# Healthy Families America


## Goals

The goals of Healthy Families America (HFA) are to: (1) to build and sustain community partnerships to systematically engage overburdened families in home-visiting services prenatally or at birth, (2) cultivate and strengthen nurturing parent-child relationships, (3) promote healthy childhood growth and development, and (4) enhance family functioning by reducing risk and building protective factors.[i]

## Program Features

In order for children to grow, develop, and reach their individual potential, they need a stable, secure, responsive, and supportive home environment. When families are faced with multiple challenges, such as previous experiences of abuse or neglect, current substance abuse and mental health issues, or violent surroundings, they often are not able to provide an environment that is supportive of positive outcomes for children. Programs that provide families who are at risk with long-term guidance about positive parenting, child health, and child development are likely to help prevent child abuse, neglect, and other poor childhood outcomes.

Healthy Families America is a home-visiting program developed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues. HFA has defined three critical elements of the program. The first critical element involves entrance into the program including the following:

- initiation of services prenatally or at the birth of the baby,
- use of a standardized assessment tool to systematically identify families who are most in need of services, and
- offer voluntary services that use positive outreach efforts to build family trust.

The second critical element focuses on service content and includes the following components:

- services are provided over the long term (three to five years) using well-defined criteria for increasing or decreasing frequency of services,

### Healthy Families America Snapshot

- **EC Profile Indicator:** FS30 - Percent of children age 0-5 with an investigated report of child abuse/neglect
- **Clearinghouse Rating:**
  - Promising Practices Network rated Healthy Families New York as Proven
  - Home Visiting Evidence of Effectiveness Review – Meets DHHS Criteria
  - California Evidence-Based Clearinghouse rated HFA as Well Supported by Research Evidence for child well-being but Evidence Fails to Demonstrate Effect for prevention of child abuse and neglect
- **Research supports** use with parents with children ages birth through five; children at risk for abuse, maltreatment, or neglect
- **Related Smart Start outcomes:**
  - Increase in positive parenting practices
- **Purveyor training required:** Yes
- **Frequency:** Weekly during first six months then monthly
- **Minimal service threshold:** The HFA minimum engagement criteria is defined as participation in 75% or more of scheduled home visits over the first 6 months of intervention.
- **Suggested Assessments:**
  - Adult-Adolescent Parenting Inventory-2 (AAPI-2)
  - Parenting Stress Index
  - HOME
- **Implementation Guidance:** http://www. healthyfamiliesamerica.org

- services should be culturally competent and materials must reflect the diversity of those being served,
- comprehensive services should support the parent as well as parent-child interaction and child development,
- families are linked to a medical provider and any additional services as needed, and
- staff should have limited caseloads (10 to15 families).

The third critical element focuses on staff characteristics and includes the following:

- service providers are selected based on their ability to establish a trusting relationship with families,
- service providers receive intensive training specific to their role, and
- staff receive ongoing, effective supervision.

Certified Healthy Families America should implement the following 12 critical elements (as noted by Frankel et.al. 2000[ii]):

(1) Intervening early to facilitate warm, secure and nurturing child/caregiver relationships.

(2) Using standardized assessments to identify families who are most in need of services.

(3) Relying on voluntary participation and trust-building to engage and retain families.

(4) Offering intensive services entailing weekly home visits for minimally the first 6 months after the birth of the baby and then tapering off to a leaner schedule and lasting for a period of 3–5 years.

(5) Assuring that services are respectful of differences in cultural values and tradition.

(6) Focusing services on three areas: (a) Stress reduction; (b) Positive parent–child interaction; and, (c) Stimulating child social, cognitive, and physical development.

(7) Linking all families to appropriate services in the community.

(8) Maintaining limited caseloads so that practitioners can devote sufficient time to meeting the unique and varying needs of each family.

(9) Selecting service providers based primarily upon personal qualities, openness to cultural diversity, and skills for performing key job functions.

(10) Giving home visitors a sound professional framework that includes knowledge of cultural differences, infant and child development, mandated reporting, domestic violence, mental health conditions, substance abuse issues, and community resources.

(11) Providing home visitors with intensive training specific to their role, including principles of (a) family assessment and home visitation, (b) preventive health care and home safety, (c) trust building with consumers, (d) individualized family support plans, (e) behavioral observation, (f) basic teaching skills, and (g) crisis intervention skills.

(12) Providing home visitors with ongoing, effective supervision.

For more information regarding Healthy Families America use this link: http://www.healthyfamiliesamerica.org.

## Target Audience

Families with infants (prenatal to shortly after birth) who are at risk for adverse childhood experiences, including child maltreatment

## Documented Outcomes

| | Type of Study | Parent-reported parent or family outcomes | | | | | | | | | | | Child socio-emotional development |
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| | | Reduction in parenting stress | Educational attainment; participation in school or training | Use of contraception; avoidance of second pregnancy | Shared reading | Use of developmentally supportive activities | Developmental screenings | Use of aggressive or harsh discipline; Abusive or neglectful parenting* | Use of safety practices | Use of parenting resources | Reduction in alcohol or substance use | Attitudes and behaviors | |
| Jacobs et.al. (2015)[iii] | Experimental | ✓ | ✓ | ✓ | | | | ✓ | | | ✓ | | |
| Green et.al. (2014)[iv] | Experimental | | | | ✓ | ✓ | ✓ | | | | | | |
| LeCroy & Krysik (2011)[v] | Experimental | | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | | |
| Dumont et.al. (2008)[vi] | Experimental | | | | | | | ✓ | | | | | |
| Ownbey et.al. (2011)[vii] | Non-experimental with comparison groups | | | ✓ | | | | | | | | | |
| Cullen et.al. (2010)[viii] | Non-experimental; one group pretest–posttest design | | | | | | | | | | | ✓ | ✓ |

*This table contains outcomes found to be associated with the program or approach. Individual studies may contain additional outcomes that were tested and not found to be associated with the program or approach.*

*Aligned with Smart Start outcome *Improved parenting practices*

## Research Evidence for Healthy Families America

- Parent outcomes range from reduction in stress, to changes in attitudes, and improved parenting behaviors. Some parents change personal behaviors such as participation in school or training programs, use of contraceptives, and use of alcohol.
- One study has documented positive child socio-emotional outcomes.

