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Participants' perceptions of healthy families: A home visitation program to prevent child abuse and neglect

Judy Krysik *, Craig Winston LeCroy, Jose B. Ashford

Arizona State University, United States

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Abstract

This qualitative study of 46 randomly selected participants of a home visitation program explores current participants' perceptions of the intake process, the program's purpose, and the relationship between the home visitor and the participant. The findings reveal that the participant and home visitor relationship is a central feature of the program. Not only do participants relate their personal achievements to the quality of their relationship with their home visitor, but through a positive relationship with the mother, the home visitor is able to address parenting behaviors that are harmful to the child. These findings are important in that prior research has questioned the ability of strength-based home visitation programs to address major risk factors for child maltreatment. Recommendations are made for improving the intake process so that fewer parents will experience initially negative reactions to home visitation.

Keywords: Home visitation; Qualitative; Relationship; Participant perceptions; Child abuse and neglect

1. Introduction

Home visitation programs comprise one of the largest and fastest growing prevention efforts in the United States to improve the health and development of children, and to prevent child abuse and neglect. As an example, Healthy Families America, a national model of home visitation programs has grown from 25 sites in 1992 to 430 sites in 2003, serving an estimated 47,500 families (Diaz, Oshana, & Harding, 2004). The momentum in Healthy Families has resulted from interest in early childhood development, positive research findings from well controlled studies,

* Corresponding author. ASU School of Social Work, Mail Code 3920, 411 N. Central Ave., Suite 800, Phoenix, AZ 85004, United States.
E-mail address: judy.krysik@asu.edu (J. Krysik).

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and the fact that home visitation offers an effective delivery method for the provision of prevention services. Paris and Dubus (2005) describe several reasons why home visitation services are perceived as effective, including that they bring the service to the participant, they provide an ecological context for understanding the mother and child in the natural environment, and they offer services in the home environment where they are more likely to make a difference. The growth in home visitation programming has also been fueled by national endorsements such as that from the U.S. Advisory Board on Child Abuse and Neglect in 1991 that endorsed home visitation as the single most critical element in a comprehensive approach to prevent child maltreatment (U.S. Department of Health and Human Services, 1991). More recently, the Centers for Disease Control and Prevention, based on a systematic review of published studies, recommended that home visitation programs be implemented or continued on the basis of "strong evidence of effectiveness" (2003, New findings section, 2).

Despite the positive coverage, home visitation is not without criticism. In 1999, *The Future of Children* issued their second issue on home visitation. In that issue, Gomby (1999) reported mixed outcomes from a multitude of studies raising important questions about whether home visitation programs were implemented well enough to assess their outcomes. Since that time additional reviews of home visitation programs have also noted mixed results depending on the study, the outcome measures used, the implementation or fidelity of the intervention, and the period of follow-up (see for example Chaffin, 2004; Guterman, 2001; Lundahl, Nimer, & Parsons, 2006; Nelson, Westhues, & MacLeod, 2003). Thus, even though overall there has been strong support for home visitation, the mixed outcomes suggest that it is essential to examine the various strategies in order to determine which will yield the greatest impact. Indeed, programmatic variations, even within a particular model, may be an important factor in understanding why some programs appear to work and others do not (Duggan et al., 2004).

While many policy makers have been focused on the outcome evaluations of home visitation, it is recognized that a more complete understanding of service delivery and implementation has been lacking. For instance, early on in a comprehensive review of home visitation programs Gomby, Culross, and Behrman (1999, p. 15) concluded, "Existing home visitation programs should focus on efforts to enhance implementation and the quality of their services." When Duggan et al. (2004, p. 615) found disappointing results in an experimental evaluation of home visitation they concluded: "We believe that the program's implementation system contributed to its minimal impact on maltreatment." Further, Paris and Dubus (2005, p. 72) note that "home-visiting interventions have been used as a means of support, education, and prevention of various areas involving the needs of women and infants during the postpartum period (Gomby et al., 1999; Taggart, Short, & Barclay, 2000), but studies are needed that detail the usefulness of the home-visitor and new mother relationships from the participants' perspective." Hebbeler and Gerlach-Downie (2002) discussed the need to elucidate the "black box" of home visiting programs. Finally, LeCroy and Whitaker (2005) suggested that future studies should continue to examine the day-to-day interactions of home visitors and families in order to better understand implementation and provide data for improving the potential impact of home visitation.

