

SOCIAL POLICY



Helping Families with Young Children — a Closer Look at Home Visitation in California

by

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and

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Home visitation is an increasingly popular strategy for delivering services to families with young children. Home visitation programs seek to improve child health and development, prevent child abuse, increase family literacy and school readiness, and encourage family self-sufficiency. There is no single model of home visitation; programs differ widely by philosophy, services, target population, and staff credentials. Although home visitation programs are difficult to evaluate, rigorous evaluations show positive, but limited, effectiveness. Research supports an array of “best practices,” including maintaining a comprehensive approach, identifying a target population, providing links to other services, *continued inside...*

A Closer Look at Home Visitation in California

This article examines the benefits and challenges of expanding home visitation services, as well as unanswered questions from evaluations of these programs.



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working with voluntary participants, using well-trained staff, and providing adequate intensity of services. The findings from existing evaluations are difficult to extrapolate to current California programs. Current California programs often have multiple goals and serve linguistically or culturally isolated populations. Furthermore, many programs are designed to link families to other resources and hence can be difficult to evaluate independently. Several California counties have developed home visitation collaboratives; however, numerous programs remain unlinked, resulting in uncoordinated services and uneven service coverage. In all cases, home visitation is an expensive, labor-intensive service that often faces unstable and complex funding streams. The limited magnitude of the effects of the programs underscores both the challenge of accurately assessing the benefits of home visitation and the necessity of viewing home visitation in the context of a broader set of services geared toward improving the outcomes for young children and their families.

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Introduction

Home visitation is an increasingly popular strategy for delivering services to families in California. Since 1998, both the Office of Child Abuse and Prevention (OCAP) in the California Department of Social Services and the California Children and Families Commission have identified home visitation as a primary strategy to prevent child abuse, promote healthy development, and improve the emotional, physical, and intellectual environments of young children. OCAP, in collaboration with the Governor's Office of Criminal Justice Planning (OCJP), funded the \$9 million Answers Benefiting Children (ABC) initiative, a family support home visitation model implemented in 17 California counties. Using funding from the Proposition 10 cigarette tax, county Children and Families Commissions have incorporated home visitation as a key practice in their strategic plans to improve outcomes for children less than six years of age.

The ABC initiative and the Proposition 10 support for home visitation are part of a state-wide—and nationwide—rise in the popularity of home visitation. The Packard Foundation estimated in 1993 that home visitation programs—programs intended to prevent child abuse, prevent low birth weight births, and improve school readiness—were serving 200,000 children and their families around the country. By 1999,

the Packard Foundation estimated that enrollment in the six most recognized programs had grown to 550,000 and that the total number of home visitation programs had risen into the thousands.¹

Despite its popularity, there are many unresolved issues pertaining to home visitation, ranging from exactly what it is, to how effective it is in achieving its goals. The costs of home visitation need to be weighed against its benefits. The passionate support that home visitation engenders in its proponents needs to be balanced by an awareness of the challenges of expanding these services, as well as the unanswered questions arising from rigorous evaluations of the service strategy. Based on our review of the existing literature and the experience of practitioners around the state, we identify seven points that should be recognized by policymakers as they consider further investment in home visitation.

Home Visitation Programs: Issues to Examine

1. *There is no single model of home visitation*

Within the health and social service context, the term “home visitation” covers vastly different intervention models. A home visit is simply a visit made by a caseworker to a family in its home. Apart from that most basic commonality, home visitation programs differ significantly. The

most critical distinction is between programs in which home visits comprise the core service and those that use home visits as an infrequent supplement to other services. From the point of view of the family, what is most important is whether the home visitor is seen as providing the main connection to the program. Discussions of home visitation usually focus on those programs where home visits are an integral and essential part of service delivery. In such programs, a visitor is typically involved with a family for up to a year or more, providing case management services, assessing the family’s strengths and needs, and linking the family to appropriate services.

While home visitation programs vary greatly, proponents of this service delivery strategy share some common beliefs. They recognize that home visitation is a uniquely intimate service, a service by and large dependent on the relationship between the visitor and the family. Most important, proponents agree that the best way to reach families who are disinclined to independently seek services in the community is to bring the services to the home. For this reason, home visitation programs are often established for new parents, low-income families, or new immigrants, all of whom may have difficulty accessing resources on their own.

