

The Massachusetts Healthy Families Evaluation-2 (MHFE-2):

A Randomized, Controlled Trial of a Statewide Home Visiting Program for Young Parents

Final Report to the Children's Trust of Massachusetts
Executive Summary



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Executive Summary



The Massachusetts Healthy Families Evaluation (MHFE-2) is a longitudinal evaluation of Healthy Families Massachusetts (HFM), a universal home visiting program for adolescent mothers across the state. The program's specific focus on adolescent parents is unique within the multi-site home visiting world, making the findings from this present study particularly noteworthy. MHFE-2 encompassed many complementary data collection methods, framed within a rigorous randomized controlled trial (RCT) design, in which eligible mothers were randomly assigned to receive HFM services or to receive service referral and parenting information only. This method enabled us to determine, with confidence, how HFM affects young mothers across a range of outcomes. Detailed information about program quality and utilization, and participants' experiences with the program, were also collected and presented within the Final Report.

This Executive Summary highlights key elements of MHFE-2. Its primary focus is on the major findings that emerged, both related to program operations and impacts; in addition, a brief summary of study methods and design is included. This document is meant primarily for a policy and program audience; readers with a greater appetite for technical detail are invited

to read the full report.

This summary first provides a brief overview of the program (HFM) and the evaluation (MHFE-2), to set the background for the findings and implications that follow. Next, we review key evaluation findings related to program operations and impacts, highlighting those most salient for policy and practice. The summary concludes with implications and opportunities for HFM specifically, the home visiting field more generally, and other services that intersect with home visiting programs, as well as areas for future research and exploration.

Healthy Families Massachusetts (HFM) HFM is a statewide, comprehensive, voluntary, newborn home visiting program for all first-time parents ages 20 and under. An affiliate of *Healthy Families America* (HFA), HFM provides parenting support, information, and services to young parents via home visits, goal-setting activities, group-based activities, secondary contacts (i.e., phone calls), and referral services. The program's stated goals are to:

1. Prevent child abuse and neglect by supporting positive, effective parenting;
2. Achieve optimal health, growth, and development in infancy and early childhood;
3. Encourage educational attainment, job, and life skills among parents;
4. Prevent repeat pregnancies during the teen years; and
5. Promote parental health and well-being.

Although there are Healthy Families affiliates in 40 states, HFM remains the only statewide implementation of that model that specifically targets adolescent parents. Since its inception in 1997, HFM has provided services to more than 33,800 young families.



The Massachusetts Healthy Families Evaluation (MHFE-2)

MHFE-2 followed a sample of approximately 700 mothers and their children from 2008 through 2012. It employed a RCT design for its impact component, collecting and analyzing data from two comparable samples of these families: one that was offered HFM home visiting services and one that was not. The evaluation sought to answer the following key research questions:

- How do those mothers enrolled in HFM utilize program services?
- To what extent do programs operate, and do participants utilize services, as intended by the HFM model?
- Is program dosage associated with outcomes?
- What is the nature of the home visitor-mother relationship?
- Does participation in HFM yield positive effects in the five HFM goal areas?

The MHFE-2 study was framed by Jacobs's Five-Tiered Approach to evaluation, a developmental model that moves evaluation activities from a primary focus on descriptive and process-oriented information at the earlier tiers to an emphasis on program effects in the latter ones.¹ MHFE-2 employed a mixed-methods approach; the data presented in this report were collected at three time points—one month post enrollment, 12 months post enrollment, and 24 months post enrollment²—from

a variety of sources, including open- and closed-ended interview questions; standardized, validated measures; home-grown surveys; and observations of parent – child interactions. In addition, the MHFE-2 team had access to comprehensive data from HFM (from the Participant Data System; PDS), state agency, and population-level (i.e., 2010 U.S. Census).

MHFE-2 participants were recruited through the combined efforts of HFM local and state personnel and MHFE-2 researchers at Tufts University. Eligibility requirements for participating in MHFE-2 included being a consenting female of at least 16 years of age, having not received any HFM services in the past (i.e., no transfers or reenrollments), being an English or Spanish speaker, and being cognitively able to provide informed consent. Eligible women who consented to the study were randomly assigned to either the treatment group (Home Visiting Services; HVS) or the control group (Referral and Information Only; RIO). In total, 704 participants enrolled in the study, of whom 433 (62%) were assigned to the HVS group, and 271 (38%) to the RIO group.

