Toolkit of Recommended Curricula and Assessments for Early Childhood Home Visiting

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Part I

Routine Home Visits that Include Health, Parenting, and Child Development Content
# THE CHILD ASSESSMENT RATING AND EVALUATION PROGRAMME

*The CARE Programme, Browne et al, 2006*

## PURPOSE
The CARE programme is a universal home visiting program designed to prevent child abuse and neglect. It was developed in response to a need for community health workers (including health visitors, midwives and community physicians) to be aware of and assess more accurately the emotional needs of all families with babies. It is focused around a child centered assessment of need and development that is completed in partnership with the parent. It has more recently been used as part of the SureStart Initiative in parts of England.

## COMPONENTS / CURRICULUM
CARE incorporates parent report and direct observation of parent and child. Home visits occur in a specific time frame and are fairly structured. The curriculum includes assessing the family risk of child maltreatment and abuse using the Index of Need (see page 29), assessing and discussing maternal mental health using the Edinburgh Postnatal Depression Scale (see page 14), observing and discussing infant attachment behaviors and parental behaviors, identifying additional services required, and a child development and hearing test. In total, five home visits are conducted. These are:

1. newborn assessment/home visit (10–15 days after birth)
2. home visit (4–6 weeks)
3. home visit (3–5 months)
4. clinic assessment/home visit (7–9 months)
5. home visit (12 months).

## EVALUATION DATA
There are no published, peer-reviewed research studies for the CARE Programme, although the CARE Programme Book includes details of its evaluation.

## COST
The CARE Programme and its tools can be found in *CARE Programme Book* that includes tools (Browne et al, 2006).

## ADVANTAGES AND DISADVANTAGES
- CARE Programme book provides considerable detail about use of the model.
- Includes specific guidelines for each home visit and tools.
- Universal home visiting program with strong focus on relationship-building
- Only applicable to children 0–1 year.
- No published outcomes studies.
- Little international use outside of UK; materials only available in English.

## AGE RANGE
Parents of children ages 0–1 year.

## DATA MANAGEMENT SYSTEM
No.

## TRAINING
Past implementation involved 3 day training with expert psychologists embedded within a larger, 10-day training program.

## COUNTRIES AND LANGUAGES
- UK and English.

## READABILITY
Not specified.

## PUBLISHER AND WEBSITE
Book that details the program is published by John Wiley & Sons, Ltd. www.wiley.com.
### Purpose
The Healthy Child Programme is an e-learning project and curriculum that aims to improve the health and wellbeing of children as part of an integrated approach to serving children and families, integrating child development and child health concerns. The e-learning project supports the implementation of The Healthy Child Programme–Pregnancy and the First Five years of Life (HCP) and describes a standard for service delivery. The HCP model is based on progressive universalism and seeks to provide services for all children, with additional services for children and families with particular needs and risks. The programme focuses on public health priorities such as obesity, breastfeeding and social and emotional development.

### Components / Curriculum
The HCP schedule includes universal guidelines (for all families) and additional guideline for women and children with risk factors. The core components of the HCP curriculum are: early identification of need and risk, health and development reviews, screening, promotion of health and behavioral change, prevention of obesity, promotion of breastfeeding, and any other appropriate prevention programs for families. The e-learning curriculum includes various modules and topics including: program basics, communication and record keeping, family health, safeguarding, positive parenting and parenting issues, development and behavior, speech, language and communication needs, growth and nutrition, immunization, health promotion, screening, and health visiting model of practice. It uses the Personal Child Health Record (PCHR) to help parents and health visitors track content of home visits.

### Evaluation Data
The HCP Manual description notes that it is outcome-driven (provided a clear set of outcomes for children that can be measured) and evidence based (based on meta-level reviews of evidence, including the publication *Health for All Children*. The program is reviewed and updated by an Advisory Committee. The manual also notes that outcomes are and should be collected by local providers, however, outcome reports have not been published and were not available online.

### Cost
Not specified.

### Advantages and Disadvantages

<table>
<thead>
<tr>
<th>Advantage</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Designed for use by healthcare professionals, including home visitors.</td>
<td>- Although the program is evidence-based, outcomes have not been published.</td>
</tr>
<tr>
<td>+ Universal home visiting program with specific schedule for children.</td>
<td>- Has not been implemented outside the UK and is available at this time only in English.</td>
</tr>
<tr>
<td>+ Training is available online.</td>
<td></td>
</tr>
<tr>
<td>+ Uses PCHR to track program use.</td>
<td></td>
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</tbody>
</table>

### Age Range
Families with children ages 0-5 years.

### Training
E-learning training is made up of 76 e-learning sessions spread across 12 modules. Each learning session takes approximately 20–30 minutes to complete.

### Readability
Not specified.

### Data Management System
No.

### Countries and Languages
- UK.
- English.

### Publisher and Website
[http://www.rcpch.ac.uk/hcp](http://www.rcpch.ac.uk/hcp)
### PURPOSE
PIPE is a parent education program designed to strengthen relationships by increasing the emotional availability of parents/primary caregivers. It is child-focused and engages parents and children in the process. The program encourages positive emotional experiences between parent and child as well as parent and parenting educator. Based on the belief that the parent is the most consistent and pervasive force shaping the life of the child, it aims to provide a framework for parents to become aware of the concepts of emotional development and attachment and to integrate them into their parenting practice.

### COMPONENTS / CURRICULUM
PIPE program is a 4 step model that includes presentation of concepts, demonstration, supervised parent-child interaction, and evaluation. It is designed to be conducted in a group setting or in individual contacts with parents. The curriculum includes an educator’s guide, parent handouts, and activity cards. Activities use every day materials and toys, and songs and games (in English and Spanish). Curriculum units and topics include: 1) listen, 2) love, and 3) play. Listen incorporates communication, patterns and expectations, and play-based activities. Love includes concepts such as temperament and attachment. Play includes concepts such as developmental stages, modeling, and teaching styles.

### EVALUATION DATA
Although there are no published, peer-reviewed research studies for (PIPE), it has been used as a curriculum for Nurse Family Partnership and Family Nurse Partnership. The How To Read Your Baby website details evidence for its use from an evaluation of Early Start in New Zealand. In addition, unpublished research from one US trial of Nurse Family Partnership suggests increased use of PIPE in the first year is related to stronger child development outcomes at 12 months of age.

### COST
$450 for curriculum package (educators guide, activity cards and parent handouts).

### ADVANTAGES AND DISADVANTAGES
- Can be administered during home visits or in a group setting.
- Uses everyday materials in activities.
- Specific focus on parent-child emotional relationship.
- Used as part of evidence-based home visiting models.

- No published outcomes studies focused specifically on PIPE curriculum.
- Materials available only in a few languages and none from the CECEGIS Region.
- High cost to curriculum.

### AGE RANGE
Parents of children ages 0–3 years.

### DATA MANAGEMENT SYSTEM
No.

### TRAINING
Training and manual are available. 2-day training workshop is $250. Educators guide is $280.

### COUNTRIES AND LANGUAGES
- USA, UK, Germany, New Zealand.
- English, Spanish, German.

### READABILITY
Unknown.

### PUBLISHER AND WEBSITE
How to Read to Your Baby.
THE SAFECARE MODEL  
*(SafeCare, Lutzker & Bigelow, 2002)*

**PURPOSE**
SafeCare is a home visiting model that was developed to prevent child abuse and neglect. It is designed for families with a history of child maltreatment or those with risk factors for maltreatment including young parents; parents with multiple children; parents with a history of depression or other mental health problems, substance abuse, or intellectual disabilities; foster parents; parents being reunified with their children; parents recently released from incarceration; parents with a history of domestic violence or intimate partner violence; and parents of children with developmental or physical disabilities.

**COMPONENTS / CURRICULUM**
SafeCare involve 1–2 hour home visits every week over a period of 18–20 weeks. Home visitors follow structured protocols and provide parent training in three modules: 1) infant and child health care, 2) home safety, and 3) parent-child/parent-infant interactions. Each module is designed to be implemented in 5–7 sessions. Assessments utilized include the Home Accident Prevention Inventory-Revised (HAPI-R) and the Planned Activities Training (PAT) Checklist. All modules involve baseline assessment, intervention (training) and follow-up assessments to monitor change. Home visitors guide families through seven steps to address target behaviors in each module. These steps are 1) describing desired target behaviors, 2) explaining the rationale or reason for each behavior, 3) modeling each behavior, 4) asking parents to practice the behavior, 5) providing positive feedback, 6) providing constructive feedback, and 7) reviewing parents’ performance.

An international version of SafeCare is currently being piloted in Belarus under Child Fund International. The international model is a stripped-down version of the curriculum to which culturally-relevant components are then added.

**EVALUATION AND EVIDENCE**
In randomized trials and quasi-experimental designs, programs using SafeCare have been shown to reduce recidivism with currently maltreating parents.

**COST**
Training costs estimated at $6,000 per home visitor in US, although costs are negotiated developing countries. Additional materials (safety latches, a choke tube, small toys, etc.) may cost additional $10–12/family.

**ADVANTAGES AND DISADVANTAGES**

<table>
<thead>
<tr>
<th>Advantage</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replicated, evidence-based model.</td>
<td>Will require modification for CEECIS countries.</td>
</tr>
<tr>
<td>Uses behavioral theory and has strong didactic focus on concrete steps families can take to improve functioning.</td>
<td>Training costs may be high.</td>
</tr>
<tr>
<td>Focus on health, safety, and parent-child interaction.</td>
<td>Originally developed for families with history of child maltreatment; may not be as relevant for populations at less risk or for focus on general promotion of child development.</td>
</tr>
<tr>
<td>Has specific tools and checklists for home visitors to use.</td>
<td></td>
</tr>
</tbody>
</table>

**AGE RANGE**
Parents of children ages 0–5 years.

**DATA MANAGEMENT SYSTEM**
Yes.

**TRAINING**
Manual and training are available, although site certification is required to use SafeCare. All training occurs on-site and cost varies according to participation. International adaptations are made only in consultation with the US national SafeCare office.

**COUNTRIES AND LANGUAGES**
- USA, UK, Belarus.
- English, Spanish, Russian.

**READABILITY**
10-12 year old reading level.

**PUBLISHER AND WEBSITE**
National SafeCare® Training and Research Center.  
IDENTIFYING CHILDREN AND FAMILIES WITH SPECIAL NEEDS

DISABILITY/DEVELOPMENTAL DELAY SCREENERS
| PURPOSE |
The ASQ-3 identifies potential delays and helps determine which children need further assessment or ongoing monitoring. It measures five domains: communication, gross motor, fine motor, problem solving, and personal-social. |
| ADMINISTRATION |
Parents/caregivers complete questionnaires and professionals, paraprofessionals, or clerical staff score them. Twenty-one questionnaires and scoring sheets are available at 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months of age. |
| PSYCHOMETRICS |
**United States (ASQ-3)** Reliability: test-rest reliability=92% and inter-observer reliability (between parents and examiners) =93%.  
*Validity:* compared to Battelle Development Inventory (BDI) sensitivity=86.1%, specificity=85.6%, false positive=14.4%, false negative=13.9%.  
**Turkey (ASQ)**. Tool can be used to screen Turkish children at risk for delays. Reliability: test-retest reliability=82% and inter-rater reliability=87%.  
*Validity:* sensitivity=.94, specificity=.84, positive predictive value=.97, negative predictive value=.75.  
**Multinational (ASQ) study,** Reliability: Test–retest and inter-observer (parents and examiners) reliability=94%.  
*Validity:* sensitivity=88% and specificity=82.5%. |
| COST |
$275 for Starter Kit (21 photocopiable print masters of the questionnaires and scoring sheets, a CD-ROM with printable PDF questionnaires, user's guide, and a quick start guide). |
| ADVANTAGES AND DISADVANTAGES |
+ Globally used including in 4 CEECIS countries.  
+ Parents participate in the process as they complete the questionnaires either alone or in collaboration with trained professional.  
+ Found to be reliable and valid in Turkey.  
+ Quick to administer and easy to score.  
+ No ongoing costs once initial kit purchased.  
+ Uses everyday objects for screening materials.  
- Social-emotional component contained in separate screening tool (ASQ:SE).  
- Initial cost (for starter kit) is high (although photocopies are allowed of initial kit) and translation costs may be high given the number of age-related questionnaires.  
- Limited usefulness for measuring child progress over time (pre- and post-test measure) or for comparing groups of children. |
| AGE RANGE |
2 – 60 months. |
| LENGTH/TIME |
10-15 minutes to complete questionnaire and 1-3 minutes for scoring. |
| TRAINING |
Training DVD available. |
| DATA MANAGEMENT SYSTEM |
Yes. $150 annually per program. |
| INTERNATIONAL USE |
Various versions of the ASQ have been used throughout the world including in North and South America, Europe, Asia, Australia, and Africa.  
**CEECS COUNTRIES**  
Bulgaria, Georgia, Kyrgyzstan, Russia, Tajikistan, Turkey. |
| LANGUAGES |
The ASQ is available in English, Spanish, and French from the publisher. Somali and Hmong are additionally available to pediatricians through ASQ-PTI (an electronic patient interview system). Georgian, Russian, and Turkish versions have been created and a Bulgarian version is under development. |
| READABILITY |
4–6 grade level. |
| PUBLISHER AND WEBSITE |
Brookes Publishing.  
### PURPOSE
This tool was developed in Turkey for use by health care providers in LMI countries to monitor and support child development and the early detection and management of developmental difficulties. The GMCD model aims to bring early childhood development concepts into health care delivery systems in these countries. It has three components: developmental monitoring, developmental support, and management of developmental difficulties. The developmental monitoring tool (discussed here) measures domains relating to expressive and receptive language, gross and fine motor skills, social skills, play skills and self-help skills. The supporting development component is an expanded version of the WHO/UNICEF Care for Development Intervention, and the management of difficulties component has been adopted by the Turkish Ministry of Health and UNICEF-Turkey to be used in a nationwide training program on child development for primary health care providers.

