Complete Summary

GUIDELINE TITLE

First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation.

BIBLIOGRAPHIC SOURCE(S)

Hahn RA, Bilukha OO, Crosby A, Fullilove MT, Liberman A, Moscicki EK, Snyder S, Tuma F, Schofield A, Corso PS, Briss P. First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation. Findings from the Task Force on Community Preventive Services. MMWR Recomm Rep 2003 Oct 3;52(RR-14):1-9. [30 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Injury associated with violence

GUIDELINE CATEGORY

Prevention

CLINICAL SPECIALTY

Emergency Medicine
Family Practice

Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers

GUIDELINE OBJECTIVE(S)

- To assess scientific evidence concerning the effectiveness of early childhood home visitation in preventing violence by the visited child against others or self (i.e., suicidal behavior), violence against the child (i.e., maltreatment [abuse or neglect]), violence by the visited parent, and intimate partner violence
- To present recommendations regarding early childhood home visitation in preventing violence

TARGET POPULATION

Populations and families believed to benefit from home visitation during the child´s first 2 years of life (e.g., teenage parents; single mothers; families of low socioeconomic status; families with very low birthweight infants; parents previously investigated for child maltreatment; and parents with alcohol, drug, or mental health problems)

INTERVENTIONS AND PRACTICES CONSIDERED

Home visitations* including (but not limited to) one or more of the following components:

1. training of parent(s) on prenatal and infant care
2. training on parenting
3. child abuse and neglect prevention
4. developmental interaction with infants or toddlers
5. family planning assistance
6. development of problem-solving skills and life skills
7. educational and work opportunities
8. linkage with community services

Services in addition to home visitations (multicomponent):

1. day care
2. parent group meetings for support, instruction, or both
3. advocacy
4. transportation
5. other services

*Definition: A program that includes visitation of parents and children in their home by trained personnel who convey information, offer support, provide training, or perform a combination of these activities.

MAJOR OUTCOMES CONSIDERED

- Child maltreatment
    - Direct measures include child abuse and neglect (e.g., child protective services reports, parent reports, visitor reports, clinic reports). Proxy measures include emergency room visits for injury or ingestion; injury, trauma; out-of-home placement
- Violence by visited children
    - Direct measures include reported or observed violence and violent crime. Proxy measures include delinquency (with violence), conduct disorder, externalizing behavior, arrests, convictions)
- Violence by visited parents
    - Direct measures include reported or observed violence and violence crime. Proxy measures include arrests, convictions
- Intimate partner violence
    - Direct measures include reported or observed partner victimization. Proxy measures include arrests, convictions for partner assault
- Benefits, costs, and applicability of recommended interventions, and barriers to implementation

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Electronic searches for intervention studies were conducted in MEDLINE, EMBASE, ERIC, National Technical Information Service (NTIS), PsycINFO, Sociological Abstracts, National Criminal Justice Reference Service (NCJRS), and CINAHL. Also reviewed were the references listed in all retrieved articles as well as additional reports as identified by the team, the consultants, and specialists in the field. Journal articles, government reports, books, and book chapters were included in the review.

Inclusion Criteria

To be included in the review of effectiveness, studies had to:

1. be primary investigations of the intervention selected for evaluation rather than, for example, guidelines or reviews
2. provide information on at least one outcome of interest from the list of violent outcomes preselected by the team
3. be conducted in Established Market Economies
4. compare outcomes in groups of persons exposed to the intervention with outcomes in groups of persons not exposed or less exposed to the intervention (whether the comparison was concurrent between groups or before-and-after within the same group).

The search covered any research published before July 2001.

NUMBER OF SOURCE DOCUMENTS

- Effects of early childhood home visitation on violence by visited children: Four studies
- Effectiveness of early childhood home visitation in preventing violence by visited parents (other than child abuse): One study
- Effectiveness of early childhood home visitation in preventing intimate partner violence in visited families: One study
- Effects of early childhood home visitation on child maltreatment: Twenty-one studies

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

On the basis of the number of threats to validity, studies were characterized as having **good, fair, or limited** quality of execution. Results on each outcome of interest were obtained from each study that had good or fair execution.

The strength of the body of evidence of effectiveness was characterized as **strong, sufficient, or insufficient** on the basis of the number of available studies, suitability of study designs for evaluating effectiveness, quality of execution of the studies, consistency of the results, and effect size.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Each study that met the inclusion criteria was evaluated by using standardized abstraction criteria and was assessed for suitability of the study design and threats to validity. On the basis of the number of threats to validity, studies were characterized as having good, fair, or limited execution. Results on each outcome of interest were obtained from each study that had good or fair execution. Measures adjusted for the effects of potential confounders were used in

preference to crude effect measures. A median was calculated as a summary effect measure for outcomes of interest. For bodies of evidence consisting of seven or more studies, an interquartile range was presented as an index of variability. Unless otherwise noted, the results of each study were represented as a point estimate for the relative change in the violent outcome rate associated with the intervention. Percentage changes were calculated by using the following formulas:

- For studies with before-and-after measurements and concurrent comparison groups:

  Effect size = [(Ipost/Ipre)/(Cpost/Cpre)] – 1

  where Ipost = last reported outcome rate in the intervention group after the intervention; Ipre = reported outcome rate in the intervention group before the intervention; Cpost = last reported outcome rate in the comparison group after the intervention; and Cpre = reported outcome rate in the comparison group before the intervention.

