

# A Process Study of the New York State Home Visiting Program

## First Year Evaluation

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A Report Submitted to  
Governor George E. Pataki and  
the New York State Legislature

April 1997

Prepared by the  
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# **EXECUTIVE SUMMARY**

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## **Introduction**

This report presents the early findings of a process study of the Home Visiting program, a primary prevention demonstration project being implemented in ten sites across New York State. This effort is part of the nationally recognized Healthy Families America initiative, a research-based model designed to prevent child abuse and neglect and promote child health and development. The model consists of providing frequent home visits on a voluntary basis to expectant or new parents of children identified at risk of maltreatment or other poor outcomes. Home visitors promote positive prenatal health practices, educate parents about child growth and development, strengthen parent-child relationships, coordinate access to health services and community resources, and support efforts to achieve self-sufficiency.

The New York State Home Visiting program is largely supported through funding from the federal Family Preservation and Support Program. It was designed by a planning team convened by the New York State Departments of Social Services and Health and informed by national and local experts in the field. In June 1994, following this planning effort, the Departments of Social Services and Health solicited grant proposals from community-based and government agencies to plan, initiate, or expand home visiting services.

Grants were awarded to ten sites from a diversity of geographical locations. Three are located in New York City—the Bronx, Brooklyn, and Manhattan—and the remaining seven are located in Albany, Chemung, Erie, Madison, Rensselaer, Steuben, and Ulster counties.

This report fulfills the requirement in the home visitation authorization to submit to the Legislature and Governor an interim report assessing home visiting programs supported by the law. The comprehensive evaluation, which will focus more on program outcomes, will be presented in the second year report.

The material presented in this document covers the first year of operation, from start-up in April 1995 through March 1996. The report describes the nature and level of service provision, implementation issues, characteristics and needs of participating families, and some of the organizational and contextual factors under which the programs are operating.

## **Identification, Screening, and Assessment**

The New York State program has instituted a rigorous identification process that has resulted in successfully identifying, assessing, and enrolling large numbers of families in need of services. The identification process initially focuses on the *community* level. Each of the ten New York State sites has designated a target area—by census tract, zip code or county—that has been found to have high rates of negative outcomes for children. The community level targeting is followed by a two-part procedure—the screening process and assessment interview—that focuses on the *individual* level. These processes are described below.

### **Screening Process**

The screening process consists of administering a 15-item checklist containing demographic variables and personal factors that are associated with a high rate of child maltreatment. The goal is to screen all expectant and new mothers who reside within the designated target area. This involves developing a close affiliation with institutions likely to serve such women. For the most part, the sites have established strong linkages with most of the major health care practices that serve expectant or new mothers who reside in the target community. Indeed, the vast majority (87%) of the more than 1,000 screens analyzed were completed at health-related facilities such as prenatal clinics, private physician offices, and hospitals at the time of delivery. Most women (83%) in the target areas screen positive, qualifying them to proceed to the second stage of the identification process — the assessment interview.

### **Assessment Interview**

For women who screen positive, a personal interview is arranged with a family assessment worker who administers the Family Stress Checklist, a semi-structured interview guide that examines a number of psychological and social risk factors. A total of 519 assessments were analyzed. The vast majority (94%) of the 519 mothers who were assessed scored positive, qualifying them to receive home visiting services.

### **Issues in Targeting Services**

**Relying on Other Institutions to Administer Screens.** For the most part, screening agents receive no compensation from home visiting programs to identify and screen potential participants. Many screening agents are reluctant to fully participate in identification procedures because they are already overburdened and resist the additional paperwork requirement. Some screening agents limit screening to only those women who appear on the surface to be most at risk and, consequently, may eliminate potentially eligible participants. Sites also reported that screening agents had confidentiality concerns and were reluctant to reveal some of the personal information requested on the form, such as history of abortions or substance abuse.

**Geographical Targeting in New York City.** One site in New York City does not rely on workers from outside institutions to conduct screens. It is the home visiting staff that “pound the

pavement" to identify and screen for eligible participants. Determining the woman's geographical eligibility for this site involves expending a great deal of time and resources since the target area is so narrowly defined and highly populated, and health care providers in the community serve many women residing outside the target area. Indeed, the site reports that workers need to approach 23 women before they identify one who resides in the target community.

***Complications of Predicting Future Risk Behavior.*** A number of recent studies have challenged how accurately the standardized assessment tool identifies families who are truly at risk of maltreatment and how well the instrument retains its validity over time. Many of the issues raised about the assessment process concern the underreporting of risk factors. Nonetheless, most families have assessed positive and have been eligible for home visiting services. However, this raises another question — how useful is the assessment process if it adds little in the ability to distinguish at-risk families from those at little or no risk. Changes in the assessment process are being considered as additional data are collected and analyzed. Although its value as a predictive measure is questionable, the assessment instrument was praised as an important diagnostic tool that can be used effectively for program planning.

### **Program Participation**

The majority of women who assess positive, accept services and enroll in the program. Of the 489 mothers who had a positive assessment score, approximately 91% enrolled in the program. Almost half (46%) of the women enrolled in the program prenatally, while the remainder enrolled shortly after they gave birth. In addition, attrition was quite low. About 94% of the cases remained in the program as of March 31, 1996. Over half of those discharged from the program had left because they moved outside the target area. However, it is still rather early in the evaluation to fully assess these numbers.

### **Description of the Population**

We analyzed information on 406 families that participated in the program. The data describing participants indicates that this is a population that is particularly disadvantaged and which faces serious problems. Participants were primarily young, unmarried, first-time parents who were unemployed and poorly educated. Many of these characteristics have been found to be related to poor parenting and child health outcomes and dependence on public assistance. The home visiting literature indicates that these are also the women most likely to benefit from home visiting services.

### **Service Provision**

#### **Service Initiation**

Once the participant qualifies for program services based upon a positive screen and assessment, a home visitor is assigned to the case. Workers found participant receptivity to services was related to a number of factors:

**Pregnant women who are at later stages of pregnancy were generally more receptive than women at earlier stages of pregnancy.** This has led some sites to establish a triage system where enrollment is postponed until the third pregnancy trimester unless the woman has some pressing issues or needs.

**First-time mothers are easier to engage than women who have other children.** These women are particularly interested in gaining knowledge about labor and delivery and child development.

**Women who have fewer family members engaged in their lives are often more receptive than women who have more involved kinship relationships.** Sometimes, other family members discourage the mother from becoming involved in the program or undermine the advice given by the home visitor.

**Mothers who have had less prior involvement with other service providers are also more likely to be receptive to home visiting programs.** Many families have had negative experiences with other systems and may be suspicious or skeptical about the service sector in general.

**Finally, mothers with more education appeared to be more interested in home visiting services.** It is possible that these women place a higher value on the learning process and have a greater appreciation for this aspect of the intervention.

### **Service Intensity**

The home visiting sites are providing services in the home with nearly the frequency prescribed by the model. There was an average of three visits per month. However, workers reported that they often attempted to make visits when participants were unavailable. This happened for a number of reasons. Some mothers lacked experience with keeping scheduled appointments, and others residing in very remote areas found it difficult to pass up an opportunity to get out even if it conflicted with a scheduled home visit. Some mothers who entered the workforce were simply not available or too busy to continue weekly visits. This suggests that as welfare reform efforts increasingly focus on returning mothers to the workforce, home visiting programs will probably need to create alternative work schedules to accommodate working parents.

### **Nature and Frequency of Services**

Overall, the sites appear to be implementing the program model as it was designed. They are providing a vast array of services to improve prenatal behavior, enhance parent-child interaction, promote child health and development, and advance parental self-sufficiency.

The following services were provided:

**Health-related activities:** More families were involved in health-related activities than any other type of activity. Approximately 91% of the families were involved in a health-related

activity in their home and these activities occurred on over half the home visits. Activities included: providing information relating to prenatal health and newborn care; informing families about the availability of health care providers and services in the community; and accompanying participants on medical appointments. Home visitors often served as a communication link between the physician and family, interpreting what the provider said or helping families address concerns.

***Parent-child interaction:*** A large proportion of families (88%) were involved in parent-child interaction services. These services occurred on the majority (63%) of home visits. Home visitors provided information related to promoting positive parent-child interaction such as child management and discipline and encouraged parents to engage in sensitive, growth-promoting care.

***Child development:*** About 65% of the families were involved in child developmental services and almost one-third of the visits included child developmental services. Workers administered the Ages and Stages Questionnaire, a standardized, parent-completed instrument designed to detect potential developmental problems so workers can make appropriate referrals. Some sites have extensive resource libraries and home visitors bring books, videotapes, and developmentally appropriate toys to parents. Workers use prenatal and postnatal curricula and many families are provided with binders to organize these materials as children progress through developmental stages.

***Self-sufficiency:*** About 64% of the families were involved in services to promote self-sufficiency and 18% of the visits included a self-sufficiency activity. There were basically two types of activities. The first was directly related to employability development such as job seeking and training; the second concerned building independent living skills in such areas as money and time management. Workers raised two issues related to employability development. It was the opinion of some workers that promoting self-sufficiency interfered with enhancing the parent-child relationship. Also, mothers who return to work are less accessible for home visiting services.

***Concrete services:*** About 87% of the families were involved in services to meet basic needs and 48% of the visits involved concrete services. These included assessing and meeting needs for food, clothing, housing, and economic stability.

***Family functioning:*** About 70% of the families were involved in family functioning activities and these services occurred in 25% of all home visits. Home visitors addressed such issues as household relationships, family violence, and substance abuse.

### **Issues Involved in Delivering Services**

Some home visitors perceived that the program model focused too strongly on the mother-child relationship and not enough on other household members. Workers felt particularly strongly that other siblings should be involved in home visits. They also felt that many times the program material failed to address the needs of the child's father. Workers expressed a clear

commitment about taking a family systems approach. Indeed, nearly 20% of the visits involved a second caregiver or sibling.

However, this is a very complicated issue. Sometimes other relations undermined what the home visitor said. Some women were involved in destructive and violent relationships and the worker chose not to encourage the participation of their partner. On the other hand, the effects of the intervention would presumably last much longer if the other network members are fully involved and reinforce the positive behavioral changes made by the mother. Other network members can also provide needed resources and services such as transportation and child care.

Another issue raised by workers concerned how directive they should be with participants in a model that advocates family empowerment. There is a potential contradiction in a model that, on the one hand, defines critical program elements that are suggested by research findings, yet, on the other hand, recommends giving participants an active role in determining the nature of the intervention. The dilemma becomes, should the model or participant's desires drive the intervention? Staff were particularly unclear about how to deal with the discrepancy between what is professionally advised and what different cultural groups practice. This was especially evident in child feeding practices and child disciplinary techniques.

### **Referrals to Other Services**

Data were collected on the referrals home visitors made to other service providers. Participants were most frequently referred to health services (34%), which is consistent with health care being a major component of the program model. Sizable proportions were referred to local Departments of Social Services or the Human Resource Administration (31%), concrete services (29%), counseling and support services (28%), family and support services (27%), and employment, training and educational services (27%). It is notable that early in the intervention, a fairly substantial percentage of families were being referred for self sufficiency services like employment and education. In fact, these were as common as concrete services.

### **Child Protective Services (CPS)**

CPS reporting requirements varied within sites based upon the varying qualifications of home visitors (e.g., nurses are mandated reporters) and differed among the sites based upon the varying types of agencies sponsoring the program (e.g., all workers employed by a preventive agency are mandated reporters). Sites also differed in their policy regarding acceptance of open CPS cases. Presumably, outcomes will differ among the sites depending on this policy.

A few home visitors conveyed some ambivalence about CPS reporting requirements. While they stated that they would not hesitate to report a case where they suspected that a child was at risk of harm, there were instances that were somewhat ambiguous — such as a case of overcrowded housing — where they were unsure of what course to follow. In such cases they feared that if a report was made their relationship with the participant would be destroyed while

little could be done by the CPS worker to improve the family's situation. A few supervisors found it helpful to consult with CPS or State Central Registry (SCR) workers rather than immediately filing a report.

## **Organizational Components**

### **Staffing Structure**

In general, the home visiting programs had the same staffing structure consisting of: (1) home visitors—the field staff who worked directly with families; (2) assessment workers—early identification workers who are trained to administer the Family Stress Checklist to determine program eligibility; (3) supervisors—health or social work professionals who oversee the work of the home visitor; and (4) program managers—professionals who are responsible for the overall program operation and serve as liaison between the parent agency and the State.

The New York State Request for Proposals required that programs demonstrate a commitment to hiring home visitors who were representative of the language and culture of the population to be served and who were from the community targeted for services. The qualifications of home visitors often exceeded the minimum requirement of a high school diploma or GED. In fact, nurses, social workers, and graduate students are among the pool of workers.

The managers and supervisors we interviewed were very satisfied with the performance and dedication displayed by the home visitors but felt they sometimes experienced difficulties working with participants who had extreme needs such as developmental disabilities, mental health problems, substance abuse problems, and domestic violence issues. Also, because some home visitors closely reflect the composition of the target population, a few have been found to hold beliefs about caregiving that were similar to participant beliefs, but that contradicted current knowledge about child development and child management. It seems that a balance needs to be found between workers who are sensitive to and have respect for the values of the target population, while at the same time, are able to internalize the basic philosophy and concepts of the intervention.

### **Training and Supervision**

A strong supervisory component is built into the model and indeed is being delivered. In addition, orientation, ongoing in-service, and advanced training are integral parts of the New York State program. All new program staff are required to attend week-long HFA-sponsored core training during the first two to three weeks of employment and receive extensive local training for additional instruction on special topics. The New York State Department of Social Services has contracted with the Behavioral Sciences Institute to organize state-wide training. The Department has also contracted with the New York State Chapter of the National Committee for the Prevention of Child Abuse to establish a Resource Center that provides technical assistance and a variety of materials to all the home visiting sites and others interested in starting a home visiting program.

## **Conclusions and Recommendations**

Although it is too early to measure program impact, the New York State home visiting program has experienced much success in the initial implementation stage. The sites have developed linkages with most of the major health care providers in the community. Large numbers of families are being identified, assessed, and enrolled in the program. They are being provided with an array of services to promote good prenatal behavior, advance child health and development, foster self-sufficiency, and improve family functioning. Few families have disengaged from services in the first six months. Workers have expressed a deep and passionate commitment to participating families and program goals.

A number of sites have initiated practices and procedures that have improved program delivery and increased effectiveness. This section will present some of these practices to encourage replication by other sites. We are also making our own recommendations based upon the data that have been collected and observations we have made.

### **Identification Procedures**

- ♦ Develop a state-level publicity campaign targeted to state and local chapters of professional medical associations to encourage their involvement in local home visiting programs. This initiative could be spearheaded by the New York State Department of Health, in conjunction with the New York State Department of Social Services and the National Committee for the Prevention of Child Abuse and Neglect/NYS Chapter.
- ♦ When possible, consider hiring assessment workers who are nurses or have backgrounds in other health-related areas and may be better able to engineer more successful contacts with the health care system than workers with other backgrounds.
- ♦ Develop new methods to reach a broader pool of pregnant women. This would include developing partnerships with additional community-based organizations, income maintenance offices, educational institutions, religious institutions, and other neighborhood groups.
- ♦ Establish procedures to reach women who are outside of all service systems. Attempts should be made to display posters and distribute flyers in neighborhood businesses (e.g. markets, laundromats), public housing facilities, and other local places where these women are likely to go. For programs that have a large target area (e.g., an entire county) public service announcements can be attempted.
- ♦ The New York State Department of Health should explore how to streamline local procedures to expedite the identification of participants through birth certificate checks.

- ◆ Consider alternative ways of involving women who are in earlier stages of pregnancy, such as a less intensive visitation schedule until the woman reaches her last trimester when she is more receptive to services.
- ◆ When possible, try to engage others in the mother's social network in the identification and recruitment process, particularly partners and grandmothers who may undermine the mother's interest in the program.
- ◆ Consider enrolling all teenage mothers who screen positive, on a trial basis. This is a very vulnerable and needy group.
- ◆ Provide follow-up information to screening agents about program successes, particularly related to those participants who they referred.
- ◆ When possible, conduct assessments in a comfortable setting that is most conducive to eliciting honest responses. While at-home personal interviews are the preferred method, this may be hard to arrange in some cases. If assessments need to be done in a crowded clinic or a busy home visiting office, space should be sought that would provide enough privacy to conduct a confidential interview. Items should be added to the assessment interview that encourage interviewees to identify family strengths.

### **Program Activities**

- ◆ Develop additional materials and design training that provides strategies for involving fathers of the baby and other important members of the mother's social network who can strengthen the effects of the intervention. Also consider ways to include other children in the household when conducting activities with the target child.
- ◆ Develop visit-by-visit protocols as guides for prenatal intervention that specifies activities for the different stages of pregnancy. Also, consider adopting a wide variety of curricula that are designed for participants who are at different levels of ability.
- ◆ Develop clear guidelines on when to discharge families and when to pursue creative outreach.
- ◆ Ensure that there is clear communication with the local department of social services to obtain clarification of regulations and procedures with Child Protective Services and temporary assistance.
- ◆ Develop procedures that expedite the process of information sharing between health providers and the program, especially relating to compliance with medical appointments and immunization schedules.

## **Administration**

- ◆ Provide more training concerning the goal-setting process and the development of individualized family support plans.
- ◆ Expand training to include how to increase the transfer of knowledge and values to participants. In addition, explore the trainees' own value system in relationship to the program model.
- ◆ Provide increased opportunities for "front-line" workers (e.g., home visitors, family assessment workers) from all sites to meet and share experiences and best practices.
- ◆ Consider flexible hours for home visitors or hire workers who can work evening hours or on weekends so they are available to parents who find employment.
- ◆ Initiate a program of staff wellness to ease worker stress, promote team building, and recognize worker contributions. Worker attrition, particularly among home visitors, can have serious consequences for the program. Some families are no longer interested in participating once their worker has left the program.
- ◆ Supervisors should make increased efforts to accompany workers periodically on home visits to get a better understanding of family dynamics and show support for the worker.

