

Healthy Families Massachusetts

FINAL EVALUATION REPORT



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Executive Summary
**Healthy Families Massachusetts
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HFM Program and Evaluation

THIS EXECUTIVE SUMMARY HIGHLIGHTS the key findings to emerge from the Massachusetts Healthy Families Evaluation, a multi-year study — begun in 1998 — of the statewide Healthy Families Massachusetts program. Assessments of both program operations and program outcomes are summarized below. This brief document is meant primarily for a policy and program audience—readers with interest in details of this evaluation and its findings are invited to request a copy of the full report.¹

Healthy Families Massachusetts (HFM) Services and Goals

Launched in 1997, HFM is an ambitious, state-wide adaptation of the Healthy Families America home visiting program — the first in the country. It was designed to be available to all families in which the mother is a first-time parent under the age of 21.² The original 1997 program Request for Responses (RFR) lists the main goals of the HFM program as follows:

- prevent child abuse and neglect by supporting positive, effective parenting skills and a nurturing home environment;
- achieve optimal health, growth and development in infancy and early childhood;
- promote maximum parental educational attainment and economic self-sufficiency;
- prevent repeat teen pregnancies.

HFM services vary from site to site, though they generally include home visits, center-based groups, and referral services. The majority of the home visitors are paraprofessionals, but there is a wide range of education, experience, and expertise represented in the statewide program. In their work with families, the home visitors are meant to model and support positive parent-child interactions; teach about child development; help the family to provide a safe and enriching environment for their child; support the parent's educa-



tional and professional development and goals; provide crisis intervention; and connect the family with other social services as needed.

Services are initiated prenatally, at birth, or within the first year of the child's life, and may continue until the child's third birthday. Families are located, referred, and recruited to HFM through a wide range of sources. The frequency, intensity, and duration of visits are determined based on each family's needs and preferences, and range from several times a week to once every few months. Currently, HFM is being delivered by catchment area, with 17 agencies, and 27 programs operating as program sites.

The Massachusetts Healthy Families Evaluation (MHFE)

Soon after the program's inception, the Massachusetts Children's Trust Fund awarded the contract for evaluating HFM to a Tufts University team, headed by Professors M. Ann Easterbrooks, Eliot-Pearson Department of Child Development; Francine Jacobs, Departments of Child Development and Urban and Environmental Policy and Planning; and Jayanthi Mistry, of the Eliot-Pearson Department of Child Development. Anne Brady, Ph.D., has served as the Project Manager since the evaluation's inception. A technical advisory board provided guidance on the design and execution of the evaluation (see Appendix A).

The MHFE team devoted the first year of funding to developing an evaluation plan;³ the second year was dedicated to program and participant recruitment and the commencement of data collection. In June 2002, data collection concluded, and analyses proceeded. Because of the exigencies of state budgets and administrative data systems, the project's data analysis phase was extended, concluding in September 2004.

Goals of the MHFE

The MHFE was commissioned to answer questions pertaining both to the operation of the program, as well as the outcomes achieved for its participants. The core questions relating to program operations included:

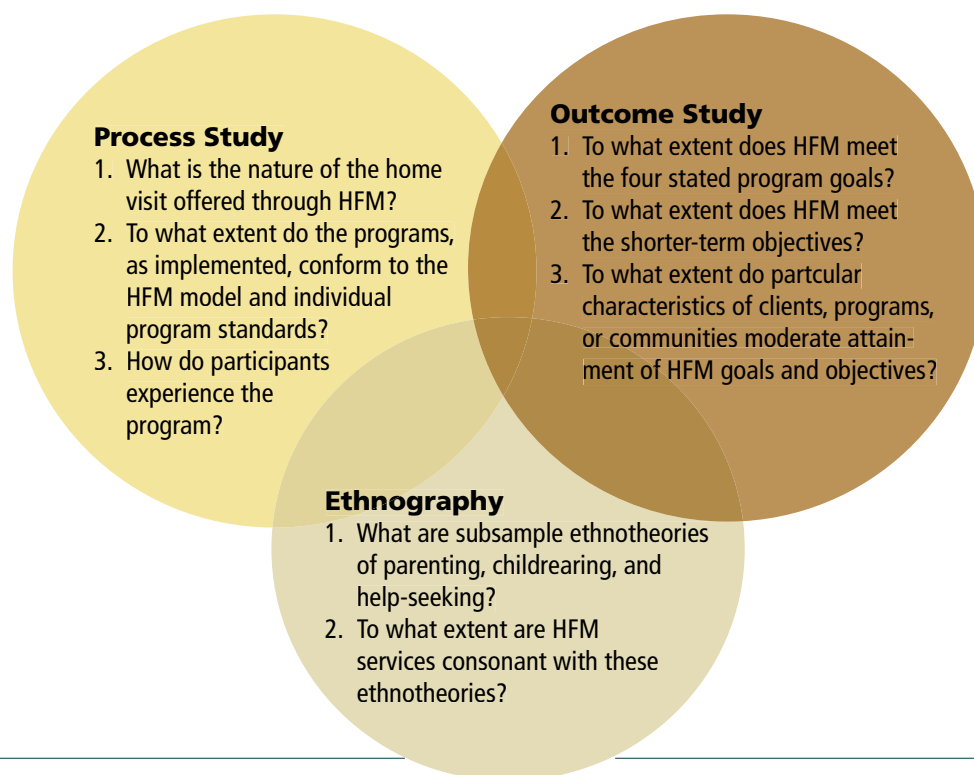
- *What is the nature of the home visit?* What are the critical elements of the relationship between home visitor and client? What is the range of topics covered during home visits? Who participates in home visits? To what extent is home visiting practice consonant with ethnotheories (culturally embedded sets of beliefs) of parenting and childrearing?

