ORANGA TAMARIKI
Ministry for Children

EVIDENCE CENTRE
TE POKAPŪ TAUNAKITANGA

New Zealand Government

Success factors for a home visiting programme

Evidence brief

The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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Family Start is an evidence-informed nationally-designed, voluntary, intensive, long-term, home visiting programme that is locally delivered by community, iwi and Māori organisations across New Zealand. With a kaupapa that is described as "child-centred…strengths-based…and…client-led" (Oranga Tamariki, 2022, p.11), Family Start's rationale is "improving children's health, learning and relationships, family/whānau circumstances, environment and safety" (Oranga Tamariki, 2022, p.10). A recently completed evaluation of Family Start (Allen+Clarke & Oranga Tamariki, 2021a, 2021b) found that the programme has a positive impact overall. However the evaluation also found that some programme components may need to be adapted to better suit some whānau. Furthermore some partner organisations are similarly asking for more flexibility on how they deliver the programme.

The purpose of this evidence brief is to review the international, and any national, home visiting programme literature to help Oranga Tamariki ensure that the current Family Start model supports all partner organisations in their practice, and that whānau receive quality and effective support from the programme. As such, Oranga Tamariki is looking to better understand key indicators of success that are essential for a home visiting service, as well as any factors that are likely to enhance rather than erode programme effectiveness for these whānau, without compromising effectiveness for other users and the programme as a whole.

The following three research questions were developed for the evidence brief.

1. What critical factors make a home visiting programme, as applicable to the Family Start context, successful?
2. To what extent do such critical factors align with:
    - Family Start as currently designed and delivered?
    - the needs of tamariki and their whānau as identified in the most recent Family Start evaluation reports?
3. Which, if any, Family Start programme components could be adapted slightly and/or delivered with a little more flexibility in order to better suit some whānau?

Having reviewed the literature generally, and systematic reviews and meta-analyses in particular, it transpires that these questions are not in fact answerable. While there is a considerable body of research on home visiting programmes, and most of this focuses on determining whether such programmes are effective, home visiting programmes are also surprisingly diverse.

However, by presenting what material is available, this evidence brief can still contribute to helping Oranga Tamariki and its partners make evidence-informed decisions while considering any adaptations to the programme to better suit whānau needs, respond to the recent evaluation recommendations to ensure cultural

responsiveness, and to further meet their obligations under section 7AA of the Oranga Tamariki Act 1989.

To that end this evidence brief also addresses:

- Home visiting programme definitions
- A comparison between Family Start features and mainstream home visiting programmes (with three Indigenous home visiting programme case studies in a companion report)
- Outcomes that home visiting programmes improve
- Why home visiting programmes are not more successful.

This brief identifies a number of possible success factors, for example, antenatal participant recruitment, high visit frequency, aligning programme choice with community needs and wishes, and the quality of the helping relationship. However, as well as recruiting and retaining a sufficient number of families (a major challenge in replicating and scaling up home visiting programmes), only antenatal participant recruitment over postnatal recruitment is strongly supported as a clear success factor.

While the literature does call for more research on such success factors, there is also a growing recognition of the importance of other factors such as:

- Revisiting fidelity and the rise of implementation science
- Greater programme flexibility and adaptability
- Increased focus on social and emotional wellbeing and the effects of trauma, and
- Those associated with the delivery organisation and the wider system in which an individual programme operates.

Introduction

Established in 1998, Family Start is an evidence-informed nationally-designed, voluntary, intensive, long-term, home visiting programme that is locally delivered by community, iwi and Māori organisations across the country. With a kaupapa that is described as "child-centred…strengths-based…and…client-led" (Oranga Tamariki, 2022, p.11), Family Start's rationale is "improving children's health, learning and relationships, family/whānau circumstances, environment and safety" (Oranga Tamariki, 2022, p.10). Family Start was originally designed for the Aotearoa New Zealand context (as it was at that time), and as well as being expanded over the years, it has also been periodically adapted and refined with, for example, the development of the online parenting resource tool (Oranga Tamariki, 2022; Rameka & Fitzpatrick, 2017).

A recently completed evaluation of Family Start (Allen+Clarke & Oranga Tamariki, 2021a, 2021b) found that the programme has a positive impact overall. However the evaluation also found that some programme components may need to be adapted to better suit some whānau. Furthermore, some partner organisations are similarly asking for more flexibility on how they deliver the programme; for example some iwi and Māori partners have reported that the prescribed timeframes do not always allow workers to engage fully with whānau.

While increasingly available in, and adapted for, other countries, historically home visiting programmes as addressed in this evidence brief are a US construct. First developed in the 1980s, usually by university research centres and supported with randomised-controlled trials, last year approximately 300,000 US families participated in home visiting programmes. In 2020, evidence-based home visiting programmes were available in all 50 states, the District of Columbia, five territories, 22 tribal communities, and 53 percent of US counties (National Home Visiting Resource Center, 2021). While US states may fund more than one or even several home visiting models, many follow either Healthy Families America and/or the Nurse Family Partnership (Lewandowski, 2018). The research organisation MDRC (n.d.) has identified nine different evidence-based home visiting programmes, while the US National Home Visiting Resource Center (2021) yearbook includes details of 15 programmes that are deemed to have met federal evidential standards as evidence-based, as well as 10 other emerging models.

The purpose of this evidence brief is therefore to review the international, and any national, home visiting literature to help Oranga Tamariki ensure that the current Family Start model supports all partner organisations in their practice, and that whānau receive quality and effective support from the programme. As such there is a need to better understand key indicators of success that are essential for a home visiting service, as well as any factors that are likely to enhance rather than erode programme effectiveness for these whānau, while also not compromising effectiveness for other users and the programme as a whole. This evidence brief on home visiting programme success factors seeks to address this need.

The following three research questions were developed for the evidence brief.

1. What critical factors make a home visiting programme, as applicable to the Family Start context, successful?
2. To what extent do such critical factors align with:
    - Family Start as currently designed and delivered?
    - the needs of tamariki and their whānau as identified in the most recent Family Start evaluation reports?
3. Which, if any, Family Start programme components could be adapted slightly and/or delivered with a little more flexibility in order to better suit some whānau?

At the outset it is important to clearly state that it transpires that these questions are not in fact answerable on the basis of the international home visiting literature as it currently stands. However, by presenting what material is available, this evidence brief can still contribute to helping Oranga Tamariki and its partners make evidence-informed decisions while considering any adaptations to the programme to better suit whānau needs, respond to the recent evaluation recommendations to ensure cultural responsiveness, and to further meet their obligations under section 7AA of the Oranga Tamariki Act 1989.

In terms of the structure of the report, following a brief background section, the report is devoted to presenting the relevant findings from the research literature. An accompanying report provides three home visiting programme case studies, used with or adapted for Indigenous people, that may be relevant to the Aotearoa New Zealand context.

Finally, a word of caution on terminology. The term home visiting program/programme is very widely used in the literature. However, extended or other terms are sometimes used. For example:

- *Home visiting program for child-well-being* (e.g. California Evidence-based Clearinghouse for Child Welfare, n.d.)
- *Maternal home visiting program* (e.g. Childhood Begins at Home, n.d.)
- *Early childhood home visiting* program (e.g. Supplee, 2016)
- *Tribal home visiting* (e.g. Parents as Teachers, n.d.)
- *Enhanced home visiting* (e.g. National Center for Healthy Safe Children, n.d.)
- *Paraprofessional home visiting programs* (e.g. Peacock et al., 2013)
- *Home-based support* (e.g. Bennett et al., 2007)
- *Evidence-based home visiting* (e.g. MDRC, n.d.)
- *Sustained nurse home visiting program* (e.g. McDonald et al., 2012).