The purpose of this qualitative study was to better understand the nature and quality of services received from a home visitation program. It focuses on understanding what the procedures and services used in this program mean to the participant. The research questions asked include: How do participants experience the intake process? How do participants conceptualize the program's purpose? How do participants' perceptions of the benefits of participating in the program compare with the intent of the program model? What factors do participants consider important relative to their retention in the program? And, how do participants perceive their relationship with their home visitor?

Participants' understanding of services can sometimes differ substantially from what is envisioned by program planners. These differences can lead to an underutilization 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 do not address the subjective standards program participants apply in their personal evaluation of the program.

2. The study

The context for this study is one particular home visitation program, Healthy Families America, which was adopted by the National Committee to Prevent Child Abuse, since renamed Prevent Child Abuse America in 1992. This study took place in Arizona, one of the first states to begin implementing the Healthy Families America home visitation program. The national Healthy Families America model is designed to help expectant and new parents get their children off to a healthy start. Families participate voluntarily in the program and receive home visiting and referrals from trained staff referred to as home visitors. By providing services to overburdened families, Healthy Families America fits into the continuum of prevention services provided to families in many communities.

The three overarching goals of the Healthy Families America program are: (a) to promote positive parenting, (b) to enhance child health and development, and (c) to prevent child abuse and neglect. Intake to the program is conducted by Family Assessment Workers. Eligible families are identified in select hospitals shortly after giving birth by a two-stage screening and assessment process. If the first screen is positive, the parent(s) can voluntarily submit to a more detailed assessment interview that is based on the 10-item Family Stress Checklist. If the score on the Family Stress Checklist is 25 or greater for either parent, and if space in the program is available, the family is offered the program. If the eligible family accepts the program, a home visitor will visit the family regularly in the home for a period of up to five years. The home visitors are a mix of paraprofessionals and entry-level professionals. Home visiting for new families is usually once a week for 1 h, but can be more frequent if determined necessary. The number of home visits a family receives is based on a level system with defined criteria for increasing and decreasing the intensity of home visitation over the course of a family's involvement. Program interventions are broad and may include: assessment of need and provision of referrals to other community services, emotional support for parenting, modeling of desired parenting behaviors, promoting the problem solving skills of the parents, reducing parental stress, and introducing activities that promote child development. A critical aspect of the program is the development of a trusting relationship between the participant and the home visitor.

3. Method

An IRB panel from the Healthy Families program reviewed and approved the research design, interview schedule, and protocols for the study. The authors of this paper served in the capacity of independent evaluators for the Healthy Families Arizona program and were not involved in program planning or the delivery of services. A stratified sample of 46 randomly chosen, currently enrolled families was administered semi-structured interviews that included open-ended and scaled response items to elicit their opinions of program services and procedures. Future research in this area should carefully consider the amount of structure in the interview. A less structured approach than was taken in this study would likely to lead to greater richness in the data.

Participants were stratified according to the three sites that were offering home visitation services, a large urban site, a medium-sized urban site, and a rural site. Each site was asked to randomly select a total of 30 enrolled participants that had participated in the program for a minimum of six months. The interviewers, who were not program staff, were instructed to contact between 15 and18 of the 30 participants from each site for face-to-face interviews. The first 15 to18 participants from each site that the interviewers were able to contact and that agreed to participate in the study were included. Some participants were difficult to contact primarily because they had moved and lacked forwarding address information. All participants who were contacted agreed to be interviewed for the study. Participants were not paid for participating in the interviews. The final sample included a total of 46 participants: 12 from the large urban site, 16 from the medium-sized urban site, and 18 from the site serving rural participants. The face-to-face interviews ranged from 30-to-90 min in length.

