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# An Analysis of Client Records to Determine the Efficacy of A Child Abuse Prevention Program for Parents

Monica Lynn DellaMea

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AN ANALYSIS OF CLIENT RECORDS TO DETERMINE THE EFFICACY OF A  
CHILD ABUSE PREVENTION PROGRAM FOR PARENTS

Thesis submitted to  
The Graduate College  
of Marshall University

In partial fulfillment of the  
Requirements for the Degree of  
Master of Arts  
Elementary Education

by

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Marshall University

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CHILD ABUSE PREVENTION PROGRAM FOR PARENTS

ABSTRACT

The alarming amount of abuse and maltreatment incurred by children in the United States has drawn large scale public attention only over the past century. Governmental agencies have since implemented programs to protect children from abusers after the abuse has been reported and sufficiently proven. Over recent decades new types of programs have originated to protect children before abuse occurs by educating parents who possess high risk factors for abusing children. These types of programs operate on the assumption that if parents can become knowledgeable about basic fundamentals of child development, learn to deal with daily stressors and challenges, and gain access to community resources, then they will be less likely to abuse their children. This study is an evaluation of a primary prevention program in Southern West Virginia. The program's effectiveness was assessed by an examination of the files of families who had participated in the program for at least nine months. Participation in the program and the evaluation was voluntary. Several specific types of data were collected from the files of 21 families participating in the primary prevention program. The data were organized into categories, and families were placed on continuums of functioning, based on the data collection and interviews with program staff. Results of the evaluation indicate that families who have at least one stable, supportive presence in their lives are more likely to function at higher levels. Additionally, the data indicate that

families who have access to education and employment are likely to function more highly. The children of families in the study tended to function at higher levels than their families, despite the challenging conditions under which they attempt to thrive. This study suggests that some families, such as those who have intense challenges, may not reach goals or improve in family functioning, despite multiple intervention and outreach efforts. The findings also suggest, however, that the supportive nurturance of the program staff did help most families gain access to resources, improve on their knowledge of child development, and reduce risk factors.

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## CHAPTER ONE: INTRODUCTION

It is a question with which I've concerned myself for some time now: Why do we, as a society, allow our most precious and vulnerable assets to become victims of senseless acts? So many of our children, innocent and impressionable, are scarred by others who abuse or neglect them. Even more nonsensical to me is the fact that so many of the abusers of children are parents—the same individuals who are supposedly responsible for the total care and well-being of the offspring they produce. Throughout the research process, I have recollected on a phrase noted in a popular 1980's comedy, where a serious comment was made amidst an array of humorous anecdotes: “you know...you need a license to buy a dog, or drive a car. Hell, you need a license to catch a fish. But they'll let any...be a father” (Grazer & Howard, 1989). Though this statement is a bit explicative, and does not include mention of abusive or neglectful mothers, the truth it speaks is chilling. The importance of child-rearing is so often underestimated by those who bring children into this world. From the noted existence of abuse and neglect come programs that seek to prevent parents from abusing their children. This thesis is a qualitative evaluation of a parent education program that seeks to eliminate abuse before it occurs.

### Research Purpose

The purpose of this study is to determine the extent to which a local parent education program meets its goals of reaching families, improving families' knowledge of child development, and increasing their access to resources. A study of this nature is needed because the early years of a child's life are critical; during this time a foundation

for subsequent educational achievement and success, among other developmental milestones, must be established. Tower (1996) notes that the “individuals in a child’s life are important. From these people he or she receives attention, learns to test reality, gets an indication of self-worth, and selects models” (p. 59). Under the best circumstances, parents are capable of and willing to provide basic needs, support, nurturance, love, and stability to their children. Moreover, our society expects that children’s parents will be in charge of teaching them the necessary life skills to adequately function in the world, and are usually the individuals who teach their children to respect values that have been deemed important to the family. Few individuals would argue that children are usually more heavily influenced by the actions of their parents than those of any other group of individuals with whom they may interact.

#### Definition of Terms

Throughout the data collection and analysis processes, certain terms occurred frequently that should be defined for the purposes of this study. For example, a *stable* family is one that is not changing or fluctuating, is steady in purpose, firm in resolution, and not subject to insecurity or emotional illness (Merriam-Webster, 1994). A *challenge* is any obstacle that presents an unwanted task or problem (Merriam-Webster).

Additionally, definitions of low functioning and high functioning families must also be made clear. A *low functioning* family is one that faces a combination of many challenges that are severe and destructive. The intensity and severity, rather than the number of challenges, typically sets low functioning families apart from other families.

Alternatively, *high functioning families* tend to reach goals more adequately, and tend to have support from at least one stable person in their personal life, along with access to

educational opportunities and employment. High functioning families also tend to know how to access community resources and assistance when in need.

### The Need for Professional Intervention

Children rely on their parents most during the early childhood years. Tyree (1995) notes that parents must understand how critical their participation is in their children's everyday lives. Miller-Perrin & Perrin (1999) comment that "most parents take extraordinary measures to protect [their] children from the problems of this world" (p. 3). However, some parents are not equipped with adequate experience, mentors, or resources to properly care for their children. This is where parent education programs can benefit the child and improve family functioning. Beckman, Newcomb, Frank, Brown, Stepanek, & Barnwell (1996) note that professionals have gained an enormous amount of knowledge about the role of families in children's lives and the ways in which professionals and families can work together on behalf of their children. "Given the history of child maltreatment," comment Miller-Perrin & Perrin, 1999 "where family victimization has been allowed to flourish 'behind closed doors,' such a community commitment is not only desirable but necessary" (p. 262). Parent education programs attempt to provide parents and other family members with the knowledge and resources necessary to enhance their child's development and well-being.

Because of the importance of the parents in the lives of children and their educational success, it is sometimes imperative that professionals intervene by providing education, support, development of appropriate skills, and strategies for parents that stress the "nurturing interactive relationship between parent and child" (Tyree, 1995).

This “nurturing interactive relationship” is not always well developed between parent and child, so intervention programs have been and are continuing to become established to foster children’s well being, often by attempting to increase parental knowledge about child development and child-rearing skills. Specifically, programs often target the prevention of child abuse and neglect. The focus of this thesis is an evaluation of a parenting program in Southern West Virginia that targets the prevention of such occurrences. Specifically this thesis evaluates the influence of a Healthy Families America (HFA) program initiative on the development of the children and the functioning of the families served by the program. The purpose of this study is to attempt to understand both the ways in which and the extent to which the goals of the program are being met. Healthy Families program goals are defined by several Critical Elements, which will be introduced in the research methods chapter and then broken down into more detail in the findings chapter of this thesis.

The families included in the study have unique stories that have been documented in family files maintained by Healthy Families America team members. By systematically studying these files, I have obtained a comprehensive view of each family’s plight and struggles, successes, accomplishments, and frustrations. This file review has revealed that many of the families in the program are living with extreme challenges that affect their everyday lives. I will describe the program’s influence on the families’ abilities to function under these challenging conditions in order to understand just how the needs of the families are being addressed and met. Since the Master’s Degree I am working toward is in elementary education, this thesis will address the

importance of fostering development in young children in order to ultimately enhance their success in school later on.

### Program Description

The Healthy Families America initiative seeks to establish a universal, voluntary home visitor system for all new parents to help their children get off to a good start in life (HFA Informational Flier). HFA is a national initiative designed to prevent the occurrence of child abuse or maltreatment. Participation in the program is voluntary. Prevent Child Abuse America, formerly known as the National Committee to Prevent Child Abuse, launched HFA in partnership with the Ronald McDonald House Charities in 1992 (Prevent Child Abuse America: Healthy Families, 2001). Nationally, Healthy Families America offers services to families who possess stress and risk factors for child abuse and/or neglect. The initiative “promotes positive parenting and child health and development, thereby preventing child abuse, neglect, and other poor childhood outcomes” (Prevent Child Abuse America: Healthy Families, 2001, p. 1). Outreach workers carry caseloads of not more than 15 families and receive intensive training (Tower, 1996). Often, collaboration with other organizations is key to provide families with access to scarce resources. The program justifies its existence by stating that it helps families “access health care and obtain a medical home both prenatally and for the infant; obtain information on child development and developmental screenings; work on goal setting and problem solving; and access appropriate community resources” (HFA Informational Flier, p. 2). Wolfe’s assertion that “healthy child-rearing patterns are sensitive to the child’s individual needs and developmental pace, and they ensure that the

child receives the necessary, expectable environment for adaptive development” (1999, p. 34) is consistent with HFA’s philosophy.

The Healthy Families America literature also specifies the program’s goal to promote the well being of children who are in the care of at-risk parents. The program has grown considerably since its creation in 1992, serving (in 1997) an estimated 18,000 at-risk families with intensive home visitation services offered by more than 270 HFA programs in 38 states and the District of Columbia (Daro & Harding, 1999). Healthy Families America programs that begin working with parents “either right before or right after birth stand the greatest chance of reducing the risk of child abuse for several reasons”:

- a. New parents are eager and excited to learn about caring for babies.
- b. Positive parenting practices are supported before patterns are established.
- c. Most physical abuse and neglect occurs among children under the age of three.
- d. Forty-four percent of fatalities due to child maltreatment occur before the first birthday.
- e. Children need to be immunized from childhood disease during the first two years of life.
- f. The most critical brain development occurs from conception through the first few years of life (Healthy Families America: Home Visiting Programs, 2001, p. 3).

These assertions serve as powerful indicators of our society’s need for parent education programs such as Healthy Families America that target high risk parents.

The program I studied is implemented under the auspices of a West Virginia child abuse prevention program. The site is located in an urban area of Southern West Virginia. Initiated in 1996, the local Healthy Families chapter has expanded its staff and number of participating families each year. A more in-depth description of the program is included in the Findings chapter.

### Research Outline

The following chapters address literature related to the subject, research methods, research findings, and how these findings relate to the existing body of knowledge on the subject. The literature review addresses the issues of child abuse and neglect, programs designed to prevent child abuse and neglect, and evaluations of such programs. The methods section addresses the type of research methods used, including sampling, receiving informal consent, data collection, validity, and data analysis. The findings chapter reveals the results of the study, as related to the program's Critical Elements. A summary of the efficacy of this study, as well as links between current literature and the findings from this study is presented in the conclusion. Limitations of the study, such as the use of a small sample that is related primarily to logs written by program staff, will also be discussed in the conclusion. Overall, this piece attempts to evaluate the extent to which a local parent education program is meeting its goal of deterring child abuse and maltreatment among at-risk families.

## CHAPTER TWO: REVIEW OF LITERATURE

### Introduction

Miller-Perrin & Perrin (1999) suggest that “preventing child maltreatment begins with social awareness, plus the recognition that expertise, energy, and money are needed to alleviate the conditions that produce child maltreatment...[yet] most community resources are tied up in responding to, rather than preventing, child maltreatment” (p. 262). Ideally, when maltreatment is absent, the child will be able to develop under much less stressful and traumatic conditions than if he or she were being abused. All the information, support, and access to resources parent education programs provide for parents are efforts to help parents facilitate their child’s development and cope with everyday problems, ultimately in hopes of improving family functioning and providing a more positive environment in which the child can grow.

### Child Abuse and Neglect

Abuse and maltreatment are under no circumstances acceptable. Minors are especially susceptible to these actions. Statistics show that child maltreatment is a social problem of staggering proportions (Reppucci, et.al., 1997). Tower (1996) notes that “the maltreatment of children is a longstanding problem. Since ancient times, children have been viewed as property to be sold, given, or exploited by adults. Throughout history, children have been overworked, prostituted, and physically maltreated for a variety of reasons” (p. 18). Abuse and neglect can take many forms, including neglect, physical abuse, emotional and psychological abuse, sexual abuse, and sexual exploitation (Tower).

Regardless of the type of abuse sustained by victims, the horrific nature of the act of abuse often becomes ingrained into the minds of those who suffer from exposure to such trauma, causing problems throughout the lifespan. To say the least, the lifelong repercussions of suffering abuse can be severe and disheartening for victims, especially children.

#### The “Cost” of Abuse in America

Direct and indirect nationwide costs resulting from child abuse and neglect are enormous, totaling over an estimated 94 billion dollars annually (Prevent Child Abuse America Statistical Evidence, 2001). Direct costs of child abuse and neglect are those associated with the immediate needs of abused or neglected children, such as hospitalization, mental health care systems, chronic health problems, law enforcement, and judicial systems. Indirect costs include costs associated with the long term effects of child abuse and neglect, such as special education, mental health, health care, juvenile delinquency, lost productivity to society, and adult criminality (Prevent Child Abuse America Statistical Evidence). Healthy Families America also recognizes the savings that can occur when preventive efforts are utilized. “For every dollar spent on prevention, at least two dollars are saved that might otherwise have been spent on child welfare services, special education services, medical care, foster care, counseling, and housing juvenile offenders” (2001, p. 1). Justifiably so, Prevent Child Abuse America asserts that “regardless of the economic costs associated with child abuse and neglect, it is impossible to overstate the tragic consequences endured by the children themselves...The costs of such human suffering are incalculable” (2001, p. 1).

Another cost of child abuse includes the effects of violence on its victims. Violence occurs in many families. Each year in the United States, an estimated 1.6 million children are seriously injured or impaired as a result of abuse or neglect; 1,100 children die as a result of child abuse each year. One third of all victims of child abuse are younger than one year of age (Children's Defense Fund, 1993). Environmental stress factors can contribute to the likelihood of child maltreatment being present within a family. Miller-Perrin & Perrin (1999) note that "stress associated with unemployment, poverty, poor housing, family demands, and lack of social support (i.e. social isolation), for example, have been associated with all forms of child abuse" (p. 238). Clearly, parents vary in their ability to cope with the stress associated with poverty (Pelton, 1994), as the vast majority of parents do not abuse their children. Wolfe (1999) defends the assertion that stress from financial instability can impact the incidence of child maltreatment in the home. He notes that "the economically based context of maltreatment—restricted child care opportunities, crowded and unsafe housing, lack of health care, and so forth—is a powerful contributor to the high incidence" of child abuse (1999, p. 14).

### The Cycle of Abuse

Abuse often occurs in cycles. Steele (1987) reports that "it is common for abusive or neglectful caretakers to give a history of having experienced some significant degree of neglect, with or without accompanying physical abuse" (p. 242). Furthermore, "it is quite rare to see an abuser who does not relate this history (of abuse) when he is questioned appropriately" (Steele, p. 242). The cyclic nature of abuse is revealed in Ito (1995), who notes how current literature and research does reveal a correlation between

the traumatic events experienced by maltreated parents and abuse or neglect of their own children. An example of the cyclic nature of abuse is seen in Wolfe (1999), who reports on Widom's (1996) longitudinal study of adults who suffered from abuse as children. Widom's study also revealed that persons with histories of physical abuse, neglect, or both were "particularly more likely to be arrested for a violent crime" (Wolfe, p. 54).

