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# Supporting Low-Income Parents of Young Children: The Palm Beach County Family Study 2009 Executive Summary

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## EXECUTIVE SUMMARY
### Introduction

During the last 3 decades, considerable progress has been made in understanding the ecological and cultural context for children's development and, in particular, the harmful effects of poverty and its correlates on family functioning and child development (e.g., Bronfenbrenner, 1979, 1986; Brooks-Gunn 2003; Gomby 2005; National Research Council and Institute of Medicine, 2000; Olds, Kitzman, Hanks, et al. 2007; Weisner, 2002). At the same time, a variety of early intervention strategies have been designed to diminish the effects of poverty on children's development and readiness for school. Increasingly, comprehensive, integrated systems of health, educational, and social services have been viewed as a promising strategy for supporting healthy family functioning and child development in low-income, at risk families (Brooks-Gunn 2003; Gomby 2005; Olds, et al. 2007; Reynolds, Ou, & Topitzes 2004).

This growing body of evidence prompted the Children's Services Council (CSC) of Palm Beach County (FL) to undertake a long-term initiative to build an integrated system of care to promote and support the healthy development of children, with a focus on the first 5 years of life. The primary goals for the Palm Beach County system of care are to increase the number of healthy births, to reduce the incidence of child abuse and neglect, and to increase school readiness, as indicated by the number of children who enter kindergarten ready to learn.[1] To pursue this aim, CSC and other stakeholders have developed a set of prevention and early intervention programs and systems serving families and their young children in targeted low-income communities called the TGAs.[2] The primary programs and systems designed to support children at different stages of their development are presented below.

[1] "Palm Beach County's Pathway to Early Childhood Development," CSC draft planning document, August 2007.

[2] At the time of this report, there are four designated TGAs or targeted geographic communities in Palm Beach County. According to the 2003 *State of the Child in Palm Beach County*, 75 to 93 percent of children in the TGAs receive free or reduced lunch; the rate of child abuse and neglect is between 4.1 and 6.6 times the county average; and crime rates in the TGAs range from 14 to 93 percent above the county rate.

**Overview of CSC Programs and Systems**

| Program/System Name | Program Description |
|---|---|
| Healthy Beginnings | A network of health and social services for high-risk pregnant women and mothers, which includes universal risk screening before and after birth; targeted assessment and home visitation; and coordinated services for families experiencing medical, psychological, social, and environmental risks that negatively impact pregnancy and birth outcomes |
| Early Care and Education | Several initiatives intended to identify and provide services for children with developmental delays and improve children's school readiness, and a quality improvement system for childcare programs |
| School Behavioral Health Programs | Designed to improve children's adjustment to school and enhance their school success by identifying social-emotional and other developmental problems and providing referrals and interventions to respond to these problems. |
| Afterschool Programs | A network of afterschool programs for elementary and middle-school youth supported by Prime Time, an intermediary working to improve the quality of school-based and community programs |

A central concern for CSC and other stakeholders in the county is the effectiveness of this emerging system. Is the service system functioning and being used by families as expected? Is it achieving its intended outcomes? Separate evaluations have been conducted on several individual programs and networks that are part of the system (e.g., Spielberger, Haywood, Schuerman, Richman, & Michels, 2005; Lyons, Karlstrom, & Haywood, 2007). Yet, these evaluations alone cannot provide information on how families use the *system* of services or the effects of multiple services on children's well-being and development.

Thus, CSC funded Chapin Hall at the University of Chicago to conduct an 8-year longitudinal study to examine the use and effectiveness of an array of services in the county in promoting school readiness and school success and improving family functioning among children and families most in need of support. The goal of the study is to describe the characteristics and needs of families the service system is intended to serve, how they use the services that make up the service system in Palm Beach County, and how service use is related to indicators of child well-being and family functioning, and child and family outcomes. It began in 2004 and addresses questions in the following areas:

- What services and supports are available and how are they used by families of young children in the TGAs? Are there patterns of service use?
- What are the correlates of service use, including demographic and other family characteristics, indicators of risk and service need, geographic location, nativity, and prior service use?
- How does service use relate to child and family outcomes, including children's school readiness, school success, and physical, social-emotional, and behavioral health; and to family functioning, rates of abuse and neglect, and parent involvement in schools?
- Does the availability of a more complete array of services change the way services are provided to families or makes individual programs more effective? Do families

experience larger effects from using an array of services than using individual services?