# CHAPTER ONE

## INTRODUCTION

### **Overview**

The well-being of our nation's children is a concern that transcends political affiliation and personal ideology. There is little disagreement that problems such as high rates of infant mortality, increasing reports of child maltreatment, alarming numbers of children living in poverty, and declining school performance are among the major issues facing our country today. In an effort to address such problems, a number of interventions have been advanced by the health, educational, and social service systems. However, these initiatives have primarily consisted of fragmented approaches that are reactive to problems that have already begun to emerge.

Across the country, home visitation is generating increased enthusiasm as an integrated, primary prevention program addressing some of the most challenging health and developmental problems facing children and their families today. Indeed, home visitation is now being offered in 210 communities in 35 states nationwide. In 1992, the General Accounting Office announced that home visitation was "the most promising strategy for developing or improving access to early intervention services that can help at-risk families become healthier and more self-sufficient."

In 1994, New York State Social Services Law authorized the New York Department of Social Services, in conjunction with the New York Department of Health, to "issue grants for home visiting programs to prevent child abuse and maltreatment, increase healthy outcomes of families, and empower families to develop and achieve their self-sufficiency goals." New York's effort is part of a nationally recognized movement — Healthy Families America (HFA) — that is designed to provide voluntary, intensive home visitation to high-risk families beginning at pregnancy or soon after the birth of their child. The program is largely supported through funds from the federal Family Preservation and Support Program.

The New York State home visitation authorization includes a provision requiring the New York State Department of Social Services (NYSDSS) to submit to the Legislature and

Governor an interim report that consists of an assessment of the home visiting programs supported by the law, followed by a comprehensive evaluation of the program. NYSDSS contracted with the Center for Human Services Research at the University at Albany's Rockefeller College to fulfill this requirement.

This document satisfies the request for an interim report. It covers the first year of program implementation and presents early findings from the evaluation. The report describes the nature and level of service provision, implementation issues, characteristics and needs of participating families, and some of the organizational and contextual factors under which the programs are operating. The comprehensive evaluation, which will focus more on program outcomes, will be presented in the second year report.

## **Programmatic Background**

In March 1994, the New York State Departments of Social Services and Health formed a home visitation planning team to design the New York State model. The team was informed by national and local experts in the field who provided advice on best practices based upon their experiences and relevant research findings. Emphasis was placed on complementing and building upon existing home visiting services and early intervention programs operating in the state.

In June 1994, following this intensive planning effort to develop the New York State model, the Departments of Social Services and Health solicited grant proposals from community-based and governmental agencies "to offer intensive home visiting services to pregnant women and new parents at risk of child abuse/neglect and/or poor health/developmental outcomes." Priority was given to high-need communities, as defined by high rates of teen pregnancy, child abuse, poverty, and infant mortality.

Over 100 proposals were received and competitively reviewed. Ten organizations across the state were selected — five receiving start-up grants, four securing funds to expand existing home visiting programs, and one obtaining a planning grant.

As depicted in Exhibits 1 and 2, the programs are located in a diversity of geographical areas and are administered by a wide variety of health and human service agencies. Although the sites are implementing the same basic model, they are unique in terms of the character of the target community, the populations being served, and the organizational context. While most information presented in this document is analyzed on a state-wide basis, some comparative analysis is offered between sites located in New York City and sites located in the rest of the state. However, it needs to be emphasized that each program is different and the overall trends that are reported may not apply to every site. We will attempt to point out where important differences have occurred. Brief descriptions of each site are provided in Appendix A.

**Exhibit 1**  
**Location of Home Visiting Sites**



**Exhibit 2**  
**Site Information**

<b>County</b>	<b>Provider/Agency</b>	<b>Type of Grant</b>
Albany	Albany County Department of Health* Parsons Child and Family Center Trinity Institution, Inc. Whitney Young Jr. Health Center	Start-up
Chemung	Comprehensive Interdisciplinary Developmental Services, Inc. (C.I.D.S.)	Expansion
Erie	Buffalo Regional Task Force for Comprehensive Prenatal-Perinatal Services	Start-Up
Madison	Madison County Community Action Program (CAP)	Start-up
Rensselaer	Samaritan Hospital	Expansion
Steuben	Institute for Human Services, Inc.* Kinship Family and Youth Services, Inc.	Start-up
Ulster	Ulster County Department of Social Services* Mid-Hudson Family Health Institute	Expansion
NYC - Bronx	Bronx Perinatal Consortium, Inc.* Visiting Nurse Service ASTAAN (Alternative Services to Abuse And Neglect) EPIC (Effective Parenting Information for Children)	Start-up
NYC - Brooklyn	Church Avenue Merchants Block Association	Planning
NYC - Manhattan	NY Society for Prevention of Cruelty to Children* Alianza Dominicana Columbia University College of Physicians and Surgeons and School of Public Health	Expansion

\*Identifies contracting entity where more than one agency is listed.

## Program Model

### ***Goals and Objectives***

The New York Home Visiting Program has three basic goals: to prevent child abuse and neglect, to promote optimal child health and development, and to enhance parental self-sufficiency.

To achieve these goals, program objectives have been designed to influence multiple domains of family functioning. This approach is based upon ecological theory that recognizes the interaction of factors operating at the personal, family, and community levels. The objectives are as follows:

- ◆ **Encourage positive health behaviors during pregnancy and compliance with prenatal medical appointments.** It is well established that unhealthy prenatal habits often lead to preterm deliveries and low birth weight babies who are at greater risk for subsequent health and developmental disorders. Home visitors educate mothers about importance of healthy prenatal behavior; support their efforts to eliminate use of cigarettes, alcohol, and drugs; and encourage them to comply with prenatal medical appointments.
- ◆ **Increase parental knowledge of child development and promote positive parent-child interactions.** Optimal caregiving is influenced by a broad range of knowledge of what children need and how they are expected to behave at different developmental stages. Home visitors help parents develop realistic expectations of infant and child behavior and encourage parents to engage in sensitive, growth-promoting care.
- ◆ **Promote infant and child health.** The emphasis is on obtaining preventive medical care before serious physical problems emerge. Home visitors ensure that children have a primary care provider, receive well-child check-ups and immunizations on schedule, and get timely lead assessments and screenings.
- ◆ **Develop the ability to access and utilize needed community resources.** Connecting with other needed services is intended to improve the environmental circumstances under which the family lives and reduce the negative effects of stressful living conditions. Home visitors assess resource needs and link families with available community services.
- ◆ **Increase parental employability and self-sufficiency.** Children who are living in impoverished circumstances are at greater risk for health and developmental disorders. Home visitors provide parents with assistance to find jobs, participate in employment and training programs, and return to school.
- ◆ **Develop participants social support system.** The literature has shown that neglectful mothers have fewer network members, fewer contacts, fewer family members living within one hour, and receive fewer emotional and instrumental resources. Home

visitors seek to enhance the informal support of family members and friends available to women prenatally and postnatally.

### ***Program Components***

New York's home visitation effort is part of the nationally recognized Healthy Families America (HFA) initiative, established in 1992 by the National Committee for the Prevention of Child Abuse. The HFA model is based upon a body of research that has led to the specification of key program components most likely to result in successful outcomes. The New York State research team is part of a national HFA research network that meets twice a year to share findings and other information relevant to evaluating home visiting programs.

All program services are planned and delivered in accordance with the HFA program model. This section will briefly describe the program elements that have been incorporated by all New York State sites.

**Universal Screening:** Each New York State Home Visiting Program site must define the target area it will serve by census tract, county, or zip code and must provide a comprehensive description of the target population, including the total number of live births per year. The goal is to screen all pregnant women and new parents residing within the designated area for program eligibility. This involves locating these individuals in prenatal clinics, physician offices, community-based organizations, and at hospitals at the time of delivery. In addition, the model calls for creative, persistent outreach to isolated and hard-to-reach families, including women not receiving prenatal care. Once identified, the pregnant and parenting women are screened for indicators of need using a 15-item checklist containing such factors as being unmarried and having inadequate income.

**Risk Assessment:** All target-area women who screen positive are assessed for risk of child abuse or neglect using a standardized instrument, the Family Stress Checklist, which consists of a series of questions regarding characteristics, beliefs, and experiences found to correlate with abuse and neglect (e.g., having been abused as a child, having a history of substance abuse). Those scoring 25 or above on the Family Stress Checklist are considered to be at risk and are offered home visiting services on a voluntary basis.

**Service Delivery:** Services are delivered to the parent and child in the environment in which they live. This leads to better understanding of individual needs, and the ability to tailor services to meet these needs more effectively than a group setting. Because home visitors bring services to a family rather than requiring the family to come to service providers, home visiting programs can reach families who otherwise might not receive services. The initiative emphasizes a strength-based approach that recognizes and builds on positive family qualities rather than more traditional practices that focus on family problems and deficits.

**Service Frequency and Duration:** Women identified prenatally receive home visits at least twice a month; new parents receive home visits at least once a week for the first six months, with the frequency of future visits based on need. Home visits must be initiated by the time the

child is three months of age and are offered until the child is five years of age or is enrolled in school or Head Start.

**Community Collaboration:** Programs must establish partnerships with hospitals and health care providers to implement screening processes and to coordinate services to address infant health and developmental problems, and with other community service providers to enable families to access needed resources. Some programs have established advisory boards comprised of representatives of the key program areas who assist in the design and implementation of the programs as well as help reduce duplication of services.

**Caseloads:** The breadth of services as well as the intensity of the visit schedule require manageable caseloads. During the first six months, when families are visited on a weekly basis, home visitors carry a caseload of no more than 15 families. Later, when most families are being visited less frequently, caseloads may rise to 25 families.

**Staffing Patterns:** Paraprofessionals from the target community are hired as home visitors because they share many of the same values, cultural backgrounds, and experiences as program participants and therefore are able to relate to them in a supportive, non-threatening manner. Paraprofessional home visitors need not have any previous experience in home visiting, counseling, or case management<sup>1</sup>. Rather, they are selected primarily on their personal attributes, such as a fondness for children, successful experience in raising their own children, belief in non-violent methods of disciplining children, a good personal support system, and a non-judgmental attitude toward families with problems. Home visitors are closely supervised by experienced health or social work professionals. Many of the assessment workers who screen women for program eligibility have backgrounds in nursing.

**Training:** All new program staff attend week-long HFA-sponsored training to learn the basic skills needed to perform assessments and conduct home visits. They also receive extensive training at their agencies on a variety of topics related to their jobs, focusing on the dynamics of child abuse and neglect, domestic violence, well-baby care, communication skills, and team building. Staff continue to receive ongoing training throughout the year.

While the HFA program model is guided by what the literature suggests to be critical elements for successful intervention, the approach also emphasizes flexibility at the state and community levels. The research upon which the model is based was conducted in a limited number of places and therefore, may not be generalizable to all sites. This study has sought to examine the applicability of the program model to the New York State sites under study.

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<sup>1</sup> While home visitors are not required to have any specified training or work experience, in practice we found that many of the staff possess postsecondary degrees, including training in nursing and social work, and had extensive experience in human service programs. The backgrounds and qualifications of home visitors will be more systematically examined in the second year evaluation.

## **Description of the Evaluation**

The material presented in this document covers the first year of operation, from program start-up in April, 1995 through March, 1996. The report presents early findings from the process study and is primarily descriptive. It addresses the following questions:

- ◆ Were home visiting programs able to reach the intended target population?
- ◆ What were the characteristics, backgrounds, and issues of the families served by the program?
- ◆ Did programs provide services of the intended type and intensity? To what extent were the services consistent with the Healthy Families America model?
- ◆ What programmatic, organizational, and contextual factors are facilitating or hindering program implementation?

This report describes the very early stages of program start-up and some of the findings reflect the common challenges associated with getting any new initiative "off the ground." We have tried to present both promising approaches as well as obstacles to implementation. We hope that disseminating these findings will assist those planning on implementing similar programs to replicate successful practices and enable existing program staff to improve service delivery.

To get a complete understanding of the program, the research team used a multifaceted approach involving a combination of both quantitative and qualitative methods. Each approach brings into focus different aspects of the intervention.

The primary source of quantitative data was an information system developed specifically for the home visiting program. In addition to providing data for the evaluation, the information system is capable of producing reports and statistics to facilitate on-site program monitoring and state-level reporting and oversight. As displayed in Exhibit 3, information is collected on program participants, services, and client outcomes utilizing standardized instruments in addition to forms designed specifically for this program.

The data used in this report includes individuals who enrolled between September 1, 1995 and March 31, 1996 at each home visiting site, with the exception of Brooklyn which was operating under a planning grant and did not begin serving clients until after the data analysis period. Our analysis is limited to those families who signed consent forms indicating their agreement to participate in the evaluation. These families account for approximately 90% of all families served.

The qualitative information was obtained from on-site interviews conducted at each home visiting site. Utilizing a standard topic guide, face-to-face interviews were conducted with program managers, program supervisors, family assessment workers, and agency administrators. Group interviews were also conducted with home visitors at each site. The interviews were conducted between February and April 1996.

Additional information was gathered from a review of project proposals and quarterly reports, state-level meetings, and interviews with staff from the New York State Department of Social Services, the New York State Department of Health, and the New York State Chapter of the National Committee for the Prevention of Child Abuse.

**Exhibit 3**  
**Data Collection Instruments**

<b>Tool</b>	<b>Measurement</b>
Screen	Screen individuals on certain risk factors
Kempe Assessment Form	Family stress indicators from in-depth parent interview
Intake Form	Family demographics, issues, family composition, health care coverage, employment data, and other sources of family income
Maternal Social Support Index (MSSI)	Qualitative and quantitative aspects of a mother's social support
Modified Child Well-Being Scale	Presence, severity, and form of child maltreatment
Ages and Stages Questionnaire	Child growth and developmental screening
Home Visit Log	Categories of activities that home visitors engage in with participants
Target Child's Medical Information	Record of immunizations, well-baby visits, lead assessments/screening, emergency room visits, and hospitalizations
Target Child Identification and Birth Outcomes	Basic target child information and birth outcomes
Service Referral Form	Service referral information and outcomes
Follow-Up Information	Updated information of family demographics, employment status, educational and training involvement, issues, public assistance utilization, and health care information
Service Status	Information on discharge

**Content and Format of Report**

This report consists of five sections. Chapter two reviews the gateways into the program — how participants are identified, assessed for eligibility, and enrolled in the program. Chapter three provides an overview of the population being served. Chapter four offers a detailed analysis of service content and delivery. The remaining two chapters consist of a brief description of the administrative issues and a summary of the findings and recommendations.

# CHAPTER TWO

## IDENTIFICATION, SCREENING AND ASSESSMENT

### **Overview of Identification Process**

New York's home visiting program is targeted to families with children who are at future risk of maltreatment or poor health or developmental outcomes. To reach this population, the New York State program has instituted a rigorous identification process that is recommended by Healthy Families America and has been adopted by many other home visiting programs in the country. Through this process, the New York State sites have been successful in identifying, assessing, and enrolling large numbers of families and targeting services to those clearly in need.

The identification process initially focuses on the *community* level — targeting geographical regions with high rates of negative outcomes for children. As already noted, priority was given in the New York State RFP to high-need communities, defined by high rates of teen pregnancy, child abuse, poverty, and infant mortality. Each of the ten New York State sites has designated a target area by census tract, zip code, or county.

The community-level targeting is followed by a two-part procedure — the screening process and the assessment interview — that focuses on the *individual* level. These mechanisms, described below, are designed to identify those individuals possessing certain attributes that have been associated with a higher risk of child abuse and neglect.

### **Screening Process**

The screening process is comprised of two steps. The first step is to locate the target audience and the second step is to administer an instrument which screens individuals on certain risk factors.

*Step 1: Locating the target audience*

The screening process is intended to be universally administered to **all** expectant and new mothers residing within the boundaries of the target area. For the majority of sites this involves developing a close affiliation with institutions that are likely to serve such women including prenatal clinics, physician offices, and hospitals. In addition, to ensure that universal screening is occurring, the sites perform outreach activities to isolated and hard-to-reach families, including women not receiving prenatal care.

As displayed in Exhibit 4, the New York State sites are receiving the vast majority of their referrals from health-related facilities. For the most part, the sites have developed strong linkages with all the major health care providers in the communities they serve. Over 87% of the more than 1,000 screens analyzed were completed at health care facilities including health clinics (33%), hospitals (32%), health care organizations (12%), and private physicians' offices (10%). Prenatal participants were most often identified in health clinics (53%); postnatal cases were most often identified in local hospitals (66%).

Some sites have also developed good working relationships with other community-based providers. Nearly 8% of the participants have been referred by a social or educational agency located in the community. A smaller proportion of participants (4%) have been recruited through media campaigns, word-of-mouth, or simply walk-ins to the agency that houses the home visiting program.

To ensure that all eligible women are being screened in the target area, some sites have reviewed county birth records. However, this practice has not been too successful because of the time it takes to obtain birth records and still be able to contact the family before the child reaches three months of age, the maximum age at which the family qualifies for home visiting services.

*Step 2: Administering the screening instrument*

Once identified, the pregnant and parenting women are screened for the presence of risk factors using a 15-item checklist. The screening process consists of either an interview of the expectant or new mother — conducted in-person or by phone — or a review of her medical records.

Overall, the data indicate that expectant mothers are generally screened by workers from health care facilities who conduct personal interviews; new mothers are primarily screened by home visiting staff who review medical charts in the hospital at the time of delivery.

