SECOND EDITION

The Art and Practice of Home Visiting

RUTH E. COOK
SHIRLEY N. SPARKS

The Art and Practice of Home Visiting

Second Edition

by

Ruth E. Cook, Ph.D.
Santa Clara University
California

and

Shirley N. Sparks, M.S., CCC-SLP
Western Michigan University
Kalamazoo

PAUL H. BROOKES PUBLISHING CO.®

Baltimore • London • Sydney

Paul H. Brookes Publishing Co.
Post Office Box 10624
Baltimore, Maryland 21285-0624
USA

www.brookespublishing.com

Typeset by Absolute Service Inc., Towson, Maryland.
Manufactured in the United States of America by

All case studies, vignettes, and examples in this book are composites and not based on real people or situations. Any similarity to actual individuals or circumstances is coincidental and no implications should be inferred.

Library of Congress Cataloging-in-Publication Data

Names: Cook, Ruth E., author. | Sparks, Shirley N. (Shirley Nichols), 1933- author.
Title: The art and practice of home visiting : early intervention for children with special needs and their families / by Ruth E. Cook, Ph.D., Santa Clara University, California and Shirley N. Sparks, M.S., CCC-SLP, Western Michigan University, Kalamazoo.
Description: Second Edition. | Baltimore : Paul H. Brookes Publishing Co., [2021] | Previous edition: 2008. | Includes bibliographical references and index.
Identifiers: LCCN 2021029781 (print) | LCCN 2021029782 (ebook) | ISBN 9781681254463 (Paperback) | ISBN 9781681254470 (ePub) | ISBN 9781681254487 (PDF)
Subjects: LCSH: Family social work. | Social work with children with disabilities. | Children with disabilities—Services for. | Parents of children with disabilities—Services for. | Children with disabilities—Family relationships. | Home-based family services. | Social case work.
Classification: LCC HV697 .C667 2021 (print) | LCC HV697 (ebook) | DDC 362.82—dc23
LC record available at https://lccn.loc.gov/2021029781
LC ebook record available at https://lccn.loc.gov/2021029782

British Library Cataloguing in Publication data are available from the British Library.

2025 2024 2023 2022 2021
10 9 8 7 6 5 4 3 2 1

Contents

About the Authors

Ruth E. Cook, Ph.D., Professor Emerita, Director of Special Education, Santa Clara University, California

Ruth E. Cook, Ph.D. is professor emerita and was director of special education at Santa Clara University in Santa Clara, California. Her primary focus as an educator was on inclusion of young children in early childhood settings.

Formerly, she was also director of two inclusive campus preschool programs: one at Mount Saint Mary's College in Los Angeles and the other at Southern Illinois University at Edwardsville. These experiences prompted her to be the lead author of *Adapting Early Childhood Curricula for Children with Disabilities and Special Needs,* now in its 10th edition. Beginning in 1982, this book helped set the stage for inclusion of young children in early childhood settings. To further encourage inclusion, Dr. Cook is currently the lead author of *Strategies for Including Children with Special Needs in Early Childhood Settings*, which is currently in its second edition. Given the expanding importance of quality home-visiting programs for young children and their families, Dr. Cook was delighted to join Shirley N. Sparks in publication of the second edition of *The Art and Practice of Home Visiting.*

Shirley N. Sparks, M.S., CCC-SLP, Associate Professor Emerita, Western Michigan University, Kalamazoo

Shirley N. Sparks, M.S., CCC-SLP, is Associate Professor Emerita, Department of Speech Pathology and Audiology, Western Michigan University, Kalamazoo. While at Western Michigan University, Ms. Sparks spent a sabbatical year with the department of public health in Battle Creek, Michigan, doing home visits with public health nurses. More recently, she was an adjunct faculty member in the Department of Special Education at Santa Clara University, Santa Clara, California. She received her bachelor of science degree in speech pathology and audiology from the University of Iowa, her master of science degree also in speech pathology and audiology from Tulane University, New Orleans, and completed all but her dissertation in the Ph.D. program in the School of Public Health at the University of Michigan, Ann Arbor.