Some of these terms may be used interchangeably. Some of these and others may capture an important characteristic of a programme, e.g. whether it is designed for indigenous people, whether it has an education focus or a support focus, or is primarily targeted at parents or their children. However, the recent emergence of the

terms *Sustained nurse home visiting program* (e.g. McDonald et al., 2012) and *Paraprofessional home visiting programs* (e.g. Peacock et al., 2013) is particularly worth noting as each of these terms is essentially referring to a different subset of home visiting programmes, i.e. those programmes that are staffed by qualified nurses and those that are staffed by paraprofessionals. When referring to empirical studies, systematic reviews and meta-analyses, I may make a distinction between these where it appears important to do so.

Background

This section starts with a brief discussion of Family Start, before placing the programme within the wider context of programmes and services to support families with young children in Aotearoa New Zealand. Attention then turns to two widely used frameworks that can be used to conceptually locate family support programmes, before a brief examination of the current Oranga Tamariki context.

Family Start

Established in 1998, Family Start was initially one part of a national inter-agency Strengthening Families umbrella strategy which, as well as Strengthening Families interagency case-conferencing, was to also include High and Complex Needs, and Social Workers in Schools (Matheson, 2020b; MSD, 2005). The strategy was launched in 1997 and was strongly supported by the Directors-General of the Department of Social Welfare and the Ministry of Health, and the Secretary of the Ministry of Education. The intent was that the Strengthening Families strategy would enable government agencies (including territorial local authorities) to work more 'efficiently and effectively' with the country's most 'at-risk children'. Initially the involvement of NGOs, including Māori and Pasifika social services was limited. Over those first few years, government ministries and departments jointly reported annually as part of a published report on cross-sectoral outcome measures for children (Matheson, 2020b).

Family Start was initially based on the Christchurch Early Start programme (Cribb, 2009; Early Start Project, n.d.; Fergusson et al., 2005, 2012) which was developed in the mid-1990s by a consortium of Christchurch Health and Development Study researchers, including the late Professor Fergusson, and Christchurch service providers (Matheson, 2020a; Vaithianathan et al., 2019). The Early Start programme which still operates in Christchurch today, was itself an adaptation of the Hawaii Healthy Start Program (Vaithianathan et al., 2019). The Hawaii Healthy Start Program, while no longer widely used in Hawaii (State of Hawaii Department of Health, n.d.) was the first home-visiting programme to be adopted in the US state-wide (Jack et al., 2015). Early Start, unlike Family Start or to perhaps a lesser extent the Hawaii Healthy Start Program (Duggan et al., 1999, 2004), is internationally recognised as an effective evidence-based early childhood home visiting service delivery model (US Department. of Health and Human Services, n.d.). Here in Aotearoa New Zealand it was also recognised as an effective home visiting programme by the Social Policy Evaluation and Research Unit (2015).

Family Start now operates across 46 provider sites. It uses a comprehensive set of referral criteria (Oranga Tamariki, n.d.); the programme specifically targets and supports new and expectant parents and their families/whānau, who may "struggle with challenges or problems that put health, education and social outcomes for their children at risk" (Oranga Tamariki, 2022, p.10). While it has not been the subject of a randomised-controlled trial, Family Start has been the subject of various research studies, evaluations and reviews (e.g. Allen+Clarke & Oranga Tamariki, 2021a,

2021b; Cribb, 2009; Davies & Roberts, 2013; Fielding, 2011; Martin, 2014; Rameka & Fitzpatrick, 2017; Vaithianathan et al., 2016).

Child and family support services

Home visiting programmes are only one of several ways for government agencies and community, iwi and Māori organisations to support expectant and new parents and their babies and young children in Aotearoa New Zealand. Some other examples are shown in the following table:

Table 1: Early years child and family support services in Aotearoa New Zealand

FUNDER	PROGRAMME/SERVICE
Oranga Tamariki	Strengthening Families (Matheson, 2020b)
Health	Well Child Tamariki Ora (Lead Maternity Carers, GP team, Well Child Tamariki Ora provider, and B4 School Check)
	Mokopuna Ora (Conectus, n.d.)
	Triple P[1] (Triple P Centre, n.d.; Whāraurau[2], n.d.)
	Parent Child Interaction Therapy (PCIT) (Whāraurau, n.d.)
	Plunketline (Plunket, 2021)
Education	Incredible Years (Ministry of Education; Whāraurau, n.d.)
	Teen parent units[3] (Association of Teen Parent Educators New Zealand, n.d.; Education Review Office, 2018; Te Kete Ipurangi, n.d.)
Te Puni Kōkiri	Whānau Ora (Te Puni Kōkiri, 2018a, 2018b, 2019)
Community, iwi and Māori organisations	Parenting Education Classes e.g. Barnardos, Parents Centres, and Plunket
	Plunket Family Centres
	Various other services and programmes

Such programmes and services, and how Family Start relates to these, can usefully be viewed from the perspective of the two following complementary models:

The Hardiker model

Building on socio-ecological theory, in the United Kingdom during the 1990s Pauline Hardiker and colleagues developed a pyramid-shaped model of the different levels of intervention needed in a society within a population of children (Hardiker et al, 1991

[1] *Online version of Triple P also available*

[2] *Whāraurau national centre for Infant, Child and Adolescent Mental Health (ICAMH) workforce development*

[3] *The Association of Teen Parent Educators New Zealand (ATPENZ) has 25 member services across the country from Invercargill, Southland to Kaikohe, Northland.*

as cited in Owens, 2010). The Hardiker model has four levels of intervention, described as follows:

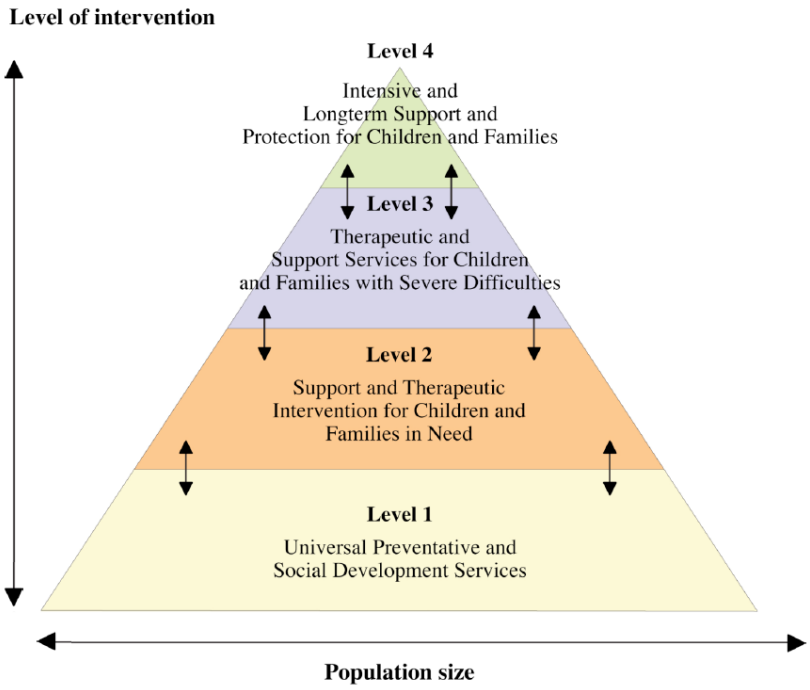
Level 1: mainstream and universal services available to all children, e.g. health care, education, community services including services targeted to specific communities – cultural, disadvantaged groups etc.