3.1. Sample

Program administrators who agreed to the study requested that the researchers not collect any identifying information such as age, marital status, and so forth. Owing to the random selection of participants from each site, it is expected that the sample reflects the population of those receiving Healthy Families services at the three sites. The population statistics revealed the following descriptive information about program participants. A significant proportion of the population, 38%, was teen mothers; 71% were not married upon entry to the program, and 63% had less than a high school education. The median, gross annual family income was $9600. The participants were culturally diverse with approximately 54% identifying as Hispanic; 22% white, non-Hispanic; 8% American Indian; 7% African American; 8% reporting a mixed-race identity, and 1% other.

3.2. Analysis and interpretation

All participant interviews were audio taped, transcribed, coded, and analyzed. Using qualitative research methods the present researchers followed a categorical-content approach (Lieblich, Tuval-Mashiach, & Zilber, 1998; Strauss & Corbin, 1990). The researchers focused on the experiences the mothers described in the process of participating in home visitation services. The interviews with the participants were analyzed across all cases after the complete set of interviews were completed. This was relatively easy to accomplish because the interviews were semi-structured and responses for each question could be compared across cases. The analysis focused primarily on examining commonalities and variations in answers to the same questions. After the interviews were transcribed a cross-case analysis was conducted to identify and label the themes. The information for each category for each case was reviewed by a research team of three individuals. This process was iterative beginning with the initial categories and then adding categories as data were reviewed. The research team worked together to guard against bias and produce decisions that were consistent across the cases. The researchers followed guidelines for conducting reliability checks and tests of internal and external validity. Three researchers coded the interviews and worked together to produce a systematic analysis process for the study. After a preliminary report was generated it was reviewed for cross-checking purposes by program staff.

4. Findings

For the purposes of this paper the researchers focused on four questions regarding the participants' experiences with the home visitation program. Specifically, these questions related

to how respondents explained: (a) their experience with the intake process, (b) what they perceived to be the program's primary purpose, (c) their perceptions of the home visitor, and (d) how their involvement in the program changed over time.

4.1. Experience with the intake process

In order to assess the process of screening and assessing eligibility for the program, participants were asked several open-ended questions to elicit their reactions to the intake process. These questions were asked to identify whether participants experienced any stigma, negative emotions, or other negative reactions to this phase of the program. Some practitioners and program designers have speculated about how such an intake process might impact participants. There is virtually no empirical evidence regarding participant reactions to being screened and assessed for risk, or offered a home visitation program in the hospital. To this end, participants were asked a wide range of questions to tap into the multiple dimensions of the intake phase of the home visitation program.

The way questions are asked can play a major role in how participants respond. Questions about the purpose of the program focus on participants' beliefs and opinions. Different levels of information can be elicited by inquiring about participants' emotional reactions to different facets of the program. For this reason, participants were asked about their initial feelings. The interviewers asked participants: "Thinking 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?"

Several themes emerged in the analysis of participant responses to this question. These included: (a) *immediate positive reaction*, (b) *initial concern*, (c) *ambivalent responses*, and (d) *neutral responses*. The researchers coded a statement *positive* if the participant said they felt good, relieved, interested, thankful, and so forth. If a participant expressed initial skepticism or a predominantly negative response then the statement was coded *initial concern*. Statements were coded *ambivalent* if they expressed both positive and negative responses to the request for participation, and *neutral* if the participant did not know or did not express a reaction that could be classified as an immediate positive reaction or initial concern.

4.1.1. Immediate positive reaction

Several of the respondents, 18 or 39% of the 46 respondents, reported an immediate positive reaction to being offered the program. These respondents initially perceived the program as a benefit and not as stigmatizing or a potential threat. A sizeable proportion of the respondents with statements 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 from different participants 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."

