Voorzorg

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Content

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1. INTRODUCTION

Title: Voorzorg
COUNTRY/REGION: The Netherlands
ENTITY: Nederlands Centrum Jeugdgezondheid (NCJ)
LINK/CONTACT FOR MORE INFORMATION:
Nederlands Centrum Jeugdgezondheid (NCJ)
Telefoon : 030-7600405
E-mail : centrumjeugdgezondheid@ncj.nl
www.voorzorg.info

2. DESCRIPTION OF THE GOOD PRACTICE

Target group:
The target group for VoorZorg is (eldest) children (aged 9 months to 2 years), born to mothers dealing with a range of risk factors to do with abuse and neglect, such as low levels of education, domestic violence, substance abuse in pregnancy, limited efficacy and pedagogical skills. VoorZorg is primarily focused on the children, but the support is directed at supporting the mothers themselves.

Objectives:
The main objective is to reduce (the risk of) child abuse in children within a specific target group of young, high-risk pregnancies in order to increase the developmental and health-related opportunities of the children.
Sub-targets:

- The pregnancy and birth outcomes for mother and child are improved.
- The health and developmental opportunities of the child are improved.
- The personal development of the mother is strengthened, so that she can have a more meaningful relationship with her child.

Intervention structure:
VoorZorg is comprised of home visits by a VoorZorg nurse during pregnancy and the first two years of life. VoorZorg works at health and safety, personal development, the mother as a parent, relationships with partner and family, use of community services.

Methodology:
Access to VoorZorg is via a two-step selection process.
The initial selection is made by professionals working with a pregnant woman. They assess whether or not the following criteria are met:

- no previous live-born child;
- maximum of 28 weeks pregnant;
- maximum age of 25 years old;

- maximum education level of VMBO (preparatory mid-level applied education) or education not completed;
- some command of the Dutch language.

The professional will check how interested the woman is in taking part and then pass her information to the VoorZorg nurse.
The VoorZorg nurse makes the second selection. During a home visit, this nurse will discuss with the woman whether there are any additional risk factors that may make support from VoorZorg particularly desirable.
Additional risk factors are:

- no partner;
- no (support from) social network;
- alcohol and/or drug use;
- current domestic or partner violence;
- woman has been abused in the past and/or experienced domestic violence;
- psychological problems: anxiety, depression;
- unrealistic ideas about motherhood;
- nurse has concerns;
- financial and/or housing problems.

Based on the input from the home visit and the balance model by Bakker http://www.nji.nl/nl/Download-NJi/BalansmodelBakker.pdf, an assessment will be made as to whether or not the mother is eligible. There will also be a clear discussion about whether or not the mother really does want the support. If so, the 'VoorZorg participation form' will be signed by the expectant mother and the VoorZorg nurse.
A good relationship between the nurse and the mother is an important basis for the success of the programme and for the mother's learning experience. During implementation of VoorZorg, the nurse will work with the mother on structured behavioural changes (healthy lifestyle, stress reduction, healthy diet, exemplary behaviour, etc.), realistic and achievable targets (in respect of attachment, play, safety, etc.) and on strengthening her skills as a mother (education and work, developing a supportive network, self-reflection, etc.)
After the intake meeting/introduction, VoorZorg will begin as early as possible in the pregnancy; theoretically, this will be between the 13th and 16th week and at the very latest before the 28th week. VoorZorg will continue until the child is two years old. The frequency is, on average, two visits per month, with more frequent visits (weekly) in the first month of the programme and during the first six weeks following the birth. During the final four months, the frequency of home visits will decrease to being once per month. Home visits are set out according to fixed structure, and last around 60 to 90 minutes.
The three handbooks describe 64 home visits: 14 in the pregnancy phase, 28 in the baby phase (0-1 years) and 22 in the toddler phase (1-2 years). The handbooks also contain information materials for the mother (and father) about all kinds of subjects.
The content of home visits is based on (sub) objectives, in which each home visit addresses the following areas:

1. Healthy mother (healthy lifestyle, good diet, stress reduction)
2. Healthy environment (home situation, safety)
3. Mother's life course (self-reflection, education and work)
4. Motherhood (care, attachment, play and exemplary behaviour)
5. Family and friends (informal support network)
6. Using community services (formal support network)

Improvements in and strengthening of the six stated areas must result in the main objective as well as the sub-objectives being achieved.

