

**QUALITATIVE INTERVIEW STUDY
OF HEALTHY FAMILIES
ARIZONA**

Prepared for

**Arizona Department of Economic Security
Child Abuse Prevention Fund
Site Code 940A
Phoenix, AZ 85005**

by

**Craig Winston LeCroy, Ph.D.
Jose B. Ashford, Ph.D.
Judy Krysik, Ph.D.
Kerry B Milligan, M.S.S.W.**

**LAM & Associates
8725 Scenic Drive
Tucson, AZ 85743**

March 1997

Executive Summary

In 1992, The Child Abuse Prevention Fund established three pilot sites of the Healthy Families Arizona program in Prescott, Tucson, and Casa Grande. Since that time 17 other sites have joined the Healthy Families Arizona program, 13 through funding provided by the Arizona legislature in 1994, and four through other funding sources.

Healthy Families Arizona has had several evaluations since its beginning in 1992. The first report examined the program outcomes in 1993 and found the program was successfully screening parents, used a variety of resources, and that mothers and children had made positive changes from baseline to post assessment periods.

The second outcome evaluation examined outcomes from 1992 to 1994 and included a comparison group. Findings from this report show that program mothers and children made significant gains on multiple outcome measures but that a matched comparison group did not make similar improvements. In fact, the direction of change for the comparison group was negative on all but two of the outcome measures showing increased stress and poor coping for families not receiving the program.

A comparison of substantiated child abuse and neglect rates found that the participants in the Healthy Families program had a lower rate of substantiated child abuse and neglect than the matched comparison group. The program was successful in that there were no child abuse and neglect reports in 97.2 % of the families served. The program also achieved success in promoting the healthy development of children and strengthening families at risk for poor outcomes..

The goal of the current study conducted in 1996-1997 was to find out how satisfied Healthy Families Arizona program participants are with services they receive from the program. A stratified random sample of 46 mothers in the pilot programs in Prescott, Tucson and Casa Grande were interviewed.

Mothers participating in the study were asked questions addressing:

- their understanding of the purpose of Healthy Families Arizona
- the process of family assessment
- benefits or outcomes of the program
- C how they perceive being treated by program staff
- C their overall satisfaction with the program
- C their relationships with their home visitor

Overall, mothers participating in the Healthy Families Arizona program reported a strong sense of satisfaction with the program and this satisfaction appeared to be closely associated with the nature and quality of the worker-client relationship. The participants perceive the program as meeting multiple needs which are consistent with the stated goals of the program as designed.

The results of this study indicate that participants see the program:

- C as helpful in addressing immediate family needs such as housing and food
- C as providing emotional support with multiple challenges parents face
- C as providing useful information about child health and development, as well as community resources.

Participants in the study were asked to rank order seven services in terms of the amount of help they believe they received. From highest to lowest level of help their rankings were:

- C child development
- C baby's health needs
- C needs as a parent
- C individual stress
- C family needs
- C community resources
- C mother's health needs

It is important to note that none of the mothers reported experiencing any form of stigma or negative social consequences as a result of being screened for the program. Overall, the screening process was not perceived as intrusive and was received in a positive manner by most mothers. There was also consistent documentation that the clients felt that workers valued their personal and social standing, treated them with respect, and the majority of mothers reported that they trusted their workers.

Many of the responses to questions in the interview support the conclusion that clients are developing a strong commitment to the program. They also indicate that mothers believe that the program has dramatically affected:

- C how they feel about themselves as mothers
- C feelings about their own sense of self
- C their relationships with their child

Introduction

Healthy Families Arizona is a home visitation program that is designed to promote healthy and safe environments for children. The goals of the program are to: (1) identify parents at risk for becoming abusive or neglectful, (2) provide prevention and early intervention services, (3) promote child wellness and development, (4) link families with medical and social services, and (5) strengthen family relationships. Family Support Specialists are expected to form a relationship with the family and to provide emotional support for the parents, informal teaching, modeling, and brokerage of services.

Families *at-risk* of child abuse and neglect are identified shortly after the birth of a child by a two-stage screening and assessment process. If a client is identified as being at risk of child abuse or neglect, they are offered the opportunity to participate in a voluntary home visitation program. Family support specialists visit the families weekly and do not reduce this rate of visitation until they have observed actual changes in client needs as is prescribed by established program guidelines.

This Qualitative Study represents one component of a comprehensive evaluation project being performed by LAM & Associates (Tucson, AZ) for the Healthy Families Arizona Program. The evaluation plan includes several aspects of program evaluation. Initially, an evaluation of program implementation was conducted. Following the implementation study, a yearly outcome or impact study has been conducted beginning in 1992. This report presents an in-depth qualitative interview study of client satisfaction and client perceptions of program procedures. A future report will present the results of a cost-benefit study.

Evaluations of social programs include examinations of the extent to which programs achieve desired outcomes or comply with objectively established standards. Although programs can meet objective standards, this does not mean that consumers are necessarily satisfied. Client satisfaction is an important principle of program evaluation. Many programs can be developed that are effective and efficient in achieving desired goals, yet conflict with other fundamental principles like client satisfaction and fundamental fairness. Policy makers and program developers are interested in evaluating all facets of a social program, including an understanding of the program from the client's point of view. This report presents the results of client evaluations of services and procedures employed in the Healthy Families Arizona program.

The goal of the qualitative interview study is to assess client satisfaction with the nature and quality of services received. It focuses on understanding what the procedures and services used in this program mean to client participants. Clients' understanding of services can differ substantially from what is envisioned by program planners. These differences can lead to an under-utilization or misuse of services. Another objective of this qualitative study is to provide program planners and policy makers with information about different dimensions of program

impact not addressed in traditional outcome evaluations. Traditional outcome evaluations focus on objective measures of program benefits and impact. These objective measures ignore the subjective standards of program participants. In sum, this report presents the results of an investigation of client views of their experiences in the Healthy Families Arizona program.

Organization of the Report

This report begins with a brief description of the assumptions and objectives that guided the design of the qualitative study. This includes a description of the procedures employed in the development of the qualitative interview questionnaire and in choosing the study's sample. The results of the study are then presented. The results are organized according to the following issues:

- *client views about the program's purpose;*
- *how the program differs from client initial expectations;*
- *client perspectives about the enrollment phase of the program;*
- *client attachment to the program;*
- *client evaluations of program outcomes and benefits;*
- *client assessments of worker treatment;*
- *questions dealing with client relationships with Family Support Specialists;*
- *client overall satisfaction with Healthy Families Arizona.*

The report concludes with recommendations about the intended and unintended consequences of the program's design and its procedural implementation.

Objectives and Procedures

The Healthy Families Arizona program is a child abuse prevention program that was modeled after Hawaii Healthy Start. As with all prevention programs, the process of identifying clients who may benefit from services is a complex issue. For example, how can program developers target families "at risk" without causing stigma? Policy makers often struggle to develop prevention programs that can be efficient (i.e., identify target populations) while not identifying or labeling individuals. It is much easier to direct services to persons who have already developed a problem of child abuse, than to direct services to families at risk of child abuse and neglect. In the case of the Healthy Families model, policy makers chose to evaluate all new parents in high risk census tracts to determine their risk for child abuse. But, how do you effectively, efficiently and fairly identify parents as being at risk for child abuse?

The selection procedures in a program like Healthy Families Arizona must identify families in need of abuse prevention services without causing harm, i.e. "creating stigma, negative self-image, or just plain discomfort among the designated high-risk population" (Berrick & Gilbert, 1991, p. 108). In fact, a concern raised by policy makers is how clients are identified to receive services. To address these concerns, it is useful to obtain information from clients

about their views of the selection procedures used in this program.. A study of client assessments of program procedures can provide useful insights into some of the subjective consequences of program procedures. That is, are clients troubled by procedures used to determine their eligibility for participating in Healthy Families Arizona?