- *How do participants experience the program?* How satisfied are participants with the program and how successful do they perceive the program to be? What patterns of participation are demonstrated, and how are these patterns of service utilization related to their experiences in the program? What are the young mothers' own theories of child development and "good parenting," and the ways they feel most comfortable seeking help with parenting?
- *To what extent, and in what ways, do sites operate with "fidelity to the model"?* To what extent do the programs, as implemented, conform to the HFM model, and to individual program standards?

The core questions related to program outcomes included:

- *To what extent is the program meeting its stated "distal," or long-term, goals?*
- *To what extent are the "intermediate," or short-term, objectives⁴ being achieved?* These intermediate objectives include:

Figure 1: **MHFE Evaluation Components**



- increasing the amount, types, and quality of social support used by young parents;
 - increasing parental knowledge of child development and enhancing parenting competence/parenting skills;
 - enhancing the quality of the parent-child relationship; and
 - promoting parental well-being.
- ***In what ways do characteristics of participants, programs, and communities moderate both utilization of program services and the attainment of the short- and long-term outcomes?*** Potential client-centered influences include maternal age, maternal developmental status, childhood history, child age at program entry, and patterns of service utilization. Program-related moderators include fidelity of the program to the Healthy Families model, the extent of cultural sensitivity in service provision, and program auspices. The MHFE is particularly interested in the potential moderating role of maternal age and developmental status, and the cultural “match” between client and service delivery.

The MHFE design is based on Jacobs’s Five-Tiered Approach to evaluation,⁵ which organizes evaluation activities developmentally, in five stages or tiers, “moving from generating descriptive

and process-oriented information at the earlier stages [of a program’s development] to determining the effects of programs later [on]”⁶ (see Appendix B).

The MHFE was divided into three overlapping components: the *Process Study*, the *Outcome Study*, and the *Ethnography*; a member of the project’s senior research group managed each of these substudies. Each substudy team was responsible for answering a discrete set of the project’s core research questions (see Figure 1).

MHFE Methods and Samples

The data collection and analysis strategies that were employed during the conduct of this evaluation are detailed in the Final Report and will not be reviewed here. In brief, the MHFE used a multi-method approach — developing, adopting, and adapting both qualitative and quantitative instruments and techniques. Client experiences were examined using a nested sample structure that included some basic descriptive information from the total HFM population of approximately 13,000 participants, in-depth information on a representative sample of participants (n = 361), and ethnographic detail on clusters of participants from three communities (n = 30). Data were also collected, using a range of instruments, from home visitors and program administrators.

HFM Program **Operations**

In the following section, key findings related to how the HFM operates are presented. The first set of findings describes basic service provision, and the extent to which the program is operating according to standards. The second set reflects the participants' experiences with HFM.

SERVICE PROVISION

Key Findings

Overall, HFM performed at least as well as, and on some indices, better than, other home visiting programs. This finding is noteworthy, given the age of the population served, and the relative youth of the program at the initiation of this evaluation.

- **Outreach and referral:** 70% of all MA teenagers, either pregnant with or parenting their first babies, were referred to HFM between 1999 and 2002. *In comparison with other universal home visiting programs, HFM appears to be quite effective at outreach and referral.*⁷
- **Enrollment:** Of those mothers who were referred, who were located and eligible, 86% accepted services. *These rates are similar to other home visiting program acceptance rates, which typically are in the 80–90% range.*⁸
- **Length and intensity of program use:** Participants stayed in the program for an average of 17 months. The majority (59%) of participants stayed for more than one year. *These retention rates compare favorably with those reported by other home visiting program evaluations.*⁹ The average number of home visits received per client was 31.
- **Service delivery:** Most families, in keeping with HFM expectations, begin the program on the most intensive service level. On average, mothers in the MHFE received 56% of their expected visits. *This figure, though low, actually compares favorably with those of other home visiting programs that target teenage populations.*¹⁰



- **Cultural consonance:** Overall, the HFM program did a very good job matching home visitors and participants along cultural lines, particularly in regard to language; almost all of the young women in the program were assigned a home visitor who could speak their preferred language.

Further Discussion

HFM uses the Healthy Families America Credentialing Site Self-Assessment Tool to make clear to individual programs the standards to which they are expected to adhere.¹¹ Those standards most pertinent to this evaluation are summarized below; for each standard we present relevant findings, and, when available, comparison data from other home visiting program evaluations. Keep in mind that HFM's performance, although not perfect, was at least as good as other, more veteran home visiting programs.