### The Effects of Abuse Among Children

Numerous empirical studies have documented the relationship between abuse and maladaptive behaviors in children (see comprehensive review by Becker, Alpert, Bigfoot, Bonner, Geddie, Henggeler, Kaufman, & Walker, 1995). Wolfe (1999) notes that "developmental dimensions such as self-control, closeness and attachment to others, peer relationships, and social competence are common themes that pervade the literature on abused children" (p. 35). Fuller and Olsen (1998) comment that "research has documented neurological, cognitive, behavioral, psychological, emotional, and intellectual effects" (p. 244) on children who are abused or maltreated. Becker, et.al. also point out how abuse hinders the development of children, and

the effects of child maltreatment are widespread and often manifest themselves differently, depending on the age of the child (e.g., physically abused infants and preschoolers may show problems with attachment, whereas school-age children may display decreased self-esteem, social withdrawal, and depression); likewise, neglected children frequently demonstrate significant deficits in cognitive, social-emotional, and language development (p. 29).

The serious consequences of abuse can be seen throughout the development of an abused child. Tower notes that each developmental period, from birth through adulthood,

“provides new conflicts” for the abused and neglected child (1996, p. 60). For children between birth and one year, abuse can manifest itself by contributing to “poor motor control, a lack of social responsiveness, slow language development, and a general mistrust of the environment” (Tower, p. 60). Furthermore, Tower suggests that abused children ages one through four often do not receive vital learning experiences necessary to promote natural development in areas of play, self-esteem, and trust.

Moreover, young children who are victims of abuse are likely to experience difficulties establishing developmental tasks such as emotional regulation, social awareness, peer acceptance, and empathy (Wolfe, 1999). By the time a child has reached the age to enter primary schooling, the effects of past (or current) abuse can be very apparent in the child’s social and academic capabilities. Wolfe notes that “abused children are significantly more likely than their peers to show impairments and delays...across various measures of cognitive development” (1999, p. 48). Additionally, children who have suffered from maltreatment are more likely to have behavior problems and difficulties establishing peer relations, “though not all abused children behave in this fashion” (Wolfe, p. 49). Davidson and Smith (1990) note how research has suggested that as many as 50 percent of the children exposed to trauma before age 10 develop psychiatric problems later in life. Children who are victims of abuse are particularly susceptible to possessing these types of problems. For example, statistical evidence provided by the Prevent Child Abuse America initiative shows that abused and neglected children are “more likely to suffer from depression, alcoholism, drug abuse, and severe obesity. They are also more likely to require special education in school and to become juvenile delinquents and adult criminals” (2001, p. 1).

Wolfe (1999) comments that “child abuse and neglect have considerable psychological importance, because these experiences happen as part of ongoing relationships that are expected to be protective, supportive, and nurturing” (p. 33). Childhood is a period of development where individuals should be nurtured and cared for in safe, supportive environments. However, “the developmental disruptions and impairments that accompany child abuse and neglect set in motion a series of events that increase the likelihood of adaptational failure and future behavioral and emotional problems” (Wolfe, 1999, p. 51). Undoubtedly, when children are neglected or abused, they often suffer more than anyone realizes. Moreover, the need for “long-term support which is adaptable enough to respond to the differing developmental needs of a child at different times, and the differing parental needs that emerge from changing circumstances” must be considered by agencies providing assistance and interventions to families (Buchanan, 1996, p. 210).

### Preventing Child Abuse and Neglect

Tower (1996) notes that “there are no easy remedies for the problem of child abuse and neglect...(but) prevention is one way to combat all forms of child abuse and neglect” (p. 410). The plausibility of advocating for children is reflected in Miller-Perrin & Perrin (1999), who note “it is important to consider the victimization of children and to emphasize the need for societal intervention and protection of our most vulnerable citizens” (p. 5). Unfortunately, our most vulnerable citizens are among the least likely to be able to defend themselves from behaviors we deem to be abusive.

## A History of Child Abuse Prevention

The history of child abuse prevention is surprisingly short, despite the suspected high frequency of abuse sustained by children over past centuries. “Until recently,” notes Wolfe (1999, p. 2), “violence against members of one’s own family was considered in the eyes of the law to be less consequential, less damaging, and less worthy of society’s serious attention than was violence between strangers. But today we know better.”

Moreover, when discussing the history of child abuse prevention, Miller-Perrin & Perrin (1999) comment how “prior to the mid-1800’s, there is little historical reference to organized child protection. Throughout most of human history, the dominance and authority of parents have been unquestioned, with children often becoming the victims as a result” (p. 242). This past dominance of parental authority is noted in Jackson (1996), who comments that in the 1990’s social policy was in the process of changing from the European adage “a man’s home is his castle” to the African proverb “it takes a whole village to raise a child” (p. 7). The first concept implies that the events occurring in the home are no one’s business except the adults (and particularly the adult males) who live there. The second conveys a different social policy message, according to Jackson: “child rearing should involve the entire community, not just the family” (p. 7). Looking far into the past, the separation of familial concerns from community goals is evident.

The social worker movement of the 19<sup>th</sup> century found an intense and frequent amount of child abuse in the home, and the reluctance of social policy makers to address the needs of children is seen in the first noted case of child abuse (Jackson, 1996):

The child abuse prevention movement grew out of the animal protection movement... The Humane Society was established in 1866 to protect animals; it

did not establish its children's division until 1875, when a young girl, Mary Ellen, was represented as an animal to receive protection from abuse (p. 15).

The Society for the Prevention of Cruelty to Children, formed in New York in 1875, "not only intervened in cases of child abuse and neglect but advocated for child protection in a variety of areas" (Tower, 1996, p. 11), such as sponsoring shelters for needy women and children and emphasizing *family rehabilitation*, which was a new concept (Tower). The National Committee for the Prevention of Child Abuse, formed in 1972, was one of the first agencies that sought to prevent child abuse on a massive scale (Tower). Jackson asserts how it was not until 1974, almost one hundred years after child abuse was first noted as a problem, that legislation was passed to formally protect children. This act, PL93-247, the Child Abuse Prevention and Treatment Act of 1974, remains a law today (Jackson). Wolfe (1999) reflects how "the importance of the parent-child relationship has evolved in recent years to become a central issue in both the promotion of healthy family relationships and the prevention of child abuse and neglect" (p. xi). Now we see that "commitment to the prevention of child maltreatment is growing, as evidenced by the many prevention interventions that are beginning to appear" (Miller-Perrin & Perrin, 1999, p. 262).

#### The Current State of Child Abuse Prevention

Parent education programs focused on preventing child abuse seek to reduce "one of the most enduring problems in all human history" (Miller-Perrin & Perrin, 1999, p. 237). Miller-Perrin & Perrin also comment that parent education programs, "especially those that incorporate *early intervention* and *home visitation*, are gaining considerable support" (p. 250). However, parent education programs that focus primarily on

preventing abuse and improving family functioning are relatively new to our society. Wolfe, Reppucci, & Hart (1995) note that preventive parent education and family support programs, “both state supported and private, have expanded and diversified since the mid-1970’s, [but] little actually is known about either their effectiveness or their implementation” (p. 17). Today, more than half of the states in our nation have parent support initiatives underway (Miller-Perrin & Perrin).

Parent education programs are on the forefront of preventing abuse; therefore, programs that aim to educate parents on how their child is developing and provide parents with resources (such as access to government agencies like the Department of Health and Human Resources and Women, Infants, and Children) are ultimately fostering the development of children. “Abuse and neglect,” comments Steele (1987), “are the outward behavioral evidences of a caretaker’s inadequate empathy for the child...such inadequate empathy is the tragic deficit present in the caretaker in all situations of abuse and neglect” (p. 243). Thompson (1995) comments how parent education programs attempt to “combat the ignorance or misunderstanding that can sometimes underlie maltreatment, strengthen parental knowledge and sympathetic understanding of children’s needs, and enhance parental pride and self-confidence in the growth and achievements of offspring” (p. 127).

Parent education programs attempt to reach these goals. For example, Daro and Harding (1999), discuss targeted outcomes of the Healthy Families America program including a reduction in child maltreatment rates; enhanced maternal and child health outcomes; more consistent cognitive and emotional development among children; and improved life course outcomes for the families. In parent education programs,

the focus of intervention is not just the child's physical well-being but also the child's cognitive and socioemotional growth. The primary goal of these efforts...is to combat the ignorance or misunderstanding that can sometimes underlie maltreatment, strengthen parental knowledge and sympathetic understanding of children's needs, and enhance parental pride and self-confidence in the growth and achievements of offspring (Thompson, 1995, p. 127).

Wolfe (1999) adds to the argument for parent education programs by noting that "abusive parents often lack the skills and resources necessary to cope effectively with child rearing and other stressful life demands, such as unemployment, crowded housing, and constant child attention" (p. 80). Parent education programs that target the prevention of child abuse can be seen as a grass-roots, holistic approach to conquering one of our nation's most serious problems.

Three types of maltreatment prevention are typically identified by professionals (Reppucci, et.al., 1997). Primary prevention consists of interventions to prevent a specified problem, such as child maltreatment, from ever happening; secondary prevention usually suggests early identification and early intervention to keep the problem from continuing; and tertiary prevention aims to reduce the severity and effects of the problem after it has occurred by some means of rehabilitation and treatment (Reppucci, et.al., 1997). Wolfe (1999) notes that the main problem with secondary and tertiary approaches to intervention is that "considerable harm may have occurred to a child's psychological development and well-being" by the time assistance is procured (p. 94). Many of the current prevention programs that aim to educate parents can be classified as primary in nature. The participants in these programs have no documented

abuse to their children (or with some programs, their prenatal children); they just have risk factors present in their lives that abusers sometimes tend to possess, such as low income, low educational levels, and housing problems. “The goals of prevention” notes Wolfe, (1999, p. 95) “involve the development of strong positive child-rearing abilities by strengthening the early formation of the parent-child relationship.”

Primary prevention programs that focus on eliminating child maltreatment operate under the assumption that if parents’ stress can be reduced, if their knowledge of child development can be improved, and if their social coping skills and supportive networks can be enhanced, then parenting strategies will be improved, and many forms of child maltreatment may be prevented (Willis, Holden, & Rosenberg, 1992). Moreover, Miller-Perrin & Perrin (1999) note that victims of child maltreatment are often insecurely attached their to parents, and “any program that enhances parenting effectiveness in general should indirectly improve the attachment bond between a parent and child, leading to lower rates of abuse” (p. 250). Programs such as Healthy Families America operate under the idea that prevention does not include the avoidance of a particular set of social dilemmas, but rather the establishment of familial and community conditions conducive to optimal child development (Daro & Harding, 1999).

#### Examples of Primary Prevention Programs

An example of a primary prevention program is the Elmira Prenatal/Early Infancy Project, which began in the 1970’s in New York State, offering a variety of services to at-risk mothers (Thompson, 1995). Highly trained nurses conducted intensive home visits to provide “parent education, enhance the social support offered by friends and extended family members, and connect the family with community service providers” (Thompson,

p. 129). Any woman in this small, semirural community who was a first-time parent was invited to participate in the program. The invitation was extended to such a large group to avoid the stigma for project participants of being perceived as needing special assistance (Thompson, 1995). “The project provides prenatal and early childhood services in an attempt to help young mothers understand child health and development and to help strengthen confidence in themselves and confidence in their capacity for change” (Miller-Perrin & Perrin, 1999, p. 252). The success of the program, according to founder Dr. David Olds, can be attributed to several factors.

First, home visitation began during pregnancy...Second, home visitors were highly trained nurses with expertise in maternal and child health...Third, the intervention strategy encompassed social support, health maintenance, parent education, and ecological concern for the family’s living conditions and contact with community resources (Thompson, p. 134).

The factors that promoted successful program outcomes for the Elmira Project are similar to other parent education programs who share many of the same goals.

The Minnesota Early Learn Demonstration (MELD) has also been particularly effective, notes Tower (1996). This program “provides mothers with intensive training and support through two three-hour weekly meetings for two years” (Tower, p. 417). This primary prevention program focuses on topics such as child development, family management, and child growth. This program does not utilize home visitation as an intervention tool, however. Instead, women meet together and listen to speakers, watch demonstrations, view films, and share experiences while their children are cared for (Daro, 1988). Another program, Good Start, is sponsored by the Massachusetts Society

for the Prevention of Cruelty to Children (Tower). This program is a voluntary, home-based program that “provides counseling, family life, medical and nutritional education, parent support groups, infant play groups, and child care/development training (Tower, p. 417). Tower also notes that this program targets families with newborns who are at risk for abuse and neglect.

Positive results have also been found with the Hawaii Healthy Start Program, which operates under the national Healthy Families America initiative. This program was begun in 1985, and was initially created by the Hawaii Family Stress Center in Honolulu (Miller-Perrin & Perrin, 1999). This program offers voluntary services to high-risk parents, “as identified by a list of 15 demographic and socioeconomic factors (e.g., marital status, education, family support, limited prenatal care, and history of substance abuse). Trained paraprofessionals visit families weekly, with visits tapering off as families accomplish certain goals” (Miller-Perrin & Perrin, p. 251). Intensive home visiting services are implemented, and services are tailored to fit the needs of families (Thompson, 1995). This project has expanded rapidly since its conception, serving (in 1995) a large number of individuals in at least 13 sites, “with annual legislative appropriations of several million dollars” (Thompson, p. 135). Both this program and the Elmira Project obtained services in a voluntary manner, ensuring the participants of their right to refuse services. Thompson adds that this stipulation “can enhance the likelihood of targeted families enlisting into a home visitation program” (p. 145).

## Home Visitation

As some of the above projects demonstrate, home visitation approaches to preventing child abuse can be particularly effective. Thompson (1995) notes several attributes of a well-organized home visitation program.

A well-conceived home visitation program entails regular contact between a home visitor and the family, during which the visitor talks with the parent(s), listens to their problems, offers advice about child development and child-rearing issues, connects the family to other resources in the community, monitors the child (or children) for signs of maltreatment, and tailors other interventions to the specific constellation of needs and challenges of that particular family (p. 125).

Additionally, home visiting programs seek to link visitors with family members by allowing them to bond and relate familiar experiences. This social support model of intervention assists parents with transitioning into parenthood, strengthening their competence levels, and attempting to reduce social isolation (Thompson). Moreover, Thompson offers factors that are likely to predict the success of home visitation programs, including

1. paid staff rather than volunteers;
2. services that are broadly accessed rather than specifically targeted;
3. services that are obtained in a voluntary, rather than compulsory, manner; and
4. reliable funding (p. 145).

These factors contribute to the success of home visitation programs such as the ones exemplified above. The national Healthy Families America's stance on home visiting adheres closely to Thompson's predictors of home visitation success.

## Evaluation of Child Abuse and Neglect Programs

“The goal of intervention, to help families within communities meet the basic needs of the children,” notes DePanfilis (1999), “is to provide the mix and intensity of services appropriate to each family’s need” (p. 220). In order to better serve the families of intervention programs, the programs should participate in evaluative measures to refine and improve program implementation. The effectiveness of parent education programs has not been heavily evaluated. Starr (1990) notes that few effective evaluations are implemented for child abuse prevention programs, even though service providers and policy makers say that evaluation is an important component of any service program. Program evaluation literature is beginning to be seen more in the professional world, though evaluations of social service agencies and programs are still relatively few in number. Miller-Perrin & Perrin (1999) comment that “although evaluations are limited, available research indicates that these programs have tremendous potential for making a positive impact” (p. 262).

