

Evaluation of the Home Visiting Pilot for Pregnant and Parenting Youth in Care: FY 2018 Preliminary Report

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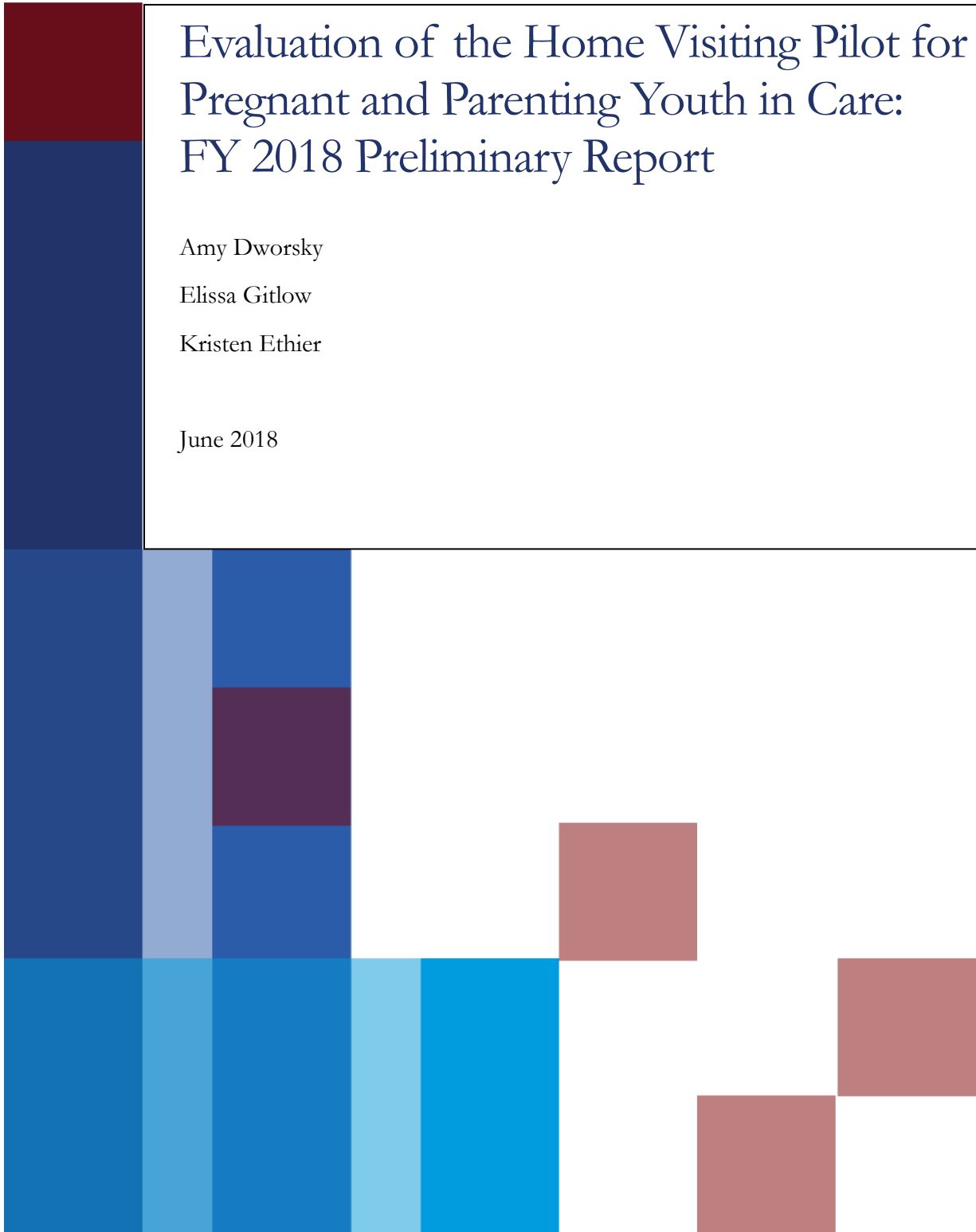


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Introduction

In January 2015, the Home Visiting Task Force, a standing committee of the Illinois Early Learning Council, established a Home Visiting-Child Welfare Sub-Committee to design and implement a Home Visiting Pilot Program that would serve pregnant or parenting youth in foster care. The Illinois Department of Children and Family Services contracted with Chapin Hall to conduct an implementation and outcome evaluation of the program. This report presents preliminary results from that evaluation.

Background

Motivation for the Pilot

Research indicates that female foster youth are much more likely to become pregnant and to begin parenting while in their teens than their non-foster peers. They are also more likely to experience a repeat pregnancy, and hence, to be parenting multiple children at an early age. Second, many adolescent parents lack adequate knowledge about child development. This can lead to unrealistic expectations and make it difficult for teenage parents to recognize and appropriately respond to their children's needs and feelings.^{1,2,3} For youth in foster care, this lack of knowledge may be compounded by the developmental impacts of the abuse, neglect, or other trauma they have experienced as well as the absence of positive and stable parenting during childhood.

Third, research suggests that children born to teenage mothers are at an increased risk of child abuse and/or neglect compared with children whose mothers were older when their first child was born.^{4,5} For example, one study that used aggregate birth certificate data and data from the Integrated Database on Child and Family Programs in Illinois found that the incidence of substantiated child maltreatment by age five was 2.7 times higher among children whose mothers were under age 18 (~11 percent) and 2.3 times higher among children whose mothers were 18 or 19 years old (~9 percent) compared to children whose mothers were at least 22 years old (~4 percent).⁶ Fourth, recent studies of intergenerational maltreatment have found that children whose adolescent mothers were neglected or abused may be at an increased risk of being maltreated compared to children whose adolescent mothers have no childhood abuse or neglect history.^{7,8}

Finally, although relatively little is known about rate of child welfare services involvement among children whose parents were in foster care when they were born, the results of one recent study suggest that children born to youth in foster care may be at high risk not only of being neglected or abused but also of being placed in foster care themselves. More specifically, an analysis of DCFS administrative data found that 39% of the children born to parents who were in foster care when their first child was born were the subject of at least one Child Protective Services ("CPS") investigation, 17% had at least one indicated report, and 11% were placed in care at least once before their fifth birthday.⁹

Potential Benefits for Pregnant and Parenting Youth in care

Rigorous evaluations have demonstrated that home visiting programs can significantly reduce child abuse, improve parental functioning and enhance child development.^{10,11,12} Moreover, some of those studies suggest that these programs may be particularly effective with pregnant and parenting teens.^{13,14,15,16} That said, although adolescents in foster care are much more likely to become pregnant, to experience a repeat pregnancy, and to begin parenting while in their teens than their non-foster care peers, pregnant and parenting foster youth have generally not been included in evaluations of evidence-based home visiting programs.¹⁷ Some efforts have been made to include pregnant and parenting foster youth in existing intensive home based interventions, but those efforts have been small in scale and reliable estimates of enrollment rates and impacts have not yet been produced.¹⁸

Despite their omission from prior evaluations of evidence-based home visiting programs, there are a number of ways in which home visiting could benefit pregnant and parenting foster youth. First, delivering services in the setting where youth live eliminates the transportation and other access barriers that may make it difficult for this population to participate in the intervention. It also provides an opportunity to engage the youth's foster parents or other adult caregivers in monitoring how the young mother interacts with her infant, modeling appropriate parenting practices, and teaching the young parent how to make informed decisions about her child's well-being. Finally, young parents who participate in a home visitation program can also learn how to better balance the demands of parenting with their own educational, employment and emotional needs.

Home Visiting Pilot

Health Families Illinois

Home visiting services are provided to pilot clients by Healthy Families Illinois (HFI) programs. HFI programs are voluntary home visiting programs modeled after the evidence-based Healthy Families America (HFA) program. HFI programs provide comprehensive services designed to support parents, improve parent child interaction, promote child health and development, and reduce the risk of child abuse and neglect. Accredited HFI programs must meet the same standards as the HFA program and use the same level system for managing the intensity of the services provided to their clients (Table 1).¹⁹ Five of the levels are for clients who are regularly engaged in home visiting services. They are based on client needs and change over time. Clients with higher needs receive more intensive services. The sixth level is for clients who are not regularly engaging in home visiting services.

Table 1. HFA Service Intensity Levels

Level	Frequency of Home Visits	Additional Information
Level P (Prenatal)	At least once a month	<ul style="list-style-type: none">• Frequency determined by HV and supervisor based on severity and complexity of problems needing attention prior to birth and client's interest in participating
Level 1	Weekly	
Level 2	At least every other week	
Level 3	At least monthly	
Level 4	Quarterly	
Creative Outreach	Length of time clients remain creative outreach depends on the situation	<ul style="list-style-type: none">• Clients new to the program who have not been consistent with home visits or who cannot be located• Clients who have been consistent with home visits for 3 months but started to become inconsistent• Clients temporarily out of the service area for more than a month

HFI accredited programs are typically required to enroll clients prenatally or before their child is three months old, and the majority of clients are enrolled within 2 weeks of giving birth. However, Healthy Families America granted a waiver that allows HFI programs participating in the pilot to enroll pilot clients during pregnancy or before the child's first birthday. This extension of the enrollment period was critical because many youth in foster care either do not know or choose not to reveal that they are pregnant until quite late into their pregnancy.

Goals of the Home Visiting Pilot Program

The Home Visiting-Child Welfare Sub-Committee identified several goals for the pilot:

- Provide pregnant and parenting youth in care with access to voluntary home visiting services in their communities;
- Promote nurturing parent-child relationships and healthy child development;
- Enhance family functioning by reducing risk and building protective factors;
- Break the intergenerational cycle of abuse, neglect, and trauma;
- Increase coordination between the child welfare system and home visiting programs;
- Create a model for delivering high quality home visiting services that can be replicated with DCFS-involved families throughout the state.

Funding

The home visiting services provided to pilot participants and the infant mental health consultation provided to home visitors is supported with Maternal, Infant and Early Childhood Home Visiting (MIECHV) funding as well as funding from the Department of Human Services (DHS) and the Illinois State Board of Education (ISBE). The Chapin Hall evaluation of the Home Visiting Pilot is funded by DCFS.

Home Visiting Agencies

The pilot is being implemented by nine Healthy Families Illinois (HFI) programs: Advocate Illinois Masonic Medical Center, Children’s Home + Aid, Children’s Home Association, Easter Seals Rockford, Family Focus Englewood, Healthy Families Chicago, Sinnissippi Centers, Stephenson County Health Department, and Teen Parent Connections. Three of these agencies serve clients in Cook County. The other programs serve clients in DuPage, DeKalb, McLean, Peoria, Stephenson, Whiteside and Winnebago Counties.

Table 2. Counties Served by Home Visiting Programs

Home Visiting Program	County Served
Advocate Illinois Masonic Medical Center	Cook*
Children’s Home + Aid	McLean & DeKalb
Children’s Home Association	Peoria
Easter Seals Rockford	Winnebago
Family Focus Englewood	Cook*
Healthy Families Chicago	Cook*
Sinnissippi Centers	Whiteside
Stephenson County Health Department	Stephenson
Teen Parent Connections	DuPage

*Select Chicago neighborhoods only

Eligibility

Youth in care are eligible for the pilot if they are currently pregnant or the parent of a child who is not yet one-year old *and* are living in a catchment area served by one of nine HFI programs. Eligible youth are identified by the Teen Parenting Services Network (TPSN). TPSN is the lead agency of a

network of service providers that offer case management, placement, and parenting services to pregnant/parenting youth in care.

