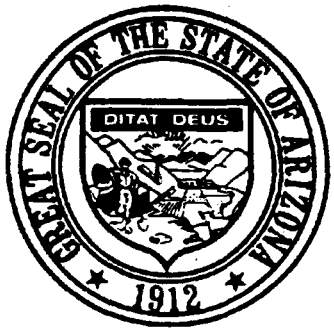

ANNUAL EVALUATION

HEALTHY FAMILIES PILOT PROGRAM

Report to the Arizona Legislature
By the Auditor General
December 1995
Report #95-19

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AUDITOR GENERAL

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OFFICE OF THE
AUDITOR GENERAL

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December 26, 1995

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Dr. Linda Blessing, Director
Department of Economic Security

Transmitted herewith is a report of the Auditor General, an Annual Evaluation of the Healthy Families Pilot Program. This report is in response to the provisions of Session Laws 1994, 9th Special Session, Chapter 1, Section 9.

This is the first in a series of three reports. The second and final evaluation reports are scheduled to be released on or before December 31, 1996, and December 31, 1997, respectively. Our evaluation study finds that the Department of Economic Security (DES) successfully brought the Healthy Families program into operation by awarding contracts in a timely and efficient manner, with low administrative costs and by developing participant eligibility criteria.

We also found that the Healthy Families program includes components that are needed for quality home visitation services along with a strong quality assurance and training program and a plan for collaboration with other programs. The DES has done this with a projected cost per participant that is comparable to the national model.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on December 27, 1995.

Sincerely,

Douglas R. Norton
Auditor General

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SUMMARY

The Office of the Auditor General has completed the first year of a three-year evaluation of the Healthy Families Pilot Program. This evaluation was conducted pursuant to the provisions of Laws 1994, 9th Special Session, Chapter 1, Section 9. This is the first of a series of three annual program evaluation reports to be issued on the Healthy Families Program. The second and final evaluation reports will be released on or before December 31, 1996, and December 31, 1997, respectively.

The Healthy Families Program aims to address the growing need for child abuse prevention. This home visitation program targets families with newborn children to prevent child abuse and neglect, promote child wellness and proper development, strengthen family relations and promote family unity, and reduce substance dependency. By connecting families with proper services, the Program also aims at reducing welfare dependency among participating families. The Division of Children and Family Services in the Department of Economic Security (DES) administers the Healthy Families Program through its Child Abuse Prevention Fund. The DES awarded 5 contracts to serve 13 sites across Arizona. The Legislature appropriated $1.7 million in fiscal year 1994-95 and $3 million in fiscal year 1995-96 for the Pilot Program.

DES Efficiently Implemented the Healthy Families Program (See pages 7 through 12)

DES successfully brought the Healthy Families Program into operation. In the process, it awarded contracts in a timely and efficient manner, developed participant eligibility criteria as mandated by the Legislature, and operated with low administrative costs.

- DES set up an efficient selection process that resulted in timely contract award. Consequently, Healthy Families was the first of the four early childhood programs (Healthy Families, Health Start, Family Literacy, and At-Risk Preschool) that were enacted at the same time to become operational.

- DES developed participant eligibility criteria in accordance with legislative mandate. It also established elaborate contractor eligibility criteria that aimed at serving the areas and communities most in need of the Program.

- DES required very few administrative personnel at the agency level to run the Healthy Families Program. Additionally, it provided the agency level administration at no cost to the Program.

While DES brought the Program into operation in an efficient and timely manner, it needs to improve its contract management practice. During the first year of implementation, DES amended some of the contracts, rather than enforcing the performance incentive clauses within them.

Healthy Families Program Design Appears Sound (See pages 13 through 19)

The Healthy Families Program planning incorporates several components needed for quality home visitation services. A strong quality assurance and staff training program, combined with plans for legislatively mandated service delivery and collaboration with complementary programs, are key to this plan.

- Compliance with the legislative mandates in terms of service delivery and the program model includes an intake procedure that is sensitive to participant rights and privacy, offering services specified by the Legislature, and a plan for moving families from one stage to the next.

- The Healthy Families Program has a well-defined quality assurance function and a nationally recognized, comprehensive staff training program that helps ensure program integrity.

Healthy Families collaboration efforts promise to both improve and streamline Arizona's home visitation services. While the Healthy Families Program has made good progress toward setting up collaborative efforts at various levels to make the services more comprehensive, more effort is needed in this area. We recommend that DES continue its collaboration efforts with the Department of Health Services' home visitation programs. Further, DES should also consider developing partnerships with At-Risk Preschool, Family Literacy, Even Start, and Head Start programs.

Projected Costs Are Comparable to National Model (See pages 21 through 24)

The projected costs for the Healthy Families Program appear comparable to the national model program in Hawaii. The State spent an average of $3,269 per participant during the first year of implementation. Taking into account the startup costs and the projected enrollment figures for a full-year implementation of the Program, it appears that the cost per participant will be comparable to Hawaii's Healthy Start Program by the third year of operation.

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INTRODUCTION

The Office of the Auditor General has completed the first year of a three-year evaluation of the Healthy Families Pilot Program. This evaluation was conducted pursuant to the provisions of Laws 1994, 9th Special Session, Chapter 1, Section 9. This is the first of a series of three annual evaluation reports to be issued on the Healthy Families Program. The second and final evaluation reports will be released on or before December 31, 1996, and December 31, 1997, respectively.

Child Abuse Is a Growing Problem Nationwide and in Arizona

The Legislature established the Healthy Families Pilot Program through the Family Stability Act of 1994 to address the growing need for child abuse prevention.[1] (See Appendix I for the definition and type of child abuse.) Child maltreatment has become an increasingly serious problem in the United States. Between 1976 and 1994, the reported number of child abuse and neglect cases increased more than four times, from 669,000 to 3.14 million. In 1976, about 10 out of every 1,000 American children were reported to have been abused or neglected. The same figure in 1994 stood at 47, indicating almost a five-fold increase. A December 1995 Gallup Organization study reports that the incidence of child abuse may be as much as 16 times the reported rate.

Between 1984 and 1994 the rate increased in Arizona as well, except in 1993-94, when the number of reported cases dipped 7 percent from the previous year. It is not clear from the available data whether the drop indicates a new trend or an exception. However, from the nationwide data, it is safe to assume that the upward trend in Arizona continues. Additionally, the number of cases involving child abuse and neglect-related fatalities in Arizona almost doubled between 1991 and 1994.

Recognizing the seriousness of the child abuse problem, a 1992 U.S. General Accounting Office (GAO) study identified three basic types of services that are needed to deal with it. These services can be viewed as a continuum of care that starts with preventative efforts. Treatment for the children and their families is an intermediate step, and if all else fails, removal of the child from the abusive environment and placement in foster care constitutes the final step.

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[1] The same act established two other pilot programs – Health Start and Family Literacy. Of these, Health Start addresses prenatal and early childhood health care needs, and Family Literacy provides learning opportunities to parents and children.

The GAO study also recognized home visitation programs as promising models for prevention efforts. These programs aid in improving family health, parental education, and increasing employment opportunities for the parents. In a more recent study, the National Committee to Prevent Child Abuse (NCPCA) argued that developing a statewide intensive home visitation system allows states to directly address multiple factors that can lead to abusive behavior and confront the symptoms of child maltreatment before a crisis occurs.

Program Goals and Services

The Legislature specified the following goals for the Healthy Families Program:

- Reduce child abuse and neglect
- Promote child wellness and proper development
- Strengthen family relations
- Promote family unity
- Reduce dependency on drugs and alcohol.