We used an Intent-to-Treat (ITT) approach for determining main program effects. This means that once mothers were assigned to the HVS (Healthy Families) group or the RIO (non-program, control) group, their assignment held—regardless of whether, for the HVS group, the mothers actually ended up receiving home visiting services. Indeed, about 14% of the mothers in that HVS group never did. While tempting to exclude these mothers from our analyses, that approach would invalidate the RCT design, as it is likely that the women who did not take up any, or took up few, home visits are somehow different from those who did participate. Including all participants in the outcomes analyses, regardless of whether they actually received the service, ensures that the main effect findings are robust and reliable.

Methodological highlights of MHFE-2 include:

- Data on a large sample of adolescent mothers;

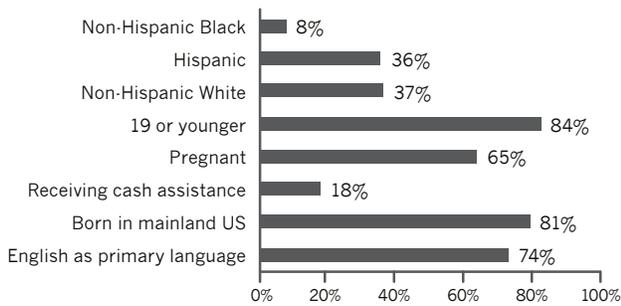
- A randomized controlled trial (RCT) longitudinal design;
- Multiple data collection methods;
- Mixed analytic approaches: qualitative and quantitative;
- A broad range of program and state agency data;
- Novel methods of measuring program utilization, program fidelity, and home visitor-mother relationships; and
- An Intent to Treat (ITT) analytic approach to detecting program impacts.

- More than one half had childhood history of maltreatment;
- More than one third were clinically depressed;
- High incidence of lifetime trauma (average of three traumatic events); and
- High rates of intimate partner violence in relationships, both as victim and as perpetrator (approximately 3.5 acts per year, on average).

Characteristics of the MHFE-2 Sample

Figure ES1 provides a description of key demographic characteristics of participants at enrollment.

Figure ES1. **Demographics of Participants at Enrollment**



The MHFE-2 sample comprises first-time mothers under 21; the average age of mothers at enrollment was 18.6, and as shown in Figure ES1, the overwhelming majority was 19 or younger. This is significant because adolescent parents are simultaneously managing the difficult transitions to both adulthood and parenthood in the context of challenging life circumstances, which may demand different and additional approaches to programming. Mothers’ challenging life circumstances at enrollment included:

- High rates of residential instability (average of two moves in the past year);

Key Findings: Program Operations

Despite the implicit assumption that an evidence-based model will operate true to its design, it rarely does. For example, most home visiting evaluations find that participants discontinue services well before the recommended duration, and receive far fewer home visits than deemed optimal.³ Documenting in detail how the home visiting program is operating, then, is crucial, both as a precursor and complement to the assessment of program effects.

Our evaluation investigated the extent to which the program was being implemented as intended, described how participants utilized and experienced HFM services, and analyzed the relations among different aspects of program operations, the associations with maternal characteristics, and the ways in which program use relates to outcomes.

It is important to note that all of these analyses focused solely on the HVS group, and therefore fall outside of the RCT; in other words, none of the associations described here can be interpreted as causal.

How do MHFE-2 participants assigned to the HVS group utilize HFM services?

On average, mothers enrolled in the program for nearly 15 months and received 24 home visits.⁴ Mothers exhibited an extremely wide range of utilization, staying in the program anywhere from less than 1 month to 46 months, and receiving from 0 to 118 visits.

Approximately 58% of HVS participants received fewer

than 18 home visits, including 30% who received fewer than 5 home visits, and 14% who did not receive any home visits at all.