The evaluation research literature that does exist attempts to explain to readers the effects of such programs on clients served by the programs. The importance of program evaluation research is stressed in Reppucci, et.al (1997), who note “the eventual success of a program’s development will depend on the willingness of staff to constantly review their growth and readjust in ways that make programming more attractive and effective” (p. 115). Miller-Perrin & Perrin comment that “many existing prevention efforts have been effective,...and there is every reason to be optimistic that public and professional attention to the problem will produce increasingly positive results” (1999, p. 237).

### Evaluation of Current Programs

An evaluation initiated by Dr. David Olds, Founder of the Elmira (New York) Prenatal/Early Infancy Project, revealed that the same program delivered “not only a meaningful reduction in the rate of child maltreatment...but also improvements in parent-child interaction, reductions in emergency room visits, and improvements in mothers’ own health care and employment” (Thompson, 1995, p. 129). This evaluation was based on “a randomized trial design comparing the outcomes of high-risk families who had been randomly assigned to different experimental groups, including one receiving intensive home visitation services” (Thompson, p. 129). Thompson also notes that this project evaluation provides “some of the most comprehensive and best-documented evidence that intensive home visitation can have significant effects on the incidence of child abuse or neglect in high-risk families” (p. 129). Additionally, follow-up evaluations on this project reveal that mothers in the study spent more quality time with their children, were less likely to abuse their children, had fewer children, waited longer to have another child, spent less time on welfare, and had fewer arrests than the control group (Olds, Henderson, Tatelbaum, & Chamberlain, 1986).

Chapters of Healthy Families America from several states in the nation have participated in evaluations to determine the extent of the effectiveness of the programs. The Hawaii Healthy Start program operates under the national HFA label. Evaluations of the program reveal positive results. For example, Fuddy (1992) reports that initial outcome evaluations of Hawaii’s Healthy Start program show lower rates of child maltreatment in Healthy Start families that are considered high-risk than high-risk families who were not participants in the program. Holden & Nabors attribute the

program's success to "specific intervention strategies as well as the provision of social support," which were "likely responsible for the program's positive effects on overall rates of maltreatment" (p. 182). This evaluation included the random assignment of high-risk families into one of two groups. Miller Perrin & Perrin (1999) report that families with children who were born on even days were offered services, and children born on odd days received no services. After 12 months of services, the evaluation reported that Healthy Start mothers were more involved and sensitive to their children's needs; the children were more responsive to their mothers; and Healthy Start children were at less risk of physical abuse.

The research methods used in the above evaluations utilized both participant input and program information to identify strengths and weaknesses in the programs. Holden & Nabors (1999) note that "multidisciplinary efforts [are] necessary to develop protocols with multiple outcome measures to evaluate interventions" (p. 185). Moreover, "researchers need to assess the relationship between the level of training and skill of care providers (e.g., paraprofessionals, nurses, pediatricians) and outcomes" (Holden & Nabors, p. 185). For example, some interventions may find that paraprofessionals are more effective than doctors or nurses, and vice versa.

### Summary of Literature

The proliferation of child abuse and neglect in our society is alarming, to say the least. Perhaps we can be comforted somewhat to know that despite the fact that the field of child protection "is young, it continues to mature as we learn to better understand the abuser and the victim" (Tower, 1996, p. 18). As our society evolves, we are becoming

better at targeting at-risk families who may abuse their children; with this realization, we are able to assist more families in alleviating challenges that may cause the extreme levels of stress that often lead to abuse. The results of evaluation research in this area are discussed in Miller Perrin & Perrin (1999) who note that “research evaluating the effectiveness of parental competency programs leads to the conclusion that such programs are generally effective in meeting many of their goals” (p. 252). However, bringing programs such as the ones described in this section to the hundreds of thousands of at-risk families in this country “is a huge task and will require a commitment to family protection that is unprecedented in the history of this country” (Miller Perrin & Perrin, p. 261). Though the complete extinction of abuse and neglect may never occur, the success of programs such as the ones discussed in this section provides justification for further outreach attempts to at-risk families.

## CHAPTER THREE: RESEARCH METHODS

### Identifying Critical Elements

In order to assess the effectiveness of the local Healthy Families America program, I used the goals Healthy Families America attempts to achieve with both participants and program operation. The Healthy Families America home visiting model is defined “by a set of Critical Program Elements” (HFA Training Manual, 1997, p. 10). These Elements, or standards, are guidelines detailing the various methods through which high-quality HFA programs are to be implemented in communities. In order to become and remain an official HFA site, programs must adhere to all 12 Critical Elements, thus providing quality services to participants. After learning that the HFA program I researched is an official HFA site, I realized that I needed to become familiar with the HFA Critical Elements so I could analyze how, and the extent to which, this particular program is meeting the required standards.

Critical Elements are divided into three implementation categories, which include those standards that relate to the initiation of service, service content, and selection and training of service providers (HFA Training Manual). Throughout all periods of service, guidelines have been formed to ensure HFA staff members know the methods through which they should deliver high-quality, appropriate services to participants. Critical Elements that relate to the initiation of service include the following requirements:

- a. initiation of services prenatally or at birth;
- b. use of a standardized assessment tool to systematically identify families who are most in need of services; and

- c. offering services voluntarily and use positive, persistent, outreach efforts to build family trust.

Critical Elements regarding service content mandate that HFA staff members

- a. offer services intensively, with well-defined criteria for increasing or decreasing intensity of service over the long-term;
- b. offer culturally competent services such that the staff understands, acknowledges, and respects cultural differences among participants; and materials used should reflect the cultural, linguistic, geographic, racial, and ethnic diversity of the population served;
- c. offer services which focus on supporting the parents(s) as well as supporting parent-child interaction and child development;
- d. ensure that at a minimum, all families should be linked to a medical provider to assure optimal health and development. Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters; and
- e. provide services to a limited number of participants to ensure that they have an adequate amount of time to spend with each family to meet their varying needs and to plan for future activities.

The third set of critical elements sets standards regarding the selection and training of service providers. These elements require that

- a. service providers should be selected because of their personal characteristics (i.e., nonjudgemental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job;
- b. service providers should have a framework, based on the education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers should receive basic training in areas such as: cultural competency, substance abuse, reporting child abuse, domestic violence, drug exposed infants, and services in their community;
- c. service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation; and
- d. service providers should receive ongoing, effective supervision so that they can develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference, in order to avoid stress-related burnout (HFA Training Manual, 1997, p 11-26).

After reading through the descriptions of each critical element, I was better equipped to collect data in order to show how the program achieves its goals.

### Applied qualitative research

My research can be described as qualitative, and more specifically, applied. Qualitative research is “multimethod in focus, involving an interpretive, naturalistic approach to its subject matter” (Denzin & Lincoln, 1998, p. 3). Bogdan and Biklen (1998) describe applied qualitative research efforts as those which “seek findings that can be used directly to make practical decisions about, or improvements in, programs and practices to bring about change with more immediacy” (p. 209). Moreover, this study falls under the subcategory of evaluation research, as I am “providing information that will help people who have the authority to develop programs and make other policy decisions” (Bogdan & Biklen, p. 211) through my work as a researcher. Bogdan and Biklen note that with evaluative research, “the researcher is most often hired by a contractor to describe and assess a particular program of change they oversee in order to improve or eliminate it. Evaluation research is the best-known form of applied research” (p. 211). The original reason I decided to complete this study was that I was one of the graduate student ethnographers on an evaluation team for Healthy Families America’s annual evaluation. Reppucci, Britner, & Woolard (1997) also note that the general intent of an evaluation “is documentation—systematically describing how a program works within its current situation” (p. 38). Daro and Harding (1999) also comment that “a variety of evaluation designs are needed to fully capture HFA impacts, particularly given the initiative’s commitment to program flexibility and community ownership” (p. 172). The qualitative methods I utilized for this thesis include document analysis and ethnographic interviewing. It was my job as the ethnographer to interpret the data

inductively and draw conclusions about the effectiveness of the program based on my findings.

### Sampling

The sampling process consisted of selecting families who had participated in the program at least nine months. This requirement was used so the evaluation could examine families whose participation in the program was more heavily documented in their files, thus producing more extensive data. Therefore, all 21 families who met this requirement and had given written consent upon entering the program for their files to be researched were included in the study. Though the Healthy Families program I studied includes three sites in two counties, the sample of families comes from only two sites in one county. This is because the most recent site addition to the program did not occur until approximately one month after the sample was chosen. The amount of time families had participated in the program varied as well. The newest family to the program had only been in the program nine months at the time of the evaluation. Of all the families in the evaluation, the one with the most experience in Healthy Families has been in the program for nearly five years.

Patton's (1987) discussion of qualitative evaluation sampling provides several types of samples that can be used by researchers. The sampling for this study is considered by Patton as both maximum variation sampling and criterion sampling. Maximum variation sampling is a type of purposeful sampling which "aims at capturing and describing the central themes or principal outcomes that cut across a great deal of participant or program variations" (Patton, p. 53). Additionally, Patton notes that the data

collection and analysis should yield both “high quality, detailed descriptions of each case which are useful for documenting uniqueness, and important shared patterns which cut across cases and which derive their significance from having emerged out of heterogeneity” (p. 53). The data I have collected do include rich details of the different families’ unique situations; yet patterns have emerged from the data that suggest trends among the families. The sample for this study can also be categorized as criterion sampling. Criterion sampling involves the review and study of “all cases that meet some predetermined criterion of importance” (Patton, p. 56). The criteria for my sample was that families had to have participated in the program for at least nine months. The point of criterion sampling, notes Patton, is to “be sure to understand cases which are likely to be information rich” (p. 56). The sampling for this study was determined by the Healthy Families Coordinator, the evaluation advisors from Marshall University, and the graduate student ethnographers (including myself).

### Consent

Prior to embarking upon the study, informed consent had to be granted by the participating families. When each family enrolled in Healthy Families America, they gave consent for their file to be reviewed at any time for research purposes. The statement includes a promise that the names of families will remain confidential in any study performed. Additionally, families were informed of their right to leave the study at any time and assured that their privacy would be protected throughout the research process (Appendices A and B).

Additional steps were taken to ensure the privacy of the families involved in the study. Before beginning data collection, I signed a confidentiality agreement stating that I would ensure the privacy of all families involved in the study. Also, as I began each family's file review, I assigned each child in the family a number to eliminate the use of names on any of the data. The number assigned to each child was placed at the top of all documents regarding that child and their family. A total of 27 children from 21 families were included in this study. The complete data set contains no names of immediate family members used in the study. To protect the privacy and confidentiality of all participants and HFA staff members, I gave pseudonyms to all individuals whose quotes I included in my findings.

### Data Collection

Data collection began in May, 2001 and continued through July, 2001. Data were taken from the family files of the 21 families chosen for the evaluation. To begin collecting data, I examined several specific aspects of each family's file to determine family functioning, challenges, strengths, and weaknesses. After an initial reading of three files that were to be included in the study, I was able to begin conceptualizing the way I would eventually organize the information from each file. I decided that I would be able to collect data in a systematic fashion if I created collection instruments that allowed me to look at specific areas of each family's file. Using Microsoft Excel, I designed six data collection forms to make the research process more manageable. These forms, which will be explained in-depth in the following paragraphs, were used to record data regarding all aspects included in each family's file. The forms served as tools for

organizing the information from each file. I searched for and recorded indicators of well-being such as immunization completion, service provided by a primary care physician, and the families' abilities to deal with challenges.

The data were recorded by hand on the already-made forms, based upon the information found in each family's file. Bogdan and Biklen (1998) note how this particular method of qualitative research varies somewhat from the best known strategies, such as participant observation and in-depth interviewing. Bogden and Biklen note that in participant observation studies, the researcher "enters the world of the people he or she plans to study, gets to know them and earns their trust, and systematically keeps a detailed written record of what is heard and observed" (p. 3). I, on the other hand, collected data through reading files and talking with Family Support Workers in two Healthy Families offices. To my knowledge, I have never come face to face with any of the program participants included in this study.

I used a variation of the other most widely-used qualitative research technique, in-depth interviewing. After collecting all the file data, I completed short, focused interviews with Family Support Workers who had families in the evaluation. The goal of these interviews was to clarify any confusing information I had found in the family files, and to ask the Family Support Workers about each family's and each child's level of functioning. I will explain my interviewing techniques more fully later in this section.

I began data collection by gathering information from each child's immunization records found in the files. Each family's Family Support Worker is responsible for getting each child's immunization records from the child's parents. Immunization schedule recommendations from the American Academy of Pediatrics were used to

determine whether or not each immunization was given on time, as reflected in the files. I recorded the name of each immunization and the date administered on this first form (Appendix C). I also noted whether or not the immunization was on time, by a “yes” or “no” in the appropriate column. The third type of information included on this form indicated whether or not the family had identified a primary physician for the child. I noted this by writing the name of the child’s physician at the bottom of the form.

I used the second form I developed to record each baby’s score on each of the Ages and Stages Questionnaires given to date (Appendix D). The Ages and Stages Questionnaire series is one that this particular Healthy Families program uses to assess the development of the babies of participating families. Ages and Stages, as they are commonly referred to, are given periodically to each baby, and are designed to track developmental achievements of the babies. Required Ages and Stages assessments are administered at 4, 8, 12, 16, 20, 24, 30, 36, and 48 months of a baby’s life (Interview with Ramona, Coordinator). Additional questionnaires may be given at 6, 10, 18, and 22 months. The questionnaire is administered by a Healthy Families representative and/or a family member. Questions are related to five different developmental areas that assess the baby’s ability to perform certain tasks. The developmental areas assessed in each questionnaire include fine motor, gross motor, personal-social, communication, and problem solving. Benchmarks are established on the questionnaires to determine when intervention should be considered. For example, in the six-month questionnaire, a child scoring below 30 in the area of personal-social development would probably require outside intervention from another program, whereas anything below a 45 in the same area would possibly require intervention in the 36 month questionnaire. For the study, I

recorded each baby's scores from each of the five assessed areas, as well as the name of each questionnaire and the date it was administered.

The next two forms used in family file evaluations consumed a large percentage of the time spent on each file. With each file review, these two pieces consisted of several pages of hand-written data that documented the events and interventions occurring with each family. One piece, which I termed "Section Three: Narrative," simply tells the family's story (Appendix E). A family's narrative was generated based on descriptive entries found in the family's file. Some families had relatively few problems, or had been in the program a shorter period of time than others, and therefore only had three or four pages of narrative. Other families faced far more challenges, had more than one child, and/or had been in the program longer. For several of these families, I generated narratives that are 12-17 pages long. Each family's narrative reflects the major events that were occurring to and around the family, specifically the child(ren).

The fourth form, which I dubbed "Section Four: Interventions," was similar to the narrative in that the length of each family's time in the program, as well as their needs, determined the number of interventions completed by the program staff. On this form I dated and described all HFA interventions for the family (Appendix F). Whereas most interventions were completed by the family's assigned Family Support Worker, the Coordinator, Supervisor, and other FSWs sometimes intervened for the families.