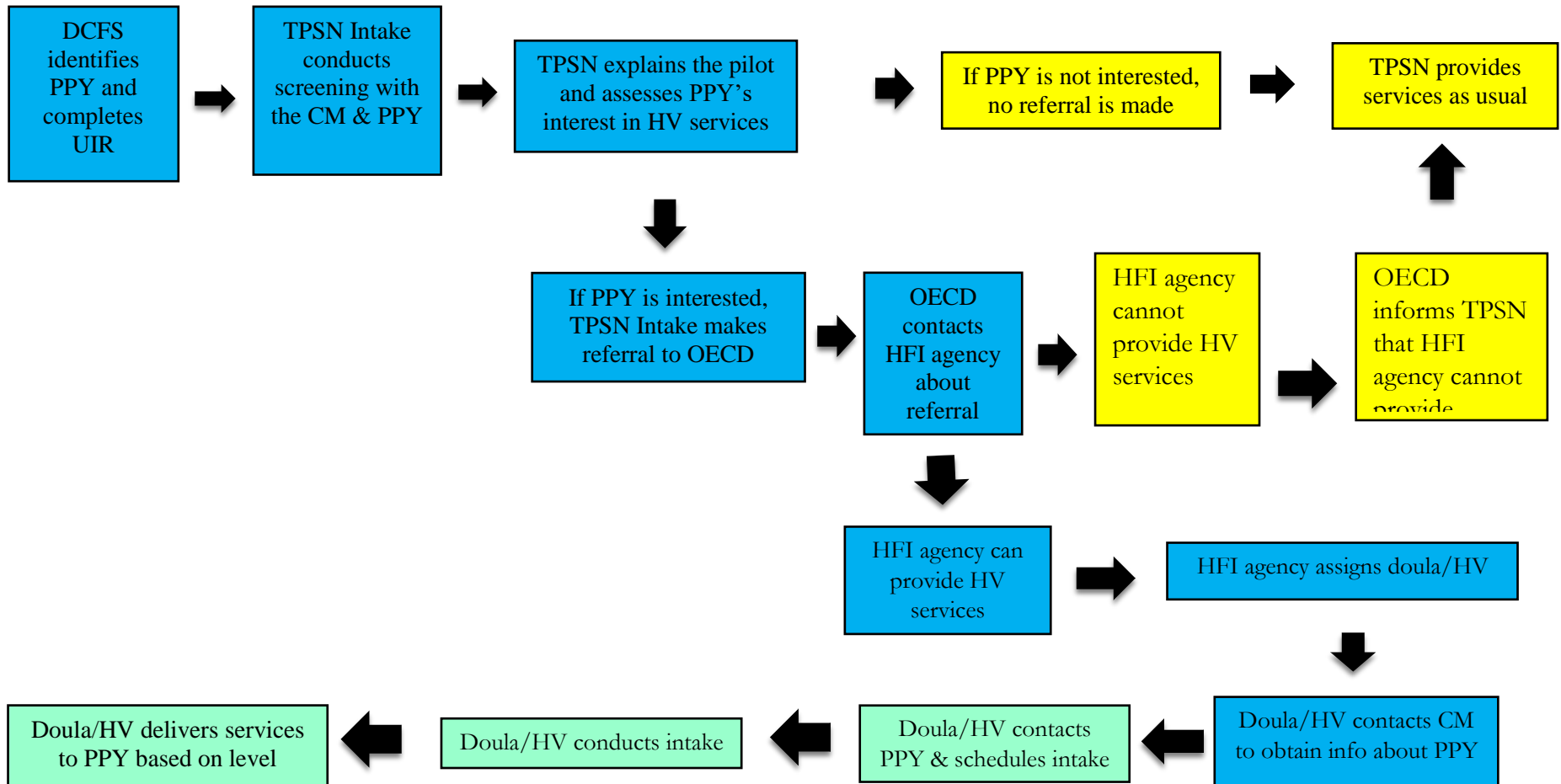
Eligibility for home visiting services does not end when youth age out or otherwise exit care. Rather, youth who enroll in the pilot remain eligible for home visiting services until their 25th birthday or their child's third birthday (or fifth birthday for some programs), whichever should come first. Moreover, because HFI is a voluntary program, youth may discontinue their participation at any time. If the child of a parent enrolled in the pilot is removed from the parent's care and taken into DCFS custody, the parent will remain eligible for home visiting services as long as the child's permanency goal is return home and the home visitor is able to conduct visits with the parent and child.

Concerns were also raised early on about the potential for a duplication of services, particularly for youth who are receiving parenting services from the pregnant and parenting providers that DCFS contracts with to complete the new birth assessment (NBA). Those services, which can be provided for up to a year, typically begin prenatally and end several months after the baby's birth. If a youth who is already receiving parenting services is referred to the pilot, she is placed on the "eligible" list until those parenting services end. As long as her child is not yet a year old, she can still enroll in the pilot at that point.

Referral, Outreach and Enrollment Process

TPSN reaches out to pregnant and parenting youth in care who reside in counties with a participating HFI agency. If a youth is interested in receiving or open to learning more about the services, TPSN sends a cover sheet containing information about the youth to the pilot project director at the Governor's Office of Early Childhood and Development (OECD). The pilot director forwards that information to the HFI program that serves the geographic area in which the youth lives. The home visiting agency assigns the client to a doula (if the client is pregnant) or a home visitor (if the client is parenting or the program has no doulas). The doula or home visitor engages in outreach to enroll the client in the pilot. Once a client accepts services, the home visitor or doula enrolls the client at Level P, if the client is pregnant, or Level 1, if the client is parenting, and begins making home visits (See Figure 1).

Figure 1. Home Visiting Pilot Case Flow



*PPY = Pregnant or parenting youth
 **CM = Case manager
 ***HV = Home visitor or home visiting

Training and Support

HFI home visitors and DCFS/POS case managers receive cross-training for the pilot from the Ounce of Prevention Fund Illinois Birth to Three Institute and TPSN. Home visitors also participate in ongoing reflective supervision with their supervisor and have access to infant mental health consultation.

Communication

Several months into the pilot, it became apparent that communication between home visiting programs and child welfare agencies was far more limited than would be needed for the pilot to succeed. Two changes were made to encourage more cross-system communication. First, the pilot project manager began sending emails to the supervisor of the home visitor assigned to each new pilot client and to that pilot client's child welfare caseworker. The email informed the caseworker that the client was receiving home visiting services as part of the pilot and provided both parties with each other's contact information.

Second, a TPSN staff member who is part of the pilot project team began sending emails to the child welfare caseworker of each new the pilot client, with the home visitor copied, to inform the caseworker that the client is participating in the pilot and to arrange a Child and Family Team meeting which the home visitor could be attend.

Logic Model

Chapin Hall worked with the Home Visiting-Child Welfare Sub-Committee to develop a logic model for the pilot that lays out the objectives of the pilot, the resources being brought to bear (inputs), the activities in which service providers are engaged, the products of those activities, and the short- and long-term outcomes at parent-, child- and system-levels. The short- and long-term outcomes are based on the indicators recommended by the Pew Charitable Trusts Home Visiting Data for Performance Initiative.²⁰

Home Visiting-Child Welfare Pilot Logic Model					
Objectives	Inputs	Activities	Outputs	Short-term Outcomes	Long-term Outcomes
<ul style="list-style-type: none"> • Provide home visiting services to pregnant and parenting youth in care using a modified version of the HFA model • Promote nurturing parent-child relationships • Promote healthy child development • Enhance family functioning by reducing risk and building protective factors • Break intergenerational cycle of abuse, neglect, and trauma • Increase coordination between the child welfare and home visiting systems in Illinois 	<ul style="list-style-type: none"> • HFI Agencies • HFI Home visitors • Cross training provided by UCAN or Ounce of Prevention • Reflective supervision • Clinical and Infant Mental Health consultation • Coordination and sharing of information among HFI programs, DCFS and TPSN • DHS and MIECHV funding • HFI programs with doulas • Coordinated referral through Governor's Office of Early Childhood Development 	<p>TPSN/DCFS will:</p> <ul style="list-style-type: none"> • Refer eligible youth (i.e., pregnant females and parents with a child under age 1) • Encourage voluntary participation in HV services • Coordinate and facilitate Child and Family Team meetings at least quarterly • Ensure basic needs of mother and child are met <p>Home visitors and TPSN will:</p> <ul style="list-style-type: none"> • Create a trusting relationship with pregnant/parenting youth • Complete the New Birth Assessment • Develop goal plans • Encourage prenatal care receipt and compliance with medical advice • Make appropriate referrals and facilitate access to needed services and community resources • Educate parents about child development, child safety (including safe sleeping) and prevention of child injuries • Provide information about childcare options, including childcare assistance and family planning • Encourage co-parent involvement <p>Home visitors will:</p> <ul style="list-style-type: none"> • Engage and retain parents in home visiting program • Provide breast feeding education and support • Assess parent-child interactions • Promote secure attachment and positive discipline techniques • Teach activities to promote child development • Screen for depression, domestic violence, and substance abuse • Promote healthy and discourage risky behaviors • Teach critical thinking, problem solving, and stress management skills • Conduct developmental screenings • Monitor child well visits and immunizations • Encourage connection to a medical home 	<ul style="list-style-type: none"> • Pregnant and parenting youth receive home visiting services • Home visitors visit pregnant and parenting youth at a frequency consistent with HFA standards • Child and Family Team meetings occur at least quarterly with the parent's assigned home visitor present • Home visitors and TPSN staff have participated in cross-training • Representatives from TPSN, DCFS and HFI programs attend quarterly meetings to discuss opportunities and challenges and provide feedback about the pilot to the Governor's Office 	<p>Birth related outcomes</p> <ul style="list-style-type: none"> • Mothers receive postpartum health care within two months of giving birth (if they were enrolled before giving birth) • Mothers breastfeed for at least three months after giving birth (if they were enrolled before giving birth) <p>Parent outcomes</p> <ul style="list-style-type: none"> • Parents quit smoking/using tobacco (if they smoked/used tobacco prior to enrollment) • Mothers are screened for maternal depression and referred for treatment if appropriate • Parents demonstrate more positive parenting and child rearing attitudes <p>Child Outcomes</p> <ul style="list-style-type: none"> • Children receive well-child checks as recommended by the AAP • Children receive a developmental screening • Children are achieving general developmental milestones at the expected ages • Children with developmental delays are referred for services <p>System Outcomes</p> <ul style="list-style-type: none"> • Home visitors and TPSN staff communicate regularly about shared clients 	<p>Parent outcomes</p> <ul style="list-style-type: none"> • Mothers do not experience a subsequent pregnancy prior to emancipation • Parents without a high school credential earn their high school diploma or GED • Parents with a high school credential enroll in postsecondary education or training program or become employed • Parents have health insurance coverage and are connected to a medical home following emancipation • Parents demonstrate more positive parenting and child rearing attitudes <p>Child Outcomes</p> <ul style="list-style-type: none"> • Children are not the focus of a child maltreatment investigation • Children are not the focus of an indicated child maltreatment report • Children are not placed in care • Children are achieving general developmental milestones at the expected ages • Children are enrolled in an accredited early learning program or licensed day care by age 3 • Children have health insurance coverage and are connected to a medical home following parent's emancipation <p>System Outcomes</p> <ul style="list-style-type: none"> • Home visiting programs have the specialized training and support needed to serve pregnant and parenting youth in care • Data are being used by TPSN, DCFS and the HFI programs to improve practice

Methodology

Evaluation Design

The home visiting pilot evaluation includes an implementation study that is examining the home visiting services that youth enrolled in the pilot receive, assessing fidelity to the HFI model, and identifying barriers to implementation. It also includes an outcome study that is measuring short-term and long-term outcomes at parent-, child- and system-levels.

Data Sources

The home visiting pilot evaluation uses three types of data.

Home Visiting Program Data

Chapin Hall developed a web-based data collection tool for collecting pilot data.²¹ Each HFI program has a unique link which its doulas and home visitors use to enter information about each completed or missed home visit with pilot clients (see Table 3). Chapin Hall provides training on how to use the data collection tool and ongoing data entry support.