Ms. Sparks is a pioneer in early intervention for clinicians, working with families, home visiting, and giving numerous presentations throughout the country. She has felt strongly that it is necessary to remain a practitioner in the field to experience real problems that early interventionists and home visitors encounter. She served as a consultant to HOPE Homestart in San José, California, a home-visiting program for children with special needs from birth to 3 years. A fellow of the American Speech-Language-Hearing Association, Ms. Sparks has authored training modules and many articles and chapters on early intervention and the family. Her previous books, *Birth Defects and Speech-Language Disorders* and *Children of Pre-natal Substance Abuse* were published by College-Hill Press.

About the Contributor

Carole Ivan Osselaer, M.A., Early Interventionist, University Supervisor, San Diego County, California

Carole Ivan Osselaer, M.A., is an early intervention teacher and university supervisor in San Diego County, California. Working with infants and families has been her passion since 1986, and she is committed to sharing that passion with others. In addition to making statewide presentations on early childhood education subjects, Ms. Osselaer served as an adjunct faculty member at the University of San Diego and Mira Costa Community College education departments. More recently, she continues to influence future teacher candidates by supervising their student teaching through Northern Arizona University and California State University San Marcos.

Ms. Osselaer started in the field of early intervention as a teacher's assistant, working with families, home visiting, and assisting in a classroom for toddlers with special needs. Recognizing her need for further training with families and their children with special needs, she enrolled in the early intervention program at Santa Clara University to earn her master's degree in early intervention and her teaching credential. It was at Santa Clara that she met Dr. Ruth Cook and Shirley Sparks. This was the start of a long friendship and mentoring by the two innovators in their fields.

After graduation, Ms. Osselaer worked as an early intervention vision teacher for the Blind Babies Foundation Northern California. This was a pivotal time in shaping her knowledge and passion for early learning and development. The nonprofit foundation provided families with young children with vision loss, home visits throughout northern and central California. The excellent resources and training through top pediatric ophthalmologists connected with Blind Babies convinced Ms. Osselaer of the importance of vision loss on early development and the critical importance of family-based home interventions. Her time at the Blind Babies Foundation would leave a lasting influence on her work in early intervention services.

She was introduced to the teachings of Lilli Nielsen from Sweden, who was doing groundbreaking work with children who had multiple disables with vision loss. The discovery of the "Active Learning" principles changed how she looked at an infant's ability to learn new skills. Ms. Osselaer took that learning philosophy to the Hope Infant Learning Program in San Diego County, where she worked with families and infants birth to 3, with brain-based visual impairment (CVI) and other vision disorders.

Ms. Osselaer has had the opportunity to experience being in a family with a special needs child. Her grandson was born with Down syndrome, autism, and other disabilities. She understands firsthand how important family-based home interventions are to the entire family unit and how when one member of a family is affected, the entire family is impacted.

Ms. Osselaer has discovered how to incorporate her love of dogs (five of them) in her work with families by becoming part of a certified dog therapy team that visits homes, centers, schools, and hospitals, bringing comfort and joy through furry friends.

1

An Overview of Home Visiting

"The test of morality for a society is what it does for its children."

–Dietrich Bonhoeffer

Learning Outcomes

After studying this chapter, you should be able to

1. Explain the value of home visiting services
2. Identify the key elements in the history of home visiting
3. Discuss how the focus of home visiting has changed over time and why the change is significant
4. Describe the importance of evidence-based practices in home visiting
5. Understand the importance of being culturally sensitive

Home visiting is a service delivery strategy that traditionally matched expectant parents and parents of young children with a designated support person—typically a trained nurse, social worker, or early childhood specialist. Services were and still are voluntary and provided in the family's home or another location of the family's choice, often reaching geographically or socially isolated families. Now, home visiting has become a two-generation approach; home visiting delivers both parent- and child-oriented services to help the whole family. It views child and family development from a holistic perspective that encompasses child health and development, parent health

and well-being, parent–child relationships, as well as optimal family functioning and self-sufficiency.

