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Healthy Families Maine: Final Evaluation Report

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Healthy Families Maine

Final Evaluation Report

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The Maine Healthy Families Program

The Healthy Families/Healthy Start program began in Hawaii in the early 1980's and was inspired by the work of pediatrician C. Henry Kempe in Denver. The program seeks to ensure healthy thriving children and nurturing families by offering short and long term home-based support and assistance. Healthy Families America (HFA) is a national effort sponsored by Prevent Child Abuse America to utilize the Healthy Start Model in developing individualized community programs.

In 1995, the Maine legislature implemented Healthy Start/Healthy Families Maine, funding three county-based pilot sites. The program was guided by the Healthy Families America Critical Elements (which are described in more detail in Oldham, Richards, Keith & Hornstein, 1999).

As first-time parents we were unsure of exactly where our child should be developing and what kinds of things we could do as parents to help our child grow and develop - this program is wonderful for teaching just that!
- parent response to Muskie survey, May 2000

In March of 1997, the Bureau of Health Services, Maine Department of Human Services, awarded a grant to the Institute of Child and Family Policy, Edmund S. Muskie School of Public Service, to evaluate Healthy Families Maine. Six county-based pilot sites were funded in 1997 and were followed in this evaluation[i]:

1. Androscoggin County - Healthy Families Androscoggin;
2. Franklin County - Growing Healthy Families;
3. Kennebec County - Kennebec Valley Community Action Program;
4. Lincoln County - Healthy Kids!;
5. Washington County - Down East Community Hospital; and
6. York County - Alliance for Healthy Families

The first year's evaluation featured a process study documenting the implementation of the program at six pilot sites [ii]. The second year evaluation report[iii] followed the evolution of the Healthy Families Maine program, through both a process study and the introduction of an exploratory outcomes study.[iv]

While the second year report focused on all of the children being served by the six Healthy Families programs, the present report is a more in-depth, longitudinal study of a group of 89 children and families served by their local Healthy Families program.

Methodology

The Year 3 evaluation includes two components: (1) a process study and (2) an outcomes study.

Process Study

The purpose of a process study is to develop a more detailed picture of the program as it is implemented and administered, to assess the quality and consistency of the intervention and to provide information to staff for program improvement. The process study involved gathering qualitative information through phone interviews and paper questionnaires with program managers, staff, parents and community collaborators. We also observed home visits at the six sites to view first-hand the delivery of services. In our questionnaires, interviews and observations, we focused on organizational profiles, inter-agency collaboration, target populations, initiation of services, service providers, and challenges and opportunities in providing services.

Outcomes Study

The purpose of an outcomes study is to measure change over time with regard to particular variables (e.g., income, amount of maternal social support) that may be associated with the ultimate goals of the program. The exploratory outcomes study involved gathering data from two sources: (1) the management information system (MIS) and (2) family and child assessments. The MIS is a database developed for sites to input information regarding characteristics of the families and information on the services the families receive. Family and child assessments were completed within the homes of families receiving Healthy Families services.

There were no particular selection criteria for families entering the study beyond participation in Healthy Families. During the intake period (12 months), families were asked to participate and had the option to refuse with no effect on the services received. The children were followed for a maximum of 18 months, and were assessed using four instruments. However, many children dropped out of the Healthy Families program before 18 months had passed. We did not follow children once they left the program; however, we did track their reasons for terminating and some demographic variables at the time of their departure.

It is important to note that our study is not designed to and does not attempt to study the "impact of Healthy Families." We did not use an experimental or quasi-experimental design; we did not compare our results for Healthy Families to that of a control or comparison group. Thus, instead of determining definitively whether "Healthy Families works", we focus on how Healthy Families was implemented and how it was received and perceived by families. Most of our measures of family and child well-being depend on parent report, not direct observation or assessment of skills. Parent report of family and child well-being can be biased by various factors such as depression or self-esteem. Finally, the sample size for our study was small, limiting the generalizability of our results.

Because of these limitations, it is important to understand what this study can and cannot do.

This study *is* able to tell us:

- Demographic information about the population served by Healthy Families.
- The factors that may influence families continuing in the program.
- The factors that may influence staff turnover.
- How the Healthy Families program is perceived by parents.
- What services are received by participating families.
- Whether the risk of child abuse and neglect, the home environment or the available social support was reduced or increased during the time that families received home visits.

This study is *not* able to tell us:

- Whether the program is effective in improving children's cognitive and social skills.
- Whether any increases or decreases in scores for assessment of family and child well-being were *caused* by the services provided through Healthy Families.

Thus, this study is helpful in providing direction on how the program may best be implemented but cannot be used to draw conclusions about whether the program has a positive effect on child outcomes.

The Process Study: Healthy Families Sites and their Connections to the Community

Community Partners Interviews

A short set of questions was asked of 15 Healthy Family Community Partners selected by Program Managers at multiple program sites. The partners included Advisory Board and Planning Committee members, Child Council leaders, Family Assessment Workers from collaborating agencies, Public Health Nurses, Visiting Nurses, Child Developmental Services and other Agency referrals and service partners. Partners were interviewed by phone by an evaluation team member. Questions focused on the community partner's present relationship with Healthy Families, the awareness of Healthy Families activities and child abuse within the community, barriers to effective community services and additional services or outreach needed in the community.

Parent Survey

All families receiving services in March of 2000 (n=210) from one of the six Healthy Families sites were asked to complete a survey regarding their involvement in the Healthy Families Program. Families were asked to complete the survey regardless of whether or not they were part of the longitudinal Muskie evaluation. Surveys were anonymous; there was no attempt at breaking down respondents by site due to small sample sizes. Fifty surveys were completed and returned for a response rate of 24%.

Although useful, the survey results cannot be assumed to accurately represent families who participate in the program as a whole. Results of the survey could be skewed by the small number of respondents; and particular "types" of families who are more apt to respond (for example, families very pleased by the program who are eager to share their responses, or families who are more comfortable reading and writing responses in a written survey format).

Staff Survey

Home visiting staff from the six sites participating in the evaluation were asked to complete a survey. The surveys focused on why families choose to participate in the program, what concerns families had, what the barriers to service were, and why families drop out of the program. Sixteen surveys were anonymously completed and returned out of the 20 home visitors employed by the six sites, a response rate of 80%.

Home Visit Observations

Staff from the Muskie school accompanied a Family Support Worker on 12 home visits (2 per site). Families were asked ahead of time if they would permit an observer in their scheduled home visit. An observational tool was developed to guide the observations. The Muskie staff recorded whether the home visitor engaged in activities addressing the four Healthy Families program goals: family strengths and needs, family functioning, parent-child interaction and healthy childhood growth and development. Because we only observed 12 home visits, we cannot presume that these results reflect the characteristics of all home visits. Because of our small sample, some observations may receive more attention than they deserve and other observations may receive less.

The Outcomes Study: The Children and Their Families

The focus of the exploratory outcomes study is on the healthy development of the child and family. Specifically, the MIS and assessments were used to gather information on parenting, parent-child interaction, child development, child health and family social supports.

Management Information System

The MIS system had entries detailing demographic characteristics of families, caregiver histories, birth circumstances of target child, medical care for the child, and home visit duration and content.

Kempe Assessment

The Kempe Assessment is a 10-item tool used by Healthy Families America as a standard instrument to assess risk factors that may impact the family. A score of 25 or greater indicates a family that has enough risks to warrant the provision of intensive services. Kempe scores help to determine the level of services families receive at the start of the program.

Child Abuse Potential

Healthy Families America was in part designed to support parents and to reduce the incidence of child abuse and neglect. Because the level of parenting stresses as well as parental beliefs contribute to the incidence of child abuse and neglect, we chose to use the Child Abuse Potential Inventory to examine those key variables. The CAP is administered at intake and then at 6 month intervals. Sample questions include: "People expect too much from me", "I am often angry inside" and "a child should never talk back."