To address these questions, we are using mixed methods to gather a wide variety of information about the characteristics and needs of families the system is intended to serve, and how families use available services. These methods include analysis of administrative data on service use and key outcomes for all families with children born in the TGAs and in the county during 2004 and 2005 over an 8-year period; annual in-person and telephone interviews with a sample of 531 mothers who gave birth to a child (referred to here as the "focal child") in the TGAs during 2004 and 2005 for 5 years; and a 3-year embedded qualitative study involving in-depth interviews and observations of forty of these families.

Mothers were recruited through two maternal child health programs that are part of the Healthy Beginnings system. To ensure a sufficient sample of mothers who were likely to use services, we over sampled mothers screened at risk around the birth of their child. Of the 531 mothers who participated in the baseline interviews soon after the birth of the focal child, 444 were interviewed in year2, and 399 in the third year; 390 mothers were interviewed all 3 years. This executive summary reports key findings from the third year of the study—when the focal child was between 24 and 30 months of age—and discusses their implications for the Palm Beach County service system.

## Findings

### Family and Household Characteristics

- Compared to the population of families with children born in the TGAs and the county during 2004 and 2005, the study sample has more characteristics associated with risks for poor outcomes. A majority (59%) has less than a high school education versus a third (35%) of the TGA birth cohort. Almost three-fourths (72%) was unmarried at the baseline interview versus 57 percent of the TGA cohort. More than half (54%) of the families in the year 3 sample had incomes at or below the federal poverty threshold the previous year. In addition, compared to the TGA cohort, higher percentages of mothers in the sample were Black (38%) and Hispanic (55%); more than half (57%) were foreign-born.
- Household sizes remained fairly constant during the first 3 years of the study. The percentage of mothers who were married in year 3 was the same as in year 2 (30%), although the percentage of unmarried mothers living with a partner (33%) continued to decline from the first (40%) and second (37%) years. Two-thirds of the sample had two or more children at the time of the third interview. Almost one-quarter (24%) of the mothers had given birth to another child since the birth of the focal child, and 8 percent were pregnant at the time of the year 3 interview.
- Although there were only modest changes in family income, educational levels, and marital status over the first 3 years there was a notable increase in the proportion of mothers working part-time or full-time. Whereas only 13 percent were employed at the baseline interview, 45 percent were working at year 2 and 49 percent at year 3.

**Maternal Functioning, Parenting Practices, and Child Development**

- Most of the study mothers (85%) described themselves as being in "good" to "excellent" physical health in year 3. Fewer mothers expressed clinical symptoms of depression (19%) or parenting stress (11%) on standardized measures than in previous years.
- More than three-quarters of the mothers reported engaging in positive parenting activities, such as praising their child, singing songs, reading books, and taking their child outside to play. For families in which husbands or partners had contact with their children, mothers reported that at least two-thirds of fathers also engaged in most positive parenting activities.
- Smaller percentages of mothers reported using negative parenting practices, such as losing their temper with their child (53%), hitting or spanking their child (31%), and getting angrier with their child than they intended (22%). Mothers reported somewhat lower percentages of negative parenting practices for their husbands or partners than they reported for themselves.
- Most mothers reported the focal children to be in "good" to "excellent" physical health, although 18 percent had asthma or other "special needs" at year 3. Based on mothers' assessments, most children were developing within ranges comparable to the national birth cohort in the Early Childhood Longitudinal Study (ECLS-B) of children's physical, cognitive, social, and language development (Andreassen & Fletcher, 2007; NCES, 2003).

