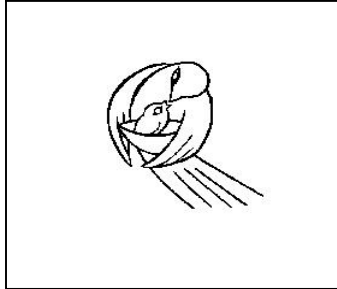


**Healthy Families District of Columbia**  
*A program of the Mary's Center for Maternal and Child Care, Inc*



***Starting Early Starting Smart***

**Final Report**

*Prepared by*  
**Donna D. Klagholz, Ph.D. & Associates, LLC**  
**April 2005**

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# I. Introduction

## A. Background and History

In October 2001, the Mary's Center for Maternal and Child Care, Inc. was awarded a three-year *Starting Early Starting Smart* (SESS) grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with the Casey Family Programs. This national partnership was designed to support the integration of mental health and substance abuse services into primary health care and early childhood settings serving children ages 0-5 years and their families/caregivers. The overarching goals of the grant are to improve access to and use of comprehensive services for at-risk families with very young children; and to improve caregiver behavioral health, family functioning, child socio-emotional development and related outcomes.

The Mary's Center for Maternal and Child Care, Inc. is the lead agency for the Healthy Families District of Columbia (HFDC) program. HFDC is a home visiting program that uses a strength-based approach to provide culturally competent, family-centered services to at-risk families with young children, with the ultimate goal of ensuring that children are healthy, safe, and ready for school. HFDC is affiliated with the national Healthy Families America initiative and is based upon the 25-year old Hawaii "Healthy Start" program, a voluntary program for the prevention of child maltreatment. As part of the HFA initiative, HFDC promotes positive parenting, child health and development, and prevents child abuse and related negative child outcomes through intensive, comprehensive, long-term (3-5 years), flexible, and culturally appropriate services. Program standards are achieved through adherence to the HFA critical elements that ensure best practices are met. Credentialed as a Healthy Families America site since 1999, HFDC uses a combined strategy of intensive home visitation and parent groups and relies on highly trained, bilingual family support workers to provide families with assistance in prenatal care, well-baby care, child development, parent-child bonding and interaction, child safety, and school/child care planning.

In 1993, Washington DC ranked worst nationally on multiple indicators of child well-being (low birth weight, infant mortality, teen birth rate, children living in poverty, and child immunizations). At that time the city was bankrupt and major city agencies, including the Department of Health, were in federal receivership. There were limited mental health and substance abuse treatment resources in the District, especially for Spanish speaking families. In 1996, in response to critical needs in DC, the Freddie Mac Foundation provided major funding to establish the HFDC collaborative. The initial success of the collaborative resulted in additional funding from the City and the awarding of a *Success by Six* grant in 2000.

While HFDC has continually demonstrated success in meeting the needs of high-risk families, as evidenced in annual evaluation reports, the program also documented outstanding needs in their participant population. In 2000, staff members identified over 150 women and over 200 men in their caseloads with mental health and behavioral needs that extended beyond the core services of the program. The majority of HFDC families typically experience high levels of stress as a result of poverty, isolation, lack of social supports, acculturation issues, low educational attainment, and unemployment, making the availability of and accessibility to quality behavioral health services even more critical. Families frequently struggle with problems

such as domestic violence, substance abuse, and unmet mental health needs. The resulting impact of these issues on child development required additional support.

## **B. Program Description**

The primary objective of the SESS project has been to build upon the existing HFDC core program services and enhance families' access to behavioral health services such as mental health treatment, substance abuse treatment, and child development, areas in which families have demonstrated needs that currently go unmet due to overburdened and limited community resources.

**Core services** -Healthy Families DC is part of a national model of home visitation programs under Healthy Families America. As such, HFDC provides wide-reaching assessment services and intensive, long-term home visitation services prenatally through age five (*see Appendix A – HFDC/SESS Logic Model*). Assessment services serve as both a means to enroll eligible families into the home visitation portion of the program as well as to make referrals for families to other community based services. Home visitors focus on sharing child development information, performing developmental screens at regular intervals with children, developing quarterly goal plans with parents, making community referrals as needed, and providing a trusting and supportive environment for families to discuss important issues in their lives. Families move through a leveling system (*see Appendix B – Service Level Descriptions*), receiving weekly or bi-weekly home visits prenatally, then weekly visits for a minimum of six months after the birth of the baby, progressing to less frequent visits as indicated by the need and desire of the family. Through limited caseloads and intensive supervision and training, the model enables Family Support Workers to receive much needed support for what can be highly stressful and demanding work. Healthy Families DC adheres to the rigorous standards and research-based effective practices delineated by the Healthy Families America model through their Critical Elements (*see Appendix C – Critical Elements of Successful Home Visitation Programs*).

During the term of this grant, Healthy Families DC was implemented through a collaboration of five community-based organizations in the District, with Mary's Center for Maternal and Child Care serving as the Lead Agency. This collaboration allowed the program to benefit from the unique array of services offered at each site and to provide services in a culturally competent way throughout the city. A brief description of each organization follows:

Mary's Center for Maternal and Child Care, Inc., located in Adam's Morgan in Northwest DC, provides holistic and culturally responsive bilingual health care to women, children, men and adolescents who reside in DC. Services include prenatal care, home visitation services, midwifery, family planning, pediatric care, dentistry, a teen clinic, mental health, and extensive social services.

Calvary Bilingual Multicultural Learning Center (renamed CentroNia in 2004) offers an array of services to children and families mainly residing in the Columbia Heights/Shaw section of the city, including an Early Childhood Education Program, School Age/Youth Program, Family Literacy Program, the Family Institute and the DC Bilingual Public Charter School, which started classes for two Pre-K and one Kindergarten class in September 2004.

For Love of Children (FLOC), located just off U St. in the Shaw neighborhood of northwest DC, houses multiple programs aimed at alleviating homelessness, strengthening families and eliminating child abuse and neglect, including foster care, transitional housing, neighborhood tutoring, youth adventure and technology programs.

Children's National Medical Center (or Children's Health Center) is an integrated health care system throughout Washington, DC and provides services from the main hospital and outpatient clinics, including Women Infants and Children (WIC) Supplemental Food Program, the Child Development Clinic, Adolescent Employment Readiness Center, the Child and Adolescent Protection Center, the Eating and Feeding Disorders Clinic, HIV services and mental health services. The Healthy Families site is located in the Anacostia section of DC.

Healthy Babies Project aims to reduce high rates of infant deaths and illnesses and improve health and parenting outcomes for families through its birthing center, childcare center, parenting education, and home visitation programs, reaching out to high-risk and low-income families mostly residing in Northeast DC.

Finally, HFDC partners with the Columbia Heights/Shaw Family Support Collaborative (CH/SFSC). Though there are no staff housed at this site, the partnership includes clinical supervision support through leadership of bi-weekly case reviews by their Clinical Director who is a LICSW practitioner.

***SESS enhanced services-*** The HFDC/SESS project utilized a two-pronged approach that included both *capacity building* and *program enhancement*. *Capacity building* focused on strengthening the linkages between HFDC and community-based providers such as the DC Addiction Prevention and Recovery Administration, Washington Behavioral Health, and the DC Commission on Mental Health Services (Multicultural Services Division). Through developing new and innovative partnerships with these agencies, HFDC could gain increased access to care, and better facilitation of referrals for families. *Program enhancement* focused on increasing staff availability and expertise to address needs in three key areas:

### ***1. Mental Health***

A bilingual mental health professional and increased time of an English-speaking mental health professional to conduct home visits and assess for mental health needs, link families with community resources that address ongoing needs, provide brief interventions as needed (particularly as a mechanism for facilitating longer term referrals), and track utilization of community services to demonstrate improved access to care.

### ***2. Substance Abuse***

A certified substance abuse counselor to conduct home visits with families at risk or with identified substance abuse issues, refer to community agencies, and track utilization of community services. In addition, all HFDC staff would receive training on issues related to substance use and abuse, including recognizing signs of drug/alcohol abuse, and understanding the consequences of exposure to drug trafficking in the home, family and community.

### ***3. Child Development***

Two bilingual Child Development Specialists will devote increased time to supporting families whose children have potential or identified developmental delays. In addition, HFDC worked on developing new activities for families aimed at promoting school readiness.

## II. Methods

The overarching goal of the SESS program evaluation was to determine whether the enhanced services that are made available through the SESS project, coupled with the core services of the Healthy Families model, significantly reduce the substance abuse, mental health, and developmental problems experienced by HFDC children and families; and whether the increased access to and utilization of these services ultimately has a positive impact on the well-being and outcomes for children, including school readiness.

The SESS evaluation started as part of a national cross-site evaluation, which required control groups, and common instruments for data collection in addition to those already collected for the HFDC program. Cutbacks in federal funding significantly reduced the cross-site activity and the potential for cross-site data analysis and reporting. As such, each SESS site conducted an independent, site-specific evaluation following many of the guidelines established during the initial cross-site discussions. Although the requirement to use a control group was eliminated, HFDC/SESS continued with its plan to utilize a comparison group. Several phone conferences, as well as a peer technical assistance meeting were held in order to support sites and foster cross-site communication.

Evaluation of the SESS project was originally designed to utilize a quasi-experimental approach with three experimental groups: 1) families receiving Healthy Families core services enhanced with SESS services; 2) families receiving “traditional” Healthy Families core services; and 3) families not receiving Healthy Families services, but who may be receiving other services from Mary’s Center for Maternal and Child Care. Due to SAMHSA funding uncertainties in Year I, the two Healthy Families groups were collapsed together, and the study design was revised to reflect only two groups: 1) the HFDC/SESS group; and 2) the ‘Other’ Mary’s Center services group (see **Table 1**). All HFDC/SESS families received the core Healthy Families services *and* SESS enhanced services as necessary. Comparison Group families received services from one of Mary’s Center’s less intensive services: 1) the Teen Mothers Take Charge program (TMTc); or the Division of Family Social Services case management services. All program and comparison families screened at-risk and enrolled prenatally or shortly thereafter.

### A. Target Population

HFDC/SESS targeted parents living in Wards 1, 2, 4, 5, 6, 7 and 8 of the District of Columbia who were identified as being at risk for child abuse and neglect and enrolled after June 2001. All participants enrolled prenatally or within 30 days of birth of the target child. Referral sites throughout the District, including community health clinics, hospitals and other social service agencies, screened potential families. The screen is designed to identify risk factors such as domestic violence, history of child abuse, and self-sufficiency limitations that may lead to poor child and family outcomes. Positive screens (indicating the presence of at least one risk factor) are forwarded to HFDC and a Family Assessment Worker contacts the family to conduct a comprehensive assessment, using the Kempe Family Stress Checklist (FSC). Families who are assessed as “Positive” are considered to be at moderate to high risk for abuse and neglect and are eligible for referral to the Healthy Families program. No additional exclusionary criteria are

used for program participation. Enrollment and ongoing participation in the HFDC program is voluntary.

The target population for the Comparison Group was families participating in either of two non-Healthy Families programs offered at Mary’s Center. The *Teen Mothers Take Charge (TMTC)* program provides monthly home visits, depression screening, parenting education (*New Beginnings*), childcare referrals, and group activities for pregnant teens, including education on substance abuse and sexually transmitted diseases (STDs). The Family Social Services program provides case management and parenting groups at Mary’s Center; and conducts home visits as necessary.

## B. Research Sample

The evaluation design planned to recruit 100 program and 50 comparison group families. As seen in **Table 1**, a total of 164 families participated in the SESS program. A smaller group of 56 families was recruited to provide a standard with which to compare outcome results. This comparison group received neither HF nor SESS services, but were administered the same outcome measures as the program group. Two program families denied consent to participate in the evaluation; therefore the research sample, upon which results are based, consists of 162 program participants and 56 comparison group participants.

**Table 1. SESS Year III Enrollment**

CONDITION	# TARGETED	# ENROLLED
<b>PROGRAM GROUP–HF /SESS Services</b>	100	164
<b>COMPARISON GROUP - No HF or SESS services</b>	50	56

Throughout the course of the SESS program, outcome measures were collected on both program and comparison group families. Initial measures were administered at enrollment (Baseline), and then re-administered after 6 months of participation, at 12 months, and annually thereafter. Due to attrition, the number of follow-up measures decreased with each subsequent administration, with very few measures being collected after 24 months. **Table 2** shows the measures administered to both groups, as well as the number collected at each timepoint.

**Table 2. Measures Collected: Program and Comparison Groups**

MEASURE	# Baseline Measures		# 6-Month Measures		# 12-Month Measures		# 24-Month Measures		# 36-Month Measures		#48-Month Measures	
	P	C	P	C	P	C	P	C	P	C	P	C
<b>Group Condition</b>												
<b>HOME</b>	66	32	25	9	46		12				2	
<b>KIDI</b>	130	48	67	16	53	1	17		1		3	
<b>CES-D</b>	133	49	83	16	60	1	17		5		3	
<b>CPSS</b>	137	51	97	15	45		18		3		3	
<b>GPRA</b>	156	52	74	17	32	6						
<b>ASQ</b>		45										

## **C. Program Goals and Objectives**

The SESS Program goals and objectives focus on addressing substance abuse issues and mental health needs within the HFDC community, fostering family and child health and development, and optimizing school readiness skills.

### ***Goal 1: To reduce the impact of substance abuse and mental health issues on HFDC families***

- Improve identification/assessment of substance abuse/mental health issues
- Improve access to community-based services for MH/SA issues
- Improve utilization of mental health/substance abuse services among HFDC families
- Reduce mental health and substance abuse symptoms among participating families

### ***Goal 2: To foster healthy child development through home visits, identification of developmental problems, and parent education***

- Improve identification and assessment of developmental delays
- Improve access to early intervention services for children with developmental needs
- Improve parental knowledge of infant and child development
- Ensure all participating children are current with their immunizations
- Ensure all participating children have access to a medical provider

### ***Goal 3: Improve school readiness***

- To increase parents' awareness of school readiness goals and academic options for their children

## **D. Procedure**

In alignment with the research approach proposed for this project, a multi-method approach to data collection and analysis was used. Individual family characteristics of race/ethnicity, language, age, education, and employment were examined in relation to outcomes. Program characteristics such as dosage, length of interventions, and type and number of referrals were also examined in relation to outcomes. The evaluation addressed the extent to which change was associated with the interventions, and how changes in risk factors of mental health, substance abuse and developmental delay in the program group compare with the comparison group and local and national comparative data.

Baseline data analysis was used to determine the match of program and comparison groups on characteristics of age, ethnicity, education, marital status level, and parenting skill. Outcome activities included the planning, scheduling, and collection, from all sources, of all outcome related data, and the organization, scoring of protocols, and data entry. Also included were the statistical analyses and summaries of outcome data, including (in progressive order) analysis of identifying variables and associations, pre/post-test comparisons, program and comparison group correlations, and between and within group analysis. For reporting purposes, evaluators focused on interpretation of results, with particular attention to synthesis of process and outcome evaluation results.

Data was collected by trained program staff, evaluation staff, and trained research assistants. Bilingual staff was used for most of the program group and all of the comparison group data collection (see *Appendix D- Description of Measures* and *Appendix E - Data Collection Schedule*). Data from the program's web-based database (KIDS), such as the HFDC screening tool, assessment tool, and intake, were exported and integrated into the evaluator's SPSS dataset for demographics, baseline risk data, and service utilization data.

In addition to outcome data tools, the evaluation also utilized process evaluation methods to document the evolution of the program and its implementation, and to provide feedback to administrators to effect program refinements. Both quantitative and qualitative data was collected on services rendered (including dosage data) in order to assess the program's effectiveness. Staff and parent satisfaction data provide an important supplement to outcome data tools in determining whether the SESS enhancements are effective in improving the wellbeing of families.

### **E. Participant Protection**

All research protocols and procedures were reviewed by an Institutional Review Board (IRB) for the protection of human subjects. Informed written and active consent from participants was required for participation in both the program and comparison groups (see *Appendix F- Consent to Participate in Program or Comparison Groups*). All protocols were coded; no names or individual identifiers were attached to the measures. All evaluation materials were stored in the evaluator's offices in secure filing cabinets, accessible to evaluation staff only. Access to the computer database was also limited to evaluation staff. Data is reported in aggregate form only.

### III. Results

#### A. Program Implementation

Funding through the SESS project enabled HFDC to enhance its core program services with targeted mental health, substance abuse, and child development services provided by newly hired professional staff. A mental health clinician, substance abuse specialist, and child development specialist were hired in Year I; however, HFDC modified the roles of these specialists in response to participant needs and staff turnover.

**Mental Health Component:** Initially, all families in need of mental health services were referred to the English-speaking counselor already employed by the HFDC program. This counselor provided home-based counseling services to English speaking families. She successfully engaged these families and provided support and informal supervision to Family Support Workers working with these families. She attended case review sessions and was able to provide valuable insight into the mental health struggles experienced by the families and offered suggestions and techniques used in therapy.

The HFDC counselor attempted to provide services to Spanish-speaking families with the assistance of the Family Support Worker (FSW). The FSW accompanied the counselor in order to act as a 'bridge' to link the family to the clinician, as well as to provide translation/interpretation services. A protocol was developed for translation of counseling sessions to ensure confidentiality and comfort of families. Unfortunately, many of the Spanish-speaking families were not comfortable with this approach, and therefore went without counseling services until a bilingual counselor was hired. Further, there was some reluctance on the part of staff to connect Spanish-speaking families to an English-only therapist.

In order to accommodate the language issue until a bilingual Mental Health Provider (MHP) was hired, HFDC attempted to link Spanish-speaking clients with outpatient services at mental health clinics in the area. Most families, however, did not follow up. Further, due to a lack of sufficient high-quality bilingual mental health services in the community, it proved to be difficult to link families with these services even when they did agree, as only the most dire mental health situations were given priority and often there were lengthy wait-lists to get an appointment. Thus, prior to hiring the bilingual MHP, counseling services within the HFDC program were more accessible for English-speaking clients. Consequently, these families were able to benefit from home-based therapy sessions sooner and more easily than Spanish-speaking families.

There was a lengthy and intensive search for a bilingual Mental Health Provider (MHP) at the start of the SESS program. However, it proved difficult to find a qualified bilingual candidate willing to perform home visitation services and the search to fill this position took over six months. A counseling student was eventually hired full-time and bilingual home-based counseling services commenced in December 2002. When this bilingual counselor resigned in August 2004 to complete a school-related internship, it was determined that a student was capable of performing these services adequately, with the condition that they receive intensive supervision by a Licensed Clinical Social Worker on staff. Initially this was the Quality

Assurance Director at the Calvary Site, who was later replaced by the Mental Health Director hired at Mary's Center. Two hours of formal weekly supervision were provided to the new MHP to ensure adequate support and quality assurance.

Both Mental Health Providers performed short-term in-home counseling services for a maximum of 10-12 weekly sessions. According to program documents, a total of 91 participants were referred for Mental Health services, with most recommended for individual counseling to address symptoms of depression. Records indicate that 33 of these participants followed through and received mental health services. The short-term counseling services concluded upon determination by the MHP and through client self-report of significant reduction in symptoms. However, for those in need of longer-term services or ongoing treatment, referrals were made to community mental health organizations.

The impact of the mental health component was evident in the significant reductions in risk for depression (CES-D scores) over the course of program implementation. Previous research findings have indicated that it takes approximately 12-24 months to see significant reductions in psychosocial variables, such as depression and social isolation. In contrast, reductions in risk for depression were significant after just six months of program services for SESS participants. A likely explanation for this significant decrease in depression over such a quick time period may be the presence of the Mental Health Providers. In-home therapy reaches a segment of the population who might not otherwise follow up with treatment. Especially in the bilingual community, there is a shortage of quality mental health services, even when families are willing to seek out such services. Therefore, some of the most isolated families, at the most risk for increased stress and depression, were able to easily access services right in their own homes.

The critical role of cultural and linguistic competence was evident in the implementation of the counseling component. Initially, the Spanish-speaking families were not easily engaged by the English-speaking counselor, despite the fact she worked in tandem with their bilingual FSW for translation. Interestingly, the African-American families were equally unresponsive to the bilingual MHP when she assumed the caseload of English-speaking MHP who resigned in January of 2004. Although the bilingual MHP was fully fluent in unaccented English, the linkages with English speaking families were not fully successful. The bilingual MHP found it difficult to locate the families and connect for visits. When she did meet with families, they were often not available for subsequent visits. Additionally, some English speaking HFDC staff were reluctant to make referrals to the bilingual MHP. Consequently, the bilingual MHP continued to serve mostly Spanish-speaking families, and for a period of time, the English speaking families were either referred to mental health agencies in the community or did not access the services they needed.

Clearly, cultural representation and competence were key variables in engaging families for mental health services. This is especially important when services are offered in the family's home. These factors appear more influential than language or credentials, as evidenced by the unresponsiveness of English-speaking families to the bilingual MHP, and conversely the success of the bilingual MHP in connecting with Spanish-speaking families.

**Substance Abuse Specialist:** It became apparent almost immediately from the intensive work of the Mental Health Providers that it is difficult, if not impossible, to separate out substance abuse (SA) and domestic violence (DV) from mental health issues. SA and DV affect a large segment of the SESS population who were often initially referred for depression only. It quickly became obvious that it was impossible to treat depression without addressing substance abuse and domestic violence issues in the home. Therefore, rather than having a separate substance abuse and domestic violence component to the program, the MHPs addressed all areas in their home visits. Trainings were provided, along with intensive supervision, to ensure that MHPs were knowledgeable and current in clinical skills regarding SA and DV. In fact, the English speaking MHP held a license as a substance abuse counselor and this was her area of expertise.

**Child Development Component:** Referrals were made to the Early Intervention (EI) Program at Mary's Center for any child development concerns. Usually, the referrals were made due to 'suspect' performance on the child's Ages and Stages Questionnaire (ASQ) completed by Family Support Worker in the home, but could be initiated by the parent, FSW, or pediatrician based on routine observation. FSWs or Site Coordinators made phone and written referrals to the EI team, who then completed an assessment with the child either at Mary's Center or in the family's home. Referrals could also be made to Children's Hospital or other Early Intervention programs through the child's pediatrician directly. Based on the results of the developmental assessment, follow-up referrals were made by the EI team for ongoing Early Intervention services. Follow-up may include home visitation services from Early Intervention specialists. Follow-up assessments on children approaching three years of age proved more challenging since that age is the cut-off for the early childhood assessment services. Children over the age of three years must be assessed by the District of Columbia Public School Child Find, which is much more difficult to schedule.