The Child Abuse Potential Inventory-Short Form is a 77-item index designed to assess physical child abuse potential[v]. The CAP was designed as a risk assessment tool for physical child abuse to be used in conjunction with other information such as interviews, observations and case histories. Alone, it can be used to look at change over time among a group of individuals.

The validity and reliability of the CAP has been well established. A number of cross-validation studies indicate that the CAP Inventory has overall classification rates of 80 percent to 90 percent.[vi] Predictive and construct validity of the CAP has been established by a number of studies.[vii] Additionally, the CAP has been normed on a wide spectrum of groups, which range with respect to race, income and level or risk of abuse and has been used in a number of pre-test/post-test design evaluations of child abuse prevention programs. Scores on the CAP can range from 0 to 486. The higher the scores, the greater the child abuse potential. There are two points at which various studies have determined elevated risk of child abuse is present. Scores over 166 indicate that there is an elevated risk of child abuse while scores over 215 indicate that the potential for child abuse is *very* elevated.

Maternal Social Support Index

A family's network of support can mitigate the multiple stressors that many of the families receiving services face. To assess social support, the Maternal Social Support Index (MSSI) instrument was used to gather information at intake, and was re-administered at 6-month intervals. The MSSI is a 21-item scale which measures support from family members with routine household chores and childrearing as well as the utilization of community services such as the public library.[viii] The MSSI has proven to be a useful measure in other Healthy Start evaluations. Possible scores on the MSSI range from 0 to 39 with higher scores indicating that the parent has more available social supports.

Home Observation for Measurement of the Environment

A primary focus of the Healthy Families program is the relationship of the parent and their child. Through measurement of the quality of emotional support and cognitive stimulation provided in the home, we are able to get a sense of the interaction between the parent and child. To explore these aspects of the home environment, we used the Home Observation for Measurement of the Environment Inventory (HOME).

The HOME is administered through a conversational interview with the caregivers. Forty-five items are completed and scored. Higher scores indicate higher levels of emotional support and cognitive stimulation. There are six subscales which address the following dimensions: emotional and verbal responsivity of parent; acceptance of child's behavior; organization of physical and temporal environment; provision of appropriate play materials; parental involvement with child; and opportunities for variety in daily stimulation. Reasonable reliability, validity and moderate stability of the HOME have been demonstrated.[ix]

Low HOME scores at early ages have been found to be predictive of later problems such as malnutrition and language delay[x] as well as later ratings of peer competence and emotional health.[xi] The HOME has been included in multiple evaluations of Healthy Families programs. Possible scores on the HOME range from 0 to 45.

Ages and Stages Questionnaire

The Ages and Stages Questionnaire (ASQ) is a "parent-completed, child monitoring" system used to identify infants and young children who show potential developmental problems. The ASQ is methodologically sound, having been extensively field tested and reliability and validity assured. Modules are completed according to the age of the child. Cutoff points are used to identify those children that should be referred to child developmental services.

A Portrait of the Families

We presented a detailed picture of the 321 families served by the six Healthy Families sites in the *Year 2 Evaluation Report*. We found that the majority of the primary caregivers were the mother of the child (99%), Caucasian (96%), about 22 years of age, and single (51%). The majority of the caregivers were high school graduates (63%) and were currently employed at least part-time (79%). An important question is whether the 89 families ("Evaluated Families) followed in our report are representative of the larger group of families ("Year Two Families") served by Healthy Families. In Appendix 1, we present demographic characteristics of the larger number of families reported on in the second year report in addition to the demographic characteristics of the 89 families followed in this report. While there is some overlap, on the whole, the 321 families in the Year Two report and the 89 families followed in this report are not the same families.

Similarities and Differences of Year 2 Families and the Evaluation Families

The 89 primary caregivers followed in this report were Caucasian (100%) and had an average age of 22 years of age. They were mostly single (47%), had incomes below the poverty line (45%), had at least a high school diploma (61%) and were unemployed (66%). About half of these families were recruited prenatally, two-thirds had only a single child in the home, and about half had two adults in the home (see Appendix 1).

It appears that the primary differences between the Year Two families and the Evaluated Families occur in the **Kempe score, the number of families using TANF and the number of families that are unemployed.** The Kempe assessment is used by Healthy Families America as a standard

instrument to assess risk factors that may impact the family. **The average Kempe score of the Evaluated Families is lower than the Year Two Families.** This difference indicates that families we followed using child and family assessments had fewer indications of risk in their lives than the larger group of families served by Healthy Families.

Comparing the Year Two Families and the Evaluated Families, **there are fewer evaluated families using TANF**. We also see many **more unemployed families** in the evaluated group of families. In sum, while our sample of Evaluated Families is similar in many ways to the larger groups of families served by Healthy Families, we do see some important differences. In general, the group we followed may have a different risk profile than the average family served by Healthy Families and thus the conclusions generated in this report will reflect that group of families.

Relation between Families Characteristics

To determine whether the data gathered were reliable and to learn more about the families that were evaluated, we looked at relations between a number of family characteristics. The relations described below are correlational relations, not causal relations. Primarily, we are hoping to see that family characteristics, such as level of education and level of income, are logically related. We describe our findings below. To look at the full 'correlation table' used to make the conclusions generated below, please see Table 1.

PRENATAL INTAKE

Prenatal intake, or intake while the mother was still pregnant, was not related to any other family characteristics. Thus, a variety of family types were approached by Healthy Families before the birth of their child.

KEMPE SCORE

The Kempe score, an important tool for determining the level of service, was highly related to many important family characteristics. A higher Kempe score (more indications of risk) was related to having less social support, less education, higher levels of risk for child abuse, less stimulating and supportive home environments, less income and higher use of TANF.

SOCIAL SUPPORT

More social support in the family system was related to a lower Kempe score, a lower risk for child abuse and higher family income. Thus, near-by family and friends may provide needed emotional and possibly, financial support.

MARITAL STATUS

Being married is related to having a high school diploma and higher income. Thus, a spouse can add important income to the family system.

HIGH SCHOOL DIPLOMA

Having a high school diploma is related to a lower Kempe score, being married, a higher HOME (measurement of the home environment) score, more income and less use of TANF. We would expect those with a high school diploma to have the potential for earning more money than those without a high school diploma. Past research also tells us that parents with more education tend to score higher on the HOME as they know more about interacting with their children in ways measured on the HOME and tend to know more about what materials to provide for a child's development.

EMPLOYMENT

Employment of the primary caregiver is not significantly related to any other family characteristics.

CHILD ABUSE POTENTIAL (CAP)
Higher scores on the CAP are related to higher Kempe scores, lower social support, lower HOME scores and lower family income. The relation between income and child abuse potential is not uncommon, as families with lower income tend to have more obstacles to deal with and thus higher stress levels.

HOME OBSERVATION FOR MEASUREMENT OF THE ENVIRONMENT (HOME)
Higher HOME scores are related to lower Kempe scores, having a high school diploma, lower CAP scores, higher income and less use of TANF. Higher income allows families to purchase more materials which can raise their HOME score.

INCOME AT INTAKE
Higher levels of income are related to lower Kempe scores, higher social support, being married, lower level of risk for child abuse, higher HOME scores, and less use of TANF.

TANF (TRANSITIONAL ASSISTANCE TO NEEDY FAMILIES)
Using TANF is related to having higher Kempe scores, less education, less supportive and stimulating home environment and much lower income.

