

Healthy Families Connecticut:
Process Evaluation of a Home Visitation
Program to Enhance Positive Parenting
and Reduce Child Maltreatment

Center for Social Research

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**Healthy Families Connecticut: Process Evaluation of a Home
Visitation Program to Enhance Positive Parenting and Reduce
Child Maltreatment**

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Report Summary

This report is a companion to the outcome report we released last year on Healthy Families Connecticut (HFC). In last year's report, we completed a four-year outcome assessment of HFC using a pre-post design. The 2000 report suggested that HFC was developing well, that it was doing a good job of identifying and recruiting a high-risk population, a reasonable job of retaining and engaging families, a good job of reducing child physical abuse and an excellent job of linking families to services in the community. There was also evidence that mothers who remain in the program for one or two years were achieving educational and employment goals, establishing independent households and making important improvements in parenting capacities, attitudes and behaviors. However, we also documented high rates of emotional neglect that were largely related to substance abuse and domestic violence in the households, and suggested that reducing child maltreatment would require a more systematic response to these problems.

Characteristics of Healthy Families Connecticut Home Visitors

Since the inception of the program in 1995, 54% of home visitors, or Family Support Workers (FSWs), were racial minorities, 77% lived in the city or town where services were provided and 36% were bi-lingual. At the time of hire, 41% of FSWs had completed at least an associate's degree from college, 26% a bachelor's degree, while 67% had previous work experience in the human services. However, hiring practices appear to be changing. FSWs hired at sites in 1995-96, were less likely to have completed a college degree at the time they were hired (only 13% had completed a bachelor's degree), were more likely to be racial minorities (71%), and were more likely to be hired as full-time home visitors (94%). Newer sites (1998-99) have hired more FSWs with college degrees (45% with a bachelor's degree), fewer racial minorities (39%) and fewer full time FSWs (64%). Earlier sites tended to stress relevant job experience when hiring FSWs (78% compared to 64% at newer sites) rather than educational achievement.

There remains a commitment among managerial staff to hire support workers who have the personal skills and experience to engage and develop trusting relationships with family members. These skills remain paramount in hiring practices, irrespective of whether the support worker has a formal education or not. Managerial staff are looking for the "right person" who can engage families and who can become, as one manager described, "baby experts." However, all of the programs are paying more attention to writing and analytical skills when they hire. Some require writing samples, others spend time in the interview session carefully assessing communication skills. They are all looking for some indication of professional ambition—whether the candidate for the job is pursuing a degree, has worked in other human service programs or plans to develop a career in the helping professions.

Strengths and Weaknesses of Paraprofessional Home Visitors

FSWs are central to the Healthy Families program. They are the liaisons between supervisory staff and families, the observers and communicators of family struggles, the shoulders that families lean on, and community workers attempting to galvanize a network of services that are, in many cases, necessary to stave off the debilitating effects of poverty. As paraprofessionals, they are selected largely based on their potential for engaging first-time mothers in constructive relationships that will result in better parenting, more effective use of community resources, greater self-sufficiency and better problem-solving skills. Usually, paraprofessionals are familiar with the ethnic and social class cultures of participating families, the communities where services are targeted, and the daily struggles that can impede parent-infant bonding. By reducing the social and cultural distance that often exists between professionals and their clients, the intention of the paraprofessional model is to increase the likelihood that clients will bond more comfortably with home visitors and, therefore, commit to the program. Herein lies the promise of the paraprofessional model and the vitality of the HFC program. However, working with non-credentialed home visitors also has its challenges.

Paraprofessionals vary in terms of their work experience. For some, a lack of work experience in professional settings may result in difficulty working with others, working independently from supervision, handling flexible work schedules, and being supervised. Limited analytical skills among FSWs was also identified as a problem and is manifested in two respects, in poor boundary setting and in poor diagnosis of problems in the families. However, the difficulties of establishing boundaries is, in part, inherent in the FSW role and needs to be understood within the context of the program. HFC places much emphasis on making connections with families, on hiring home visitors who can identify and empathize with families' struggles, and on facilitating a mentoring relationship between the FSW and the mother. At the same time, program protocols require FSWs to establish boundaries, or professional distance, when working with families. Managing both closeness and distance is a difficult skill to develop, especially in the context of working with vulnerable families.

The problem of not communicating family problems, dynamics or issues to supervisory staff is also a complicated one. It may be related to poor analytical skills in identifying problems, different thresholds of tolerance in defining what a problem is or to limited documentation or communication skills. It may also be related to the FSWs unwillingness to communicate family problems or issues to supervisory staff. The willingness of staff to share information about the family is related to the extent to which they "buy-into" the program's philosophy, goals and methods, to the quality of their relationships with supervisory staff, and to the degree to which they feel the need to protect their families due to their own mistrust of the program or the helping professions at large.

The Evolution of the FSW Role as Home Visitor

FSWs are at the frontlines of the program's overall approach and strategy. They deliver the services and represent the program to the community. As such, FSWs are expected to translate theory into practice, research findings into real life applications. Put another way, the efficacy of

the paraprofessional model is predicated on the ability of FSWs to assume the role of "cultural broker." As we are using the term, a "cultural broker" is one who is relatively fluent in the languages, practices, and "ways" of two different cultures generally unable or unaccustomed to communicating meaningfully and directly with each other. FSWs, as envisioned by the model, are expected to "broker" the cross cultural communication between the culture of professionalism and the culture of their communities.

In order to better understand why in some instances FSWs and their professional supervisors forge a productive alliance, while in others they remain separate and marginalized, we need to explore the promise and the reality of the paraprofessional role in Healthy Families. The ideal evolution of the FSW role would proceed as follows:

Marginality \Bi-cultural competence \Cultural broker

Marginality describes the original status of FSWs, who find themselves straddling community culture and the culture of professionalism. Bi-cultural competence refers to a base of knowledge and set of abilities enabling the FSW to create a bridge between the culture of the community and the culture of professionalism. The bridge from community culture to professional culture involves FSWs establishing an empathic connection with community families, earning their trust, understanding their lives, and communicating their needs, concerns, and difficulties to professional supervisors. Simultaneously, the bridge from professional culture back to community culture involves taking the knowledge, philosophies, and practices of the Healthy Families model of parenting back to community families by demonstrating its value, application, and relevance to their lives. When this process occurs, the FSW is indeed in the role of cultural broker, acting as the interpreter, facilitating genuinely reciprocal communication between two cultures in which this communication does not normally and naturally occur. Thus, we are arguing that bi-cultural competence is an ability, a set of skills and a base of knowledge. It includes both the understanding of community culture and professional culture, as well as the communication skills and facility to interpret the language and "ways" of each culture to the other. However, we hasten to add one caveat that we believe to be crucial to the successful transition of the FSW to cultural broker. Bi-cultural competence appears to be a necessary but insufficient basis for an FSW to fully embrace the role of cultural broker. The final step in the transition to cultural broker must include FSW willingness to serve in that role. Consequently, Healthy Families should endeavor to develop not only the ability of FSWs to function in that capacity, but also their willingness to do so. Thus we are arguing that bi-cultural competence is an ability, while cultural broker represents that ability plus the willingness to utilize it in all aspects of the job. With the concept of "willingness" so central to the transitional process of FSW to cultural broker, we will explain it in more detail.

"Willingness" is comprised of two complementary beliefs concerning the relationship between Healthy Families and their communities. The first belief concerns the potential value of professional culture as symbolized by the Healthy Families curriculum. Can the lives of community families be meaningfully improved by professional knowledge and practices? Do professional knowledge and program practices genuinely have relevance and application to their communities? If this belief is held, then it will facilitate FSW willingness to interpret, or "broker" professional culture to community culture. The second belief essential to generate FSW

willingness to function as a cultural broker is the trust that professional culture, as represented by Healthy Families' supervisors, is first and foremost committed to improving the lives of community families. If this belief is held, then it will facilitate FSW willingness to interpret, or "broker" community culture back to professional culture. To the extent that either of these beliefs is not accepted, the full circle of "brokered" communication between the FSW and her supervisor will not be complete. The absence of the first belief makes FSWs reticent to interpret professional cultural knowledge to community families as they doubt its value and relevance. The absence of the second belief about the true motivations of professional culture casts the FSWs into the role of protector of their families from the judgmental scrutiny of their supervisors. Certainly such an outcome will preclude FSW willingness to interpret, or "broker" community culture to professional culture.

In the following illustration, we identify site characteristics where we believe most FSWs have progressed from a position of marginality to one of cultural broker.

Illustration #1: Site Characteristics Where FSWs Function as Cultural Brokers

- < Professionalism, rather than avoided as a barrier to connecting with families, is embraced as essential to establish the appropriate boundaries between the FSW and family to facilitate a productive relationship.
- < FSWs accept the efficacy of the Healthy Families model and parenting curriculum to offer valuable guidance and assistance to families.
- < Consequently, there is a firm commitment on the part of FSWs to "do curriculum" or at least focus a portion of home visits on parenting education. This commitment is derived from the belief that the curriculum education is relevant and that it provides the most effective means to professionalize the FSW/family relationship.
- < FSWs trust that their professional supervisors genuinely share a deep concern for community families. Therefore, FSWs can openly share impressions and information about families, secure in their belief that by doing so, they are helping, rather than betraying their community families.
- < While the initial bond with families is based almost exclusively on empathy, FSWs actively seek to make the transition toward a more professionalized role based on their knowledge and authority on parenting.
- < FSWs strive to achieve bi-cultural competence as paraprofessionals.
- < Bi-cultural competence comes to be combined with the willingness and desire to embrace the role of cultural broker as the FSWs believe both in the efficacy of the Healthy Families program and the commitment of their professional supervisors to improving the lives of community families as their foremost concern.

Conversely, in illustration #2, we identify site characteristics where most FSWs have *not* moved into the role of cultural broker.

Illustration #2: Site Characteristics Where FSWs do NOT Function as Cultural Brokers

- < Professionalism is rejected by FSWs as a viable role. It is seen as a barrier to forging meaningful connections to community families.
- < The Healthy Families model and curriculum is seen as irrelevant or even antithetical to the needs of community families. Consequently, it is for the most part ignored in home visits and can provide no means to professionalize the boundaries between the FSW and the family.
- < Without professional boundaries evolving, the FSW role that becomes dominant in relation to the family is friend/mentor. Furthermore, this friendship bond is likely to reflect not just empathy, but a shared mistrust, suspicion of the intentions of professional authority and the procedures of bureaucratic structures.
- < When the FSW alliance with her families and community casts the Healthy Families program into the role of "outsider," bi-cultural competence will not be sought and genuinely reciprocal communication will not be achieved.
- < Mistrust and alienation will make the FSW unable and/or unwilling to interpret, or "broker" professional culture to community culture, as she doubts its efficacy, and the mistrust and alienation will simultaneously make her unwilling to interpret, or "broker" community culture to professional culture, as she seeks to protect her families from the negative judgment of professional authority.
- < FSWs remain in the marginalized status in which they began and in a role far less conducive to achieving program goals than that of cultural broker.

While individual families might derive some benefit from a mentor relationship with a FSW, this relationship, by itself, does not represent the intended Healthy Families intervention. It is our firm belief that while paraprofessional marginality is at the core of the paraprofessional model, it is so only as a starting point for FSWs--not as an end product. Unless FSWs develop the bi-cultural competence to pursue the transition to the role of cultural broker, the program will become mired in an unproductive stalemate, whether detached or adversarial in nature.

Managing Paraprofessional Home Visiting Services: Working with Multi-problem Families

Home visitors confronted with on-going crises are pulled into the orbits of family struggles that require of them much more than they were prepared for by either their job descriptions or their training. These circumstances hone their skills as home visiting *generalists*; they need to be

prepared for anything. They deal with landlord disputes, negotiate problems with school authorities, help mothers understand changing welfare regulations, intervene in family conflicts, tend to mothers who have been battered by partners, find housing for mothers who are thrown out of their homes by landlords, family members or partners, accompany family members to court, confront substance abuse in the family or drug dealing in the home or neighborhood, nurture depressed mothers or advise mentally challenged mothers, and much more. In many instances, FSWs feel as if their daily struggles with their families are not appreciated or understood as supervisory staff attempt to narrow the scope of their involvement with the families, emphasize the imperative of structuring home visits around a parenting curriculum, or demand that paperwork stay up-to-date.

Supervisory staff expect that their home visitors will develop into *specialists*, that they will learn how to facilitate parent-child attachment despite the problems in the home, that they will learn how to instruct mothers in providing a safe and nurturing home environment, and that they will become adept at redirecting visits to parent-child issues.

Perhaps the most powerful and troubling tension that many FSWs experience revolves around the basic parameters of their role as Healthy Families home visitors. Can they best serve their families within the prescribed boundaries of the program (their supervisors' perspective) or are those boundaries too constraining to do what needs to be done? This tension is structured within the need for the FSW to be both a generalist, as required by the multiple problems they often encounter within families, and a specialist, as required by focused program objectives to facilitate parent-child bonding, healthy child development and attentive parenting practices.

Managing Paraprofessional Home Visiting Services: The Art of Supervision

The problems of working with non-credentialed home visitors identified earlier—limited analytical skills, poor boundary setting, poor writing and communication skills, limited to no work experience in a professional setting, high thresholds of tolerance for family problems—must be addressed by supervisors. In addition, as our ethnographic study indicates, the willingness of the FSWs to “buy-into” the program’s philosophy, goals, and practices is largely based upon their relationships with supervisors. In other words, the problems of the paraprofessional model identified in the bulk of this report become the exclusive responsibility of the direct supervisor.

While the interaction between the FSW and the family member is at the heart of the program, the FSW’s relationship with her supervisor will also greatly influence the effectiveness of program services. As we have seen, the FSWs development as a professional, her education as a “baby expert,” her knowledge of community services and her understanding of family dynamics will evolve largely from her relationship with her supervisor. Moreover, her *willingness* to deliver Healthy Families services that focus on parent-child dynamics and child development will also be primarily shaped by this relationship. But similarly, supervisors’ understanding of the community and the families they serve depends, in part, upon their willingness to learn from their FSWs. Information and learning need to flow in both directions for this model to work. Just as FSWs must learn to straddle community and professional culture, so too must supervisors, for they are the conduit, the interpreter of program philosophy and objectives, who must figure out how to apply these principles to the community and family contexts in which

home visits occur. While, they are likely to be better versed in program philosophy and professional culture more generally, they should rely on FSWs to learn more about the families and community.

Despite the importance of direct supervision in fostering an effective service model for home visiting, the amount of time that is given to this task varies considerably across sites. At some program sites, the supervisory role is performed by the program manager, who already has many demands on her time as the program coordinator. Of the 12 sites that we studied in 1999-2000, six employed supervisors and only four as full-time positions. Furthermore, when we examined supervisor's program responsibilities, the range of expectations was daunting. In addition to the multiple roles they perform in managing a paraprofessional model (teacher, boss, counselor, master strategist), they also may be expected to prepare for credentialing, meet the research needs of the evaluation, reorganize data collection to meet the requirements of the nationwide Program Information Management System (PIMS), meet administrative responsibilities (approve time-off, oversee staff hours and vacations, hire new staff, etc), write grants, sit on advisory boards, write quarterly reports and do assessments. The central importance of the supervisor's role in delivering effective home visiting services is, in our view, being neglected by a lack of program support and training, by adding a range of responsibilities to the supervisor's role beyond direct supervision and by not providing supervisor's with the time necessary to perform their roles adequately (i.e. limiting position to part-time work).

Assessment Process

Most families interviewed score 25 or above on the Kempe, making them eligible for services (scores on the Kempe range from 0-100). In our 2000 report, we found that 93% of families assessed met this criterion and that 91% of families referred to HFC accepted services. These are high percentages, which suggest that the Revised Early Identification Screen (REID), referral and outreach processes are highly effective in identifying and recruiting a high-risk population. In fact, this finding raises the question of whether the Kempe is a necessary screening tool at all, given that it only screens out 7% of the population assessed. Furthermore, only about one-half of families who screen positive on the REID are actually assessed on the Kempe, leaving many potential families without program services. Eliminating the Kempe as an assessment tool would make anyone testing positive on the REID screen eligible for services and would reduce the time and expense necessary to administer the Kempe.

In our analysis of the Kempe, we offer the following observations. First, there is not much literature on the validity and reliability of the Kempe; only one study provides strong support for its predictive validity. Two, our data provide support for the validity of the Kempe using the CAPI as a comparative measure. Three, some of the categories on the Kempe do not appear to be appropriate for first-time mothers and some items on the rating scale may not be culturally appropriate. Four, while the general sentiment of the HFC staff is favorable towards the Kempe, they raise some important concerns, especially regarding mothers' willingness to make disclosures about their pasts.

Conclusion

In this year's report, we turn our focus to program practices. More specifically, we explore the theoretical rationale of a paraprofessional model, examine its strengths and weaknesses, and identify the dilemmas that paraprofessionals confront as they attempt to bridge the terrain between the community culture of program participants and the professional culture of program supervisors and managers. In addition, we examine the assessment process that HFC uses to identify and recruit a high-risk population. The paraprofessional model, while filled with potential as a vision, is difficult to implement. However, we also believe that the lessons learned from the frontlines of a paraprofessional program hold great promise to maximize the impact of human services on the lives of families most in need of assistance. To this end, we offer several recommendations in the body of the report. In Connecticut, we have begun a process through which a series of committees will be established to discuss our recommendations. Committee members will include staff from different locations within the program, including frontline staff as well as supervisory staff and program leaders. The goal of this process is to conduct an overall review of program practices and to make changes to the program where it is judged as appropriate by the HFC community.

Recommendations

In the following, we recommend a series of committees to deliberate on the issues raised in this report. Committees should consist of staff members from different locations within the program, including frontline staff as well as supervisory staff and program leaders. Each committee should submit a proposal to a statewide committee to recommend any program changes it believes would adequately address the issues assigned to it. The statewide committee should include representation from the Children's Trust Fund, Prevent Child Abuse Connecticut, the evaluation research team, as well as program representation from frontline and supervisory staff. In the course of our research, we have learned the value of perspectives that are formed from different locations within the program and strongly believe that this process will be constructive as long as it is inclusive of individuals from the frontlines to the boardrooms.