Table 3. Information Captured by Data Collection Tool

Visit date	Child date of birth
Visit missed or completed	Prenatal or postpartum visits
Reason for missed visit	Well-child visits/immunizations
HFI level	Breastfeeding status
Client gender	Activities engaged in during visit
Client date of birth	Screenings or assessments administered
Pregnancy status	Referrals made
Due date if pregnant	Interactions with child welfare system
Birth outcome	Outcomes (entered after final visit only)

Interview Data

Semi-structured interviews are being conducted with home visitors, doulas, home visiting supervisors and youth. The youth will be interviewed twice: approximately three months following their enrollment in the program or three months after giving birth if they enroll prenatally, and then again six months after the first interview.

Administrative Data

DCFS administrative data will be used to examine the demographic characteristics and placement histories of the youth who participate in the pilot and to track child welfare services involvement among the children of pilot participants.

Participation in the Evaluation

During the engagement process, the home visitor or doula informs the client about the evaluation of the pilot. Client may accept home visiting services but decline to participate in the evaluation.

Pilot Enrollment

Figure 2 shows the number of clients enrolled in the pilot as well as the status of those clients since the pilot began. By the end of May 2018, a total of 38 clients had been enrolled, and 27 of those clients were still receiving services. This includes four clients whose cases were transferred from one HFI program to another because they had moved. Two clients are waiting for their cases to be transferred to another HFI program. Nine clients are no longer receiving services: two moved out of state or to an area with no HFI program; two indicated that they no longer needed services; one decided to receive services from a non-pilot program, and failed to respond to repeated outreach efforts by their HFI program.

Figure 2. Number and Status of Pilot Clients Over Time

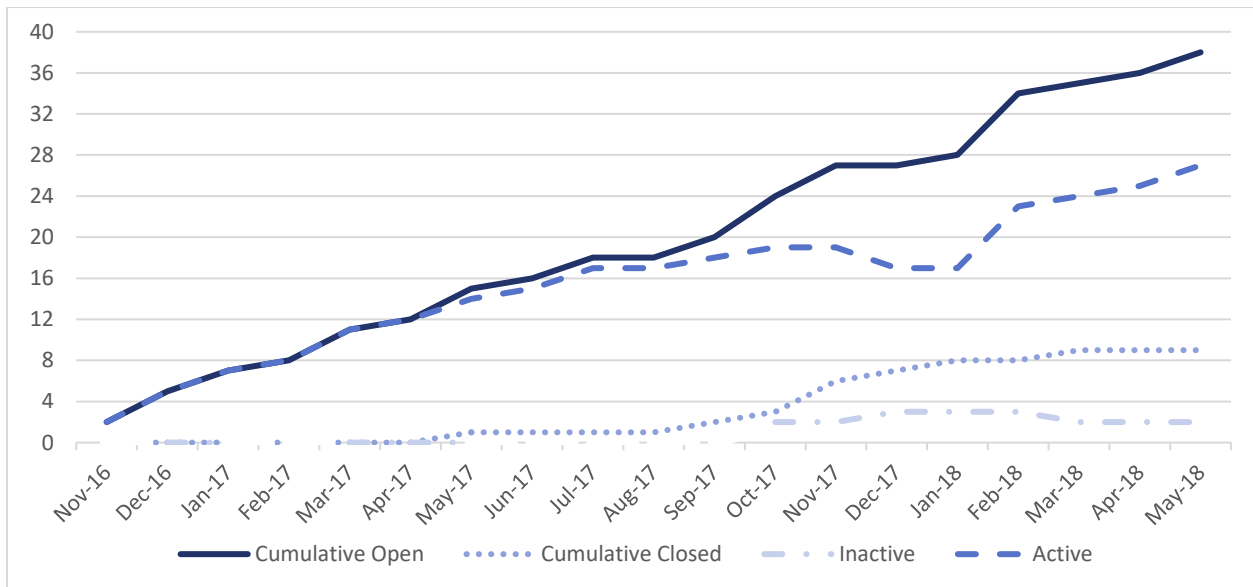
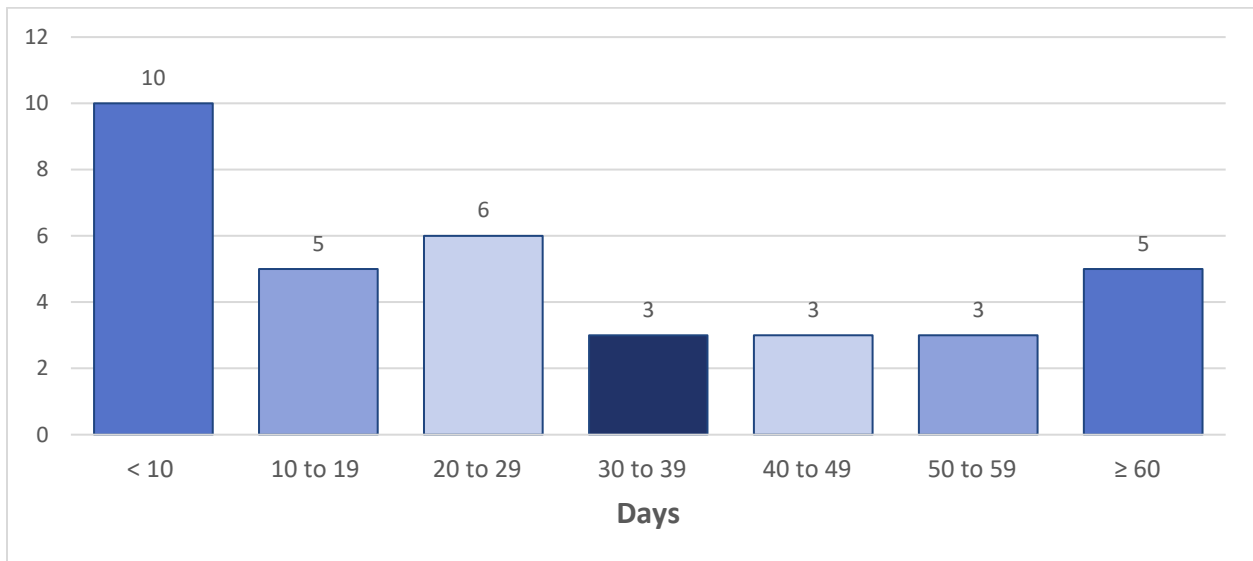


Figure 3 shows the distribution of days from referral to enrollment. On average, clients are enrolling in the pilot 39.6 days after they have been referred.

Figure 3. Days from Referral to Pilot Enrollment



Characteristics of Pilot Clients

Although young fathers in care are also eligible for the home visiting pilot, all of the pilot clients thus far have been female. Figure 4 shows the distribution of client age at enrollment. On average, pilot clients were 18.4 years old at the time they enrolled.

Figure 4. Pilot Client Age in Years at Enrollment

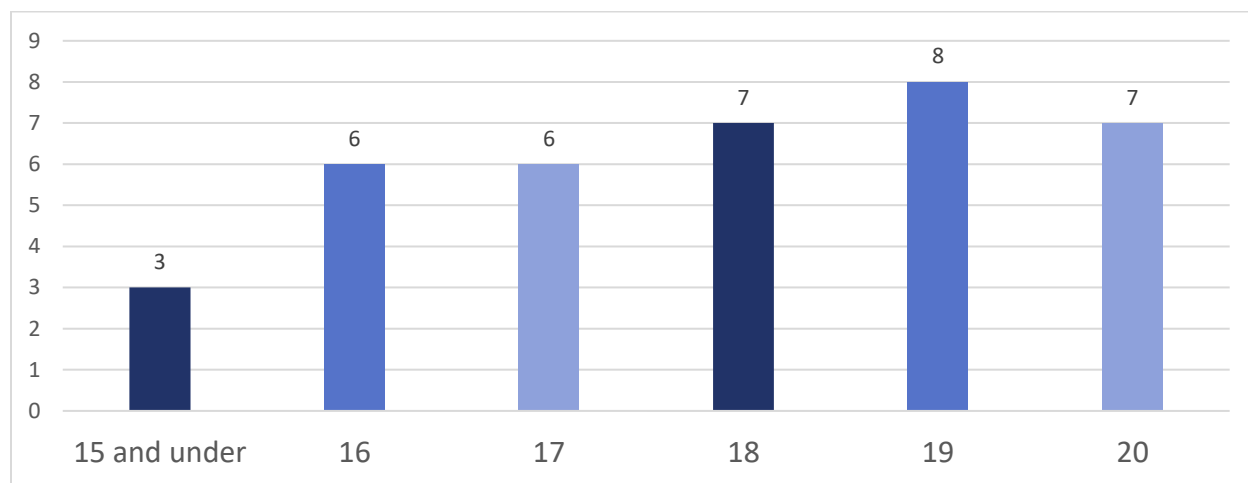


Figure 5 shows the race/ethnicity of the pilot clients. Three quarters are African American.

Figure 5. Race/Ethnicity of Pilot Clients

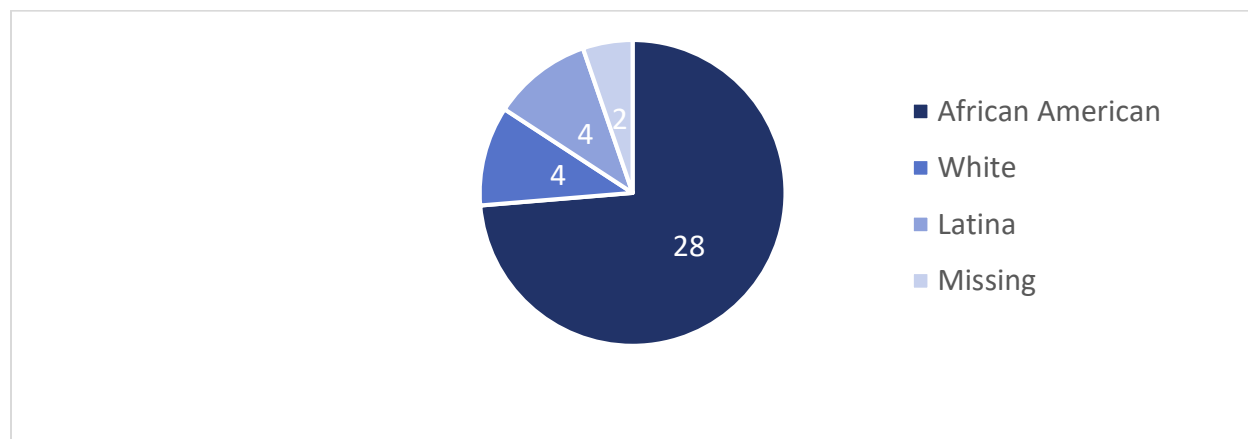


Figure 6 shows both the types and duration of placements pilot clients experienced *since they enrolled in the pilot*. Although some pilot clients had relatively stable placements, others experienced multiple placement changes or disruptions due to running away, detentions or hospitalizations.