Table one depicts correlations (or relations) between key family characteristics. A correlation is an indication of the degree to which two pieces of information are related. Higher numbers indicate a stronger relation. Positive numbers indicate a positive relation (e.g. as Kempe scores increase, scores on the CAP also increase) and negative numbers indicate an inverse relation (e.g. as Kempe scores increase, social support (MSSI) score decrease). A statistically significant relation is denoted by an asterisk and bold characters.

Table 1. Correlations between Family Characteristics

	Prenatal Intake	Kempe Score	MSSI Score	Marital Status	High School Diploma	Employed	CAP score	HOME Score	Income at Intake	TANF use
Prenatal Intake	1.00	-.06	-.01	.15	-.12	-.07	.02	-.00	.17	-.07
Kempe Score	-.06	1.00	**-.29****	-.12	**-.28***	-.13	**.47****	**-.28***	**-.41***	**.29****
MSSI Score	-.01	**-.29****	1.00	.11	-.02	.11	**-.32****	.20	**.35***	-.21
Marital Status	.15	-.12	.11	1.00	**.32****	.15	-.09	.19	**.35***	-.14
H.S. Diploma	-.12	**-.28***	-.02	**.32****	1.00	.15	-.13	**.35***	**.30***	**-.23***
Employed	-.07	-.13	.11	.15	.15	1.00	-.01	.19	.07	-.00
CAP Score	.02	**.47****	**-.32****	-.09	-.13	-.01	1.00	**-.24***	**-.32***	.20
HOME Score	-.00	**-.28***	.20	.19	**.35***	.19	**-.24***	1.00	**.34***	**-.22***
Income at Intake	.17	**-.41***	**.35***	**.35***	**.30***	.07	**-.32***	**.34***	1.00	**-.53****
TANF use	-.07	**.29****	**-.21**	-.14	**-.23***	-.00	.20	**-.22***	**-.53****	1.00

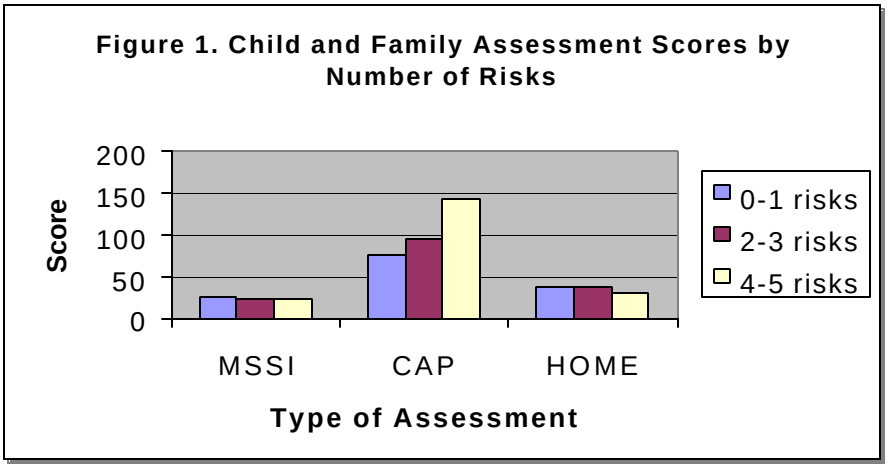
****** Correlation is significant at the 0.01 level (2-tailed).
***** Correlation is significant at the 0.05 level (2-tailed).

The Effect of Family History

Conversations with Family Support Workers and Program Managers indicate a perception that family history has a strong effect on willingness to participate in the program as well as success in achieving the program and individual goals. We examined the histories of the evaluated families in two ways: (1) through the use of a "risk index" and (2) through their exposure to some type of child abuse.

First, we investigated the notion that those families with a higher number of risks or obstacles in their environment would score lower on measures of family and child well-being. Our risk index was composed of the following factors: non-marital relationship, low educational achievement (less than a high school diploma), high Kempe score (score of 25 or greater), use of TANF, primary caregiver's exposure to any type of abuse as a child (physical, sexual or neglect), premature birth and more than two children in the home. These factors have been associated with negative outcomes in previous research (see Oldham, 1999 for a review).[xii] The 61 families (28 had missing data on at least one variable) had anywhere from zero to five of the seven possible risk factors in their environment. We divided the 61 families into three group – those with 0-1 risks (n=21 families), 2-3 risks (n=24 families) and those with 4-5 risks (n=16 families). We then examined whether these three groups had significantly different scores on the CAP, MSSI and the HOME. Using a MANOVA, (multiple analysis of variance) controlling for parent's age, we found a significant difference for the HOME ($F(3, 54) = 4.92$, $p < .01$) and a moderately significant difference for the CAP ($F(3, 54) = 2.26$, $p < .10$). Maternal social support score did not differ for families with different levels of risk (See Figure 1).

Figure 1. Child and Family Assessment Scores by Number of Risks

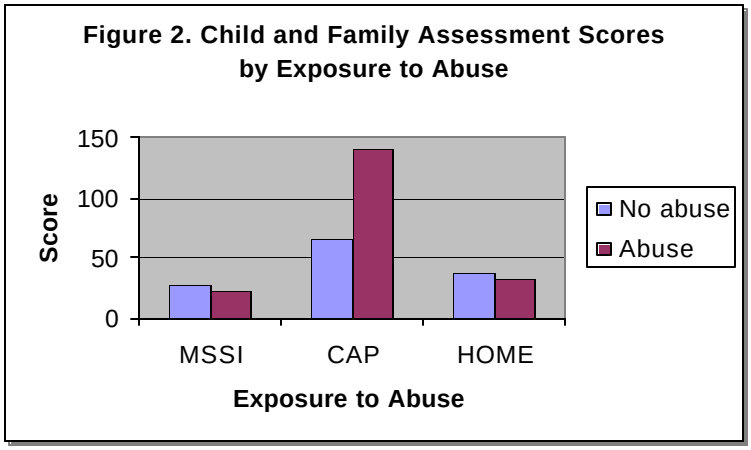


Therefore, **families with more risks in their environment expressed more beliefs associated with child abuse and had a home environment lacking emotional support and cognitive stimulation**. Families with more risks did not differ from families with less risk in terms of the social support network or the number of people available for emotional, financial and child care support.

Next, we looked at whether the primary caregivers had been exposed to any type of abuse when they were younger and how that impacted their current scores on measures of family well-being. Thirty-three percent (33%) of primary caregivers had been exposed to some type of abuse (physical, sexual or neglect). About one-fifth of the sample had been exposed to physical abuse (17%), sexual abuse (20%) or neglect (19%). Examining scores on the family and child assessments, we find that primary caregivers with histories of abuse score significantly higher on the CAP and lower on the HOME. Again, MSSI scores do not differ for primary caregivers with or without early exposure to abuse. Therefore, **primary caregivers with some exposure to abuse have a higher propensity to hold beliefs associated with child abuse**. This is a common finding in the research literature.

However, **these primary caregivers are also likely to have homes with less emotional support and cognitive stimulation**.

The finding that the backgrounds of the primary caregivers strongly relates to current family well-being is not surprising. Many Family Support Workers and program managers felt that the histories of caregivers had a significant impact on the engagement and success of families in the Healthy Families program.



Engagement and Retention of Families

Why do Families enter the Healthy Families Program?

Once we've established a routine of visiting and a relationship, the parents usually see that they are able to 'use' their FSW in ways they didn't know they needed, i.e. referrals to agencies, life goals, breastfeeding and other support.
- Family Support Worker, responding to Muskie Survey, May 2000

We asked both the parents and the staff why they thought families initially entered the Healthy Families program. There were some interesting similarities and disparities between their answers. Parents (88%) and staff (94%) agreed that families entered the Healthy Families program to learn about child development. More parents (86%) than staff (50%) report that families entered to learn about parenting and child management skills. The majority of staff (75%) thought parents entered the program to get emotional support whereas only 26% of parents reported they entered the program for this reason. Although this is a large disparity, 58% of the parents report that one of the best things about the program is the emotional support they receive. This is evidence of the importance of providing emotional support in families' lives even when the need for it is not initially recognized by the parent. Finally, 38% of staff and 26% of parents report that they expected to get referrals to community services.