The responses in the *positive* category demonstrated that participants with perceived needs had positive initial reactions. If they felt that they needed supports, then they were more likely to have had positive initial reactions. One specific statement stands out in this regard. The participant

stated, "I was going through a really bad time with the postpartum 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 in to talk to me and wanted to know what I felt, it was great and got me interested."

4.1.2. Initial concern

Although many of the initial responses to the program were reportedly positive, the interviews uncovered some initial concern among 8 (17%) of the 46 respondents. The responses coded *initial concern* included a range of themes. Respondents attributed some of their concern to not knowing how they were identified for services. For instance, one participant stated, "I didn't know what was going on. How did they get my name?" Others reported that they were initially skeptical 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 that centered on issues of child abuse. For example, one participant said, "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." Similarly, another mother said, "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 participants may be initially fearful of the program when it is seen as a child abuse prevention program. However, this occurred with only two of the 46 participants in the sample. Other concerns were related to how the participants were identified for the program and why it was assumed that they would benefit from the services.

4.1.3. Ambivalent

Three of the 46 respondents' comments (7% of the sample) were classified as ambivalent. An example of a statement coded *ambivalent* was: "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 would give me someone to talk to. Otherwise, I would be stuck home with just my kids to talk to."

4.1.4. Neutral

The statements of 17 respondents, 37% of the sample, did not allow for classification into any of these categories, and were coded *neutral.* The neutral responses suggest that the program intake process did not leave a lasting impression with these participants.

The analysis indicates that the participants were most likely to have one of two reactions to being offered the program. The two largest categories of respondents in the study, 18 and 17 women respectively, perceived the intake process as either a positive event that provided an opportunity to receive some assistance, or they did not articulate a lasting impression of the intake process. It may be that the women who were neutral in their responses had been in the program longer and were more distanced from the intake process than those who had a definite impression; or it may be that they felt less need for the program. Data are not available from this study to evaluate these hypotheses. Women articulating they had greater needs in the postpartum period appeared to initially view home visiting as more important and potentially helpful and were not concerned by the nature of the questions that they were asked in the hospital. The intake process requires workers to ask questions about matters such as past history of abuse, history of substance abuse, and history of criminal

activity. While many of the mothers recalled that personal questions were asked in the hospital, most mothers understood the purpose and were not concerned about being asked these personal questions. Eight participants, however, were concerned about the questions and these participants were also concerned about the way that the program was explained because it produced some initial concerns about the nature of the program. Lastly, the intake process was evaluated to examine if participants felt any pressure to join the program. All but one of the 46 participants interviewed indicated that they did not feel pressure to join the program.

4.2. Perceptions of the program's primary purpose

All participants were asked the question: "What is your understanding of the purpose of the Healthy Families program?" Most of the respondents described Healthy Families as a "program that offered help and services." The modal responses were represented as follows: (a) 34% of the sample reported the purpose is to support, help, and provide services; (b) 21% reported that the purpose is to provide participants with information (e.g., developmental or parenting information); (c) 9% reported the purpose is to support and provide counseling; and (d) 7% reported the program is for single or new moms. The other responses did not allow for meaningful categorization. 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 home visitor 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."

Most of the responses that were coded "to provide participants with information" described the program as being fundamentally for the care of the child. A sample of responses assigned this code 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."
>
> "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."

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, 9%, of the sample perceived the home visitors as having skills akin to being a counselor. Under the Healthy Families America model, home visitors are not intended to be counselors, and the results of this survey suggest that while most participants support this view, a minority may perceive otherwise.

Some of the respondents defined the program's purpose as providing services for a specific target population. One respondent said, "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." A second mother noted, "It is for single mothers who need help because of their immaturity." A third participant stated, "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 only child abuse and neglect.

Evaluations of satisfaction can be influenced by participant expectations. In social psychology, this is often referred to as an expectancy confirmation sequence. This concept suggests that 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, each of the respondents was asked: "Has the Healthy Families program turned out differently than you expected?" Eight respondents (17%) reported that it had. The reasons given included:

> "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 home visitor 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?"
>
> Participant: "Yes, just someone coming in and being very professional and staying only 10 minutes and leaving. My home visitor 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: participants move through level changes that represent changes in service intensity).