### *Review of Experimental and Quasi-Experimental Studies*

| Citation | **Jacobs, F., Easterbrooks, A., & Mistry, J. (2015). The Massachusetts Healthy Families Evaluation-2 (MHFE-2): A randomized, controlled trial of a statewide home visiting program for young parents. Final Report to the Children's Trust of Massachusetts, Tufts Interdisciplinary Evaluation Research (TIER).** |
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| **Population and Sample** | The study incorporated 684 Massachusetts mothers who were randomly assigned to a treatment group (n=417) that received Home Visiting Services; HVS) or a control group (n=267; Referral and Information Only; RIO). |
| **Methodology** | Experimental; Intent-to-Treat |
| **Purpose** | The study was a statewide evaluation of Healthy Families Massachusetts (HFM). The study was a longitudinal evaluation, with a focus on adolescent parents. The study's five research questions were:<br>1. How do those mothers enrolled in HFM utilize program services?<br>2. To what extent do programs operate, and do participants utilize services, as intended by the<br>3. HFM model?<br>4. Is program dosage associated with outcomes?<br>5. What is the nature of the home visitor-mother relationship?<br>6. Does participation in HFM yield positive effects in the five HFM goal areas?<br>The five goal areas were:<br>• Prevent child abuse and neglect by supporting positive, effective parenting,<br>• Optimal health, growth, and development in infancy and early childhood,<br>• Encourage educational attainment, job, and life skills among parents,<br>• Prevent repeat pregnancies during the teen years, and<br>• Promote parental health and well-being. |
| **Measures & Assessments** | • Parenting Stress Index<br>• Phone Interview<br>• In-Person Interview<br>• Public Agency Data (Department of Children and Families, Elementary and Secondary Education, Public Health, Transitional Assistance)<br>• Participant Data System<br>• Census Data |
| **Study Implementation** | • Eligible participants were at least 16 years old and female who also (a) provided informed consent to participate in the study; (b) had not received HFM services in the past; and (c) spoke either English or Spanish. Participants were randomly assigned to treatment or control groups.<br>• Participants received three semi-structured phone interviews at: one month after enrollment, 12 months after enrollment, and 24 months after enrollment. Interviews were conducted in the home. Participants also received written questionnaires and the study team conducted observations of the mother-child interactions.<br>• Data extracts retrieved from public agencies were used to assess outcomes.<br>• There were 10 implementation fidelity measures, which were developed for the study and based upon Healthy Families American program elements:<br>1. 60% of referrals made during prenatal period, first contact with 80% new participants either prenatally or within 2 weeks of birth,<br>2. contacts made with 100% of new participants within 10 days of referral,<br>3. first home visit completed with 100% of participants within 20 days of referral,<br>4. 90% of eligible parents accept services,<br>5. participants receive at least 18 visits per year enrolled,<br>6. 75% of participants receive at 75% of their visits according to their service level, |

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| | 7. 100% of participants receive at least 18 months of services,<br>8. 85% of home visitors receive weekly supervision lasting 1.5 hours (program-level only),<br>9. 100% of participants receive weekly home visits for at least 6 months following the birth of their baby/enrollment if enrolled postpartum (individual-level only),<br>10. 100% of participant receives at least one home visit.<br>• Program-level and individual participant-level fidelity was tracked for the study. Overall, program fidelity averaged a score of .74 (range of .71 to .80) on a scale of 0 to 1, where 1 indicates highest possible model fidelity. As regards individual participant fidelity, 85% of 433 treatment mothers had data on all indicators and 12% were missing data on one indicator (3% were missing data on two-three indicators). Overall, participants met about half of the individual participant implementation indicators. |
| **Staff Qualifications** | • Paraprofessionals, trained in the program |
| **Key Findings** | Prevention of Abuse and Neglect<br>• There was no program impact related to the reduction of the rate of child maltreatment, in either the treatment or control group.<br>• In families in which there was substantiated maltreatment reports, in the treatment group, 90% of mothers were identified as the person committing the offense, compared to 60% of control group mothers.<br>• One possible explanation is that the presence of the HFM home visitor contributed to more observance of the home environment, or "increased surveillance," which might be linked to a higher rate of treatment mothers being identified.<br>Parenting Stress<br>• At Time 2 (12 months post-enrollment) and Time 3 (24 months post-enrollment), treatment mothers reported less parenting stress as measured by the Difficult Child (Time 2) and Parental Distress (Time 3) subscales of the Parenting Stress Index. Treatment mothers scored, on average, 23 points on the Difficult Child and 28 points on the Parental Distress subscales, compared to 24 points and 30 points, respectively, for control mothers.<br>• Effect sizes were .22 for the Difficult Child and .25 for the Parental Distress subscales.<br>• At T2, 24% of treatment mothers reported the use of harsh discipline, compared to 30% of control group mothers.<br>Optimal Health, Growth, and Development in Infancy and Early Childhood<br>• There were no significant program effects identified on measures of child behavior, English language skills, child responsiveness, or infant (baby) health.<br>Encourage Educational Attainment, Job, and Life Skills Among Parents<br>• A significant program effect was identified for mother's educational attainment. Treatment mothers were more likely to finish at least one year of college by T3, compared to control group mothers (Odds Ratio = 1.92, p=.007)<br>• By T3, 17% of treatment mothers completed at least one year of college, compared to 10% of control group mothers.<br>Prevent Repeat Pregnancies During the Teen Years<br>• A significant program effect was identified for use of condoms.<br>• At T2, 25% of treatment mothers reported using condoms, compared to 18% of control group mothers.<br>Promote Parental Health and Well-Being<br>• Twenty-five percent of treatment mothers reported engaging in three or more risky behaviors, compared to 36% of control group mothers.<br>• Eleven percent of treatment mothers reported using marijuana, compared to 20% of control group mothers.<br>• Thirty-nine percent of treatment mothers reported perpetrating acts of intimate partner violence more than once in the past year, compared to 51% of control group mothers.<br>• Thirty-six percent of treatment mothers were victims of domestic violence, compared to 39% of control group mothers. |