Secondary activities (i.e., non-visit activities conducted by the home visitor or HFM staff with, or on behalf of, the participant) were reported 62 times per mother, on average (median = 43). The vast majority of secondary activities had content related to issues of enrollment/engagement (10%) or scheduling of visits (38%), and attempted visits that did not happen (10%). Only 16% of secondary activities—10 activities per mother, on average (median = 4)—could be described as substantive, in which mothers verbally connected with their home visitors about something other than scheduling.

Based on characteristics at enrollment, mothers who were less active in HFM (based on the number of home visits received) enrolled postpartum, were less likely to live with an older relative or guardian, were less residentially and financially stable, were more likely to receive public programs since pregnancy, notably food stamps, and were less likely to be depressed at enrollment.

Although HFM uptake varied considerably, with a sizable proportion of the evaluation sample receiving no, or only a few, home visits, analyses of secondary activities revealed evidence to suggest that substantial effort was being made by home visitors to connect with mothers, including some who may not have been interested in participating at all or only for a short period of time. These findings are in line with utilization findings other home visiting evaluations have been reporting for the past two decades.⁵ That the potential HFM participants are adolescents probably compromises utilization figures even further. We see here a pattern in which mothers' low utilization seems to signal both strengths *and* vulnerabilities. On the one hand, mothers who failed to engage with the program were less residentially and financially stable. On the other hand, mothers who used less of the program were less depressed, and perhaps more self-sufficient, at least based on the degree to which they are already hooked

into services and supports, such as food stamps.

To what extent do programs operate, and do participants utilize services, as intended by the HFM model?

Our program-level fidelity index provides a broad overview of how faithfully HFM programs were *implementing* services at the time of data collection. Program-level fidelity was quite high, on average, and the range of program-level fidelity scores was quite narrow. In terms of individual-level fidelity—the way that mothers actually used the program—on average, mothers met about half of the indicators, and the scores ranged considerably. Mothers were more compliant with the HFM model for indicators related to initial exposure (i.e., implementation), than they were with indicators related to overall exposure (i.e., utilization). *Fidelity* generally is defined as the extent to which an intervention is implemented as intended by its designers. Considering that HFM is being implemented by multiple types of agencies across a state with considerable geographic and demographic diversity, the fact that such a high, invariant degree of fidelity has been achieved across programs is laudable, and unusual in a statewide initiative. There is a great deal of flexibility built into the HFM model; the expectation is that the home visitor will work with each participant to establish goals, settle on a service delivery plan, and adjust home visit content and schedule in both anticipation of, and reaction to, the participant's needs. It is perhaps not surprising, then, that when you look at utilization at the individual level, a radically different story of engagement and adherence emerges. What these data suggest is that even a program operating at considerably high standards may not consistently engage its target population.

Is program dosage associated with outcomes?

An examination of the associations between dosage (i.e., the number of home visits HVS mothers received) and program outcomes revealed similarly mixed results, with more dosage associated with both maternal strengths and vulnerabilities. (Main program effects—i.e., differences between HVS and RIO mothers—on the outcomes

related to the five HFM goal areas are discussed in the following section.) In sum, mothers who received more home visits were:

- Less likely to be reported to DCF for child maltreatment,
- More likely to use birth control,
- Less likely to have a repeat pregnancy, and
- More likely to report being a victim of inter personal violence.

What we can conclude from the analysis examining program dosage with outcomes—as we would from any correlational analysis—is that there is a relation between number of home visits and some outcomes, but that we cannot necessarily predict the *direction* of the association (e.g., does receiving more home visits result in better outcomes, or do women with better outcomes take up more home visits?); nor do we know if another variable is driving this association. It is likely the case, for instance, that some mothers may be better able to stay on course with the program and receive proffered services, and subsequently achieve more favorable outcomes. On the other hand, home visitors probably work harder to engage and serve young women who are faring poorly at enrollment, which may result in worse outcomes sometimes being observed among women with more home visits, even if they demonstrate relative improvements over time. The same argument can be made for women who leave the program early: It may be a signal of strength or vulnerability, and in the case of the child maltreatment outcome, whether women stay or go could be directly related to the outcome in question.