STANDARD: Services should be initiated prenatally or at birth. At enrollment, the majority of participants were pregnant (64%). Although HFM strives to enroll young women prenatally, or as close to the births as possible, the program has also made a concerted effort to provide services to young women who are already parenting.

STANDARD: Services should be offered intensively with well-defined criteria for increasing or decreasing intensity of services and over the long term. The vast majority of participants had a weekly service assignment, in keeping with HFM expectations that participants begin the program on a more intensive service level and remain at that level for a minimum of six months after the birth of the baby.

STANDARD: Participants at the various levels of services offered by the program should receive the appropriate number of visits, based upon the level of services to which they are assigned. Mothers with an assigned service level received approximately 56% of their expected visits. *These figures compare favorably with those of other home visiting programs.*¹² Further research by MHFE staff into this service slippage found:

- Both home visitors and clients attributed more than half of the visits clients missed to “reasons that may have been beyond the client’s control.” For example, many of the young mothers missed visits because of medical appointments, work, school, or other similar “positive” commitments, that is, commitments that represent responsible decisions on their part.
- According to the home visitors, 80% of the missed visits were the responsibility of the client, and 20% of the visits were missed because of home visitor circumstances.
- On average, home visitors were unable to schedule even 22% of the visits they were expected to complete.

STANDARD: Services should be culturally competent to the extent that staff understand, acknowledge, and respect differences, and be able to form relationships among participants; staff and materials used should reflect the cultural, linguistic, geographic, racial, and ethnic diversity of the population served. Overall, the HFM program did a very good job matching home visitors and participants along cultural lines, particularly in regard to language; almost all of the young women in the program were assigned a home visitor who could speak their preferred language.

Cultural competence was interpreted in a variety of ways by programs in different communities, including using a family-centered approach, having familiarity with the community, and sharing cultural and socioeconomic characteristics with the families.

STANDARD: Delivery of services should be guided by the Individualized Family Support Plan (IFSP) — a document, developed collaboratively between the family and home visitor, that sketches out the personal goals each mother sets for herself. To begin, home visitors do appear to be respectful of their clients’ goals for themselves, in that the content of home visits reflects the mothers’ interests. For example, mothers with a greater number of goals pertaining to “parenting and providing a nurturing home” received more home visits that covered child development, parent-child interaction, parent and family health, social-emotional health, and family interaction.

The most prominent goals were those related to continued education and economic attainment, and those related to the health, growth, and development of the child. Relatively few families had goals related to preventing repeat pregnancy.

Mothers for whom a higher percentage of home visits focused on education and employment achieved a greater percentage of those goals.

STANDARD: The program should use a developmental screen to monitor infant/child development at specific intervals. Completion rates for the developmental screening assessment were lower than they should have been, according to HFM standards. Even when a more lenient standard was applied (percentage of children who received *within one* Ages and Stages Questionnaire (ASQ) of their expected amount [e.g., four out of five; or three out of four]), only 57% of the participants’ children were assessed on time. These low rates may be attributable to the ASQ’s rigid guidelines for completion. Alternatively, the relatively low ASQ completion rates may reflect the high number of visits that are missed in HFM.

CLIENTS' EXPERIENCES OF THE PROGRAM

The MHFE was interested in both how clients experienced the program (their degree of satisfaction with it), and what they experienced — that is, the content of the home visit. Both of these aspects are described briefly below.

Key Findings

- Most clients were very well-satisfied with the program.
- Most clients felt that their home visitors were family centered, respectful, and caring.
- Clients who dropped out of the program most commonly reported that they were simply too busy for it.

Further Discussion

In general, families reported very positive experiences of the HFM program, believing that HFM had at least “met” their expectations.

- While most clients rated their home visitors as being family centered, this term had different meanings across cultural communities. Some mothers focused more on grandmother and extended family participation, and others on involvement by the teenagers' partners or the babies' fathers.
- Participants who had dropped out of the program as of the end of the evaluation reported a wide range of personal and programmatic reasons for doing so. Mothers who dropped out most commonly reported that they were too busy for the program, that they did not need the program, or had experienced home visitor turnover that made it difficult to continue. Those participants indicated that they would have stayed if they had had a different home visitor, the program had better accommodated their schedules, or their home visitor had not changed.

THE NATURE OF THE HOME VISIT

Key Findings

- The relationship between the home visitor and her client appears critical to keeping mothers engaged with HFM. Indeed, it may be as important as any particular curriculum or activity — the traditional “content” of home visits.
- When asked about their home visitor's role, the majority of the young mothers described their home visitors as “friends.”
- About half of the home visitors considered racial match to be an important ingredient in a successful relationship with a client. On the other hand, only 20% of the mothers reported that having a home visitor of the same race was important.
- A minority of both home visitors and mothers felt that a language match between home visitor and client was important, although the vast majority of assignments were made with this consideration in mind.
- Close to half of both home visitors and clients felt that it was helpful if the home visitor was also a parent, and a quarter of the mothers believed it was important to have a home visitor who had been a teen parent.

