Healthy Families New York: Reflections
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1. **Design and theoretical rationale.** Based on the Healthy Families America home visitation model, Healthy Families New York (HFNY) targets expectant parents and parents with an infant less than three months living in communities marked by high rates of poverty, infant mortality, and teen pregnancy, and who are considered at high risk for child abuse and neglect. Trained paraprofessionals, who typically live in the same communities as participating families and share their language and cultural background, deliver home visitation services until the child reaches five or is enrolled in Head Start or Kindergarten. HFNY’s home visitors provide families with support, education, and linkages to community services designed to address the following goals: 1) to prevent child abuse and neglect; 2) to enhance parenting skills and parent-child interactions; 3) to ensure optimal prenatal care and child health and development; and 4) to increase parents’ self-sufficiency.

More specifically, home visitors provide in-home activities aimed at establishing nurturing, non-coercive parenting practices, and stimulating children’s cognitive and social development. Home visitors also provide information regarding community resources, assist parents in coordinating health care and other needed services, and work with families to address issues like family planning, substance abuse and mental illness. Improved parenting skills are expected to reduce risks for child abuse and neglect and other negative child outcomes.
Similarly, better access to health resources and increased safety and health-promoting behaviors are expected to have a direct impact on maternal psychological functioning, and, in turn, promote economic self-sufficiency, overall family stability, and positive child outcomes. Home visitation services are provided bi-weekly during the prenatal period, weekly until the child is at least six months old, and periodically thereafter based on the needs of the family until the child turns five or is enrolled in Head Start or Kindergarten.

2. **Necessary organizational/institutional and financial/human resource capacities.**

HFNY currently operates in 37 high-need communities throughout New York State including 10 entire counties and 9 sites in New York City. Since HFNY began in 1995, the program has provided over half a million home visits to more than 17,000 families. Leadership of HFNY comes primarily from the Central Administration Team, comprised of New York State Office of Children and Family Services (OCFS), State University of New York Center for Human Services Research, and Prevent Child Abuse New York (PCANY). An advisory group, the HFNY Home Visiting Council, guides HFNY. The Council is comprised of representatives from government, public and private agencies who meet twice a year to provide advocacy and/or support.

OCFS provides overall management of the initiative and funding, as well as, ongoing support to the 37 program sites, through monitoring, technical assistance and training. OCFS staff conducts frequent site visits to provide technical assistance and monitor compliance with HFA and HFNY standards. In addition, OCFS contracts with the Center for Human Services Research of the State University of New York at Albany to maintain a comprehensive data system that collects information used in managing and assessing program performance. OCFS has also established target standards for the program sites to stay focused on HFNY's objectives. Sites are
assessed on a regular basis against these target standards and technical assistance is provided to programs whose performance falls below expectations. OCFS contracts with Prevent Child Abuse New York (PCANY) to conduct basic core training and advanced training on selected topics for all HFNY staff, and to visit each site on a biannual basis to observe home visits, assessments, and supervisory sessions, as part of OCFS’ quality assurance.

3. **Evidence of efficacy, effectiveness, and cost effectiveness.** In 2000, the New York State Office of Children and Family Services’ Bureau of Evaluation and Research, in partnership with the Center for Human Services Research at the University at Albany, initiated a randomized control trial (RCT) in three counties with established HFNY programs. Women eligible for HFNY at each site were randomly assigned to either an intervention group that was offered HFNY services or to a control group that was given information and referrals to other appropriate services. Baseline in-home interviews were conducted with 1,173 of the eligible women. Follow-up interviews with study participants were conducted at the time of the child’s birth, and first, second, and seventh birthdays. At Age 3, a videotaped in-home observational assessment of mothers interacting with their children was conducted with a subsample of 522 dyads to evaluate the program’s parenting effects at a more detailed behavioral level. At Age 7, field staff interviewed 942 of the original study participants and conducted face-to-face assessments with 800 children. Videotaped observations of parents interacting with their seven-year-old children were also obtained for a subset of the study’s families. In addition, the research team has obtained administrative data pertaining Child Protective Services reports, foster care placements, federal and state-supported benefits and program services and costs.¹

**Costs.** The cost to deliver the HFNY program varies across participants, but was approximately $4000 to $4500 per family. **Effectiveness.** Findings from the longitudinal RCT
trial evaluation have shown significant program impacts on child abuse and neglect\textsuperscript{1,2,3}. First, there have been program impacts on maternal and child reports of physical abuse at Ages 1,\textsuperscript{2} 2, and 7\textsuperscript{1}, revealing a sustained pattern of effects over the first seven years of life\textsuperscript{1}. Reduction in the rate of confirmed reports of child abuse and neglect has been found for two subgroups within the sample: mothers who were already involved in a substantiated Child Protective Services (CPS) report prior to random assignment (the Recurrence Reduction Opportunity, or RRO, subgroup) and first-time mothers under age 19 who were offered HFNY early in pregnancy (the High Prevention Opportunity, or HPO, subgroup). In the RRO subgroup, the program has shown lower rates of involvement—from random assignment to Age 7—in confirmed CPS reports of abuse or neglect, in confirmed reports of physical abuse, and in preventive, protective, and placement services\textsuperscript{1}.