### ADMINISTRATION
Open-ended interview with parent/caregiver.

### PSYCHOMETRICS
**Turkey.** Reliability: inter-rater reliability (medical students and child development specialists) $\kappa=.83–.88$. Validity: Comparing GMCD to comprehensive evaluation, sensitivity=.88, specificity=.93, positive predictive values=.84, negative predictive values=.94.

### COST
Cost is not specified but is likely low given the tool was designed to be implemented in LMICs and cost was a consideration in its design.

### ADVANTAGES AND DISADVANTAGES
+ Developed in Turkey for use in LMICs.
+ Short administration time.
+ Helps develop a relationship between health provider and caregiver and does not focus on testing the child.
- Has only been used and/or tested in Turkey and India.
- Only screens children up to 3.5 years.

### AGE RANGE
0–3.5 years.

### LENGTH/TIME
7 items / 7–20 minutes.

### TRAINING
3-day training workshop implemented in Turkey.

### INTERNATIONAL USE
This tool was developed in Turkey to be used in LMICs. It has been studied in India as well.

### CEECIS COUNTRIES
Turkey.

### LANGUAGES
Turkish, Hindi.

### READABILITY
Tool is easily understood by caregivers. Most caregivers (64%) had less than 5 years of education and understood the tool.

### PUBLISHER AND WEBSITE
For information regarding tool, contact the author, Iili Ertem, at ertemilgi@yahoo.com.
# Parents’ Evaluation of Developmental Status (PEDS)

**(PEDS; Glascoe F, 1998)**

## Purpose
PEDS is designed to elicit and address parents’ concerns about their child's development and health and to identify children at risk for school problems and those with undetected developmental and behavioral disabilities. PEDS areas of measurement include global/cognitive, expressive, language and articulation, receptive language, fine motor, gross motor, behavior, social-emotional, self-help, and school.

## Administration
Parent/caregiver questionnaire or interview.

## Psychometrics
**United States. Standardization:** PEDS was re-standardized in 2012 on a nationally representative sample.  
**Reliability:** test-retest reliability=94%, inter-rater reliability=95–97% (between coders and scoring analyzer) and 74% (between parents and teachers).  
**Validity:** sensitivity=86%, specificity=74%

**Other studies.** The PEDS is currently being studied in Turkey. A summary of PEDS international studies can be found at [http://www.pedstest.com/Research/PEDSStandardization.aspx](http://www.pedstest.com/Research/PEDSStandardization.aspx).

## Cost
- $36 for complete set (brief guide, 50 response forms, 50 score/interpretation forms).
- $18 for 50 response forms.
- $18 for 50 score/interpretation forms.

## Advantages and Disadvantages
+ Translated and standardized in numerous languages and currently being studied in Turkey.  
+ Initial cost and cost of data managements system are low.  
+ Short administration time.  
+ Parents are partners in the process.  
- Ongoing costs for response forms and score/interpretation forms.  
- Less detailed than other screening tools.

## Age Range
0–6 years.

## Length/Time
10 items / 2 minutes.

## Training
Manual available.

## Data Management System
Yes. $1–3 depending on number of users.

## International Use
The PEDS has been used throughout the world including in North and South America, Europe, Australia, Asia, and Africa. It has been translated into 21 languages and standardized separately in many other nations and languages.

**CEECIS Countries**
- Turkey.

## Readability
4–5 grade level.

## Languages
English, Spanish, Vietnamese are currently available and the publisher is currently licensing translations in the following languages: Arabic, Chinese, Farsi, French, Filipino Tagalog, Galician, German, Haitian-Creole, Hebrew, Hmong, Icelandic, Indonesian, Laotian, Malaysian, Portuguese, Russian, Swahili, Somali, Taiwanese, Thai, and Visaya.

## Publisher and Website
Ellsworth & Vandermeer Press.  
IDENTIFYING CHILDREN AND FAMILIES WITH SPECIAL NEEDS:

MATERNAL MENTAL HEALTH
# EDINBURGH POSTNATAL DEPRESSION SCALE

(EPDS; Cox, Holden, Sagovsky, 1987)

## PURPOSE

The EPDS is designed to detect postnatal depression in mothers 6–8 weeks after delivery. It is a short (10-item) self-administered tool originally designed to identify the presence of depression in women following childbirth, although it has been used during pregnancy and other periods, including with fathers. The scale measures symptoms of depression including sadness, fear, anxiety, self-blame, and sleeping difficulties.

## ADMINISTRATION

Parent self-report 6–8 weeks after delivery.

## PSYCHOMETRICS

**UK.** Reliability: Standardized $\alpha= 0.87$, split-half reliability$=0.88$.  
Validity: sensitivity$=86\%$, specificity$=78\%$, positive predictive value$=73\%$.  
**Turkey.** Reliability: $\alpha =.72$.  
Validity: As compared to SCID-I sensitivity$=75.5$, specificity$=71.5$, positive predictive value $= 30.3\%$, negative predictive value$=94.5\%$.

## COST

None.

## ADVANTAGES AND DISADVANTAGES

+ No cost.  
+ Short administration time.  
+ Widely used throughout world.  
+ One of the tools used in the CARE Programme (see page 4).  

- Authors who studied Turkish version recommended that it be improved given it found a high prevalence of postnatal depression which may be a function of the test’s low validity.  
- Cultural specificity of the language and the exclusion of certain diagnostic criteria for depression.  
- All items on the EPDS are similar to those in general depression scales. None are written specifically to address new motherhood.

## AGE RANGE

6–8 weeks.

## LENGTH/TIME

10 items / 10 minutes to administer and 5 to score.

## TRAINING

None specified.

## DATA MANAGEMENT SYSTEM

No.

## INTERNATIONAL USE

EPDS was developed in the UK and has been used throughout the world including in North and South America, Europe, Asia, Australia, and Africa.  
**CEECIS COUNTRIES**  
Turkey.

## LANGUAGES FROM PUBLISHER

A copy of the English version is available at http://www.psychiatrictimes.com/all/editorial/psychiatrictimes/pdfs/EdinbPostDepScale.pdf. The EPDS has been translated into over 23 languages including Turkish. Some of the translations are provided in the book Perinatal Mental Health: A Guide to the EPDS and/or online through the Government of Australia at http://www.folkhalsoguiden.se/upload/Psykisk%20H%20C%20A%20APdf/Edinburgh%20Depression%20Scale%20Translated%20Government%20of%20Western%20Australia%20Department%20of%20Health.pdf.

## READABILITY

3–7 grade level.

## PUBLISHER AND WEBSITE

Unknown.
# THE ALCOHOL, SMOKING, AND SUBSTANCE INVOLVEMENT SCREENING TEST

**(ASSIST; World Health Organization, 1997)**

## PURPOSE

The ASSIST is a tool that screens for alcohol, tobacco, and other substances such as cannabis, amphetamines, cocaine and opiates. It was developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings.

## ADMINISTRATION

**Interview with parent/caregiver.**

## PSYCHOMETRICS

**Multinational Validation and reliability testing involved sites in Australia, Brazil, India, Ireland, Israel, the Palestinian Self-Rule Areas, Puerto Rico, the United Kingdom of Great Britain and Northern Ireland and/or Zimbabwe.**

**Reliability:** $\alpha > .80$, test-retest reliability $\kappa = .58–.90$.

**Validity:** ASSIST was significantly correlated to the MINI Plus for global continuum of substance use and lifetime substance use. Compared to hair analyses, sensitivity=66–91% and specificity=73–91%.

## COST

**None.**

## ADVANTAGES AND DISADVANTAGES

| + Reliability and validity were established in a multinational study. | - Designed initially for use in medical care settings. |
| + Translated and standardized in numerous languages. | - Does not provide any additional guidance to home visitor regarding supports or services to offer. |
| + No cost. | - Not specifically developed for use with parents of young children. |
| + Short administration time. | |
| + Includes comprehensive list of substance, including tobacco. | |
| + Has been used in home visiting programs, including SafeCare. | |

## AGE RANGE

Not specified.

## TRAINING

**Manual available.**

## INTERNATIONAL USE

The ASSIST has been used and studied extensively throughout the world including in Australia, Brazil, India, Ireland, Israel, Korea, Philippines, the UK, the USA, the West Bank and Gaza Strip, and Zimbabwe.

## CEECIS COUNTRIES

Russian and Ukrainian translations are available.

## LENGTH/TIME

**8 items / less than 15 minutes.**

## DATA MANAGEMENT SYSTEM

**No.**

## LANGUAGES


## PUBLISHER AND WEBSITE

IDENTIFYING CHILDREN AND FAMILIES WITH SPECIAL NEEDS

CHILD MENTAL HEALTH CONCERNS
**BRIEF INFANT TODDLER SOCIAL EMOTIONAL ASSESSMENT**

*(BITSEA; Carter and Briggs-Gowan, 2006)*

### PURPOSE
The BITSEA provides a brief comprehensive screening to evaluate social and emotional behavior and identify children with delays in these areas. If delays are identified, follow-up evaluation with the ITSEA (Infant Toddler Social Emotional Assessment) is recommended. BITSEA items are drawn from the ITSEA and include items from all four ITSEA domains: 1) externalizing, 2) dysregulation, 3) internalizing and 4) competence.

### ADMINISTRATION
Forms are completed by parents/caregivers and child care providers. Parent/caregiver forms can be administered as an interview.

### PSYCHOMETRICS

**United States (BITSEA).**
**Reliability:** \( \alpha = .65-.79 \), test-retest reliability (interclass correlation coefficient (ICC))=.85-.87, inter-rater reliability (ICC)=.61-.68 (between parents) and .28-.59 (between parent and provider).

**Validity:**
Compared to the Child Behavior Checklist (CBCL), BITSEA detected 95% with clinical CBCL scores and 85% with subclinical/clinical CBCL scores. False positive rates<30%.

**Turkey (BITSEA) Reliability:** \( \alpha = .72-.81 \), test-retest reliability (Spearman’s rho)=.41-.49 for mothers, inter-rater reliability between parents (Spearman’s rho)=.68-.71.

**Validity:**
BITSEA/P scores were significantly correlated with CBCL scores, but BITSEA/C scores were not. For clinical CBCL scores, sensitivity=83–90%, specificity=88–91%.

**Romania (ITSEA)**
A Romanian version of the ITSEA was used in Romania in 2005 to examine behaviors and competencies in children and in an evaluation of foster care programming for infant and toddler children. The Romanian version, however, has not been normed or validated.

### COST

- $42 for 50 parent forms.
- $42 for 50 childcare provider forms.

### ADVANTAGES AND DISADVANTAGES

**+**
- Has been used in Romania and Turkey and found to be reliable and valid in Turkish.
- Ongoing costs.
- Short administration time.
- Parents participate in the process.

**-**
- No data management system.
- Age range is limited to 1–3 years.

### AGE RANGE

1–3 years.