Why do Families Leave the Healthy Families Program?

We followed families for a maximum of 18 months. Most of the families (62%) were still enrolled in the program at the end of the study period. However, 34 out of the 89 children left the program during the study period, indicating **a 38% drop-out rate**. If we only consider the families that were in the program for at least 12 months, we find a 42% drop-out rate (32 families out of 76 dropped out). **The families remained in the program for an average of 11 months** (mean = 10.9, s.d.. 4.4). Six families (7%) stayed in for less than 6 months.

Families terminated services with the program for a number of reasons. Six percent (or 2 families) left because they had accomplished all of their goals and "graduated." Unfortunately many more left

because there was a change in their schedule, most often obtaining a job or education (12%) or because they moved out of the service area (21%). Healthy Families Program Managers noted the transient nature of the families and the need to create an "elastic boundary" to continue to serve families that moved but would return to the targeted service area within a short period of time. Especially in the case of domestic violence issues, sites have made exceptions to their targeted service area in order to continue to serve a caregiver who was forced to move to another county.

Families (initially) only want to engage for the short-term because they don't have good attachment histories. Then they find out that (the program) is about what they need.
- Family Support Worker, August 2000

Another group of families was either never successfully engaged in the program (9%), refused services once they started (18%) or programs were subsequently unable to locate the family (6%). In a single case, a household member other than the primary caregiver objected to the program (3%). Finally, 21% of the families terminate services because their Family Support Worker left the program and they choose not to accept a new home visitor. Family Support Workers work tirelessly to build trust with a family; having to rebuild another trusting relationship is difficult for both the family and the new home visitor.

Information gathered from staff about their beliefs on why families leave the Healthy Families program concurs with the information above. The most commonly cited reason for families leaving Healthy Families is that their demands from work and school leave no time for home visiting (56% of staff reported this). Half of the staff felt that families left the program because they moved out of the service area, because of home visiting staff turnover and because they were stressed to the point of not being able to follow-through with the program. Seven of the sixteen staff felt that families are doing well and that is one of the major reasons that they leave the program. A few of the staff noted domestic violence, lack of interest or lack of concrete services as reasons for dropping out.

Due in part to the voluntary and longitudinal nature of Healthy Families, it is important to understand why families enter the program, how long they stay and why they leave the program. Other Healthy Families program evaluations have noted the difficulty of retaining families in the program. It is important to understand whether the families that dropped out of the study were in some way different from those families that stayed in the program. For example, it would be useful to know whether families who dropped out were initially at higher levels of risk or had higher levels of education so that programs can develop new strategies to encourage parents to continue receiving services.

We conducted a discriminant function analysis to determine what variables could discriminate families who dropped out from those that stayed in the program. We considered the following variables in the analysis:

- Marital status (married/not married)
- Educational status (H.S. Diploma/less than H.S. diploma)
- Employment status (employed full or part time/ not employed)
- Level at intake (prenatal/postnatal)
- TANF utilization (yes/no)
- Kempe score for primary caregiver
- HOME score at baseline
- Maternal Social Support Index at baseline

Income could not be considered due to large amounts of missing data and the Child Abuse Potential score was too highly related to the Kempe score to be used. Our results indicate that three variables can discriminate between families who stay and family who drop out: **TANF utilization, HOME**

score and the Kempe score. Families who drop out have homes with less emotional support and cognitive stimulation, higher scores on the Kempe risk assessment and are less likely to be using TANF. Thus, we may be looking at a group of parents that have higher indications of risk when first assessed by the program and fewer resources in the home. Lower use of TANF could suggest a group of families who are less connected to needed social services or could indicate "working poor" families who are not eligible for social services.

In sum, the competing demands of employment and education for time, staff turnover and the geographic limitations of service all figure prominently in the ability of Healthy Families to serve their clients. With pushes toward full employment and self-sufficiency linked to welfare reforms, home visits during work hours may not meet the needs of many families. While some sites are now offering early morning, lunch time and evening home visits, many families are simply too busy for home visits once employment enters the picture. Staff turnover is a common theme that inhibits the effective delivery of services. Low wages, life choices (e.g., having a child) as well as the physical and emotional demands of the job may be critical components of the turnover seen in the program. Another important component of staff turnover was reported to be the unstable funding and sustainability of the Healthy Families program itself. The geographic limitations of the program may improve as new monetary sources from Start ME Right are pumped into the home visiting system.

Home Visits

The goals of the program are primarily accomplished through home visits. It is during the home visit that Family Support Workers provides the family with services such as referrals, child development information, help in setting and achieving family-generated goals, and follow-up on previously discussed issues. The skilled Family Support Worker facilitates everything from a check-in on recent medical visits to negotiating family crises to playing on the floor with the child.

Not only are the home visits the core of the program, they also appear to meet the expectations of the vast majority of parents (94%). Home visits are well thought of by the families, with 96% of parents responding to the parent survey reporting that home visits were helpful to their family. The infrequent complaint was for more concrete services such as "cribs and baby clothing" or for more concrete activities during visits. As reported in the Year 2 report, the average home visit lasts over an hour (average = 72 minutes). When families were asked what aspects of the program needed improvement, 20% of the families reported wanting longer home visits (6% said they wanted fewer visits).

Community Connections

A key component of the Healthy Families program is the connection to the larger community, both in linking parents to community resources and in coordinating community agencies. We talked to 15 community partners about their perception of the program. We were specifically interested in their view on the contributions of Healthy Families, changes in the community and remaining barriers to efficient and effective services for new parents.

In general, all of the respondents remain enthusiastic about the program and the services offered to families. Collaborators report the program meets a real need for eligible families and should be expanded. The community partners see the core contributions of Healthy Families as being "the home visit", and while they did not spontaneously comment on the child development and parenting components of the program, partner valued the effectiveness of the staff in linking new families to multiple sources of support in the community. They view the program and staff as being very collaborative and not duplicative. To the credit of Healthy Families, community partners noted that their participation with the Healthy Families program is among the most collaborative and rewarding interagency efforts they have ever experienced.

Collaborators continue to view child abuse and neglect as a serious and growing problem in their communities but are now seeing gradual changes in the response among other systems including the courts, police, and hospital sectors. Once all first-born children and their families are served, community partners recommend expanding the program to all families having subsequent births. Collaborators expressed concern about arcane geographical distinctions in determining families eligibility for Healthy Families services. Community partners expressed support for the concept of reaching all parents, not just families at high risk, with varying and appropriate levels of service.

Meeting the Program Goals of Healthy Families

We were interested to see if the Healthy Families programs are in fact meeting the goals that are stated by Healthy Families America. Thus, our next set of findings are discussed in relation to the four Healthy Families Program Goals listed below.

Healthy Families Program Goals

- To systematically assess for families strengths and needs and refer as needed
- To enhance family functioning by
  - Building trusting relationships
  - Teaching problem solving skills, and
  - Improving the family's support system
- To promote positive parent-child interaction
- To promote healthy childhood growth and development

Family Strengths and Needs

The first goal of the Healthy Families program is to address family strengths and needs. Assessing a family's strengths allows the Family Support Worker to build upon the strengths that are present; it also reinforces the strength-based philosophy of the program. Identifying needs assists the program in targeting potential resources for families.

