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CENTER FOR CHILDREN
AT THE UNIVERSITY OF CHICAGO

The Palm Beach County Family Study

Second Annual Report

Executive Summary

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Introduction

Over the course of several years, Florida's Palm Beach County has begun to build an integrated system of services to promote and support the healthy development of children from birth to 8 years of age, with the goal of improving their readiness for school and success in school. Although the aim is to create a comprehensive system of supports for the entire county, the effort began with a set of prevention and early intervention programs and systems serving families in four targeted geographic areas (TGAs)—the Glades, Lake Worth/Lantana, Riviera Beach/Lake Park, and West Palm Beach—that have high levels of poverty, teen pregnancy, crime, and child abuse and neglect.[1] Designed to support children at different stages of their development, this infrastructure of services is made up of the four primary programs and systems, as follows:

- The Healthy Beginnings service system, formerly known as the Maternal and Child Health Partnership, is a network of health and social services providing support and intervention services, including universal risk screening and targeted home visitation, to high-risk pregnant women and new mothers.
- The Early Care and Education system comprises several initiatives intended to improve the quality of child care and early education programs, provide services for children with developmental delays, and improve children's school readiness.
- The Children's Behavioral Health Initiative (CBHI) is a school-based intervention to improve children's adjustment to school and enhance their school success by identifying social-emotional and other developmental problems and providing referrals and intervention services to respond to these problems.
- A network of after-school programs for elementary and middle-school youth is supported by Prime Time, an intermediary working to develop the quality of after-school activities in school-based and community programs.

This report summarizes findings from the second year of a longitudinal study commissioned by the Children's Services Council (CSC) of Palm Beach County to examine the use of this service system and its effects on children and families.

The Palm Beach County Longitudinal Study

Separate evaluations have been conducted on several individual programs and networks that are part of the Palm Beach County service system (e.g., Lyons & Winje, 2007; Spielberger et al., 2005). However, 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. The goal of the longitudinal 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 addresses questions in four key areas:

[1] According to the 2003 *State of the Child in Palm Beach County* (Children's Services Council, 2003), 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.

- 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, immigrant status, and prior service use?
- How does service use relate to 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 use of an array of services have larger effects than the use of individual services?

In order to examine the use and effectiveness of the service system in Palm Beach County on children's early development and school readiness, it is important to track families during the early years of a child's life when they are most likely to come into contact with the service system. Thus, we selected as our primary study group families with newborns living in the TGAs, with the intent of following them for at least 8 years into the children's early school years. The study uses a mixed-methods approach to examine the relations among the service systems in Palm Beach County, indicators of child well-being and family functioning, and child and family outcomes. Methods include the following:

- An analysis of administrative data on service use and key outcomes of all children born in the TGAs and in the county during 2004 and 2005 and who remain in the county at various data collection points during an 8-year period. Administrative data analyzed for the second year came from Department of Health Vital Statistics, the Right Track database for the Healthy Beginnings system, and the Department of Children and Families (DCF) HomeSafenet database on reports of child abuse and neglect reports.
- An 8-year longitudinal survey of the service use experiences of a sample of families with young children in the TGAs, employing annual in-person interviews with a baseline sample of 531 mothers of newborn children, brief phone interviews with the same parents about 6 months after each interview, as well as administrative data on service use and child and family outcomes. A total of 444 mothers were interviewed in the second year.
- A 3-year qualitative study involving in-depth interviews and observations of a small sub-sample of fifty families to enhance what is learned through analysis of structured interviews and administrative data about service use, motivations to use services, and how services fit into families' lives.

Year 2 Key Findings

Family Characteristics

Because risk criteria were used to identify the TGAs, it was not surprising to find that the analysis of the characteristics of mothers who gave birth in Palm Beach County in 2004 and 2005 showed that those living in the TGAs were more likely to have more demographic risk factors than those residing outside the TGAs. That is, a higher proportion of mothers living in the TGAs, compared to mothers living in other parts of Palm Beach County, were unmarried

(57% vs. 27%), had less than a high school education (35% vs. 13%), were foreign-born (48% vs. 37%), were Black or Hispanic (61% vs. 27%), and were teen mothers (14% vs. 6%).