When considering programs that rely on home visitation, policymakers should start by comparing the

following elements:

- **Goals and approach:** Home visitation programs most commonly seek to improve child and family well-being by focusing on child health and development, child abuse prevention, family literacy and school readiness, or family strengthening and self-sufficiency. The primary goal of the program may guide its approach: some programs concentrate on the child, while others focus on the parent or on the interactions between the parent and child. However, the nature of family dynamics may make it difficult to effectively address one of these dimensions without addressing other interrelated issues. Therefore, in practice, most home visitation programs necessarily have multiple goals.
- **Services:** Home visits are used both to conduct assessments and to deliver services. Some of the best known programs rely on a well-defined curriculum. The services provided generally include a mix of activities: modeling effective parenting and problem solving; educating parents on topics such as child nutrition, discipline, and pre-literacy activities; and assisting families in obtaining additional services in the community, such as income and nutritional assistance, childcare, and health care. Referrals are generally made for specialized

¹ D.S. Gomby, P.L. Culross and R.E. Berhman (1999), “Home Visiting: Recent Program Evaluations – Analysis and Recommendations,” *The Future of Children*, 9(1): 4-26.

services – mental health treatment, substance abuse treatment, and speech and language therapy – if they are not available through the program.

- **Client participation:**

Most programs are voluntary, although some home visitation programs, such as those linked to child protective services, may be mandatory (generally as prescribed by federal or state requirements).

- **Target population:** Each program typically specifies a target – or eligible – population for its services. Target populations may include children of a particular age, mentally ill and disabled children, or special populations, such as youths on probation. A majority of the programs are geared toward children from zero (or prenatal) to five-years old, often with teenaged or first-time mothers.

- **Staff credentials:** Home visitors come from a variety of professional backgrounds, including nursing, social work, nutrition, teaching, and counseling. Paraprofessionals are also commonly employed as home visitors. Such staff members do not have strong academic credentials but are typically trained to work with families by the program that hires them. Paraprofessionals are most common in programs serving culturally or linguis-

tically isolated populations, where community members may be particularly effective in reaching out to others. Many programs rely on a team of visitors from a mixture of professional and nonprofessional backgrounds.

- **Duration and intensity:**

Programs vary in length (from a single visit to several years) as well as in intensity (from weekly visits to monthly or even less often). Both of these parameters are generally set by the program design, yet in practice are directly dependent on the individual participant's needs and compliance. Thus, it is common to find variation within a program on the "dosage" of the service delivered.

- **Program administration:** Both public and private organizations, as well as collaborative groups, run home visitation programs. Some agencies operate more than one home visitation program, usually as a mechanism for serving different target populations.

- **Size and worker caseload:** Home visitation programs range in size, with some delivering services to only 20 families a year and others serving 1,000 or more. Accordingly, the structure of a program and the number of home visitors it employs differ across programs. The frequency

of visits largely determines the caseload for a visitor; however, programs that employ regular (weekly or biweekly) visits typically limit the visitor caseload to about 20 to 25 families. Restrictions on the number of cases a visitor can carry naturally imply that some programs will face waiting lists for their services, as they are constrained by limited financial and labor resources.

2. *Rigorous evaluations show positive effects of home visitation programs*

The success of home visitation programs is difficult to quantify. A number of early home visitation programs, however, have been the subjects of rigorous evaluations using experimental methodology to assess the impact of participation in the programs.² Examples include Hawaii Healthy Start, Healthy Families America, Parents As Teachers and the Comprehensive Child Development programs. By far the best known and best documented program is the Nurse-Family Partnership Program, frequently referred to as the "Olds model" after its founder Dr. David Olds, which followed mothers and children over 15 years after entry into the original program in Elmira, New York.³

All of the evaluated programs showed improvement in at least one of the measured outcomes. Several models of home visitation

² For example, see D.S. Gomby & P.L. Culross, Eds. (1999), "Home Visiting: Recent Program Evaluations," *The Future of Children*, 9(1): 1-224.