Home visiting can benefit all families that welcome a child into their lives. For families facing additional stressors, such as unemployment or health concerns, a consistent lifeline can provide the stability they need to get back on their feet. Home visitors get to know each family over time and tailor services to meet their needs. A home visit might include an assessment of child and family strengths and needs, provision of information on child developmental stages and progress, structured parent–child activities, family goal setting, assistance addressing crises or resolving problems, coordination with needed community services, or emotional support during stressful times (National Home Visiting Resource Center [NHVRC], 2018).

HISTORY OF HOME VISITING

Home visiting is not a new profession. Historically, educators, along with other professionals such as doctors, nurses, and social workers, have used home-community visits as an effective tool to provide support and services to children. Home visiting can be documented as being in operation during the reform era (1870–1920). Mary Richmond (1912) recognized it as an arduous profession and wrote a handbook on how to seriously, systematically, and scientifically conduct friendly visits among the poor (Bhavnagri & Krolikowski, 2000). Pioneer home visitors recognized the unique feature of home visiting: that the visitor's willingness to enter a family's home and neighborhood signals a less formal, more relaxed relationship between visitor and parent, thereby equalizing the balance of power between the two.

Photograph courtesy of Visiting Nurse Service of New York.

A brief early history of home visiting is included here because 1) we can draw parallels between the challenges of those early home visits and what we find today, and 2) we can learn from the successes of those early pioneers. A brief look at similarities to the present time in each of these societal conditions may hold some surprises for modern home visitors.

Eradication of Poverty by Changing Environmental Conditions

During the reform era (1870–1920), many believed that poverty could be ameliorated by positively transforming the crowded urban environment (providing adequate health care, housing, parks, playgrounds, support

services, and public welfare). Child advocates today also believe that the United States needs to improve the status of its children. Like children living in poverty during the reform era, children living in poverty today are precariously housed, suffer from impaired health, and have higher rates of school failure. In the 1960s, the war on poverty increased scrutiny on social issues such as poverty, teen pregnancy, and the increasing number of low birthweight babies. Then and now, poverty and welfare, the role of communities, and government and individual responsibility are the subjects of intense debate. In times of financial shortfalls, the federal government may cut programs meant to lift families out of poverty.

Today, we have funding from private organizations, from cities or states and from federal funds such as the Maternal Infant Early Childhood Home Visiting (MIECHV) program brought about by the Patient Protection and Affordable Care Act of 2010 (PL 111-148; Roibal, 2016). In addition, volunteer organizations, such as the Children's Defense Fund (childrensdefensefund.org), are active in advocating for social programs for families to assure every child a good start in life. The March of Dimes (marchofdimes.org) is another such organization structured to advocate for children's health issues.

Massive Arrival of Immigrants

The United States Immigration Commission reported that in 1909, 57.8% of schoolchildren in the nation's 37 largest cities were of foreign-born parentage. As of 2017, one of every four children age 5 years and younger had at least one immigrant parent in the United States. Of those, nearly one-third were **dual language learners (DLL)** (Park & Katsiaficas, 2019). Dealing with myriad cultures and languages is not unique to modern home visitors. Earlier, the mission of the early volunteers was to "Americanize" immigrants. Today, people of different countries and cultures are not rushed to embrace American culture. Moreover, home visitors are required to be **culturally competent.** For example, immigrants are encouraged to speak their own language at home and to teach it to their children. Home visitors who share the language and culture with the family are known to be most accepted in immigrant families (see Chapter 6).

Rapid Transformation of Society

During the reform era, American society was rapidly undergoing transformation from a rural agrarian society into an urban industrial society. As we make the changes necessary for a technologically literate nation, families face new forms of instability (e.g., mothers must work and find child care, families are fragmented, relatives are not close by). Today, American society continues in the process of transforming itself from an industrial society into an information and technical society.