## Exhibit 4

### Screens

	Total	Prenatal	Postnatal
	N=1,063	N=598 (56.3%)	N=462 (43.5%)
<b>Referral Source</b>			
HEALTH-RELATED FACILITY	920 (87.3%)	516 (86.7%)	404 (88.0%)
Private Physician	110 (10.4%)	97 (16.3%)	13 (.2.8%)
Health Clinic	349 (33.1%)	314 (52.8%)	35 (7.6%)
Hospital	339 (32.2%)	35 (.5.9%)	304 (66.2%)
Other Health Organization	122 (11.6%)	70 (11.8%)	52 (11.3%)
SOCIAL/EDUCATION AGENCY	79 (.7.5%)	50 (.8.4%)	29 (.6.3%)
OUTREACH/MEDIA/WALK-INS/FRIENDS	44 (.4.2%)	27 (.4.5%)	17 (.3.7%)
OTHER	11 (.1.0%)	2 (.3%)	9 (.2.0%)
<b>How Screen Done</b>			
In Person	403 (38.5%)	261 (44.1%)	142 (31.2%)
Record Review	531 (50.7%)	248 (41.9%)	283 (62.2%)
By Phone	73 (.7.0%)	46 (.7.8%)	27 (.5.9%)
Other	8 (.8%)	7 (.1.2%)	1 (.2%)
Don't Know	32 (.3.1%)	30 (.5.1%)	2 (.4%)
<b>Who Conducted Screen</b>			
Home Visiting Staff	657 (62.3%)	277 (46.6%)	380 (82.6%)
Nurse	208 (19.7%)	175 (29.4%)	33 (.7.2%)
Other Medical/Health Staff	95 (.9.0%)	76 (12.8%)	19 (.4.1%)
Social/Case/Outreach Worker	88 (.8.3%)	63 (10.6%)	25 (.5.4%)
Other	7 (.7%)	4 (.7%)	3 (.7%)
<b>Screen Result</b>			
Positive	876 (83.2%)	547 (92.1%)	329 (71.7%)
Negative	177 (16.8%)	47 (.7.9%)	130 (28.3%)

#### *Results of the Screen*

A screen is positive if the following criteria are met:

- ♦ any of these risk factors exist: single parent status, received late or no prenatal care, or considered abortion for the present birth; or
- ♦ at least two of the fifteen risk factors on the screening instrument are present; or
- ♦ the presence of seven of the risk factors cannot be determined.

The individual risk factors on the screen were analyzed for those who scored positive.<sup>2</sup> Overall, as depicted in Exhibit 5, the most commonly reported risk factor was single parent status (85%), an item which automatically qualifies the client for an assessment interview. This is also an item that is relatively easy to determine. Single parent status was followed by inadequate income (64%), education less than 12 years (48%), partner unemployed (43%), and marital/family problems (29%). A substantial proportion of participants were reported to have a history with or be currently experiencing depression (25%), to have previous abortions (22%), to have prior substance abuse issues (18%), or to have a psychiatric history (10%).<sup>3</sup> Approximately 22% were reported to have received late or no prenatal care. Since most of the referral sources were health-related facilities, it seems likely that most women were receiving some level of prenatal care. As home visiting programs become better known in the communities they serve, perhaps more women who do not seek prenatal care will become aware of and interested in the program.

According to the screening forms we received, most women in the target area (83%) screen positive and there is a much greater proportion of negative screens for postnatal cases as compared with prenatal cases (28% vs. 8%). A positive screen qualifies the woman to proceed to the second step of the identification process — an assessment interview.

## **Assessment Interview**

This component of the identification process involves a personal interview with the mother<sup>4</sup> and, if possible, her partner by a Family Assessment Worker who is specially-trained in the techniques of interviewing and information gathering. It is the responsibility of assessment workers to locate all women who screen positive and administer the assessment instrument.

Workers exert enormous effort in trying to meet with the women who have screened positive. Many women are difficult to reach because they have no phone, are not home for scheduled appointments, or do not reply to written correspondence. Sometimes the woman has moved since the screen and cannot be located. There have also been cases where a woman has given a false address so it appears that she lives in the target community and qualifies for home visiting services when she is in fact ineligible.

Assessment workers have developed a variety of mechanisms to increase the likelihood of connecting with all those women who screen positive. Some workers have found it effective to try to "catch" the woman when she comes in for her next prenatal appointment. Bedside assessments in hospitals are sometimes attempted for postnatal cases. However, this can

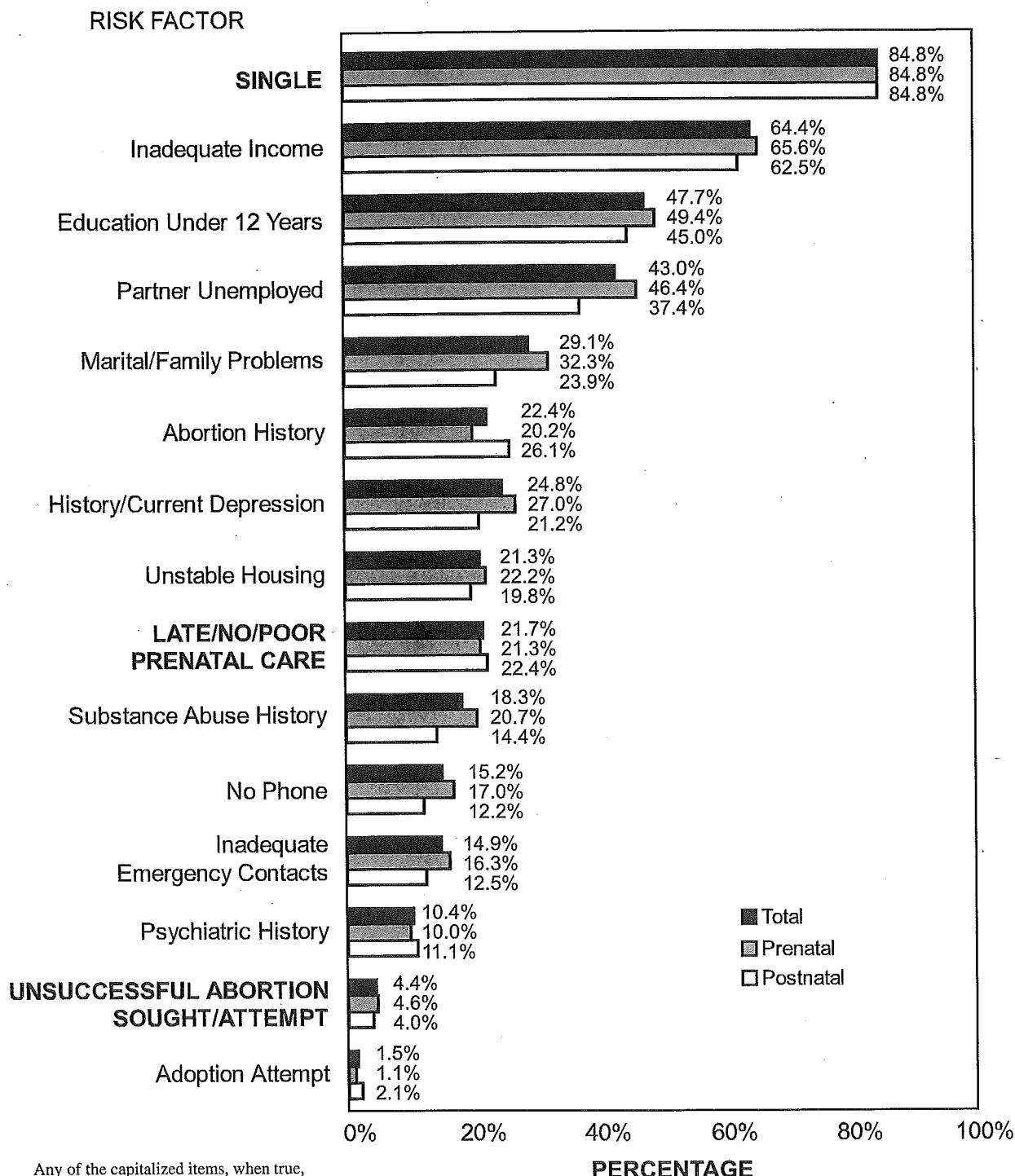
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<sup>2</sup> There is some doubt that all negative screens were forwarded by the screening agents. (The reasons why negative screens were not forwarded are discussed in the issues section of this chapter.) Therefore, we limited our analysis of issues to only those women who scored positive on the screen.

<sup>3</sup> It is suspected that the numbers are even higher for some of the more sensitive items, for it was reported that some screening agents were reluctant to share this information.

<sup>4</sup> The data were collected for the primary caregiver which in most cases (99%) is the child's mother. For simplicity, we will refer to the primary caregiver as the mother throughout this document.

**Exhibit 5**  
**Screen Items — Prenatal and Postnatal Cases**  
**Positive Screens Only**



Any of the capitalized items, when true,  
result in an automatic positive screen.

be difficult to arrange because of short hospital stays after delivery and the stress of being interviewed shortly following delivery.

The assessment consists of administering the Family Stress Checklist, a semi-structured interview guide that was developed in 1978 by the Child Protection Team at the University of Colorado Health Services Center. The checklist is a measure used to identify whether or not a parent is at risk of abusing or neglecting his or her child. It examines the following ten items:

- (1) childhood history of abuse or neglect
- (2) current or previous criminal behavior, substance abuse or mental illness
- (3) suspected or confirmed case of child maltreatment
- (4) low self-esteem, social isolation, depression, or no lifelines
- (5) multiple crises or stresses
- (6) potential for or demonstration of violent temper
- (7) rigid or unrealistic child expectations
- (8) harsh punishment of a child
- (9) perception of child as provocative or difficult
- (10) child is unwanted or is at risk of poor bonding

In each area, respondents are assigned a "0" if no risk is present, a "5" if a mild risk is present, and a "10" if a severe risk is present. Those families with at least one parent scoring over 25 on the Family Stress Checklist are offered home visiting services.

A total of 519 assessments that were conducted between September 1, 1995 and March 31, 1996<sup>5</sup> were analyzed. Of the 519 mothers assessed, the vast majority (94%) assessed positive, i.e., received a score over 25. As displayed in Exhibit 6, we analyzed the frequency of severe and mild levels on each risk factor. The most frequently reported risk factor was "stressors or concerns" (93% of mothers). This risk factor includes family conflicts, financial problems, recent loss of a loved one, job changes, moves, separations or divorce, and chaotic lifestyles.

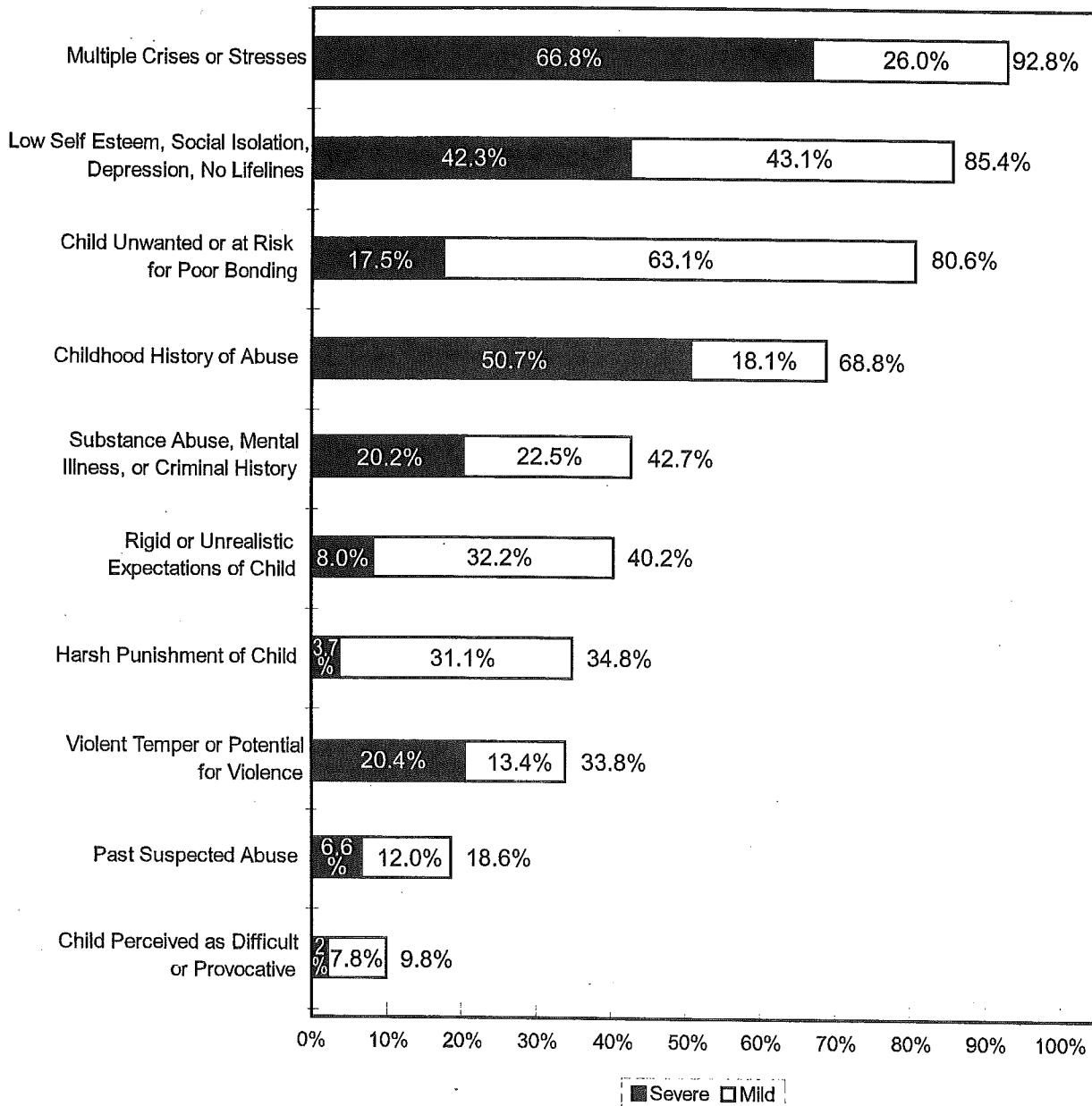
The second most common risk factor was low self esteem, social isolation, depression or no lifelines (85% of caregivers). About 81% of the women were reported to have an "unwanted" child or were at risk for poor bonding; and 69% were subjected to excessive physical discipline, abuse or neglect as a child. Substantial proportions of parents were reported as having criminal, mental illness, or substance abuse histories (43%); having rigid and unrealistic expectations of the child (40%); demonstrating harsh punishment of a child (35%); and having the potential for violent outbursts (34%). Relatively few caregivers were reported as having been suspected of or have a confirmed case of child abuse (19%) and perceiving their child as difficult or provocative (10%).

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<sup>5</sup> We believe that a much larger number of assessments were conducted. However, the sites could not submit the assessment form until after the first home visit was completed. This was necessary because workers needed to designate an intake date (i.e., the date of the first home visit) on the form which is part of the client identification number.

**Exhibit 6**  
**Assessment Risk Factors**

**Risk Factors**



## Issues in Targeting Services

Home visiting is a primary prevention program that channels services to families with children who are determined to be at *future* risk of maltreatment or poor developmental outcomes. Predicting the likelihood of future harm, however, is a highly complex issue. There is not a single instrument or method that can determine with absolute certainty that maltreatment will occur. Every identification method is susceptible to two kinds of errors:

- ♦ selecting families where children are not headed for abuse or other negative outcomes.
- ♦ failing to select families where children are headed for poor outcomes.

Some argue that it is better to err on the side of inclusion and decrease the possibility of missing those children likely to be abused or to display poor developmental outcomes. Others contend that at a time of increased concern over public expenditures, it is necessary to make hard choices and therefore limit service provision to those who are clearly most in need. This debate undoubtedly goes beyond the scope of this report. However, workers raised issues concerning the screening process and assessment interview that pointed to the possibility of each kind of error.

### *Relying on Other Institutions to Cooperate and Accurately Administer Screens*

Failing to identify those in need is often a consequence of relying on other institutions to willingly cooperate and precisely administer the screen. Home visiting staff reported that some providers were reluctant to fully participate in identification procedures. For the most part, screening agents receive no compensation for their efforts to identify and screen home visiting participants. Many screening agents argue that they are already overburdened and resist any additional paperwork requirement. They contend they are simply too busy to complete a screening instrument on every new patient that comes to their practice.

Sometimes, screening agents may choose to conduct the screen on a select group of women — those with the most obvious or pressing needs — rather than all women who go to their practice. These workers do not want to “waste their time” with unnecessary paperwork by completing a screen on a woman who, on the surface, does not appear to require the service. However, this practice may potentially eliminate a woman who does in fact possess risk factors that would qualify her for services.

We believe that the high proportion of positive screens may have been the result of selective screening of the most at-risk cases by the participating agencies. We also found a greater proportion of negative screens for postnatal cases as compared with prenatal cases. We believe this occurred because postnatal screens are most often performed by home visiting workers (83%) who are less likely to selectively screen.

Another reason for the high proportion of positive screens is that some screening sites are simply not bothering to forward to home visiting programs the negative screens that are

completed. Since the woman who screens negative will not be offered home visiting services, these agents can see no reason for submitting the forms.

Workers noted that some screening agents had concerns about confidentiality issues and felt uncomfortable about reporting such personal items as abortion history or substance abuse. To convince reluctant providers to cooperate and screen their patients, sites minimized the importance of completing all screen items. As a result, some screening agents merely completed items that are less sensitive in nature such as the single parent status category, which automatically scores the woman as positive.

Despite the shortcomings of relying on outside institutions, the home visiting sites have managed to gain the participation and cooperation of most major health care providers who serve the target population. Many sites maintain daily contact with outside agencies, which ensures their continued commitment. A few workers have reported that it is vital to develop a good relationship with the nurse manager or other gatekeeper of the health care facility, rather than rely exclusively on the physician who is in charge to ensure that screens are completed. Some sites have discovered that screening agents have been more receptive when the home visiting program is represented by a health care professional, often a nurse who is the assessment worker. These workers appear better able to engineer successful contacts with medical providers than workers with other backgrounds.

#### *Geographical Targeting Issues in New York City*

One of the New York City sites does not rely on workers from outside institutions to identify eligible women and to conduct screens. Instead, these tasks are done by workers employed by the home visiting program who literally "pound the pavement" and visit a variety of health-related facilities and other service providers in the community. The major issue for this site is determining the woman's geographic eligibility. It takes workers an enormous amount of time to identify women who reside in the target area because it is so narrowly defined (by census track) and highly populated. Health care providers utilized by women in the target community also serve many women residing outside the target community. Indeed, the site reported that workers need to approach 23 women before they come across one who resides in the target community. This involves expending a great deal of time and resources.

#### *Issues Associated with Predicting Risk*

A number of issues were raised about the assessment process that have an effect on who qualifies for services and, to a lesser degree, who accepts services.

