
RESEARCH REPORT

Enhancing Caregiving Capacity for Very Young Children: Your Journey Together Home Visiting Intervention

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Principal Investigator:

Ms. Deborah Alleyne, MS, Ed.
Devereux Center for Resilient Children

Dr. Ana Leon, Ph.D., LCSW
University of Central Florida

Key Project Staff:

Gabriel T. Smith, MA, LSW
Research Associate
Devereux Center for Resilient Children

Shannon Holliker, MSW, LCSW
Graduate Research Assistant
University of Central Florida

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CONTENTS

Abstract	1
Project Description	2
Problem Statement and Scope	2
Purpose of the Study.....	2
Curriculum Intervention	2
Description of Data Collection Sites and Inclusion Criteria	3
Implementation Sites	3
Control Sites.....	3
Training the Data Collection Sites	3
Methodology	4
Data Collection Process	5
Technical Assistance and Support to Agencies	5
Fidelity Visits	6
Compensation	6
Descriptive Data Included in the Study.....	6
CFSR Data Included in the Study.....	6
Results	6
Discussion.....	15
Interpretation of Results	15
Implications for Home Visiting Programs.....	15
Engagement and Attrition	16
Intervention Secondary to Immediate Needs	16
Demographic and Psychosocial Risk-Factors.....	17
Intervention Facilitation by Home Visitors	17
Limitations to the Study and 'Lessons Learned'	17
Challenges in Data Collection Process	18
Practical Application of the Study and Sustainability Plan.....	18
Implications for Research.....	18
Implications for Program Planning	18
Sustainability	19
References	20

Abstract

This project studied the effectiveness of a resilience curriculum for vulnerable families with children birth through five years of age, Your Journey Together (YJT). The specific research questions for this study included:

Will caregivers who complete the 15-session YJT intervention:

- Show a decrease in child abuse and neglect reports during and after completing the intervention compared to caregivers in the control group?
- Show more permanency and stability in the child's living situation?
- Increase their adult resilience score compared to caregivers in the control group?
- Improve their caregiving capacity to provide for their children's needs compared to caregivers in the control group?
- Show greater improvement in their perception of their child's social and emotional strengths compared to caregivers in the control group?

Due to data collection challenges, the study was recast as a descriptive study. Descriptive data highlight risk factors and psychosocial stressors experienced by participating caregivers and their children. The majority of the caregivers were in the medium or high-risk group for Lack of Empathic Awareness on the AAPI-2. The CD-RISC scores suggest lower resiliency at pretest than the normative mean. Caregivers also reported lack of support with raising their children, and childhood abuse or trauma. Paired samples t-tests indicated no statistically significant results on any of the three measures (CD-RISC, AAP1-2, DECA).

Data highlight the challenges of conducting curriculum interventions and research with populations experiencing significant psychosocial stressors. However, surveys completed by caregivers suggest that with further modifications YJT may show promise in improving resilience and caregiving skills.

Project Description

This project studied the effectiveness of Your Journey Together (YJT), an innovative and promising research- and consumer-informed resilience curriculum for vulnerable families with children birth through five years of age. This evaluation was a collaborative effort between the University of Central Florida (UCF) and Devereux's Center for Resilient Children (Devereux) located in Bartow, Florida. It also established partnerships with multiple community-based child welfare agencies in Florida.

The study was initially designed to collect data using a quasi-experimental, pretest-posttest (nonequivalent control group) design. However, the research team encountered numerous challenges that prevented acquiring the anticipated sample and data. After careful consideration, the team made the decision that due to the data collection challenges, the study would be recast as a descriptive/cross sectional study. This change was made after consultation with the funder, Florida Institute for Child Welfare (FICW).

The study includes pretest data, demographic data, and information on special events/psychosocial stressors affecting this population. Some baseline data is provided without a posttest component. This offers an opportunity to provide the FICW, Florida Governor, and the Department of Children and Families (DCF) with information on lessons learned and potential challenges of research and data collection on child welfare related studies in Florida. Additionally, the team developed a short survey to solicit feedback from home visitors on their experiences with the research study and the perceived barriers to engaging clients and collecting data.

Problem Statement and Scope

The relationship between caregivers and children under the age of five is a critical component for healthy social and emotional development (Landy, 2009). Researchers refer to the reciprocity of this relationship as the 'serve and return' nature of the interactions between very young children and their caregivers (Shonkoff, 2011). It is through this relationship that children are provided with opportunities to develop motor, social, emotional, language/communication, cognitive processing, and self-regulation skills (Landy, 2009). These skills are necessary to ensure that children reach optimal levels of functioning essential for productive relationships not only within the family system, but also at school, with peers and other adults, the community, and eventually with other members of the greater society (Landy, 2009). Development of these skills enriches language abilities and helps children master learning skills in the academic settings (Landy, 2009).

Parenting very young children is challenging under the best of circumstances. However, it becomes more of a struggle for caregivers who experience a variety of psychosocial stressors which may include their own history of child abuse, mental illness, alcohol and substance abuse, financial distress, food insecurity, unemployment or employment challenges, their own health problems or those faced by their children (LeCuyer-Maus, 2003). Due to risk factors such as these, many caregivers in the child welfare system enter the child-parent relationship with unresolved emotional issues, and lacking knowledge on age appropriate caregiving skills and strategies (LeCuyer-Maus, 2003).

Need for the Study

In Florida, the estimated 2013 population of children under 5 years old was 1.09 million and 211,231 children were less than one-year-old (Florida Child Abuse Death Review Committee, 2014). The data on the age of Florida's maltreatment victims follows the same trend as the overall United States, with the youngest children experiencing the highest rates of victimization and fatality (U.S. DHHS, 2015).

Of the confirmed victims of child maltreatment in 2013, there were 1,484 child fatalities, 121 of which occurred in Florida. This places Florida in the top 10 states for the highest child fatality rates (U.S. DHHS, 2015). In a Florida child fatality study conducted by the Casey Family Programs (2013), it was found that 90% of the child fatalities related to maltreatment were children less than 5 years of age. Between 2011 and 2013, maltreatment deaths of children less than one year old represented approximately 40% of the child maltreatment deaths among Florida children. The death rates for children less than one year old were nearly four times higher than the death rate for children aged 1-4 years old, who had the second highest rates among children. Black children had the highest rate of child maltreatment deaths per 100,000 compared to white and children of other races. This is similar to racial disparities in maltreatment deaths between black and white children that are seen at the national level (Florida Child Abuse Death Review Committee, 2014).

Purpose of the Study

The study examined the impact of a home visiting strengths-based curriculum intervention, Your Journey Together, for caregivers of children under five years of age. The aims of the study were to: 1) evaluate the effectiveness of a curriculum-based home visiting intervention on three Child and Family Service Review (CFSR) outcomes: child abuse and neglect reports, permanency and stability in a child's living situation and caregiving capacity; 2) evaluate the effectiveness of a curriculum-based home visiting intervention on caregiver resiliency; 3) evaluate the effectiveness of a curriculum-based home visiting intervention on the caregiver's perceptions of the child's social and emotional strengths; and 4) evaluate the intervention's potential as a home visiting best practice for children ages birth to five years.

Curriculum Intervention

A home visiting model combined with a structured strengths-based curriculum for caregivers was used in this study. The primary objective was to test the impact of the Your Journey Together (YJT) curriculum on several variables. The YJT curriculum consists of four modules and 29 15-minute stepping-stones (lessons) used by the home visitor over a period of 15 home visit sessions.

YJT is designed to promote the social and emotional well-being and resilience of vulnerable children and their families. The curriculum is a "journey" of discovery, learning, and reflection. A YJT coach, who is typically a social worker or other family-serving professional working with adults responsible for parenting young children, facilitates it. It uses everyday routines, activities, and interactions to help parents promote resilience in their children and themselves and better cope with life's challenges.

The YJT curriculum focuses on empowering parents and promoting a safe, trusting and healing environment—all key elements of a trauma-sensitive program.

Specifically, YJT focuses on helping parents to:

- 1) Nurture children's social and emotional competencies including attachment/relationships, self-regulation and initiative
- 2) Strengthen their own social and emotional competencies
- 3) Learn parenting practices that promote children's overall safety and well-being

Much of the success of YJT relies upon the positive and strength-based relationship of the coach with the parents. A YJT coach focuses on individual and family strengths, asks thoughtful and open-ended questions, listens, respects and encourages discussion. Coaching is also considered a form of "capacity building." The Coach helps caregivers to increase their resilience-building capacity. Caregivers complete their work with the Coach once significant progress on goals is evident.

Description of Data Collection Sites and Inclusion Criteria

The study was implemented with families with very young children from four sites in Circuits 9, 10, 13, and 19. The four sites included two implementation and two control sites.

Implementation Sites

Children's Home Society's Care Program is under contract with the Circuit 9 community-based care (CBC) agency, Community Based Care of Central Florida, to provide diversion services to families in the circuit who are at high risk for having their children removed from the home due to abuse and neglect. Family stabilization and safety are the goals of the program. Services are provided in the home by 11 bachelor's or master's level social workers. Each family receives a minimum of 15 visits. Services provided to families include parenting support and education; case management; helping families to meet concrete needs such as food, housing, and employment; and crisis intervention.