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| **Citation** | **Green, B. L., Tarte, J. M., Harrison, P. M., Nygren, M., & Sanders, M. B. (2014). Results from a randomized trial of the Healthy Families Oregon accredited statewide program: Early program impacts on parenting. Children and Youth Services Review, Volume 44, pp. 288-298.** |
| **Population and Sample** | The study incorporated 803 first-time Oregon mothers who were randomly assigned to treatment (n=402; Health Families Oregon with seven programs) or control (n=401) groups. |
| **Methodology** | Experimental; Intent to Treat |
| **Purpose** | The study was a component of a larger, randomized study that assessed Healthy Families America as |

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| | implemented in Oregon, or Healthy Families Oregon (HFO). The study team conducted a telephone survey with a randomly selected group of mothers to assess early outcomes at children's 1-year birthday. The study focused on the following questions:<br>(1) What short-term program effects can be detected at children's 1-year birthday? In particular, compared to control families: (a) Do parents in the HFO group report more positive parenting behaviors and skills compared to families in the control group? (b) Do parents in the HFO group report lower parenting stress, less depressive symptomatology, and more positive family functioning compared to families in the control group? and (c) Do children in the HFO treatment group experience more supports for healthy development, specifically increased breastfeeding and increased rates of developmental screening?<br>(2) Are there outcome differences for key subgroups of families? In particular, do outcomes differ for: (a) prenatally vs. postnatally enrolled mothers; (b) Hispanic vs. White/Caucasian mothers; (c) teenage vs. older mothers; (d) mothers with depressive symptomatology vs. non-depressed mothers; and (e) families with more vs. fewer total risk factors. |
| **Measures & Assessments** | • New Baby Questionnaire<br>• Telephone Survey<br>• Home Visiting Records<br>• Adult Adolescent Parenting Inventory, Corporal Punishment Subscale (AAPI-CP)<br>• Parent-Child Activities Scale (PCAS)<br>• Family Functioning subscale of the Protective Factors Survey (PFS)<br>• Parenting Stress Index – Short Form (PSI-SF)<br>• Pregnancy Risk Assessment Monitoring System (PRAMS) |
| **Study Implementation** | • For the larger study, families were screened for inclusion in the study using the New Baby Questionnaire. Eligible parents were then randomly assigned using a random-number generator to program or control groups.<br>• Following assignment, a first home visit was scheduled with parents assigned to the program group to conduct additional program intake assessments. Comparison families were mailed a standard resource and referral information packet.<br>• For the telephone interview component presented in this article, a subsample of 1,604 mothers was randomly selected to complete telephone surveys. Families who participated received a $15 gift card. Telephone surveys were completed with 803 mothers. |
| **Staff Qualifications** | • Not addressed |
| **Key Findings** | Shared Reading<br>• Treatment mothers reported reading with their infants significantly more frequently than control group mothers. Participants were asked "how often they read to their young child" with the possible responses: Not at all, Seldom, A few times, 3–4 times per week, About once a day, or More than once a day. The average score for treatment mothers was 4.74, compared to an average score of 4.43 for control group mothers ($p<.01$).<br>• Sixty-two percent (62.4%) of treatment mother reported "reading at least daily to their young children," compared to 52.1% of control group mothers.<br>Developmentally Supportive Activities<br>• As measured with the Parent-Child Positive Activities Scale (a 6-point Likert scale), treatment mothers had an average score of 4.84, compared to an average score of 4.73 for control group mothers ($p<.05$).<br>Corporal Punishment<br>• As measured by the AAPI, there was no significant difference between treatment (mean score 1.89) and control group (mean score 1.97) mothers.<br>Developmental Screenings<br>• Treatment mothers were significantly more likely to report that their child received a developmental screening (Odds Ratio .4, $p=.000$)<br>• Of the parents and children screened, treatment mothers were less likely to be told their child had a development concern (Odds Ratio 1.72, not significant at $p=.078$)<br>Health<br>• There were no other significant differences between treatment and control group mothers on health outcomes.<br>Parenting Stress<br>• While the treatment mothers reported less overall depression or parenting stress, as measured by the Parenting Stress Index, these results are not statistically significant. The average score for treatment mothers on depression was 2.17, compared to an average score of 2.22 for control group mothers (not significant). The average score on the Parenting Stress Index-SF for treatment mothers was 1.9, compared to an average score of 2.0 for control group mothers (not significant). |