### LENGTH/TIME

42-item parent form / 7–10 minutes.
Length/time of interview form not specified.

### TRAINING

Manual available.

### DATA MANAGEMENT SYSTEM

No.

### INTERNATIONAL USE

The ITSEA and BITSEA are used in numerous countries including countries in North America, Europe, and Asia.

**CEECIS COUNTRIES**
Romania, Turkey.

### LANGUAGES

English and Spanish versions are available from the publisher. Given that the tool is used in various countries, other translations also exist, including Romanian and Turkish.

### READABILITY

4–6 grade level.

### PUBLISHER AND WEBSITE

Pearson Assessments.
http://www.pearsonassessments.com
**DEVEREUX EARLY CHILDHOOD ASSESSMENT – INFANT/TODDLER**  
*(DECA-I/T; LeBuffe and Naglieri, 1999)*

### PURPOSE
The DECA-I includes items that reflect positive behaviors (strengths) typically seen in resilient infants. These positive behaviors comprise two protective factor scales: initiative and attachment/relationships. Initiative assesses the infant's ability to use independent thought and actions to meet her or his needs. Attachment/relationships assess the mutual, strong, long lasting relationship between the infant and significant adults such as family members and teachers. A total protective factors scale, which is a composite of the above two scales, provides an overall indication of the strength of the infant's protective factors.

### ADMINISTRATION
Completed by provider at least 4 weeks after knowing and observing the child and speaking with caregivers.

### PSYCHOMETRICS

**United States (DECA-I).** Reliability: $\alpha = .90–.94$, test-retest reliability=.83–.94, inter-rater reliability =.53–.58 (between parents).  
Validity: sensitivity=27–47%, specificity=87, total correct prediction=63%.

**DECA-T.** Reliability: $\alpha = .94–.95$, test-retest reliability=.72–.99, inter-rater reliability=.49–.63 (between parents).  
Validity: sensitivity=41–57%, specificity=80–87%, total correct prediction=78%.

### COST
- $200 for DECA-I/T Kit (20 infant and 30 toddler forms, strategies guide, user guide, 5 reproducible parent teacher masters, 20 parent strategy guides, 3 adult resilience journals, and forms CD).
- $20 for 20 infant record forms.
- 30 for 30 toddler record forms.

### ADVANTAGES AND DISADVANTAGES
- One of the few measures of child protective factors (resilience).
- Requires minimal training and time (about 10 minutes) to administer and score.
- Questions are designed to measure directly observable behaviors.
- Has not been used in CEECIS or LMIC countries.
- Start up and data management costs are high and ongoing.
- Teachers were more consistent raters than parents, so that scores obtained from parent raters require some caution in interpretation and use.
- Some behaviors measured are more likely to occur in a group care context.

### AGE RANGE
**DECA-I:** 4 weeks–18 months.  
**DECA-T:** 18–36 months.

### LENGTH/TIME
**DECA-I:** 18 items.  
**DECA-T:** 36 items.

### TRAINING
Webinar trainings and conference trainings are available.

### DATA MANAGEMENT SYSTEM
Yes. $250/year plus ratings by child ($3/child) or by administration ($1/rating).

### INTERNATIONAL USE
The DECA is primarily used in English-speaking countries such as the USA, Canada, and UK.  
**CEECIS COUNTRIES**  
None.

### LANGUAGES FROM PUBLISHER
English and Spanish are available from publisher.

### READABILITY
Not specified.

### PUBLISHER AND WEBSITE
Kaplan Press.  
ASSESSING HOME ENVIRONMENTS
### HOME ACCIDENT PREVENTION INVENTORY-REVISED
*(HAPI-R; Tertinger, Greene, and Lutzker, 2002)*

<table>
<thead>
<tr>
<th><strong>PURPOSE</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Home Accident Prevention Inventory (HAPI) is designed to assess hazards in the home. Hazards include fire and electrical, mechanical-suffocation, ingested object suffocation, firearms, and solid/liquid poisons. It is one of the assessments used in the SafeCare model (see page 7).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ADMINISTRATION</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent report and observation during home visit. The tool is scored using a checklist measuring the number of environmental and health hazards accessible to children in each room of a home.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PSYCHOMETRICS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown. The HAPI was initially validated using multiple-baseline design and case studies. Its ongoing validation has been within the context of SafeCare efficacy and effectiveness evaluations (see <a href="http://publichealth.gsu.edu/968.html">http://publichealth.gsu.edu/968.html</a>).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>COST</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Available with purchase of SafeCare Model. Cost of tool not specified.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ADVANTAGES AND DISADVANTAGES</strong></th>
<th></th>
</tr>
</thead>
</table>
| + Designed for use during home visits. + Has been adapted for use in Belarus. | - Belarus version in pilot stage.
- Use in any new culture/context will require Modification.
- Currently an only be used as part of SafeCare program. |

<table>
<thead>
<tr>
<th><strong>AGE RANGE</strong></th>
<th>LENGTH/TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homes with children 0–5 years.</td>
<td>Varies. Conducted in the context of one home visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>TRAINING</strong></th>
<th>DATA MANAGEMENT SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual available.</td>
<td>Electronic version of HAPI using smartphones has been developed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>INTERNATIONAL USE</strong></th>
<th>LANGUAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The HAPI-R is used in the UK and USA. Russian adaptation currently being piloted in Belarus.</td>
<td>English and Spanish versions are available from publisher.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CEECIS COUNTRIES</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Belarus.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>READABILITY</strong></th>
<th>PUBLISHER AND WEBSITE</th>
</tr>
</thead>
</table>
### Purpose
The HOME Inventory measures the quality and quantity of stimulation and support available to a child in the home environment. The focus is on the child in the environment and the child as a recipient of inputs from objects, events, and transactions occurring in connection with the family surroundings.

- The Infant/Toddler (IT) HOME Inventory includes six subscales: 1) parental responsivity, 2) acceptance of child, 3) organization of the environment, 4) learning materials, 5) parental involvement, and 6) variety in experience.
- The Early Childhood (EC) HOME Inventory includes eight subscales: 1) learning materials, 2) language stimulation, 3) physical environment, 4) parental responsivity, 5) learning stimulation, 6) modeling of social maturity, 7) variety in experience, and 8) acceptance of child.
- HOME Inventory – Short Form (HOME-SF) was created for use in the National Longitudinal Survey of Youth (NLSY79). It contains fewer items than the original instrument and items are not organized into component scales like they are in the original HOME.

### Administration
Administered during a 45–90 minute home visit with target child and caregiver. It includes caregiver report and interviewer observation.

### Psychometrics
**United States (HOME).** Reliability: internal consistency=.44–.89, inter-observer agreement=90%, test-retest reliability was moderate after 18 months.

Validity: Small to moderate correlations were found between HOME and seven socioeconomic status variables.

**Other versions of HOME.** All versions are considered reliable and valid in the United States.

**CEECIS countries.** The HOME has been used in numerous CEECIS countries, however it has not been validated in any of the countries.

### Cost
$50 for the comprehensive manual (all editions); $15 for 50 IT forms; $25 for 50 EC forms.

### Advantages and Disadvantages
+ Start-up costs are low.
+ Used extensively throughout the world and in numerous CEECIS countries.
+ Validation studies show the HOME correlates with SES measures to a moderate degree as well as early measures of cognitive development.
+ Designed for administration during home visit.

- HOME-SF has not been studied internationally.
- Full HOME scale is formal assessment that can take 90 minutes to administer.
- Test examiners need practice with the instrument to develop the level of observational skills necessary to assure reliable scoring.
- Ongoing clinical concern about content not relevant to some cultures/contexts.

### Age Range
- IT HOME: 0–35 months.
- EC HOME: 36–71 months.
- HOME-SF: 0–14 years.

### Length/Time
- IT HOME is 45 items (45-90 minutes), HOME-SF is 18 items in 0-3 period (approximately 20 minutes).

### Training
Manual available.

### Data Management System
No

### International Use
The HOME is used extensively throughout the world including countries in North and Latin America, Europe, Asia, Australia, and Africa.

### CEECIS Countries
FYMR, Kosovo, Romania, Russia, Serbia, Turkey

### Languages
English is available from the publisher. Given the international use, many other translations exist.

### Publisher and Website
Arizona State University. 
# THE HOME SCREENING QUESTIONNAIRE  
*(HSQ: Coons, Frankenburg, Gay, Ker, 1981)*

## PURPOSE
This tool was designed to quickly identify home environments likely to be suboptimal for the development of children. The HSQ items were developed from the HOME Inventory. Whereas the HOME Inventory requires a home visit, the HSQ consists of two forms, one for children from 0–3 years, another for 3–6 years, which can be completed by parents without a home visit.

## ADMINISTRATION
Completed by parents/caregivers.

## PSYCHOMETRICS
**United States.** 
Reliability: test-retest reliability=.62 (0–3 years) and .86 (3–6 years) over a period of 4 months. 
Validity: Compared to the HOME inventory correlation coefficients (ICC)=.61 (0–3 years) and .71 (3–6 years), false positives 14% (0–3 years) and 21% (3–6 years), false negatives 11% (0–3 years) and 7% (3–6 years).

## COST
- $28 for manual. 
- $26 for 25 forms for 0–3 years.  
- $26 for 25 forms for 3–6 years.

## ADVANTAGES AND DISADVANTAGES
| + Low initial cost. | - On-going cost for additional HSQ forms. |
| + Adapted from HOME which has been used internationally. | - No evidence of its use within CEECIS countries. |
| + Parents are partners in process as they complete the questionnaire. | - Less widely used than HOME. |
| + Designed for administration during home visit. | - Not suggested for use with families of children below one year of age. |

## AGE RANGE
0–6 years (given the low test-retest reliability for 0–1 year, it is not recommended for use before age 1).

## LENGTH/TIME
- 0–3 years questionnaire has 30 items, 3–6 years questionnaire has 34 items. Both use the same 50-item toy checklist. / 15-20 minutes to complete and 5 minutes to score.

## TRAINING
Manual available.

## INTERNATIONAL USE
The HSQ has primarily been used in the USA and Australia. Beyond the West, it has been used in Asia (Japan and India) and South Africa.  
**CEECIS:** None.

## LANGUAGE
**English is available from the publisher.** However, the HSQ is adapted from the HOME, which has been widely translated (see page 21).

## READABILITY
3–6 grade level.

## PUBLISHER AND WEBSITE
Denver Development Materials.  
IDENTIFYING PARENT-CHILD RELATIONSHIP AND ATTACHMENT DIFFICULTIES
**PARENTING STRESS INDEX, 4TH EDITION**  
*(PSI-4, Abidin, 1995)*

### PURPOSE
The PSI-4 is designed to evaluate the magnitude of stress in the parent-child system. Two domains – the child and parent domains – combine to form the total stress scale. The child domain includes sources of stress from parent report of child characteristics and has six subscales: 1) distractibility/hyperactivity, 2) adaptability, 3) reinforces parent, 4) demandingness, 5) mood, and 6) acceptability. The parent domain measures sources of stress related to parent characteristics. It has seven subscales: 1) competence, 2) isolation, 3) attachment, 4) health, 5) role restriction, 6) depression, and 7) spouse/parenting partner relationship. The PSI-4 can be used to evaluate the parenting system and identify issues that may lead to problems in the child’s or parent’s behavior. This information may then be used to design a treatment plan, set priorities for intervention, and/or a follow-up evaluation.

A short form version of the PSI-4 (PSI-4-SF) is also available. It includes three domains: 1) parental distress, 2) parent-child dysfunctional interaction, and 3) difficult child, which combine to form a total stress scale.

### ADMINISTRATION
Parent/caregiver report.

### PSYCHOMETRICS
**United States.** Reliability: \( \alpha = 0.75 – 0.88 \) for child and parent domains and \( \alpha \geq 0.96 \) for total stress score, test-retest reliability = 0.52 – 0.96.

Validity: Validity has been investigated in studies that focused on at-risk children, attachment, ADHD, child abuse, forensic contexts, medical treatment adherence, substance abuse, parental depression, and more. A full list of validity studies can be found at the author’s website: [http://people.virginia.edu/~rra/validity.html](http://people.virginia.edu/~rra/validity.html).

### COST
- **PSI-4:** $210 for introductory kit (includes manual, 10 reusable item booklets, 25 answer sheets, and 25 profile forms), $65 for 10 reusable item booklets, $72 for 10 answer sheets, and $25 for 25 profile forms.
- **PSI-4-SF:** $135 for kit (includes manual and 25 profile forms) and $80 for 25 profile forms.