Peace River's Home to Stay Program is under contract with the Circuit 10 CBC, Heartland for Children, to provide home visitation services to families in the circuit where the children have been living in out-of-home care and are scheduled to be reunified and return to their birth homes. Family stability and safety are the goals of the program. Home visitation service is provided to families by six bachelor's or master's level social workers for a period of up to one year with visits occurring at least weekly. Services provided to families include parenting support and education; case management; helping families to meet concrete needs such as food, housing, and employment; and crisis intervention.

Control Sites

The Gulf Coast Jewish Family and Community Services Diversion Program for Safe Families is under contract with the Circuit 13 CBC, Eckerd Community Alternatives. The goal of the program is to support families in the circuit who have been reported for abuse or neglect and have been determined to be at high risk for

DCF court involvement in order to maintain family stability and safety. Home visitation services are provided by 10 bachelor's level social workers. Each family receives a minimum of 15 home visits. Services provided to families include parenting support and education; case management; helping families to meet concrete needs such as food, housing, and employment; and crisis intervention.

Behavior Basics is under contract with the Circuit 19 CBC, Devereux. Support services are provided to families whose children are living in the birth home and are at high risk for removal, or have been living in out-of-home care with the intent to reunify with their birth family. The goal of the program is to educate and build the competency of parents to provide safe discipline and enable parents to raise their children independently while maintaining a safe family home. Four bachelor's or master's level Behavior Coaches meet weekly with parents in their homes for 12-15 sessions.

It should be noted that the researchers encountered challenges in identifying and recruiting agencies willing to participate. These challenges will be addressed in the limitations section of this report. The sites chosen were from among those who were willing to participate and met the inclusion criteria. The inclusion criteria included:

- 1) All caregivers were identified as high-risk families by DCF and referred to a CBC provider.
- 2) All caregivers were at risk for committing child abuse and neglect.
- 3) All caregivers were receiving home visiting services.
- 4) All caregivers have at least one child in the birth to five age range.
- 5) A major program goal for all caregivers was preventing removal of their child from the home.

The study included English-speaking adult parents (age 18 years or older) of at least one child five years of age or younger. The study excluded parents with an identified learning disability that would prevent them from being able to actively participate. Participants were required to have their child residing in the home at the time of enrollment.

It was initially identified that home visitors delivering the curriculum in the implementation group should have a bachelor's degree, but changes were later made to these criteria. Some of the home visitors who participated in data collection had less than a bachelor's degree, while others had higher level degrees (bachelor or master).

Training the Data Collection Sites

Data were collected between July 8, 2015 and May 10, 2016. All home visitors responsible for collecting data attended training on the procedures they would follow as part of the study. Home visitors who collected data as part of the control sites (Gulf Coast Jewish Family Services or Behavior Basics) attended a live webinar training split into two three-hour sessions. The control site training included the following key topics:

- Overview of the research study
- Research ethics and protection of human research participants and Institutional Review Boards (IRB)
- The roles and responsibilities of the home visitors as data collectors

- Instruments and forms to be used in data collection, and how to introduce them
- The informed consent process and getting informed consent for research participation
- Process for submitting data packets to the research team
- Technical support to be provided for home visitors
- Plans for future dissemination of the research findings

This training was provided to five home visitors and two supervisors at Behavior Basics, and twelve home visitors and two supervisors at Gulf Coast Jewish Family Services. Home visitors responsible for delivering the curriculum with fidelity as part of the implementation sites (Peace River Home to Stay and Children's Home Society Care Program (CHS) of Seminole County) attended a two-day, in-person training. The first day focused on the curriculum intervention and the second day on the research/data collection procedures. Components of the implementation site training included the following topics in addition to those delivered as part of the Control Site Training:

- Introduction to resilience and the Your Journey Together curriculum
- Your Journey Together Module 1 — Introducing Resilience
- Your Journey Together Module 2 — Strengthening Caregiving Practices that Promote Resilience
- Your Journey Together Module 3 — Strengthening Children's Protective Factors
- Your Journey Together Module 4 — Promoting the Resilient Adult Caregiver
- Coaching the Your Journey Together Curriculum

Six home visitors and one supervisor were trained at Peace River Home to Stay in Polk County, and eleven home visitors and one supervisor were trained at CHS Care Program in Seminole County. During the control site and implementation site trainings, ID codes for caregivers and home visitors were identified to be used on forms in the completed data packets and for data entry. This would enable participants to only be known to the researchers as code numbers.

Following the initial training, technical assistance was provided to the sites via monthly conference calls and email and phone check-ins conducted by the graduate research assistant. The primary author of the curriculum, who served as part of the project team from Devereux, also checked in on a monthly basis with the site supervisors to offer support if needed and brainstorm solutions to barriers to implementation of the curriculum or research procedures. Additional details on technical assistance are provided below.

There was some difficulty in coordinating training dates and handouts between four research team members and the agencies. The agencies were each located in different regions and each committed to being research participants at a different time.

Methodology

Research Design

The original research design of the study was a quasi-experimental, pretest-posttest design intended to collect data from caregivers of children ages birth to five years who were referred by DCF to one of the four data collection sites. That original research design included hypotheses aimed at exploring the relationship between variables identified earlier. However,

due to data collection challenges, the research team could not collect enough pretest-posttest data to continue with the original research design. After consultation with FICW, the research team opted to provide descriptive data collected from the 42 pretests and to emphasize 'lessons learned' and considerations for conducting research with this population of caregivers.

Measurements Used with Caregivers

The following measurements were used during the data collection period of July 8, 2015 through May 10, 2016:

Caregiver Information Form: This form was completed at the beginning of service delivery and was coded with a participant code number. It recorded basic demographic information (age, race/ethnicity, gender, highest level of education, marital status, which of the four sites the caregiver received services from, age of primary child, ages of other children, other parenting curriculum or related services received within the last 6 months, etc.).

Other Circumstances Form: Originally, this form was to be used at pretest and at posttest. However, because the research design was changed, this form was then used before service delivery began. The form gave the researchers data on psychosocial stressors such as child abuse reports or removal of a child; major family incidents; major mental health/substance abuse changes; changes with the child; changes in financial status, housing, and social support systems.

Children and Family Services Reviews (CFSR) Outcomes Log: This form collected data on the two CFSR outcomes: 1) child abuse and neglect reports; and 2) permanency and stability in a child's living situation. The agencies and home visitors for the two control sites and two implementation sites were asked to provide information on the number of reported hotline calls and number of child removals for each participant enrolled in the study. These reports were initially to occur at the posttest mark and again three months after study completion. However, since this study is no longer a pretest/posttest design, CFSR outcomes were received only at the time of the study completion.

Connor-Davidson Resilience Scale (CD-RISC 25): The version used in this project was the 25-item version of the CD-RISC assessment. The purpose of the CD-RISC 25 is to quantify the level of resilience of the individual taking the assessment. For the CD-RISC 25, the scores range from 0-100, with 100 equaling the highest level of resilience.

The Adult Adolescent Parenting Inventory 2 (AAPI-2): The Adult-Adolescent Parenting Inventory 2 is a 40-item instrument on a five-point Likert scale that assesses the parenting and child rearing attitudes of parents in four subscale areas. The AAPI-2 assesses attitudes and changes in parenting attitudes before and after treatment. For purposes of this study, only the 'empathy towards children's needs' subscale was used. Both raw scores and sten scores are reported to correspond with each construct. For this instrument, it is recommended that the sten score (or standard sten score) is used for interpretation. The scores utilize the normal curve, changing percentiles to stens, where 5.5 of the N-sten is the median raw score for normally distributed sten scores (AAPI-2 Online Development Handbook, 2010, p. 6). There are three risk groups, low, medium, and high, which correspond with each construct.

DECA P2 or the DECA Infant & Toddler: The Devereux Early Childhood Assessment for Preschoolers, Second Edition (DECA-P2) is a 38-item behavior rating scale that is completed

by parents and/or teachers. It provides an assessment of child protective factors central to social and emotional health and resilience, as well as a screener for behavioral concerns in children ages 3 through 5 (i.e., up to the sixth birthday). The measurement tool has three subscales: 1) Initiative (the child's ability to use independent thought and action to meet his/her needs - 9 items); 2) Self-Regulation (the child's ability to express emotions and manage behaviors in healthy ways - 9 items); and 3) Attachment/Relationships (the child's ability to promote and maintain mutual, positive connections with other children and significant adults - 9 items). It also includes an additional 11 item behavioral screener that assesses behavioral concerns. Like the sten score on the AAPI-2, the DECA generates a standard score, the T-Score (28-72), which is used for interpretation.

Measurements Used with Home Visitors

Reflections on impact of curriculum (by participant & home visitor) Form: This form captured qualitative data on the caregiver's and home visitor's perceptions of the delivery and effectiveness of the Your Journey Together (YJT) curriculum.