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| | • On the PSI, General Distress subscale, the average score for treatment mothers was 1.78, compared to an average score of 1.86 for control group mothers (not significant).<br>• On the PSI, Parenting Stress subscale, the average score for treatment mothers was 2.02, compared to an average score of 2.14 for control group mothers (not significant).<br>Family Relationships<br>• As measured by the Family Functioning subscale of the Protective Factors Survey (5-point Likert scale), the average score for treatment mothers was 4.16, compared to an average score of 4.15 for control group mothers (not significant).<br><br>The study team examined outcomes by sub-groups and found:<br>• Non-depressed mothers exhibited stronger program effects on frequency of parent-child interactions than depressed mothers (p=.042). Non-depressed treatment mothers exhibited stronger program effects on the frequency of parent-child interactions than non-depressed control group mothers.<br>• There were no significant differences between treatment and control group families with two or fewer risk factors, on measures of depression or stress.<br>• In moderate and high-risk families, treatment mothers exhibited less stress and fewer depressive symptoms, compared to control group mothers.<br>• As regards the use of harsh discipline or the endorsement of corporal punishment, the program appears to have the strongest effect on higher risk families and especially those families with the highest level of risk. |

| **Citation** | **LeCroy, C. W., & Krysik, J. (2011). Randomized trial of the healthy families Arizona home visiting program. Child and Youth Services Review, Volume 33, pp. 1761-1766.** |
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| **Population and Sample** | The study incorporated 195 families who were randomly assigned to treatment group (n=97) and child development control group (n=98) at a single site in a large metropolitan area in Arizona.<br><br>The treatment and control groups were found to be equivalent on most characteristics. Mothers in the treatment group were significantly younger than mothers in the control group. There also were significant differences on the use of prenatal care, income, health insurance, employment, and car ownership. More treatment parents reported being involved with Arizona's Child Protective Services, compared to control group mothers.<br><br>All participants (n=195) completed baseline assessments. As the six-month time period, 94% of treatment and 91% of control group mothers were retained in the study. At the one-year time period, 88% of treatment and 89% of control group mothers were retained in the study. |
| **Methodology** | Experimental |
| **Purpose** | The purpose of the paper was to examine the effectiveness of home visiting as a means of improving parental, child, and maternal outcomes and preventing child abuse and neglect. The study incorporated a program that had a quality assurance approach and statewide accreditation. |
| **Measures & Assessments** | • Revised Parent-Child Conflict Tactics Scale (CTS-R)<br>• Adult-Adolescent Parenting Inventory-2 (AAPI-2)<br>• Home Visiting Records<br>• Emotional/Social Loneliness Inventory |
| **Study Implementation** | • The screening and enrollment process for the study included administration of a 15-item screen assessing at-risk criteria such as teenage mother and a positive score led to a parent survey, a modified version of the Kempe Family Checklist. If the score on the survey was 25 or greater for either parent, then participation in the study was offered. If the parent accepted participation, random assignment to either the Healthy Families Arizona program or the Arizona Child Development Study (the control condition) was offered.<br>• The program had a quality assurance protocol that was monitored by program staff. |
| **Staff Qualifications** | • Home visitors had a bachelor's degree or equivalent years of experience; all received training |
| **Key Findings** | Violent Behaviors<br>• There were significant differences between treatment and control group mothers on measures of aggressive discipline practices.<br>• There were not significant differences on a measure of family violence.<br>Parenting Attitudes and Practices<br>• There was a significant difference between treatment and control group mothers on Safety Practices (as measured with the AAPI-2), at six months. Treatment mothers had an average score of 17.95, compared to an average score of 16.05 for control group mothers (p=.04). |

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| | • There were not significant differences between treatment and control group mothers on Inappropriate Expectations, Lack of Empathy, Belief in Corporal Punishment, Reversing Roles, Oppressing Child's Independence, or Mother's Reading.<br>Parenting Support<br>• There were significant differences between treatment and control group mothers on the use of resources, at both the six-month and 1-year time periods.<br>Mental Health and Coping<br>• There were significant differences between treatment and control group mothers on the use of alcohol, at the 1-year time period. Twelve percent of treatment and 20.5% of control group mothers reported alcohol use (p=.04).<br>• There were not significant differences between treatment and control group mothers on Emotional Loneliness or Pathways to Goal.<br>Maternal Outcomes<br>• There were significant differences between treatment and control group mothers in participation in schooling or training, at the 1-year time period. Thirty-five percent (35.2%) of treatment mothers and 6.8% of control group mothers reported participation at the 1-year time period (p=.01).<br>• There were not significant differences between treatment and control group mothers on use of birth control. |