Further Discussion

Among the hundreds of evaluations of home visiting programs, there are few reports that detail the nature of the home visit — what actually happens during that encounter. In our explorations, we have found home visits to be complexly organized and dynamic service units, comprised of a broad range of activities and information, and bounded and shaped by the relationship that develops between the home visitor and, primarily, the young mother. In the end, it appears that this relationship with a home visitor may be as important to the mothers as any other element of the program. If this is the case, then home visitor turnover, which fractures that relationship, is of real concern.

Although this relationship was defined differently among individual mothers, and according to our Ethnography, across communities, a full 75% of the MHFE mothers perceived of the home visitor as a “friend” (as opposed to a professional, or a parent/other adult figure), and therefore saw this relationship as something different from what is conventionally established between professional helpers and clients. For example, in one community, the young mothers emphasized both the vast array of instrumental support they received and the emotional connection they felt with their home visitors. In another, the teenagers believed that their home visitors’ willingness to “go the extra mile” demonstrated a special level of caring for them and their families. And in the third community, the young mothers highlighted their home visitors’ respect for differences, and provision of prompt, reliable support.

Participants in the MHFE — home visitors and mothers — did not always agree about the importance of home visitor-client matches of several sorts. About half the home visitors identified racial match as an important ingredient in a successful relationship; on the other hand, only 20% of the mothers noted that having a home visitor of the same race was important. In terms of linguistic match, about 20% of the home visitors, and 34% of the mothers, thought that being able to speak in the mother’s native language was of real value.

As to having a home visitor that was also a parent, close to half of both home visitors and mothers thought this was a helpful characteristic for home visitors. In addition, about 25% of the mothers believed that it was important to have a home visitor who had been a teen parent.

HFM Program **Outcomes**

The MHFE considered three genre of program outcomes: The first is what we call “perceived effects” in that they are outcomes that the mothers and/or their home visitors identify as having been achieved, related to the personal goals set during the IFSP development process. These outcomes are considered “perceived” and not actual because they are not verified by an objective observer or measurement. The second type of outcome is categorized here as an “intermediate objective.” These intermediate objectives, described earlier, represent steps along the way to attaining the major goals of HFM. Finally, the four distal, or more long-term, goals, as articulated by HFM, are the outcomes of most general interest. Findings related to each outcome type are included in this section.

PERCEIVED EFFECTS

Key Findings

Overall, both home visitors and clients thought the HFM program had positive effects on the mothers and their families.

- Clients emphasized most strongly the positive impact their home visitors had in the area of child development.
- When asked to describe their perceptions of the benefits of HFM, mothers highlighted the informational/educational support they received from their home visitors.
- Ninety-two percent of the mothers felt that the program had no effect on their plans to have more children.
- Most mothers felt they made progress on their individual goals, and more than one-third reported achieving their goals.
- Home visitors rated mothers as having achieved a high proportion of their IFSP goals by the first follow-up. Families tended to achieve goals in less than the six-month time frame suggested by the HFM program.



- Goals pertaining to teen education and economic attainment, however, had the lowest achievement rate likely because of their long-term nature.

Further Discussion

Information from both clients and home visitors indicate that the program was perceived as effective in a range of areas. The three areas of positive impact mentioned most frequently by mothers were *knowledge of child development*, followed, in sequence, by *education*, and then *housing*. In fact, receiving useful information in many domains was noted by mothers as the most helpful kind of support provided, with “emotional support” (i.e., someone to talk to, or the opportunity to interact with other teen moms) and then “instrumental support” (i.e., help with daily living) following in importance. When asked if they felt they had made progress on their individual goals, most mothers reported making progress, and more than one-third said they had reached their goals.

In addition, most mothers felt that the home visitor had helped them with parenting, and had enhanced their feelings about themselves. Ninety-two percent felt that the program had no effect on their plans to have more children.

According to home visitors, at the IFSP follow-up that occurred closest to the end of the MHFE, the majority of the families had achieved at least one of their personal goals.

- On average, families had achieved more than half of their goals by this point.
- Maternal education and economic attainment goals had the lowest achievement rate (presumably because they are longer-term endeavors).
- Of the families that had not achieved their goals at this point, more than half had made at least some progress on at least one goal.

ATTAINMENT OF INTERMEDIATE OBJECTIVES

Key Findings

Mothers in the MHFE sample achieved many changes, a substantial number of which were in a positive direction.

- Toward the end of the evaluation, mothers held more optimal parenting attitudes; they were increasingly more appropriate in their expectations, more empathic, and engaged in fewer role-reversing behaviors.
- On average, participants' knowledge of infant development increased during the course of the evaluation.
- Overall parenting stress did not increase over the time of the evaluation.
- Although statistically there was a decrease across time in the percentage of mothers who scored within the clinically significant range of depressive symptoms, at the end of the evaluation there was still a very high proportion of mothers (45%) who were depressed.
- Twenty-seven percent of the mothers were considered chronically depressed (depressed at three or more time points).
- Mothers with fewer symptoms of depression reported more optimal parenting beliefs and knowledge after a year in the evaluation.
- Mothers who were less depressed had children who behaved more optimally during mother-child teaching interactions later in the evaluation.
- Mothers relationships with their romantic partners were related to their parenting strategies. Mothers who engaged more in partner negotiation strategies held more optimal parenting beliefs and child development knowl-

edge, and experienced less parenting stress by the end of the evaluation. Mothers who had supportive relationships with their current partners were more confident about their parenting.