Home Visitor Feedback on the Research Survey: Administered at the culmination of data collection, this qualitative survey provided feedback from the home visitors (collecting data) on the challenges, barriers, and opportunities of participating in the study.

Data Collection Process

Informed Consent

The Institutional Review Board reviewed and approved the informed consent forms that would be distributed to participants. Each prospective participant was provided with a copy of the informed consent while a second one was sent back to UCF and filed in a locked cabinet (in a separate file than the data packets). In order to maximize efforts to ensure voluntary participation, participants were also asked to complete a short survey indicating their perceptions of the informed consent process.

Pretest/Posttest Packet Administration

Both the implementation and the control sites were asked to administer pretest packets at the initiation of services. They were then asked to collect posttest data from the families upon completion of services. The forms that were included in the packets were reviewed by Institutional Review Boards at UCF and Devereux prior to administration. The pretest and posttest packets for both the control and implementation sites were quite similar. The pretest packets included: 1) a checklist of items in the packet; 2) a script to assist the home visitors with administering the informed consent; 3) two informed consents (copy for participant to keep and copy for participant to sign); 4) an informed consent feedback form; 5) a client information sheet; 6) three assessment tools (DECAs for each age group, CD-RISC, and AAPI-2); and 7) a special circumstances form.

The posttest packets included the same documents, with the exception of the client information sheet and the informed consents and their accompanying script and feedback form. There were slight differences between packets provided to the control and implementation sites as participant informed consents were tailored towards their respective group. Further, only the

implementation sites had the Reflection on the Impact of the Curriculum Forms for participants completed at the posttest stage. The two implementation groups completed the pretest packets prior to delivering the sixteen-week Your Journey Together (YJT) curriculum, and then administered the posttest packets at completion. The control sites administered the pretest packets at the start of services, using the interventions that were specific to their program, and were asked to complete pretest packets after approximately 15 home visits.

The following steps were included in the data collection process:

- a. During the first home visit, the home visitor discussed the study with the caregiver, answered caregiver questions about the study and invited caregivers to participate.
- b. Informed consent forms were obtained prior to beginning the intervention and caregivers completed the short form providing feedback on how they experienced the informed consent process.
- c. If a client was experiencing a major crisis, the home visitors were instructed to instead address the crisis and attempt to engage the client in the study at the next visit, assuming the crisis was resolved.
- d. After the caregiver completed the consent form and pretest instruments, the home visitor mailed them to the primary UCF researcher within 3-4 days.
- e. A research team member either called or emailed (a dedicated email address was created) home visitors on a weekly basis to ensure data collection process was going as planned, to answer questions and provide support. During periodic calls, the researchers obtained information on the child abuse and neglect and permanency and stability outcomes for each participant's child.
- f. Researchers met with home visitors in a group (via teleconference or in person) to discuss data collection, answer questions and provide support. Minor enhancements to the data collection process were identified and implemented.
- g. Home visitors continued integrating the curriculum lessons into home visits until all 15 home visits and all lessons are completed. Home visitors at the implementation sites who were not delivering the curriculum being tested utilized their own curriculum/services and completed those over a 15-16-week period.
- h. During the last session, home visitors administered the posttests and mailed those completed to the primary researcher within 3-4 days.

In total, a combined 42 pretest packets and 6 posttest packets were completed across all data collection sites. All of the posttest packets were completed at the implementation sites.

Technical Assistance and Support to Agencies

The agencies were provided support from the UCF-Devereux team for the duration of the study. During the trainings, the home visitors were introduced to the research team members from both UCF and Devereux. The home visitors were provided with an email address and contact telephone number (as necessary) as support options. Telephone conferences or in-person meetings with the implementation sites were facilitated by the UCF-Devereux team at regular intervals to discuss challenges and

progress of data collection. These meetings were scheduled every several weeks during the first phase of data collection. The intention of these meetings was to improve data collection and participant retention since these two areas presented as problematic, particularly for the second implementation site. A member of the UCF research team also provided regular telephone calls and email check-ins to supervisors and home visitors to help home visitors trouble-shoot any identified challenges, obtain specific information, and to receive updates on progress of participants. Both implementation sites were contacted monthly by the primary author of the YJT curriculum, who offered support and problem solving around curriculum implementation.

Once the control sites were trained, an email was sent out to the participants to ensure they were connected with the research team. The majority of the communication with control site supervisors transpired via email. However, one telephone check-in was conducted with the home visitors of the control sites in order to receive information on progress and attempt to identify barriers to participant enrollment.

In January 2016, a revised data collection timeline was created and distributed to all sites. This was to reflect the extended deadline of May 9, 2016 for final enrollment of new participants. In concert with the revised data collection timeline, the UCF-Devereux team initiated support meetings to specifically address challenges with enrollment and retention at both implementation sites. A member of the UCF team facilitated these meetings in a face-to-face format while at least one member of the Devereux team joined in via telephone. This intervention did not yield an increase in enrollment with either site.

Fidelity Visits

To ensure that the curriculum was delivered as intended, home visitors from the two implementation sites were expected to sign up for a fidelity visit with the designated research team member. These visits occurred once data collection began and were to take place during one of the early visits during curriculum implementation. The research team member responsible for fidelity visits utilized a checklist created by Devereux to ensure that the home visitor was delivering the curriculum correctly. The fidelity visits presented challenges which will be further discussed in the limitations section.

Compensation

Store gift cards with a ten-dollar value were distributed with pretest and posttest packets at the control and implementation sites. For both implementation sites, a gift card was provided to the participating caregiver when he or she completed a pretest or posttest packet. These were accounted for by asking the home visitor to collect a gift card receipt upon distribution. Home visitors in the implementation groups were also provided with a \$10 gift card when they submitted a pretest or posttest packet completed by a caregiver on their caseload. The control sites were provided with a similar arrangement, but one of these agencies elected against providing gift cards to their home visitors. The agencies participating as implementation sites will also receive \$50 of monetary compensation for each family that completed the curriculum with fidelity and both pre and posttest data packets. The agencies participating as control sites received \$10 for each

participating family that completed both pre and posttest data packets.

Descriptive Data Included in the Study

Descriptive data collected from the caregivers of the birth to five year-old children is reported on the following:

- Description of the sample
- Pretest scores on the three measurements used (CD-RISC, AAPI-2 and the DECA)
- CFSR data on the two outcomes identified: 1) child abuse reports during the intervention and 2) removal of a child from the home during the intervention
- Special events/psychosocial stressors affecting the families receiving services
- Caregiver reflections on the impact of the curriculum

Additional data collected from the home visitors included:

- Home visitor reflections on the impact of the curriculum (for implementation sites only)
- Home visitor feedback on participation in the study

CFSR Data Included in the Study

The researchers encountered major challenges in the data collection process and this prevented the team from collecting post data on the CFSR outcomes as originally planned. However, descriptive data is provided in the results section on the following Child and Family Service Review outcomes:

The researchers encountered major challenges in the data collection process, and this prevented the team from collecting post data on the CFSR outcomes as originally planned. However, descriptive data is provided in the results section on the following Child and Family Service Review outcomes:

Safety Outcome - #1 Children are first and foremost protected from abuse and neglect

Permanency Outcome - #3 Children have greater permanency and stability in their living situations (fewer placements)

Well-Being Outcome - #5 Families have enhanced capacity to provide for their children's needs.

Please see the Results section for data.

Results

Description of the Sample

Thirty caregivers participated at the implementation sites and twelve caregivers were enrolled at the control sites. At the implementation sites, 16 (53%) caregivers indicated that they had been involved with other early intervention programs for their child, in comparison to 12 (28.6%) from the control sites. Nineteen (45%) of all the caregivers in the implementation sites reported that their child had experienced a previous DCF placement outside of the home (See Table 1).

Table 1: Study and Participant Characteristics (N = 42)

Program	Implementation N = 30	Control N = 12
Other programs	Site #1 n = 16 Site #2 n = 12 Unknown n = 2	Site #3 n = 2 Site #4 n = 10
Early Intervention Programs	Childcare n = 9	No program n = 2
DCF placement outside of home	Yes n = 19	Yes n = 3

Data on Measures from Pretest

The average age range of the caregivers was between 23-27 years of age. Thirty-seven (88%) participants were female, four (9.5%) were male and one did not indicate sex/gender. Twenty-five (59.5%) participants were Caucasian, two (4.8%) were Hispanic/Latino, one was native American/Alaskan, twelve (28.6%) were African American and one did not identify a racial background. Ten (23.8%) of the caregivers had completed high school, 16 (38%) had some high school education, and six had some higher education. Six were married and twelve reported a domestic partner. In regards to having other adults helping with the caregiving of a child under the age of 5, 16 (38.1%) of the caregivers reported that a grandparent was of support, 17 (40.4%) had no support, 3 (7.1%) reported their spouses as support, 4 (9.5%) reported other supports, and 1 did not respond. Twenty-four (57.1%) of the caregivers reported no other children over the age of five years (See Table 2).