The fifth aspect of the data collection was focused on family background information. I entitled this piece "Section Five: Family Background Information" (Appendix G), and it turned out to be relatively useless, because the same exact information could be found on the Kemp Family Stress Checklist, which is completed by

a Family Resource Specialist or the Coordinator before services begin. The Family Stress Checklist looks at several different areas of the parents' functioning, including their childhood history; substance abuse, mental illness, or criminal history; previous or current child protective services involvement; self-esteem; stressors; potential for violence; expectations of the infant's milestones and behaviors; discipline of the child; their perceptions of the new infant; and bonding or attachment issues. Instead of recopying all the information from one sheet to the next, I decided to make a copy of each family's Family Stress Checklist and include it with the rest of their file review.

The sixth form I designed was the "Section Six: Researcher Log" (Appendix H). On this log, I wrote questions or concerns I had about each family as I reviewed their file. Many of the items I identified just needed clarification from the FSW, such as the meaning of certain initials used in the file. Other concerns required further explanation from the FSW, or another look into the family's file.

After collecting data from all files and completing researcher logs for each file, I arranged a time to speak with each FSW about the families she serves. The FSWs gave me written consent to record and transcribe the short (usually five to fifteen minutes in length) interviews. Interviews with the FSWs were transcribed verbatim. During these interviews, I asked questions I had already identified on the researcher log. I also asked the FSWs to place each family, and then each child in the family, on a continuum of either high, middle, or low functioning, and to explain their placement of each family and child on this continuum. The interviews turned out to be among the most useful strategies I utilized to gain insights about the families included in the study.

After completing the above data collection, I calculated the total number of contacts the program had with each family since the family began the program. I decided this information was important to gather because I initially thought that families who were lower in functioning might be more difficult to make contact with. For example, I thought I might find that FSWs were able to complete more scheduled home visits with families that were more independent than those families whose immediate needs, such as housing and food, were serious, daily challenges. These data are purely numerical, and were generated from the monthly contact logs that the FSWs must complete on each family. The HFA monthly contact log is housed in a specific section of each family's file. After reading through some of the family's contact logs, I decided to generate a seventh data collection piece that would allow me to see at a glance the total number of contacts the program had made with each family during each month of their participation. The Microsoft Excel form I created is entitled "Section Seven: Contacts" (Appendix I). This form identifies several specific types of contacts, as well as attempted contacts, the program affiliates may make with families.

### Validity

With qualitative research, validity is crucial to establish. Patton (1990) suggests that validity in qualitative research "hinges to a great extent on the skill, competence, and rigor of the person doing fieldwork" (p. 14). To ensure the validity of the data I collected, I spent a great deal of time perusing each family's file. I dedicated approximately 150 hours to collecting data from the files. Additionally, I included member checks to promote the validity of the study. Johnson and Christenson (2000) describe member

checks as a strategy of participant feedback in which “the feedback and discussion of the researcher’s interpretations and conclusions with the actual participants and other members of the participant community for verification and insight” are used to help ensure validity. During interviews with the FSWs, I often asked for clarification or more information about the data I had already collected from the family files. Moreover, I allowed the program Coordinator to read drafts of the program description included in this thesis. The Coordinator is the person who is the most knowledgeable about the way the program functions. She was able to give me feedback and validate the program description I had written.

### Data Analysis

I employed several strategies to analyze the data I collected. No formal coding methods were used, as the forms on which I had gathered the data had already coded the information from the family files into specific categories. I began analysis by examining the Ages and Stages Questionnaire results. For each completed questionnaire that each child was administered, I averaged a score from the results of questioning in the five different developmental areas(see Methods section for a list of these areas). For example, if a child scored 50, 45, 55, 50, and 50 in each of the five developmental areas on the eight month questionnaire, the child’s eight month Ages and Stages average would be 50. The instrument I used to collect Ages and Stages data allowed me to record all the scores from each child’s performance from every Ages and Stages questionnaire administered (Appendix J).

When collecting data centering around the number of contacts reported by HFA program workers each month, I documented the number of contacts and attempted contacts the FSWs reported making with each family during each month of participation. The data contains instances of actual contacts reported between the FSW (or other program worker) and some member of each participating family, whether in person or over the phone. Contacts I added to my data include scheduled home visits; unscheduled home visits; other contacts; Healthy Families group sessions; telephone calls; transportation; and contacts with family members other than the primary participating family. After compiling the total number of contacts reported between the program and participants, I calculated the number of months each family had participated in the program. Then, I averaged the number of contacts made per month, as reported by the program (Appendix K).

To further analyze the functioning levels of families, I divided the 21 families included in the evaluation into levels of functioning, based on evidence from my file reviews and analysis, and interviews with each family's Family Support Worker. I categorized each family as either high, middle, or low functioning. Additionally, I grouped the children into optimal, middle, and lower developing categories, again based on the above evidence. Through inductive analysis, I looked to see what type of trends or patterns emerged from families and children in each grouping. Patton (1990) notes that "observational data must have depth and detail. The data must be descriptive—sufficiently descriptive that the reader can understand what occurred and how it occurred" (p. 26). I was the reader of the family files. The more descriptive the FSWs were in detailing the families' lives, the easier it was for me to gain a clear sense of what

was really happening to each family. Further, the more detailed I was when collecting data and organizing it into categories that looked for specific types of information, as seen in the coding forms, the easier it was to paint a picture of maximum variation, meaning that even though the families had unique stories, many possessed similar characteristics. The next chapter will more fully describe characteristics of the families included in the study, as well as the findings that resulted from the methods I utilized.

## CHAPTER FOUR: FINDINGS

### Introduction

In this section, I present the information found from the data I collected. I first describe the methods utilized by the program to achieve optimal operation. Then I will present general information regarding the families included in the study. The data from the forms I used to gather data will reveal the program's success at meeting goals. Additionally, I will weave together the stories of several of the 21 families as described to me in interviews with the FSWs and in each family's file to show readers the challenges and successes families experience. The goal of this section is to demonstrate how, and the extent to which, the program has met each of its goals, as defined by Healthy Family America's set of Critical Elements, which were presented in the Methods chapter.

### Program Operation and Participants

This section addresses findings regarding the methods of program operation on the local level, as well as basic information taken from the family files about the families. The subsection on program operation will discuss how families are enrolled in the program, the roles of various Healthy Families America staff members, staff training methods, and general program features. Basic participant information, such as ages of the babies and their parents, educational levels of parents, and an introduction to the challenges some families face, are found in the Participant subsection.

## Program Operation

After reading the family files and program informational literature, and talking with the program Coordinator, I quickly learned about the way the program operates. According to the program Coordinator, mothers participating in HFA must be pregnant with or have just given birth to their first child. This varies from the national HFA model, which does not place a stipulation on mothers regarding any previous births. Fathers, however, can have children from previous relationships. Families are initially evaluated for risk factors by the completion of the Kemp Family Stress Checklist, which is completed by a Family Resource Specialist after meeting with the family. Previously, Family Resource Specialists were titled Family Assessment Workers; however, the Coordinator and other employees of the program felt that most families would much rather have a *Family Resource Specialist* visit their homes than a *Family Assessment Worker*. Many employees felt that a negative connotation was being associated with the former job title. The Healthy Families program studied utilizes two Family Resource Specialists who perform initial assessments in the form of the Family Stress Checklist and other narrative documentation, which is all included in the family's file. The Family Stress Checklist is a standardized assessment tool used to systematically identify families who are most in need of services. Use of this tool by the program workers to seek families who are likely to benefit from services meets the HFA Critical Element that requires a consistent way for families to first be evaluated to determine if there is a need for services. A certain number of points are given for each stressor according to the intensity of each family's situation. If a family scores at or above a 25 on the checklist, the family is considered at-risk, and is eligible for HFA services. If the family is

considered at-risk for possible abuse or maltreatment and is receptive to services, then an invitation to join the program is extended. Participation in the program is voluntary, as is participation in this program evaluation.

According to the Coordinator, once a family is invited to join the program, a Family Support Worker (FSW) is assigned to the family by either the Healthy Families Coordinator or Supervisor. The Coordinator of the sites included in this study manages three Healthy Families sites, which are located in two West Virginia counties. The Coordinator works to ensure the success of the program by supervising all HFA staff members. She often goes beyond her immediate duties by corresponding with already established families, performing initial visits with new families, and even taking over the duties of vacant staff positions. The Coordinator has a Bachelor's degree in social work. Immediately beneath the Coordinator in command are the site Supervisors. Supervisors work closely with the Family Support Workers in the implementation of services for families in the program. Additionally, the Supervisors meet individually with each Family Support Worker on a weekly basis to discuss the progressions and challenges of each family with whom the FSW visits. At this time, possible goals are addressed for each family. Also, the FSW and Supervisor collaborate to come up with ways to help families reach these goals and overcome both current and longstanding challenges they are facing. The Supervisor completes a log each week detailing each meeting, and the logs are kept in each family's file. Also, the Supervisor completes home visits and other forms of correspondence with families when necessary. Supervisors have Bachelor's Degrees in human service-related fields.

### Family Support Workers

The role of the Family Support Worker is perhaps the most crucial in the success of the program. Program staff, including the Coordinator and several FSWs, offered information regarding the duties of FSWs. The Family Support Worker is a paraprofessional who actually implements the goals of the program with the participating families. FSWs receive several different types of training at the onset of employment; training continues throughout the first six months of their tenure. Family Support Workers receive 32 hours of core training, which is provided by certified Prevent Child Abuse America trainers, prior to providing services to families. An orientation is also provided during the first weeks of employment. Topics that are covered during orientation include program goals, services, policies, and procedures; child abuse and neglect indicators and reporting requirements; relationship with other community providers; the history and philosophy of home visiting, and issues of confidentiality (interview with Ramona, Coordinator). Additionally, FSWs complete a total of 88 “wrap around” training hours over a period of six months after employment. These training sessions vary in topic. In each session, FSWs learn about issues both they and their HFA families may face. Topics that are covered in the wrap around training sessions include infant care; child development and health; parental health and well-being; language development; the role of culture in parenting; family violence; substance abuse; parental issues; HIV/AIDS; and staff-related subjects (interview with Ramona, Coordinator). Sessions are usually presented by local experts in the various fields. The Coordinator seeks individuals from other local agencies who can present on a topic about which they possess ample information. For example, speech pathologists are often brought in to

implement trainings on language development. Sometimes individuals within HFA will complete these trainings if they possess expertise in a particular area of content. For example, one of the local HFA Supervisors has taught birthing classes for several years; therefore, she usually completes training on labor and delivery, which would fall under the category of parental health and well-being.

The role of the Family Support Worker is to help families identify and reach individualized goals, despite the numerous challenges the families may face. The Family Support Worker helps families achieve their goals by implementing interventions that range from reminding parents about taking their child to a well-baby visit, to problem solving with them about how to find baby formula or adequate housing. The interventions are not a substitute for family functioning, but are a springboard for families to eventually gain enough autonomy so they can perform tasks and achieve more goals independently. Additionally, according to the Coordinator, FSWs, and family files, the FSWs strive to provide emotional support in times of crisis, while remaining non-judgmental about the choices a family may make.

The FSWs take on caseloads small enough that they can visit and communicate with families the required number of times for each family each month. Depending on the level of need, families are assigned to a level of service. For example, Level I families must be visited by the FSW at least weekly, while families at Level IV are only required to be visited at least quarterly. The level of care for each family is assessed periodically; when families progress or regress, their level of care is adjusted accordingly. Throughout the family's participation in the program, the Family Support Worker remains closest to the families, often forming close relationships with them. One Family Support Worker

was particularly descriptive in explaining the nature of her close relationship with the families with whom she works:

I jokingly say that the mothers and fathers are my children and their children are my grandkids. That's kind of how you see it. You feel protective for them... You're happy when they're happy. You're sad when they're sad, and that's a lot to take care of. It's a lot, and it's hard to do (interview with Jessica, FSW).

### Participants

Twenty-seven children were included in the evaluation. The children ranged in age from five months, nine days to 51 months, 24 days at the date of their family's file review. Twenty-one families were included in the evaluation, as five of these families had multiple births. All of the families were enrolled in the program when the mother was either pregnant or had just given birth to her first child. This demonstrates that the program reached its Critical Element goal of initiating services prenatally or at birth.

### Mothers and Fathers: Basic Information

The mothers and fathers included in the study varied widely in age. Of the 22 fathers included in the evaluation, the birth dates of only 10 were recorded in the files. Perhaps the dates simply had not been recorded by the Family Support Worker; however, the identity of some fathers was not known. Of the ten fathers whose birthdays were recorded, the average age of each father at the birth of their first HFA baby was 23 years, 0 months. Fathers varied in age from 17 to 47 years at the birth of the HFA baby. The average age for the mothers at the birth of their first baby was 21 years, six months. Appendix L shows the form used to gather data regarding the ages of mothers and fathers

at the birth of their first HFA baby. Each mother's birth date was found in the files. The mothers ranged in age from 16 years, 3 months, 4 days to 35 years (no birth date available) at the birth of their first child. The majority of the mothers, however, were teenagers or in their early twenties. Only four mothers were over thirty years of age.

I also determined the educational levels of the mothers and fathers included in the evaluation. Appendices M and N are the forms on which I gathered data regarding the educational levels of participants. The educational levels of ten fathers were unknown; nine had "some high school"; one had received a G.E.D.; three had earned a high school diploma; one was enrolled in a trade school; and one had attended a university. Information on the mothers was more available than that on the fathers. In fact, the HFA workers documented the educational levels of each mother in her family's chart. One mother had an education below the eighth grade level; nine mothers received "some high school" (their exact amount of completed high school education is unknown); two had ninth grade educations; three had G.E.D.'s; seven received high school diplomas; one had technical training; two attended a community college; one was enrolled in a trade school; and three had attended a university. From these findings, it is obvious that the many of the participants faced challenges in attending school. Either the importance of receiving an education was not fostered by these individuals' families, or other challenges (such as finances, pregnancy, or family crises, for example) did not allow many of the participants to complete a great deal of schooling.

#### Stress Factors

Numerous stress factors were present for many of the families included in the study. Drug and alcohol abuse, domestic violence, mental illness, and a lack of resources

were the most prevalent stress factors that families faced. The Kemp Family Stress Checklist and initial assessments taken by the Family Resource Specialists or Family Support Workers were especially helpful in determining stress factors for the families. Other areas of stress evaluated by the checklist include current or past Child Protective Services involvement; childhood history (of the parents), presence or lack of self-esteem, available lifelines, discipline issues and expectations of the infant as he or she develops, and bonding or attachment issues. As current literature suggests, challenges such as the ones HFA families face can affect the functioning of the families in many ways. The challenges families encounter on a regular basis make it difficult to function normally, and in turn, often make it difficult to foster the optimal development of their child(ren). This next section will relate the plights of some of the families included in the study who live with some of the stressors found among several HFA participants.

### Facing Challenges

All the basic information I collected from the family files, such as educational levels and ages of participants, helps to describe the situations many families face. However, the detail-rich data I gathered from both the written sections of the family files and FSW interviews provide a much more personal view of the challenges many of the families face. Moreover, these data provide insight regarding the extent to which the HFA goals have been met by service workers. Some challenges are experienced by many of the families. These challenges include financial instability, domestic violence, drug abuse, and mental instability.