The first issue concerns the assessment instrument, the Family Stress Checklist, which was recommended by the National Committee for the Prevention of Child Abuse and is considered the best available measurement tool to assess women for home visiting services. Indeed, it is the most widely-used assessment instrument by home visiting sites across the country. However, recent studies have questioned how accurately the instrument identifies families who are at risk of maltreatment. An in-depth study by the National Committee found

demographic markers such as poverty, single parent status and limited service access to be more important determinants of future maltreatment than the risk assessment instrument. Furthermore, it is unclear how well the instrument retains its validity over time, since the level of risk for maltreatment varies as families face new situations or challenges due to changes within the family structure or the child's developmental needs.

The second issue concerns difficulties in obtaining complete and accurate information from the assessment interview. Sometimes, assessment workers had doubts about how honest participants were when responding to highly personal items, especially substance abuse history, childhood history of abuse, and violence in the household. Indeed, home visitors reported that many issues surfaced later in the course of the intervention that were not identified at the time of the assessment. This occurred for several reasons. First, many sites reported that teenagers are particularly reluctant to reveal personal information. As one worker noted:

“With teens, they say everything is OK. Based on the information they give you, you have no choice but to score them negative ... Early in the pregnancy, it's not that real; they're in denial.”

Second, some families distrusted assessment workers and consequently were reluctant to be completely forthright. In some cases they confused assessment workers with child welfare workers and had misplaced fears about the nature of the intervention.

Third, the circumstances under which the assessment is administered also affected the validity of the information received. While the majority of sites conduct in-person interviews, one site conducts a major proportion of interviews by phone. In-person interviews are completed in different places: the client's home, a crowded health clinic, and at the hospital bedside of a new mom. Sometimes other household members are present during the interview. Workers reported that the preferred method was the personal, in-home interview where the interviewee is more comfortable and seems more willing to reveal personal information. Workers also report that interviews conducted in the home offer the opportunity to observe the condition of the household, acquire a sense of the adequacy of the living arrangements, and obtain a more complete assessment.

In general, assessment workers felt that mothers who score negative may require services, but may fail to disclose enough information to score positive. Some assessment workers admitted that “when in doubt,” they would err on the side of inclusion and try to “push the score” to 25 to ensure that all those who needed the service would receive it.

Some assessment workers experienced philosophical problems with the assessment process. They were uncomfortable with assessing someone's risk for abuse and felt the identification of individual deficits contradicted the program's strength-based approach. To counter this, some sites have supplemented the interview protocol with items to identify family strengths.

Despite the fact that a number of issues have been raised about the assessment process, especially regarding the underreporting of risk factors, most families assess positive and are eligible for home visiting services. However, this raises another question — how useful is the assessment process if it adds little to the ability to distinguish high-risk families from families at little or no risk of maltreatment but, nonetheless, involves the expenditure of a great deal of resources<sup>6</sup>. This issue is not unique to New York State. Other HFA programs throughout the country are also reporting high proportions of positive assessments.

However, workers have argued that the assessment instrument has provided them with important information about families. The utility of the assessment instrument may lie more in its application as a diagnostic tool for program planning than in its use as a predictive measure to target appropriate families. Further examination of the identification process is warranted.

## Program Participation

As displayed in Exhibit 7, the vast majority of women who assess positive, accept services and enroll in the program. Of the 489 mothers who had a positive assessment score, approximately 91% enrolled in the program and 9% did not enroll. Reasons for not enrolling included: refused the program (55%), CPS status of the case<sup>7</sup> (9%), client moved (9%), referred to other program (6%), and other (20%).

We did not collect further data on the reasons why clients refused the program. This issue will be explored in more depth in the second-year evaluation. However, workers provided some anecdotal reports of why families refuse services that pointed to the challenges that workers face. As already noted, some families associated home visitors with child welfare workers and misunderstood the intent of the intervention. Second, a few families were offended by items on the assessment and that resulted in their rejecting service. Third, a partner or other family member sometimes discouraged mothers from participating. Workers suspected that there may have been a domestic violence situation or an illegal activity in the household and partners were reluctant to have a stranger visit their home. Finally, some grandparents believed they could provide their daughter with enough support and knowledge about childrearing and because of this, home visitation was unnecessary.

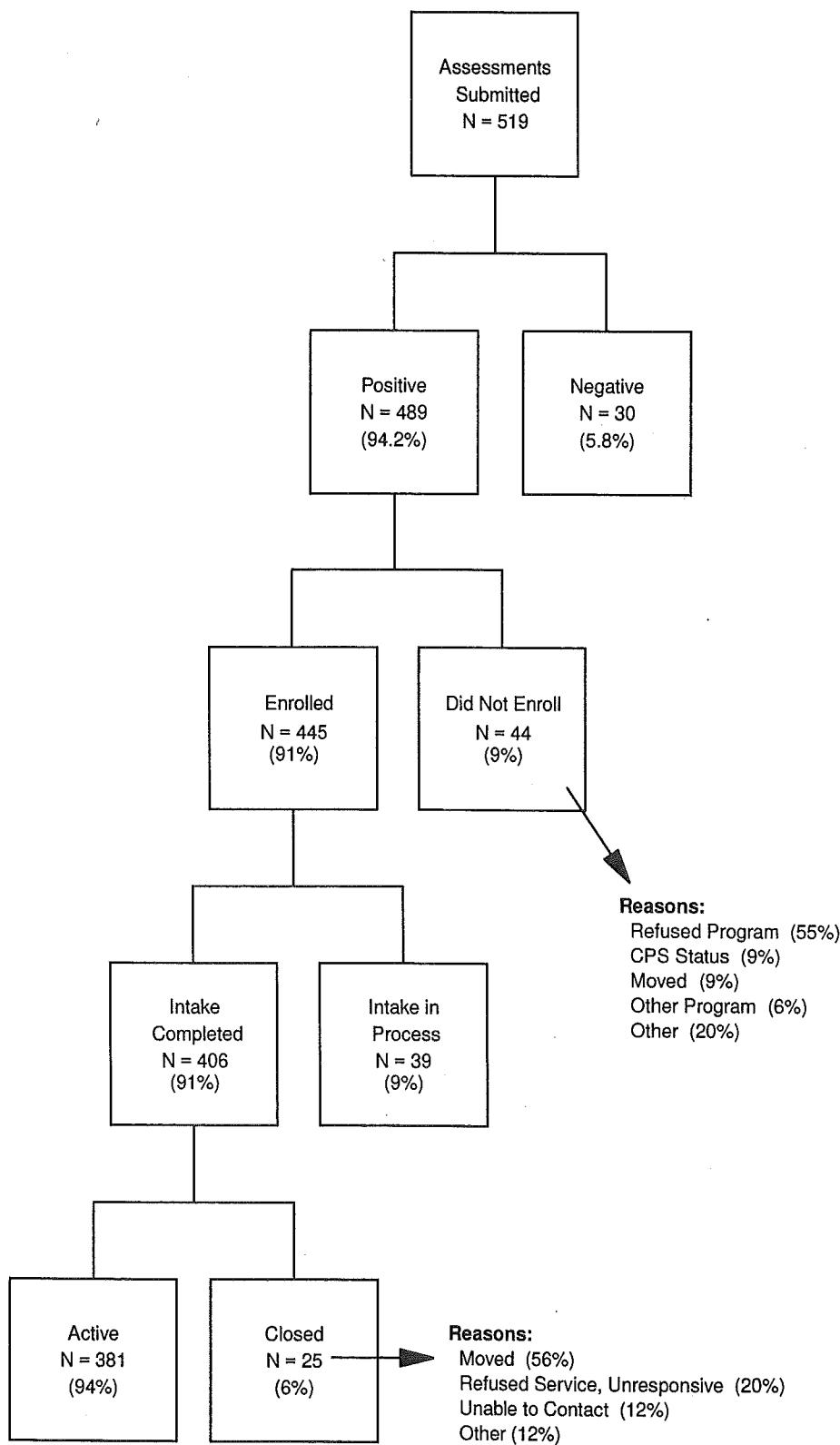
We also examined the retention in the program of families who entered the program between September 1995 and March 1996. As Exhibit 7 shows, 94% of the cases remained in the program as of March 31, 1996. Of the families who were discharged, over half left the program because they moved outside of the target area. While the attrition rate is quite low, it is still rather early in the evaluation to fully assess these numbers.

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<sup>6</sup> Each program has at least one full-time position devoted to the assessment process in addition to supervisory time and assessment worker training.

<sup>7</sup> Some programs did not enroll active CPS cases since home visiting is a primary preventive program; other programs accepted many of these cases. The CPS status of participants is explored in more depth in Chapter three of this document.

**Exhibit 7**  
**Assessment Results and Enrollment**



# CHAPTER THREE

## DESCRIPTION OF THE POPULATION

### **Sample Description**

We analyzed information on 406 families who enrolled in the program between September 1, 1995 and March 31, 1996.<sup>8</sup> Information was collected on the mother, the biological father, and the target child (i.e., the newborn). If the biological father was not living in the household, information on a second caregiver living in the household was also collected.

Nearly three-quarters of the families in our sample were from the seven sites located outside of New York City. Data were collected on families from two New York City sites — Bronx and Manhattan. The third New York City home visiting site — Brooklyn — was operating under a planning grant and did not begin to enroll families until after the data analysis period. Some cases from the Manhattan program are excluded from this analysis. The Manhattan site is conducting a randomized experimental design and we analyzed only those families receiving home visiting services; families in the control group were not included since this report is not examining program impact.

We will be offering a comparative analysis between the sites located in New York City and the sites located in the rest of the state. However, we emphasize that results reported for the two New York City sites may not apply to both, just as results reported for the rest of state do not apply to every upstate site.

### **Enrollment Status**

Almost half (46%) of the women enrolled in the program prenatally, while the remainder enrolled shortly after they gave birth. Consistent with the program model, the vast majority of the postnatal cases (85%) had enrolled by the time the child reached three months of age. (See Exhibit 8).

<sup>8</sup> According to the assessment data presented in the previous section, a total of 445 families enrolled between September 1, 1995 and March 31, 1996. We received completed intake forms on 406 families. Of the remaining thirty-nine, twenty-eight (72%) families were assessed too late in the data collection period for intake forms to be completed and submitted. The remaining eleven cases represent missing data.

## New York State Home Visiting Program

New York City sites reported a lower proportion of prenatal cases than the rest of the state (39% vs. 48%). New York City also enrolled a smaller proportion of children over three months of age than the rest of the state (11% vs. 17%).

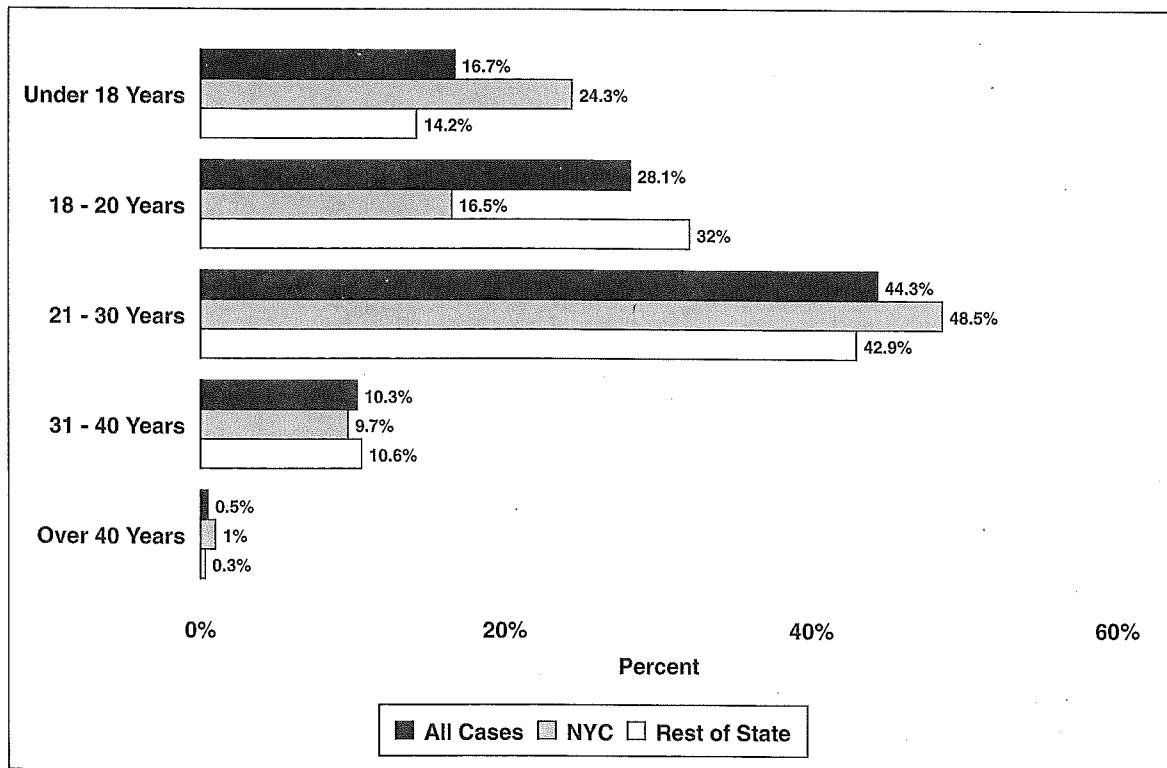
### Exhibit 8 Enrollment Status

	Total	NYC	Rest of State
Prenatal	185 (45.6%)	40 (38.8%)	145 (47.9%)
Postnatal	221 (54.4%)	63 (61.2%)	158 (52.1%)
Child under 2 weeks	25 (11.4%)	6 ( 8.6%)	19 (12.7%)
Child 2-4 weeks	64 (29.1%)	16 (22.9%)	48 (32.0%)
Child 5-8 weeks	54 (24.5%)	22 (31.4%)	32 (21.3%)
Child 9-12 weeks	44 (20.0%)	18 (25.7%)	26 (17.3%)
Child over 12 weeks	33 (15.0%)	8 (11.4%)	25 (16.7%)

### Mother's Age

As displayed in Exhibit 9, most of the mothers enrolled in the Home Visiting Program were fairly young: 17% were under 18 years, 28% were between 18 and 20, and 44% were 21 to 30 years old. Only 10% were between 31 and 40 and less than 1% were over 40. The average age was 23 years.

### Exhibit 9 Mother's Age at Intake

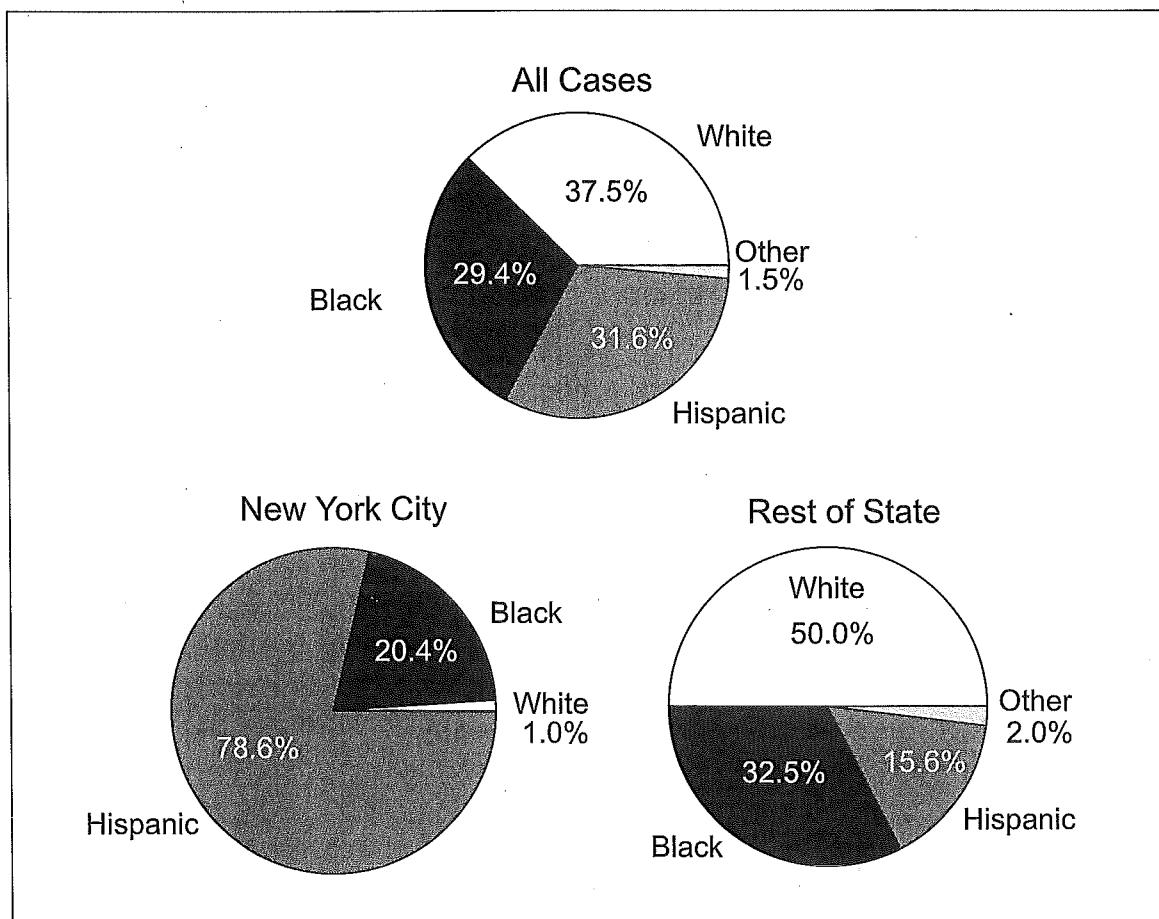


The program did not target the teen parent population as other home visiting initiatives have. The reason why there is such a large proportion of participants under 21 years is that teenage parenthood correlates closely with many of the risk factors used for screening and assessment, such as being single, inadequate income, and lacking a high school diploma.

## Mother's Race

Exhibit 10 indicates that 38% of the mothers were white, 32% were Hispanic and 29% were black. However, there were vast differences in racial composition of participants between New York City and the rest-of-the-state sites. Mothers from the New York City sites were nearly 79% Hispanic, 20% black, and 1% white; mothers from the rest-of-state sites were 50% white, 33% black, and 16% Hispanic. The large number of Hispanic mothers in New York City is partially as a result of the unique population of Washington Heights where the Manhattan site is located. This area contains a largely Dominican population and the site reported an enrollment of 100% Hispanic caregivers.