Figure 6. Placements Since Pilot Enrollment

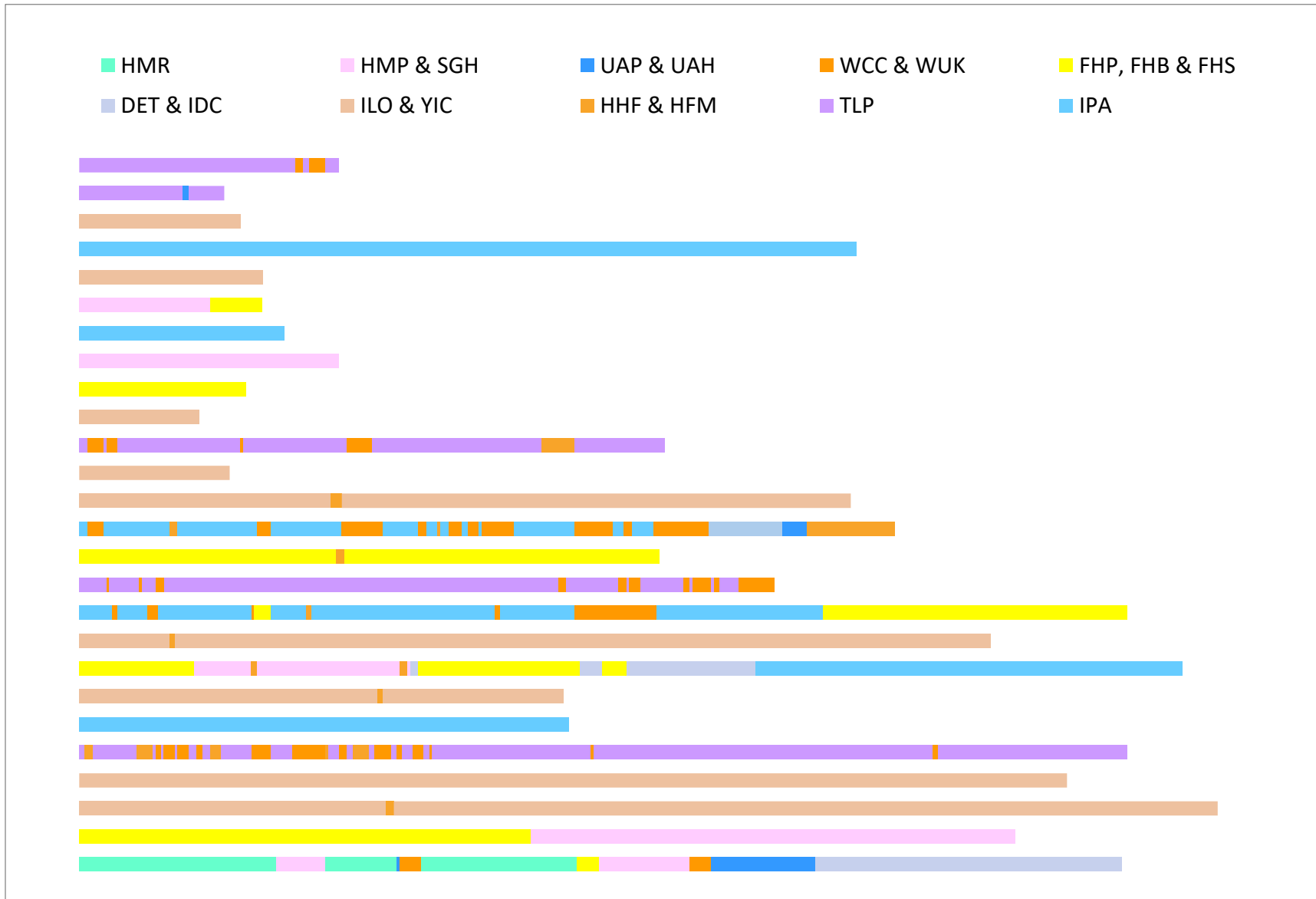


Figure 7 shows the pregnancy status of pilot clients at the time of enrollment. Twenty-three of the pilot clients were pregnant. The other 15 were not pregnant but were the parent of a child who was not yet one year old. Two of the pregnant clients also had at least one child. Eighteen of the 22 clients who were pregnant at enrollment have given birth.

Figure 7. Pregnancy Status at Pilot Enrollment

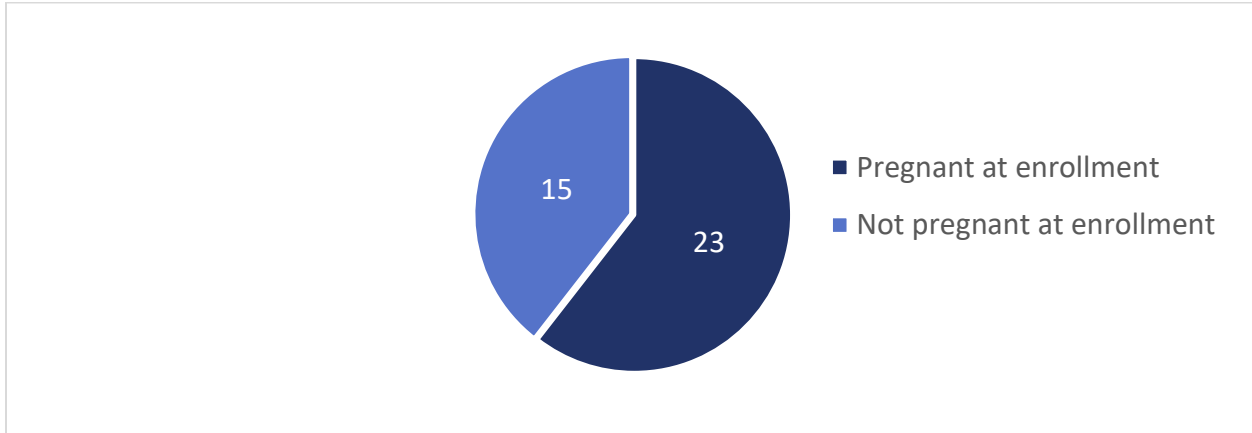
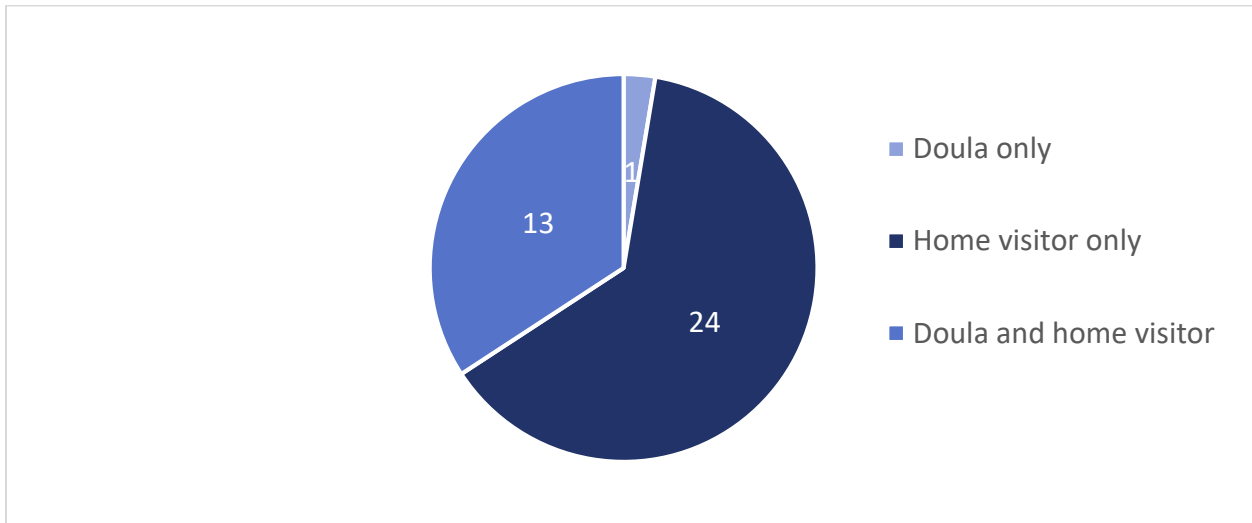


Figure 8 shows the number of pilot clients who have been assigned a home visitor, a doula or both. Twenty-four clients have had only a home visitor, one client has had only a doula and 13 clients have had both a home visitor and a doula.

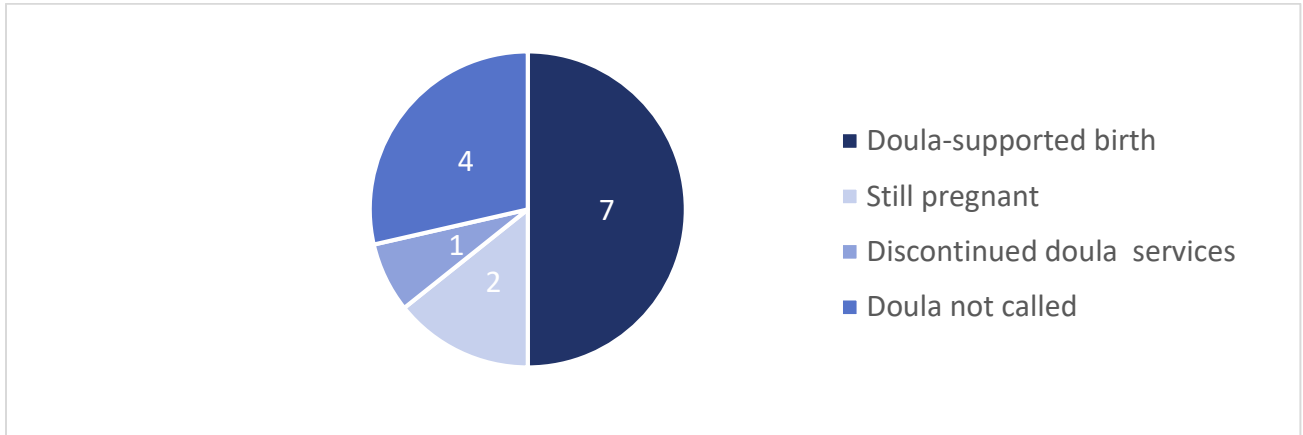
Figure 8. Home Visitor and Doula Assignments



Since the pilot began, 14 of the 22 clients who were pregnant at enrollment have been assigned a doula. As Figure 9 shows, seven of those pilot clients had a doula-supported birth, two are still pregnant, one discontinued doula services, and four either could not or did not call the doula while

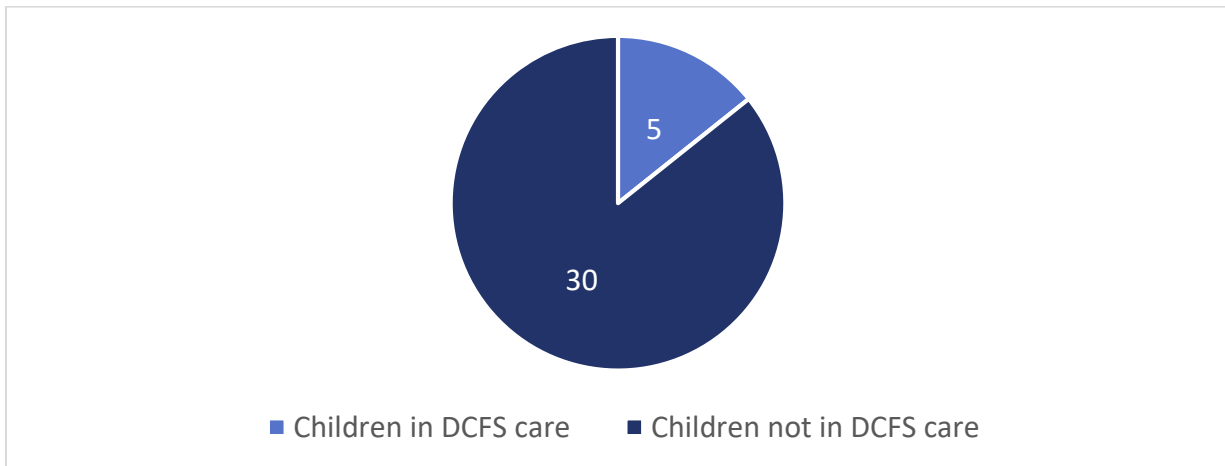
they were in labor. This includes one pilot who was in congregate care. She did not have a phone and staff did not call the doula.

Figure 9. Birth Experiences of Pilot Clients Assigned Doulas



As of May 2018, 35 pilot children were also receiving home visiting services. Nineteen of those children have been born since the pilot began. As Figure 10 shows, 5 pilot children have been placed in DCFS care.