### Financial Instability

Virtually all the families included in the study have financial needs documented in their files. Families with two competent adults running the household, whether husband and wife, boyfriend and girlfriend, mother and daughter, etc... where at least one was steadily employed seemed to not have as many financial hardships as those families who were composed of a single adult heading the household. On many occasions, family files revealed that a family member had called in saying they had no more formula to last until their next relief check or WIC (Women, Infants, and Children) voucher came in. Also, sometimes families reported being without food to feed their older children or themselves. Intervention by FSWs at these times generally consisted of referring families to alternative non-profit agencies where they could get food to last through the crisis; often, FSWs brainstormed with families about ways to gather the money required to buy the needed supplies.

Another financial challenge for some families involved paying rent and utilities. During these crises, FSWs worked with families to brainstorm ways for them to get the necessary funds, or referred them to assistance agencies that could help families pay outstanding utility bills. In times where rent was the issue, FSWs intervened in similar ways as above, but sometimes families had to consider moving to subsidized housing where the rent was usually more manageable than their current monthly rent. If this was the case, FSWs often helped families fill out the necessary forms to apply for or become eligible for different living situations. Despite the efforts of FSWs to help families, the uncertainty of financial instability weighed heavily on many of the participants.

## Domestic Violence and Drug Abuse

These stressors are grouped together because when one was present in the home, the other was usually also present. Some of the mothers included in the study were in relationships with men who had abusive tendencies and even criminal backgrounds. One teenage mother, Natasha, age 16, had her baby with an 18 year old boyfriend who served time in prison. “Drugs was the initial charge for going to prison but then he held Natasha at gunpoint” (Interview with Abigail, FSW). Since he was released from prison, Natasha’s FSW tells me that

he and Natasha have resumed their relationship, and he is controlling her and everything still yet, and I believe that’s why I haven’t seen Natasha in awhile—I don’t think he liked my involvement with Natasha and the baby. Natasha’s phone has been disconnected and I’ve dropped by several times and there’s no answer at the door, and I’ve gone by her work, too. And I’ve written her numerous letters, and it’s not like her not to get back in touch with me—she’s always been good about that.

During the months following this interview, I learned that Natasha had resumed regular services with Abigail, and has become pregnant with her second child from the same father. After noting to Abigail that Natasha was quite young, Abigail replied “yes, and surprisingly enough, she’s very, very, very appropriate with the baby. She’s had good influences from the maternal grandmother.” As for the baby, Abigail says he’s functioning very highly—“doing really great” despite the challenges his mother has faced.

Another example of how drug abuse and violence has affected the functioning of a participating family is seen in the story of one 33-year-old woman, her drug-abusing live-in boyfriend, and their baby girl. The father of the baby admitted to the FSW that he had a chemical dependence, and that he was wanted by the police for an outstanding charge of “fleeing.” The father was eventually taken to jail, placed in a detoxification unit, sentenced to six months in jail, and then placed on home confinement for one year. During this time, he was given regular drug tests. “There was someone coming over and giving him a drug test every night and he had to go to work—he had to check in” (interview with Debbie, FSW).

Shortly after the father’s home confinement began, the logs reflect that the family seemed to be functioning better. One day when speaking to the FSW, the father said “I have two miracles God has given me—my daughter and my freedom.” Just four months after the father was placed on home confinement, in June, the mother confided in the FSW that she felt the father was abusing prescription morphine he had received after wrecking his truck. Over time, the mother said she never felt they would have “a real family” because of the father’s addiction to prescription drugs. After the father was taken off home confinement, problems arose. “The day he got off of home confinement, he got back on crack...I mean, they had all these plans to go on vacation, and ...it was just so unbelievable that he would go the very day and you know, get caught up in that again” (interview with Debbie, FSW).

By March of the next year, the FSW noted that the baby was acting aggressive, and the mother was withdrawn. The father continued using drugs, including crack cocaine and pot. The father once assaulted the mother in the head with a screwdriver

because the mother would not give him money to buy crack cocaine. The father is currently in jail and the mother is caring for the baby, who is often aggressive, spitting and hitting the mother and FSW when they get near. In the last home visit record I documented, the mother told the FSW that “tomorrow is a new day and I will survive.”

When I asked Debbie how she feels the program has helped the family, she noted

I believe that we've been a stability in her life. The baby is very, very bright, but I think that is because [the mother] has worked with her. [The baby] is kind of aggressive because of the stuff she's been around, and she's two [years old].

...I think we've been like a sounding board...the other day I was talking to her [the mother]... and she actually told me that we have been really good about not making judgments on her life and giving her an option. And sometimes you don't realize you're doing that...You think 'well I hope I didn't sound negative or I hope I didn't push her too much in one direction' because it would be really easy to go in there and say 'look, get over him. He is bad news.' But we've got to take into consideration that later on he may be back in the picture, and then there wouldn't be any kind of links to her.

...So I think maybe we've just been a support, or a sounding board. She'll call and ask if there's some kind of service available to her. And as far as information about the development of the baby—we do provide that for her and I think she enjoys the information (interview with Debbie, FSW).

This family is just one of several who experiences challenges that are difficult to overcome. Unhealthy relationships and situations result when these negative factors occur in the lives of most families, especially those who are already facing additional challenges. The next subsection will address the challenge of mental illness, a factor that affects many individuals in our society.

### Mental Instability

When mental illness is present in the family, members face challenges that can seem overwhelming. Ann was 18 years old and living with a friend when she began participation in the HFA program. According to her FSW, Ann has “a bipolar and manic depressive disorder,” and deals with the challenges of her mental illness as the illness often affects her ability to achieve set goals. This family has a “surrogate” father who thought for some time that he was the biological father of the baby. Blood tests revealed he was not, yet he remains a stable presence to the mother and her children. This family’s FSW notes that they are probably middle functioning, because of Ann’s illness:

We knew there was a history of mental illness, just by her telling us about her history and stuff. But we—over the process of the couple of years we’ve worked with her, we have actually been able to see a lot of the mental illnesses. Like sometimes, she has a mood stability problem. Like one minute she will be real happy and like ‘I’m going to do this’—ready to conquer the world, and then at other times she’s confused and gets really angry...you know how you see some people that are bipolar or manic depressive, and maybe in like three months you see a difference? Well I think that maybe when we were starting to work with her

she was on the high end of that and we've just kind of seen the differences in the cycle (interview with Debbie, FSW).

Despite the mother's obstacles with her illness, the FSW notes that "the baby is very intelligent and his motor skills are very high—probably even on the high end of development."

Logs in Ann's family file demonstrate that the interventions for this family were uniquely focused on the events and challenges surrounding the family members. Some of the interventions include providing information on domestic violence; discussing prenatal changes and birthing plans; discussing infant brain development; brainstorming ways for Ann to meet her baby's needs and develop trust; discussing safe sex and STD's (after Ann was diagnosed with an STD); giving baby clothes; and modeling ways to play with the baby and how to use positive discipline with the baby. Additionally, Ann's FSW, Debbie, helped her deal with her mental disorder by allowing Ann to discuss her feelings and frustrations. For example, Debbie informed Ann of her counseling options on many occasions, and encouraged her to seek counseling because of her mental illness and the stressors she experienced. Yet another specific intervention for this family was providing transportation when Ann and her baby had no other way to get to appointments with physicians, the Department of Health and Human Resources, Early Head Start to see about enrolling the baby in the program, and to Ann's high school to discuss classes and eventually to pick up her graduation cap and gown when she received her high school diploma. From the logs found in this family's file, it is obvious that this family's FSW remained attuned to the needs of Ann and her baby in order to help the family improve in their ability to function.

### A Summary of Challenges

The anecdotes shared in the above subsections relate many of the major challenges HFA families face, often on a regular basis. As I perused each family's file, it became more clear that while some families' problems are less severe than others', it seems that the intensity and number of the challenges, along with other situational obstacles, influences the level of each family's functioning. As each family differs, so do the obstacles they face. Both the duration and severity of the challenges families endure contribute to their self-esteem and ability to set and achieve goals. The next section of this chapter will detail the functioning of several families from the study in order to relate how challenges affect different families in different ways.

### Family Functioning

Every HFA family functions differently. The number of challenges a family faces, combined with the intensity of each challenge, presents a unique set of obstacles each individual family must overcome. Conversely, each family may have certain positive influences in their lives that help reduce the effects of hindering challenges. As described in above sections, the initial evaluation and completion of the Kemp Family Stress Checklist seeks to discover each family's challenges in order to determine if the program is likely to be appropriate and beneficial to each family. With this in mind, all of the families in this study exhibit certain risk factors that make them eligible for HFA services. However, some of the families evaluated experience a plethora of challenges on a daily basis, while other families seem to have far fewer challenges to overcome. After grouping all families into low, middle, and high functioning categories, it was easy to see

that the low functioning families were very different from the families on the high end of the spectrum. In the following subsections, I will discuss some of the families from both the low and high functioning groups in order to demonstrate representative trends from both groups. Through my research, a large difference became clear from families who were considered low functioning than those who function highly. I selected to discuss the following families because their stories reflect many of these differences.

#### The “Lost People”: Low Functioning Families

Those families who were considered low in functioning possessed many of the same traits that made it difficult for the family members to achieve goals. Drug abuse and alcoholism were common problems often facing low functioning families. Moreover, any form of strong social or familial support seemed to be absent with these families. It is with these families that program staff often spent more time than with families who seemed to function at higher levels. Next I will share the plights of some families who, based on reviewing their files and talking with their FSWs, seem to function at low levels.

#### Christina and Randy

Christina, age 19, and Randy, age unknown, parents of a 14 month old boy, have been described by their FSW as “very intelligent, very, very bright, and very smart—very clever.” Yet neither parent has a job, and Christina “really seems to have a hard time sticking with something. You know, like she’ll get a job and then get fired” (Interview with Debbie, FSW). Data taken from the family’s file indicate that Christina felt she “had nothing to offer the baby” before he was born. Christina had no high school diploma, job, or driver’s license when this family enrolled in the program. Debbie assisted Randy and

Christina with a housing application, and the two moved in together shortly before the baby was born. Christina also got her driver's license, and eventually received her G.E.D. After the birth of the baby, Debbie noted the existence of alcohol bottles and cans at several home visits. Christina reported on many occasions that she "had been out drinking the night before." When Christina became pregnant with her second child, she reported to Debbie that she received an abortion to terminate the pregnancy. Despite all this, Debbie reported that both parents participated in many home visits and were often affectionate toward their baby. Christina reported that their baby's doctor said the baby was healthy and alert.

When asked to categorize this family's level of functioning, their FSW commented the family seems to be functioning low,

from just not being able to stick with things. The baby is—I would say he is medium functioning. But the family, when I go over—well, they sleep a lot. But this mother, it's like all of a sudden she'll wake up and she'll try to do everything, and then she'll sleep. And I'll be, you know 'what about this?' that needs done, and she just doesn't stay on task very good. Which is really unusual, because as far as intelligence, you know, when you talk to her, you just know that she's so bright! And she could do whatever she wanted to do, and we were talking about that yesterday. She was telling me how she had been fired from a housekeeping job at a hotel. And I said to her "Christina, what are you doing? The first thing is, you're just too smart to do that, no offense, but just have so much potential to do whatever you want to do. You've just got to stick to something."

With the families they serve, FSWs attempt to determine the causes of the challenges families face in order to help them change unhealthy situations and reach goals. When I asked their FSW about what she thought was keeping Christina and her family from reaching their potential, the FSW noted

I believe that it's just the cycle. I think it's the way Christina's family is structured—her extended family. Her grandmother was an alcoholic. I also think her father was an alcoholic, and he also has some mental illnesses. I think that there's drugs—prescription drugs that are easily accessed. They belong to this little group here in this area—it's like I call them the *lost people*. This same group—and I've had a little bit of experience with some of their friends in the group, too—and they all seem to sleep all day, and they're up until all hours of the night. And they hang out on the plaza there, and they can easily get the drugs. Prescription drugs. And you know, it's really devastating because you see these really good minds that are just going to jello.

The cyclic effects of abusive tendencies are evident from the above testimony.

As with other babies of families who seem to be low functioning, Christina and Randy's baby, a 14 month old boy, may have some delays. Debbie describes the relationship between Randy, Christina, and their baby:

As far as them loving him, I do believe they work with him some, because he wouldn't be where he's at developmentally if they haven't. He's done okay on the Ages and Stages except for the language development, which worries me a little bit, but I think that's just because they don't talk. I really think it's just a different family structure. I really wish she would get involved in something, and that's

something I hope to help her be interested in—to get Christina involved in some program and possibly get the baby in with a daycare so he could get some more interaction with other kids and maybe get him on a decent schedule. But you know it would be pulling him out of—this is how their lifestyle has been all their lives. And I don't think they would actually hurt the baby intentionally—physically or emotionally. I mean, she has never, never yelled at him or anything when I've been there. She doesn't seem like she loses her patience or anything. I mean, she's basically a good mother. But she just has those differences in family structure and a lot of issues. And sometimes when I visit her, it's like I'm not getting anywhere, but then other times we'll have a good talk, and hopefully she's going to get somewhere, we'll see.

This family exhibits characteristics that indicate how intensive services will need to continue by HFA in order to help the family help themselves. Yet this family remains at Level II, receiving a minimum of one home visit every two weeks, at the family's request.

#### Katie and Matthew

Another family that falls on the low end of the family functioning spectrum faces challenges from alcoholism and limited communication. This family consists of two married parents, Katie and Matthew, and their toddler son. Katie is 25 years old and Matthew is 28; neither have high school diplomas. The baby was planned and welcome, note FSW logs taken from the family files. However, alcoholism is a challenge that affects the capabilities of this family. The baby's paternal grandfather, who lives above

the family in an apartment, and Matthew are alcoholics. The family's FSW related the following to me during our interview:

I have been over there a couple of times where [paternal grandfather] and Matthew have been wasted, and it was like eleven o'clock in the morning. And I know that they've been sloshed. And Katie has said-once in a blue moon when she would talk, she would tell me a little bit about it. You know, that Matthew would start drinking, and he never really physically abused her, but verbally gets really aggressive and stuff.

Several notations in the family file logs show that on home visits, Matthew and his father would be sitting in the yard drinking at different times of the day, apparently already drunk, according to the FSW. The strains of alcoholism also affect Katie, according to their FSW. "At one point she said that she had drank because it was easier to just drink with Matthew than to, you know" (interview with Debbie, FSW).

As for the baby, this family's FSW feels he may be delayed in the area of verbal communication:

He just does not talk. I think it's because of him not getting that communication at home, you know. And I would tell them that, but it just never would quite sink in. And they are just not open enough, and I've tried, to get [other agencies] to come to the home. But they were like 'no'... You know I don't think Matthew really liked me or anybody really coming around... I've tried to get [the baby] into preschool, but Matthew says 'no' (interview with Debbie, FSW).

Though this family is considered low functioning because of their immense challenges, Debbie notes that the baby's basic needs are met by the mother, their home is always

clean, and Katie seems interested in her child's development. Alcoholism and the unwillingness to communicate with each other, as well as Matthew's intolerance of outside agencies are hindrances which have severely affected this family. Now that the plights of two low functioning families have been shared, the next subsection will present some of the families from the program who are considered higher in functioning than other participants.