**Exhibit 10**  
**Mother's Race**



## Mother's Education

Exhibit 11 shows a large proportion of mothers (61%) did not have a high school diploma or GED at the time of intake. About 29% of the mothers had graduated high school or obtained a GED and an additional 10% had some postsecondary education.

A smaller proportion of mothers from New York City were high school graduates or had GEDs than mothers from the rest of the state sample (22% vs. 32%), probably due to the large number of immigrants in the New York City sample.

**Exhibit 11**  
**Mother's Education**

	Total	New York City	Rest of State
Less than 12 years	243 (61.1%)	69 (68.3%)	174 (58.6%)
HS Graduate or GED	116 (29.1%)	22 (21.8%)	94 (31.6%)
Postsecondary	39 ( 9.8%)	10 ( 9.9%)	29 ( 9.8%)

## Marital Status and Living Arrangement

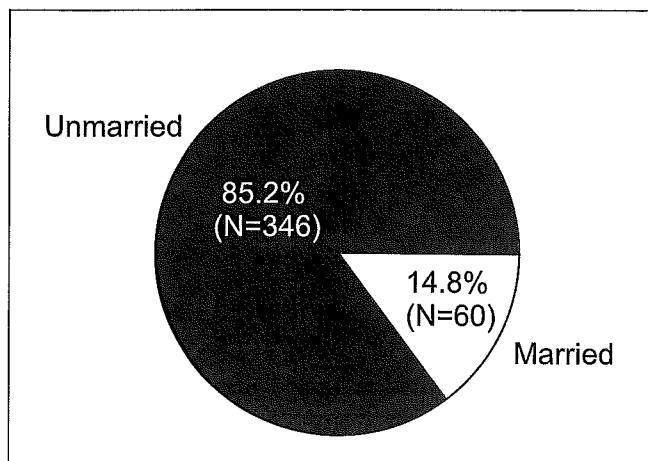
As noted in Exhibit 12, only 15% of the mothers were married at the time of intake. There was little difference in the marital status of mothers in the New York City sites and the rest-of-state sites (14% vs. 15%). Indeed, it is not surprising that there are so many unmarried mothers in the program since single parent status is a qualifying factor for program enrollment.

About 64% of the households reported the presence of a second caregiver, who was the biological father in 47% of the total cases (see Exhibit 13). We did not expect to find such a large proportion of fathers living in the household because most of the mothers were unmarried. However, a greater proportion of fathers are residing in rest-of-state households than in New York City households. The biological father resided in over half (52%) of the rest-of-state households and in a third (32%) of the New York City households.

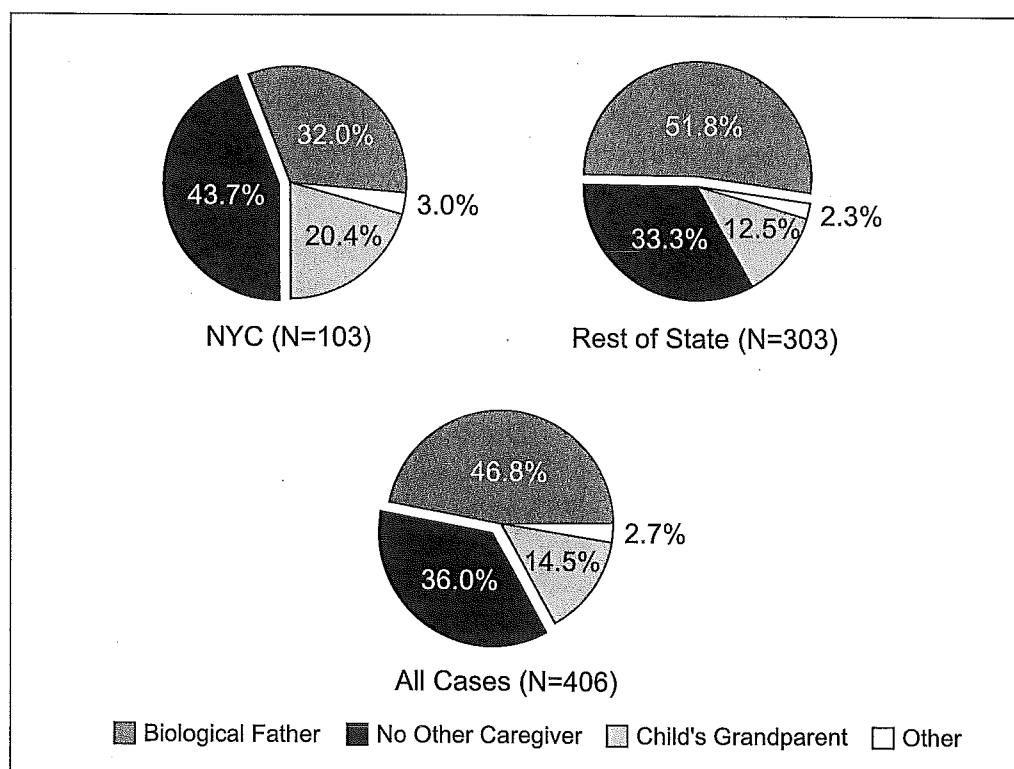
In nearly 15% of the households the child's grandparent was identified as the second caregiver. The grandparent was more often the second caregiver in New York City households than rest-of-state households (20% vs. 13%).

The prevalence of second caregivers suggests that social isolation may not be as big a problem as hypothesized for these families. On the negative side, the presence of a second caregiver provides more opportunity for interference in the intervention.

**Exhibit 12**  
**Mother's Marital Status**



**Exhibit 13**  
**Second Caregiver in Household**



## Household Employment

Exhibit 14 shows that in over half of the households at least one resident was employed within the past year — either the mother (16%), the second caregiver (20%), or both the mother and the second caregiver (17%). In 47% of the households no one was employed in the past year. There was more unemployment among New York City households than rest-of-state households. In New York City, no one was employed in 59% of the households; in the rest of the state no one was employed in 43% of the households.

**Exhibit 14**  
**Household Members Employed**  
**within the Previous Year**

Household Member Employed	Total	NYC	Rest of State
Mother Only*	63 (15.5%)	16 (15.5%)	47 (15.5%)
Second Caregiver Only	82 (20.2%)	18 (17.5%)	64 (21.1%)
Both Household Members	69 (17.0%)	8 ( 7.8%)	61 (20.1%)
Neither Household Member*	192 (47.3%)	61 (59.2%)	131 (43.2%)
Total	406 (100.0%)	103 (100.0%)	303 (100.0%)

\* Includes some households without a second caregiver

## Involvement of Fathers Who Reside Outside the Household

The involvement of fathers living outside the household in their children's lives was rated along three dimensions: emotional, physical, and financial.<sup>9</sup> Exhibit 15 shows that the majority were rated as very or somewhat emotionally involved (60%) with their children. This would suggest that there is some potential to involve many fathers living outside the household in the intervention. Lower proportions were reported to be physically involved (46%) or financially involved (38%).

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<sup>9</sup> *Emotional involvement* includes demonstrations of a loving relationship between father and child, such as talking and playing with the child.

*Physical involvement* includes taking part in the basic care of the child such as feeding and bathing and changing diapers.

*Financial involvement* includes contributing money to the care of the child.

**Exhibit 15****Involvement of Biological Fathers  
Residing Outside of the Household**

	Total	NYC	Rest of State
<b>Emotional Involvement</b>			
Very involved	28 (23.5%)	9 (24.3%)	19 (23.2%)
Somewhat involved	43 (36.1%)	11 (29.7%)	32 (39.0%)
Not at all involved	48 (40.3%)	17 (45.9%)	31 (37.8%)
<b>Physical Involvement</b>			
Very involved	13 (10.9%)	3 ( 8.1%)	10 (12.2%)
Somewhat involved	42 (35.3%)	14 (37.8%)	28 (34.1%)
Not at all involved	64 (53.8%)	20 (54.1%)	44 (53.7%)
<b>Financial Involvement</b>			
Very involved	10 ( 8.5%)	3 ( 8.1%)	7 ( 8.6%)
Somewhat involved	35 (29.7%)	11 (29.7%)	24 (29.6%)
Not at all involved	73 (61.9%)	23 (62.2%)	50 (61.7%)

**Public Support**

Consistent with the high unemployment rate, nearly half (47%) of the families received Aid to Families with Dependent Children (AFDC) or Home Relief at the time of intake, 62% received food stamps, 75% received WIC, and 12% received SSI or SSD. (See Exhibit 16)

A larger proportion of New York City families reported receiving AFDC or Home Relief compared to the rest of the state (55% vs. 45%). This is consistent with our finding that there is more unemployment in New York City households than in households in the rest of the state. However, a smaller proportion of families from New York City as compared with the rest of the state reported receiving food stamps (60% vs. 63%), WIC (72% vs. 76%), and SSI/SSD (11% vs. 13%).

**Exhibit 16**  
**Public Support**  
**Received at Intake**

Type of Support	Total	NYC	Rest of State
AFDC or Home Relief	192 (47.3%)	57 (55.3%)	135 (44.6%)
Food Stamps	254 (62.6%)	62 (60.2%)	192 (63.4%)
WIC	305 (75.1%)	74 (71.8%)	231 (76.2%)
SSI/SSD	50 (12.3%)	11 (10.7%)	39 (12.9%)

## **Other Children**

Exhibit 17 shows that nearly half (49%) of the participants were first-time mothers. More than one-quarter (26%) had one other child, 14% had two other children, and 10% had three or more other children. There were few differences between New York City families and the rest-of-state families.

**Exhibit 17**  
**Number of Other Children in the Family at Intake**

	Total	NYC	Rest of State
None	200 (49.3%)	55 (53.4%)	145 (47.9%)
1 child	107 (26.4%)	25 (24.3%)	82 (27.1%)
2 children	58 (14.3%)	14 (13.6%)	44 (14.5%)
3 or more	41 (10.0%)	9 ( 8.8%)	32 (10.5%)

## **Child Welfare Cases**

Exhibit 18 shows that overall, about 13% of the mothers were reported to have prior involvement with Child Protective Services (CPS)<sup>10</sup>. Approximately 5% of the mothers had an active CPS case at intake and 5% had another child who had been placed in foster care. These numbers are even greater when analyzing just those families with other children: 20% of the mothers had prior involvement with CPS, 7% had an active CPS case at intake, and 6% had another child who had been placed in foster care.

Proportionately, fewer New York City families were reported to have present or previous involvement with the child welfare system than families from the rest of the state. Furthermore, there was great variation in the proportion of CPS cases among all the sites. This is partially explained by the fact that the sites differ in their policy regarding acceptance of open CPS cases. Some sites are subcontracted by the local social services district and are obligated to accept CPS cases, some sites do not accept any CPS cases, and most sites review client involvement on a case-by-case basis.

**Exhibit 18**  
**Child Welfare Cases**

	Total	NYC	Rest of State
Prior Involvement with CPS	52 (13.3%)	2 (2.0%)	50 (17.4%)
Active CPS Case	18 ( 4.7%)	2 (1.0%)	17 ( 6.0%)
Child Previously in Foster Care	19 ( 5.0%)	1 (1.0%)	18 ( 6.0%)

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<sup>10</sup>The information received on child welfare cases was, to a large extent, gathered by self-report from participants. The research team will further verify this item through data matches with the State Central Registry and present the findings in the comprehensive evaluation report.

## Health and Birth Information

As shown in Exhibit 19, most of the mothers had health insurance at the time of intake. Approximately two-thirds (63%) were receiving Medicaid and 24% had some other type of health coverage. Sixteen percent of the mothers had no health insurance at the time of intake. While a larger percentage of New York City mothers reported Medicaid coverage compared with mothers in rest-of-state sites (66% vs. 62%), more New York City mothers had no health insurance than mothers in other parts of the state (23% vs. 14%). The percentage of mothers receiving Medicaid is likely to decline as women give birth and lose the coverage that is available to them only when they are pregnant. In other words, the 16% non-insured rate may be artificially low because of the point at which it was measured for women entering the program prenatally.

**Exhibit 19**  
**Health Care Information at Intake**

		Total	NYC	Rest of State
MOTHER	Health insurance <sup>1</sup>			
	Medicaid	257 (63.3%)	68 (66.0%)	189 (62.4%)
	PCAP	24 ( 5.9%)	15 (14.6%)	9 ( 3.0%)
	Private insurance	40 ( 9.9%)	4 ( 3.9%)	36 (11.9%)
	Other health insurance	33 ( 8.1%)	1 ( 1.0%)	32 (10.6%)
	No health insurance	66 ( 16.3%)	24 (23.3%)	42 (13.9%)
	Has a primary care provider at intake	350 (90.2%)	86 (86.0%)	264 (91.7%)
	Level of prenatal care received			
	Regular	263 (90.4%)	74 (87.1%)	189 (91.7%)
	Sporadic	27 ( 9.3%)	10 (11.8%)	17 ( 8.3%)
	No care	1 ( .3%)	1 ( .3%)	0
	Where prenatal care received			
	Health clinic	149 (51.2%)	46 (55.4%)	103 (49.5%)
	Private practice	93 (32.0%)	1 ( 1.2%)	92 (44.2%)
	Hospital	45 (15.5%)	34 (41.0%)	11 ( 5.3%)
	Other	4 ( 1.4%)	2 ( 2.4%)	2 (1.0%)
CHILD	Receives Medicaid <sup>2</sup>	142 (82.6%)	44 (78.6%)	98 (84.5%)
	Child has primary care provider	256 (98.1%)	67 (95.7%)	189 (99.0%)
	Full-term delivery	269 (88.8%)	74 (86.0%)	195 (89.9%)
	Type of nursery			
	Normal	259 (86.6%)	75 (87.2%)	184 (86.4%)
	Intensive	39 (13.3%)	11 (12.8%)	39 (13.6%)

<sup>1</sup> Item totals more than 100% because multiple responses were allowed.

<sup>2</sup> Child Medicaid item was added onto a later version of the data collection system and percentage is based only upon cases that responded to this category.

The vast majority (90%) of the mothers had a primary care provider at intake. Ninety percent received regular prenatal care, 9% of the mothers received sporadic prenatal care, and only one case was reported where no prenatal care was received. This is not surprising since most women were initially identified through a health-related facility. Over half (51%) of the prenatal care services were received in a health clinic, about one-third (32%) in a private obstetrical/gynecological practice, and 16% in a hospital. Private practices were more often utilized in the rest of the state than in New York City (44% vs. 1%), while hospitals were more frequently used in New York City than in the rest of the state (41% vs. 5%).

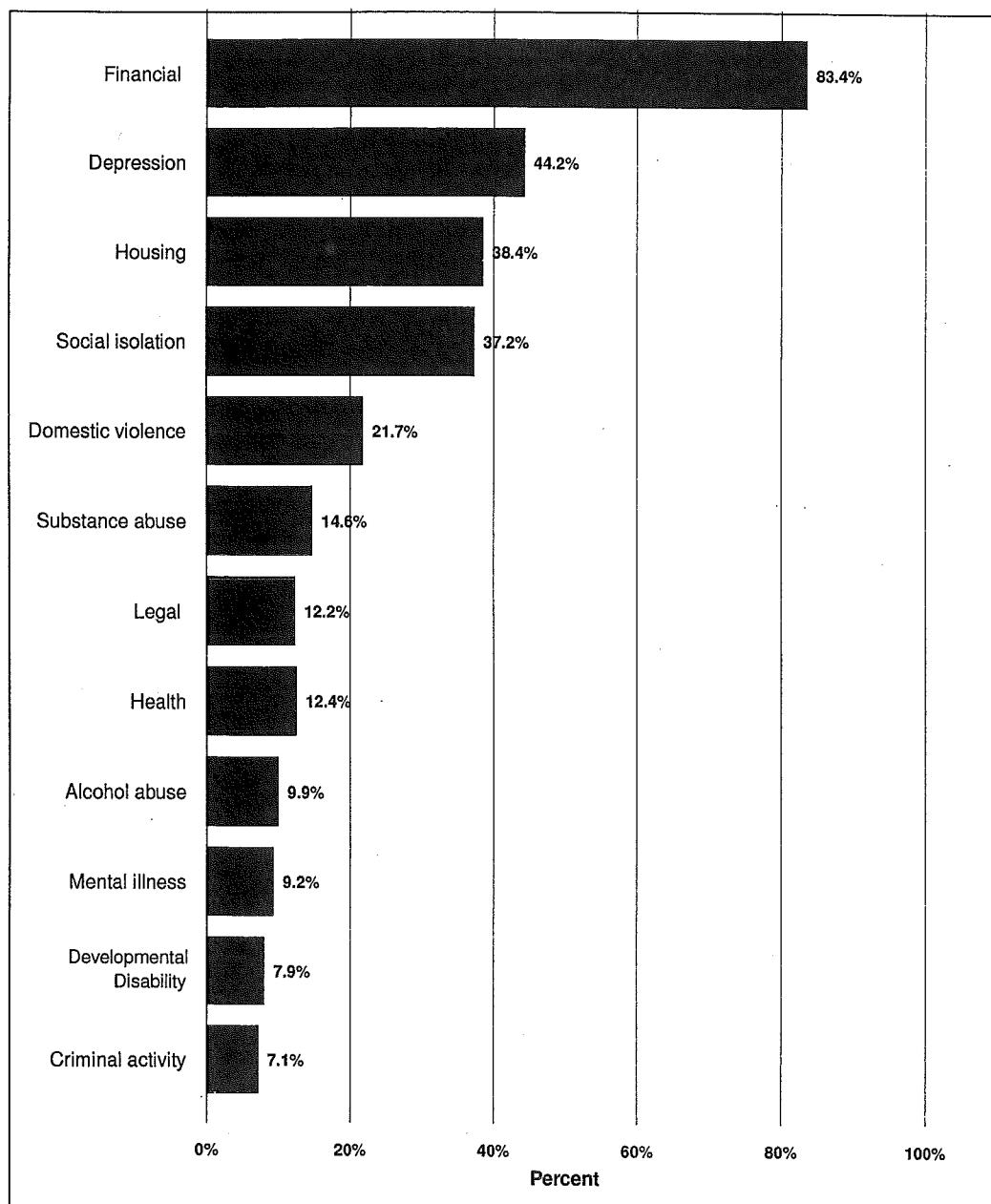
Approximately 83% of the children were receiving Medicaid benefits and 98% had a primary care provider at time of enrollment. Nearly 89% were born full-term and 86% received normal nursery care, as opposed to intensive care, while in the hospital.