Recommendation #1

We recommend that a committee be established to identify the protocols for conducting home visits. In the past four years, program sites have experimented with different parenting curricula and have supplemented and modified curricula to make it more appropriate to their communities or families. The results of these efforts—the lessons learned--should be identified and disseminated to the statewide Healthy Families community. In addition, a set of protocols or guidelines for conducting home visits needs to be established. How often should a parenting curriculum be used? Should it be central to home visits and to the program in general? What other types of services should home visitors be prepared to provide besides services focused on a parenting curriculum and how should these services be delivered? To answer these questions and to provide guidelines for home visitors, we believe it is important to consider the following:

- < *First, home visiting requires support workers to be both generalists and specialists. These differing orientations to the job need to be integrated in a meaningful and coherent way. To do so, however, may require that the community orientation of many FSWs, that leads them both to develop and value the skills of the generalist, be understood as something distinct from the more narrowly defined program orientation held by supervisory staff that values the parenting and early childhood expertise of the home visitor. These different conceptions need to be openly discussed and examined in an effort to locate their relative importance within the scope of conducting home visits.*
- < *Second, to facilitate the developmental process from marginality to cultural broker, FSW training, both at the outset and throughout employment, should be more pointedly focused on building trust in and allegiance to the overall Healthy Families philosophy of parenting and curriculum. If the focus remains only on knowledge, skills, and abilities, the willingness to fully adopt the role of cultural broker may not simply follow as a natural outcome. Especially in predominantly minority communities, the marginality experienced by minority group FSWs may go beyond the community culture-professional culture divide encountered by all FSWs. Furthermore, the common life experiences that forge the empathic bond with community families may include some that have produced a deep mistrust of the efficacy and intentions of the programs and managers of white, middle class professional culture. As these issues, if left to fester, may produce an*

adversarial or detached stalemate, they must be acknowledged, addressed, and worked through by FSWs and supervisory staff. Of course this also requires that the philosophy, practices and curricula of Healthy Families be opened up to critique by both supervisory staff and frontline workers, otherwise it is less likely that support workers will “buy-in” to the program. Presently, FSW willingness to fully assume the entire range of responsibilities of their role is often more a function of their particular relationship with a supervisor than a function of a their acceptance of Healthy Families’ philosophy, practices and expectations. Offering Healthy Families services to high-risk families in disenfranchised communities will require that frontline workers trust and believe in the philosophy and merits of the program. This can occur only when the underlying assumptions of the program and its strategies for implementation are opened up to critique.

- < *The pleas for autonomy by FSWs resonate with the overall philosophy of "empowerment" stressed by Healthy Families as a desired outcome for clients. FSWs argue persuasively that just as Healthy Families seeks to empower families, supervisors similarly should empower FSWs to genuinely utilize their unique understandings of their communities. They insist that Healthy Families should not be perceived as a fixed, predetermined entity to be imposed on a community. Rather it should be conceptualized as an evolving "work in progress" responsive to the culture and needs of a specific community, able to adapt and change as more is learned about the community from its FSWs. When such FSW knowledge does indeed play a significant role in constructing the reality of Healthy Families practices at specific sites, it serves the essential function of building and sustaining direct FSW allegiance to the entire program. If FSWs have reason to believe that they have participated in the evolution of the Healthy Families model to be taken to their community, then they more readily embrace it as their own. This provides a vital, final link in the chain to Healthy Families ambassador and cultural broker. Despite the vexing difficulties that both FSWs and their supervisors will undoubtedly encounter in their joint efforts to turn marginalized FSWs into cultural brokers, we remain convinced that it is the best path to providing needed parenting education to families in socially isolated communities.*

Recommendation #2

We recommend that a committee be established to develop strategies for addressing several challenges to delivering effective home visiting services, including working with families in which substance abuse, domestic violence or poor mental health is prevalent. While these issues should be the priority of the committee, there are other challenges that the committee may want to consider as well. As families remain in the program beyond the first year of the child’s life, many mothers take jobs in the workforce. This decreases the availability of mothers for services, poses challenges to scheduling home visits and requires more flexibility on the part of program sites—and in some cases more flexibility than a parent agency is willing to make. Further, with increased employment among mothers, child care needs are becoming paramount. Program responses to the quality of child care options might be considered, including the availability of licensed child care facilities and the use of family members, friends or unlicensed day care programs, and whether these arrangements provide care that is consistent with the objectives of

the Healthy Families program.

Recommendation #3

We recommend that a committee be established to provide strategies for effective supervision, that should include initial and on-going training and the best practices for supervision (including an examination of case and home supervision). Further, the committee should identify the range of supervisor responsibilities that are reasonable and the minimum number of hours necessary (per home visitor) to adequately provide direct supervision. Finally, this committee should recommend strategies for facilitating the FSWs development from a position of marginality to cultural broker.

In this context, we believe that the following should be considered:

- < *Healthy Families would benefit from more supervisor training specifically focused on the paraprofessional model, its potential advantages and pitfalls, and on managing and relating to paraprofessional staff. A middle management position of field, clinical supervisor should be present at each site, rather than a program administrator serving in both capacities. A field supervisor accompanying FSWs on home visits on a regular schedule provides a valuable bridge/buffer between FSWs and program administration. The field supervisor faces the challenging task of needing to ensure program fidelity by encouraging FSWs to make the curriculum the centerpiece of home visits thus professionalizing the relationship. At the same time, she must exhibit the flexibility to grant FSWs the discretionary power to adapt and improvise. Too much supervisor adherence to a strict, "by the book" approach is often interpreted by FSWs as a lack of trust, confidence, and respect for their knowledge of their community. Supervisors find themselves in the unenviable position of "walking a tightrope" between the conflicting demands for program fidelity voiced by administrators and pleas for autonomy from FSWs.*

- < *At some Healthy Families sites, FSWs have had the opportunity to advance in their careers. We see many benefits for both FSWs and the program in general from creating such a career ladder and recommend that all sites move in that direction. Institutionalizing "senior" FSW positions based not just on seniority but on the acquisition of expertise through in-service training and continuing education opportunities strongly signals program recognition of the value of FSW service. It demonstrates that their knowledge and skills play a significant role in constructing the reality of the Healthy Families program at specific sites. Furthermore, the previously noted allegiance to the professional model may be easier to build and sustain when FSWs have participated in its evolution. FSWs will recognize that by acquiring bi-cultural competence in conjunction with a demonstrated capacity to serve as cultural brokers, they can advance in their careers as well as provide better services to their community families.*

Recommendation #4

We recommend that committee be established to develop organizational channels for FSWs to communicate perspectives on family needs and to participate in statewide decision-making. FSWs, along with FAWs, are the only staff who do not meet regularly with one another to discuss common issues and problems and to communicate these issues to statewide leaders. FSWs work on the frontlines and are therefore most familiar with the daily struggles of families. Their perspectives on families and on program services in meeting the needs of families are important and need to be available to program leaders. Moreover, they are positioned to be advocates for families—to articulate their needs and to identify misguided policies or policy gaps—which can have important policy ramifications if supported by a statewide program structure.

Recommendation #5

We recommend that a committee be established that will examine program costs and establish a standard for properly funding Healthy Families sites. This issue might be included within the purview of a statewide committee that has as its main task recommending statewide practices for Healthy Families.

Recommendation #6

We recommend that a committee be established to examine the assessment process in light of our findings. Given that 93% of families assessed, using the Kempe, qualify for the program, we are raising the question whether the Kempe is a necessary screening tool, especially given the time, expense and stress involved. To help guide the program in making this decision, we gathered additional data on the Kempe. We found that, one, there is not much literature on the validity and reliability of the Kempe, and that only one study provides strong support for its predictive validity. Two, we found that our data provides moderate support for the construct validity of the Kempe using the CAPI as a comparative measure. Three, we raise some concerns about whether the Kempe is appropriate for first time mothers and whether some of the items are culturally appropriate for a Puerto Rican population. Four, while the general sentiment of the HFC staff is favorable, they raise some important concerns, especially regarding mothers' willingness to make disclosures about their pasts, and are open to the prospects of either modifying the Kempe or selecting another assessment tool. In Connecticut, we are fortunate to have Dr. John Leventhal from Yale School of Medicine on our research committee. Dr. Leventhal has written extensively on risk measurement and would be an ideal candidate to chair this committee. In addition, we would recommend that at least two experienced FAWs sit on the committee. This committee should work towards determining if the Kempe is the best assessment instrument for the Healthy Families program. If not, they should recommend whether the Kempe should be replaced, modified, or if the EID screen currently used by the program is sufficient for determining program eligibility.

Healthy Families Connecticut: Process Evaluation of a Home Visitation Program to Enhance Positive Parenting and Reduce Child Maltreatment

This report is a companion to the outcome report we released last year on Healthy Families Connecticut (HFC). In last year's report, we completed a four-year outcome assessment of HFC using a pre-post design. The 2000 report suggested that HFC was developing well, that it was doing a good job of identifying and recruiting a high-risk population, a reasonable job of retaining and engaging families, a good job of reducing child physical abuse and an excellent job of linking families to services in the community. There was also evidence that mothers who remain in the program for one or two years were achieving educational and employment goals, establishing independent households and making important improvements in parenting capacities, attitudes and behaviors. However, we also documented high rates of emotional neglect that were largely related to substance abuse and domestic violence in the households, and suggested that reducing child maltreatment would require a more systematic response to these problems.

Our outcome study, however, did not include a comparison group. Thus, our findings, while largely positive, need to be qualified. Without a comparison group, we can not attribute our outcomes to the program intervention with any degree of certainty. We know that, on average, families meeting high-risk criteria and receiving services in HFC for one or two years are making progress in areas that program services are attempting to improve—especially changes in parenting. Nonetheless, without a more rigorous research design, i.e. a random control study, we cannot know if these changes are attributable to other influences—such as parental maturity, better employment and child care opportunities, or other service programs—and could have, therefore, occurred without HFC services.

The positive evaluation of the program using a pre-post design is encouraging, but now needs to be more rigorously tested in order to meet higher scientific standards. But first, we believe it is important to conduct a thorough process evaluation. The purpose of a process evaluation is to identify the specific practices that comprise the intervention, to account for any variation in program practices across sites, to identify the strengths and weakness of the intervention, to document the program dynamics that can facilitate or impede service delivery, and, most importantly, to document the lessons learned from the experiences of staff providing services. The goal of such an endeavor is always to strengthen services—to create the most supportive organizational structures for staff on the frontlines to deliver effective program services. To this end, we delve deeply into the dynamics of a paraprofessional home visitation program and put our critical faculties to work. We do not leave many stones unturned in this report—we look closely at the difficulties of organizing services for vulnerable families; we raise serious questions about the risk assessment protocols used by HFC; we closely examine the strengths and weaknesses and the overall difficulty of implementing a paraprofessional program; and we expound on both the successes and the failures of the program in implementing a paraprofessional model.

There are two related developments within the research world that also have inspired this report.

Anne Duggan and her colleague's study of Healthy Start Hawaii, published in the *The Future of Children*,¹ provides a rigorous examination of a paraprofessional home visitation program. Their outcome findings are mixed and remind us not to have high expectations for programs working with vulnerable families. But one of their more salient findings was that outcomes varied considerably across program sites, underscoring the importance of process studies that analyze the dynamics of program implementation and attempt to improve them. Second, David Olds and his colleagues have been critical of paraprofessional home visitation programs, arguing that services are better implemented by nurse-trained home visitors.² We do not try to refute Olds and his colleagues argument in this report but start with a different premise. Given the serious nursing shortage widely publicized in the U.S., finding biculturally competent nurses to staff home visitation services for vulnerable families as the demand for these programs grows seems a daunting task. Instead, we begin with the premise that paraprofessional home visitation is a practical strategy for reaching and providing support services to vulnerable families and, therefore, focus on ways of improving it.

The purpose of this study is to promote an informed dialogue about home visitation with the goal of developing better, more effective services. In Connecticut, we are taking a program that shows much promise and are attempting to strengthen it by subjecting it to critical review. Program leaders should be commended for their courage in this process. They have not attempted to thwart our efforts, to dissuade our inquires or to impede our critical observations in any way. While perhaps a bit nervous at times, they have nevertheless supported and encouraged our inquiry.

For this process, however, to come to fruition it should not end with this report. This report, we believe, is not the type that belongs on the proverbial backroom shelf gathering dust. On the contrary, its purpose is to further discussion about strengthening program services. To this end, we suggest in this report that a series of committees be established to address various issues and recommendations that we raise in the report, and that proposals for improving the program ensue from these committees. We have a unique vantage point as researchers. We can throw ourselves into the fray of program services, observe, question, and document, but then step back and look at the broader picture as well. We can talk to people located in different places within the program: frontline staff, supervisors and managers, program leaders, and then try to integrate their varying perspectives into a coherent interpretation of the program. Most of our work is simply reframing what others, struggling within the context of the program, have already learned. We learn from insiders and then provide an interpretive framework for the insiders to consider, to reflect on and to ultimately embrace or refute. The committee structure we are recommending is part of this process. The question remains whether staff, in various program roles, will see their work, their struggles, their visions of the program in the interpretations we provide. Regardless, we hope to set into motion a process in which *all staff*, from the frontlines

¹See Duggan et al. (1999). Evaluation of Hawaii's Healthy Start Program. *The Future of Children*, 9(1), 66-90.

²See Korfmacher et al. (1999). Differences in Program Implementation Between Nurses and Paraprofessionals Providing Home Visits During Pregnancy and Infancy: A Randomized Trial. *American Journal of Public Health*, 89(12), 1847-1851.

to the boardrooms, can participate in a dialogue to move the program forward.

This report is divided into two sections. In the first section, we focus on the dynamics of paraprofessional home visiting support services. In the second section, we examine the risk assessment protocol used by HFC. The research methods used in the process study included individual interviews, focus groups and ethnographic study. We elaborate on the methods we used for acquiring specific types of information in our discussion and interpretations of that information below.

The Paraprofessional Home Visitor Model

Characteristics of HFC Program Staff

HFC sites are located in a variety of geographical areas—urban, suburban and rural towns, serve groups that differ by race/ethnicity, social class, age and risk status, and are located within differing types of agencies or organizations. The consequence is that HFC sites begin with diverse service philosophies and strategies, adapt the Healthy Families model to meet their community and organizational needs, and evolve differently as they made adjustments to more effectively implement program services. These varying strategies and adjustments include hiring priorities. In its origin, HFC promoted a paraprofessional model, in which professional supervisory staff were hired to train and monitor the work of primarily non-credentialed paraprofessional home visitors—that is, individuals who do not have college degrees or certified professional training in nursing or human services. With only a few hiring exceptions, the first five HFC sites—Hartford, Waterbury, Bridgeport, Manchester and the Naugatuck region—all abided by this model. Since then, however, many of the new sites and even a few of the earlier sites have hired professional (or credentialed) home visitors. Thus, it is difficult to still maintain that, as a whole, HFC is a paraprofessional home visitation program. We surveyed the 12 HFC program sites to better document staff characteristics across sites.

Among the 12 HFC programs operating at the end of the 1999-2000 fiscal year, there were 63 staff employed. In addition, we have information on 26 staff who terminated employment. Among current program managers, all are white, two-thirds have graduate degrees (degree areas include Psychology, Social Work, Education, Marriage and Family, and Nursing), and one-half work full-time for Healthy Families. Six of the programs employ supervisors—three are white, one is African American and two are Puerto Rican, all have completed at least a bachelor's degree and four work full-time for the program. Programs use different staffing strategies for conducting assessments. Two of the programs require supervisors to also conduct assessments and three of the assessment workers also do home visits. Among the 13 staff members conducting assessments, six are white, three are African American, and four Puerto Rican; seven have completed bachelor's degrees and eight work full-time for the program.

Examining closely the characteristics of home visitors, or Family Support Workers (FSWs) sheds light on the extent to which HFC actually utilizes a paraprofessional model. We have

information on 53 FSWs who have worked for HFC since the inception of the program. Fifty-four percent are racial minorities (mostly African American and Puerto Rican), 77% have lived in the city or town where services are provided and 36% are bilingual. At the time of hire, 26% had a GED or high school education, 31% had completed some college courses (but had not completed a degree), 15% had an associate’s degree, 20% a bachelor’s degree and 6% a master’s degree. Another way of saying this is that 41% of FSWs had at least an associate’s degree from college, while 26% had at least a bachelor’s degree when they were hired by HFC. Furthermore, two-thirds of FSWs had previous experience working in the human services. These figures underscore the question--is HFC a paraprofessional program and has the hiring trend changed over time within the program?

When we compare the first five program sites to offer HFC services (1995-96) with programs that began offering services more recently, hiring practices appear to have changed. As shown in Table 1, FSWs hired at the earlier sites were less likely to have completed a college degree at the time they were hired (only 13% had completed a bachelor’s degree compared to 45% at newer sites), were more likely to be racial minority (71% v. 39%), and were more likely to be hired as a full-time home visitor (94% v. 64%). Earlier sites tended to stress relevant job experience when hiring FSWs (78% compared to 64%) rather than educational achievement.

Table 1: Comparison of FSW Characteristics at Earlier and Later Established Sites

<u>FSWs Characteristics</u>	<u>Earlier Sites (1995-6)</u>	<u>Later Sites (1998-9)</u>
% Racial/Ethnic Minority	71%	39%
% Bachelor’s Degree	13%	45%
% Relevant Job Experience	78%	64%
% Full-time	94%	64%
Median Age	39	34

The reason for these differences, however, may be related to the locations of newer sites. If sites are located in primarily white communities with less poverty, then the racial/ethnic and educational characteristics of FSWs may differ accordingly. When we compare FSWs at sites in which the majority of mothers receiving services are racial or ethnic minorities to FSWs at sites in which mothers are mostly white, indeed we do see differences. As indicated in Table 2, programs hire FSWs who resemble the racial and ethnic characteristics of the families served--68% of FSWs are white at sites where more than one-half of mothers receiving services are white, while 75% of FSWs are racial/ethnic minorities at sites where the majority of mothers are racial/ethnic minorities. Educational achievements at the time of hire also differ--42% of FSWs at majority white sites had completed at least a bachelor’s degree compared to 16% at sites that served mostly racial/ethnic minorities. There are a couple of possible explanations for this. One, it may be more difficult to hire credentialed racial minority FSWs--the pool is smaller and they are in greater demand in the human service job market. Two, sites that serve primarily racial minority families may be more likely to embrace a paraprofessional model as a strategy to reach racial minority families who are more culturally and socially isolated from the mainstream, and

who therefore may be more suspicious of home visitation services that promote or challenge parenting styles.

