

EVALUATION OF CLIENTS' PERSPECTIVES
ON THE H.S. PROGRAM

A Thesis

Presented to
The Faculty of the Department of Psychology
The College of William & Mary in Virginia

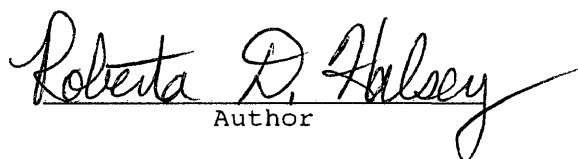
In Partial Fulfillment
Of the Requirements for the Degree of
Master of Arts

by
Roberta D. Halsey
1995

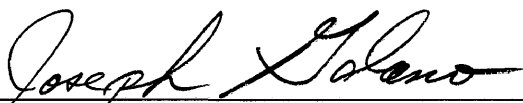
APPROVAL SHEET


This thesis is submitted in partial fulfillment of
the requirements for the degree of

Master of Arts


Author

Approved, August 1995


Dr. Joe Galano, Ph.D
Chair


Dr. Lee Huntington, Ph.D

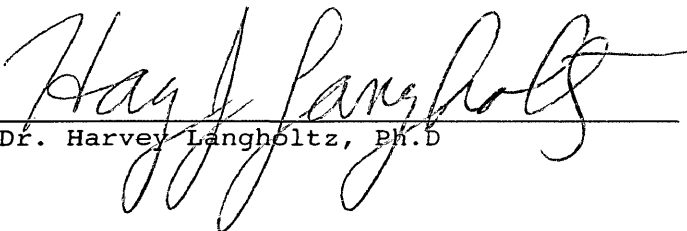

Dr. Harvey Langholtz, Ph.D

TABLE OF CONTENTS

	PAGE
ACKNOWLEDGEMENTS.....	iv
LIST OF TABLES.....	v
ABSTRACT.....	vi
INTRODUCTION.....	2
METHOD.....	19
RESULTS & DISCUSSION.....	28
SUPPORT RESULTS.....	30
NURTURE RESULTS.....	39
FUTURE RESULTS.....	44
ADDITIONAL HYPOTHESES.....	49
CONCLUSIONS & RECOMMENDATIONS.....	55
OVERALL CONCLUSIONS.....	55
ISSUES FOR CONSIDERATION.....	58
SCIENTIFIC VS. CLIENT-FOCUSED.....	62
REFERENCES.....	66
TABLES.....	69
APPENDICES.....	85
VITA.....	102

Acknowledgements

I wish to express my appreciation to Dr. Joe Galano and Dr. Lee Huntington for their guidance, patience, and help during this study. I extend sincere thanks to Dr. Harvey Langholtz for taking the time to read and criticize this manuscript. I would also like to thank Dr. Kelly Shaver for his help and encouragement during my second year at William & Mary.

I want to extend my thanks to the Healthy Start administrators and family social workers who helped me during this project. I also want to extend special thanks to Diane, the administrative assistant at Healthy Start, for all her help with the little details.

Finally, I wish to express my appreciation and admiration for my parents, Robert and Margaret Halsey. They have been an endless source of love, support, and encouragement. Their constant support and their belief in me helped me to succeed always. Thanks also to Jason for being there and always loving me unconditionally.

LIST OF TABLES

Table	Page
1. Healthy Start Evaluation Plan	
2. Correlations Between Items in the Support, Nurturing, and Future Domains of the CPSS	69
3. Overall Means for the Support Domain, the Nurturing Domain, and the Future Outcomes Domain	69
4. Mean Scores for Clients on the Support Domain of the CPSS	70-71
5. Mean Scores for Clients on the General Help and Support Subdomain of the CPSS	72
6. Mean Scores for Clients on the Personal Support for Mothers Provided by FSWs Subdomain of the CPSS	73
7. Mean Scores for Clients on the Support/Help for Child Subdomain of the CPSS	74
8. Mean Scores for Clients on the Convenience Subdomain of the CPSS	75
9. Mean Scores for Clients on the Recommendations Subdomain of the CPSS	75
10. Mean Scores for Clients on the Nurturing Domain of the CPSS	76-77
11. Mean Scores for Clients on the Information Subdomain of the CPSS	78
12. Mean Scores for Clients on the Parenting Changes Subdomain of the CPSS	79
13. Mean Scores for Clients' Responses on the Future Outcomes Domain of the CPSS	80-81
14. Mean Scores and Outcomes for Clients' Responses in the Education and Employment Subdomain of the CPSS	82
15. Mean Scores for Clients on the Family Planning Subdomain of the CPSS	83
16. Mean Scores for Clients' Responses on the Changes in Mother's Future Subdomain of the CPSS	84
17. Mean Scores for Clients' Responses on the Changes in Child's Future Subdomain of the CPSS	84

ABSTRACT

Healthy Start (H.S.) is a home visitation intervention program designed to prevent child abuse and neglect for pregnant women and their families in the City of Hampton. This study collected perceptions of the clients involved in H.S. in order to understand whether the program was implemented as intended, and to evaluate how successful the program was in achieving its goals. The author created the Clients' Perceptions and Satisfaction Survey (CPSS) specifically for this study. The CPSS evaluates three domains: (a) parent nurturing, (b) social support, and (c) long-term child and maternal outcomes. Specifically, the goals of the study were to: (a) collect client feedback which was not previously gathered; (b) observe whether there was any relationship between client perceptions and the standardized measures of child and maternal outcomes used in the H.S. evaluation, to ascertain the potential use of the measure in a predictive manner; (c) determine whether the intervention was equally appropriate for first-time mothers as compared to repeat mothers; and (d) investigate whether client perceptions were predictive of those who completed the program versus those lost by attrition. The author used both data collected by this study on perceptions, and for the comparative portions, used data already existing from the H.S. evaluation conducted by Drs. J. Galano and L. Huntington at the College of William & Mary. Client feedback was collected in three ways: (a) questionnaires by mail, (b) telephone interview, and (c) one-to-one interviews. A total of 71 clients completed the CPSS. Findings were as follows. Overall, there was strong support from client perceptions that the program was being implemented as intended. Because of high ratings in all three domains, it was concluded that the program was generally successful in achieving its goals. Specifically, no differences were found in the perceptions between the first-time and the higher-risk repeat mothers; their perceptions of satisfaction and usefulness were equally positive. No significant relationships were found between client perceptions and the standardized measures of the H.S. evaluations for child and maternal outcomes; nor were client perceptions predictive of either completion of the program by clients, or of attrition. The lack of significant findings may be due in part to the fact that the number of clients reached was limited by the transient nature of the population. As the reachable client base increases, more relationships that may exist may emerge. This study was especially relevant for the following reasons. First, the CPSS provided valuable client feedback as a necessary tool for the Hampton Healthy Start evaluation, feedback that had previously been lacking. It provided detailed and specific information on the program's relative strengths and weaknesses, which will be used, at a future time, towards improvement of the program. Secondly, the client feedback confirmed that the H.S. intervention could extend its client base to include the higher-risk repeat mothers. The H.S. program is part of a major national initiative to prevent child abuse and neglect, which previously focused mainly on first-time mothers. As a major contribution to the overall body of literature on this topic, this study suggests that the program can also be extended to repeat mothers.

Running Head: PERCEPTIONS & SATISFACTION

PERCEPTIONS AND SATISFACTION:
EVALUATION OF CLIENTS' PERSPECTIVES
ON THE HEALTHY START PROGRAM

Perceptions and Satisfaction:

Evaluation of Clients' Perspectives on the Healthy Start Program

This investigation assessed clients' perceptions and satisfaction with services provided by the Healthy Start Program, a component of the Hampton Family Resource Project (HFRP). The Healthy Start Program is a replication of Hawaii's home-based early intervention model designed to prevent child abuse and neglect among at-risk parents of newborns (Galano & Huntington, 1993). A specially designed survey was constructed for this evaluation and that survey development process is described later in this report. The survey focused on clients (both first-time and repeat mothers) who had participated in Healthy Start for at least 6 months. The survey assessed perceptions and satisfaction in three domains: (a) support provided by the program; (b) infant-oriented nurturing information provided by the program; and (c) the program's impact on the mother and child's future. The survey was administered in three modalities: (a) personal interviews, (b) telephone interviews, and (c) mailed surveys. The purpose of administering in three modalities was to examine the similarities and differences of results among the modalities and to determine the usefulness of each modality for future surveys.

Healthy Start's goals include health promotion, problem solving, parent-child interaction, and improving child development. The program strives to strengthen families, prevent child abuse and neglect, and promote the healthy development of children, so that they become productive responsible adults (Galano & Huntington, 1993). Healthy Start enrolls pregnant women as early in their pregnancies as possible. Emphasis on early intervention promotes good medical care during the pregnancy and provides the individual with information regarding the birth process and infant care. Each Healthy Start client is assigned a

Family Support Worker (FSW) who works with a family during the course of their participation in the program. The FSW provides support, information, and advice concerning child health, child development, and life concerns of the clients. The FSW also offers help with financial matters, provides transportation, and refers the client to other sources of support outside of Healthy Start. The referrals to other agencies and programs suggested by the FSWs are useful because they increase the support network and introduce alternatives that would otherwise not be accessible. Healthy Start provides these services to ensure that children are born healthy, develop healthy, and stay healthy until they start school.

The client perception and satisfaction survey elicited information concerning the program's success in accomplishing the following goals: (a) ensuring all targeted children are born healthy and undamaged; (b) advancing optimal child development and preventive well-baby care during early childhood; (c) enhancing parent-child interaction/bonding and parenting skills; (d) promoting parents' problem-solving ability to meet the family's needs; and (e) preventing child abuse and neglect (Hampton Family Resource Center Abstract, 1992). The survey was used to investigate the Hampton Family Resource Project's success in attaining these goals. The researcher chose the domains of support, nurturing issues, and future outcomes as factors which may contribute to these program goals.

Importance of Program Evaluation

Initially recognized in the mid-seventies, the profession of evaluation is still in its adolescence. The emergence of the American Evaluation Association (AEA) in 1984 increased the amount and scope of the distribution of evaluation literature. The number of programs designed to provide services emphasizing primary prevention and early intervention have also increased in the past decade. Innovative programs have provided services in areas ranging from psychologically

related mental health care to in-home maternal education for at-risk populations. While these programs appear promising, they require scientific, practical, evaluation to demonstrate their value. Without rigorous evaluation which provides a system of checks and balances for programs, their utility remains in question. Evaluation allows implementors of a given program to "check" the usefulness of the program using assessment techniques that provide feedback; the feedback allows programs to make needed adjustments or "balances" that help ensure the program accomplishes its stated goals and objectives. Patton (1988) suggests that useful evaluation should assess decision makers' goals, examine how well programs have been implemented, and test theories of program action. In addition, evaluation researchers have defined additional components and qualities that are necessary for all useful evaluations. For example, Patton (1990) suggests that the profession of evaluation needs three things in order to thrive: (a) vision; (b) quality products and processes; and (c) skilled, trained, evaluators. Incorporating these three elements leads to a more efficient, useful evaluation.

Another perspective concerning how to evaluate the utility of a program is to compare relative benefits and strengths in relation to the relative shortcomings and weaknesses. In this instance utility is defined as information worth using for evaluation, information which should reflect all possible outcomes. Often evaluators worry about accountability to agencies and administrators who are funding a project. These accountability concerns may put pressure on evaluators to search for only strengths or weaknesses in programs; this undermines the concept of utility by placing a "good" or "bad" label on the program (Patton, 1990; Rutman, 1990). Evaluation is better viewed as an intricate part of the program development and program improvement cycle. This model suggests that evaluation should be used in a cyclical fashion to provide valuable information which can be used to refine and improve

the program. Patton also discusses the need for evaluation that includes a wide variety of data from multiple perspectives to help shed light on evaluation questions (1980). He recognizes that one of the realities in the evaluation world is that the specific disciplinary training of evaluators is often too narrow. This creates the problem of tunnel vision and biases for evaluators trying to first develop and then convey useful information in real world settings. James Bell comments on this from a health evaluator's standpoint. Bell states that there are missed opportunities in health policy research because many policy makers are too wedded to certain solutions or only a limited range of evaluation techniques. He suggests evaluators can remedy this problem by adapting a multi-disciplinary approach and avoiding looking at situations solely from the perspective of an economist, sociologist, or other disciplinarian (Johnson, 1990). Thus, there is a need for open-minded evaluation and multifocused information collection.

Education evaluators are also conscious of the importance of using feedback to generate questions in evaluation, the validity of this cyclical use of information, and the importance of not overlooking valuable sources of information. The literature in education evaluation has numerous examples of evaluation findings that were never useful to programs (Tomlinson, Bland, & Moon, 1993). Frequently, excess information which could potentially contribute to better programs is generated but never used. To counteract this unfortunate trend, Tomlinson et al. (1993) suggest that each evaluation of a specific program component be inspected for its use in program improvement, protection, and other goals such as accountability to a funding source, that a program may have. The survey designed in this study attempted to generate useful information that could then be used to improve the evaluation process and improve the program for future clients.

Quantitative and Qualitative Sources of Information

The process of collecting data to accomplish these program

evaluation goals in many disciplines has focused primarily on empirical strategies and designs. For many years, this dominant approach assumed that quantitative and standardized measurement, experimental design, multivariate statistics, and parametric statistical analyses were necessary to achieve good science (Patton, 1980). Unfortunately, for many issues or problems in evaluation, quantitative data may not represent a complete and accurate assessment of the program. Numbers do not always fully reflect all aspects of what happens in a program, and standardized or easily quantifiable measures do not always tell program administrators what they really need to know. Often, quantification alone may not produce the most useful data for evaluative research.

Patton (1980) insists that this dominant deductive method is no longer adhered to as strictly as it once was. He cites the 1978 meeting of the Evaluation Research Society which gave much time and consideration to qualitative methods as a supplement to quantitative measures. In traditional research, quantitative information provided more accuracy in data and results and this was of primary importance to researchers. Since then, qualitative research has taken on a greater role, often in conjunction with quantitative methods; using both methods for a research design enhances the quality of the interpretation of evaluation outcomes. The importance of qualitative data becomes more obvious when considering the goals and standards for good evaluation: (a) utility, (b) feasibility, (c) propriety, and (d) accuracy (Patton, 1988). For evaluators, the utility of the evaluation and its ability to contribute to program improvement is of utmost importance. Using only measures which quantify peoples' feelings, perspectives, and outcomes is not helpful to many programs and often does not ensure adequate evaluation of the program. In experimental designs involving specific hypotheses, collecting quantifiable data is an appropriate strategy. However, quantifiable data alone, may not be sufficient to assess a program with a complex variety of goals. Outcomes evaluated solely

with preexisting standardized measures may rely too heavily on numbers and too little on the relevance of the information to answer complex questions.