In order to achieve these goals, the Legislature determined that the following services need to be provided to the participating families:

- Informal counseling or emotional support services
- Assistance in developing parenting and coping skills
- Education on the importance of good nutritional habits to improve the overall health of their children
- Education on developmental assessments so that early identification of any learning disabilities, physical handicaps, or behavioral health needs are determined
- Education on the importance of preventative health care and the need for screening exams such as hearing and vision
- Assistance and encouragement to provide age-appropriate immunizations
- Assistance and encouragement to access comprehensive private and public preschool and other school readiness programs

- Assistance in applying for private and public financial assistance including employment services
- Assistance in accessing other applicable community and public services including employment services.

Prior Program Efforts

Prior to the legislatively mandated Pilot Program, DES had administered a Healthy Families Program at three sites in Arizona through its Child Abuse Prevention (CAP) Fund.[1] The Program started in October 1991 at two sites in Tucson and Prescott. A third site in Casa Grande was funded in November 1992. An additional site in Yuma is funded by the Regional Behavioral Health Authority. With the new funding, DES has expanded the Program to 13 additional sites around the State.

Program Model

Arizona's Heathy Families Program, like similar programs around the country, uses a *home visitation* model fashioned directly on Hawaii's Healthy Start Program, which is considered a national model by various child abuse prevention experts. Apart from the home visitation concept, Arizona's program closely follows Hawaii's in terms of its goals, mandated services, and the type of personnel it employs to deliver these services.

Like Hawaii's Healthy Start, Healthy Families Arizona (HFA) aims at improving family functioning, promoting optimal child development, positive parenting skills, and positive parent-child interactions as steps to prevent child abuse. It also incorporates the following major components from Hawaii's program:

- Systematic hospital-based screening to identify high-risk families from a specific geographic area
- Community-based home visiting family support services
- An individualized plan stating the intensity of service based on the family's need and level of risk
- Linkage to a medical facility
- Coordination of a range of health and social services.

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[1] The Child Abuse Prevention (CAP) Fund was established by the Legislature in 1982 to promote child abuse prevention and to provide grants to community-based agencies for this purpose. Between 1982 and 1995, the CAP Fund has provided $5.5 million to 50 different children and family service programs.

While Hawaii's Healthy Start serves families from the prenatal period whenever possible, Healthy Families Arizona can serve only from the time the target child is born.

The staffing pattern in Arizona's Healthy Families Program is also similar to that of Hawaii's Healthy Start. At the site level, the Program employs three types of staff — program supervisors, early identification workers, and family support workers. Each site typically employs one professional supervisor who supervises a team of paraprofessional family support workers. The family support workers are responsible for ongoing home visits for up to five years. Each worker is responsible for about 15 cases the first year, 18 the second year, and 21 the third, as services to some families become less intensive. The early identification workers are responsible for conducting the initial risk assessment. Initially, staff receive four days of intensive training and subsequently attend numerous in-service training programs.

Appropriations

The Legislature appropriated $1.7 million for fiscal year 1994-95 and $3 million for fiscal year 1995-96 from the state general fund to the Department of Economic Security to implement the Healthy Families Pilot Program.

Scope and Methodology

Pursuant to Laws 1994, 9th Special Session, Chapter 1, Section 9, this annual program evaluation looks at the Program's effectiveness, its organizational structure and efficiency, the level and scope of services included within it, the type and level of criteria used to establish eligibility, and the number and demographic characteristics of the persons who receive services from the Program.

For the first-year evaluation, the following broad areas were reviewed:

- Program implementation by the Department of Economic Security including contract awarding and management
- Healthy Families Program design including staff training, service delivery, and quality assurance
- Program costs including cost per family and cost comparison with similar programs in the country.

Methods used in this evaluation include interviews with agency and program staff, analysis of program revenues and expenditures, analysis of participant enrollment and

characteristics from the Program's participant database, program document and file reviews, literature reviews, and direct observation of existing sites and staff training.

The Auditor General and staff express appreciation to the Director, Healthy Families Coordinator, and staff of the Arizona Department of Economic Security's Division of Children and Family Services, as well as the Healthy Families Pilot Program staff for their cooperation and assistance during the first year of the Healthy Families Pilot Program Evaluation.

FINDING I

DES EFFICIENTLY IMPLEMENTED THE HEALTHY FAMILIES PROGRAM

The Department of Economic Security, the agency responsible for administering the Healthy Families Program, successfully brought the Program into operation. Since the key program activities such as service delivery, staff training, quality assurance, and data management are contracted out, the Agency's performance hinged on the awarding and managing of these contracts. DES acted in a timely and efficient manner in awarding contracts. DES also established contractor and participant eligibility criteria pursuant to legislative mandate, and completed all necessary administrative tasks with low administrative overhead. In terms of contract management, however, DES needs to abide by its original contracts as much as possible, and enforce the performance incentives contained in the contracts.

DES Awarded Contracts in a Timely and Efficient Manner

Of all four early childhood programs that were enacted at the same time, Healthy Families was the first to be implemented. Several factors contributed to this early implementation by DES. Foremost, DES awarded the contracts in a timely fashion. It developed a comprehensive Request For Proposal (RFP), followed by an efficient selection process that resulted in distribution of program funds across 13 sites. The experience of previously administering a similar program helped DES in understanding local needs and developing program guidelines.

An efficient selection process resulted in timely contract awards — An efficient contracting process enabled DES to award contracts in a timely manner. The timely development of a comprehensive RFP, a clear definition of eligibility and selection criteria, and early establishment of an independent proposal selection committee ensured an efficient selection process. Consequently, of all four early childhood intervention programs that were mandated at the same time — Healthy Families, Health Start, Family Literacy, and At-Risk Preschool Program, Healthy Families started operating first. Table 1 (see page 8) compares the starting time for these programs. The early start was made possible by DES' prompt action following the enactment of the law. DES issued the RFP within one month from the passage of the Family Stability Act bill in June 1994. As a result, it was able to select service providers and finalize the contracts by November 1994, and service delivery began in January 1995.

Table 1

Comparison of Implementation Time for Four Early Childhood Programs

Program	Agency	Contract Award Date	Program Start Date
Healthy Families	DES	11/94	01/95
Health Start	DHS	03/95[a]	03/95
Family Literacy	ADE	03/95	04/95[b]
At-Risk Preschool	ADE	08/95[c]	08/95

[a] Some Health Start contracts were not signed until May 1995.
[b] Most Family Literacy sites did not start operating until August 1995 or later.
[c] Approximately one-third of the contracts were awarded at this time.

Source: Auditor General staff analysis of program contracts and interviews with agency staff and contractors.