Mothers in the interview sample had a somewhat higher proportion of these risk factors than other mothers in the TGAs because of the selection criteria used for developing the sample.[2] For example, compared with the 2004-2005 TGA birth cohort, a higher proportion of mothers in the Year 2 survey sample had not graduated from high school (57% vs. 35%), were single (70% vs. 57%), were foreign-born (57% vs. 48%), Hispanic (54% vs. 34%), and Black (37% vs. 27%).

Of the 444 mothers who completed the Year 2 survey, 13 percent lived in the Glades TGA, 81 percent lived in the non-Glades TGA, and 6 percent had moved from a TGA to a non-TGA area of the county in the previous year. Mothers living in the Glades, non-Glades TGAs, or outside the TGAs differed on a number of demographic and other family characteristics. A majority of Glades mothers identified themselves as Black, whereas a majority of mothers in the non-Glades TGAs and outside of the TGAs identified themselves as Hispanic. Correspondingly, Glades mothers were more likely to speak English as their primary language than mothers living in other areas. More mothers in the Glades and those living outside of the TGAs had graduated from high school than in the non-Glades group, but Glades mothers were less likely than non-Glades mothers and those living outside of the TGAs to have attended college or vocational school. Mothers in the Glades reported lower incomes than those in the non-Glades TGAs and outside the TGAs, but they were more likely to report that their families own their homes than mothers in the other TGAs. Glades mothers also were more likely to report that transportation was easy than other mothers.

> *I can't go out because I don't drive. I can't go by taxi because they won't take me because there are four kids…. I can't take the bus. I could easily get lost, and it is very difficult with the kids. They won't sit down and I have hardly ever gotten on a bus. One time I got lost, and since that no more. It is difficult [when] they go on their route and you don't know the system.*
>
> ~Amanda, age 26, unmarried mother of two

Notably, more of the 444 mothers worked in Year 2 (44%) than in Year 1 (14%). This marked change may be one reason for the aggregate Year 2 improvement in the mothers' well-being reflected in their household income and living conditions. Although mothers' estimates of their household income for the preceding year continued to be quite low, a smaller percentage in Year 2 than in Year 1 reported incomes of less than $20,000 (52% vs. 64%). There was some indication of improvement in their living conditions. A larger

> *[We got parks for kids] but they're tore up and believe it or not, you be in the park and [there are] drive-bys. I'd rather take my kids to a white park. No disrespect [but] the environment is better. The swings and stuff aren't broke ... I won't even take them to the park. My little girl she gettin' so grown now, starting to say things and learn too many things, and I try to keep her on the right track. I don't want my kids to grow up like that. 'Cause that's how I grew up, [and] I can't just let my babies get killed out here.*
>
> ~Shirley, age 20, unmarried mother of two

[2] The sample for the interview study is stratified along two dimensions. First, to ensure that the sample contains enough families identified as high risk (children at high risk or families at high risk of dysfunction), we structured the sample such that about half were mothers identified as being "at risk," based on scores on either a home assessment by a Healthy Start visiting nurse or a hospital risk screen administered by a hospital liaison soon after birth. Second, because the Glades TGA is sparsely populated and has higher poverty rates than the other TGAs, we also wanted to ensure that the sample was large enough to make reasonable estimates of its characteristics. Thus, about 20 percent of the sample came from the Glades. In the analysis of data, however, data were weighted so that the results would better represent the population of newly delivered mothers in the TGAs in 2004 and 2005.

percentage in Year 2 (26%) than in Year 1 (20%) lived in a home that was owner-occupied rather than rented, and the mean score on the negative living conditions index was smaller in Year 2 (1.2) than Year 1 (1.4).

Health Status, Maternal Functioning, and Parenting

Most mothers in Year 2 described themselves and the target child as being in "good" to "excellent" health. Almost a fifth of the mothers reported that the target child had special medical needs. Less than 10 percent of the mothers drank alcoholic beverages and, according to Vital Statistics records taken at the time of the target child's birth, less than 5 percent smoked. Over half (55%) of all mothers had breastfed the target child, and 11 percent were still breastfeeding this child at the time of the Year 2 interview. Five percent of the mothers had given birth to a subsequent child, and 11 percent were pregnant with a subsequent child.