Premature termination of the programme

If a mother does not wish to continue to take part in VoorZorg and the safety of the child is not at risk, then VoorZorg will be put on hold for six months. The child remains part of VoorZorg, as experience shows that there is a great deal of unpredictability within these families, which means that VoorZorg is often required again at a later date. After six months, the VoorZorg nurse will re-establish contact with the mother and during a home visit will discuss whether it is desirable and possible to stop, given the development and safety of the child. If VoorZorg does stop, they will say their goodbyes and following consultation, care will be transferred to the child healthcare team, and other involved parties will be alerted.

If more support agencies are involved than just VoorZorg, then a 1Family1Plan meeting will be organised if necessary. The various objectives, tasks and roles of the involved parties will be discussed and synchronized as much as possible, making it possible to create a joint approach plan.

Costs related:

A full VoorZorg trajectory lasting two and half years costs around €13,000 per mother (at the 2013 rate). The following costs are taken into account in this sum:

- time spent on preparation, implementation and review (reporting, etc.) of home visits by the nurse;
- time spent on teaching and supervision by the implementing organisation;
- time spent on introductory conversations/ intake (including intakes that do not lead to participation in the programme);
- the cost of basic training and national meetings;
- the cost of network contacts and multidisciplinary consultations;
- licensing costs per organisation.

Costs may vary in practice depending on the rates applicable to the organisation, the formative scope of the VoorZorg nurses and the turnover of staff.

Further information:

The intervention is carried out by experienced HBO (vocational university) trained child care experts with additional training as VoorZorg nurses. Training to become a VoorZorg nurse includes modules on Pregnancy, Babies, Toddlers and VHT (video home training, specially developed for VoorZorg).

Resources available:
An extensive description and contact details are included in the database of the Nederlands Jeugdinstituut (Dutch Youth Institute). See http://www.nji.nl/nl/Databank/Databank-Effectieve-Jeugdinterventies.

3. DIMENSIONS

Please make the cross if the good practice meets the proposed items. Also, try to expand the information in each section.

3.1. EVIDENCE OF POSITIVE AND/OR PROMISING RESULTS IN ORDER TO ELIMINATE CORPORAL PUNISHMENT

Training/Education

The program increases the use of positive disciplinary methods for parents and educators/teachers:

☒ Promoting the positive parenting (promoting positive relationships, care and development the child's capacities, offering recognition and guidance to the child, establishing limits that allow the full development of the child).

☒ Offering alternative educational strategies to corporal punishment, that promotes democratic family educational model.

☒ The program promotes to caregivers, the knowledge and skills for protect the children.

☒ The program promotes a positive dynamic and healthy family relationships.

Promotes protection

☒ The program will focus attention on children to understand their worries and circumstances.

☒ The program works on emotional education as a protective factor for violent behavior.

Empowerment

☐ The practice provides skills for children, promote their resilience and resources to deal with situations of violence.

☒ The practice promotes and improves parental skills such as: behavior of control and emotional self-regulation.

Living environment approach

☒ The program has references to the real living environment of parents and children (social environment, living environment, etc.).

☐ The program takes into account, cultural differences in the intervention.

Formal networking

☒ The program implies networking and cooperation with other Institutions: with comprehensive services for care, recovering, children reintegration, teens at risk or victims of corporal punishment.

☐ There is a networking/cooperation with other stakeholders in the local and professional environments.

☒ The program is included in the structure of the national/regional system and it depends on several people.

VoorZorg is the translation and application of the Nurse Family Partnership Program (NFP). NFP was developed by D. Olds in the USA and is the only evidence-based programme for the primary prevention of child abuse and neglect, worldwide.

VoorZorg is based on three theories that form the basis of the proven effective home visit programme of the Nurse Family Partnership:

- Bandura's Self Efficacy theory: Bandura's theory states that the behaviour of a person is determined by three factors: attitude, social influences and own efficacy. Cognitive processes play a significant role in learning and maintaining new behavioural patterns.
- The ecological model according to Bronfenbrenner: Bronfenbrenner developed a model to explain the influence of environment based on the development of an individual. The immediate environment is the most determining factor, in which the interaction between mother and child is the greatest predictor in the development of the child.
- Bowlby's attachment theory: Bowlby's attachment theory assumes that the degree to which adults are able to enter into sensitive and responsive relationships (with their own children) is, to a significant degree, influenced by their own upbringing and early attachment experiences. If parents have had negative or traumatic attachment experiences, they will be less able to react to their own child in a sensitive and responsive way. The quality of the interaction between parent and child is a significant determining factor in the development of the child.