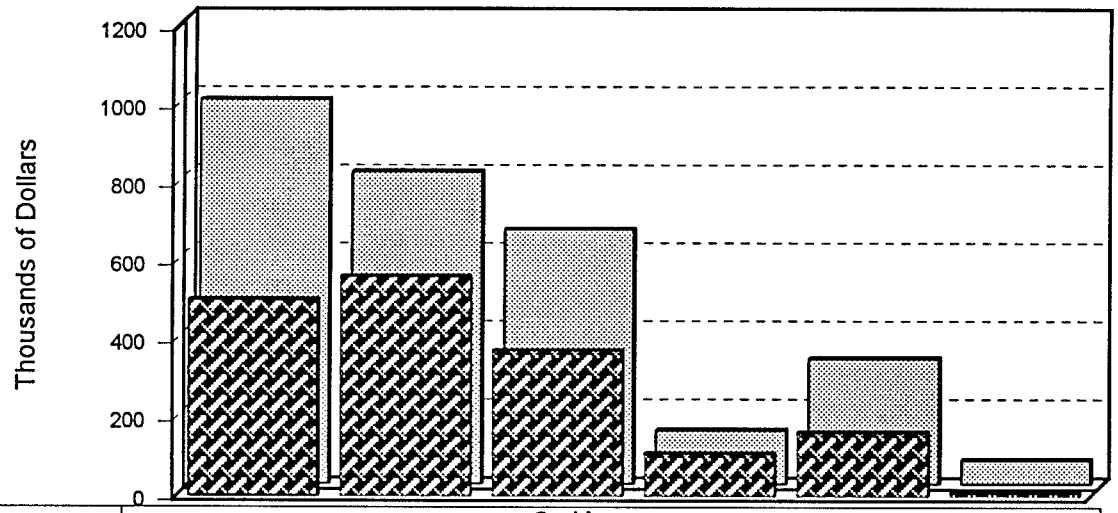
High percentage of the appropriated amount allocated to service delivery — DES allocated 94 percent ($1.7 million) of the fiscal year 1994-95 appropriation for service delivery. Of the remaining amount, 5 to 6 percent was spent on providing program oversight through one of the contractors who had experience in running a previous Healthy Families site. Data management, involving the development and updating of a program database, accounted for less than 1 percent of the total appropriation. The total appropriation for fiscal year 1995-96 is $3 million. DES did not award any new contracts for fiscal year 1995-96 but used the additional $1.3 million to expand the current contracts and serve more participants. From the 1995-96 appropriation, $49,476 remains unallocated. The Child Abuse Prevention Fund (CAP) coordinator indicated that the unallocated amount resulted from conservative budgeting and would be used to expand some of the smaller programs.

DES awarded 5 contracts to serve 13 sites — DES awarded 5 contracts to serve 13 sites in 6 counties. Figure 1 (see page 9) provides an overview of these contracts. One of the contractors, Tucson Association for Child Care (TACC), received two separate contracts for urban and rural sites, respectively. In both the TACC contracts, TACC acts as an umbrella organization that brings together a number of not-for-profit organizations as service providers. Their urban contract includes the cost of providing statewide program oversight through a quality assurance coordinator.

DES contracted out the database management function to a data management firm. Our Office determined that while the Program collected sufficient data, it lacked a proper database to comply with the legislative mandates. Accordingly, DES extended the existing data management contract to meet the legislative as well as the long-term program needs. The increase in data collection costs is reflected in the fiscal year 1995-96 budget.

Figure 1

Distribution of Monies among Program Sites
(Unaudited)



County	Maricopa	Pima	Cochise Santa Cruz	Yavapai	Coconino	N/A
Contractor	Southwest Human Development	Tucson Assoc. for Child Care (Urban)	Tucson Assoc. for Child Care (Rural)	Marcus J. Lawrence Medical Ctr.	Coconino County Dept. of Public Health	Data Collections
Number of Sites	4	3	3	1	2	N/A
Fiscal Year '95 Budget	$500,000	$558,894	$369,304	$106,252	$160,000	$5,550
Fiscal Year '96 Budget	$983,000	$799,174	$650,523	$136,403	$320,096	$61,328

Source: Auditor General staff analysis of Healthy Families Program contracts.

DES Developed Family Eligibility Criteria in Accordance with Legislative Mandate

As mandated by the legislation, DES developed eligibility criteria individual families must meet to participate in the Program. DES followed a nationally recognized set of criteria for participant eligibility. Additionally, contractor eligibility criteria were defined with a view to serve communities and geographic areas that most need the Program.

Participant eligibility criteria — DES specified eligibility criteria for individual families following Hawaii's Healthy Start model. In order to receive Healthy Families services, a family must:

- Have a newborn baby
- Reside in one of the program target areas where the contractors operate
- Screen positive on two separate screening tools that identify families under stress and therefore at risk for child abuse.

Contractor eligibility criteria — DES developed the contractor eligibility criteria with a view to serve communities and geographic areas that most need the Healthy Families Program. In determining which contractors were eligible to apply for funding, DES used different criteria for rural and urban applicants. The eligibility criteria for rural program sites are based on geographic area distinguished by zip codes. These rural zip code areas must have:

- At least 350 live births annually
- At least 75 Child Protective Services (CPS) reports involving children 0-5 years of age
- A low rate of prenatal care
- Underutilization of health care services.

Some rural area towns, whose citizens may need Healthy Families Programs, do not meet the eligibility criteria because of their small population. Consequently, contractor applicants are encouraged to pursue creative staffing options through positioning some family support workers in neighboring high-risk towns.

For urban areas in Maricopa and Pima counties, DES identified certain zip code areas in need of services based on CPS statistics and available services. Applicants wishing to

operate in other zip code areas of these two counties had to demonstrate the need for a program in those areas.

DES Has Kept Administrative Program Costs Low

DES maintained very low administrative overhead costs at the agency level to run the Healthy Families Program. For example, it did not expend any program dollars for agency-level administration. As a result, a high percentage of the legislatively appropriated funds were spent on actual service delivery. While DES has hired additional personnel to cope with the increased funding and resulting program expansion for fiscal year 1995-96, DES managed to absorb the increased cost without taking money from the program budget.

The Division of Children and Family Services (DCFS) administers the Healthy Families Program through its Child Abuse Prevention (CAP) Fund. The CAP Fund administrator was given this responsibility because of her previous experience administering the existing Healthy Families Program. In fiscal year 1994-95, the CAP Fund had only one full-time employee — a program specialist, who coordinated the Fund's programs. According to her own estimate, the CAP Fund Coordinator spent approximately 70 percent of her time administering the new Healthy Families Program, 15 percent on the existing Healthy Families Program, and 15 percent on other CAP Fund activities. Thus, the Healthy Families Program essentially required only 0.7 FTE in fiscal year 1994-95.

Beginning fiscal year 1995-96, a full-time program specialist position has been added to assist the CAP Fund Coordinator with the additional administrative responsibilities associated with the increased appropriation and the resulting expansion of the existing contracts.[1] As with the CAP Fund Coordinator position, DES is shouldering the personnel costs associated with the program specialist position.

DES Should Enforce Contract Provisions Regarding Performance Incentives

While DES performed well in terms of timeliness and efficiency in bringing the Program into operation, it needs to improve the contract management process. During the first year of implementation of the Healthy Families Program, DES amended some of the contracts rather than enforcing their performance incentive clauses.

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[1] Program appropriations increased from $1.7 million in fiscal year 1994-95 to $3 million in fiscal year 1995-96. DES hopes to serve 917 families in 1996-97, which is almost double the figure served in 1995-96. The number of online staff also increases from 42 to 55 at the same time.

DES typically employs a negotiated rate in reimbursing the contractor for service delivery. Generally, a negotiated rate is obtained by simply dividing the total budget dollars by the number of months in the budget period. The contractors receive this monthly payment automatically if they fulfill the obligations outlined in the contract.

For Healthy Families contracts, DES computed the negotiated rate differently, not only to ensure that the contractors enroll the number of participants as specified in the contract, but also to make sure contractors are not overly penalized for failing to meet specified enrollment rates. DES recognized that some factors, such as the birth rate and program refusal rate, are out of the contractor's control. Accordingly, 80 percent of each contractor's approved budget amount was awarded at the monthly negotiated rate. The remaining 20 percent for each contractor was awarded on a per-participant basis to encourage contractor performance in terms of participant enrollment.

However, DES failed to enforce the contracts' performance incentive clauses. Instead, when two of the contractors failed to meet the target numbers by significant margins, DES chose to amend their contracts to reimburse the full amount anyway. According to DES, mitigating factors contributed to these contract amendments; namely, unrealistic target numbers for some areas, and the need for startup time. While the total reimbursement ceiling remained unaffected, this action defeated the original intent of the 80-20 split. This resulted in a higher cost per participant than originally projected since the same amount of money was spent on fewer participants. Moreover, such actions set a bad precedent and treated unfairly those contractors who actually met or exceeded the target enrollment figures. The 80-20 split serves the dual purposes of providing contractors with sufficient monthly cost reimbursement yet retaining a portion based on performance. DES should abide by this control and continue this incentive.