The other aim of the study is to assess levels of client satisfaction with the nature and quality of services received. To this end, clients are asked questions about program outcomes. Clients make judgments of services at many different levels. They assess programs in terms of: a) specific benefits or outcomes; b) specific procedures or ways that the program treats them; and c) the person or persons providing the services. Each of these dimensions of program satisfaction are examined in this qualitative study.

Client satisfaction is well recognized as an important determinant of program success (Blais, 1990; Pascoe, 1983). If parents are not satisfied with the program's services or how staff treat them, then this can affect their levels of commitment to the program and their levels of overall participation and motivation. The satisfaction literature has documented, on a consistent basis, that rates of dropout in many different types of programs are highly associated with client satisfaction (Hall & Dornan, 1988). It also confirms that the best way to measure satisfaction is to examine each component of a given service (Blais, 1990). Global assessments of services provide minimal insights into the specific reactions of clients. Moreover, the results tend to be highly skewed in a positive direction which offers a level of feedback to program planners that is generally of minimal utility. For this reason, we relied more heavily on qualitative procedures to get at the kinds of information that would be of use to program planners.

Because client satisfaction is significantly related to measures of program success, it is often considered an important outcome itself. Open-ended questions were used to obtain information about clients' satisfaction with the program. Standardized instruments provide reliable results, but risk filtering out genuine client reactions to program components. However, some standardized survey questions were included in the study for purposes of uncovering discrepancies in client self-reports.

A stratified random sample of 46 families were administered semi-structured interviews that included open ended and scaled response items to elicit their subjective evaluations of program services and procedures. Clients were stratified according to three sites: Tucson, Casa Grande, and Prescott. Each site was asked to randomly select a total of 30 clients that have participated in the program for a minimum of six months. Interviewers were instructed to contact between 15-18 clients in each site for face-to-face interviews. The first 15-18 clients from each site that the interviewers were able to contact were included in the study. Some clients were difficult to contact primarily because they lacked forwarding address information and had moved out of town. The final sample included a total of 46 clients: 16 from Casa Grande, 18 from Prescott, and 12 from Tucson. Client interviews were audio taped, transcribed, coded and analyzed for the purposes of this report.

Client Views of Program's Purpose

All participants in the qualitative interviews were asked the question: *What is your understanding of the purpose of the Healthy Families Program?* (see Appendix A for the questions used in this study). Most of the respondents described the program as a “*program that offered help and services*”. The modal responses were coded as follows: a) to provide parents with information (e.g. developmental or parenting information) --21 %; b) to support, help and provide services-- 34%; c) to support and provide counseling -- 9%; d) a program for single or new moms-- 7%. The other responses fell into categories that did not allow for meaningful comparisons.

A sample of responses assigned a code of “providing parents with information” included:

“The program’s purpose is to help mothers understand their children, for example, how to discipline your kids.”

“It gives you good advice on what to do if your child needs to gain weight or what to do with discipline.”

“To see how the baby is developing by age.”

“I don't know, but the girl came and started to talk to me and showed me many things related to babies, they showed how to take care of them, things that they need and so on.”

“I don't know. She just comes and tells me things I should do if something is wrong.”

Most of the responses that were coded "to provide parents with information" described the program as being fundamentally for the care of the child.

Examples of statements that were coded as "to help, support or provide services" were:

“Help me to get my goals and get a better job.”

“I don't really know. I just know that my worker has always been there for me for anything that I've needed. Financial support, mental.... anything. For myself and my child.”

“They are there when you need them. If you are having problems with your boyfriend or when there is something wrong with the kids you can call them up and they will be there for us. It is difficult being a teen parent.”

“To help me if there is anything that they can help me with like being a better parent. Finding day care for them and also to educate me as to where my children are at as far as physically and they have a self-administered questionnaire to help you know where your child is at and how you handle them.”

If respondents described the purpose of providing support and mentioned counseling in their description, the response was coded “to support and provide counseling”. This category illustrates that a small percentage of the sample perceived the workers as having skills akin to being a counselor. Under the Healthy Families model, workers are not intended to be counselors and the results of this survey support this assumption. That is, client definitions of the program were not at significant odds with the expectations of program designers.

Some of the respondents defined the program’s purpose as providing services for a specific target population. Responses included:

“The program was designed to see how I am as a mother and how I am coping with the baby’s behavior as a new mom.”

“It is for single mothers who need help because of their immaturity.”

“Families who had a risk of substance abuse or child abuse or from the stresses of being single.”

It is important to point out that only one respondent in this group of comments viewed the program as having something to do with families at risk of child abuse or neglect. Her statement indicates, however, that she saw it as being targeted for multiple risk statuses and not just abuse and neglect.

Evaluations of satisfaction can be influenced by client expectations. In social psychology, this is often referred to as an expectancy confirmation sequence. This concept means individuals will judge an experience based on their expectations for that experience. Their expectations color their assessments of their experiences. Research has demonstrated that the perceiver of an experience has a set of beliefs about a target and behaves toward the target on the basis of those beliefs. With this principle in mind, we asked each of the respondents: *Has the program turned out differently than you expected?* Eight respondents reported that it had. The reasons given as to how it varied from their expectations included but were not limited to the following examples:

“Yes, it has. My worker would come and she was really nice.”

“Yes, she helped me. She brings me toys from the toy library. A lot of books and pamphlets. She brought him an outfit when he was born. She has really helped us out a

lot. I didn't think she would help us much."

"Yes, they helped me a lot. My worker helped me a lot with like financial problems. Things that I really didn't expect that I was going to have trouble with, but they helped. Like I needed somebody to talk to."

"Well, when I got into the program I didn't know I would come to care for the Healthy Families person as much as I have. That is the plus in it all. I didn't realize that she would become such a big part of the family."

Interviewer: *"So when you started you thought it would be more professional?"*

Client: *Yes, just someone coming in and being very professional and staying only 10 minutes and leaving. My worker would stay an hour or more just talking and playing. The hardest part was when I had to drop. For a year we had her every week. Then it dropped to every two weeks and that was OK. I feel kind of separated now."* (Note: clients move through level changes that represent changes in service intensity).

The respondents who stated that the program was different from what they expected tended to be surprised that they received as much help as they did. Others reported being surprised by the good quality of their relationship with their Family Support Specialist. The overall results suggest that many were pleased by how much help the program provided regardless of their initial expectations:

Interviewer: *"Has it turned out differently than you expected?"*

Client: *"Yes and no. I knew that they were going to help, but I didn't know how they were going to help me. It was the first time that I'd ever heard of them when my baby was born. It was something new to me and I didn't know it. At first I clammed up and I didn't say anything. They would ask me why I didn't want to talk. Then I finally started talking. I figured if they can't help me nobody else can. It was a free program. At least for me it was free. It was like I might as well and they helped me."*

Interviewer: *"Has it turned out differently than you expected?"*

Client: *"No, it has been more than I thought it would be. They were there every time that I needed them. They supplied things even when I didn't have the questions. They knew what I needed before I knew it. All these young girls. I needed help in my alcohol problem and they got me in a treatment program (Wildflowers) with the baby. They got to attend Wildflowers with me. I think it is a good program. If I hadn't of had this program I don't know how I would have made it myself. I didn't know what to do. To get over my drinking problem I had to drop all of my so-called friends. They were the support that I needed to get into my counseling and back in my AA. To form a new circle and a new life. It is like starting all over and for me it was more difficult because I'm older. I figured that I knew everything. Obviously I didn't."*

Evaluator Impressions

Client responses to questions about the program's purpose suggest that the clients truly understand the design of the program. They see the primary goals as providing developmental information or to help, support, and provide needed services--to enhance overall family functioning. The fact that parents perceive the program as representing broad goals bodes well for the impact of the program. Gomby, Larson, Lewit and Behrman (1993, p. 11) point out that "home visiting programs which seek to address a broad spectrum of family needs are more effective than single focus programs." The mothers' comments indicated that the program responded to broad needs such as parental information about discipline and health and support and services by "being there when you need them". Interestingly, many clients noted that the program was different from their initial expectations and that it turned out better than clients expected. Many of these clients are likely to have had past negative experiences with social service agencies. The experience of the Healthy Families program appears to help them by providing needed support in response to their immediate needs.