The Healthy Families program actively identifies and supports a family's strengths. Strengths were identified within the first few home visits, through the observation of the FSW, and/or by the primary caregiver's self report. In the Year 2 report, two-thirds of the primary caregivers were noted as having the motivation and support that may be needed to have a rewarding experience with Healthy Families. Eighty-two percent had a strong interest in child development, 77% had supportive friends and family and about two-thirds of the families understood their child's needs, had positive interactions with their child and had realistic personal goals. Information collected from the parent survey reinforces the notion that families are strongly interested in their child's development.

While families clearly come into the program with a variety of strengths that will enhance their experience with Healthy Families and ultimately their child's experiences, these same families also have a variety of needs. The identification of these needs begins when the families enter the program. Some needs are identified through completing the initial assessment including the Kempe assessment. As the families continue through the program, needs are identified and referrals are made to address those needs. During our observations of the home visits, the first activity was usually a "check-in" to assess where the family was in dealing with on-going issues or new issues. Family strengths were usually reinforced through casual conversations and needs were identified in the same manner.

Examining the use of services noted at intake of the families as well as referrals made during the programs gives us insight into the families needs and the program's response to those needs. Table 2 lists the percent of families receiving services at intake and the percent of families referred for services during participation in the Healthy Families program. The most common services already being accessed by families were (1) WIC, the nutritional program for women, infants and children, (2) medical services for children including prenatal visits, (3) medical services for adults, and (4) food stamps. Thus, the families were utilizing social service programs that are well known and relatively easy to access. Once joining the program, at least one-third of the families were referred to WIC, medical providers, well-child visits, housing, educational/vocational services, food stamps, child care, and parenting education. About one-quarter of the families were referred to adult health care, employment, public health nurses, and mental health services. Although there were fewer families referred, important connections were made between families and legal assistance (14%), child protective services (13%), domestic violence (9%) and developmental services (8%). Once families were connected to the program, they were introduced to many of the available services in the community. These linkages have the potential to remain even when the family is no longer participating in Healthy Families.

Table 2. Referral Services

Type of Services	Percent of families receiving services at intake	Percent of families referred for service during participation
• **WIC**	**55%**	**48%**
• **Medical Services**	**42%**	**36%**
• **Well-child Visits**	12%	**34%**
• **Housing**	12%	**33%**
• **Educational/Vocational**	13%	**33%**
• **Food Stamps**	**34%**	**32%**
• **Child Care**	3%	**30%**
• **Parent Education**	13%	**30%**
• **Adult Health Care**	**43%**	28%
• **Employment**	22%	27%
• **Public Health Nurse**	19%	25%
• **Mental Health services**	18%	25%
• **Family Planning**	6%	20%
• **Prenatal Visits**	**34%**	14%
• **Legal Assistance**	3%	14%
• **Child Protective Services**	12%	13%
• **Food Pantry**	6%	11%
• **Transportation**	5%	9%
• **Domestic Violence**	2%	9%
• **Budget Counseling**	3%	9%
• **Prenatal Support**	25%	8%
• **Developmental Screening**	2%	8%
• **Head Start**	0%	6%
• **Early development intervention**	0%	5%
• **Teen Program**	5%	5%
• **Sexual Assault**	0%	2%
• **Boys/Girls Clubs**	0%	2%

Family Functioning

Family functioning is enhanced through the development of trusting relationships, teaching problem solving skills and improving the family support system.

TRUSTING RELATIONSHIPS

The establishment of trusting relationships allows the Family Support Worker to engage in meaningful activities and conversations with the primary caregiver. Building a trusting and positive relationship with the parent is critical in order to teach caregivers parenting skills so that they can build positive, healthy relationships with their child. Therefore, there is an emphasis on hiring Family Support Workers with the potential and desire to build healthy relationships with families. This emphasis on building relationships with caregivers and teaching positive relationship skills to parents is incorporated into the core training for Healthy Families. At times, new home visitors must wait for core training. We found that while 56% of the Family Support Workers received the core training within 4 months, 44% waited did not receive this core training until 5 months into their employment (range 5-10 months).

> *I expected the (home visits) to be more of an evaluation of how well your child was being cared for…instead it is relaxed and you become friendly with your support worker and the child gets to know the person and we both feel comfortable.*
> *- parent response to Muskie survey, May 2000*

Trust must be established in the first few months of the relationship. We saw that many families dropped out before a year in the program had passed. We also saw that many families drop out because they could not be engaged in the program or because they refused services once they had started. Therefore, it is critical that the families feel comfortable with their home visitor. **Responses from the parent survey indicate that the majority of parents do feel comfortable with their Family Support Worker (94%).** In fact, many feel so attached to their particular home visitor that they refuse to switch to a new Family Support Worker (usually due to the Family Support Worker leaving the job).

Our observations of the home visits gave us an opportunity to observe whether the Family Support Worker appeared to have the trust of the family. In the majority of the observations, the primary caregiver spoke easily with the home visitor about both casual and sensitive topics, conveying the impression that the Family Support Worker had developed a trusting relationship with the primary caregiver. In a limited number of cases, the need for trust of the family overrode the ability to accomplish a great deal on the visit. A couple of Family Support Workers were very casual or passive in their style resulting in a nice conversation but not a great deal of activity that went along with the goals of the program. In other cases, the trust observed between the Family Support Worker and the primary caregiver was critical to moving forward, especially in crisis situations. One issue of trust appeared particularly challenging to home visitors. This was with families in which there were possible child abuse or domestic abuse issues. Family Support Workers were faced with conflicting goals: address the sensitive issues yet keep the family engaged in the Healthy Families Program. In some cases, losing contact with the Healthy Families program could be more detrimental to a family than moving slowly on program goals.

PROBLEM SOLVING

As part of the home visit observations, we recorded examples of problem solving. While problem solving is one of the primary teaching goals of the Healthy Families program, we did not see it in the majority of home visit observations (8 out of 11 visits). Those Family Support Workers that did teach problem solving were very skilled at it. They effectively helped the primary caregiver identify a problem and brainstorm how to solve the problem. Some of the problem solving situations involved finding housing, reacting to an aggressive partner and how to balance multiple jobs.

IMPROVING THE FAMILY SUPPORT SYSTEM

The family support system was quantitatively and qualitatively assessed. During our home visit observations, we found many instances (7 out of 11 visits) of interactions between the Family Support Worker and the primary caregiver that helped to build the family system. Home visitors often talked to parents about what supports were available to the families, whether the influence of the parent's social circle was positive or negative, and in what ways. There were attempts to link mothers to additional support – through encouraging the use of the internet for parenting groups or encouraging participation in a Healthy Families-organized parenting group.

> *I feel more knowledgeable about parenting and share information and ideas with relatives pertaining to the Healthy Families Program.*
> *- parent response to Muskie survey, May 2000*

To assess changes in family functioning from the families' point of view, we asked in the parent survey if and how personal and family relationships had changed since entering the program. Thirty-five out of the fifty families responded to the question, describing what they perceived had been the effect of participating in Healthy Families on their relationships. Many families reported that family interactions had changed for the better, with some families specifically mentioning parent-child interactions improving. The word "closer" was often used to describe relationships; one parent wrote "I've learned to control my temper and ways to work with(my child's), so we're closer". Other parents wrote that their confidence and self-esteem in themselves and their parenting had been positively affected. One mother responded, "I feel that I am a better mom and I feel good about who I am." More confidence in their parenting was described as helping family relationships in general; one respondent wrote, "I am more confident and don't care so much what other people think. (I can) share feelings more openly. (My) communication is better".