- Mothers who were enrolled in higher quality programs were more likely to have more optimal parenting knowledge/beliefs scores later in the evaluation.
- Over the course of the evaluation, mothers' total amount of informal social support increased.
- Mothers with a higher quantity and better quality of social support showed better parenting knowledge and beliefs.
- Mothers participated in significantly fewer health risk behaviors over the course of the evaluation.

Further Discussion

As noted above, mothers in the MHFE sample made progress in each of the intermediate objectives categories (increasing social support, parenting knowledge and behavior, and maternal well being) during the 18-month study period. What aspects of the HFM program appear to have been related to these changes? A number of clear links emerged: Participants enrolled in better quality programs were more likely to be better informed about child development, and hold more appropriate attitudes about parenting. Participants who received a larger number of home visits were likely to report more dependable social support at their disposal (perhaps because they had learned how to choose where to go for it). Mothers who exhibited *more* appropriate parenting behaviors on one MHFE measure used HFM *less* intensively. And mothers who used less positive coping strategies *received at least the number of home visits required* by the program. In our view, these latter two findings are positive ones, in that they suggest that home visitors correctly assess their clients' parenting knowledge and competence, and adjust program dosage accordingly. Mothers with more competence receive less service; mothers who use less positive coping strategies receive at least what they should. These findings also speak to the complexity of understanding program utilization — more service does not necessarily yield better results.

On the worrisome end are the data related to maternal depression, particularly the chronicity of depression documented for 27% of the MHFE sample. Although these rates appear no worse than those obtained in a number of studies with comparable groups, they are, in any case, unacceptably high. Maternal depression is acknowledged to compromise even the best of parenting intentions; HFM cannot do its best job in the face of this real mental health barrier.

REACHING PROGRAM GOALS

Key Findings

Mothers in the MHFE achieved positive outcomes in three of HFM's four primary program goals areas — enhanced educational and economic attainment, promoting healthy child (infant and toddler) development, and reducing child abuse and neglect. Adequate comparison standards in the other goal area — preventing repeat pregnancies (or births) — were not available, so the results cannot be judged to be positive or negative.

- Eighty-three percent of mothers were in school or had graduated/received a General Equivalency Diploma (GED) by the end of the evaluation, compared to 56% at its beginning. *This rate compares favorably to national data indicating that only 53% of women who became mothers under the age of 20 had graduated from high school or completed a GED by the age of 25.*¹³
- Almost 70% of the mothers who were not in school or a GED program at the beginning of the evaluation changed this status within the 18-month period of the MHFE.
- Mothers were more likely to progress in their educational attainment when their friends behaved in more positive ways as well.
- The better the quality of HFM program, the more likely it was that mothers would continue or complete their schooling.
- Educational attainment during the study period varied across and within the communities included in the Ethnographic substudy. Several distinct patterns emerged: “Education is necessary and possible;” “Education is necessary but impossible;” and “Education is not necessary.”
- The rate of Temporary Assistance for Needy Families (TANF) participation at the end of the MHFE was 35%. Although that rate represents an increase from the participation rate at the beginning of the evaluation (22%), it nonetheless compares favorably to rates of receipt of public assistance reported elsewhere. *The proportion of teen parents receiving welfare has ranged from 44% for all teen mothers to as much as 75% for teen mothers who remain unmarried five years after the birth of their child.*¹⁴
- Almost 12% of MHFE mothers were identified as perpetrators of maltreatment against their own children, according to DSS records. *This rate compares favorably to a small Rhode Island study for which a 33% maltreatment rate among teen mothers was reported.*¹⁵ *Other comparison data are not available.*
- The large majority (93%) of the MHFE sample's substantiated maltreatment cases involved neglect only. *Sixty percent of the maltreatment cases in the Rhode Island study represented neglect.*¹⁶
- According to DSS records, 26% of the MHFE sample were substantiated victims of maltreatment during their own childhoods; this number is likely an underestimate, as DSS records only pertain to those participants whose childhoods were spent in Massachusetts.
- Mothers who report more physical and psychological abuse in their own childhoods, and who exhibit signs of depression, engage in more risky behaviors, and live in less healthy and safe homes and neighborhoods are more likely to be perpetrators of child maltreatment.
- Just over 14% of women in the MHFE sample had repeat births within two years of the birth of their first children.
- Mothers with repeat births within two years were less likely to have completed their high school education/GED or to currently be enrolled in school.
- Community differences in second birth rates emerged within the Ethnography, suggesting that in certain communities, having a second birth as a young mother is a more accepted practice than in others.