³ This program was formerly known as both the Prenatal and Early Intervention Program and the Nurse-Home Visitation Program.

exhibited at least one positive effect on reducing child abuse and neglect, an underlying goal of many programs. Almost all of the evaluated programs are associated with at least one improvement in the home environment or in parenting skills, while a few appear to favorably alter the mother's life course. Programs in which the home visitors focused on health were more likely to see some improvements in the health status or use of preventive health care for children. Likewise, programs in which home visitors focused on child development were most likely to have positive results in this area, with far weaker outcomes found in other programs. Lastly, the one study with long-term follow-up (the Elmira trial of the Olds model) found some positive effects on children's behavior into adolescence.

Nevertheless, we urge caution in drawing conclusions from the evaluation findings. First, the results not only vary across programs, but they also vary within a program for different subgroups of participants and across different replications of the same model. This makes it difficult to predict outcomes based solely on the program model. Second, a gap always exists between the elements defining a program and how the service is actually delivered. None of the evaluated programs were able to deliver the full range of planned services; on average, they provided half of the intended visits and had 15 to 65 percent of their

clients leave the program before the endpoint identified by the service provider.

3. Evaluation findings suggest an array of "best practices"

As with many social services, there is an interest within the field of home visitation in developing a set of "best practices." Evaluation results lend support to the notion that there is no "best" program model, but that it is possible to identify the best elements from the wide array of models. The proposed best practices presented below comprise the characteristics and strategies most likely to induce positive outcomes based on existing evaluations:

- Philosophy and culture: Keep the program comprehensive in focus, with an aim toward being an integral part of a broader community support system.
- Home services: Base home services on a well-defined curriculum compatible with a family's needs, culture, and language.
- Client participation: When possible, keep client participation voluntary.
- Target population: Focus on a targeted population - rather than a universal one.
- Attrition: Ascertain why clients enroll and why they choose to leave; address specific barriers

to client continuation in the program.

- Staff caseloads: Restrict caseloads to a fixed number of clients per visitor.
- Credentials of staff: Use nurses, trained paraprofessionals, or staff with an advanced degree in a related discipline. Visitors' skills and program objectives should be well matched.
- Duration and frequency: Greater intensity (weekly or biweekly visits) is more effective than longer duration.
- Other: Maintain flexibility and visitor attention to individual client needs; establish clear channels of communication among all parties involved and the community; implement continuous evaluation and modification as needed.

4. Evaluation findings are difficult to extrapolate to current California programs

The range of programs considered in the literature does not directly

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coincide with typical programs operating in California (and many other locations) today. Most of the home visitation programs subject to rigorous evaluation have been largely independent and self-contained, with a somewhat limited range of goals and a very specific target population, such as low-income young mothers. Recent home visitation initiatives differ in three major ways from these earlier programs. First, they are frequently part of a comprehensive system of services rather than a stand-alone program – often operating out of one or more family resource centers that provide a broad array of services. Second, particularly in California, home visitation programs reach out to linguistically or culturally isolated individuals. Third, many current programs have a broader range of goals and focus on more universal coverage.

What we see in California today is essentially a new – albeit related – approach to home visitation, where the program operates within a system of other community services. As well as providing specific services such as parenting education, one explicit objective of these new home visitation programs is to link participants to a range of other services within the

community, fostering the connections necessary to ensure that program participants will receive needed services from other existing resources. Envisioning home visitation as a bridge into a variety of services is not new, but the closer linkage of home visitation and these other services makes current programs somewhat different from those previously evaluated. Moreover, there is little research on how best to integrate home visitation with other services.

Home visits bring resources to homes where families (especially mothers of infants and young children) may not be aware of the network of services in the community. In California, these are often immigrant families who may be isolated because of language, immigration status, or cultural barriers. Findings from past evaluations are specific to the group and program studied, and expected outcomes are not necessarily comparable across different populations. The major experimental programs, such as the long-term follow-up in the Olds model, involved participants with very different characteristics from those now served in California. The evaluation results cannot necessarily be directly applied from group to group or across programs. However, replications of the Olds model in a number of cities suggest that effective programs have common characteristics regardless of the families they serve. Nonetheless, adopters of these models

for the diverse populations served by programs in California should recognize that curricula and other program features may need to be modified in order to be culturally relevant and responsive to such families.