### ADVANTAGES AND DISADVANTAGES
- Maintains its validity with non English-speaking cultures.
- There are translations for several CEECIS region languages.

### AGE RANGE
Parents of children ages 0–12 years (primarily intended for parents with children ages 0–3 years).

### LENGTH/TIME
- **PSI-4:** 120 items / 20 minutes.
- **PSI-4-SF:** 36 items / 10 minutes.

### TRAINING
Manual available

### INTERNATIONAL USE
The tool has been used in countries in North America, Europe, and Asia.

### CEECIS COUNTRIES
Although validated Croatian and Serbian translations of the tool exist, it is unclear if it has been studied in the CEECIS region.

### LANGUAGE
Various versions of the tool are available in Arabic, Chinese, Mandarin Chinese, Croatian, Dutch, Finnish, French Canadian, French, German, Greek, Hebrew, Hmong, Icelandic, Indonesian, Italian, Japanese, Korean, Norwegian, Polish, Portuguese, Serbian, Spanish, and Swedish. A Russian translation is in progress.

### READABILITY
5th grade level.

### PUBLISHER AND WEBSITE
PAR.  
| PARENTING INTERACTIONS WITH CHILDREN:  
| CHECKLIST OF OBSERVATIONS LINKED TO OUTCOMES  
| (PICCOLO; Roggman, Cook, Innocenti, Akers, Jump 2007) |
| PURPOSE |
The PICCOLO measure parenting behaviors in four domains: affection, responsiveness, encouragement, and teaching. Each domain includes 7–8 parenting behaviors. The PICCOLO reveals what parents can do to support a child’s development, what they believe is important, what they feel comfortable doing in front of others, and what they know how to do with their child. It will also help providers plan interventions for families.

| ADMINISTRATION |
Observation with parent/caregiver and child during play-based activity or family routines. Video-recording the observation and scoring it later is recommended but not required.

| PSYCHOMETRICS |
United States. Reliability: α >.70 for all domains across all ethnic groups, inter-rater reliability >70% agreement for across all ethnic groups, r=.85.  
Validity: For all ethnic groups, domains are statistically significantly correlated with other measures of the same observations of parenting interactions.

| COST |
Currently available at no cost after workshop. Actual cost to be determined by publisher.

| ADVANTAGES AND DISADVANTAGES |
+ Designed specifically for use in home visiting programs.  
+ Captures both strengths and areas of challenge.  
+ Ideal for use during home visits.  
- Recommended age range: 1–3 years.  
- Has not been published yet; training depends upon arrangements made with authors of tool at undetermined cost.  
- Has been used mostly in US, although training internationally is beginning.

| AGE RANGE |
1–3 years (the tool was validated for children over 10 months and should be used with caution with infants should be used with caution with infants up to 10 months).

| LENGTH/TIME |
29 items / Activity should last at least 10 minutes.

| TRAINING |
Workshops available.

| DATA MANAGEMENT SYSTEM |
No.

| INTERNATIONAL USE |
Reports of tool use mostly from USA, although international training has begun, including validation work in Turkey at Ankara Üniversitesi  
CEECIS COUNTRIES  
Turkey

| LANGUAGES |
The tool is currently available in English and Spanish and has recently been translated into Turkish.

| READABILITY |
Not specified.

| PUBLISHER AND WEBSITE |
Brookes Publishing (available early 2013).  
DOMESTIC VIOLENCE
AND CHILD MALTREATMENT
**THE ABUSE ASSESSMENT SCREEN**  
*(AAS, McFarlane, Parker, Soeken and Bulloc, 1992)*

### PURPOSE
The Abuse Assessment Screen (AAS) is designed to determine the frequency, severity, perpetrator, and body sites of injury of physical abuse within the past year in pregnant women. There are two versions of the screening in use currently: one includes 5 items while another has 3 items. There are also versions of the tool that have been designed for all women, including those who are not pregnant.

### ADMINISTRATION
Parent/caregiver self-report.

### PSYCHOMETRICS
*United States.* **Reliability:** Cronbach’s $\alpha=0.56$, test–retest reliability=0.91.  
**Validity:** sensitivity=93%–94%, specificity=55%–99%, positive predictive value=33%, negative predictive value=97%

*Turkey.* The AAS was used in a Turkish study but has not been validated in Turkey.

### ADVANTAGES AND DISADVANTAGES
<table>
<thead>
<tr>
<th>+</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cost.</td>
<td>Does not screen for emotional abuse.</td>
</tr>
<tr>
<td>Quick to administer.</td>
<td>Provides only basic information about domestic violence.</td>
</tr>
<tr>
<td>Has been studied in Turkey.</td>
<td>Provides no guidance for follow-up.</td>
</tr>
<tr>
<td>Specifically developed for screening of abuse with pregnant women.</td>
<td></td>
</tr>
<tr>
<td>Found to detect abuse during pregnancy better than standard social service interviews and as well as longer validated self-administered questionnaires.</td>
<td></td>
</tr>
</tbody>
</table>

### COST
None.

### AGE RANGE
None specified.

### LENGTH/TIME
5 items / None specified.

### TRAINING
None specified.

### INTERNATIONAL USE
The AAS has been used in some countries outside the USA including Brazil, China, Sri Lanka, and Turkey.  
**CEECIS COUNTRIES**
Turkey.

### LANGUAGES
An English version is available online but has been translated into other languages including Turkish.

### PUBLISHER AND WEBSITE
American Medical Association.  
## Purpose

The CAPI is a screening tool to detect physical child abuse. It was designed to be used in investigations of reported child abuse cases. The primary clinical scale (abuse) can be divided into six factor scales: 1) distress, 2) rigidity, 3) unhappiness, 4) problems with child and self, 5) problems with family, and 6) problems with others. The Brief CAP Inventory (BCAP; Ondersma, Chaffin, Simpson & LeBrenton, 2005) is also available and it all its items are drawn directly from the CAP Inventory.

## Administration

Tool is completed by parents/caregivers who are suspected of abuse.

## Psychometrics

### United States (CAP)

**Reliability:** internal consistency (Kuder-Richardson 20)=.87–.95, test–retest reliability at 3 months=.75.

**Validity:** Compared to the CAP risk cutoff sensitivity=.93, specificity=.93.

### United States (BCAP)

**Reliability:** internal consistency (Kuder-Richardson 20)=.89.

**Validity:** The scale correctly classified 83% of the participants in the abuse group and 78.8% of the participants in the control group, specificity=83%, false negatives= 21.2%.

### Turkey (CAP)

**Reliability:** α=94.

**Validity:** The scale correctly classified 83% of the participants in the abuse group and 78.8% of the participants in the control group, specificity=83%, false negatives= 21.2%.

## Cost

- $180 for introductory kit (includes CAP inventory manual, 10 forms, 10 raw score summary sheets, 10 inconsistency scale scoring sheets, and 1 complete scoring template set).
- $26 for 10 forms booklets.
- $3 for 10 CAP raw score summary sheets.
- $3 for 10 inconsistency scale scoring sheets.

## Advantages and Disadvantages

**Advantages:**
- Administration time for BCAP is short.
- The tool has been used in Croatia and Turkey.
- Widely used and studied, with strong validity.

**Disadvantages:**
- Start-up cost is high and there are ongoing costs.
- Does not capture strengths.
- Parents not used to questionnaires may resist filling out even the BCAP; Does not promote working partnership between visitors and families.

## Age Range

18–99 years.

## Length/Time

**CAP:** 160 items / 20 minutes.

**BCAP:** 33 items / 5 minutes.

## Training

Manual available and specific qualifications required.

## Data Management System

No.

## International Use

The CAP has been used throughout the world including countries in North and South America, and Europe.

**CEECIS Countries**

Croatia, Turkey.

## Readability

4th grade level.

## Languages

The English version is available from the publisher and other translations exist as well.

## Publisher and Website

PAR.

**INDEX OF NEED**  
* (Index of Need; Browne, Hamilton, Hegarty, 2000 & 2006) 

<table>
<thead>
<tr>
<th>PURPOSE</th>
<th>This tool is designed to identify families who are at risk for child maltreatment and abuse. The tool includes static risk factors and dynamic risk factors. Static factors include birth complications, premature birth, child disability, birth spacing, parent not biologically related to child, and parent has a history mental health difficulties, is under 21 years old, and has a history of physical or sexual abuse. Dynamic risk factors include current mental health difficulties, substance abuse issues, violent adult family member, social isolations, financial difficulties, and indifferent feelings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMINISTRATION</td>
<td>Parent/caregiver self-report and home visitor interview. Items are weighted by severity level to arrive at a total score. Home visitors start with an initial interview, leave the self-report forms for parents to fill out, then score Index of Need at follow-up.</td>
</tr>
<tr>
<td>PSYCHOMETRICS</td>
<td><em>United Kingdom.</em> Initial analyses show sensitivity=70.4% and specificity= 96.4 %. Follow-up analyses showed the Index distinguishes between parents with and without a history of maltreatment who are then reported to maltreat their own children.</td>
</tr>
<tr>
<td>COST</td>
<td>The CARE Programme and its tools can be found in <em>CARE Programme Book</em> that includes tools (Browne et al, 2006).</td>
</tr>
</tbody>
</table>
| ADVANTAGES AND DISADVANTAGES | + Designed for use during home visits.  
+ Can be used as part of a universal home visiting program.  
- Limited age range (parents of children ages 0-1 year).  
- Designed to be used as part of multiple sessions, although could be adapted to one-time use.  
- Does not appear to be used or studied internationally. |
| AGE RANGE | Parents with children ages 0–1 year. |
| TRAINING | Manual available. Training conducted in a 1-day workshop embedded in larger training on use of risk factors and behavioral indicators for identifying families in need of service. |
| LENGTH/TIME | 14 items. |
| DATA MANAGEMENT SYSTEM | No. |
| INTERNATIONAL USE | This tool was developed in the UK as part of the CARE Programme. |
| CEECIS COUNTRIES | None. |
| LANGUAGES | English is available from the publisher. |
| READABILITY | Not specified, although parent report form suggests that readability is appropriate at most levels. |
| PUBLISHER AND WEBSITE | John Wiley & Sons, Ltd.  
REFERENCES


General Assessment Reviews


Part II

Review of Tools and Instruments for Early Childhood Home Visiting for the CEE/CIS UNICEF Region
**Introduction**

The Early Childhood Development, Health and Protection Sections of UNICEF Regional Office for CEECIS are supporting country policies and approaches that enhance the wellbeing of children birth to three years of age. Home visiting is a promising mechanism in which services can be delivered to promote positive child development, increase protection, and improve family functioning in the early years. At the same time, however, there are ongoing concerns about the content of the home visits as they currently exist, and the lack of appropriate tools or measures that may be used to assess children and their parents and guide home visiting content.¹ A recent review of home visiting in 17 of the countries suggests that home visiting by community nurses to pregnant women and families of young children is fairly common (Aston et al., 2012; UNICEF, 2012). Most of these countries have national or sub-national home visiting systems, typically through the health ministry. Many of these systems specify at least the number of home visits and content, yet at least half do not provide a standardized curriculum or service model, and few require the use of any monitoring or assessment tools. There is also concern about the professional development of the home visitors, in terms of their training to approach children and families in a holistic, integrated matter that attends to issues beyond basic health.

**Purpose**

The purpose of this review is to provide guidance for the use of tools and checklists during home visits of community nurses with pregnant women and with families of newborns and young children, in order to improve the targeting, content and results of home visits for children and their caregivers. It will focus on the following areas:

- Guides and curricula for routine home visits that include health, parenting, and child development content, both for universal and targeted home visiting approaches
- Identifying children and families with special needs, including:
  - Disability and developmental delay
  - Parent mental health concerns
  - Child emotional and behavioral concerns
- Home environments, including:
  - Home safety
  - Developmental appropriateness
- Identifying difficulties in attachment or parent-child relationship
- Family violence, including domestic violence and risk of child maltreatment

Attached to this review is a toolkit of 20 recommended measures for use in home visiting programs in the CEECIS region across these five broad areas. In the review of tools for inclusion in the toolkit, particular attention was paid to the following criteria:

1) **Scientific credibility.** Does the tool demonstrate adequate reliability and validity, and has its psychometric properties been demonstrated in multiple settings and populations?