**Parent Advisory Board:** Integral to the HFDC/SESS program is the involvement and input of program families. Healthy Families DC organized a Parent Advisory Board (PAB) at the start of the SESS program in 2001. Initially, the plan called for two different Board meetings, one for Spanish-speaking families at the Mary's Center site, and another for English-speaking families at the Healthy Babies Project site. The long-term objective was that there would be just one group for both Spanish and English speakers that would be held bilingually, but that due to distance and comfort of families, two separate meetings would be more successful at engaging parents. However, after a year of monthly meetings with low attendance at the two sites, it was observed that the families who did attend were primarily participants from that site. Consequently, the Healthy Families DC management team decided to hold individual PAB meetings at each of the five sites on a monthly basis, beginning in January 2004. Once each site developed a strong group of PAB members, the program could then move to combine the groups into one bigger meeting.

Attendance at the individual site meetings, unfortunately, continues to be a struggle. HFDC at Calvary Bilingual Multicultural Learning Center had a standing monthly playgroup with excellent participant attendance. The PAB meeting at that site was scheduled to be directly after the playgroup for any participants who were interested. This proved to be a successful strategy and most months about five members attended the meetings. The group also planned a potluck Mother's Day event that was held at Calvary at lunchtime in May 2004. Attendance at

the event was excellent with about 15 families participating (including one father). However, in October 2004, the HFDC Calvary site was closed and families were absorbed into the Mary's Center site.

Mary's Center has an FSW who is extremely committed to holding the Parent Advisory Board meetings. She continues to plan meetings, holding them at different times of the day to encourage participation. However, it continues to be a struggle for families to find time to attend and most months, only one or two families are able to come.

The Healthy Babies Project (HBP) HFDC site attempted to hold regular Parent Advisory Board meetings, but ran into the same obstacles as the other sites with attendance problems. They often would have just one or two families in attendance. Unfortunately, the HBP site was also terminated as of October 2004 when downsizing of the HFDC collaboration occurred. Most families from this site were transferred to the FLOC site, with a few going to Children's Health Center, depending on location of the family.

FLOC is currently attempting to hold monthly "celebrations" as a way to gather together families in the program. The idea was that at these gatherings, someone could talk about the PAB, and the importance of obtaining family input into the program. So far, there is one family who has expressed interest in serving on the board.

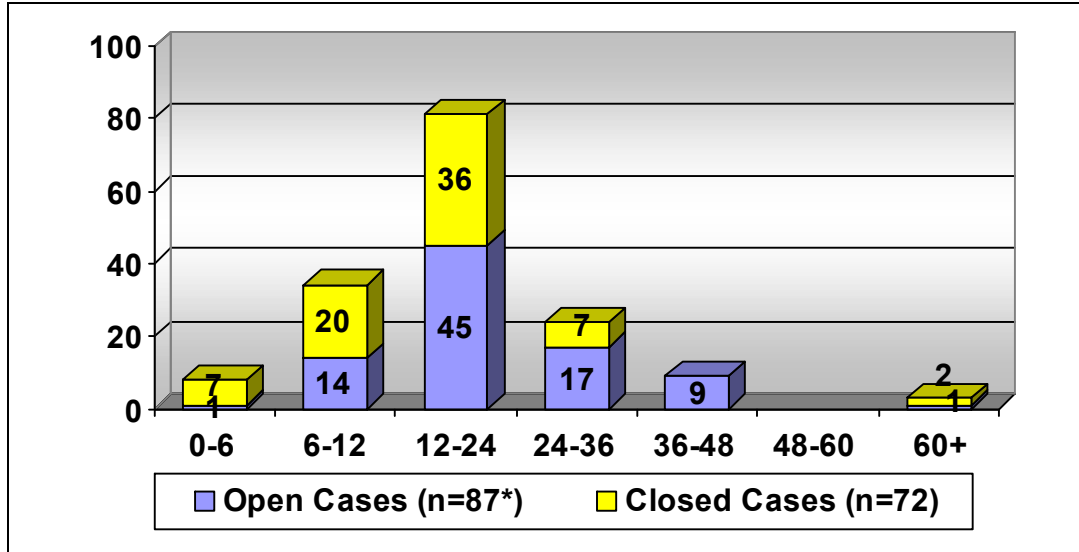
Finally, due to staffing issues at the Children's National Medical Center site, the Parent Advisory Board at this site has not been put into effect. Largely due to staff turnover, families dropped out of the program, and there was neither the consistency in staff to maintain the PAB nor the pool of families from which to draw.

Because of the ongoing struggle to establish a strong PAB, the program added exploratory questions to the most recent Participant Satisfaction Survey, which solicited interest in serving on the board as well as days and times that would be best. Further, a bilingual flyer was included to explain the purpose and importance of the PAB. However, feedback indicated no consistent day or time. Moreover, there was not a great amount of interest shown in the PAB from the surveys. The HFDC/SESS program is committed to family involvement in the program and will continue its efforts to establish an ongoing Parent Advisory Board.

## **1. Participant Dosage**

Participant enrollment information was examined in the SESS Program Group. Participants received an average of 27 home visits, ranging from a low of 0 to a high of 142. A total of 88 cases were open as of 3/31/05, with 72 having terminated services since the program began, representing a total retention rate of 55% and an attrition rate of 45%. As seen below in **Figure 1**, most participants, both current and past, stay in the program between one and two years, although the average enrollment for each group differs. The average length of enrollment for open cases is 22 months, compared to an average of 16 months for those families who terminated services. Cases that remained open as of 3/31/05 included participants who had been enrolled from six months to five years. Whereas the majority of closed cases terminated services between one and two years after enrollment, two cases terminated after five years of enrollment.

**Figure 1. Length of Enrollment in Months– Open and Closed Cases (n=159)**

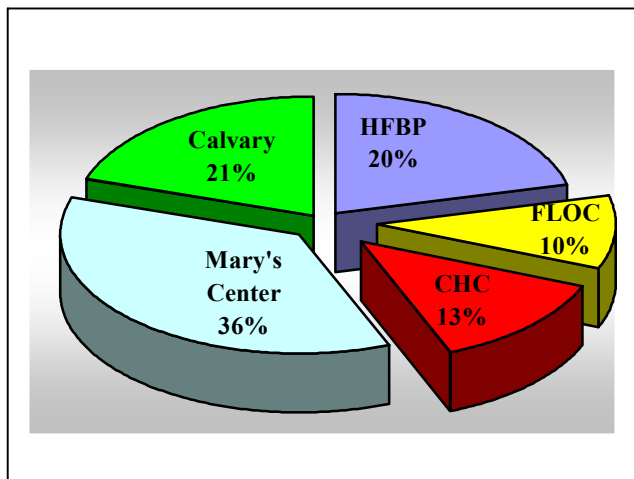


\* Enrollment date missing on three open cases

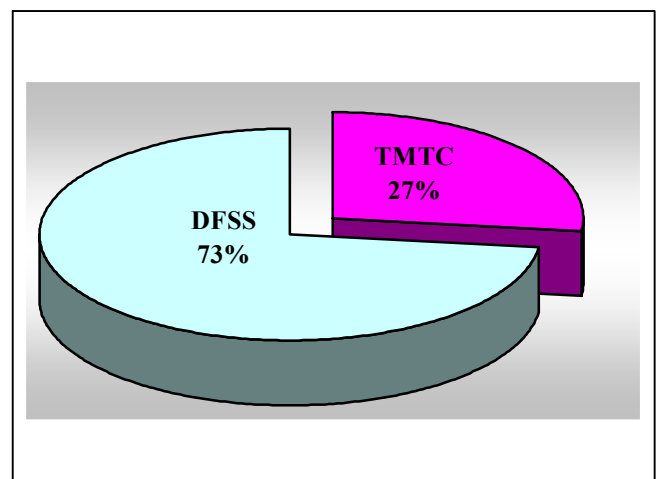
## 2. Enrollment Sites

As can be seen in **Figure 3**, over one-third of the total SESS program group participants (36%; n=58) have been enrolled at Mary’s Center, while almost equal numbers were enrolled at the Calvary Bilingual Multicultural Learning Center (21%; n=34) and at the Healthy Babies Project site (20%; n=32). Children’s Health Center (CHC) enrollees comprise 13% (n=22) of SESS participants, while the remaining 10% (n=16) were enrolled at the For Love of Children (FLOC) site. **Figure 4** shows that enrollees in the comparison group are comprised of mothers from the Teen Moms Take Charge (TMTC) program (73%; n=41) and from the Mary’s Center Department of Family Social Services (DFSS)(27%; n=15).

**Figure 2. Program Group Enrollment (n=160)**



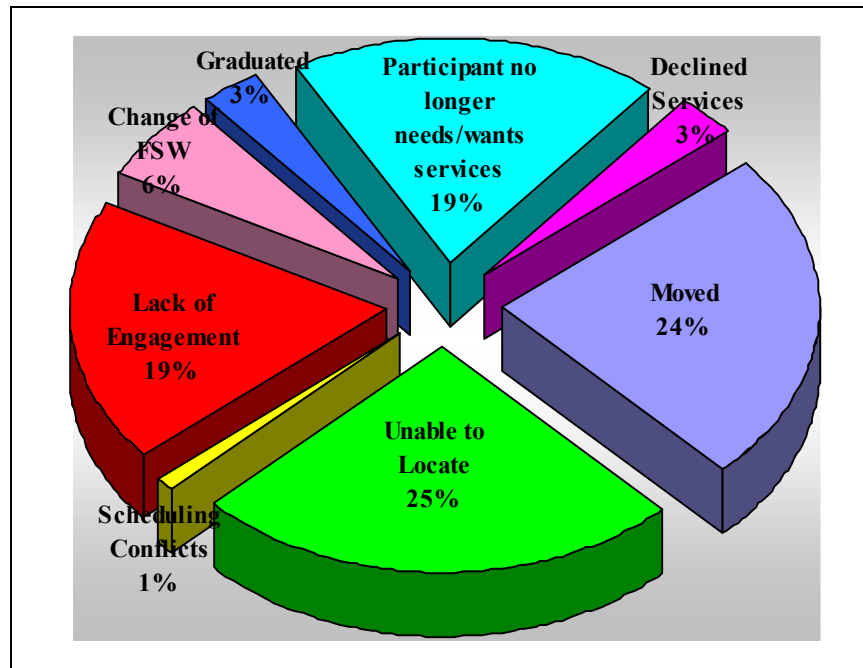
**Figure 3. Comparison Group Enrollment (n=56)**



### 3. Terminated Cases

The reasons for termination by the 72 families who discontinued services during the course of the program are shown below in **Figure 2**. As seen in the figure, about half of all terminations (49%; n=35) were due to the participant moving out of the service area or an inability to maintain contact with the participant. Nineteen percent (n=14) of participants stopped engaging in the program, while an equal number felt they no longer needed or wanted to continue receiving services. Two participants declined services after just two and four months of enrollment.

**Figure 4. Reasons for Termination (n=72)**



One of the greatest challenges faced by the program was significant attrition in the comparison group. Due to the transient nature of the targeted population, it was difficult to maintain contact with many of the families who originally consented to participate. Of the original 56 participants in the comparison group, a total of 23 (41%) terminated participation throughout the course of the grant. Nine of the 23 mothers (39%) enrolled in other programs subsequent to initially agreeing to participate in the comparison group. An additional six (26%) were unable to be reached for follow-up data collection despite numerous attempts on the part of the evaluation staff to maintain contact. Six other mothers (26%) moved out of the service area and were consequently unavailable for continued participation. Finally, two mothers (9%) felt they no longer wanted to participate.

#### 4. Participant Demographics

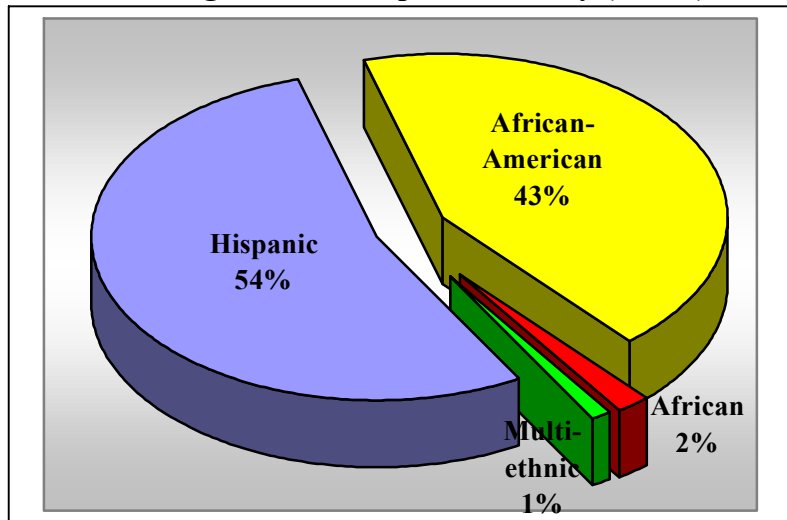
The characteristics that define the program population provide a context within which to interpret outcome results. As such, these demographics offer evidence of the risk and resiliency factors with which families enter the program. To be eligible for inclusion in the SESS program, participants must be enrolled in the HFDC program. These families demonstrate multiple risk factors as determined through screening and assessment procedures conducted prior to enrollment.

The demographic information presented in this section (Ethnicity, Age, Marital Status, and Education Level) reflects those HFDC participants who enrolled in the SESS program and consented to participate in the evaluation (n=162), as well as those who consented to participate in the comparison group (n=56).

##### Ethnicity

**Figure 5** shows the ethnic composition of the 162 SESS participants. Over half of program participants are Hispanic/Latino mothers (54%; n=88), while 43% (n=70) are African-American. The remaining mothers are African (2%; n=3) or Multi-ethnic (n=1). All 56 mothers in the comparison group are Hispanic.

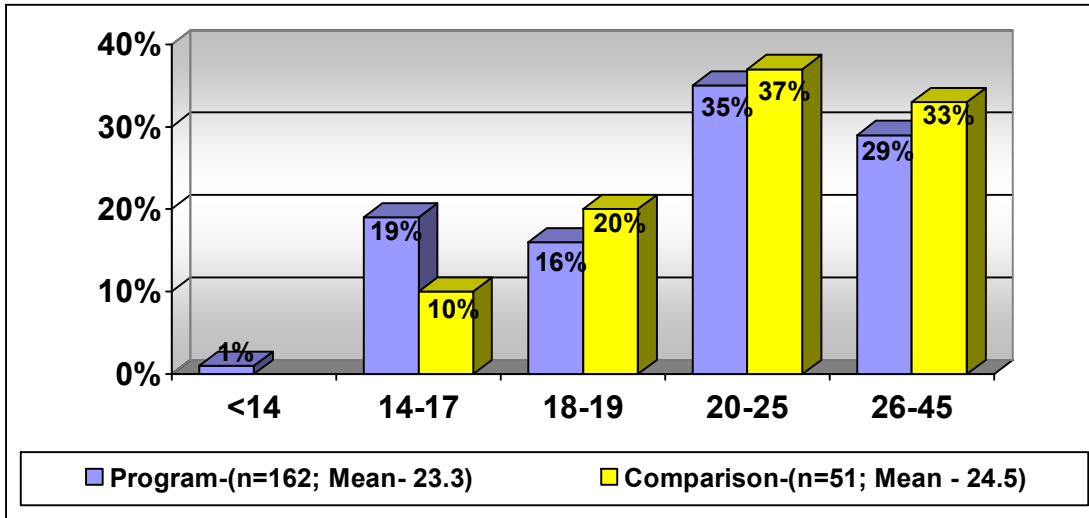
**Figure 5. Participant Ethnicity (n=162)**



##### Mother's Age at Enrollment

Age at enrollment was available for all 162 participating mothers. Both the range and mean age for both program and comparison groups are comparable. The mothers in the program group ranged in age from 13 to 45, with a mean age of 23.3 years. The range of ages for the comparison group mothers is from 15 to 39, with a mean age of 24.5 years. As seen in **Figure 6** below, most program mothers (64%) and comparison group mothers (71%) are over the age of 20. While less than a third of comparison group mothers are teens, 36% of SESS participants enrolled as teens between the ages of 13 and 19.

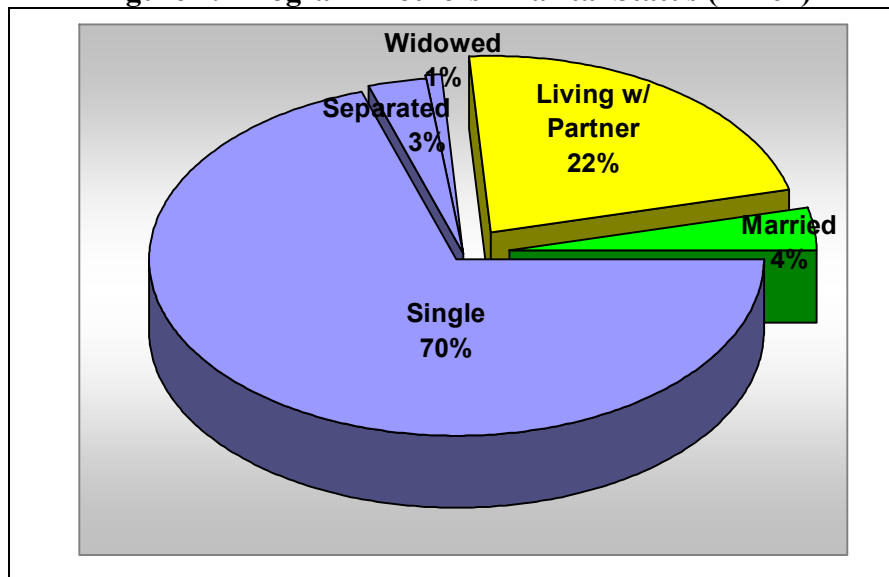
**Figure 6. Mothers' Ages at Enrollment (n=162)**



**Marital Status**

As seen below in **Figure 7**, approximately three-quarters of program participants (74%; n=120) are single mothers, including those who are separated or widowed. Twenty-two percent of mothers (n=36) are living with their partners, and 3% (n=6) are married. Marital status data is unavailable on comparison group mothers.

**Figure 7. Program Mothers' Marital Status (n=162)**

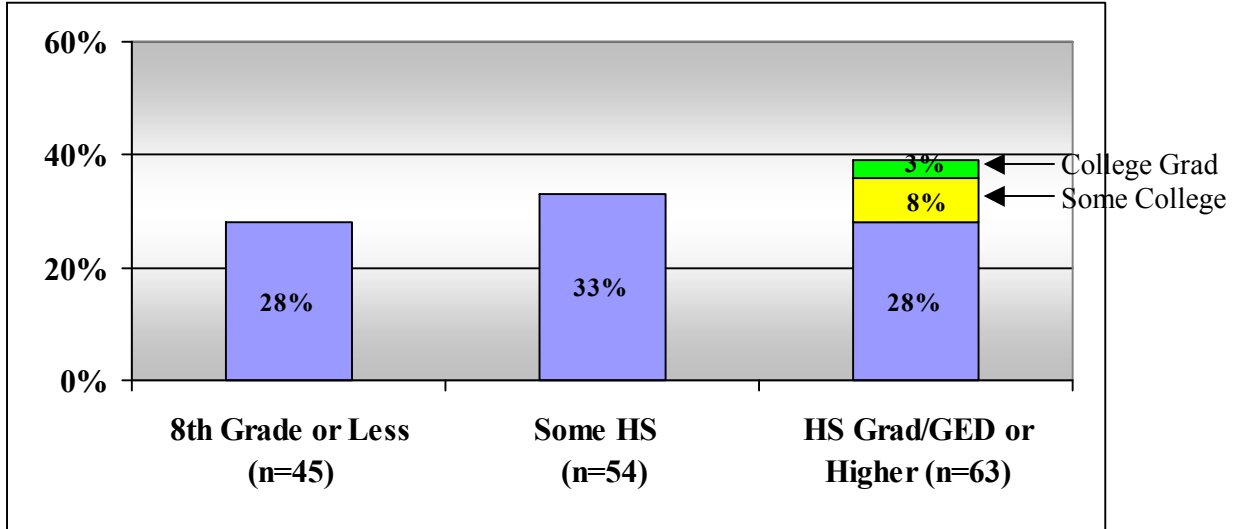


**Education**

Education status of both program and comparison group mothers was determined by examining data on the highest grade completed at program entry. As shown below in **Figure 8**, 39% of program mothers (n=63) have a high school or higher education. Of these, 45 mothers are HS graduates or have attained a GED, 12 have attended some college, and four are college graduates. About one-third of mothers (34%; n=54) completed some high school, many up through the 11<sup>th</sup> grade. The remaining group of mothers (28%; n=45) have an 8<sup>th</sup> grade

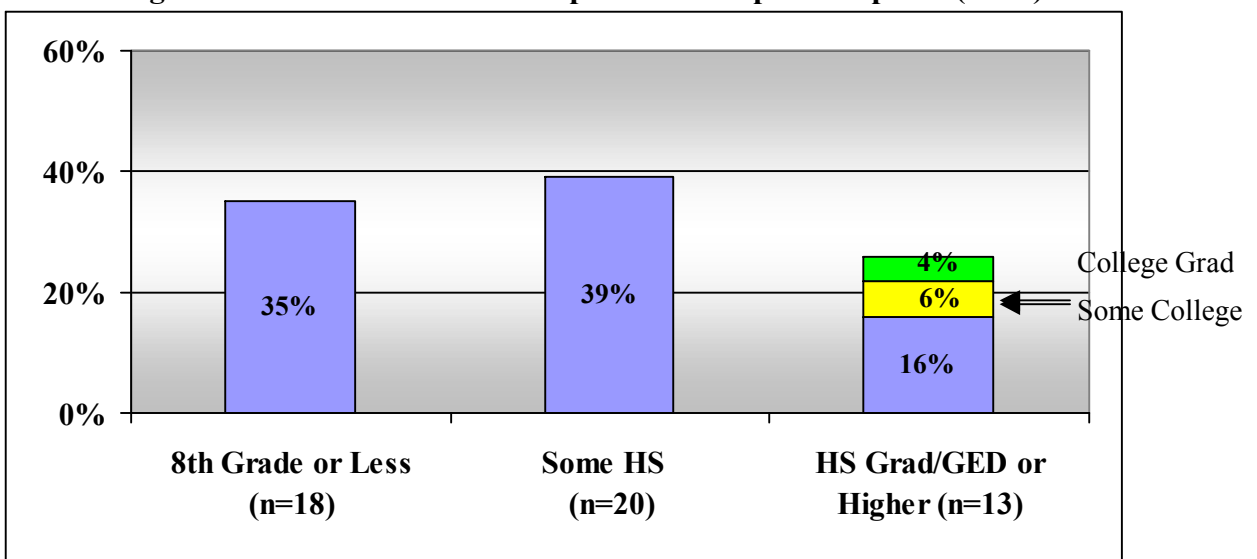
education or less. The mean grade level of program group mothers was  $\bar{x}=9.53$ , while the mean grade level of comparison group mothers was  $\bar{x}=8.67$ . Both groups had a range of no school to college graduate.