Table 2: Comparison of FSW Characteristics at Sites Where Mothers are Mostly White to Sites Where Mothers are Mostly Racial/Ethnic Minorities

<u>FSWs Characteristics</u>	<u>Mothers>50% White</u>	<u>Mothers>50% Minority</u>
% Racial/Ethnic Minority	32%	75%
% Bachelor’s Degree	42%	16%
% Relevant Job Experience	71%	72%
% Full-time	77%	84%
Median Age	39	34

In interviews with supervisory staff, it was clear that hiring practices had changed. Even in sites, usually urban sites, that had maintained a commitment to hiring paraprofessional home visitors, concerns about writing skills, workplace socialization and professionalism were paramount in hiring practices. One program manager requires candidates to complete a writing sample during the interview process, another indicated that she is starting to recruit more from community colleges, and a few said that they are targeting more skilled, professional and experienced home visitors, even though starting salaries often inhibited their efforts. Sites that had attempted to hire welfare-to-work clients in the beginning had abandoned this effort. Remaining within the guidelines of Healthy Families America’s (HFA) critical elements, supervisory staff insisted that personal qualities such as being engaging, empathic and caring were still foremost in their hiring efforts, but at the same time they were paying increased attention to analytical abilities, professional conduct and writing skills. Hiring home visitors who had similar experiences and backgrounds with families receiving services became a double-edged sword—a potential for developing close connections with families, but also a threat to professional protocols, such as establishing boundaries with and analyzing problems among their families. We will elaborate on this in the next section of the report.

In sum, HFC’s commitment to a paraprofessional model appears to be changing. Newer sites are less likely to hire FSWs without at least an associate’s degree, and nearly one-half of FSW hires since 1998 had bachelor’s degrees. However, sites that serve mostly racial or ethnic minority families are more likely to hire FSWs without college degrees. In the next section, we explore the paraprofessional home visiting model more closely, providing interpretations that are based upon interviews and focus groups with program staff as well as an ethnographic study of home visitors.

Strengths and Weaknesses of Paraprofessional Home Visitors

In the a recent Healthy Families America newsletter, a question was asked about the appropriateness of paraprofessionals providing professional services. The response from HFA was:

While many HFA programs may have staff with expertise in specific areas, HFA was

designed to be a *paraprofessional model*. The critical elements encourage program staff to build relationships with other service providers in the community. These collaborative relationships enable staff to meet the multiple needs of their families by facilitating referrals to appropriate supportive services.³ (Our emphasis in italics)

To learn more about the Healthy Families home visiting model, and especially the strengths and weaknesses of paraprofessional home visitors, we conducted interviews and focus groups with supervisory staff. In 1999, we conducted individual interviews with seven program supervisors and nine program managers and, in 2000, we conducted two focus groups with all program supervisors and managers. All interview and focus group transcripts were transcribed and coded. In this section we will describe supervisory staff's perspectives on paraprofessional home visitors.

Part of the problem of discussing this issue is defining what is meant by the term paraprofessional. Usually the reference to a paraprofessional concerns credentials. Often, the term distinguishes staff by whether they have acquired a college degree, usually a bachelor's degree. While college educated staff may not yet be trained to provide specialized services, the analytical preparation they have achieved through a college education presumably provides them with the potential to develop more specialized skills. In working with vulnerable families, the underlying assumption is that college-educated professionals will most likely have acquired the analytical skills that will enable them, with further training, to become proficient at diagnosing health problems, identifying and reducing risk factors, strengthening family resiliency, enhancing child development, and facilitating parent-child bonding. These skills may be more difficult for paraprofessionals to learn without a formal education that cultivates a dispassionate theoretically-informed perspective, critical self-awareness and professionally detached observation. This argument is, of course, debatable.

There is a long history to the debates on paraprofessional family support. The use of non-credentialed home visitors is not new; the strategy was particularly salient during the 1960s and 70s when the debates were quite lively. As is often the case in the history of support services, old strategies have been renewed and old debates have resurfaced. The debate on paraprofessional home visitors has been particularly rekindled by David Olds and his colleagues in Denver, where they have designed research to compare the effectiveness of home visiting services provided by non-credentialed and nurse-trained staff.⁴ In these debates, paraprofessionals are usually referred to as support workers, often home visitors, who, while not fully credentialed to work independently as professionals, do assume professional responsibilities in at least part of their work role. Beyond the potential cost effectiveness of employing paraprofessionals, their utilization is often justified by their community ties and shared experiences with families targeted for services. It is believed that such connections may

³See "Questions from the Field" in *HFA Research and Practice Spotlight* (Winter 2000).

⁴Kormacher et al. (2000) "Differences in Program Implementation Between Nurses and Paraprofessionals Providing Home Visits During Pregnancy and Infancy: A Randomized Trial."

help to reduce family resistance to program services and enhance engagement.

Healthy Families Connecticut and, more generally, Healthy Families America provide a puzzling profile of their “paraprofessional” home visitors. As described earlier, 15% of home visitors in Connecticut have associate’s degrees, 20% bachelor’s degrees and 6% master’s degrees. In their 1999 national profile of Healthy Families’ home visitors, HFA found that 45% had at least a bachelor’s degree and another 36% some college.⁵ The HFA profile is similar to the educational characteristics of home visitors hired in newer HFC program sites identified above. Thus, home visiting staff in Connecticut and across the country include both credentialed and non-credentialed staff. Hiring criteria recommended by Healthy Families America can be found in the program’s critical elements. The critical elements for selecting and training service providers include the following:

Select Family Support Workers (FSWs) based on their personal characteristics (i.e., non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

Select FSWs who possess an *educational or experiential* framework for handling the variety of situations they may encounter when working with at-risk families. Also, provide all FSWs with basic training in areas such as: cultural competency, substance abuse, reporting child abuse, domestic violence, drug exposed infants, and services in their communities. (Our emphasis in italics)

Thus, the critical elements stress personal characteristics, willingness and ability to work in culturally diverse communities, in addition to educational background or personal experience that would prepare one for home visiting practices. These are broad guidelines and hiring practices will vary accordingly. In our discussions with supervisory staff, it is clear that they are looking for the “right” individual for the job. By this, they mean someone with the educational qualities or the analytical skills to become support workers who can effectively diagnose problems, identify and reduce risks, fortify family strengths, and promote parent-child bonding and child development. However, supervisory staff are also looking for someone who is culturally sensitive, can empathize with the struggles of families in varying social environments and can readily engage family members. The ideal candidate is someone who possesses both—analytical skills and cultural competencies. This is not unlike most home visiting programs, irrespective of whether the program hires professional or non-credentialed frontline workers—nurses, social workers or paraprofessionals. Programs that employ nurse home visitors, for instance, search for racial minority or culturally competent nurses to work in poor, minority communities. Similarly, programs that hire non-credentialed staff often seek more educated staff (completed some college for instance) who harbor professional ambitions. The difference is one of emphasis, and our interviews revealed the same—that program sites have different emphases in

⁵See Deborah Daro and Carolyn Winje (2000) *Healthy Families America: 1999 Profile of Program Sites*, National Center on Child Abuse Prevention Research, Chicago.

terms of what they value in home visitors. Hiring preferences are based upon differences in community needs, in managers' experiences of working with paraprofessionals, and in the home visiting philosophies and bureaucratic requirements of agencies.

While supervisory staff differ in their commitments to non-credentialed staff, all have adjusted their hiring practices to require a higher standard of education among home visitors. Nonetheless, most of the supervisory staff remain wed to the program's central commitment to hiring home visitors who can empathize and connect with families through shared culture, experience and history. One of the more experienced program supervisors elaborated:

Well, obviously the strengths are in the one on one relationship, the "I've been there, done that" mentality, that our workers have. If they did not experience what the moms are going through, they know somebody very close to them who did. And in fact, most have similar, many, many similar stories in their history and I think that's one of the real pluses with the paraprofessional model because they are really able to feel—empathy is the key to this program. If our moms feel that the workers know what's going on and what they're feeling, I believe the outcomes are going to be greater. Some of our moms are just taking longer to get there, to show us. But I see many, many improvements in families I didn't have any hope for before—maybe two year's ago, and the third year you see some change, or the fourth year. And again, I think it's all tied up with the interpersonal relationships this model allows.

Several made comparisons between paraprofessionals and professional home visitors:

It's very easy, I think, for our workers to go in and maybe they, themselves, have experienced a level of poverty and they know what it is to live with somebody who's violent..and they can then identify on a different level than maybe a clinician can. I mean, I'm so often thinking the other side of it and that's why I really value the work that they do. Because if you can find a family support worker that comes with that engagement [type] of skill and...can go into a home and really just identify what the issues are and move on with it. We've been very lucky at our site. We really have some really good, strong workers that really can do quality work better, I think, than a degree person.

I think that they're more willing to accept families the way they are and maybe give them that little bit of slide. The little bit that they really need. Where the professional's more like keeping within their role. I don't see that same kind of connection. It's connection at a different level [with paraprofessionals] and they really connect to them.

A few insightful comments were provided about how family members respond differently to professionals:

...the moms that are young definitely have a harder time with the person who's been

educated and not [walked in] their shoes, only in the fact that they find it difficult to share their tough times. They want to pretend they're doing better than they are because, you know, they don't want to feel like I'm really not doing well here in front of someone, like, with an education.

Well what makes [paraprofessionals] better is that they get better connections. I mean you can see it right away. They'll bring me [a program manager] in when there's like a serious problem and I am like the police. I put my stethoscope around my neck...They really connect with people as people. That's what's always sort of amazed me about this model because what we put stock in is their ability to small talk, their ability to connect, their ability to conjoin, their interpersonal skills, and truthfully, you can't teach that. I'm convinced of that, you just can't.

In short, supervisory staff, when discussing the strengths of a paraprofessional service delivery model, emphasized the FSW's non-judgmental qualities, their patience and their genuine concern for their families, in addition to their abilities to engage and connect with families. By grounding the working relationship in shared culture, experience and history, it is believed that the paraprofessional will possess more relevant authority to challenge or confront family members' behaviors and attitudes. In this way, paraprofessionals can provide a bridge between service agencies and communities, between professionals and socially marginalized families. However, this is not an easy bridge to establish, a point that we will elaborate on later in the discussion of our ethnographic study. Because paraprofessionals often have experienced many of the same burdens that program participants confront, they are easily viewed as role models. In poor communities where daily struggles can overwhelm residents, paraprofessionals represent survivors--individuals who have managed to surmount obstacles in their own lives. They fulfill a role as mentor and, because of their personal experiences, can offer realistic coping strategies and suggest community networks that may help family members better negotiate the circumstances of their lives. They become "generalists" whom families can turn to for "kitchen table" counseling, for advocacy with welfare agencies, landlords, workplace bosses, and school authorities, for community referrals, and for support in times of crisis. Their authority is derived more from experiential learning than from formal education or HFC training. The identity of community worker is reinforced through these types of interpersonal relationships, and the paraprofessional can acquire a stronger sense of self as a community leader, as someone who "gives back" to the community. When paraprofessionals embrace the identity of mentor and communicate empathy and sensitivity to the difficulties of their families' lives, they acquire a unique capacity to influence program participants. Herein lies the strength of the paraprofessional strategy, the vitality of the HFC program, the promise of the model. However, working with non-credentialed home visitors also presents challenges.

Supervisory staff identified a range of challenges presented by working with non-credentialed home visitors, who often live in the same communities where services are provided and share many of the personal and cultural characteristics of families. Paraprofessionals vary in terms of their work experience. For many, a lack of work experience in structured settings may result in difficulty working with others, working independently from supervision, handling flexible work

schedules, and being supervised. In short, paraprofessionals need to be socialized to work in a setting that is more consistent with professional values and expectations. Problems identified by supervisory staff included not showing up for work regularly and on time, not organizing their time effectively, managing flexible work schedules and conforming to professional norms of conduct (addressing grievances, putting aside personal problems during work time and dressing professionally). One of the program managers indicated that these issues can require much time and energy among supervisory staff:

....the reality is that you're dealing with an immature workforce...[which] presents very hard issues. Those are the issues where on Monday, today, two people just called out because it's like OK to do that. Well it really isn't OK to do that. So I don't think [supervisory staff] got any hard core training [from Prevent Child Abuse America] about motivation, about understanding where [paraprofessionals] are in terms of workmanship, professional ethics, work ethics, those kind of things. That can take a long, long time to develop.

Sometimes supervisory staff assume too much of their inexperienced workforce:

Some were afraid to use the phone. I remember asking one FSW early on, "well, you've got to call and check that out." She'd never done that before, she'd never called. And I could tell she's delaying, delaying, delaying. Then it hit me, the reason why she's delaying is because she didn't know how to do it....But that's what I mean, those little kind of things...

In many instances, however, the failure to meet work expectations is not related to inexperience but to the life circumstances of some paraprofessionals. Some of the FSWs are themselves managing demanding family lives, or as one program supervisor observed: "...their lives are very similar [to their families]. I think, what I found is [with] some of their personal lives, you just wonder, with the crises, the problems, how they even get to work at all." Many of the non-credentialed staff are from low-income families or are single mothers, who themselves are struggling with limited resources, child care issues and family problems. A program manager commented:

We need to pay attention to things that we don't think about. If you're working in an urban setting, these are urban women who you're working with that have urban health problems [like] asthma...We have some social problems in the family we probably wouldn't run into in lots of working places. We have to be very careful because sometimes their problems are only one step from where the [clients] are...[and] how they go into other people's homes and listen to those problems when they're going through them themselves, I have no idea. I don't know how they do it.

Another program manager provided an extreme example of working with a FSW whose home life had become chaotic:

There are so many issues going on in the home that they can't be at work. I had a woman work with me for nine months. She missed 40 days of work. [Interviewer: Because of the chaotic family life?] Yeah, the husband was in jail. Her son was in Long Lane [Juvenile Detention facility], and the daughter was pregnant. You know, just so many different things going on, but she was a wonderful home visitor. So, I worked with her. I tried to rearrange her schedule. I tried to, you know, maybe she could go part-time. You know, what were her needs—we really, really worked with her and then finally it just wasn't working because she had to continually cancel home visits and then families, you know, were taking it personally or were starting to drop out of the program. It was really affecting the job performance and unfortunately it was really things that were beyond her control.

Of course, less extreme cases are more common. But working with non-credentialed frontline staff who have limited work experience and who struggle with problems characteristic of low-income communities poses a number of challenges for supervisory staff.

Limited analytical skills among FSWs was also identified as a problem of working with a non-credentialed workforce. This problem is manifested in two respects, in poor boundary setting and in poor diagnosis of problems in the families. Without a formal education that cultivates a dispassionate theoretically-informed perspective, critical self-awareness and professionally detached observation, paraprofessionals are sometimes viewed as too impulsive and emotionally involved to work effectively with families. They are viewed as unable to establish boundaries between their own needs and the needs of their clients. Moreover, if the paraprofessional is going through or has recently gone through problems similar to those her client is facing, she may have a tendency to over-identify with the client and lose her objectivity. The boundary that exists between a paraprofessional and a family member is often rather permeable and difficult to clearly maintain, especially when issues the family member is struggling with trigger painful memories, emotional associations, or unresolved conflicts for the paraprofessional. This may lead to the problem of counter-transference, where the paraprofessional reacts to the family member based more upon feelings that are associated with her own unresolved conflicts than upon sound professional judgment. Without formal education to help reflect on these issues, professionals will argue that paraprofessionals cannot achieve the analytical distance necessary to help others with problems they are confronting, or have dealt with, themselves.

A program supervisor explains:

I think in certain professions we are taught that boundary of being able to separate our issues from the client's issues and we are able to do that. I think it's very difficult, it's not impossible, but I think it's very difficult for our [paraprofessional] workers to do that.

Several observations were made about boundary problems that occur when a FSW is addressing a family problem that she herself is either dealing with or has been through.

With paraprofessionals, I'm talking about real financial difficulties, relationship

problems, lack of support for themselves, single moms bringing up children. So they presently have the difficulties, they've had the difficulties, so it's a real intense identification with the family, and mistrust [of others]. They're not going to expose that family. They're very, very protective. Extremely protective.

...there are some paraprofessionals who have been through this [problems with DCF] who are very bitter and who are...going to the house and put themselves in the parent's role and, "yeah, you should tell them to do this, you know, DCF, because that's not right to you!" There's boundary crossing because they've been through it and they're still angry about it, you know. There are problems there. There are paraprofessional problems with boundaries. They put themselves into that position and all their buttons are pressed.

I have dealt with the new person we've hired...who clearly says, "My ex-husband was like that and I know exactly what to tell her to do and not to do." And it's like, "Nah!" Then I go back to the goals, the Healthy Families goals. Why are we there? What are we doing? You know, you're not marriage counselors. We're not going to be marriage counselors. And she feels that she's going to make it better that way. She has this issue with herself and agenda that she's gonna go out and make the world better cause she finally learned what 'better' is to her.

Boundary problems are, of course, an ongoing issue that professional staff also have to manage. But formal education presumably provides the analytical skills to help a home visitor identify and grapple with boundary issues. A program manager explains:

I think that the main thing that I see in the professional...is on boundary issues. The professional, being that they've had the schooling, that really helps them in determining where [are] my limits, where are my boundaries--I can't be their best friend, I can't be their mother. I can't take them here and there and everywhere, and I can't take them in my house and feed them. It really helps because I saw the difference hiring a paraprofessional who wanted to coddle, take them home, drive them in her car.