Early Home Visitors

The early home visitors were volunteers who visited the homes of people living in poverty—mostly immigrant families—to promote the importance of education. Long before Bronfenbrenner (1979) called a child's multiple settings *microsystems* and linked them together to form the child's mesosystems, these volunteers visited not only the child's home but also the whole community. They knew the children as individuals by intimately knowing the families and the neighborhoods in which they were raised. Their dedication was extraordinary as is the dedication of the home visitors of today who are paid for what they do.

Lessons From the Past

These dedicated pioneers achieved some major successes; for example,

1. They were able to help parents view play as an educational activity and not as a frivolous waste of time. A transformation occurred in their child-rearing practices (Brown, 2014).

2. They became experts in networking and helped families to effectively use the community and welfare services as resources. They helped to change child labor laws and to start kindergartens. In her classic work, Klass (2008) recommended that the modern professional visitors should network with community agencies, institutions, and organizations to reduce barriers to services for children and families. This networking is exactly what the early visitors were doing, and we learned from their efforts. Unhampered by restrictions of confidentiality and legal missteps, they saw a need for service, so they moved to implement it—from health care to social service agencies. They were able to provide true wraparound programs, or family-centered, community-based, integrated, and full-service education.

3. They established rapport with families and were welcomed into the families' homes. Wiggin articulated how she used multiple strategies (e.g., flexibility, respect, sensitivity, empathic identification) as she built relationships during home-community visits:

> I never entered any house where I felt the least sensation of being out of place. I don't think this flexibility is a gift of especially high order, nor that it would be equally valuable in all walks of life, but it is of great service in this sort of work. Whether I sat in a stuffed chair or on a nail keg or an inverted washtub, it was always equally agreeable to me. The "getting into relation" perfectly, and without the loss of a moment, gave me a sense of mental and spiritual exhilaration. I never had to adapt myself elaborately to a strange situation in order to be in sympathy. My one idea was to keep the situation simple and free from embarrassment to anyone to be as completely a part of it as if I had been born there; to be helpful without being intrusive; to show no surprise whatever happened; above all, to be cheerful, strong, and bracing, not weakly sentimental. (1923, pp. 112–113)

4. They worked with families of non–English-speaking children and with families whose cultures did not value education or democratic values. One of their goals was to help these families adjust to their new country.
5. They established standards of professionalism. The pioneer home visitors were well-educated professional teachers, social workers, and nurses. The high frequency of visitations and intensity of contacts positively affected results. From all accounts, the pioneer home-community visitors worked with missionary zeal, and their home-community visits were of such high frequency and intensity that they often moved into given neighborhoods to devote their entire lives to their work (Bhavnagri & Krolikowski, 2000).
6. The pioneer home-community visitors taught us how to serve children and families by providing multiple individualized and customized services. They laid the groundwork for our present-day philosophy and approach to home visiting discussed next.

The war on poverty, in the latter half of the twentieth century, aroused the nation to pay attention to child health needs. Interest grew in the early 1980s when home visitations by nurses showed promising results. The nurses provided education about health care and personal development, parent–infant interaction, and child development to unmarried teenagers prenatally and during the first 2 years of their children's lives. Fifteen years later, those who received the program were significantly better off than those who did not (Finello, 2020).

HOME VISITING TODAY

In light of the positive research found in the nurses' program, the U.S. Advisory Board on Child Abuse and Neglect recommended a universal home-visiting program to prevent child abuse and neglect (Metrikin-Gold, 2015).Over time, home visiting focus turned from child-centered to a two-generational approach in which the home visitor works with parents on self-improvement and goal setting while also focusing on the children. These home-visiting programs see the nuclear family as a whole, so they also address relational problems and conflicts.

Despite more than 100 years of home-visiting services, programs seem to be facing the same challenges as those experienced by families in the 1800s. Therefore, families are currently served by a number of providers representing different services. Multiple agencies such as developmental services, public health, school districts, and other public agencies also may be involved. The roles of these home visitors vary. Some home visitors are **specialists** with very specific therapeutic roles (e.g., speech-language pathologist, physical therapist, occupational therapist, vision specialist, teacher of the hearing impaired, social worker). Others may interact with

the family primarily as consultants or as monitors of a child's progress. These are called **generalists**. A family will be served by an early interventionist or early childhood special educator whose focus is a comprehensive view of the family as a system. There may or may not be specialists who also visit the home. Someone on the team acts as team coordinator and may be differentiated as the service coordinator for this family.