In the HPO subgroup, confirmed CPS reports began to emerge at around Age 5, or at time of entry into school. During the child’s fifth to seventh years of life, the cumulative rate of substantiated abuse or neglect for HFNY children in the HPO subgroup was significantly lower than the rate for their counterparts in the control group (9.9\% versus 19.3\%,\textsuperscript{p<.10})\textsuperscript{1}. Among the HPO subgroup of mothers, HFNY was also effective in reducing maternal use of aggressive and harsh parenting practices. These effects have been sustained from early childhood to school age\textsuperscript{1-3}: Mothers in the HPO subgroup were found to be substantially less likely to report engaging in minor physical aggression and harsh parenting at Age 2\textsuperscript{2}, and effects of a similar magnitude emerged from the observational micro-level assessments at Age 3. HFNY mothers displayed lower rates of harsh parenting behaviors while interacting with their children during structured tasks as compared to their control counterparts\textsuperscript{3}. At Age 7, HFNY mothers in the HPO subgroup
were also found to be less likely to report using psychological aggression and minor physical aggression with their children than were control mothers\(^1\).

In terms of **parenting competencies**, program effects have been found on the establishment of positive parenting practices that support and encourage children’s cognitive and social development across developmental stages. At Age 2, HFNY mothers showed use of appropriate limit setting\(^4\); At Age 3, HFNY mothers showed more responsiveness to the child’s needs and used more strategies that stimulated the child’s cognitive skills during a series of structured tasks\(^3\). At Age 7, HFNY mothers were more likely than control mothers to use non-violent discipline strategies, and also used these strategies more often\(^1\).

In addition to parenting, HFNY has shown effects on **improved birth outcomes**. Mothers who enrolled in HFNY before their 31\(^{st}\) week of pregnancy were only about half as likely as control group mothers to deliver low birth weight babies, and the program was particularly effective in reducing LBW among black and Hispanic mothers—groups that persistently experience high levels of poor birth outcomes\(^5\).

At Age 7, HFNY is also showing effects on **school-related outcomes**. Children in the HFNY group were more likely to participate in a gifted program and less likely to receive special education services and to self-report skipping school than were children in the control group. Additionally, children in the HPO subgroup were less likely to score below average on a standardized vocabulary assessment and to repeat a grade, and more likely to participate in a gifted program\(^1\).

**4. Improvements that should/could be made in the model.** From these assessments, two major recommendations have emerged:
1) Establish strong links between local department of social services and HFNY. The robust program effects on confirmed reports of child abuse and neglect among the group of HFNY women with prior confirmed CPS reports suggest that HFNY can create meaningful differences in the lives of other families with prior histories of confirmed reports. We recommend encouraging local child protective services agencies to refer recent or active indicated CPS cases to HFNY when the mother is expecting or has recently delivered a child.

2) Prioritize services for pregnant women, especially those fitting the descriptions of the two subgroups. Prioritizing prenatal service initiation would capitalize on the program’s effectiveness in helping mother’s attain better birth outcomes (Lee et al., 2009). When young, first-time mothers or those with a prior substantiated report are referred during pregnancy, we recommend giving priority to these individuals. However, we do not recommend limiting home visiting services to these groups. Home visiting services should be provided to all other eligible mothers whenever a slot is available. This strategy would retain the opportunity for all women to access services, takes full advantage of the opportunity for women to benefit from prenatal services (i.e., delivering a healthy weight baby), and maximizes the opportunity for the program to achieve the greatest degree of change possible.

5. Potential/constraints for scaling the intervention to achieve coverage of all in jurisdictions. Funding is the major impediment to support the expansion of an infrastructure that is already in place. Costs involved in taking the program to scale include ongoing support for training field support workers, assessment workers, data entry managers, and supervisors, and continued evaluation of quality assurance. Another type of constraint is the difficulty in identifying those families who are eligible but who do not seek services.
6. **Subpopulation Issues.** As described above, who is offered home visitation services may affect program impacts on child maltreatment. Of particular interest have been the two policy-relevant subgroups described above: (1) the HPO subgroup, consisting of young, first-time mothers who initiate home visiting services prenatally and (2) the RRO subgroup, which includes women who have had at least one substantiated child protective services report (as a non-victim) prior to random assignment. Although the sample sizes for these two subgroups are limited, to the extent possible, we have evaluated the effects of the program on their outcomes, and, where appropriate, we are examining the potential mechanisms through which HFNY achieves its effects.

**References:**