Excessive quantification of information often results in much data that simply goes unused. Integrating open-ended, qualitative-style questions and standardized quantitative-style questions may decrease the problem of unused data. As defined by Patton (1980):

"Quantitative measures are succinct, parsimonious, and easily aggregated for analysis; quantitative data are systematic, standardized, and presented easily in short space...qualitative measures are longer, more detailed, and variable in content with more difficult analysis due to lack of systematization and standardization."

Though quantified measures are "succinct" and "easily aggregated," they often have little meaning and may not be useful because quantified questions are likely to evoke only positive responses (McKillip, Moirs, & Cervenka, 1992). Qualitative measures add useful aspects to program evaluation, because like human experience, qualitative measures allow for diversity and specifics in experience. Explicit open-ended questions may evoke unsolicited responses that reveal the shortcomings of a program; knowledge of these shortcomings is more helpful for program improvement (McKillip et al., 1992). An overreliance on quantitative measures may undermine effective program evaluation, while combining quantitative and qualitative information may enhance these evaluations.

Qualitative measurement provides important information and plays an important role in program evaluation. Qualitative data helps in the design of quantifiable measures and also serves as a means to gain important information on differences among individuals participating in a program. The task for the qualitative methodologist is to provide a framework encouraging people to respond in a way that represents

accurately and thoroughly their points of view about the world (Patton, 1980). Obtaining this type of information is a crucial part of designing measures to answer questions important to evaluators and to those who are the major beneficiaries of the programs, that is the clients or participants. Including clients' interests and concerns leads to more effective evaluation. Most programs, even though they frequently measure everyone by the same standard, do not expect identical outcomes for all their participants, and qualitative methods in evaluation account for the role of individuation. Individuation by definition is a match between program services to needs of individual clients (Patton, 1987). Lofland (as cited in Patton, 1980) suggests that discovering terms provided by people to describe what is happening is superior to imposing evaluative terms based on a preconceived outsider's scheme about which terms may be important. Allowing individuation to influence a program evaluation may generate information which the evaluators would not have even begun to consider.

Consumer Satisfaction and Client Perceptions

For the present study, a standardized questionnaire to assess different domains of client satisfaction and perceptions was designed. This questionnaire incorporates qualitative data collected from discussions with clients. The present study combined qualitative and quantitative information examining client perceptions and satisfaction; often subjective and objective information is not integrated during evaluation (Johnson & El-Hato, 1990). Overlooking clients' opinions may undermine the evaluation. Including clients' input about a program helps to ensure that the evaluation results truly represent consumers' beliefs.

In health-related studies, patient (client) involvement can enhance the validity of a program and give consumers more control over their treatment (Polowczyk et al., 1993). Evaluations which assess

outcomes without necessarily addressing how the outcomes are related to actual participant satisfaction do the program an injustice.

Programs developed to aid, intervene, or enhance peoples' lives, should include evaluative input from the clients of the program. For example, consumer satisfaction has been equated to a greater emphasis on quality assurance (Benedict & Horton, 1991). Producing programs which affect consumers in an attempt to improve some aspect of their lives but neglect the consumers' opinions and satisfaction with the program calls the "success" of the program into question. Paying attention to client/consumer satisfaction within a program is important to assure the success of the program.

However, there are some cautionary views regarding using qualitative data to represent consumer satisfaction. Hawkins (1991) cautions against making certain assumptions from consumer satisfaction ratings. He suggests these ratings are better viewed as supplementary information to add to the programmer's judgments about the program. However, he does suggest seven reasons to measure consumer satisfaction: (a) to suggest the need for education; (b) to discover further behavioral and environmental resources; (c) to suggest promising adjustments in procedures; (d) to predict or detect undesired effects; (e) to assess the comprehensiveness of the effects; (f) to document a program's effects on numerous clients; and (g) for public relations effects (Hawkins, 1991). Hawkins' reluctance to overemphasize the value of consumer satisfaction measures comes from his applied behavior analysis perspective. For the present study, the use of consumer satisfaction measures was appropriate and indeed supplemented and added to already existing data.

Quality of Life

Consumer satisfaction ratings and measures in evaluation become useful when a primary goal of a program is to enhance the participants' quality of life and related outcomes. "Quality of life" refers to the

collective feelings, opinions, and perceptions a person has about their life. Measures of subjective quality of life can be useful in evaluation because they focus on levels of contentment in life rather than on fixing a problem, which is consistent with a holistic perspective of consumer satisfaction (Cheng, 1988). Using quality of life as a variable in program evaluations appeals to clients, administrators, and funders (Cheng, 1988). Evaluating a program without considering a consumer's subjective level of satisfaction does a disservice to the goal of improving quality of life. Johnson and El-Hato (1990) suggest that for clients to think that a program is positive, there needs to be some subjective evaluation of quality of life. Perceived well-being is an important indicator of life satisfaction, and the personal perceptions of a program's clients should be a primary part of program evaluation (Cheng, 1988).

Measuring quality of life and client satisfaction is not an easy task. Certain factors may bias how data are reported. For example, methods of data collection, an individual's culture, and an individual's race may affect perceived quality of life. When collecting the data, the modality of collection may affect the results. Bremer & McCauley (1986) found that patients had more positive responses about quality of life when they were interviewed than when they answered the questions at home using a questionnaire about disease treatment.

In addition, culture and race may differentiate between groups and may affect the reliability of the test for a group of clients. A study of (Reid and Gundlach, 1983) cultural and racial differences demonstrated that Mexican American and African American families report lower satisfaction with quality of life than caucasian respondents. The researchers conclude that this effect might be due to how different populations use the services available and the type of services they use. Measures designed to examine how quality of life is affected by a program cannot completely distinguish all the factors which affect

quality of life (Cheng, 1988). This creates a problem for evaluators trying to assess changes in quality of life associated with the program.

Survey Methods

One factor that may affect the utility of information obtained with surveys such as the Clients' Perceptions and Satisfaction Survey is the form in which the survey is distributed or administered. Three common ways to distribute surveys and gain information about perceptions and satisfaction are mail surveys, telephone surveys, and personal interviews. Each mode may yield differing reflections of clients' perceptions and satisfaction; some methods may be more reliable than others. Understanding how these methods differ and examining their reliability is important.

Mail Surveys

There is of course no perfect method of data collection and each of the methods specified above have strengths and weaknesses that are important to understand. Mail surveys are the most popular method used to collect self-reported data on clients' perceptions and satisfaction (Sorenson, Kantor, Margolis, & Galano, 1979; Weltzien, McIntyre, Ernst, Walsh, & Parker, 1986; McKillip, Moirs, and Cervenka, 1992). Questionnaires are the easiest and most cost-effective of the three methods to develop and administer. Surveys do not require reimbursing the respondents, nor do they require travel time (Narins, 1995). They allow respondents time to think about the questions and to generate good answers (Narins, 1995). They can be mailed, they are more easily distributed to more people at more sites, they can be strictly anonymous, and they remain more uniform because each client answers the same questions (Morris and Fitz-Gibbon, 1978). Interviewer bias is not a problem because the interviewer is not usually present while the surveys are completed (Narins, 1995).

The disadvantages of questionnaires are also important to

consider. One disadvantage is the inflexibility of the questionnaires as opposed to interview questions. Some people are better oral respondents than written respondents and interviews make it easier for them to express their thoughts. Another disadvantage of questionnaires (especially mail surveys) is the low return rate. Return rates for mail surveys vary between approximately 20% and 60% (Weltzien, McIntyre, Walsh, and Parker, 1986; Brennan & Hoek, 1992; Narins, 1995). This may result in a response bias because the people who return the questionnaires are not representative of the population. Lebow (1982) reveals that written methods produce less positive results than oral methods, perhaps the result of presentation. Another study reveals that given a choice, subjects more often returned a survey to a collection box than through the mail (Burgoyne, Wolkon, Staples, Kline, & Powers, 1977). This suggests that individual circumstances may affect the rate of return and how a survey is completed.

Telephone Interviews

Telephone interviews are another useful mode for collecting evaluative data. Telephone interviews are less costly than personal interviews (Narins, 1995). Research (Posavac & Carey, 1980) indicates that the material obtained is consistently as valid as information gathered through personal interviews. Phone surveys also prevent participant loss and virtually insure some response. There is also less possibility of interviewer bias in phone interviews (Narins, 1995).

The biggest disadvantage of telephone surveys involves the clients who do not have telephones (Posavac and Carey, 1980). This factor may produce bias because the people without phones may differ in meaningful ways from the people who do own telephones. Another disadvantage of telephone interviews concerns the amount of time it takes for training and conducting interviews. Questions designed for a phone interview must be clear and concise. The interviewer must be careful because information is easily lost between what the respondent says and what the

interviewer records (Narins, 1995) Although problems exist in telephone interviewing Lebow (1982) suggests that telephone interviews appear to have the "least glaring strengths and weaknesses." He found that telephone surveys seem to produce better results than either mailed questionnaires or personal interviews because they are less susceptible to the biases normally associated with mail and personal interviews. For example, people who return mail surveys and those who do not may differ in important, but unspecified ways, while personal interviews may cause more variable reactions compared with mail surveys. Telephone interviews may not have these problems.

Personal Interviews

Finally, personal interviews present their own unique set of strengths and weaknesses. They may be used to acquire information that is otherwise unobtainable because clients do not want to take the time to write detailed opinions (especially if they are positive). The open-ended interview style may allow clients a forum to express other ideas that are not part of the proposed interview format. This aspect of the interview setting is especially important for the assessment of clients' perceptions and satisfaction because it allows for respondents to ask for clarification of the interview questions. It also allows the interviewer control to expand on any questions of interest (Narins, 1995). Interviews permit flexibility of responses and clients may feel free to express themselves especially if they are interviewed in comfortable or familiar surroundings. Bremer and McCauley (1986) found evidence that interviewees responded more positively to questions during interviews than in self-report questionnaires. However, interviews are costly and time-consuming, and the interviewer may confound information with personal biases or influence clients' responses through leading questions (Morris and Fitz-Gibbon, 1978; Posavac and Carey, 1980).

The Clients' Perceptions and Satisfaction Measure

Presently, Healthy Start participants (mother and child) are being evaluated using a battery of measures. These include measures of the clients medical and social demographics, abuse potential, life stress, social support, the home environment, mother-infant interaction, and child development (see Table 1). Each mother and child enrolled in Healthy Start is tracked using these measures from the prenatal period until the child is five years old, providing quantitative data relevant to the five target areas of Healthy Start. Many of these measures target information regarding the mother-infant interaction and the child. The Clients' Perception and Satisfaction Survey focuses on the role mothers play in this program by eliciting their personal perspectives regarding their participation in the program. It is the only measure focusing on the mothers' perceptions about the utility of the Healthy Start program. It also provides information which can be included and analyzed with the forementioned measures. It is hypothesized that discrepancies between qualitative and quantitative data may pinpoint problematic areas in the program and increase information regarding program goals which are not adequately addressed.

The Clients' Perceptions and Satisfaction Survey developed in this study utilized clients' comments. This preliminary input from participating mothers was used to design a succinct group of questions for use in the questionnaire and interviews. It was imperative to design a measure that pinpointed and reflected areas important to client satisfaction. To acquire this important information, a focus group, which entailed an open-ended discussion with two participating mothers was conducted. During the discussion, focus areas were introduced that were believed to be of primary importance to the goals of the program. By soliciting responses in this open-ended manner, an understanding of clients' involvement in Healthy Start was gained without putting

pressure on clients to limit themselves only to specific topics or to reply in a particular manner. This allowed a forum for clients to acknowledge other topics of personal interest to them. These interviews influenced the decision to select three major domains.

Three Domains of the Clients' Perception and Satisfaction

Three domains are specified in the organization of the Clients' Perceptions and Satisfaction Survey. These three specific areas represent the goals of Healthy Start and issues related to: (a) social support, (b) nurturing, and (c) maternal and child outcomes (future). The clients had opportunities to respond to and discuss questions related to these areas, and they were also given the opportunity to raise and discuss topics not generated by the evaluators.

Social Support

In the area of social support, interviewers asked questions regarding the extent of perceived support mothers receive from the Healthy Start program. Social support has been conceptualized as the individual's belief that he or she is cared for and loved, esteemed and valued, and is part of a network of mutual obligation and communication (Dubow & Ullman, 1989). Support is defined here as any action, information, or aid that a Healthy Start representative (supervisors, nurses, social workers, and FSWs) offers the client. The interviewer assessed how clients report their interactions with Healthy Start facilitators and what kinds of impact the program has on their lives.

Measuring support provided to clients by Healthy Start is important because support has is related to the program's goals of reducing child abuse and neglect and promoting better problem solving for parents. A good support system of medical workers and family support workers can provide objective information and advice about health issues, parenting, and coping skills that can aid clients in reaching program goals. This questionnaire tries to pinpoint areas of support the program provides and discover the areas where clients feel

there is a lack of support.

Nurturing

Nurturing issues exemplify the mothers' abilities to understand and respond to their children in an appropriate, productive manner. The National Council on Prevention of Child Abuse (NCPA) reported that some children do not receive adequate care because their parents do not possess the emotional stability, knowledge, or skills and may not know how to obtain help (Hampton Family Resource Center, 1992). One goal of Healthy Start is to provide information on bonding, interacting, and communicating between the mother and child. Assessing nurturing is very important because lack of knowledge and ability to interact with the child may lead to abuse and neglect. Obtaining information from mothers becomes vital for this assessment because only the participants can attest to how well the program provides helpful information on nurturing issues. Inquiries were made about specific nurturing activities such as participation in nurturing courses offered by Healthy Start and the usefulness of these activities for mothers. Key concepts guiding the development of questions about nurturing included: (a) responsiveness to the child; (b) interactions with the child; (c) a mother's understanding of age-appropriate behaviors for their child; (d) perceptions of the influence mothers have over their child's acquisition of skills; (e) discipline; and (f) self-efficacy in parenting.