- For studies with post measurements only and concurrent comparison groups:

  Effect size = (Ipost – Cpost)/Cpost

- For studies with before-and-after measurements but no concurrent comparison:

  Effect size = (Ipost – Ipre)/Ipre

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Other

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Task Force recommendations are based primarily on the effectiveness of interventions as determined by the systematic literature review process. In making recommendations, the Task Force balances information about the effectiveness of an intervention with information about other potential benefits and potential harms. To determine how widely a recommendation should apply, the Task Force also considers the applicability of the intervention in various settings and populations. Finally, the Task Force reviews economic analyses of those interventions found to be effective and summarizes applicable barriers to intervention implementation. Economic information is provided to assist the reader with decision making but generally does not affect the Task Force´s recommendation.

Recommendations regarding interventions reflect the strength of the evidence of effectiveness (i.e., sufficient or strong evidence of effectiveness). Other types of evidence can also affect a recommendation. For example, evidence of harms

resulting from an intervention might lead to a recommendation that the intervention not be used if adverse effects outweigh improved outcomes.

A finding of insufficient evidence to determine effectiveness should not be interpreted as evidence of ineffectiveness but rather as an indicator that additional research is needed before the effectiveness of the intervention can be determined. In contrast, sufficient or strong evidence of harmful effect(s) or of ineffectiveness leads to a recommendation that the intervention not be used.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Strength of Evidence of Effectiveness = Strength of Recommendation

The strength of each recommendation is based on the evidence of effectiveness (i.e., an intervention is **recommended** on the basis of either strong or sufficient evidence of effectiveness).

If **insufficient evidence to determine effectiveness is found**, this means that it was not possible to determine whether or not the intervention works based on the available evidence.

COST ANALYSIS

The only available cost-benefit analysis of a nurse home visitation program to reduce child maltreatment was based on a limited, government perspective (i.e., including only those costs and benefits incurred by the government). In the whole study sample, costs exceeded economic benefits directly attributable to reduced child maltreatment services by $3,000 per family. Including benefits beyond those of the government, such as averted health-care costs, productivity losses, and other costs to the victim, is likely to result in greater net benefits. Program cost estimates --- largely dependent upon frequency of home visits and program duration --- ranged from $958 to $8,000 per family (in 1997 dollars). In the study subsample of low-income mothers, the analysis showed a net benefit of $350 per family (in 1997 dollars). Differences in costs may be due to differences in duration and frequency of visits, and items included in estimates.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline was submitted for extensive peer review, including review at various stages by a "consultant team," an external team of subject matter and methodologic experts, and peer review of the finished product by agencies and professional groups.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The relationship between the strength of evidence of effectiveness and the strength of the recommendation is defined at the end of the "Major Recommendations" field.

On the basis of **strong evidence of effectiveness**, the Task Force **recommends** early childhood home visitation for prevention of child abuse and neglect in families at risk for maltreatment, including disadvantaged populations and families with low-birthweight infants.

Evidence was **insufficient** to determine the effectiveness of early childhood home visitation in preventing violence by visited children. The studies also yielded **insufficient evidence** to determine the effectiveness of early childhood home visitation in preventing violence by visited parents (other than child abuse and neglect) or intimate partner violence in visited families.

Definitions:

Strength of Evidence of Effectiveness = Strength of Recommendation

The strength of each recommendation is based on the evidence of effectiveness (i.e., an intervention is **recommended** on the basis of either strong or sufficient evidence of effectiveness).

If **insufficient evidence to determine effectiveness is found**, this means that it was not possible to determine whether or not the intervention works based on the available evidence.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are based on qualifying studies, all of which had good or fair execution quality. In general, the strength of evidence of effectiveness corresponds directly to the strength of recommendations (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall Potential Benefits

Home visitation programs, reviewed in this guideline, might be useful in reaching several objectives of *Healthy People 2010*, the disease prevention and health promotion agenda for the United States. These objectives identify major preventable threats to health and focus the efforts of public health systems, legislators, and law enforcement officials in addressing those threats. Many of the *Healthy People* objectives in Chapter 15, "Injury and Violence Prevention," relate to home visitation and its proposed effects on violence-related outcomes.