RECOMMENDATION

DES should enforce the provisions of the Healthy Families' contract performance incentives.

FINDING II

HEALTHY FAMILIES PROGRAM DESIGN APPEARS SOUND

The Healthy Families Program design includes several components needed for quality home visitation service delivery. Home visitation services vary both in type and intensity for each participant; therefore, the Program must ensure staff deliver services that are appropriate for each participating family. To accomplish this task, the statewide program design attempts to ensure program quality in the following ways. First, home visitation practices comply with legislative intent. Second, a strong quality assurance component and extensive staff training work to ensure staff follow standard and approved practices for home visitation. Finally, the Program seeks collaboration with other Arizona agencies and programs to provide better coordinated and more comprehensive home visitation services. These collaboration efforts should be further strengthened and diversified.

Program Complies with Legislative Mandates for Home Visitation Services

The Healthy Families Program incorporates legislated home visitation requirements. For example, existing intake procedures and service components ensure families are appropriately enrolled, offered a broad array of services, and progress toward individual and program goals and objectives.

Intake procedure protects participant rights and privacy — Because of the sensitive and personal nature of Healthy Families service delivery, program administrators developed a comprehensive set of rules for the intake process. These rules also address the legislated intake requirements. The procedures require that initial contact and assessment respect the needs and rights of the potential participants and ensure that:

- When possible, the initial contact and assessment is conducted in the hospital.
- No contact during the intake process occurs at the potential participant's home without prior consent.
- Parents are aware of their rights and responsibilities.
- Parents are allowed sufficient time to make enrollment decisions.
- An informed consent has been obtained before service delivery begins.

Healthy Families staff are trained to appropriately perform the intake procedures. Their adherence to established procedures is further monitored through the quality assurance function. In our opinion, these steps adequately protect the potential participants' privacy and allow them to make informed enrollment decisions.

Model incorporates mandated services – The Healthy Families model incorporates the specific services required in the program legislation. DES requires program contractors to offer the following services at every site:

- Crisis intervention
- Emotional support to parents
- Teaching and modeling of parenting, home management, nutrition, child development, preventive health education, and life coping skills
- Education on child development and early identification of learning disabilities, physical handicaps, or behavioral health needs
- Bonding and attachment activities and utilization of an in-home curriculum
- Linkage to medical home for comprehensive preventive health care
- Assistance and encouragement to fully immunize program children
- Information about school readiness programs
- Use of formal and informal community resources to include referrals to job training and employment services
- Training and instruction in child care, behavioral management, and physical and emotional development
- Case management services
- Information and referral
- Transportation by Healthy Families Program staff.

Staff conducting home visits are required to document services as they are delivered to the families. This documentation, along with other required forms, provides a way to track compliance with legislated service components. If the family needs a particular service, the site supervisor or the quality assurance coordinator can make sure the appropriate service was provided. Compliance checks are also completed by the quality assurance coordinator through site visits and home visitation observations.

The Program distributes informational materials to participating families to comply with mandated service components. While many of these informational materials are recommended by the National Committee to Prevent Child Abuse, the Program incorporates locally available materials whenever appropriate. As required by the legislation, the Program also distributes the *Arizona Family Resource Guide*[1] developed by the Department of Health Services. While the informational materials distributed to the participants are meaningful and understandable, the program staff receive more specialized materials as part of their Healthy Families training. The majority of these materials were developed by the Hawaii Family Stress Center after years of research. We reviewed selected materials for both participants and staff, and found them to adequately address program needs.

Home visitation model includes plan for transitioning families — Healthy Families has developed specific criteria for moving participants along and transitioning them to a less program-dependent situation. Families who exhibit growth toward individual and program goals move from initially intensive services to services that are less frequent and necessary. As families effectively transition through the Program, they move closer to the long-term legislated goals of reducing illiteracy, reducing dependency on welfare, increasing employment, and achieving self-sufficiency.

The Healthy Families model includes four levels of service that depend on the intensity of the participants' needs. The first and most intensive level requires that the family is visited at least once a week by a Family Support Specialist (FSS). Participants in the second level require one home visit every two weeks, and the third level requires only one visit a month. The fourth level signifies "graduation" from the Program. The FSS maintains minimum contact with the participant, usually once every three months, until the child enrolls in a preschool program.

Staff move families from one level to the next based on criteria specified in the program model. Decisions to move families depend primarily on improvements in home environments, parental coping skills, parent-child interactions, identification of a support network, and meeting the child's medical and immunization needs. For instance, no occurrence of crisis situations for a month, or appropriate response to a crisis situation for a family with high child abuse potential, is considered in making the transition decision.

Although there is no fixed time for level-to-level transitions, interviews with program personnel suggest that the level of a participant's at-risk behaviors upon enrollment is a strong predictor of the program duration necessary for that participant. On average, program personnel estimate that it takes between 6 and 12 months for level 1 participants to move to level 2. They also believe that the transition from level 1 to level 2 is the hardest and most critical one for participants to achieve. This transition signifies overcoming a great motivational barrier. Once this hurdle is passed, the subsequent transitions should be easier.

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[1] *Arizona Family Resource Guide* contains a comprehensive list of agencies who provide emergency and other services for children and families.

However, the new program personnel do not yet have any direct experience with the subsequent transitions because the program is less than one year old. Based on the quality assurance coordinator's estimates, the total program length will vary between two and three years for the participants.

Quality Assurance and Comprehensive Training Helps Ensure Program Integrity

The Healthy Families Program contains strong quality assurance and training components to ensure staff deliver services as they were intended. Because the Program has a lengthy list of procedures and extensive documentation requirements, it must provide consistent monitoring and training to maintain quality services. DES administrators and the quality assurance coordinator preserve program integrity through visits to all Healthy Families sites, communication with program staff, on- and off-site problem solving, and ongoing staff development training.

Strong quality assurance component — Healthy Families Program integrity, compliance with DES and legislative requirements, and meeting nationally accepted standards are assured through a statewide quality assurance coordinator. This is a unique position that DES defined and contracted out for, along with the staff training responsibilities, to the Tucson Association for Child Care (TACC). Typically, this function would be handled at the state agency level. However, TACC can provide this service at a lower cost than DES.

The quality assurance coordinator is certified as a national trainer for Healthy Families Program staff by the National Committee to Prevent Child Abuse. She is responsible for providing adequate staff training, monitoring program data collection and recordkeeping, service delivery, and general compliance with program requirements. The coordinator has been instrumental in developing and adopting most of the program materials in Arizona. Family support specialists in Pima and Maricopa Counties consistently articulated the program goals, their responsibilities, and participants' needs. We attribute this to the Program's quality assurance function.

Staff training — DES requires each worker to receive at least 30 hours of training on the Healthy Families Program concept and implementation. Healthy Families provides compulsory initial training for all new staff, and then supplements training with a staff retreat and in-service training.

- **Initial Staff Training** — The initial training addresses topics recommended by the National Committee to Prevent Child Abuse — the leading child abuse prevention advocacy and research organization in the country. The training is intended to provide staff with the basic knowledge and expertise needed to start home visitation. This four-

day training is mandatory for all new Healthy Families workers and supervisors. A nine day training is mandatory for all supervisors.

- **Statewide Staff Retreat** – The statewide staff retreat serves two functions: a) to provide specialized and more in-depth training that staff need on certain topics; b) to allow interaction among program staff from different sites. The staff retreats are mandatory, and give employees an opportunity to interact with other staff throughout the State, and to receive specialized training and feedback.