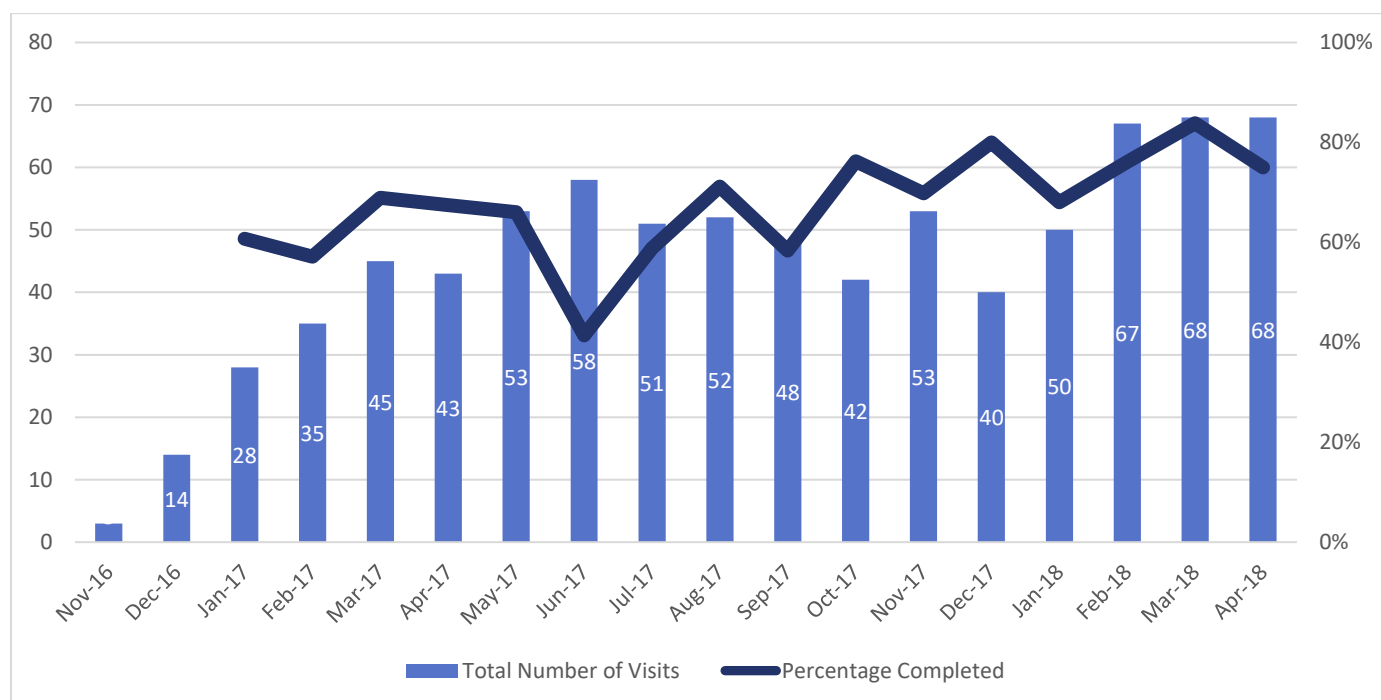
Figure 10. Number of Pilot Children in DCFS Care



Home Visits

Figure 11 shows the total number of visits reported by home visitors and doulas between November 2016---when the pilot began---and April 2018. It also shows the percentage of those visits that were completed. Of the 811 visits that were reported during those 18 months, 562 or 69 percent were completed.

Figure 11. Completed Home Visits as a Percentage of All Home Visits



Home visitors and doulas engage in a wide variety of activities with their clients. Figure 12 shows the number of home visits during which home visitors and doulas engaged in different types of activities. The four most common activities home visitors engaged in were observing clients interacting with their babies, promoting healthy behaviors, promoting secure attachment and providing child development education.

Figure 12. Number of Visits Engaged in Activities

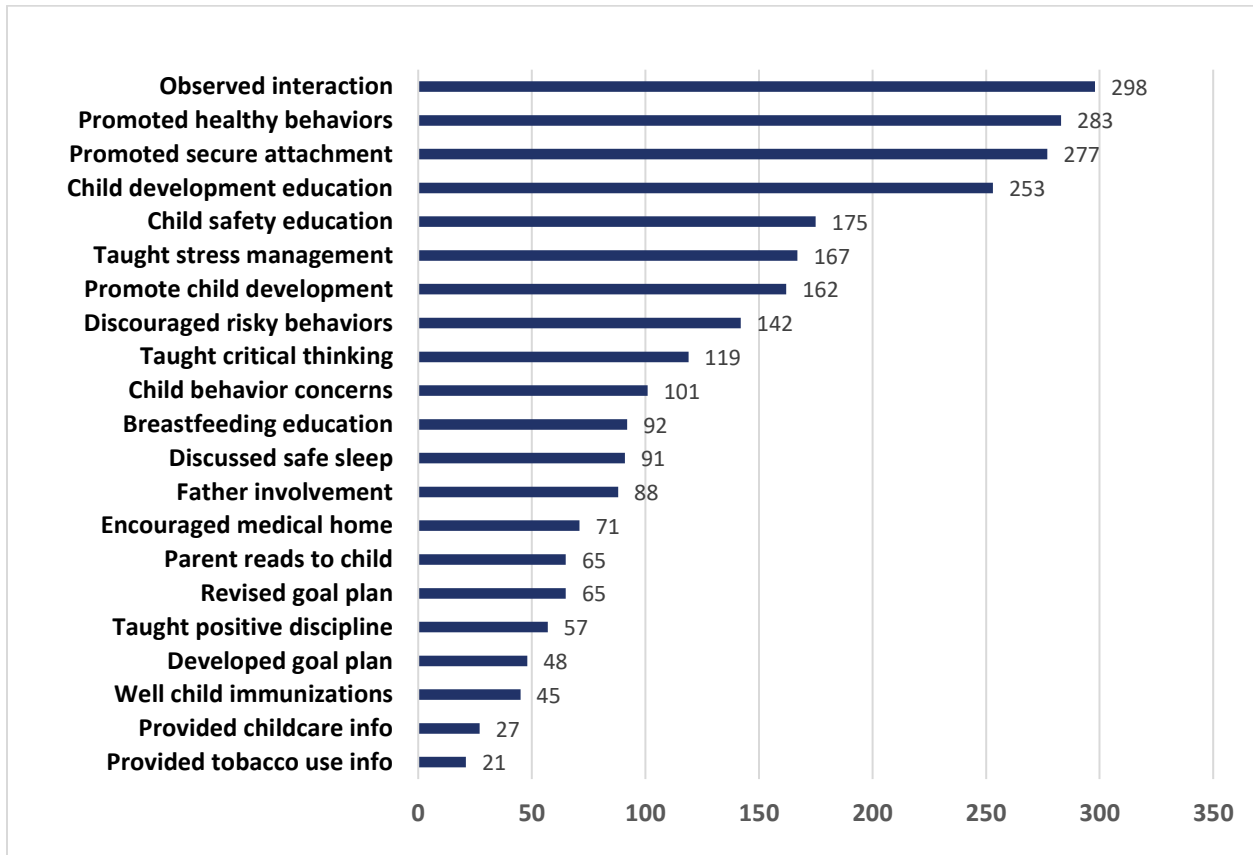


Figure 13 shows the number of pilot clients with whom home visitors or doulas engaged in these activities at least once. Not surprisingly, perhaps, promoting healthy behaviors, promoting secure attachment and providing child development education were also the three activities that home visitors and doulas had engaged in with more than 30 pilot clients. Observing clients interacting with their babies was probably not at the top of the list because some pilot clients were still pregnant.

Figure 13. Number of Clients Engaged in Activities

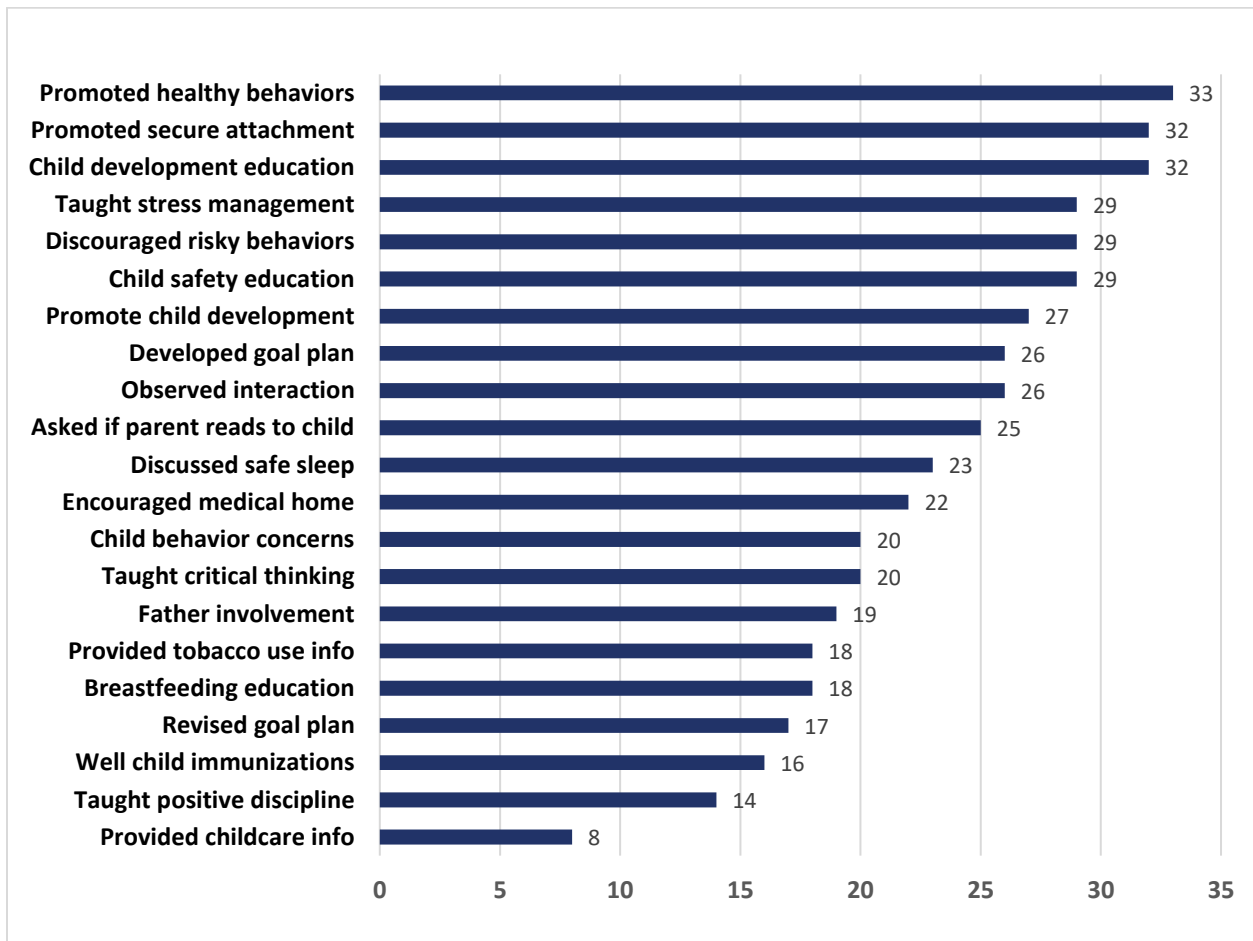
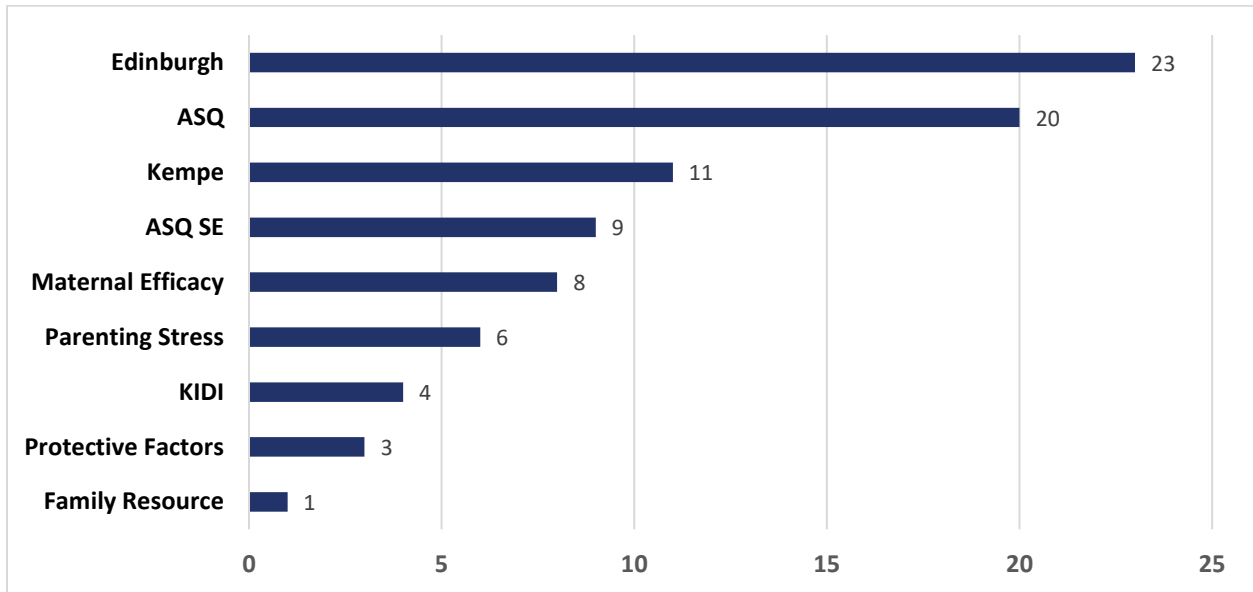