Level 2: services to children who have some additional needs and are characterised by having a referral system and requiring parental consent, e.g. behavioural support, parenting support and programmes, additional educational services, and specific services where there are identified child needs.

Level 3: support for families or individual children and young people where there are chronic or serious problems, e.g, services and interventions that come through court recommendations, protection registers, etc.

Level 4: support for children and families where the family has broken down temporarily or permanently, and where the child or young person goes into the care of social services or youth justice custody.

Figure 1: The Hardiker model of intervention frameworks



Note: Reproduced from Hardiker et al, 1991, as cited in Owens (2010), p.18.

The two-generation (2Gen) model

Rather than framing programmes and services in relation to the level of risk that a child may face and seeing responses on a continuum from universal through to intensive specialist and longer-term support, the two-generation (2Gen) model instead frames child welfare services around the extent to which they are focused on the child, focused on the parent, or focused on the family as a whole (Ascend at the Aspen Institute, 2018). The developers advocate that more child welfare

programmes and services should address the needs of the whole family rather than choosing between those of the child or the parent. This approach is particularly applicable in Aotearoa New Zealand where the wellbeing of the child is both culturally and legally intrinsically linked to that of the whānau (Office of the Children's Commissioner, 2015). The 2Gen continuum nonetheless encourages service designers and providers to be much clearer about what they actually mean when they use terms such as *child-focused* or *parent-focused*.

Figure 2: Child-focused to parent-focused – the 2Gen continuum

Note: Reproduced from '2Gen approach' by Ascend at the Aspen Institute. Copyright 2018 by author.

Oranga Tamariki

With the establishment of Oranga Tamariki in 2017 and as recommended by the Expert Panel on the Modernising of Child, Youth and Family (2015), the Oranga Tamariki high level operating model had a much strengthened focus on prevention and early intervention; the organisation's outcomes framework (Oranga Tamariki, 2018) reframed this as *early support.* In relation to tamariki Māori and their whānau, the new Section 7AA of the 1989 Act imposed specific new duties on the Oranga Tamariki Chief Executive in order to "recognise and provide a practical commitment to the principles of the Treaty of Waitangi (te Tiriti o Waitangi)". These include seeking to develop strategic partnerships with iwi and Māori organisations, including iwi authorities, in order to "agree on any action both or all parties consider is appropriate" (Oranga Tamariki Act, 1989, s7AA(c)(vi)). Such legislative requirement is understood to be the first time in the history of Aotearoa that *Te Tiriti o Waitangi* has been mentioned in legislation relating to children.

These developments have been given significantly more impetus with the recent publication of *Hipokingia ki te Kahu Aroha Hipokingia ki te Katoa* (Ministerial Advisory Board, 2021) and the associated Cabinet Paper and Oranga Tamariki Future Direction Action Plan. The government established the Ministerial Advisory Board in January 2021 to help reform Oranga Tamariki, as part of its response to widespread criticism of the attempted removal of a Māori newborn infant from a Hastings hospital in 2019 (Office of the Chief Ombudsman, 2021; Office of the Children's Commissioner, 2020a, 2020b, 2020c; Oranga Tamariki, 2019), as well as the subsequent and broader report by the Waitangi Tribunal (2021). Family Start is not now, nor has it ever been, an alternative to either Oranga Tamariki child protection services or other emergency or crisis help from organisations such as the Police or Women's Refuge (Oranga Tamariki, n.d.) and it does not appear to have been directly or indirectly implicated in any of these inquiries. However, the centrality of engaging and supporting *at risk* expectant and new parents who need extra

support and their babies in their communities generally, and particularly so in relation to Māori, and taking every possible step to avoid babies having to come into the care of the State, has perhaps never been higher.

In terms of the Ministerial Advisory Board's (2021) three overarching interim report recommendations, perhaps of most significance to Family Start is their first recommendation:

> *In order to lead prevention of harm to tamariki and their whānau, collective Māori and community responsibility and authority must be strengthened and restored in a way that is fit for purpose within a modern and future context. The Crown's role is to support this Kaupapa (p.9).*

However, although perhaps to a lesser degree, the *Oranga Tamariki Future Direction Action Plan*'s focus on partnership and evidence (Oranga Tamariki, 2021), is also relevant to this evidence brief.

Methodology

The primary information sources for this evidence brief were systematic reviews[4] and meta-analyses[5]. However, given the unusually large volume of published home visiting systematic reviews and meta-analyses, several overviews of (systematic) reviews[6] have also been included. Academic and professional journal articles, books, and book chapters were identified, selected and reviewed using EBSCO (information services journal database) and Google Scholar. Searches of the Campbell Collaboration and Cochrane Library online systematic reviews databases were also undertaken.

Other data sources included the following:

1. EBSCO and Google Scholar were also used to search for individual research and literature reviews (i.e. not systematic reviews) of home visiting programmes or programme components, as well as some research studies on individual select programmes.
2. US Home Visiting Evidence of Effectiveness (HomVEE) reviews website (Department of Health and Human Services).
3. Select evidence-based websites:
    - California Evidence Based Clearing House for Child Welfare
    - Blueprints, and
    - Investing in Children.
4. Grey literature, i.e. online government reports and select home visiting programme websites.
5. A limited amount of unpublished New Zealand material.

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[4] *"A systematic review attempts to collate all empirical evidence that fits pre-specified eligibility criteria in order to answer a specific research question. It uses explicit, systematic methods that are selected with a view to minimizing bias, thus providing more reliable findings from which conclusions can be drawn and decisions made (Antman 1992, Oxman 1993). The key characteristics of a systematic review are: a clearly stated set of objectives with pre-defined eligibility criteria for studies; an explicit, reproducible methodology; a systematic search that attempts to identify all studies that would meet the eligibility criteria; an assessment of the validity of the findings of the included studies, for example through the assessment of risk of bias; and a systematic presentation, and synthesis, of the characteristics and findings of the included studies" (Higgins et al., 2021, section 1.2.2).*

[5] *"Meta-analysis is the use of statistical methods to summarize the results of independent studies (Glass 1976). By combining information from all relevant studies, meta-analyses can provide more precise estimates of the effects of health care than those derived from the individual studies included within a review…They also facilitate investigations of the consistency of evidence across studies, and the exploration of differences across studies" (Higgins et al., 2021, section 1.2.2).*

[6] *"Overviews of Reviews…use explicit and systematic methods to search for and identify multiple systematic reviews on related research questions in the same topic area for the purpose of extracting and analysing their results across important outcomes. Thus, the unit of searching, inclusion and data analysis is the systematic review" (Higgins et al., 2021, section 1.5.2).*

All research studies have their limitations, and this evidence brief is no exception:

- This is an evidence brief rather than a full literature review. As such it represents a good, but not necessarily a comprehensive, summary of existing literature.
- By definition the evidence brief is limited to findings from the large (evidenced-based) *home visiting programme* (research) literature, i.e. no interviews were undertaken with researchers or providers, no programme manuals were accessed for more detailed information beyond the Family Start one, little unpublished material was included, and randomised controlled trial groups aside, no comparisons were made between evidence-based home visiting programmes and other forms of parenting support services.
- For inclusion in systematic reviews and meta-analyses, article inclusion criteria usually require the use of an experimental research design, e.g. randomised-controlled trial. As such there is the potential that the characteristics and success factors of some other effective or theoretically more effective programmes are not included. Furthermore, systematic reviews and meta-analyses may 'mask' important differences across different programmes and have the effect of 'averaging out' the results from high and low scoring programmes.
- While a very limited number of book chapters available through EBSCO and Google Scholar and the grey literature have been included, most academic and professional books are not available through EBSCO or other academic journal databases.