- **In-Service Training** – Individual contracting agencies are responsible for in-service training of their staff. Healthy Families Arizona provides a general list of topics for these in-house training sessions, but recommends that the actual topics be selected based on local needs. This is the only training that could potentially differ substantially from site to site depending on the contractors' resources, access to qualified trainers, and staff development programs.

Interviews with supervisors and family support specialists indicate the training provided by Healthy Families Arizona seems to adequately address the training needs of the program staff. As the program evolves, we plan to monitor the training to determine if it continues to meet the training needs of the supervisors and family support specialists.

Collaboration Efforts Help Improve Services and Should Be Expanded

Healthy Families collaboration efforts promise to both improve service quality and to streamline Arizona's home visitation services. Collaboration and partnerships have several potential benefits including more comprehensive services for participants, sharing of expertise, less duplication of services, reduced cost, and in general, better utilization of available outside resources. We have identified three areas of collaboration where the Healthy Families Program has already made significant progress, and some others where further efforts are needed.

The Healthy Families Program has already made substantial progress in establishing some of the needed partnerships that allow sharing of resources and expertise among program personnel and the community-at-large. These partnerships help improve service quality.

- **Within-Program Collaboration** – Healthy Families fosters within-program collaboration through a Policy and Procedure Council that consists of program staff from all levels and from different sites. Collaboration within the Healthy Families Program is crucial to maintain program standards, enhance staff morale, and share expertise available within the Program. The council provides a forum for discussion on service delivery issues and recommends policies and procedures to overcome existing and potential problems.

- **Community Partnerships** — The Program has made considerable progress in setting up community partnerships that require the involvement of a broad range of entities, including people with active interests in child abuse prevention, hospitals, local businesses, and other community organizations. These partnerships provide additional resources and may occur at the contractor, regional, or state level. At the contractor level, for instance, partnerships with the local hospitals help facilitate the initial screening. Additionally, much of the in-kind contributions that are part of the individual contractors' budget have come from private donations or through local businesses. For example, the contractor in Maricopa County provided almost a quarter of the total service cost in the County through in-kind contributions. These partnerships underscore the communities' commitment to the Program as well as make the programs more cost-efficient.

- **State-Level Advisory Council** — At the state level, a number of persons from both governmental and nongovernmental agencies who are committed to preventing child abuse have formed a Healthy Families advisory council. This council brings together individuals with varying expertise and is actively involved in long-term, strategic planning for the Program.

While the Program has made progress in establishing some of the needed partnerships, more effort is needed to foster others that will help streamline services for children in Arizona as well as make them more comprehensive for the families in need. These partnerships involve collaborating with other government agencies or programs with similar or complementary goals and services.

- **Collaboration with the Department of Health Services (DHS) Programs** — Healthy Families needs to collaborate and coordinate with other community programs to effectively cater to the differing needs of its families and to streamline home visitation services. Currently, program administrators are in the process of setting up coordinated efforts with several programs run by the Department of Health Services. These programs include another Family Stability Act program — Health Start, plus the Newborn Intensive Care Program, Community Health Nursing, and Teen Prenatal Express. This will allow Healthy Families to provide a more comprehensive array of services to families with newborn children. These partnerships will be particularly relevant for the level 1 participants who have the greatest need for early childhood intervention programs.

- **Recommended collaboration with preschool programs** — As more participating families move to levels 3 and 4, Healthy Families should collaborate with programs catering to preschool children's needs. Coordination with programs such as At- Risk Preschool, Head Start, Even Start, and Family Literacy may help fulfill this need. Since transition to levels 3 and 4 will occur as early as 1995-96 for some of the participants, the Program should pursue developing partnerships with these four designated programs as quickly as possible.

RECOMMENDATION

The Healthy Families Program should continue to enhance its collaborative efforts. Specifically,

- It should continue collaborating with DHS, and set up at least one model site where it can work with select DHS programs during the Program's pilot phase.

- Healthy Families should also collaborate with programs catering to preschool children's needs. Particularly, the Program should consider developing partnerships with At-Risk Preschool, Family Literacy, Even Start, and Head Start Programs.

FINDING III

PROJECTED COSTS ARE COMPARABLE TO NATIONAL MODEL

The projected costs for the Healthy Families Program appear comparable to the available costs for the national model program in Hawaii. Using cost per family as an indicator of program costs, the first-year costs seem somewhat higher than the national model. However, when startup costs and the projected enrollment figures for a full-year implementation of the Program are taken into account, it appears that costs will become comparable to Hawaii's Healthy Start Program by the third year of operation.

The total program cost in fiscal year 1994-95 was $1.92 million. Of this total, $1.7 million came from state appropriations and the remaining $220,138 came from in-kind contributions. Ninety-four percent of the total state appropriation went to actual service delivery, while only 5 percent was spent on quality assurance and less than 1 percent was spent on data management. The Department of Economic Security provided the state-level administrative services at no cost to the Program.

Costs per Family

The State spent an average of **$3,269** per family during the first year of program implementation. State costs per family were lower than what the Program actually spent for each family. This occurred because of in-kind contributions from the contractors. Although the RFP did not specifically call for in-kind contributions, these voluntary contributions, as proposed by the contractors, were written into the contracts once the budgets were finalized. Once the in-kind contributions are taken into account, the cost per family becomes $3,693. On average, the contractors contributed more than 10 percent of per-family costs. Table 2 (see page 22) provides details of program costs, contractor contributions, and the costs per family.

Projected Cost per Family Compares Well with the National Model

The projected cost per family in Arizona's Healthy Families Program is comparable to Hawaii's Healthy Start Program. While the first-year costs were somewhat higher, after taking into account certain factors associated with the first year of implementation as well as the projected costs, the Arizona Healthy Families Program cost appears reasonable. In addition, the costs per family should decrease once the Program is better established and has a mix of participants from different levels.

Table 2

Cost per Family — Fiscal Year 1994-95

Contractor	County	Total Service Cost	State Cost	In-Kind Other Sources	Families enrolled as of June 30, 1995	Total Cost Family (Actual Enrollment)	State Cost/ Family (Actual Enrollment)
SWHD[a]	Maricopa	$ 666,151	$ 500,000	$166,151	182	$3,660	$2,747
TACC (Urban)	Pima	481,049	463,003	18,046	143	3,364	3,238
TACC (Rural)	Cochise and Santa Cruz	386,677	369,304	17,373	117	3,305	3,156
CCDPH[b]	Coconino	160,000	160,000	0	57	2,807	2,807
MJLMC[c]	Yavapai	117,772	106,252	11,520	21	5,608	5,060
TACC[d] (Quality Assurance)		102,939	95,891	7,048	N/A	N/A	N/A
Data Management Contractor		5,550	5,550	0	N/A	N/A	N/A
Total		$1,920,138	$1,700,000	$220,138	520		

[a] SWHD - Southwest Human Development
[b] CCDPH - Coconino County Department of Public Health
[c] MJLMC - Marcus J. Lawrence Medical Center
[d] TACC - Tucson Association for Child Care

Source: Auditor General staff analysis of Healthy Families Program contracts.

Cost comparison with other similar programs remains a difficult task as evaluators have, to a large extent, traditionally ignored cost-effectiveness issues in evaluating the efficacy of social programs. In the case of Healthy Families programs, only Hawaii's Healthy Start Program provides any detailed cost calculations. Additionally, the National Committee to Prevent Child Abuse (NCPCA) has recently published its own estimate of how much a program like Healthy Families should cost per family in the first year of implementation.

The first-year cost per family is somewhat high — The State spent an average of $3,269 per Healthy Families participant in Arizona, which is 16.7 percent higher than Hawaii and 9 percent higher than the NCPCA estimate. The total cost per family in the Hawaii program stands at $2,801, of which 86 percent is spent on case management and 5 percent is spent on screening and assessment. The rest is split among staff training, statewide retreat, and monitoring- and evaluation-related activities. The NCPCA estimate of cost per family, while theoretical, nevertheless provides a more realistic comparison figure since it explicitly predicts the first-year costs. According to NCPCA, the cost per family in the first year of implementation should be approximately $3,000.