A smaller percentage of mothers in Year 2 (24%) than in Year 1 (34%) met the established criteria for having "depressive symptoms" on the CES-D measure of depression (Radloff, 1977). This change may reflect subsiding postpartum depression as the Year 1 measure was taken soon after some mothers had given birth. Regarding other indicators of maternal functioning, about one-quarter of mothers' scores on the Parenting Stress Index/Short Form (Abidin, 1995) were at clinically high stress levels, and 8 percent had at least one DCF abuse or neglect report recorded in 2004 or 2005. DCF records also indicated that 5 percent of the mothers had a confirmed report of abuse or neglect, a rate that is comparable to the 2004-2006 estimates of abuse and neglect for children from birth to 2 years of age in the four TGAs.

The hardest thing is when I am really tired. I don't know where the energy comes from, but once I get home … or when she was in child care, once I pick her up, it is like I get another burst of energy. It just comes. Just to see her. She makes me so happy. She really does. She gives me so much joy.
~Marlene, age 41, single mother of one

Approximately two-thirds of mothers reported engaging in a variety of positive parenting activities in the 3 months prior to the interview, including praising their child, going outside to play, reading books, telling stores, and singing. The proportion of positive parenting practices that mothers engaged in increased from Year 1 to Year 2. This finding may indicate some improvement in mothers' parenting skills but also may reflect the fact that their children were older, and the parenting items in the survey are more relevant to older children. There was no change from Year 1 to Year 2 in mothers' reported negative parenting practices. About half of the sample had lost their temper with their child, almost a third had hit or spanked their child, and a quarter had gotten angrier with their child than they had intended.

Mothers' parenting practices were associated with a number of maternal characteristics, including education, age, employment, marital status, number of children, and the involvement of fathers with their children. For example, mothers who had completed high school, were married, had more children, and had greater access to informal supports used more positive parenting practices. Mothers who were employed and reported that the target child had special medical needs used fewer positive parenting practices. Mothers who used more negative parenting practices were mothers who were married or single and living with a partner, had a larger number of children, scored highly on the parenting stress measure, and received services

for concerns about their children's development. In contrast, mothers who had greater access to support and those having children with special medical needs used fewer negative practices.

Social Support and Use of Child Care

Similar to Year 1, mothers who had husbands or partners relied mostly on them for support in Year 2. Many mothers also received support from their mothers or stepmothers and siblings. Although, on average, mothers received less support from family and friends in Year 2 than in Year 1, most were satisfied with whatever support was provided. Smaller proportions of mothers received support from individuals in the community. Less than half (43%) of the sample received some kind of community support, and less than 20 percent received help from any one source of help. Community supporters usually offered advice on children or household problems but rarely helped with money, food, or clothing.

The proportion of mothers who used child care doubled from Year 1 (24%) to Year 2 (49%). This finding is not surprising given the number of mothers who entered the workforce in Year 2. Mothers' child care arrangements varied by race or ethnicity and immigrant status. Whereas Black mothers tended to use center care, Hispanic and White mothers typically relied on their relatives for child care. Foreign-born mothers, who were largely Hispanic, most often arranged child care with relatives, friends, or neighbors. In contrast, U.S.-born mothers used center-based care more often than other forms of child care. Although almost a third of the study families had school-age children, only 11 percent said that these children were involved in activities or child care after school.

> *If they go to the day care they can, you know, do some ABCs or do some work like that. That's my main focus—to try to educate them. 'Cause if they stay in here they're not gettin' educated. They'll just be behind by the time they go to school. So I really want them to go in day care.*
>
> ~Michelle, age 23, unmarried mother of two

Service Use

Data on service use came from both mothers' self-reports and Right Track administrative records. Administrative data indicated that among mothers in the TGA birth cohort, almost half received services from Healthy Beginnings, a network of health and social services providing universal risk screening and targeted home visitation to high-risk pregnant women and new mothers. Mothers who were teens, were unmarried, had less than a high school education, were Hispanic, were foreign-born, or had "at risk" screens recorded in Right Track were more likely to receive these services.