**Figure 8. Education Status at Program Entry – Program Group Participants (n=162)**



Information on education status is available on 51 of the 56 comparison group participants. As shown in **Figure 9**, slightly more than one-quarter of all comparison group mothers (26%) have a high school education or higher. The 13 participants comprising this group include five mothers who went on to attend college, two of whom are college graduates. Data reveals that approximately three-quarters (76%; n=38) of comparison group participants have not finished high school. This group includes 18 mothers who reported that the last grade they had completed was 8<sup>th</sup> grade or lower and an additional 20 who attended some high school.

**Figure 9. Education Status-Comparison Group Participants (n=51)**



## 5. Participant Satisfaction

Throughout the course of the SESS initiative, the program distributed annual participant surveys in order to solicit families' feedback regarding their needs and perceptions of the services provided, as well as suggestions for improvement in any aspect of the program. These surveys were able to capture valuable information, which was used to ascertain the level of participant satisfaction, thereby enabling the program to better meet the needs of participating families. Surveys were distributed once per year during the grant period: July 2002, July 2003, and July 2004 (*see Appendix G-Participant Satisfaction Survey and Report-2004*), and were provided to enrolled families in either English or Spanish. In 2002, a total of 59 surveys were completed and returned; in 2003, 63 were returned; and in 2004, 43 surveys were returned.

Differences in service levels are reflected in participants' responses to the frequency of visits, which ranged from once per week to once per month. About half of participants each year (50%, 56%, and 49%, respectively) reported weekly home visits with their FSWs, and most (68%, 71%, and 64%) indicated that visits usually lasted from 30 minutes to one hour. Participants also reported individual lengths of enrollment, ranging from less than a month to over four years.

Questions regarding the performance of Family Support Workers and such attributes as respect, understanding, caring, knowledge, cultural competence and others were consistently answered in a strongly positive way. The attributes identified by participants to describe their FSWs were overwhelmingly positive and reflect the strength of the relationships that have been established. The FSWs were most often depicted as warm and caring, helpful, respectful, understanding, and supportive. The attribute that increased the most in percentage of respondents citing it as descriptive of their FSWs was "Understanding," which was reported by 71% of respondents in 2002, by 84% in 2003, and finally by 91% in 2004, a three-year increase of 20 percentage points. Other attributes that showed consistent increases were "Encouraging" (+17pp), "Knowledgeable/Informed" (+14pp), "Warm/Caring" (+10pp), and "Supportive" (+6pp).

In 2003, 59% of parents responding to the question regarding a change of FSW reported that they had experienced such a change, compared to 2002 (51%) and 2004 (47%). This increase is not surprising in light of the increase in staff turnover experienced by the program during the reporting period. However, most families reported that they were doing well with their new FSW(s).

Participants' satisfaction with program assistance in raising their children remains high. 95% responded positively when asked if the program had been helpful in raising their children. Specific questions addressed child development, parenting, health care, stress and community resources, with some results showing decreases in positive responses. For example, 84% reported increased knowledge of baby growth and development in 2002, while 76% reported the same in 2003. This decline may be reflective of respondents' length of enrollment and the fact that their children are no longer infants.

Overall program satisfaction remains high, with 98% of program participants reporting they were “Satisfied or Very Satisfied” in 2004. In addition, 100% of participants said they would recommend the program to a friend, and some had already done so.

Throughout the course of the grant period, SESS participants were highly satisfied with the program and staff. Comments offered by participants consistently conveyed a sincere appreciation for the support, guidance and encouragement they received from their FSWs and demonstrated the extent to which they value the knowledge they have gained. It is evident that the relationships between the mothers and their FSWs were key factors in their satisfaction. Additionally, participants regularly reported feeling more knowledgeable about such areas as parenting, assessing the needs of their children, coping with stress, setting and achieving goals, and accessing community resources.

## **6. Staff Satisfaction**

At two intervals during implementation of the SESS initiative, the program also distributed staff surveys in order to provide information and feedback to the program about staff perceptions regarding the nature and quality of support and benefits they have received, as well as their views on program strengths and weaknesses, job stress, and overall job satisfaction. Questionnaires were collected from 16 staff members in August 2002 and from 11 in September 2004 (see *Appendix H-Staff Satisfaction Survey and Report-2004*), representing a response rate of 85% each time. As with the participant surveys, all staff questionnaires were completed anonymously.

Whereas the 2002 survey presented a series of nine statements regarding program effectiveness to which staff were asked to agree or disagree, the 2004 survey contained 14 statements accompanied by a 5-point Likert scale in which they were asked to select “Strongly Agree,” “Agree,” “Not Sure,” “Disagree,” or “Strongly Disagree.” Overall, the 2004 results yielded stronger agreement with statements reflecting positive perceptions of their jobs than those of 2002. For instance, all 2004 respondents (100%) strongly agreed that they understand HFA’s critical elements, as compared to 94% in 2002. The most significant improvement was noted with regard to the cultural appropriateness of the program materials, as 100% of 2004 respondents agree, compared to only 67% in 2002. The most recent findings also indicate that all agree that they understand the goals and objectives of HFDC/SESS, that they receive an adequate amount of supervision, and have participated in trainings during the past six months. All staff members also agree that the program optimizes child development through support to families and that the program is strength-based and family centered.

In the 2004 survey, several new items were added focusing on additional aspects of cultural competency, school readiness, and effectiveness of the SESS behavioral health supports. In response to these items, all staff agreed that they feel comfortable working with culturally diverse families, that the program helps to prepare children for school, and that the mental health, substance abuse, and child development components of the program significantly help program participants. The majority also feels that the staff is culturally representative of the community they serve and that the program uses bilingual materials appropriately. The lowest percentage of agreement was in staff’s perception of the responsiveness of management to their needs. Overall,

staff appear to feel that the program is very effective in providing services to all its families and meeting its goals related to parenting, family functioning, and child development.

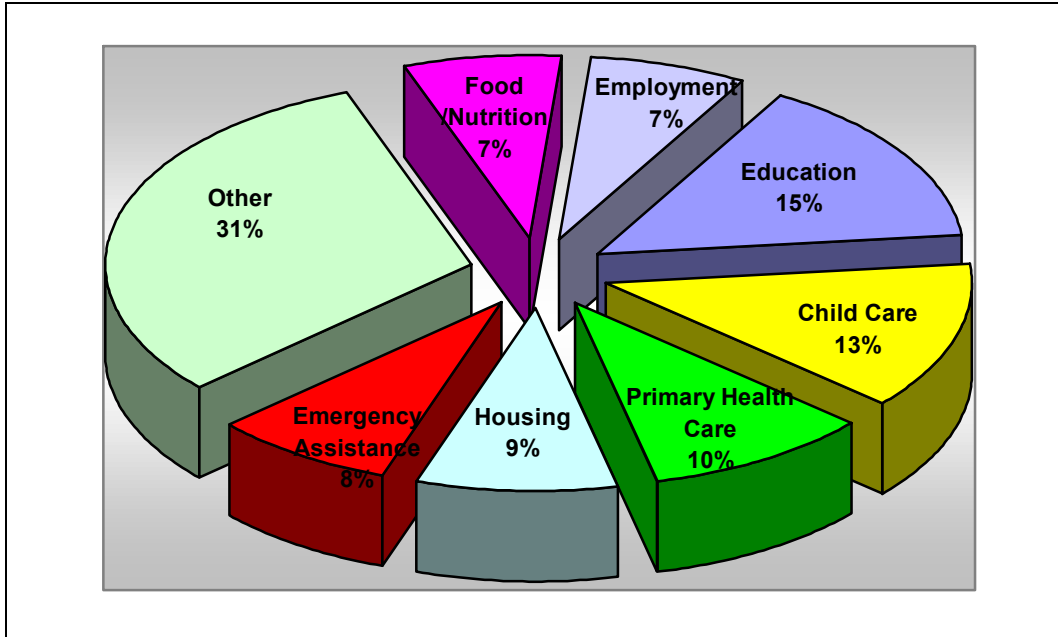
Staff members were asked two open-ended questions designed to elicit their views of particularly strong or weak program areas. While the staff responses regarding program strengths consistently highlighted the nature of the family-centered services provided to participants, perceptions of other strengths evolved as the program matured. For instance, in 2002, about one-third of the staff cited the professional development trainings they received as a main program strength, but these were not emphasized in 2004. Instead, the latter surveys revealed the perception on the part of the staff that their collective dedication to their relationships with their families, as well as the clinical supervision they received (cited as a program weakness in 2002), were some of the strongest aspects of the program. Also, whereas the cultural competence of program materials was considered a weakness by staff in 2002, the 2004 results reflect the efforts made on the part of the program to address this issue, as staff subsequently reported the materials not only to be culturally appropriate, but to be one of the program's main strengths.

One area of program weakness that was consistently cited by staff was that involving salaries. While mentioned in 2002, financial compensation, along with funding, were the main areas that emerged as warranting further exploration in the 2004 surveys. Some staff feel compensated in ways other than financial, and most reported receiving some benefit from their work, usually through certification or promotion. However, at both timepoints, the majority did not feel adequately compensated for their work. Despite this and reports of moderate job-related stress, however, all staff members consistently stated that they do enjoy their work and almost all are satisfied with their position in the program. This appears to be indicative of a high level of commitment and dedication on the part of the HFDC staff.

### **Referrals for Services**

In addition to referrals for mental health services, the HFDC/SESS program utilized its partnerships and linkages with supportive community resources by referring participating families for other appropriate services as needed. As seen in **Figure 10**, the largest percentage of these referrals (15%) was for educational services. The majority of these services were for ESL classes, with others such as adult literacy, parenting education, HS/GED programs, and job training. Childcare referrals were made for 13% of families, most of whom were seeking day care services. Other more frequently referred services included Primary Health Care (9%, *i.e.*, prenatal care, medical evaluations, etc.), Housing (7%, *i.e.*, Section 8 vouchers/certificates, housing applications, transitional housing, etc.), Emergency Assistance (8%, *i.e.*, furniture, clothing, telephone, etc.), Food/ Nutrition (7%, *i.e.*, WIC, Food Pantry, Food Stamp applications, nutritional counseling, etc.), and Employment (7%, *i.e.*, employment searches, employability assessments, etc.). The remaining 31% of referrals include services such as financial and legal services, dental care, domestic violence services, entitlements (*i.e.*, general assistance, TANF, SSI), Family Issues (*i.e.*, life skills, relationships, reunification, family planning, etc.), and other support needs (*i.e.*, motivational support, furniture, etc.).

**Figure 10. Referrals for Services**



## Outcome Evaluation

### Achievement of Program Goals and Objectives

The SESS Initiative has been successful in accomplishing many of its goals set forth at the onset of the program, particularly in the area of parent-child interaction and parental knowledge of child development. Program outcomes are discussed below in the context of the goals and objectives addressed by each.

### Initial Comparability

The initial comparability of the program and comparison groups on demographic and risk status was analyzed at the conclusion of Year I of the SESS project. Results indicate a clear difference in ethnicity exists between the program and comparison groups in that the program group is comprised of 56% Hispanic families, while all families in the comparison group (100%) are Hispanic. This is due to the referral sources for the groups, which reflect the ethnic ratios of the different Wards of the city. HFDC draws from all Wards, resulting in approximately half Hispanic and half African American, while the Comparison groups were drawn from two programs that reside at Mary's Center and serve the primarily Hispanic local community.

The mean ages for both groups are comparable, with the mothers in the program group ranging in age from 13 to 45 ( $\bar{x}$  = 23.3) and those in the comparison group ranging from 15 to 39 ( $\bar{x}$  = 24.5). Comparability on marital status could not be determined, as this data was not available for the comparison group. The mean levels of education for the two groups are not significantly different. As seen below in **Table 3**, participants in both groups ranged in grade from 0 (No school) to College Graduate.

**Table 3. Mean Age and Level of Education by Group**

Group	Mean Age	Age Range	Mean Grade	Grade Range
Program (n=162)	23.3	13-45	9.56	0-16
Control (n=51)	24.5	15-39	8.67	0-16

Baseline comparison of the program and comparison groups on standardized outcome measures indicates comparability on measures of parent-child interaction (HOME) and on parenting knowledge (KIDI), while differences exist on initial risk for depression and social support. As seen in **Table 4**, the program group mean on the CES-D indicates higher risk for maternal depression, while the comparison group mean on the CPSS indicates higher risk for social isolation. Both groups screened to be at risk on the initial screening conducted by the referral sources.

**Table 4. Baseline Mean Scores for Program and Comparison Groups**

Measure	Program Group $\bar{x}$	Comparison Group $\bar{x}$
<b>HOME</b> ( <i>Parent-Child Interaction</i> )	32.36 (n=66)	34.61 (n=33)
<b>KIDI</b> ( <i>Parenting Knowledge</i> )	7.68 (n= 131)	8.43 (n=49)
<b>CES-D</b> ( <i>Depression Risk</i> )	17.56 (n=133)	13.27 (n=49)
<b>CPSS</b> ( <i>Social Support</i> )	24.21 (n=137)	20.67 (n=52)

**Goal 1. To reduce the impact of substance abuse and mental health issues on HFDC families**

- a. Improve identification/assessment of substance abuse/mental health issues
- b. Improve access to community-based services for MH/SA issues
- c. Improve utilization of mental health/ substance abuse services among HFDC families
- d. Reduce mental health and substance abuse symptoms among participating families

**1a. Assessment of Substance Abuse**

As part of SESS program enhancement, families are provided with mental health and substance abuse prevention and treatment services. Funded by the Substance Abuse Mental Health Services Administration (SAMHSA), the program is required to administer the Client Outcome Measure for Discretionary Programs as required by the Government Performance Results and Accountability Act (GPRA) in order to measure client outcomes in the areas of substance abuse. Data over the course of the grant is available on 153 participants at baseline, 75 participants after 6 months of enrollment, and 31 participants at the 12 month follow-up. Items on the GPRA include current (30-day) ATOD use, age of onset of ATOD use, perceived health risks associated with ATOD use, and attitudes toward adult ATOD use.

**Usage**

Several items on the GPRA target participants' frequency of ATOD use. Specific items included 'gateway substances' like alcohol, cigarettes, and marijuana, as well as other illegal substances such as crack cocaine, heroin, methamphetamines, and hallucinogens. **Table 5** shows the participants' responses to questions regarding current usage that was within the 30 days prior to survey completion. Results are presented for all three: baseline, and the 6- and 12-month follow-ups. As shown in the table, at baseline, only 9 participants reported the use of alcohol (6%), with frequency ranging from one day to 28 days. Although the number of respondents decreased at each subsequent administration, percentages reporting alcohol use increased to 7% at 6 months, and to 21% at 12 months. Additionally, at 12 months, one respondent reported drinking to intoxication 7 out of the 30 days prior to survey completion. Cigarette smoking was more common among participants, with 18 participants (12%) reporting use in the 30 days prior to completion of the survey. The rate of current smokers remained unchanged after 6 months, but dropped to 10% after one year of enrollment.

Comparison Group participants reported no current use of any substances at Baseline and at the 12-Month follow-up. At 6 months, however, two individuals reported current use of tobacco products.

**Table 5. Current ATOD Usage: Program and Comparison Groups**

30-Day Usage	Baseline		6 Months		12 Months	
	P N=153	C N=52	P N=75	C N=17	P N=31	C N=6
Past 30 days drank alcohol?	6% (n=9)	-	7% (n=5)	-	19% (n=6)	-
Past 30 days drank to intoxication?	-	-	-	-	3% (n=1)	-
Past 30 days used illegal drugs?	1% (n=2)	-	1% (n=1)	-	3% (n=1)	-
Past 30 days used cocaine?	1% (n=1)	-	-	-	-	-
Past 30 days marijuana?	1% (n=2)	-	1% (n=1)	-	3% (n=1)	-
Past 30 days used heroine?	-	-	-	-	-	-
Past 30 days used methadone?	-	-	-	-	-	-
Past 30 days used hallucinogens?	-	-	-	-	-	-
Past 30 days used methamphetamines?	-	-	-	-	-	-
Past 30 days used barbiturates?	-	-	-	-	-	-
Past 30 days inhalants?	-	-	-	-	-	-
Past 30 days used other drugs?	-	-	-	-	-	-
Past 30 days smoked cigarettes?	12% (n=18)	-	12% (n=9)	12% (n=2)	10% (n=3)	-
Past 30 days used chewing tobacco?	1% (n=1)	-	1% (n=1)	-	-	-
Past 30 days used snuff?	-	-	-	12% (n=2)	-	-
Past 30 days smoked cigar?	-	-	3% (n=2)	12% (n=2)	-	-
Past 30 days smoked pipe?	-	-	1% (n=1)	12% (n=2)	-	-

In addition to questions targeting frequency of ATOD use are questions targeting lifetime use and age of onset. Some participants chose not to answer several questions regarding the use of ATODs and, therefore, the *n* for each question varies. As seen in **Table 6**, ATOD lifetime usage for Program Group participants ranged from a low 13% (n=19 of 148 respondents) for illicit drugs like heroin and crack to 25% (n=37 of 146) for marijuana and a high 60% (n=84 of 139) for alcohol. Cigarette use was reported by 39% of participants (n=55 out of 140 respondents). Overall, Comparison Group participants reported lifetime ATOD use with lower frequency than those in the Program Group.

**Table 6. Lifetime Usage – Reports at Baseline: Program and Comparison**

Lifetime Usage	Program Group N=153	Comparison Group N=52
Ever smoked cigarettes?	39% (n=55)	37% (n=19)
Ever drank alcohol?	60% (n=84)	50% (n=25)
Ever used marijuana?	25% (n=37)	4% (n=2)
Ever used illegal drugs?	13% (n=19)	2% (n=1)

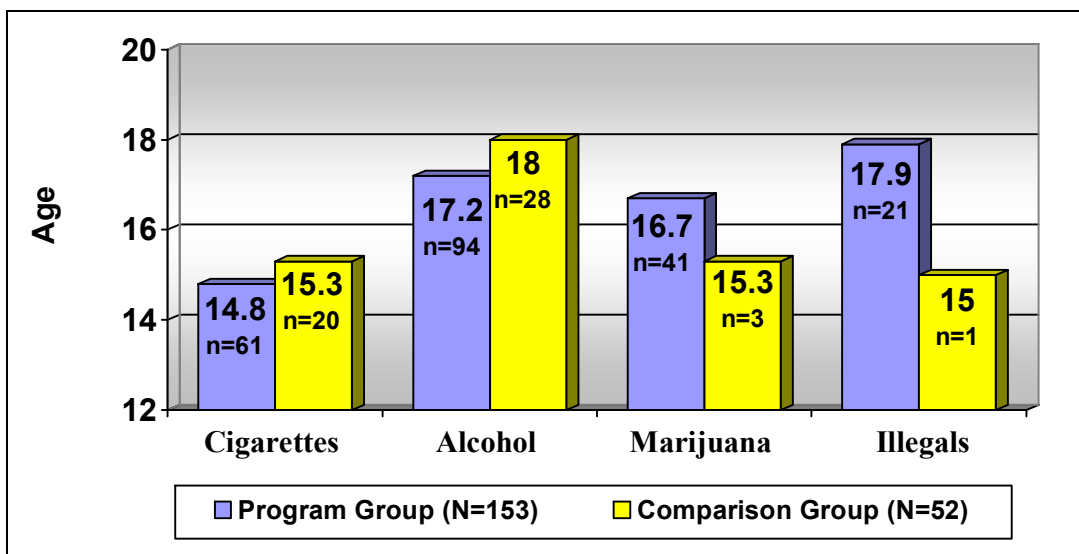
**Figure 11** shows average age at onset across SESS program group participants. Evidently, some participants who declined to answer the previous questions regarding lifetime usage responded to subsequent questions about the age of onset for each substance. Therefore, the *n*'s used in calculating the mean ages for first-time usage are slightly higher than those represented above for lifetime use. For example, while only 55 program participants reported ever smoking a cigarette, 61 participants responded to a question asking how old they were the

first time they smoked. As can be seen in the figure, the mean age for these participants was almost 15 years old when they first smoked a cigarette. Modal age was 13, with 23% of participants reporting onset of use at that age. The average age of onset for alcohol use was 17, four years higher than that for cigarettes. Average age of onset for illicit drug use was almost 18 years old ( $\bar{x}$  =17.9), slightly over one year later than the age reported for first marijuana use. The modal age for both marijuana and illegal drugs was 15.

Mean age at onset for the comparison group is similar to that of the program group for cigarettes, and is slightly older for alcohol. The number of comparison group participants who reported ever using marijuana or illegal drugs is very small (n=3 for marijuana and n=1 for illegal drugs). The average age of the three respondents who had used marijuana was 15.3, over a year younger than program group participants, and the one individual who had reported using illegal drugs reported doing so at age 15.

Data regarding onset for both the SESS program and comparison groups reflect expected trends for cigarette use. What was less expected, however, was the delayed age of onset for alcohol use, especially in the comparison group. That participants report experimenting with marijuana before alcohol suggests a stray from more normative trends that consider cigarettes and alcohol as ‘gateway’ drugs to more extreme experimentation with marijuana and illicit substances.