The participants 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

quality of their relationship with their home visitor. 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?"
>
> Participant: "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?
>
> Participant: "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 with the baby. They got to attend 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."

Participant responses to questions about the program's purpose suggest that the participants understand the purpose of the program. They see the primary program goals as providing developmental information, and to help support and provide needed services to enhance overall family functioning. The fact that participants 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, as well as the provision of support in the form of being there when the participant felt they needed this type of support.

4.3. Perceptions of the home visitors

The nature and quality of relationships is widely recognized as a key factor in providing health and human services. Each participant was asked: "Tell me about your home visitor. Was she like a friend, a teacher, a parent or an authority figure?" The intent of this question was to examine how the participant viewed their relationship with the home visitor. Twenty-nine of the 46 respondents (63%) characterized their relationship with the home visitor as being more like a friend than a parent or teacher. Some examples of their responses include:

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

Participant: "Friend."

Interviewer: "Why?"

Participant: "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."

As these responses indicate, many of the participants in our study felt a close emotional bond with their home visitor. Another theme noted in these and other responses to this question was the value that the participants placed on being able to talk to their home visitor about any topic. Many participants made reference to the importance of the home visitors' nonjudgmental approach. The participants' answers indicate that they value having informal relationships with their home visitors and that they assign substantial weight to these relationships in their evaluations of the Healthy Families program.

Five of the respondents (11%) characterized the home visitor 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 home visitor 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 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 she did. It was like she was taking the place of my mom."

There were three fundamental themes observed in the participants' responses to the question about what they liked best about the home visitors. The majority of the participants responded to this question by focusing on identifiable factors that they attributed to *personal qualities* possessed by the home visitor. 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 next modal response to what the participants liked best about the home visitors included answers that focused more on the *forms of concrete help* that were 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."

> "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."

Three of the participants 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 calls me so that I don't forget."

The participants in the study were also asked what they liked least about their home visitor. The majority of the respondents reported "Nothing." However, four of the 46 participants identified factors that they did not like about the home visitor, and three participants commented with regard to a dislike about the process. Home visitor related comments 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. The last statement, however, and some other statements made by the women in this study indicate that some participants are engaging in some sort of comparative identification with the home visitors. Three of the respondents used humor in responding to the question about what they liked least about their home visitor. These jokes included a subtext that indicated that they compared themselves with their home visitor in other respects. For instance, one participant 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."

Of the three participants who voiced dislikes about the home visitation process, one mother pointed out that the only thing that she did not like was when her home visitor called the CPS worker. Nonetheless, she still considered the home visitor "real nice" and still liked her as a friend. A second mother responded, "I can't get hold of her" and this was what she liked least about her home visitor. Lastly, one participant reported that she did not like having to complete all the tests for the program.

Participants were also asked to describe whether their relationship with the home visitor was difficult or easy in the beginning. A sizable number of participants, 20 of the 46 interviewees or

43%, reported having some difficulties in the beginning of the home visitation process. Examples of their remarks include:

> "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."

> "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."

The majority of participants reported that they did not have any significant problems in developing an initial relationship with the home visitor. Mothers were also asked "How easy or hard was it to ask your home visitor questions?" Thirty-one of the 46 respondents (67%) reported that it was easy asking their home visitor questions. Only a small number of participants reported that initially they could not discuss personal information with their home visitor, whereas most reported being able to discuss personal issues.

Mothers were also questioned about whether they ever felt like the home visitor criticized them. This question was approached by the interviewers 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 home visitor?" Almost all of the participants reported not feeling criticized by the home visitor. Three participants did report feeling criticized by the home visitor. 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 all three of the previously quoted respondents expressed concerns about being criticized for discipline issues, each characterized her relationship with the home visitor as one of friendship. This suggests that the home visitors are focusing on sensitive issues related to child abuse and neglect in their relationships with the participants. Two examples presented in this paper involved some report of the mothers' activities to a supervisor or outside agency. Despite these incidents, the relationships between participant and home visitor were maintained. Overall,

most of the participants reported that the home visitors were not judgmental or critical in relating with them about their parenting abilities.