Nearly all of the mothers in the survey sample reported using one or more services during the year prior to the Year 2 interview. A majority (84%) received services from Healthy Beginnings. On average, these mothers had 5 days of contact with Healthy Beginnings service providers who primarily delivered care coordination. Most of these services were provided during the 3 months before and after the birth of a child. Roughly one-third of the mothers received more intensive care coordination and other services. Mothers who received these intensive services had, on average, 27 days of contact with the service provider between the first trimester and 18 months after giving birth (or an average of one contact per month).

The survey asked mothers whether they or their families used any of sixteen types of services in the previous year. Of the sixteen services, mothers most often reported using health care (95%), food programs (85%), and family planning or birth control services (36%). One-quarter of the mothers reported receipt of dental care and parenting information. Less than a quarter had received any of the other services. Compared with Year 1, significantly larger proportions of mothers in Year 2 reported receiving assistance with food (85% vs. 67%), health care (95% vs. 72%), and child care (19% vs. 15%). However, fewer mothers in Year 2 (24%) than in Year 1 (69%) received parenting information. Although many mothers received parenting information from the Healthy Mothers/Healthy Babies and Healthy Start programs around the time of their child's birth, they apparently were unlikely to continue receiving parenting information unless they were receiving intensive care coordination services. The percentage of mothers covered by health insurance also decreased from Year 1 (56%) to Year 2 (40%). This decline may have occurred if mothers who had been covered by SOBRA during their pregnancy were no longer eligible for this or other public insurance after the target child was born.

> *I applied for Medicaid, and I was almost 18 weeks when I was able to be taken care of for the first time. First they take a long time in giving a response, and then they said some immigrant papers or something was missing, and I had to make copies again, and then everything took a long time. I was almost 20 weeks when I had my first ultrasound and found out there were two babies.*
>
> ~Maria, 37, married mother of three

Some mothers also reported unmet needs for services. Services that mothers sought but did not get were dental care (32%), child care (25%), housing or shelter (25%), and help with paying rent or bills (23%). Reasons mothers gave for not receiving these services usually were related to program parameters or provider limitations. That is, mothers were told they were not eligible for services, were put on waiting lists, or were told that services were not available. A small number of mothers also acknowledged they did not receive services because they had not followed up on referrals, missed appointments, lost paperwork, or were unable to get the transportation or child care that would enable them to go to a program office. Furthermore, mothers' help-seeking varied by service area. A large majority of mothers sought help when they were concerned about their own or their children's physical health, but only half or less sought help when they had concerns in other areas.

Overall, mothers' service usage was characterized by four distinct service patterns, which were differentiated by both the number and the kinds of services used. *Low service users* typically relied on only two or three kinds of services, primarily family health care and food assistance. Two groups of *moderate service users* each reported using, on average, four services. Large percentages of mothers in both groups received food assistance and family health care, but mothers in one group also used family planning services whereas mothers in the second group received services for their children's physical health and illness. *High service users* received seven or eight services, on average, across multiple service areas.

These service patterns were associated with families' demographic characteristics, health status, social support, maternal functioning, and previous service use. At the same time, somewhat different factors appeared to influence low and high service use. Mothers were more likely to be low service users, relative to the other three service patterns, if they had a high school diploma or GED, were employed, and had access to informal support. Mothers were

more likely to fall into the high service user group, rather than another group, if they were born in the United States and lived in the Glades. They also were more likely to be high service users if they had more children, a target child with special medical needs, received intensive care coordination, and a confirmed DCF report. Nativity was by far the best predictor of high service use. Mothers who were born in the United States were 21 times more likely than mothers who were foreign-born to be high service users.

Overall, these factors explained only about 19 percent of low service use and about half of high service use. Thus, much of the variation in mothers' service use remains to be explained by other factors. Other factors that may help explain service use patterns were identified in the first two waves of qualitative interviews on barriers to and facilitators of service use in four areas—health care, income supplements, social services, and child care. Factors that affected mothers' help-seeking behaviors, decisions to use services, and participation in services were related to the characteristics of individual families, communities, providers, and programs.