¹ In this review for convenience and clarity, “parent” is used as the term for the child’s primary adult caregivers, although children are raised in many different family configurations and these persons may not be child’s biological parents.
2) **Content.** Does the tool cover domains of functioning that are relevant to the needs of the home visiting program?

3) **Cultural Validity.** Has the tool been developed, standardized, translated, or at least applied to the culture, ethnicity, or nationality of the population seen by a home visiting program? Is there evidence that the tool has cross-cultural validation?

4) **Access.** Does the tool exist in the language of the community in which the home visiting program resides? Is it available in a form that is cost-effective (i.e., free or low-cost, with minimum additional infrastructure or data recording requirements).

5) **Strength-based vs. problem-focused.** Clinical tools are often calibrated to pick up problems or challenges in development or functioning. This is important when dealing with clinical or high need populations. For service planning, however, it is also important to capture strengths and protective factors within families, as well as capture variation among families who may participate in a universal program where not all families are seen as high-need.

6) **Practicality.** Is the tool easy to be trained on and to use? What are the literacy demands, particularly for tools that require family self-report? To what extent can the tool be incorporated into the context of home visits and into the record-keeping or management information system of the home visiting program while minimizing documentation burden of the nurse home visitors?

It is important to note that many of the tools and curricula reviewed for this project do not meet all of the criteria specified above, even those recommended and included in the toolkit. Although an attempt was made to give priority to tools already in established use in countries in the CEECIS region, there were few tools to choose from that were standardized and which psychometric information was available. Weight was also given to tools that were judged to have practical use and that could be used in the context of an ongoing relationship between the home visitor and mother. That is to say, in many cases an emphasis was placed, where possible, on tools that required ongoing observation or interaction with the family, rather than a one-time self-report questionnaire. On the other hand, it was important to consider the learning curve required for these tools so that administration, scoring, and interpretation would not be overly burdensome and difficult to the home visitor. Given the goal of the UNICEF Regional Office that these tools provide a way to guide content and service delivery in home visiting programs, their use as a professional development aid (enriching the knowledge base and performance of the nurse home visitor) is also paramount. In other words, how the tool may be used is also an essential element of the review.

**Sources for the review**

Sources for this review came from guided examination of the home visiting and early childhood literature and from direct correspondence with resident experts in the CEECIS countries.

**Literature Review.** In the United States, as emphasis has increased on the use of evidence-based practices, there exist different summaries and compendiums of early childhood screening and assessment tools designed for programs and researchers to use to guide their selection. Because of the lead author’s knowledge of the home visiting and early childhood service landscape in the United States, this served as initial starting point. Literature on international programming was also reviewed, with particular attention paid to the UK, given its national home and health visiting initiatives. In addition, reviews of tools used in low and middle-income countries were also consulted as sources. These sources are listed in Appendix A. Staff from the Early Childhood Development Section of the CEECIS UNICEF Regional Office also supplied documentation for review, including policy briefs and
report summaries. Each CEECIS country’s UNICEF page was also reviewed, specifically the overview, activities and media centre (publications) sections of the sites. Sites were searched for mention of home visiting, and early childhood programming and relevant country-related documents were examined.

Consultation with Experts. In November 2012, email correspondence was initiated with 34 identified experts in early childhood and home visiting. Attempts were made to identify and contact at least one expert in each of the 22 countries within the CEECIS area. In addition, we sought out the opinion of other international experts who have experience in early developmental issues. These experts do not reside or work in the CEECIS region but have been engaged in research in these areas or have analyzed home visiting and early childhood health and development service delivery in low and middle-income countries. In some cases we also contacted the author of an identified instrument and engaged in personal correspondence to collect more information on that particular measure (e.g., Robert Bradley for the Home Observation Measure of the Environment). Finally, a draft of this report was presented to the International Technical Advisory Group on Home Visiting for Young Child Wellbeing in CEECIS Region for feedback and review, which included some of the same experts with whom we were in initial contact.

Responses and were received from 19 individuals (see Appendix B). Although valuable feedback on this report and toolkit was provided, most informants residing in CEECIS region states did not provide information on specific tools used in their country, instead describing the services delivered in general terms. In a few cases, copies of tools used were provided but they appeared to be locally developed and non-standardized (e.g., child health records). This further suggests the need for an initiative focused on this topic.

Home Visiting Health, Parenting and Child Development Content

A major objective of the review is to define the key programmatic content provided during home visits to all, at-risk, and vulnerable families. Given its history and multi-disciplinary nature, home visiting in early childhood encompasses many different potential targets of focus. Education, public health, mental health, child protection, family support, and other human services all potentially contribute to home visiting models. Although child well-being drives virtually all home visiting initiatives, determining what content home visiting programs “must” include becomes a professional or systemic preference. It will depend on the orientation of the home visiting stakeholders, the service structure within which the home visiting program exists, the needs of whatever agency or body is funding the initiative, and which families are targeted. For the CEECIS Region, most home visiting programs operate within the health sector, so that a focus on child health has been the principle component of most home visiting programs, although an increased focus on linked outcomes of child health, nutrition and development is increasingly recognized as essential programming components (Aston et al., 2012).

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2 Within the time frame of the project, no experts were identified from the following countries: Armenia, Kyrgyzstan, Montenegro, Tajikistan, or Turkmenistan
Program Models & Content

United States. In the United States, home visiting exists both as a service delivery mechanism in the context of larger service systems and as a service program in its own right. For example, early childhood centers may provide occasional home visits to families in order to foster home-school connections. Child protective services often typically conduct their investigation and follow-up in the context of home visits, as do early intervention services specifically targeted towards children with identified delays and disabilities. But “home visiting programs” as they have become to be known are slightly different. These programs are prevention-oriented, working either universally or (more commonly) targeting at-risk populations of vulnerable parents, such as new parents, young parents, or low-income families.

The current federal administration has placed an emphasis on home visiting with the creation of the Maternal Infant and Early Childhood Home Visiting program (MIECHV), a funding mechanism that provides resources to the states to conduct evidence-based home visiting. Although the specific content of the home visiting is largely unspecified, MIECHV does demand that programs monitor themselves according to benchmarks in seven key areas, providing at least a rough guide to what home visiting programs need to address: maternal health; child health; maltreatment; child development/school readiness; domestic violence and delinquency; parenting economic self-sufficiency; and service coordination and referrals (see http://mchb.hrsa.gov/programs/homevisiting/).

As part of MIECHV, the US Federal Government commissioned a review of home visiting programs that specified 13 home visiting models that can be considered “evidence-based” (see http://homvee.acf.hhs.gov/). These models vary in the extent to which they cover these seven areas. They also vary in whether or not they include specific curricula to be used. For example, both Early Head Start and Healthy Families, popular home visiting models in the United States, have program standards, but do not have program manuals that specify content covered in home visits. There are also program areas that are covered by the models and are expected to be monitored in the benchmarks that nonetheless have little empirical evidence to support home visiting’s role in addressing these areas (e.g., service coordination, reducing domestic violence and delinquency). This is noted simply to demonstrate that the decisions made regarding what home visits should address are a complex political negotiation involving the intersection of research, policy, and practice, and are not always based on the empirical literature.

There are common themes across most of the major home visiting models in the United States. Most target at-risk families. Most focus on providing basic information on child development, health, and well-being (see Table 1). Health concerns are addressed, although the emphasis will vary by who provides the home visits. Nurses, for example, typically focus on child health to a greater extent than non-nurse home visitors. Parents are taught developmental milestones and how to recognize them in

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3 MIECHV specifications seem to preclude universal programs from funding, in that the priority populations for the most part focus on at-risk families, specifically those that: (A) reside in communities identified from a legislatively required needs assessment; (B) have low-income; (C) include adolescent pregnant women; (D) have a history of child abuse or neglect or interactions with child welfare services; (E) issues of substance abuse, including tobacco products in the home; (F) have a history of, or have children with low student achievement; (G) have children with developmental delays or disabilities and (H) include members of the military (REF).
their child. They are also taught developmental activities they can do with their child to promote their child's development, such as early reading activities, peek-a-boo games, or singing nursery rhymes and lullabies. A primary goal of most of these interventions is fostering the emerging positive relationship between the parent and child. Concepts borrowed from attachment theory (Bowlby, 1988) are pervasive in these program models, with home visitors discussing and promoting the importance of sensitive and contingent responding. In some program models, an explicit emphasis on the parent’s behavior to the child and the child’s response to the parent is made, while in other programs this relationship is seen to form by promoting the developmental activities noted above and simply encouraging the parent and play with and spend time with their child.

Finally, most programs recognize the importance of attending to the well-being of the adult family members in order to promote child health and well-being. Recognizing and responding to signs of depression, substance abuse, and social isolation are key features of most home visiting programs, despite the fact that many home visitors in the United States feel ill-prepared to work with these issues (e.g., LeCroy & Whitaker, 2005). Home visitors help parents think through their own life-course development, including issues such as employment, education, and repeat pregnancies. They also link families to appropriate community resources in health and social services.

**United Kingdom.** Nations that make up the United Kingdom have also had a long history of providing home visiting services. In contrast to the United States, however, the emphasis until recently has been on universal models, so that every family with an infant is visited, regardless of risk. The emphasis has traditionally been on visits that focus on the basic health and well-being of the young child in visits that are more infrequent and larger-spaced than those seen in the United States home visiting models. There has been little research on the effectiveness of these services, although they are a popular and important component of the country’s health care system (Kamerman and Khan, 1993, Elkan et al., 2000). At the same time, it has been seen as stressful work, and health visitors often report strong dissatisfaction with their workload (see Royal College of Nursing, 2011).
Table 1. Content Covered in Home Visits

<table>
<thead>
<tr>
<th>Child Health &amp; Safety</th>
<th>Child Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>- prenatal health and well-being (if applicable)</td>
<td>- prenatal development</td>
</tr>
<tr>
<td>- preparing for labor and delivery (if applicable)</td>
<td>- physical/motor development</td>
</tr>
<tr>
<td>- immunization</td>
<td>- cognitive development</td>
</tr>
<tr>
<td>- breastfeeding and nutrition</td>
<td>- language development</td>
</tr>
<tr>
<td>- physical activity</td>
<td>- social-emotional development</td>
</tr>
<tr>
<td>- basic care: sleep, bathing, dressing child</td>
<td>- temperament/emotional regulation</td>
</tr>
<tr>
<td>- hearing/vision</td>
<td>- brain development</td>
</tr>
<tr>
<td>- monitoring growth</td>
<td>- emergent literacy</td>
</tr>
<tr>
<td>- recognizing signs of illness</td>
<td>- play</td>
</tr>
<tr>
<td>- promoting well-care visits (prenatal and child)</td>
<td></td>
</tr>
<tr>
<td>- dental hygiene</td>
<td></td>
</tr>
<tr>
<td>- monitoring for signs of child maltreatment</td>
<td></td>
</tr>
<tr>
<td>- child injuries, ingestion/poison</td>
<td></td>
</tr>
<tr>
<td>- home safety review, including crib &amp; carrier safety</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent-Child Relationship</th>
<th>Family Health &amp; Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>- recognizing signs of attachment</td>
<td>- caregiver stress and mental health</td>
</tr>
<tr>
<td>- reading child cues</td>
<td>- caregiver physical health/postpartum care</td>
</tr>
<tr>
<td>- Parent (realistic/unrealistic expectations) of child</td>
<td>- domestic violence &amp; family violence</td>
</tr>
<tr>
<td>- promotion of positive parent-child interactions</td>
<td>- caregiver substance use</td>
</tr>
<tr>
<td>- non-coercive discipline strategies</td>
<td>- social support</td>
</tr>
<tr>
<td>- relationship disruptions &amp; transitions</td>
<td>- connection to community resources</td>
</tr>
<tr>
<td>- family systems/role of other family members</td>
<td>- parent life course development</td>
</tr>
<tr>
<td>- relationship history &amp; impact on parent-child relationship</td>
<td></td>
</tr>
</tbody>
</table>

A recent review from the UK noted that there is little clear evidence to address the debate of universal versus targeted services (Barlow et al, 2008). Instead of choosing sides, recent UK policy and service changes, such as the Healthy Child Programme - Pregnancy and the First Five Years (see Shribman & Billingham, 2009), have emphasized tiered or progressive services, so that universal services still work with most families, but families with greater need may be visited more often or be referred to specialty services, such as Family Nurse Partnership (FNP), the UK version of Nurse Family Partnership (but see Browne & Jackson, in press, for concerns about the efficiency of the risk assessment process for FNP).