Competencies Needed

With the realization of the importance of family-centered work, home visitors must be well-educated in more dynamics related to the family than was true of earlier pioneers. They must be trauma informed; culturally sensitive; able to coach; and knowledgeable about infant mental health, physical health, and developmental problems. They must be good team members and willing to seek the expertise of other professionals. They must have some personal characteristics in common with the early volunteer pioneers: the ability to form and maintain empathic relationships, a self-awareness allowing for reflective practice, an attitude of life-long learning; and a belief in the ability of their client families to change by relying on their strengths and recognizing the importance of the environment in change efforts (Schaefer, 2016). In subsequent chapters, we will discuss all these topics.

The expertise of the primary home visitor should coincide with the family's major concerns about their child. If the major concern is delay in motor function, an occupational therapist or physical therapist may be the primary service provider, or he or she may serve as a consultant who visits the infant educator and family in the home. A specialist may provide intensive assessment, make recommendations, and model interventions and then "back off." In this context, the specialist may not have the time to let a relationship with the family take root and blossom. Developing a relationship always takes time. Collaboration between the generalist and the specialist is an effective way to serve the family.

Home Visitors as Coaches

As discussed in Chapter 5, the movement toward **family-guided routines-based intervention** required a shift from the traditional home visit model to the model of home visitors as coaches. Through **coaching**, we can encourage parents to take credit for the positive changes that result from their efforts. That is the outcome we strive for. It is called **parent empowerment**.

Attention is given to building on the knowledge and desires of the caregiver by sharing new information coming from the coach's expertise.

Remote Home Visiting

Families are being supported via videoconferencing technology such as Zoom, Skype, FaceTime, or other methods of connecting with families via

both video and audio. These families have usually been in remote areas or the military and, of course, had to have internet connection and appropriate devices such as a smart phone, laptop, or tablet. Given the COVID-19 pandemic during 2020–2021, it is realistic to expect there will be an increase in remote home visiting. Furthermore, as the focus of home visiting shifts, in some cases, to coaching instead of direct service, remote visitation may become the preferred method of connecting with families. Given that substantial research on the effectiveness of remote home visiting is not now available, this text focuses on promoting quality in home visitations.

HOME VISITING PHILOSOPHY

As home visitors, our philosophy of early intervention provides the overarching framework for how we interact with children and families in their homes. It encompasses how we believe a child learns and how the child's nature and environment interact in normal development. As we learn from studying, from mentors, from exchanges with other professionals, and from our own experience, we develop a personal philosophy. In addition, agencies are also driven by philosophical principles. Conflicts can arise when agencies and home visitors differ in philosophy and approach.

APPROACHES TO HOME VISITING

As we have noted previously, approaches to home visiting have undergone huge changes in recent years. The sciences of neurodevelopment and intervention have converged and brought about changes in the law to make early intervention family centered. The family's needs and point of view must be considered. No longer does the home visitor assess the problem (although perhaps with the input of a multidisciplinary team), set goals only for the child, and proceed to tell the family how to move the child toward those goals. In that earlier child-centered approach, the family worked with the child on tasks assigned as the result of assessment. The parent reported each week on progress made, and the home visitor set new goals for the following week. This approach seemed natural to home visitors who were used to the clinic or educational model of intervention. The environment and intervention were controlled by the home visitor, at least for their sessions in the home. Today, the two competing schools of thought about the target of intervention are loosely categorized as child focused and family focused.