#### High Functioning Families: What Are Their Characteristics?

Of the 21 families included in this evaluation, a handful could be considered high functioning at least most of the time. These families possessed similar traits. Access to employment and the desire to receive an education are factors that seemed to be common to the high functioning families. One other factor is the presence of at least one positive, stable person who cares for and is personally involved with the mother and child. The following examples show evidence of how the presence of the above positive factors can make a difference in the lives of families.

#### Sara and Jason

Not all families who began with numerous challenges remain in such turmoil.

Take for example the case of Sara, her two children, and Jason, the biological father of the youngest child. Sara has a history of childhood abuse from her father, and suspected marijuana use was reported by her FSW in the family file's logs. In fact, when she began to participate in the program, this mother was associated with the family previously described (Christina and Randy), and the "lost people". Family file logs reveal that after the birth of the first baby, Sara rarely interacted with her baby. The maternal grandmother provided the majority of the baby's care. The first baby's father is uninvolved with the

family; in fact, her FSW had no information about him. However, Jason is “the father to both babies, really,” notes her FSW. This man is a high school graduate, and the FSW notes how he seems to have made a positive impact on Sara:

I’ve met his family, and they are very supportive of him. And I think he gives Sara stability. And I just think he’s a real good influence. I think that she follows through more because he kind of pushes her. And he’s there to help, of course, with the babies. And he’s interested in the babies. And when I say the babies I mean both of them. I mean, Jason is very good with both babies. I’ve seen a lot of changes since he’s been in the picture, you know, with her. She seems to feel a little bit more positive about herself (Interview with Debbie, FSW).

At the time of the evaluation, Sara had gotten her GED, and both parents were trying to get into a trade school. The older baby lives at the maternal grandmother’s much of the time as a result of the early bond formed between her and the baby, and because the younger baby experienced many complications at birth. Born three months early, the younger baby is “a miracle,” says their FSW. “He seems to be moving right along. Now, he is going to be delayed for awhile because he was a preemie. But as far as I can tell, he is developing probably on the four to five month level, which is right for when he was supposed to be born (in Feb. 2001)” (interview with FSW).

#### Ellen and Henry

Another family which is considered high functioning consists of two unmarried high school graduates, Henry, age 21, and Ellen, age 19, and their infant child. Henry has a full time job working in a local factory, and Ellen comes from a family of “very high

functioning, upper middle class people” (interview with Debbie, FSW). This family is no longer in the program, as Ellen was signed up to attend a local technical school.

She will be involved with that program—I believe it’s a program for a surgical tech, and so—well she’s a very high functioning person. She just didn’t need our services, you know, it was really hard for her to keep our appointments because she was always so busy and trying to get things settled. I mean she’s in school and the baby’s in daycare now, full time. I mean she hated to drop out. I remember the day she called me and I think she was afraid she was going to hurt my feelings. But it was like I’d rather them be honest. So that’s why—she just got busy  
(Interview with Debbie, FSW).

The baby in this family was developing “really good. I mean you could just tell [the mother] was really interested in his development and she read a lot of stuff. And [the maternal grandmother] was a nurse, so they were like really up on things, you know, as far as development, and knowing to ask questions, and stuff” (interview with Debbie, FSW). It is apparent that this family’s familial support, when tied with employment and access to education, are positive factors that have helped them become successful.

#### High Versus Low Functioning Families

From the above examples of families who can be considered both high and low functioning, it is apparent that even though all families face challenges, they can overcome many of their challenges if certain positive factors are present in their lives. Having one stability factor in a person’s life seems to offer positive results most of the time. Additionally, when one has access to and the ability to take advantage of

educational advancement, they will probably be more likely to succeed. Employment is another factor that seems to improve the chances of overcoming challenges.

In addition to the number of challenges families may face, the intensity of each challenge must be considered when working with families. For example, as seen above with Sara and Jason, Sara was abused as a child, and also was suspected to have abused marijuana. But these challenges were not so prolific that she could not overcome them. The presence of Jason in her life, along with the support her FSW, Debbie, seemed to be positive factors that increased Sara's ability to reach goals and function at a higher level. The support HFA staff members provide to all participants, no matter how the family functions, is key in providing high-quality services. The next section will address Critical Elements that demonstrate how HFA reaches its clients to the best of its abilities.

### The Nature of Service Implementation

The importance of providing high quality services to families is identified and explained in HFA's set of Critical Elements (see Research Methods chapter for a detailed description of these Elements). In order to ensure that families are best served, HFA mandates certain requirements that increase the likelihood of both program and familial success. Several different aspects of service implementation are enacted by the program. In the following subsections, Critical Elements regarding the limitation of caseloads, remaining positive and persistent, and providing intensive services to participants will be addressed.

### Quality Time: Limiting Caseloads

The Healthy Families America organization mandates that each FSW should only be responsible for a limited number of participants in order to provide the highest quality of services as possible. HFA's Critical Elements note that "home visitor caseloads should be limited for several reasons" (1997, p. 22). Obviously, limited caseloads allow FSWs to spend more time with each family, thus increasing the probability that strong bonds will be formed between families and their FSW. Having a limited number of families to work with also facilitates "intensive and responsive services" (1997, p. 22), in order for FSWs to work with families and help them develop and implement realistic service plans. Limited caseloads also provide more time for training and reduce the likelihood of FSW burnout and staff turnover (Critical Elements). According to the local HFA Coordinator, Ramona, FSWs at the program studied carry loads of approximately 15 families each, but this number will depend on the level of service of each family, as well as the severity of challenges facing each family.

Each family served by HFA requires a different amount of time from their FSW. Most families require more time and attention from FSWs when they first begin participation, but many become stable after time and require less attention. Some families, particularly those with numerous challenges, require intensive home visiting services. Other families may only require intensive services at certain crucial points in their lives, when intense challenges arise. For example, when families are evicted from their home or when they are unable to provide their baby with adequate food until their next check comes in, their FSW will make that family her top priority until the crisis is solved. A balance must be decided and weighed each day by FSWs so they can

adequately serve families. Family Support Workers must have enough time in their days to communicate and interact with, and advocate for the families they have been assigned.

Documentation of events is another time-consuming aspect of the FSWs job. Each form of communication with each family or outside agency, as well as each phone call, intervention, or attempt at communicating or intervening with families must be documented in each family's file. This is another reason why FSWs must have a limited number of families to serve. According to the local HFA Coordinator, Ramona, FSWs at the site studied do a more than adequate job of reaching families. She reports that the home visit completion rate for 2001 was 96 percent, which is much higher than the national HFA average. In a later subsection of this chapter, I discuss my findings regarding contact completion rates of the local program.

#### Remaining Positive and Persistent

The Critical Element of providing positive, persistent outreach efforts to build family trust is one which program workers strive to maintain daily. Each day is different for each member of the HFA team. For example, a typical day for an FSW may include some type of correspondence with families (by phone or in person), advocacy for the well-being of families, documentation, and other forms of communication with the families and outside agencies affiliated with families. In addition to the daily duties required of each FSW, they must also remain positive and accepting of the decisions made by the families they serve. However, even though FSWs are required to remain nonjudgemental when communicating with families and agencies who serve families, FSWs may still form their own personal views of family members. As previously mentioned, it is the job and responsibility of each FSW to remain positive and open to

families despite any personal views, grudges, or discrepancies they may have against family members.

For example, when reviewing one family's file, I found the logs written by the FSW nonjudgemental and unbiased, except for a few notes such as "[mother] still in dreamland, doesn't realize importance of school, career, stable home, paternity. A lot to learn." During my interview with the FSW, I learned that she appeared to have some strong discouraging feelings about this mother.

Personally, [I think] she has no business having kids. And I know that's terrible for me to say because I'm a mother and someone might say that about me some day, but you know, this is not anger talking, this is not frustration talking, this is not burnout talking, this is the God's truth. I know the only reason she wants these kids is so she can get a check...She's terrible with the kids. Baby 2 [age 3] is responsible for baby 3 [age 1 ½]...

...[the mother] really needs guidance...There is just no getting through to her. I mean I would bring her out some information...and she just doesn't want it. She just wants another check. She thinks that everybody owes her something. And she's always been this way, from day one...honestly, I don't know why she's in the program (Interview with Jessica, FSW).

When I asked the FSW how she would categorize the family in terms of functioning, she replied:

so frustration won't talk, I'll say medium, because she does provide for the babies' basic needs. As far as her interaction with the kids—I think that's

downright terrible. But I will say that their basic needs are being met...I just hate that we are ending [our interview session] with her because I was on such a high note from talking about all the other families. It's just very frustrating. There's nothing really positive to say about the family, except for thank God the kids have the intelligence they have (Interview with Jessica, FSW).

Despite the disheartening feelings this FSW shared with me about this one family, the logs she kept in the family's file show that she completed or attempted to complete what appears to be as just as many interventions as she did with other families. The FSW provided information to this mother on topics such as housing; the mother's education; discipline; developmental progress; newborn curriculum; family planning; how to get baby needs (wipes, diapers, formula, etc...); the importance of immunizing the children; finances; living independently; how to enroll the children in Early Head Start; where to find a baby sitter while the mother is at work; the effects of verbal abuse on the babies; and how the mother can get bail money for the babies' grandmother, just to name a few. It is obvious that despite the FSW's opinions of the mother, she still manages to remain focused on her duties of providing the family with access to resources and helping foster the development of the babies. Even though FSWs may have negative feelings about a family, they still can remain supportive and do their jobs by attempting outreach efforts to improve the family's functioning and help them gain access to resources.

Perceptiveness is often an important element of the FSWs job, as they must use cues from family members to determine the type of interventions that must be attempted. While some families are very direct with FSWs and inform them what they need, such as food, baby supplies, information about child development, etc, other families do not

reveal their needs directly to FSWs. On these occasions, FSWs provide interventions based on observations of the families and discussions with family members. For example, when one FSW noticed a mother yelling at her two-year old child frequently, she provided information about how to deal more positively with toddlers who are working to gain autonomy. Another example of how FSWs use perceptiveness to provide interventions was when an FSW provided a mother with information regarding safe sex, and the risks of not practicing safe sex, after the mother confided to an FSW that she had been with multiple partners. This indirect style of working with mothers is practiced by FSWs who are attuned to the mothers' needs. Perhaps the nature of the relationship between each family and their FSW partially determines the extent to which families will directly share their needs with their FSW. Or, perhaps the individual characteristics of family members will dictate just how much they want to share with the FSW regarding their needs. Despite the needs of each family, all families must be serviced by HFA staff on intensive, predetermined schedules in order to help families achieve goals. The next subsection discusses how services are provided through maintaining contact with families.

#### Provision of Intensive Services: Reaching the Families

The HFA goal of offering services intensively is met through the outreach methods practiced by HFA team members. This Critical Element is designed to “allow home visitors to establish rapport and trust with families” (Critical Elements, 1997, p. 16). Some of the families included in the evaluation were more difficult to reach, according to the FSWs. One family who is considered low functioning was extremely hard to develop rapport with, notes their FSW, Debbie. When I asked the FSW why it was so hard to develop trust with this family, she replied to me

This family-they are originally from one of the counties that are more rural than [the town]. I think that they have a real close knit family. It's kind of like, if you're an outsider, you're not going to come in. You know, Appalachian kind of culture, you know. So it has been... really hard to get that you feel that you've completed anything with this family because they don't talk. They do not talk, and so that would be like the main goal when you get there is to try to get them to talk. And there's alcoholism involved, too, which also closes people out.

This excerpt shows how sometimes it can be very difficult to establish trust and rapport with families. Unfortunately, it seems not all families can be reached, as exemplified by the above family's plight.

When a need or challenge is identified by a Healthy Families staff member, they will work with each other and the family members themselves to brainstorm ways to ultimately help the family help themselves. As previously mentioned, certain families were more difficult to make contacts with than others. I determined this through reading logs taken from family files and from gathering data from the Monthly Contact Logs in each family's file. This contact log is added to as each HFA staff member communicates or attempts to communicate with or on behalf of each family. Then monthly, the total contacts and attempted contacts are added up by the FSWs, and a new Monthly Contact Log is added to the family file. At the right of the Log is space for a description of the contact or attempted contact. On this Contact Log, space is provided to tally the total number of scheduled home visits completed; unscheduled home visits completed; "other" contacts made with family members; family member participation in Healthy Families group activities; telephone calls completed; transportation; and contacts with other family

members rather than the immediate HFA participants. The Contact Log also provides space to tally attempted contacts (home visits, unscheduled home visits, and telephone calls), cancelled visits (by either party), and contacts with outside agencies or other professional organizations on the family’s behalf.

In order to determine the total number of contacts HFA staff actually made with family members, according to their monthly tallies, I gathered the information from the Monthly Contact Logs of each family for each month since they began participation in the program. My findings show that on average, families were contacted by HFA staff 5.07 times each month, as reported on the Monthly Contact Logs. Appendix K shows the document on which I collected information regarding HFA’s contacts with families included in the study. Table 4.1 is a summary of HFA contacts as recorded on Monthly Contact Logs.

TABLE 4.1

**Average Contact Completion Rates  
as Recorded on HFA Monthly Contact Logs**

Child	Average Number of Completed Contacts/Month
1	5.85
2	5.1
3	3.8
3	4
4	2.47
5	11.56
6	6.24
8	4.74
9 and 10	4.54
11	2.7
12	4.92
13 and 14	1.86
15	4
16	3.56
17	4.5
18	2.27
19	10.11
20	3.09
21 and 22	5.73
23 and 24	11.48
25, 26, 27	4.05
<hr/>	
average:	5.07

As demonstrated in the previous table, some families were contacted far fewer times per month, while others, especially those who initially faced seemingly insurmountable challenges, were contacted as many as 10.11, 11.48, and 11.56 times on average per month. Interestingly enough, two of these three families are currently functioning in the medium to high range, whereas if they had been categorized when beginning services, they would have most certainly been considered low functioning families. This suggests that communication and contact with families can help improve family well-being.

As noted by the above contact information, HFA staff could not or did not make contacts with some families as designed by the program. In order to help families, HFA strives to serve families intensively in order to improve family functioning. Creative outreach efforts are practiced daily as FSWs attempt to help families reach goals and become proactive individuals. For example, monthly contact logs from the families' files indicate that most families had contact with HFA staff multiple times each month; however, some families, particularly those with hectic schedules or unstable living arrangements, were likely to be contacted fewer times on average. Moreover, the attempted contacts for these families tended to be high in number because HFA staff used outreach efforts, though often unsuccessful, to make contact with these hard to reach families on multiple occasions. Despite this method of intervention, not all families remain in the program for the total amount of time they are allowed to stay (when their youngest child reaches age 5). The next section of this chapter will address some of the reasons families leave HFA.

### Attrition Rates: Why Do Some Families Leave the Program?

As with any voluntary program, HFA participants have the right to refuse services at any time. Of the 21 families included in the evaluation, seven left the program during the process of this evaluation. The reasoning behind each family's decision to leave the program varies. Some families left HFA because they had to move out of the area to get jobs, and some left the program because they were functioning so well that they no longer needed services. Additionally, one family left because they simply did not want to take time to develop rapport with a new FSW when their previous one took another job. The following stories provide examples of families who are no longer with HFA.