**Figure 11. Average Age at Onset – ATOD**

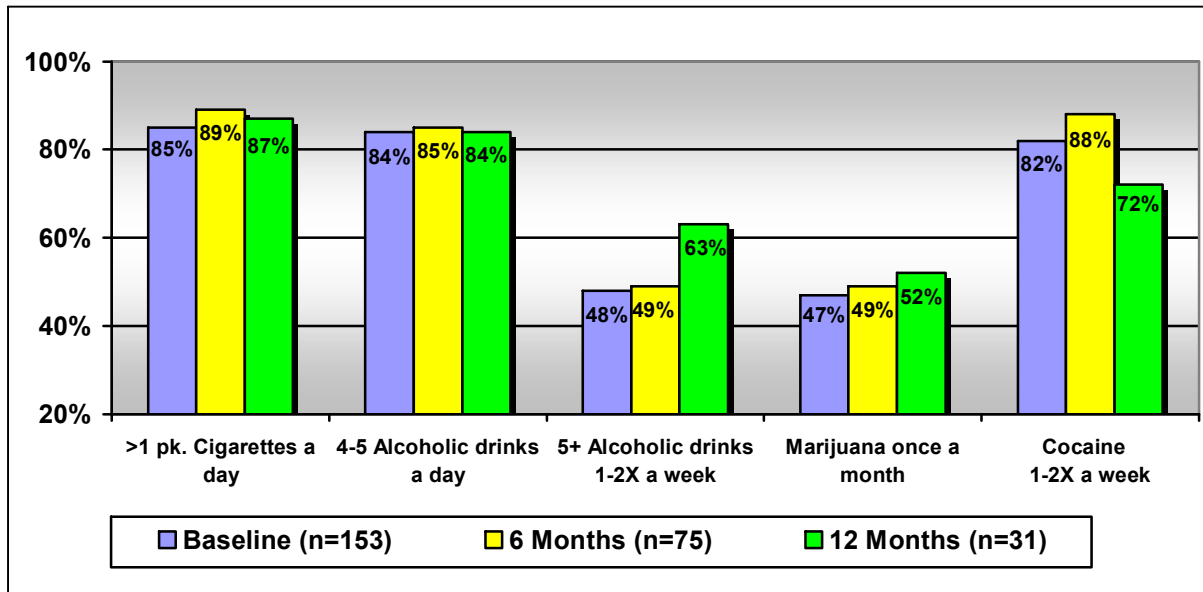


### Attitudes and Beliefs

Finally, participants’ impressions and opinions regarding risk of ATOD use were solicited. Specifically, participants were asked to report perceived risk of engaging in cigarette, alcohol, marijuana, and/or cocaine use on a weekly or monthly basis. **Figure 12** below shows percentage of participants at three timepoints who felt that “great risk” is associated with regular use of these four substances.

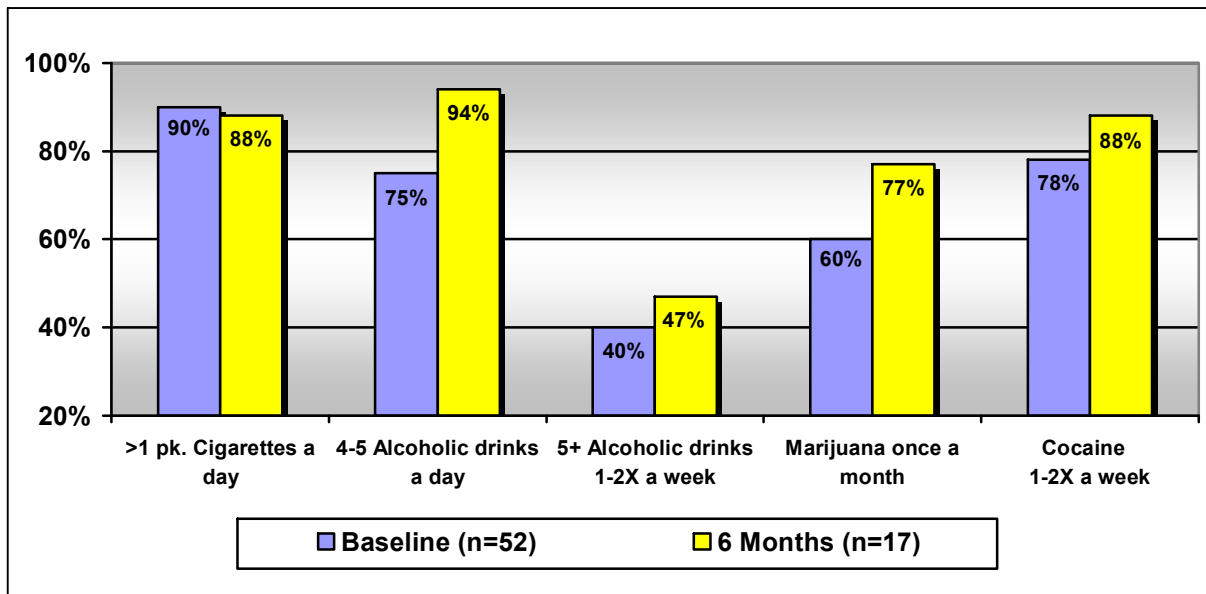
As seen in the figure, most participants (>80%) consistently associate great risk with daily cigarette smoking, daily alcohol use, and, at baseline and 6 months, with weekly cocaine use. Conversely, less than half of participants see great risk in heavy drinking up to twice per week and in monthly marijuana use, although percentages increase after 12 months of enrollment (up to 63% for heavy drinking and 52% for marijuana). Interestingly, the percentage of participants who see great risk in cocaine use decreased after 12 months by 16 percentage points (from 88% at 6 months to 72% at 12 months).

**Figure 12. Perception of Great Risk of ATOD Use at Three Timepoints: Program Group**



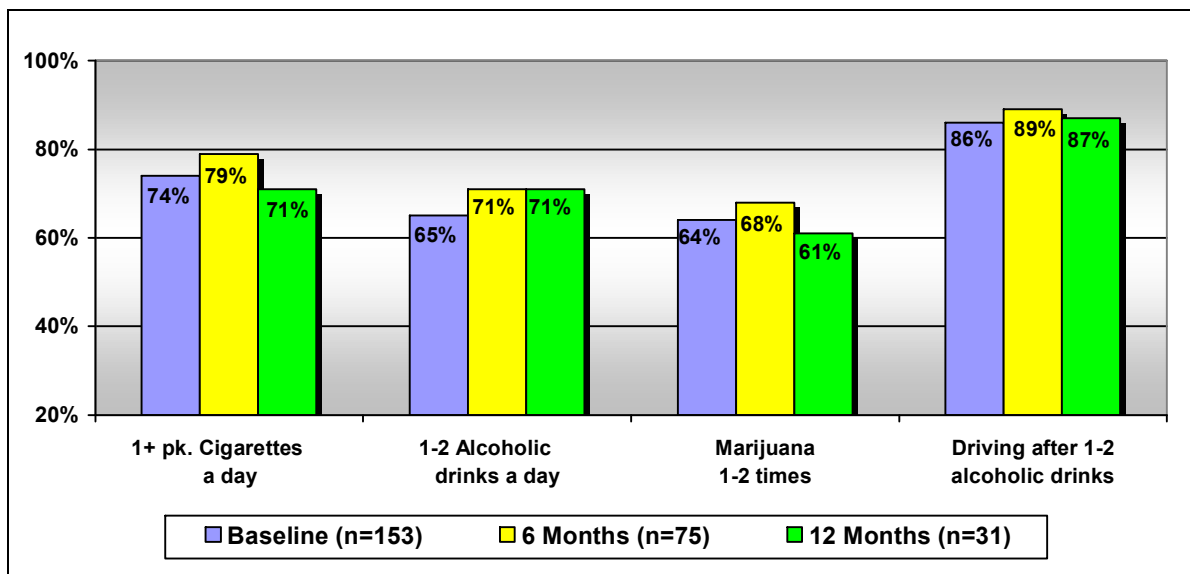
As seen in **Figure 13**, Perceptions by Comparison Group participants generally mirror those of the program group, particularly with regard to cigarettes, infrequent heavy drinking, and cocaine use. Interestingly, while fewer comparison than program participants saw great risk associated with daily consumption of 4-5 alcoholic drinks at baseline, follow-up data indicates a significant increase in risk perception (+19 percentage points), whereas rates for the program group remained relatively stable at 84%-85% through the 12-month timepoint. Additionally, in contrast to program group results, a significant increase of +17 percentage points was found at follow-up in the comparison group's perception of risk of marijuana.

**Figure 13. Perception of Great Risk of ATOD Use at Two Timepoints: Comparison Group**



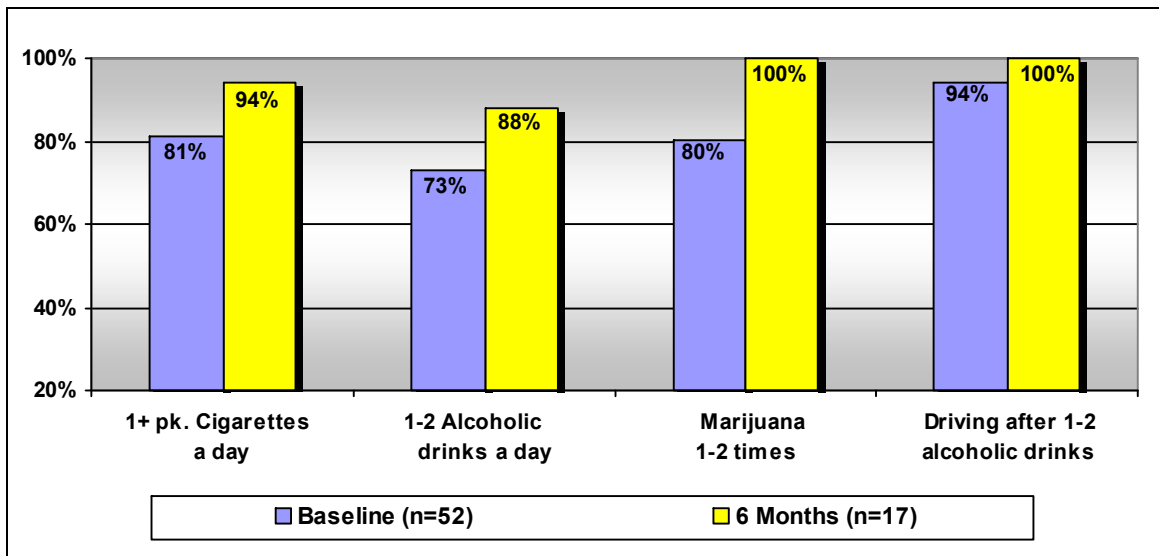
When asked to reflect on personal attitudes regarding adult use of ATODs, responses reveal an increase in censure, particularly at 6 months, and mostly in regard to alcohol use. As shown in **Figure 14**, the percentage of program participants who strongly disapprove of drinking one to two alcoholic beverages per day increased at 6 months and remained stable through 12 months, while disapproval of both tobacco and marijuana slightly decreased at the 12-month timepoint. Over 85% of respondents at each timepoint were strongly critical of those who drink and drive.

**Figure 14. Strong Disapproval of Adult Risk Behavior at 3 Timepoints: Program Group**



As seen in **Figure 15**, the comparison group’s overall rates of disapproval of risk behaviors were higher both at baseline and follow-up than those for program participants. Moreover, not only were comparison group baseline rates higher than program rates for all behaviors, but comparison group increases were also larger in all areas.

**Figure 15. Strong Disapproval of Adult Risk Behavior at 2 Timepoints: Comparison Group**



GPRA results found that overall, current usage of ATODs is relatively low for both groups, particularly the comparison group. However, rates of ‘ever usage’ were highest for alcohol and tobacco where about 55% and 38% of both groups, respectively, reported usage. The program group reported a higher lifetime use of marijuana (25%) than the comparison group (4%). Age of onset for both groups ranged between 15-18 years of age and varied by substance, with cigarette and marijuana use preceding alcohol and illegal drug use. Participants’ responses generally reflect positive health habits. Differences in usage between the two groups are reflected in differences in attitudes and beliefs regarding perception of risk and disapproval of risk behaviors. Results indicate that while initial differences were evident in that more comparison group participants appeared to attach great risk to ATOD use and to disapprove of risky health behaviors, more significant improvements in these attitudes and beliefs were found in the comparison group. Interestingly, the program group’s perception of risk associated with cocaine use decreased at the third timepoint, while the comparison group increased in their perception of the health risks associated with cocaine use 1-2 times weekly. These findings suggest that program participants may benefit from direct educational services aimed at increasing ATOD knowledge and intensified efforts to strengthen healthy behaviors.

**1b. Access to community-based mental health and substance abuse services/  
1c. Utilization of mental health and substance abuse services**

Previous to the SESS funding, HFDC used a part-time mental health consultant. The overwhelming mental health and substance abuse needs identified by Family Support Workers (FSWs) and on standardized measures such as the CES-D, indicated a large gap in services for families with these problems. Over the three years of SESS program implementation, HFDC significantly increased access to services through the hiring of two specialists; initially a full-

time Mental Health Specialist and a full-time Substance Abuse Specialist. Staffing was later changed to two full-time Mental Health Specialists since it was found that substance issues were usually subsumed within the family's mental health issues. As a result of training and consultations provided to FSWs, in-home assessments and therapy conducted, and support groups provided, as well as linkages to psychiatric consults and referrals to outside services, HFDC experienced a significant increase in the access and utilization of mental health services.

A total of 91 participants were referred for Mental Health services, with most recommended for individual counseling to address symptoms of depression. Of these referrals, 33 followed through and received mental health services. Those participants that were identified and referred but did not receive services typically refused mental health services. Short-term in-home counseling services were provided by the specialist for a maximum of 10-12 weekly sessions. Counseling services were terminated upon determination by the MHP and through client self-report of significant reduction in symptoms. However, for those in need of longer-term services or ongoing treatment, referrals were made to community mental health organizations.

#### **1d. Reduced mental health and substance abuse symptoms**

##### **Maternal Depression**

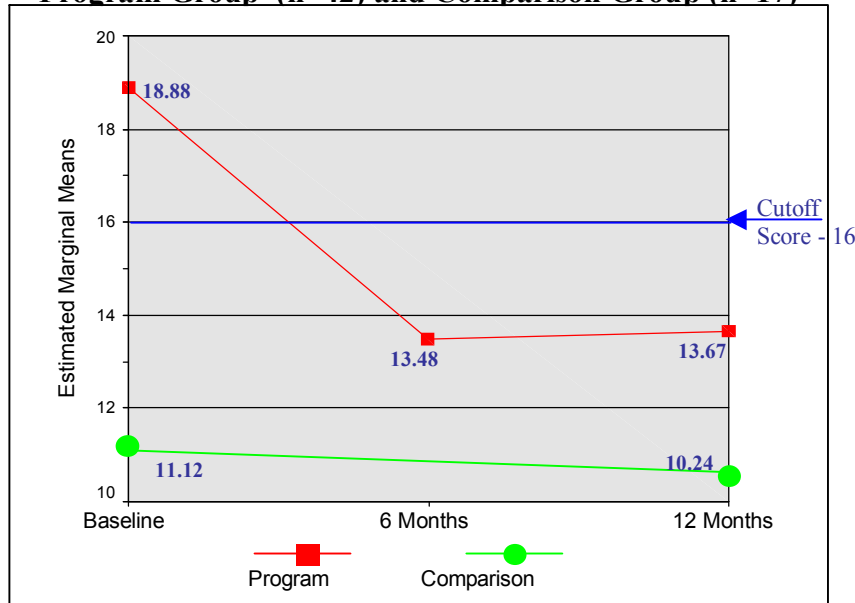
In order to assess the degree of risk for maternal depression experienced by program participants, the Center for Epidemiological Studies-Depression Scale (CES-D) is administered. The CES-D presents a series of depressive symptoms to which respondents indicate the frequency they have been experienced during the week prior to administration. Responses are coded on a 4-point Likert scale with total scores of 16 or greater considered at-risk. Program participants were administered a baseline CES-D either prenatally or within three months of the birth of the baby. At that time, more than half (55%; n=73/133) scored at risk for depressive symptomology. Results of follow-up administrations indicated a decreased percentage of participants at risk for depression at the 6-month follow-up (31%; n=26/83), and remaining at 30% (n=18/60) at the 12-month follow-up.

Comparison group baseline scores indicated that 35% (n=17/49) of participants scored at risk for depression. While too few measures were administered at 6 months for valid analysis, results at the 12-month timepoint indicate that only 20% (n=4/20) still scored at risk for depression one year after the birth of their baby.

GLM repeated measures analyses, which calculate pre-post score variance within the same individual participants, were conducted on CES-D scores from baseline to 6-months and from baseline to 12-months. Of the 162 SESS participants, 42 had CES-D scores for these three time intervals. These mothers entered the program around the birth of their baby and stayed in the program for at least one year. As seen in **Figure 16** below, mean scores decreased significantly from baseline to 6-months ( $F(1,41)=9.204; p<.001$ ) and remained at those levels to 12-months. When comparison group participants are examined over the same 12-month period for depression risk, the baseline mean is lower ( $\bar{x} = 11.12$ ), indicating less risk, but the slight decrease found at 12-months is not significant. These results, in comparison to those of the

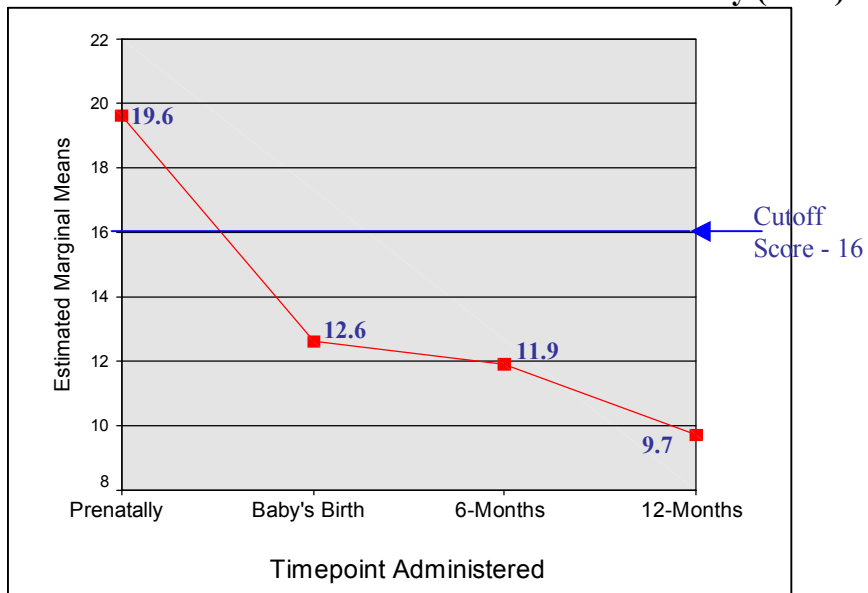
program group, highlight the dramatic decrease in depressive symptomology reported by SESS participants, particularly after receiving just 6 months of services.

**Figure 16. Repeated Measures: CES-D Results  
Program Group (n=42) and Comparison Group (n=17)**



Mary’s Center for Maternal and Child Health is fortunate to be able to engage mothers prenatally in their clinics. The impact of this is evident in **Figure 17** below. Ten mothers who were enrolled prenatally were administered the CES-D at four consecutive timepoints. These prenatal mothers tended to have higher mean scores for depression risk initially and lower mean scores at the 12-month follow-up than those who enrolled postnatally. Significant reductions in reports of depressive symptomology can be seen within a few months, at baby’s birth ( $F(1,9)=20.760$ ;  $p=.001$ ), and continue to decrease at 6-months and again at 12-months. These results indicate that prenatal mothers may be at more risk for depression and yet benefit from more program participation if services are initiated earlier.

**Figure 17. CES-D Results: Prenatal SESS Enrollees Only (n=10)**



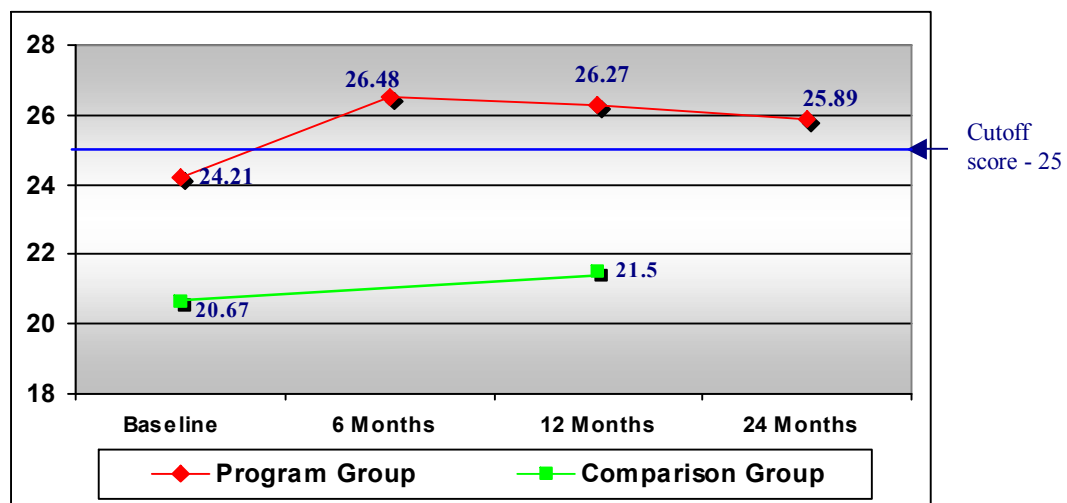
## Social Isolation/Support

The Carolina Parent Support Scale (CPSS) was administered to program mothers at program entry (baseline), after 6 months of enrollment, and annually thereafter. This instrument is used to assess the amount of informal (family and friends) and formal (organized professional services) support available to families.

Data was examined on measures administered from Baseline through 24 months, as data past this timepoint was insufficient. A total of 137 program participants were administered the CPSS at baseline. At that time, about half (56%; n=76) scored below 25, indicating risk for inadequate social support. As seen in **Figure 18**, the program group's mean at baseline ( $\bar{x}$  = 24.21) was also suggestive of risk for social isolation. A subsequent increase in social support occurred at 6 months and remained essentially the same at 12 months, but the mean score decreased slightly at 24-months. Although this decrease is not significant, the program may want to increase efforts in monitoring participants' support networks as children get older.