Future Outcomes

A final important domain that this evaluation assessed was the participants' feelings and views about how Healthy Start will affect future outcomes for them and their child. Many targeted outcomes have been identified in earlier sections including the prevention of child abuse and neglect and the fostering of healthy child development. However, for this study, a broader range of outcomes were considered including any aspect of a participant's life which was affected or changed by participation in Healthy Start. Soliciting information from

mothers about the perceived influences of Healthy Start for themselves and their child is important. Participants were asked if Healthy Start affects their feelings about parenting, their sense of self-efficacy, or their ability to affect their child's development and future. The questionnaire also contained questions designed to determine if the program increased clients' feelings of control over other areas of their lives and their perceived quality of life. Questions about mothers' perceptions and satisfaction with their child's developmental outcomes and its relationship to perceptions and feelings about the development of the child were addressed by the questionnaire.

The literature supports the important role of evaluation for the success of programs, and accurate information about client satisfaction and perceptions contribute to strong evaluation. The clients' perceptions are extremely important and these perceptions are an invaluable part of the evaluation process. The open-ended discussions aided in the creation of an accurate client perceptions and satisfaction survey. Addressing the relevant areas of interest, specifically support, nurturing issues, and outcomes, and incorporating these topics into a concise questionnaire to complement the overall evaluation of the Healthy Start Program was a goal of this study.

The primary goal of this study was to assess the clients' overall perceptions and satisfaction with the program to aid future program development and improvement. Moreover, this study assessed the domains of support, nurturing, and future outcomes to determine if they reflected important issues for the clients in H.S. Clients' responses on these domains may suggest that the Clients' Perception and Satisfaction Survey did not adequately address areas that are important to clients; on the other hand, the clients may believe the program was accomplishing its goals especially if the responses are predominantly positive. Differences in qualitative and quantitative responses were examined to locate items which may be unclear and to assess

discrepancies between quantitative and qualitative responses. It was hypothesized that clients would rate Healthy Start more positively on the domains of support and nurturing than on the domain of future outcomes. Clients may have more positive opinions about issues that affect them in everyday situations such as support and nurturing. The future may only be a secondary concern to many of these clients.

In addition, differences in ratings on these domains between first-time and repeat mothers were predicted. Mothers with prior experience in childrearing may believe they do not need many services offered by Healthy Start while many new mothers may eagerly seek them out. Pinpointing differences in the perceptions of first-time and repeat mothers may lead to ideas about ways to improve this program.

Another important evaluation question addressed in this study was which modality, mailed survey, phone interview, or personal interview, was the best one to survey this population of clients. It is predicted that there will be differences in data as a function of data collection modality. Specifically, mailed questionnaires are expected to have more variability in responses compared with responses in personal interviews and telephone interviews. The two modalities of telephone and personal interviews are expected to have similar responses whereas mailed questionnaires may produce a greater variety of responses. It is also hypothesized that telephone and personal interviews will evoke more positive responses than the mailed surveys.

Methods

Clients

A sample of clients enrolled in the Healthy Start Program for at least six months participated in the consumer satisfaction and perceptions study. The clients were 278 women (mean age = 22.8 years) who had a child who was being tracked in the Hampton Healthy Start Program. The majority of the clients (n=170) were mailed a questionnaire. Fifty-four clients were contacted by telephone or letter and asked if they were interested in giving a personal interview. Another 50 clients were contacted by telephone to ask if they were interested in participating in telephone interviews. Seventy-one clients completed a questionnaire in one of the three modalities: mailed questionnaire (n=43), telephone interviews (n=16), and personal interviews (n=12).

Clients were unmarried women (69%) of African American (70%), White (27%), Hispanic (.6%), and Asian (1.8%) decent. Thirty-seven percent of the clients had completed high school, and 25% had at least some form of education beyond high school. Many women received some government aid (Welfare/ADC/Food Stamps) and 35% of the clients listed government aid as their primary source of income (Galano & Huntington, 1994). However, almost half of the mothers (46%) held jobs.

The clients who participated in this study may not be representative of the overall population of H.S. clients. To examine this issue, clients in this study were compared to the overall H.S. client population on two critical measures. The H.S. clients' mean scores on the Child Abuse Potential Inventory (CAP) and the Family Stress Checklist (FSC) were used to assess the comparability of clients in this study. The clients who were surveyed had slightly lower FSC scores (M = 40.23) than the overall population of H.S. clients (M = 43.0), but the means were not significantly different between this study's sample and the overall population.

However, there were differences between clients in this study and the overall population of H.S. clients when their mean scores on the CAP were compared. The clients in this study had lower scores on the CAP ($M = 124.97$) than the general population of H.S. clients ($M = 146.20$). This suggests that clients who responded to the questionnaire or gave an interview may have been less at-risk for child abuse and neglect and needed less help coping with stress.

The selection of clients in this study was not random and this may have resulted in a sample of respondents who differed in important ways from those clients who did not respond. However, this was an applied study, and some compromises were inevitable. We strived to make as few as possible. Unfortunately, our ability to generalize these findings to the entire H.S. population is limited since we do not completely understand how these two groups differed.

Survey and Design

This section summarizes a series of steps taken to develop the Healthy Start Clients' Perception and Satisfaction Survey. These steps were designed to ensure a measure which adequately reflects domains and concerns crucial to clients enrolled in the Healthy Start Program.

Step 1: Program Managers. A meeting was held with the project coordinators involved in the Healthy Start Program to solicit their input on important topics which should be emphasized when assessing perceptions and satisfaction with participating mothers. The supervisors were asked to identify particular topics or areas of the program on which they would like specific feedback to use in program development. This discussion was open-ended and informal. The supervisors expressed interest in many topics including learning more about the mothers' values, perceived progress in the program and their feelings about people coming into their homes (i.e. was this viewed as intrusive or supportive).

Step 2: Family Support Workers. Next, there was a meeting with Family Support Workers (FSWs) to discuss their opinions concerning appropriate survey material and concerns about the program that they would like included as topics in the focus groups with the mothers (Step 3 of this process). FSWs provided specific ideas about questions regarding social support (eg. does H.S. provide support above and beyond the support clients already receive), nurturing issues (eg. has the program and the FSWs provided sufficient and useful information about discipline and handling stress), and outcomes (eg. do the clients feel more in control of their lives now compared to before entering the H.S. program) which they thought would be important to include in the final questionnaire. The FSWs also offered good suggestions about how to introduce or approach certain topics during focus groups with mothers.

Step 3: Clients. An informal group discussion with two clients in Healthy Start was used to guide the initial development of this questionnaire. The information collected from the discussion group was very useful in developing the pilot version of the Clients' Perceptions and Satisfaction questionnaire. The target areas for this study, namely, support, nurturing issues, and outcomes, were incorporated into the focus group discussion using material identified from the prior program manager and FSW interviews. In addition, questions used in Hawaii's Healthy Start evaluation were reviewed and many were used in the focus group (Appendix A). Clients were encouraged to discuss their feelings about the Healthy Start Program among themselves during the discussion group while the moderator (the current investigator) suggested topics and mediated conversations. Clients suggested topics including many not previously included and offered comments and observations that added depth to topics already identified.

Step 4: The Pilot. A pilot questionnaire based on the areas identified as critical in the group discussions with mothers was designed. The draft version of the questionnaire was piloted with a

small sample of four clients in order to assess the time required for completion. Clients also evaluated the appropriateness of the questionnaire's content, and the clarity of the questionnaire. Clients were asked if there were any problems with the questionnaire or any issues they thought should be added.

Step 5: Pilot Follow-up. To assess the pilot data, clients' responses were examined, and some of the survey questions were clarified for the final draft of the questionnaire. Originally, the plan was to conduct a follow-up meeting with the clients who participated. However, it was very difficult to convene clients for a second meeting so no follow-up meeting was held.

Step 6: Updated Mail-out Questionnaire. The questionnaire was modified based on the feedback received and a final version was distributed to 150 clients from the program (See Appendix B) These surveys were mailed. One month later, clients who had not returned the mailed surveys were contacted by phone and asked to return the questionnaire. If the clients had not received the first questionnaire, they were sent another questionnaire. Twenty follow-up questionnaires were sent to clients who agreed to complete them.

The questionnaire required about 15-20 minutes to complete. In addition, a cover letter explaining the nature of the study and its importance accompanied each questionnaire (Appendix C) The cover letter also included a description of a lottery for clients who returned the questionnaire. Each client who returned a questionnaire was entered in a lottery and 4 \$25.00 prizes were awarded. Clients participating in the personal and telephone interviews were also eligible and were entered into the lottery. Four names were drawn, and the clients chosen were sent a check for \$25.00 after the study was completed

Step 7: Telephone Interviews. Phone interviews (10-15 minutes in length) were conducted using a subgroup of items selected from the complete questionnaire. Items used for the telephone interviews are

identified in Appendix B. The questions for the phone interviews were carefully selected to sample equally the three specific domains of interest. Shortening the questionnaire was necessary to complete the telephone interviews in 10 to 15 minutes.

Step 8: Personal Interviews. One-to-one personal interviews (approximately 1 hour) were conducted with 12 mothers. Four general questions concerning clients' overall perceptions and satisfaction with the program were asked at the beginning of the interview. These questions were identical to the open-ended questions that clients answered as the final part of the mailed questionnaire (See Appendix B).

Following the general questions, three domain-specific questions were also asked to personal interview clients (See Appendix D). These questions were asked to obtain information about clients' feelings concerning the support they received from H.S., the nurturing information they received from the program, and the effect of the H.S. Program on their futures. The personal interview clients were administered the complete survey at the end of the interview. Each respondent participated in only one modality (mail, telephone, or personal interview).

Sample Issues: Notes on the Design & Process.

The process and methods used in this study of clients' perceptions and satisfaction influenced the evaluation. The design of this study posed several obstacles that may have affected the outcomes of this survey. These obstacles include: (a) the difficulty of locating clients; and (b) issues related to acquiring clients' participation.

Difficulty of Finding Participants

A random process was initially employed to divide the 278 clients into three groups that either received the mailed survey, were asked to participate in either a telephone or a personal interview. Originally, 37 women randomly assigned to the personal interview group were sent a letter describing the study. The letter explained the purpose of the

study, assured clients of the study's validity, and explained the "thank you" lottery. The forty-three clients assigned to the telephone interview group were sent similar letters.

The original lists of clients for personal and telephone interviews were quickly exhausted. The transient nature of the clients and their individual situations lead to difficulty finding many clients. Some clients did not reside at the address where their letters or questionnaires were sent. Some telephones were out of service or had been disconnected with no forwarding number. Furthermore, some clients gave numbers of friends or relatives' residences so that they could be reached if there was an emergency. However these clients often did not reside at these residences.

It became evident that the original telephone and personal interview lists were not sufficient to obtain enough clients, and other clients from the overall list of 278 clients were chosen and contacted. Fifteen additional women were contacted for personal interviews and ten additional women were contacted for telephone interviews. The selection of additional clients for telephone and personal interviews was not random. All the clients (15%) who had not previously been sent a mailed survey or been asked to give an interview (telephone or personal) were included on the second telephone and personal interview lists.

Finally, the return rate suggests that many clients chose not to respond to the survey. Five surveys that never reached a clients were returned. It was suspected that many additional clients never received a survey and did not have an opportunity to respond. Only two clients refused to give a personal interview.

Conducting the Interviews: Another Difficult Process

Problems also arose when clients were contacted to give personal or telephone interviews. First, some women had not received the letters explaining the study and thus, did not understand the study. Some clients were skeptical about participating because their FSWS did not

tell them anything about this study, but only two clients refused to give personal interviews. Other clients agreed to participate but repeatedly cancelled their personal interview appointments or failed to come at the scheduled times. Some clients who agreed to give telephone interviews scheduled times to conduct the interviews and repeatedly failed to be at home when they were called. The interviewers ceased to contact these clients after two or three attempts to schedule a personal or telephone interview. It is plausible that clients may have felt coerced into participating despite the interviewers' attempts to reassure them that their participation was totally voluntary. This is one explanation for why some clients who initially agreed to participate never gave an interview.

Statistical Analysis

The data from the Clients' Perceptions and Satisfaction Survey (CPSS) was analyzed to answer questions at three primary levels: (a) to present the structure of clients' responses and provide a description of responses to survey questions; (b) to examine potential differences between groups of participants based on the modality by which the survey was presented or their status as first-time or repeat mothers; and (c) to examine client characteristics that may affect clients' ratings on the survey and to examine existing measures used by the H.S. Program that could be potential predictors of clients' ratings on the CPSS.

The internal consistency (using an odd/even item split) of the Clients' Perceptions and Satisfaction Survey was analyzed using Cronbach's Alpha. To examine clients responses on the survey, the frequency distribution for each item was computed. Overall mean scores and summary means for each domain (support, nurturing, and future outcomes) were calculated. The quantitative data from the mailed questionnaires, personal interviews, and telephone interviews were

analyzed using Pearson product-moment correlations to examine the relationship between specific items within domains. Correlations between the three domains were computed to examine the relationship between the three domains of interest. Finally, a multivariate analysis of variance (MANOVA) was performed to examine differences among clients' responses in the three domains of support, nurturing, and future outcomes.

Differences between first-time and repeat mothers ratings on the CPSS were analyzed using an independent groups analysis of variance (ANOVA). In addition, a repeated measures multivariate analysis of variance (MANOVA) was used to examine differences between first-time and repeat mothers' ratings in each domain (i.e. support, nurturing, and future outcomes). Differences between clients' ratings in the three modalities of presentation (i.e. mailed surveys, telephone interviews, and personal interviews) were analyzed using an independent groups ANOVA with planned comparisons.

The length of time the clients participated in the program was correlated with their ratings on the CPSS to examine the relationship between these variables. Four existing H.S. measures which assess parent-child interaction, risk for abuse, and the stimulation provided in the home environment were entered in a multiple regression analysis to examine their utility as predictors for clients' ratings on the CPSS. Correlations were also performed to analyze the relationship between the existing measures and the CPSS.