To gauge the families' support system, The Maternal Social Support Index (MSSI) was administered at baseline and then at six-month intervals throughout the first 18 months the families were involved in Healthy Families. Possible scores on the MSSI range from 0-39. Baseline scores for 89 families ranged from 11 to 37. At baseline, the average MSSI score was 23.8 (see Table 3). By the 12 month point, the average score was 24.0. This score is comparable to scores found for families at the beginning of the Connecticut Healthy Families Evaluation. At 12 months, the average MSSI score in the Connecticut Evaluation was 22.4. Using a repeated measures analysis, **we found no difference in the MSSI scores over the 12 month period** (we did not consider the 18 months scores in this analysis due to small sample size). While one might expect to find an increase in social support scores over time as the family connects with other families or resources in the community, we do not see any significant changes over the course of involvement with the Healthy Families program. The finding that the social support networks of the families has not changed may reflect the young age of the children or may reflect the isolated nature of the families especially in rural areas of the state.

Table 3. Maternal Social Support Index Scores of Evaluated Families

	Baseline	6 months	12 months	18 months
Number of children assessed	89	61	29	11
MSSI score	23.8	24.6	24.0	24.5

Promoting Positive Parent-Child Interaction

Parent-child interaction was observed using multiple methods. Qualitative observations were made during the home visit observations and quantitative observations were made using the Home Observation for Measurement of the Environment (HOME) and the Child Abuse Potential (CAP) measure.

There was a strong focus on parent-child interaction during the **home visits** we observed. Positive parent-child interaction was often encouraged through the use of toys and activities provided by the Family Support Worker and in one case through the use of the Ages and Stages Questionnaire. Parent-child interaction was often modeled by the Family Support Worker and the primary caregiver was encouraged to join in on the activities. The encouragement for the primary caregiver to interact with the child was overt in many cases but passive in other cases. Many of the Family Support Workers would actively encourage or complement the parent when they were displaying positive parent-child interaction with their child. At times, the activities seemed more driven by the Family Support Worker than the primary caregiver (perhaps, due to necessity). One would presume that this balance would shift over time as the parent became more comfortable with her child and with the Healthy Families program.

The results of the **parent survey** reinforce the impression that the parents were learning useful parenting information and techniques during the home visits. **Eighty-six percent of the parents felt that had become better parents since they started the program.** In fact, parents seemed eager to share how their parenting had changed, with 39 out of 50 families writing about how the program had positively affected their parenting. Families often noted that the program allowed them to go from feeling completely inexperienced, with little or no information about parenting, to feeling informed and comfortable as parents. One family wrote "As first time parents we were clueless. This helped us a lot".

I have learned better ways to discipline my child and understand the phases of development better which makes me more patient and flexible.
- parent response to Muskie survey, May 2000

The provision of child development information was repeatedly mentioned by parents, and importantly, the effect that this information had on parents' perception and treatment of their children. One parent wrote "I feel my patience level has become better, especially reading information about child development". Parents also described how activities and information helped them feel more connected with their children; for instance, one parent stated "I understand why my child behaves the way he does in certain situations and I can support him". Activities that parents were shown, and ways to play with their children also seemed important to this group of parents. One wrote, "My Healthy Families worker brings many ideas and activities for me to share with my child." Another described her situation: "I now know some activities that I can do with my child even though he's a baby. I never knew that before". Some parents expressed that the encouragement they received from their home visitor helped them view themselves positively as parents, as one parent wrote: "I get reinforcement and encouragement from the support worker which helps me to continue to strive to be the best parent I can be".

One of our quantitative measures of parent-child interaction was the **Home Observation for Measurement of the Environment (HOME)**. The average HOME score was 32.6 at baseline and increased to 34.6 at 6 months and 37.4 at 12 months (see Table 4). Using a repeated measures analysis, **we found a significant increase in HOME scores over time**. As a comparison, HOME scores in the Connecticut Evaluation increased significantly from 27.8 at baseline to 33.3 at 12 months. However, as children age, more toys are purchased for the home and more interaction is common between parents and their children. These naturally occurring changes in the home will cause the HOME scores to increase. Examining the subscales, we can see where the increases are occurring. There was a significant increase in the mother's emotional and verbal responsiveness toward the child, in the provision of play materials, in the parental involvement with child, and in the variety of opportunities provided for the child (e.g. visits with relatives, reading, telling stories, etc.). Without a comparison group, we do not know whether the increases are due to the natural changes in the home as children age or whether some of the increases are due to the Healthy Families program.

Table 4. HOME Scores of Evaluated Families

	Baseline	6 months	12 months	18 months
Number of children assessed	89	61	29	11
HOME score	32.6	34.6	37.4*	36.4
Responsivity	7.7	7.4	8.5*	7.4
Acceptance	6.8	6.6	6.7	6.6
Organization	5.2	5.2	5.5	5.8
Play Materials	5.6	7.2	7.7*	8.3
Involvement	4.0	4.3	4.8*	4.3
Variety	3.3	3.9	4.0*	4.0

* significant change between baseline and 12 months.

The **Child Abuse Potential (CAP)** measure was used to examine whether parenting beliefs changed over time. CAP scores can range from 0 to 486. The higher the scores, the greater the child abuse potential. At baseline, the score for families ranged from 5 to 386. Examining scores on the CAP using a repeated measures analysis, **we find that the scores do not change significantly over the course of the study**. Examining the data another way, we looked at the percent of families that were above two pre-determined cutoffs at which there is an elevated risk of child abuse. At baseline, 18% of our sample was above the threshold for elevated risk while 15% percent were above the threshold for very elevated risk (These numbers are not mutually exclusive - see Table 5). There are slight variations in scores, but generally, **about one in five families were at an elevated risk for child abuse throughout the course of the study**. This certainly does not indicate actual child abuse but only an *elevated risk* for child abuse.

Table 5. Child Abuse Potential Scores of Evaluated Families

	Baseline	6 months	12 months	18 months
Number of children assessed	88	60	27	11
Average score	110.9	105.1	107.2	127.5
% above 166 (elevated risk)	18%	22%	22%	18%
% above 215 (very elevated risk)	15%	12%	19%	18%

Healthy Childhood Growth and Development

We assessed the final Healthy Families program goal of healthy childhood growth and development through analyzing immunization records, well-child visits records, home visit observations and through the Ages and Stages Questionnaire.

We analyzed the **immunization records** of the 89 families in our study. A goal of the Healthy Family program is to support families in finding a "medical home for the family and infant and for educating and advocating for consistent well child care and immunizations." In fact, during our **home visit observations** medical visits and immunizations were common topics of conversation One Family Support Worker brought a checklist of medical appointments to her two visits.

Family Support Workers were asked to review medical and immunization visits with families and to record the dates of each in the Healthy Families record and MIS data base. Evaluation staff reviewed these data and asked sites to fill in forms on missing data and to update data on families who terminated services.

The goal for the **immunization records** was for infants to receive 100 percent of vaccines recommended by the American Academy of Pediatrics and the State of Maine, unless varied by their provider. The vaccines included Diphtheria/Pertussis/Tetanus (DPT), polio, Hepatitis B, Hem. influenza type B (Hib), Measles, mumps and rubella (MMR). Varicella (chicken pox) was optional.

The MIS data on each case were reviewed using guidelines for 1999-2000 by an evaluation team member who is a pediatric nurse practitioner. The potential variation due to vaccine developments and individual infant factors is quite complex, and the broadest interpretation was used. For example different Hib brands lead to different injection sequences and polio can be oral or injectable with different numbers of vaccinations needed. Birthdates, dates of well-child visits, and the dates of last contact or official termination if prior to April 30th 2000 were also used to predict which vaccines should have been complete or accounted for by the termination date.