Intake Process into the Program

In order to assess the process of screening and assessing clients into the program, clients were asked several open ended questions to elicit their reactions to the intake process. We administered these questions to identify whether clients experienced any stigma, negative emotions, or other negative reactions to this phase of the program. Many practitioners and program designers have speculated about how such an intake process might impact clients. But, there is virtually no empirical evidence regarding client reactions to being screened and assessed for risk or offered a home visitation program in the hospital. To this end, we asked a wide range of questions to tap into the multiple dimensions of the intake phase of Healthy Families Arizona.

The way questions are asked can play a major role in how clients respond. Questions about the purpose of the program focus on client beliefs and opinions. Different levels of information can be elicited by inquiring about client emotional reactions to different facets of the program. For this reason, we asked clients about their initial feelings. Prior to asking the question about feelings, the interviewer stated, *Think back to when you were first offered the opportunity to be involved in Healthy Families. How did you feel about participating in the program when you were first contacted?* For this question, one response was missing from the transcriptions of the interviews and the interviewers failed to ask this question of two respondents.

Several clear themes emerged in the analysis of the responses. These included: a) *immediate positive reaction*; b) *initial fear/ambivalence responses*; and c) *neutral responses*. A statement was coded *positive* if the client said they felt good, relieved, interested, thankful and

so forth. If a client expressed initial fear, skepticism, ambivalence, or a predominantly negative response, then the case was coded *initial fear/ambivalence*. The cases coded *neutral* were all the responses in which clients did not know or did not express a reaction that could be classified as immediate positive reaction or initial fear.

Immediate Positive Reaction. Most of the respondents had an immediate positive reaction (38%). Many perceived the program as a benefit and not as a stigma or potential threat. A sizeable proportion of the cases coded this way appeared to be influenced by the fact that they were offered the program while in the hospital. Their statements indicated that they were feeling vulnerable and that the program responded to this need. Examples of the positively coded statements include:

“I felt good because I would have someone to talk to.”

“I was excited, I liked it because of the kids.”

“I felt wonderful. I wanted something because I knew that I was at the end of my rope. I drank through my pregnancy. I didn’t need a baby. I was grateful for such a thing.”

“I thought that I would not qualify, I was hoping that I could get it.”

“Being a new mom I wanted as much information and help as I could get.”

“Thought it was a good idea that they came to see me in the hospital.”

The responses in the *positive* category demonstrated that clients with insight into their needs had positive initial reactions. If they were aware that they needed supports, then they were more likely to have had a positive initial reaction. One specific statement stands out in this regard. The client stated,

“I was going through a really bad time with the post-partum depression. That hit me hard. I felt alone most of the time. I didn’t have any friends. When they brought up this program and they came into talk to me and wanted to know what I felt, it was great and got me interested.”

Initial Fear/Ambivalence Responses. Although most of the client responses were assigned to a positive code, the survey uncovered some initial fears (18%). These responses, coded *initial fear*, included a wide range of themes. Respondents attributed some of their fear to how they were identified for these services. For instance, one client stated, *“I didn’t know what was going on. How did they get my name?”* Others included in this category were just skeptical. Others reported that they were initially concerned because they did not think that they needed this type of program. For instance, one mother said, *“I really didn’t have an interest in it because I had been a mother before. I thought that I knew everything.”* Two responses included specific fears about the nature of the program. These responses contained themes which

centered around abuse issues:

“At first they were asking weird questions. They asked me about my husband’s background and if he was a violent person. It was like I didn’t want to join it. I thought what if my husband asked me about the program. It made you feel like CPS will come out and ask you all these questions about how you treat your kids. This is how I felt.”

“Just the way that it was explained to me, I felt it was a child abusing thing. She wanted to come into the household to see if the baby was being fed and well loved. I felt like they thought I was going to abuse my child.”

The prior responses indicate that some clients may be fearful of the program when it is seen as a child abuse prevention program. However, this occurred with only two clients in the study’s sample.

The sample had 7% of the cases classified as *ambivalent* responses. The responses coded as *ambivalent* responses were statements like:

“I guess I really wasn't sure. I didn’t know if I really wanted to or not. I thought how I was treated when I was a kid and thought maybe it would be good for me because it give me someone to talk to. Otherwise, I would be stuck home with just my kids to talk to.”

“First of all, they came to the hospital right after she was born. I was kind of like out of it. I went along with it. I thought why not. They told me if I didn’t like it I didn’t have to continue.”

Neutral Responses. The remaining cases (37%) did not allow for classification into any of these categories, and were coded *neutral response*.

Workers who are responsible for the screening of clients are initially apprehensive about asking clients about personal history issues before developing a long term relationship. For this reason, we asked a number of questions to evaluate how clients judged this portion of the program. In Healthy Families Arizona, workers are expected to administer the Kempe Family Stress Checklist to parents to screen them for program eligibility. This instrument includes questions about history of abuse, criminal behavior, substance abuse, and other risk factors. To evaluate the impact of the Family Stress Checklist questions, interviewers asked: *What type of questions were you asked?* Because this question refers to past experiences, questions about the reliability of client memories is an important consideration. The validity of clients' memories of these experiences will be contingent on the salience of the screening process.

In coding responses to this question, it was difficult to determine whether clients understood the question. Some responses indicated that several clients might have

misinterpreted what the interviewer was asking. Their statements focused on content that appeared more consistent with the nature of the interview on the initial home visit. Some examples are:

"They asked if I had some income coming in. Like if I need help with diapers and formula."

"I just remember her asking me what I did when the baby was crying. Did I know if she was sick."

"Just where do I live and stuff like that."

In addition to asking clients what type of questions they were asked, clients were asked if they recalled the specific questions asked by the Family Assessment Workers at the hospital. In the follow-up questions, they were asked whether these specific questions made them uncomfortable or if they considered them too personal. If clients did not remember any specific questions, their responses were assigned a code of "O". If respondents did recall specific questions, but these questions did not involve content associated with items from the Family Stress Checklist, then the case was assigned a code of "1". This category represented statements of a nonsalient nature. However, if clients recalled questions that contained content with references to items in the Family Stress Checklist, then they were assigned a code of "2". Code 3 was assigned to those who did not respond to this set of questions. The results of this coding process revealed the following:

(Code 0): 8 respondents (17%) reported no recollection of questions that were asked in the hospital.

(Code 1): 18 respondents (39%) did recall questions, but their content did not relate to the sensitive issues that are explored in the Family Stress Checklist.

(Code 2): 17 respondents (37%) did recall questions that contained content that corresponded with the questions contained in the Family Stress Checklist.

(Code 3): 3 respondents (6%) did not respond to this set of questions.