The Questionnaire Structure

The Clients' Perceptions and Satisfaction Survey was comprised of 44 5-point Likert-style items and four open-ended questions which addressed issues related to the Healthy Start clients' feelings and opinions concerning their participation in the program. The internal consistency of the survey was analyzed using Cronbach's index of reliability, $r(71) = .95$. A Pearson product-moment correlation between

odd/even questions on the survey was also significant, $r(71) = .94$, $p < .001$. These results suggest that the internal consistency of items on the survey is high.

The 44 Likert-style items were divided into three primary domains: (a) support, (b) nurturing, and (c) future outcomes. A shortened version of the questionnaire was administered during telephone interviews. All clients were asked the four open-ended questions which assessed opinions including: (a) suggestions for program improvement, (b) overall perceptions of the program, (c) the most satisfying things about the program, and (d) the least satisfying things about the program. The clients participating in personal interviews were also asked 3 specific questions pertaining to each of the three domains: (a) support, (b) nurturing, and (c) future outcomes.

Pearson product-moment correlations were computed to analyze the relationship between the three domains: (a) support, (b) nurturing, and (c) future outcomes (see Table 2). There were significant correlations between the three domains which suggests that there is a relationship between the items in these domains. However, the degree of the correlations also suggests that the items in each of the three domains have some unique domain-specific characteristics. If the correlations were higher, an argument might exist for collapsing the three domains into one general domain. For the goals of this evaluation, enough evidence is provided from the correlations to justify the separation of the clients' responses into three separate domains. The initial data analysis plan specified factor analysis as the method to assess the psychometric properties of the proposed domains of the CPSS; however, the low number of client responses to the survey made factor analysis an unreliable method to examine this questionnaire.

The strongest relationship exists between the items in the support domain and the items in the future outcomes domain, $r(67) = .68$, $p < .001$. This relationship suggests that there are similarities between

the various sources of support the program provides the clients and the influence of the program on the clients' futures. One explanation for this finding is the nature of the items in each of the two domains. The support domain focuses on overall support provided by the program and the FSWS while the future domain focuses on issues which include specific questions about support and help with planning the future.

Pearson product-moment correlations were also used to examine the relationship between the items within the three domains of the CPSS (See Appendices E-G). In general, the relationships between the items within each domain suggest that each domain includes a coherent set of questions which assess clients' perceptions and satisfaction with: (a) support provided by the program, (b) the nurturing information they receive, and (c) the help they receive concerning the future.

Results and Discussion

Clients' Overall Ratings of Perceptions and Satisfaction with the Healthy Start Program

The means for the clients on the three domains of support, nurturing, and future outcomes are high and reflect the clients' general contentment with the H.S. Program (See Table 3). Clients were the most satisfied with the support that they received from H.S., $M = 4.33$, $SD = .55$. Overall, clients felt that they "often" received needed support services, thought support was offered "most of the time," and "definitely" would recommend the program to others.

Clients' overall ratings within the domain of nurturing and the domain of future outcomes were similar to each other (means of 3.76 and 3.73 respectively) but both were significantly lower than the scores on the support domain (see Table 3). Clients were pleased with the information and help they received on issues related to child development, nurturing, and parenting. Clients felt they received

information on nurturing issues "sometimes" to "most of the time," ($M = 3.76$). Most clients felt that nurturing classes were good sources of information, that the program had provided them with useful information on nutrition for their child, and that the program had offered ideas about parent-child interaction which were helpful. Some clients believed that the program had influenced the quality of health care their child received and others felt that H.S. had positively affected their overall parenting style. Clients also felt the H.S. Program had a positive effect on their future. Clients "agreed" or thought that the H.S. Program and the FSWs were "somewhat helpful" with planning the future for themselves and their child, ($M = 3.73$) while the ratings were more variable in the future domain, most clients' ratings were between 3.0 to 4.0, indicating a generally positive overall perception. Many clients felt that H.S. was helpful in getting them to consider plans to further their education. Clients also believed that the program had a positive impact on their child's development, and felt the program helped them to plan their child's future.

A multivariate analysis of variance (MANOVA) was performed with the three domains of support, nurturing, and future outcomes as different levels of clients' perceptions and satisfaction. Planned comparisons were performed to examine differences between the three domains. There was a significant overall domain effect.

The mean scores for the support, nurturing, and future outcomes domains are presented in Table 3. Univariate F-tests show a significant difference between the three domains, $F(2, 132) = 36.12, p < .001$. Planned comparisons revealed that there was a significant difference between clients' ratings on the domain of support and their ratings on the nurturing and future outcomes domains, $F(1, 66) = 114.91, p < .001$.

These findings support the creation of separate domains on the CPSS and offer guidance concerning the best ways to divide the items on the questionnaire. Clients rated the overall support they received from

H.S. significantly higher than they rated their overall satisfaction with the services and information they received comprising the nurturing and future planning domains. H.S. clients believed the support (social and tangible) they received from the program was the most positive aspect of their participation in H.S. However, clients' ratings on the nurturing and future outcomes domains were also positive, although lower than support ratings. This pattern of findings suggests that the domains of nurturing and future outcomes are useful and can serve as an important vehicle to examine clients' feelings about the program.

The individual items that made up the three domains were analyzed further to examine the structure of clients' responses. These analyses are presented in the following section. First, the scores on each item are presented within a domain. Then these items are grouped into conceptual subdomains and discussed. Finally, responses to open-ended interview questions which further supplement the discussion are presented.

The Clients' Perceptions and Satisfaction Survey (CPSS): Support Domain

Parents may feel stress after the birth of a new baby. This happens in all homes even when there are two parents, a helpful family, and a network of friends to provide support. Unfortunately, in many cases when there is a new child, a support network does not exist for the mothers, especially single mothers. The program philosophy of Healthy Start states that increased stress from the birth of a new child, along with difficult life circumstances, and a lack of support can not only stress parents but can overwhelm them. These constant overwhelming feelings and the accompanying exhaustion and despair become a part of the causal chain that can eventually lead to neglect and abuse (Galano & Huntington, 1993).

Healthy Start tries to provide an increased network of support for

its clients, prenatally and postnatally. Administrators, health care workers, and FSWs strive to provide sources of personal as well as more tangible support (i.e. resources, transportation, etc.). Because not all support offered is experienced as helpful or empowering, it is important to assess clients' perceptions of the support they received from the program. The support Healthy Start offers its clients can be organized into 5 different subdomains: (a) overall help and support; (b) personal help for the mothers provided by the FSWs; (c) help for the child provided by the FSWs; (d) convenience of help and support; and (e) recommendations made about the H.S. Program by clients. The responses to all of the items constituting the overall support domain are represented in Table 4. Each of tables 5 through 9 present the questionnaire items that comprised the 5 support subdomains. The mean scores for the 19 items that constitute the support domain of the CPSS are presented in Table 4. Support was measured with 1-5 point scales ranging from "almost never" to "almost always," "strongly disagree" to "strongly agree," "definitely not" to "most definitely," or "very rarely" to "very often." Items labeled in the tables with an asterisk (*) were on the survey in the negative form. To be consistent with the representation that higher scores on the items are positive, these items have been recoded. For example, for the item "FSW criticizes my behavior," the response "very rarely" was originally the 1-point response on the scale and has been recoded to be the 5-point response. Another note, the mean rating for each item and the number of clients who responded to each item are presented in the tables. However, percentages were used in text to make the information easier to summarize for the reader.

To examine the clients perceptions of support more closely, the following sections examine responses to these items grouped by conceptual subdomains of the support domain.

General Help and Support Provided by the Program

A primary goal of the H.S. Program is to offer help and support in many areas of the clients' lives. Clients rated general program help and support favorably. In fact, 69% of the clients responded that they "almost always" received the help they were hoping to get from Healthy Start. "Help" for this question was subjectively defined, by the clients themselves (see Table 5, Help). The majority of clients (65%) reported that the program provided a source of support for them that they may not have had otherwise. Only 9% of the clients did not feel that they received any more support from Healthy Start than they would have received if they had not participated in the program (See Table 5, Otherwise).

Clients also were pleased with H.S. as a source of overall support for them and their families. Most clients (72%) believed that the H.S. program was a good support system to them personally. Only 8% reported that the program was not a very good source of support for them. The respondents who were not satisfied with the program as a source of support may have had unrealistic expectations about the program and its goals or may represent a small subsample with needs that go beyond the capacity of an FSW with an average caseload of 25 clients.

Finally, 88% of clients "agreed" or "strongly agreed" that if they had a problem, H.S. helped them as quickly as possible. Clients clearly felt that the program was good source of support if there was a crisis or problem that needed immediate attention. This is a very positive finding because clients' perceptions and satisfaction with help in a crisis may more strongly influence or motivate them than the more routine day-to-day aid that constitutes the majority of the program's services.

Personal Help for Mothers Provided by FSWs

FSWs play a crucial role in accomplishing the goals of Healthy

Start. The FSW is often the individual who has primary contact with the client, and she is the individual who must actively engage the client's participation in all parts of the program. Home visiting services provided by the FSWs are essential if H.S.'s prevention and health promotion goals are to be realized. Galano and Huntington (1993) state:

"The home visitor (FSW) builds trust, helps at-risk families deal with crises, identifies needs and provides assistance in obtaining resources, works with the mother to promote quality prenatal, delivery, and postpartum care, encourages bonding, healthy home environment, and provides emotional and social support (p.39)."

These roles, played by FSWs, provide the cornerstone for the program's goals and help the clients succeed. Assessing clients' perceptions and satisfaction with their FSWs and the support they offer may provide insights for why some clients are satisfied with the program and others are not.

The data summarizing clients' perceptions and satisfaction with personal support from their FSWs are presented in Table 6. First, most clients (68%) felt their FSWs "very often" told them helpful information for everyday situations. Many clients (66%) also felt comfortable discussing a variety of issues (eg. personal problems, money issues, etc.) with their FSW. Finally, clients reported that their FSW "very rarely" criticized their personal behavior (83%). Clients (87%) were also pleased with the FSW's ability to help them find resources and other agencies that provide useful services.

Most clients felt that FSWs provided personal support, yet there were some clients who perceived a lack of support in certain areas. There was considerable variation among clients' comments when asked if FSWs offered them advice about how to handle situations that make them frustrated with their children (See Table 6, Nerves). First, over half (54%) of the clients did not answer this question or responded that it was "not applicable" to them. Some of the clients (50%) did not have

the opportunity to respond because they were given the modified survey not containing this item during the phone interviews. Forty-two percent of the clients who responded were very pleased with advice offered by the FSWs, 24% felt they received at least some useful advice, and 21% felt their FSW did not offer advice or help with handling frustrating situations. The variability in responses and the high number of clients who did not respond to this question suggest that the question may not be clear.

Two explanations for the differences in responses among clients may be the wording of the question and client bias. Clients may conceptualize "gets on my nerves" in different ways or the client may feel reluctant to report that her child ever gets on her nerves. The client may believe that admitting she is sometimes frustrated may reflect poor parenting abilities or reveal some maternal flaws (i.e. lack of patience). This question requires clarification and rewriting for use in future surveys to elicit more responses from more clients.

Clients were pleased with the numerous opportunities they were given to ask their FSWs questions about a variety of issues (See Table 6, Questions). Eighty-three percent of all clients gave the highest possible rating to this item. This confirms that clients feel comfortable discussing a variety of issues with their FSW. This is an important finding since the FSWs have been almost exclusively assigned the role of accessing clients and informing them about parenting issues. The FSWs are able to successfully engage clients, to talk with them, and to make the clients feel comfortable asking questions.

Support and Help Provided for the Child by the FSWs

The FSWs also play an important and ongoing role in the life of children born to mothers enrolled in the program. Most often the FSW influences the child's life indirectly by helping the mother. The FSW offers support concerning parenting and discipline, and gives advice about childrearing. Clients' feelings about the support they receive

concerning their children are presented in Table 7.

The responses to a number of items suggest that good rapport exists between FSWs and clients. The FSWs' success in providing support was shown by the data concerning the FSW's criticism of the parent's behavior with her child (See Table 7, Critical). When asked if their FSWs were critical of their behavior with their child, 82% of clients said "very rarely." Very few clients (6%) felt their FSWs were critical of how they behaved with their children. In general, these results suggest that FSWs were often able to offer advice which the clients found acceptable and constructive.

Clients also appeared to believe that their FSWs gave them positive feedback regarding their parenting and offered advice about any other children they had. Most clients (83%) felt that their FSWs made positive comments about their parenting abilities "often" or "very often" (Table 7, Positive). Clients (62%) who had more than one child felt that their FSWs offered advice about their children who were not targeted by the program. The clients appreciated the extra help with their children and the concern their FSW showed for the children who were not participating in the program.

Clients' opinions varied widely when asked how often FSWs discuss discipline (See Table 7, Discipline). Most of the clients (69%) reported that they received information on discipline from their FSW between "sometimes" and "very often." Twenty-nine percent of the clients felt that they "rarely" or "very rarely" received such information. Of the clients reporting little discussion of discipline, 20% reported that their FSWs "very rarely" (a rating of "1") offered ideas or discipline alternatives. These results likely reflect real differences in the amount of discussion between FSWs and clients concerning issues related to discipline. A more complete understanding of these differences could prove very useful because of the direct relationship between "discipline" and abuse/neglect.

Another explanation for the results concerning FSWs and advice on discipline may involve the clients' dismissing certain topics during discussions. Certain clients appreciated receiving ideas about discipline, yet others felt they knew how to discipline children because of past experience (i.e. repeat moms). Some clients may have felt bombarded by information and this may have lead them to dismiss or not pay attention to the specific details of how to provide good discipline and thus not implement the suggestions.

Convenience of Help and Support

It is important for FSWs to access the clients through home visits, and it is also important to understand how clients feel about privacy and issues related to the inconvenience of home visits. Clients's feelings about the home visits are presented in Table 8.

The majority of the clients (75%) felt that their FSWs' visits were "almost never" an intrusion on their privacy. Moreover, 80% of the clients described the FSWs' home visits as "rarely" or "very rarely" inconvenient. Only 9% of the clients reported that their FSW's visits were "almost always" an intrusion, and 7% added that their FSW's visits were "very often" inconvenient. Some clients suggested that home visits were sometimes inconvenient because of their work and activity (eg. softball practice in the afternoons) schedule.