Factors associated with first-year implementation should be taken into account — While comparisons with Hawaii and the NCPCA estimate are helpful in giving an idea of how expensive the Arizona Healthy Families program is when compared to similar programs in the country, it is somewhat unfair to the Arizona Program. The figures available for the Arizona program come from the first year of program implementation, which includes the following mitigating factors.

- The Program was implemented for only part of the fiscal year, which prevented some sites from fulfilling their target number of families while paying for the personnel costs. This contributed to higher costs per family because costs were allocated among fewer families.

- Nearly all the participating families in the first year needed the most intensive level of services, limiting the number that could be served by each worker. In subsequent years, an increasing mix of levels should enable each worker to serve more families.

- We used a conservative estimate of cost per family in Arizona by not including those who enrolled and later dropped out before the end of the year. Currently, we do not have good criteria for determining how long a family should remain in the Program before being considered full participants. However, if any allowance is made for part-year participation in the Program, the estimated cost-per-family will decrease.

Projected program growth will reduce costs — Once the Program is better established with full-year implementation and a mix of participants from different levels, the cost per family in Arizona should decrease and become more comparable to the cost in Hawaii as early as fiscal year 1996-97. Table 3 (see page 24) shows the projected growth in the number of families and the consequent reduction in cost per family. These projections are based on the assumptions that target enrollment numbers will be reached in subsequent years, the

family support specialists (FSS) will be able to handle higher caseloads, the predicted live birth and refusal rates will hold constant, and state appropriations between fiscal years 1996 and 1997 remain constant.

Table 3

Projected Enrollment Numbers and the State Cost per Family

Fiscal Year	Allocation in Millions	No. of FSS	Projected Enrollment	Caseload/ FSS	State Cost/ Family
1994-95[a]	$1.70	42	520	12.38	$3,269
1995-96	2.95[b]	55	917	16.67	3,218
1996-97	3.00[c]	55	1,095	19.91	2,740

[a] Fiscal year 1995 numbers are all actual.
[b] Excludes $49,476 from state appropriation that DES is yet to allocate.
[c] Not yet appropriated, projected only.

Source: Auditor General staff analysis of DES Healthy Families projection.

RECOMMENDATIONS

This finding provides information only; therefore, no recommendations are presented.

STATUTORY ANNUAL EVALUATION COMPONENTS

Pursuant to Laws 1994, 9th Special Session, Chapter 1, Section 9, our Office is required to include the following information in the annual program evaluation.

1. Information on the number and characteristics of the program participants.

Of the 607 families that enrolled in the program, this report contains demographic information on families for whom data were available. Demographic information includes the families that left the program before June 30, 1995. In general, more complete information was available on the mother of the child than on the father. Figure 2 (see page 27), portrays various participant demographic information.

- **Participants by County** – At the end of program year 1994-95, the Healthy Families Program was serving 520 families. Over 60 percent of these families came from the urban areas of Maricopa and Pima Counties. The rest came from four predominantly rural counties, Coconino and Yavapai in the north and Cochise and Santa Cruz in the south.

- **Participants by Age, Employment, and Education** – The information available on these three characteristics varies in reliability and completeness. The median age of the participating mother was 22 years. The median age of the father was 24 years. Thirty-one percent or almost one-third of the mothers were teenagers, with the youngest being just 13 years old. In contrast, less than 15 percent of the fathers were teenagers, although the youngest among them was only 15 years old.

  Information on participants' employment status and education is much less complete. In fact, no information is reported on the father's employment status or educational background due to the unreliability of the data. Most mothers in the Program (86.7 percent) reported being unemployed. In addition, of the 61 percent of the mothers for whom education information is available, 45 percent reported having graduated from high school or possessing a GED while 55 percent reported possessing neither.

- **Other Demographic Information** – As illustrated in Figure 2, the marital status and living situations of mothers participating in the Program varies widely. Almost 62 percent (61.7) of the participating mothers were single while another eight percent were either divorced or separated. However, only 15 percent actually lived alone while a majority lived with their parents, husbands, other relatives, or nonrelatives. While one-quarter (25.6 percent) of all participating mothers lived with their parents, the percentage rose to almost half (49 percent) for the teenage participants. Most

participants 30 years or older, on the other hand, tended to live alone or with persons other than their parents.

Most program participants belonged to impoverished households. Among the 309 households whose income including wages and assistance, could be determined, almost three-quarters (72.8 percent) reported annual household income, including government assistance, below $10,000 translating to a median income of only $6,656 per family. Only 11 families reported income higher than $20,000. A large number of families depended on one or more welfare benefits, most commonly AFDC, food stamps, and WIC programs. Only 13.6 percent reported having private or other insurance while over 80 percent were on AHCCCS (see Figure 2, page 27).

The ethnicity of the program participants varies; however, most are of Hispanic origin. Over 56 percent (56.8 percent) of the mothers and 57.9 percent of the fathers were of Hispanic origin. Non-Hispanic White participants accounted for 29.4 percent of the mothers and about 25 percent of the fathers. African-Americans accounted for less than 10 percent of the participants.

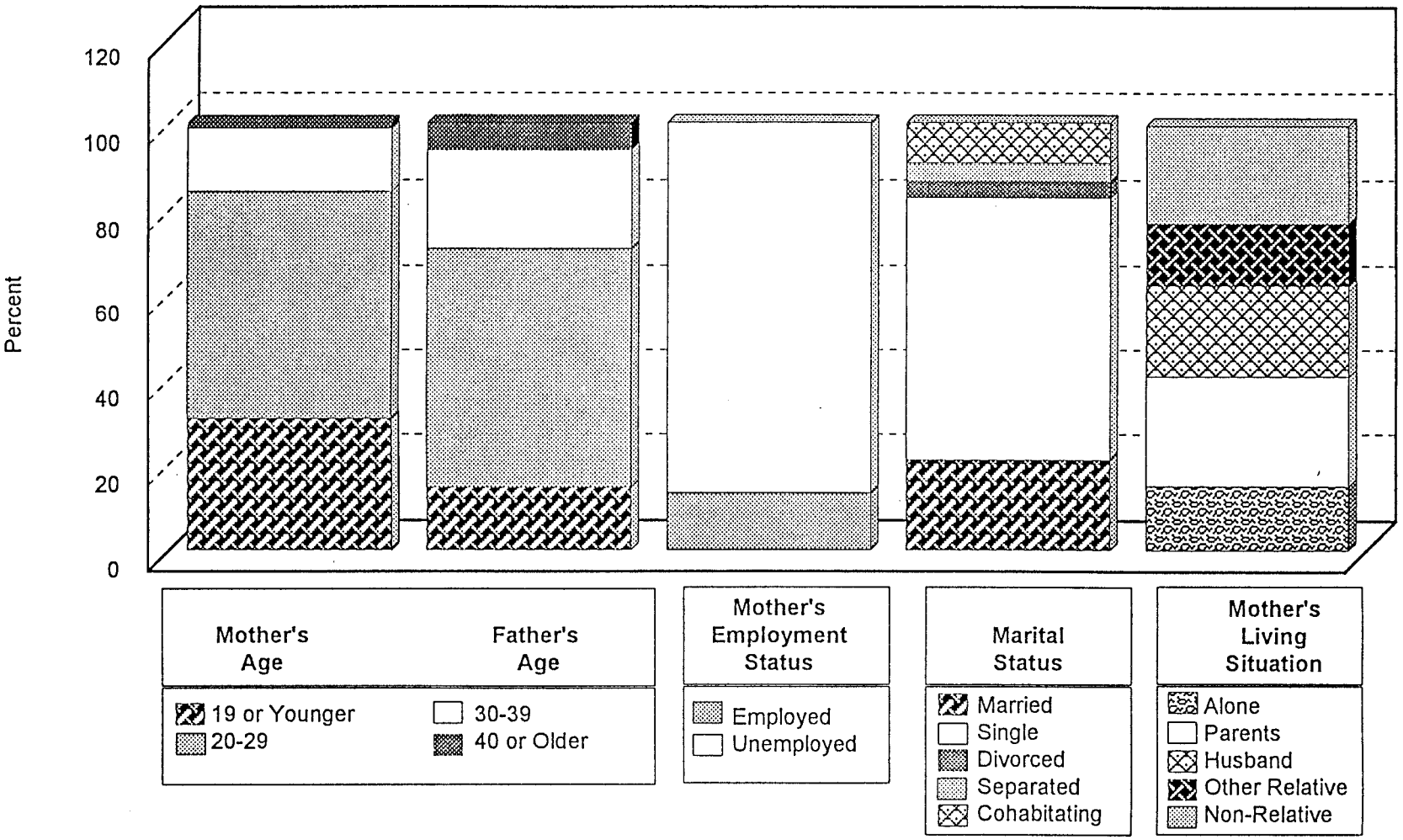
2. Information on contractors and program service providers.