### **Issues Identified at the Time of Intake**

As indicated in Exhibit 20, the mothers were assessed for the presence of a number of issues at the time of intake. This measure will be administered periodically to analyze any changes in issues over the course of the intervention. Clients were not asked directly whether they had a problem in a certain area. Rather, workers relied on observation, information volunteered by the participant, and responses to other assessment tools such as the Family Stress Checklist.

The most prevalent issue facing mothers at time of intake was financial problems (83%). Other common problems were depression (44%), housing problems (38%), and social isolation (37%). Less frequently reported issues included: domestic violence (22%), substance abuse (15%), legal issues (12%), health problems (12%), alcohol abuse (10%), mental illness (9%), developmental disabilities (8%), and criminal problems (7%). A large number of "unknowns" were reported on some of the more personal items, particularly for the New York City participants. Some workers were reluctant to report that a participant had a problem unless they were absolutely certain. Thus, the data probably underestimate the level of problems faced by participants.

**Exhibit 20**  
**Mother's Issues at Intake**



### **Concluding Comments**

The data describing participants indicates that this is a population that is particularly disadvantaged and faces serious problems. Participants are primarily young, unmarried, first-time parents who are unemployed and poorly educated. Many of these characteristics have been found to be related to poor parenting and child health outcomes and dependence on public assistance. On the other hand, home visiting research indicates that these are also the women who are most likely to benefit from home visiting services.

*New York State Home Visiting Program*

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## CHAPTER FOUR

# SERVICE PROVISION

This section will describe the services offered to program participants. We will begin with a discussion of how cases are initiated and then explore, in some depth, the issues of participant engagement and involvement. This will be followed by a description of the kinds of services provided directly by the home visitor and the types of services provided through referrals to other providers. The chapter concludes with a summary of some of the challenges facing home visitors in service delivery.

### **Service Initiation**

Once the participant qualifies for program services based upon a positive screen and assessment, a home visitor is assigned the case. It is the supervisor who usually makes the assignment, sometimes in consultation with the assessment worker who has already met the family and can provide more insight on family needs based upon her encounter.

The match between home visitor and family involves a number of factors. Many times it is based upon logistics — the worker's current caseload (both in terms of number and severity of cases) or the geographical proximity of the new client to the other families that the home visitor serves. Some families require bilingual workers. And some case assignments are based on a worker's area of expertise. For example, one site assigns a former public health nurse who had substantial experience working with pregnant women to all prenatal participants.

In most cases the home visitor makes the initial visit by herself. At one site the assessment worker introduces the home visitor to the family. In a few programs the supervisor accompanies the home visitor on the initial visit. Some supervisors also make it a practice to accompany workers when there is a situation that may seem somewhat precarious (e.g., a violent neighborhood or suspected criminal activity in the home).

For the most part, home visitors found it helpful to have the supervisor accompany them for several reasons. For one, the participant recognizes that the home visitor has someone she may need to consult with before making a major decision. Home visitors felt that this "left them off the hook" when they were unsure about how to respond to a particular family circumstance.

Second, the family was familiar with another worker should a crisis arise and the home visitor was unavailable. Finally, visiting the home provided the supervisor with a more comprehensive understanding of the case and gave her the opportunity to judge the safety of the household. However, there were a few workers who felt constrained when accompanied by their supervisor.

Most workers reported it was preferable to initiate services prenatally rather than postnatally. They felt it provided them with the opportunity to establish the relationship with the mother before the baby was born and allowed them to resolve concrete needs before turning their attention to parenting skills and child development activities.

### **Misconceptions about Home Visiting**

Upon the first home visit, some workers discovered that families had misconceptions about the nature of the intervention, the level of services offered, and their expected commitment. Some families believed that the program could provide a variety of needed material goods and resolve long-standing issues such as substandard housing, that simply went beyond the scope of the intervention. According to the home visitors, some families were surprised to discover that they would make weekly visits.

The misconceptions were the result of a variety of factors. In a few cases an uninformed screening agent who misunderstood the nature of home visiting may have provided erroneous information. It was also reported that information contained in brochures at some of the sites was unclear. In other cases it seems that assessment workers may have been overzealous in their attempts to "sell" home visiting, especially in early periods of program start-up when there was pressure to build enrollment. Finally, some families may have misconstrued the nature of the program because they "selectively heard" what the assessment worker told them or misinterpreted the information they were given in light of their experiences with other programs. Further, the program's emphasis on family empowerment and involvement in service planning may have led some families to focus on resource needs and minimize other aspects of home visiting.

Nonetheless, the experiences of a few workers have suggested that some parents are more interested in the educational aspects of home visiting than some sites may suspect. For there were many instances where workers gave examples of engaging mothers by providing educational materials and information relating to child development and newborn care.

### **Characteristics Related to Receptivity of Participants**

Engaging and maintaining the participation of families is a critical challenge for any voluntary program. Indeed, if a sizable number of target families do not enroll or become involved in services, many families that need help will not receive it. In addition, it is unlikely that the intervention can have the desired outcomes at the community level. Home visitors found

that receptivity to services varied among participants based upon the following individual factors.

***Pregnant women who are at later stages of pregnancy were generally more receptive than women at earlier stages of pregnancy.*** It seems that women who are closer to delivery, when the stresses of pregnancy are most severe, are the most vulnerable and needy. For this reason, some programs have postponed enrolling participants until a potential client has reached her last pregnancy trimester. The sites were aware that while this practice is more likely to reach participants when they are the most receptive, it does preclude intervening at an early stage in the pregnancy to improve adverse health-related behaviors (e.g., inadequate nutrition, and use of cigarettes, illegal drugs, and alcohol) that can result in health, neurological and other negative consequences for the newborn. Therefore, a few program managers have developed a triage system that assigns priority enrollment to those prenatal cases where poor health practices may be a concern. At one site, screening agents are requested to write "Urgent" on a screen if the woman presents pressing issues that need to be addressed immediately.

***First-time mothers are easier to engage than women who have other children.*** Workers have found that women who are experiencing childbearing and childrearing for the first time are "thirsty" for knowledge about labor and delivery and child development.

***Women who have fewer family members engaged in their lives are often more receptive than women who have more involved kinship relationships.*** In fact, other family members often played a critical role in determining the extent of the mother's involvement, especially the baby's father and grandparents who reside in the household. As reported in the section on the screening and assessment process, some workers suspected that certain partners were resistant to inviting a stranger into their home because of their involvement in domestic violence or illegal activity. Some grandparents discouraged the mother from participating because they felt they could provide their daughter with enough support and knowledge about childrearing.

***Mothers who have had less prior involvement with other service providers are also more likely to be receptive to home visiting programs.*** Many families have had negative experiences with other systems and may be suspicious or skeptical about the service sector in general. Some participants became suspicious when they were asked to sign program and evaluation consent forms, and were particularly reluctant to participate once they discovered that the program was sponsored by social services. These families confused home visitors with child welfare workers and misunderstood the intent of the program. In addition, a few workers reported that families had recently been involved in questionable recruiting practices conducted by health maintenance organizations which negatively affected their openness to another health-related initiative.

***Finally, mothers with more education appeared to be more interested in home visiting services.*** A few workers reported that women with more education seemed to be particularly interested in what they could learn about parenting practices. It is possible that those women who have more education place a higher value on the learning process and have a greater appreciation

for this aspect of home visiting. Unfortunately, those with less education are in greatest need of the program and are most likely to benefit from it.

There were a number of program components that had a positive effect on the receptivity of participants. The voluntary nature of participation was particularly appealing to many families. Participants found it reassuring to know that they could discontinue services at any time. They also appreciated workers establishing schedules at the family's convenience.

For the few families who are offered home visiting services but do not immediately accept, program sites are persistent in their outreach efforts to attempt to engage families in the program. Outreach commonly continues for about three months, or until the family no longer qualifies for services because the newborn is beyond the cut-off age of three months.

A variety of outreach methods have been attempted by the sites with mixed results. Some sites periodically call the prospective participant or send her personal correspondence, program brochures, or informational materials relating to pregnancy or child development. Some women who have declined prenatally, are approached again after the baby is born. The second year evaluation will examine outreach methods more systematically. However, anecdotal reports indicate that gaining acceptance for the program has more to do with factors related to the mother's individual circumstance at a moment in time than the type of outreach method used. For example, workers reported that an initially reluctant mother may change her mind when a crisis has arisen, when the baby's father has left the household, or when she is closer to the due date and "the reality of giving birth and having a baby hits her."

## **Service Intensity**

The data show that families are receiving nearly the intensity of service prescribed by the model. According to the Healthy Families America (HFA) model, all participants enter on Level 1 or Level 1-Prenatal and should receive weekly (or four per month) home visits. Some prenatal families who are judged as not needing weekly visits may receive a minimum of two visits per month.

As displayed in Exhibit 21, across all sites there was an average of 2.99 visits per month for prenatal cases and 3.00 visits per month for postnatal cases. We did not include in our measurement the number of attempted visits made by home visitors when participants were unavailable. Therefore, the data represent only visits when workers were able to connect with families and provide services.

Workers reported that no shows and canceled appointments were common. This was very disappointing to them. In addition to the factors related to receptivity discussed previously, several other reasons were noted. Some mothers simply lacked experience with keeping scheduled appointments. In some rural sites it was noted that at times a mother could not pass up an opportunity to get out of the house, even if it meant missing the home visitor. Workers also reported that mothers who entered the workforce were simply not available during the day and

were either too tired or too busy after work for a home visit. This suggests that as welfare reform efforts increasingly focus on returning the mother to the workforce, home visiting programs will probably need to be more flexible, including providing services during evening and weekend hours.

It was also reported that there are some families who become disinterested in services and may not participate for many months. Some of the families are classified under a special category called "creative outreach." Attempts are made to re-engage these families for several months. However, there are families who are clearly no longer motivated to commit to the program and remain in creative outreach for extended periods of time. While this "keeps the door open" for the family to reenter the program, it potentially may waste limited resources on families where discharge is inevitable. It is also very frustrating to home visitors who feel they are intruding in the lives of families and undermining the voluntary nature of program participation.

### Exhibit 21

#### Average Number of Home Visits Per Month

	Total	Prenatal	Postnatal
Less than once/month	6.2%	8.6%	8.3%
1 to 1.99 times/month	15.6%	19.0%	15.3%
2 to 2.99 times/month	28.3%	25.9%	26.0%
3 to 3.99 times/month	25.4%	27.6%	25.6%
4 to 4.99 times/month	17.1%	6.9%	18.6%
Five times/month and more	7.4%	12.1%	6.2%

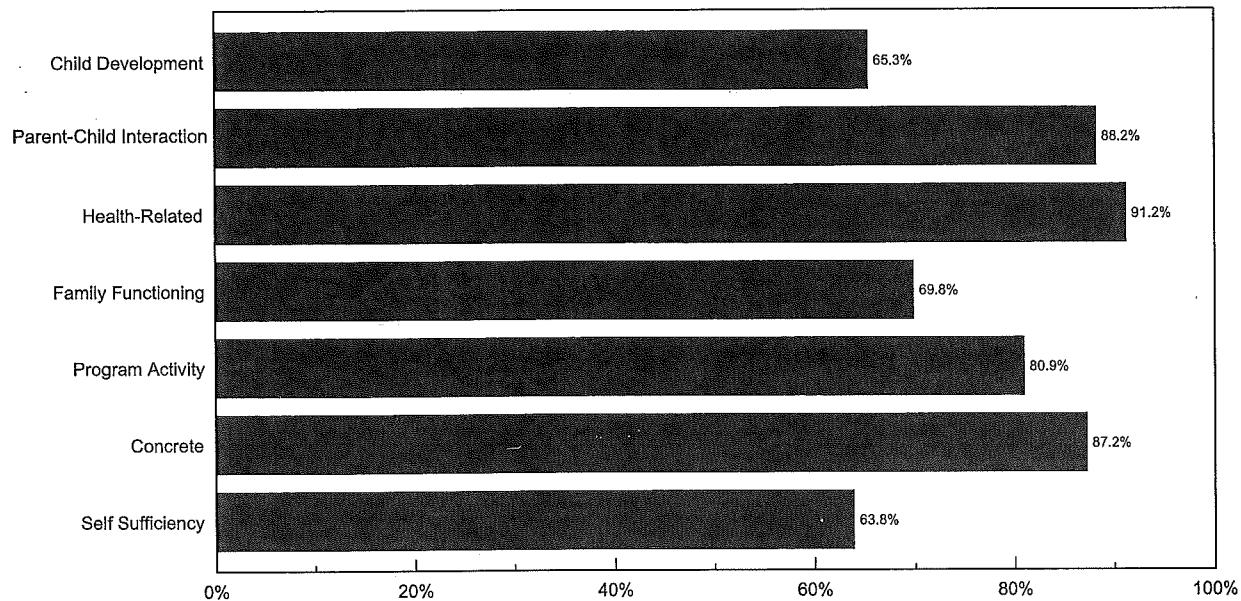
Average (Mean) Number of Visits Per Month  
All Cases = 3.00  
Cases Receiving Prenatal Visits = 2.99  
Cases Receiving Postnatal Visits = 3.00

### Nature and Frequency of Services

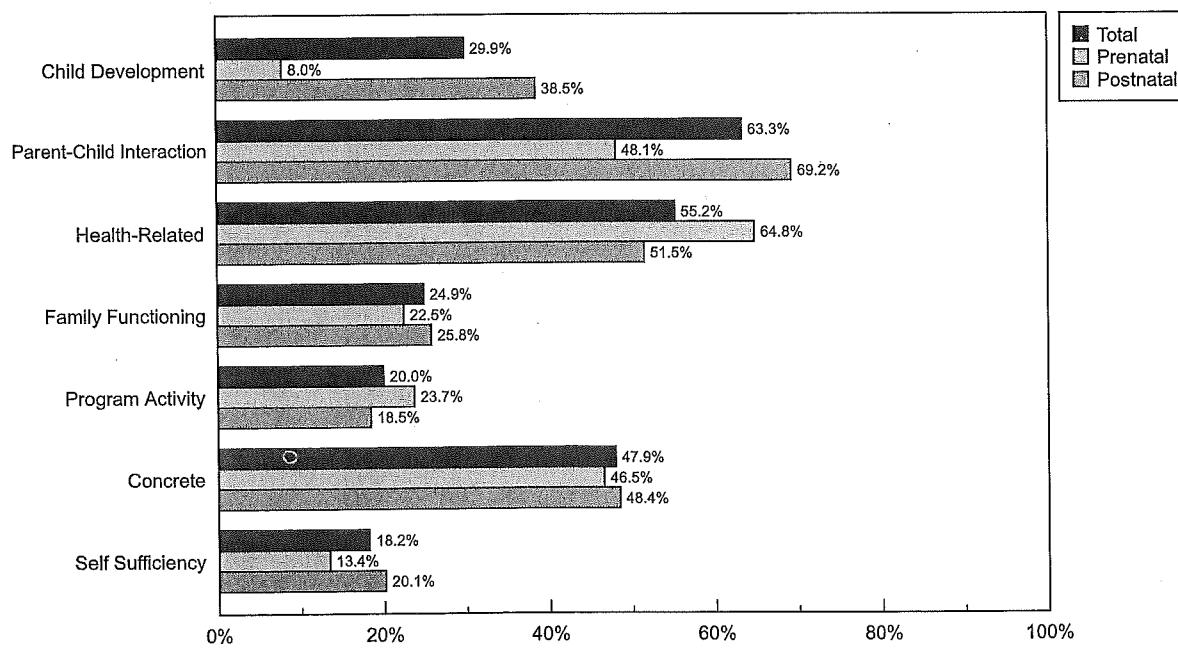
This section will examine the services that home visitors provide during their visits with families, as well as issues involved in the provision of service. The services have been organized into seven different categories which will be discussed in turn: health care, parent/child interaction (PCI), child development, self-sufficiency, concrete activities, family functioning, and program enhancement activities (See Appendix B for a listing of activities that fall under each service category).

The type of service that home visitors provided to families during their home visits was analyzed in two ways. First, we examined how widely the service was offered — that is, the proportion of families that received the service (see Exhibit 22). Second, we examined how frequently the service was provided — that is, what proportion of home visits included the service (see Exhibit 23). In the second case, the data were broken down by prenatal and

**Exhibit 22**  
**Percentage of Families Receiving Various Types of Services During Home Visits**



**Exhibit 23**  
**Percentage of Home Visits That Included the Service**



postnatal visits, since the nature of the service parallels participants' needs as they progress from one stage to the next.

### ***Health-Related Activities***

Home visitors provided participants with information on a variety of health-related topics, most often pertaining to prenatal health and newborn care. Workers also spent considerable time addressing areas of adult health care after the baby was born. It was reported that there are many more medical services available to pregnant women than postpartum women, who may lose their health insurance coverage postnatally. Home visitors informed participants about the availability of health care providers and services in their community and sometimes accompanied them on their medical appointments.

Health care was a very important component of the intervention. Indeed, as shown in Exhibit 22, more families received health care services from their home visitors than any other type of service. Approximately 91% of the families received some type of health care service and these services occurred in over half (55%) of the visits. Health care services were provided more frequently in prenatal visits than in postnatal visits (65% vs. 52%).

#### *Prenatal Health-Related Activities*

Often, the prenatal intervention involved encouraging healthy behavior (e.g., promoting good nutrition and educating about the hazards of smoking, drinking, and illicit drugs), and preparing women for labor and delivery. Indeed, the data indicate that a large proportion of families (75%) were provided with information on pregnancy and prenatal care during prenatal home visits.

Another aspect of prenatal involvement consisted of providing information on available health care services and encouraging compliance with scheduled medical appointments. A few home visitors reported that they were contacted by a woman's health care provider when she failed to keep her scheduled medical appointments.

While prenatal health was given much attention by home visitors, workers expressed a need for additional materials on working with pregnant women and desired additional training in this area.

#### *Postnatal Health-Related Activities*

Child safety was an important component of the postnatal intervention and home visitors worked with participants to child-proof their households and obtain car seats. Some sites also actively encouraged and supported mothers efforts to breastfeed their newborn.