While not methodological limitations per se, it is also worth noting that:

- Only two studies (McDonald, 2021; Paulsell et al., 2014) comparing the use of different home visiting programmes were identified and neither of these were empirical research.
- Beyond a synthesis of evidence on parenting programmes more generally that includes but is not limited to home visiting (Social Policy Evaluation and Research Unit, 2015), no Aotearoa New Zealand home visiting programme systematic reviews or meta-analyses were identified.

Findings

What are home visiting programmes?

Home visiting programmes are now in place in several countries including Australia, Bulgaria, Canada, Germany, Netherlands, Norway, Sweden, Switzerland and the United Kingdom[7] (Australian Nurse-Family Partnership Program, n.d.; Edvardsson et al., 2011; Enns et al. 2019; Howard & Brooks-Gunn, 2009; Kempe et al., 2018; Knoke, 2009; Leirbakk et al., 2018; Mejdoubi 2014, 2015; National [Canadian] Collaborating Centre for the Determinants of Health, 2009; Nguyen et al., 2018; Parents as Teachers, n.d.). However, while child protection systems across countries vary considerably (Gilbert et al., 2011; Parton, 2017) home visiting programmes are essentially a US construct and originally designed for the US context where there is little or no universal provision for expectant and new parents.

First developed in the 1980s, usually by university research centres and supported with randomised-controlled trials, today around 300,000 families are registered with a US home visiting programme. Home visiting programmes in the US were given impetus when the *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programme* was instigated by the Obama administration as part of its 2009/10 Affordable Care Act legislation (Center for Public Impact, 2016).

The US *Home Visiting Evidence of Effectiveness* website (Department of Health and Human Services, n.d.) recognises 21 different home visiting manualised programmes (aka Manualized Evidence-supported Treatments) as meeting their criteria for an evidence-based early childhood home visiting service delivery model for the purposes of accessing federal funding. The following are perhaps the four best-known ones (Duggan et al., 2018; Howard & Brooks-Gunn, 2009; MDRC, n.d.).

- Healthy Families America
- Nurse-Family Partnership
- Parent as Teachers – aka Parents as First Teacher in the UK where it currently operates and Aotearoa New Zealand (Ministry of Social Development, 2011) where it previously operated, and
- Early Home Start (home-based option).

Definitions of home visiting programmes tend to be very broad. For example, the California Evidence-based Clearinghouse for Child Welfare (n.d.) offers the following definition:

> *…any home visiting programs with a goal to improve child well-being, including physical health, development, and school readiness. Home visiting is a mechanism to provide direct support and coordination of*

[7] *Some programmes, for example the Nurse-Family Partnership, have been adapted differently across the countries that make up the United Kingdom.*

> *services for families which involves direct services to the family in the home setting. While services can also be received elsewhere, the home is the primary service delivery setting. Programs vary, but components may include 1) education in effective parenting and childcare techniques; 2) education on child development, health, safety, and nutrition; 3) assistance in gaining access to social support networks; and 4) assistance in obtaining education, employment, and access to community services.*

This definition from the US Child Welfare Information Gateway (n.d.) is a little more specific:

> *Home visits are recognized as a cost-effective means of promoting infant and child health, preventing maltreatment, and improving family functioning. In home-based programs provide new and expectant parents with support to build their basic caregiving skills and assist parents and other primary caregivers in bonding with children to encourage healthy child development and a positive home environment. They address issues such as maternal and child health, positive parenting practices, safe home environments, and access to services (para. 1).*

Because home visiting, as Howard and Brooks-Gunn (2009) argue, is a method of service delivery rather than a theoretical approach individual programmes can differ dramatically:

> *They vary with respect to the age of the child, the risk status of the family, the range of services offered, the intensity of the home visits, and the content of the curriculum that is used in the program. Furthermore, programs vary in terms of who provides services (typically nurses vs. paraprofessionals), how effectively the program is implemented, and the range of outcomes observed. What all share is the belief that services delivered in the home will have some sort of positive impact on families and that altering parenting practices can have measurable and long-term benefits for children's development (para. 3).*

How does Family Start compare with other mainstream home visiting programmes?

Beyond there being regular visits to expectant and/or new mothers or parents, home visiting programmes are remarkably diverse. Largely drawing upon the Family Start (Oranga Tamariki, 2022) theory of change diagram[8] and programme manual, and work by Howard and Brooks-Gunn (2009), the key features of Family Start, are identified as follows[9]:

- Developed for the Aotearoa New Zealand context as for example Early Start (rather than for the US, as for example the original Nurse-Family Partnership).
- Specifically targets parents or carers who are at risk, using detailed referral criteria which have some similarities with the screening tools used by Healthy Families America, Hawaii Health Start and Early Start (rather than serving broader populations such as low-income first-time mothers as with the Nurse-Family Partnership).
- Whilst taking prenatal referrals (unlike for example Hawaii Healthy Start Program, the Comprehensive Child Development Program, and the Infant Health and Development Program), most referrals and 'case activations' are postnatal (unlike for example the Family Nurse Partnership, Healthy Families America, and Early Headstart).
- Aims to improve a broad range of outcomes, i.e. health, education and social outcomes for children, parents' parenting capability and practice, and children's and parents' personal and family circumstances (rather than more specific outcomes such as reducing risk of child abuse/neglect as in the Queensland Study or improving maternal sensitivity as in the Netherlands study) (both cited in Brooks-Gunn, 2009).
- Developed and owned by a government department as for example Parent as Teachers and the Hawaii Healthy Start Program (rather than a university, as for example the Nurse-Family Partnership).
- Staffed by professionals as for example in the Nurse-Family Partnership and Early Start (rather than by paraprofessionals, for example Parents as Teachers and Healthy Families America).

[8] *Central to the Family Start theory of change are 12 core quality and service components as below:*

Core quality components (inputs/resources): *Qualified and professional Family Start workers, Quality Family Start worker - client relationships, Reflective clinical supervision, Effective data management and support, Community outreach and cross agency coordination, Adequate and sustained funding and Parent education.*

Core service components (outputs/activities): *Regular and ongoing home visits, Support parents' understanding of child development and positive parenting practice, Identification of issues impacting on health and wellbeing of the child (e.g. alcohol and drugs, family violence), Identification of social connections to community/whānau/hapu/iwi, Setting of specific, measurable, attainable, realistic, timely (SMART) goals to achieve families' aspirations.*

- Predominantly staffed by non-nursing professionals, (rather than those with nursing qualifications as in the Nurse-Family Partnership).
- A competency framework to guide the organisation's own training provision (rather than compulsory comprehensive programme training for all workers with the programme developer as with most mainstream programmes).
- A variable case load model approach with three levels of need-based visiting frequency (rather than frequency prescribed based on time on the programme as for example the Infant Health and Development Programme's weekly visits over the first 12 months and then biweekly).
- Flexible use of an online parenting resource tool as needed, rather than a prescribed curriculum as, for example, with the Nurse-Family Partnership.
- Grounded in theories of human ecology, self-efficacy, human attachment, strengths-based child-centred approach, partnership models and Tikanga Māori (Oranga Tamariki, 2022).
- Often used alongside other services such as antenatal care, Well Child, mental health services or counselling (rather than more standalone like many mainstream US programmes).
- Has never been the subject of randomised controlled trials – although over the years, Family Start has been extensively researched and evaluated using a wide range of methodologies including comparator group analysis using a quasi-experimental trial approach (for example, the Nurse-Family Partnership and Early Start).