- Sixty-three percent of all the mothers in the MHFE, and 64% of mothers under age 20, breastfed their first child. This rate for teenagers compares favorably to national data indicating that only 55% of teen mothers breastfeed.¹⁷
- Eighty-three percent of the infants and toddlers whose mothers participated in the MHFE were reported to be completely current with their immunizations. *Nationally, 76% of two-year-olds are immunized; the Massachusetts rate is 89%. There are no comparable data for children of young mothers, either nationally or in Massachusetts.*
- Children of mothers in the MHFE were generally developing well — that is, without problems — in the five developmental domains assessed with the screening instrument chosen by HFM (the ASQ).

Because we have presented an extensive array of findings above, we will not provide more detail here. Additional discussion of both outcome and process findings are included in the following summary section.

Discussion Points

Each of the following discussion points emerges from a major finding. Within the context of *generally encouraging evaluation findings*, many of these points raise provocative questions, at least in our view, about some aspect of HFM, often regarding its choice of outcome goals and/or process goals (goals for program operations/program standards). These points are discussed in detail below.

Mothers were well-satisfied with the program overall, and appreciated their home visitors particularly. Nonetheless, they participated in the program less intensively than their established service level dictated. Approximately 56% of the visits that, according to HFM standards, should have occurred over a period of time observed by the MHFE in fact occurred. Families with biweekly and monthly service levels generally received their prescribed allotment, but families with weekly plans often received about half. (This finding is in keeping with utilization figures achieved by other home visiting programs as well.) Our Ethnographic Study suggests that there are patterns to participation, and that these patterns are influenced by program-related events (e.g., home visitor turnover), client-related events (e.g., a new job, a new living arrangement), cultural and community factors, and simple disagreements between what home visitors believe a family needs and what that family actually wants.

There was also little surprise expressed among HFM program administrators at the local or state level that assigned service levels were not being fully met. The lives of young mothers are full of unexpected demands that pull them out of their scheduled activities; home visitors also experience unanticipated interruptions of their routines. The missed visits that result are often difficult or impossible to reschedule. These realities may well need to be considered more realistically in setting, and revising, individual service levels for families, and perhaps even standards for service provision statewide. In fact, HFM might achieve more intensive participation, over a longer period of time,



were it to consider alternative program modalities (e.g., drop-in centers, email listservs, etc.).

The home visitor-client relationship is likely the core element of HFM. The contours of this relationship are not fixed, and do not always conform to the role as it is defined by the statewide program; help-seeking behaviors are not universal. Nonetheless, these home visitor-client relationships are built over time and maintained. Given the challenging circumstances confronting many of these young mothers, the home visitor often provides an essential link to the adult world, and, therefore, a break in that relationship (e.g., through staff turnover) may represent more than an inconvenience or a temporary service lapse. It can be experienced by the mother as a serious breach or loss, another broken relationship that cannot be replaced.

The goal of pregnancy prevention does not appear to be a priority for most young mothers. Although this desired result ranked high among HFM program developers, it does not appear in the goals mothers generate for themselves, and over 90% of the mothers reported that their home visitors' opinions on the topic of repeat pregnancy and birth did not affect their decisions. It also seems that the extent to which home visitors attempt to "push" this message with their clients varies across programs, and even within programs.

We were not able to track the relationship of concerted home visitor efforts on this topic to the goal of preventing repeat pregnancies and births. But we suspect that the decision to have a second child is held, by most of these young mothers, as a personal or personal/familial/cultural issue — not something easily within the reach of a public program to affect.

On the other hand, when participants and the program are aligned in their choice of goals, the results appear to reflect that. For example, participants expressed the greatest interest in gaining knowledge about child development, and indeed, there was a significant increase in that knowledge across the period of the evaluation. These benefits are related to the quality of the program in which these mothers were enrolled. So here the mothers wanted what the program had to provide, and those mothers who did best were enrolled in high quality programs.

The ecology of these mothers' lives is complex, with many people, institutions, and values exerting powerful influences on them. These influences include their families of origin, the smaller family units they have created with the birth of this child, the friends they had prior to giving birth and the friends that remain afterwards, the communities in which they live, and the institutions and organizations in which they are members. In noting these ecological contributions to parenting, we are raising the obvious point that HFM, in serving youth who are also parents, operates in a particularly complicated context. Setting both process goals (e.g., cultural sensitivity, or extended family involvement) and outcome goals (e.g., preventing repeat births) that reflect that context is, likewise, a complicated but necessary matter.

HFM appears successful at enhancing the social supports on which young mothers depend. Early on we posited that social support might be viewed as the unifying construct for this program; virtually all that occurred during home visits fit into one of the categories of social support — informational, emotional, or instrumental. Our analyses, both quantitative and qualitative, have borne this out. Dependable, ample social support, of both formal and informal types, is associated with many benefits for these young women. Although social

support can be obtained in many ways, from many quarters, HFM appears to have played a substantial role here.