Some home visitors found that it was important to accompany families on doctors appointments. Because participants are often intimidated by doctors or do not understand their recommendations, the home visitors serve as a communication link, interpreting what the

physician said or helping families ask questions and address concerns. Staff at one program are members of a high-risk pediatric team associated with a practice that serves many home visiting participants. The workers are able to present doctors with a more complete understanding of families, which allows the doctors to provide more informed and sensitive care. A number of programs have established strong linkages with Public Health Nurses who provide newborn care information for several home visits.

Workers reported that it was sometimes difficult to establish linkages with pediatricians, partially as a result of confidentiality concerns. A few programs addressed this problem by developing a release form procedure that is signed by participants, allowing pediatricians to share information with home visitors.<sup>11</sup> It is vitally important that workers establish strong linkages with medical providers so they can receive timely information about the child's health status and encourage parents to comply with preventive visits and immunization schedules.

### ***Parent-Child Interaction***

Home visitors provided families with information related to promoting positive parent-child interaction. This often included such topics as child management and discipline. Some parents needed encouragement to interact with their babies. According to one worker:

"I got this case late. The baby was two months old. Mom and dad did not see the importance of putting the baby on the floor. Sometimes parents don't realize what their baby can do until you ask questions. They're not interacting with the kids. They didn't know how the baby responds when he looks at a mirror; they never did that."

A large proportion of families (88%) were involved in parent-child interaction services. These services occurred in the majority (63%) of home visits. As expected, services to promote positive parent-child interaction occurred more often in postnatal visits than prenatal visits (69% vs. 48%) when workers could use such techniques as modeling to demonstrate positive child-rearing practices.

Workers presented parents with a variety of ways to discipline children. Some home visitors helped mothers anticipate potentially troubling situations and offered advice on how to cope with such circumstances ("If you take the child on a medical appointment, remember to bring a snack.") One worker was successful in convincing a mother to use time-out with a particularly difficult child. And workers taught participants not to worry about spoiling the baby when they respond to infant crying.

### ***Child Development***

Participants were provided with information on child development and age-appropriate behavior. About 65% of the families were involved in child developmental services and almost

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<sup>11</sup> Since these procedures were often already established with prenatal care providers for screens, a separate release form was not usually necessary to communicate with providers about prenatal issues.

one-third (30%) of the visits included child development services. These services were provided more frequently in postnatal visits than in prenatal visits (38% vs. 8%).

Workers were required to administer the Ages and Stages Questionnaire (ASQ), a standardized parent-completed instrument designed to detect potential developmental problems. The ASQ is administered approximately every four months until the child is two years of age, and then again at 30, 36, and 48 months. Workers reported that it has been well-received by families and provided them with valuable information on child development. When the ASQ score suggests the child is experiencing developmental delays, home visitors refer the family for developmental screening.

All programs are also required to link with a child developmental specialist to provide information to workers and consulting services on children's needs. Specialists have helped workers interpret the ASQ and have suggested follow-up activities in areas that are deficient as indicated by the test results.

Some sites have rather extensive resource libraries and workers bring books, videotapes, developmentally appropriate toys, and other materials on parenting to participants. The sites are required to adopt curricula related to child development. While workers found these materials to be comprehensive, some felt that they needed to be adapted for the varying levels of ability of the participant population. Many sites provide mothers with a loose-leaf binder to organize these materials as the child progresses from one developmental stage to the next.

### ***Self-Sufficiency***

There were basically two types of activities to promote self-sufficiency. The first was directly tied to employability development — informing parents about educational and training opportunities and assisting them in their efforts to find a job. The second concerned building skills in independent living — teaching money management, organizational practices (e.g., using a calendar or appointment book), and how to use public transportation.

While 64% of the families were involved in services to promote self-sufficiency, only 18% of the visits included a self-sufficiency activity. This is partially explained by the fact that employment-related services were often provided by other agencies that participants were referred to. (See referral section in this chapter.) After the referral was made by the home visitor, service provision became the responsibility of another institution. Another reason is that most of the participant population was either pregnant or had recently given birth during the period covered by this report and it was not the optimal time to encourage participants to seek employment or pursue educational and training opportunities. We would expect to see an increase in this type of activity as children get older and participants are in the program longer.

Workers raised two issues concerning employability development. Some have found that mothers who return to work are less accessible and more difficult to engage in services. And some believe that promoting self-sufficiency interferes with enhancing the parent-child relationship. As welfare reform increasingly focuses on promoting entry to the workforce, home

visiting programs will need to take a serious look at the meaning this has for methods of program delivery such as creating alternative worker schedules that include evening and weekend hours.

### ***Concrete Services***

Many times the initiation of home visiting involved assessing and meeting the basic needs of families, including food, clothing, housing, health care, and economic stability. In addition, home visitors assisted families in resolving problems and handling crises. These activities, classified as concrete services, occurred with about 87% of the participating families. About 48% of the visits involved concrete activities, nearly the same on prenatal visits and postnatal visits.

Overall, it was believed that an effective prevention program must first deal with a family's basic needs before the educational components can be addressed. If a family has inadequate shelter, or not enough food to feed all the members of the household, it is unlikely that they will fully engage in parenting education or child development activities. In addition, the well-being and safety of children are related to meeting basic needs and thereby reducing household stress. Workers also attempted to help families develop ways to systematically address problems so they cease operating out of crisis.

Workers found that addressing a concrete need builds the relationship between worker and participant and engages the family early on. However, workers were also cognizant that home visiting is much more than a program to meet basic needs and reported that there is the potential for participants to lose track of this. In a few cases, families lost interest in the program after their concrete needs were met. The most successful approach seems to be integrating the educational components while recognizing and addressing the family's basic care needs.

### ***Family Functioning***

Home visitors addressed issues relating to family functioning including substance abuse, household relationships and family violence. About 70% of the families were involved in family functioning activities and these services occurred in one-quarter (25%) of all home visits.

Home visitors expressed a commitment to taking a family systems approach and perceived that the model places too much emphasis on the mother-target child dyad and not enough on other household members. While Healthy Families America advocates a family-centered philosophy, it appears to many workers that it fails to address such an approach in practice. Workers felt particularly strongly about working with siblings, and they make a good point. It is not uncommon to find only one abused child in a household where other children lived. From this perspective it would be hard to argue that other children should not be targeted for program services. This is not to say that the Healthy Families America model advises workers to ignore cases of maltreatment in the household. However, an argument can be made that focusing exclusively on the target child may be undesirable.

Another related issue concerns the involvement of the father of the baby. Some workers make extra efforts to include the baby's father. Home visitors spoke of scheduling visits when the father was home, such as after work hours; meeting a need of his; and arranging longer visits when the father is around. Since nearly half the households have the biological father present, there would appear to be ample opportunity to involve him in many cases. However, this is often not the case. Workers indicated that many mothers are in destructive and violent relationships, and for this reason they choose not to encourage the participation of the father. Some fathers were said to be unreceptive to the intervention because they are jealous of the relationship between the mother and the home visitor. And finally, workers agreed that curricula and activities are primarily designed for mothers and they are unclear how to fully engage the father in service delivery.

Home visitors also spoke about the challenges of engaging other important members of the mother's social network. As already indicated, some mothers were discouraged from participating in home visiting by other household members. Oftentimes, the worker's advice was contradicted by others in the mother's social network. Workers reported that members of the mothers network sometimes challenged their advice on such matters as smoking during pregnancy, when to introduce the baby to solid foods, and consoling a crying baby because of fear of spoiling the child.

While home visitors found working with other family members to be difficult, the data clearly show that they are making strong efforts to include other household members in home visits. Nearly 20% of all visits involved a second caregiver or a sibling.

Encouraging mothers to take advantage of others in her social network is indeed a very complex issue. The presence of friends and relatives can increase stress and undermine what the home visitor is trying to accomplish. In addition, attending to the needs of other household members necessarily limits the time available to meet the specific needs of the mother and child. However, the effects of the intervention would presumably last much longer if the other network members are fully involved and reinforce the positive behavioral changes made by the mother. Other network members can also provide needed resources and services such as transportation and child care. Indeed, one of the program objectives is to overcome social isolation by increasing the participant's social support system. The literature has shown that mothers who abuse their children had fewer network members, fewer contacts, fewer members living within one hour, and received fewer emotional and instrumental resources.

### ***Program Enhancement Activities***

Program enhancement activities included assessing needs and developing an Individualized Family Support Plan (IFSP), organizing support groups, and fulfilling some program requirement such as providing orientation to services, completing forms, or administering a standardized instrument. About one-fifth of all the visits involved one or more of these program activities.

In spite of the fact that the model is fairly well-defined, workers felt strongly about being responsive to family concerns and were encouraged to allow participants to have an active voice in determining the nature of the intervention. One way this was accomplished was through the preparation of an Individualized Family Support Plan (IFSP). The IFSP provided the opportunity for workers to spend time with participants to identify needs and establish goals. The IFSPs also helped families get organized by prioritizing needs and specifying the steps to be taken to accomplish their goals. Lack of organization was identified as a major obstacle confronting many families.

While home visitors found that the IFSP provided a focus for the family and the intervention, a few expressed concern that it would point to individual weaknesses if the established objectives had not been met, contradicting a strength-based approach upon which current social work practice is based. They also expressed the need for additional training on the goal setting process. The sites are experimenting with different models of IFSPs to find the best methods to work with families to establish goals.

Some programs initiated parent support groups as a way to develop the mother's social support network. Overall, these groups provided an excellent socialization experience for participants.

## **Referrals to Other Services**

Data were collected on the referrals home visitors made to other service providers. For each referral, home visitors were asked to describe the nature of the referral — whether the home visitor merely provided information about service providers or if s/he made the actual arrangements for participants to receive services. The services were classified into eight categories: 1) health care; 2) nutrition; 3) Department of Social Services or Human Resource Administration (DSS or HRA) services; 4) family and social support services; 5) employment, training, and education; 6) counseling and support services; 7) concrete services; and 8) other services. (See Appendix C for a listing of the specific services comprising each category.)

As shown in Exhibit 24, the type of service that clients were most frequently referred to was health services (34%), which is consistent with health care being a major component of the program model. Sizable proportions of families were referred to DSS or HRA (31%), concrete services (29%), counseling and support services (28%), family and support services (27%), and employment, training and educational services (27%). It is interesting that early in the intervention, a fairly substantial percentage of families are being referred for self-sufficiency services like employment and education. In fact, these were as common as concrete services.

**Exhibit 24**  
**Percent of Cases Referred to Service Type**

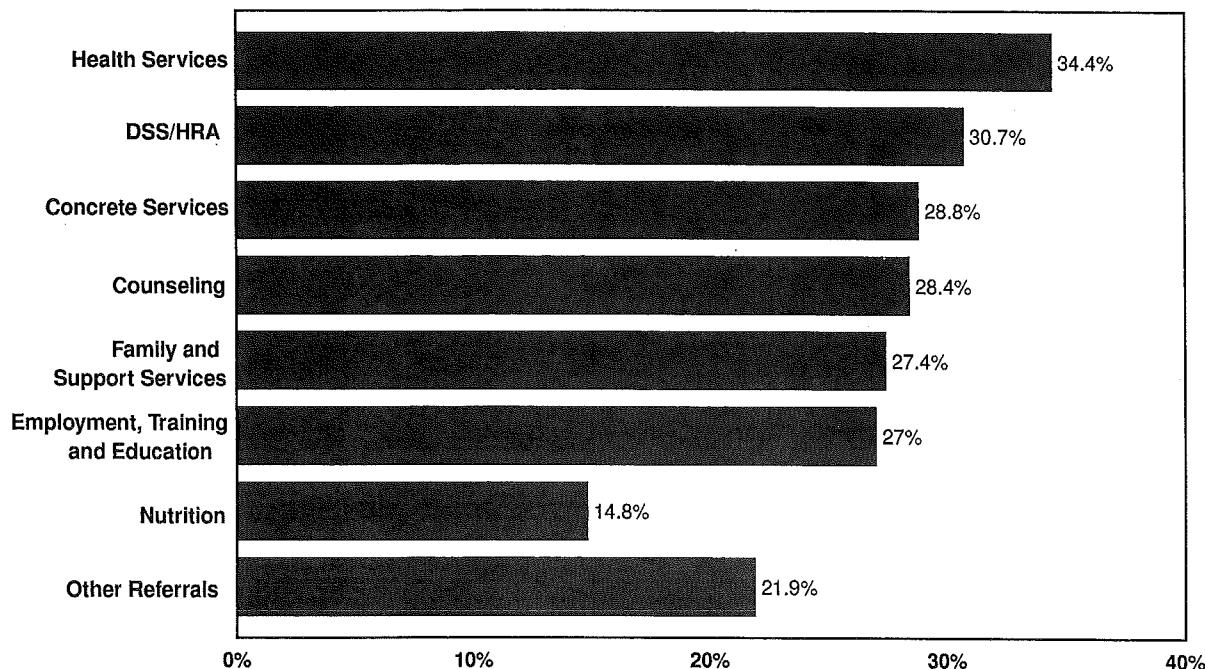


Exhibit 25 shows that the majority of referrals (63%) involved the worker making the arrangements for the client rather than simply providing information. Since the data were collected at an early point in the intervention, we expect that this may change once participants are in the program for a longer period of time and develop the ability to access needed assistance from outside sources on their own. Promoting this ability is one of the goals of the program so that the participants do not become too dependent on the home visitor and can effectively function on their own.

Most of the referrals (64%) were for the mother and about 13% involved the target child. Consistent with our findings about taking a family-centered approach, about 10% of the referrals were made for the second caregiver and another 10% for another child in the household.

**Exhibit 25**  
**Nature of Referrals and Individual Referred**

<b>Nature of Referral</b>	
Arrangements made for participant	70 (62.5%)
Information given to participant	42 (37.5%)
<b>Individual Referred</b>	
Mother	645 (63.5%)
Target Child	135 (13.3%)
Second Caregiver	105(10.3%)
Other Child	104 (10.2%)
Other	27 ( 2.7%)

Workers at all sites have helped participants apply for temporary assistance at the local department of social services. It was reported that income maintenance workers tended to be insensitive to the needs of participants. This was consistent throughout every site in the state. Workers spent a lot of time helping participants navigate the system, assisting them with compiling needed paperwork and attending fair hearings. Without financial assistance, families could not meet basic needs, resulting in difficulty with focusing on child developmental issues.

### **Child Protective Services**

The NYSDSS reporting guidelines state that home visitors are not *legally* required to report suspected child abuse/maltreatment unless the home visitor is a registered nurse or is employed by an agency under contract with the local social services district. This differs within sites based upon the varying qualifications of home visitors (e.g., social workers are mandated reporters) and differs among the sites based upon the varying types of agencies sponsoring the program (e.g., all workers employed by a preventive agency are mandated reporters).

Sites also differ in their policy regarding acceptance of open CPS cases. Some sites argue that to be a true primary preventive program, they cannot accept any cases that are a part of the CPS system. Other sites are subcontracted by the local social services district and are obligated to accept CPS cases. (Even in these sites the number of families with active CPS cases is low.) And some sites consider accepting open CPS cases on a case-by-case basis. Presumably, outcomes will differ among the sites depending on this policy.

The different sites maintain different relationships with the local district office. A few sites reported strong relationships with the local CPS office. In fact, some home visiting programs are staffed by former CPS workers and maintain close ties to their former colleagues. The State has served as a liaison to promote communication between the home visiting site and the local district office.

However, a few home visitors conveyed some ambivalence about CPS reporting requirements. They stated that they would not hesitate to report a case where they suspected that a child was at risk of harm. And indeed, a few reports have been made. However, there were instances that were more ambiguous — such as a case of overcrowded housing — where the worker observed that the child was well cared for and was clearly at no risk for harm or neglect. In cases like this one, home visitors were unsure of what course to follow. The fear was that their relationship with the participant would be destroyed when a report was made, while little could be done by the CPS worker to improve the family's situation. A few supervisors found it helpful to consult with CPS or SCR workers rather than immediately filing a report.

### **Other Issues Involved in Delivering Services**

One issue that was raised by workers concerned family empowerment. This was addressed most explicitly in the area of goal-setting where workers were perplexed how directive they should be, while at the same time encouraging family empowerment. That is, how to advise participants who developed, from the workers viewpoint, unrealistic or undesirable goals.

Indeed, this is a highly complicated issue that not only affects the goal-setting process but has implications for the entire program. If research suggests what program components produce the strongest impact, how much of a voice do participants really have, or should they be given, in determining the nature of the intervention? The dilemma becomes, should the model or participant's desires drive the intervention? In most cases, workers instinctively know when they need to take a stand and advocate a certain position despite the mother's wishes. For example, one site reported success with convincing a very stubborn mother to get her newborn immunized after repeated, intensive efforts. However, there are other situations that are not as simple or straightforward and need further discussion. Staff were particularly unclear how to deal with the discrepancy between caregiving methods that are professionally advised and caregiving methods that are practiced by different cultural groups. This was especially evident in child feeding practices (e.g., when to introduce solid foods) and child management techniques (e.g., when to console a crying baby).

Perhaps the most controversial finding concerned workers' beliefs in disciplinary practices toward children. While home visitors know that physical punishment is not condoned by Healthy Families America (HFA) or the State, and most promote the HFA perspective in their work with families, it is clear that a few have not internalized these concepts.

The issue of disciplinary practices is highly complex. Respecting differences in parenting styles may conflict with recommended practices that have been determined to lead to the most positive outcomes in children. Furthermore, it is not only home visitors who are baffled at what to recommend, but there is widespread disagreement among professionals in the area of what the most appropriate disciplinary measures are. These issues require much further examination by program administrators and front-line workers.

## **Concluding Comments**

Overall, the sites appear to be implementing the program model as it was designed. They are providing the kinds of services recommended by the model. They are providing services in the home, with almost the frequency advocated by the model. But they have to grapple with many issues, such as empowerment of participants versus fidelity to the philosophy of the model.

*New York State Home Visiting Program*

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# CHAPTER FIVE

## ORGANIZATIONAL COMPONENTS

### **Staffing Structure**

In general, the home visiting programs had the same organizational structure consisting of the following staffing pattern:

**Home visitors** — trained community workers who work directly with participants throughout the intervention.

**Assessment workers** — early identification workers who are trained to administer the Family Stress Checklist to determine eligibility for the program. Many assessment workers are nurses with substantial experience working with expectant and new mothers.