As well as this, VoorZorg uses two Dutch programmes:

1. Stopping or cutting down on smoking during pregnancy: V-MIS (minimum intervention strategy) for stopping smoking.
2. (Short-term) Video Home training: This programme aims to promote healthy (social emotional) development of children and prevent behavioural and development problems or reduce these by strengthening parenting skills in the parent and improving the parent-child relationship. This is done using positive feedback to video recordings of interactions between parent and child and by providing (specific) information about parenting and emphasising what is going well.

The programme has been researched in America for 35 years and has proven effective in various ways. The research outcomes in the Netherlands have also been very positive. The most significant results from this research are:

- There was a 19% instance of child abuse in the control group, whereas this was 11% in the intervention group passed to VoorZorg.
- the VoorZorg mothers tend to be less frequent victims of domestic violence.
- VoorZorg is recognized by the sub-commission of child health care, prevention and health promotion dated 01-10-2015.

Assessment: Effective according to significant indications

Explanation: Research into Voorzorg gives good indications of positive effects in pregnant women and mothers with young children in respect of child abuse, smoking during and after pregnancy, smoking in the presence of the baby, frequency and duration of breastfeeding and victims of domestic violence.

The reference to the document is: A. Crijnen, S. van den Heijkant, E. Struijf, M. Timmermans (August 2015).
Database of effective youth interventions: description 'VoorZorg'. Utrecht: Nederlands Jeugdinstituut (Dutch Youth Institute).

Quality control

The Netherlands Centre for Youth Health (NCJ) ensures the following activities within the framework of quality control:

- Programme integrity: Two VoorZorg trainers are recognized by the University of Denver, the organisation in the USA that manages the Nurse Family Partnership (NFP).
- Schooling: Organizing training of programme workers and case conferences. The accreditation commission of the V&VN professional

association provides accreditation to the training courses and case conferences.

- Expertise commission: If a VoorZorg nurse has any doubts about whether or not a pregnant woman would be eligible for the programme, she can put this to the national expertise commission, made up of VoorZorg experts. The commission will make a binding ruling as to whether or not the mother may be accepted.
- Monitoring the programme: The programme is monitored using a digital registration system that is updated annually to include those organisations that execute the programme.
- Handbooks: Nurses can use a range of handbooks and can refer back to a supervisor within their own organisation. Handbooks and additional supporting materials can be found on the secure part of the website www.voorzorg.info.

Research in the Netherlands

a) Graaf I de & Riper H. (2006). Care for mother and child. VoorZorg Program: home visits by a nurse during pregnancy and the first two years of life. Evaluation - Research.
b) Utrecht: Trimbosinstituut
c) Evaluation research. The information in 32 files about participating mothers was analysed in this report over a period of ten to fourteen months. 23 mothers were interviewed by two researchers using a structured survey. In-depth interviews were conducted with two VoorZorg nurses.
d) The study resulted in the following conclusions:
    1. The identified target group was being reached.
    2. The mothers receiving VoorZorg care were young, were in the early phases of their pregnancy and were often ambivalent about the pregnancy. The mothers were also often poorly educated or unemployed, had limited financial means and had a limited network of significant others able to support them. The mothers had often been abused or neglected during their own childhood.
    3. The mothers were able to gain a great deal of support via the relationship developed with the VoorZorg nurse. The programme also largely met the needs of the mothers.
    4. The nurses were up to date with the protocols surrounding the home visits and the use of materials. They aimed to implement the programme strictly.

5. The supporting materials largely met the needs of the mother and the nurses.
6. The nurses considered the discussions in the supervision session about the problems and dilemmas encountered by the nurses during implementation of the programme to be very useful.

A number of recommendations were formulated. These recommendations have led to changes being made to the work sheets and registration forms.

Articles resulting from PhD research at the VU Medical Centre, Dept. Social Health, EMGO+ Institute:

a) Mejdoubi J, van den Heijkant S, Struijf E, van Leerdam FJM, Crijnen A, Hirasing RA. (2015). The identification of pregnant woman at risk for child abuse. Gynecol Obstet Res Open J; 1(1):18-25.
b) Demographic characteristics were collected. Questions were asked about the history of domestic violence and substance use. The EPDS was also undertaken (Edinburgh Postnatal Depression Score).
c) A brief summary of the results: in the 460 women who took part in the study based on the two-step section procedure, they looked at the prevalence of risk factors for child abuse: single parent; 76%, drug or alcohol abuse 25%, depression 19%, violence in the past and/or currently 68%, no job or education 74%. In total, it appeared that 98% of the women had four or more risk factors for child abuse. The intended target group was being reached.
d) They were asked whether or not they wanted the pregnancy: 31% said that they did not want the pregnancy. Within the general population, this prevalence is 11%.
e) Depression (measured using the EPDS) occurred in 19% of participants. The VoorZorg nurses also asked about psychosocial problems, which were admitted by 99% of participants. Within the general population, this prevalence is 12%.
f) Mejdoubi J, van den Heijkant S, van Leerdam F et al. (2013). Effect of nurse home visits vs. usual care on reducing intimate partner violence in young high-risk pregnant women: a randomized controlled trial. Plos One, 10.1371/journal.pone.0078185.
g) At the start of the study, they were asked whether they had experienced any form of violence in the past and/or in their current relationship. As well as this, they underwent the Revised Conflict Tactics Scale (CTS2) at 32 weeks of pregnancy and 24 after the birth13. The Composite Abuse Scale (CAS) was undertaken at 16 to 28 weeks of pregnancy.