| **Citation** | **Dumont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. Child Abuse & Neglect, Volume 32, pp. 295-315.** |
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| **Population and Sample** | The study incorporated 1,173 families who were at risk for child abuse and neglect. Families were randomly assigned to either an intervention group (n=579) or a control group (n=594); 34% of mothers in the study were white, non-Latina; 45% African American, non-Latina; and 18% Latina; 31% were under 19, 54% were first-time mothers, 53% had not yet completed high school or received a GED, and 82% were never married.<br><br>The study team determined that there were no significant differences between the treatment and control on descriptive characteristics. Further, the team found that 20% of the sample had a prior Child Protective Services (CPS) report and that 9% of the sample also had a substantiated report of child abuse or neglect, prior to baseline. Of these, over 40% of reports were considered "open" at the time of random assignment to treatment and control groups. |
| **Methodology** | Experimental |
| **Purpose** | The study was designed to evaluate the effects of Healthy Families New York (HYNY), a variant of Healthy Families America, a home visiting program focusing on parenting behaviors in the first 2 years of life. The study was designed to assess women assigned to treatment or control groups prior to the giving birth to their first child. The study also included older women who already had a child.<br><br>The study was designed to assess four goals associated with HYNY:<br>(1) promote positive parenting skills and parent-child interaction;<br>(2) prevent child abuse and neglect;<br>(3) support optimal prenatal care, and child health and development; and<br>(4) improve parent's self-sufficiency.<br><br>The study also focused on:<br>(1) documenting the program's ability to reduce child abuse and neglect;<br>(2) exploring and testing prevention versus intervention approaches; and<br>(3) evaluating program services as provided to the psychologically vulnerable. |
| **Measures & Assessments** | • Parent-Child Conflict Tactics Scale (CTS-PC)<br>• Office of Child and Family Services (OCFS) database; substantiated CPS reports |
| **Study Implementation** | • After enrollment and random assignment to groups, intervention families were appointed a home visitor who set up an initial visit to complete the enrollment process. After enrollment in HFNY, families were offered the services typically provided by the program.<br>• Control group participants were provided with information about other services in the community and made referrals based on the needs identified during the initial assessment for study eligibility. They were not referred to other home visiting programs similar in type, duration, and intensity to HFNY and the study did not follow up to determine whether they followed through with the referrals.<br>• Following the baseline interview, participants were interviewed in their homes shortly after the birth of their children (if they entered the study before the birth), at the time of the children's first |

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| | and second birthdays, and, for a subsample, again at age 3. Interviews ranged from 45 minutes to an1 hour and 15 minutes. Baseline and Years 1 and 2 data were included in the current report.<br>• At each follow-up, data were extracted from the OCFS database tracking child abuse and neglect reports and determination. Mothers also completed a paper-and-pencil version of the CTS-PC and placed the completed instrument in a sealed envelope. |
| **Staff Qualifications** | • Not addressed |
| **Key Findings** | • Mothers in the intervention group committed fewer acts of serious abuse at age 2.<br>• Among women who were "psychologically vulnerable," HFNY mothers were one-quarter as likely to report engaging in serious abuse and neglect as control mothers (5% versus 19%) at age 2.<br><br>Did HFNY have an effect on abusive or neglectful parenting?<br>• The study team did not find statistically significant ($p<.05$) program effects related to the prevalence of events (or, whether an event occurred), as self-reported by participants, at year 1 or year 2 time periods.<br>• There were significant differences between treatment and control group mothers on several sub-scales related to the frequency of events (or, how often an event occurred. For example, at year 1, treatment mothers reported significant fewer acts of "very serious physical abuse, minor physical aggression, and psychological aggression in the past year" and "harsh parenting in the past week."<br>• At year 2, treatment mothers reported fewer "acts of serious physical abuse in the past year," compared to control group mothers. Specifically, treatment mothers reported one-fourth as many acts as control group mothers.<br>• There were no significant differences between treatment and control group mothers on the prevalence or frequency of substantiated CPS reports of abuse or neglect, at either year 1 or year 2.<br><br>Were effects of HFNY concentrated in the prevention subgroup?<br>• Analyses were conducted on first-time mothers under the age of 19. These mothers were randomly assigned to treatment or control groups at a gestational age of 30 weeks or less.<br>• At year 2, treatment mothers in the sub-group analysis were significantly less likely to report engaging in minor physical aggression against their children in the past year, compared to control group mothers (51% versus 70%, respectively).<br>• At year 2, treatment mothers in the sub-group analysis were significantly less likely to report harsh parenting behaviors in the past week, compared to control group mothers (41% versus 62%, respectively).<br>• Analyses of what the authors term the more "diverse group" of parents indicated comparable rates of minor physical aggression in the past year and harsh parenting in the past week, for treatment and control group mothers.<br>• The authors reported that there did not appear to be a moderating effect related to the frequency of sub-scale items. Further, the patterns of non-significant effects for CPS reports and self-reported maltreatment, at year 2, were consistent with significant effects identified for minor physical aggression and harsh parenting.<br><br>Were effects of HFNY concentrated in the psychologically vulnerable subgroup?<br>• Analyses were conducted on a sub-group considered to be psychologically vulnerable.<br>• At year 2, 5% of treatment mothers in this sub-group reported "engaging in acts of serious abuse or neglect," compared to 19% of comparison mothers. The authors also noted that "there was no difference in rates of self-reported serious abuse and neglect for the remaining women."<br>• At year 2, there were significant differences between the sub-group of psychologically vulnerable mothers and comparison mothers on the frequency of serious abuse and neglect, with the sub-group reporting fewer incidents ($p<.05$).<br>• At year 1, there were significant differences between the sub-group of psychologically vulnerable mothers and comparison mothers on the frequency of psychological aggression.<br>• The authors reported that psychological vulnerability did not moderate differences between treatment and control group mothers on substantiated CPS reports. |

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| **Citation** | **Duggan, A., Caldera, D. Rodriguez, K., Burrell, L., Rohde, C., & Crowne, S. S. (2007). Impact of a statewide home visiting program to prevent child abuse. Child Abuse & Neglect, Volume 31, pp. 801-827.** |
| **Population and Sample** | The study incorporated 325 families, who were enrolled in six Healthy Families Alaska (HFAK) program. Participants were randomized into treatment (n=162) and control (n=163) groups. Treatment and control |