The Healthy Child Programme, like the Framework for the Assessment of Families in Need and Their Children (UK Department of Health, 2000) that came before it, seeks to integrate child health with child development and appropriate caregiving. The Framework, for example, laid out the major tasks of parenting, which includes providing safety, emotional warmth, stimulation, guidance and boundaries, and stability. This frame was applied to the Child Assessment and Rating Evaluation Programme (CARE Programme; see Browne, Douglas, Hamilton-Giachritsis, & Hegarty, 2006), a low-intensity (5 visits in the first year) child abuse prevention program. It was developed in response to a need for
community health workers (including health visitors) to be aware of and assess more accurately the emotional needs of all families with babies. It has more recently been used as part of the Sure Start initiative in areas of England (Dixon, Browne, and Hamilton-Giachritsis, 2009), and addresses many of the core ideas seen in the Healthy Child Programme. One of the noteworthy features of the CARE Programme is the use of detailed clinical assessment instruments to assess family risk of maltreatment and observe the parent-child relationship.

An online training component has been developed to support the Healthy Child Programme. The e-learning course, open to all UK health care professionals, is comprised of 76 sessions, within 12 learning modules. Each learning session takes approximately 20-30 minutes to complete. For example, the module “Positive Parenting and Parenting Issues” includes six sessions focused on promoting attachment and well-being (two sessions), defining and implementing parenting support (two sessions), and parenting relationships (two sessions).

**Other International Models.** In the United States and in the United Kingdom, home visiting programs promote parenting ideals that may be bounded by cultural and class assumptions. The notions, for example, that the primary parent or caregiver is the most important “teacher” to the child, or that parents should “play” with their children, or that there should be just one or two primary caregivers as attachment figures are not cultural universals, and may reflect, in part, middle- and upper-class concerns with child academic achievement and development of autonomy.

There is an active debate about the cross-cultural importance of a primary sensitive caregiver in a child’s development (e.g., Mesman, van IJzendoorn, and Bakermans-Kranenburg, 2012; Posada et al., in press). This is important to consider for any home visiting initiative that is applied across multiple cultures. The extent to which the local culture supports and promotes these concepts of parenting may influence the success of home visiting content as it is transferred or adopted to new settings. On the other hand, however, some home visiting models are developed to challenge culturally-accepted caregiving practices (see below), and it is possible to show that different caregiving strategies can be beneficial to promoting child development in these countries. A recent review of programs to promote early childhood development in low- and middle-income countries suggests that a focus on positive parenting practices do improve developmental outcomes for young children (Engle et al., 2011).

Different international program models and guides also place a premium on the same qualities of parenting promoted by attachment theory and home visiting models in the United States and in United Kingdom. The Integrated Management of Childhood Illness (IMCI) Guidelines of Care for Child Development published by WHO, for example, focus on activities to improve interaction with children to stimulate growth and learning and to promote responsive care for the child’s health, and recommend play and communication activities to promote development (WHO, 2001). This model has been used and evaluated in at least three CEECIS countries and adapted in a fourth, although not yet in the context of home visiting (Engle, Smeby, & Grover, 2010; Ertem et al., 2006; Evans, Berdaga, & Jelamschi, 2006).

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5 Kyrgyzstan, Moldova, Tajikistan, & Turkey.
There are multiple examples of home visiting programs in particular developed in non-industrialized nations that include an emphasis on learning games for children and caregivers in the context of a warm and sensitive relationship. One such example is Cuba’s *Educa A Tu Hijo* (Educate Your Child; see Tinajero, 2010), a multisector, community-based program run by the Ministry of Education that places the family at the center of program activities. It was designed for pregnant women and children under six years. In Cuba, about 70% of children participate, making it essentially a universal program, although it is longer and more intensive than most UK universal Health Visiting initiatives. It has been successfully exported to and studied in a number of countries in Latin America, including Brazil, where it has been implemented on a large scale in the state of Rio Grande del Sul with over 1000 home visitors (Schneider, Ramires, Paiva, & Almeida, 2009).

In a somewhat similar fashion, the *Roving Caregivers Programme*, developed in Jamaica and used within the Caribbean, also promotes teaching parents activities to promote their child’s development, although the home visitors (called roving caregivers) often model this activity by interacting directly and providing stimulation to the child. The stated aim of the program is to provide “culturally and developmentally appropriate stimulation activities while also challenging traditional child-rearing beliefs” (Foundation for the Development of Caribbean Children, n.d.).

Although filling in gaps in parent knowledge is an important part of the Roving Caregivers Programme, the urgency of this last statement suggests the concern that direct action is necessary to overcome parenting limitations and challenges in highly stressed families, and that the program needs to confront traditional forms of child care that are not seen as supportive of child development. It is important to consider the extent to which these challenges exist in CEECIS countries as well. In Belarus, for example, the NGO that funds an adaptation of the *SafeCare Model* (see below) implemented by child welfare home visitors provides the rational for the service in this fashion:

Families in Belarus also face serious gaps in the education system and lack information about sound parenting practices. Parents themselves were victims of a repressive instruction system, frequent use of physical punishment and general lack of understanding of children’s needs. By teaching clear, sound guidelines for parenting as well as nonviolent conflict resolution, we help them develop a foundation of discipline and respect within their families (Child Fund International Belarus, n.d.)

This suggests that, in some areas, program content that is concrete and didactic and focused specifically on problem-solving and teaching may be seen as more valuable than a curriculum that focuses on the dynamic emergence of the parent’s own natural competencies.

SafeCare, borrowing from behavioral theory, fits into this view of programming. It is an evidence-based, in-home parent training curriculum designed to reduce the recurrence of child maltreatment for parents with children ages 0-7 who are at risk or have been reported for child abuse or neglect (Guastaferro, Lutzker, Graham, Shanley, & Whitaker, 2012). It targets families identified as having a history of neglect and/or physical abuse, or having risk factors for neglect or abuse. The intervention entails 8-20 home visits, conducted weekly. Using

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6 Both *Educa A Tu Hijo* and Roving Caregivers are given as examples of international programs and are not included in the toolkit.
manuals with carefully designed lesson plans, parents are taught specific caregiving skills (e.g., how to take a baby’s temperature). Home visitors work with families to improve the parents’ skills in several specific domains, including health, home safety, parent-child interaction, and problem solving and counseling.

Curricula as a Home Visiting Tool

In addition to a home visiting program’s model or structure, there are specific curricula used to provide guidance to the home visitor for actual content of what activities to promote and what developmental information to provide in a home visit. These curricula are useful tools on top of assessment and screening measures, and can be used to enhance home visitor practice. Examples are provided in the accompanying toolkit. The previously-mentioned Healthy Child Programme, for example, has detailed training components for Health Visitors and uses as a core component the Personal Child Health Record (PCHR), or “Red Book”, which allows health visitors to record and share with families information on specific topics, such as birth information, health conditions, immunizations, screening and reviews, and developmental progress. In general, the PCHR show a stronger emphasis on health than development topics, and most do not have places to record information on the parent-child relationship, although they can provide information on environmental and contextual health issues, such as maternal depression or domestic violence. The effectiveness of the PCHR has not been well-evaluated, although parent satisfaction with it has been shown to be high (Hamilton, & Wyver 2012).

While some programs include a specific curriculum (Educa A Tu Hijo or SafeCare are other examples) others do not, so that a home visiting program is required to purchase and train on a curriculum separately. These curricula typically are accompanied by a manual and other training activities. The main body of the curricula is developmental information, activities and handouts that are to be used with families on a visit-by-visit basis, often arranged by age and/or topic. Usually there is flexibility in which topics can be introduced based on the needs of the parent, so that individualization is a key element of their use. These curricula may be accompanied by specific screening and assessment tools for home visitors to use to gather information, although this is not always the case.

Curricula may be comprehensive in approach, covering all of the dimensions of program content summarized in Table 1. As one example, Partners for a Healthy Baby (PHB), a popular stand-alone curriculum for home visitors in the United States, covers preparing for baby, baby/toddler development, baby care, family development, and maternal and family health. Program materials are contained within large books that coincide with different phases of development, with tear off pages that become colorful handouts and activity sheets left with the family and written in simple language (samples may be viewed at http://cpeip.fsu.edu/PHB/PHB_samp.cfm).

On the other hand, Partners in Parenting Education (PIPE) is a set of curricula more singularly focused on the emotional experience of the child and the promotion of emotional availability of the caregiver to the child (see Emde, Robinson, and Korfmacher, 1997, for more details). It relies to a large extent on

7 Because PHB has not been used outside of the United States, it is not included in the Toolkit and is included here only as an example.
8 Because PHB has not been used outside of the United States, it is not included in the Toolkit and is included here only as an example.
the introduction of simple interactive activities (or “activity cards”) that the parent and child can do together, using common household materials as appropriate. It uses a four-step instructional model to explain the theoretical concept, model the activity, supervise the parent and child in the activity together, and provide feedback. The three modules are labeled “Listen”, “Love”, and “Play”, which provides a good sense of its theoretical orientation. Although some activity cards are tied to developmental milestones (e.g., the emergence of attachment behaviors), home visitors have discretion regarding which cards to use. Although developed independently, PIPE is a primary curriculum of Nurse Family Partnership, a popular evidence-based model of home visiting in the United States, and has been used in other countries as well, including New Zealand, Canada, Germany, and the UK (where it is embedded in Family Nurse Partnership).

**Program Content Summary**

Overall, program content has been little studied in empirical research, with most outcome research assuming that families within a program group all receive essentially the same intervention. There is some evidence that variation in content is important to understand. For example, one study of Early Head Start in the United States has shown that a heavier focus on child development activities is related to positive parenting practices and improved child outcomes (Raikes et al, 2004). Few curricula have subjected themselves to empirical study, showing that increased use of the specific curriculum is associated with improved child outcomes, although this is an emerging area of implementation science. PIPE has undergone some evaluation of its use, although most of its research has been unpublished or not contained in peer-reviewed journals (see [www.howtoreadyourbaby.com/us/pipe](http://www.howtoreadyourbaby.com/us/pipe)).

A challenge with the import of any particular curricula into a new context is ensuring both that an appropriate translation is available and that the content covered is culturally appropriate. Very few of the curricula reviewed have been used within the CEECIS region and there is large diversity of languages spoken by different populations within the country. This suggests that any curriculum considered for adoption would need to go through translation and cultural adaptation while ensuring that key concepts are maintained. In addition, these curricula may need to be adapted to the local concerns and needs of the region. SafeCare, for example, as it is being implemented in Belarus, has had to undergo significant modification (Guara, 2011). The program authors removed items specific to the United States in order to better capture cross-cultural principles. For health, a simplified, decision-making flowchart was created and more simple role-play scenarios were generated around this new decision making process. In addition, more emphasis was added for health prevention, such as exercise, nutrition, immunizations, and hygiene. A similar process was also undertaken for the home safety and parenting components. Such a systematic process is necessary to ensure the local validity of the home visiting content.

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9 As opposed to the Roving Caregivers Programme, in PIPE the demonstration is not done with the child, but with a doll or toy animal. This is a deliberate strategy so that the parent does not feel that the home visitor is taking over for them or relinquishing her role as the child’s teacher.
Assessment and Screening Tools

The remainder of this report focuses on issues in the use of screening and assessment tools in the context of home visiting programs in four areas: identifying children and families with special needs; home environments; potential failure or breakdown in attachment between parent and child; and family violence, including domestic violence and child abuse and neglect risk screeners.

Identification of Children and Families with Special Needs

For the purposes of this review, we are restricting discussion of special needs to three major topic areas: 1) disability and developmental delay in the child; 2) parent mental health concerns; and 3) child emotional and behavioral concerns. In all three areas, how the assessment tool is used is of central importance. In general, the main purpose of a screening is simply to decide whether or not there is a need for more in-depth referral or follow-up. For this reason, they are designed to be short, simple to administer, easy to understand, low-cost, and require minimal training in interpretation (Meisels & Atkins-Burnett, 2005). They often rely on parent report instead of direct observation. These factors make the use of screeners appealing to home visiting programs, especially when there are concerns about both the professional level of the home visitor and the literacy level of the parent.

Brief screeners are also valued for sensitive topics (such as drug use and mental health concerns) so as to reduce the discomfort of being queried in detail.