Mothers were also asked about whether they considered questions from the Family Stress Checklist too personal. They were asked how comfortable or uncomfortable they were with the questions. A sample response:

Client: *"Uncomfortable, well just the one about when I was a kid because a lot of bad things happened to me when I was a kid. I really didn't want to talk to them about it but for some reason I did".*

Interviewer: *" Were they too personal? "*

Client: *"I never really thought about that. My worker never really judged me by them, so I've never thought about it."*

Although a few of the clients were uncomfortable with some of the questions, they said they understood why they were asked these questions. However, other clients did not understand why the workers needed this information to offer them the program.

Clients were also asked if they felt they were pushed into the program and whether they felt that they could refuse the services. All of the clients except one reported not feeling pushed in the program.

Most clients reported that they saw the program as a major source of help. For instance, one client responded this way:

Interviewer: *"Did you feel pushed into the program?"*

Client: *No. I didn't think there was any retribution. I needed something and it was there. It was a miracle."*

Similar themes were noted in many of the other responses.

Evaluator Impressions

The majority of parents in the study perceived the intake process as a positive event and as an opportunity to get some help that they needed. Indeed, they responded in a manner that suggests that they were grateful to have such a program. Some parents had concerns that included initial fears about the nature of the program. However, this was a very small number. Families with more needs also appeared to perceive home visiting as more important and helpful and were not concerned by the nature of the questions that they were asked at the hospital. The intake process includes the use of the Family Stress Checklist which requires workers to ask questions about matters such as past history of abuse, history of substance abuse, and history of criminal activity. While many mothers recalled that personal questions were asked in the hospital, most understood their purpose and were not concerned about being asked this kind of information. Lastly, the intake process was evaluated to examine if clients felt any pressure to join the program. All but one of the clients interviewed indicated that they did not feel they had to join the program. Overall, the intake process was not perceived as intrusive and was responded to in a positive manner by a majority of the mothers evaluated in this study.

Client Attachment to the Program

The degree of bonding to services and other social institutions is considered an important factor in reducing many forms of risky behavior. If clients value a program and are committed to cooperating with its requirements, then they are more likely to benefit from the intended objectives of the program. This study set out to examine various dimensions of client motivation and attachment to the program. This information is considered useful in assessing client attachment to the program and in providing further insights into client fears and reactions to the various phases of the program. To explore these dimensions we asked: *How has your commitment to the program changed from the beginning to now?*

Responses for this survey question were coded: a) *remained the same*; b) *increased*; c) *decreased*. The results of the coding for this interview question were: a) *remained the same*: 21 respondents (48%) reported their commitment was the same; b) *increased*: 15 respondents (34%) reported that their commitments had increased; , and c) *decreased*: 8 respondents reported (18%) that their commitment had decreased.

Two of the interviews did not contain responses for this question. A subanalysis was performed on the cases coded as *decreased*. Some mothers reported that the decrease in their commitment to the program was due to changes in their life circumstances that influenced their need for help. For example, some mothers did not need the program and had become self-sufficient. Examples are:

"It has decreased now because he is a little older. I don't need as much help now."

Interviewer: *"Has your commitment to the program changed from the beginning to now?"* Client: *"What do you mean?"*

Interviewer: *"Maybe at first you could have been more committed and you are less now?"*

Client: *"At first with the oldest one I had no help. No one to talk to. Nothing in particular or sometimes it would be something specific. Sometimes I would ask for an evaluation form to see how far along they are. Of if they are behind for their age. Information about potty training. Discipline. Every thing that I've asked for, I've gotten that she could provide. I've also done some of my own research . That was at the beginning. Now, it is harder to get a hold of her because she is unavailable or in a meeting. I don't know her schedule and I know if she is busy. I leave messages. If she is sick or something, I'm notified. Interviewer: Do you feel that she returns your calls?"*

Client: *Yes, as soon as she can, but she is hard to get hold of. Now, I don't know. In the beginning, it was like she was instantly there."* (Note: the availability of the worker changes as the mothers move through level changes and service intensity becomes less).

In sum, responses assigned the code *decreased* in level of commitment was because of either changes in the relationship with the Family Support Specialist, change of Specialists, or changes in life circumstances. The changes in life circumstances included events like obtaining

a job or getting married. An important point noted in some of the statements coded *decreased* was differences in the relationships between the client and a Family Support Specialist. Several clients reported not being able to connect with the new Specialist.

The quality of the client's relationship with the Family Support Specialist also appeared to be an important consideration noted in many of the statements assigned to codes representing *increased* levels of commitment. One of the more illustrative examples is:

Client: *"In the beginning I wasn't really into it. I wasn't committed. I didn't want to meet twice a week. I think after the mix up with all those people and they stuck...well, not stuck, but assigned one person to me, we got to know each other personally. Things just went really good from there. She is a good person and listens. She offers her support and her opinions and thoughts on different things. I think that is important that the worker is able to work with the people. They can't just assign anyone.*

Interviewer: *"How interested are you in the program now?"*

Client: *"I'm still interested in staying with it. She is a real good friend of mine and I think we get along really well. She has done so much for me that I've told her that if there was anything I could ever do for her or the program, like help some other unfortunate mothers. I see myself as a little better than when I met her. I'm in school now and I've been at my job for two years. That is the most I've ever been at any job! I think I've found a little bit of responsibility and trust with her."*

This client's personal observations indicate that changes in her behavior are influenced as much by the quality of the relationship as the information or services provided. That is, the client appears to be identifying with the worker in some respects and that her self-esteem and role transformation is associated with her relationship with the worker.

Each of the surveys were also coded to determine whether the clients were: a) very interested in the program; b) somewhat interested in the program; and c) not interested in the program. Thirteen (29%) of the respondents indicated that they were "very" interested in the program now. Twenty-eight (64%) reported that they were still interested or somewhat interested. And three (7%) indicated that they were not interested. Typical responses from the respondents who indicated that they were very interested include:

Interviewer: *"How interested are you in the program now?"*

Client: *"I'm really interested in it. They tell you a lot. What ever you ask they are always finding an answer for you."*

Client: *"Very much so."*

Client: *"I have more interest in it. She is helping me go through school through ICS and helping me get my driver's license. I'm studying goals and she is helping me try to get those goals. I don't want to end the program but there will come a time when I will have to be off."*

Some of the reasons why some mothers were not as interested were:

Interviewer: *“How interested are you in the program now?”*

Client: *“Not as much as I was before. It is kind of like they come to me every two weeks now and they've done so much for me in the beginning, I'm getting on my own now.”*

Client: *“In the beginning I was real interested because I liked it a lot. I'm not interested in being with anyone but I know that I can be on my own now without any help. I'm not saying that I'm not interested but I know I can do it on my own.”*

Client: *“Now not as interested, because I work a lot. When I work, I work nights and she usually comes early in the morning so I'm tired. So, I am not as interested.”*

Many of the above responses indicate that clients are becoming more self sufficient. This is consistent with the goals of the program. Clients were also asked: *Would you choose to be involved in Healthy Families again?* All of the clients said yes except two who answered “no”. One of the clients was monolingual and her remarks were not very expressive. She stated: *“Well, maybe I wouldn't like it anymore, or something”*. The other respondent's remarks need to be examined within the broader context of the other remarks and questions:

Interviewer: *“How interested are you in the program now? Like rating it on a scale from one to ten with one being you never wanted to see the program again?”*

Client: *“Five.”*

Interviewer: *“Would you choose to be involved in Healthy Families again?”*

Client: *“I don't think so.”*

Interviewer: *“Can I ask why not?”*

Client: *“I don't really feel like I'd need it again.”*

Only two mothers reported that they would not be interested and their lack of interest appears to be related to their enhanced self sufficiency.

Evaluator Impressions

A program's effectiveness is associated with a client's commitment to it. When clients feel attached and motivated in a program there is a greater likelihood that they will be able to benefit from its intended objectives. Individuals will not move to action unless they have made commitments of time and energy (Prochaska, DiClemente & Norcross, 1992). The interview data document that mothers were aware of their needs and willing to take advantage of a program that offers help. Thus, program developers have a unique opportunity to impact the lives of these mothers.