Recommendations about the H.S. Program

One way to assess clients' perceptions and satisfaction with H.S. is to find out if the clients would recommend the program to others. Eighty-four percent of clients reported that they would "definitely" or "most definitely" recommend this program to a friend (see Table 9). The majority of the clients (90%) also stated that they would tell family members that H.S. could be helpful/useful for them. This is very important because over time word of mouth by current and former clients to prospective clients may be the best form of advertising for the H.S. Program.

Open-ended Data: Social Support

The open-ended data are important and may either support the quantitative responses of the clients or pinpoint any discrepancies between qualitative and quantitative responses. The open-ended portion of the questionnaire contains questions related to overall opinions and perceptions of the program and specific questions about the three domains: (a) support, (b) nurturing, and (c) future outcomes (See Appendices B & D).

Predominantly, clients' comments about the program were positive and confirmed and supported their quantitative responses. The qualitative comments allowed the clients to emphasize parts of the program they found most and least helpful. Most clients felt the program services and in particular FSWs were accessible and helpful. A variety of services including transportation, providing basic supplies at short notice, and most importantly, kindness and care were specifically cited. Some verbatim comments made by Healthy Start clients provide the reader with a personal sense of their sentiments:

"The workers are very kind and supportive. They don't look down on you [clients] or make you [the client] feel bad even if you make a mistake."

"Families just need someone to show them they "care" and that [the families] can make it."

More specifically, most clients reported that they had good relationships with their FSWs and appreciated the FSW's help. Clients had different reasons for appreciating their FSWs:

"I really like how if I have a wild question, I can ask her and she will be honest with me."

"My FSW gives me the incentive to make my life better...she gives me the confidence about what kind of mother I am to my child...she is the best thing that has happened to me and my family."

Other clients offered suggestions for program improvement or program change. Clients suggested that Healthy Start should organize

more programs and activities for the children and families. They also inquired about the possibilities for a Healthy Start affiliated daycare or a list of good babysitters for clients to use. Most of the women felt they could rely on their FSWs for transportation, but some clients said that their FSWs did not like to "take them places." These responses regarding satisfaction with transportation services may reflect the FSW's attempts to increase the independence and self-sufficiency of the clients. Clients who must plan and organize outings and find appropriate means of transportation may develop a greater sense of independence than the clients who rely on FSWs as their sole means of transportation, but may report that FSWs were less available for transportation.

The greatest differences in opinion found in clients' comments to open-ended support questions concerned the FSW's visits. These comments reflected a discrepancy in the clients' desired amount of home visits by FSWs. Many clients wanted their FSW to visit their home more than once a week. At least three clients desired more time with their FSWs. Two of these moms were first-time mothers while one was a repeat mom. Three other clients felt that the FSWs should visit less often than once a week. One client believed that bimonthly visits would be better. Others felt that the initial visits after birth were good but thereafter should be available as needed and as requested, rather than pre-scheduled for each week. These results do not necessarily reflect a problem with the present schedule of FSW home visits. These comments may reflect the expected distribution of opinions in any group of individuals. Although there are some clients who would prefer different schedules for home visits (eg. fewer or more visits), the majority of the clients appear to be satisfied with how often their FSW visits the home.

Overall the client comments were positive. One client sums up the general feelings about Healthy Start and the FSWs:

"The program is wonderful but even the "best" programs are no better than the people that work for it...[My FSW] is always there when I need her and she is encouraging. It's people like her that make Healthy Start a great program."

The Clients' Perceptions and Satisfaction Survey (CPSS): Nurturing

Domain

An important goal of the Healthy Start Program is to encourage optimal child development and promote productive interaction and bonding between parent and child (Galano & Huntington, 1993). Increasing the nurturing skills of parents is also important because these skills can help clients deal with stressful situations related to childrearing and problems related to child development. Clients who understand how to effectively interact with their children are less likely to neglect or abuse the child. Nurturing abilities also increase the parents' self-efficacy and beliefs that they can be good parents. The majority of nurturing information is taught and distributed by providing written educational materials for the clients and by the FSWs and health care workers during home visits. Experts suggest that including a wide range of issues in home visiting programs is the desirable (Ramey & Ramey, 1993). The H.S. Program and the FSWs strive to accomplish this goal and make the home visits as productive as possible by monitoring a variety of issues and helping the mother as well as the child.

Nurturing Domain Outcomes

Clients' perceptions of aid on nurturing issues were organized into 2 subdomains: (a) information on nurturing provided to the clients and (b) changes in parenting behavior. The results for the nurturing domain are presented in Table 10. The majority of issues were measured with 1-5 point Likert-type scale items that ranged from "very rarely" to "very often," "strongly agree" to "strongly disagree," and "not at all helpful" to "very helpful." One question required a dichotomous (yes or

no) answer. A second question requested information on nurturing class participation.

The following sections discuss the results on the subdomains of the nurturing domain.

Information on Nurturing

The primary strategy that Healthy Start uses to provide information to clients about nurturing is the FSWs' weekly home visits. The program also provides useful information during nurturing classes and through mailed newsletters. Clients responses to questions about the information they were provided are presented in Table 11.

Most clients (42%) felt that they at least "sometimes" gained information about parenting that they would not have known otherwise (see Table 11, Known). Many clients (35%) felt the program provided novel information "often" or "very often." Only 23% of clients felt that they "rarely" or "very rarely" received any new information about parenting. Clients who reported that they did not receive novel information may have had more experience with children prior to program involvement. Some repeat mothers felt that since they had successfully raised children before enrolling in H.S., the information they received was not very new or useful. However, the ratings confirm that Healthy Start is effectively providing important information to the majority of its clients.

Clients were also satisfied with the information they received regarding proper nutrition for their child. The majority of the clients (73%) reported that their FSW gave them nutrition information "often" or "very often." These ratings suggest that H.S. is accomplishing its goal of encouraging mothers and providing helpful child development materials.

Clients reported that their FSWs discussed activities (reading, playing, and outings) to do with their child and useful ways to communicate with their child. Clients (72%) felt that their FSWs "very

often" discussed appropriate activities they might do with their child. The clients (73%) were also pleased with the quantity of information they received concerning parent/child communication (see Table 11, Talk).

Many clients (48%) participated in either program nurturing classes or home-based nurturing sessions provided by the FSWs. Most clients (59%) felt that the classes were "very helpful," another 16% thought they were "helpful", and 22% believed that they received some useful information. The classes appear to provide a helpful source of information about nurturing issues and child development for participating clients.

The same trend was evident for the clients (96%) who received the Healthy Stages newsletter. Clients who received the newsletter rated it as "somewhat helpful" (31%) or "very helpful" (23%). The difference in the reports of the helpfulness and utility of the newsletter and the classes may be due to self-selection and the medium in which they were presented. Clients may not take the time to read the newsletter thoroughly and they may overlook helpful information. It appears that active participation, especially by a subgroup of motivated parents who have self-selected themselves, in classes and emphasis on specific topics is a more useful way for the clients to gain information and learn about how to parent.

Parenting Behavior Changes

Another subdomain of nurturing assesses changes in the clients' parenting behaviors and skills (see Table 12). This subdomain includes questions related to specific topics about the impact of H.S. on parental behavior and attitudes.

Most clients (82%) felt that they "often" or "very often" interacted with their child (eg. singing, reading, etc.) (see Table 12, Song). Another 18% of clients reported that they "sometimes" engaged in activities with their child. None of the clients reported that they

"rarely" or "very rarely" sang, read, or did other activities with their child.

Clients' opinions varied concerning the amount of health care their child received because of their program involvement (see Table 12, Care). Some clients (29%) felt H.S. had helped their child to receive much better health care. Most clients (42%) neither agreed nor disagreed that H.S. had helped their child get better health care. Surprisingly, 25% of the clients did not believe their child received much better health care because of program participation. An "optimistic" interpretation would be that the routine health care offered to low income mothers at the Hampton Health Department is very good and mothers perceive it as such. Indeed the Department has a reputation for being highly committed to its low-income clients.

One third of responding clients (33%) "agreed" or "strongly agreed" that H.S. provided parenting information and that they have changed the way they parent (a rating of 4 or 5) (see Table 12, Parent). An almost equal number (29%) reported that they "strongly disagreed" or "disagreed" (a rating of 1 or 2) that H.S. influenced the way they parent. Finally, 39% of the clients were neutral, neither agreeing or disagreeing, about the program's influence on their parenting style (a rating of 3). The wide range of scores among clients suggests large individual differences in how the clients perceive the impact of the H.S. program on their parenting ability and style.

Clients evaluations of the degree to which the program had increased their enjoyment of their child also varied (see Table 12, Enjoy). Many clients (35%) "strongly agreed" that participating in the program had made their relationship with their child more enjoyable. However, 38% of the clients "neither agreed nor disagreed" that the program helped them to enjoy their child more. Responses to this question may have suffered from a kind of ceiling effect. If clients already enjoyed their child there would be no reason to see the

intervention as leading to higher levels of enjoyment. It would be ideal if a pre-measure were used so that the analysis only included the responses of clients whose initial enjoyment levels were moderate or low. The issue remains important because an enjoyable relationship between the clients and their children may reduce the chances of abuse and neglect that result from indifference or frustration.

Open-ended Questions: Nurturing

The open-ended questions elicited primarily positive responses concerning the information clients received from the program and from FSWs on nurturing issues, positive parent-child interaction, and parenting. A specific open-ended question related to child development was also asked to all 10 clients who reserved a personal interview. This specific question and the general open-ended questions (i.e. overall perceptions of the program) evoked positive sentiments about a variety of topics related to child development and parenting:

"[My FSW] helps me make sure [the baby's] shots are up to date."

"[The program] does tests to see if [my child] is at the right level of development."

"[My FSW] gives me papers about development and information on child safety."

Many clients felt that the leaflets and literature on development were useful. They appreciated having a checklist which helped them to know what to expect as their child developed and that they could use to monitor their child's development. The clients participating in the nurturing classes were very satisfied with the information gained from the course. One client stated, "The parenting classes offered by H.S. are excellent...", and another client remarked, "H.S. is a beautiful way for the first-time mother to gain knowledge and proper care for nurturing..." Even clients who had some prior experience received new, useful information, "... Even though they give me information that I have heard before, there is always something new embedded in the literature that I did not know before..."

Only a few clients felt that the developmental information and literature provided were not as useful as they had hoped. Some clients suggested that there should be additional information for repeat moms. One client felt that FSWs should be more sensitive to individual differences in child development since her child was developing ahead of schedule and the information she received was outdated.

In general, the clients' comments were useful and constructive. One client's comment summarizes well the ideas about parenting and nurturing:

"[H.S.] has made me feel like I can make a new beginning with my kids, and they are there when I need help finding resources (such as parenting classes and helping find things I need for my kids)."

Clients' Perceptions and Satisfaction Survey (CPSS): Future Outcomes

Domain:

Although the H.S. model begins with pre-natal intervention aimed at preventing deficiencies at birth, followed by a major emphasis on improving mother-infant interaction, many of the ultimate goals of the program are longer-term in nature. Through its comprehensive approach of medical, education, and social services, H.S. tries to prepare the child and parent for future events such as the child starting school ready to learn and the parent returning to school or work. Providing these services as well as having the FSW discuss future plans and opportunities is intended to aid clients in creating a more positive future.

In addition, to influencing the clients' futures by helping the mothers to make their lives better by returning to school or getting a job, H.S. helps them make educated plans about their family's future (eg. birth control and family planning). The H.S. program hopes these

positive changes in their clients' lives will result in a better sense of self-esteem and self-efficacy about themselves, as well as more positive feeling concerning their family.

Clients' perceptions about future outcomes are presented in Table 13. The data for overall perceptions of future outcomes revealed that clients found the program helpful in discussing current concerns and planning for the future. The future outcomes domain is comprised of 4 subdomains: (a) help in finding a job or furthering education, (b) family planning, (c) program effect on the mother's life and, (d) program effect on the child's life. These items were measured on a 1-5 point scale which ranged from "strongly disagree" to "strongly agree," "very little effort" to "very much effort," "not at all helpful" to "very helpful," or "very rarely" to "very often".

The following sections discuss the results of the subdomains of the future outcomes domain.

Employment and Education

Many clients reported that they were trying to find employment (61%) or further their education (76%) (see Table 14). For clients seeking employment or educational opportunities, 21% of the clients thought the program was "somewhat helpful" in finding employment possibilities while 39% believed the program was "very helpful" at making suggestions about opportunities to further their education. It appears that clients felt the H.S. program was more helpful in finding education opportunities than jobs. Part of this problem may result from the fact that many clients have little or no work experience. In addition, the educational experience of clients who are seeking employment is very diverse making it challenging for FSWs trying to identify opportunities. Obtaining information on education and helping a client reenter school may be easier than locating acceptable employment opportunities.

Family Planning

Clients' responses to family planning questions are presented in Table 15. Most clients felt that FSWs helped them with family planning issues. Specifically, clients (94%) believed that FSWs offered "some help" to "a lot of help" in thinking about family planning. Only 6% of the clients reported that their FSWs offered "little" to "very little" help in family planning. Some clients (48%) felt that their FSW did not try to force her personal opinions about birth control, however, some clients (38%) suggested that their FSWs forced personal opinions on birth control "often" or "very often" (see Table 15). Birth control and family planning are sensitive issues, so FSWs' best attempts at presenting information on these subjects may still be misinterpreted by clients as intrusive or coercive.

Changes in Mother's Future

Clients (65%) "agreed" or "strongly agreed" that the Healthy Start Program had a positive impact on their lives (see Table 16, Positive). Some clients (24%) did not notice any changes in their lives because of participation in H.S.. Finally, some clients (11%) "disagreed" or "strongly disagreed" that there were positive changes since starting the H.S. Program. It would be interesting to know if the women who did not think there were changes had more problems that were different or more intense than their counterparts who experienced change. In addition, many health department clients were living at or below the federal poverty level in a city with little available public housing and their assessment that the program was not able to "fix" their problems may be accurate.

In addition, several women commented that the program was not thoroughly explained to them when they started participating. The clients who did not acknowledge any positive changes may be women who did not fully understand or fully accept the goals of the program and felt pressure to participate in H.S.. More information about the clients' individual problems and their reasons for enrolling may reveal

evidence for why some clients do not feel H.S. made positive changes in their lives.