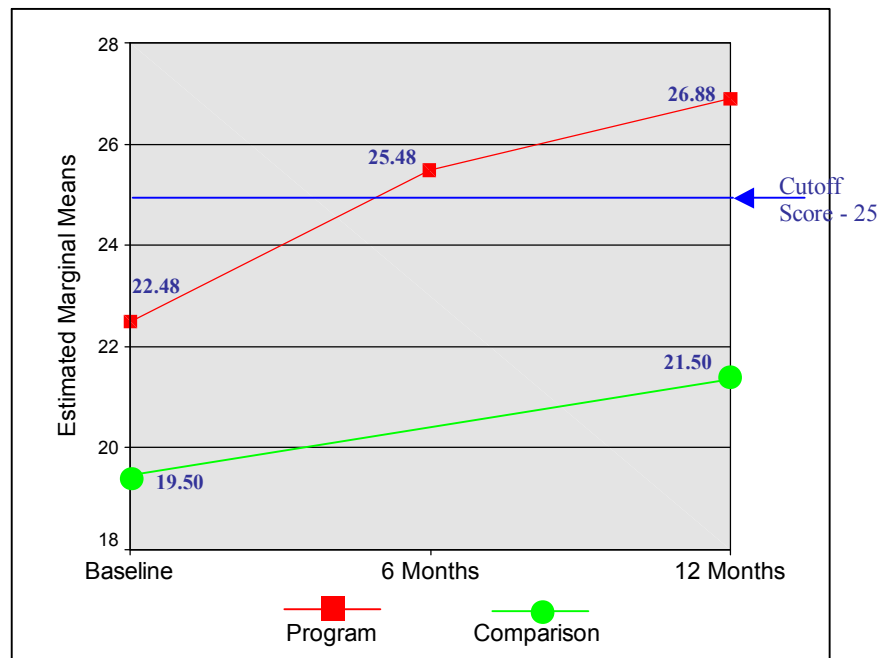
Of the 52 comparison group participants on whom CPSS data is available, slightly over two-thirds (67%; n=35) scored below 25 at baseline, with this group's mean score ( $\bar{x}$  = 20.67) substantially lower than that of the program group. The slight increase noted in the comparison group's mean score at 12 months is not significant.

**Figure 18. CPSS Mean Scores at Multiple Timepoints:  
Program and Comparison Groups**



GLM repeated measures analyses were conducted on individual program participants' CPSS scores from Baseline to 6-months and 12-months. As seen in **Figure 19**, across the one-year time period, a statistically significant increase in CPSS scores was found at 6 months ( $F(1,32) = 6.171$ ;  $p = .018$ ), as well as again at 12 months ( $F(1,32) = .967$ ;  $p = .333$ )\*. Repeated measures analysis was conducted on 18 comparison group participants at two timepoints: baseline and 12 months, yielding a non-significant increase in mean scores from  $\bar{x} = 19.5$  to  $\bar{x} = 21.5$ .

**Figure 19. Repeated Measures Analysis: CPSS Scores– Baseline through 12 Months Program Group (n=33) and Comparison Group (n=18)**



\* All tests of statistical significance were done at the .05 level.

**Goal 2. To foster healthy child development through home visits, identification of developmental problems, and parent education**

- Improve identification and assessment of developmental delays
- Improve access to early intervention services for children with developmental needs
- Improve parental knowledge of infant and child development
- Ensure all participating children are current with their immunizations
- Ensure all participating children have access to medical provider

**2a. Identification and assessment of developmental delays**

The HFDC/SESS program adheres to a rigorous standard in monitoring children’s cognitive, motor, language, social, and emotional development. The Ages and Stages Questionnaire (ASQ) is administered with each target child in the program at 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, 48, 54, and 60 months. The ASQ is a child-monitoring system designed to identify, through a combination of observation and parental interview, infants and young children who demonstrate potential developmental delays in any one of five areas: (1) communication; (2) gross motor; (3) fine motor; (4) problem solving; and (5) personal social. Each item, focusing on performance of a specific behavior, is marked “yes,” “sometimes,” or “not yet.” These regular screenings with the ASQ enable program staff and parents to monitor the children’s developmental progress, provide appropriate stimulation at each stage, and identify potential delays.

In addition to screening all children, the ASQ is used as a teaching tool with the parents to build on their knowledge of child development and to have appropriate expectations of their child. It also helps parents anticipate growth and to use activities that foster positive development. This is supplemented with strong parenting and child development curricula (i.e.,

Parents As Teachers), which extends the parents skills and knowledge. Further, FSWs prepare activities to conduct with children during home visits and encourage parents to both participate in the activities during the home visit and to do the same or similar activities with children in between visits. *HFDC/SESS was able to achieve 93% of its program children being screened for developmental delays in the final year of the SESS project.*

## **2b. Access to early intervention services**

Children identified as being at risk were referred to either the program's Early Intervention Specialist, the Early Intervention Program at Mary's Center, or the child's pediatrician for a follow-up referral to Early Intervention services. The Early Intervention Specialists or the pediatricians ensure that the child is referred to the appropriate agency to conduct assessments in the child's area of need. The Early Intervention Specialists coordinate with Family Support Workers to provide the family with appropriate information on activities to stimulate growth in the area of concern. Also, the Early Intervention Team is able to use the family's health insurance to ensure that appropriate coverage is offered for whatever follow-up services are deemed necessary given the delay. Early Intervention workers continue to work with families by conducting home visits, linking families with other community agencies, and hosting a weekly playgroup that all families are encouraged to attend.

Family Support Workers regularly check in with families to ensure that they have followed up with any assessments or appointments related to the child's possible delay. If families are reluctant to follow up, FSWs strongly encourage them to seek assistance. In the final year of the SESS project, the program referred 100% of the children, but only 98% of the families followed through on the referrals and sought EIT assessment and services.

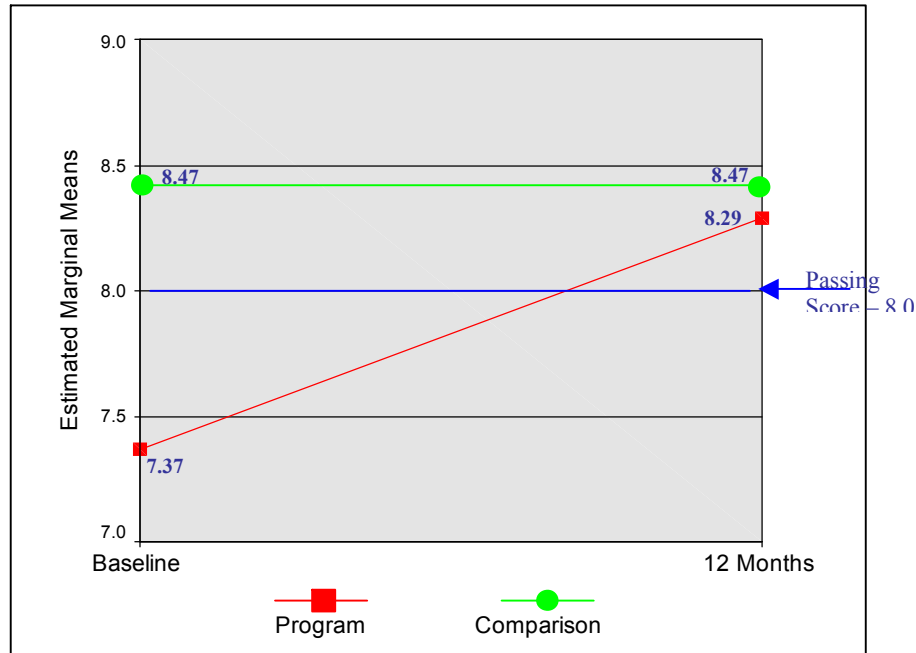
## **2c. Parenting Knowledge**

The Knowledge of Infant Development Inventory (KIDI) is used to assess participants' knowledge of parental practices, developmental processes, and infant norms of behavior, child health and development. The 14-item version of the KIDI is comprised of items measuring parent knowledge of child development up to the age of one year. A total of 130 program participants were administered the KIDI at baseline. At that time, slightly over half (59%; n=77) had a passing score. Results of follow-up administrations reveal increasing numbers of participants who passed. At 6 months, the number of participants passing increased to 69% (n=46/67), decreased slightly at 12 months to 64% (n=34/53), and then increased to 71% at 24 months (n=12/17). Almost three quarters of comparison group participants (71%; n=35/49) earned passing scores at baseline, with this percentage increasing to 77% (n=14/18) at the 12-month follow-up.

GLM repeated measures analyses were conducted on KIDI scores from baseline to 6-months and 12-months. Analysis of program participants' scores at baseline and 6 months yielded statistically significant increases in scores ( $F(1, 55) = 9.496; p = .003$ ). Additionally, as seen in **Figure 20**, across the baseline to 12-month period, a significant increase in KIDI scores was also found ( $F(1, 48) = 4.451; p = .040$ )\*. In contrast, repeated measures analysis on 17 comparison group participants found no increase at all in KIDI scores from baseline to 12 months. Although the comparison group's scores yielded a higher mean at baseline ( $\bar{x} = 8.47$ )

than that of the program group, the comparison group's mean remained unchanged after 12 months, indicating no improvement in parenting knowledge.

**Figure 20. Repeated Measures Analysis: KIDI – Baseline & 12 Months  
Program Group (n=49) and Comparison Group (n=17)**



\* All tests of statistical significance were done at the .05 level.

Results of analysis of outcome measures of depression, social support, and parenting indicate that at baseline, the program and comparison groups were comparable in the area of parent-child interaction as measured by the HOME Inventory and on parenting knowledge (KIDI). Both groups had mean HOME scores at each timepoint that were well above the cutoff point for demonstration of adequate parent-child interaction skills; however, only the program group increased their mean score at a statistically significant rate. Likewise, the program group's significant increase in parenting knowledge as evidenced by KIDI scores is in direct contrast to the comparison group's unchanged mean score, indicating no improvement in this area.

Initial differences did exist, however, on risk for depression and social support. The program group's baseline mean on the CES-D was indicative of risk for depression, whereas that of the comparison group implied no risk. However, follow-up results suggest a direct correlation between the dramatic decrease in maternal depression risk shown by the program group at 6 months and the mental health services provided to these participants. The impact of SESS participation on maternal social support is also evident in the program group's CPSS scores. The program participants' mean scores were consistently higher than those of the comparison group, yet this group's scores still increased at a statistically significant rate at each timepoint. In contrast, the comparison group's scores did not significantly increase and remained below the cutoff score even after 12 months.

## Parent-Child Interaction

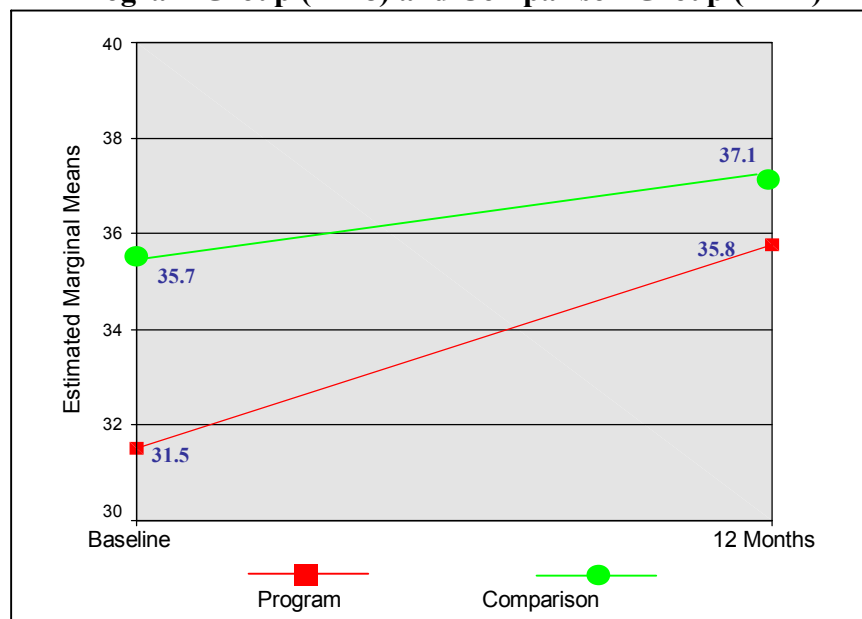
In Spring 2002, the program began administration of the *Home Observation for Measurement of the Environment (HOME)* in order to effectively assess parent-child interaction. Based on solid research findings that cognitive stimulation in the homes of young children is associated with language development, intellectual development, and academic achievement, the HOME provides a comprehensive assessment of the quality and quantity of the stimulation available to a child in the home environment. Through observation and semi-structured interviews, it is designed to assess the quality of the home environment as it relates to aspects of parent-child interaction and optimizing child development.

Since the adoption of the HOME as an assessment tool, a total of 65 SESS program participants have been administered the instrument as a baseline measure of parent-child interaction. Results show that at enrollment, 86% (n=56) achieved passing scores; **after 12 months of enrollment, 98% (n=43/44) achieved passing scores.** Comparison group results show that rates of passing scores remained consistent both at enrollment (90%; n=30/33) and after 12 months (90%; n=10/11).

GLM repeated measures analyses were conducted on the program group's HOME scores from Baseline to 6-months and 12-months. Twelve program participants had both a baseline and a 6-month HOME. Analysis of scores at these two timepoints, while not statistically significant, showed a mean increase of 3.41 points. There were, however, 18 participants who were administered the HOME both at baseline and at 12 months. As seen in **Figure 21**, during this period of enrollment, a statistically significant increase in HOME scores was found ( $F(1,17) = 11.774; p = .003$ )\*.

GLM repeated measures analysis was also conducted on the HOME scores of 11 comparison group participants from baseline to 12 months. While mean scores for the comparison group at both timepoints were higher than those of the program group, the level of increase found was non-significant.

**Figure 21. Repeated Measures Analysis- HOME Scores: Baseline & 12 Months Program Group (n=18) and Comparison Group (n=11)**



\* All tests of statistical significance were done at the .05 level.

## **2d. Child immunizations**

Families are more likely to complete immunizations when they are covered by health insurance and have a medical home. Therefore, the success of immunizing children is related to high rates for linkage with health insurance and a medical home, a focus of the HFDC/SESS program. Family Support Workers regularly check in with families regarding their children's immunizations. Each family is provided an immunization "passport" in which they ask the doctor to record each round of immunizations the child receives. Starting even prenatally, FSWs provide information on the importance of immunizations for a child's health. FSWs often remind families of when immunizations will be due. If families have trouble making appointments due to lack of a phone, or because they don't speak English, FSWs may initially assist them with making phone calls until the FSW is able to devise a plan with the family so that they can schedule their own appointments. FSWs may also at times attend appointments with families, either when translation may be needed or when a family feels uncomfortable attending an appointment on their own. FSWs can help families to ensure that they ask all necessary questions and that they understand the answers to their questions. The goal is to empower families to eventually feel comfortable on their own taking charge of their healthcare needs.

At the end of the SESS project, **95% of children were up to date with their immunizations.** This is far above the national average of just 78% of children current on their immunizations.

## **2e. Access to medical provider**

A primary focus of the HFDC program is to ensure that families are linked with health insurance and health care providers. Washington, DC offers health coverage to low-income children through its Medicaid program. Mothers are covered prenatally, but medical coverage for low-income adults and the working poor can be hard to access, particularly for undocumented immigrants. Washington, DC does have some programs that fill the gaps, like DC Healthy Families for the working poor and Alliance. Healthy Families DC staff work to link families with insurance even during their initial assessments, providing information and referrals even if families are not enrolled into the home visitation portion of the program. Once enrolled, Family Support Workers work with families to ensure that they follow up on appointments regarding health insurance, assist families in completing forms, reading materials related to their insurance to ensure they understand their coverage, and help them to choose their healthcare providers. FSWs also provide translation services when needed throughout the process of enrolling in a health insurance program. Finally, FSWs are able to assist families in maintaining their health coverage by helping them to complete any follow-up paperwork for themselves or their babies. In the final year of the SESS project, **94% of children were linked with a healthcare provider/insurance.** This exceeds the national average of 89%.

## **Goal 3. Improve school readiness**

Family Support Workers work with families regarding educational referrals for children starting when and if families want their children to be enrolled in a daycare setting. FSWs help families identify potential daycare options in their neighborhoods, go with families to visit potential centers, and assist them in seeking information and asking questions to assess the quality of their daycare options. The same holds true when children are at an age to enroll in either public or private pre-school or kindergarten. FSWs make sure that families understand the

array of possibilities that exist including public, charter, and private schools with scholarship programs, so that families do not feel that they are tied down to their local DC Public School, which may not be of the highest quality. FSWs start educating families early on about their options, because often, early applications can lead to more opportunities.

***HFDC/SESS was able to provide information to 100% of families regarding their options around schools.*** All Family Support Workers regularly provide information to families regarding their school options, ensuring that by the time their children are school ready, they are well aware of their choices.

## Summary and Conclusions

Over the past three and one-half years, the Starting Early, Starting Smart (SESS) program has engaged over 150 families enrolled in Healthy Families DC in enhanced services designed to integrate professional mental health, substance abuse, and child development services with the core services of the Healthy Families home visiting model implemented by HFDC. By doing so, the HFDC/SESS program sought to increase participants' access to and utilization of comprehensive services, particularly those relating to caregiver behavioral health, family functioning, child social-emotional development, and related outcomes.

The HFDC/SESS project utilized a dual approach in attaining its goals: (1) *Capacity Building*, which focused on strengthening the linkages between HFDC and community-based providers, thereby increasing access to care and better facilitation of referrals for families and (2) *Program Enhancement*, which focused on increasing the availability and expertise of professionals to address needs in the areas of mental health, substance abuse, and child development. The innovative integration of these two methodologies with core program elements that are implemented with a recognition and respect for the rich cultural diversity of the participant population has helped HFDC achieve recognition recently through the HFA re-credentialing process, as well as in press releases from DC Mayor Anthony Williams.

A total of 164 HFDC families participated in the SESS program. Families were eligible for participation if mothers were prenatal or within two to three months postnatal and assessed to be at risk on multiple risk factors associated with child abuse and neglect. HFDC/SESS participants received all core Healthy Families services as well as behavioral health and child development screening, treatment and referrals if necessary. In addition, a comparison group of 56 families was recruited from two other Mary's Center programs: the Teen Mothers Take Charge (TMTTC) and the Family Social Services (DFSS) program. This group received only the usual and customary services of their respective programs and did not receive any HF or SESS services. All Treatment and Comparison group mothers were administered the same outcome measures following the same repeated measures schedule. Overall, results of outcome measures provide evidence that the SESS program achieved success in reducing risk factors while promoting positive parenting and facilitating social networking and support.

Analysis of initial comparability of both the program and comparison groups found the groups to be comparable on age (program  $\bar{x}$  = 23.3; comparison  $\bar{x}$  = 24.5) and education levels (program  $\bar{x}$  = 9.56; comparison  $\bar{x}$  = 8.67). Due to the referral sources for the groups, however, the ethnic make-up of the groups differed; specifically, the program group was comprised of 56% Hispanic families, while all families in the comparison group (100%) were Hispanic. Analysis of baseline measures of depression, social support, and parenting indicate that the program and comparison groups were initially comparable in the areas of parent-child interaction and parenting knowledge. The two groups differed in risk for depression and for social isolation. The Treatment group had significantly higher mean scores for depression risk at baseline, while the Comparison group was at significantly higher risk for social isolation at baseline.

Repeated measures analyses of data from follow-up data points indicated significant improvements in parenting and risk reduction for the Treatment group, which were not matched

by the Comparison group. In the area of parenting, although both groups had adequate mean parent-child interaction (HOME) scores at each timepoint, only the Treatment group had a significant increase in their mean score at follow-up datapoints through 24 months. Likewise, the Treatment group's significant increase in parenting knowledge (KIDI) contrasted sharply with the comparison group's unchanged mean score, providing evidence of a lack of improvement in the absence of intervention.

Further, significant reductions in depression risk for the Treatment group were not matched by the Comparison group. Although the groups were dissimilar at baseline on risk for depressive symptomology (the comparison group's baseline mean on CES-D implied low risk for depression; treatment group's mean was clearly indicative of risk), the Treatment group had significantly lower mean scores within three to six months after enrollment with continued significant decreases through 12 and 24 months, while the Comparison group's mean was unchanged. Most striking was the reduction in risk for mothers enrolled in the HFDC/SESS program prenatally. Although the baseline risk was higher for prenatal mothers than either the total program or comparison groups, they had significant reductions in risk more rapidly and of greater proportion than the other groups. Results suggest a relationship between the dramatic decrease in maternal depression risk shown by the program group and the addition of the mental health component to the core services provided to these participants. Whereas previous research had found that it took approximately 12-24 months to see significant reductions in psychosocial variables, such as depression and social isolation, SESS program participants showed significant reductions after just three months of services. The availability of both English and Spanish-speaking Mental Health Providers clearly made it possible to provide in-home therapy to a segment of the population who might not otherwise follow up with treatment. Specifically, some of the most isolated families, at the most risk for increased stress and depression, were able to easily access services right in their own homes.

The impact of SESS participation on social support is also evident in the program group's CPSS scores. The program participants' mean scores were consistently higher than those of the comparison group indicating greater social support, yet this group's scores still consistently increased at a statistically significant rate throughout their first year of enrollment. In contrast, the comparison group's scores did not significantly increase and remained below the cutoff score even after 12 months indicating sustained social isolation despite involvement in the TMTC or DFSS programs.

Significant accomplishments were also achieved in the areas of maternal and child health, and child development. The efforts of the HFDC/SESS program to ensure that each family is covered by medical insurance and linked with a medical provider are evident in the program's success in related goals. In the final year of the SESS project, 94% of children were linked with a healthcare provider/insurance. This not only exceeds statistics for the District of Columbia (86%)<sup>1</sup>, but also surpasses the national average of 89%<sup>2</sup>. In addition, the program's achievement in this area led to a corollary success in its goal of ensuring that all program children are current with their immunizations. At the end of the SESS project, 95% of children were up to date with their immunizations. Again, this is far above the national average of just

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<sup>1</sup> US Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2003.

<sup>2</sup> CDC National Center for Health Statistics: 2002

78%<sup>3</sup> of children current on their immunizations. The program regularly utilized the Ages and Stages Questionnaire (ASQ) to enable program staff and parents to monitor children's developmental progress, provide appropriate stimulation at each stage, and identify potential delays. As a result, HFDC/SESS was able to achieve its goal of improving identification and assessment of potential developmental problems, with 93% of its program children being screened for developmental delays in the final year of the SESS project.

Several key factors have contributed to the success of the integrated model implemented by the HFDC/SESS program, including:

- The program was implemented within a strong lead agency, the Mary's Center for Maternal and Child Care, Inc., which provides support and agency resources, endorses and promotes the program, and links program families to the agency's other services.
- The strength of the core comprehensive services and existing program infrastructure of HFDC which facilitated the successful outcomes in the areas of parenting, maternal and child health and child development; and which eased the integration of the mental health and substance abuse specialists and enhanced services into the program.
- The responsiveness of the program to ongoing staff and evaluation feedback regarding the effectiveness of program components and the specialists. It was precisely this feedback that identified the outstanding and ongoing family issues with substance abuse and depression and resulted in the SESS enhanced model. Additionally, when it was evident through qualitative feedback that substance abuse issues were subsumed within the family's mental health issues, HFDC refined the SESS staffing pattern and added a second Mental Health Specialist to replace the Substance Abuse Specialist.
- The availability of a culturally competent and bilingual Mental Health Specialist made it possible to engage the large Spanish-speaking population for behavioral health screening and services.
- The training and consultation the Mental Health and Child Development Specialists provided to the Family Support Workers extended the reach of the professional services and built capacity within the program to increase the identification and referral of families for mental health and/or substance services, as well as developmental interventions.