Specific Potential Benefits

- Compared with controls, the median effect size of home visitation programs was a reduction of approximately 40% in child abuse or neglect. Benefit was found whether the outcome was directly assessed in terms of reported abuse or neglect or indirectly assessed as reported injury.
- Programs delivered by professional visitors (nurses or mental health workers [with either post--high school education or experience in child development]) yielded more beneficial effects than did those delivered by paraprofessionals. Programs delivered by nurses demonstrated a median reduction in child abuse of 48.7% (interquartile range: 24.6–89.0%); programs delivered by mental health workers demonstrated a median reduction in child abuse of 44.5% (interquartile range not calculable). However, programs of two or more years duration delivered by paraprofessionals were also effective.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The independent, nonfederal Task Force on Community Preventive Services (the Task Force) is developing the *Guide to Community Preventive Services* (the *Community Guide*) with the support of the U.S. Department of Health and Human Services (DHHS) in collaboration with public and private partners. Although The Centers for Disease Control and Prevention (CDC) provides staff support to the Task Force for development of the *Community Guide*, the recommendations presented in this report were developed by the Task Force and are not necessarily the recommendations of U.S. Department of Health and Human Services or the Centers for Disease Control and Prevention.
- Recommendations regarding interventions reflect the strength of the evidence of effectiveness (i.e., sufficient or strong evidence of effectiveness). Other types of evidence can also affect a recommendation. For example, evidence of harms resulting from an intervention might lead to a recommendation that the intervention not be used if adverse effects outweigh improved outcomes. When interventions are determined to be effective, their costs and cost effectiveness are evaluated, insofar as relevant information is available.
- Although the option exists, the Task Force has not yet used economic information to modify recommendations. A finding of insufficient evidence to determine effectiveness should not be interpreted as evidence of ineffectiveness but rather as an indicator that additional research is needed

before the effectiveness of the intervention can be determined. In contrast, sufficient or strong evidence of harmful effect(s) or of ineffectiveness leads to a recommendation that the intervention not be used.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Use of the Recommendation in States and Communities

Given the substantial burden of child maltreatment in the United States and the importance of this problem both from public health and societal perspectives, the Task Force saw the need to specifically review the effectiveness of home visitation programs in reducing this and other forms of violence. The finding that these programs are effective in reducing child abuse and neglect should be relevant and useful in various settings.

The Task Force recommendation supporting early childhood home visitation interventions for prevention of child abuse and neglect in families at risk of maltreatment can be used to support, expand, and improve existing home visitation programs, and to initiate new ones. In selecting and implementing interventions, communities should carefully assess the need for such programs (e.g., the burden of child maltreatment) and clearly define the target populations. Home visitation programs included in this review were generally directed to those populations and families believed to benefit most from common program components, such as support in parenting and life skills, prenatal care, and case management. Target populations included teenage parents; single mothers; families of low socioeconomic status; families with very low birthweight infants; parents previously investigated for child maltreatment; and parents with alcohol, drug, or mental health problems. The population that might benefit is large. For example, in 1999, approximately 33% of the 4 million births in the United States were to single mothers, 12.2% were to women aged <20 years, and 22% were to mothers with less than a high school education; 43% of births --- approximately 1.7 million --- were to mothers with at least one of these characteristics (B. Hamilton, National Center for Health Statistics, CDC, personal communication, 2002).

Studies included in this review were conducted in a variety of geographic locations in the United States and Canada and in populations with various ethnic and cultural backgrounds. The available evidence on the effectiveness of home visiting programs of sufficient duration indicates benefit for population subgroups in greatest need, provided that appropriate care is taken to tailor programs to local circumstances. Because no study reviewed assessed the effectiveness of home visitation in preventing violence in the general population, the broader applicability of these programs (e.g., to the general population) is uncertain.

Public health professionals and policy makers should carefully consider the attributes and characteristics of the particular program to be chosen for implementation. Given the heterogeneity of home visitation programs in the United States, which differ in focus, curricula, duration, visitor qualifications, and target populations, no single optimal, effective, and cost-effective approach could

be defined for the multiplicity of possible outcomes, settings, and target populations. However, the robust findings across a spectrum of program characteristics increase confidence that these programs can be effective in a range of circumstances and reduce concern that effectiveness hinges on particular characteristics of one intervention or one context.

The Task Force found insufficient evidence to determine the effectiveness of early childhood home visitation in preventing violence by visited children and between adults. This conclusion does not imply that the intervention is ineffective in preventing these outcomes. Rather, the finding reflects a lack of enough high-quality studies with long enough follow-up periods to make a determination. These areas merit further research.