Perceptions of Program Benefits or Outcomes

Clients were provided scaled and open-ended questions to assess their evaluation of the outcomes or benefits received from the services provided by Healthy Families Arizona. For the scaled responses, clients were asked: *In what areas did you receive the greatest help from Healthy Families Arizona? Please assign numbers to the following areas, with 1 being the area(s) in which you received the most help, and 7 being the area(s) in which you received no help. For example, if you got a lot of help with your health needs it would be assigned a one. If you got a little help, it would be assigned a number in the middle. If you got no help, then it would be assigned a 7.*

The clients were asked to evaluate seven areas of service. The results of this analysis are reported in Table 1. These results indicate that the mothers felt that they received the greatest help in the areas of child development (Mean= 1.71) and in the area of the baby’s health needs (Mean= 1.85). The rank order of means from the greatest help to the least were:

| | |
|-----------------------------|-------------|
| 1) Child development | (Mean=1.71) |
| 2) Your baby’s health needs | (Mean=1.85) |
| 3) Your needs as parent | (Mean=3.00) |
| 4) Your individual stress | (Mean=3.02) |
| 5) Your family needs | (Mean=3.92) |
| 6) Community resources | (Mean=4.32) |
| 7) Your Health needs | (Mean=4.53) |

These rankings are consistent with the intended goals of the program where the emphasis is on the child’s health and development and on modifying parenting abilities. The areas in which they reported the least help were in helping the mother with her health needs (Mean= 4.53) and in the area of community resource needs (Mean= 4.32).

Table 1 Client Rankings Of Areas In Which They Received the Most Help

| Variable: Needs | Mean | Standard Deviation | Values 1-7 | Frequency | Valid Percent |
|---------------------------|------|-----------------------|---------------------------------|----------------------------------|---|
| Baby's Health Needs | 1.85 | 1.09 | 1 2 3 4 5 | 21 10 6 3 1 | 51.2 24.4 14.6 7.3 2.4 |
| Child Development Needs | 1.71 | 1.22 | 1 2 3 4 5 6 | 27 7 4 2 1 1 | 64.3 16.7 9.5 4.8 2.4 2.4 |
| Community Resources Needs | 4.32 | 2.36 | 1 2 3 4 5 6 7 | 9 3 3 3 6 5 11 | 22.5 7.5 7.5 7.5 15.0 12.5 27.5 |
| Family's Needs | 3.92 | 1.92 | 1 2 3 4 5 6 7 | 6 5 3 9 5 7 3 | 15.8 13.2 7.9 23.7 13.2 18.4 7.9 |
| Individual Stress | 3.02 | 1.88 | 1 2 3 4 5 6 7 | 12 9 5 5 6 3 2 | 28.6 21.4 11.9 11.9 14.3 7.1 4.8 |
| Mom's Health Needs | 4.53 | 2.14 | 1 2 3 4 5 6 7 | 6 2 4 4 8 4 10 | 15.8 5.3 10.5 10.5 21.1 10.5 26.3 |

| | | | | | |
|-----------------|------|------|---|----|------|
| Needs as Parent | 3.00 | 1.70 | 1 | 9 | 23.1 |
| | | | 2 | 8 | 20.5 |
| | | | 3 | 10 | 25.6 |
| | | | 4 | 3 | 7.7 |
| | | | 5 | 5 | 12.8 |
| | | | 6 | 3 | 7.7 |
| | | | 7 | 1 | 2.6 |

Note: 1=Most helpful, 7=Received no help

Client perceptions about the benefits that they obtained from the program were also assessed by asking them several questions that allowed for more subjective descriptions of perceived benefits or outcomes. These questions included:

1. *How has participation in Healthy Families Arizona program affected your relationship with your child?*
2. *How has participation in Healthy Families Arizona affected your relationship with your partner?*
3. *How has participation in Healthy Families Arizona affected your relationship with your other children?*
4. *How has participation in Healthy Families Arizona affected your relationship with your pediatrician?*
5. *How has participation in Healthy Families Arizona affected your feelings about yourself?*
6. *How has participation in Healthy Families Arizona affected your feelings about being a parent?*
7. *Are there other areas that you felt it could have provided help? (see Appendix A).*

The results from this set of questions indicates that mothers felt that Healthy Families Arizona has influenced their relationships with: the program's target child-- 67% (n=31), their feelings about themselves-- 72% (n=33), and their feelings about being a parent-- 76% (n=35). Almost all of the mothers interviewed, 93.5% (n=43), reported that their relationship with their child was being affected by participation in the program. Two respondents provided comments that were assigned a code representing ambivalent statements. In essence, clients articulated that they saw clear effects from the program in how they related with the target child, how they felt about themselves, and how they felt about themselves as a parent.

Eleven mothers (24%) reported that the program affected their relationship with their partners. Many of the clients had no responses to this question, but this was often because they were single parents or were not in contact with their partners. However, many of the respondents' comments indicated that clients felt their Family Support Specialists were helping with their mates if an appropriate circumstance would arise, but that this was not recognized as a fundamental aim of the program. That is, very few clients saw the program as impacting their relationships with their partners. Similarly, few reported changes in their relationships with

other children, other people or their pediatricians. Thirteen clients (34%) reported that it impacted their relationships with others. The most common response was "with my mother" (n=5). One respondent pointed out that her relationships with her in-laws was positively influenced by her participation in the program.

Evaluator Impressions

Overall, clients have perceived that they benefitted from the program in directions intended by program planners. Furthermore, their perceived benefits seem to match most of what is emphasized in the program’s design. Most telling is that almost all clients reported that their relationships with their children was positively affected by participation in the program. These benefits are important, as Olds and Kitzman (1993, p. 88) state, “programs that are considered valuable by the families they serve will be better able to engage those families and promote many aspects of maternal and child health.”

Perceptions of Treatment by Workers

Clients were asked a set of questions to assess how they evaluated the worker and the worker's treatment of them in the program. Although clients can be satisfied with the outcomes of a program, these assessments can be affected by their treatment in the program. For instance, a client can go to court and have their ticket thrown out, but be dissatisfied because they were not given an opportunity to prove the inaccuracies of the allegation (Lind & Tyler, 1988). Similarly, a client could like the resources that a worker provided on a home visit, but evaluate their satisfaction with the program negatively because of the manner in which it was provided by the worker. For this reason, utilizing a five point scale clients were asked fixed responses about how they were treated by the Family Support Specialist(FSS). The frequencies of responses for each of these items are reported in Table 2. The variables focusing on issues of personal control were not rated as high as the factors dealing with the manner in which the worker treated the clients. Most of the clients felt that the workers treated them with respect and were fair in their dealings with them. In fact, the items that received the highest positive ratings were "My Family Support Specialist (FSS) is a fair person" (Mean=4.86) and "My FSS is polite" (Mean=4.91). In essence, the findings in Table 2 indicate that clients were very satisfied with how the workers treated them in the program.