Finally, many of the evaluations highlight the particular curriculum of a program as an important link to the observed outcomes. In contrast, the outreach and referral role embedded and emphasized in almost all current California programs necessarily leads to a much larger set of program goals, tied closely to family circumstances and needs, than established by a formal curriculum designed to influence specific outcomes. Moreover, the success of any home visiting program – past or present—depends largely on the strength of the relationship between the home visitor and the family, an aspect that is difficult to quantify and compare across models.

Taken together, these differences suggest that the existing evaluations cannot always be applied directly to specific elements of many current models of home visitation. Nevertheless, overall findings from past research that highlight the importance of the quality of the program are clearly applicable to current models. Hence, developers and managers of the emerging framework of home visitation can find lessons in existing research but must bring their own judgment of the needs of their communities and



the strengths of potential visitors to determine the best practices for their specific program.

5. The placement of home visitation in a network of services makes it difficult to evaluate separately

The intimate relationship that develops between the visitor and participant – frequently a contact between two women – may be critical for bringing a mother into the network of community services. A successful home visitation program builds on this relationship to involve a family in a wide range of services that they would not otherwise access. However, this integration of services makes it difficult to measure the impact of home visitation separately from the other services. In fact, it makes more sense to ascribe credit for a family's progress to the "village of services," as each program ultimately plays an important role in combination with the others. Observable outcomes may then result from these subsequent services rather than from the home visits themselves. For a family with a multitude of stressors, the direct effect of home visitation alone may be too subtle to realistically expect a measurable impact; however, without the home visitor, a family might not be able to take advantage of other services that potentially have greater measurable effects. Since the success of home visitation is closely associated with the degree of services available

within a community, it is also difficult to compare the impact of home visitation in one community to that in another.

Proponents of home visitation also point to other benefits, not easily (or reliably) quantifiable, that may accrue from the relationships that grow between a visitor and her clients. The visits may enable simple yet important breakthroughs, such as getting a socially isolated young mother out of the house or helping her to take her child to the park. Indeed, the sequence of visits may also empower the visitor. Frequently the home visitor is a paraprofessional, perhaps a parent with the same background or from the same community as the program client. The experience of being a home visitor and working with families may encourage the home visitor to go back to school or advance her own personal and professional growth. Her additional knowledge of the community's resources and the social capital she develops in dealing with the social service system may build connections for members of the community beyond her immediate clients.

6. Home visitation is an expensive service, often facing unstable funding

One reason to move carefully into the home visitation arena is the high cost of the service. Home visitation is extremely labor intensive. Because clients are seen

The high cost and long duration of services make securing an ongoing funding stream a particular concern.

one-on-one in their homes, extra time must be allowed for travel in addition to the time for the visit itself. As a result, caseloads are small, especially for the most intensive programs where visitors may carry only 20 to 25 clients in a year. For example, the cost to develop a Nurse-Family Partnership replication site capable of serving 100 families is estimated at approximately \$780,000 over three years. This total can be broken down into the initial start up costs of \$80,000 or more, and the ongoing cost per family, which nears \$7,000 per service cycle (from prenatal to a child's second birthday). Likewise, an intensive home visitation program under the auspices of Orange County's collaborative of community organizations costs \$2,500 per family over a one-year period.⁴

Like many social services, home visitation programs are often operated by nonprofit organizations that are funded by a variety of grants and donations. (These programs are also operated through public health departments and county child welfare agencies.) Almost all programs provide services at no charge to the participants and are fully reliant on

⁴ Cost estimates for the Nurse-Family Partnership replication are drawn from "Promising Practices: Prenatal And Early Childhood Nurse Home Visitation Program" by the Welfare Information Network, (available online at www.welfareinfo.org/prenatalandearlychildhood.htm) and from "The Prenatal and Early Childhood Nurse Home Visitation Program" in Strengthening America's Families: Effective Family Programs for Prevention of Delinquency (available at www.strengtheningfamilies.org/html/programs_1999/12_PECNHVP.html). Information on Orange County provided in personal communication with the Child Abuse Prevention Center of Orange County.

outside funds. Service providers thus find themselves facing trade-offs between the expense of home visitation and less expensive service approaches—such as group classes or center-based services – as they consider ways to fund their programs.