What outcomes do home visiting programmes improve and for whom?

There is now a very large body of literature on whether home visiting programmes work, including many systematic reviews and meta-analyses. One systematic review (Paulsen & Avellar, 2011) revealed more than 10,000 citations on home visiting programmes.

From this literature, it is clear that home visiting programmes can and do *work*. However, they do not always work, nor to the degree expected (Duggan, 2012; Gubbels et al., 2021; Howard & Brooks-Gunn, 2019; Peacock et al., 2013; Supplee, 2016; Sweet & Appelbaum, 2004). As the systematic review undertaken by Filene and colleagues (2013) also put it: "Home visiting programs evidenced small but significant overall effects, with wide variability in the size of effects. Communities may need complementary or alternative strategies to home visiting programs" (Filene, 2013, S100).

Several other studies and systematic reviews have questioned the strength of the research evidence base to support existing home visiting programmes. *The Cochrane Database of Systematic Reviews'* infamous study *Home-based support for disadvantaged teenage mothers* (Macdonald et al., 2007), since withdrawn following a complaint by the developers and owners of the *Nurse-Family Partnership* model (Olds, 2007), found that while home visiting improved some outcomes, the evidence

overall provided only limited support for it as a means of improving the range of maternal and child outcomes. The same UK research team's companion systematic review *Home-based support for disadvantaged adult mothers*, also since withdrawn by Cochrane, was more definitive in finding no statistically significant differences for those receiving home visiting in comparison to control groups.

There are particular challenges around replicating and scaling up home visiting programmes (Paulsen & Avellar, 2011). Some caution also needs to be exercised in relation to the extent to which positive findings in home visiting from one country can be expected to successfully 'transplant' to another country's context (London Economics, 2008), and adapting home visiting models for use in other countries. For example, while an evaluation of an adapted Nurse-Family Partnership model in the Netherlands (Mejdoubi et al., 2014, 2015) found the model to be effective, the same was not the case with an English independent evaluation. Robling and colleagues' (2016) national randomised controlled trial of the Family-Nurse Partnership model (called the Family Nurse Partnership in England, FNP) concluded that "adding FNP to the usually provided health and social care provided no additional short-term benefit to our primary outcomes. Programme continuation is not justified on the basis of available evidence" (p.146). While there has been some methodological debate as to whether the evaluation's three selected outcome measures were the most appropriate or sufficient (for example, Barlow et al, 2016; Olds, 2015), this has led to some radical changes in the English model (as will be discussed later).

From the many primary and secondary research and evaluation studies, we can see that effects do vary across outcomes and subgroups (Molloy, 2021; van Assen et al., 2020). Typically, an 'effective' home visiting programme will meet a statistically significant threshold for an outcome, but not necessarily for more than one outcome (McDonald et al., 2012; Howard & Brook-Gunn, 2009). Furthermore some programmes demonstrate few if any positive outcomes at all.

> *The results of several meta-analyses suggest that home-visiting programs do have positive effects for participants, though those effects are often modest. Some studies, such as those testing the efficacy of the Nurse-Family Partnership program across several sites, have shown positive outcomes in multiple domains for both mothers and children, with some of these effects continuing into the adolescent years. Other studies, however, such as the Hawaii Healthy Start Program and similar Healthy Families America programs have had much more limited success. Still others, like Early Head Start, have shown modest effects at the end of the intervention, although follow-up data are not available (Howard & Brooks-Gunn, 2009, para 4).*

The following table identifies whether major home visiting programmes have been deemed to be effective in relation to eight identified domains.

Table 2: Howard and Brooks-Gunn (2009) select programmes and domain effectiveness

Program[10]	Substantiated child abuse & neglect	Parent-report child abuse & neglect	Child health & safety	Home environment	Parenting responsivity & sensitivity	Parenting harshness	Depression & parenting stress	Child cognition
NFP-Elmira	Yes		Yes	No	Yes	Yes	No	Mixed
NFP-Memphis			Yes	No	Mixed		No	Mixed
NFP-Denver				Yes	Yes		No	Mixed
Hawaii Healthy Start	No	No	No	No	No		Mixed	No
HFA-San Diego		Yes	No	No	No	Yes	Mixed	Mixed
HFA-Alaska	No	Yes	No	Yes	No	Mixed	Mixed	Yes
HFA-New York	No	Yes	No			Yes	Mixed	
Early Headstart			Yes	Yes	Yes	Yes	Yes	Yes
IHDP				Yes	Yes	Yes	Yes	Yes
CCDP			No	No	No	No	No	Mixed
Early Start	No	Yes	Yes		Yes	Yes	No	
Queensland programme			No	Yes	Yes		Mixed	
Netherlands programme					Yes		No	

Note: Adapted from 'The role of home-visiting programs in preventing child abuse and neglect' by K Howard & J. Brooks-Gunn, 2009. Copyright 2009 by Children and Youth Care.

Three particular aspects of the table are worth mentioning:

- The contrast between some of the programmes is rather marked, for example the Hawaii Healthy Start Program with no effective domains and Early Headstart with six.
- The contrast across some of the domains is also notable in that some appear to be well-evidenced and others not so much.
- Only one trial of one programme, the (1986) Nurse-Family Partnership randomized trial in Elmira New York, is shown to have improved outcomes in relation to the substantiation of child abuse and neglect; in a new systematic review Gubbels and colleagues (2021) conclude from their systematic review and meta-analysis that:

[10] *Abbreviations in table: NFP (Nurse-Family Partnership); HFA (Healthy Families America (HFA); Infant Health and Development Program (IHDP); and Comprehensive Child Development Program (CCDP).*

> *home visiting programs can prevent child maltreatment only to a small extent. Larger effects were found when programs focused on improving parental expectations of the child or parenthood, and when programs focused on improving parental responsiveness or sensitivity to a child's needs (p. 1).*

One of the challenges with the home visiting literature is that evaluations of programmes rarely collect detailed information on the services provided to families, and as such, "it is difficult to know whether impacts on particular outcomes are associated with implementation or with features of the home visiting model" (Duggan et al., p.iii).

As well as average outcomes, effects may also vary across different subgroups (Peacock et al., 2013); overall outcomes for an individual programme will therefore also be impacted by the particular cohort.

Why are home visiting programmes not more successful?

