brothers and children and of their homes and possessions. This will be the work of months and years, with evident consequences for the emotional development of children, particularly the young children.

Some of our colleagues may be involved in providing help to these families, either with refugees in their own country, or through international organizations at work in Kosovo. This is most important. On the other hand, I also tend to see our involvement from a more futuristic and idealistic perspective: if we can invest our energies in mental health interventions with infants and young families in these crucial early years, maybe we could help to prevent the kind of aggres-

sions we have seen in these recent months. Of course, many factors coalesce to lead to such abominable aggressions; but we know now that the foundation for controlling human aggression is created and laid down in the early years of a child's life. To achieve this objective of preventing aggression through the medium of mental health intervention, we have to be active not only at the clinical and research levels, but also at a more public level where social policies are decided upon and enacted into laws and interventions.

WAIMH's Social Policy Study Group could be an excellent vehicle for achieving our objectives. In the last *Signal* (Vol. 7, No. 2) Hi Fitzgerald wrote a eulogy for Sonya Bemporad, the organizer of the first meeting of this study group in Tampere in July 1996. The group worked on child care and child protective matters, and Sonya had hoped to create a document on the rights of infants that could be submitted to the World Health Organization. Her untimely illness and premature death have prevented her from finishing this important project.

I have decided, along with our President-Elect, Peter de Chateau, to resume her efforts. At this point, in light of Sonya's objectives, we thought it was important to conduct a survey in the areas where affiliate societies are active to see what has already been achieved in terms of

infant mental health social policy, and what still needs to be done. There is a particular need to know about the work being done in disadvantaged areas with families and infants.

This is an ambitious project. We have asked our regional vice-presidents to work with us on it and we already have received, in response to our questions, several encouraging descriptions of work being done by them and their associations. We intend to present the results of this survey and our analysis in Montreal in July 2000.

Yes, this may be idealistic and a drop in the ocean. But I still believe that any small effort to help young families with infants moves the whole society towards more human functioning, and thus maybe prevent further tragic aggressions and proliferation of transgenerational suffering.
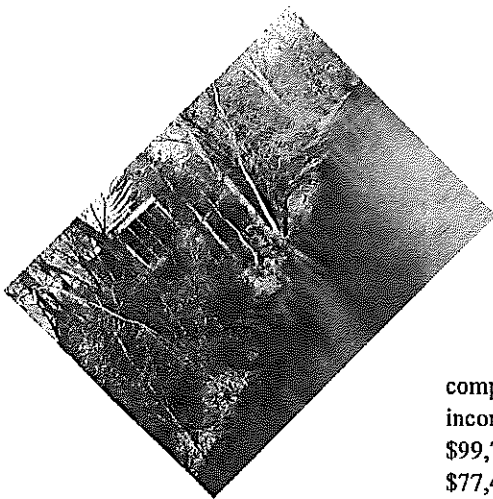
from the Red Cedar

Hiram Fitzgerald
Executive Director

' As we pass the half-way point in 1999 I thought it was time to inform the membership about a variety of issues related to our organizational functions. So this edition of "From the Red Cedar" is basically a business report, an informational memo to the members about organizational activities and an invitation for response and commentary about any of the items below. Don't hesitate to contact me or any member of the Executive Committee through electronic means or by good old fashioned pen and ink or telephone. Let's start with finances.

WAIMH's Financial Health

Mid summer in the United States is the time when WAIMH receives its various financial reports for the prior year, in this case for 1998. WAIMH finished 1998 with a cash balance of $14,223. We began 1998 with net assets of $111,680 and ended the year with net assets of $118,285. So, from a business perspective, we had a successful year. We were able to carry out all of our program activities and ended up with slightly more money in our operational fund than we had at the beginning of the year.

As of June 1999, our cash balance was $24,612. This is a typical balance entering into the summer months when our revenues tend to be lower because most of the membership drive has been completed from the prior year. Total income for the first half of 1999 was $99,725 and total expenses were $77,470. Keep in mind that WAIMH handles several in and out accounts; subscriptions for the Infant Mental Health Journal, memberships for the International Society for Infant Studies, and office activities for the Michigan Association for Infant Mental Health. Because subscriptions and memberships are increasing, this inflates WAIMH's office income and expenses. So even though our income at the six-month mark is nearly at the level for all of 1998, our actual operational expenses remain about the same. How much does it take to actually operate WAIMH's business office: about $45,000. How much would it cost to duplicate WAIMH's office elsewhere (in North America)? About $85,000, not including salaries for personnel or such items as postage, printing, software, and other "consumable" items. We estimate only furniture, space, computers, telephones (but not monthly costs), etc. We perform this analysis about every five years because the Institute for Children, Youth, and Families at Michigan State University provides space and other office support without charge. In the event that the central office had to be moved, WAIMH must be prepared to handle the expenses necessary to establish and maintain an office independent of a university affiliation. So, the best estimate that Melanie Smith and I were able to come up with was the 85K figure.

We continue to benefit from the strong United States stock market. One year ago at this date our Edward Jones investment accounts were valued at $102,033. Today their value is $103,097, despite the fact that we sent $10,000 in January to the World Congress Local Arrangements Committee in Montreal in support of the year 2000 congress. One of our accounts, Euro-Pacific Growth Fund is designated for the Beacon Club. It currently is valued at $4,083. Through the Beacon Club we distribute outreach memberships, including copies of the *Infant Mental Health Journal* and *The Signal* to nearly 11 sites and continue to receive requests for such support from friends around the world. Each Beacon Club membership is designated for three years and is potentially renewable. The Executive Committee is discussing ways to expand WAIMH's outreach efforts. A special pre-conference session on social policy issues is being offered at the Montreal Congress and everyone is invited to participate in this work session.