The role of individual family characteristics in accessing services was especially evident in the experiences of immigrant families. These families experienced problems with lack of transportation and child care, and lost wages when time was taken off from work to apply for services. Similar to native mothers, immigrants reported having long waits at program offices. However, immigrant mothers whose English or literacy was limited found it more difficult than native mothers to use public health clinics and WIC services because of their need for bilingual services or staff willing to help them with reading and writing. Language barriers also kept immigrant families from acquiring information about service eligibility. Some families had received misinformation about adverse consequences they or their children could face for using services. Foreign-born mothers were also apprehensive about applying for services that required extensive documentation.

Based on the account of mothers in this study, other program evaluation reports (Lyons & Winje, 2007; Spielberger et al., 2005) and the literature (e.g., Andersen, 1995; Goerge et al., 2004; Lowe & Weisner, 2004; McCurdy & Daro, 2001), we believe decisions to apply for and use services are shaped by a host of cultural and ecological factors. These include individual characteristics (language, transportation, perceptions of and attitudes towards services, social networks, economic stability, and past program experiences), program characteristics (intake procedure, waiting time), provider characteristics (behavior, cultural competency, communication style), and neighborhood characteristics (transportation, social networks, safety). The study findings also suggest that the role these various factors play in shaping service use may vary from one service area to another. For example, mothers' decisions to use or not use child care may be shaped by their parenting beliefs as well as their need for child care and the choices available to them. On the other hand, their use of health care or food supplement programs may be influenced more by need than by personal beliefs or ease of application.

The worst part for me [as a parent] is when I know they want something and I can't get it. I wish I was more stable sometimes. But now that I gotta good job, I probably won't have to worry about it. [Now] the only thing that's hard [is] having to take them places and don't have way to go. If I get a car I'll be all right. That's the only thing I'm working on now, getting a car. That's the only thing hard is like have to go places and have to ask people. Or get one of my family members to take me.

~Karol, age 24, single mother of two

Finally, a recurring theme in the qualitative data and one we will continue to follow over time was the apparent instability in the lives of some of the study families. This instability—which was also reflected in the finding that more than a third (39%) of the sample had moved at least twice during the past year—complicates service use. The personal and formal support, income, employment status, work schedules, child care, and housing of many of the mothers participating in the qualitative interviews all appear to be markedly fragile. When so much in their lives is temporary, it is difficult for parents to create and sustain the kind of routines and activities that are healthy for children and foster their development.

Conclusions and Implications

By concentrating services in the four areas of Palm Beach County with the highest rates of poverty, teen pregnancy, crime, and child abuse and neglect, CSC aims to assist families whose children are most vulnerable to falling behind in school. Underlying CSC's efforts is the assumption that a strong system of community supports and prevention services in the TGAs will result in healthier families, children who are better prepared for school and more likely to succeed, and fewer families needing more intensive mental health, child welfare, and juvenile justice services. In order to obtain the benefits that services might provide, though, families must use them. Thus, the longitudinal study's central questions are what services are available to and used by families and whether services help parents care for their children.

As indicated by the Year 2 findings, the demographic characteristics of families living in the TGAs are the ones associated with children's poor outcomes for school readiness and performance. In this regard, 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 having difficulty in succeeding academically. However, the study's findings also suggest that some services may not be reaching many families in the TGAs who might 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 kinds of services were much smaller.

For example, administrative records show that the vast majority (84%) of the study families had contact with the Healthy Beginnings system around the birth of their child, but only about a quarter were still receiving services 6 months after birth. Mothers' reports indicate that only one-quarter of the sample received parenting information and less than 5 percent used mental health services in the year prior to the Year 2 interview. In addition, although half of the sample used child care, only about a third used the center-based programs or family child care that participate in CSC's early education and child care quality initiatives or the Comprehensive Services program's screening and referral services. Although families' use of center care may increase as their children get older, the racial and ethnic disparities

observed in Year 2 are likely to persist both because of the lack of affordable quality child care and child care subsidies and because of the individual preferences of families for different types of care.