But these same reasons for screening tools’ appeal are also their major weaknesses. They do not provide nuanced or in-depth information and for this reason can be difficult to use for program planning or individualizing content. Domains of assessment are typically covered by a minimal number of items, so they do not capture the full range of functioning. They are rarely strength-based, in that their main purpose is to identify potentially negative conditions. Screeners are judged by their sensitivity (how well it identifies clients truly in need of follow-up) and their specificity (how well it eliminates those who do not need follow-up), but it is exceedingly difficult to design a screener that is both highly sensitive and specific. Screeners typically over-identify people who may be considered at-risk, with the assumption the follow-up assessment will safely eliminate those false positives who initially scored high on the screener (see Meisels & Atkins-Burnett, 2005).

How a tool is used is related in large part to the overall service context in which the home visiting program exists. If home visitors use screeners but have no mechanism to provide follow-up referral or assistance based on the result of the screening, then the practical utility of collecting this information (along with the ethical and rights issues involved) is uncertain. An alternative approach is to conduct an in-depth assessment of a child or family’s strengths and challenges around these selected areas of risk, such as a full developmental assessment using a standardized assessment instrument such as the Bayley III (Bayley, 2006), or an in-depth observation of the child’s behavioral functioning (Danis, Hill, & Wakschlag, 2008). For highly trained and qualified home visiting staff, this may be an appropriate intervention. Such an assessment could be used to provide valuable feedback to families, guide

10 Although not considered a low-literacy region in general, there is wide variation in the reading skills of the population across the CEECIS countries (e.g., UNICEF, 2009). In addition, patronage nurses in the CEECIS region typically have low education levels (Aston et al, 2012). This suggests that the reading level of the instrument is an important consideration.
program planning, and gauge the progress of the child and family as they make use of the home visitor’s services. On the other hand, these in-depth assessments can be burdensome to families, may be expensive to purchase, and may require considerable training and professional experience in its use and interpretation. This makes them impractical to use in many home visiting contexts, particularly in low- and middle-income countries. Some have advocated for “stretching” the use of well-validated screening instruments for use in diagnostic processes or service planning when the alternative is either no other assessment of development or the use of informal or unvalidated measures (Bricker, Squires, & Clifford, 2010). This approach needs to be very cautiously considered.

**Disability and developmental delay.** There are particular issues in assessing disability and developmental delay using screening instruments in low- and middle-income countries. As noted in a recent review:

> Due to the high prevalence of developmental difficulties in high risk populations, families may not have an appropriate baseline of what typical development is. In addition, many families may not be willing to discuss their concerns. When families are asked questions from a very structured checklist, they may not express their concerns. This is due to a variety of reasons, including the stigma associated with disability. Families may not feel comfortable discussing a sensitive issue with a care provider who does not have an ongoing relationship with them. The low level of literacy presents an additional problem and does not allow the use of written forms or questionnaires that might offer more privacy or anonymity. (Krishnamurthy & Srinivasan, 2011; p.4)

One advantage of using patronage nurses to conduct disability screens in the context of home visits is that they can take advantage of the ongoing relationship with the family to increase the caregiver’s comfort with the process of collecting information. In certain cases, the disability screen, when used regularly over time, may also be used to assist in ongoing monitoring and guidance to the parent about their child’s development.

There exist multiple screeners for delays and disabilities. Some tools directly assess the child’s performance in a testing-like experience, such as the *Denver-II* (Frankenburg, Dodds, & Archer, 1992). Although the Denver II is a popular screening tool and has wide international use, its scoring sheet is less straightforward than other screening tools, it uses specific standardized items in its administration, and it requires considerable training for reliability, suggesting some challenges for its use in a home visit. For this reason, as well as persistent psychometric concerns about the Denver-II (e.g., Glascoe et al., 1992), the *Ages & Stages Questionnaire* is suggested as an alternative (see below). Other instruments rely solely on parent report, asking parents to report on attainment of milestones and other features of their child’s development. One example is the *Ten Questions Screening Instrument* (TQSI), specifically developed for use in low-income countries. As its name suggests, it has ten questions, six focused on intellectual or cognitive functioning. It is one of the most widely used screeners for disability and delay in low and middle-income countries (Maulik & Darmstadt, 2007); however, its applicability for birth to three programs may be limited in that it was not designed to be used for children under two years of age (for this reason it is excluded from toolkit).

Of particular note are tools that are already in use in the CEECIS Region. One such tool is the *Guide for Monitoring Child Development*, developed in Turkey (GMCD; Ertem et al., 2008). It uses a short
series of open-ended questions that address parents’ concerns and their view of their child’s
development across different domains. It has less focus on severe disability compared to other
instruments, which may increase parent’s engagement in the screening process. Although originally
designed for use in pediatric settings, there are unpublished reports of its use with community health
workers in India (see Krishnamurthy & Srinivasan, 2011). An alternative is the Parents’ Evaluation of
Developmental Status (PEDS; Glascoe, 1998). PEDS is a 10-question screener designed to elicit and
address parents’ concerns about their child’s development and health, and to identify children at risk for
school problems and those with undetected developmental and behavioral disabilities. PEDS areas of
measurement include global/cognitive, expressive, language and articulation, receptive language, fine
motor, gross motor, behavior, social-emotional, self-help, and school functioning. It has wide
international use, including use in Turkey. Its brevity is both its greatest asset and its most limiting
factor. Since each area of development receives only one question, there is little room for a nuanced
understanding of the child’s capacities and challenges.

The Ages and Stages Questionnaire, 3rd Edition (ASQ; Squires & Bricker, 2009) is another common set
of age-related developmental screening tools. An earlier version was used in two of the three CEECIS
countries (Kyrgyzstan and Tajikistan) participating in the IMCI Development of Care program, as
reported by Engle and colleagues (2010). A Turkish version is available (Karabekiroglu et al, 2009),
and it is being studied in Georgia and Russia. A version is also under development in Bulgaria (Holly
Hix-Small, personal communication). The ASQ is designed to be either used as a parent-report form,
or conducted as a direct assessment with the child. One of the primary benefits of the ASQ is its
interactive process, which encourages the parent to engage with the child around these tasks rather than
the screening agent. In addition, separate forms are created at roughly two month intervals, allowing
for the screener to be repeated on a regular basis (sometimes alternating with parent report). If used in
this way, the tool provides ongoing developmental guidance to the parent and can be used to monitor a
child’s development over time in a way that most screening instruments cannot (see also Bricker et al.,
2010). Its milestone focus and anticipatory guidance structure also can serve as a professional
development tool for a home visitor with less experience.

Parent mental health. Parent mental health includes both psychological conditions such as depression
and anxiety, but also substance abuse. Research increasingly shows that within home visitor caseloads
are significant numbers of participants experiencing elevated levels of depression, anxiety and trauma,
even for programs that are not specifically targeting at-risk populations (Ammerman, Putnam, Bosse,
Teeters, & Van Ginkel, 2010). Depression is often targeted specifically for screening given its high
incidence and co-occurrence with other psychiatric disorders, so that it serves as a marker for assessing
further conditions. There are a number of valid and efficient screens for maternal depression that can be
used by home visitors, and multiple reviews have compared these different instruments (e.g. Boyd, Le,
& Somberg, 2005; Tandon, Cluxton-Keller, Leis, Huynh-Nhu, & Perry, 2012). The most widely used
and studied is the Edinburgh Postnatal Depression Inventory (EPDS; Cox, Holden, & Sagovsky,
1987), a short (10-item) self-administered tool originally designed to identify the presence of
depression in women following childbirth, although it has been used during pregnancy and other
periods, including with fathers. The scale measures symptoms of depression including sadness, fear,

11 The developers of the ASQ provide guidelines for cultural and linguistic adaptation of their measure. See
anxiety, self-blame, and sleeping difficulties. Although such a screener is relatively easy to administer, it is important to note that establishing appropriate clinical cut-offs can vary by cultural group and timing of the administration. In addition, as with any screening instruments, home visitors need to feel prepared to address mental health needs once identified, so that training in how to work with mothers with heightened levels of depression is crucial (Tandon, Mercer, Saylor & Duggan, 2008).

Although nurse home visiting programs by themselves are not considered an effective way to work with parents where there are substance abuse concerns (Watson, Munro, Wilson Kerr, & Godwin, 2010), these behaviors have a significant impact on child development, particularly when the substances are used during pregnancy. Specific screeners exist for alcohol consumption which can be effective in identifying use in pregnant women in as few as four questions (see Burns, Grey, and Smith, 2009, for review). A more comprehensive screen that covers multiple substances is the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), developed by the WHO for multinational use (see www.who.int/substance_abuse/activities/assist/en/index.html). In an interview format, respondents are asked about specific drug use (lifetime and last three months) and its consequences. It has been translated into 10 languages, including Russian and Ukrainian. Although originally designed for primary medical care settings, it has been used in home visiting programs, such the SafeCare home visiting model.

Child emotional and behavioral concerns. The identification of children with specific emotional or behavioral control issues is relatively new topic of investigation in the birth to three period. Although there have been measures of temperament (see Sosna & Mastergeorge, 2005, for a good selection of measures developed in the United States), these are designed to address normative variation in child temperamental style and have limited clinical utility. In addition, there are few examples in the literature of these tools being used internationally. Although there exist some observational measures of behavior difficulties (e.g., the Disruptive Behavior Diagnostic Observation System, or DB-DOS; see Danis et al., 2008) that extend down to this age range, these observation systems typically require extensive training and/or a clinical background. For the most part, this area of functioning relies on parent or caregiver report. Caregivers are asked to report on the symptomatology and severity of certain behaviors or emotional states. This again highlights the cautions that must be made when transferring any established measure into a new cultural context, where both symptoms and severity may be viewed through a different lens.

The most widely-used tool in the category is the Achenbach Child Behavior Checklist (CBCL), (Achenbach, 2009), a comprehensive parent- and teacher-report instrument that covers multiple domains of child behavior problems. It has considerable empirical data, international use and validation across multiple societies, and has been translated into many different languages, including many represented in the CEECIS (see www.aseba.org/ordering/translations.html#R). On the other hand, it begins at 18 months, with many of the translated instruments not beginning until 24 months or even 4 years, making its application to the birth to three population more tentative. In addition, it is a long instrument (typically 100 items with forced response of a 3-point scale), making it less interactive. It is also strongly problem-focused, with little assessment of child strengths. For these reasons, the CBCL was not included in the toolkit. Despite the advantages of the CBCL with its established translated versions, other tools may make more sense for use in CEECIS home visiting programs, including the

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12 it is unclear how many translated versions have country-specific norms
brief screening version of the Infant-Toddler Social-Emotional Assessment (BITSEA; Carter, Briggs-Gowan, 2006) or the infant-toddler version of the Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 1999). Although these, like the CBCL, are adult-report instruments about children, they are shorter, more strength-based (the DECA in particular), and cover more of the birth to three period. Their disadvantage, in turn, is a lack of established translated versions and (so far) limited international use, although the BITSEA has been used in Turkey (Karabekiroglu et al, 2009; Karabekiroglu et al, 2013), and a longer version of the BITSEA has been used in Romania as part of the Burcharest Early Intervention Project (see Smyke et al, 2009).

Home environments

Home environments can be measured both in terms of safety (allowing the child to live in an environment free from hazard and neglect) and developmental appropriateness. As part of their curriculum, SafeCare uses the revised version of the Home Accident Prevention Inventory (HAPI-R; Mandel, Bigelow, Lutzker, 1998), and has continually adapted it and its surrounding curriculum, including a version used with cell phones (Jabaley, Lutzker, Whitaker, & Self-Brown, 2011). Given the great variation in living standards, household composition, and living arrangements that exist internationally, however, one must be particularly careful about using any standardized home safety screen into a new community, particularly measures developed in higher and industrialized countries and transferred to lower-income countries. In many cases, specific items may not make sense (e.g., asking about the safety and appearance of electrical equipment or household appliances). Jordaan and colleagues (Jordaan, Atkins, van Niekerk, & Seedat, 2005) document the process of developing a safety measure in low-income communities in South Africa and the amount of effort and community input that is needed to make sure it is ecologically valid. As noted previously, the developers of SafeCare are currently piloting a process of adapting their measures to different international contexts, including the use of the HAPI-R in home visiting in Belarus.