The issue of establishing boundaries, however, is a complicated one in a paraprofessional home visiting program. In some ways the problem extends beyond formal education and analytical skills, and is rooted in the structural organization of the program. Hiring home visitors who are valued because they live in the community and share experiences and culture with participating families is likely to foster problems with establishing boundaries. A program manager explained, "But sometimes I think that we set them up, we are like okay the mentorship piece is so important, and being a peer, and being quite similar, and all that good stuff. But then, they get caught in the boundaries that we're talking about." A program supervisor explains the problem FSWs face by virtue of living in the same community as their families:

What we've found... is that our family support workers who work in [the city] and live in [the city] are continually struggling with telling families not to call them at home because they're listed in the [phone]book...One worker said, "I changed my McDonald's three

times. There's nowhere else to go," because the family members are typically working there. Or how many times in the grocery store she's stopped. So I think it's very difficult coming from a very specific community and...forming friendships with these women and still trying to maintain that, "I'm not their friend." [They say], "I'm not their friend, I'm their what?"

In a focus group, a program supervisor not only pointed out that the struggle with establishing boundaries is inherent in the organizational structure of the program, but she went on to defend the program's emphasis upon making connections with family members even if it results in boundary crossing. She argues:

I am amazed at how a mom—she may not have ever had that nurturing, trusting relationship with another person on the planet, and...their self esteem for instance is so worn by the time you get them that they have none. I think our biggest role is to help them have a connection with a human being—someone they can rely on and who can teach them that the world is not all negative and bad. So, in return, what will happen is then they have a really better chance of helping their child through a life....I've been doing this since we started four years ago and it's incredibly interesting how that some of the young moms have really been taught to become mothers under their circumstances. That's what I think the connection is [about], that's what I think Healthy Families is, and if they have to be friends, well, they need to be friends, and we'll have to deal with those boundaries.

Thus, the difficulties of establishing boundaries need to be understood within the context of the program. A paraprofessional home visiting program places much emphasis on making connections with families, on hiring home visitors who can identify and empathize with families' struggles, and on facilitating a mentoring relationship between the FSW and the mother. Program protocols then require the FSW to identify and to establish professional boundaries when working with vulnerable families. This is a difficult skill to develop, especially in this context. In some ways, FSWs are expected to be both a mentor/friend whose understanding of the community and of the families' struggles provides them with a unique capacity for engaging the family and, at the same time, a professional who can distance themselves from the family member, avoid becoming drawn into their personal problems and maintain a focus on a parenting curriculum. Managing both closeness and distance is a difficult skill to develop, especially in the context of working with vulnerable families. When this fails to happen, or when FSWs struggle with these expectations, supervisory staff identify poor analytical skills as the problem. Certainly, learning to perform in this seemingly contradictory role will require analytical skills that are often associated with professional training. But, as we discuss in the next section, developing the skills necessary to professionalize the relationship with vulnerable families also requires a willingness on the part of home visitors, an issue which is itself more complicated than one might expect.

The other issue that supervisory staff associate with limited analytical skills is the difficulty that

FSWs have in identifying problems in the home. The significance of this issue was discussed by program managers during a focus group. But understanding where the problem lies is, once again, complicated. Many of the program managers believe that a lack of education and training prevents frontline workers from identifying problems--from seeing problematic family dynamics, poor parenting styles or patterns of neglect. Others feel that the problem is associated with different thresholds of tolerance. Since many of the FSWs from low-income communities struggle with similar problems in their own families, they may not hold the same beliefs about what constitutes a problem as their supervisors. They may be more tolerant of problems, or have a higher threshold for what constitutes a problem. This could apply to relationship problems that might affect the welfare of the child or to methods of discipline used by the mother. FSWs and their supervisors may view the seriousness of these problems differently.

The Healthy Families model attempts to deal with this issue through supervision. FSWs meet with their supervisors weekly to discuss their cases. Supervisors play an educational role by discussing family problems with the FSWs and teaching them to define and respond to problems as they occur. For the paraprofessional model to function effectively, supervision is vital. The frustration that many supervisors experience, however, is that they rely on FSWs to share with them what is going on in the homes. If a FSW fails to identify problems in the home, then the supervisor does not have an opportunity to develop strategies for addressing the problem. But again, it is not clear where the problem lies. Poor analytical skills or differing thresholds of tolerance may explain it, or the problem may lie with poor communication and documentation skills. All of the supervisory staff identified poor writing and documentation skills as problems among their frontline workers. FSWs are required to document their home visits, but as one program manager commented: "Their notes are so poor that when I go back and look at them and say what did you really do here and they tell me, it's different than what they wrote."

A program supervisor commented:

...documentation is something they hate. They're very good speakers; they're very good social people. They can open anybody up and that is their strength. They're very social, very friendly. Working with different, defensive, resistant people, they get in, where another clinical person wouldn't stand a chance. They just have that gift. The weakness that I see is when you get down to written work. When you get down to really documenting what you've done. And that's a real weakness.

Poor documentation of family visits can be a frustration for supervisors, but these expectations can create anxiety among frontline workers as well. FSWs, praised for their abilities to connect with family members, can feel anxious or inadequate if they are unable to effectively communicate their observations to supervisory staff. They can feel inordinate job pressure if they have not been well prepared to meet the more professional demands of the job, including identifying and communicating family problems and issues. A supervisor observed, "There's also that feeling of frustration that I sense from them that they're expected to do this role that they feel they don't have the formal education to do." Another program supervisor expounded

on her own experience:

She didn't have that educational background....and because she very much wants to meet the standards of the program, she's always worried about that. Paperwork can overwhelm her and the writing very much so. I had a discussion with her yesterday in supervision. I said, "you know, the last week I've been worried about you." She lost her smile and her "umph" and she said she had headaches. And I really thought she was getting burned out from home visiting. She said not at all. She loves her families, she loves the work. The paperwork coming back from a visit started to overwhelm her....That's what I need to teach her.

Thus, the problem of not communicating family problems, dynamics or issues to supervisory staff may be related to poor analytical skills in identifying problems, different thresholds of tolerance in defining what a problem is or to limited documentation or communication skills. In addition, the problem could also be related to the FSWs unwillingness to communicate family problems or issues to supervisory staff. The willingness of staff to share information about the family is related to the extent to which they "buy-into" the program's philosophy, goals and methods, to the quality of their relationships with supervisory staff, to the degree to which they feel the need to protect their families, or to their general mistrust of the program and the helping professions at large. We expand on the issue of FSW's *willingness* to comply with Health Families protocols and to share information with supervisors in the next section. But clearly, the concern about limited analytical skills among supervisory staff is a multifaceted issue.

Even though the data suggest that program sites are hiring more credentialed workers, there remains a commitment among managerial staff to hire support workers who have the personal skills and experience to engage and develop trusting relationships with family members. These skills remain paramount in hiring practices, irrespective of whether the support worker has a formal education or not. Managerial staff are looking for the "right person" who can engage families and who can become, as one manager described, "baby experts." But all of the programs are paying more attention to writing and analytical skills when they hire. Some require writing samples, others spend time in the interview session carefully assessing communication skills. They are all looking for some indication of professional ambition—whether the candidate for the job is pursuing a degree, has worked in other human service programs or plans to develop a career in the helping professions. The trend in hiring that we found in our quantitative data was confirmed, though qualified, in our interviews and focus groups. Whether staff have professional credentials is less important than whether they have professional ambitions along with the personal qualities and experience to connect with families.

Moreover, many of the managerial staff have been quite satisfied with the development of their non-credentialed support workers. Many FSWs have matured, completed degrees, learned how to establish boundaries, become "baby experts" and respected community workers, learned the networks of services available in the community, and learned to identify and communicate family problems better. Furthermore, many of the supervisory staff have learned much about the communities they are serving from paraprofessional staff as well as ways of changing program

services to better meet the needs of families. In one interesting exchange in a focus group, a program manager explained how she had learned about the value of the parenting curriculum from her FSWs:

But in talking about the curriculum, that's exactly when you need to be using this curriculum—when the crises [in the family] are just going on and on and on. I didn't determine that, the family support workers determined it, that basically [the curriculum] is what you come back to. And I think that's what helps when you look at all the problems that [families] have, you see that they're not taking it out on the kid's life, that is [what the curriculum does]. [Group facilitator: The home visitors taught you that?] Yeah. [Group facilitator: Do you think that your home visitors came to that conclusion.] None of these ideas came from me, none of them!

For FSWs to progress, especially non-credentialed FSWs, good supervision is essential. This becomes apparent in the next section, where we propose what we believe is the ideal trajectory for the development of FSWs in a home visitation program for vulnerable families.

From Marginality to Bicultural Competence

In 1998, we began an ethnographic study of service delivery at HFC program sites.⁶ By the summer of 2000, three trained field researchers had conducted ethnographies at seven program sites. Time at the sites varied from approximately three months at one to as much as one year at another, with an average of six months per site. In an effort to understand the program as FSWs experience it, the ethnographers "shadowed" FSWs in virtually all aspects of their jobs. Our ethnographers observed the staff dynamics in the office, accompanied FSWs on home visits and discussed these visits with the home visitors afterwards, observed supervisory sessions, staff meetings and Healthy Families trainings, attended both formally sponsored and informal events, and, in some cases, met with home visitors in more relaxed settings outside of work to discuss their perspectives on the program. Our ethnographers took copious field notes recording their observations and discussions with FSWs and supervisors. They also met regularly with members of the evaluation team to discuss their observations and experiences and to plan subsequent field research activities. From these field experiences, as well as individual interviews and focus groups with FSWs, we have developed a model that we believe the program should promote for support workers to develop into effective home visitors and for the program to function most effectively. *This model involves moving the FSW from a position of marginality within the program to one of bicultural competence, and eventually to the role of cultural broker.* Let's examine the first part of this process: moving from marginality to bicultural competence.

Marginality is often referred to as one's position on the border of two different cultural worlds.

⁶Ethnographic studies take place in the natural environment in which interaction occurs. It is an attempt to understand the meanings that are attributed to the situations in which interaction occurs by those who are participants in it. In other words, ethnographers strive to see and then portray events and behaviors as they actually unfold.

This is an experience shared by members of recent immigrant ethnic groups, whose identities are often derived from the influences of their traditional ethnic group, as well as by the accommodations they make to mainstream culture. Often, the marginal individual, while engaging in frequent and sustained primary contacts in both of those cultural worlds, feels as if he or she is fully a member of neither. The process of assimilation occurs when immigrants gain access to institutional networks and acquire social capital. It is this process that sometimes enables immigrants to use their marginality as a route to bicultural competence. The marginal status of paraprofessionals offers a somewhat analogous route to bicultural competence.

The marginality of the paraprofessional role in Healthy Families is actually crucial to the ability of FSWs to provide effective interventions. But such marginality needs to be managed in order for paraprofessionals to become biculturally competent, and thereby proficient in their role as home visitor. FSWs operate at the border of two distinct cultural worlds with different prescribed roles. The paraprofessional in a community-based social service program must balance the demands of professional culture with those of community culture. The role expectations of professional culture stress the need to maintain objectivity and emotional distance from clients in order to establish an authority based on expertise, educational training, and credentials. The role expectations of the community culture to which the paraprofessionals remain attached offer an alternate route to authority. As an "insider" member of the community, FSWs can achieve an authority derived from trust. Trust evolves from empathy wherein clients perceive that you've "walked in their shoes," faced their problems, succeeded and consequently can mentor them through difficult circumstances. As we indicated in the previous section, these qualities are highly valued in home visitors and are central to a paraprofessional home visiting model. As one FSW remarked:

I honestly feel that this is something that you have to have somewhat lived through it or have experienced it to really understand it. Because a lot of time (professionals) say, "oh, how can they not have any motivation to go to school? How can they not want to better their future for their kid?" And I can relate because I didn't go back to school until I had my second child. Before that, I had no motivation. I was kind of stuck. And they don't see that because they didn't go through that.

Paraprofessionals have the opportunity to establish rapport with clients as trusted confidants and mentors that their professional supervisors, seen primarily as formal authority figures, are unlikely to achieve. An experienced FSW put it this way:

If you don't know the community, you don't know what people go through from day to day, to make it through one day. But if you're there, you can see it with your own eyes... you see what people go through, you see how frustrated they can be, you see what they achieve. You know, I just engage them. I don't even know how I do it. I just connect with them. Sometimes I have to go over to the hospital and present the program and they have social workers over there that will tell them a little about the program and then we'll come in and present the program. And they feel a little leery about accepting the program when it's introduced by a social worker as opposed to when I come in. I had a

family tell me once, "wow, now that you come in, we want to consider listening to what the program's about. What that other lady was saying, I don't think we want that." So it really depends who's presenting it and how you present it. It really makes a difference.

FSWs can use their community cultural capital to gain access, to engage family members and to become role models for young vulnerable mothers. A young FSW describes this opportunity to connect:

Well, first of all, I really think that me being a teenage mother has a lot to do with what I can offer my moms, because I'm not just bringing them information--look, researchers say this and that. I can say to her, you know I made it. I was also a teenage mother, I had one child after another. I know how difficult it is for you to do this and this and that. I made it--you can definitely make it. So I think that helps a lot for the moms to know that I went through very similar issues that they are going through.

To maximize effectiveness with clients, paraprofessionals must learn to "finesse" the boundaries between their dual roles of "outsider" professional and "insider" mentor. Learning how to set permeable boundaries is one of the skills essential to becoming biculturally competent. "Finessing" boundaries is best accomplished by keeping the boundaries elastic rather than rigid, and in the background rather than the foreground of interactions with clients. If the boundaries are fluid, they can expand or contract to accommodate the movement of paraprofessionals into the appropriate role for the circumstances encountered. Both client and paraprofessional should be aware that they are not simply friends, but participants in a more formal and instrumental relationship. Only if and when the client fails to respect that boundary in her behavior or expectations will the existence of the boundary be gently acknowledged by the biculturally competent paraprofessional. How adroitly the paraprofessionals manage to walk that "tightrope" between outsider and insider is crucial to the effective delivery of service. In our ethnography, several experienced paraprofessionals demonstrated this ability. When appropriate to the situation, biculturally competent FSWs assume the insider role and exert influence derived from trust, emotional connection, and shared life experiences. But when it is called for, the biculturally competent paraprofessional, because of her training, knowledge, and expertise, can also assume the outsider role to invoke authority and encourage compliance on certain important issues.

Learning to be biculturally competent and to manage marginality exacts a substantial toll in terms of job stress. Even the experienced, biculturally competent paraprofessionals struggle with the ambiguity that their role in the program creates. One said:

A lot of our clients become very comfortable with us, like I told you, and from time to time there have been times where I've had to say, you know that's not a good situation and this is what can happen and I have to explain my role to them over again. Because they tend to see you--that this person is there for me and they're very comfortable talking and *they forget that there's an office behind us and that there's rules*. For example, I've had moms that wanted me to be the godmother of their baby. And they don't understand

why we're saying no. They don't understand why that should be a rule.

The role of being part-friend and part-professional requires vigilance and tending, as illustrated by this comment:

Every once in a while I remind them what I'm there to do. Because after a while, they tend to see you as a friend, as part of the family. Which is good, but at the same time, you have to remember to draw that line. I'm here to work with you, not just to sit here and listen to what you have to say.

We cannot overemphasize the difficulty and complexity of the task of “bridging cultures” between community and professional cultures. It demands diligence and sensitivity from both the paraprofessional and supervisor, as they attempt to forge a connection across the same racial, ethnic and social class chasms that continue to divide the wider society.

“Bridging Cultures”: From Biculturalism to the Role of Cultural Broker

“Bridging cultures” is a metaphor that needs to be elaborated. Too often, the process of service delivery seems to involve efforts aimed at adapting disenfranchised families to the routines and values of a middle class lifestyle without adequate awareness of the broader social context and dynamics that make such an outcome highly unlikely. Subsequently, when intervention programs fail to achieve that outcome, they are denigrated as well-intentioned, but ill-conceived, liberal efforts. If we are to learn from our failures, then we need to more closely examine the social contexts in which these interventions take place, or in this case, the social dynamics that paraprofessionals confront as home visitors. The success of implementing a paraprofessional model depends upon understanding these social dynamics.

First and foremost, paraprofessional home visitors are not simply working with individual families, but with families enmeshed in social structures that severely limit options. The historical dynamics of urban economic and political isolation are manifest in the lives of many families they serve. Further, as Robert Halpern (1993:159) reminds us, "services are strongly shaped by and are reflective of the ideals, tensions, contradictions, ambiguities, and myths of the society in which they are embedded."⁷ Paraprofessionals don't simply straddle cultures, they employ intervention strategies rooted in historically and culturally-shaped responses to poverty problems that seek to change individual families more than the social circumstances in which they live.

Paraprofessional home visitors work on the frontlines; on a daily basis, they battle the gamut of emotional reactions to conditions of deprivation--anger, shame, denial, depression, and bitterness. They engage first hand the shattered lives of women who are prisoners of domestic violence, victims of sexual abuse or child abuse themselves, and who often desperately cling to

⁷Robert Halpern (1993) The Societal Context of Home Visiting and Related Services to Address Poverty. *The Future of Children* 3(3), 159.

their own ideals of motherhood as their last vestige of self-value. They enter the chaotic lives of families who scramble to find adequate income, housing and food, and into the homes of people whose lives are organized around an often fruitless search for respect and acceptance. Paraprofessionals don't merely engage families through empathy and trust, they often become their allies in a world in which they are largely misunderstood, ignored and disrespected. They search for the right words to converse with professionals about the lives of their families, and the daily struggles they encounter. When professionals are able to distance themselves from the ideological lens that has shaped the human services and listen to the accounts of their paraprofessionals, the gulf between the two cultures narrows. But when program managers, supervisors and researchers disregard the testimonies of paraprofessionals as over-identification or poor boundary setting, when they insist on redirecting the conversation to the program curriculum, to whether families have established and are pursuing goals, or to the various research measures and scales that need to be implemented, the gulf between community culture and professional culture widens. Moreover, when program and institutional authorities fail to acknowledge the limitations of support services, or when they fail to recognize that these program interventions are not panaceas for depressed communities, they tend to blame poor outcomes exclusively on the deficits of the community culture, or on frontline workers themselves.