Most clients (56%) "agreed" or "strongly agreed" that H.S. had helped them to make plans for their futures, (see Table 16, Plansfut). Also, most (97%) felt that they put forth "some effort" to "very much effort" (a rating of 3 to 5) to accomplish the program goals established for them (see Table 16, Effort). It appears that most clients feel that H.S. helped them to start planning their futures and accomplish some important goals.

Changes in Child's Future

Clients generally felt that the program encouraged healthy child development and helped with planning their children's futures (see Table 17, Impact and Childfut). Most clients (66%) "agreed" or "strongly agreed" that the program had a positive effect on the development of their children. Another 27% of the clients were not sure if the program had an impact while only 8% believed that participating in the program had not benefited their child's development. Clients had similar opinions about the program's help in planning their child's future. Sixty-nine percent of clients believed that the program helped them to start planning their child/children's futures. Some clients (17%) did not have an opinion, and 15% felt the program did not help them to plan for their child's future.

Open-ended Questions: Future Outcomes

A specific question about the future was asked to 10 of the clients who participated in personal interviews. This question did not evoke many more responses than the set of general questions about overall program perceptions that were asked of all the clients. However, the specific question did evoke one interview client's response, "[My FSW] really influenced my decision to further my education." Most personal interview clients did not give specific ways the program affected their future, but they felt that it did have some

effect on their lives and their children's lives.

In general, clients felt that the program was influencing their future. However, some clients expressed problems when the topic of family planning was raised. One older client believed that she had waited a long time to have children, and she did not appreciate her FSW's opinions or advice on the topic of birth control. Other clients expressed some discontent with how birth control issues were handled in the program, but they did not make specific comments. Indeed the very clients who most need and could most benefit by more discussion of planned pregnancies and family size may be the same clients who are upset when FSWs discuss these issues.

Clients' comments about the future were predominantly intermingled with comments about support and nurturing, so differentiating between domain-specific comments was difficult. In general, clients felt that H.S. was helping them with many parts of their lives including their futures. One client's comment reflects the general feelings about the future:

"[The program] helps me greatly consider my future, [it] offers me suggestions on how I can make my future more clear for me and my children."

Additional Hypotheses and Inquiries for the CPSS

Two additional hypotheses concerning client satisfaction and two inquiries concerning the relationship between the CPSS and known mediators of child abuse and neglect were explored. These four areas of inquiry are summarized below:

1. Do first-time mothers and repeat mothers' scores differ on the CPSS?
2. Are there significant differences among clients' ratings of perceptions and satisfaction as a function of the modality used? (i.e. mailed surveys, telephone interviews, or personal interviews)
3. Is there a relationship between a client's length of participation in the program and their ratings on the CPSS?
4. Are existing measures used in the H.S. program evaluation predictors of clients' scores on the CPSS?

Client Satisfaction: First-time versus Repeat Mothers

In order to better understand possible differences between the perceptions and satisfaction of first-time mothers compared with repeat mothers, clients' CPSS scores between these two groups were compared. Thirty-eight first-time mothers and 28 repeat mothers completed the survey, $\bar{M} = 66.47$, $SD = 11.02$ and $\bar{M} = 63.43$, $SD = 13.25$, respectively. A oneway analysis of variance revealed that there were no significant differences between CPSS scores for first-time and repeat mothers, $F(1,64) = 1.03$, $p = n/s$. This finding does not support the original hypothesis that first-time mothers would demonstrate higher levels of satisfaction with the H.S. Program than repeat mothers. Furthermore, a repeated measures MANOVA revealed no interaction effect between clients' ratings on each of the three domains and their status as a first-time or repeat mother.

These results suggest women experiencing parenthood for the first time as well as for mothers who have other children find the services and information provided by H.S. useful. The results can also be interpreted positively for the program since the literature and reports from the H.S. program evaluations nationally suggest that repeat mothers are more difficult to engage and serve than first-time mothers. Open-ended responses on the CPSS also support this finding. Clients who had children prior to enrolling in H.S. generally felt that they acquired useful information and were able to use many of the services provided by the program. H.S. offers help and services that are valued to both groups of mothers.

Client Satisfaction: Differences Among Three Modalities

A oneway analysis of variance with planned comparisons was performed to examine differences between scores on the CPSS when it was administered to clients as: (a) a mailed survey, (b) a personal interview, or (c) a telephone interview. Specifically, the planned comparisons examined differences between scores on the mailed surveys compared to personal interview and telephone interview scores. Comparisons were also performed to examine differences between personal interview scores and telephone interviews scores.

There were no significant differences in clients' scores among the three modalities of distribution, $F(2,64) = .84, p < .44$. It was hypothesized that clients who were sent a mailed survey would express more variability in responses than clients who gave personal interviews and telephone interviews. Clients' responses to the survey items during personal and telephone interviews were expected to be more similar to each other and more positive than responses given by clients on the mailed surveys. The method of distribution for this survey had no effect on the clients' perceptions and satisfaction with the H.S. Program.

The original hypotheses about differences in clients' responses among the three modalities were not supported, but the consistency of answers across the three modalities does imply that there is consensus about the H.S. program across these three groups. In addition, mail surveys which were the most random method of distribution, produced responses which were as positive as the clients' responses elicited through telephone and personal interviews. The consistency of responses on mail surveys with responses on telephone and personal interviews and more importantly, the fact that clients were selected through a scientifically random procedure, increased the evaluators' confidence that the surveyed clients were similar to the non-surveyed sample. It must be noted that the sample sizes were small for clients who received personal or telephone interviews. Increasing the sample size for these modalities may reveal differences in perceptions and satisfaction among clients that this study was unable to detect.

The Relationship between Program Participation Time and Client Satisfaction

The length of time that clients had participated in the program was compared with the clients' scores on the CPSS to examine whether clients' level of satisfaction changed over time. Eighty-six percent of the clients had been in the program 10 months or longer. The longest time clients (3%) had participated was 33 months.

There was no significant relationship between length of time in the program and scores on the CPSS, $r(62) = -.037$, $p = n/s$. The results suggest that clients' perceptions and satisfaction with the H.S. Program were not affected by the length of time the client participated in the program. However, it is important to note that the sample used to test this relationship may be biased because a disproportionate number of unsatisfied clients may have left the program or failed to return the survey or give an interview. Having access to these non-

responders to determine if they differ systematically from our sample would be ideal but goes beyond the resources (time and personnel) available to conduct this evaluation.

Predictors of CPSS Scores: The Family Stress Checklist, The Child Abuse Potential Checklist, The NCAST Home Environment Scale, and the NCAST Feeding Scale

Clients' scores on important predictors and mediators of child abuse and neglect used by the H.S. Program in their comprehensive program evaluation were examined to understand their relationship to CPSS scores and to assess their utility as predictors of CPSS scores. These variables included: (a) the Family Stress Checklist (FSC), (b) the Child Abuse Potential Inventory (CAP), (c) the NCAST Home Environment Scale (HOME), and (d) the NCAST Feeding Scale (FEED). The Family Stress Checklist is a screening device which assesses risk factors related to abuse and neglect, and the CAP provides a standardized measure of risk for physical abuse and maltreatment. These scales were administered to clients at their initial screening. The HOME measures the adequacy of the developmental stimulation being provided in the participant's home environments, and the FEED is used to examine the status of parent-child interaction. These measures were administered by observation of the clients when the child was 1 and 6 months of age. The FEED is considered to be a valid and highly respected instrument which provides the program with a crucial measure of current mother-child interaction (a major area targeted by the H.S. intervention model).

A multiple regression analysis was performed using clients' scores on the FSC, the CAP, the 1-month HOME score, and the 1-month FEED score as predictors for clients' scores on the CPSS. The child's 1-month scores were used in this analysis because data from the 6-month follow-up were too incomplete. The 12-month follow-up scores were also not appropriate because not enough clients who had 12-month data had been participating in the program for more than a year. The FSC ($M = 57$) =

38.77, $SD = 12.26$) and the CAP ($M (57) = 124.68$, $SD = 79.87$) were not significant predictors of clients' scores on the CPSS, $b (57) = -.18$, $p < .14$ and $b (57) = .01$, $p < .42$, respectively. Furthermore, Pearson product-moment correlations did not reveal any significant relationships between clients' scores on the FSC and the CPSS, $r (57) = -.11$, $p = n/s$ or the CAP and the CPSS, $r (57) = .20$, $p = n/s$.

The multiple regression analysis also determined that the 1-month scores on the HOME ($M (57) = 27.11$, $SD = 4.70$) were not a predictor of clients' scores on the CPSS, $b (57) = -.05$, $p = n/s$. The correlation between the clients' initial HOME scores and the scores on the CPSS was not significant, $r (57) = -.23$, $p = n/s$.

Finally, the multiple regression revealed that the clients' 1-month FEED scores were a predictor for the clients' scores on the CPSS, $b (57) = -.68$, $p < .01$. These results should be considered with caution because the correlations between the 1 month FEED scores and the CPSS scores were significant but counterintuitive, $r (61) = .53$, $p < .001$. These results suggest that clients who scored higher (a more positive score) on the 1-month FEED assessment reported lower ratings on the CPSS (a more negative score). Conversely, this finding also implies that clients who scored lower (a more negative score) on the 1-month FEED assessment reported higher ratings on the CPSS (a more positive score). Mothers who scored lower on the FEED might report higher satisfaction (i.e. a higher CPSS score) with the program because it led to them to being identified as being deficient in this area and, ultimately, to setting goals to enhance parent-child interaction and to receiving more information and FSW support focused on parent-child interaction.

Difference scores were also created by subtracting the clients' one month FEED scores from their six month scores. The difference scores were correlated with the CPSS scores to examine the relationship between changes in the amount and quality of parent-child interactions and clients' overall feelings about the H.S. Program. No significant

relationship was found between changes in assessments of parent-child interactions and clients' satisfaction with the program, $r(52) = -.04$, $p = n/s$. These results suggest that improvements in the quality of parent-child interaction, bonding, and communication are not related to perceptions and satisfaction with the program. It is important to note that overall there were only modest improvements in parent-child interaction after 6 months. Under these circumstances it was difficult to assess if high versus low change was differentially related to satisfaction. If the improvements on the FEED at one year are more substantial (this data will be available in September, 1995) testing this relationship again may be worthwhile. Finally, the lack of 6 month FEED scores for some clients is another reason to examine these results with caution. It is plausible that the clients who had 6 month FEED assessments differed in important ways (eg. more cooperative, more involved) than the clients who did not have the 6 month assessment.

Conclusions and Recommendations

Overall Conclusions and Suggestions about Clients' Perceptions and Satisfaction with the Healthy Start Program:

Clients believe that Healthy Start is a valuable source of support as well as a program providing information on nurturing and parenting and help for planning their and their children's future. These are important findings with positive implications for the program and its clients. Clients' satisfaction with the FSWs and the home visiting component were equally important because they represent a central premise concerning what services families need to be strong and how these services can best be delivered. Clients felt that their FSW was accessible, helpful, understanding, and in some cases was their only confidante or friend. The clients in the H.S. Program strongly believe that their FSWs are the cornerstone of this program. The H.S. Program provided what was most important to these clients, interaction with supportive and caring people. For many clients, the first step in improving their situation was finding someone to talk with about all their concerns and worries. Feelings of isolation and despair were often problems for these women and the FSWs helped to dispel these feelings. Providing clients with people that care about them was one of Healthy Start's real strengths.

The information provided by this program pleased clients. Most clients believed that H.S. and especially FSWs provided them with a lot of useful information on a wide variety of issues (eg. child development, housing, etc.). However, clients' feelings about the usefulness and helpfulness of this information may often go unnoticed by FSWs, health care workers, and administrators because of the urgency of the clients' other problems. Many clients expressed positive sentiments during interviews and on mailed surveys concerning the information they were given. Clients may appear to only appreciate tangible services and

goods, (eg. help paying bills, baby supplies, making appointments for the baby) but they desire and appreciate the information about how to cope with the stress of bills they cannot pay, information about influencing their child's development through the appropriate use of toys or by reading, and information about why it is important for them to make and keep appointments so their child can get the proper immunizations and checkups. Although the tangible services are emphasized by clients, these clients also benefit from and appreciate the FSWs taking the time to offer information about the issues that affect the mothers and children's lives.

Suggestions for Making the CPSS More Useful:

Although there are no obvious differences between clients' responses in any of the modalities, the mailed surveys appear to be the best way to acquire the most information. Clients who returned mailed surveys responded to more items and made more thorough responses to open-ended questions than clients who were given personal or telephone interviews. This suggests that the domain-specific items, such as the three used in the personal interviews, would yield more information if they were included in the mailed surveys. Clients who responded to mailed surveys were under less time constraints and felt more comfortable expressing both their positive and negative feelings about the program.

Although clients' responses to mailed surveys were more thorough and more variable, it is important to recognize the benefit gained by using a multimodal strategy. This study gathered useful information from the telephone and personal interviews as well as from the mailed surveys. Clients' responses to open-ended questions during personal and telephone interviews were insightful and helpful. Clients also provided opinions about the clarity of the items on the questionnaire during personal interviews. To make future interviews more productive, a different interview format might be experimented with. Clients could be

interviewed in a group setting to promote discussion among the mothers and to reduce the clients' pressure to respond to all the items. In this situation, interview questions would be asked to a small group of clients (eg. 3 or 4 women at one time) who could discuss their answers with one another as well as with the interviewer. This would allow clients to emphasize topics that are important to them. Using more specific questions about a variety of issues during personal interviews could elicit more thorough responses from clients.

Finally, to increase the effectiveness of the telephone and personal interviews, the interviewer should have more access to clients. This is often a difficult challenge because of the transient nature of many clients. One way to make personal interviews easier to administer would be to allow the interviewer access to clients' home if the clients are willing. Some clients repeatedly made appointments for interviews, but either cancelled or failed to keep the scheduled appointment. The clients who gave interviews appreciated the opportunity to express their opinions about the program. The women who cancelled appointments may have wanted to give an interview, but the process was too inconvenient for them to participate. Interviews at the client's home may produce feelings of comfort and security and encourage more thorough responses.