This review considered only studies that evaluated violent outcomes. Home visiting may also affect other outcomes. Other studies have reported many other desirable outcomes of early home visitation, including health benefits for premature, low birthweight infants and for disabled and chronically ill children as well as long-term benefits, including reductions in need for public support of visited mothers, particularly single mothers of low socioeconomic status. However, all home visiting programs are not equal. Some are narrowly focused, oriented, for example, only toward improving vaccination coverage. Others might influence a broader range of outcomes. Program selection and design should consider the range of options relevant to the particular communities. To meet local objectives, recommendations and other evidence provided in the *Community Guide* should be used in the context of local information --- resource availability; administrative structures; and the economic and social environments of communities, neighborhoods, and health-care systems.

In conclusion, this review should prove a useful and powerful tool for public health policy makers, for program planners and implementers, and for researchers. It may help to secure interest, resources, and commitment for implementing these interventions, and will provide direction and scientific questions for additional empirical research in this area, which will further improve the effectiveness and efficiency of these programs.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Hahn RA, Bilukha OO, Crosby A, Fullilove MT, Liberman A, Moscicki EK, Snyder S, Tuma F, Schofield A, Corso PS, Briss P. First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation. Findings from the Task Force on Community Preventive Services. MMWR Recomm Rep 2003 Oct 3;52(RR-14):1-9. [30 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Oct 3

GUIDELINE DEVELOPER(S)

Task Force on Community Preventive Services - Independent Expert Panel

SOURCE(S) OF FUNDING

U.S. Department of Health and Human Services; Centers for Disease Control and Prevention (CDC)

GUIDELINE COMMITTEE

Task Force on Community Preventive Services

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Community Guide Web site.

Print copies: Available from the Community Guide Branch, Centers for Disease Control and Prevention, 1600 Clifton Road, MS E-90, Atlanta, GA 30333.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Hahn RA, Bilukha OO, Crosby A, Fullilove MT, Liberman A, Moscicki EK, Snyder S, Tuma F, Briss P. First reports evaluating the effectiveness of strategies for preventing violence: firearms laws. Findings from the Task Force on Community Preventive Services. MMWR Recomm Rep 2003 Oct 3;52(RR-14):11-20. Available from the Centers for Disease Control and Prevention (CDC) Web site.

General Background Articles:

- Briss PA, Brownson RC, Fielding JE, Zaza S. Developing and using the Guide to Community Preventive Services: Lessons learned about evidence-based public health. Annu Rev Public Health 2004; 25:281-302.
- Truman BI, Smith-Akin CK, Hinman AR, Gebbie KM, Brownson R, Novick LF, Lawrence RS, Pappaioanou M, Fielding J, Evans CA, Jr., Guerra F, Vogel-Taylor M, Mahan CS, Fullilove M, Zaza S, Task Force on Community Preventive Services. Developing the Guide to Community Preventive Services—overview and rationale. Am J Prev Med 2000 Jan;18(1 Suppl):18-26.
- Pappaioanou M, Evans CA, Jr. Development of the Guide to Community Preventive Services: A U.S. Public Health Service initiative. J Public Health Manag Pract 1998 Mar;4(2):48-54.
- Zaza S, Lawrence RS, Mahan CS, Fullilove M, Fleming D, Isham GJ, Pappaioanou M, Task Force on Community Preventive Services. Scope and organization of the Guide to Community Preventive Services. Am J Prev Med 2000 Jan;18(1 Suppl):27-34.
- Briss PA, Zaza S, Pappaioanou M, Fielding J, Wright-de Aguero L, Truman BI, Hopkins DP, Mullen PD, Thompson RS, et al, and the Task Force on Community Preventive Services. Developing an evidence-based Guide to Community Preventive Services—methods. Am J Prev Med 2000 Jan;18(1 Suppl):35-43.
- Zaza S, Wright-de Aguero L, Briss PA, Truman BI, Hopkins DP, Hennessy MH, Sosin DM, Anderson L, Carande-Kulis VG, Teutsch SM, Pappaioanou M, Task Force on Community Preventive Services. Data collection instrument and procedure for systematic reviews in the Guide to Community Preventive Services. Am J Prev Med 2000 Jan:18(1 Suppl):44-74.
- Carande-Kulis VG, Maciosek MV, Briss PA, Teutsch SM, Zaza S, Truman BI, Messonier ML, Pappaioanou M, Harris.J.R., Fielding J, Task Force on Community Preventive Services. Methods for systematic reviews of economic evaluations for the Guide to Community Preventive Services. Am J Prev Med 2000 Jan;18(1 Suppl):75-91.
- Novick LF, Kelter A. The Guide to Community Preventive Services: a public health imperative. Am J Prev Med. 2001 Nov;21(4 Suppl):13-5.

Users can access the complete collection of companion documents at the Community Guide Web site.

Print copies: Available from the Community Guide Branch, Centers for Disease Control and Prevention, 1600 Clifton Road, MS E-90, Atlanta, GA 30333.

PATIENT RESOURCES

None available

NGC STATUS

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Date Modified: 10/13/2008