**Childcare Arrangements**

- At year 3, more than half (53%) of the mothers were using nonparental care for the focal child, motivated largely by their need for childcare as they returned to work. The most frequently reported type of nonparental arrangement was center care, followed by relative care, and care by a friend or neighbor.
- Although mothers who were employed or in school were significantly more likely to use childcare than mothers who were not, mothers' race/ethnicity and immigrant status also affected childcare use. Mothers who identified themselves as Black—both foreign-born and U.S.-born mothers—were much more likely to use childcare than foreign-born Hispanics.
- Several factors influenced mothers' choice of childcare arrangements including cost, availability, location, and access to transportation. They also were influenced by their beliefs and values about who should care for their children, the quality of care they desired, and their children's development. With children's increasing independence and verbal skills and the greater availability of center-based programs for 3- and 4-year-olds, mothers expressed more interest in childcare that would benefit their children socially and educationally than in previous years.

## Social Support

- Mothers with husbands or partners continued to receive a majority of their support from them, although reported levels of support were lower in year 3 than in year 2. Otherwise, mothers relied on other family members, especially siblings and mothers or stepmothers. Friends were an additional source of support, but for less than half of the sample.
- The overall level of reported community support rose between year 2 and year 3, suggesting more interaction with community members than in previous years. More than half of the mothers reported receiving support in the form of advice on children or household problems or help with money, food or clothing from someone in the community. In particular, more mothers cited doctors and teachers as a source of support in year 3 than in year 2.

## Service Use, Patterns, and Trends

### *Healthy Beginnings Services*

- Among mothers in the 2004-2005 TGA birth cohort, fewer than half (40%) received services from Healthy Beginnings. Consistent with the population targeted by the Healthy Beginnings system, mothers who were teens, were unmarried, had less than a high school education, were Hispanic, or were foreign-born were more likely to receive services.
- Compared to the TGA cohort, twice as many mothers in the year 3 study sample (80%) used Healthy Beginnings services. Most services were provided during the 3 months before and 6 months after the birth of a child. Only about a quarter of the sample continued to receive services 6 months after the birth of the focal child.

### *Other Services*

- A majority of the study families received help with health care and food assistance during the first 3 years of the study. Across the 3 years, about the same proportion of mothers—20 to 25 percent—received help with dental care, and about a third received help with family planning in years 2 and 3. Compared with year 1, there was a small increase in the proportion of mothers getting help with childcare in year 3.
- All of the focal children received regular medical care and 79 percent were covered by health insurance in the year 3. However, almost a third of all children in the study families (and 21 percent of the focal children) were not covered is a concern.
- An additional concern was that only 39 percent of mothers reported having health insurance for themselves, although a majority (73%) reported receiving regular medical care at the time of the year 3 interview. Native-born mothers were both more likely to receive regular care (82%) than foreign-born mothers (66%) and more likely to have health insurance in the third year (71% versus 15%).
- Even though a majority of mothers received food assistance in year 3, there was a significant decline in assistance years 1 and 2. Qualitative data suggested that, in

some cases, changes in employment or family composition affected eligibility for food assistance. Other reasons were mothers' perceptions of their needs, alternative sources of help, assessments of the benefits of assistance versus the application costs of time, transportation expenses, and obligation to share personal information, and missed deadlines for recertification of benefits.