What is the nature of the home visitor-mother relationship?

The great majority of participants viewed their relationships positively. In-depth analyses of home visitor-mother relationships revealed that mothers' impressions of their home visitors fell into four relationship profiles, three of which were largely positive:

Positive Friend: characterized by closeness,

comfort, familiarity, informality, compatibility, expertise, but also authority and boundaries;

Positive Family Member: characterized by emotional investment, caring, closeness, support, availability, directness;

Positive Professional: characterized by understanding, support, acceptance, flexibility, listening; and

Negative Primarily Professional: characterized by disagreements, lack of flexibility, disinterest, appearing judgmental.

Relationships in each of the positive profiles—Friend, Family Member, and Professional—seemed to strike a balance between emotional intimacy and what is generally considered acceptable professional distance, but each in a unique way. In contrast, mothers in the Negative Professional profile reported major “disconnects” that were sometimes intensified because other relational qualities or characteristics of the home visitor (e.g., the home visitor's skill at relating to the mother, her expertise and her ability to communicate it to the mother) were lacking. Not surprisingly, mothers in the Negative Professional profile received significantly fewer home visits than mothers in the other relationship profile groups.

Mothers across the relationship profiles were quite similar to one another, with a few noteworthy exceptions. Most strikingly, close to 60% of the mothers in both the Negative Professional and Positive Family Member profiles scored above the clinical cutoff for depression; this rate was nearly double that of the Positive Professional profile and nearly triple that of the Positive Friend profile. None of the four profiles stood out in terms of consistently achieving more favorable parenting and child outcomes.

The most commonly cited reason for remaining engaged in the program over time was mothers receiving useful help, followed by the belief that HFM was a good

program, mothers liking their home visitors, and finally, feeling that the program could be a future source of support for them. Participants attributed reasons for their discontinuing services to personal issues, the program's structure or content, qualities of their home visitors, or a combination of home visitors and personal reasons.

The great majority of participants viewed their relationships positively, including those who characterized their home visitors' posture as professional. The range of mothers' positive experiences of their relationships with their home visitors suggests there is no one "right" type of home visitor-mother relationship, but rather a wide range of relational styles that can work, with certain dyads, under certain conditions.

Key Findings: Program Impacts

A primary goal of this evaluation was to understand whether HFM was effective at achieving its five stated goals. To that end, analyses were conducted to see whether the intervention group (HVS) was significantly different from the control group (RIO) on a variety of indicators within the goal areas.

Results revealed that HFM had impacts on development in areas that are particularly relevant to adolescents, and especially to adolescent parents.

There are several facts about adolescent development that help to frame the findings below.

- Compared to older mothers, adolescent mothers are more likely to report unrealistic expectations regarding the needs of their children, and exhibit less supportiveness and positive regard toward their infants.⁶
- Adolescence often is marked by increases in problem behavior following the onset of puberty. Problematic behaviors typically begin to decrease around 17 or 18 years of age. However, preexisting problems may be

accentuated for adolescents during times of transition or change.⁷

- The prefrontal cortex—the part of the brain responsible for critical planning, problem solving, and emotional regulation functions—is still developing during late adolescence and early adulthood. It may be particularly challenging for adolescents to resist the impulse to engage in risky behaviors, at a time when the potential impacts of, for example, substance use can have a particularly deleterious impact on brain development.⁸
- On the other hand, the fact that individual development is proceeding apace during adolescence underscores the opportunities to promote positive adaptation and growth.

Does participation in HFM yield positive effects in the five HFM goal areas?

Goal 1: Prevent child abuse and neglect by supporting positive, effective parenting. Although HVS and RIO mothers were no more or less likely to be reported to DCF for maltreatment, HVS mothers were more likely to be identified as a perpetrator of maltreatment in substantiated cases than mothers in the control group (RIO). Our findings underscore the *preventative* role home visitors may play as observers of early parenting behavior, with home visitors filling a crucial gap in the detection and prevention of child maltreatment. That is, an extra set of "eyes and ears" in the home probably made it more likely that HVS mothers' worrisome behaviors, which may have been subtle and hard to detect outside of the home, were flagged early on. This surveillance hypothesis was supported by additional subgroup analyses demonstrating that, among mothers with riskier behaviors, those in the HVS group were more likely than those in RIO to be reported to DCF.