There are also several recommended changes to the questionnaire itself which may make it a better instrument and a more useful measure for the H.S. Program. First, the questionnaire could be modified by dividing the existing items into two main sections. One section would contain items related to support and another section would focus on items related to aid/information. The aid/information section would be created by collapsing the nurturing and future outcomes domains. Because of the importance of home visits, items concerning this topic could also be treated as a new, separate domain. Specific items about home visits may provide information about "how often" the FSW engaged in certain activities (eg. discussion of parent-child interaction,

discipline techniques, etc.). These specific questions about activities during home visits may provide better explanations for why some clients were more satisfied than other clients.

Issues for Consideration

Confusion and Disagreement Concerning H.S. Goals and Objectives:

Clients had mixed feelings about their participation in the program and the effect of the program on their lives. Some clients believed that the program was not thoroughly explained to them when they enrolled. These clients did not deny that the program could be useful, but they did not fully understand why they needed to participate in H.S. They did not feel the program had much effect on their lives and were unsure of the program's goals. The clients who were confused about program goals may be women who entered the program during its first year. When the program began, FSWs were often the first H.S. representatives to visit the clients and orient them to the program. Clients may have viewed the FSW as "just another social worker" who reminded them of the stigma associated with being a welfare recipient. The clients' already biased impressions of FSWs might have resulted in confusion about the program and its goals.

To reduce the misconceptions of clients, the enrollment process was changed during the second year of the program and a public health nurse was assigned the role of initial home visitor. During the first visit, the nurse goes into the home to check on the newborn's health and to provide clients with information and explain the program. Allowing nurses to initiate the enrollment process may have reduced some of the clients' misgivings and misconceptions. Also, the nurses emphasize positive parts of the program by addressing how H.S. can aid with childrearing and child health care; she does not highlight issues related to neglect/abuse that could trigger negative feelings about

participating in the H.S. Program. The nurse also helps to dispel clients' initial fears that they may be stigmatized if they receive help from outside sources such as H.S. Clients' pre-existing biases and the program's desire to only accentuate the positive may have inadvertently led clients to misunderstand H.S. and its goals.

Discrepancies among clients' feelings about services such as transportation may also reflect misunderstandings of the goals of H.S. The H.S. Program tries to empower its clients by providing information and helping clients find ways to help themselves. Some clients expressed discontent when FSWs did not always provide transportation when they requested it. An FSW with a caseload of 25 may not only have to make decisions about the necessity of transporting her clients, but also must try to instill feelings of independence in her clients. Clients who felt they did not receive enough help with transportation may be overly dependent on FSWs who in return are attempting to help them become more self-sufficient.

Home Visits: An Important Part of H.S.:

The FSWs' home visits are a vital part of the H.S. Program because they provide the primary opportunity for contact between FSWs and clients. Ramey and Ramey (1993) suggest that including a wide variety of issues and maintaining an unlimited focus in home visiting programs is vital for the success of these programs. They reiterate that programs which are not intensive and comprehensive and target for change only a few domains of functioning, are not likely to create beneficial, lasting changes (Ramey and Ramey, 1993). The FSWs try to follow this belief and strive to initiate positive changes in a variety of areas when they enter the H.S. clients' homes. For example, the home visits allow the FSWs an opportunity to analyze the child's home situation and offer advice and information (eg. nutrition or safety) to mothers about improving the home environment. A positive home environment helps to encourage good health and development for the child. The FSW is also

able to provide information on childrearing and discipline which helps to reduce the likelihood of neglect and abuse and encourages better relationships between parent and child. These are only a few examples of goals that FSWs hope to achieve when they make home visits. FSWs address the crucial issues during home visits (eg. assuring child safety, nutrition, etc.) while striving to integrate specific issues (eg. teaching parents ways to stimulate the child through songs or reading); the FSWs understand that creating a balance between a wide variety of issues produces the most lasting benefits for the child.

A Sensitive Subject: Clients' Opinions about Family Planning and Birth Control:

The issue of birth control and family planning was a sensitive topic for FSWs and clients. FSWs must perform a delicate balancing act when they discuss family planning issues with clients. This evaluation revealed that many clients were very satisfied while many others were equally dissatisfied. The clients enrolled in H.S. vary in age and their stage of life. Some clients are teenagers who had unwanted pregnancies while other clients are older women with children who wanted to have another child but are not able to effectively provide for their children. FSWs must make judgments about how to discuss birth control and family planning with each individual client. The FSWs try to do this constructively while also accomplishing the goal of trying to prevent or delay repeat pregnancies. This is especially a goal for FSWs working with teenage mothers. This counseling task may also be difficult for FSWs because many of their clients do not consider family planning very important and do not take the initiative needed to use birth control properly.

Although family planning is a sensitive issue, data revealed that the teen pregnancy rate for individuals in the H.S. Program has been positively affected by the FSWs' efforts with clients. In a recent report (Galano & Huntington, 1995), the H.S. repeat teen pregnancy rate

(10%) was lower than either the overall Virginia rate (25%) or the Hampton rate (29%). Some clients felt their FSWs forced discussions about family planning and birth control, yet it appears that these efforts have had an impact on the clients' decisions not to have more children. It should also be emphasized that a FSW might have the same discussion about family planning with two individual clients, and one client will find it helpful and the other may find it intrusive. FSWs will continue to encounter mixed responses from clients about family planning issues, and hopefully will also become increasingly more adept at handling the topic appropriately. This is an important area and probably warrants additional supervision by team leaders and continued support and in-service training.

The clients' opinions about family planning and the decrease in repeat pregnancy rates among H.S. clients is a good example of two types of data, primary data (i.e. repeat pregnancy rates above) and secondary data (i.e. clients' perceptions and satisfaction). Understanding the connection between primary and secondary data is important for successful program evaluation. Clients may report that they have certain beliefs and attitudes about family planning/birth control but their attitudes may not be predictive of their behavior. For example, clients may not agree with their FSWs' opinions about birth control, or they may feel that the discussion of sensitive issues like family planning is intrusive. However, the rates of repeat pregnancies among H.S. clients compared with Virginia and Hampton repeat teen pregnancy rates suggests that the FSWs' intervention has had the positive effect of reducing unwanted and repeat births.

An important issue for evaluators to acknowledge is the importance of integrating primary and secondary information in program evaluation. Furthermore, it is important to recognize any discrepancies between these sources of data. Positive primary data might not always be accompanied by positive secondary data, and it is the task of the

evaluators to decipher the implications of these differences.

Program Balance: Support, Nurturing, and the Future:

The FSWs, health care workers, and administrators have provided needed support, information on nurturing, and help with making plans for their futures. One of the most difficult tasks facing FSWs is how to adequately balance the help and services they provide clients in each of these domains. Often in a program such as H.S., clients have a list of needs that must be prioritized by the program and the clients. It may be easiest to focus on the most pressing and immediate needs or on one domain (eg. support) that is definitely needed by all the clients. However, clients also need help with issues such as appropriate ways to teach children (eg. nurturing) or with planning for their own futures. It is important for FSWs and H.S. representatives to be guided always by a model that maintains the importance of all three domains, support, nurturing, and future outcomes, as parts of the overall goal of helping clients to make a better life for themselves and their child.

Scientific Versus Client-focused?:

The Goal of Evaluation Research

The method and paradigm underlying good research in all areas, including evaluation research, was traditionally scientific and quantitative in nature. As evaluation has emerged as a "genuinely interdisciplinary field of professional practice," the emphasis on the appropriateness and credibility of the methods used in evaluative research have been emphasized (Patton, 1988). Evaluative research relies on evaluators to address the "realities" of people's lives and actions. Often to adequately accomplish the goals of evaluation and understand the realities of the world, quantitative and qualitative methods must be used simultaneously. These methods and techniques have been called utilization-focused evaluation. Patton (1988) explains

utilization-focused research as:

[Utilization-focused evaluation] being practical in orientation, replaces the traditional search for truth with a search for useful and balanced information and replaces the mandate to be objective with a mandate to be fair and conscientious in taking account of multiple perspectives, multiple interests, and multiple realities (p.197).

Utilization-focused or client-focused techniques are important to evaluative research and the usefulness of these techniques were evident in this study. One of the first decisions I faced was the choice of using a scientific or a client-focused approach for my study. The prior training I have received made it difficult to accept that quantitative and qualitative methods could be integrated successfully. I also had difficulties focusing on the main objective of the study, understanding and summarizing clients' feelings. Disassociating numbers from "meaning" was a hard task because statistical methods have been repeatedly emphasized during my research training. Given the importance of research design for an evaluation's success, I constantly reminded myself that the evaluation should be performed with a more generalist outlook. My goal of effectively collecting client responses and clearly conveying clients' feelings to people in the program was often hard to accomplish because of the competing perspectives from my training.

Finally, I began to appreciate the difficulty of gathering accurate and useful data in applied settings. Each individual I interviewed or encountered presented new perspectives or ideas about the study. I also perceived the importance of integrating qualitative and quantitative methods in evaluative research. The evaluation of clients' perceptions and satisfaction would not have been as thorough or useful without including a qualitative format.

I also faced the inevitable subjectivity associated with open-ended and qualitative measures as I attempted to discuss qualitative

comments. I realized that my interpretations of clients' positive and negative feelings about the program could arguably be different than those of individuals who have more experience with the program and individuals with different perspectives.

Before ending this section, I want to acknowledge some of the limitations of this survey and of questionnaire driven research. This survey did not and could not address every issue related to client satisfaction. The questionnaire was also unable to pinpoint reasons why there were differences in clients' responses on certain issues. For example, there were disagreements among clients concerning family planning and birth control; this evaluation could not provide conclusions about these disagreements. The CPSS was not able to identify all the issues involved in "family planning" such as individual values, contraceptives, and sexual activity. Moreover, the family planning items on the CPSS were not able to distinguish between the reasons why some clients were not satisfied with their FSW's discussions of family planning while other clients thought the discussions were appropriate and useful. Issues such as these reflect some of the limitations of this study and some of the limitations of the questionnaire itself.

During my time as a Healthy Start evaluator, I learned that a program like H.S. is often a "lifesaver" for some individuals. I met a woman with five children who valued the help H.S. provided when she felt overwhelmed. Another woman told me that her FSW was her only confidante, and she would have felt lost without her. Over time I began to understand how important the H.S. program was to so many people, but I also realized that I could never fully understand the problems and harsh realities of many clients' lives. The clients in this program are women who face innumerable challenges, however, their active participation in this program reflects their sincere desire to improve their lives and the lives of their children.

An effective evaluation of a program that affects peoples' lives is a delicate "art" that requires continuous thought and careful integration of various methods, measures, and perspectives. Studies such as this one do not rely exclusively on basic research and scientific methods that often only question theory. The Clients' Perceptions and Satisfaction Survey represents my first applied research effort and I hope it contributes in some way to improving the lives of the "real" people who participated in it.

References

- Benedict, R.H.B., & Horton, A. M. (1991). Evaluation of consumer satisfaction with information derived from neuropsychological assessment. Evaluation Practice, 12, 33-38.
- Bremer, B. A. & McCauley, C. R. (1986). Quality of life measures: Hospital interview versus home questionnaire. Health Psychology, 5, 171-177.
- Burgoyne, R. W., Wolkoob, G. H., Staples, F., Kline, F. & Powers, M. (1977). Which patients respond to a mental health consumer survey? American Journal of Community Psychology, 5, 355-360.
- Burnham, B. (1990). Is diversity an inherent part of good evaluation? Evaluation Practice, 11, 89-91.
- Cheng, S. T. (1988). Subjective quality of life in the planning and evaluation of programs. Evaluation and Program Planning, 11, 123-134.
- Dubow, E. F. & Ullman, D. G. (1989). Assessing social support in elementary school children: The survey of children's social support. Journal of Clinical Child Psychology, 18, 52-64.
- Galano, J. & Huntington, L. (1993). First-year evaluation of the Hampton Family Resource Project. Williamsburg, VA: College of William & Mary, Department of Psychology.
- Galano, J. & Huntington, L. (1994). Second-year evaluation of the Hampton Family Resource Project. Williamsburg, VA: College of William & Mary, Department of Psychology.
- Galano, J. & Huntington, L. (1995). Third-year evaluation of the Hampton Family Resource Project. Williamsburg, VA: College of William & Mary, Department of Psychology.
- Hampton Department of Social Services. (1992). Hampton Family Resource Center Abstract, 1-35.
- Hawkins, R.P. (1991). Is social validity what we are interested in? Argument for a functional approach. Journal of Applied Behavior

Analysis, 24, 205-213.

Johnson, P. (1990). Ron Carlson & James Bell discuss the challenges facing health evaluators in the 1990's. Evaluation Practice, 11, 127-133.

Lebow, J. (1982). Pragmatic decision in the evaluation of consumer satisfaction with mental health treatment. Evaluation and Program Planning, 5, 349-356.

Narins, P. (1995). Choosing the right administration method for your research. Keywords, 56, 6-7.

Patton, M.Q. (1980). Qualitative evaluation methods. Beverly Hills, CA: Sage Publications, Inc.

Patton, M.Q. (1987). How to use qualitative methods in evaluation. Newbury Park, CA: Sage Publications, Inc.

Patton, M. Q. (1988). The Methodology dragon: The paradigms debate in perspective. In Appropriate methods, pp. 177-217.

Patton, M.Q. (1990). The challenge of being a profession. Evaluation Practice, 11, 45-51.

Ramey, C.T. & Ramey, S.L. (1993). Home visiting programs and the health and development of young children. In R.E. Behrman (Ed.) & D.M. LeyVa (Man. Ed.), The Future of children: Vol. 3. Home Visiting (pp. 129-139). Los Altos: The Center for the Future of Children.

Reid, P. N., & Gundlach, J. H. (1983). A scale for the measurement of consumer satisfaction with social services. Journal of Social Service Research, 7, 37-54.

Rutman, L. (1990). Serving management and accountability: A conflict for program evaluation? Evaluation Practice, 11, 39-43.

Sorenson, J. L., Kantor, L., Margolis, R. B., & Galano, J. (1979). The extent, nature, and utility of evaluating consumer satisfaction in community mental health centers. American Journal of Community Psychology, 7, 329-337.

Stake, R. (1991). Excerpts from: "Program Evaluation,

particularly responsive evaluation." Evaluation Practice, 12, 63-76.

Tomlinson, C., Bland, L. & Moon, T. (1993). Evaluation utilization: A review of the literature with implications for gifted education. Journal of the Education of the Gifted, 16, 171-189.