Recommendations include:

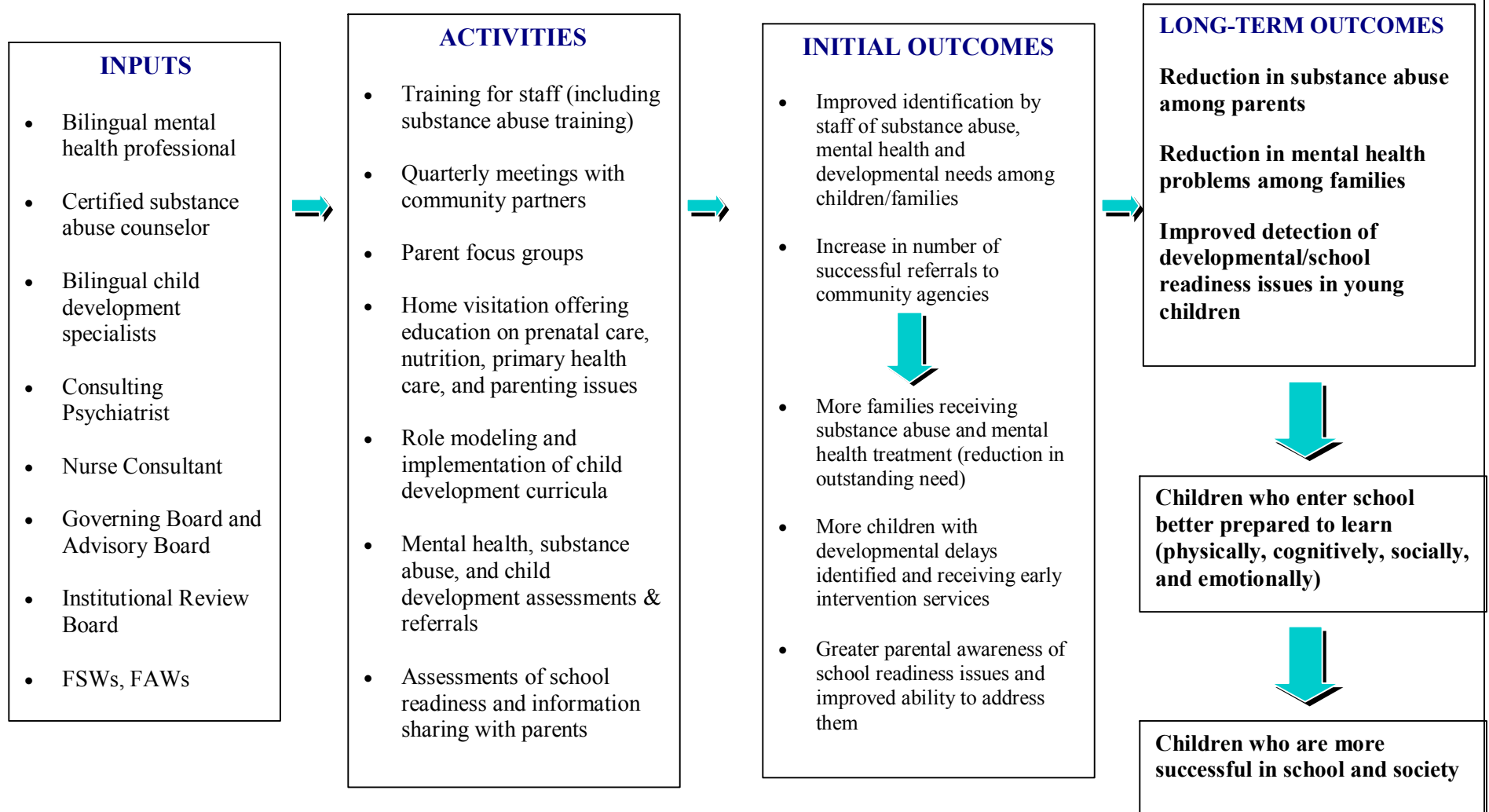
- Sustain Mental Health Specialist(s) that can work with both the Spanish speaking and African-American populations.
- Continue efforts to enroll mothers prenatally and screen for depression risk.
- Increase capacity of Child Development Specialist to track completion of regular developmental screening and conduct assessments on children with suspected delays.
- Continue/Increase capacity building in mental health through staff trainings and availability of consultation with culturally competent MH specialists.
- Increase documentation of Mental Health and Child Development Specialists' activities to better understand the relationship between the program enhancements and outcomes.

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<sup>3</sup> CDC National Center for Health Statistics: 2002

**APPENDIX A**

**HFDC/SESS Logic Model**



**APPENDIX B**

**Healthy Families DC Service Level Descriptions**

<b>A. ACTIVITY LEVELS</b>		
<b>Level</b>	<b>Definition</b>	<b>Number of Home Visits Due</b>
P1	Prenatal and until baby is due, or baby’s birth, which ever arrives first. All participants must be placed on P1 if they enter at or beyond their third trimester of pregnancy.	4 per month (weekly)
P2	Prenatal and until the month the baby is due or the baby arrives, whichever comes first.	2 per month (biweekly)
SS	Prenatal or after the baby is born and average length of time is 3-4 months with exceptions documented in files.  Family requires more than 4 visits per month due to a particularly difficult period confronting family. It is identified that the FSW is spending more than merits based upon the assigned level with the family and/or linking the family to additional resources.  Temporary placement for a family if a second child is born.	Minimum of 4 per month  Can be more if necessary
1	Begins last month of pregnancy, or day of baby’s birth, whichever arrives first. Continues for at minimum 6 months.	4 per month
2	Average length of time is 6 months to 1 year. Criteria for promotion/less intensive services are met.	2 per month
3	Average length of time is 6 months to 1 year. Criteria for promotion/less intensive services are met.	1 per month
4	Family is achieving independence from HFDC. Criteria for promotion are met.	1 per quarter
X	Creative Outreach. Three months are provided to work to engage or re-engage family in program. Average length of Creative Outreach is 3 months with extensions documented in files. Family may remain on Creative Outreach throughout pregnancy, as cases are not closed during pregnancy unless family clearly indicates they are not interested in receiving services.	1 per month (Minimal)
E	After baby is born. May remain as long as the situation requires. Should schedules change, family returns to original level.  Families work and/or school commitments make scheduling home visits difficult; however family is engaged in the program and wants to continue receiving services. This Level applies only to Level 1 and 2 families. Phone calls allow FSW to maintain engagement with the family and to identify child’s developmental milestones, well baby schedule, progress on goals and any additional needs.	1 per month (min) and weekly phone calls. Phone calls documented in client notes. Do not count in statistics.
<b>B. INACTIVE LEVEL</b>		
T	Case Terminated	

## **APPENDIX C**

### **Critical Elements of Successful Home Visitation Programs**

1. Initiate services at birth or prenatally.
2. Offer services voluntarily and use positive, persistent outreach to build family trust in accepting services.
3. Use a standardized assessment tool to differentiate between families who need intensive service and those who do not.
4. Offer home visits intensively (1x per week) with well-defined criteria for changing intensity of service and maintaining service over the long term (3-5 years).
5. Services should be culturally competent.
6. Services should focus on supporting the parent-child relationship and child development as well as supporting the parent.
7. Link families to community services as needed, including medical home.
8. Limit caseloads of staff or ensure time and energy for quality services.
9. Select service providers for their personal characteristics that reflect their ability to do this demanding work.
10. All service providers must have a framework for handling the variety of situations they may encounter and therefore must receive training on a broad range of topics.
11. Service providers must receive intensive training specific to their role.
12. Regular, ongoing, effective supervision is required for all staff.

## Appendix D

### Description of Measures

#### **Ages & Stages Questionnaire (ASQ)**

Authors: Jane Squires, Ph.D., LaWanda Potter, M.S., and Diane Bricker, Ph.D.

Description: The ASQ is a child-monitoring system consisting of 11 questionnaires designed to identify infants and young children who demonstrate potential developmental problems. The questionnaires were developed to use when the child is 4, 8, 12, 16, 20, 24, 30, 36, and 48 months of age, with optional forms available at 6 and 18 months. Each questionnaire features 30 developmental items in five areas: (1) communication, (2) gross motor, (3) fine motor, (4) problem solving, and (5) personal-social. Each item, focusing on performance of a specific behavior, is marked “yes”, “sometimes”, or “not yet”. Children are identified as needing further testing and possible referral for early intervention services when scores fall below designated cutoff points.

#### **The Carolina Parent Support Scale (CPSS)**

*Author: Marie Bristol, PhD*

Description: The Carolina Parent Support Scale, a 23-item questionnaire, is used to measure the number and perceived helpfulness of various sources of social support at the individual, family, neighborhood and community level for families with infants with disabilities. Adjusting for the population served, the HFDC program uses a modified version of the 23-item CPSS in which specific references to support for families with infants with disabilities has been removed. The program’s modified 15-item version measures 8 sources of informal and 7 sources of formal support. Informal support is provided through unorganized resources such as family members and friends; whereas formal support is provided through organized professional resources. In addition to measuring these separate support levels, a total support score is also generated. Parents are asked to rate a list of people or services on a 5-point Likert scale from “Not at all helpful” to “Extremely helpful” as they consider how or if each has made their lives easier.

#### **Knowledge of Infant Development Inventory, Short Form (KIDI)**

*Author: David MacPhee, Ph.D.*

Description: The Knowledge of Infant Development Inventory, Short Form (KIDI/SF) is designed to assess one’s knowledge of parental practices, developmental processes, and infant norms of behavior, child health and development. The KIDI/SF consists of 14 statements reflecting parents’ knowledge of how babies behave, how they develop, and how to best care for them. The statements are rated on a 5-point Likert scale, ranging from “strongly agree” to “strongly disagree.” The KIDI/SF may be self-administered or administered by interview. It is used as a baseline measure to obtain information on parental knowledge of infant development, and at follow-up points of 6, 12, and 24 months.

#### **Center for Epidemiologic Studies – Depression (CES-D)**

**Author: The Center for Epidemiologic Studies, National Institute of Mental Health**

Description: The CES-D is used to measure maternal depression. This 20-item self-reporting instrument focuses on depression symptomology rather than diagnose clinical depression. It consists of four separate factors: depressive affect, somatic symptoms, positive affect, and interpersonal relations. The evidence that shows a casual link between symptoms of depression and children’s

well-being provides the rationale for including this construct in the Parent Interview. It has been used in many rural and urban populations and cross-cultural studies of depression.

**Home Observation for Measurement of the Environment (HOME) Third Edition, 2001**

**Authors: Bettye M. Caldwell & Robert H. Bradley**

Description: The HOME is used to measure the quality of the home environment. Currently in its third revision, this measure is used to objectively assess the quality and quantity of stimulation and support available to a child in the home environment. At present, there are four versions of the HOME: Infant/Toddler (Ages 0-3), Early Childhood (Ages 3-6), Middle Childhood (Ages 6-10), and Early Adolescent (Ages 10-15). It has a strong track record in previous research and has been used with a variety of different racial/ethnic groups. Studies using the HOME have repeatedly found that cognitive stimulation in the homes of young children is associated with language development, intellectual development, and academic achievement.

**SAMHSA GPRA Client Outcome Measures for Discretionary Programs**

Description: Multiple-choice questions regarding drug and alcohol use, family and living conditions, and attitudes and beliefs about alcohol and drugs.

**Appendix E**

**Healthy Families DC/SESS**  
**Description of Evaluation Measures and Schedule**  
*Donna D. Klagholz, Ph.D. & Associates, LLC- 2004*

Name of Measure	Administration Schedule
<i>Evaluation Consent</i>	◆ At enrollment
<b>Measures</b>	
	<b>Minimum Requirement</b>
<i>ASQ</i>	<ul style="list-style-type: none"> <li>◆ Every four months up to two years of age, and then</li> <li>◆ Every six months up to five years of age.</li> <li>◆ Program may decide to administer developmental screen more frequently, as needed (previous ‘suspect’, or FSW or parent concern)</li> </ul>
<i>HOME</i>	<ul style="list-style-type: none"> <li>◆ 60-90 days after birth of the baby</li> <li>◆ Annually thereafter</li> </ul>
<i>KIDI</i>	<ul style="list-style-type: none"> <li>◆ First within three months of enrollment or prior to completion of 8 HV</li> <li>◆ Annually thereafter</li> </ul>
<i>CES-D</i>	<ul style="list-style-type: none"> <li>◆ First within three months of enrollment or prior to completion of 8 HV</li> <li>◆ Second after the birth of the baby (45-60 days)</li> <li>◆ Annually thereafter</li> </ul>
<i>CPSS</i>	<ul style="list-style-type: none"> <li>◆ 30 days after initial contact</li> <li>◆ Six months after baseline</li> <li>◆ Annually thereafter</li> </ul>
<i>GPRA</i>	<ul style="list-style-type: none"> <li>◆ 30 days after initial contact</li> <li>◆ Every six months thereafter</li> </ul>
<i>HFDC/SESS Parent Satisfaction Questionnaire</i>	<ul style="list-style-type: none"> <li>◆ Completed by the conclusion of the fiscal year.</li> <li>◆ May also complete for closed families at the time of discharge from the program.</li> </ul>



## Starting Early Starting Smart

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### PARENT CONSENT FOR PARTICIPATION IN STARTING EARLY STARTING SMART (SESS) EVALUATION

***Purpose of the Project:***

Mary's Center for Maternal and Child Care, Inc. and several other agencies are participating in a program called Starting Early Starting Smart (SESS). This three-year program works with families to promote children's health and well-being through home visits, assessments and referrals to community agencies. As part of the program, a study is being conducted to see whether these services help families, especially their children. If our program is successful, it will give us a greater ability to bring more services of this type into your community.

***Participation in the Evaluation of the Project:***

In order to better plan our program, meet the needs of children and their families, and determine which services work best, we need to learn about families' ideas and attitudes about parenting, their children, and their community. If you agree to participate in this study, we will be asking you to complete some questionnaires. The questionnaires have to do with your health and the health of your family members (including your children). There are also questions about your child's behavior, your feelings, and your relationships with people in your family. The questions will be read aloud to you, and will be read to you in your native language if you are not comfortable answering them in English. You do not have to answer any questions that you do not understand or do not want to answer. Your responses to the questions will be completely anonymous and confidential.

You will be given the questionnaires prior to beginning the program, and once a year for annual follow-up. Our staff will assist you in completion of the questionnaires, which will then be sent directly to our evaluator in a sealed envelope without your name on it.

Participation in the evaluation is entirely ***voluntary***. Should you decide not to participate in the completion of the questionnaires, this will not prevent you or your child from participating in SESS or any other program offered by Mary's Center for Maternal and Child Care, Inc. and their partnering agencies. If you decide that you do not want to continue to be in the study, you can withdraw from participation at any time.

**Protection of Privacy**

All information is ***confidential***, no names are attached to the information you give us (only code numbers), and information from all families participating in the study is looked at as a whole. The program and evaluation staff follow strict policies about protecting the privacy of all participants. Project reports will not give names and will only report information for the whole group. All information will be kept at the evaluator's office in a confidential file for the entire time the study is being conducted. The information will only be seen by the evaluator. Certain exceptions to confidentiality are legally required in cases of continuing child abuse and specific court ordered disclosures.

***Risks and Benefits to Participants:***

Programs such as SESS have been successful in helping parents to provide their children with a healthy and safe environment in which to grow. Participation in this program should be a help to you and your family. Results of the study will be used to help families in other communities. There are few risks. Strict confidentiality procedures are in place to guard against any disclosure of confidential information. The exception would be cases of child abuse or criminal behavior, where authorities would need to be informed.

If you have any questions about the SESS program or the evaluation project, please call the SESS staff or Donna Klagholz, Evaluator, at \_\_\_\_\_.

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I have been informed about the SESS study in a language that I understand. I understand participation is voluntary, and that staff will collect the above-described information. I understand that everything is confidential and anonymous. I hereby agree to participate in the SESS Evaluation.

I understand that this consent will terminate on **6/30/2005** unless revoked by the undersigned in writing.

**Parent/Guardian Name (please print):** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone (home):** \_\_\_\_\_

**Child Name (please print):** \_\_\_\_\_

**Relationship to Child:** \_\_\_\_\_

**Researcher Name (please print):** \_\_\_\_\_

**Researcher Signature:** \_\_\_\_\_

**\*\* Interagency Release of Information \*\***

For the purposes of this study, I give permission for the evaluator to obtain information from records held at from the following agencies:

\* Mary's Center for Maternal and Child Care, Inc.

\*

\*

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



7. Does (did) your FSW usually call you in between visits? *(check one answer)*

- yes  no phone  
 no  no answer  
 sometimes/occasionally

8. Does (did) your FSW visit you often enough? *(check one answer)*

- yes, s/he visited me often enough  
 no, I wish s/he had come more often  
 s/he came too much  
 no answer

9. Do you think your FSW is (was) aware of your needs and helped you with these needs? *(check one answer)*

- yes  don't know  
 no  no answer

10. What makes you think so?

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- I don't know  
 no answer

11. How would you describe your FSW? *(check all that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> knowledgeable/informed         | <input type="checkbox"/> truthful/honest                               |
| <input type="checkbox"/> warm/caring                    | <input type="checkbox"/> calm  |
| <input type="checkbox"/> understanding                  | <input type="checkbox"/> helpful                                       |
| <input type="checkbox"/> encouraging                    | <input type="checkbox"/> organized                                     |
| <input type="checkbox"/> respectful                     | <input type="checkbox"/> supportive                                    |
| <input type="checkbox"/> available                      | <input type="checkbox"/> scattered                                     |
| <input type="checkbox"/> firm                           | <input type="checkbox"/> insensitive                                   |
| <input type="checkbox"/> smothering                     | <input type="checkbox"/> too business-like                             |
| <input type="checkbox"/> understand my culture/heritage | <input type="checkbox"/> respect my culture/heritage                   |
| <input type="checkbox"/> other _____                    | <input type="checkbox"/> don't know <input type="checkbox"/> no answer |

12. Do you think that your Family Support Worker respects you, tries to understand things about you, like where you were born, what are your likes and dislikes, and different things about your family values? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, in what ways?: \_\_\_\_\_

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If no, what would help your FSW in this area? \_\_\_\_\_

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13. Since enrolling in HFDC, how many FSWs have you worked with? \_\_\_\_\_  
If more than one, what do you think about having more than one FSW while in the  
program? \_\_\_\_\_

\_\_\_\_\_ I don't know \_\_\_\_\_ no answer

14. Has this program been helpful to you in raising your child? (*Check one answer*)

\_\_\_\_\_ yes  
\_\_\_\_\_ no  
\_\_\_\_\_ no answer

15. I feel I know more about: (*check all that apply*)

\_\_\_\_\_ babies' growth and development and what to expect  
\_\_\_\_\_ taking care of baby  
\_\_\_\_\_ resources in the community  
\_\_\_\_\_ parenting information/I feel I am a better parent  
\_\_\_\_\_ coping with problems/stress in daily life and other relationships  
\_\_\_\_\_ talking to other parents with young babies  
\_\_\_\_\_ well baby care visits and/or immunizations  
\_\_\_\_\_ other (*specify* \_\_\_\_\_ )  
\_\_\_\_\_ no answer

16. Have you been satisfied with the group gatherings (play groups, fathers' groups, parties, Parenting classes)?

\_\_\_\_\_ yes (*specify which ones* \_\_\_\_\_ )  
\_\_\_\_\_ I haven't attended any  
\_\_\_\_\_ no (*specify which ones* \_\_\_\_\_ )  
\_\_\_\_\_ no answer

17. Suggestions on how to make group gatherings better or more convenient.

\_\_\_\_\_  
\_\_\_\_\_

18. What do (did) you like the best about the program? (*check all that apply*)

\_\_\_\_\_ advice/suggestions/information about parenting  
\_\_\_\_\_ advice/suggestions/information on baby's health, growth, development  
\_\_\_\_\_ having someone visit me at my home  
\_\_\_\_\_ parent groups/play groups/activities  
\_\_\_\_\_ respectful of culture  
\_\_\_\_\_ assistance with transportation  
\_\_\_\_\_ having someone around to listen and help  
\_\_\_\_\_ have someone go with me to appointments  
\_\_\_\_\_ help getting my child into daycare and/or school  
\_\_\_\_\_ helps me get resources on the community  
\_\_\_\_\_ help my family find doctors.  
\_\_\_\_\_ other (*specify* \_\_\_\_\_ )

\_\_\_\_\_ none of the above. Why? \_\_\_\_\_  
\_\_\_\_\_

19. What do you like best about the home visits?

\_\_\_\_\_ activities with me and my child  
\_\_\_\_\_ information given  
\_\_\_\_\_ ASQ  
\_\_\_\_\_ help me think of goals  
\_\_\_\_\_ other (specify \_\_\_\_\_)

20. Sometimes on the home visit your Family Support Worker asks you questions from forms to better understand the needs of your family, support you and identify other ways we can support you and the community. How do you feel about these questionnaires?

The questions are easy to understand? Yes \_\_\_\_\_ No \_\_\_\_\_  
I am okay with answering them? Yes \_\_\_\_\_ No \_\_\_\_\_  
I feel that the reason for the questionnaires was explained well? Yes \_\_\_\_\_ No \_\_\_\_\_  
Please provide additional comments about them in the space below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Don't Care                      \_\_\_\_\_ Never Done One

21. Please add suggestions of how Healthy Families DC or your home visitor can better assist or support you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. Overall, how satisfied are (were) you with this Healthy Families DC program?