In order to better understand why in some instances FSWs and their professional supervisors forge a productive alliance, while in others they remain separate and marginalized, we need to explore the promise and the reality of the paraprofessional role in Healthy Families. The ideal evolution of the FSW role would proceed as follows:

Marginality \Bicultural competence \Cultural broker

Marginality, as already explained, describes the original status of FSWs, straddling community culture and the culture of professionalism. Bicultural competence refers to a base of knowledge and set of abilities enabling the FSW to create a bridge between the culture of the community and the culture of professionalism. The bridge from community culture to professional culture involves FSWs establishing an empathic connection with community families, earning their trust, understanding their lives, and communicating their needs, desires, concerns, and difficulties to professional supervisors. Simultaneously, the bridge from professional culture back to community culture involves taking the knowledge, philosophies, and practices of the Healthy Families model of parenting back to community families by demonstrating its value, application, and relevance to their lives. When this process occurs, the FSW is indeed in the role of cultural broker, acting as the interpreter, facilitating genuinely reciprocal communication between two cultures in which this communication does not normally and naturally occur. Thus, we are arguing that bicultural competence is an ability, a set of skills and a base of knowledge. It includes both the understanding of community culture and professional culture, as well as the communication skills and facility to interpret the language and "ways" of each culture to the other. However, we hasten to add one caveat that we believe to be crucial to the successful transition of FSW to cultural broker. Bicultural competence appears to be a necessary but insufficient basis for a FSW to fully embrace the role of cultural broker. There must also be a

willingness to function in that capacity. The final step in the transition to cultural broker must include FSW willingness to serve in that role. Consequently, Healthy Families should endeavor to develop not only the ability of FSWs to function in that capacity, but also their willingness to do so. With the concept of "willingness" so central to the transitional process of FSW to cultural broker, we will explain it in more detail.

"Willingness" evolves as a function of two complementary beliefs which may or may not develop in FSWs concerning the relationship between Healthy Families and their community. The first belief concerns the potential efficacy of professional culture as symbolized by the Healthy Families curriculum. Can the lives of community families be meaningfully improved by professional knowledge and practices? Do they genuinely have relevance and application to their community? If this belief is held, then it will facilitate FSW willingness to interpret, or "broker" professional culture to community culture. The second belief essential to generate FSW willingness to function as a cultural broker is the trust that professional culture, as represented by Healthy Families supervisors, is first and foremost committed to improving the lives of community families as their overarching goal. If this belief is held, then it will facilitate FSW willingness to interpret, or "broker" community culture back to professional culture. To the extent that either of these beliefs is not accepted, the full circle of reciprocal, "brokered" communication between the FSW and her supervisors will not be complete. The absence of the first belief makes the FSWs reticent to interpret professional cultural knowledge to community families as they doubt its value and relevance. Furthermore the absence of the second belief about the true motivations of professional culture casts the FSW into the role of protector of their families from the judgmental scrutiny of their supervisors. Certainly such an outcome will preclude FSW willingness to interpret, or "broker" community culture to professional culture.

In the following illustration, we identify site characteristics where we believe most FSWs have progressed from a position of marginality to one of cultural broker.

Illustration #1: Site Characteristics Where FSWs Function as Cultural Brokers

- < Professionalism, rather than viewed as a barrier to connecting with families, is embraced as essential to establish the appropriate boundaries between the FSW and family to facilitate a productive, working relationship.
- < FSWs accept the efficacy of the Healthy Families model and parenting curriculum to offer valuable guidance and assistance to families.
- < Consequently, there is a firm commitment on the part of FSWs to "do curriculum" or at least to focus a portion of home visits on parenting education. This

commitment is derived from the belief that the curriculum education is relevant and that it provides the most effective means to professionalize the FSW/family relationship.

- < FSWs trust that their professional supervisors genuinely share a deep concern for community families. Therefore FSWs can openly share impressions and information about families, secure in their belief that by doing so, they are helping, rather than betraying their community families.
- < While the initial bond with families is based almost exclusively on empathy, FSWs actively seek to make the transition toward a more professionalized role and relationship based on their knowledge and authority on parenting.
- < FSWs strive to achieve bicultural competence as paraprofessionals.
- < Bicultural competence comes to be combined with the willingness and desire to embrace the role of cultural broker as the FSWs believe both in the efficacy of the Healthy Families program and the commitment of their professional supervisors to improving the lives of community families as their foremost concern.

Conversely, in illustration #2, we identify site characteristics where most FSWs have *not* moved into the role of cultural broker.

Illustration #2: Site Characteristics Where FSWs do NOT Function as Cultural Brokers

- < Professionalism is rejected by FSWs as a viable role. It is seen as a barrier to forging meaningful connections to community families.
- < The Healthy Families model and curriculum is seen as irrelevant or even antithetical to the needs of community families. Consequently, it is for the most part ignored in home visits and can provide no means to professionalize the relationship and boundaries between the FSW and the family.
- < Without professional boundaries evolving, the FSW role that becomes dominant in relation to the family is friend/mentor. Furthermore, this friendship bond is likely to reflect not just empathy, but a shared mistrust, suspicion of the intentions of professional authority and the procedures of bureaucratic structures.
- < When the FSW alliance with her families and community casts the Healthy Families program into the role of "outsider," bicultural competence will not be sought and genuinely reciprocal communication will not be achieved.
- < Mistrust and alienation will make the FSW unable and/or unwilling to interpret,

or "broker" professional culture to community culture, as she doubts its efficacy, and the mistrust and alienation will simultaneously make her unwilling to interpret, or "broker" community culture to professional culture, as she seeks to protect her families from the negative judgment of professional authority.

< FSWs remain in the marginalized status in which they began and in a role far less conducive to achieving program goals than that of cultural broker.

While individual families might derive some benefit from a mentor relationship with a FSW, this relationship, by itself, does not represent the intended Healthy Families intervention. It is our firm belief that while paraprofessional marginality is at the core of the paraprofessional model, it is so only as a starting point for FSWs--not as an end product. Unless FSWs develop the bicultural competence to pursue the transition to the role of cultural broker, the program will become mired in an unproductive stalemate, whether detached or adversarial in nature. Having compared site characteristics relevant to the transitional process to cultural broker, the next issue we will address concerns how the Healthy Families program might best facilitate this process.

Managing Paraprofessional Home Visiting Services

The paraprofessional model is not an easy one to implement. There are many lessons that we have learned from program staff who have struggled with these program dynamics. In this section, we identify some of the difficulties that staff confront as well as the lessons learned, and make a series of recommendations for program staff to consider. This section is divided into two parts, beginning with a section on working with multi-problem families and ending with a discussion of the art of supervision.

The Challenge of Working with Multi-problem Families

Perhaps no problem plagues the human services more these days than working with multi-problem families within a service system in which services and funding have become fragmented and increasingly categorical (and therefore more narrowly defined). In a paraprofessional home visiting program designed to promote positive parenting and to reduce child abuse and neglect, the saliency of this issue threatens the foundation of program services. Working with multi-problem families requires well-organized networks of services, including collaborative working relationships between state agencies, the courts, community service agencies, neighborhood groups and the schools. When these networks fail to materialize, the resulting burdens fall on the shoulders of frontline workers. They are confronted with the day to day struggles of vulnerable families and are pulled in a multitude of directions as they and their supervisors seek some pattern of coherent service delivery. Of course, these issues are more apparent in communities suffering from concentrated poverty, racial and ethnic segregation and social isolation.

Home visitors confronted with on-going crises are pulled into the orbits of family struggles that require of them much more than they were prepared for by either their job descriptions or their training. These circumstances hone their skills as home visiting *generalists*--they need to be

prepared for anything. They deal with landlord disputes, negotiate problems with school authorities, help mothers understand changing welfare regulations, intervene in family conflicts, tend to mothers who have been battered by partners, find housing for mothers who are thrown out of their homes by landlords, family members or partners, accompany family members to court, confront substance abuse in the family or drug dealing in the home or neighborhood, nurture depressed mothers or advise mentally challenged mothers, and much more. In many instances, FSWs feel as if their daily struggles with their families are not appreciated or understood as supervisory staff attempt to narrow the scope of their involvement with the families, emphasize the imperative of structuring home visits around a parenting curriculum, or demand that paperwork stay up-to-date. Consider the following quote from a FSW:

I feel that we have a role description and we do *way* more than what's written. I mean, I've gone into homes and I've taken out lice from hair. I've sat there and I've untangled hair so that the maternal grandmother will stop focusing and putting down this mom for having this huge knot in her hair. I mean, we go in there and we do a lot of things that is not in our job description. Why can't the supervisors also be that way? You know, why do they look at you like you're asking for something out of this world when you say, can I do this or can I help them with this and they give you that look like, are you crazy? Why can't they see things the way we see things? That sometimes, you know, you have to go out of your real [job] description in order to help these families.

The following field note provides a glimpse into the world of some of the HFC families. Consider how realistic it would be for a FSW to conduct a curriculum-based home visit with this mom at this time:

For awhile all I notice is how “hard” she appears. She engages in hand motions like that of a young hip-hopping male, waving her hands in the air and seemingly grabbing her crotch area, and using her hands and her body to accompany her telling of her story. I only hear bits and pieces of the conversation from where I am sitting in the car. She talks mainly about the fight she and her friend had last night. She maced him, used her metal baseball bat to hit him once he was down, she kicked him and of course cursed him out. I see her explaining to [her FSW] the marks on her neck and telling her that he tried to choke her. She explains to [the FSW] that she was, like, “hit me again motherfucker” and every time he hit her she “came back for his ass” (or fought back).

Supervisory staff expect that their home visitors will develop into *specialists*, that they will learn how to facilitate parent-child attachment despite the problems in the home, that they will learn how to instruct mothers in providing a safe and nurturing home environment, and that they will become adept at redirecting the visits to parent-child issues:

I think that there are families, a lot of families that we work with, that are continuously in crisis. If that's all the focus is every week all the time, they're never going to move on, and I think that's part of the whole [Healthy Families] philosophy, if you will, that we need to bring to the parent and empower them to move on. Because even though all of

these things are going on, you know, let's not forget about what's going on with your child.

Furthermore, supervisors are insistent that professionalizing the FSW-family relationship is an outgrowth of establishing the appropriate boundaries. "Doing curriculum" or at least focusing a portion of every visit on some facet of parenting education is the key to professionalizing the FSW role and relationship to the family. While they recognize that family crises are sometimes a constant, ongoing struggle for many impoverished families and consequently must be managed to some extent during home visits, they maintain nevertheless that these crises should not dominate the agenda of every visit. If professional boundaries have not been created, supervisory staff argue, the FSW will likely become so enmeshed in the quagmire of daily crises that she will lose touch with her intentions as a Healthy Families home visitor. As one supervisor observed:

What's being done in the home with the kids and the mom and teaching about basic principles?...Do 50 percent of [the visit] with the concrete stuff going on, but I still have to figure out a way to get 50 percent parent-child stuff in there. Because that's what really sets Healthy Families apart. We have got to concentrate on the importance of parent-child positive interaction. And that's real hard when you're wondering what you're going to feed this kid. It's real hard to be thinking about singing to him, reading books, playing, touching, massaging, all those other things....What makes us different is that we have that kid [to protect] so that you don't abuse and neglect that kid and that kid also feels loved and respected all his life. And if we miss that part, I don't think we're doing our job. That, I think is really important.

Another supervisor describes how the curriculum can be used despite on-going crises in the family:

...if we're just focusing on the crisis all the time, then we're not breaking cycles and changing patterns....So, I guess, our feeling is that we do want to bring [the curriculum] into the visit, even if it's a difficult situation...We have a mom, you know, with tons of issues but she reads everything the home visitor gives her and she has questions for the next time regardless of the fact that, you know, she hasn't paid her rent in six months and the father of the baby is crack addicted and now in jail and has, you know, physically abused her several times during her pregnancy...But, you know, she really has connected with the home visitor and really does do the parent-child activities. She does find time for it in all the chaos. So, we're doing something right. I think that's really a success story. I think that's what Healthy Families really is.

The theme echoed by virtually all supervisors is that unless the initial connection between FSW and family is nurtured into a working relationship focused on parent training, then FSWs will not be fulfilling the primary responsibility of their job in the Healthy Families program. One supervisor summed it up this way:

That's how I always think of Healthy Families -- that we're trying to prevent that cycle of child abuse and neglect. And if we're not educating the moms on the developmental stages of the child, when they come upon these stages with very little to no knowledge, there's a lot of frustration I think that could cause, you know, abuse and neglect. So, I think it's two-fold. Definitely the trust and the connection [is important] but I honestly believe [in the program]--which is why I say to them, I want that curriculum brought out every visit whether it's a good one or a bad one.

As is so often the case with a set of blueprints detailing how some process, ideally, ought to function, its application to the real world proves considerably more daunting. One FSW in response to a question about the necessity of "doing curriculum" at every home visit as demanded by her supervisor replied:

Believe me when my supervisor came out to some of my houses, they go, "oh, my god? How can you get anything done?" It actually does take bringing them along. I said to my supervisor, "it's like telling a hungry person how to get a job. Until you feed them, they don't want to hear anything about how to get a job." So until they're able to get off some of these things they need to talk about, they don't want to hear about a curriculum.

Perhaps the most powerful and troubling tension that many FSWs experience revolves around the basic parameters of their role as Healthy Families home visitors. Can they best serve their families within the prescribed boundaries of the program (their supervisors' perspective) or are those boundaries too constraining to do what needs to be done? This tension is structured within the need for the FSW to be both a generalist, as required by the multiple problems they often encounter within families, and a specialist, as required by focused program objectives to facilitate parent-child bonding, healthy child development and attentive parenting practices. One FSW seems to be struggling with just this tension, as she appears to be at the crossroads of choosing to fully adopt the cultural broker role or remaining a marginalized "free agent":

The curriculum should be based on the community of the people. What's gonna serve the people best? I'm not gonna say we got the best people in the world, but, I mean, they're giving. And I'm gonna be honest--35 to 45 percent of the time our home visitors do not cover curriculum. We have to put that down somewhere...because there's so many issues where these girls don't even have foundations. My clientele is what, 14 to 18 [years old]. We're worried about food--I have clients their mothers are incarcerated and the baby's father left them. They're living with the father of the baby's parents. They're not treating them right. How can I sit down and try, okay, let's do this curriculum? I'm trying to get you out of this house because I know you're not being treated right. You're collecting Social Security and they're taking half of your check and that's not including your meals. So, how am I supposed to sit down and talk about a curriculum when I know you have serious issues to consider before the curriculum. And then, once I get her out of that house and into a stable environment, then I can move on and...the two of us can play with the baby. There's always that but I can't sit down and say, "let's read this book" [when] I

know I gotta get you out of this house. We have to go to Housing, we gotta go to court, we gotta get you an education, and gotta do this, and we do that. So I think as far as the curriculum, itself, it should be based on the community. What serves the population better?

Clearly, the experiences of FSWs in the field reveal some of the difficulties of actually negotiating that successful transition from marginality to cultural broker. The nature of the FSW/supervisor relationship is a critical factor in promoting or inhibiting the transition. For many FSWs the Healthy Families program comes to be personified by the supervisors and program managers with whom they interact on a daily basis. The qualities, attributes, and deficits ascribed to the program by FSWs are often direct reflections of their view of their supervisors. When a positive, supportive relationship exists, FSWs are likely to extend the interpersonal trust earned by their supervisor to the full range of Healthy Families responsibilities, some of which they might ordinarily avoid or dismiss as irrelevant. One FSW comments on the trust that a new supervisor has acquired in contrast to a former supervisor:

Not to put the other supervisor that we had before down, but everything was like just oneway and one way only. And we were the ones that were out there getting to know these families and we come back and say, "This family needs this." "No, you can't do that. You're overstepping the line. You can't do this, you can't do that. This has to be this way and this way only." And she wasn't really like hearing what we were saying about what we were out there seeing with these families. Whereas, with the supervisor that we have now, we sit down, we tell [our supervisor] and [the supervisor] will say, "Well, you know the family better than I do. You know what's going on. You're out there every week. I'm gonna let you make that call. I'm gonna support you in whatever you do. If you feel this is best for this family, then this is what you need to do."

If FSWs feel listened to and heard by their supervisors, communication channels remain open and two-way. However, when they feel that their insights are ignored or not respected by their supervisors, communication channels shut down. Note the following examples of FSWs who have either completely withdrawn from supervisors or found ways to manage them, "cool them out," while they do what they believe needs to be done:

We've been there before where you feel that you're beating your head against the wall. You keep bringing up issues and you bring them up and you bring them up and nothing is done about it. You will see the family support workers get to the point where you shut down and even as a group you decide, you know what, we're not even gonna bother with this anymore because it's not worth it.

Another put it this way:

When it comes to our clients, our supervisors can't do anything that's gonna tell us not to do anything for our clients. Our clients are like our family whether [our supervisors]

want to accept it or not. And what my supervisor says to us, it means nothing, you know, because I'm gonna do what I'm gonna do because these are my people. I love them. And I feel the work that we do with them, they benefit from them, they do whatever we ask them to do, we compromise. I mean, for someone sitting up in the office to tell me what to do with my client, they don't know their personality, they don't know their demeanor. I may come in there one day I know off the bat if they got a bad day, so what I put down on my paper, if they can't understand it and want me to explain it, then that's their problem. Because if every person is totally different. Every community is different. The weave of the community is totally different. You cannot sit up in the office and say, this and this and this has to be done. You have to be out there. We don't, we haven't shut down but we have told our supervisor, "Look, we do a lot of things extra and above board. You don't want us to stop."

Other FSWs seem to doubt that their supervisors are genuinely committed to their clients as their foremost concern:

It's about getting in there and making the numbers look good. It's about if you have a visit and you don't see them today, go back tomorrow, call them, drop by--just get in that visit that same week because you gotta make sure you have a visit with the family so that the numbers are up there. You should have this amount of home visits this month and you actually have that amount of home visits that month. It's not about being sensitive to the families...