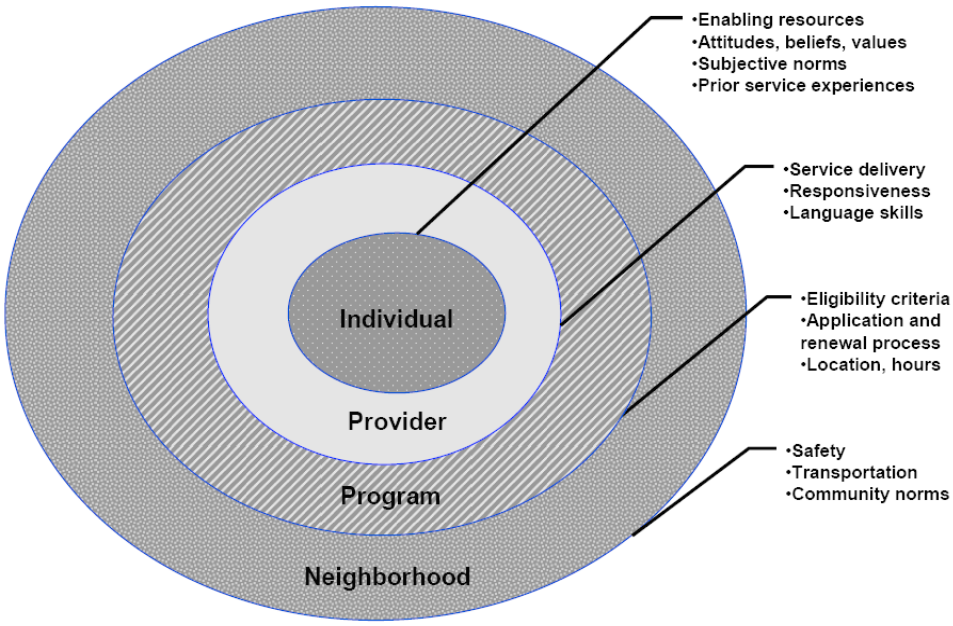
- The proportion of mothers who received help with parenting information also declined significantly between year 1 and year 3. One reason for the decline appeared to be that although still sought this support, they increasingly turned to other sources, including books, magazines, pediatricians, and teachers for parenting information.
- In general, mothers with greater needs received more help, and that mothers whose circumstances changed for the worse also received more help. Results also suggested that, all else being equal, foreign-born mothers—both Black and Hispanic—were less likely to receive help.

**Barriers and Facilitators of Service Use**

- Qualitative data suggested that service use was influenced by many factors at different but interconnected levels—the individual, the provider, the program, and the neighborhood level. As shown on the next page, at the individual level, we identified factors such as personal enabling resources (e.g., immigration status, concrete resources, knowledge of services, personal social networks), perception of need, attitudes and beliefs about services, subjective norms (e.g., family approval or disapproval), and previous service experiences.
- Barriers and facilitators to service use among the study mothers began at the individual level and were often related to their personal resources (e.g., language, income). In addition, what posed a barrier to one mother—for example, having to use the computer to apply for a service—would, in fact, be a facilitator for another mother.
- Mothers' commitment to their role as parents and to ensuring their children's well-being was a primary motivation to use services. Although mothers described personal goals (e.g., to go back to school, get a better job, learn a new language, and achieve financial stability) and said they preferred to be independent and not rely on formal services, they faced innumerable obstacles to achieving their goals. Yet many mothers were willing to make the personal effort needed to address the individual-level barriers, such as transportation, language, and conflicting information about service requirements, to use available services if it meant improving the welfare of their children.
- At the provider level, characteristics of providers such as staff responsiveness, language skills, and cultural competency affect service use. At the program level, factors include eligibility requirements, program structure, availability of translation services, location of services, intake procedures, and the waiting time to apply for or receive services. And at the neighborhood level, factors such as neighborhood safety

and community transportation systems affect families' access to and decisions to use services.[3]

**Conceptual Model of Barriers and Facilitators of Service Use**




- Foreign-born mothers were less likely to seek help from formal service providers than native-born mothers but also encountered more challenges in getting help they sought.
- Social workers and case managers played an important role in connecting study families to needed services that they might not be able to access on their own. Although these providers often were a direct source of parent education and mental health services, among others, they also were an essential bridge to basic services, including Medicaid, food assistance, and childcare subsidies.

## Outcomes at Year 3

- We found a small, positive relationship between the number of services mothers used in year 3 and their use of positive parenting practices; we also found a small, positive relationship between a mother's use of services and her child's language development. Thus, providing support services to mothers of young children might lead to improved parenting skills and, ultimately, enhanced child development. On the other hand, we also found a small, negative relationship between service use and

[3] We also recognize that the broader social, economic, and political context—for example, national and state immigration policies, the availability of affordable housing, jobs, and transportation systems, and the costs of energy and food—also impacts family circumstances, needs, and access to services.

the number of developmental milestones reached by the focal child, so it will be important to continue to examine the relationship between service use and child outcomes.