Several themes emerged in the analysis of participant perceptions of their relationships with their home visitors. Most respondents characterized the relationship as being one of a trusted friend. When stress or problems with the relationships were noted, comments were more closely linked with negative judgments about home visitor turnover. In most of these circumstances, the participant had more than two home visitors. In some instances, participants had difficulty adjusting to the new home visitor, but not in all circumstances.

Participants valued their connections with the home visitors and for the most part these connections were perceived as supportive. As the interviews revealed, the open and honest relationship allowed the home visitor 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. That is, 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, participants' statements revealed that they valued having a trusting, informal relationship with the home visitor. They did not view the home visitor solely in a teacher or other authoritative-type role. To some extent, this might be explained by their need to rationalize their acceptance of help from the home visitor. Many of the respondents seemed surprised by the level of trust that they developed with their home visitor, and by the closeness of the relationship. 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 home visitor. However, participants who experienced problems with parenting did view the home visitor as monitoring their behavior.

4.4. Involvement in the program over time

The degree of bonding to services and other social institutions is considered an important factor in reducing many forms of risky behavior. If participants 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 (Prochaska, DiClemente, & Norcrosss, 1992).

This study set out to examine various dimensions of participant motivation and attachment to the program. This information is considered useful in assessing participants' involvement in the program and in providing further insights into participants' reactions to the various phases of the program. To explore these dimensions the interviewers asked: "How has your commitment to the program changed from the beginning to now?"

Responses for this question were coded: (a) *remained the same*; (b) *increased*; and (c) *decreased.* Two respondents did not respond to this question. The results indicate that 21 of the 44 respondents or 48% reported that their commitment to the program remained the same over time; 15 or 34% of respondents reported that their commitment had increased; and 8 or 18% of respondents reported that their commitment had decreased.

Among the eight women who reported a decrease in their commitment to the program, several indicated that it was due to changes in their life circumstances that influenced their need for help. For example, some mothers indicated that they no longer needed the program as they had become self-sufficient. This is consistent with the goals of the program. The changes in life circumstances included events like changes in the developmental status of the

child, obtaining a job, or getting married. Responses reflective of reduced need due to self-sufficiency include:

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

Other responses assigned the code *decreased* level of commitment related to changes in the relationship with the home visitor.

> "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. Or if they are behind for their age. Information about potty training. Discipline. Everything 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." (Note: the availability of the home visitor changes as the mothers move through level changes and service intensity decreases).

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

> "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 home visitor is able to work with the people. They can't just assign anyone."
>
> Interviewer: "How interested are you in the program now?"
>
> Participant: "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 participant'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 participant appears to be identifying that her self-esteem and role transformations are associated with her relationship with her home visitor.

Participants were also asked: "Would you choose to be involved in Healthy Families again?" All of the participants said yes except for two, both who reported that they would not be interested and their lack of interest appeared to be related to their enhanced self sufficiency.

5. Conclusion and practice implications

This study describes the experiences of 46 women who participated in a home visitation program. The overall focus of the study was to examine, from the participants' point of view, how they understood the nature and quality of services received from the Healthy Families program. This subjective account adds a more complete understanding of how this program is implemented. In particular, the study focused on four aspects of the participants' experience: their experience with the intake process, their understanding of the programs primary purpose, their perceptions of their home visitors, and how their commitment to the program has changed over time.