While the paraprofessional home visiting model is a difficult one to implement, we remain encouraged that it can be a vital strategy for working with vulnerable families. The challenge of defining the home visitor role within the parameters of being both a generalist and a specialist, of being both a mentor/friend and a "baby expert" must be systematically confronted. For this model to work, focus needs to remain on the struggles of frontline workers and program supervision.

We recommend that a committee be established to identify the protocols for conducting home visits. In the past four years, program sites have experimented with different parenting curricula and have supplemented and modified curricula to make it more appropriate for their communities or families. The results of these efforts--the lessons learned--should be identified and disseminated to the statewide Healthy Families community. In addition, a set of protocols or guidelines for conducting home visits needs to be established. How often should a parenting curriculum be used? Should it be central to home visits and to the program in general? What other types of services should home visitors be prepared to provide besides services focused on a parenting curriculum and how should these services be delivered? To answer these questions and to provide guidelines for home visitors, we believe it is important to consider the following:

§ *First, home visiting requires support workers to be both generalists and specialists. These differing orientations to the job need to be integrated in a meaningful and coherent way. This may require that the community orientation*

of many FSWs, that leads them both to develop and value the skills of the generalist, be understood as something distinct from the more narrowly defined program orientation held by supervisory staff that values the parenting and early childhood expertise of the home visitor. These different conceptions need to be openly discussed and examined in an effort to locate their relative importance within the scope of conducting home visits.

§ *Second, to facilitate the developmental process from marginality to cultural broker, FSW training, both at the outset and throughout employment, should be more pointedly focused on building trust in and allegiance to the overall Healthy Families philosophy of parenting and curriculum. If the focus remains only on knowledge, skills, and abilities, the willingness to fully adopt the role of cultural broker may not simply follow as a natural outcome. In predominantly minority communities, the marginality experienced by minority group FSWs may go beyond the community culture-professional culture divide encountered by all FSWs. Furthermore, the common life experiences that forge the empathic bond with community families may include some that have produced a deep mistrust of the efficacy and intentions of the programs and managers of white, middle class professional culture. As these issues, if left to fester, may produce an adversarial or detached stalemate, they must be acknowledged, addressed, and worked through by FSWs and supervisory staff. Of course this also requires that the philosophy, practices and curricula of Healthy Families be open to critique by both supervisory staff and frontline workers, otherwise it is less likely that support workers will “buy-into” the program. Presently, FSW willingness to fully assume the entire range of responsibilities of their role is often more a function of their particular relationship with a supervisor than a function of a their acceptance of Healthy Families’ philosophy, practices and expectations. Offering Healthy Families services to high-risk families in disenfranchised communities will require that frontline workers trust and believe in the philosophy and merits of the program. This can occur only when the underlying assumptions of the program and its strategies for implementation are open to critique.*

§ *The pleas for autonomy by FSWs resonate with the overall philosophy of “empowerment” stressed by Healthy Families as a desired outcome for clients. FSWs argue persuasively that just as Healthy Families seeks to empower families, supervisors similarly should empower FSWs to genuinely utilize their unique understandings of their communities. FSWs insist that Healthy Families should not be perceived as a fixed, predetermined entity to be imposed on a community. Rather it should be conceptualized as an evolving “work in progress” responsive to the culture and needs of a specific community, able to adapt and change as more is learned about the community from its FSWs. When such FSW knowledge does indeed play a significant role in constructing the reality of Healthy Families practices at specific sites, it serves the essential function of building and sustaining direct FSW allegiance to the entire program. If FSWs have reason to*

believe that they have participated in the evolution of the Healthy Families model to be taken to their community, then they more readily embrace it as their own. This sense of ownership provides a vital, final link in the chain to Healthy Families cultural broker. Despite the vexing difficulties that both FSWs and their supervisors will undoubtedly encounter in their joint efforts to turn marginalized FSWs into cultural brokers, we remain convinced that it is a viable means to providing needed parenting education to families in socially isolated communities.

The tension between the home visitor-as-generalist and the home visitor-as-specialist is inescapably embedded in the dynamics of the program and in the structure of the helping professions more generally. Of course, the more multi-problem families in a program, the more difficult this tension is to resolve. Programs with fewer multi-family problems have fewer problems focusing services on a parenting curriculum. Conversely, programs serving many multi-problem families find it difficult to keep home visiting services focused on a curriculum when recurring crises often demand immediate attention. The views of supervisory staff on this issue are the most widely communicated across program sites, to researchers and to the public, but frontline workers have to manage these tensions in their daily work. They are the observers of family problems and the ones who must respond to program demands, on one hand, and the demands and needs of their families on the other. Unlike supervisors and program managers who meet regularly to discuss program issues and problems, FSWs do not have institutional channels to communicate their concerns and struggles to statewide program leaders.

We recommend that a committee be established to develop organizational channels for FSWs to communicate perspectives on family needs and to participate in statewide decision-making. FSWs, along with FAWs, are the only staff who do not meet regularly with one another to discuss common issues and problems and to communicate these issues to statewide leaders. FSWs work on the frontlines and are therefore most familiar with the daily struggles of families. Their perspectives on families and on program services in meeting the needs of families are important and need to be available to program leaders. Moreover, FSWs are positioned to be advocates for families—to articulate their needs and to identify misguided policies or policy gaps—which can have important policy ramifications if supported by a statewide program structure.

As long as HFC is working with multi-problem families, there probably is not a simple prescription for entirely resolving the generalist-specialist tension. At the national Healthy Families conference in Atlanta, there was much discussion about whether multi-problem families are appropriate for a paraprofessional program, and whether services need to be augmented with focused professional services to address issues such as domestic violence, substance abuse and poor mental health among participating families. Similar discussions have ensued among the leadership of HFC. During a focus group with program managers the comment was made:

I don't know what it's like in other programs and we're new, but I think if you're constantly putting out fires and that's all you're doing, then maybe that family shouldn't have been in the program. You're not really providing that Healthy Families model or

service. You're a social worker or a mental health professional or a substance abuse counselor if you start dealing with those issues. You're not a Family Support Worker providing HF services. That's my feeling.

Last year, a bill was introduced before the state legislature to fund a professional position at each HFC site to provide and coordinate treatment for extremely high-risk families. Even though the bill was eventually tabled, the discussion on how to deal with extremely high-risk families needs to continue, which is evidenced by one of the more pertinent findings in our outcome study completed last year. Among the 667 families who received HFC services between July 1, 1998 and June 30, 1999, there was only one substantiated case of physical abuse during their participation in the program. Instead, the majority of substantiated cases involved emotional and physical neglect. For emotional neglect cases (43% of HFC cases), nearly one-third of cases involved drugs and nearly two-thirds domestic violence. HFC has been very successful in identifying a high-risk population, but the large number of multi-problem families that this includes strains the capability of a paraprofessional program to meet the needs and demands of such a burdened population.

We recommend that a committee be established to develop strategies for addressing several challenges to delivering effective home visiting services, including working with families in which substance abuse, domestic violence or poor mental health is prevalent. While these issues should be the priority of the committee, there are other challenges that the committee may want to consider as well. As families remain in the program beyond the first year of a child's life, many mothers take jobs in the workforce. This decreases the availability of mothers for services, poses challenges to scheduling home visits and requires more flexibility on the part of program sites—and in some cases more flexibility than a parent agency is willing to make. Further, with increased employment among mothers, child care needs are becoming paramount. Program responses to the quality of child care options might be considered, including the availability of licensed child care facilities and the use of family members, friends or unlicensed day care programs, and whether these arrangements provide care that is consistent with the objectives of the Healthy Families program.

The Art of Supervision

Much of our analysis thus far has focused on the role of the home visitor and especially the process of becoming a cultural broker. Focusing on frontline work is essential to developing supportive services for vulnerable families. But providing useful home visiting services and facilitating a process for FSWs to become cultural brokers cannot happen without effective, sensitive supervision. The role of the supervisor is vital to the success of the program. Most of the program sites employ a supervisor who directly oversees the work of FSWs, even though some sites leave this responsibility to the program manager and choose not to hire a supervisor. The ongoing attention given to the home visitor and the family can result in a tendency to neglect the significance and the difficulty of the supervisory role. A program manager commented during a focus group:

I don't know if it's neglecting supervision or neglecting supervisors. Because I know...with [a previous supervisor] , she found it very isolating being the supervisor and [she did not get] a lot of support and...before she left she just was struggling with the issue—is she failing or is it the model. And she met with everybody's supervisor and really felt validated that other supervisors had the exact same perception. And when you think of all the attention that's put on the FSWs and the two hours a week of supervision, and make sure that they get the wrap around training, and yadda, yadda, yadda, and keep low caseloads, and then you step back and look at your supervisor who's responsible for *sixty* families and doesn't have the same support...it leaves them really kind of feeling overwhelmed and isolated...you know, everyone's on their best behavior talking about all the strengths of the program and never talking about the real issues of the day-to-day challenges of supervising paraprofessionals, being responsible for sixty high-risk, high-need families!

By now, the difficulty of the supervisor's role should come as no surprise. Indeed, as the program manager above indicated, the supervisor is responsible for services provided to a large number of high-risk families. She is also responsible for managing the development of family support workers, many of whom are non-credentialed staff embarking on their first job with professional expectations. The problems of working with non-credentialed home visitors discussed earlier in the report—limited analytical skills, poor boundary setting, poor writing and communication skills, limited to no work experience in a professional setting, high thresholds of tolerance for family problems—must be addressed by supervisors. In addition, as our ethnography indicates, the willingness of the FSWs to “buy-into” the program's philosophy, goals, and practices is largely based upon their relationships with supervisors. In other words, the problems of the paraprofessional model identified in the bulk of this report are managed by the direct supervisor, and when the relationship between supervisor and FSW is constructive, grounded in mutual respect and viewed as a shared effort to effectively address family problems, the likelihood that the FSW will develop into a cultural broker is greatly enhanced. When this relationship is not well established, an unproductive stalemate is likely to occur. The supervisor has to balance multiple roles of being, at times, an educator, who teaches FSWs about parent-child interaction, child development, family systems and child attachment, and mother-child health issues; a boss, who makes sure that proper documentation occurs, that program rules and norms are followed, that paperwork is done on time; and a counselor, who encourages FSWs to discuss how their own personal issues may be affecting their work with families. She also needs to be a master strategist, who works with the FSW to develop strategies for addressing the unique challenges that each family presents.

Supervisors meet with FSWs two hours each week to discuss their cases. Often, they also meet as a group for case presentation and group discussion. But many supervisors have found that these methods fall short of effective supervision and have added home supervision to the process, where supervisors, on a rotating basis, accompany FSWs on home visits. The addition of home supervision grew largely out of the frustrations that supervisors felt in attempting to acquire needed information about families from their FSWs. Whether due to poorly documented

home visitation logs, limited communication skills, poor diagnosis of family problems or an unwillingness to share information about a family, supervisors found themselves too much in the dark about families and the intervention. Home supervision was an attempt to overcome some of these problems. A supervisor explained:

This is where I think Healthy Families [America] was a little bit short sighted, because when we did the supervision model, I purposely put in home visits—that the supervisor would go out on home visits, and not just when they need to but every month....That’s the only way you’re going to know. It was just recently that I went out with a family support worker and I was stunned. When I went in the home she was reading the wrong month [in the curriculum] and then we went to another home and she was using an activity that was a newborn activity with a five-month old. So you need to address it right then and there.

Given the central importance of the supervisory role in making the paraprofessional model effective and the extensive work this involves, it would seem imperative that more attention be given to it. The core national training devotes very little time to the supervisor’s role, focusing instead on risk assessment and home visiting. The consensus among program managers on this issue is reflected by the following:

[We need to] refocus on the supervisors. [At the national core training] they do program manager intro kind of stuff and then focus on the assessment and family support worker. There’s not a lot for supervisors so [changing] that could definitely be beneficial, to at least prepare them that these are the challenges you will face using a paraprofessional model.

A few years ago, a training for HFC supervisors was conducted by Caroline Wisehart from Superkids, a group of human service trainers. The training was viewed as a huge success, largely because it validated and aired the issues that too many supervisors were struggling with in silence. Interviews with supervisory staff indicated that supervisors returned from the training rejuvenated and brimming with new ideas. One supervisor explained:

Oh my god! This was like—this is what I needed from day one! The other training was like “Okay, yes we know people need supervision”...But this last training was such an eye opener for me. I think I can say to you, “God, I was doing it all wrong!” I need a better way of doing this and I came back thinking, you know, just test different ways of doing it.

Another commented:

Since then we’ve had supervisory training. In fact we just had one. It was excellent. What she did—Caroline Wisehart—she reviewed many of the things with the supervisors that she wanted to get sifted down to the family support workers. She talked about things like ownership and responsibility so that the workers feel that they want to make those

visits every month.

A program manager also identified the importance of this training:

Our supervisor went to advanced training, I think last spring, and it was marvelous for her. She came back with so much enthusiasm—different ideas, different tactics, and, yes, we [Healthy Families] should've done that sooner.

What was striking about the training was not merely how supervisors felt renewed nor even how practices changed—and indeed many programs altered their supervision practices—but how starved supervisors were for ideas and direction. The training revealed the program's neglect of the supervisor's role and their development. It underscored their isolation and their lack of preparation for managing paraprofessional frontline workers.

In addition to this training, a supervisor's group was also established in Connecticut. They meet monthly to discuss issues unique to their role as supervisors. For many, these meetings are helpful—they validate the supervisor's struggles and provide a venue for exchanging ideas. But the meetings can also produce anxieties:

[The meetings] have been very helpful. Jeannie Beck came to the first meeting, it was held at Wheeler. And then she bowed out saying OK this is just [for supervisors]...We just want to get together as supervisors. A lot of venting went on...and I felt that I could bring to that group anything I wanted, [but] I didn't a lot of times. A lot of times...listening to everybody...I'd get nervous...and I'd bring it back to [the program manager] and I'd say, you know, they're doing supervision this way or they're doing this, this way. Do you think we ought to be doing it? Because in the back of my head, I was always fearful of Healthy Families saying to us, "you're not doing it right." But for the most part, the exchanges were helpful.

Prevent Child Abuse Connecticut provides training and technical support to supervisors as well. The support from PCA-CT is highly valued by virtually all supervisory staff, but as the program has grown and as credentialing has become a statewide preoccupation, less time is available for supervisor support. As one program supervisor put it: "We need more Jeannie's" referring to one of PCA-CT's highly skilled staff members. PCA-CT added a new staff member in January of 2000, Peg Coffey, to help with training and technical support, but with increasing demands upon their time and the addition of new programs sites, it is unlikely that they can provide supervisors with the full attention that their role in the program demands.

While the interaction between the FSW and the family member is at the heart of the program, the FSW's relationship with her supervisor can powerfully influence the nature of that frontline interaction. As we have seen, the FSW's development as a professional, her education as a "baby expert," her knowledge of community services, and her understanding of family dynamics will come largely from her relationship with her supervisor. Moreover, her *willingness* to deliver Healthy Families services that focus on parent-child dynamics and child development will also

be largely shaped by this relationship. But similarly, supervisors' understanding of the community and the families they serve depends, in part, upon their willingness to learn from their FSWs. Information and learning need to flow in both directions for this model to work. Just as FSWs must learn to straddle community and professional culture, so must supervisors, for they too must establish and maintain the bridge between cultures and figure out how to apply the program to the community and family contexts in which home visits occur. They are likely better versed in program philosophy, and in professional culture more generally, than they are in community culture, and therefore must rely on FSWs to learn more about this. Many of the supervisory staff discussed the educational value of their relationships with FSWs. One supervisor commented on how doing home visits with her FSWs enhances her relationship with them, reduces the racial and ethnic distance between them and allows her to learn from them:

But I think the black community, the Hispanic community, you can sense it when you go out there...you can sense with the people, like, this is someone different and I think [paraprofessionals] have taught me, they've opened me up a lot that your clinical skills, you can't use those entirely out in the community, to be successful you need to adapt to that culture...I think to work with paraprofessionals you can't be that formal, clinical person...you have to be very free. You have to be able to say, "Yeah, that's okay. You are teaching me by the dictionary of street language. And I take it very seriously." I say, "well, I don't know it, so you guys have to help me." They take pleasure in that...It breaks down the barriers...And they'll accept what I'm trying to teach them to a degree. They'll open themselves to it because I opened myself...But that will only happen after they've sized you up and said, "yeah we trust you."

Despite the importance of direct supervision in fostering an effective service model for home visiting, the amount of time that is given to this task varies considerably across sites. As we alluded to earlier, at some program sites the supervisory role is performed by the program manager, who already has many demands on her time as the program coordinator. Of the 12 sites that we studied in 1999-2000, six employed supervisors and only four as full-time positions. Furthermore, when we examined supervisor's program responsibilities, the range of expectations was daunting. In addition to the multiple roles identified above that they perform in managing a paraprofessional model (teacher, boss, counselor, master strategist), supervisors may also be expected to prepare for credentialing, meet the research needs of the evaluation, reorganize data collection to meet the protocols of the nationwide Program Information Management System (PIMS), meet administrative responsibilities (approve time-off, oversee staff hours and vacations, hire new staff, etc), write grants, sit on advisory boards, write quarterly reports and do assessments. The central importance of the supervisor's role in delivering effective home visiting services is, in our view, being neglected by the lack of program support and training, by adding a range of responsibilities to the supervisor's role beyond direct supervision and by not providing supervisor's with the hours necessary to perform their roles adequately (i.e. limiting position to part-time work).

We recommend that a committee be established to provide strategies for effective supervision, that should include initial and on-going training and the best practices for supervision

(including an examination of case and home supervision). Further, the committee should identify the range of supervisor responsibilities that are reasonable and the minimum number of hours necessary (per home visitor) to adequately provide direct supervision. Finally, this committee should recommend strategies for facilitating the FSW's development from a position of marginality to cultural broker.