- There were some notable relationships between mothers' ethnic characteristics and selected maternal outcomes. First, Black foreign-born mothers were almost 14 times more likely to have depressive symptoms than Hispanic foreign-born mothers; however, we did not find significant differences in the odds of depressive symptoms between U.S.-born Blacks and foreign-born Hispanics, or between U.S.-born and foreign-born Hispanics. Mothers who gave birth as teenagers and mothers who reported more problems with housing were at higher risk of experiencing depression. Second, Black foreign-born mothers also had over 5½ times the odds for a Hispanic foreign-born mother of experiencing parenting stress. In addition to race and nativity, we also found that having more children, and having a child with special needs, increased the odds of experiencing parental stress.

## Conclusions and Recommendations

Given that the demographic characteristics of families living in the TGAs are the ones associated with children's poor outcomes for school readiness and achievement, CSC's strategy of targeting its services to families in the TGAs appears to be a sound one for reaching children who are most at risk of not succeeding in school. However, study findings to date suggest that some services might not be reaching many of the TGA families who could benefit from them. Although a large percentage of the study families used available food and health care services in the early years of their children's lives, the percentages using other services were much smaller.

For example, a large majority (80%) of the year 3 sample had contact with the Healthy Beginnings system around the birth of the focal child, but only about a quarter were still receiving services 6 months after birth. In addition, although half of the mothers in the sample used some form of childcare arrangement, only about a third were using either center-based programs or family childcare that might be touched by CSC's early education and childcare quality initiatives or the Comprehensive Services program's screening and referral services. Although families' use of center care probably will increase as their children get older, differences are likely to persist because of the lack of affordable quality childcare and childcare subsidies as well as the individual preferences of families for different types of care.

Just a small proportion (15%) of the study families received services in five areas or more in the third year. Their high service use was associated with being native-born, being Black, having more children, and having a child with special medical needs. They were also more likely to have received services through the Healthy Beginnings system. This means that they had contact with a care coordinator, nurse, social worker, or another professional for a longer period of time, which likely facilitated their participation in services. Families in our sample with greater needs were more likely to use services, but we also found that immigrant families were less likely to receive services than native-born families.

Thus, as described below, our findings to date suggest both opportunities and challenges in CSC's effort to improve access to and participation in the service system.

### 1. Keeping families involved in services over time

In this study, more mothers decreased than increased their service use. We saw declines in use of food assistance and formal parenting information. In the case of parenting information, the decline might reflect less perceived need for these services or more pressing concerns, such as food and health care. But it also might reflect the lack of connections to family support and educational services for parents once they leave the Healthy Beginnings system. For example, less than 20 percent of mothers still received intensive care coordination services—services that could connect them to additional parenting resources—after the focal child's first birthday.[4]

In the case of food assistance, fluctuations in employment or family composition might have affected some families' eligibility for food assistance. However, qualitative data suggest a number of other factors that prevented families in need from receiving help with food, including the application costs of time, transportation expenses, and obligation to share personal information, and missed deadlines for recertification of benefits. In this regard, social workers appeared to play an important role in linking mothers to needed services. Expanding case management services for mothers who, while not necessarily "at risk," need help in maintaining their services might be a service that CSC could continue to fund after the initial postnatal period to maintain connections to needed services.

In addition, the responsiveness of service providers was another factor in service use. This indicates the importance of CSC's investments in training for service providers in culturally appropriate and family-strengths-based approaches. Families can be intimidated by program concepts and requirements, and staff who are trained to help families through application processes can reduce future duplication of paperwork as well as client and staff frustration. Over time, investing in changing staff behaviors to better serve disfranchised families with young children might boost families' self-respect, make them feel more positive about seeking and accepting help, and prove cost-effective in reducing their future service needs.

### 2. Making location and timing of services convenient for families

Of the many factors that constrain service use, the locations of program offices, their hours, and waiting times are often inconvenient for families, especially if they have transportation or childcare problems. Strategies that CSC-funded programs use, such as home visits and traveling service vans, are good alternatives to office visits, especially if they are available during evening and weekend hours. Basing services at schools, Beacon Centers, or childcare centers is another option for reaching families who have children enrolled in school or formal childcare. Efforts to persuade health care providers,

[4] Although mothers might have been referred to additional services within or outside the system, it also is not clear from available data whether they are connected to these services.

schools, and service agencies to provide services at times that are convenient for families, as well as working with employers to allow families time off for appointments with teachers, doctors, or service agencies without jeopardizing their wages, might also increase families' access to services. Raising public awareness of the literacy and educational needs, as well as the service needs, of families might reinforce these efforts.