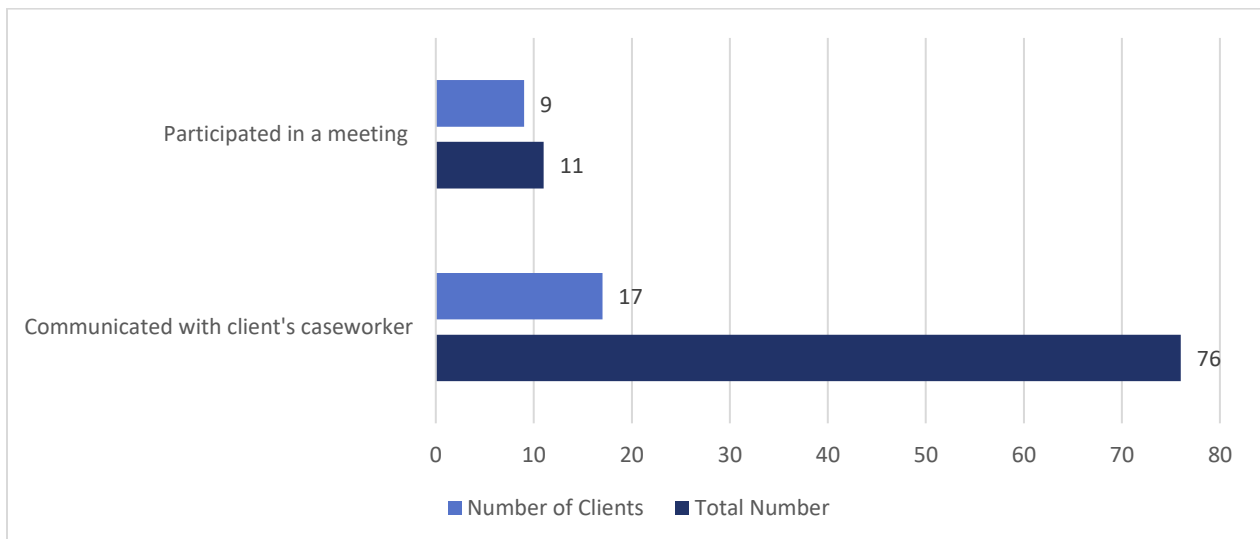
Figure 14 shows the number of pilot clients with whom home visitors and doulas have completed different assessments at least once. By far, the two most commonly administered assessments were the Edinburgh Postnatal Depression Scale,²² a screening tool for postpartum depression, and the Ages and Stages Questionnaire, a screening tool for developmental delays. These assessments are used by all, or nearly all, of the HFI programs. The other assessments are used by some programs but not others.

Figure 14. Assessments Administered to Pilot Clients



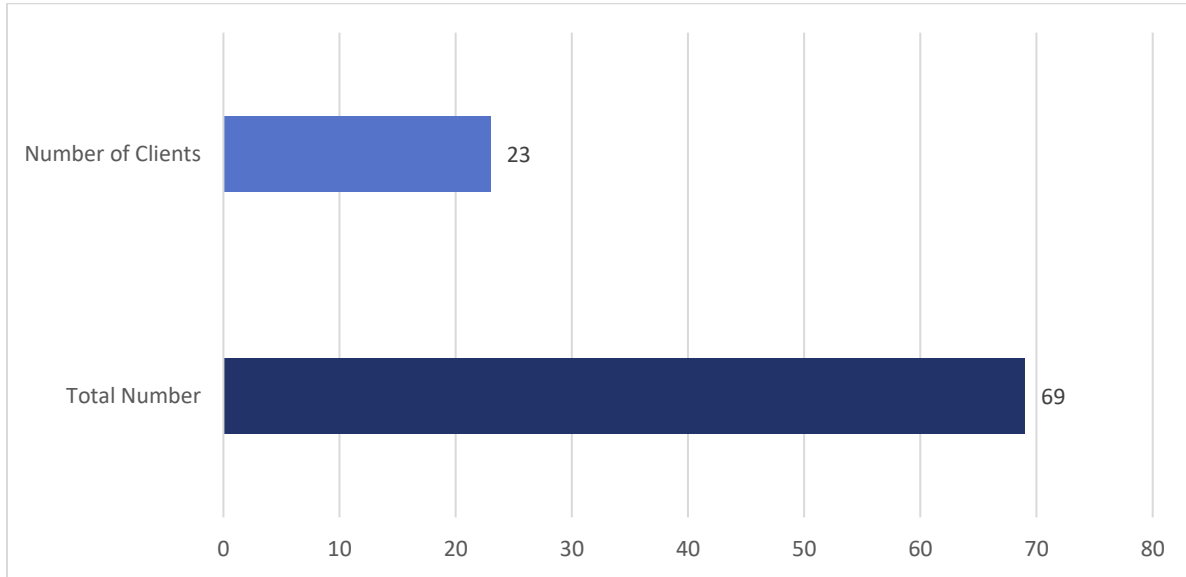
A major goal of the home visiting pilot is to promote collaboration between home visiting programs and the child welfare system. Figure 15 shows the number of times home visitors or doulas reported communicating with a client’s caseworker or attending a meeting (e.g., CIPP, Child and Family Team meeting) and the number of clients involved. Although there were 76 reports of communication with caseworkers, all of the communications were about or on behalf of 17 clients. It is also worth noting that home visitors and doulas have attended only 11 child welfare-related meetings since the pilot began in November 2016.

Figure 15. Collaboration with Child Welfare System



Each of the home visiting programs participating in the pilot has access to infant mental health consultation. Figure 16 shows the number of times home visitors or doulas reported seeking support from an infant mental health consultant and the number of clients who were the focus of those consultations.²³ These data indicate that home visitors and doulas have sought support from an infant mental health consultant for about 60 percent of the pilot clients.

Figure 16. Use of Infant Mental Health Consultation



Home Visiting Program Perspective

As of May 2018, we had conducted interviews with 10 home visitors, three doulas, and two home visiting supervisors. Some of what they shared with us is summarized below.

Pilot Training

Prior to the start of the pilot, home visitors, doulas and supervisors were invited to participate in a cross-training with child welfare workers. The purpose of the training was to provide home visitors with information about the children welfare system and the Teen Parenting Services Network (TPSN), to provide child welfare workers with information about home visiting, and to provide both groups with information about the pilot.

The training was designed by members of the Child Welfare Subcommittee of the Home Visiting Taskforce and delivered by members from TPSN, Erickson Institute and the Ounce of Prevention. The trainings were held in three sites across the state. Most of the attendees were home visitors or home visiting supervisors. Relatively few child welfare workers attended.

Home visitors found the information they received about the resources (e.g., the \$107 infant supplement) and parenting education available to pregnant and parenting youth to be helpful. One home visitor who had attended the cross-training was able to share what she had learned about items such as the crib and the car seat with a client who was unsure about what DCFS would provide when the baby was born.

Despite attending the cross-training, home visitors still lack basic information about "how DCFS works," such as the frequency with which clients meet with their caseworker, the length of time clients can stay in care, and caseworkers' roles and responsibilities. One home visitor put it this way:

I need a little bit more training on just kind of knowing where these girls are coming from, learning a little bit more about the system and how it works, so that I'm not completely clueless when they're talking about certain things. When they talk about the people that are there to support them, I don't really know what their roles are sometimes, or who to go to for certain things.

This same home visitor was particularly confused about the resources provided to her clients by DCFS.

They talk about how much money they're receiving from the state every two weeks...[but] they also talk about not having enough money for school or diapers, and so it's confusing to me when they're supposed to be receiving their check every two weeks. I don't know how much other resources to give them, because I've been told that....they can't maybe apply for other services, because their needs are supposed to be met with what they receive every two weeks. So that has been confusing to me.

Although some home visitors have received training on trauma-informed practice, one home visitor recommended that additional trauma-informed practice trainings be provided to home visitors who are working with youth in care, including training on how to support clients who have experienced sexual abuse as they prepare for birth and parenting. Another recommendation was for training on building relationships with clients who are always "on guard."

Enrolling Pilot Clients

In some cases, enrolling pilot clients in the HFI programs is no different from enrolling any other client. One home visitor even noted that her pilot client was "more receptive than other clients that I have had in the past." However, some pilot clients can be more difficult to enroll. Just contacting potential pilot clients can be a challenge.

Home visitors typically reach out to potential clients a certain number of times before concluding that they're not interested in services. Some home visitors felt uncomfortable when they were asked to continue outreach efforts after they normally would have stopped because HFI is supposed to be a voluntary program. One home visitor expressed concern that a pilot client who was initially unresponsive to outreach efforts might have "got kind of pushed into doing the program" because her participation was very inconsistent. She missed about two thirds of her scheduled home visits.

That said, in some cases, additional outreach efforts have paid off. One supervisor described how her program continued outreach efforts for two months before the client, who had experienced a series of crises after giving birth, finally enrolled and has been consistently engaged. Had this occurred outside of the pilot, the program would likely have "deemed her not a good fit for HFI."

The supports currently in place with this pilot make all the difference, it feels like we have "a pass" on not meeting productivity requirements with these families and allows us the freedom to devote more time for outreach/engagement. We can keep them on creative outreach longer, and we can still feel successful when we only meet with a family once or twice a month, versus weekly.

Enrolling clients who were placed in with one congregate care provider was particularly challenging. Youth in that facility cannot not schedule their own appointments and staff acted as gatekeepers. As the home visiting and residential staff have become more familiar with one another, enrolling clients has become less challenging.

Finally, lack of awareness of the pilot among caseworkers also created some confusion. For example, a caseworker, who rarely works with pregnant or parenting youth, referred a pregnant youth to a home visiting program that was not part of the pilot. That same pregnant youth was also referred to the pilot. Once it was determined that the youth was receiving services from two home visiting programs, she chose to end her pilot participation.

Relationships

The relationship between the home visitor and the client is central to the HFI model. The home visitors we interviewed had a variety of experiences when it came to establishing relationships with their pilot clients. Some home visitors established relationships with their pilot clients as easily as

they establish relationships with any other client. Other home visitors described their pilot clients as being guarded, distrustful and slow to open up:

I think these girls have a general distrust of others...and of systems and people who are there to support them...They've been disappointed before...felt like the people that were supposed to be there to support them were not. And so...they're kind of expecting me to do the same thing. 'You'll come visit me a couple of times and then you'll stop coming around, or you won't follow through, and then that's the end of that.' So I feel like just now after working with them for a few months...I'm starting to get through for them to trust me a little more. I feel like I'm always being tested...like with all the cancellations..."How long are you gonna keep trying for?"