In this context, we believe that the following should be considered:

§ *Healthy Families would benefit from more supervisor training specifically focused on the paraprofessional model, its potential advantages and pitfalls, and on managing and relating to paraprofessional staff. A clinical supervisor should be present at each site, rather than a program administrator serving in both capacities. A field supervisor accompanying FSWs on home visits on a regular schedule provides a valuable bridge/buffer between FSWs and program administration. The field supervisor faces the challenging task of needing to ensure program fidelity by encouraging FSWs to make the curriculum the centerpiece of home visits thus professionalizing the relationship. At the same time, she must exhibit the flexibility to grant FSWs the discretionary power to adapt and improvise. Too much supervisor adherence to a strict, "by the book" approach is often interpreted by FSWs as a lack of trust, confidence, and respect for their knowledge of their community. Supervisors find themselves in the unenviable position of "walking a tightrope" between the conflicting demands for program fidelity voiced by administrators and pleas for autonomy from FSWs.*

§ *At some Healthy Families sites, FSWs have had the opportunity to advance in their careers. With the creation of a career ladder, we see many benefits for both FSWs and the program in general, and we recommend that all sites move in that direction. Institutionalizing "senior" FSW positions based not just on seniority but on the acquisition of expertise through in-service training and continuing education opportunities strongly signals program recognition of the value of FSW service. It demonstrates that their knowledge and skills play a significant role in constructing the reality of the Healthy Families program at specific sites. Furthermore, the previously noted allegiance to the professional model may be easier to build and sustain when FSWs have participated in its evolution. FSWs will recognize that by acquiring bicultural competence in conjunction with a demonstrated capacity to serve as cultural brokers, they can advance in their careers as well as provide better services to their community families.*

Finally, we recognize that some of the proposed changes may also require that more funds be spent on the supervisory role. For instance, requiring full-time supervisors at all sites, with say three or more FSWs, would increase the current costs of most programs. This has become a sore spot for many program managers, who recognize the central importance of the supervisory role but do not feel as if they have significant funds to address this need adequately. As one program manager argued in a focus group, "...maybe we need to throw lifelines to these family support workers and get them adequate supervision instead of bringing on two new programs this year, six new programs or ten next year." There are other committee recommendations that may also require increased program costs, like hiring a professional at each site to coordinate treatment for very high-risk families or creating a senior-level FSW position.

Thus, we recommend that a committee be established that will examine program costs and establish a standard for properly funding Healthy Families sites. This issue might be included within the purview of a statewide committee that has as its main task recommending statewide practices for Healthy Families.

Risk Assessment Process

In the final section of the report, we review the assessment process that is used by HFC to determine eligibility in the program. The Kempe Family Stress Checklist (Kempe) is used by HFC and HFA sites throughout the country to assess a mother's and/or father's risk for child maltreatment and to determine their eligibility for program services. Rather than simply develop social-demographic criteria for determining eligibility, such as age, income and marital status, HFA recommends the use of the Kempe to assess social-psychological characteristics of parents to better identify families who are at-risk of child maltreatment. Measures of risk are, however, imprecise predictions about subgroups of the population; they are based on probability formulas that attempt to find relationships between group characteristics and the prevalence of child abuse and neglect. By identifying a population more likely to abuse or neglect their children, the population in need of services becomes more targeted. However, if risk measures are too narrow in scope, families who could benefit from services may not be included, or if risk measures are poor predictors, then families may be included who are at low-risk of abusing or neglecting their children. With limited funds for services, it seems that attempting to measure risk may be a worthwhile endeavor, if, despite the imperfections of the process, families more likely to benefit from services can be identified.⁸ The question then becomes, is the Kempe a good measure for

⁸Of course, the alternative would be to make parenting services, at different levels of intensity, available to the entire population. However, this does not seem to be a realistic option within the parameters of current public policy. Nevertheless, an argument could be made for such an initiative. Much of the population would refuse these services because they already have access to this information through "coffee table" books. A "non-reading" population, or a population without access to this information, might take advantage of the latest theories on child development and positive parenting practices through a variety of community initiatives from lesser to more intensive practices—i.e. from parenting groups organized at local public institutions

targeting a high-risk population?

The assessment process in HFC occurs as follows. After the program receives a referral that is assessed positive using the Revised Early Identification Screen,⁹ a Family Assessment Worker (FAW) contacts the first-time mother and arranges a time to visit her, usually at her home. The reasons given for the visit vary, but most often the FAW explains that she would like to talk to the mother about resources or programs in the community that are available to help first-time mothers. FAWs may arrive with resource guides, pamphlets, photo albums of Healthy Families' babies and their mothers, or gifts (diapers, formula, toys, hand lotion, nail polish, pacifiers, car sunvisors or t-shirts). The FAW engages the mother in directed conversation to learn as much about the mother and father as possible and then scores the Kempe after the interview is completed. Since the interview takes place in the home, there are often interruptions and the mother may not always feel comfortable talking about some sensitive issues because of the presence of others (i.e., a maternal grandmother or father). Furthermore, the mothers' willingness to be interviewed may not be shared by others in the household. Maternal grandmothers are sometimes offended by the intrusiveness or the line of questioning, and fathers, when present, are often suspicious about the nature of the visit and, at times, have exercised their authority in the household by escorting the FAW to the door. The greatest concern is that the FAW works for the Department of Children and Families (DCF) and that their inquiries will lead to the removal of the baby from the home. FAWs often have to convince the family members that they are not from DCF and that their interests are to inform the mother about resources in the community and to see if they might be appropriate for Healthy Families services. The program is presented as a parenting education and support program. Mothers sign a consent form giving their permission for the information from the interview to be recorded and assessed for program eligibility.

Most families interviewed score 25 or above on the Kempe, making them eligible for services (scores on the Kempe range from 0-100 with higher scores indicating higher risk). In our 2000 report, we found that 93% of families assessed met this criterion and that 91% of families referred to HFC accepted services. These are high percentages, which suggests that the Revised Early Identification Screen, referral and outreach processes are highly effective in identifying and recruiting a high-risk population. In fact, this raises the question of whether the Kempe is a necessary screening tool at all, given that it only screens out 7% of the population assessed. Furthermore, where the outreach and assessment process tends to breakdown is in reaching

to home visiting practices for more vulnerable families. To some extent, Connecticut has moved in this direction, by attempting to reach all first-time parents in thirteen communities and to provide them with information about different parenting programs in their respective communities. For more on this, contact the Children's Trust Fund in Hartford, Connecticut.

⁹The Revised Early Identification Screen consists of 17 risk factors for child abuse and neglect. It is used as a general screen to determine if the mother might be a candidate for the program and is often completed in consultation with a referral source, e.g. a hospital social worker. For more detailed information on the REID screen, see our outcome report published last year, Black et al., 2000.

families who screen positive on the REID for an assessment on the Kempe—about one-half are never assessed for a variety of reasons.¹⁰ Eliminating the Kempe as an assessment tool¹¹ would make anyone testing positive on the REID screen eligible for services and would probably reduce the large number of families who are never referred for Healthy Families services because they are not assessed. Of course, this would also reduce the time and expense necessary to administer the Kempe as an assessment instrument. Before jumping to any conclusions, however, let's first examine the effectiveness of the Kempe in identifying a high-risk population.

There are several ways of assessing the Kempe. We will examine the literature on the validity of the Kempe, will compare the results of the Kempe in Connecticut to results from the Child Abuse Potential Inventory (CAPI), will closely examine the items on the Kempe to determine whether they appear appropriate for the HFC populations receiving services, and will present the views of assessments workers and other staff members in the HFC program regarding the Kempe.

Published reviews of the Kempe are lacking. In fact, given the age of the Kempe and its frequent use by Healthy Families programs alone, this is a surprising, if not glaring, oversight among researchers. While Kormacher (2000) points out that reliability tests have been completely ignored by published research, he does identify a report by Aphra Katzev and her colleagues at the Oregon Healthy Families site who tested for inter-rater reliability. Katzev et al., in 1997, reported very high reliability scores ($r=.93$) when using independent raters to review *notes* taken from assessment interviewers. While encouraging, their test did not include independent observations and evaluations of the assessment interview itself. Unfortunately this is the only reliability study cited by Kormacher. There have, however, been a few tests of validity.

The most widely cited study was published by Murphy and his colleagues (1985). Reviewing hospital charts to determine incidences of abuse and neglect among mothers who had completed the Kempe, they found that 80% of maltreating mothers had scored high-risk (40 or higher) on the Kempe; conversely, 89% of non-maltreating mothers scored no risk (10 or below) on the Kempe. Predictive validity was also high. Among all mothers scoring high-risk on the Kempe, 52% were found to maltreat their children, while there was evidence for maltreatment among only 3% of the no risk group. These are strong indicators of validity.

The results from Deborah Daro and her colleagues' study of the Healthy Start program in Hawaii (1998) were modest in comparison. The number of substantiated cases of child maltreatment were too small to make meaningful comparisons between group scores on the Kempe. When using Daro and her colleagues' data to compare high-risk (25 and above) and low-risk (20 and

¹⁰See Black et al. 2000.

¹¹The Kempe could still be used by a home visitor on the first few visits to acquire information about the family in order to focus services and make relevant community referrals. Several of the staff commented on the usefulness of the Kempe in preparing FSWs for working with a family. Eliminating it as a tool for determining eligibility does not preclude it from being used for information gathering.

below) scores on the Kempe to child abuse risk scores on the Child Abuse Potential Inventory (CAPI), Kormacher found a moderate relationship.¹² Among families scoring above the cut-off score (166) on the CAPI at the six month point, an indication of what Kormacher refers to as caregiving dysfunction, 89% were scored as high-risk on the Kempe. However, among those scoring beneath the cut-off score, only 28% scored as low-risk. Predictive validity was also modest. Among the high-risk population on the Kempe, 37% of families at six months and 25% at one year were found to be above the cut-off score on the CAPI.¹³ Further, when Daro and her colleagues compared CAPI scores from families who qualified for program services but did not actually receive them (control group) with families who were screened out of the program using the Kempe, they found that predictive validity decreased over time.¹⁴ While Murphy and his colleagues' study provides strong evidence for the Kempe's validity, Daro and her colleagues' study suggests caution. Clearly more work needs to be done.

Our analysis of the Kempe in Connecticut provides some support for its validity. For families participating in the program in 1999, there were 67 confirmed reports of child abuse or neglect filed with Connecticut's Department of Children and Families (DCF) at some time during the families' participation in the program. Information on the Kempe had been completed for 56 of these mothers.¹⁵ In Table 3, we divided HFC mothers into two groups based upon their Kempe scores, establishing a low to moderate risk group (0-35) and a high to severe risk group (40 and above). Of the 76 reports filed with DCF, 30% came from the low to moderate risk group while 70% came from the high to severe risk group. Of the 56 reports confirmed, 25% had been assessed low to moderate risk and 75% higher risk.¹⁶

¹²The CAPI is a well established instrument designed by Joel Milner to assess parenting attitudes and behaviors. See Joel S. Milner (1986) *Child Abuse Potential Inventory: Manual (2nd Ed.)*. Webster, N.C.: Psytec Corporation.

¹³Note, however, that the low predictive validity may be a function of the decision to use a score of 25 and above to define high-risk. This criterion will include families who are at moderate risk of child maltreatment, many of whom will not score high enough on the CAPI to meet the criterion for caregiver dysfunction. Using a higher score on the Kempe, 40 or higher for instance, would most likely have increased the percentages of high-risk mothers on the Kempe scoring above the cut-off score on the CAPI.

¹⁴ In Daro, McCurdy and Harding's study, 36% of families who scored at-risk (25 or higher) had lower risk scores on the Kempe after one year than the average score among families who were screened out. Similarly, 20% of families who were screened out had higher risk scores on the CAPI than the average score of at-risk families one year later.

¹⁵If enough information is not acquired to judge risk for an area on the Kempe this category is not scored. We only included Kempe scores for families in which all 10 categories had been scored and a total score had been calculated.

¹⁶We also calculated abuse and neglect rates for everyone scoring either in the low to moderate or the high to severe risk range. Again we found statistically significant differences. Of all participating mothers scoring in the low to moderate risk range on the Kempe, 10% had at least one report of abuse or neglect filed and 6% were confirmed; whereas 16.5% of the high to severe risk group had reports filed and 13% were confirmed. Thus, the high to severe risk group

Table 3: Kempe Risk Status of HFC mothers with DCF reports, 1999

<u>Kempe Risk Status</u>	<u>Reports (N=76)</u>	<u>Confirmed Reports (N=56)</u>
Low/Moderate (0-35)	30%	25%
High/Severe (40+)	70%	75%

These data, however, are not a good test for predictive validity. All of the families in our analysis received program services, so our analysis of predictive validity is confounded by the program effect. In other words, we are assessing whether the Kempe can predict incidents of abuse and neglect for families who have received services in the program. If the program is effective, we would expect to find diminishing incidents of reported abuse and neglect, and we have no way of knowing if the intervention effects differ for lower or higher risk groups. The better way to assess predictive validity would be to examine abuse and neglect rates among a population of families who do not receive program services. This was not possible in our study because of limited funding.

In our analysis of validity, we also compared the results from the Kempe to the scores on the Child Abuse Potential Inventory (CAPI), both taken at the time of program entry. First, we simply correlated the two measures. In other words, we examined whether an increase on the Kempe (indicating higher risk) was related to an increase on the CAPI (also indicating higher risk). We found a moderate relationship (Pearson $r=.34$).

Second, we calculated the mean CAPI score for the low/moderate and high-risk groups on the Kempe. These results are reported in Table 4. Consistent with our correlation analysis, we see a very significant difference with the low/moderate group scoring on average 140 on the CAPI and the high-risk group scoring 190 ($p<.001$). As discussed previously, Joel Milner, the author of the CAPI, considers 166 to be a cut-off score, which has been interpreted by Daro et al. (1998) as an indication of elevated risk of maltreatment and by Kormacher (2000) as an indication of caregiver dysfunction. As we can see, the low/moderate group scores well below the cut-off score, while the high-risk group scores well above it.¹⁷

were about twice as likely to have a confirmed report of abuse or neglect compared to the low to moderate group. We should also point out that our low to moderate group (0-35) is made up mostly of mothers or fathers scoring in the moderate 25-35 range, since a score of 25 and above determines program eligibility. Parents with scores below 25 could receive services if both parents were assessed and the other parent scored above 25. But less than 5% of scores on the Kempe fall into the low-risk range (0-20).

¹⁷There was some variation across program sites. When we examined Kempe and CAPI scores for the five primary HFC sites (the first five sites established in the state between 1995-96), two sites had very consistent scores across the two measures with correlation scores above .4 ($p<.01$), two had moderate correlation scores (.2-.3, $p<.05$), while one site did not establish enough consistency to meet statistical significance (Pearson $r=.15$).

Table 4: Mothers' CAPI abuse score at birth by Kempe risk status

<u>Kempe Risk Status</u>	<u>Mean CAPI abuse score</u>
Low/Moderate (N=266)	141
High/Severe (N=366)	190

Finally, in Table 5, we provide a crosstab analysis by dividing the Kempe scores into three categories (low/moderate risk, 0-35; high-risk, 40-60; severe risk, 65+) and comparing them to three established categories on the CAPI. On the Kempe we used the 166 cut-off explained above, but also the 215 cut-off, which represents the top 5% of scores on Milner's normative sample and has been defined as a high-risk category for physical abuse (Daro et al. 1998). These results also lend some support for the Kempe's validity. Seventy percent of mothers who scored in the low/moderate range on the Kempe also scored beneath the 166 cut-off on the CAPI, while 61% of families scoring in the severe risk range on the Kempe scored above the 215 cut-off on the CAPI. Our chi-square score indicated that the relationship between the two scales was significant at the .001 level.

Table 5: Mothers' Kempe risk status by CAPI abuse scores

<u>Kempe Risk Status</u>	<u>CAPI Risk Status</u>			<u>Total</u>
	<u>Low-risk (0-166)</u>	<u>Elevated Risk (167-214)</u>	<u>High-risk (215+)</u>	
Low/Moderate (0-35)	122(69%)	19(11%)	36(20%)	177(100%)
High (40-60)	109(49%)	32(14%)	81(36%)	222(100%)
<u>Severe (65+)</u>	<u>13(24%)</u>	<u>8(15%)</u>	<u>33(61%)</u>	<u>54(100%)</u>
Total	244(54%)	59(13%)	150(33%)	453(100%)

Chi-Square 40.732, p<.001

At this point in our analysis, it would seem that there is some evidence to support the Kempe's validity using our data. Next, let's examine more closely how the Kempe is actually scored to see if the items are indeed appropriate for the HFC population. In Appendix A, the categories and the items used to score each category are provided. The ten areas in which the Kempe is assessed are provided below in Table 5 along with the percentages of HFC mothers scoring as either mild risk (5) or severe risk (10) for each category.

Table 5: Mothers' itemized Kempe scores by severity of risk

	5 <u>mild risk</u>	10 <u>severe risk</u>	5 or 10 <u>total at-risk</u>
Childhood history of abuse or neglect (N=1071)	19%	57%	76%
History of crime, drug abuse, or mental illness (N=1071)	25%	30%	55%
Child Protection Services history (N=1056)	4%	7%	11%

Low self-esteem, social isolation, depression (N=1092)	43%	50%	93%
Multiple stresses (N=1093)	28%	62%	90%
Potential for violence (N=1053)	13%	25%	38%
Unrealistic expectations of child (N=1082)	42%	14%	56%
Harsh punishment (N=1040)	23%	6%	29%
Negative perception of child (N=985)	24%	11%	35%
Child unwanted/at risk of poor bonding (N=1077)	67%	24%	91%

There are several notable problems. First, two of the categories include measures of multiple constructs--measures of substance abuse, mental illness and criminal histories are all included in one category, while measures of low self-esteem, social isolation, and depression together make up another category. Not only is it likely that the scores for these categories will be high, there is no apparent rationale for grouping them together. Furthermore, the scores from these categories tell us very little about the population. For instance, there is an important difference between a population of parents with low-self esteem and parents who suffer from depression--both in terms of providing services and assessing risk. Even more striking, there is an important difference between parents with a history of substance abuse and parents with a history of mental illness, but again, these differences cannot be discerned from the scores on the Kempe.