The level of depression among these young women is extremely high. Although the overall level of depression for mothers in the MHFE declined over the period of the evaluation, and that decline was statistically significant, we do not consider a 45% figure (mothers who were “clinically depressed”) at the end of the evaluation as a positive sign. Approximately 27% of the mothers were considered to be “chronically depressed,” meaning that they scored above the clinical cut-off on the measure we used at either three or all four of the data points in the evaluation.

Depression is related to a broad range of factors that compromise personal well-being — childhood history of maltreatment, domestic violence, and so forth. It is also, not surprisingly, implicated in a host of parenting difficulties. Apart from the concern for the crippling personal toll it takes, from a strategic perspective, dealing with depression and the factors that correlate with it is critical if HFM is to make even better progress on its goals in the future. And given how stretched community mental health resources in most communities are, addressing this concern effectively seems to us nigh impossible without substantial cooperation and collaboration from other public agencies.

HFM mothers are particularly successful at continuing their education. We appreciate that this goal is not shared by all young mothers, at least at the present time. Nonetheless, that over 83% of mothers in the MHFE were in school or had graduated by the end of the evaluation is certainly noteworthy. Numerous mothers in our sample spoke about how powerful and effective support from their home visitors was in helping them achieve this goal. Moreover, the quality of the program differentiated between mothers who were successful and those who were not; mothers enrolled in programs with less turnover, more “match” between home visitors and parents, quicker intake, and a greater likelihood that they were receiving their full complement of services, had higher completion rates.

Economic self-sufficiency is more difficult to measure, for this population, in a meaningful way, and may be immediately less relevant anyway.

Other evaluations use receipt of public assistance as a core measure of economic attainment, and we collected those data as well. Indeed, the rate of TANF receipt among HFM participants compared favorably with those achieved for other programs, although it did increase over the period of the evaluation. We do not consider that increase a negative finding, in that a percentage of the mothers electing to use TANF accepted the support so that they could return to school. In fact, since it appears to be HFM's belief (supported by a considerable amount of research) that a high school diploma is among the best hedges against extended periods of economic dependency, then one might look, instead, to providing greater public financial assistance, early on, to these new mothers so that they can attend school. The premium should probably be placed on school (or GED) completion first, then financial self-sufficiency at some later point. (And neither of these

goals takes into account advice from the Ethnographic Study — that a third trajectory, one that includes family-building first, before either educational or economic attainment, should be considered as well.)

Finally, the children of these young mothers, as a group, look to be doing quite well developmentally.

Often the concern in teen parenting programs is for the teens' children, who the research literature identifies as "at risk" for many negative consequences. By the end of our evaluation these children were generally developing adequately, with no serious red flags in any developmental domain. That positive finding is worth noting for a number of reasons, but primarily the following: It allows us to underscore the fact that, despite the challenges described above and the low expectations that many in the public hold for young parents, many of these young women have admirably met the challenges of parenting and young adulthood.

Program & Policy **Recommendations**

We sketch out below only a few of the most important recommendations for the statewide HFM and local programs to consider:

- HFM should reconsider the concept of “service level,” and reconceptualize optimal patterns of program utilization. Additional service modalities (e.g., contact via internet, or a drop-in center, etc.) should be considered.
- HFM should attempt to more closely align certain program standards with program goals: If cultural norms differ regarding particular outcomes, then cultural competence is difficult, perhaps impossible to achieve. All program standards should be assessed in this way.
- HFM should consider decoupling the goal of educational attainment from that of economic self-sufficiency. Receipt of public assistance may well facilitate educational attainment.
- HFM should focus resources (or coordinate resources with other agencies) in the service of addressing maternal depression, especially the chronic depression that was evident by the end of the evaluation.
- A more efficient and accessible management information system is critical to improving services and initiating new research.
- HFM might reconsider the goal of preventing repeat births, refocusing it on preventing those repeat births for which the proper supports are not likely to be available.



- The professional attributes that are considered critical for home visitors should be examined in light of the findings related to the range of seemingly positive home visitor-client relationships.
- With the understanding that the home visitor-client relationship may be key to participant retention, HFM should work to develop strategies to keep home visiting staff employed for longer periods of time.

We hope that these findings contribute, at least modestly, to improving the operations of HFM and thus, the possibilities of achieving its goals.