\_\_\_\_\_ very satisfied      \_\_\_\_\_ dissatisfied  
\_\_\_\_\_ satisfied              \_\_\_\_\_ very dissatisfied  
\_\_\_\_\_ no answer

23. Would you recommend the program to a friend?

\_\_\_\_\_ yes      \_\_\_\_\_ no      \_\_\_\_\_ no answer

24. How long have you been a Healthy Families DC participant? \_\_\_\_\_

25. Are you familiar with the Parent Advisory Board (PAB)? \_\_\_\_\_ yes      \_\_\_\_\_ no

26. Are you already a member of the PAB? \_\_\_\_\_yes \_\_\_\_\_no

27. If not, are you interested in becoming a member of the PAB? \_\_\_\_\_yes \_\_\_\_\_no  
If no, why not?:

\_\_\_\_\_ Childcare issues – don't have anyone to watch my child

\_\_\_\_\_ Don't feel I have anything to contribute

\_\_\_\_\_ Don't understand what the purpose of the PSB is

\_\_\_\_\_ Don't have time generally

\_\_\_\_\_ The time the group is held is not good for me

\_\_\_\_\_ Transportation difficulties

\_\_\_\_\_ Other

If Other, please explain

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28. What could the HFDC program do to make you more interested in participating in the PAB?

\_\_\_\_\_ Offer meetings directly after playgroups or other family gatherings

\_\_\_\_\_ Offer meetings at a particular time of day that is more convenient for me

Please check when would be a better time:

\_\_\_\_\_ Evenings \_\_\_\_\_ Weekends \_\_\_\_\_ Mornings \_\_\_\_\_ Afternoons

\_\_\_\_\_ Other (Please explain) \_\_\_\_\_

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**Thank you for taking the time to complete our survey!!!**

**Healthy Families District of Columbia/SESS  
Year 9 Participant Satisfaction Report  
July 2004**

Prepared by  
**Donna D. Klagholz, Ph.D. & Associates, LLC**  
*January 2005*

As in past years, participants in the Healthy Families District of Columbia (HFDC) Program were asked to complete satisfaction surveys. These questionnaires were distributed by the Family Support Workers (FSWs) and mothers completed them anonymously. Completed surveys were forwarded to the independent evaluator for tabulation and analysis. A total of 43 surveys were completed and returned.

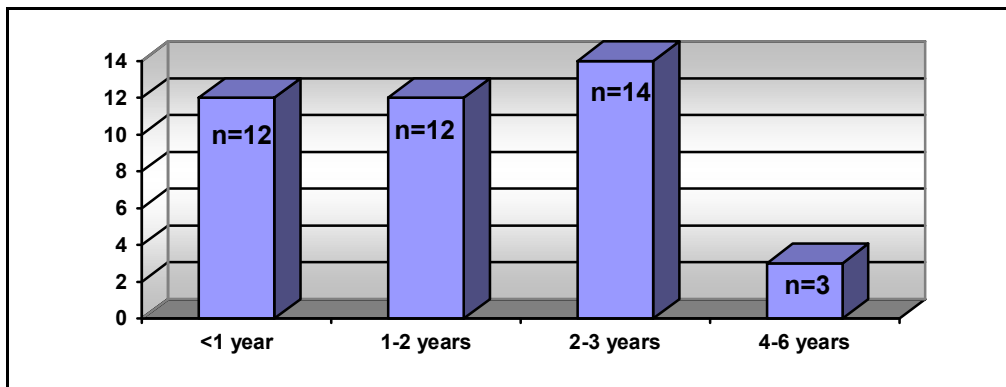
Surveys were returned from four HFDC sites: Children’s Health Center (CHC), For the Love of Children (FLOC), Calvary Bilingual Multicultural Learning Center, Mary’s Center for Maternal and Child Care, Inc. The number of surveys returned from each site is shown below in **Table 1**.

**Table 1. Survey Returns by Site (n=43)**

Center	Number returned
FLOC	24
Mary’s Center	9
Calvary	9
Children’s Health Center	1
<b>Total</b>	<b>43</b>

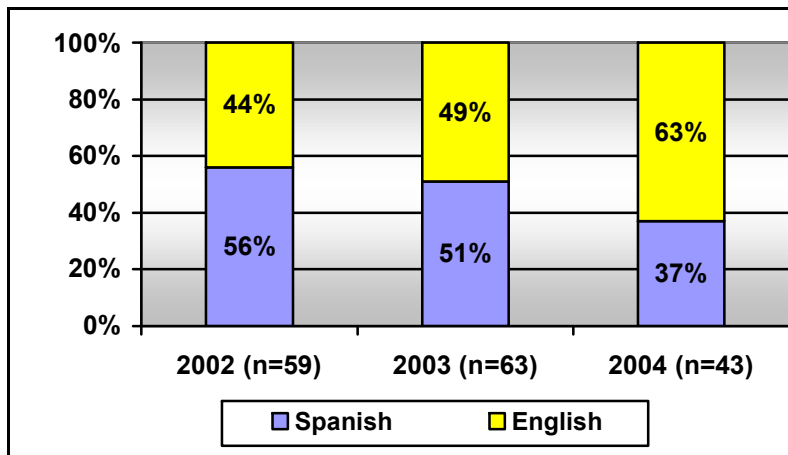
**Figure 1** displays enrollment data for 41 survey respondents. At the time of survey completion, 70% (n=29) of respondents had been enrolled in the program for one year or longer. The length of enrollment reported ranged from two months to six years, with average enrollment at 19 months.

**Figure 1: Length of Enrollment (n=41)**



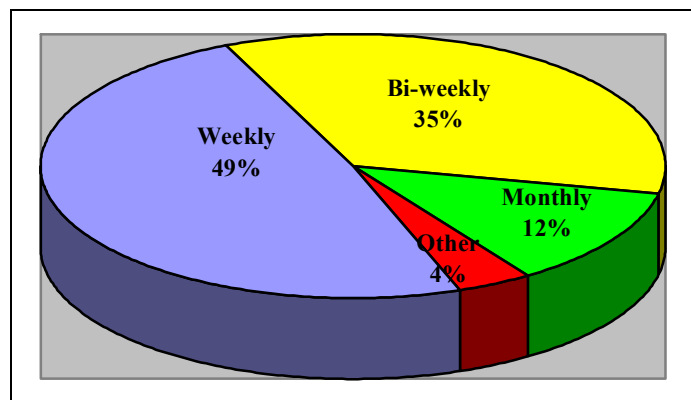
Questionnaires were distributed to participants in both English and Spanish, depending on the primary language of the mothers completing the surveys. As illustrated in **Figure 2** below, there has been a trend over the past three years toward increasing numbers of surveys being completed in English, while surveys completed in Spanish have been decreasing. In contrast to the past two years when over half of surveys completed were in Spanish, only slightly over one-third (37%) of current surveys were completed by Spanish-speaking participants. While completed surveys represent only a sampling of the families served, this finding reflects the shift in ethnic composition of the HFDC population, as recent expansion of services into Wards 5 and 6 of the District has enabled the program to serve increased numbers of African-American families.

**Figure 2: Survey Respondents' Primary Language**



Differences in leveling are reflected in the responses to the frequency of visits, which range from once per week to once per month. **Most participants reported home visits with their FSWs either once a week or twice a month.** About half of respondents (49%; n=21) of respondents reported receiving weekly visits, with an additional 35% (n=15) reporting bi-weekly visits (twice per month). Five respondents (12%) reported receiving visits monthly. The two remaining responses were categorized as “Other” and included two mothers who indicated that they were visited more often than weekly, but did not specify the frequency. **Figure 3** shows the frequency of home visits as reported by program mothers.

**Figure 3: Frequency of Visits (n=43)**



Most participants reported seeing their FSWs in other settings as well as in their homes. This included pediatric doctors' offices (19%; n=8), FSWs' offices (21%; n=9), and parents' doctor's offices (12%; n=5). Other settings mentioned included daycare/work (9%; n=4), others' homes (7%; n=3), Calvary playgroups (2%; n=1), school (2%; n=1), and the park (2%; n=1). n=2).

Participants were asked a question regarding when their last FSW visit had taken place. The majority of respondents (70%; n=30) indicated that their last visit with their FSW occurred within the week prior to survey completion. An additional 19% (n=8) reported that they had been visited within the previous two weeks, while 12% (n=5) indicated that their last visit had taken place within the month.

Most respondents (64%; n=27) indicated that visits with their FSWs lasted from 30 minutes to one hour. The remaining 46% (n=15) of respondents reported visits between one and two hours. Eighty-six percent (n=) of participants reported that their FSWs arrived on time for visits, while four indicated that their FSWs were "usually" on time (9%) and two (5%) responded "sometimes/occasionally." Most (67%; n=29) report that their FSW usually calls between visits and almost all (98%; n=41) feel they were visited often enough.

Participants were asked if they felt that their FSWs were aware of their needs and, if so, what made them think so. Virtually all respondents (100%; n=43) affirmed that their FSWs were aware of their needs and had been of help to them. In elaborating, 34 respondents offered evidence of their FSWs' awareness of their needs and willingness to help. The overwhelming majority of comments focused on the reliability and availability of the FSW and her willingness to answer any questions and provide information on a variety of topics. Respondents mentioned specific actions taken by the FSWs on their behalf, some of which included: help with finding employment and housing, referral to English classes, shopping together at Wal-Mart to assist in family budgeting, help getting back into school, and making phone calls and reading papers to non-English speaking participants. The value of the FSW/client relationship was clearly recognized by those that offered comments, and is evident in the remarks of one respondent: "We maintain an environment of trust that makes my family and I feel very comfortable."

Participants were asked to describe their FSWs by checking off as many attributes they felt applied to their individual FSW from a list of 20 options. Both positive and negative characteristics were presented. **Table 2** presents the attributes selected by respondents in order of frequency. As can be seen in the table, FSWs were most often characterized as understanding, warm and caring, and knowledgeable and informed. Most also describe their FSWs as helpful, encouraging, and supportive. Interestingly, while three-quarters of respondents selected "Available" to describe their FSWs, this percentage seems relatively low in light of most respondents' previous comments focusing on how their FSWs are always available to answer questions and provide information when needed. Very few respondents endorsed items describing their FSWs in negative terms.

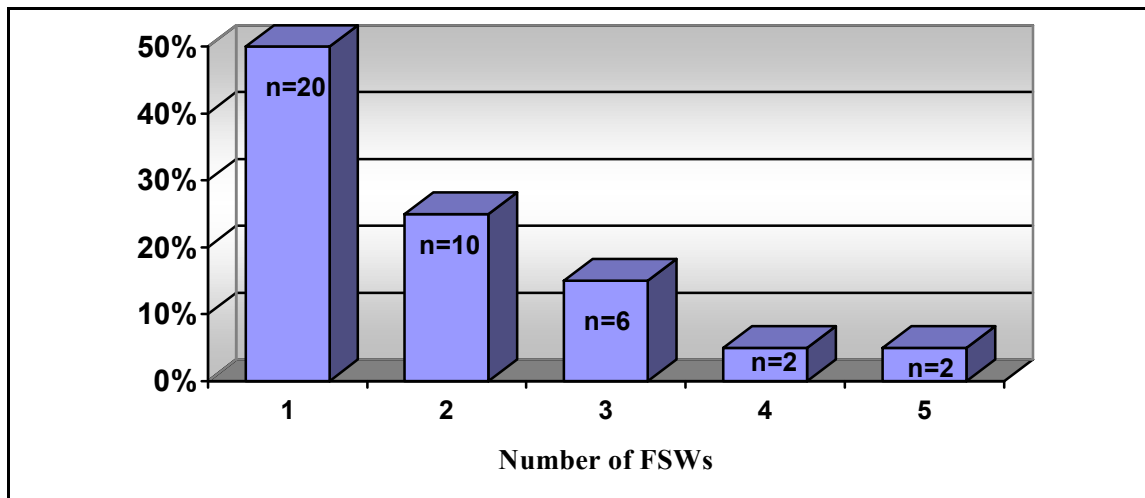
**Table 2: FSW Characteristics**

Attribute	% of total (N=43)	Attribute	% of total (N=43)
Understanding	91%	Calm	61%
Warm/caring	88%	Understands culture & heritage	44%
Knowledgeable /informed	86%	Well-mannered (Spanish only)	41%
Helpful	84%	Firm	35%
Encouraging	84%	Respects my culture & customs (English only)	35%
Supportive	84%	Smothering (English only)	16%
Truthful/honest	77%	Too business-like	7%
Respectful	77%	Insensitive	5%
Available	74%	Scattered	5%
Organized	63%	Other: (Good sense of humor, fantastic)	5%

Participants were asked if they felt that their FSW respects them, tries to understand various things about them, such as their backgrounds, likes and dislikes, and family values. A total of 38 participants responded to this question, with all 100% agreeing that their FSWs do respect and try to understand them. 23 participants offered comments as to the ways they are respected, many focusing on the same characteristics mentioned in reference to why they think their FSW is aware of their needs and has helped them. Others also cited reasons more specific to the subject of respect, saying that the FSW “knows my background very well,” “is very supportive and not judgmental,” “is from my country and understands that we are very united,” “is always respectful when she enters my home,” “wants to learn about [my family’s] lifestyle,” and “never has a word of reproach. She adapts and tries to do everything like I am accustomed so I feel comfortable.”

In order to determine the impact that staff turnover may have had on the quality of participants’ experiences in the HFDC Program, the survey asked respondents to indicate how many FSWs they had worked with since their enrollment in the program. **Figure 4** below shows how many FSWs each of 40 respondents reported having worked with since enrollment. As shown in the figure, half of respondents (48%; n=20) have only worked with one FSW.

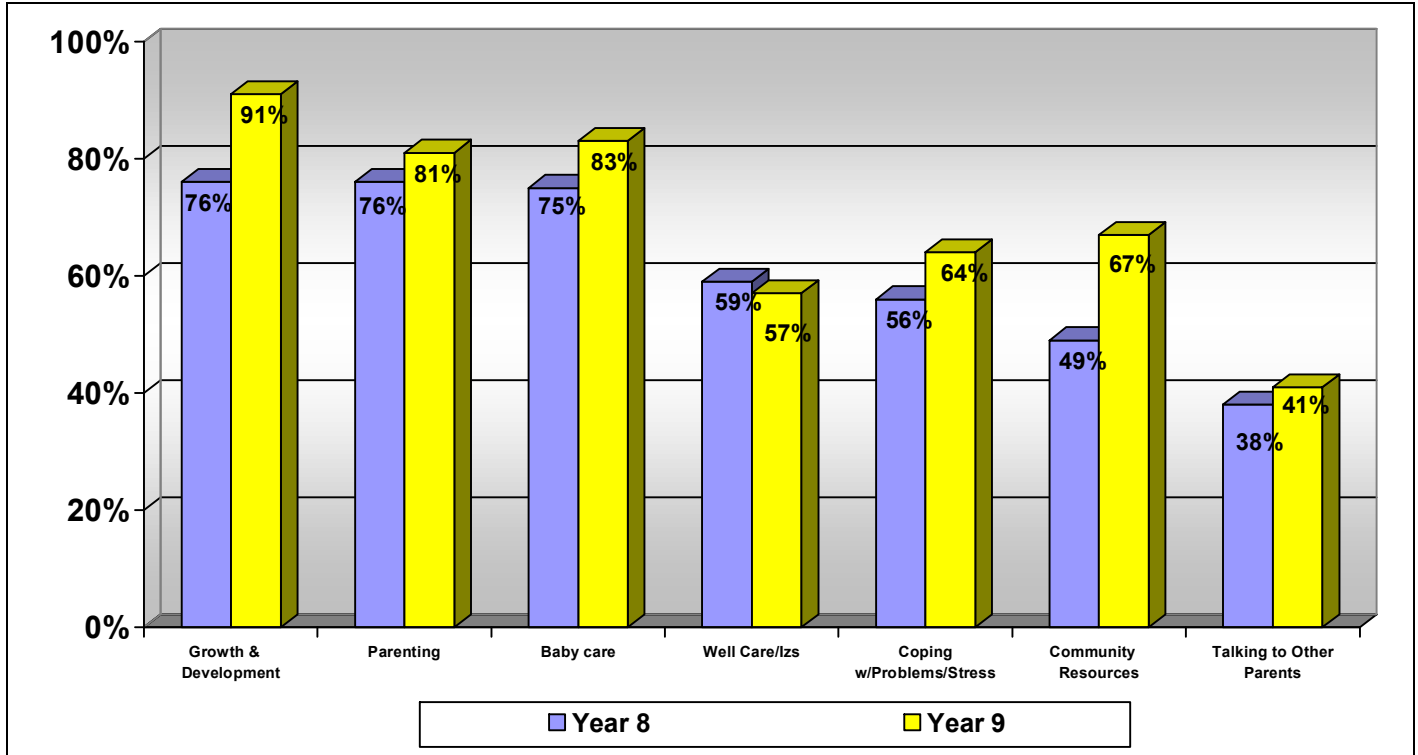
**Figure 4: Number of FSWs per Participant (n=40)**



Of the 20 respondents who indicated that they had been assigned to more than one FSW, 15 offered their thoughts about working with different FSWs. The majority of respondents (n=12) were positive, saying that they are very happy with the FSW they are now working with. Of these 12, eight acknowledged being initially disappointed when their FSW was reassigned, but have developed strong relationships with their new FSWs. The remaining four indicated that they were “OK” with the change. Three respondents seemed disappointed that they had lost their initial FSW, offering comments such as, “*I feel very bad because I am used to dealing with the same person,*” “*I don’t like them to change so often. I would like to have the same person for a long time,*” and “*HFDC should try to retain their good workers.*”

A total of 38 out of 42 respondents (93%) feel that the program has been helpful to them in raising their children. **Figure 5** below shows the Years 8 and 9 percentages of all respondents who report increased knowledge in various areas of program focus. As seen in the figure, with the exception of “well baby care visits and immunizations”, current results indicate that greater percentages of participants this year feel more knowledgeable in all areas, especially with regard to their babies’ growth and development (+15 percentage points) and to the resources available to them in their communities (+18 percentage points). In addition to the areas represented in the figure, individual participants also reported knowing more about “jobs and housing information” and “problems between couples and [with] myself.” A total of 22 parents (52%) also reported being very satisfied with the group gatherings, such as parenting classes, the Mother’s Day event, play groups, family gatherings, outdoor activities, and English classes. In response to a follow-up question soliciting suggestions on how to make the group gatherings better or more convenient, eight respondents offered their ideas for improvement. These included providing more activities (n=3), adjusting the scheduling of activities and/or giving more advance notice in order to accommodate working moms (n=3), providing transportation and food (n=1)

**Figure 5: Parents' Perceived Areas of Increased Knowledge (n=43)**



Participants were provided with a list of program elements and asked to indicate which they liked best. They were also asked to select the most liked aspects of home visiting from a list of four elements. **Table 3** shows the percentages of respondents that indicated each of the program and home visiting elements as best liked. As seen in the table, the most frequently cited aspect of the program was “*having someone visit me at home.*” Three quarters of respondents also indicated that they most appreciated “*having someone around to listen and help*” and “*Advice/suggestions/information on baby’s health, growth, development.*” In that area of home visiting, the majority of participants (81%; n=35) indicated that the information they receive from their FSWs during the visits is a primary benefit they recognize and appreciate.

**Table 3: Best-liked Aspects of the HFDC Program (n=43)**

“What do you like best about the program?”	% responses
<i>Program:</i>	
▪ Having someone visit me at my home	81%(35)
▪ Having someone around to listen and help	74% (32)
▪ Advice/suggestions/information on baby’s health, growth, development	74% (32)
▪ Advice/suggestions/information about parenting	70% (30)
▪ Help accessing community resources	56% (24)
▪ Help getting child into daycare and/or school	51% (22)
▪ Parent groups/play groups/activities	42% (11)
▪ Respectful of culture	30% (28)
▪ Having someone go with me to appointments	28% (12)

▪ Help with finding family doctors	19% (8)
▪ Assistance with transportation	19% (8)
<i>Home Visits:</i>	
▪ Information given	81% (35)
▪ Activities	65% (28)
▪ Goal setting	58% (25)
▪ ASQs	49% (21)
▪ Other (including: <i>friendship; the time to talk to someone</i> )	5% (2)

FSWs often use questionnaires with families in order to better understand their needs and enable the best possible linkage to community resources. Participants were asked three questions designed to ascertain their perceptions of the questionnaires they are asked to complete. They were asked about the level of difficulty of the questions, how they felt about answering them, and whether they felt the reason for the questionnaires was explained well. Each of the questions was answered by varying numbers of respondents, as indicated in **Table 4** below. Only one respondent apparently experiences some difficulty understanding the questions, while all are “okay” with answering them and feel the reasons for the questionnaires are explained well.

**Table 4: Feedback on Program Questionnaires**

<b>II. Statement</b>	<b>Yes</b>	<b>No</b>	<b># Responses</b>
The questions are easy to understand.	97% (n=38)	3% (n=1)	39
I am okay with answering them.	100% (n=35)		35
I feel that the reason for the questionnaires was explained well.	100% (n=34)		34

Eight mothers offered additional comments about the questionnaires, seven of which were overwhelmingly positive and demonstrated a recognition that the purpose of the questions was to help them reach their goals. Their comments included several statements specific to their individual needs, as well as some general remarks:

- ... (regarding depression measure) “[My FSW] evaluates how I am, how I feel about my family, and if there are no difficulties, provides help whenever I need it.”
- ... the questionnaires are self-explanatory
- ... it is good because one learns from those questions.
- ... it has helped me achieve my goals
- ... the questions are helpful

One mother, however, commented, “*Some of the questions are offensive and try to trick you.*”

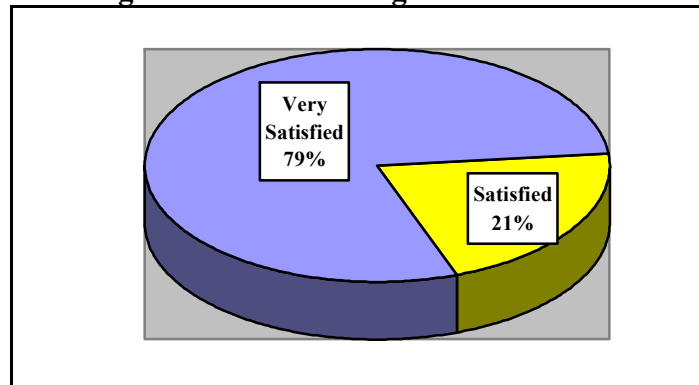
When asked to offer suggestions as to ways the program or home visitor could better assist or support them, the majority of respondents (n=39/43) indicated that the program needed no improvement. One respondent wrote a fervent request that her FSW not retire, suggesting that if her leaving was due to her salary, the program could possibly give her a raise. Other suggestions included:

- Provide transportation and assistance in finding housing
- More access to the day care centers

- Provide programs or groups for participants who have graduated, perhaps once per month to review things
- Provide information about institutions and the services they offer, such as physical or emotional help. Let us know where to go when we need different types of help.