Distrust is not the only factor that made it difficult for home visitors to establish or maintain relationships with their pilot clients. In some cases, it has been difficult for home visitors to build relationships with pilot clients because they are frequently "on run." Additionally, a number of pilot clients have been hospitalized or in juvenile detention---often unbeknownst to their home visitor. Sometimes pilot clients are unresponsive, not because they don't want services, but because so much else is happening in their lives.

Some home visitors expressed frustration that their pilot clients miss so many scheduled appointments. Although other clients also "no-show" on occasion, pilot clients seem to do so at a higher rate. For example, one home visitor was only able to complete four home visits in a 3 month-period with a client who was supposed to be visited weekly. Her other clients might miss one or two weekly visits in a quarter.

Home visitors have used a number of different strategies to maintain relationships with these pilot clients, with varying degrees of success. Their strategies include making multiple attempts to visit in a single week, waiting at the child welfare office on "check day," and texting if they are in the area. One home visitor gave her phone number to a pilot client she had not seen for two months and reminded her "that you can still reach out to me and I could still try to find ways to provide a service for you."

Despite these challenges, home visitors have developed trusting relationships with their pilot clients. One home visitor described having a "very deep conversations" with a pilot client who shared her feelings about taking her child to visit his father in jail, her son's reactions to that visit, and her own reactions having visited her own father in jail. Another home visitor described working with a pilot client and her client's partner, both of whom were generally both present for home visits with their baby.

They have opened up about different disagreements that they have had and asked me for a little advice here or there. [I] just give them that space to vent and to talk to each other calmly.

Yet a third home visitor developed a close relationship with a client who she transported to a crisis nursery several times a week.

I don't know if I just got really lucky, but she's one of my favorites right now. I just feel very honored to get to work with her.

Clients in Congregate Care

Home visitors have had different experiences working with pilot clients in various types of congregate care including residential facilities and transitional living programs. Some of these differences can probably be attributed to the different care providers with whom pilot clients have been placed.

One home visitor reported that she could neither visit with nor speak to her pilot client for several weeks because her pilot client was placed with a care provider several hours away and the home visitor had not been placed on the list of individuals with whom the pilot client could communicate. Another home visitor is able to schedule visits with a pilot client who is placed with a different care provider as long as staff are made aware of when the visits are scheduled to occur. Home visitors are also able to communicate directly with pilot clients who are placed with a third care provider and can ask staff to relay messages to pilot clients they are having trouble reaching. However, they expressed concern that staff at this facility were entering clients' rooms during their visits without even knocking and could potentially walk in on a pilot client who was breast-feeding or not fully dressed.

Home visitors whose pilot clients are placed with a fourth care provider have faced a number of other challenges. First, home visitors must go through staff to schedule appointments or otherwise contact their clients, and these "gatekeepers" have control over whether and when visits will occur. A doula reported that staff had canceled the prenatal appointment at which she was supposed to meet her pilot client, and a home visitor reported that staff would not allow her pilot client to cancel their appointment even though she was tired and not up to visiting.

Second, home visitors are prohibited from visiting with clients in their rooms. Instead, they are required to visit with their clients in common spaces where their conversation might be overheard by staff or other residents. Home visitors expressed concern that this prevents clients from opening up to them as much as they might in a more private setting.

We can only meet in the common area, and there's been a few times that that has really irritated [pilot client]. She's like, 'I can't even hear you right now. Everyone is being so loud.' I can tell it's really upsetting her because she always has so many questions and wants more information. We...can't go into her room and talk, even with the door open, which is almost a little bit against our...policy because...we do home visits...where you're most comfortable...and confidentiality. So people are walking back and forth. Maybe she doesn't open up and share as much because there's staff or there's other moms there and she doesn't want them to hear.

Third, although the typical home visit lasts about an hour, home visitors are unable to spend an hour with pilot clients who are placed with this care provider.

They have strict schedules. They get home right at 3:30 and they have group at 4:00. So, we just really meet for sometimes 30, 25 minutes right in between that.

That's really hard because we're trying to build rapport, but also prepare her for birth. That's hard to do in 20 minutes.

Home visitors have also expressed concern that pilot clients who are placed with this care provider are being admonished by staff not to hold their babies because they will become spoiled. In fact, a large body of research shows that responsive parenting behavior promotes infant development.^{24,25}

One of the lessons home visitors learned about pilot clients placed with this care provider is that they do not like sharing “their” home visitor with other residents. Consequently, this HFI program has decided that it will not assign the same home visitor to more than one pilot client placed with this care provider again. At the same time, building relationships with pilot clients placed with this care provider has become easier because home visitors are now a familiar presence. One home visitor noted that her colleague had “already opened that door, so it was an easier way to kind of build that rapport with them...They already kind of trusted us.”

Differences between Pilot Clients and Other Clients

Some home visitors perceived few differences between their pilot clients and their other clients. For example, one home visitor described her pilot client as “pretty much just like the rest of my participants that I serve.” However, other home visitors identified multiple ways in which their pilot clients are different. One home visitor observed that “nobody is teaching [pilot clients] how to be responsible adults.” Other home visitors also commented on the fact that pilot clients often lack basic independent living skills such as knowing how to budget for the items that they and their children need.

Another key difference is that the lives of pilot clients are so unstable. One home visitor noted that although some of her non-pilot clients also have a history of trauma but they at least know where they are going to be living from one day to the next. By contrast, one of her two pilot clients was aging out and the other was constantly on-run and ended up being moved.

Yet another difference relates to pilot clients’ knowledge about their bodies. Doulas typically educate clients about epidurals and other medical interventions they might experience during childbirth. However, one doula reported needing to review basic anatomy (e.g., uterus, cervix, umbilical cord, and placenta) with her pilot clients before talking about those medical interventions because her pilot clients are less familiar with their bodies than the non-pilot clients with whom she works.

By far, the biggest difference between pilot clients and the other clients with whom home visitors and doulas work is their much greater need for support. Pilot clients need significantly more support because they have little in the way of a natural support system. One home visitor described her pilot clients as “having zero family support,” which is not the case with her other clients. Another home visitor explained that her pilot clients are not like the other mothers she works with because those other mothers “have somebody that they could call or have more of a friend group that could help them.”

In some cases, home visitors are providing what a natural support system otherwise would. One home visitor explained that if her other clients had questions, they “might just ask their mom..., their grandma..., or a friend...but I was that person [her pilot client] would call or text and ask those

questions to.” Another home visitor described herself as “someone that [her pilot client] can ask questions to and she...wouldn't feel judged.”

Home visitors also identified several other factors as contributing to why pilot clients need significantly more support. One is prevalence of mental health problems among the pilot clients. One supervisor noted that two clients had been hospitalized while in the program, including one client who has been hospitalized for depression at least three times in less than a year. Another home visitor reported that her client attempted suicide. In addition to mental health problems, some pilot clients are also dealing with intimate partner violence.

Effects on Service Delivery

This need to provide pilot clients with extra support has affected the delivery of home visiting services. One home visiting supervisor described how her home visitors have not been able to provide services the way they normally do:

There's no way we could expect anyone to do what they normally do as a Healthy Families [home visitor] with this population... We have not done like anything we're supposed to do in terms of the initial assessment. We...normally do [it] within the first 30 days, and it's been literally months, like half a year... Some of the core things... we're supposed to be doing for Healthy Families, it's a complete wash. We're not doing any of it... We barely use curriculum... so in that way it is completely different from what we're doing with other families.

This same supervisor went on to explain how conflicted she feels about the situation. She knows that pilot clients need the services home visitors provide but delivering “services as usual” can seem inappropriate when pilot clients always seem to have more immediate needs to deal with.

It's more just like what's the latest crisis? Let me support you and talk to you while you're ... actively in crisis... It's just like it would be a totally inappropriate thing to do, to be like, ‘Oh, let me bring out this handout and go over it with you.’... I feel super conflicted because I just feel like something like this and more needs to be offered to these young women.

One home visitor echoed this sentiment, noting that because the basic necessities of her pilot clients were not being met, “it makes it hard for me to focus on their parenting and it makes it hard for them to be receptive as well.”

Some home visitors suggested that their pilot clients should be weighted more heavily than their other clients because delivering services to pilot clients requires so much extra effort. For example, one home visitor spends two to three hours per week transporting one of her pilot client to weekly supervised visits with her child. However, this client is weighted the same (i.e., Level One) as her other Level One clients with whom she spends much less time.

Home visitors also pointed out that the HFI levels, which dictate how frequently client are supposed to be seen, can be problematic when applied to pilot clients. For example, clients who have recently given birth are typically placed on Level One and supposed to be seen weekly by their home visitor. However, pilot clients on Level One are sometimes on-run or otherwise unable to meet weekly due

to school or work schedules. In some cases, home visitors have kept these pilot client on Creative Outreach, rather than moving them to Level One despite their need for weekly visits.

Some HFI programs offer “baby bucks” as an incentive for participating in certain activities, such as attending a parent group, or reaching certain goals. These “baby bucks” can be exchanged for baby items in the program’s “pantry” or “store” such as diapers, clothing, formula, bottles, toys, car seats and swings. One home visiting program created a mobile version of its pantry for their pilot clients who are placed with the same congregate care provider and unable to visit the program’s pantry to exchange their “baby bucks.” This same program also began offering a parenting class at that congregate cares setting.

Role of Infant Mental Health Consultation

Infant mental health consultants are professionals who contribute to effective practice by helping home visitors, doulas and supervisors reflect on their work with families and process issues that arise in the course of that work. Home visitors appreciate having the support of the infant mental health consultants. One home visitor, who worries about her pilot clients because they “bounce around” feels “refreshed” after meeting with her infant mental health consultant because the consultant provides new ideas about how to approach upcoming visits with her pilot clients. Another home visitor, who finds working with pilot clients “extremely challenging” and “different from what we’re used to,” described how the infant mental health consultant was able to help her when she was feeling overwhelmed.

I was getting emotionally overwhelmed. Just hearing her story, and hearing her struggle, and her mom's struggle, and how history repeating itself. Now [she] is in the same situation that her mom was in and...I was getting very overwhelmed emotionally. The infant health consultant was very helpful in helping me see things a little differently, in a more hopeful way.

Use of the FAN

Home visitors from several of the programs talked about using the FAN in their work with their pilot clients.²⁶ The FAN refers to Facilitating Attuned Interactions (FAN), a conceptual framework and practical tool for strengthening the practitioner-parent relationship, increasing parents’ confidence and competence, and building parents’ capacity to use resources and find positive support. The FAN helps home visitors focus on reading their pilot clients’ cues and responding in empathetic ways. One home visitor explained that the FAN approach provides structure to her visits with pilot clients. Another home visitor uses the approach to check in with her pilot client on how she is feeling at the beginning of the visit. If the client is frustrated or angry, she focuses on those feelings before moving on what she had planned.

Role of Doulas

Doulas are paraprofessionals who provide physical, emotional and informational support to mothers before, during and shortly after childbirth. Research has demonstrated the benefits of having a doula-supported birth including a reduction in the use of pain-relief medications (e.g., epidurals, oxytocin), a reduction in the rate of cesarean births, and more positive childbirth experiences.²⁷ One doula, who was present at the birth of her pilot client’s baby, described how proud she was of her client for “coping so well with [her] contractions. The client

remembered what she had learned from her doula and “kept on breathing and saying *I can do it. I can do it.*”

Having a doula-supported birth may be especially important for youth in care. One doula reported that she was the only person present to support her pilot client when her client gave birth. Another described the experience of a pilot client who had wanted the baby’s father to be present at the birth:

Then she waited and waited and waited...the baby was crowning and she wasn't pushing because she was waiting for dad. She was holding on to the baby until dad came, and dad came. For me, the most disappointing part of it all was that when dad did come, he only stayed for maybe 15 minutes and left.

For pilot clients to really benefit from having a doula, their doula must be present at during childbirth. After one doula was not called to the birth of her pilot client’s baby by the client’s congregate care provider, another doula, whose pilot client was also placed with that same provider, educated residential care staff about the role that doula’s play during childbirth. She was called when her pilot went into labor and her client had a doula-supported birth.