Infant Mental Health Journal

In 2000 we will celebrate the 20th anniversary of the IMHJ. We will begin publishing 6 issues yearly. Starting next year and every other year, the abstracts from the World Congress will constitute a double issue of the journal and so abstracts for the world congress will enter into a formal archival system. We will continue to publish two (2) special

topic issues. All of the other issues will represent the same open topic peer-reviewed papers that have characterized the IMHJ since its founding in 1980. So the 2000 issue will be an anniversary issue of the journal as well as the first volume of the 21st century and each volume will add 600 pages of clinical and scientific studies in infant mental health to your personal library. We hope that all WAIMH members will continue to view the Journal as an outlet for their clinical and scientific studies of social and emotional development of infants, parent-infant relationships, preventive-intervention and therapeutic programs, cultural and ecological influences on early development, and all aspects of development that place infants at risk. Our extraordinary editor, Joy Osofsky, and her skillful team of associates, consulting editors, and staff deserve much applause for the continued quality improvement of the journal.

WAIMH's Organizational Structure

WAIMH's current organization involves a Board of Directors (8 individuals), 7 Regional Vice Presidents, and a President for each of its active Affiliates. A committee chaired by Tuula Tamminen is beginning an analysis of this structure focusing initially on the role of the Regional Vice Presidents in the structural and functional operation of WAIMH. The annual meeting of the Executive Committee will be held Oct. 2-3 in Montreal. If there are any issues you would like the EC to address, please do not hesitate to pass them on to the WAIMH office, or to any member of the Executive Committee or to a Regional Vice President. There is a strong desire to involve more individuals in the governance structure, but the key is to determine how to do this

and still maintain an operational structure that is efficient and functional. The Executive Committee hopes to have a variety of proposals ready for action at the biennial meeting of the membership during the Montreal World Congress.

2000 World Congress

Hopefully everyone has received a copy of the Call for Papers and is busy making plans to submit a proposal to the program committee for the World Congress. This congress starts WAIMH on a two-year cycle for its world meetings. The 2002 World Congress is scheduled for Amsterdam, with Peter de Chateau and his colleagues serving as hosts. We will have more to say about this in Montreal. To date, we do not have a site for 2004 or 2006 so if you have any interest in hosting a world congress please contact the WAIMH office to get details about submission requirements. Past World Congresses have taken place in Portugal, Sweden, France, Switzerland, the United States, and Finland, and of course, Canada in 2000. Successful regional meetings have taken place in Brazil, Uruguay, Australia, Austria, Japan, and the United States. And of course, many Affiliates have their own annual conferences. Anyone interested in hosting a future WAIMH world congress should contact the office as soon as possible.

Well, time to wrap up this edition of "From the Red Cedar." On behalf of the Executive Committee I can say that we not only encourage inquiries from the membership but actively solicit opinions, comments, and suggestions because WAIMH is a membership organization and exists only to fulfill the goals and objectives for which it was founded.

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WAIMH
Affiliate News

German speaking Affiliate

A rapidly growing German-speaking Association for Infant Mental Health (GAIMH) sponsored its 4th annual meeting in Kolu and are now preparing for the 5th annual meeting in Zurich next February 24-26, 2000.

Australian Affiliate

Members of AAIMH are anticipating their 6th annual conference in November, 1999 in Melbourne. The theme of the conference is: The Baby Speaks: The Therapuetic Process, the Baby and Her Family." Professor Colwyn Trevarthen from the University of Edinburgh will present on research on the development of infants' capacities to enter into the minds of others. Professor Bernard Golse, Child Psychiatrist and Professor of Child and Adolescent Psychiatry, at the University of Paris will present a European perspective on infant parent psychotherapy, the emergence of infantile psychic life and early signs of the development of disorders of empathy and the infant parent relationship. Dr. Ann Morgan, Psychotherapist and Pediatrician in Melbourn, will present the Winnicott Seminar.be complemented by workshops and panel discussions.

WAIMH Francophone

On July 9, 1999 a video-conference on the origins and prevention of abuse connected participants in France, Mexico, Peru, Argentina and Brazil. The conference was created by WAIMH members Serge Lebovici, M.D., and Bernard Golse, M.D. and sponsored by la Commission Amerique Latine and WAIMH Francophone

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News & Views

Training Opportunities

Australia

November 26-28, 1999. Victoria, Austrailia. *Australian Association for Infant Mental Health 6th Annual Conference.* Keynote speakers are Professor Colwyn Trevarthen, Professor Bernard Golse, MD, and Ann Morgan, MD. For information contact Fiona Campbell at: f.campbell@pb.unimelb.edu.au or Michael Sullivan at: m.sullivan@pb.unimelb.edu.au

United States

October 18-19, 1999. Chicago, Illinois. *The Loyola Forum on the Child.* "Reclaiming Childhood: Shaping Policy for the Future." For information call: (312)-915-8567 or visit their web site: www.luc.edu/childforum

October 29, 1999. Chicago, Illinois. *Annual Conference of the Illinois Association for Infant Mental Health.* Theme: Engaging the Overburdened Family: Theory and Practice. Keynote speakers are Susan McDonough, Ph.D., MSW, and Arnold J. Sameroff, Ph.D. For information contact Nancy Mork at (847 412 4357).

December 9-12, 1999. Washington, D.C. Council for Exceptional Chilren. *International Early Childhood*

Conference on Children with Special Needs. For information call 1-888-232-7733 or visit their website: www.dec-sped.org

November 15-17, 1999. *Developmental Interventions in Neonatal Care.* Chicago. For information call Contemporary Forums at 925-828-7100. (8 a.m.-5p.m. PST)

December 3-5. Anaheim, California. *Zero to Three. 14th National Training Institute.* For information contact Meeting Management Services at 703 271 1296.

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