Endnotes

- 1 Jacobs, F.H., Easterbrooks, M.A., Brady, A.E., & Mistry, J. (April 2005). *Healthy Families Massachusetts Final Evaluation Report: January 1998 – June 2002*. Medford, MA: Massachusetts Healthy Families Evaluation, Tufts University.
- 2 In its first year of operation, HFM was open only to first-time parents under the age of 20 years.
- 3 See Brady, A., Easterbrooks, M.A., Jacobs, F., & Mistry, J. (1998, June). *Massachusetts Healthy Families Evaluation Plan*. Medford, MA: Massachusetts Healthy Families Evaluation, Tufts University.
- 4 The theoretical model that serves at the rationale for choosing these intermediate objectives is contained in the MHFE evaluation plan. See Brady, A., Easterbrooks, M.A., Jacobs, F., & Mistry, J. (1998, June).
- 5 Jacobs, F.H. (1988). The Five-Tiered Approach to evaluation: Context and implementation. In H.B. Weiss & F.H. Jacobs (Eds.), *Evaluating family programs* (pp.37-68). Hawthorne, NY: Aldine de Gruyter; Jacobs, F.H. (2003). Child and family program evaluation: Learning to enjoy complexity. *Applied Developmental Science*, 7(2), 62-75; Jacobs, F.H. & Kapuscik, J. (2000). *Making it count: Evaluating family preservation services*. Medford, MA: Family Preservation Evaluation Project.
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- 8 Black, T., Powell, J.L., Clay, M., & McDill, P. (2000). *Healthy Families Connecticut: Final outcome report of a home visitation program to enhance positive parenting and reduce child maltreatment*. Hartford, CT: Center for Social Research; Galano, J., & Huntington, L. (2001). *Healthy Families Virginia: FY 2001: Statewide evaluation report*. Williamsburg, VA: Author; Williams, Stern, & Associates. (2002). *Healthy Families Florida: Statewide evaluation: Formative report 2002*. Miami, FL: Author.
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- 10 Kelsey, M., Johnson, A., & Maynard, R. (2001). *The potential of home visitor services to strengthen welfare-to-work programs for teenage parents on cash assistance*. Washington, DC: Administration for Children and Families, U.S. Department of Health and Human Services; Wagner, M.M., & Clayton, S.L. (1999). The Parents as Teachers Program: Results from two demonstrations. *The Future of Children*, 9 (1), 91-115.

- 11 The HFM programs currently rely on an updated tool (2003), but we report here the standards listed on an original version of the tool (1997), since it covers the time period during which we collected our program data.
- 12 This calculation does not include mothers who were on “creative outreach” for the entire period, since this service level does not carry a specific number of expected visits.
- 13 Rate calculated from data presented in: Klepinger, D.H., Lundberg, S., & Plotnick, R.D. (1995). Adolescent fertility and the educational attainment of young women. *Family Planning Perspectives*, 27, 23-28.
- 14 American Public Human Services Association (1999). *Washington Memo: “Second Chance Homes.”*
- 15 Flanagan, P., Garcia Coll, C., Andreozzi, L., & Riggs, S. (1995). Predicting maltreatment of children of teenage mothers. *Archives of Pediatrics and Adolescent Medicine*, 149, 451-455.
- 16 Flanagan, Garcia-Coll, Andreozzi, & Riggs (1995).
- 17 National Immunization Survey. *Breastfeeding practices: Results from the 2003 National Immunization Survey*. Retrieved November 1, 2004, from http://www.cdc.gov/breastfeeding/NIS_data.

Appendix A

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Appendix B

Program Evaluation: The Five-Tiered Approach

Description of Evaluation Activities for the Five-Tiered Approach*

Tier	Purposes of Evaluation	Types of Evaluation Activities
TIER 1: Needs Assessment	<ul style="list-style-type: none"> To document the size and nature of a public problem To determine unmet need for services in a community To propose program and policy options to meet needs To set a data baseline from which later progress can be measured To broaden the base of support for a proposed program 	<ul style="list-style-type: none"> Review existing community, county, and state data Determine additional data needed to describe problem and potential service users Conduct "environmental scan" of available resources Identify resource gaps and unmet needs Set goals and objectives for intervention Recommend one program model from range of options
TIER 2: Monitoring and Accountability	<ul style="list-style-type: none"> To monitor program performance To meet demands for accountability To build a constituency To aid in program planning and decision making To provide a groundwork for later evaluation activities 	<ul style="list-style-type: none"> Determine needs and capacities for data collection and management Develop clear and consistent procedures for collecting essential data elements Gather and analyze data to describe program along dimensions of clients, services, staff, and costs
TIER 3: Quality Review and Program Clarification	<ul style="list-style-type: none"> To develop a more detailed picture of the program as it is being implemented To assess the quality and consistency of the intervention To provide information to staff for program improvement 	<ul style="list-style-type: none"> Review monitoring data Expand on program description using information about participants' views Compare program with standards and expectations Examine participants' perceptions about effects of program Clarify program goals and design
TIER 4: Achieving Outcomes	<ul style="list-style-type: none"> To determine what changes, if any, have occurred among beneficiaries To attribute changes to the program To provide information to staff for program improvement 	<ul style="list-style-type: none"> Choose short term objectives to be examined Choose appropriate research design, given constraints and capacities Determine measurable indicators of success for outcome objectives Collect and analyze information about effects on beneficiaries
TIER 5: Establishing Impact	<ul style="list-style-type: none"> To contribute to knowledge development in the field To produce evidence of differential effectiveness of treatments To identify models worthy of replication 	<ul style="list-style-type: none"> Decide on impact objectives based on results of Tier 4 evaluation efforts Choose appropriately rigorous research design and comparison groups Identify techniques and tools to measure effects in treatment and comparison groups Analyze information to identify program impacts

* Jacobs, F.H. (2003). Child and family program evaluation: Learning to enjoy complexity. *Applied Developmental Science*, 7(2), 62-75.

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