DES awarded 5 contracts to serve 13 sites in 6 counties. Table 4 (see page 28) provides an overview of these contracts. One of the contractors, Tucson Association for Child Care (TACC) received two separate contracts for urban and rural sites, respectively. In both the TACC contracts, TACC acts as an umbrella organization that brings together a number of not-for-profit organizations as service providers. Their urban contract includes the cost of providing statewide program oversight through a quality assurance coordinator.

DES contracted out the database management function to a data management firm. Our Office determined that while the Program collected sufficient data, it lacked a proper database to comply with the legislative mandates. Accordingly, DES extended the existing contract with the data management contractor, to meet the legislative as well as the long-term program needs. The increase in data collection costs is reflected in the fiscal year 1995-96 budget.

Figure 2

Demographic Information on
Healthy Families Participants



Source: Auditor General staff analysis of Healthy Families participant information provided by DES Data Management Contractor.

Table 4

Distribution of Program Sites and Funding

Contractor	County	Number of Sites	Fiscal Year 1995 Budget	Fiscal Year 1996 Budget
Southwest Human Development	Maricopa	4	$ 500,000	$ 983,000
Tucson Association for Child Care (Urban)	Pima	3	558,894	799,174
Tucson Association for Cochise Child Care (Rural)	Santa Cruz	3	369,344	650,523
Marcus J. Lawrence Medical Center	Yavapai	1	106,252	136,403
Coconino County Dept. of Public Health	Coconino	2	160,000	320,096
Data Management Contractor	N/A	N/A	5,550	61,328
Total	6	13	$1,700,000	$2,950,524

Source: Auditor General staff analysis of Healthy Families program.

3. Information on program revenues and expenditures.

The State appropriated $1.7 million in fiscal year 1994-95 and $3 million in fiscal year 1995-96 for the Healthy Families Pilot Programs. Additionally, the Program received another $220,138 through in-kind contributions from the contractors in fiscal year 1994-95, raising the total program revenue to $1.92 million. For fiscal year 1995-96 the contractors have committed a total of $442,759 in in-kind contributions which will potentially raise the revenue to $3.44 million.

Of the fiscal year 1994-95 state appropriation of $1.7 million, DES spent 94 percent for service delivery and took no agency administrative cut at all. Of the remaining amount, 5.6 percent was spent on statewide quality assurance of the Program. Data management cost less than 1 percent of the total appropriation. The fiscal year 1995-96 state appropriation is $3 million. DES plans to spend over 91 percent on service delivery, 5.3 percent on quality assurance, 2 percent on data management, and 1.6 percent remains unallocated. The CAP Fund coordinator indicated that the unallocated amount resulted from conservative budgeting and could be used to expand some of

the smaller programs. She does not foresee this amount remaining unspent at the end of the fiscal year. Revenue, expenditure, and allocation figures for fiscal year 1994-95 and 1995-96 are presented in Table 5.

Table 5

Fiscal Year 1994-95 Revenues and Expenditures
Fiscal Year 1995-96 Allocations
(Unaudited)

	Fiscal Year 1994-95			Fiscal Year 1995-96		
	State Expenditures	Contractor Contributions	Total Expenditures	State Allocations	Contractor Commitments	Projected Expenditures
Service Delivery	$1,598,559	$213,090	$1,811,649	$2,730,332	$440,759	$3,171,091
Quality Assurance	95,891	7,048	102,938	158,864	2,000	160,864
Data Management	5,550	N/A	5,550	61,328	N/A	61,328
Total	$1,700,000	$220,138	$1,920,138	$2,950,524 [a]	$442,759	$3,393,283

[a] $49,476 remains unallocated from the state appropriation of $3,000,000.

Source: Auditor General Staff analysis of Healthy Families Program contracts.

4. Information on the number and characteristics of enrollment and disenrollment.

At the end of fiscal year 1994-95, Healthy Families Arizona was serving 520 participants out of the state-appropriated fund against an original target number of 585. The Program enrolled a total of 607 families. On average, 14 percent attrition occurred statewide. There was no significant difference in this rate across the State. However, the sites in Sierra Vista, Page, and Tuba City reported less than 7 percent attrition in fiscal year 1994-95. As of August 31, 1995, the latest date for which information was available, the Program was serving a total of 606 families.

Of the 87 families that terminated from the Program, 31 percent were reported to have moved and another 20 percent could no longer be contacted.

5. Information on the average cost for each participant in the program.

In fiscal year 1995-96, Healthy Families programs spent an average of $3,693 per family. Per-family costs by contractor range from $2,800 in Coconino County to $5,600 in Yavapai County. The high per-family costs in Yavapai County resulted from significantly lower than expected enrollment figures. While the CAP Fund coordinator attributes this to a lower than expected birth rate, we were unable to determine the exact causes at this time. At all other sites, the cost per family was lower than $4,000.

These figures were obtained by dividing the total program funds by the number of enrolled participants. Because the total program fund also included contractor in-kind contributions, these figures are higher than what the State actually spent per family. The State spent only $3,269 per family, a reduction of about $400 from the actual cost per family. Contractor contributions made the Program more cost-efficient from the State's perspective. Finding III (see pages 21 through 24) presents detailed cost figures for the program.

6. Information concerning progress of program participants in achieving goals and objectives.

This report does not address the progress of participants in achieving program goals and objectives. During the part-year implementation of the Program in fiscal year 1995, most participants remained in the most intensive service delivery level. The rate of progress will become clearer during the next fiscal year. Information demonstrating progress toward reduced child abuse and neglect, promotion of child wellness and proper development, strengthened family relations and family unity, and reduced substance dependency for the participating families will be available in 1996, after programs deliver services for one full program year.

Instruments that are being used to measure program participants' progress in achieving goals and objectives are described in Appendix II.

7. Recommendations regarding program administration.

Overall, the program administration was efficient and the administrative tasks at the DES level were completed in a timely fashion. At this time, we have two recommendations to make regarding program administration.

a. DES should not amend its Healthy Families contracts too frequently. Doing so may create inequity among different contractors and contribute to higher per-family costs in certain areas.

b. DES should enhance its collaborative efforts with other agencies such as DHS and ADE to provide more comprehensive services to the participants. We recognize

that at this time the Department has already made significant progress toward collaboration with DHS and encourage such efforts at all levels.