The high cost and long duration of home visitation services also make securing an ongoing funding stream a particular concern for service providers. Federal, state, local, and private agencies currently fund home visitation programs in California. Despite many funding opportunities, programs face numerous problems in matching funds to the program goals. For example, grants are often short-term – one or two years – and frequently large enough to cover only a fraction of program costs. In addition, grant renewals are typically contingent on some measure of program performance, which is a challenge for programs with long service periods where outcomes may take substantial time to emerge. Thus, programs must dedicate significant resources to maintaining funding instead of directing those efforts to improvement or expansions in service provision. Recently, ongoing support for these programs has become even more difficult, given the effect of the current economic situation on both government revenues and foundation resources.

The fact that many programs receive funding from two or more

sources adds complexity to both program design and reporting. Funders generally exert a strong degree of influence over the programs they fund, so home visitation programs are accountable to a range of (sometimes competing) expectations and conditions. In some cases, the funder decides which model of home visitation is used. This is true in the case of OCAP's ABC Initiative, in which OCAP specified the Cal-SAHF model of family home visitation.⁵ In other cases – such as the programs funded by Proposition 10 – the funder provides financial support for a certain objective or set of objectives and allows individual programs to determine how the identified goals are fulfilled in practice. Yet the funder's target outcomes may only be a subset of the goals of a comprehensive home visitation program, resulting in a mismatch between funding provided for certain targeted outcomes and the program's objectives.

Of course, this complex array of funding strategies is not unique to home visitation programs. Indeed, it is commonplace in the social services arena and unlikely to change in the near future. Moreover, programs must meet increasing standards of accountability, as funders (and policymakers) appropriately demand more concrete measures of program effectiveness. The fluctuating economy, the continued need for multiple funding sources, and the

growing demands for documenting outcomes all add to the existing instability of funding sources for home visitation and highlight the difficulty of securing an ongoing funding stream.

7. Several counties in California have home visitation collaboratives; however, coordinating services remains difficult

In spite of the many challenges, a number of California counties have initiated countywide home visitation programs with the hope of standardizing and widening service delivery. Three early adopters of these broad initiatives – Orange, Sacramento, and San Mateo Counties – provide valuable lessons on the potential benefits of and difficulties in developing effective home visitation collaboratives. Each county has a core countywide program but is also home to independent home visitation programs. Although having more programs in a county might seem to represent a larger investment in home visitation, and so might be viewed as an unambiguously positive indicator, the existence of numerous programs can result in a system of uncoordinated services with uneven service coverage. We first discuss the countywide programs in California, which are a novel extension of the “traditional” stand-alone home visitation programs frequently considered in research; then, we turn to the existence of other independent programs and their

⁵ The California Safe And Healthy Families (Cal-SAHF) Family Support Home Visiting Program was developed by the California Department of Social Services, building on lessons from the Healthy Families-San Diego and other early programs.

effect on the integration – or lack thereof – of services in the county.

Home Visitation Collaboratives in Orange, Sacramento, and San Mateo Counties

Proposition 10 and new monies in Orange County; the tragic deaths of two children in Sacramento County; and discussions among social service providers, health care providers, and foundations in San Mateo County were some of the many catalysts pushing these counties to form a collaborative of community organizations with home visitation as one central service strategy to promote the healthy growth of children and families. In each, preventative services to support child welfare (as opposed to child protective services) are an important theme. Each county, drawing on these collaboratives, has created a countywide home visitation program to serve its residents: Project Connections.FRC in Orange County, Birth and Beyond in Sacramento County, and the Prenatal to Three Initiative in San Mateo County.

Not surprisingly, the nature of service provision, the organization, and the funding streams of the programs in each of the three counties varies, despite the common theme. First, they differ in the service selected as the first step in family support. For example, Orange County uses access to healthcare as a first

Maria was pregnant

with her third child when she was introduced to the Prenatal to Three community worker. Although in her mid-thirties and an experienced mother, Maria had some persistent health problems and her family had many resource needs. The community worker and Public Health Nurse worked together closely to ensure that Maria's health care needs were met. Toward this end, her community worker often took Maria to appointments with her physician and provided linkages to other services.