Mothers in the treatment group (HVS) exhibited fewer negative parenting attitudes and behaviors than mothers in the control group (RIO). Notably, HVS mothers

were less likely to report parenting stress than were RIO mothers. Further, maternal reports of corporal punishment—both attitudes and actual behavior—were lower among some subgroups of HVS mothers compared with RIO mothers, including mothers with higher exposure to traumatic events, young women who enrolled while parenting, and non-Hispanic Black mothers. HFM, therefore, provided early support to mothers to help them reduce their negative parenting attitudes and behaviors, which could lead to improved maternal and child well-being, including declines in child maltreatment, down the road. The whole of these parenting findings are important, particularly when considered in the context of the adolescent sample, the obstacles they face as parents, and the promise early supports may offer.

Goal 2: Optimal health, growth, and development in infancy and early childhood. No program effects were found for outcomes in this goal area, including language development, behavioral problems, and birth outcomes, for the full sample.

The lack of impacts on target children must be considered alongside the fact that all mothers—regardless of whether they received home visits or not—were eligible for universal health coverage and insurance in Massachusetts, which may have provided sufficient support for very young children’s health and well-being. There was not much variability between children of mothers in the HVS and RIO groups on some of the outcomes examined in the evaluation, particularly in terms of newborn health. In the present study, we know that mothers were involved with HFM for 15 months, on average—with significant variability around this average—thereby curtailing the home visiting support when their children were very young, and before the potentially challenging toddler years. As part of our ongoing longitudinal study of this participant sample (see Endnote 2 below), we will have the opportunity to investigate a fuller panoply of child outcomes, as well as to further examine other early childhood services mothers have since used as a result of their participation in HFM, and how the full package of

supports mothers have received since pregnancy has affected their children’s well-being.

Goal 3: Encourage educational attainment, job, and life skills among parents. Mothers in HVS were more likely than RIO mothers to have finished at least one year of college (17% vs. 10% for HVS and RIO, respectively). HVS mothers who self-identified as Hispanic were less likely to graduate high school or receive a GED than were Hispanic RIO mothers. No program effects on employment were found.

The finding that HFM mothers were more likely to attend college, a first among randomized controlled trials of Healthy Family America affiliates, is particularly exciting, given the age of this population. Although the percentage of women who attended college was small across the sample (14%), HVS mothers were 1.7 times as likely as RIO mothers to do so, which may have important implications in the future. Given a rising demand and premium for skilled workers, this finding is one to watch to see if first-year college attendance yields better educational and employment outcomes in the future.

Goal 4: Prevent repeat pregnancies during the teen years. Mothers in HVS were more likely than mothers in RIO to use condoms. Among women who were older at birth and self-identified as non-Hispanic Black, HVS were less likely than RIO to have a repeat pregnancy, and among women who enrolled postpartum, HVS were less likely than RIO to have a repeat birth.

With the exception of condom use, the program had no impacts for the full sample on reproductive health outcomes related to birth and future pregnancy. The increases in condom use among HVS participants, as well as being a finding related to reproductive health, could also be interpreted as a decrease in risky behavior (i.e., unprotected sex). From this standpoint, the finding on condom use aligns nicely with the findings reported for the Goal 5 area (see below). It is difficult to surmise what led to the decrease in subsequent pregnancies or births among only certain subgroups of mothers; further

analyses of these data, as well as additional data being collected as part of the longitudinal MHFE-2-EC, will allow us to develop a deeper understanding of these interesting patterns.

Goal 5: Promote parental health and well-being.

Compared to mothers in RIO, mothers in HVS reported that they were less likely to engage in risky behavior, use marijuana, and perpetrate intimate partner violence. HVS mothers who had experienced more trauma, had higher levels of depression, and self-identified as non-Hispanic Black were less likely to smoke than RIO mothers with the same background characteristics. These findings suggest that in the midst of significant changes in these young women's lives (i.e., becoming parents), HFM was able to help participants manage their risky behaviors and begin an appropriate, more stable, transition to parenthood. Mothers' ability to manage and rein in impulsive and potentially harmful behaviors should have long-lasting effects on their own achievements, as well as on their children's health and well-being.