Table 2: Participant Demographics (N = 42)

Age					
Average age 23-27 years					
Sex					
Female n = 37		Male n = 4		Unknown n = 1	
Race/Ethnicity					
White/Caucasian n = 25	Hispanic n = 2	Black/African American n = 12		Native American/Alaskan n = 1	Unknown n = 2
Education					
High school n = 10	Some high school n = 16			Some higher education or higher degree n = 6	
Marital status					
Domestic partner n = 12	Married n = 6	Single n = 6		Separated n = 6	Widowed n = 4 Unknown n = 1
Income					
4,999–15,999 n = 22	16,000–26,999 n = 12	27,000–37,999 n = 5	38,000–48,999 n = 0	49,000–above 60,000 n = 2	Unknown n = 1
Other people providing support in raising 0-5 year old					
Grandparents n = 16	No Support n = 17	Spouse n = 4	Multiple sources including other institutions (childcare) n = 4		Unknown n = 1
Other children over age 5					
No other children n = 24		At least one child ages 6-11 years old n = 13		One child 12-15 years old n = 1	Unknown n = 4

When asked about their own childhood abuse/trauma, 16.7% of caregivers (n = 7) reported childhood physical abuse, 23.8% (n = 10) reported emotional abuse, 9.5% (n = 4) reported neglect, 19.0% (n = 8) reported sexual abuse, 19.0% (n = 8) reported domestic violence and 12.0% (n = 5) reported other trauma (See Table 3).

Table 3: Caregiver Childhood Abuse/Trauma (N = 42)

Types of Childhood Abuse/Trauma

	Physical Abuse	Emotional Abuse	Neglect	Sexual Abuse	Domestic Violence	Other
Yes	7	10	4	8	8	5
No	34	31	27	33	33	35
Unknown	1	1	1	1	1	1

It should be noted that each participant could indicate a history of more than one type of trauma. When response frequencies were examined they indicated that 53% (n = 22) of the sample reported no childhood abuse or trauma, and 45% (n = 19) reported at least one type of childhood abuse or trauma. One participant did not respond to this question. The range of childhood abuse or trauma categories reported by the 19 participants ranged from 1-6 types of abuse or trauma experienced.

The majority of the children were in the 2-5-year-old range. In regards to disability, four (9.5%) caregivers reported that their child under the age of five had been diagnosed with a physical disability, while three (7.0%) reported a mental disability diagnosis. Thirty-four (80.9%) of the parents reported their child’s health as excellent and only five (11.9%) reported their child’s health as good or fair. All of the caregivers were the biological parent of the child (See Table 4 on next page).

Table 4: Child Demographics (N = 42)

Child Characteristics as Reported by Parent			
Child Physical Disability	Physical Disability n = 4	No Physical Disability n = 36	Unknown Physical Disability n = 2
Child Mental Disability	Mental Disability n = 3	No Mental Disability n = 37	Unknown Mental Disability n = 2
Child Health	Excellent n = 34	Good or fair n = 5	Unknown n = 3
Child's Relationship to Caregiver	Biological child of caregiver N = 42		

Comparisons of pre (N = 42) and post (N = 6) for number of events, CD-RISC score, DECA T-score, and AAPI-2 STEN scores were calculated by using an independent samples t-test. Independent means tests are based on pre and post groups without matching pre and post. AAPI-2 risk categories were calculated using chi-square test of independence.

While the pretest-posttest design was not completed as planned, a comparison of the 42 pretests and the 6 posttests was conducted. The only comparison showing a statistical difference was the number of special events with the average of 3.5 in the pretest completion compared to the average of 1 for the posttest completion. A severe limitation of this comparison is that posttest number of events was only reported by six participants and these do not represent a random sample. Additionally, the best comparison would be to use a paired analysis, but due to the very low sample size, this comparison was not selected. For those six cases that completed the posttest, there were no statistically significant results on any of the three measures (CD-RISC, AAPI-2 or the DECA). None of the other comparisons were statistically significant (See Table 5). In regards to the third measure, the AAPI-2, raw scores determine the sten scores for Construct B of this instrument and those sten scores indicate a range of risk for Parental Lack of an Empathic Awareness of Children's Needs. The risk categories are high risk for lack of empathic awareness of children's needs, medium risk, and low risk. On the AAPI-2, 14 caregivers were in the high-risk group, 27 were in the medium-risk group and only 1 was in the low-risk group.

Table 5: Pre and Post Summary

	Pre (N = 42)	Post (N = 6)	p-value
Number of special events	Average 3.5 events	Average 1.0 event	0.001*
CD-RISC Score	Average 77.2 (std. dev. = 15)	Average 81.3 (std. dev. = 15)	0.53
DECA-T Score	Average 46.5 (std. dev. = 12)	Average 42.4 (std. dev. = 15)	0.14
AAPI-2 STEIN Score (1-8)	Average 5 (std. dev. 2)	Average 6 (std. dev. = 1)	0.14
AAPI-2 Risk group - high	14	0	0.16
AAPI-2 Risk Group - medium	27	6	
AAPI-2 Risk Group - low	1	0	

*Statistically significant difference

Data on Special Events/Psychosocial Stressors Affecting this Population

It was important to understand the types of special events or psychosocial stressors that caregivers of children ages birth to five experience and that may prevent 'good enough' parenting. Table 6 indicates that the major stressors experienced by caregivers in this sample were: changes in child visitation with another parent, caregiver starting a new job, domestic violence, and loss of income or benefits. Table 6 also denotes other special events that were noted by caregivers: death in the family, loss of transportation, child hospitalization, and caregiver separation from a significant other.

Table 6: Number of Caregivers Reporting Special Events/Psychosocial Stressors at Pretest (N = 42) and Posttest (N = 6)

Special Events Experienced Within Last 4 Months (before Pretest & Posttest)	# of Caregivers Reporting Special Event at Pretest	# of Caregivers Reporting Special Event at Posttest
Eviction from home	3	0
Utilities turned off	5	1
Written up at work for absences or tardies	6	0
Child diagnosed with a new medical condition	3	0
Child spent time in the hospital	8	1
Loss of income or benefit	10	1
Death in the immediate family or close friend	9	0
Lost source of transportation	9	0
Victim of identity theft/credit card stolen	5	0
Serious auto accident	4	0
Child in serious auto accident	2	0
Witnessed a traumatic event	6	0
Victim of domestic violence	11	0
Childcare teacher concern about child's behavior	5	0
Child recently diagnosed with developmental disorder	3	3
Child undergone extensive medical testing	2	0
Moved multiple times	7	0
Lost home to fire or major storm	0	1
Changes in child visitation schedule with a parent/guardian	12	1
Caregiver been a victim of crime	6	0
Child been a victim of crime	3	0
Child been a victim of bullying	0	0
Caregiver started school/college	4	0
Caregiver started a new job	11	0
Caregiver experienced recent divorce or separation from significant other	8	0
Moved into a new apartment or house	7	0

Children and Families Services Review Data

The three CFSR outcomes that were included in this study were:

Safety Outcome #1 - Children are first and foremost protected from abuse and neglect.

Permanency Outcome #3 - Children have greater permanency and stability in their living situations/fewer placements.

Well-Being Outcome #5 - Families have enhanced capacity to provide for their children's needs.

While it was the original intention of the study to assess outcomes #1 and #3 throughout the study and for three months after the data collection phase, complications in data collection did not allow for this. Instead, the data collection sites provided information on these two outcomes at the end of the study. Table 7 shows that a total of five child abuse calls during the course of the caregivers' involvement in the study were made to the Department of Children and Families (DCF). Two of the implementation sites had four child abuse calls to DCF, corresponding to four out of thirty implementation families (13.3%) enrolled in the study. One of the control sites had one child abuse

call to DCF corresponding to one out of twelve control (8.3%) families enrolled in the study. From the four implementation site cases called into DCF, three of the four children were removed and placed out of their homes. One of the control sites had one child abuse call to DCF, and the same site had two children removed from the home for out-of-home placement. The other control site had no calls and no removals, but it should be noted that the site also did not enroll many caregivers in the study (see Table 1). There were several reasons for why caregivers dropped out of the study before they could complete the study. The primary reason appeared to be related to 'cancellations' of appointments or services by caregivers.

There were also challenges in assessing CFSR Outcome #5 using the original pretest-posttest design. Therefore, the researchers only report on pretest data on this outcome as measured by the AAPI-2. The descriptive data on this is presented with the other measurement data. It can be speculated that the AAPI-2 'empathy towards child's needs' captures whether parents have the capacity at the pretest stage of data collection to provide for their child's needs. While the posttest data on this was not collected, the pretest data shows the baseline for this outcome among the caregivers (See Table 7 on next page).