### 3. Providing continuity of services during periods of instability

Economic support and childcare subsidy programs with strict income thresholds or work requirements can be problematic for low-income working parents, whose sources of income are irregular. Programs and policies that recognize the changing circumstances of low-income families and try to add to the stability of their lives are more likely to impact a larger number of families. One example is CSC's Continue-to-Care Initiative, which provides transitional support when changes in mothers' education or employment status jeopardize their eligibility for childcare subsidies and lead to disruptions of children's care arrangements. Similar programs in the areas of health care and food assistance might also benefit families.

### 4. Improving channels of communication for service information

There may be other vehicles (e.g., radio, television, faith-based organizations, and public libraries) for disseminating information to families with limited education or literacy skills, families who do not receive information through family or friends, and families who are not already using other services. The local offices of federal benefit programs are also channels for disseminating information about CSC-funded programs; for example, one of the study mothers was referred by a nurse in the WIC office to a provider in the Healthy Beginnings system.

### 5. Strengthening relationships with community organizations and other services

CSC's strategies to enhance children's school readiness by improving the quality of childcare and providing referrals through the Comprehensive Services program could benefit families who use formal childcare services, but will not reach the many mothers who are not working, who are either not eligible or on a waiting list for a childcare subsidy, or who prefer to use other childcare settings. Other strategies are needed to reach these families, for example, through community outreach and other service providers. Family empowerment programs also can be an effective source of information about services, support, and advocacy and might be most effective when they partner with the programs most families already use, such as WIC, public health clinics, and Medicaid.

Most mothers in the study sample told us that they get what they perceive as an adequate level of support from family members, but there is also evidence that these informal support networks can be fragile and may not always add stability to their lives. On the other hand, there was an increase in reported levels of community support, especially by medical personnel, in the third year. Strengthening connections with pediatricians and nurses and informing them about available parenting services might be another way to increase families' awareness and knowledge of these services.

### 6. Engaging harder-to-reach families

Some segments of CSC's target population appear harder to reach and engage in services than others. Immigrant families, especially those with undocumented members, pose a particular challenge. Although the adults in these families might be ineligible for some programs, their children who are U.S. citizens are eligible for services such as food stamps, health insurance, and health care. More effort could be given to informing these families of their children's rights to services and the potential benefits to their children of using them and helping families with the language, literacy, technical, or other knowledge needed to navigate the application process is also needed. Besides reaching these families through the services they do use, this implies partnering with agencies that work specifically with immigrant populations and identifying other resources in immigrant communities through which to reach these families. Mobile units might be another way to reach families in more isolated communities with parenting, literacy, and health services.

### 7. Improving sources of information on service availability, use, and need

The FOCiS database is an important source of information on services families receive in the Healthy Beginnings system and referrals to providers outside the system. There may be more analyses we can do with the data systems currently available to understand how families enter and leave the system over time. At the same time, additional sources and analysis of information on the location of services, community needs for services, referral outcomes, and service participation would assist funders and service providers with planning and funding decisions. An integrated data system would, furthermore, make it easier to monitor use and outcomes of services in multiple systems.

In conclusion, to be effective, program policies and practices need to be grounded in the circumstances of the families they are intended to serve and take into account the multiple systems with which they interact. Services that have more flexibility to adapt to the circumstances of the low-income families they are intended to help might be more likely to reach these families and help to stabilize their daily lives. Families are less likely to use services, such as childcare, that do not fit with their daily routines, are not easy to get to, or do not fit with their work hours, or that conflict with their values. As we continue to learn more in the course of this study about families and services in the TGAs—including the reasons for service disparities, the needs of families, their sources of information about services, their service experiences, and the other factors that affect family functioning and children's development—we will learn more about how to strengthen community supports and design effective and flexible services and service delivery to fit the diverse needs and circumstances of these families.

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