Second, three categories on the rating scale of the Kempe (see Appendix A) do not appear appropriate *for first-time mothers*, the population being served by HFC. The third category in the table above--Child Protection Services History--is the assessment of whether a parent has been suspected of abuse in the past. This category rarely applies to the first-time mother, but in some instances may apply to a father who has a previous child. Only a small proportion of fathers, however, are assessed for program services.¹⁸ The eighth category above assesses whether the parent engages in harsh punishment of the child, like physically punishing or shaking the baby. But again, this category is not appropriate for prenatal first-time parents. To get around this issue, HFC provides hypothetical situations that would require disciplining an infant and a toddler and asks the parents to respond to the situation. Their responses are then recorded. The ninth category above--Negative Perception of Child--assesses whether the child is perceived as difficult and/or provocative by the parents. Again, this category assumes parental experience. To assess this category, assessment workers ask about the mother's prenatal experience with the fetus. Here the intention is to measure any fears or projections the mother may harbor towards the fetus--fears that the child will be just like a family member, that it will be demanding, poorly behaved or a "bad" child. In each case, however, the original intent of the Kempe has been modified to fit a population of first-time moms, which of course raises some concern about the appropriateness of the instrument for the HFC population. As we might expect, the total at-risk scores shown in Table 5 for these three categories are lower than any other category.

Third, the items used to assess the categories on the Kempe may not be culturally appropriate for

¹⁸Of all assessments recorded in our data base, only 10% are on fathers and, in most of these cases, information about the father was provided by the mother.

some of the ethnic populations being served by HFC. It is important to note that the categories on the Kempe have not themselves been validated, nor have they been normed for different racial and ethnic populations. Thus, they may not be good measures for some cultural groups. For instance, if a parent was raised as a child by more than two families, they are scored as having been severely deprived (a 10 on the Childhood History item). However, multiple parenting is common among Puerto Rican families, especially given the dispersion of family members across Puerto Rico and the U.S. mainland. Program leaders in Connecticut are aware of this issue and have modified the risk item so that parents only score at risk on the item if they were raised in two or more families *and felt as if they were shuffled around rather than nurtured*. Another item of concern on the rating scale is that co-habiting parents who are not legally married are scored in the mild range (5) for having an unwanted child or as being at-risk of poor bonding with the child. Co-habitation and “common-law marriage” are quite common in lower income neighborhoods, and especially among Puerto Rican families. If culturally normative, it would be inappropriate to consider the practice a predictor of child maltreatment.

Finally, we might also quibble with the appropriateness of including some items as indicators of risk. We are not experts on scale construction; nevertheless, we want to draw attention to some of these items. While many of the items used to score severe risk appeared appropriate for the HFC population, one item seemed particularly dubious--if a male partner is present in the household and is not the natural father of the baby, the family is scored in the severe risk range for having an unwanted child or being at-risk for poor bonding irrespective of whether the male parent states he wants the baby. In areas of concentrated urban poverty or isolated rural poverty, relationships are often unstable and tenuous.¹⁹ It is not clear that the household presence of a male partner who is not the natural father of the baby is an indicator of an unwanted child or that it diminishes the chances for parent-child bonding. We would at least question whether this is an indicator of severe risk (10) and would want to see that it had been empirically verified. Most of the items we would question, however, concern the mild rating (5) of risk. Perhaps the best way to demonstrate our concern is to provide a few hypothetical cases to demonstrate the potential problems of using the Kempe as a screening tool. Consider the following: an unemployed mother, who has two speeding tickets, whose finances are “tight” but nevertheless manageable, who delivers a premature baby, and who has fears around being an unsuccessful parent would score in the moderate range (25) for risk of child maltreatment and would be appropriate for services. Or, a mother without a high school education, who has used marijuana twice, lives in crowded living conditions, co-habitates with the father of her baby, and has fears around being an unsuccessful parent would score in the moderate range (30) for risk of child maltreatment. Perhaps these mothers should have access to a parenting program, and maybe any mother or father who has fears around being a successful parent should have access to a parenting program. However, the likelihood for child maltreatment among this population would appear low, and deciding to include these families in an intensive intervention like Healthy Families means that the program is filling program slots with a low-risk rather than a high-risk population.²⁰ Perhaps

¹⁹See Elijah Anderson (1999). *Code of the Streets*, New York: W.W. Norton and Co., Inc. and William Julius Wilson (1996) *When Work Disappears*, New York: Knopf, Inc.

²⁰In our 2000 report, we found that 36% of HFC mothers score in the moderate-risk range

the easiest solution to this problem would be to raise the qualifying criteria to a score above 25, to maybe 35 or 40.²¹

As a final consideration in our analysis of the Kempe, we now turn to the perspectives of program staff. The following information is taken from individual interviews and focus groups with Family Assessment Workers (FAWs), FSWs, Program Supervisors and Managers.

Overall, program staff are satisfied with the Kempe as an assessment tool, even though few had considered the possibility that another protocol or assessment tool might be used. A few staff articulated that a social-psychological assessment provided much better indicators of abuse and neglect potential than more general criteria such as income or age and also that the specific types of information acquired from the Kempe helped prepare FSWs for approaching and working with the family. Certainly, most of the FAWs have become quite skilled at acquiring personal information in an informal conversational manner. FAWs expounded on their techniques during our focus groups, demonstrating impressive strategies for exploring sensitive topics in non-threatening ways. However, they raised a number of concerns about the Kempe and are in many ways its most sensitive critics.

Their foremost concern is the problem of disclosure. Many mothers are eager and comfortable discussing their personal histories and current struggles with these skilled listeners, but some are not. In several cases, program staff have found that after working with mothers for awhile and developing rapport, mothers provide information about themselves that they withheld in their assessment interviews--information which would have increased their risk scores, in some cases considerably. While FAWs are driven by this challenge, they admit that some mothers will remain suspicious or uncomfortable and will not disclose information about some areas on the Kempe. Given that scoring is based on the mothers' willingness to disclose sensitive information during the interview, the accuracy or validity of the results is questionable. One FAW explained, "I've assessed them and had them be just barely, you know, scoring 25 and then, you know, three or four visits later you find out that they probably should've scored 75."

Another FAW, who also works as a home visitor, elaborated on her experience:

...I've been working with this girl. Her baby is almost a year old and all of a sudden one day she came out and shared all kinds of stuff with me. I'm like, whoa! I don't remember any of this. So you know, it's been a long time since I've seen the assessment so I pull it up and I'm like, there's a lot of people, I'm sure who don't even score [as eligible for the program] and if we were still in with them I guarantee we're gonna get

(5-35), 48% in the high-risk range (40-60), and 12% in the severe-risk range (65+). Another 4% score in the low-risk range (5-20) and are eligible for services because the fathers score 25 or above.

²¹We should point out, however, that 6% of families scoring beneath 40 on the Kempe had substantiated reports of abuse or neglect filed with the state, which accounted for 25% of all confirmed reports filed on the HFC population in 1998-99.

more information out of them. I mean this girl was raped when she was 12 and molested and moved around a hundred different times and [this] was not on her scoring thing at all. And, I'm like, you know, this took almost a year for her to come out and tell somebody this. And then it was just all kinds of stuff started coming out and like you could almost reassess her and give her a score, instead of like a 35, a score of almost 55...

FAWs indicate that conducting the interview in the home is useful, especially for more reserved mothers, because it gives the assessment worker the opportunity to observe the mother's behavior with the infant and to observe the home. In some cases, the home interview exposes contradictions between what the mother is saying and what is observed. One FAW provides the following example of how observations in the home can be useful in assessing a family for services.

Mom may not be responding to the baby's cues—completely detached herself. There's a lot of vulgar language. There are alcohol bottles on the tables or something, you know. There may be too many [people] knocking on the door while I'm doing an assessment and I might be seeing an observed transaction or something. There might be safety zone issues as far as screens on the windows and just stuff that I see that [do not produce] good feelings about the environment, and the mother is just saying, "everything's fine..."

While conducting the assessment in the homes may provide useful observations, the presence of others in the home can compromise mothers' disclosures. One FAW explains:

Sometimes it's easy because some people just like to spill everything and other people when you go in, you know, when you're trying to lead this conversation and they aren't leading with you. (laughter) They're just sitting there thinking, "I'm not gonna tell this lady anything." Especially if they are with their mother—the maternal grandmother is there or another family member. I did one in a household where this girl was living in her boyfriend's grandmother's house and we sat at a table somewhere, I don't know if it was the dining room or the kitchen, but there were so many people in that house that just kept people from talking. I knew this girl was not telling me what she would've told me if we were alone somewhere, okay. But what I did get from her was enough to qualify her, okay. And then, as the FSWs make their visits, then we find out, you know, they become comfortable with them and then a little bit more comes out and a little bit more...

The opposite can occur as well:

I had one...where the mom, she was 15, and her mom was with her and signed some papers and she said, "Tell 'em, tell 'em what you did. Tell 'em why you're on probation." And grandmother would be sitting there saying stuff like that. "Tell 'em what the father of the baby will do if you don't always do what he says." "I don't know." "No, you know. Tell her." It's like, I feel so bad for the girl. The girl almost, I mean, she does break. She starts crying and...I just want to kick that grandma out of the room cause it was, I mean, I got a lot of stuff out of the poor girl, but it was just a horrible experience

for her. And I think it could've been done in a better way without mom.

In more extreme cases, the presence of others in the home can prohibit future participation in the program:

I met the mother in the hospital and she was going home the day that I met her and she wanted the program. I told her about the program and she was interested and made an appointment to go see her the following week. I went there and the boyfriend was there and the boyfriend's mother. First, they opened the door and walked away and I was standing there outside and I was waiting out there and I looked back and said, okay, I guess I can go in. So I started with a little spiel about what the program was about so he'd know and then, you know, I started to talk to her and to him and he wouldn't say two words to me. She was completely different than when I met her in the hospital, I mean, she wouldn't even say a word without looking at him first, and before it was halfway over, he stood up and he said, "I do think you should be leaving" and [I was] out the door. And I couldn't get out of there fast enough.

HFC staff all agreed that when the Kempe is successfully administered it is often a stressful encounter for the mother that may bring to the surface painful memories and anxieties. Some staff were adamant that the Kempe should only be administered when there are openings in the program to spare mothers from needlessly going through such an encounter. Others commented on how difficult it is to leave the mother in her vulnerable state, knowing they would not return to the home.

Overall, perspectives on the Kempe were mixed, though mostly positive. HFC staff were open to changes in the assessment process, including modifying the Kempe or searching for a better assessment instrument. One small group of FAWs agreed that the assessment should focus more on the "here and now" rather than on personal and family histories. They argued that the willingness to disclose or the ability to recall childhood histories, or histories of substance abuse or violence in the families, varied among mothers and was therefore unreliable. Instead, they suggested that collecting current information on age, income, educational achievement, social support and parenting expectations would provide better criteria for determining eligibility.

We recommend that a committee be established to examine the assessment process in light of our findings. Given that 93% of families assessed with the Kempe qualify for the program, we are raising the question whether the Kempe is a necessary screening tool, especially given the time, expense and stress involved. To help guide the program in making this decision, we gathered additional data on the Kempe. We found that, one, there is not much literature on the validity and reliability of the Kempe, and that only one study provides strong support for its predictive validity. Two, our data provide support for the validity of the Kempe using the CAPI as a comparative measure. Three, we raise some concerns about whether the Kempe is appropriate for first-time mothers and whether some of the items are culturally appropriate for HFC populations. Four, while the general sentiment of the HFC staff is favorable, they raise some important concerns, especially regarding mothers' willingness to make disclosures about their

pasts, and are open to the prospects of either modifying the Kempe or selecting another assessment tool. In Connecticut, we are fortunate to have Dr. John Leventhal from Yale School of Medicine on our research committee. Dr. Leventhal has written extensively on risk assessment and would be an ideal candidate to chair this committee. In addition, we would recommend that at least two experienced FAWs sit on the committee. This committee should work towards determining if the Kempe is the best assessment instrument for the Healthy Families Connecticut program. If not, they should recommend whether the Kempe should be replaced, modified, or if the REID screen currently used by the program is sufficient for determining program eligibility.

Conclusion

After five years of researching the HFC program, we conclude with both a pre-post outcome study report and, now its companion, a process study report. In the former, we found outcomes that were promising—that suggested high-risk families remaining in the program for one or two years were, on average, making important gains in parenting capacities, establishing independent households, regularly immunizing their children, completing high school educations or GEDs and going to work, even though jobs did not increase their incomes much or decrease their need for public assistance. Further, it is rare to find a case of physical child abuse among participating mothers or fathers, even though there was a significant number of neglect cases involving substance abuse and domestic violence.

In this year's report, we turn our focus to program practices. More specifically, we explore the theoretical rationale of a paraprofessional model, examine its strengths and weaknesses, and identify the dilemmas that paraprofessionals confront as they attempt to bridge the cultural terrain between the community culture of program participants and the professional culture of program supervisors and managers. In addition, we examine the assessment process that HFC uses to identify and recruit a high-risk population. The paraprofessional model, while filled with promise as a vision, is difficult to implement. Nonetheless, we believe that the lessons learned from the frontlines of a paraprofessional program hold great promise to maximize the impact of human services on the lives of families most in need of assistance. To this end, we offer this report not as an end in this process, but a new beginning, in which program staff from different locations within the program come together in committees to discuss issues that we raise in the report. The goal of this process is to conduct an overall review of program practices and to make changes to the program where it is viewed as appropriate by the HFC community.

The Healthy Families program is structured around twelve critical elements or principles.²² These elements are abstract and thereby allow for flexibility in program practices as different parent agencies or hospitals existing within unique networks of community services organize home visiting practices to meet the needs of their particular families. Thus, program sites are similar in that they are organized around the twelve critical elements but different in their service strategies and in the types of communities they serve. We have found in our research that

²²The critical elements are presented in the outcome study report. See Black et al., 2000.

programs that remain flexible and innovative and that promote collective decision-making are more likely to effectively engage families, promote the development of home visitors and adapt to the needs of their communities. These are typically sites that view the program as a work-in-progress, never as a static set of practices that can be encrypted in a service manual.

Furthermore, they are programs that are located within parent agencies that are supportive and provide flexibility—that recognize the value of supervision, the difficulties of working with

vulnerable families whose lives are often in flux, and the priority that frontline work takes over bureaucratic requirements.

There are several innovations that program sites have attempted, from revising the parenting curriculum to routinely practicing home supervision to bolder, more imaginative strategies. For instance, to establish workplace norms, one site turned this responsibility over to FSWs to identify appropriate workplace rules and expectations. This resulted in a stronger commitment to abiding by and informally enforcing the norms. In another case, after we had first identified the issue of marginality among FSWs in our 1998 report, one site contracted with a counselor outside of the program to meet regularly with FSWs to address their experiences of marginality in the program and to provide a forum for them to discuss the issue openly without the presence of supervisory staff. In another case, the issue of marginality was addressed when all staff met to develop a “union statement,” that committed program staff to making the workplace respectful and receptive to everyone and to improving work routines. The statement laid the foundation for subsequent “Family Support Worker Days,” in which staff met to address any grievances and to maintain fairness and equity in workloads.

One of the most innovative practices was to turn the responsibility of developing trainings over to home visitors themselves. Home visitors would decide on an issue that they wanted to learn more about, for instance breaking the cycle of domestic violence. They would then plan a service training by inviting one or two professionals in the community to speak about the issue and by gathering information on the topic themselves to present at the training, using library sources and the internet. They would then selectively invite family members they thought would benefit most from the event. This innovation encouraged home visitors to take responsibility for their own education and training, empowered them to decide which issues were the most salient in their communities and promoted a democratic workplace in which supervisory staff, home visitors and family members worked together in addressing a community issue and learned from one another. There were two consequences to this process. One was that the FSWs began to develop their own expertise, or niches, in the program. That is, they each began to develop an informed understanding about a particular topic, like substance abuse, child discipline, nutrition, and then became a resource for the other FSWs to use. The second was that the FSWs made a presentation at the Healthy Families America conference in Atlanta on these self-organized trainings, expounding on its value in their professional development and aptly demonstrating the success the process has had in increasing both their knowledge and confidence as professionals.

These types of innovations are important to the success of Healthy Families, but they do not come prepackaged. They require that supervisory staff and home visitors continually work

together to discover new strategies and practices that enhance the quality of frontline work with vulnerable families. As first-time mothers re-enter the workforce, the need to be flexible in conducting home visits has become particularly important. Programs that do not encourage flexibility have a difficult time meeting the needs of families encumbered by the demands of work, who are arranging child care and transportation on a daily basis. To service these families, programs have to adapt.

Many of the innovations that we learned about did not work; but that too is an important part of this process. At the retirement dinner for Jane Bourns, the former director of Prevent Child Abuse Connecticut, she imparted only a few words of wisdom accrued from her many years of experience working with vulnerable families. They were to “let yourself fail.” There is an important truth in these words. In order to be creative and innovative, programs need to be willing to fail and to try again. They have to work continually to strike a balance between structure and flexibility, between honing the skills of the home visitor as both generalist and specialist, between making professional demands on frontline workers while encouraging them to cultivate and maintain their identities within the communities they serve. Moreover, programs have to foster open exchanges between supervisory staff and FSWs, to genuinely learn from one another in a collective effort to transcend racial, ethnic and social class differences that can undermine programs designed to provide support services to socially isolated communities and vulnerable families. Healthy Families is a difficult model to implement. Yet, we believe, after five years of research, that when a structure is well established within which training and technical support is organized, and when creative and innovative strategies are programmatically encouraged and facilitated, the model holds great promise in providing support services to vulnerable families.

We view HFC and indeed all human service endeavors as works-in-progress. Policies change, theories change, social contexts change, lives change...and consequently services need to be fluid and dynamic as well. But more importantly, we believe that the focus for improving support services always should remain on the frontlines, where staff and program participants come together. Even organizational or policy changes should occur with this challenge in mind, of how to improve frontline services. When organizational impediments to frontline service delivery exist, they need to be identified, analyzed and changed. The promise of the HFC program requires that it avoid entrenched and routinized practices that are driven more by bureaucratic requirement than by demonstrated success. Instead, its promise rests upon a process whereby program practices can be scrutinized and renewed by fresh ideas and creative innovations, always focused on the impact that program services have on the lives of families served. This report is intended to facilitate such a process.

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