Implications and Opportunities

Implications are discussed in far more detail in the final chapters of the report. Here, we very briefly summarize some observations/recommendations related to HFM program operations, and its relationship to other organizations and agencies.

Recommendations for Program Practices

Consider prioritization of program goals.

HFM supports program goals in five areas of child and adolescent functioning: positive parenting, infant and toddler development, maternal health and well-being, educational attainment and employment, and family planning. On the one hand, these goal areas reflect the inextricably interconnected, core aspects of life within the young families the program serves. On the other hand, the sheer breadth of these goal areas creates challenges, both for the program and its evaluators. It simply is not reasonable to expect that all five goal

areas will be equally salient, or achievable, to all participants at all times. Our data suggest a number of possibilities regarding goal achievement: It may be that success in one area tempers or delays success in another; it may be that success in one area is dependent on success in another; it may be that certain goals are important primarily to the program, and not to the participants themselves; and it may be that some goals require a longer duration in the program, or different timing of enrollment, than do others. A more explicit recognition of this tension among the goal areas—that some objectives may be more important, or may need to be accomplished before others are likely to be—may help HFM clarify expectations about what would constitute a “success” for each participant.

Revisit eligibility requirements in certain circumstances.

In light of the adolescent population HFM serves, we suspect that there are gains to be made by critically reviewing several of the program's current eligibility requirements. HFM policy states that new mothers must enroll before their babies turn one year old, but it may be that mothers who rejected HFM initially, or were not residents of Massachusetts during their babies' first year would greatly profit from the program once their children are more active, rapidly developing language, and becoming more assertively themselves. This could happen when the babies become 18-month-old toddlers or even two-year-olds, and their mothers have matured as well. Might HFM consider a smaller initiative that includes those mothers, who would otherwise be excluded? Relatedly, although the vast majority of participants left the program before their children turned three years of age (the age limit for HFM), about 15% did so because their children graduated from the program. Graduation is something to be celebrated, and indeed HFM appropriately makes much of these young mothers' successes. On the other hand, these eager consumers of the program, some of them still teenagers, might well benefit from, and probably would make good use of, a modest amount of continuing support.

Preserve home visitor-mother relationship in the context of participants' moves.

Our data suggest that residential instability is a critical challenge for many young mothers, who then cannot, or choose not to, maintain regular HFM participation. Many HFM home visitors already go to extraordinary lengths to keep these mothers enrolled. Might these efforts somehow be formalized, with HFM establishing a specialized arm of the program for these mothers, offering them the opportunity to drop in and out, perhaps use different forms of contact, even maintain initial home visitor continuity if they move out of the initial program's catchment area?

Focus less on initial engagement, and more on the re-engagement, of participants.

Two of our program findings taken together, (a) that home visitors invest a great deal of time attempting to find, enroll, and reach participants who may never be fully involved, and (b) that even the most engaged adolescents are likely to drop out of the services for a while, suggest that HFM may want to experiment with relaxing a few of those standards related to initial engagement. This would free up more time for home visitors to work with families who have already demonstrated both the willingness and ability to more fully engage.

Experiment with structural changes that may encourage longer participant engagement.

There are many possible approaches to lengthening participants' tenure, most of which HFM is well aware. Still, we offer two here as illustrative options:

A more varied menu of service modalities. The HFM home visit, as the program's core service, has demonstrated its effectiveness in a number of goal areas, and should remain in its central position. At the same time, however, it might prove worthwhile to more formally endorse/enable wider use of other forms of communication, ubiquitous with today's youth, such as Skype, FaceTime, chatting, texting, and even email

for maintaining contact and providing services. Securing participants free calling cards or facilitating access to tablets or laptops might allow for continued engagement of mothers who would otherwise discontinue services.

Concerted effort to reduce home visitor turnover.