**Supervisors** — health or social work professionals who oversee the work of the home visitor.

**Program managers** — professionals who are responsible for the overall program operation and serve as liaison between the parent agency and the State.

The New York State RFP required that programs demonstrate a commitment to hiring home visitors who were representative of the language and culture of the population to be served and who are from the community targeted for services. For the most part, the home visitors hired by the programs are paraprofessionals. However, their backgrounds do vary and often exceed the minimum requirement of a high school diploma or GED. In fact, nurses, social workers, and graduate students are among the pool of workers.

### **Staffing Issues**

The managers and supervisors we spoke with were very satisfied with the performance and dedication displayed by the home visitors they had hired. They believe that important qualities for home visitors include a high level of energy, sensitivity, flexibility, the ability to let the client take the lead, and the ability to empathize with participants.

However, administrators did point to some drawbacks in hiring paraprofessionals. For the most part this involved difficulty in working with participants who have extreme needs such as developmental disabilities, mental health problems, and domestic violence issues. Professionals are better able to deal with more serious problems than paraprofessionals and can do direct counseling rather than referring clients out to other providers. Also, because some home visitors so closely reflect the composition of the target audience, a few have been found to hold the same erroneous beliefs about child development and child management as the participant population. Workers may relate more closely with the family's perceptions than the approach recommended by the program model. It seems that a balance needs to be found between workers who are sensitive to and have respect for the values of the target population, while at the same time, are able to internalize the basic philosophy and concepts of the intervention.

## **Training and Supervision**

A strong supervisory component is built into the model and indeed is being delivered. Each home visitor and each assessment worker must have a two-hour session scheduled with his/her supervisor at a regular time each week. In order to provide the requisite level of supervision, it is required that each supervisor directly supervise no more than six assessment workers and/or home visitors.

Orientation, ongoing in-service training, and advanced training are integral parts of the New York State program. All new program staff are required to attend week-long, HFA-sponsored core training during the first two to three weeks of employment, which orients them to the home visiting model and provides instruction in the basic skills needed to perform their jobs. Assessment workers are trained in administering and scoring the Family Stress Checklist; home visitors receive training on parent-child interaction, child development, and strength-based service delivery; and supervisors receive training on their role in ensuring quality services. The New York State Department of Social Services has contracted with the Behavioral Sciences Institute to organize state-wide training.

In addition to mandated core training, all new staff participate in local wrap-around training to receive additional instruction on such special topics as the dynamics of child abuse and neglect, domestic violence, well-baby care, communication skills, and team building. The training contractor is working with the local sites to standardize the wrap-around training and is coordinating three advanced regional training sessions.

Most sites provided home visitors with detailed curricula and a variety of resources to bring on home visits. The Department has contracted with the New York State Chapter of the National Committee for the Prevention of Child Abuse to establish a Resource Center that provides technical assistance and a variety of materials to all home visiting sites and other organizations interested in starting a home visiting program.

Home visitors responded well when the parent agency had a strong commitment to worker wellness. Staff outings, retreats, and other activities focusing on the well-being of home visitors are important for preventing staff burnout and gaining staff commitment. A few programs reported that some families declined services after their home visitor left the job. Worker attrition was not a major problem during the first year, but it can have serious consequences.

Home visitors responded very positively to meeting their counterparts from other sites at regional meetings conducted by the New York State Department of Social Services. Additional experiences should be arranged that offer the opportunity for workers from different programs to get together. A state-wide conference is planned in the second program year which will provide another opportunity for this to happen.

## **Administrative Structures**

There are a variety of parent organizations that administer the home visiting program. It is difficult to label the organizational type associated with each program because of complicated contractual arrangements. For example, in one site the local department of social services holds the contract, but subcontracts a health care agency to deliver home visiting services. Another site has four different agencies — preventive, health, and multi-service providers — with a rather complex supervisory structure. We do not have hard data on the type of administrative arrangement that works best and plan to address this issue further in the second year evaluation.

On a state level the program is administered by highly committed staff employed by the New York State Department of Social Services in conjunction with the New York State Department of Health. State employees have taken a very active role in program implementation, making extensive on-site visits to talk to workers and administrators and review records and reports. Local program managers meet bi-monthly to establish policy, discuss pressing issues and share insights.

*New York State Home Visiting Program*

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# CHAPTER SIX

## CONCLUSIONS AND RECOMMENDATIONS

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Although it is too early to measure the program impact on the families served and the communities they live in, the New York State home visiting program has experienced much success in the initial implementation stage. The sites have developed linkages with most of the major health care providers in the community. Large numbers of families are being identified, assessed, and enrolled in the program. They are being provided with an array of services to promote good prenatal behavior, advance child health and development, foster self-sufficiency, and improve family functioning. Few families have disengaged from services in the first six months. Workers have expressed a deep and passionate commitment to participating families and program goals.

A number of sites have initiated practices and procedures that have improved program delivery and increased effectiveness. This section will present some of these practices to encourage replication by other sites. We are also making our own recommendations based upon the data that have been collected and observations we have made.

Recommendations are offered in three major areas: the participant identification process, service delivery, and administration.

### **Identification Procedures**

While the sites have been able to involve the major health care providers of their communities in the screening process, a few have been reluctant to participate. Further efforts are needed to increase the participation of all local health care providers that serve the target population, so sites can identify and offer services to all women who qualify. The following activities are suggested:

- ♦ Develop a state-level publicity campaign targeted to state and local chapters of professional medical associations (e.g., NYS Chapter of American College of Obstetricians and Gynecologists, NYS Academy of Family Physicians, NYS Association of Health Care Providers, NYS Nurses Association) to encourage their involvement in local home visiting programs. This initiative could be spearheaded by the New York State Department of Health, in conjunction with the New York State

Department of Social Services and the National Committee for the Prevention of Child Abuse and Neglect/NYS Chapter.

- ♦ When possible, consider hiring assessment workers who are nurses or have backgrounds in other health-related areas and may be better able to engineer more successful contacts with the health care system than workers with other backgrounds.

Additional efforts are needed to increase the involvement of women who are unlikely to seek timely prenatal care. This would obviously require going beyond the medical community to identify participants. The following recommendations are made.

- ♦ Home visiting programs need to develop new methods to reach a broader pool of pregnant women. This would include developing partnerships with additional community-based organizations, income maintenance offices, educational institutions (including high schools and alternative schools), religious institutions, and other neighborhood groups.
- ♦ In addition, further efforts are needed to reach women who are outside of all service systems. Attempts should be made to display posters and distribute flyers in neighborhood businesses (e.g. markets, laundromats), public housing facilities, and other local places where these women are likely to go. For programs that have a large target area (e.g., an entire county) public service announcements on radio and television may be attempted.
- ♦ The New York State Department of Health should explore how to streamline local procedures to expedite the identification of participants through birth certificate checks.

There are some participants who are more difficult to involve in home visiting than others. The following recommendations are made to foster engagement:

- ♦ Consider alternative ways of involving women who are in earlier stages of pregnancy, such as a less intensive visitation schedule until the woman reaches her last trimester when she is more receptive to services.
- ♦ When possible, try to engage others in the mother's social network in the identification and recruitment process. These efforts should be specifically targeted toward gaining the acceptance of home visiting from other adult family members, particularly partners and grandmothers who may undermine the mother's interest in the program.
- ♦ Programs should consider enrolling all teenaged mothers who screen positive, on a trial basis. This is a very vulnerable and needy group.
- ♦ While efforts to encourage participation should be attempted, programs need to provide a clear and consistent message of the nature of the intervention and the expected commitment from participants.

Some screening agents are not completing screens correctly. Since these agents have shown some interest in the home visiting initiative simply by agreeing to identify participants, additional efforts should be made to increase their level of commitment. We recommend the following:

- ◆ Provide follow-up information to screening agents about program successes, particularly related to those participants who they referred.
- ◆ Maintain contact with screening agents on a regular basis.
- ◆ Consider introducing self screening tools that participants can complete themselves.

While most participants assess positive, there have been instances where workers have questioned the honesty of responses on assessment items. In addition, workers have argued that the assessment process contradicts a strength-based approach and undermines later efforts to emphasize such a perspective. We recommend the following:

- ◆ When possible, conduct assessments in a comfortable setting that is most conducive to eliciting honest responses. While at-home personal interviews are the preferred method, this may be hard to arrange in some cases. If assessments need to be done in a crowded clinic or a busy home visiting office, space should be sought that would provide enough privacy to conduct a confidential interview.
- ◆ Items should be added to the assessment interview that encourage interviewees to identify family strengths.

## **Program Activities**

The following steps are recommended to strengthen program content and delivery:

- ◆ Develop additional materials and design training that provide strategies for involving fathers of the baby and other important members of the mother's social network who can strengthen the effects of the intervention. Also consider ways to include other children in the household when conducting activities with the target child.
- ◆ Develop visit-by-visit protocols as guides for prenatal intervention that specifies activities for the different stages of pregnancy. Also, consider adopting a wide variety of curricula that are designed for participants who are at different levels of ability.
- ◆ Further develop clear guidelines when to discharge families and when to pursue creative outreach.
- ◆ Continue efforts to ensure that there is clear communication with the local department of social services to obtain clarification of regulations and procedures with Child Protective Services and temporary assistance.
- ◆ Develop procedures that expedite the process of information sharing between health providers and the program. Home visitors need to be well informed about compliance with medical appointments and immunization schedules. They can also give health

providers a more complete understanding of the family that may result in more sensitive and appropriate care.

## **Administration**

A few areas were mentioned where better training is needed:

- ◆ Provide more training concerning the goal-setting process and the development of individualized family support plans.
- ◆ Expand training to include how to increase the transfer of knowledge and values to participants. In addition, explore the trainees' own value system in relationship to the program model.

Finally, the following staffing recommendations are made:

- ◆ Provide increased opportunities for front-line workers (e.g., home visitors, family assessment workers) from all sites to meet and share experiences and best practices.
- ◆ Consider flexible hours for home visitors or hire workers who can work evening hours or on weekends so they are available to parents who find employment.
- ◆ Initiate a program of staff wellness to ease worker stress, promote team building, and recognize worker contributions. Worker attrition, particularly among home visitors, can have serious consequences for the program. Some families are no longer interested in participating once their worker has left the program.
- ◆ Supervisors should make increased efforts to accompany workers periodically on home visits to get a better understanding of family dynamics and show support for the worker.

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## Appendix A

### Description of Home Visiting Sites

**Albany** -- The target area is comprised of specified zip codes within the city of Albany, defined by the Neighborhood Based Alliance (NBA) target area. This consists of the four non-contiguous communities (Arbor Hill, West Hill, North Albany, and the South End). The site has a unique administrative arrangement. The lead agency is the Albany County Department of Health, which subcontracts with three other agencies -- Parsons Child and Family Center, Trinity Institution, Inc., and Whitney Young Jr. Health Center -- to provide home visiting services. The program also has a steering committee consisting of administrators from the county health department and the three subcontracted entities. A family resource center is available to all families in the program.

**Chemung** -- The target area consists of the entire county. Chemung has been operating home visiting programs since the 1970's. The program is administered by the Comprehensive Interdisciplinary Developmental Services, Inc. (C.I.D.S.) which has a long and rich history in providing child health and development programs in Chemung county, including the Prenatal Early Infancy Program (PEIP), one of the earliest models of home visiting nationally, ICHAP, the Child Teen Health program, and Family Preservation program. C.I.D.S. also operates an infant registry identifying all infants born in the county for the purpose of offering regular developmental screenings.

**Erie (city of Buffalo)** -- The target area consists of seven zip codes located within the six census tracts of Buffalo's Neighborhood Based Alliance community. The program is administered by the Buffalo Regional Task Force for Comprehensive Prenatal-Perinatal Services which also coordinates the Community Health Worker program, the outreach component of the Prenatal Care Assistance Program, and the Lead Poisoning Education Program. Families who do not qualify for home visiting because they score under 25 on the Family Stress Checklist are referred to the CHW program.

**Madison** -- The target area in year one was comprised of eight townships in southeastern Madison County. (chosen because they were above the Madison County norm in the following areas: percentage of total poverty, children in poverty, adults who did not graduate from high school, and unemployment). The program is administered by the Madison County Community Action Program which also provides housing assistance, case management, emergency food pantry, and other advocacy programs.

**NYC - Bronx** -- The target area consists of the 10463 zip code, located within the Neighborhood Based Alliance (NBA) neighborhood of Morris Heights, part of Community District 5. The program is administered by the Bronx Perinatal Consortium (BPC) which employs home visitors. They subcontract with a primary prevention agency, Alternative Services to Abuse And Neglect (ASTAAN) which also employs home visitors to serve the most overburdened families. The Visiting Nurse Service is subcontracted to do screens on women from providers from which they have preexisting agreements (mostly postnatal women with

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special needs). Parenting groups for program participants are conducted by another subcontractor, Effective Parenting Information for Children (EPIC).

**NYC - Manhattan** -- The target area consists of two census tracks located in the Washington Heights section of Manhattan. The grant is administered by the New York Society for the Prevention of Cruelty to Children (NYSPCC), a nonprofit child abuse prevention agency. The program is collaboration between NYSPCC and Alianza Dominicana, a multi-service community-based provider; and Columbia University College of Physicians and Surgeons and School of Public Health. This site is jointly funded by the New York State Departments of Social Services and Health. They also receive a substantial amount of private funding. Columbia's School of Public Health is conducting a random assignment evaluation of the program.

**Rensselaer County (Troy)** -- The target area in the first part of year one consisted of designated streets in the 12180 zip code in the city of Troy; in the second part of year one and year two the target area was expanded to also include designated streets in the 12182 zip code. The grant is administered by Samaritan Hospital which provides home visiting services. The local department of social services also funds two staff positions. The program has 24-hour on-call coverage that is rotated among the workers.

**Steuben County (Addison)** -- The target area in year one consisted of the Addison school district; in year two it has been expanded to Steuben County. The Institute for Human Services, Inc. is the grant administrator which subcontracts with Kinship Family and Youth Services to provide home visiting services. The Institute also subcontracts with St. James, Corning Hospital, and Bath Hospital to do screens and make referrals and the Family Service Society for clinical consultation operation of a parent support group.

**Ulster County (Kingston)** -- The target area consists of the city of Kingston (12401 zip code). In addition, the program serves patients that receive care from PCAP clinics located in Ellenville and New Paltz. The grant is administered by the Ulster County Department of Social Services which subcontracts with the Mid-Hudson Family Health Institute to provide home visiting services. The Institute is a health-care agency that provides PCAP services and prior to managed care, was the County's primary Medicaid provider. The BOCES Flag Program provides educational and employment training to home visiting program participants. The program also receives the New York State Department of Health Early Intervention funds.

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## Appendix B

### Home Visiting Activities

**Child Development**

- Ages & Stages Questionnaire
- Education/Information on Child Development
- Provide Toys/Books
- Other Child Development

**Parent Child Interaction**

- Provide Education/Modeling
- Child Management
- Discuss Feelings About Baby
- Provide Support on Parenting Stress
- Other Parent Child Interaction

**Health Care**

- General Health Information
- Child Health Information
- Child Feeding Information/Support
- Nutrition/Food Preparation Information
- Family Planning/Safe Sex/STD Information
- Education/Information on Pregnancy/Prenatal Care
- Information on Health Providers/Services
- Support/Accompany to Medical Providers
- Child Safety
- Other Health Care

**Concrete Activities**

- Provide/Arrange/Pay for Transportation
- Provide/Arrange/Pay Goods
- Housing
- Advocacy/Support/Accompany to Medical Providers

**Family Functioning**

- Violence in Household
- Discuss Family Relations
- Discuss Substance Abuse
- Teach Housekeeping/Management Skills
- Teach Problem Solving/Decision Making
- Other Family Functioning

**Self Sufficiency**

- Use Calendar/Appointment Book
- Teach Use Public Transportation
- Help Look for Job
- Teach Money Management
- Discuss Education/Training Options
- Other Family Functioning

**Program Activities**

- Introduce Program/Complete Forms
- Support Groups
- Assess Needs/IFSP

**Crisis Intervention**

- Help Resolve Problems/Handle Crises
- Other Crises

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## Appendix C

### Types of Service Referral

**Health Care**

- ◆ Adult primary care
- ◆ Child primary care
- ◆ Dental services
- ◆ Family planning
- ◆ HIV testing
- ◆ IHAP
- ◆ EIP
- ◆ Attention Deficit or Hyperactivity
- ◆ Immunization
- ◆ Lead assessment and testing
- ◆ Prenatal care
- ◆ Postpartum care
- ◆ Pregnancy testing
- ◆ Public health nursing
- ◆ STD testing
- ◆ Child Health Plus
- ◆ Development screening and services
- ◆ Other health services

**Nutrition**

- ◆ Food pantry
- ◆ WIC
- ◆ Nutritional counseling

**DSS/HRA**

- ◆ AFDC/Home Relief
- ◆ Food Stamps
- ◆ Medicaid
- ◆ Emergency Assistance
- ◆ SSI
- ◆ HEAP
- ◆ Child Protective Services
- ◆ Preventive Services

**Concrete Services**

- ◆ Clothing, furniture, other household items
- ◆ Housing assistance/emergency shelter
- ◆ Transportation

**Family and Social Support Services**

- ◆ Childbirth education
- ◆ Parenting education/training
- ◆ Day care/babysitting
- ◆ Parent aide services
- ◆ Recreational services

**Employment, Training and Education**

- ◆ Adult basic education
- ◆ English as a second language (ESL)
- ◆ GED preparation
- ◆ Special education
- ◆ Vocational or job skills training
- ◆ College
- ◆ Other educational services
- ◆ Job readiness/employability skills
- ◆ Job search and placement assistance
- ◆ Work experience
- ◆ Translation services
- ◆ Other Services (specify)

**Counseling and Support Services**

- ◆ Psychiatric or psychological treatment
- ◆ Other mental health counseling
- ◆ Domestic violence services
- ◆ Substance abuse services
- ◆ HIV support/counseling
- ◆ Support groups

**Other Services**

- ◆ Legal services
- ◆ Money management
- ◆ Immigration services
- ◆ Translation services
- ◆ Other services