Table 7: CFSR Outcomes and Reasons for Dropping Out of Study (N = 42)

#	Agency	Reason Caregiver Dropped Out	CFSR # of Calls to Hotline	CFSR # of Removals
1	IMPL	Mother relapse child placed with relatives	1	1
2	IMPL	Successful completion	0	0
3	IMPL	Moved out of country following eviction	0	0
4	IMPL	New report/child removed	1	1
5	IMPL	Mom canceled services	0	0
6	IMPL	Too many cancellations	0	0
7	IMPL	Case closed early at mother's request	0	0
8	IMPL	Mother withdrew, feeling overwhelmed by too many other family things	0	0
9	IMPL	Parent request	0	0
10	IMPL	n/a	0	0
11	IMPL	DCF case closed, no longer wanted services	0	0
12	IMPL	Completed	0	0
13	IMPL	n/a	0	0
14	IMPL	n/a	0	0
15	IMPL	n/a	0	0
16	IMPL	Completed	0	0
17	IMPL	Completed	0	0
18	IMPL	Completed	0	0
19	IMPL	n/a	0	0
20	IMPL	Mother dropped, missing visits	0	0
21	IMPL	No calls, no shows per home visitor	0	0
22	IMPL	Child Removal	1	1
23	IMPL	n/a	0	0
24	IMPL	n/a	1	0
25	IMPL	No longer wanted services	0	0
26	IMPL	Noncompliance with program	0	0
27	CONTROL	n/a	0	0
28	CONTROL	n/a	0	0
29	CONTROL	n/a	0	0
30	CONTROL	n/a	0	0
31	CONTROL	n/a	0	0
32	CONTROL	n/a	0	0
33	IMPL	n/a	0	0
34	CONTROL	Parent treatment/child with relative	1	1
35	IMPL	n/a	0	0
36	CONTROL	Child removal	0	1
37	CONTROL	n/a	0	0
38	CONTROL	n/a	0	0
39	CONTROL	n/a	0	0
40	CONTROL	Family moved out of area	0	0
41	IMPL	n/a	0	0
42	IMPL	n/a	0	0

Data from Participant Reflections on the Impact of the Curriculum

It was important to assess the caregivers' perceptions of the curriculum. Using a Likert scale survey, caregivers indicated their level of agreement with statements about the impact of the curriculum. All of the caregivers rated the curriculum highly (See Table 8).

Table 8: Reflections on the Curriculum (N = 6)

	Strongly Agree or Agree	Not Sure	Disagree or Strongly Disagree
YJT was easy to understand	6	0	0
YJT was helpful for my home visits	6	0	0
Home visitor was engaging	6	0	0
Home visitor made efforts to adapt YJT to my needs	6	0	0
YJT helped me learn better ways to parent my 0-5 child	6	0	0
YJT activities were helpful	6	0	0
YJT helped me understand how my home environment can help my children grow	6	0	0
YJT helped me become a more resilient caregiver	6	0	0
During YJT, I felt supported in my caregiver role	6	0	0
YJT helped me to improve my parenting for my 0-5 year old	6	0	0
I would recommend YJT to other parents of 0-5 year olds	5	1	0

Caregivers were asked via the Reflections on the Impact of the Curriculum Survey what they liked best and least about the curriculum and to also comment on changes to the curriculum.

When asked what they liked best, examples of their comments included:

“When it talks about initiative, self-regulation, and bounce resilient.”

“It was helpful sometimes.”

“How it taught me to be a better caregiver and to bounce back from bad situations.”

“The information from YJT blended well with what was going on with my life.”

“The leaflet and explanations are easy to understand.”

When asked what they liked least about the curriculum, respondents provided the following comments:

“All the testing.”

“There was nothing I didn't like.”

“A lot of reading at times.”

When asked about changes to the curriculum, the caregivers provided the following information:

“I won't change nothing. Everything sound right to me.”

“I wouldn't change nothing it was presented in an understanding way.”

“I would add more hands on activities.”

“Maybe add short videos?”

Data from Home Visitor Reflections on the Impact of the Curriculum

Nine out of the ten active home visitors at the implementation sites responded to the Reflections on the Impact of the Curriculum survey. Home visitors completed this survey at the end of the study. It is important to note that only three home visitors implemented the entire curriculum and the responses may be impacted by this. Of interest is the perception that eight of the nine home visitors reported the Your Journey Together curriculum was easy to understand; eight also indicated that the step-by-step curriculum guide and the coach key concepts were helpful. Five disagreed that they were able to work through all the modules and stepping stones of the curriculum. Three home visitors reported that the curriculum enhanced their work with the caregivers of children ages birth to five; three identified new skills after using the curriculum; and three believed that the curriculum enhanced the resiliency of the caregivers. Only five of the home visitors identified that the curriculum helped share more appropriate ways for caregivers to parent of children age birth to five; two were not sure; and two disagreed with this statement. Eight of the home visitors were not sure that the curriculum would help reduce child abuse reports and one participant disagreed that the curriculum would affect child abuse reports. Four home visitors identified that the time devoted to the curriculum was adequate; three were not sure the time was adequate; and two disagreed that the amount of time was adequate (See Table 9 on the next page).

Table 9: Reflections on the Curriculum from Home Visitors (N = 9)

	Strongly Agree or Agree	Not Sure	Disagree or Strongly Disagree
Raising children ages 0-5 is hard	9	0	0
YJT is easy to understand	8	1	0
YJT is useful for home visitors	5	1	3
Able to work through all the modules and stepping stones with caregivers	3	1	5
Step by Step curriculum guide was helpful	8	1	0
The coach key concepts were helpful	8	1	0
YJT helped share more appropriate ways for caregivers to parent 0-5 child	5	2	2
YJT enhanced my work with caregivers of 0-5 year old children	3	3	3
After working with YJT, I believe I have new skills for working with parents	3	3	3
I believe caregivers enhanced their resilience by using YJT curriculum	3	4	2
I was able to address individual needs of caregivers	3	2	4
The amount of time devoted to YJT curriculum was adequate	4	3	2
I believe caregivers who participate in YJT curriculum will have fewer abuse reports	0	8	1
I would recommend YJT for other home visiting programs	5	3	1

The Reflections on the Impact of the Curriculum survey also asked home visitors what they liked best about the curriculum, liked least about the curriculum, and what they would change in the curriculum. When asked about what they liked best about the curriculum, the home visitors responded with the following statements:

- “The tips it gave the parents.”
- “I liked the strengths-based approach and the hands on demonstrations (such as the rubber band).”
- “The resiliency aspects of curriculum. The actual content.”
- “The info had good flow. Great set up.”
- “The participant involvement. The activities.”
- “The curriculum was very thorough.”

When asked what they liked least, the home visitors responded with the following statements:

- “Some parts felt repetitive, but repetition is good for parents to learn.”
- “It was difficult to address/implement the curriculum AND clients’ other needs.”
- “I believe that for the level of high-risk referrals that the program receives, this YJT curriculum was difficult to implement due to the importance of helping clients achieve their basic needs to stabilize their household and prevent their children being sheltered. Therefore, it was difficult to meet the required timelines of the YJT curriculum consistently.”
- “Concepts were too large and at times general for our families. Families in our program require basic safety information and ‘day-to-day’ parenting skills.”
- “Some words used in the curriculum were not words known by the families that I was working with.”
- “Too many clients at one time. Our clients have too many issues to address.”

When asked what recommendations they had for the curriculum, the home visitors provided the following sample comments:

- “I don’t believe it was the curriculum, but our program. It was difficult to implement with high-risk clients as there were too many other things needed.”
- “I would deliver the curriculum in a voluntary parenting program where parents are specifically looking to enhance their insight on parenting young children.”
- “Content of Your Journey Together curriculum did not address concrete parenting skills or safety measures that our families require before discussing topics like attachment, self-regulation, etc. Great concepts but difficult to share with high-risk families.”
- “In my opinion we need more time for each stepping stone.”
- “I would change length of modules due to we are not in home. Cases close early and they are not able to complete in timely manner.”
- “Able to deliver well without any issues.”

Examples of other comments provided by the home visitors on the curriculum include:

- “It was difficult at times to utilize curriculum in-home due to distractions in home, environmental hazards and safety risks that required immediate attention over beginning curriculum.”
- “I feel that it was difficult to implement with our programs due to changed client base of higher-risk families.”
- “Was glad to be a part of this. Will continue to use the YJT curriculum.”
- “My client/mother liked it until her daughter was in crisis.”

Data from Qualitative Home Visitor Feedback Survey

Four home visitors, four program supervisors and one ‘other’ person (nine individuals out of 38 possible staff members)

returned the final survey on their participation in the study. This survey particularly assessed the home visitors' experience as part of a research study. Not all nine responded to all of the open-ended questions. Eight were female, one was male and they ranged in ages from 26 years to 47 years. Years of experience in child welfare with children in the birth to 5-year-old group ranged from 1-20 years with four of them indicating that they had 18-20 years of experience. Seven reported their race/ethnicity as Caucasian and two indicated they were Hispanic. Three indicated that they had participated in another research study within the last three to four years; three indicated they had not participated in a research study within the last three to four years and two indicated that this was their first research study. One respondent did not answer this question. Five were from the implementation site, three from the control site and one did not indicate the site. The combined respondents reported that they had each enrolled 1 to 20 caregivers into the pretest phase of the study. Various questions were asked about their experience in participating in the study and the questions and responses are numbered below.