Providing Services to Clients with Children in DCFS Care

Home visitors do not typically work with clients whose children are not in their custody for an extended period of time. However, the HFI programs participating in the pilot are making exceptions for their pilot clients. Three home visitors whose pilot clients have children in DCFS care arranged to be present during part of the two-hour supervised visits their clients have with their children. One of those home visitors transports her pilot client to and from the daycare center where the supervised visits take place and uses that time to talk with her client about being separated from her baby. This home visitor is spending two to three hours more per week with this client than with her other clients but wonders how much impact she can have given that the separation.

The other two home visitors attend supervised visits at the home of the pilot client or the foster home of the client’s child. Both of those home visitors have modified what they do during these supervised visits in recognition of the fact that their clients might not know how their child is developing in some domains. For example, one home visitor described how administered the Ages and Stages Questionnaire (ASQ), a standardized child development assessment, but

“stuck to things she would be able to notice, such as how he was playing versus [his] sleeping habits, since I didn’t want to make her feel like she was missing out on so much of his life.”

Another home visitor had one client whose child was in DCFS care and another client whose child was living with his paternal grandmother. Although the home visitor continued to visit with both clients, their children were never present, which limited the types of activities in which the home visitor and clients could engage.

Progress of Pilot Clients

Despite the challenges that providing services to pregnant and parenting youth in care presents, several of the home visitors we spoke with were encouraged by their pilot clients’ parenting skills.

One home visitor described a pilot client who is very bonded with her child and attuned to his needs. Another home visitor noted the “loving” and “nurturing” interactions one of her pilot clients has talking and playing with her child. Yet a third home visitor pointed to how her pilot client talks to and tries different things with her child when he is having a tantrum.

Home visitors also are encouraged by the questions pilot clients are asking about their caring for their children and promoting their development. One home visitor talked about a client who wanted to know how to dress her son for the cold weather because she had been told she was not dressing him warmly enough. The home visitor explained, in a non-judgmental way, that it is usually recommended that babies wear an additional layer until they are a year old. Another home visitor described a pilot client who wanted information about activities she could she and her baby could do together.

She would ask me different ways to do tummy time because she had concerns about the baby dropping her head on the floor and hurting herself... She has been thinking about all these things and wanting to protect and keep her baby safe...She was looking for more ways to help strengthen her baby's neck and some other activities to do with her.

Finally, one home visitor was encouraged by the fact that one of her pilot clients has developed a stronger relationship with the father of her baby. The home visitor attributed this change to the “conversations around healthy relationships” that she and her client have had.

Cross-System Collaboration

We asked home visitors, doulas and supervisors about their efforts to collaborate with the child welfare system.

Communication between Home Visitors and Child Welfare Caseworkers

Some home visitors are regularly communicating with the caseworkers of their pilot clients. More frequently, however, communication with caseworkers has been irregular at best. In some cases, home visitors have reached out to a pilot client’s caseworker and received no response. In other cases, home visitors have not reached out.

This lack of communication means that home visitors are often unaware that a pilot clients has experienced a significant event such as psychiatric hospitalization, incarceration, or a suicide attempt. One home visitor described how she reacted when she arrived for a home visit only to learn that her client’s baby was longer in her care.

I wish that I could have been there to hold her hand and just give her support. Our program is very unique and we are out there; we love to help our moms. All my girls are like daughters to me and I try to empower them that you can do this. It was very upsetting to know that the baby was taken away and the circumstances and everything.

Home visitors also reported not being informed when a pilot client goes “on-run,” returns from being “on run,” or experiences a placement change.

Information Sharing

One issue home visitors seem to be divided on is how much information about a pilot client's background they want caseworkers to share with them. Some home visitors believe that having information about a client's background would be helpful because they would "know what we're facing." Others believe that knowing about a client's background is not that important. One home visitor questioned whether she really needed to know that her pilot client had been diagnosed with bipolar disorder and had a history of drug use since they "clicked right away" when they met.

A supervisor explained how her program's thinking about this issue evolved. At first, she and her colleagues wanted caseworkers to share background information about their pilot clients.

'We don't even know what's going on....we just don't know. The caseworker doesn't tell us anything.'

Over time, however, they realized that it was better for pilot clients to share this information when they were ready.

We kind of struggle with like is there a benefit from us knowing? What do we gain from that?...[T]he circumstances don't really matter. It's that relationship. If they turn to us, they're not going to turn to us for help in those areas; they're going to turn to us, because they need more of the emotional support and a safe person to talk to. So anyway, that's...how we changed our minds a little bit in that regard.

By contrast, there was consensus among home visitors that that having certain information was essential to their jobs and that they needed to be given that information in a timely manner. Specifically, home visitors want to be notified if a pilot client (1) experiences a "significant event" such as hospitalization, incarceration or a suicide attempt; (2) goes "on run," returns from being "on run," or changes placement; or (3) has a child placed in care. They would also like caseworkers to share updated contact information for their pilot clients. And, as already noted, doulas need to know when their pilot clients are in labor so they can be at present at the birth.

Home visitors are also grappling with the question of information they can and should share with their pilot clients' caseworkers. Some home visitors have been asked to provide progress reports on their pilot clients. These home visitors expressed concern that doing so could undermine the relationship they have established with their clients and wondered whether caseworkers clearly understand the voluntary nature of home visiting services.

Meetings

Some of the home visitors we interviewed had attended a Child and Family Team (CFT) meeting or Clinical Intervention for Placement Preservation (CIPP) and found their presence to be beneficial. Two home visitors were able to help devise a plan that would allow their pilot client to have supervised visits with their babies (who were in care). One of these home visitors also became aware of her client's goal plan and what she could do to support her client's efforts to achieve her goals. Yet a third home visitor learned what was being done to prepare for her pilot client's emancipation, which allowed her to focus on her client's pregnancy. Other home visitors were less certain that being present was a good idea. One home visitor was "just not sure if it's a benefit or a disadvantage for us to be around that table."

Another problem some home visitors reported is that they were either not notified that a meeting had been scheduled or they were notified but not informed about the meeting's purpose. In one case, a home visitor arrived at the meeting and neither she nor her pilot client knew that the other would be present. Fortunately, this did not adversely affect their relationship but it certainly could have.

Client Perspective

As of May 2018, we had conducted interviews with 13 pilot clients. Some of what they shared with us is summarized below.

Learning about the pilot

Pilot clients reported learning about home visiting services in a variety of ways. Some learned about the pilot from their case worker (or case manager if they were in congregate care). One client learned about the pilot from her home visitor who knocked on her door.

Deciding to enroll

All but one of the interviewed clients described their decision to participate in the pilot as voluntary. The one exception was a client in congregate care who worried that she would be viewed as non-compliant by staff if she refused to participate.

In general, clients were motivated to enroll in the pilot by two factors. First, pilot clients recognize their need for parenting education and supports. For example, one young mother in the pilot “felt like I wasn't doing that much right,” but her home visitor answered her questions about parenting and affirmed her identity as a parent. Another young mother in the pilot “always asks [her home visitor] for a second opinion and advice” when it comes to parenting.

Second, clients were motivated to participate because some of the home visiting programs provide items for their babies such as diapers, swings or strollers. For example, some clients can earn Baby Bucks for engaging in positive behavior such as keeping appointments, attending school, taking their baby to the pediatrician and these baby bucks can be redeemed for baby items.

Relationship with Home Visitors and Doulas

Put simply, pilot clients love their doulas and home visitors. Their faces often light up when asked to talk about these service providers and recognize when and how home visitors go above and beyond to provide support.

Importantly, clients view the relationships they have with their doula/home visitor as very different from the relationships they have with other helping professionals who are part of the child welfare system (e.g., case workers, residential staff, therapists).

One of the things clients most appreciate about the home visitors and doulas is their consistency. Clients value the extent to which their doulas and home visitors keep appointments, arrive on time, bring educational materials, and provide program resources. As one client put it, “[My doula] doesn't break promises.” Their consistency goes along way when it comes to developing clients’ trust.

Young parents in the pilot are aware that building trust with helping professionals is an ongoing challenge for them. However, they have all been able to build trust with their doulas and home visitors more quickly than with other helping professionals and attribute this to their non-judgmental, caring approach. As a result, clients they feel they can talk to their home visitors about “anything and everything.” As one young mother explained

"It was like I'm not the type of person that when I meet somebody I feel like I can trust them and talk to them. With [my doula and home visitor] it just different like, it just felt like they understood me."

This trust leads young parents in the pilot to turn to their doulas and home visitors for parenting and relationship advice, child development information, and in some cases, advocacy with DCFS. One young mother explained that her doula helped her identify and seek treatment for postpartum depression.

"When I was sad, or when I was going through my post-partum depression phase, she was there. She's the one that actually warned me about, she prepared me to know the signs of post-partum depression."

One barrier to developing this trusting relationship is the frequency with which pilot clients go "on run." One client explained how going on run to be with her child's father served as a "distraction" and made it difficult to develop a relationship with her home visitor. However, some clients are staying in contact with their doula or home visitors while they are on run because they value their relationship.

Perceived Benefits

Among the ways young parents are benefiting from the pilot are an increase in their knowledge about child development and the development of coping and communication skills.

Child Development Knowledge

The young mothers report that home visitors provide them with information about their child's development in the form of handouts and developmental assessments. They appreciate that their home visitors ask them to share what they notice about their child's development and give them opportunities to ask questions related to parenting. They have also learned about the importance of talking and reading to their baby to promote speech and language development.

Skill Development

Not surprisingly, perhaps, young mothers report learning how to feed, bathe, and otherwise care for their infants from their home visitors. They have also learned about sleep training and safe sleep. Several also described how their home visitor helped them become more attuned to the impact their behavior can have on their babies and develop self-regulation skills for when they are feeling angry or frustrated. Other young mothers described how their communication skills have improved and how this has led to better relationships with the fathers of their children.

DCFS Collaboration

There is disagreement among pilot clients with respect to how much they want their doulas and home visitors to collaborate with DCFS. At one extreme was a client who stated that her home visitor can "be at any meeting I have." At the other extreme was a client who does not think her home visitor needs to be involved with DCFS because she views her home visitor as a support for her child. Although most of the clients we interviewed consider it helpful for their doulas and home visitors to attend Child and Family Team meetings, they want some control over how much their

doulas and home visitors know about their abuse and neglect histories. Overall, the young parents in the pilot view their doulas and home visitors as advocates who can speak on behalf of their parenting skills, particularly if their children become DCFS involved.

Moving Forward

Although we have learned a great deal from the data we have collected and analyzed thus far, a number of important questions about the home visiting pilot have yet to be addressed. Among these are questions about the ways in which pilot clients and their children are benefiting from the services they receive, the extent to which services are being provided to pilot clients with fidelity to the HFI model, and the factors that facilitate or act as barriers to collaboration between the home visiting and the child welfare systems. Equally important, we will also seek to identify the changes that need to take place before service provision can be expanded statewide on a sustainable basis.

Our plan for FY 2019 is to continue enrolling pregnant and parenting youth in the evaluation through the end of March 2019. We anticipate that enrollment in the home visiting programs that are participating in the pilot will continue even after the evaluation ends. We will continue to interview home visitors, doulas and supervisors and will begin interviewing child welfare caseworkers whose youth are enrolled in the pilot to determine what they know about the pilot, how they think the pilot is benefiting youth, whether they have collaborated with home visitors or doulas. We will also continue to interview pilot clients to better understand how they and their children are benefitting from home visiting services. About half of these will be second interviews with pilot clients who have been in the program for nine to 12 months.

We will continue to collect services data from the home visitors and doulas and will expand our analysis of those data to include some data we have not yet analyzed including referrals made by home visitors and doulas, the receipt of prenatal, postpartum and well child care, and standardized assessments scores. We will also focus more on what we can learn about the pilot clients and their children from the DCFS administrative data. In particular, we will examine the relationship between the consistency of home visits and placement (in)stability and the prevalence of child welfare services involvement, including maltreatment investigations and out of home care placements, among pilot children

Endnotes

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