Child Focused

Many families choose intervention programs that feature **child-focused** strategies for their child with unique needs. For example, parents may choose to have their child participate in intensive behavioral approaches for children who have established challenges such as autism. These approaches

are carried out primarily by specialists such as speech-language pathologists, occupational therapists, physical therapists, and behavioral specialists. Child-focused programs do not totally ignore family needs. However, family involvement is primarily enabling family members to meet the child's needs while at the same time meeting some of their own needs.

Family Focused

Family focused is defined as concentrating services equally on the child and on the child's family. Each member of the family is considered equally important. All family members have needs and wants, and those of the child do not have priority over those of any other family members. In the child-focused approach, the "tutoring" task assigned to the parents has higher priority than the need for the husband and wife to have time together. A family-focused approach gives high priority to family empowerment, defined as enabling families to help themselves. *Family empowerment* recognizes family members as capable individuals who are asking for guidance from a knowledgeable home visitor in order to solve their own problems.

Collaborative Team

A collaborative approach, with the family providing information and goal-setting priorities in collaboration with home visitors, is now the preferred approach. Everyone's viewpoint is considered—parents, grandparents, child-care providers, and anyone else who interacts regularly with the child—and goals are established together. Instead of assigned tasks to meet the goals, the family is given guidance on their child's next developmental steps. Everyone decides together how best to provide an experience that will facilitate a desired behavior. Everyone who regularly interacts with the child must be informed of the decisions so that the child's environment is kept as consistent as possible. There is no therapy time set aside for family members to work on specific goals because goals are embedded into daily activities.

A cautionary note: As the pendulum has swung from child focused to family focused, there is a risk that the proverbial baby can be thrown out with the bath. A home visitor who allows his or her better judgment to be subverted in favor of a family member's alternative and, perhaps unrealistic, goal is not serving as an equal member of the team. Intervention

is not the sole purview of the home visitor, but decisions should not be made solely by the family either. It is the home visitor's job to know what is developmentally next and to show the family how to get to that stage. At the same time, however, the home visitor must take into account the family's priorities and readiness for change as well as their cultural values. Home visitors are neither dictators nor servants. Likewise, family focused does not always mean that direct therapy should not be given as intervention. For example, a child who will soon make the transition to preschool and who runs around the room and shows no interest in play materials may need direct therapy such as being put in a high chair to get him or her to focus attention and engage in a task. By doing this, the parent observes that the child can pay attention to a book or a puzzle. The child does not always need to be the leader in the interaction.

EVIDENCE-BASED PRACTICE

Although home-visiting programs may share common features, it must be remembered that home visiting is a method for delivering service rather than a service in and of itself. It is critically important to consider what works for what challenges and under what conditions. Personal philosophies and implementations of those philosophies are also shaped by what is now called evidence-based practice. Contemporary approaches to evidence-based practice can be traced to evidence-based medicine. Education is becoming part of this paradigm shift, however, by favoring research-based intervention and encouraging the use of evaluation instead of relying solely on common sense.

Dozens of home visiting models exist in the United States and abroad. They vary in target populations, content, and the ages served. Some enroll families prenatally and others enroll them in infancy or later in early childhood. Home Visiting Evidence of Effectiveness (HomVEE) began in 2009 in an effort to assess the effectiveness of a variety of home-visiting models (OPRE Report, 2019). The stringent criteria for inclusion as an evidence-based program involved having two independent studies of effectiveness. Twenty-one programs of the 50 reviewed met the criteria. Two of the largest are Parents as Teachers (PAT) available in 49 states and the District of Columbia and the Nurse-Family Partnership (NFP) available in 42 states and the U.S. Virgin Islands (Sandstrom, 2019). The research is limited to models that sought to improve outcomes in at least one of the areas that follow. For details on the effectiveness of home visiting, go to https://homvee.acf.hhs.gov/evidence-overview.

- Child health
- Child development and school readiness
- Family economic self-sufficiency

- Linkages and referrals
- Maternal health
- Positive parenting practices
- Reductions in child maltreatment
- Reductions in juvenile delinquency, family violence, and crime

CRITICAL NEEDS POSITIVELY IMPACTED BY HOME VISITING

The National Home Visiting Resource Center (NHVRC) provides a comprehensive picture of home visiting at the national and state levels. It produces an annual yearbook with data about what home visiting is and its potential impact on families. Its *2019 Home Visiting Yearbook* highlighted a positive impact on the critical needs that are highlighted next (NHVRC, 2019a).