Questions for Caregivers

What Did You Like Most About Participating in the Research Study?

1. No comment
2. Learning new curriculum
3. No comment
4. I found the curriculum to be very interesting. I enjoyed the use of the activities to relate to the curriculum and the ability to be a part of the study.
5. Materials all prepared and ease of sending in
6. It was easy to follow
7. Curriculum
8. Getting to know the YJY better and getting used to teaching

What challenges did you encounter in recruiting caregivers to participate in the study? (Please share specific examples when possible).

1. Our cases were too high risk. It was difficult to sign families up that were experiencing a lot of crisis at the time we were initiating services.
2. None
3. N/A
4. Finding participants that met criteria, a lot of ours were outside age range OR out of home.
5. There were a few of my families who were not willing to do anything that was not a requirement and did not want to do anything extra — the pretest paperwork seemed overwhelming to some clients.
6. Some just didn't want to do it.
7. Cases were too high risk and inappropriate for the study. Families did not find material directly relatable and/or did not want to commit additional time.
8. No matter how well you explained it some people looked at it as extra work even if you were going to the YJT without

the study.

Were there characteristics of your agency, program, or job that made it challenging to participate in the study?

Yes (please explain in text below)

1. As mentioned the program is voluntary and works with very high-risk cases where child safety has to be the first priority. Several cases had housing issues too which made it difficult to deliver the curriculum consistently.
2. We have families with a lot of other tasks to complete.
3. Safety risks presented in referrals and families are frequently in crisis initially. Required paperwork for intake, assessment, and treatment plan interfered with ability to address crisis and enroll family in YJT.

No (please explain in text below)

4. No, there were no additional challenges. Just an add on of a few sessions/home visits.
5. No, not really
6. My team uses the YJT and has for some time. The only difference is instead of using specific pieces we were doing the entire curriculum.

What challenges did you experience in completing the Your Journey Together curriculum? (This question is ONLY for the Implementation Sites that used that curriculum — all others write in Not Applicable).

1. Our cases are voluntary and either closed out prior to staff finishing the curriculum or in two cases, the children were removed from the parent's care, and our case had to be closed out early.
2. None
3. Not applicable
4. The families have other situations that need immediate attention and assistance in resolving causing the YJT curriculum to be left for another day, causing it to take longer than planned to complete it.
5. Clients have other issues that also had to be addressed not just doing the research.
6. Curriculum did not address basic parenting skills that are critical for our families in order to ensure child safety. Family had difficulty understanding the concepts or staying on task to complete stepping stones. Curriculum was difficult to present when family would be experiencing crisis and I found it difficult to transition between curriculum and paperwork that is required in our program.
7. Clients missing scheduled visits. Clients closing services after DCF case closed. Clients level of ability, i.e. reading and writing.

Questions for Home Visitors

What challenges did you experience in participating in the research activities with caregivers? (Please be specific, i.e., “services ended because child went back into foster care”)

1. Cases were high risk with too many crises occurring to address curriculum. Child safety had to be addressed and maintained first. The program is voluntary so parents stopped participating in program and did not complete the curriculum. Two families had children removed and their case closed early.
2. None
3. Two families had children removed during course of treatment and disqualified for study.
4. Clients who we had to code as drop outs due to removals and/or substance abuse.
5. One of my children was removed from parents. A few of my cases closed due to parents not wanting services.
6. I didn't, supervisor
7. Services ended due to the mother missing scheduled home visits. Typically, our program closes a case after three missed visits but due to family's participation in YJT curriculum, family's case was open for an extended period of time and missed significant number of home visits
8. Same as listed above

What suggestions do you have for overcoming any of the research challenges you have identified above? Please list as many suggestions as you can.

1. It may be better to use community counseling programs, agencies, private practices where the caregivers come seeking assistance and are not in crisis situations.
2. Nothing at this time
3. NA
4. Expanded age range. Have materials more clear as to what needs to be filled out and on which form.
5. Dealing with the immediate needs seems to be the best approach in my experience that way there is time to address non immediate topics.
6. More time to do the curriculum
7. Looser time frame

Were there characteristics of your clients (caregivers, children, families) that made it challenging to participate in the research study?

Yes (please explain in text below)

1. Yes, parents were unstable due to substance abusing issues, domestic violence issues, and financial issues
2. Yes, age range and out of home at times.
3. Every family has their own dynamic. Some had several children that were hard to handle and made going through YJT difficult.
4. Some clients can't read

5. Family was inconsistent and had difficulty engaging with material outside of visit.

No (please explain in text below)

6. No
7. Also same as above in #7

Were there characteristics of your clients (caregivers, children, families) that made it challenging to participate in the research study?

Yes (please explain in text below)

1. Yes, it is important to see how effective curriculum is with different populations.
2. Yes
3. Important to validate new programs and monitor outcomes to provide evidence base.
4. I believe collaboration is extremely important.
5. Yes, so that we can evaluate what works for our families.
6. Yes. That is how we know what to improve and do better.
7. Yes
8. I think it is important for programs to participate in research because it allows programs to learn new methods of providing services to families.
9. Allows program to highlight benefits or problems within the study/curriculum when utilized in the field with families.
10. I am more indifferent than sure either way, but do not feel negatively about it.

Discussion

Interpretation of Results

The study's research design and small sample size limitations did not allow the researchers to collect pretest and posttest data as planned. Subsequently, the data cannot be used for generalizations. Instead descriptive data on a sample of 42 caregivers of children ages birth to five years and 9 home visitors who collected data is presented. Despite the exploratory and descriptive nature of the study, the data provide information for future research. Of note in the caregiver demographics is the low number of Hispanic/Latino caregivers, despite the increasing growth of this population in Florida. The lack of support reported by 17 participants in raising a child ages birth to 5 years is important to note. Raising very young children is already a stressful endeavor, and single parents particularly require support from others in their social network and community. The lack of support has more implications for those young mothers who require parenting help from others. In this study, the average age range was 23-27 years of age.

In corroboration with the professional literature, the data indicate that some caregivers experienced their own childhood abuse or trauma. The literature is rampant with research that indicate generational cycles of abuse and trauma among families. While the majority of the caregivers reported no childhood abuse or trauma, one must question whether the data on this question is under-reported, due to the sensitive nature of this topic and prevalence of this issue in the literature. In addition to abuse and trauma, the literature also highlights the many psychosocial stressors affecting the population of parents with children at risk for removal. The Special Events form reflects psychosocial stressors that include eviction, death of someone in the family or an immediate friend, serious car accident, witness of a traumatic event, domestic violence, child with problem in school, fire in the home, and victim of a crime. While there were low numbers of caregivers ($N = 6$) who completed both the pre and posttest Special Events form, when tested, the number of special events for those six caregivers decreased from the pretest to the posttest phase of the study.

On the AAPI-2 measure, the majority of the caregivers ($n = 41$) were in the medium or high-risk group for Parental Lack of an Empathic Awareness of Children's Needs. These findings are not surprising as the caregivers are referred to their community-based providers because they either had recently been reunified with their child, or were identified as being at risk for losing their child to out-of-home placement. The fact that all but one caregiver fell in these higher risk categories at the time of pretest suggests that it is important to provide parenting services to help parents increase their empathic awareness in rearing children birth to five years of age. The literature indicates that it is especially important for parents to engage in empathic tuning into the child's social, physical, emotional, cognitive and interpersonal needs. Parents lacking in empathic awareness of their child's needs are not able to provide the types of caregiving environments children in this age group need for optimal development.

On the CD-RISC, the normative sample's mean score is 80.4. The average mean score for the sample of 42 caregivers in this study is 77.2, and for those six caregivers who completed the posttest phase, the score is 81.3. These scores suggest lower resiliency levels than the normative mean score at pretest, and for the six posttest cases, they indicate higher levels of resiliency

at the posttest phase. While it is difficult to attribute the posttest score changes to the curriculum being tested, it is promising to consider that perhaps the curriculum, as one factor, made a slight difference in resiliency in the posttest cases ($N = 6$). Future research should examine resiliency among this group of child caregivers to determine if resiliency can be enhanced with a structured, strengths-based curriculum such as Your Journey Together.

When asked about the special events or psychosocial stressors experienced four months before pretest and posttest, it was evident that these stressors matched up with the challenges in completing the curriculum as identified by home visitors. As per Maslow (1943), individuals are not able to focus on higher-level activities or self-actualization if they are challenged by the basic necessities of life. The caregivers in this study clearly reflected this theory, as they reported basic stressors such as the caregiver starting a new job, domestic violence, and loss of income or benefits. Other special events that were noted by caregivers included: death in the family, loss of transportation, child hospitalization, and caregiver separation from a significant other. These stressors made it difficult for caregivers to keep appointments and for home visitors to implement the curriculum with fidelity. Priority in service delivery must always be given to helping clients resolve their crises of daily living.