8. Recommendations regarding informational materials distributed through the programs.

The Healthy Families Program distributes informational materials in accordance with the state-mandated services. Our office reviewed selected materials related to child development, parent-child attachment, and bonding issues and found them to adequately address the program needs (see page 15). No recommendation is deemed necessary regarding informational materials distributed through the Program at this time.

9. Recommendations pertaining to program expansion.

Recommendations regarding program expansion can only be made after the programs have operated for at least the mandated period of three years and some outcome information is available.

Agency Response

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1717 W. Jefferson - P.O. Box 6123 - Phoenix, AZ 85005

Fife Symington
Governor

Linda J. Blessing, DPA
Director

December 20, 1995

Mr. Douglas R. Norton, CPA
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85004

Dear Mr. Norton:

Thank you for the opportunity to review the preliminary draft report of the first Annual Evaluation of the Healthy Families Pilot Program.

I am pleased that this report captures the tone and direction of the initial steps the department has taken to establish a Healthy Families Program in Arizona. As you are aware, the reform of Arizona's child welfare services is the department's top priority. Toward that end, the establishment of a successful Healthy Families Program is central to our prevention efforts.

Please know that the department will thoroughly and enthusiastically analyze and implement the recommendations for improvement contained in the report. Finally, the department wishes to express its appreciation to you and your staff for the time and effort invested in this critically important audit.

Sincerely,

Michael Koppelman
for Linda J. Blessing

Appendix I

Definition and Types of Child Abuse

Definition and Types of Child Abuse

Child abuse occurs when a parent or caretaker inflicts or allows the infliction of physical, sexual, or emotional abuse, neglect, or abandonment. The Child Protective Services (CPS) classifies child abuse cases into the following broad categories:

- **Physical Abuse** – Physical abuse is any non-accidental injury to a child under the age of 18 by a parent or caretaker. Non-accidental injuries may include beatings, shaking, burns, human bites, strangulation or immersion in scalding water, with resulting bruises and welts, broken bones, scars, or internal injuries.

- **Sexual Abuse** – Child sexual abuse is the exploitation of a child or adolescent for the sexual gratification of another person. It includes behaviors such as intercourse, sodomy, oral-genital stimulation, verbal stimulation, exhibitionism, voyeurism, fondling, and involving a child in prostitution or the production of pornography. Incest is sexual abuse that occurs within a family. The abuser may be a parent, step-parent, grandparent, sibling, cousin, or other family member.

- **Neglect** – Neglect is the chronic failure of a parent or caretaker to provide a child under 18 with adequate food, clothing, medical care, protection and supervision.

- **Emotional Abuse** – Emotional abuse is a chronic pattern of behaviors, such as belittling, humiliating, and ridiculing a child. Related to this, emotional neglect is the consistent failure of a parent or caretaker to provide a child with appropriate support, attention, and affection.

Causes of Child Abuse

Child abuse may occur in various situations within and outside the family. Experts have identified four levels of factors that may contribute to child maltreatment. These are 1) individual, 2) family, 3) community, and 4) culture. The Healthy Families Program aims at alleviating mainly the individual and family level factors. Some of these factors are marital conflict, decreased family cohesion, lack of intellectual and recreational activities, deficient parenting skills, and in general, an above-average negative adult-child interaction pattern. Studies have also identified these factors to be intergenerational in nature. For instance, parents with a childhood history of abuse report more family conflicts than those without.

Appendix II

Outcome Evaluation Instruments

Pursuant to the legislative mandate the Office of the Auditor General is required to report on the Program's impact on family unity, child abuse, child development, and welfare dependence in the final outcome evaluation due in December of 1997. Accordingly, in collaboration with program personnel, we have selected the following instruments which capture most of these constructs. For impact on welfare dependence, we are negotiating with the Department of Economic Security for instituting a tracking mechanism across some major databases that maintain welfare recipient data. For the other factors, the following instruments have been selected for use with the Program.

Instruments

Family Unity
Family Adaptability and Cohesion Evaluation Scale II (FACES II)*
Authors: David Olson, U. of Minnesota; Volker Thomas, Purdue University

FACES II is a self-report instrument designed to measure both perceived and ideal family function. This is accomplished by measuring two key constructs - *family cohesion* and *family adaptability.*

There are two separate sub-scales for the two constructs. Each subscale consists of 10 items. The cohesion subscale (alpha = .77) is more reliable than the adaptability subscale (alpha = .62). Items follow a 5-point Likert scale ranging from almost never to almost always.

FACES II is usually administered to both parents and adolescents in a family. In the context of Healthy Families, the instrument could be administered to the parents only. This instrument will be fast and easy to use and will not require extensive training for the home visitors.

Note: FACES III, the latest version that we reviewed, was not commercially available at the time the instrument was selected. The authors recommended using FACES II which, they assured us, will function the same way as FACES III.

Home Environment
Home Observation for the Measurement of the Environment (HOME)
Authors: Bettye M. Caldwell & Robert H. Bradley, University of Arkansas

HOME is a widely used observation and interview instrument that measures some key elements in a child's home environment. Different forms are used for three different age groups — 0-3 years (infants & toddlers), 3-6 years (preschoolers), 6-10 years (elementary school age). Healthy Families Arizona uses only the first one meant for infants and toddlers. The 0-3 years form consists of six subscales measuring the following six factors of home environment — 1) Emotional and verbal *responsivity* of parent, 2) *acceptance* of child's behavior, 3) *organization* of physical and temporal environment, 4) provision of appropriate *play materials*, 5) parent *involvement* with child, and 6) opportunities for *variety* in daily stimulation.

Apart from the measurement needs, this instrument allows the assessment workers to identify areas of home environment that need strengthening or improvement. As a measurement instrument it allows comparison with the FACES II, which is a self-report instrument.

Child Abuse Potential
Child Abuse Potential (CAP) Inventory
Author: Joel Milner, Northern Illinois University

CAP Inventory (Form VI) is a self-report physical child abuse screening device. The inventory contains a total of 160 items in a dichotomous, agree/disagree format. Of these, 77 items form a physical child abuse scale. The scale has a third-grade readability level.

The physical abuse scale contains six descriptive factors: *distress, rigidity, unhappiness, problems with child and self, problems with family,* and *problems from others.* The CAP Inventory also contains three validity scales: a *lie* scale, a *random response* scale, and an *inconsistency* scale. The validity scales are used in various combinations to form three response distortion indices: the *faking-good* index, the *faking-bad* index, and the *random response* index.

The author reports that the inventory has been successfully employed to evaluate child abuse prevention programs. In one of the larger studies involving several sites, the National Council on Prevention of Child Abuse used this instrument and found significant decreases in abuse scores from the pre-intervention period to the post-intervention period.

Child Development
Ages and Stages Questionnaire (ASQ)
Authors: Jane Squires, LaWanda Potter, Diane Bricker, University of Oregon

ASQ is a parent-completed child monitoring system. The questionnaire can be administered 11 times, until the child turns 4. However, depending on program needs it can be administered fewer times. After assessing the Program and evaluation needs of Healthy Families Arizona, we decided to use the questionnaire 8 times.

Each administration time has a corresponding set of developmentally appropriate questions. The questionnaire addresses the following five areas of child development: 1) Communication, 2) Gross Motor, 3) Fine Motor, 4) Problem Solving, 5) Personal-Social. In addition, an *overall* section asks about general parental concerns.

ASQ is not a diagnostic tool. It can be used to identify developmental delays, but once detected, the child needs to be assessed with a diagnostic instrument by a trained professional. However, research shows the ASQ to have strong correlations with established diagnostic instruments.

The fact that the instrument can be used only to identify problems but not to diagnose them, serves the Healthy Families Program's needs well. The family support specialist can refer the identified child to a professional for further assessment.