Healthy Babies

Home visitors have been able to increase the percentage of expectant others to get prenatal care who would, otherwise, have delayed getting care or would get none at all. Therefore, fewer infants have been born prematurely or died. Home visiting also promotes infant caregiving practices like breast feeding, which has resulted in positive long-term outcomes related to cognitive development and child health.

Safe Homes and Nurturing Relationships

Home visitors provided the knowledge and training needed to make homes safer so fewer children ages 0–5 years have had to visit an emergency room. After educating parents about how to "baby proof" their home, children have had fewer unintentional injuries, which had been a leading cause of death and disability among children ages 1–4 years. Child maltreatment resulting in child abuse decreased after parents were taught how to engage with their children in positive, nurturing, and responsive ways.

Optimal Early Learning and Long-Term Academic Achievement

Because home visitors offered parents timely information about child development, including the value of reading to their child, children's early language and cognitive development resulted in greater academic achievement in grades 1–3.

Self-Sufficient Parents

By offering parents solid support and resources, parents are more likely to be employed with higher monthly incomes and become enrolled in school where they complete at least a high school education.

CULTURAL INFLUENCES

Culture influences every aspect of human development and is reflected in child-rearing beliefs and practices. Being aware of another culture and its practices is not enough. Home visitors must become culturally competent. That is, they must have "the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services" (Futures Upfront, 2016). They must be aware of any tendencies they might have to change a family's cultural practices to fit their own. Such tendencies would only set the stage for mistrust. Throughout this book, we offer illustrations on to how to practice cultural sensitivity, which is critical to a home visitor's success.

Home visitors are guests in the homes they visit, and the culture of those living in the home and the home visitor's sensitivity to that culture play a large part in the acceptance and development of trust in the home visitor. Shoes are not worn in the homes of people of a variety of cultures, so the home visitor would do well to always wear shoes that can be slipped off at the door. It is customary to offer refreshment to a guest in many cultures, and to refuse that refreshment is considered rude. If refreshment is the custom, a few minutes of drinking tea or coffee and exchanging polite conversation or catching up on the past week can reap rewards. A seasoned home visitor will be acquainted with the diet of the various cultures with whom she or he works, particularly if feeding is one of the issues for intervention.

Cultural differences play a large role in the next scenario. Because Melissa, the home visitor, was sensitive to the Asian Indian culture of the family, the visit went smoothly, even though Melissa was perplexed by what she observed.

Melissa, an African American home visitor, is assigned to visit Sanjay, a 2-year-old who has a history of hypotonia. His pediatrician recommended him to the home-visiting program because he was not walking at 15 months. His history also included low weight gain and little interest in food. His parents' main concern was his eating.

Melissa left her shoes at the door, presented her card, and asked if she might wash her hands (a part of every home visit). Sanjay's mother, Radha, offered a cup of tea, which Melissa accepted. Melissa entered the family room where Sanjay was sitting on the floor. His grandmother was rocking in a chair close by. Melissa approached the grandmother and presented her with her card and offered her hand, which the grandmother shook. Radha said that her mother-in-law was visiting from India and did not speak English. Melissa made it a point to glance at the mother-in-law occasionally and smile, which was returned.

Melissa inquired about a typical day for Sanjay, including everything he ate, how it was delivered (fed by his mother or grandmother or self-fed), and how much he ate. Radha said that Sanjay drank whole milk from a sippy

cup, which she held for him while holding him on her lap. Sanjay fed himself oatmeal with a spoon for breakfast. Radha fed him with her hands for lunch and dinner without utensils. Sanjay held his own cup with a straw for water. He would not tolerate any texture other than puréed food and gagged and vomited if any lumps were in his food. The diet was nutritious with rice, vegetables, and whole grains that were puréed in a blender.