Table 2. Worker Treatment Variables

| Variable | Mean | SD | Values | Frequencies | Valid Percent |
|----------|------|----------------------|--------|-------------|---------------|
| | | (Standard Deviation) | | | |

| | | | | | |
|--|------|------|-----------------------|------------------------|-----------------------------------|
| My FSS treats me with respect | 4.85 | .43 | 3 4 5 | 1 5 38 | 2.3 11.4 86.4 |
| I can influence my FSS | 4.30 | 1.09 | 1 3 4 5 | 3 3 13 25 | 6.8 6.8 29.5 56.8 |
| I can't trust my FSS | 1.30 | .93 | 1 2 3 5 | 39 1 2 2 | 88.6 2.3 4.5 4.5 |
| I have a say when my FSS visits | 4.34 | 1.16 | 1 2 3 4 5 | 3 1 3 8 29 | 6.8 2.3 6.8 18.2 65.9 |
| Race treated differently | 1.27 | 1.02 | 1 5 | 41 3 | 92.2 6.8 |
| Satisfied with treatment | 4.68 | .56 | 3 4 5 | 2 10 32 | 4.5 22.7 72.7 |
| I have a say in what I work on with FSS | 4.48 | .93 | 1 2 3 4 5 | 1 1 4 8 30 | 2.3 2.3 9.1 18.2 68.2 |
| Like the way FSS teaches me about my child | 4.68 | .77 | 1 3 4 5 | 1 2 6 35 | 2.3 4.5 13.6 79.5 |
| My FSS is a fair person | 4.86 | .35 | 4 5 | 6 38 | 13.6 86.4 |
| My FSS is polite | 4.91 | .29 | 4 5 | 4 40 | 9.1 90.9 |

Note: 1=strongly disagree, 5=strongly agree

Evaluator Impressions

The overall ratings of the Family Support Specialists show favorable reactions by the clients. The clients indicate that workers show respect, can be trusted, and are generally satisfied with their treatment. Such factors are critical to successful program as Gomby et al. (1993, p. 16) describe “ the entire context and tone of the program should be one of respect for families--

their desires and strengths”.

Client Assessments of Overall Program Satisfaction

Respondents were administered six Likert items by the interviewer to measure their overall satisfaction with the program. They were asked to assign a value from 1 to 5 to indicate their level of agreement with the statements contained in the questionnaire, with "1" representing "Not at all" and 5 representing "Extremely." A summary of the frequencies of responses for each of the items in this six-item scale are reported in Table 3. These results indicate that the clients reported being very satisfied with the services provided by Healthy Families Arizona. A majority of the clients, 78.6%, assigned a value of "extremely" to the question: *I would recommend this program to other mothers*. When asked to rate the question, *I have benefitted from this program*, 85% indicated very much or extremely. Perhaps more revealing were their answers to the question, *I don't know what I would have done without this program*, where 56% gave a response of very much or extremely. Overall, most of the clients reported that they benefitted from the program and that they were satisfied with the services that they received.

Table 3 Program Satisfaction Variables

| Variable | Mean | SD (Standard Deviation) | Values | Frequencies | Valid Percent |
|---|------|-------------------------------|--|-------------------------|------------------------------------|
| Healthy Families Arizona has changed my life | 3.55 | 1.88 | 1 not at all 2 a little 3 somewhat 4 very much 5 extremely | 2 4 13 15 8 | 4.8 9.5 31.0 35.7 19.0 |
| How satisfied were you with services received | 4.31 | .75 | 2 a little 3 somewhat 4 very much 5 extremely | 1 4 18 19 | 2.4 9.5 42.9 45.2 |
| I have not learned much from the program | 1.86 | 1.03 | 1 not at all 2 a little 3 somewhat 4 very much 5 extremely | 18 18 1 4 1 | 42.9 42.9 2.4 9.5 2.4 |
| I feel that I have benefitted from this program | 4.34 | .73 | 2 a little 4 very much 5 extremely | 2 21 18 | 4.9 51.2 43.9 |
| I don't know what I would have done | 3.88 | .97 | 2 a little 3 somewhat 4 very much 5 extremely | 3 13 12 14 | 7.1 31.0 28.6 33.3 |
| I would recommend this program to others | 4.74 | .59 | 2 a little 4 very much 5 extremely | 1 8 33 | 2.4 19.0 78.6 |

Evaluator Impressions

A major theme that emerges from the client responses to overall satisfaction revolve around the significance of the worker-client relationship. There is significant debate as to how this relationship should be conceptualized. One dominate view is that the relationship should be “conceptualized as modern-day versions of the traditional extended family” (Powell, 1993; p.28). The results of this study clearly support the conclusion that Family Support Specialists in the Healthy Families program have developed relationships that are akin to that of the traditional extended family. Much of the research on home visitation has pointed to the special relationship as the key to program effectiveness in enhancing the environment and promoting child well being (Launer, et al. , 1992; Olds& Kitzman, 1990; Wasik, 1993; Pawl, 1995). The data from this study provide convincing evidence that the Healthy Families Arizona program is utilizing the worker-client relationship in providing effective services. And while this is often treated as a

key component it may not always be easily achieved. Ware et al. (1987) aptly point to the significant challenges of home visitor interventions, observing that one of the most difficult challenges for the home visitor is to form a positive relationship with each of their clients. Home visitors can confront rebellion and rejection--especially from younger mothers. Yet, when a strong relationship is formed it can be powerful and become therapeutic. As Weiss (1993, p. 166) describes, "the helper has to enter the client's world not just to gain trust, but to gain 'significance'." Through the relationship, the worker must create possibilities for change. It is in this sense that the relationship is often seen as beginning with the parent's emotional dependence on the worker which opens up the process of "reparenting" (Breakey, et al., 1991). The process of being a nurturing parent is modeled by the helper and the mother has exposure to a parent figure who is caring, available and trustworthy.

Questions Dealing with the Family Support Specialist Interventions

The nature and quality of relationships is widely recognized as a key factor in providing health and human services. Each client was asked the following question: *Tell me about your Family Support Specialist. Was she like a friend, a teacher, a parent or an authority figure?* The intent of this was to examine how they saw their relationship with the helper. Was it more like a professional friend or a teacher? Twenty-nine respondents (63%) characterized their relationship with the Family Support Specialist as being more like a friend than a parent or teacher. Some examples include:

"A friend. Someone who never judges you. She understands everything I am going through."

"More like a best friend. She knows everything. There is nothing that I haven't told her. When things happen I call her. If she is going to give me support then she needs to know everything. She is like a best friend."

Client: *"Friend."*

Interviewer: *"Why?"*

Client: *"She is just easy to talk to. I think I tell her just about everything that happens in my life. She is just easy to talk to."*

"She is real friendly and real polite. She'll ask me if I need anything and I think she really cares about me. She is a really nice person. She is more like a friend. She is not really like an authority."

"A young friend. She is younger. I would definitely say she is a friend. I can tell her anything."

As these responses indicate, many of the clients in our study felt a close emotional bond with their worker. Many respondents also focused on issues dealing with the levels of intimacy that they had with their worker. Another theme noted in these and other answers was the value that the respondents placed on being able to talk to their worker about any topic. Many respondents also made reference to the importance of the worker's nonjudgmental way of dealing with them.

Five of the respondents (11%) characterized the worker as a friend **and** a teacher. For example:

"She is a friend and teacher. She was there to help me and teach me about my child. Yes, I knew about my child but I didn't know certain things that mothers should know. It wasn't my first time being a mother but it was my first time realizing some of the problems that I had."

"The worker that I liked best was understanding of what I was going through. She was supportive and she told me that I could be whatever I wanted to be in life instead of what other people want me to be."

"She was just real easy to talk to. She makes you real comfortable. The information that she brings. She always brings me something."

"Her attitude. Always smiling. Always coming when she said she would. Always being there for me."

"You name it. She is great and I wouldn't give her up for the world. I remember that she was once talking about switching jobs and I told her that if she left the program I had to leave. She is my world."

"She never just came out and told me that things were not right. She just went along and I made the decisions and she just supported it. That is something that my mom would not do, but did. It was like she was taking the place of my mom."