Over time, the community worker became an important source of emotional support for Maria, whose difficult childhood had left her ill-prepared to cope with a troubled marriage, the demands of motherhood, and the loneliness of being far from her home country. A turning point came when her community worker needed to make a referral to Children and Family Services after Maria disclosed that her husband had spanked their three-year old hard enough to leave a mark. At this time, Maria also accepted the community worker's recommendation that she speak with a therapist regarding the difficulties the family was experiencing.

As the therapist assisted Maria in addressing her depression, its impact on her relationship with her children, and her pattern of dependence on abusive men, her community worker continued to provide concrete assistance and developmental guidance.

Maria has recently made a leap toward empowerment that even surprised her workers. She is enthusiastically pursuing her goals of learning English and learning to drive. She is setting clear limits with her husband with regard to her expectation that she be treated well. Parenting continues to present many challenges for Maria, but as her confidence blossoms, there appears to be a corresponding decrease in her toddler's anxiety. Maria can now build on her successes.

service, while San Mateo concentrates on building parent skills and confidence. The target populations, staffing, and site locations also differ. Orange County's ProjectConnections.FRC Health Access serves the largest target population, providing home visits to families with children aged zero to five. In contrast, Birth & Beyond in Sacramento County concentrates on families

with pregnant women or children up to three-months old at intake, and the Prenatal to Three Initiative in San Mateo County restricts services to Medi-Cal families with prenatal to three-year-old children. Another major distinction – the location of program sites – separates Orange County and Sacramento County from San Mateo County. In the first two counties, home visitation sites

operate as part of family resource centers that provide other services, such as health and child development information, nutrition services, and the Women, Infants, and Children (WIC) Program. By comparison, the home visitation sites in San Mateo operate through agreements with independent community organizations but are not directly associated with a network of family resource centers. Lastly, although all three programs rely on a multi-disciplinary approach, employing a mix of paraprofessional and professional home visitors, the types of paraprofessionals vary across counties. For example, in Orange County emphasis is placed on the cultural competence of paraprofessionals, known as *promotores* (health advocates); in Sacramento County, some of the paraprofessionals are AmeriCorps members who have faced and overcome similar challenges themselves.

Multiple Programs Result in Uncoordinated Services and Gaps in Service Coverage

The presence of a countywide home visitation program does not necessarily mean home visitation is thoroughly integrated into the complex set of social service programs in these communities. Beyond the countywide program, all three counties have other independent home visitation programs, including the Nurse-Family Partnership Program in Orange County and Sacramento

County. The schools and the health care delivery systems are, of course, also concerned with child welfare and the prevention of child abuse. Finally, and not to be overlooked, are the families that participate in home visitation programs but also interact independently with general social service programs (operated by county social services or health care agencies as well as private charities).

Because these countywide home visitation programs focus in part on linking families to other community resources, coordination between all relevant service providers is critical. However, the experiences of these three counties show that while these collaborative approaches are a step toward integrating services across the county, communication between other providers does not follow directly from these bold initiatives. Instead, triage and referrals across and within programs are frequently performed in an ad hoc manner, and accountability for such transfers is rarely explicitly defined. Other services have no affiliation or regular interaction with the countywide program, and there is no consistent method to identify either gaps or duplications in service coverage. Service providers recognize these issues and are increasingly trying to identify ways to integrate multiple programs into a coherent system of service delivery.

Conclusion

In summary, recent literature and reported experiences with home visitation suggest that it can be an effective method to link young families to beneficial resources, especially if they are isolated by poverty, language, or geography. There is some evidence that these programs can result in reductions in child abuse, improved child health and development, and improvements in parental life course. At the same time, the limited magnitude of the effects of the programs underscores both the challenge of accurately assessing the benefits of home visitation, which are very difficult to measure, and the necessity of viewing home visitation in the context of a broader set of services geared toward improving the outcomes for young children and their families. In addition, the high cost of these programs needs to be taken into account. As county governments and policymakers look to the future, it will be necessary for them to acknowledge what we do and do not know about home visitation, supporting effective programs yet keeping expectations realistic.

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