Many home visiting programmes have struggled to maintain their apparent effectiveness when replicated and scaled up (Paulsell & Avellar, 2011; Paulsell et al., 2014). In the Paulsell & Avellar (2011) study on the challenges of replicating, implementing, scaling up, and sustaining home visiting programmes, the authors investigated the effects of the *Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment* initiative. The programme funded organisations to design and implement programmes by selecting from five pre-determined evidence-based home visiting models. Those in the study successfully met a number of fidelity standards. They were usually successful at "hiring and training appropriate staff, obtaining appropriate referrals, delivering most of the planned visits, and covering the planned content during the home visits" (p. 23). However, many struggled to maintain consistent contact with families at the level of intensity required by the various home visiting models, i.e. they sometimes struggled to provide participating families with the correct 'dosage' of contact for the home visiting model(s) they had chosen; they also struggled to retain participating families.

While there could be a plethora of reasons explaining why an individual home visiting programme is not successful, meeting programme visit frequency requirements, as well as programme retention, regularly feature across the literature. Chiang and colleagues (2018) estimate that most home visiting studies show attrition rates ranging from 30% to 70%. There is also some evidence that those most at risk, as variously defined, are more likely to leave a programme. In their study of retention and attrition in a *Teacher First* home visiting programme in Alabama, Fifolt and colleagues (2017) found that "participants who were pregnant and under the age of 21 years were nearly eight times more likely to leave the programme than their peers" (p.1782).

Improving our understanding of attrition is therefore key to advancing work in home visitation (Ammerman, 2016; Chiang et al., 2018). Related to this is the issue of initial programme take-up, for example the Social Policy Evaluation and Research

Unit (2015) found in their review that only one-third of invited families enrolled on parenting programmes (including home visiting ones).

While an individual exercising agency by not taking up a home visting programme, not making themselves available for all (required) visits or leaving a programme early may sometimes be entirely appropriate, identifying, attracting and retaining target families is absolutely fundamental to any understanding of programme success factors.

Furthermore, Duggan makes the point that despite there being substantial literature that has generated evidence on home visiting impacts on family functioning, parenting, and child outcomes, many gaps in our knowledge about home visiting programmes still exist, including information about program implementation (Duggan et al., 2018, p.iii).

Where programmes are effective, what are their success factors?

We cannot fully answer this question from the literature. Certainly effective home visiting programmes appear, to varying degrees, to have some characteristics is common. From an Aotearoa New Zealand perspective on parenting programmes more generally, the Social Policy Evaluation and Research Unit (2015) found from their synthesis that:

> *Effective programmes tend to focus on positive problem-solving approaches, have a clear theoretical framework, be manualised and professionally supervised, and to have been robustly evaluated. Awareness of these characteristics can inform the design, development, monitoring and continuous improvement of new and existing programmes.*

However beyond this, as Howard and Brooks-Gunn (2009) state: “The wide variability in programs makes it difficult to draw solid conclusions about the [particular] conditions under which home visiting is most effective” (Howard & Brooks-Gunn, 2009, para 4). In a very recent meta-analysis, Gubbels and colleagues (2021) similarly concluded that “home visiting programs are widely endorsed for preventing child maltreatment. Yet, knowledge is lacking on what and how individual program components are related to the effectiveness of these programs”.

In their systematic review on home visiting possible success factors, McDonald and colleagues (2012), identified 20 possible components from the literature and then assessed the strength of the evidence in relation to each. These are shown in the following table.

Table 3: 20 home visiting programme components

PROCESS	CONTENT	WORKFORCE
Number of Visits	Parenting	Home Visitor Qualifications
Age Commencing/Finishing	Parent Health	Home Visitor Competencies
Antenatal vs Postnatal Recruitment	Child Health and Development	Caseload
Eligibility Criteria	Addressing Background Factors	Clinical Supervision
Use of Quality Improvement	Summary of Content Delivery Mechanisms	Training and Coaching
Use of ICT	Approaches to Delivering Content	
Implementation Science/Evaluation Principles		
Service Coordination		
Maintaining Engagement With Itinerant Families		

Note: Adapted from 'The Sustained nurse home visiting for families and children: A review of effective programs' by M. McDonald, T Moore, & S. Goldfeld, 2012, pp.16-52. Copyright 2012 by The Royal Children's Hospital Centre for Community Child Health, Murdoch Children's Research Institute.

However, there was strong evidence to support only one of these components, that being antenatal versus postnatal recruitment, i.e. recruiting programme participants before they had given birth was a success factor. Otherwise the review was unable to identify any other characteristics that appeared to 'make the difference' in terms of effectiveness. Similarly, Filene et al. (2013) and Peacock et al. (2013) found no overall success factors that were not outcomes-specific either.

McDonald and colleagues (2012), concluded that the findings of their review showed: "(a) the evidence regarding the 'components' of home visiting programs is contradictory or contested or (b) the evidence is not available" (p.51).

Taking a different approach, Gubbels and colleagues (2021) reviewed the evidence in relation to 32 potential programme components, with a particular focus on child maltreatment. Their findings on strongly evidenced programme components, were similarly inconclusive, including for prenatal or postnatal recruitment:

> *None of the coded contextual factors (i.e., the specific individual program, age of the child, whether the program starts prenatally or postnatally, whether or not telephonic consultation was provided, and whether or not all family members were targeted) or structural elements (i.e., the type of home visiting professional, whether or not home visitors received training, whether or not home visitors were matched to families, whether or not a curriculum was used, program duration, average number of home visits, average duration of home visits, and home visit intensity) significantly moderated the overall effect of home visiting programs.*

However, in another new systematic review specifically focusing on sustained nurse home visiting programmes (Beatson et al., 2021), the authors found seven, albeit largely broader, core components or potential 'active ingredients' that have demonstrated positive effects on maternal or child health, psychosocial development, or self-sufficiency outcomes among disadvantaged families as follows:

> *Comparison of the seven eligible programs showed seven common core components: antenatal commencement, support to child age 2 years, at least 19 scheduled visits and experienced or highly qualified nurses with program-specific training, caseloads of approximately 25 families, regular supervision, and multidisciplinary supports. Outcome-specific program content was generally not well reported.*

What other potential success factors have at least some supporting evidence?

Using the headings from McDonald and colleagues' (2012) in Table 3, and incorporating findings from Beatson et al. (2021), McDonald et al. (2012) and Gubbels et al. (2021), the following are identified as potential success factors:

Process

- Antenatal recruitment (Beatson et al., 2021; McDonald et al., 2012).
- Targeting families who are at risk and/or have multiple or complex problems (although there is some evidence that high-risk families may not benefit as greatly as moderately at risk-families) (McDonald et al., 2012).
- A greater number (Beatson et al., 2021) and frequency (Nievar et al., 2010) of visits, over a longer period of time (although for some specific outcomes less intensive approaches may be effective) (McDonald et al., 2012). Both Peacock et al. (2013) and Supplee (2016) particularly emphasise the need for more research on the optimal number and length of visits, given that some programmes only require three visits while others may continue for multiple years.
- Ensure that any chosen home visiting model (and particularly one that does not allow for adaptations) aligns with community needs and goals (Osbourne, 2016; Supplee, 2016); context matters (Osbourne, 2016).
- An approach of cultural and ethnic sensitivity to home-visit programmes seems to work well for families with an ethnic minority status (and by extension possibly Indigenous people status) (Gubbels, 2021).
- Incorporation of motivational interviewing (Biggs et al., 2018) and potentially other evidence-based individual practices (Chorpita et al., 2007; Embrey & Biglans, 2008; Shlonsky & Benbenishty, 2014).