h) A brief summary of the results:
i) Domestic violence decreased in the VoorZorg group versus the standard care group (significant variations were named):
   - during pregnancy, particularly psychological incidents (C: 56% vs. I: 39%) and physical violence (level 1 C: 58% vs. I: 40% and level 2 C: 31% vs. I: 20%).
   - during pregnancy, sexual violence decreased more in the intervention group than in the control group (C: 16% vs. I: 8%).
   - 2 years after the birth, the variations mainly concerned physical violence (C: 44% vs. I: 26%) and sexual violence (C: 18% vs. I: 3%).
   - it also seemed that women in the VoorZorg group were using less violence themselves: psychological violence (C: 60% vs. I: 46%), physical violence (C: 65% vs. I: 52%) and injuries (C: 27% vs. I: 17%).

Multilevel logistical regression analysis shows that there was a significant reduction in both victims and perpetrators of domestic violence in women in the VoorZorg group 2 years after the birth of their baby.

3.2. DATA ON IMPACT OF THE PRACTICE

Effectiveness of the elimination of corporal punishment

The practice has demonstrated a good impact on:

☒The decreases of corporal punishment.

☒The increase in positive interactions parents / mother / infant caregivers.

☒The increase in timeshare.

☐The improvement of communication and resolution of conflicts without using corporal punishment.

☒ A significant increase in knowledge, skills and confidence of parents or caregivers.

☒ An improvement of the welfare of the participants.

Sustainability of the impact

☒The effects on the target group are sustainable.

3.3. COMPREHENSIVE NATURE

Please, tick the items the practice address to:

Dimension 1: Social and cultural context towards corporal punishment and alternative methods (including MEDIA analysis)

☒ The program promotes support and guidance to parents in developing a responsible parenthood that will reduce corporal punishment.
☐ The program supports teachers and school support staff in improving their skills and management skills of non-violent learning methods.
☐ It involves parents and tutors through established participatory Organizations (AMPA and others), prevention and elimination of corporal punishment.
☐ The practice promotes the child-youth movement through the creation and / or consolidation of representative organizations in communities.

Dimension 2: Legal framework conditions and other procedural, judicial frameworks related with the implementation of the law
☐ The practice responds to the objectives of education and social reintegration provided by law.
☒ It is consistent with the existing legal framework for protection of violence against children and teenagers, to ban explicitly corporal punishment.

Dimension 3: Awareness and training efforts concerning corporal punishment and alternative methods:
☒ The program raises awareness about the importance in eliminating corporal punishment.
☐ The practice provides training about corporal punishment elimination methods.

Dimension 4: Resources available on positive parenting techniques and complementary knowledge
☒ The practice provides resources available on positive parenting techniques and complementary knowledge

3.4. INNOVATION

☐ The program has an innovative character, or implies innovative aspects (e. g. actual knowledge, new ideas or methodology, etc.).

3.5. COST-EFFICIENCY

☒ The cost-efficiency is adequate.
☐ There are no lower cost alternatives to achieve the same impact.

3.6. TRANSFERABILITY POTENTIAL

☒ There is access to the methodology and how the program has been implemented (e. g. process description, manual etc.).
☒ The program has already been successfully transferred to another region.
The program can be transferred to other frame conditions in international contexts:

☒ The program does not rely too much on specific aspects of the national/regional system.
☒ The program does not depend too much on one/few specific professional qualifications and/ or profiles.
☒ The program can be transferred if the material, program or license are paid.

The Netherlands Centre for Youth Health (NCJ) has created an info-graphic about the VoorZorg intervention. It shows how VoorZorg works, how many women are eligible for VoorZorg in each region of the Netherlands, what the programme does and what it costs. Such an instrument is also applicable in other European countries (https://voorzorginfographic.ncj.nl/).

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