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| | group mothers were similar on measures of demographic characteristics. It was common to find depressive symptoms, substance abuse, and partner violence at the time of baseline assessments.<br><br>Compared to control group mothers, treatment mothers were less likely to have "poor psychological resources" and to have enrolled in the program prenatally.<br><br>Follow-up interviews were completed for 85% of the treatment group and 86% of the control group. The follow-up mothers were more likely to "have worked prior to study enrollment," "more likely to be "married to or living with the child's father, and "less likely to have enrolled prenatally." |
| **Methodology** | Experimental |
| **Purpose** | The purpose of the study was to assess the impact of Healthy Families Alaska, which was described as a "voluntary, paraprofessional home visiting program in preventing child maltreatment and reducing the multiple, malleable psychosocial risks for maltreatment for which families had been targeted." |
| **Measures & Assessments** | • Center for Epidemiological Studies Depression Scale (CES-D)<br>• Mental Health Index (MHI-5)<br>• CAGE score<br>• Revised Conflict Tactics Scale (CTS2)<br>• Parent–Child Conflict Tactics Scale (CTS-PC)<br>• Infant-Toddler version of the Home Observation for Measurement of the Environment (HOME) Inventory<br>• Nursing Child Assessment Satellite Training (NCAST) Teaching Scale.<br>• Short form of Abidin's Parenting Stress Index (PSI)<br>• Adult-Adolescent Parenting Index (AAPI)<br>• Child Protective Services Reports<br>• Pediatric Medical Records<br>• Mother/Primary Caregiver Interview<br>• Observations |
| **Study Implementation** | • Baseline family attributes were collected by trained research staff (blinded to family group assignment)<br>• Follow-up data were collected when children were 2 years old<br>• Study investigator conducted pediatric medical chart review<br>• The study team identified measures of "adequate services," which included (a) enrollment ≥12 months, (b) enrollment ≥24 months, and enrollment ≥24 months and receipt of ≥75% of expected visits and ≤3 months on Level X, where Level X is intensive outreach to re-establish contact with families who are difficult to engage.<br><br>• Adequate services also were defined for each parental risk; measures of "service adequacy" were based on visit content. The measures included:<br>  • Any documented general discussion of the risk with the parent, such as a general discussion of the dangers of substance use.<br>  • Any documented specific action taken to address the risk, such as giving the mother information for accessing substance use services.<br>  • General discussion and maternal agreement with two statements: "I can talk with my home visitor about everything" and "My home visitor talks with me about sensitive issues."<br>  • Specific action and maternal agreement with these statements.<br><br>• Implementation fidelity was designed to include factors such as "staff recruitment and training, policies, protocols, and mechanisms to integrate HFAK with other services." The study team used multiple methods to assess implementation, including "home visitor surveys, review of training curricula, observation of selected training sessions, review of policy and procedure manuals, and discussion with program leaders." Further, home visitation staff completed questionnaires (in both 2001 and 2003) in which they rated their own competence in behaviors such as "developing a trusting relationship with parents," "helping parents acquire knowledge and skills," "working with mothers," and "working with fathers." |
| **Staff Qualifications** | • Not addressed |
| **Key Findings** | The program did not prevent child maltreatment, nor reduce the parental risks that had made families eligible for service. There was little evidence of effectiveness in preventing child abuse although this was clearly a high-risk sample—17% of control families and 16% of HFAK families had substantiated reports in the child's first 2 years of life.<br><br>Impact on child maltreatment reports. |

- The authors found that treatment and control group mothers were similar on rates of substantiated reports overall and with regard to neglect.
- Treatment and control group mothers were found to be similar on substantiated and unsubstantiated reports, combined.
- Nearly one-third of families had at least one report in two years.
- Over a quarter of families were reported for neglect.
- The authors did not find treatment versus control group mother differences in number of reports.

Impact on indicators of potential child maltreatment, disciplinary strategies, and parenting attitudes.

- The authors found that treatment and control group mothers were similar with regard to the percent of families in which the birth mother relinquished her role. The authors also found that the groups were similar with regard to the percent of children who were hospitalized for ambulatory care sensitive conditions and using the emergency department.
- Treatment and control group mothers were similar with regard to the percent of mothers who reported specific disciplinary strategies and neglectful behaviors and who were observed to interact poorly with their children.
- Treatment mothers were significantly less likely to provide a poor quality home environment, as measured using the HOME Scale. Specifically, 20% of treatment mothers were found to provide a poor quality home environment, compared to 31% of control group mothers ($p<.001$).
- Treatment and control group mothers were similar with regard to the frequency of hospitalizations and emergency department visits.
- Treatment mothers reported a lower incidence of use of mild physical and psychological disciplinary tactics, compared to control group mothers.
- Treatment and control group mothers were similar with regard to reported frequency of more severe forms of physical discipline and neglectful behaviors.
- Treatment and control group mothers were similar with regard to attitudes toward corporal punishment.
- Treatment and control group mothers were similar with regard to total AAPI scores.
- Treatment and control group mothers were similar with regard to all four AAPI subscales.

Impact on parent risks for child maltreatment and use of community services.

- The authors reported that it was common to find poor maternal mental health, substance use and partner violence, at follow-up.
- Treatment and control group mothers were similar on all but one of the binary outcomes identified by the authors. There was a trend towards reduced risk for maternal problem alcohol use, at follow-up.
- Treatment and control group mothers were similar with regard to mean scores on all but one of the measures of mental health and partner violence. There was a trend for treatment mothers to have lower total Parenting Stress Index scores.
- Treatment and control group mothers were similar with regard to reported use of community services to address mental health or substance use issues or partner violence.