A simple method of quantitatively scoring the completion rate was developed by the observer. A score of 100% was given when all types of vaccines due by the termination age were documented in their complete series. A score of 75-80% was given when 3 of 4 or 4 of 5 series were completed and incomplete series were started. A score of 50-60 % was given when 2 or 3 were completed and a score of 25% was given when some vaccines were documented, but no or only one series was completed. For example, a child terminated at 14 months is up to date in the DPT, polio, Hib, and HepB series but the MMR due at 12 months is not documented. The score in this case would be 80%.

Of the 89 cases, 1 transferred to a different site and data were not found. Fifteen cases came from 3 sites which appeared to submit no immunization data and did not respond to the up-date request. Of the remaining 73, 20 cases had no data recorded, and 53 had at least some vaccines documented. For the 53 cases with data, the results of the analysis are listed below in Table 6. Please note that this is an optimistic evaluation of the immunization records. The large amounts of missing data made it impossible to determine when no date of immunization indicated an actual lack of immunization or just a lack of information.

Table 6. Recorded Immunizations at Termination or 18 Months of Age

Immunizations complete at:	Number of children	Percent complete
25%	7	13
50-60%	3	6
75-80%	13	24
81-100%	30	57

Many cases could not be followed with regular Family Support Worker visits and therefore updated immunization records were not kept. If a family remained in creative outreach for months before terminating, vaccines may have been administered but not reported to Healthy Families. However, the documented data do show substantial success in reaching the goal that vaccines were started and completed in a timely manner. If the program goal is to be sure that all children receive timely immunizations, a greater commitment to documentation and more systematic follow-up by the sites is needed.

During the **home visit observations** a number of Family Support Workers discussed child developmental stages as well as the safety issues that related to the particular stage. When primary caregivers expressed frustration with child behaviors related to a developmental stage, some home visitors offered empathy to the parent, others brainstormed with the primary caregiver to come up with solutions to deal with thee current child rearing concerns. Some visits included a discussion of child-related events the mother should expect to see in the coming months. Family Support Workers

had different skill levels with this task, which ranged from simply reading a checklist to an in-depth discussion addressing the primary caregivers questions and concerns. The Ages and Stages Questionnaire was administered during three observed visits. However, in only one of the visits was the tool used to encourage positive parent-child interaction in addition to ensuring proper development. In one case, the ASQ was administered inappropriately (e.g. as a verbal checklist rather than an interactive tool as intended).

The Ages and Stages Questionnaire (ASQ) is a "parent-completed, child monitoring system" used to identify children that may have developmental issues. Subscales of the ASQ include communication skills, gross motor, fine motor, problem solving and personal social skills. Based on multiple samples, cutoffs have been designated for the ASQ. These cutoffs indicate the score below which the child should be referred for child development services. For example, if a 12 month old child scores below 15.8 on the communication subscale, they should be referred for services. We looked at the number and percentage of children falling below the cutoffs at 6, 12 and 18 months for each subscale (see Table 7). At six months, only one percent of the 76 children assessed scored below the cutoff on all of the subscales except for personal-social for which 3% (2 children) scores below the cutoff. At twelve months, a maximum of 8% (3 children) scored below the cutoff for gross motor skills. By eighteen months,1 child out of 11 (or 9%) scored below the cutoff for the communication and personal-social subscale.

Table 7a. Children Below Cutoff for Typical Development by Type of Development

Children below cutoff for typical development at:	Communication	Gross motor	Fine motor	Problem solving	Personal-social
6 months (total n=76)	1 (1%)	1 (1%)	1 (1%)	1 (1%)	2 (3%)
12 months (total n=36)	1 (3%)	3 (8%)	2 (6%)	2 (6%)	1 (3%)
18 months (total n=11)	1 (9%)	1 (9%)	0 (0%)	0 (0%)	1 (9%)
# of different children with identified issue	3	3	2	3	4

Table 7b. Children Below Cutoff for Typical Development

Children below cutoff for typical development at:	Total # of Children
6 months (total n=76)	4
12 months (total n=36)	5
18 months (total n=11)	2

As mentioned, the ASQ can function as a way of identifying children who need a referral to developmental services. There was only one child that continually (e.g. over 18 months) received lower than typical scores on the ASQ. That child was referred to child developmental services. Interestingly, three of the children that scored low at one time point but were not referred to developmental services were in contact with Child Protective Services. Three of the children with low scores on the ASQ did not have any data on referrals. Missing data are an on-going challenge to analyzing information on referrals.

It is important to note that beyond the utility of the ASQ for identifying potential referrals, the ASQ was seen as very useful to the parent's knowledge base. A Family Support Worker reported that one of her families thought that the ASQ was the most valuable part of the home visit. This parent stated that the ASQ had "opened her eyes and increased her awareness of her child's development."

Do Family Demographics Change with Involvement in Healthy Families?

In this section, we looked at how families were faring approximately 12 months after entering the Healthy Families program. At the beginning of the study, the majority of families were high-school educated and mostly unemployed. One important question is whether families enrolled in Healthy Families are continuing their education or enhancing their employment experience. We looked at the families when they entered the program and around 12 months later (or when they terminated services).

Table 8. Characteristics of Primary Caregivers at Intake and Approximately 12 Months Later

Characteristics of Primary Caregivers	Intake	~ 12 months later	Increase/ Decrease
Marital Status			
Married	29%	31%	
Divorced	1%	1%	
Single/never married	**47%**	**27%**	
Separated	2%	4%	
Consensual relationship	**20%**	**37%**	**+17%**
Education Level			
Less than High School	39%	28%	
High School Diploma	51%	40%	
Post-secondary education	**10%**	**32%**	**+22%**
Employment Status			
Employed full-time	19%	21%	**+2%**
Employed part-time	16%	23%	**+8%**
Unemployed	**60%**	**40%**	**-20%**
Disability	1%	4%	
Full-time student	**4%**	**12%**	**+8%**
Housing			
Own Home	20%	15%	
Rent Home	51%	66%	
Shared living quarters	27%	19%	**-8%**
Homeless	2%	0%	

Approximately twelve months after joining the Healthy Families program, **many primary caregivers were moving from being single to being in consensual relationships** (See Table 8). While in Healthy Families, many primary caregivers had **obtained post-secondary education (22%)** or **gone from being unemployed to part- or full-time employment (9%)** . Some families also moved from shared living quarters into a rented apartment. Ironically, while families are gaining important skills and gaining ground in terms of "self-sufficiency", the jobs and education they move into may not allow them to participate fully in the Healthy Families program and may even cause a family to drop out of the program.

Summary

We found that the Healthy Families program is highly valued among the families that participate. In this study, we did not attempt to pass judgment on whether the Healthy Families home visiting program is successful in changing child and family outcomes due to a number of limitations of the study design. We did not use an experimental or quasi-experimental design (and thus cannot make causal conclusions), we relied on parent reports for most of our measures of child well-being and we only examined a small number of families. Keeping in mind these caveats, some of our major findings are reviewed below.

The Healthy Families Model

- Families are satisfied with the home visits they are receiving. 94% of parents feel comfortable with their Family Support Worker.
- Families are often referred to services they were not previously utilizing. Healthy Families is an **important vehicle for referring families to needed nutritional, medical, educational and vocational services.**
- Community agency partners were extremely enthusiastic about their collaboration over the several years of planning and service of Healthy Families. They reported a **substantial increase in linking new parents into a wide network of services.**

Family History

- Families with multiple risk factors and/or past exposure to abuse are more likely to hold parenting beliefs that are associated with child abuse (i.e. they scored higher on the Child Abuse Potential Index). These primary caregivers are also likely to have homes with less emotional support and cognitive stimulation.