These findings suggest there are opportunities to improve service access and use in the TGAs. At the same time, the challenges are many. Given the variability in family circumstances, services that have more flexibility to adapt to the circumstances of the low-income families they are intended to serve may be more likely to reach these families. In other words, services will be most beneficial if they are designed to fit into and add to the stability of families' daily lives. Families are less likely to use services such as child care that do not fit well with their daily routines, are not easy to get to with available transportation or do not fit with their work hours, or that conflict with their values. Thus, the second-year findings imply several challenges for improving access to and use of CSC's prevention and early intervention services, as outlined below:

- **Keeping families involved in services over time**
  In this study, we saw a decline in both the use of and perceived need for formal parenting information. This decline may be the result of individual factors such as mothers not perceiving a need for these services, perhaps because they feel more confident in their parenting skills or rely on informal sources for parenting information, or have more pressing concerns such as food and health care. But given that each new developmental stage brings with it its own challenges for parents, it also may reflect the lack of a comparable network of services for parents as they enter the second year of their children's lives. Or it may mean that parents were not fully involved in the Healthy Beginnings system in a way that might encourage them to participate in other parent education and family support services that are available.

- **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 child care 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 child care centers is another option for reaching families who are using them. It may be difficult to persuade employers to allow families some time for appointments with teachers, doctors, and service agencies without jeopardizing their wages. However, it may be more feasible to persuade health care providers, schools, and service agencies to do more to address families' problems in accessing their services.

- **Providing continuity of services during periods of instability**
  Economic support and child care 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 families' 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

might jeopardize their eligibility for child care subsidies and result in disruptions of children's care arrangements. Similar programs in the areas of health care and food may also benefit families.

- **Improving channels of communication for service information**
  There may be other vehicles (such as radio, television, faith-based organizations, and public libraries) for disseminating information that will reach 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.[3] The local offices of federal benefit programs are also channels for disseminating information about CSC-funded programs, as in the example of a mother who was referred by a nurse in the WIC office to a provider in the Healthy Beginnings system.

- **Strengthening relationships with community organizations and other service systems**
  CSC's strategies to enhance children's school readiness by improving the quality of child care and providing referrals through the Comprehensive Services program could benefit families who use formal child care services, either center-based programs or family child care. However, this approach obviously will not reach the many mothers who are not working, who are either not eligible or on a waiting list for a child care subsidy, or who prefer to use other child care settings. Other strategies are needed to reach these families, for example, through other service providers such as WIC and community outreach. Family empowerment programs also can be an effective source of information about services, support, and advocacy and may 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 already received what they perceived as an adequate level of support from family members, but very few reported having additional support from community sources such as faith-based organizations, health care providers, social workers, or child care and school staff. Efforts to increase communication and collaboration among service providers in the TGAs for the purpose of improving families' access to services, including smaller community-based organizations, may strengthen relationships between community supports and service providers to the benefit of families.

- **Engaging harder-to-reach families**
  Some segments of CSC's target population may be harder to reach and engage in services. Immigrant families, especially those with undocumented members, pose a particular challenge for service delivery. Although the adults in these families may be ineligible for some programs, their children as U.S. citizens are eligible for services such as food stamps. More effort could be given to informing these families of their children's rights to services and the potential benefit to their children of using them. Addressing immigrant families' concerns about using services by providing accurate information about programs 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

[3] CSC has recently started making more use of the media to provide information about child care and other parent education.

immigrant groups and identifying other resources in immigrant communities through which to reach these families.

In conclusion, the second-year results indicate wide variability in service use among families in the TGAs. A small proportion (11%) of the study families received multiple services. Their high service use was associated with being native-born, living in the Glades, and several factors that indicated a higher level of need than other mothers (i.e., target children with medical needs and DCF reports of child abuse or neglect). High service users had higher levels of depression and were more likely to have received a high-risk screen at the birth of their child than low service users. These findings suggest that services are reaching families most in need. However, there likely are many families—especially those in our two moderate service use groups—who are receiving only some of the services they need and who might benefit from the prevention and early intervention services funded by CSC.

The variations in service use observed here suggest both opportunities and challenges for improving families' access to services. They also imply the need for additional information and analysis. To be effective, program policies and practices need to be grounded in the circumstances of the low-income families they are intended to serve and take into account the range of different services and systems with which they may have contact. 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 services and service delivery to fit the diverse needs and circumstances of these families.

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