At the end of the chronology of the day, Melissa asked if anyone other than Radha fed Sanjay. Radha answered that her mother-in-law often fed him lunch or dinner. She force-fed him by holding his hands with one hand and keeping his jaw open with the other. Then, she or Radha would insert a spoon into his mouth. Radha said this was a fairly common practice in India. Her husband had been fed this way by his mother when he did not eat. She reported that when that happened at night, Sanjay was often so upset and crying that they put him in the car and drove around until he fell asleep.

There are many unanswered questions in this brief scenario, but we want to focus on the cultural aspects of eating and feeding children. It was obvious that Radha was not willing to give up holding Sanjay on her lap while he drank his milk, and she was concerned that he would not accept any food that was not perfectly smooth. Melissa did not comment on any aspect of Radha's chronology of the day, but she asked Radha why she thought Sanjay did not show more interest in eating. Radha said that he had always been this way and that she had probably done something wrong to make him that way. Melissa was shocked to hear about the forced feeding. She did not want to contradict the parenting skills of the mother or the authority of the grandmother. For this case, where there was conflict with her values of child rearing, she needed help and advice from her supervisor.

Melissa and her supervisor, Patricia, looked at all the behaviors surrounding eating and separated them into physical and cultural. Physical factors included Sanjay's hypotonia and suspected sensory-based eating aversion. Cultural factors were the diet, hand feeding, forced feeding, and dominance by the grandmother. What was not cultural was driving Sanjay around to help him sleep. Melissa felt strongly that several things in the home needed to be changed and changed immediately: Of primary importance was to stop force feeding Sanjay in order to let him have more control over how he was fed in hopes of reducing his mistrust and aversion to unfamiliar foods.

Patricia helped Melissa to see that the ways of feeding this child were embedded in culture and were nearly impossible to change. She certainly should not tell the family that things should be done the American way. There was no need to change the diet, which was healthy. However, Melissa would need to be informed so that all new foods that she introduced were acceptable as part of a vegetarian Indian diet. In this way, Melissa would make some changes in herself.

The grandmother would need to be involved in all planning and she would need to see success. If Sanjay ate without being forced, there would be no need to continue that method. So, Melissa and Patricia compiled information that addressed the physical difficulties, beginning with explaining sensory-based feeding aversions and pointing out how well Sanjay did when eating with a spoon and drinking from a straw. Melissa asked if Radha and her mother-in-law would like to help Sanjay try a new food, and she offered to show them how to introduce it.

SUMMARY

This chapter focused on presenting the essence of what constitutes effective home visiting beginning with what has been learned from early home visitors. A glimpse of the role of a home visitor today with a general view of essential competencies and potential changes were explained. Attention was given to philosophy, and basic approaches to home visiting were introduced. Consideration was given to the importance of evidence-based practice. Finally, a real-life scenario revealed the necessity of being culturally competent.

READ-REFLECT-DISCUSS

1. Compare and contrast societal conditions across the history of home visiting. What remains the same today? What is different? Jot down at least 5 implications for your future work as a home visitor.
2. Recall a time in your life when you experienced a cultural practice different from your own. Reflect on the experience. Consider whether and how the information in this chapter offers a new way of thinking about cultural differences. Exchange your thoughts with a classmate.
3. As you're being introduced to the competencies required as a home visitor, develop a list of personal strengths and weaknesses. Compare your list to the competencies you will need to develop as a home visitor. First, celebrate your strengths! Then, develop a plan to help strengthen areas where you need more practice. Include goals that have measurable outcomes.
4. Visit the website https://homvee.acf.hhs.gov/evidence-overview. Choose one of the evidence-based models. Research the model and write a short report on the evidence base and effectiveness of the model. Share with classmates.
5. Consider the case study with the home visitor, Melissa. What cultural differences might have created a difficult situation for Melissa when she visited Sanjay at home? What could she have done prior to the visit to be considered culturally competent? Consider how you might handle the same situation as a home visitor. Compare answers with classmates.