Engagement and Retention

- Families stayed in the Healthy Families program for an **average of 11 months**. Out of the 89 families observed, there was a **38% drop-out rate** from the Healthy Families program within the first 18 months.
- Families who terminate services with Healthy Families have homes with less emotional support and cognitive stimulation, higher scores on the Kempe risk assessment and less likely to be using TANF.
- The most common reasons for leaving the program are **Family Support Worker turnover, re-location of family, and demands from employment and/or education.**

Family and Child Wellbeing

- **86% of parents felt that they had become better parents** since starting the Healthy Families Program.
- After 12 months in the Healthy Families program, more parents are in consensual relationships. More parents have **finished high school** or are in **post-secondary education** and more parents are **employed.**
- Over the first 12 months in the program, there were **no changes in the level of social support** available to families as measured by the Maternal Social Support Index.
- There were **significant increases in cognitive stimulation and emotional support available in the home** as measured by the HOME Observation for Measurement of the Environment. However, the increase may be expected due to natural increases in parent-child interaction and play materials as children age.
- There were **no changes in parenting beliefs related to an increased risk for child abuse and neglect** as measured by the Child Abuse Potential index. **About one-in-five families was at an elevated risk for child abuse and neglect throughout the study**.

Child Health and Development

- The vast majority of the children served by Healthy Families (95%) were in the range for **normal development**. Children routinely scoring low on a measure of child development were referred for developmental services.
- 81% of children with data submitted (n=53) had received at least 80% of their **immunizations**. Documentation was weak in this area.

Some themes emerged from our findings. It is apparent that the Healthy Families program is facing old and new challenges.

Staff turnover. Staff turnover is a critical weakness in the Healthy Families program, affecting the stability of local sites and the services families receive. However, this may be part of a larger trend. Social service programs traditionally hire mainly female workers at low wages. This has, unfortunately, come to be an expected part of programs serving children and families in all communities. As more financial support is available for home visiting programs, staff salaries should be considered a critical part of attracting, nurturing and retaining a quality workstaff who form the backbone of the program.

Family turnover. Related to staff turnover is family turnover. While certainly some exits from the program should be seen as a positive move for families who are succeeding in their goals as parents, many exits are due to personal and professional moves as well as staff turnover. Other families don't respond well to the program and are never fully engaged. We cannot expect every family to respond enthusiastically to the Healthy Families model, however, we can be creative in thinking about how to respond to the various reasons for family turnover. A stable staff, wider geographic coverage and flexible service hours are critical components as are re-thinking the services offered to hard-to-engage families.

Location of services. It was relatively common for families to move out of the service area making them no longer eligible for services. We also heard complaints of sites not being able to serve families from particular towns. In a rural state such as Maine, where people commonly convene upon a single hospital for prenatal and birth services, it is perhaps shortsighted to define boundaries by towns. A new infusion of money and a desire to have home visiting services available to all parents in Maine should go a long way towards addressing this issue.

Service Model. The model of providing home visiting during the day works well for parents who are unemployed or on maternity leave. However, the current service model may be incompatible with the current push for increased employment rates through welfare reforms. Some programs have already begun to address this problem through offering early morning, lunch-time and evening visits. Programs should pay close attention to whether the hours of service complement the goals of the parents served by the Healthy Families program. Programs may also want to consider the possibility of combining their services with preschool programs to maximize the number of families able to participate.

First-Time Parents. Many first time parents, especially teenage parents, are not emotionally nor sometimes developmentally ready for a Healthy Families program when they have their first child. By the time they are ready, they are older with multiple children and cannot access services. Many community partners and Healthy Families program managers mentioned the need for services targeted to families with multiple children.

Recommendations

PROGRAMMATIC RECOMMENDATIONS

- **Ensure that the various curriculums used with the Healthy Families model meet the needs of all families.** As Maine makes home visiting services available to all first-time families, it is critical that the curriculum be well-defined yet flexible for families with greatly varying needs. Cross-training on various curriculums (e.g. Parents as Teachers) reduces the time spent preparing for home visits and enhances the experience with the family.

- **Ensure that home visiting staff are retained through competitive salaries and a clear career path.**

- **In the process to expand home visiting, efforts not to "water-down" the quality of home visiting services are critical**. Client-to-staff ratios should be maintained as should requirements for staff credentials and staff training.

- **Resources should be allocated to updating computer and information management systems at all sites.** While some sites are isolated geographically, they do not need to be isolated *electronically*. Contemporary computers with virus-software and internet access should be a standard for sites.

- **Examine the overlap between Healthy Families and other early education programs to determine how comprehensive services could be offered.**

EVALUATION RECOMMENDATIONS

- **We do not recommend using home visiting staff to collect child and family assessments in future evaluation efforts**. Reliability of information and staff burden were issues. Adding additional work to under-paid, often over-worked staff was unwise. Maintaining a well-trained data collection effort was also problematic. While four training sessions were conducted (two initially and two due to staff turnover) and monthly conference calls were held to assist sites, additional staff turnover and staff apathy were issues. Appropriately trained, paid research assistants and/or community members and routine quality control checks are recommended.

- **We recommend a focus on family turnover in future evaluations**. Understanding why families leave and what, if anything, should be done about it will be important to the success of Healthy Families and home visiting in Maine.

- **We recommend a stronger focus on curriculum in future evaluations**. Programs have begun to experiment with cross-training on various home visiting models (e.g. Parents As Teachers). Understanding the curriculum(s) used in the home visiting program are critical to evaluating whether appropriate, quality services are being delivered.

- **We recommend developing a management information system that serves the needs of both the sites and the evaluation**. While a management information system was created for purposes of the evaluation, it did not adequately serve the needs of the Healthy Families sites. A relevant, user-friendly management information system should be installed (preferably using an intranet) to assist the sites in complying with state reporting requirements, in obtaining funding from foundations and others, and becoming credentialled.

- **We recommend looking to other state and national evaluation efforts to determine what the strengths and weaknesses are of various evaluation designs.** Understanding the limitations of non-experimental designs is important when viewing the reported results.

[i] Healthy Families and Nurturing Families of Knox county contracted with the Muskie School to be included in certain aspects of the evaluation.

[ii] *Implementation of Maine's Healthy Families Initiative: Initial Process Study Report*, October 1998

[iii] Oldham, Richards, Keith & Hornstein (1999). Maine's Healthy Families Initiative: Year 2 Evaluation Report. Portland, Maine: Edmund S. Muskie School of Public Service.

[iv] We refer to our outcomes study as "exploratory" because we were not fully funded to conduct an experimental or a detailed outcomes study.

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Appendix 1. Demographic Characteristics of Participating Families

	Year Two Families (n = 321)	Evaluated Families (n = 89)
a. Ethnicity of Child		
Caucasian	91%	84%
African-American	1%	0%
Native American	1%	0%
Mixed Ethnicity	7%	16%
b. Age of Parent (mean)	22 years	22 years
c. Prenatal Recruitment	48%	53%
d. Single child in home	77%	71%
e. Two adults in home	60%	61%
f. Kempe Score (mean)	32.1	27.2
Kempe Score, 25+	70%	60%
Kempe Score, 45+	41%	22%
g. Income		
$0-7,200	38%	45%
$7,200-14,400	29%	21%
$14,400-25,200	15%	13%
$25,200+	18%	21%
h. TANF Receipt	30%	21%
i. Housing		
Rent unsubsidized	45%	38%
Rent subsidized	16%	12%
Shared living quarters	21%	27%
Own home	17%	20%
Homeless	1%	3%
j. Education		
Less than H.S. diploma	37%	39%
H.S. Diploma	51%	51%
More than H.S. diploma	12%	10%
k. Employment		
Full-time employment	4%	16%
Part-time employment	80%	15%
Unemployed	16%	69%
l. Marital Status		
Married	26%	30%
Divorced	3%	1%
Single/ never married	51%	47%
Separated	2%	2%
Consensual relationship	18%	20%