Content

- Focusing on improving realistic expectations with and of parents regarding their child and/or parenthood (Gubbels, 2021; Osbourne, 2016).

- Focusing on parental responsiveness and sensitivity to cues of the child (Filene et al., 2013; Gubbels, 2021; Howard & Brooks-Gunn, 2009).
- More parenting programme components (Gubbels, 2021) including teaching discipline and behaviour management techniques as well as problem-solving (Filene et al., 2013).
- Using video-recordings of parent-child interactions (Gubbels, 2021).
- Fidelity is important, but so is innovation (Osbourne, 2016).

Workforce

- Quality of the helping relationship (Fifolt, 2017; Sierau et al., 2016): Highly experienced or qualified nurses with programme-specific training (Beatson, et al., 2021), and if targeting families with multiple and complex problems, employing an appropriately skilled and experienced workforce (McDonald et al., 2012).
- Define expectations of home visitors more precisely (McDonald et al., 2012).
- A caseload of about 25 families, regular supervision and multidisciplinary support (Beatson et al., 2021).
- Build implementation systems that support home visitors in how to:
    - Increase family engagement and programme retention through gaining a better understanding of the influence of the both the worker's and the mother's individual attachment style (high or low anxiety, and high or low avoidance) and the impacts upon the effectiveness of their relationship (Duggan, 2012; McFarlane et al., 2010, Peacock et al., 2013).
    - Raise sensitive topics effectively, build mothers' readiness to address these topics, empower them to take action and affirm their successes (McDonald et al., 2012).
    - Introduce individual family support plans to families and how to help families articulate their goals (Duggan, 2012).
- Go beyond linking families with other services, and collaborate with other service providers (where appropriate to do so) (Duggan, 2012).

Internationally, what is the direction of travel?

Revisiting fidelity and the rise of implementation science

The conventional wisdom has long been that 'evidence-based' home visiting programmes will work if they are implemented with high levels of fidelity, i.e. "the extent to which delivery of an intervention adheres to the protocol or programme model originally developed" (Mowbray et al., 2003, p.315). While there are calls for greater attention to programme fidelity (Ammerman, 2016), the research is increasingly reflecting a broader concept of programme fidelity that goes beyond inputs such as staffing requirements, visiting schedules, curriculum, and professional tools, and seeks to better address programme reach, engagement, and retention. As

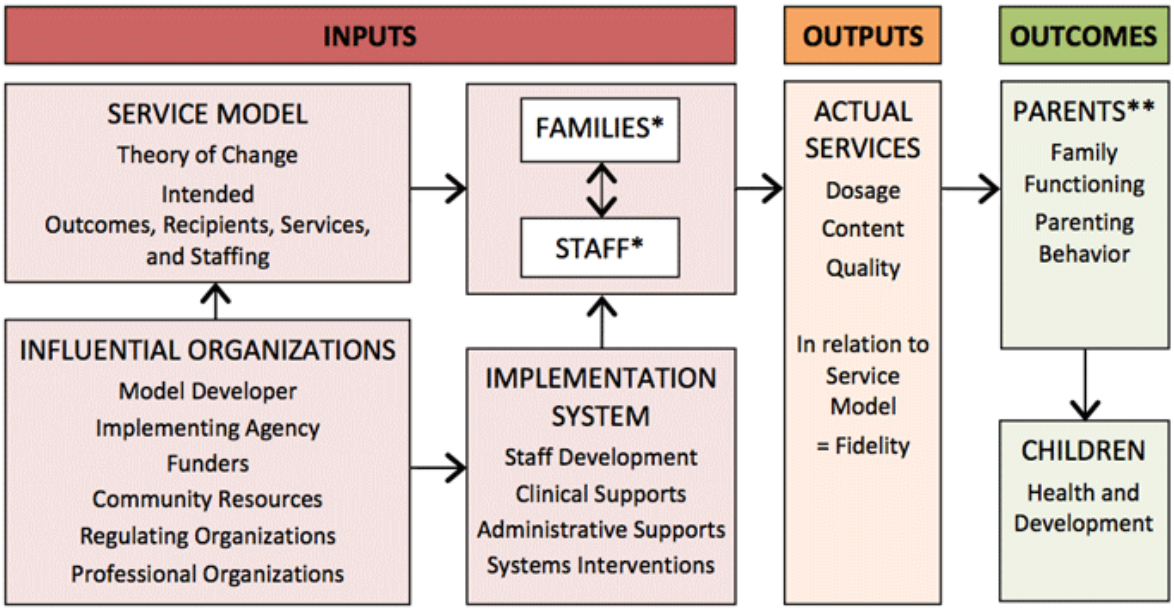
discussed previously, this is being reflected in a strengthened focus on replication, scaling up, and sustainability (Durlak & DuPre, 2008; Mathematica, 2014; Paulsell & Avellar, 2011; Paulsell et al., 2014).

Duggan (2012) argues that to better understand our current and future home visiting outcomes, we need to better understand how our programmes and wider systems are meant to work and operate in practice:

> *Most published studies of home visiting focused on outcomes rather than looking at actual service delivery, which can strongly impact family outcomes. In contrast, our work looks at how services are delivered to families, and the possible reasons for unintended variation in service delivery. We do this by using 1) an implementation science conceptual model—that is, a roadmap leading from the program's service model to its desired family outcomes—that considers both organization- and individual-level factors, and 2) behavioral theories, such as attachment theory, to better understand how services are delivered (para 4).*

As such, Duggan (2012) proposes the following as her home visiting roadmap to service delivery conceptual model.

Figure 3: Duggan's home visiting roadmap to service delivery conceptual model



Note: Reproduced from 'Service is everything: How home visiting service delivery impacts family outcomes'.Copyright 2012 by Harvard Family Research Project.

** For both families and staff, key attributes include Demographics; Psychosocial Wellbeing; Cognitive Capacity; and Attitudes, Perceived Norms, Personal Agency, Knowledge, and Skills regarding Expected Behaviors.*
***This diagram illustrates the model for a programme that improves outcomes for the child indirectly, through direct benefits for parents. The diagram could also be altered to show direct benefits for the child (e.g., to represent an early intervention programme that provides direct services to the child).*

On the basis of their meta-analysis, Segal and colleagues (2012) also recommend the rigorous use of a logic model approach to ensure strong alignment across

objectives, theory of change, target population, and programme components; they found that where that was the case, programme outcomes were more likely. While in some respects Duggan's (2012) model is similar to many other logic models and theories of change, including the diagram for Family Start, this has three particularly significant elements.

- There is a clear focus on dosage, content and quality, through the actual service that is delivered, being what transforms inputs into desired outcomes
- It recognises that neither families nor staff are homogeneous groups, and
- The changing context and the important or critical role of influential organisations is also captured.

In another development with implications for both implementation and fidelity, there has also been a growing recognition of the importance of community engagement in determining needs and aspirations, in the choice of any particular home visiting model (for example, Mattox et al., 2013); in Aotearoa New Zealand the Social Policy Evaluation and Research Unit (2015) made a similar point in relation to parenting programmes more generally.

Greater programme flexibility and adaptability

Some home visiting models specify rigid implementation, with a highly specified visiting schedule and the use of a specific curriculum, and specified tools and target outcomes, while others are more flexible (Supplee, 2016). While not necessarily mutually exclusive, as some programmes are looking to strengthen fidelity, there is increasing recognition of the value of programme flexibility and adaptability in order to meet particular needs and circumstances (Social Policy Evaluation and Research Unit, 2015).