There were three fundamental themes observed in the client responses to the question about what they liked best. The majority of the clients responded to this question by focusing on identifiable factors that they attributed to *personal qualities* possessed by the worker. Some examples include:

"She is nice. She is not quiet. She likes to talk a lot and she loves to be with my girls and my girls like her a lot."

"She is a caring person. She also listens".

"I like everything about her. She is one of those unique individuals. My son has a party

this weekend and if she gets back in time she is going to come to his party. If I invite her to come she has always shown up. Someone you can always count on like best friends."

"The openness that we had. We were equal."

"She is always happy."

The next modal response-type included answers that focused more on the *form of help* that the Family Support Specialist provided. Examples of this theme are:

"I like that they came and told me a lot. Taught my daughter lots of things."

"We would talk about the kids and she would give me advice. Sometimes we would go for tests and things."

"When she would take me places and bring me diapers."

"Because there are times when I need to go to the store to buy milk for both of my kids and she will come and take me. I have to take them for shots and she takes me to the appointments and she comes and takes me for everything and she helps me."

"She would help me with things. I would tell her he's in jail and I didn't know what to do. She would help me out with things. Whatever I would tell her she would give me a good answer. I didn't have to think too hard. I really did like that. She would have the right answer."

Three of the clients in our sample also commented on how much they liked the home visitation component of the program. For example, one mother said, *"I didn't have to go anywhere. I didn't have to get to an office. She called me so that I don't forget"*.

The participants in the interview study were also asked what they liked least about their Family Support Specialist. The majority of the respondents reported "Nothing". However, four mothers identified factors which they did not like. These included:

"Just that she needs to walk a mile in my shoes. To understand why I deal with my child the way I do. I have to spank him but it is something that has to be done. Every kid has to be spanked in my eyes. She thinks that is wrong. I don't see what is wrong with it."

"I'd have to make sure my house was clean. Because it is on a Friday. That is the day after pay day and I have to go do things. During the winter it is fine, but during the summer I wear out by 11 AM and I don't get up until later."

"Sometimes I don't talk because she might react and tell me what to do. She don't know a lot. You can take that from a friend or a family member but not from someone you don't

know.”

“It has to do with when you see her because of the happiness in her. She is always happy and I'm always the one who is depressed.”

No clear themes are evident in these responses. But, the last statement and other statements in this study indicate that clients are engaging in some comparative identification with the workers. Three of the respondents used humor in responding to the question about what they liked least about their support worker. These jokes included a subtext that indicated that they compared themselves with their workers in many other respects. For instance, one client stated,

“She was prettier. No, nothing really. She even helped me with a diet. I got mad once because my husband came over and asked who she was and he told me she was pretty and skinny.”

One mother pointed out that the only thing that she didn't like was when her worker called the social worker. Nonetheless, she still considered the worker *“real nice”* and still liked her as a friend. One respondent also said, *“I can't get hold of her”* and this was what she liked least about her Family Support Specialist. Lastly, one client reported that she did not like having to complete all the tests for the program..

Each mother in the interview study was also asked to describe their relationship with their Family Support Specialist in their own words. Some examples include:

“I love it. I think it is fun. I have a friend who is suppose to be my best friend, and her husband won't let her come see me because I'm white and she is Mexican. I think the worker is now my best friend right now. She has gone through everything in the past three years that I've gone through.”

“It was more like a friend. We would talk about things that were happening first and then what she came for.”

“I guess you can say that we are on a friend basis. If I ever saw her, I could always say Hi. I know that I can just stop and talk to her.”

“The first one. After the first one left, they told me that I could not contact her again. It was kind of like we were closer because I knew her son. The second, we were not that close. The third not as close as the first two.”

“She is part of the family. She has always been part of the family. So when-----comes the kids run up to her and it is like having an aunt or another grandmother. She always talks to me and asks the children what is going on. It is not like an interview. She is just like someone who comes to visit and see how we are.”

These responses reinforce some of the other observations noted in other portions of this interview study. The clients' answers indicate that they value having informal relationships with their support worker and assign substantial weight to this relationship in many of their subjective evaluations of Healthy Families services.

Many Healthy Families Arizona staff were unclear, in the implementation study, as to how to define the focus of their services, on the development of the child; or on the needs of the mother. Although clients appear to see the program's purpose as being informational in nature, they consistently report that they value having a close relationship with the worker and define the relationship in these more personally relevant terms. Another trend running through many of their responses was a lack of social distance. They consistently avoided viewing the relationship as a formal helping relationship. They prefer to see it in terms of a friendship or as a friendly visitor. In essence, the program is providing valuable information as well as meeting the emotional needs of mothers.

Mothers were also asked to describe whether the relationship was difficult or easy in the beginning. A large number of mothers (45%, n=20) reported having some difficulties in the beginning of the home visitation process. Examples of their remarks are:

“It was hard because I had never been in something like that. It was different since I was not used to it. Then I started talking to her and she made it go easier. It was easy after that.”

“It was kind of... It was having someone come over that I didn't know. In about a week's time and I spoke to her on the second visit, I was more comfortable with her and I realized that she was not here to spy on me. She was here to help me with things I needed.”

“It was difficult. I didn't know her and what she was like. It was hard talking to her. I didn't know her.”

“It was difficult because I had already had like three support workers before her and it was hard to get used to her.”

“I found out that she really cared and that it was not just a scam. I thought it was just another federal funded something. I was somewhat skeptical. She answered my questions and became a true friend.”

Several of the respondents spoke about the difficulties of having more than one Support Specialist. This appears to be an important factor in how they evaluate various aspects of the program. One client said that it took her approximately one year before she felt comfortable to open up with her Support Specialist. She said,

"I guess it took me about a year to really open up to my worker and really start to talk to her. Up to that point, I think she did most of the talking. Now she can't get me to shut up. I wouldn't talk she would do it all."

Another client's comments contained remarks indicating that age had something to do with her bonding with one of the workers. She said,

"At first it was her and another lady that would come over. They were just asking questions and I didn't really like it. I didn't want them coming over and I didn't want them here and to tell them things. I don't know about the other one but I felt more comfortable with ----- . I didn't want the older women to hear things I said."

The majority of clients reported, however, that they did not have any significant problems in developing an initial relationship with the Family Support Specialist.

Mothers were also asked *'How easy or hard was it to ask your Family Support Specialist questions?'* Thirty-one of the respondents (70%) reported that it was easy asking their Family Support Specialist questions. Some sample responses were:

"It wasn't hard. It was always easy."

"It is easy. I just ask for something and it is there."

"At the beginning it was hard because I was kind of embarrassed. But it is easier now."

Six mothers reported that it was hard asking questions. A sample of their responses are:

"I still don't know what her childhood was, or anything, just me. In the beginning it was hard to adjust to that because it was everyone else but me before that. It is better. She is what I wish I could be."

"For me it was really hard because I hate the word no. It took me a long time to figure out that if I needed like transportation, the worker was going to tell me no. It took me forever to start asking her questions and stuff. I just hate the word no. I started asking questions about the time that I started warming up to her."

"In the beginning it was hard, but sometimes I wouldn't ask them for things but the next time I would ask them. It would just get worse if I had a problem. Now I ask for anything."

A small number of clients reported that they could not discuss personal information with their worker. Most clients reported being able to discuss personal issues with the worker. Mothers in the interview study were also asked: *Did you feel like you could be honest with your Family Support Specialist?* Almost all of the clients stated that they felt that they could be

honest with their Family Support Specialist. Two respondents reported not being able to be honest with their worker, but only one offered the interviewer a reason for this response. She said, “*No not really because I didn't know her at first.*” One respondent also provided a more mixed response. She stated: “*Maybe about certain things. What happened with my first one and she reported it.*” This respondent was indicating how the relationship changed as a result of her contacting outside authorities. However, she said that the worker was not critical of her and this respondent had also more than one Family Support Specialist. Almost all the clients who had more than one Family Support Specialist noted difficulties in the relationship. This appears to be a significant factor in how client’s evaluated their relationship with the Family Support Specialist.