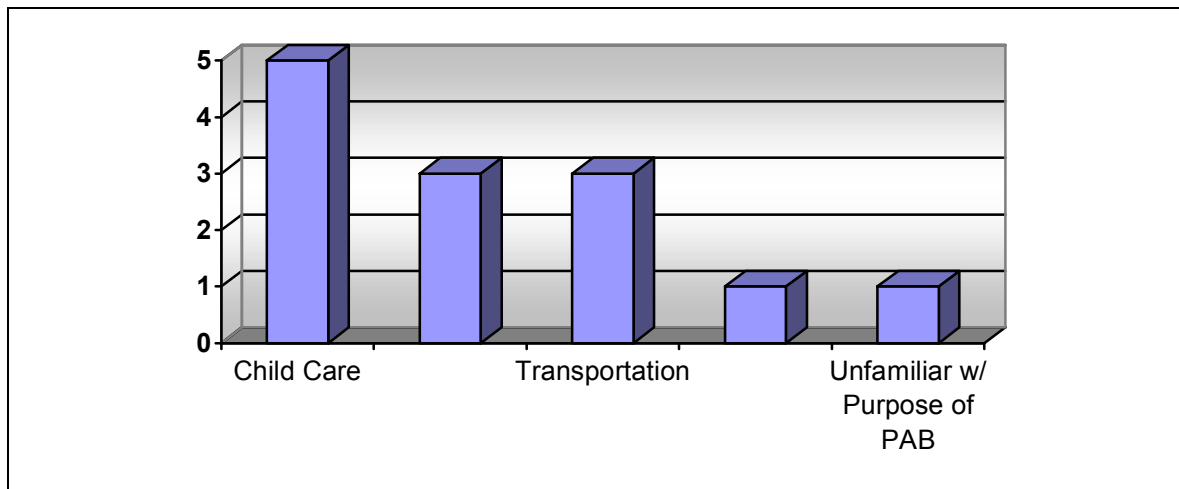
Forty-two respondents answered a question asking them to indicate how satisfied they are with the program by checking one of five choices: *Very Satisfied*, *Satisfied*, *Dissatisfied*, *Very Dissatisfied*, and *No Answer*. As can be seen in **Figure 6**, 79% (n=33/42) reported being Very Satisfied, and 21% (n=9/42) were Satisfied. In addition, 100% of all 43 respondents indicated that they would recommend the program to a friend.

**Figure 6: Overall Program Satisfaction**



In order to assess current participation and levels of interest in the HFDC Parent Advisory Board (PAB), the 2004 survey included several questions designed to probe familiarity with the Board, interest in membership opportunities, and barriers to involvement. Twenty-five percent (10/40) of respondents reported being familiar with the Parent Advisory Board, with only half of those (n=5) reporting that they are already members. Of those that are not currently members, almost half (47%; n=18) did express interest in becoming one. As seen in Figure 7, 13 respondents offered reasons why they are not members, the most frequent reason being child care issues.

**Figure 7. Participant Barriers to Becoming PAB Members (n=13)**



When asked for suggestions as to how the program could build interest in Board membership, 10 respondents indicated that offering meetings at a particular time of day would make them more interested, while 4 respondents felt that offering meetings directly following playgroups would be an incentive to join. Respondents indicated that evenings would be the most desirable time for meetings (n=7), followed by mornings (n=5) or afternoons (n=5). Only two respondents opted for weekends.

### *Summary*

Although the number of participant surveys completed and returned was relatively low (n=43), the responses appear to be an accurate representation of feedback from the HFDC population as a whole. The changing ethnic composition of the participant population continues to be reflected in the language in which the surveys are completed; English surveys have increased in the past three years from 44% to 63% of total surveys completed and returned. At the time of survey completion, most respondents (70%) had been enrolled in the program for one year or longer. As in the past, feedback is overwhelmingly positive and affirms that participants view the program as beneficial to them and their families, and that they place great value on the relationships they have developed with their FSWs. Although half of respondents have experienced an FSW reassignment, almost all were able to transition seamlessly and rebuild rapport with a new FSW. This is evident in the attributes identified by participants to describe their FSWs, which were overwhelmingly positive and reflect their perception that their FSWs are understanding, warm and caring, and knowledgeable and informed.

An interesting trend was revealed when current results were compared to those of the previous year in respondents' perceptions of the areas in which they have gained knowledge as a result of program participation. Significant increases were noted in the percentages of participants who currently report gaining knowledge in a variety of areas, especially in knowledge of community resources and child development. Awareness of resources available in the community is also reflected in participants' responses to questions about the best-liked aspects of the program, where 56% identified "help accessing community resources" as what they appreciated most. Additionally, over 80% of respondents specified both "having someone visit in the home" and being provided with information as what they liked best. All respondents (100%; n=42) report being satisfied or very satisfied with the program and all (n=43) would recommend it to a friend.

Suggestions for how the program or FSW could better assist or support participants reflect a desire to increase participation through more activities and through scheduling adjustments on the part of the program in order to accommodate working moms so they can more fully participate. The desire for better scheduling (as well as child care concerns) also appears to be a factor influencing participants' decisions regarding Parent Advisory Board membership. Holding evening PAB meetings may facilitate increased parent involvement, in that parents' work schedule problems and child care issues could be alleviated. Difficulty with transportation also emerged as a concern to participants, not only in terms of impacting PAB membership, but also in the ability to participate in program activities. The fact that eight respondents cited "Assistance with transportation" as their best-liked aspect of the program suggests either that some participants may be unaware that transportation is offered or that all FSWs are not able to provide it to their families.

**Healthy Families District of Columbia/SESS  
Staff Survey**

Date \_\_\_\_\_

Please share your experiences with the Healthy Families District of Columbia/Starting Early Starting Smart (HFDC/SESS) program by taking a few minutes to answer the questions below. Your answers and recommendations are important to us and will assist us as we continue to suggest program improvements and plan future activities. All surveys are confidential. Please do not put your name on your survey. We want them to remain anonymous. Thank you!

1. In what capacity do you work with HFDC/SESS? (Please check one)

- Administrative
- Management/Supervisory
- Family Support Worker (FSW)
- Family Assessment Worker (FAW)
- Other \_\_\_\_\_

Program Services	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I understand the HFA Critical Elements					
I understand the goals and objectives of HFDC/ SESS					
I receive an adequate amount of supervision to help me get my job done in a quality manner.					
HFDC/SESS is designed to optimize child development through comprehensive support to families					
The program management is responsive to the needs of staff.					
HFDC/SESS is strength-based and family centered.					
I have participated in training that adequately prepared me for my position.					
I have participated in training in the past six months.					
The agency and program management represent the community.					
The staff is culturally representative of the families served					
The program uses materials that are culturally appropriate.					
The program uses bilingual materials as appropriate.					
I feel comfortable working with culturally diverse families.					
HFDC/SESS helps prepare children to be ready for school					
The SESS behavioral health (mental health, substance abuse, child development) supports have significantly helped HFDC families.					

**2. Please respond to the following statements by checking the appropriate box:**

<b>A. Job Satisfaction</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Not Sure</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
I enjoy my work.					
I find my work worthwhile.					
I find the work that I do is hard.					
I find my work boring.					
The work I do uses my skills.					
I am satisfied with my position.					
I am appropriately compensated for my position.					
I feel appreciated by HFDC/SESS management for the work I do for the program.					
I believe I have made a positive impact on the children and families I work with.					

**3. Which areas of the program are particularly strong?**

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**4. Which areas of the program need improvement?**

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**5. How stressful is your job? (Please check one)**

- Always stressful
- Usually stressful
- Sometimes stressful
- Rarely stressful
- Never stressful

6. Which of the following benefits have you received as a result of your participation in work-related trainings?

None \_\_\_\_\_ Promotion \_\_\_\_\_ Wage increase \_\_\_\_\_ Bonus \_\_\_\_\_  
Certification \_\_\_\_\_

Other (Please specify) \_\_\_\_\_

**Additional Comments (*use reverse side for more space*):**

**THANK YOU VERY MUCH!**

**Healthy Families District of Columbia/SESS  
Year 9 Staff Satisfaction Survey  
September 2004**

**Prepared by  
Donna D. Klagholz, Ph.D. & Associates, LLC  
January 2005**

Annual staff questionnaires were distributed to employees of the HFDC program in September 2004. The purpose of the questionnaire is to provide updated information to the program about staff perceptions as to the nature and quality of support and benefits they have received, as well as their views on program strengths and weaknesses, job stress, and overall job satisfaction. Questionnaires were distributed to all 13 individuals on staff at the time of the survey. Eleven questionnaires were returned, representing a response rate of 85%, and forwarded to the evaluation team. In order to maintain the confidentiality of the information provided, all surveys were completed anonymously.

Staff members were asked to identify their roles within the program. Eight staff members identified themselves as Family Support Workers and three as Management/Supervisory staff.

Whereas the previous survey presented a series of nine statements regarding program effectiveness to which staff were asked to agree or disagree, the current survey contains 14 statements accompanied by a 5-point Likert scale in which they were asked to select “Strongly Agree”, “Agree”, “Not Sure”, “Disagree” or “Strongly Disagree”. **Table 1** presents current results, as well as comparative results from the previous survey where appropriate. As seen in the table, when current results of the eight original statements (one of the original nine was discontinued) are compared to those from 2002, increased percentages of staff members reflected positive responses. Currently, all respondents (100%) strongly agree that they understand HFA’s critical elements, as compared to 94% in 2002. The most significant improvement is in relation to statement #10, “The program uses materials that are culturally appropriate,” where 100% of respondents now agree, compared to only 67% in 2002. Currently, all also agree that they understand the goals and objectives of HFDC/SESS, that they receive an adequate amount of supervision, and have participated in trainings during the past six months. All staff members also agree that the program optimizes child development through support to families and that the program is strength-based and family centered.

Several newly added statements focus on additional aspects of cultural competency, school readiness, and effectiveness of the SESS behavioral health supports. All staff agree that they feel comfortable working with culturally diverse families, that the program helps to prepare children for school, and that the mental health, substance abuse and child development components of the program significantly help program participants. A smaller majority also feels that the staff is culturally representative of the community they serve and that the program uses bilingual materials appropriately. The lowest percentage of endorsement was in staff’s perception of the responsiveness of management to their needs. Overall, staff appear to feel that the program is very effective in providing services to families and meeting its goals related to parenting, family functioning, and child development.

**Table 1. Staff Impression of the Effectiveness of the HFDC Program (n=11)**

Statement	2002 Agree	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. I understand the HFA critical elements.*	94%	11 (100%)	0	0	0	0
2. I understand the goals and objectives of HFDC/SESS.	n/a	10 (91%)	1 (9%)	0	0	0
3. I receive an adequate amount of supervision to help me get my job done in a quality manner.*	93%	10 (91%)	1 (9%)	0	0	0
4. HFDC/SESS is designed to optimize child development through comprehensive support to families.	n/a	9 (82%)	2 (18%)	0	0	0
5. The program management is responsive to the needs of the staff.*	73%	6 (55%)	3 (27%)	1 (9%)	1 (9%)	0
6. HFDC/SESS is strength-based and family centered.*	94%	9 (82%)	2 (18%)	0	0	0
7. I have participated in training in the past six months.*	94%	8 (73%)	3 (27%)	0	0	0
8. The agency and program management represent the community.*	79%	5 (46%)	5 (46%)	0	1 (9%)	0
9. The staff is culturally representative of the families served. (n=10)*	80%	6 (60%)	3 (30%)	0	1 (10%)	0
10. The program uses materials that are culturally appropriate.*	67%	5 (45%)	6 (55%)	0	0	0
11. The program uses bilingual materials as appropriate.	n/a	8 (72%)	2 (18%)	1 (9%)	0	0
12. I feel comfortable working with culturally diverse families.	n/a	10 (91%)	1 (9%)	0	0	0
13. HFDC/SESS helps prepare children to be ready for school.	n/a	6 (55%)	5 (45%)	0	0	0
14. The SESS behavioral health (mental health, substance abuse, child development) supports have significantly helped HFDC families.	n/a	5 (45%)	4 (55%)	0	0	0

*\*Statement included on previous survey.*

Staff members were asked two open-ended questions designed to elicit their views as to areas of the program that are particularly strong and those that are weak. As seen in **Table 2**, the staff responses regarding program strengths touched on a wide range of program components. There were four areas that four staff each cited as strengths. These were the curriculum and child development information provided to families, the support given to families by the program, the dedicated staff who are able to form close relationships with families, and clinical supervision. Two individuals cited cultural competence as a particular strength and two cited linking families with community services. Other areas identified were the ASQ developmental screens, prevention of child abuse and neglect, and staff trainings.

**Table 2. Staff Members’ Perceived Areas of Program Strength (n=11)**

<b>B. Program Strength</b>	<b>Frequency of Response</b>
Child development and information on activities/Curriculum	4
Support to families (strength-based)	4
Dedicated staff who truly understand the communities we serve/relationships between staff and families	4
Clinical Supervision	4
Cultural competence	2
Linking families with community services	2
Developmental screens	1
Prevent child abuse and neglect	1
Trainings	1

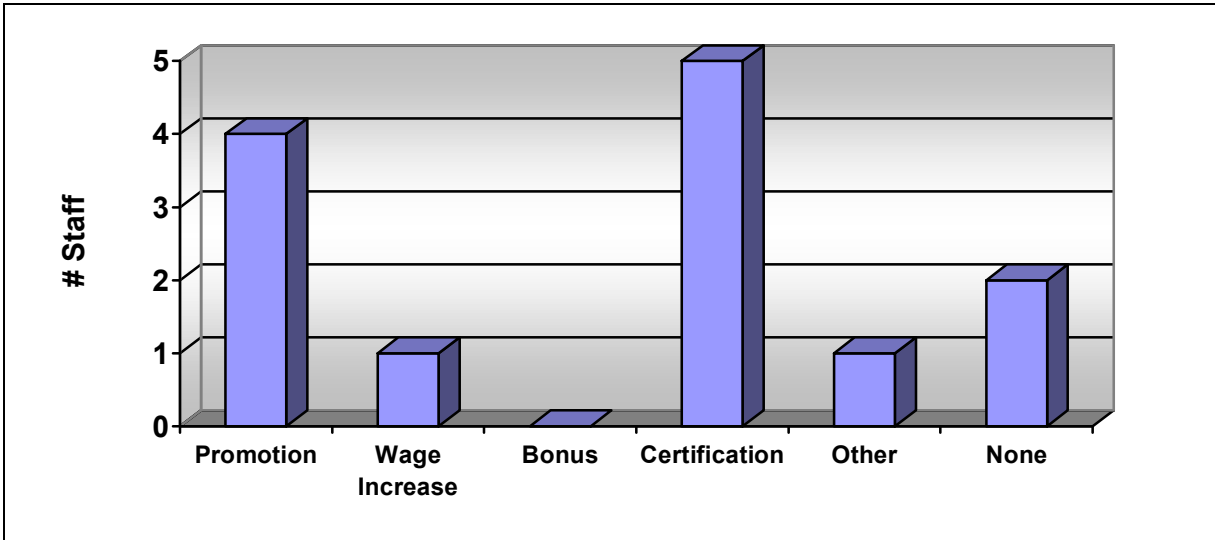
**Table 3** presents program weaknesses identified by staff. By far the most frequently cited program weakness was staff compensation/salaries and program funding, with half of respondents (n=6) identifying these as a concern. Two staff members identified three other areas. These were activities for families (with food), communication with and support for each other, and supervisors and staff being overburdened with their work. Finally, six program components were cited by one person each. These were counseling (unclear if this meant counseling services for families or for staff), the San Angelo Curriculum, staff gatherings, preparing children for school, some aspects of the program evaluation and staff sharing of community resources. Finally, one person stated, “All areas could use improvements”.

**Table 3. Staff Perceptions of Program Weaknesses (n=11)**

<b>Program Weakness</b>	<b>Frequency of Response</b>
Salaries/compensation/funding	6
Activities for Parents (with food)	2
Communication with each other/support each other	2
Supervisors/staff overburdened with work	2
San Angelo Curriculum	1
Counseling	1
More staff gatherings	1
Preparing children for school	1
Program Evaluation (some aspects)	1
Staff sharing of community resources	1
All areas	1

Staff members were asked to identify benefits they have received as a result of participation in work related training. Such benefits might include promotion, wage increase, bonus, certification, none and/or other. All eleven staff responded to this question, with two reporting more than one benefit each. As seen in **Figure 2**, the most frequently cited benefit (n=5) is receiving certification. All staff members attended the Parents as Teachers Training this year, and most completed and received certification for this, so this number appears to be low. Four staff members reported receiving a “Promotion”, while one individual reported a “Wage Increase.” One person responded with “Other”, specifying “knowledge gain” as the benefit s/he has received. Two staff members reported receiving no benefits at all.

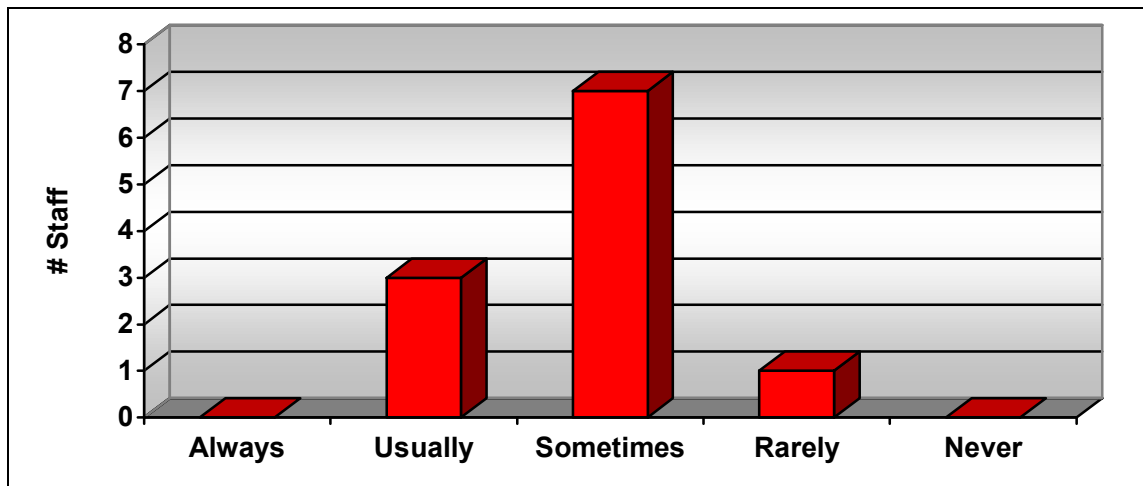
**Figure 2. Benefits Received by Staff (n=11)\***



\* Two staff members reported two benefits each.

Staff members were asked to rate the amount of stress they feel in their jobs on a 5-point Likert scale ranging from “Always” to “Never”. All eleven staff responded to this question and, as indicated in **Figure 3**, all reported at least some degree of stress. The greatest majority feels the job is “Sometimes” stressful (64%, n=7). Three staff members find their jobs to be “Usually” stressful (27%) and one staff member finds the job “Rarely” stressful. No staff members view their jobs as always or never stressful.

**Figure 3. Job-related Stress (n=11)**



Several aspects of job satisfaction were assessed by asking respondents to indicate their agreement to a series of nine statements, again using a 5-point Likert scale ranging from “Strongly Agree” to “Strongly Disagree”. As shown in **Table 4**, responses indicate that staff members experience a high degree of satisfaction in their work. All 11 staff members reported that they enjoy their work, find their work worthwhile, feel that they use their skills, are satisfied

with their positions, and believe that they have made a positive impact on the children and families with whom they work. Interestingly, while all respondents feel their work is not boring, staff members are evenly split on their perceptions of the difficulty of their work. Evidently, while many staff do not consider their jobs difficult, they clearly find them challenging enough to recognize the impact they have on the families and to warrant consideration for increased compensation. While almost all staff report that they feel appreciated by program management for their work, only 36% (n=4) feel appropriately compensated for their work.

Overall, staff generally feels fulfilled in their jobs and appreciated by management, however, they do not feel adequately compensated financially. This perception was also reflected in their responses to questions regarding areas where the program needs improvement.

**Table 4. Job Satisfaction of HFDC Staff (N=11)**

<b>Job Satisfaction</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Not Sure</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
I enjoy my work	7 (64%)	4 (36%)	0	0	0
I find my work worthwhile.	8 (73%)	3 (27%)	0	0	0
I find the work that I do is hard.	2 (18%)	3 (27%)	1 (9%)	3 (27%)	2 (18%)
I find my work boring.	0	0	0	7 (70%)	3 (30%)*
The work I do uses my skills.	8 (73%)	3 (27%)	0	0	0
I am satisfied with my position.	6 (55%)	5 (45%)	0	0	0
I am appropriately compensated for my position.	1 (9%)	3 (27%)	0	4 (36%)	3 (27%)
I feel appreciated by HFDC/SESS management for the work I do for the program.	6 (55%)	4 (36%)	1 (9%)	0	0
I believe I have made a positive impact on the children and families I work with.	8 (73%)	3 (27%)	0	0	0

*\* One staff member did not respond to this question*

## *Summary*

The HFDC staff continues to report a high level of overall satisfaction both with the program itself and their jobs within the program. Increased perceptions of the effectiveness of the program are evident in current respondents' understanding the core elements of the program, their acknowledgement of adequate supervision and the family-centered nature of the program, and in their recognition of improvements in the program's culturally appropriate curriculum materials.

The main area that emerged as warranting further exploration is that of financial compensation and funding. Some staff seem to feel compensated in ways other than financial, and most staff members reported receiving some benefit from their work, usually through certification or promotion. However, most do not feel adequately compensated for their work and a small percentage of staff do not feel that management is responsive to their needs. Despite these feelings, staff report a high degree of job satisfaction overall and view the clinical supervision they receive as a strength. The HFDC program would benefit from exploring current as well as new sources of funding to alleviate concerns staff have over their salaries and the program's funding. Additionally, several staff identified a lack of group activities for parents, and a burdensome workload that impedes mutual support among staff as areas for improvement. HFDC should examine these areas more closely and reevaluate the San Angelo curriculum, school readiness, counseling, and evaluation to determine what specific elements need improvement.

Overall, the degree of satisfaction reported, despite moderate job-related stress, is indicative of a high level of commitment and dedication on the part of the HFDC staff. Additionally, the fact that half (46%) stated that their jobs were not hard is evidence of the support the HFDC program is providing to its staff.