The reason that affected one family's decision to leave the program involves the lack of job opportunities in the area. This couple, ages 18 and 19, had to move to a nearby state to get jobs. Their FSW notes "they're much better off now" that they are away from their families. The extended families of both parents posed additional challenges for these parents, who were young and poor, as described by their FSW. The FSW describes the father's family life as "very complicated, [with] a lot of incest, and a lot of mental illnesses. I think he was actually receiving SSI at one point. He is much better off away from his family." Their FSW explains the family's reasoning for leaving the area, and provides an update regarding the family's ability to cope with challenges:

They just wanted to go and get a better start because they had had such a hard time here—he just wasn't able to find a job and keep a job here. And it could be just to get away from their families and everything—they just needed a new start. They're doing okay—he has a job up there making pretty good money. It's better

than nothing. She has plans to go back to school. They seem to be pretty stable right now, but it's hard to tell" (interview with Debbie, FSW).

Alternatively, two families left the program because they simply felt they didn't need services anymore. Ellen and Henry, one of the high functioning families featured in a previous subsection in this chapter, is one of the families that no longer required the services of HFA. Another example of a family that dropped out of the program due to keeping such a hectic schedule is composed of Julie, age 19, and her infant child. Julie has a high school diploma and was attending a local Junior College when she found out she was pregnant. Julie reports that her parents "were addicted to cocaine when [she] was younger" and this was a concern of hers. Her boyfriend, age 21, has no high school diploma. Logs taken from family files indicate that the relationship between Julie and her boyfriend was rocky, as sometimes he wanted to be involved, but often she was "concerned with his temper." Additionally, the logs show that on several occasions, Julie showed her FSW bruises on her arms, and told her FSW that her boyfriend had broken down her door and that she was concerned with his possible drug use. At one point, Julie told her FSW that "he never hit me, but he's grabbed me, and shook me, and punched the wall beside me." Additionally, logs indicate that one time Julie "was upset because she found another woman's underwear in [her boyfriend's] bedroom".

It appears from the family files that Julie's maternal aunt is a stable presence in her life, though, and was even her labor coach during the delivery of her baby. Julie "is very assertive", notes her FSW, as she seems to value her education, got a job, and applied for WIC early on in her pregnancy. Julie has attended counseling and tried to get her boyfriend to go with her to counseling sessions. Despite having an affair with another

woman and using drugs, Julie's boyfriend remains in their lives. In April 2001, Julie told her FSW, Jessica, that she wanted to discontinue services "due to her busy schedule."

When I asked Jessica what she thought about this family's decision to leave, I found out that Jessica had just become Julie's FSW in February 2001. "The previous FSW took another job," noted Jessica. I asked Jessica if she ever got a chance to develop rapport with this family, and she said:

no, not anything...she [Julie] was really very busy with school, and it was just hard to get in there to see her, you know...but as far as she was concerned, it seemed like she was on the right track, trying to get her credit together...and the baby was going to be christened that weekend coming up (interview with Jessica, FSW).

I asked Jessica about Julie's challenges with her boyfriend, as well as how the baby was doing, and Jessica provided the following insightful comments:

...well, he had been arrested like two days before [my home visit]...but the baby, seemed like he was doing just fine. He was very alert—very playful. You could tell there was a lot of parent-child interaction. I did see a lot of that between the baby and both the mother and father. And the maternal aunt did come in with her daughter...and I could tell there was a lot of interaction with them [the baby, maternal aunt, and the maternal aunt's daughter].

Julie's struggle with her parent's drug abuse and unstable boyfriend seems to have been countered by her assertiveness (with continuing her education and procuring resources on her own, etc...) and also by the relationship with her maternal aunt. This is an example

of a high functioning family, overall, though, because Julie does seem to be functioning at a level where she can deal with the challenges that come her way.

With yet another family, the reason for leaving HFA is clear, according to one FSW: “I took this family over in Feb. 2001, when [the previous FSW] moved away. I visited the family only four times and then sent letter after letter to reach them with no response. The mother explained to me that she really liked [the previous FSW] and that it would be difficult for her to trust anyone else.” The FSW shared her feelings about “losing” this family:

This was a really sweet and nice family. When they were handed over to me, at the very beginning, the mother told me she didn’t want to put the time and effort into establishing trust with me. She said it was nothing personal, but ‘How do I know you’re not going to up and leave?’ And she’d also give me hints, like saying how the baby is getting older now and doing so well. I really tried to remain in contact with them, and thought well maybe if I can just get my foot in the door and connect with them, but it didn’t work out that way (Interview with Andrea, FSW).

The feelings of this mother and the previous mother, Julie, regarding the formation of strong relationships with their new FSWs demonstrate the uniqueness of the relationship between participant and FSW. The value of rapport between family and FSW seems to have an effect on the nature and even duration of the family’s participation in HFA. As exemplified by the two previous families, when an FSW leaves, it can be extremely difficult for the new FSW to develop rapport with the families she must take over.

### Linking Families with Resources

A main priority of the FSW is to provide families with access to community resources that can help improve family functioning and well-being. Specifically, FSWs prioritize the health and developmental well being of the babies of participating families. The following subsections will address how HFA staff members assist and encourage families to gain access to resources. Areas of resources that will be addressed in this section include encouraging families to receive immunizations on time, find a primary physician for the children, and develop links to community resources.

#### Immunizations and Primary Physicians

Most immunizations were clearly recorded in the family files. Two of the files reviewed had no immunization records on file. One additional file showed discrepancies, as the records in this particular file included two pieces of paper with conflicting dates the child received his immunizations, so I did not include this record in the completion data. Therefore, a total of 24 children's immunization records were included in the following percentages. The recommended immunization schedule from the American Academy of Pediatrics was utilized to determine whether each immunization was given on schedule. Of the immunizations recorded, 68.7 percent were considered on time or early, while 31.3 percent were recorded as not being received on time. Appendix O shows the master form on which I collected all the children's immunization data. When I asked the FSW about the child whose immunization records showed conflicting dates, she informed me of her opinion about the collection of the immunization records:

See, we have to try to get their immunization records, and sometimes—I mean, we actually rely on the family to give us the information. And that’s a little problem we’re having right now, well I’m having right now. Well I actually think the whole program is, well some of us are... When we first set up our immunization log, it reflected the way we were being able to get information. Well now, it’s reflecting differences because, like the health department, they have a list of the immunizations and they’ll have different dates on them because some of the babies receive different dosages at different times... And I have thought and thought about a way that we could get immunization information, because a lot of times families don’t know where their records are or whatever (interview with Debbie, FSW).

This excerpt suggests that the FSWs may experience difficulties collecting accurate immunization information from families, since it is the responsibility of the family to provide FSWs with immunization information.

The data revealed that one hundred percent of all families studied had identified a primary physician for their child’s health care needs. Appendix P shows the form on which I collected data regarding each child’s presence of a primary physician. This shows that the Critical Element stating all families should be linked to a medical provider to assure optimal health and development has been met. HFA program literature asserts that when families have access to health care, their health needs are met more adequately (HFA Informational Flier, 2001). Logs reveal that many of the families utilized their physicians when children and adults became ill. Often, families would call their FSW

first and share their child's symptoms; the FSWs would then usually suggest that the families call their physician's office for further advice regarding the illness.

#### Linking with the Community

Healthy Families asserts that program goals are met through collaboration with other organizations, "providing services to families in order to wisely use scarce resources, provide a comprehensive array of services to families, and avoid duplication of services" (HFA Informational Flier, 2001). For example, Birth to Three and Early Head Start are two resources families commonly utilize after HFA staff informs them of agencies such as these.

Additionally, FSWs talk with families about the positive effects outside services can have on their children. An example of this is seen with Cecelia, age 32, who gave birth to her child in 1998. According to the FSW logs in Cecelia's file, Cecelia "really wanted to provide well for her baby, because she had such a bad childhood." With 10 other siblings, Cecelia was abandoned at birth at the hospital and was placed in state custody until she was age 18. She reports both physical and sexual abuse as a child in foster care. When Cecelia began participation in HFA, she had virtually no assets, no job, was uncertain of the identity of her baby's father, and was living with a friend. In fact, Cecelia told her FSW that the Reverend living next door to her had posted her "story" on an evangelical website, hoping for donations. The results of this posting were not revealed in the family's file.

After the baby was born, Cecelia managed to find housing, through the assistance of her FSW because the relationship between Cecelia and her housemate was unhealthy. After getting settled in subsidized housing, Cecelia's baby, Michelle, seemed to be sick

quite frequently, with conditions such as thrush, extremely raw diaper rash, ear infections, sinus infections, chest congestion, a yeast infection, and “horrible colds”. Cecelia did attend to Michelle’s medical needs by taking her to her pediatrician when necessary. Cecelia even got a job (in which she has since been promoted and is an assistant manager), began taking Michelle to Early Head Start, and has been “very assertive” with making changes in her life, notes her FSW. When the teachers at Early Head Start began noticing what seemed to be delays in Michelle’s motor development, they shared their concerns with Cecelia and her FSW. Michelle has since been referred for occupational therapy, physical therapy, and speech therapy. Additionally, when Michelle’s physician noted that her left eye was turning in, Cecelia agreed to take Michelle to a specialist, who recommended surgery for Michelle’s lazy eye. After surgery, Michelle’s good eye was to stay patched for a specified amount of time to strengthen the weaker eye; later on, Michelle received prescription eyeglasses to help her vision. Throughout all the health and personal challenges Cecelia and Michelle have endured, Cecelia has worked diligently to achieve her goals. Jessica, Cecelia’s current FSW, insists that she “did it all on her own, and you don’t see that very often. I can’t begin to tell you how proud I am of this woman.”

Another goal of Healthy Families is to improve family functioning by working on goal setting and problem solving with the family (HFA Informational Flier). Therefore, not all interventions are focused on the children. As discussed earlier in this chapter, issues such as housing, finances, and family members’ health are serious concerns for the families. FSWs attempt to assist with matters such as these. A perfect example of this comes from the above anecdote regarding Cecelia and her daughter, Michelle. Cecelia’s

first FSW helped her a great deal at the onset of services, because she was in such dire need of assistance. However, as Cecelia began to set and reach goals, she did not require as many interventions from her FSW. In September 1999, Cecelia got a new FSW, because her previous one left HFA to begin another job. The relationship established between Cecelia and her new FSW, Jessica, has been very positive. Though Cecelia's family file notes that she refers to Jessica as "my Angel from God," Jessica is adamant that Cecelia achieved her goals primarily on her own: "And I am so, so proud of her for all she's done."

#### Other Interventions

The goal of providing families with access to community resources is met through the intervention process. The Family Support Workers seek information for the families that will increase their knowledge about the available resources, as well as how to utilize these resources. For example, intervention logs reveal that FSWs have assisted with providing the number for Medi-Cab (transportation for medical appointments); referrals to Lucy's Attic, a local charity/consignment shop; information about available housing, after calling local landlords; and ways to deal with not having enough food for the family. It is obvious that each family's situation is different, and therefore the nature of interventions completed by the FSWs varies from case to case. If I were to list every intervention completed by HFA, it would most certainly take several pages of typed text to indicate the various outreach and intervention methods they have attempted and implemented. Of these interventions, however, perhaps the central focus of all relate to the well being of the children served by the program. The next section will detail how the program fosters the well being of the children served by HFA.

### Supporting the Well Being of Children

A large component of the Healthy Families America program revolves around the nurturance of healthy development in the children of participants. HFA uses several techniques to help parents learn to help their children develop optimally. Program workers see the importance of educating parents about the normal course of child development, as well as variations that may occur, so that parents will respond to their child's development with less stress. Included in this Critical Element is a focus on supporting child development, parent-child interaction, and parents. The following subsections will address how HFA staff meet the goals of this Critical Element through administering Ages and Stages Questionnaires, providing various developmental curriculum to family members, intervening on behalf of the children, and modeling positive parenting skills.

#### Ages and Stages Performance

Many of the children scored highly on the Ages and Stages Questionnaires. Completion rates for Ages and Stages Questionnaires were also high. HFA Coordinator, Ramona, reports that the percentage of Ages and Stages Questionnaires completed on time in 2001 was 92. The question is whether the results are fully representative of the children's abilities, because on many occasions the family members did the questionnaires with their children without the Family Support Worker being present. The highest score a child could receive on any questionnaire is 60. Table 4.2 shows the average Ages and Stages scores for each questionnaire administered.

TABLE 4.2

**Ages and Stages Questionnaires  
Mean Scores**

<b>Questionnaire</b>	<b>Mean</b>
4 month	55.19
6 month	51.33
8 month	54.31
10 month	58
12 month	51.38
16 month	54
18 month	51
20 month	46.17
22 month	56
24 month	51.43
30 month	52.2
36 month	52
48month	50

As described in the Program Operation subsection of this chapter, only certain Ages and Stages are required to be administered. I asked Ramona, the program Coordinator, why only specific questionnaires are required. Ramona notes that she “looked at other Healthy Families programs to see what they were using, and also [looked at] credentialing standards” to determine which questionnaires would be required. She also notes that “all credentialing standards really requires is that we use a good, reliable tool to measure development.” However, six children had no Ages and Stages Questionnaires in their files. Of these six children, five were members of families who were no longer participating in HFA, while the other child was born prematurely and had spent months in a neonatal intensive care unit. This child had been home for approximately three months at the time of the evaluation.

### Sharing Child Development Curriculum

Beginning at the onset and continuing consistently throughout service, FSWs provide family members different written curricula based on child development. The program uses the San Angelo and Partners Curriculum, each of which focuses on several different stages of prenatal and early childhood development (through age five). Standard curriculum is given to family members at certain intervals (monthly during the prenatal period and infancy, and then every few months after the period of infancy). Also, if an FSW sees that a parent is experiencing difficulty with a specific stage in child development, such as developing autonomy, biting, or adjusting to a new sibling, she will provide the family with additional information on that subject. The family file logs reflect each time the FSWs provide and discuss any sort of curriculum with family members.

### Responding to Concerns

Because each family served by HFA is different, the nature of interventions completed by the FSWs regarding child well being is also different. The parents of children have various amounts of experience with children; since the program studied mandates that mothers who enter HFA are pregnant or have just given birth to their first child, many mothers do not have prior experience with children. Moreover, many of the mothers had childhoods where abuse and other detrimental factors were present. The ages of the mothers is also an issue, as many mothers are very young. It is the FSW's job to help parents learn how to increase the well being of their children. As previously stated, discussion of the Ages and Stages developmental tasks and sharing child development curriculum are efforts to inform all parents. But sometimes situations arise that require further intervention on the part of HFA.

Cindy is the 19-year-old mother of an 11-month-old baby girl. According to her FSW, Cindy

has a lot of issues. She's adopted. This is actually the adoptive grandfather she lives with. And she came from a family that I'm assuming didn't nurture her and they were killed in a fire. And she will very often do things to get attention from me, like feed the baby inappropriately. Now, she bonds with the baby well and she really seems to be interested in the care of the baby, but she will do things to get outside attention.