Mothers were also questioned about whether they ever felt like the Family Support Specialist criticized them. This question was approached by the interviewer as follows: *Most parents have at some time felt criticized by others about how they were raising their children. Did you ever feel criticized by your Family Support Specialist?* Almost all the clients reported not feeling criticized by their worker. Three clients did report feeling criticized by the worker. The reasons that accompanied these responses were:

“Well sometimes when she comes and my child is here, you know that when she starts crying she must be tired. Sometimes I scold her and she tells me, look, do this for her, do it this way, do that for her. But it is also why I like her.”

“Yes, she got mad one time. I know because I spanked his hand because he was playing with the books. He ripped up the Encyclopedia. I didn't hurt him and when I hit him he started laughing. She got mad.”

“There was this one time. I know I should not have done it but, I really hit the kids but there are times when they do something really bad I just spank them. I don't spank them with the belt, but there was this one time _____ was here and I raised the belt. She reported it to her supervisor.”

Although two of the prior respondents expressed concerns about being criticized for discipline issues, each of these respondents characterized their relationships with the worker as one of friendship. This points out that the workers are focusing on the issues of abuse and neglect in their relationships with the clients. Clients also tended to stress positive personal qualities when they were asked to describe what they liked best about their worker. Each of these cases also involved some report of their activities to a supervisor or outside agency. In spite of these incidents, the relationships were not jeopardized. Overall, most of the clients reported that the workers were not judgmental or critical in relating with them about their parenting abilities.

Evaluator Impressions

Several clear themes emerged in the analysis of client perceptions of their relationships with their Family Support Specialists. Most respondents characterized their relationship as being one of a trusted or professional friend. When stress or problems with the relationships were noted, this appeared to be closely linked with comments including negative judgements about worker turn-over. In most of these circumstances, the client had more than two Family Support Specialists. In some instances, clients had a difficulty adjusting to the newer worker, but not in all circumstances.

There is a connectedness with the worker and this provides a degree of social control for the mothers. As the interviews revealed, the open and honest relationship allowed the Family Support Specialists to be able to directly confront behaviors that were likely to be harmful to the child. And this is precisely what the program desires to achieve- a capacity to reach out to mothers and through a special individualized relationship understand the needs of the family in a manner that provides an early preventive interaction that can respond and intervene with families at risk for child abuse.

In general, client statements revealed that they preferred having a trusting informal relationship with the Family Support Specialist. They did not want to see the Family Support Specialist in a teacher or other kind of authoritative role. To some extent, this might be explained by their need to rationalize their acceptance of help from the worker. Many seemed surprised by the level of trust that they developed with their worker and by the closeness of their relationship with the Family Support Specialist. Although many of the respondents indicated that they learned much from their worker, they did not see the worker's role as that of a teacher or authority figure. It appeared easier for many of these respondents to classify this level of intimacy as being like a "close" friendship. Given the backgrounds of many of the respondents, they probably lacked prior experience with sharing personal information with a nonfamily member. From their perspective, this is the kind of closeness that one would expect in a trusting relationship and not from someone employed by a service organization. They also emphasized in many of their answers that they valued how "friendly" they found the Family Support Specialist. The level of perceived friendliness appeared to be closely associated with how they viewed the worker and how they described their relationship with the Family Support Specialist. However, clients who experienced problems with parenting did see the workers as monitoring their behavior, but in a nonjudgmental fashion.

Conclusions And Recommendations

1. Healthy Families Arizona is a complex and multifaceted service program, yet, in spite of this, participants have a good understanding of the program's goals and objectives. Also the program appears to meet a variety of different client needs. **These results support the approach taken by staff in describing the program to families and engaging them in the process of receiving services.**
2. The intake process used in the Healthy Families Arizona program is perceived as positive by the majority of the participants. Although the intake process includes asking mothers personal questions, most mothers are comfortable with the screening process. **To further ensure the comfort of the participants, workers should continue to provide a clear rationale for asking screening questions.**
3. Overall, the clients have strong commitment and attachment to the program. Mothers were aware of their need and willing to take advantage of a program that offers assistance. **Program staff should continue to build on client commitment and attachment to the program recognizing this as a unique opportunity to help create positive changes in families.**
4. Clients of the Healthy Families program reported that they benefitted from the program. Furthermore, their perceived benefits matched the primary goals of the program. **The perceived positive benefits of the program support the potential for achieving positive client outcomes.**
5. The home visitors or Family Support Specialists are perceived as helpful, respectful and trustworthy. The significance of the worker-client relationship was documented in this study and is seen as a critical key to program effectiveness. Staff development training should reinforce the importance of the nature of the relationships with newly hired workers and that workers are less likely to be successful with working with the clients when they approach their role as being an "expert" in areas of parental education. **The program should continue to support and train workers in the skills of helping relationships.**

References

- Berrick, J.D., & Gilbert, N. (1991). With the best of intentions: The child sexual abuse prevention movement. New York: Guilford Press.
- Blais, R. (1990). Assessing patient satisfaction with health care: Did you drop somebody? The Canadian Journal of Program Evaluation, 5, 1-13.
- Breaky, G. Pratt, B., Morrell-Samuels, S. And Kolb-Batu, D. (1990). Healthy Start program manual. Honolulu: Hawaii Family Stress Center.
- Gobmy, D. S., Larson, C.S., Lewit, E.M., & Behrman, R.E. (1993). Home visiting. Analysis and recommendations. The Future of Children, 3, 6-22.
- Hall, J.A., & Dorman, M.C. (1988). What patients like about their medical care and how often they are asked: A meta analysis of the satisfaction literature. Social Science and Medicine, 27, 935-939.
- Larner, M. Halpern, R., Harkavy, O. (1992). Fair start for children: Lessons learned for seven demonstration projects. New Haven, CT: Yale University Press.
- Lind, E. A., Tyler, T. R. (1988). The social psychological of procedural justice. New York: Plenum Press.
- Olds, D.L., & Kitzman, H. (1990). Can home visitation improve the health of women and children at environmental risk? Pediatrics, 86, 108-116.
- Olds, D., L., & Kitzman, H. (1993). Review of research on home visiting for pregnant women and parents of young children. The Future of Children, 3, 53-92.
- Pascoe, G.C. (1983). Patient satisfaction in primary health care. A literature review and analysis. Evaluation and Program Planning, 6, 185-210.
- Pawl, J. H. (1995). The therapeutic relationship as human connectedness. Being held in another's mind. Zero to Three, 15, 3-5.
- Powell, D. R. (1993). A conceptual overview of the diversity of home visiting programs. The Future of Children, 3 23-38.
- Prochaska, J. O., DiClemente, C.C. & Norcross, J.C. (1992). In search for how people change. American Psychologist, 47, 1102-1114.

Tyler, T.R. (1989). The psychology of procedural justice: A test of group-value model. Journal of Personality and Social Psychology, 57,830-838.

Ware, L.M. Osofsky, J.D., Eberhart-Wright, A., & Leichtman, L. (1993). Challenges of home visitor interventions and adolescent mothers and their infants. Infant Mental Health Journal, 8, 418-427.

Wasik, B. H. (1993). Staffing issues for home visiting programs. The Future of Children, 3, 140-157.

Weiss, H.B. (1993). Home visits: Necessary but not sufficient. The Future of Children 3, 113-128.

APPENDIX A

Healthy Families Arizona Qualitative Interview Questions