Although similar cautions would seem to equally apply to measures of the home caregiving environment, there is one tool that appears to have influenced much of the work around measuring the contextual elements of caregiving environment. The most widely-used instrument is the Home Observation Measure for the Environment (HOME; Caldwell & Bradley, 2003), an almost 30 year old measure that has been adopted both by researchers and program staff to assess the quality of a child’s environment, to examine relationships between parenting and child development, and to document family response to interventions. The HOME Inventory measures the developmental potential of a child’s home environment through both direct observation and parent report. The evaluator rates the home of the family while the child is awake and interacting with the parent or primary caregiver. In addition, there are interview questions that are asked of the parent. The dual process makes the measure somewhat difficult to master and fairly lengthy (one assessment typically takes one hour, with each child of the family the focus of a separate assessment). Although it measures some structural aspects of the caregiving environment (e.g. cleanliness of the house, number of books), it also measures the quality of the interaction between the child and primary caregiver. Because it assesses the emotional level of the caregiving environment, it is also often used as a proxy measure of the parent-child relationship.

The HOME has a strong international presence (Bradley and Corwyn, 2005) and has been translated into multiple languages and adapted to fit the unique needs of some communities (this has happened, in
part, because there is looseness to the standardization of the tool. It has been used in a number of CEECIS countries, including Russia, Romania, Serbia, Turkey, Kosovo, and FYMR (R. Bradley, personal communication). Despite some evidence that indicators combine to create different parenting constructs between cultures, there is emerging evidence across cultures of similarities in relationship between exposure to stimulation, parent responsiveness and child adaptive functioning (Bradley and Corwyn, 2005). Because its length and complexity can be a hindrance to some programs, attempts have been made to reduce the HOME, either as a short form, or as simple parent checklist, such as the 30-item Home Screening Questionnaire (Frankenburg & Coons, 1986). The questionnaire removes the observation component and focuses on parent report of the caregiving environment.

**Identifying parent-child relationship and attachment difficulties**

There are two primary approaches to identifying attachment problems. The first is by assessing parent attitudes towards children and child-rearing. Parents may be asked to think about children in general, such as with the Adult-Adolescent Parenting Inventory (AAPI; [www.assessingparenting.com/assessment/aapi](http://www.assessingparenting.com/assessment/aapi)), or they may be asked to reflect on their struggles with a specific child, as with the Parent Stress Inventory (PSI-4; Abidin, 1995). The PSI-4 is designed to evaluate the magnitude of stress in the parent-child system. Two domains – the child and parent domains – combine to form the total stress scale. The child domain includes sources of stress from parent report of child characteristics, such as distractibility/hyperactivity, adaptability, and mood. The parent domain measures sources of stress related to parent characteristics, such as isolation, health, and attachment concerns (there is also a third factor that can be derived focused on stress external to the parent-child relationship).

The PSI-4 can be used to identify issues that may lead to problems in the child’s or parent’s behavior and this information can be used to set priorities for intervention or follow-up. Although it is important for home visitors to have methods to identify attachment problems as they develop between the parent and child, it is also important to identify competencies, given the strength-based, family-centered approach often advocated in established home visiting programs, a focus that the PSI-4 does not have.  

The PSI-4 is an example of a parent questionnaire. As such, it is a proxy measure of the parent-child relationship. The alternative approach is to train home visitors in direct assessment of parent-child interaction. Within the context of an ongoing relationship, home visitors will be able to see interactions between the parent and child as they accumulate over time. As noted above, the HOME is sometimes used as a proxy measure for the parent-child relationship, as it measures the nurturing quality of parenting as observed in the home or reported by the parent in the interview. Different program models have also developed their own specific assessments with rubrics, simple scales, or checklists that home visitors can use. The CARE Programme is one example. At each home visit, the visitor looks for signs of developing attachment, as well as indicators of concern. As another example, SafeCare uses a very structured parent-child assessment that is embedded within its parent training curriculum; home visitors rate how well parents can implement the specific caregiving strategies that the home visitor is teaching them. Often, however, home visitors are left to their own devices to assess the quality of the parent-

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13 The AAPI was recently revised to reflect this more strength-based approach; however, the PSI is included in the toolkit instead because it has been translated into some languages that are used in the CEECIS region and because it has a short form.
child relationship. One focus group study of home health visitors in the UK likened the process to putting together a jigsaw puzzle, with visitors qualitatively assessing different dimensions of the relationship based on their own clinical judgment and experience (Wilson et al, 2008).

There have been attempts to develop more specific and structured assessments that can aid home visitors in the process of putting together an overall view of the parent-child relationship and identify attachment problems that may be emerging. One promising measure is the Parenting Interactions With Children: Checklist Of Observations Linked To Outcomes (PICCOLO; Roggman, Cook, Innocenti, Akers, & Jump 2007). The PICCOLO was developed from review of thousands of video segments of parent-child interaction recorded as part of the national Early Head Start evaluation in the United States. Home visitors measure parenting behaviors in four domains: affection, responsiveness, encouragement, and teaching. Each domain includes 7-8 parenting behaviors. Non-technical language and simple rating scales are used, and the measure has demonstrated strong reliability and validity. From these ratings, the tool allows home visitors to emphasize areas of competence and strengths as well as explore more difficult interactions. Although mostly in use in the United States, a Turkish version is currently being validated as part of a research project at the Ankara Üniversitesi (Bayoğlu, Unal, Elibol, Karabulut, & Innocenti, in press).

Both the CARE Programme Rating Scales and the PICCOLO are limited by the amount of training that is needed to feel comfortable with the scales. Their use would be considered a substantial training investment, but would also contribute significantly to the professional skills of the home visitor. Their primary purpose is to provide guidance to home visitors regarding what to look for in parent-child interaction. They are not a screening for referral for child welfare services, but a tool to assist in their interactions with families.

**Child Maltreatment Risk and Family Violence**

Assessment of child maltreatment is complicated by a number of factors. The first, as noted by Browne and colleagues (2006), is the lack of standard definitions of maltreatment. In addition, given the great social stigma associated with child maltreatment, it is rarely witnessed and can be difficult to assess after the fact. With young children, who cannot verbally report on their experiences, we rely on reports of those who are often the very agents of the maltreatment. Nevertheless, it is possible to train home visitors to watch for warning signs of differing levels of severity (what the CARE Programme notes as Yellow and Red Symptoms, as well as Green symptoms that connote protective factors; see Browne et al, 2006).

In addition there have been attempts to assess the risk of or to predict child maltreatment, such as by looking at response to parent attitude questionnaires, such as the aforementioned Parent Stress Index, or the Child Abuse Potential Inventory (CAPI; Milner, 1986), where harsh or negative parent attitudes are associated with the increased likelihood of some types of maltreatment (sexual abuse is often not captured by these measures). There is a level of overlap between these risk screeners and questionnaires focused on the parent-child relationship, as both try to capture hostile and unrealistic attitudes towards children that will predict harsh care. The CAPI’s primary clinical scale (abuse) can be divided into six factors: 1) distress, 2) rigidity, 3) unhappiness, 4) problems with child and self, 5) problems with family, and 6) problems with others.
In other cases, checklists or rating scales that incorporate aspects of the parents’ history or living situation beyond their attitudes may be used as risk assessments. The CARE Programme (Browne et al., 2006), for example, developed a weighted Index of Need, assessing qualities such as parent age, isolation, financial stress, drug dependency, or history of maltreatment. Scores above a certain threshold are used to place families at high priority for additional support and services. The assessment of these individual items comes from an ongoing process of an initial interview of the parents by the home visitor, parents filling out a self-report form that is similar to the questions asked in the interview, and then a follow-up review of the parents’ report together with the home visitor. Involving the parents in this way is seen to increase their willingness to discuss these issues with their home visitor.

The same concerns with sensitivity and specificity that were discussed in the context of child development screens apply to child maltreatment risk screens. That is, screeners are not perfect instruments at capturing the actual presence (or future presence) of child maltreatment. Although both the CAPI and the Index of Need have demonstrated validity in classifying those parents who do have active cases of maltreatment, the costs of misidentifying families must be carefully considered. Obviously, a home visitor does not want to perpetuate a cycle of silence by missing a family where there is actual maltreatment. But the other form of error is also very difficult. In a region where there has been a history of high rates of removals of children from families and placements into institutionalized care, the dangers of a false positive are heightened for the family. The results of any single screening instrument must be used in conjunction with other forms of data, as the Index of Need does by combining its results with actual observations of the relationship.

Finally, domestic violence is increasingly recognized as a traumatic event with serious deleterious repercussions for infants and toddlers (e.g., Lieberman and Van Horn, 2003). It, too, is often stigmatized, so that parents may often feel that it is not a topic that can be comfortably discussed. Home visitors may also feel uncertain about the topic, creating a “zone of silence” that impedes the relationship between visitor and family and reduces the effectiveness of the visitor’s work (see Musick and Stott, 2000, for further discussion). There are short domestic violence screeners, however, that have been incorporated into home visiting programs as an effort to allow home visitors to directly ask these questions and give the parent permission to talk about them. A good review is provided by Rabin and colleagues (2009). Although many measures do not show adequate test-retest reliability, there is some evidence to support the Abuse Assessment Screen (AAS; McFarlane, Soeken, Parker, and Bulloc, 1992), a five question screen with international data developed for use during pregnancy that assesses directly whether or not a woman has been emotionally, physically, or sexually abused, and whether or not she fears for her partner. As with maternal depression screens, the administration of these questions is merely the first step. Home visitors need support and training in order to be able to appropriately follow-through with parents where there are reports of family or intimate partner violence.

Conclusions
This review has covered tools and assessments that can be used to assist patronage nurses for an integrated early childhood home visiting program that attends to both the developmental and health needs of young children and their families. Accompanying this review is a “toolkit” of recommended curricula and screening/assessment instruments, including a brief description of the background and use, training requirements, and a summary of each tool’s advantages and disadvantages. The age ranges of the tools across the different categories of the toolkit are summarized in Figure 1.
This report has focused on tools and assessments that can provide some standard level of quality and content to home visits. Having increased structure and precise strategies and content is one way to promote these clear expectations. This can be very helpful for some home visitors, especially those with less experience or training. It can also be very helpful for programs in regions that are trying to establish uniform standards of quality. These tools tend to focus on what home visitors should do. However, this is only one half of the equation. How home visitors are with families is equally important, and less subject to manualization (Korfmacher, 2001; in press).

It can be argued that home visiting is a mixture of science and clinical insight (or, if one prefers, “art”). As much as we wish we could be prescriptive about what home visitors should do with families based on carefully controlled empirical studies, it is an art to figure out what a family needs and know how to help them. There will always be some mystery in determining what actually works between specific home visitors and specific families. Because of this mystery, ongoing experiential training is important. Programs in the United States are moving beyond a focus on intensive introductory trainings and planning more for the professional development of home visitors over time, including an increased emphasis on supervision that involves direct observation of practice and feedback (e.g., Roggman, Boyce, & Innocenti, 2008). In addition, paying attention to the parallel process is an important component of any relationship-based intervention such as home visiting. A good supervisor helps the
nurse home visitor make sense of their feelings, just as a nurse home visitor may help the parent with their feelings, as parents help their child make sense of the world.

Deborah Daro, a leading home visiting expert in the United States, has summarized into four categories the ways that parents help their children’s development beyond basic care and nutrition: 1) teaching them; 2) helping them to problem-solve; 3) regulating their feelings; and 4) scaffolding or supporting them as they take explore and take risks (Daro, 2011).

These same processes are involved when home visitors provide help to a parent. As we have detailed in this report, in an integrated child health and development program, nurse home visitors teach parents about child development and health. They help parents to problem-solve issues in caring for their children. They can help regulate the feelings of parents when they are overwhelmed with the stresses of caregiving. They also provide scaffolding to the parent as she takes risks in her relationship with her child—such as providing activities that a young mother can do with their child to promote bonding when there are few family traditions for these activities—or in seeking our further help and support, such as assisting parents when they interact with other providers. Furthermore, these they are the same processes that should be involved when supervisors oversee the work of the patronage nurses. A supervisor teaches, problem-solves, regulates, and scaffolds the nurse as they support the parent.

The nurse home visitor and the supervisor, in turn, are supported by a program’s administration and infrastructure, which includes strong leadership, ongoing relationships with other health, educational, and social services in the state or community, and sound fiscal planning. Although the use of curricula, assessments, and screeners in the toolkit that accompanies this review may provide a strong foundation for programming, paying attention to these other structural and process features of the program is equally important and necessary for the ongoing success of home visitation in the CEECIS region.
References


PICCOLO (Parenting Interactions with Children: Checklist of Observations Linked to Outcomes) 


APPENDIX A
Compendiums of early childhood instruments commonly used in home visiting programs