The logs taken by the FSW note that on several occasions, Cindy fed her two month old baby Pepsi and Oreo cookies. Her FSW, Abigail, reports that "I've discussed the issue with her of letting her [the baby] drink pop. But whether that's worked—I haven't observed her feeding the baby pop since then." Now the baby is old enough to eat solid food, and providing information about nutrition for infants is one intervention FSW completed for this family. "The baby is large," notes FSW, "but I think that's due to the inappropriate feedings earlier on." This is just one example of how an FSW intervened to help a mother learn how to feed her baby healthier foods.

#### Modeling Positive Parenting Skills

Since FSWs visit families on a regular, predetermined basis that has been mutually decided upon by both parties, the FSWs often get to spend time interacting with both adults and children in the family. On some occasions family members ask FSWs how to complete tasks regarding the care of their child. More than one new mother was uncertain about how to bathe her newborn, so the FSWs modeled the correct way to bathe a baby, being certain to involve the mother (or father) in the bathing process. Usually

during subsequent visits, the FSWs document how they watched the mothers bathe their babies and gave “pointers” or lent assistance when necessary.

However, intuition sometimes comes into play when an FSW senses that a parent or other family member is experiencing difficulty interacting with their child. For example, FSW logs in the family files suggest that many parents do not know at first how to play with their children. Moreover, these logs reveal that some parents believe that it is not important to interact or play with their very young children. This is where the curricula mentioned above can be helpful; additionally, the modeling of positive parent-child interaction by the FSWs is usually even more productive. FSW logs show that when parents can watch another person play and interact positively with their baby, they will usually try to do some of these techniques with their children, as well. At various ages in each child’s development, the child requires different levels of interaction and play, so it is often necessary for the FSWs to share with family members what is and what is not appropriate as far as interacting with their child at different stages of their development.

As seen in this section, FSWs and other HFA staff work to provide positive interaction and parenting techniques for families who need assistance in these areas. The Critical Element of offering services which focus on supporting the parents(s) as well as supporting parent-child interaction and child development is met through these interventions. FSWs learn to work with diverse families who have a wide array of different challenges. Through this process, FSWs meet the Critical Element of offering culturally competent services by understanding and acknowledging cultural differences among participants.

## Summary of Findings

My research findings reveal that in most cases, the amount of familial and social support seems to have a great deal to do with the level of family functioning. My research suggests that Healthy Families America can be effective for most families. Services are likely to be more effective when positive support, education, and employment are present in the family's lives. Services may take a long time to show success. And not all families are able to be helped by HFA, particularly those with numerous or intense challenges involving the presence of drugs, alcohol, or domestic violence. Similarly, though not with all families, the children tend to thrive despite challenging conditions they and their families may face. Nevertheless, through sharing literature about child development and modeling positive parenting behaviors with the family, FSWs foster the well being of families by attempting to reduce the family's stress levels through intensive home visitation and multiple interventions based on each family's needs.

## CHAPTER FIVE: CONCLUSION

Compounded risk factors and familial challenges contribute to the likelihood of abuse among both adults and children. The various challenges families face can be extremely deterrent to family functioning. It is the goal of the Healthy Families America program to help deter abuse by informing participants about child development and helping provide them access to resources which may help relieve the stressors from challenges they are facing.

### Meeting Critical Elements

Of the Critical Elements to which accredited HFA programs attempt to adhere, I focused on those concerning the families, child development, and service implementation. Findings reveal that the program I studied is diligently working to meet the Critical Elements in each of these of these categories. Though some families have not been helped by the program, the persistence of program staff to reach families and help them improve in functioning and gain access to resources is evident from reading family files and interviewing the FSWs.

These findings are consistent with literature on the occurrence of child abuse. For example, considering the existence of domestic violence in the home, “studies estimate that anywhere from 45 to 70 percent of men who batter their female partners also abuse the children in the home” (Fuller & Olsen, 1998, p. 237). Though it is not the job of HFA staff to tell abused women to get out of their unhealthy relationships, HFA staff members do inform participants of their options to help them get out of the abusive relationship.

Informing mothers of alternative temporary housing for abuse victims, assisting them with domestic violence petitions, and assisting them to find their own housing are some of the interventions HFA staff offered. Moreover, when the safety of any child is in jeopardy, HFA staff calls Child Protective Services to report any suspected abuse or neglect, and then follow up accordingly with CPS, while continuing to work with the family to try to help them eliminate negative behaviors. Simply stated, HFA does not want family members to become part of statistics such as the one at the beginning of this paragraph.

A large part of preventing abuse is educating parents about tendencies of basic child development. The philosophy of HFA centers around parent education as a method through which abuse and neglect can be deterred. Experts such as Fuller and Olsen (1998) note that often “abusive parents simply don’t understand how damaging certain attempts to discipline or punish young children can be” (p. 239).

Perhaps the intent of HFA is clearly summarized by Fuller and Olson (1998), who contribute the following:

Caretakers who resort to violence in their interactions frequently are described as making poor decisions in a time of stress...their reactions may be intensified by the lingering presence of drugs or alcohol (or the effects of an addiction), the effects of mental illness, the presence of physical illness or depression, or unhappiness about their life situation” (1998, p. 238-239).

Each of these issues raised by Fuller and Olson are among the challenges many HFA families face. This provides justification for the existence of such a primary prevention program. Others, such as Daro and Harding (1999) agree with the need for programs such

as HFA. They assert that if trained staff can reach and educate families before the abuse occurs, despite the sometimes enormous problems that may be occurring in the families' lives, then there is a good chance that abuse will not occur (1999). Moreover, Miller-Perrin and Perrin (1999) notes that current evaluation research on child abuse prevention programs shows positive outcomes, with the likely potential for making positive impacts on families.

Through looking at the goals of the Healthy Families America Critical Elements, it can be noted that the success of a parent education program such as the one studied for this thesis is based at least partially on the dedication and flexibility of the individuals who work for the program. This statement can be tied to Miller-Perrin and Perrin's argument that programs attempting to reach families and improve familial and community bonds should lead to stronger relationships between family members, thus reducing the likelihood of abuse. "Clearly, the foundations for making substantial progress in the prevention of neglect have been forged" (Holden & Nabors, 1999, p. 187).

Additionally, it takes a motivated Family Support Worker to communicate and assist families everyday with issues that sometimes seem hopeless. Success does not occur overnight for any family. It is a combination of the partnership with the FSW and attitude of most families that aid in the likelihood of their success. Thompson's (1995) description of quality home visiting programs justifies the interactive partnership between families and home visitors. This statement is also consistent with Wolfe's (1999) assertion of how families often lack the necessary skills to cope with life's stressful demands; therefore, a positive relationship with someone who possesses the ability to gain access to resources is likely to assist families reach goals. The more challenges a

family has, the more difficult it is to help the family become more competent.

Specifically, when factors such as drug abuse, domestic violence, alcoholism, and mental illness are present within a family, families will typically require more intensive services.

Even though some families will not be helped as much as others by programs such as HFA, it is the goal of HFA to encourage families to take small steps forward in order to help improve family functioning. Holden and Nabors' (1999) assertion that "multidisciplinary efforts are necessary" (p. 185) to reach families relates to the above statement. Put simply, though, parent education programs cannot do it all for families. "Even with intervention," note Fuller and Olson (1998), "sometimes the condition and conduct are so pervasive and deeply ingrained in the family structure that successes are small and take time" (p. 239-240).

This study reveals that family members must possess the initiative to want to make positive changes in their lives and in the lives of their children. Additionally, the presence of support by at least one stable, caring person in the mothers' lives can increase the chances of the family achieving its goals and eliminating challenges. Finally, employment and educational experience are factors that can aide the likelihood of a family achieving goals. When families can eliminate stressors, they are less likely to abuse their children (Miller-Perrin and Perrin, 1999; Pelton, 1994; Wolfe, 1999; Tower, 1996; Thompson, 1995; Willis, Holden, & Rosenberg, 1992). Healthy Families America attempts to do just that through intensive home-visiting and support services.

## Methodological Impacts

The instruments utilized to complete this study were purposefully and thoughtfully created to collect data in an organized manner. The forms I created to gather data allowed me to collect specific information about each family. When I began to analyze the data and write my findings, I found it very easy to sort through the data I had collected since it was already organized into specific categories. Moreover, deciding to interview the FSWs was a wise choice that provided insightful information about the families. My goal was to achieve triangulation through perusing both the FSW and Supervisory logs, and then interviewing the FSWs to see if they had similar feelings regarding the functioning of the families and children. Triangulation was achieved in this study through comparing the family files, my impressions, and the FSWs' comments. There are many more similarities than disparities. The methods I used throughout the study were successful in determining the extent to which HFA has achieved its Critical Elements.

Furthermore, the results of this study should be helpful to those affiliated with the field of child abuse prevention, particularly the HFA program, because they identify and describe several components of a high-quality parent education program. Future HFA program evaluators may want to utilize similar forms on which they can gather data from family files in order to collect the large amounts of detailed data that are required of an evaluation of this nature.

## Limitations

While effective in determining the extent to which the local Healthy Families America program reaches Critical Element goals as described above, the study itself had one main limitation which prohibited me from fully understanding the plights and successes of participating families. The file reviews I completed provided ample information regarding the families as seen through the eyes of program staff; however, I was never able to personally meet or interview any of the participants. Therefore, the study is based on the assumption that program staff accurately recorded the actual feelings, relationships, challenges, and successes of the families. Had the design of my study allowed me to visit or at least meet with participants, I would have been able to form my own conclusions regarding the functioning of the families. However, the contract under which I completed the program evaluation stipulated that I would only review files and speak with program staff. The other graduate level ethnographer involved in the program evaluation was responsible for interviewing and attending home visits with participants. I believe the actual program evaluation will be even more successful in getting a panoramic view of the families and program operation, though, since the both my data and the data of the other graduate ethnographer will be combined to complete the document we will present to the local HFA chapter.

## Significance

This study provides much information regarding the lives of families who face various risk factors. Through reviewing the files of families who had participated in the Healthy Families America program for at least nine months, I was able to gather a large

amount of data on most families. Moreover, the method I used of reviewing files for specific types of data was effective, along with interviews with program staff, in determining the extent to which the local program reaches its Critical Element goals. Triangulation was achieved through the data collected from the files about families, reading Family Support Worker and supervisory comments, and interviewing program staff. Additionally, the literature and findings presented in this study assert that the lifelong consequences of child maltreatment clearly suggest that the prevention of maltreatment should be a national goal.

### Recommendations

I would recommend that Healthy Families America staff develop a more effective method to improve the adequacy of obtaining immunization information regarding the children of participants. Perhaps this area should be addressed with the Coordinator and explored in future evaluations of the program. I also recommend that program staff continue to work closely with participants in the area of goal setting. Current literature and my findings reveal that when families are provided opportunities to reach goals, they are more inclined to continue striving to reach additional goals.

## PERSONAL AFTERWARD

Though it is difficult for some of us to believe that families endure such challenges as have been presented in this thesis, these challenges are very real for those who live through them. Perhaps we should consider that when it seems difficult for us to achieve goals, there are many individuals in our society, across all ethnic, socio-economic, geographical, and racial boundaries that face far more challenges than others. We should be thankful if we are fortunate enough to be in positions where goals are attainable—where education, employment, and mental, financial, and social stability can legitimately be reached. We should be thankful if we have not fallen into the cycle of abuse, which can destroy not only our own lives, but the lives of our offspring. Moreover, we should realize that our chances for success are much greater if we have not been subject to abusive tendencies of any type.

Finally, if we can realize that many of those who face numerous challenges can be helped through intervention methods and social support, we should make a solid effort to help these families reach their own goals and eliminate stressors that contribute to the likelihood of abuse within their family. Teachers, such as myself, should plan to do this everyday, through communication with students and their families. Educators, professionals, and program staff such as those that work with Healthy Families America should help the families they serve understand that resources are available that can be of assistance to them. Moreover, as child and family advocates, we should make sure that families know they can communicate with individuals in the community to find access to resources.

While reading the family files during this study, I kept thinking about my early childhood years, and how they differed from the childhoods of many of the children whose parents are HFA participants. I have to wonder to myself what these children think about at night, when they go to bed hungry, or when their mother's boyfriend comes home and beats her in front of them. Growing up, my family certainly was not rich, but I always remember having a place to live, having enough to eat, communicating with family members and friends, and most importantly, feeling *safe*. Not once do I remember feeling jeopardized by anyone. All children deserve to feel this sense of security. A call for action has been made. Healthy Families America is an example of a high-quality, action-oriented program that works collaboratively to assist families. Now let us see, as educators, professionals, and independent members of our communities, how we can help at-risk families learn to function at higher levels so they will be less likely to possess chronic negative habits which so often lead to the abuse of their children.

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APPENDIX B

**Family Rights and Confidentiality Policy**

Healthy Families shall ensure that the following policies and procedures are followed so that your family’s rights are protected.

- The right to help plan services designed individually for your family.
- The right to refuse services.
- The right to confidentiality of records
- The right to access your own records
- The right to information and referral to other provider’s services

The only time we would share this information about you without your permission:

- If we have reason to believe any child is being abused or neglected, we are required to report it to the Department of Health and Human Resources
- You will be informed before any such report is made, except in a life-threatening emergency.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Family Support

Worker Signature \_\_\_\_\_ Date \_\_\_\_\_

Healthy Families works with organizations that give us money to run our program, and organizations that we pay to evaluate our program. We need your permission for these people to see your records. They will be looking at the success of the program and also looking at how we could have helped more. Everything learned about a family will be held strictly confidential. Your name will not be used in any reports.

I give permission to funders and/or evaluators to see my family’s records.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

I do not give permission to funders and/or evaluators to see my family records.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

APPENDIX C

<u>Baby Identifier</u>	<u>Date of Birth:</u>		<u>Date of Evaluation:</u>
<b>Section One: IMMUNIZATIONS</b>			
<b>Immunization</b>	<b>Date Received</b>	<b>Earliest</b>	<b>Latest</b>
		(In months)	
Hepatitis B # 1		0	2
HepatitisB # 2		1	4
DTP # 1		2	3
OPV # 1 (IPV # 1)		2	3
Hib # 1		2	3
DTP # 2		4	5
OPV # 2 (IPV # 2)		4	5
Hib # 2		4	5
DTP # 3		6	7
Hib # 3		6	7
Hepatitis B # 3		6	19
OPV # 3 (IPV # 3)		6	19
MMR # 1		12	16
Hib # 4		12	16
DTP # 4		15	19
Varicella		12	19
DTP # 5		48	72
OPV # 4		48	72
MMR # 2		48	72







**Baby Identifier:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date of Evaluation:** \_\_\_\_\_

**Section Five: Family Background Information**

**Education History:**

**Childhood history of parent(s):**

**Substance abuse, mental illness, or criminal history:**

**Child Protective Services involvement:**

**Stressors, concerns:**

**Self esteem, available lifelines, depression:**











APPENDIX M

Educational levels attained by babies' mothers												
Baby	unknown	less than HS	HS	HS + grade	Post-Grad							
1												
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27												

APPENDIX N

Baby	Educational levels attained by babies' fathers														Post-Grad
	Unknown	"None" U.S.	Below 8th	8th grade	9th grade	10th grade	11th grade	12th grade	GED	U.S. diploma	Tech. Diploma	Comm. College	University	Post-Grad	
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APPENDIX P

**Primary Pediatrician Identified in Family File? (Yes or No)**

**Baby**

**Yes or No**