This has perhaps been most apparent in the expansion of the Nurse-Family Partnership internationally. For example, the Australian Nurse-Family Partnership Program has been particularly adapted for the Australian context; it is only available for children who are Aboriginal or Torres Strait Islanders, and includes an additional Aboriginal Family Partnership Worker role in all home visiting teams. The Family Partnership Worker works in partnership with the Nurse Home Visitor (NHV) (Australian Nurse-Family Partnership Program, n.d.; Molly Wardaguga Research Centre, n.d.).

In England, there have also been significant adaptions. The Family-Nurse Partnership (as it is called in the UK) has co-developed and incorporated an assessment tool called the *New Mum Star* (Outcomes Star, 2018). While Outcome Stars are widely used in the UK across a range of groups including new mothers, this assessment tool was specifically designed for young first-time mums and spans pregnancy and the first 1-2 years after birth. Organised around nine topics (the points of a star), the tool helps mothers to see whether they are 'stuck', 'starting to engage', 'trying to engage', 'finding what works' or have achieved 'self-reliance'. While building a shared understanding of needs and aspirations, the tool is also used to make decisions with the mother on programme adaptations. As well as 'flexing content' to better meet needs and aspirations, other forms of programme

personalisation used are 'dialing up or down' the frequency and intensity of visits (i.e. dosage), and the possibility of early graduation (Family Nurse Partnership National Unit & Dartington Service Design Lab, 2020).

Supplee (2016) notes "there is currently little research on the extent to which giving implementation agencies the ability to be flexible and tailor their programs is related to greater impact for families" (para 6). In particular, it is worth noting that neither the Australian Nurse-Family Partnership Program nor the recently redeveloped English Family Nurse Partnership models appear to have yet been externally evaluated. However, it is interesting to note that in an attempt to increase retention, the developers of the Nurse-Family Partnership in the US have also made some changes to enable the programme to be delivered in more flexible and adaptable ways. This from David Olds, Nurse-Family Partnership Programme Founder and Professor of Paediatrics:

> *The FNP programme has been designed from the very first trial in Elmira, New York [Olds et al., 1986] to be adapted to individual families on a visit-to-visit basis. We failed to embody this principle in a sufficiently thorough way, however, in programme design, nurse education and US replication – a shortcoming carried over in our guidance to those responsible for creating nurse education outside of the US (and that we have since worked hard to correct) (Family Nurse Partnership National Unit & Dartington Service Design Lab, 2020, p.5).*

Increased focus on social and emotional wellbeing and the effects of trauma

Mental health issues, trauma, and partner violence are often prevalent in families served by home visiting programmes. Where programmes have not been designed with this in mind, programme effectiveness can and will be compromised (Cairone et al., 2017; National Home Visiting Resource Center, 2020). The former *National Center for Healthy Safe Children*. (n.d.) in the US developed *Project LAUNCH*, that aimed to integrate mental health supports into existing home visiting programmes. A federal initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), key features were:

- Training home visitors on social and emotional wellbeing and behavioural health of young children and families
- Integration of social-emotional and behavioural health screening into home visiting programmes
- Provision of reflective supervision and case consultation for home visiting staff
- Brief intervention, including mental health consultation and crisis intervention, prior to a warm handoff for additional services and supports
- Increased coordination and information sharing across home visiting programmes.

As such, Project LAUNCH had the stated aim of enhancing, rather than duplicating, the efforts and effectiveness of existing home visiting programmes.

Taking a broader trauma perspective, a recent research brief from the US National Home Visiting Resource Center (Morrison et al., 2020) entitled *Implementing Trauma-Informed Approaches in Home Visiting* and drawing on the home visiting and wider literature (for example, Cairone et al., 2017; Mersky & Janczewski, 2018), argues for the adoption of more trauma-informed approaches in home visiting programmes:

> *Home visiting participants typically face more adverse experiences, such as abuse, food and housing insecurity, or exposure to violence, than their counterparts. Yet many families—and even members of the same family—process negative events differently, with only some perceiving them as traumatic (p.1).*

The authors recommend that organisations train home visiting staff on the prevalence, causes, and consequences of trauma, implementing trauma screening, and strengthen service coordination.

Beyond individual programmes: Components of a successful home visiting system

Many or most US states fund several different home visiting programmes. Focusing on home visiting system infrastructure rather than individual programmes, the US Center for Healthy Safe Children (2010) developed a home visiting system self-assessment and planning tool to help states to "replicate high-quality programs and maintain model fidelity. Strong and collaborative home visiting state systems provide the infrastructure to support these important decisions" (p.1). This collaborative tool, which has relevance to the Family Start context, helps states to identify and strengthen the key components of their state-wide home visiting systems. The individual self-assessment components are identified as:

- Needs assessment and programme planning
- Evaluation and quality assurance
- Programme standards
- Professional development and technical assistance
- Early childhood partnerships and collaboration
- Public engagement
- Administration and governance
- Financing and sustainability
- State-specific considerations.

Growth in home visiting programmes for Indigenous people

Over recent years there has been a growth in home visiting programmes for Indigenous people in both the US and Australia. For example:

- Family Spirit is a US home visiting programme developed by Indigenous people for Indigenous people.
- The Nurse-Family Partnership Australia is a mainstream US home visiting programme with major adaptations designed specifically for Aboriginal and Torres Strait Islander people in Australia.
- Parents as Teachers Tribal Maternal Home Visiting is a mainstream US home visiting programme applied (in particular their curriculum) in a range of different ways by and with Indigenous people.

None of these programmes were originally developed by government and only the Australian Nurse-Family Partnership Program is managed by a government department. Family Spirit was specifically developed by and for Indigenous People. Indigenous academics and researchers have a critical role to play in relation to both Family Spirit and the Australian Nurse-Family Partnership Program, through the John Hopkins University Center for American Indian Health and the Charles Darwin University Molly Wardaguga Research Centre respectively. Beyond indigeneity, neither Family Spirit nor the Australian Nurse-Family Partnership model specifically target families at risk. Family Spirit, the Australian Nurse-Family Partnership and Parents as Teachers Tribal Maternal Home Visiting all incorporate Indigenous teachings (see the companion report on Indigenous case studies for more on these programmes).

Conclusion

Comparatively, home visiting programmes have been subject to more research than perhaps any other form of child welfare provision, yet the primary focus of this literature over the last 40 years has been on whether home visiting works. It tells us considerably less about second order questions such as why programmes may work, who they may work for and in what circumstances, and how barriers may be overcome. Furthermore, while most but not all systematic reviews and meta-analyses have deemed home visiting programmes to be effective, results have tended to be modest. In part this is because all home visiting programmes are in their own way unique, with different aims, participants, processes, content, and workforces (and increasingly different countries). Many home visiting programmes have also faced challenges around replication, scaling up, and sustainability, particularly so in relation to attracting, recruiting and retaining families.

A number of possible success factors are identified, for example, high visit frequency, aligning programme with community needs and wishes, and the quality of the helping relationship. However, only one factor is strongly supported by the research evidence, i.e. that antenatal participant recruitment is preferable over postnatal recruitment.

However, much of this literature remains focused on whether home visiting works. Along with the challenges around replication, scaling up, participant attrition, and sustainability, there is much that we still do not know, and there are some limitations on the application of learning from contexts that are very different to our own.

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