Baseline attributes as moderators of HFAK impact.

- The authors did not find evidence that program outcomes were moderated.
- The authors found that “mild physical assault of the child” was less common among treatment mothers who were multiparous and mothers not in a violent relationship at baseline.

Association of parent risks with parenting behavior

- The authors found positive associations between parental risks that included depressive symptoms, problem substance use, and partner physical assault and measures of parenting.
- The authors found a significant association of “favorable attitudes toward corporal punishment” with severe physical assault, assault on the child’s self-esteem, and the frequency of common corporal punishment.

Program efficacy

- The authors found “negligible evidence” of program efficacy in preventing maltreatment or reducing risks, in families enrolled ≥12 months and families enrolled ≥24 months.
- The authors failed to find statistically significant differences in 24 comparisons of child maltreatment, as reported in the first 2 years of life, combined.
- There were no differences between treatment and comparison groups with regard to a number of binary outcomes identified by the authors. That stated, treatment mothers (with enrollment ≥12

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| | months) were significantly less likely to report mild physical assault (p<.05 and p<.01) and common corporal punishment (p<.05). Treatment mothers ≥12 months enrollment were significantly more likely to report hitting the child with a hard object (p<.05).<br>• Treatment mothers with ≥24 months enrollment were less likely to threaten the child's esteem (p<.05). Treatment mothers with ≥24 months enrollment were more likely to report hitting the child with a hard object (p<.01).<br>• As regards the 11 continous outcomes identified by the authors, there were no statistically significant differences between treatment and control group mothers.<br><br>Parental risks for child maltreatment.<br>• Treatment mothers with ≥24 months enrollment were less likely to report physical partner violence (when excluding women without a partner, p<.05, and when categorizing the mothers as negative for physical violence, p<.05).<br>• The authors also examined substance use at follow-up and illicit drug use. Both risk were more likely for treatment families, with specific home visitor actions addressing it (substance abuse at follow-up, p<.001, and illicit drug use, p<.05). |

## *Review of Meta-Analyses*

None

## *Review of Descriptive and Non-Experimental Studies*

| **Citation** | **Ownbey, M., Ownbey, J., & Cullen, J. (2011). The effects of a Healthy Families home visitation program on rapid and teen repeat births. Child and Adolescent Social Work Journal, Volume 28, pp. 439-458.** |
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| **Population and Sample** | The study incorporated 140 treatment mothers (including 90 teen mothers) and 241 comparison group mothers (including 130 teens). The participants were expecting parents or parents with a child under three months of age.<br><br>There were some significant differences between treatment and comparison group mothers, specifically with regard to average number of risk factors (5.9 for treatment and 5.0 for comparison group mothers, p=.001). However, the two groups did not differ significantly with regard to race/ethnicity or the proportion of teen (or, adolescent) parents. |
| **Methodology** | Non-experimental, post-test only with comparison group (no random assignment); Chi-squared tests of homogeneity |
| **Purpose** | The prevention of Rapid Repeat Births (RRBs) and Teen Repeat Births (TRBs) is an important indicator of the effectiveness of home visitation programs that serve mothers who are at-risk for child maltreatment. This study examined the effects on RRBs and TRBs of a rural/small town home visitation program based on the Healthy Families America (HFA) model. The study addressed the following hypotheses:<br>• The distribution of RRBs in the treatment group will not differ from the distribution of RRBs in the Comparison group.<br>• The distribution of TRBs in the treatment group will not differ from the distribution of TRBs in the Comparison group.<br>• The distributions of TRBs in the Treatment and Comparison groups will not differ from those that would be expected based on county-wide census and public health data. |
| **Measures & Assessments** | • Referral Records<br>• County Birth Records |
| **Study Implementation** | • An informal pre-screening checklist was used to generate referrals. Families who received a referral then were screened using the Kempe Family Stress Inventory (KFSI). Families who scored in the at-risk range on the KFSI were enrolled in HFA. Treatment mothers started services either prenatally or shortly after birth. HFA services were provided for at least six months.<br>• Treatment fidelity was assured through the application of HFA standards to staff recruitment, training, supervision, and evaluation.<br>• Supervision included weekly one-on-one reflective supervision and co-visits throughout the program. |

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| | • Home visitation staff performance was evaluated through direct observation and collection of consumer satisfaction surveys.<br>• Intervention integrity was not directly assessed. |
| **Staff Qualifications** | • Staf were experienced in human services, working with culturally and ethnically diverse populations, and education ranged from high school graduate through bachelor's degrees, though degree status was not a significant factor in personnel selection; additional training was provided.<br>• Practitioners administering the AAPI and ASQ-SE received training in the administration and scoring procedures of the instruments<br>• Staff participated in trainings that included:<br>  • Connecting with Families: Family Support in Practice, a 6-day training program;<br>  • Family-Centered Practice in Family Preservation Programs, a second 6-day training program;<br>  • HFA Role-Specific Core Training, a pre-service curriculum that addresses principles of home visitation, family assessment, and/or program management;<br>  • HFA-mandated continuing education; and<br>  • On-going in-service training on various topics.<br>• Newer staff were allowed to "shadow" more experienced staff. |
| **Key Findings** | • Relative to the comparison group and the community at large, clients of the HFA program examined in this study exhibited significantly reduced rates of RRB and TRB.<br>• Specifically, rates of RRB were 60% higher in the comparison group and teen mothers in the comparison group were three times more likely to have a second birth during adolescence.<br>• Teen mothers in the treatment group were more than 67% less likely to have a TRB than comparison teen mothers and 63% less likely to have a TRB than teens in the community at large.<br>Rapid Repeat Births<br>• There were statistically significant differences between treatment and comparison groups on Rapid Repeat Births. Eighteen percent of treatment mothers and 30% of comparison mothers had a RRB (p=.0243).<br>Teen Repeat Births<br>• There were statistically significant differences between treatment and comparison groups on Teen Repeat Births. Nine percent of treatment mothers and 27% of comparison mothers had a TRB (p=.0029).<br>• There were statistically significant differences among treatment mothers, comparison group mothers, and the county-wide TRB rate (the latter of which was 24%, p=.0027). This was interpreted to mean that study data did not "conform to county-wide norms", because of the lower TRB rate among treatment mothers. |