On the Reflections on the Impact of the Curriculum survey, caregivers almost unanimously rated the items positively—thereby indicating that they did find the curriculum helpful. Their responses to the qualitative, opened-ended questions reinforced that the caregivers found the curriculum helpful and that they found specific aspects of the curriculum valuable. This information suggests that with further alterations, such as shortening the curriculum, adding video clips and more activities, the Your Journey Together curriculum may show promise in helping parents with their resiliency and caregiving skills.

On the Reflections of the Impact of the Curriculum survey that the home visitors completed, the majority of caregivers felt that YJT is easy to understand, that the step-by-step curriculum guide was helpful, and that the coach key concepts were helpful. In particular, home visitors struggled with feeling they were able to address the individual needs of caregivers, and that they were able to get through all the modules and stepping stone with caregivers. This may suggest that the population of caregivers studied had too many immediate needs and psychosocial stressors for a curriculum that focuses on resilience and caregiver capacity to be adequately delivered with fidelity.

Implications for Home Visiting Programs

There has been a recent increase in support for the utilization of home visiting services as they aim to enhance the health and outcomes of children (Azzi-Lessing, 2013). Ammerman, Putnam, Bosse, Teeters, and Van Ginkel (2009) explain that "in-home visitation, a home visitor (who, depending on the program model, is a nurse, social worker, or paraprofessional) provides psychoeducational training and case management services to mothers and children (p. 192)." Home visiting programs are credited with offering an array of support services where intervention begins with mothers, before a baby is born, but can remain in effect until a child reaches toddlerhood or school-age (Ammerman, et al., 2009). Since there is such wide

variation in goals and characteristics of home visiting programs, research on overall effectiveness remains difficult (Finello, Terteryan, & Riewerts, 2016; Nievar, Van Egeren, & Pollard, 2010). Most research focusing on well home visiting programs keeps a focus on outcomes that are short-term in nature (Finello, et al., 2016). Consequently, there is still much to be learned about the role of home visiting programs in producing and sustaining positive results for high-risk families (Azzi-Lessing, 2013). Although the present study's initial purpose was to explore the efficacy of Your Journey Together (YJT) curriculum within pre-established home visiting programs; low recruitment in combination with retention challenges resulted in changes to the study purpose. However, the difficulties in enrollment and retention in the present study offer important implications for future research.

Engagement and Attrition

Home visiting programs were developed in part to reduce difficulties that interfere with client service engagement (Damashek, Doughty, Ware, & Silvosky, 2011). If a service provider can visit a family's home, then the theoretical obstacles, such as transportation, are eliminated (Damashek, et al., 2011). The significance of the relationship between parents and home visitors in helping families cannot be understated (Barak, Speilberger, & Gitlow, 2014). This is especially important because supportive relationships improve parental engagement, a necessary element for home visiting service delivery (Astuto & Allen, 2009; Azzi-Lessing, 2013).

Although parents may disengage or drop out of services at any time, it is more likely to occur at the beginning of services as this is when a relationship between home visitor and parent is not strongly established (Ammerman et al., 2006). The reasons for client disengagement and attrition vary among participants, but some research has focused on this question. In a qualitative study evaluating the reasons for disengagement among parents during the first six months of home-based service delivery, Stevens, Ammerman, Putnam, Gannon, and van Ginkel (2005) reported on the themes related to why engagement and disengagement happen. They explain that parents do not readily engage because they may have felt as though they were asked to disclose too much personal information, they feared being reported for child abuse (even if they readily participated), and/or they felt that their home visitor's characteristics did not match their needs. Stevens, et al. (2005) further assert that participants make a decision to either actively tell their service provider that they want to stop receiving services or they will quit through failure to respond to contact attempts. A major concern identified with attrition was the resources (time, money etc.) used by home visitors who often try and re-establish services with clients who have not remained active in services (Stevens, et al., 2005).

In the present study, it was expected that participating agencies delivered services, engaged clients, and closed clients, based on existing agency protocols. The reasons that participants dropped out in the present study appear consistent with those cited in the existing literature. There were some cases that were closed before completion as a direct result of parent request, while others were due to lack of compliance with program expectations. In a commentary outlining information obtained from Healthy Families of Alaska and other home visiting programs, Gomby

(2007) offers "lessons learned," applicable to other home visiting programs. The first observation suggests that "program content drives results" because home visiting is a "strategy, not a specific intervention" (Gomby, 2007, p. 794). A home visiting program is only as effective as the discussion quality, relationship quality, and content delivery quality between the home visitor and the client (Gomby, 2007). It is important to note the YJT curriculum was a supplemental intervention provided within the context of a broader scope of services. Accordingly, in implementation groups, dropping out of the agency's program automatically resulted in discontinuation of the intervention. The reasons that participants dropped out of their respective programs were for reasons other than the YJT curriculum. Future research should consider common reasons for attrition from home visiting programs when establishing a research timeframe and design.

Intervention Secondary to Immediate Needs

It is common for home visiting programs to target at-risk populations who may experience problems with parenting, but specific risk factors vary among individuals (McFarlane, et al., 2013). Ammerman, et al. (2006) conducted a study to predict how client engagement occurred during the first year of receiving services. Results showed that those mothers with the most significant psychosocial stressors at admission spent longer time and duration in services than those mothers who had more support resources (Ammerman, et al., 2006). These findings suggest that if parents with significant psychosocial circumstances can have these concerns addressed by the home visitor, they may be more successful in utilizing services. Stevens, et al. (2005) also found that supervisors, home visitors, and mothers collectively agree that "social support, psychoeducation, and tangible assistance" were all pros for participating in home-based services (p. 84). Many home visiting programs target high-risk groups with higher psychosocial stressors, leading to changes in service or curriculum delivery to meet the individualized needs of the family. A significant challenge in home visiting is that planned intervention focusing on the child is not likely to occur if a more pressing basic need arises (Finello, et al., 2016). In an Illinois-based qualitative study of home visitors, home visitors often deviated from planned intervention in order to meet the client's immediate needs (Barak, et al., 2014). Consequently, there were times that home visitors in the study were left to decide between prioritizing client relationship-building by having a flexible schedule or risk losing the client by adhering to a rigid routine. One home visitor illustrated how helping a client get basic utilities turned back on took precedence over completing a planned intervention (Barak, et al., 2014). In the present study, during face-to-face meetings with one implementation site, one challenge that the home visitors frequently identified was the inability to consistently deliver the curriculum because more immediate psychosocial needs of the families needed to be addressed. These findings highlight the importance of ensuring that the home visiting program model can meet the requirements of intervention delivery. Additionally, curricula such as YJT may be more appropriate for families who have fewer psychosocial stressors, or should be implemented using a timeframe and structure that allows for addressing the immediate needs for the family in addition to the delivering the curriculum. Curricula such as YJT might be effective if there is mandatory participation leverage from either DCF or the court.

Demographic and Psychosocial Risk-Factors

The existing literature explains that certain demographics, such as insufficient income, can place some parents at risk of having more parenting strains (Ammerman, et al., 2009). These findings are consistent with the financial demographics of the present study as 22 out of the 42 participants reported an income of less than \$16,000 per year (see table 2). This is considerably less than the federal poverty line for a household of 4 in 2015 (\$24,300). Thompson and Haskins (2014) explain that poverty and instability in housing can sometimes go hand in hand. Children who live with housing instability are more likely to experience being removed from their family, if they are already under child protective investigation (Fowler, et al., 2013). Children reared in environments with parental income-related stressors are at higher risk of maltreatment or neglect (Thompson & Haskins, 2014). The complexity of these psychosocial challenges can make it difficult for home visitors to deliver intended interventions. In a study exploring the relationship between unstable housing and participation in an Early Head Start home visiting program, Staerkel and Spieker (2006) found that housing instability resulted in lower participation rates. After parents exert the energy necessary for addressing stressors to meet basic familial needs, they do not have the focus for interventions directed at secondary needs like child development (Staerkel & Spieker, 2006). It is important to point out that the other problem with housing concerns is that they interfere with home visiting intervention delivery and effectiveness measurement (Brand & Junman, 2013). This is because if a parent moves due to housing problems, they may not be able to access the same services in their relocation area (Brand & Junmann, 2013).

Previous research has focused on the effects of risk factors such as, maternal depression or substance misuse on client engagement (Damashek, et al., 2011). These significant psychosocial issues are an important consideration when addressing barriers to delivering home-based interventions. The present study experienced barriers to service delivery as a result of client substance misuse and other special circumstances. Of course, child and family safety lie at the forefront of all service delivery and it was expected that agencies follow their protocols for addressing any immediate crisis concerns. It is beyond the scope of this study to further evaluate the role that these significant psychosocial circumstances played in programmatic service delivery. However, it should be noted that the effects of these barriers on parenting curriculum delivery is an area warranting further research.