Home visitor turnover is implicated in some mothers' decisions to cease program participation; in these cases it is the relationship with that particular home visitor, rather than with the local program, that is the key. Of course home visitors should be allowed the choice to leave their positions; we also note, however, the challenging (though obviously satisfying) nature of the job, its relatively low pay, and the relative lack of a career ladder within this field, and suggest that there may be steps yet untaken to stabilize the home visiting workforce.

Implications for HFM Within Communities and Across Sectors

HFM cannot be expected—nor should it expect—to solve the problem of child maltreatment on its own, but as a well-tooled, well-received, effective home visiting program for young mothers, it can join forces with others in communities to make its mark felt more considerably. The challenge here is to generate bold and innovative approaches across service systems; in our view, HFM is well up to that task. We offer the following thoughts.

Claim, and maintain, a “seat at the table.”

The potential cross-agency policy implications of this research are numerous, and beg for collaborations at the state and federal levels of government as well. We note the increasingly vocal chorus of policymakers, program managers, citizens, and youth themselves who believe that developing and maintaining positive relationships is a critical component of successful living for all teens and young adults. Initiatives of this nature in the fields of juvenile justice, domestic violence prevention, child welfare, and secondary education, to name a few, are evidence of this wise approach. Given its expertise with a diverse population of young mothers, HFM has much to contribute to this conversation.

Continue to advocate for funding, programming, and public policy change, particularly in those policy areas most salient to the HFM population.

The success of HFM could be greatly enhanced by policy development in three arenas critical to these young families, namely housing, child care, and public support for college attendance. Admittedly, new public policy initiatives to benefit vulnerable children and adolescents are rarely popular, even less so in the current political climate. Yet it is unlikely that HFM participants and their peers will make the advances necessary to secure their own and their children's futures without a more coordinated, integrated, and yes, generous public investment in this hopeful, early developmental period of their lives—as infants, parents, and young families.

Conclusion

Results from this evaluation suggest that HFM is able, in some significant and critical ways, to help a teenage parent population navigate what can be a fairly tough time of transition. In this regard, HFM is a quintessentially preventive program, working with populations on the cusp—infants moving through early development, new families being formed, and young parents working to establish themselves as adults and caregivers—in contexts that often are extremely challenging. The idea that one home visiting program would be sufficient to “fix” the problems these families encounter represents overreaching to some considerable extent. And yet, as part of a more cohesive community strategy to help young families, home visiting has the potential to be a powerful family support tool. It is hoped that results from this and other home visiting evaluations will further this critical conversation.

Endnotes

¹ Jacobs, F. H. (2003). Child and family program evaluation: Learning to enjoy complexity. *Applied Developmental Science, 7*, 62-75.

² As a result of continued support by the Children's Trust, and a grant from the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), we have been able to add two more data collection time points to our study: approximately 4.5 years post-enrollment, and 5.5 years post-enrollment. The final report for this longitudinal study, entitled Massachusetts Healthy Families Evaluation-2-Early Childhood (MHFE-2-EC) is slated to be com-

plete by September 30, 2016.

³ Boller, K., Daro, D., Del Grosso, P., Cole, R., Paulsell, D. Hart, B., Coffee-Borden, B., Strong, D., Zaveri, H., & Hargreaves, M. (2014). *Making replication work: Building infrastructure to implement, scale-up, and sustain evidence-based early childhood home visiting programs with fidelity*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. Princeton, NJ: Mathematica Policy Research.

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⁴ The median values were 10 months and 14 visits, respectively.

⁵ Boller et al., 2014

⁶ Brooks-Gunn, J., & Furstenberg Jr., F. F. (1986). The children of adolescent mothers: Physical, academic, and psychological outcomes. *Developmental Review, 6*(3), 224-251. doi:10.1016/0273-2297(86)90013-4

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⁷ Bongers, I. L., Koot, Hans M., van der Ende, J., & Verhulst, F. C. (2003). The normative development of child and adolescent problem behavior. *Journal of Abnormal Psychology, 112*(2), 179-192.

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⁸ For more details, see <http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/teen-brain.pdf>