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| **Citation** | **Cullen, J. P., Ownbey, J. B., & Ownbey, M. A. (2010). The effects of the Healthy Families America home visitation program on parenting attitudes and practices and child social and emotional competence. Child and Adolescent Social Work Journal, Volume 27, pp. 335-354.** |
| **Population and Sample** | The study was an analysis of clinical data for 64 individual participants (55 families) from a Healthy Families America credentialed program in rural Western North Carolina. The sample was 78% white, 100% under-resourced, 96% English speaking, 73% were teenagers and/or first-time mothers (80%) who were unmarried (91%), 36% had more than one child living in the home, 44% held full or part time jobs, and 56% had less than a high school diploma. |
| **Methodology** | One group pretest–posttest design. |
| **Purpose** | This study examined the effects of a Healthy Families America (HFA) credentialed home visitation program on the parenting attitudes and practices of a sample of at-risk parents. It also examined the social and emotional competence of children whose parents successfully completed the program. Three hypotheses were addressed:<br>  • Graduates of a credentialed HFA program will show no change between pre- and post-test on a standardized measure of positive parenting attitudes and practices.<br>  • Compared to the standardization sample, graduates of a credentialed HFA program will perform significantly below the mean on a standardized measure of positive parenting attitudes and practices.<br>  • Compared to the standardization sample, there will be no difference in the frequency with which children of graduates of a credentialed HFA program score in the at-risk range on a standardized measure of social and emotional competence. |
| **Measures & Assessments** | • Kempe Family Stress Inventory (KFSI)<br>• Adult-Adolescent Parenting Inventory (AAPI-2)<br>• Ages and Stages Questionnaire- Social Emotional (ASQ-SE) |

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| **Study Implementation** | • An informal pre-screening checklist was used to generate referrals. Families who received a referral then were screened using the Kempe Family Stress Inventory (KFSI).<br>• Participants started the program during their children's prenatal period or shortly after birth and continued in services until graduation from the program.<br>• Services conformed to the HFA Home Visitation Model.<br>• Treatment fidelity was assured through the application of HFA standards to staff recruitment, training, supervision, and evaluation.<br>• Supervision included weekly one-on-one reflective supervision and co-visits throughout the program.<br>• Home visitation staff performance was evaluated through direct observation and collection of consumer satisfaction surveys.<br>• Intervention integrity was not directly assessed. |
| **Staff Qualifications** | • Staff were experienced in human services, working with culturally and ethnically diverse populations, and education ranged from high school graduate through bachelor's degrees, though degree status was not a significant factor in personnel selection.<br>• Practitioners administering the AAPI and ASQ-SE received training in the administration and scoring procedures of the instruments.<br>• Staff were experienced in human services, working with culturally and ethnically diverse populations, and education ranged from high school graduate through bachelor's degrees, though degree status was not a significant factor in personnel selection; additional training was provided.<br>• Practitioners administering the AAPI and ASQ-SE received training in the administration and scoring procedures of the instruments<br>• All FSW staff participated in trainings that included:<br>  • Connecting with Families: Family Support in Practice, a 6-day training program;<br>  • Family-Centered Practice in Family Preservation Programs, a second 6-day training program;<br>  • HFA Role-Specific Core Training, a pre-service curriculum that addresses principles of home visitation, family assessment, and/or program management;<br>  • HFA-mandated continuing education; and<br>  • On-going in-service training on various topics.<br>• FSW staff were allowed to "shadow" more experienced staff. |
| **Key Findings** | Attitudes and Behaviors<br>• There were positive changes in each of the AAPI sub-domains (Expectations, Empathy, Corporal Punishment, Family Roles, and Independence; $p<.001$). More specifically:<br>  • The average "pre" score for Expectation was 5.25; the average "post" score was 7.7<br>  • The average "pre" score for Empathy was 4.14; the average "post" score was 7.6<br>  • The average "pre" score for Corporal Punishment was 4.6; the average "post" score was 7.21<br>  • The average "pre" score for Family Roles was 4.35; the average "post" score was 8.33<br>  • The average "pre" score for Independence was 5.29; the average "post" score was 7.49<br>  • The average overall "pre" score was 4.73; the average overall "post" score was 7.67<br>• The study authors compared average scores to HFA standard scores and concluded "graduates of the program were no more likely and in, many instances, significantly less likely than randomly selected individuals to espouse parenting attitudes and practices that have been associated with child maltreatment."<br>Ages and Stages Questionnaire: Socio-Emotional<br>• Data were obtained from 55 children, whose parents graduated from the program.<br>• There were no "at-risk" scores; all 55 children were assessed as being within the "normal" range for the instrument. The authors concluded that "when compared to their age peers, children whose families graduated from an HFA credentialed program exhibit higher levels of social and emotional competence as measured by the frequency with which they display social and behavioral challenges." |

## End Notes

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