The findings support that the intake process was perceived by most program participants as positive or neutral and as an opportunity to receive help. However, 17% of the participants expressed concerns about being recruited into a voluntary home visitation program. While some local policy makers have questioned whether a program like Healthy Families is too intrusive, this study suggests that this is not the case for most mothers, although a noted limitation is that only current program participants were interviewed. Although the intake process includes asking mothers personal questions, most mothers did not express any concern with the screening process. To further safeguard the comfort of all potential participants, the findings of this study suggest that the Healthy Families intake workers should: (a) provide a clear rationale for why the mother is being contacted; (b) emphasize that the program is for all mothers with newborns and not only for first-time, single, or low-income mothers; (c) explain the need for the nature of the screening questions; and (d) frame the program's purpose within the broad goal of giving children a healthy start. A model introduction to the program, contrasted with what impressions to avoid, could be developed for the core Healthy Families training.

In examining whether participants understood the primary purpose of the program the study found that most participants clearly understood the program, and understood the broad goals the program is based on. The qualitative data showed that the program met the participants' basic expectations, and several participants expressed that the program was better than they expected. As many of the eligible families are likely to have had negative experiences with social service programs in the past, this finding is important. Home visitation programs such as Healthy Families Arizona may provide a positive experience for families that will promote future involvement with other social service programs when families need help in the future. It is possible that some of the testimonials about the program from participants, especially from those who were initially doubtful about the program, could be utilized in describing the program to families and engaging them in the process of receiving services. A minority of participants, 9%, alluded to a counseling function of the home visitor, which is not included in the intent of the program model. It is important that the home visitors clarify their role in this regard.

The findings suggest that participants perceive that they have very close relationships with their home visitors and this facilitates implementation of the program model. Owing to the personal nature of family problems there is a need for consistent contact and the home visitor and participant relationship becomes important to the delivery of feedback that may be considered critical of the parent's behavior. Also, past studies and reviews (Gomby et al., 1999; Guterman, 2001; McCurdy & Daro, 2001; McGuigan, Katzev, & Pratt, 2003) have noted the lack of family retention as a critical

issue in the delivery of home visitation services. This study found that mothers were either initially aware of their needs or became aware through their participation in the program and remained committed to participating in the program as long as they felt it was benefiting them. The current study, however, is likely to be biased favorably toward the program because only current program participants were included. Additional research is needed to address the limitations of this study. Such research should examine the perceptions of prospective participants who either declined the initial assessment and the perceptions of those who do not enroll when offered the program. Research should also examine the perceptions of participants who have terminated services prior to the optional five-years.

A trusting relationship is seen as essential in the delivery of home visitation services (Paris & Dubus, 2005). A major theme that emerges from the participants' responses to overall satisfaction with the program revolves around the significance of the home visitor and participant relationship. There is significant debate as to how this relationship should be conceptualized. One dominant view is that the relationship should be "conceptualized as a modern-day version of the traditional extended family" (Powell, 1993; p.28). The results of this study suggest that home visitors 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 (Larner, Halpern, & Harkavy, 1992; Olds & Kitzman, 1990; Paris & Dubus, 2005; Pawl, 1995; Wasik & Bryant, 2001). Yet, other research has questioned whether the strength-based approach tends to overlook risk in pursuit of family-driven goal setting (Duggan et al., 2004). The data from this study suggests that the Healthy Families Arizona program is utilizing the home visitor and participant relationship in providing effective services. Although this is often treated as a key component in home visitation it may not always be easily achieved. Ware, Osofsky, Eberhart-Wright, and Leichtman (1987) aptly point to the significant challenges of home visitor interventions, observing that one of the most difficult is to form a positive relationship with each of the participants. Home visitors will confront rebellion and rejection, yet, when a strong relationship is formed it can be powerful and therapeutic. As Weiss (1993, p. 166) describes, "the helper has to enter the participant's world not just to gain trust, but to gain 'significance.'" Through the relationship, the home visitor must create possibilities for change. It is in this sense that the relationship is often seen as beginning with the participant's emotional dependence on the home visitor which opens up the process of reparenting (Breakey, Pratt, Morrell-Samuels, & Kolb-Batu, 1990). The process of being a nurturing parent is modeled by the helper, and the participant has exposure to a parent figure who is caring, available, and trustworthy. Program staff should continue to build on participant commitment and attachment to the program, recognizing this as a unique opportunity to help create positive changes in families.

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