Intervention Facilitation by Home Visitors

The present study was initially interested in exploring the effectiveness of a parenting curriculum when it is utilized in home-based service delivery. "Fidelity is widely defined as the degree to which practitioners' implementation of evidence-based programs matches the intent of the programs' developers (Barak, et al., 2014, p. 50)." In addition to this, more research is needed to explore characteristics that contribute to enhancing and interfering with relationship-building between the client and the home visitor (Barak, et al., 2014).

One of the greatest challenges and lessons learned from the present study is that it was expected that the present study would meet the targeted number of participants to complete a pretest/posttest design. Thus, fidelity visits to ensure accurate curriculum

delivery among implementation sites occurred. The curriculum appeared to be delivered effectively, but it was sometimes difficult for home visitors to transition from work on immediate and concrete family needs to delivering a curriculum. It was not uncommon for home visitors to meet with their clients about other items that required support. This often led to challenges in delivering the curriculum within the allotted time frame or having the ability to deliver the correct dosage. Observations for implementation fidelity were further complicated by cancellations, mostly by the participants, but also occasionally by the home visitor.

In order to address challenges presented by home visitors, Tandom, Mercer, Saylor, and Duggan (2008) found that home visitors often feel conflicted between addressing competing immediate needs of either basic care concerns or psychosocial crisis (such as, domestic violence or substance abuse). They recommend that home visitation programs take a more direct role in formalizing procedures for addressing immediate psychosocial crisis and helping families identify services that will address psychosocial problems that interfere with effective parenting (Tandom, et al., 2008). Future studies aiming to add to the evidence-based literature of parenting curricula for at-risk families should consider recruiting programs that can add the intervention to work with families that are already stabilized.

Limitations to the Study and 'Lessons Learned'

Agency Recruitment and Staff Challenges in Data Collection

In retrospect, a major challenge to conducting this study as planned was the recruitment process and selection of the data collection sites. From the beginning, this difficulty was evident when two of the original agencies, after agreeing to participate, decided to pull out at the very last minute prior to starting the project. What followed were numerous futile and frustrating efforts to engage other community-based agencies that were serving the population needed for the study sample. Agencies did not wish to participate for a number of different reasons:

Their workers already had a great deal of work and responsibility and could not handle any new tasks related to curriculum implementation and/or research.

Agencies did not have any children under the age of five or had very few of those cases.

Administratively, some agencies were not supportive of the research because they had their own research underway or their top level administrators would not support it.

Agencies did not meet the criteria for length of service delivery with families.

Other agencies did not feel that they could get their staff on board with the idea.

The comments from the Home Visitor Reflections of the Impact of the Curriculum bear out that the greatest challenge the home visitors experienced was attempting to implement the entire curriculum with families who were at high risk and needed to resolve numerous psychosocial crises.

The first implementation site was trained without incident shortly after the start of the study. There was a significant delay in the time that the first implementation site was trained and the other sites. The second implementation site was trained in

October 2015, but the control sites were not trained until January 2016. The data collection process was slow from the beginning. The researchers made efforts to extend data collection deadlines, but this did not increase participant enrollment at the sites. It should be noted that one implementation site and one control site met their targeted number of enrolled participants. However, both of these sites were ones that expected to have the smaller number of enrollments and they each had some participants drop early from the study. It was determined that it was unrealistic to continue forward in trying to meet the sample size necessary for completing the original study design. The deadline to enroll participants was extended by six months, but these efforts did not significantly improve enrollment or retention. Despite the efforts made to support the staff collecting data and the technical assistance provided, it appeared that not all agency staff made strong efforts to collect data.

Length of Curriculum

The YJT curriculum may be too long for a population of caregivers that are not mandated to participate in the curriculum and also encounter numerous psychosocial stressors. Due to the needs of the families, some home visitors at the implementation sites took longer than anticipated on each of the curriculum modules and stepping stones. When asked, some home visitors reported that the time allotted for their work with families did not allow for delivery of the entire curriculum. Others reported that clients either canceled their sessions or had too many 'crises' to resolve that veered them off the curriculum.

It became evident that many home visiting programs are contracted for a limited number of visits to stabilize families in crisis. The limited time frame or number of home visits allotted can prevent home visitors from supporting caregivers beyond basic needs. Home visitors are limited in their ability to teach sustainable skills for healthy child development.

Challenges in Data Collection Process

A summarizing list of reasons for why the data collection process did not go as planned include:

1. Due to the nature of home visiting services with this population, home visitors provide essential psychosocial and crisis intervention services that often take time and sometimes prevent delivery of the curriculum intervention and the completion of pretest packets.
2. Slow referrals from agency that match criteria for study—the agencies do not have exclusive birth to five year-old clients—therefore it took longer to identify this age group and to ensure that the participants met the other inclusion criteria.
3. Home visitors have small caseloads—they conduct 10-12 home visits per week but that is combined—i.e. a family may be seen more than once and other ages are also referred.
4. Home visitors did not begin to deliver the curriculum intervention within the expected timeframe.
5. Poor retention of families: cancellations, no shows, family crises that prevent from keeping appointments.
6. Programs received high-risk cases which take longer to stabilize—not leaving enough time or motivation to get

started with the study and the curriculum delivery. More immediate needs take priority—shelter, eviction, Baker Acts & other psychosocial stressors.

7. Some home visitors indicated that the curriculum intervention could not be delivered in the timeframe allotted (number of visits contracted) for work with some families.
8. It was challenging to complete the necessary fidelity home visit observation for each home visitor due to client cancellations.
9. Permanent or temporary loss of home visitors due to: illness, hospitalization, maternity leave, changes in position, etc.
10. Originally, agencies only agreed to participate to a shorter duration of data collection. Since data collection was quite slow, and upon request from Devereux, the agencies continued their participation beyond their original dates. The extension of the data collection may have resulted in fatigue for some home visitors, who may have lost interest in the process.

However, it should be noted that the challenges mentioned above were in fact similar to challenges experienced by the control sites.

Practical Application of the Study and Sustainability Plan

Implications for Research

There is a scarcity of research on the capabilities and skills that caregivers possess to help children ages birth to five achieve their optimal development. The literature in infant mental health identifies the important role of caregivers in helping children achieve social and emotional health, emphasizing the need to continue research on this topic. It is evident that in order to continue research on caregivers involved with the child welfare system, researchers must consider selecting data collection sites carefully and perhaps select those programs where caregivers are mandated to participate for an adequate amount of time for curriculum delivery.

This requirement will ensure that caregivers stay in parent education groups until completion and therefore provide data on important research related to their challenges in raising children under the age of five. It is also possible that the high-risk population of child welfare is not appropriate for curriculum implementation with fidelity due to the number of psychosocial stressors that must be immediately addressed within the family. Therefore, a lower-risk population in need of parenting education may be most appropriate for curriculum interventions.

It would be of benefit to conduct more comprehensive evaluation of curriculum delivery in programs using YJT. This would allow perceived barriers to delivery to be addressed before attempting to conduct another pretest/posttest study.

Implications for Program Planning

Program delivery and services/interventions: Consider shorter curriculum formats for those programs that do not serve families for lengthy periods of time. Additional studies may look at the implementation of just one module of the curriculum, or the

effectiveness of the curriculum with abbreviated versions of the modules. In order to have a significant impact on children and families, contracts for longer service delivery may be necessary in order to stabilize families, and then move toward parent education in child development and social emotional health. YJT intervention “dosage” of two stepping stones per visit proposed for this study may be too time consuming. While each stepping stone is designed to take about 15-20 minutes, the timeframe for the research study and service delivery led the researchers to propose completing 2-stepping stones per visit with families. It may be beneficial to explore ways to shorten the time spent on the curriculum per visit, especially since most families have other needs to be addressed.

Implications for client participation: Recruitment efforts should include programs with parents who are stable and have additional requirements to meet prior to reunification with their child or following family reunification. Some families closed services once their DCF case was closed and in some cases, prior to the close of their case. It is also possible that curriculum interventions such as YJT might work best in stable homes, as a way of enhancing parenting and preventing disruption, rather than in homes with such high risk of child removal.

Implications for home visitors: The curriculum was regarded as positive for most home visitors, but it may be of benefit to determine effective ways to help home visitors ease into curriculum delivery to ensure that they are able to reach more

clients beyond the provision of supporting immediate needs. This may require evaluating the workload and other responsibilities of the home visitors.

Sustainability

All curriculum resources that were funded by this project and distributed to Peace River Home To Stay and Children Home Society’s Care Programs will remain the property of those programs and will be used with their families indefinitely after this project ends. Should these programs wish to order additional future copies of any YJT resources, they will be able to do this at Devereux’s discounted rates. Devereux staff will remain committed to providing technical assistance via email or telephone to both programs. Both control sites, Gulf Coast Jewish Family Community Services and Behavior Basics, have committed to having their staff trained by Devereux in use of the curriculum and will be given YJT kits and implementation training in 2016. All participating agencies will have unlimited access to the password protected YJT website which contains documents and information that would be useful for future grant/funding applications, in addition to resources to support coaches in delivery and enhancement of the curriculum.

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