Weltzien, R. T., McIntyre, T. J., Ernst, J. A., Walsh, J. A., Parker, J. K. (1986). Crossvalidation of some psychometric properties of the CSQ and its differential return rate as a function of token financial incentive. Community Mental Health Journal, 22, 49-57.

**Table 1
HEALTHY START EVALUATION PLAN**

Evaluation Point	Admin.	Intake	Assessment	1	6	12	24	36	Purpose/Domain
Screening/Recruiting Measures									
Phase I Screening	SW	*						*	Selection
Phase II Screening	SW	*						*	"
Consent & Release	SW	*						*	"
Family Demographics	SW	*			*	*	*	*	"
Child Abuse Potential	SW	*			*	*	*	*	"
Initial Assessment									
Child & Family Assessment Sched.	TL*								Implementation
Medical Demographics	RN		*		*	*	*	*	Child Health
NCAST Network Survey	FSW		*		*	*	*	*	Parenting Skills
NCAST Diff Life Circ	FSW		*		*	*	*	*	"
NCAST Comm Life Skill	FSW		*		*	*	*	*	"
NCAST HOME	RN		*		*	*	*	*	"
NCAST Feeding Scale	RN		*	*	*	*	*	*	Implementation
Follow-up Measures									
Client Tracking Sheet	TL								Implementation
Monthly Contact Report	FSW		Monthly						"
Monthly Services Report	FSW		Monthly						"
NCAST Teaching Scale	RN				*	*	*	*	"
Nurturing Quiz	HFP**				*	*	*	*	Maternal Knowledge
Denver R-PDQ	FSW				*	*	*	*	Child Development
Battelle Developmental Inven	FSW				*	*	*	*	Child Abuse & Neglect
CPS Records	SW				*	*	*	*	Implementation
FSW Interviews	Eval.				*	*	*	*	Implementation
Client Interviews	Eval.				*	*	*	*	Implementation

*Team Leader **Healthy Family Project

Table 2

Correlations Between Items in the Support, Nurturing, and Future Domains of the CPSS

Item	1	2	3
1.Support	--	.53**	.68**
2.Nurturing		--	.46**
3.Future			--

* p < .01 ** p < .001

Table 3

Overall Means for the Support Domain, the Nurturing Domain, and the Future Outcomes Domain

Overall	<u>M</u>	<u>SD</u>	n
Support	4.33	.55	71
Nurturing	3.76	.63	71
Future	3.73	.80	71

Table 4
Mean Scores for Clients on the Support Domain of the CPSS

Support	<u>Frequency of Scores</u>					M	SD	n
	1	2	3	4	5			
I received the help...from the H.S. Program (Help).	0	0	8	14	49	4.58	.69	71
*How often do you feel participation... is a waste of time (Waste)?	0	1	8	10	35	4.46	.82	54
I would recommend...to a friend (Friend).	0	1	8	10	35	4.46	.82	54
I would tell family members...helpful and useful for them (Family).	0	3	2	11	37	4.55	.82	53
The Healthy Start Program... source of support for you or your family (Source).	1	3	11	8	31	4.20	1.07	54
Healthy Start is providing... support that I would not have received otherwise (Otherwise).	5	1	13	11	24	3.89	1.27	54
My FSW tells me helpful... daily situations (Everyday).	3	1	10	9	48	4.38	1.06	71
*My FSW's home visits... intrusion on my privacy (Private).	1	2	6	9	53	4.56	.87	71
*How often are home visits inconvenient (Inconvenient)?	3	4	4	6	37	4.30	1.22	54
My FSW offers me advice... when my child gets on my nerves (Nerves).	5	2	8	4	14	3.61	1.48	33

Table 4 Continued

Support	1	2	3	4	5	<u>M</u>	<u>SD</u>	<u>n</u>
How often does FSW make... about your abilities as a parent (Positive)?	2	1	6	4	41	4.50	1.02	54
My FSW offers help about... other children (Advice).	0	3	5	3	18	4.14	1.33	29
How often FSW talk about discipline...(Discipline)	14	6	11	17	22	3.39	1.51	70
My FSW gives opportunities... about a variety of things (Questions).	0	0	3	6	43	4.77	.55	52
*My FSW criticizes behavior child (Critical).	3	1	4	3	58	4.62	.99	69
*My FSW is critical... personal behavior (Personal).	0	3	3	3	43	4.65	.84	52
I feel comfortable talking with FSW...(Issues).	6	1	10	7	47	4.24	1.26	71
When I need help... my FSW helps find agencies and resources (Resources).	3	2	1	10	33	4.39	1.13	49
If I have a problem, H.S... as quickly as possible (Quick)	0	1	7	13	47	4.56	.74	68

*Represents questions that were recoded before the data were analyzed.

Table 5

Mean Scores for Clients on the General Help and Support Subdomain of the CPSSFrequency of Scores

General Help and Support	1	2	3	4	5	M	SD	n
I received the help...(Help)	0	0	8	14	49	4.58	.69	71
*How often do you feel... waste (Waste)?	0	1	8	10	35	4.46	.82	54
The H.S. Program...source (Source).	1	3	11	8	31	4.20	1.07	54
H.S. is providing...support not received otherwise (Otherwise).	5	1	13	11	24	3.89	1.27	54
If I have a problem...as quickly as possible (Quick).	0	1	7	13	47	4.56	.74	68

*Represents questions that were recoded before the data were analyzed.

Table 6

Mean Scores for Clients on the Personal Support for Mothers Provided by FSWs
Subdomains of the CPSS

	<u>Frequency of Scores</u>							
<u>Personal Help for Mothers</u>	1	2	3	4	5	M	SD	n
My FSW tells me helpful... (Everyday)	3	1	10	9	48	4.38	1.06	71
My FSW offers me advice... when child gets on nerves (Nerves).	5	2	8	4	14	3.61	1.48	33
My FSW gives opportunities... about a variety of things (Questions).	0	0	3	6	43	4.77	.55	52
*My FSW is critical... personal behavior (Personal)	0	3	3	3	43	3.65	.84	52
I feel comfortable talking FSW...(Issues).	6	1	10	7	47	4.24	1.26	71
When I need help... my FSW helps me find other agencies and resources (Resources).	3	2	1	10	33	4.39	1.13	49
*Represents questions that were recoded before the data were analyzed.								

Table 7

Mean Scores for Clients on the Support/Help for Child Subdomain of the CPSSFrequency of Scores

Support/Help for Child	1	2	3	4	5	M	SD	n
How often does FSW make... about your abilities as a parent (Positive)?	2	1	6	4	41	4.50	1.02	54
My FSW offers help about... other children (Advice).	0	3	5	3	18	4.14	1.33	29
How often FSW talk about discipline (Discipline).	14	6	11	17	22	3.39	1.51	70
*My FSW criticizes behavior with child (Critical).	3	1	4	3	58	4.62	.99	69

*Represents questions that were recoded before the data were analyzed.

Table 8

Mean Scores for Clients on the Convenience Subdomain of the CPSS

Frequency of Scores

Convenience	1	2	3	4	5	M	SD	n
*My FSW's home visits... intrusion on my privacy (Private).	1	2	6	9	53	4.56	.87	71
*How often are home visits inconvenient (Inconvenient)?	3	4	4	6	37	4.30	1.22	54

*Represents questions that were recoded before the data were analyzed.

Table 9

Mean Scores for Clients on the Recommendations Subdomain of the CPSS

Frequency of Scores

Recommendations	1	2	3	4	5	M	SD	n
I would recommend...to a friend. (Friend).	0	1	8	10	35	4.46	.82	54
I would tell family members...helpful and useful for them (Family).	0	3	2	11	37	4.55	.82	53

Table 10

Mean Scores for Clients on the Nurturing Domain of the CPSS

Nurturing	1	2	3	4	5	M	SD	n
My FSW talks to me about... and communicate with my child/children (Talk).	2	1	3	8	37	4.51	.99	51
My FSW discusses... such as play activities, reading, outings etc. (Play).	2	3	2	13	50	4.51	.96	70
How often do you read... sing songs, and/or nursery rhymes (Song).	0	0	10	12	32	4.41	.79	54
*My child has received... is enrolled in this program (Care).	13	5	30	6	14	3.04	1.33	68
*I have learned...since beginning the H.S. Program (Responsible).	10	4	13	7	13	3.19	1.48	47
Healthy Start has not changed...parent my child (Parent).	10	5	21	4	14	3.13	1.40	54

Table 10 Continued

Nurturing	1	2	3	4	5	M	SD	n
*I realize...were unrealistic (Unrealistic).	13	4	26	7	3	2.68	1.16	53
*Healthy Start...enjoy my child/children more (Enjoy).	8	3	26	8	24	3.54	1.32	69
Have you participated in: A., B., or C (Teach).	22	12	24	--	--	2.03	.90	58
If you circled A or B, how... the classes (Classhelp)?	0	1	7	5	19	4.31	.93	32
Healthy Start provides... parenting I would not have known otherwise (Known).	10	2	22	5	13	3.17	1.38	52
Do you receive Healthy Stages newsletter (News)?	Y 49	N 20	--	--	--	1.29	.46	69
If yes, are newsletters useful to you (Newsuse)?	1	2	22	8	16	3.74	1.04	49
My FSW gives me info... providing good nutrition for my child (Nutrition).	7	1	17	20	26	4.17	1.04	71

*Represents questions that were recoded before the data were analyzed.

Table 11

Mean Scores for Clients on the Information Subdomain of the CPSSFrequency of Scores

Information	1	2	3	4	5	M	SD	n
My FSW talks to me about... and communicate with my child/children (Talk).	2	1	3	8	37	4.51	.99	51
My FSW discusses... such as play activities, reading, outings etc. (Play)	2	3	2	13	50	4.51	.96	70
*I have learned...since beginning the H.S. Program (Responsible).	10	4	13	7	13	3.19	1.48	47
*I realize... were unrealistic (Unrealistic).	13	4	26	7	3	2.68	1.16	53
Have you participated in: A., B., or C (Teach).	22	12	24	--	--	2.03	.90	58
If you circled A or B, how... the classes (Classhelp)?	0	1	7	5	19	4.31	.93	32
H.S. provides...parenting I would not have known otherwise (Known).	10	2	22	5	13	3.17	1.38	52
Do you receive Healthy Stages newsletter (News)?	Y 49	N 20	--	--	--	1.29	.46	69
I yes, are newsletters useful to you (Newsuse)?	1	2	22	8	16	3.74	1.04	49
My FSW gives me info... providing good nutrition for my child (Nutrition).	7	1	17	20	26	4.17	1.04	71

*Represents questions that were recoded before the data were analyzed.

Table 12

Mean Scores for Clients on the Parenting Changes Subdomain of the CPSSFrequency of Scores

Parenting Behavior Changes	1	2	3	4	5	M	SD	n
How often do you read... sing songs, and/or nursery rhymes (Song).	0	0	10	12	32	4.41	.79	54
*My child has received... is enrolled in this program (Care).	13	5	30	6	14	3.04	1.33	68
H.S. has not changed... parent my child (Parent).	10	5	21	4	14	3.13	1.40	54
*H.S....enjoy my child/ children more (Enjoy).	8	3	26	8	24	3.54	1.32	69

*Represents questions that were recoded before the data were analyzed.

Table 13

Mean Scores for Clients Responses on the Future Outcomes Domain of the CPSS

Future Outcomes	<u>Frequency of Scores</u>					M	SD	n
	1	2	3	4	5			
I have noticed positive... since starting H.S. (Positive).	7	1	17	20	26	3.80	1.24	71
*Healthy Start...impact on the development of my child (Impact).	1	3	14	6	28	4.10	1.11	52
Healthy Start helped...make plans for future (Plansfut).	4	2	24	17	22	3.37	1.12	69
Healthy Start helped...plan my child/children's future (Childfut).	4	4	9	15	20	3.83	1.25	52
How much effort...put forth to accomplish the goals the program has for you (Effort)?	2	0	12	13	22	4.08	1.04	49

Table 13 Continued

Future Outcomes	1	2	3	4	5	M	SD	n
Are you interested... employment (Interest)?	43	19	--	--	--	1.31	.47	62
If yes, is program helpful... employment(Possibilities)?	5	5	15	6	8	3.18	1.28	39
How much help has FSW... family planning (Plan)?	2	1	11	12	25	4.12	1.07	51
*How often does FSW force personal opinions on you... birth control choices, family planning etc. (Choice).	12	7	3	4	24	3.42	1.73	50
Are you interested in...ed (Education)?	55	13	--	--	--	1.19	.40	68
If yes, how helpful... further your ed (Edfut).	7	0	11	8	28	3.93	1.39	54

*Represents questions that were recoded before the data were analyzed.

Table 14

Mean Scores and Outcomes for Clients Responses in the Education and Employment Subdomain of the CPSS

	<u>Frequency of Scores</u>							
Education and Employment	1	2	3	4	5	M	SD	n
Are you interested... employment (Interest)?								
YES	43							
NO	19							
If yes, is program helpful... employment (Possibilities)?	5	5	15	6	8	3.18	1.28	39
Are you interested in... education (Education)?								
YES	55							
NO	13							
If yes, how helpful... further your ed (Edfut).	7	0	11	8	28	3.93	1.39	54

Table 15

Mean Scores for Clients on the Family Planning Subdomain of the CPSSFrequency of Scores

Family Planning	1	2	3	4	5	M	SD	n
How much help has FSW... family planning (Plan)?	2	1	11	12	25	4.12	1.07	51
*How often does FSW force personal opinions on you... birth control choices, family planning, etc. (Choice)	24	4	3	7	12	3.42	1.73	50

*Represents questions that were recoded before the data were analyzed.

Table 16

Mean Scores for Clients Responses on the Changes in Mother's Future Subdomain of the CPSS

Changes in Mother's Future	<u>Frequency of Scores</u>					M	SD	n
	1	2	3	4	5			
I have noticed positive... since starting H.S. (Positive)	7	1	17	20	26	3.80	1.24	71
H.S. helped...make plans for my future (Plansfut).	4	2	24	17	22	3.37	1.12	69
How much effort...put forth to accomplish the goals the program has for you (Effort)?	2	0	12	13	22	4.08	1.04	49

Table 17

Mean Scores for Clients Responses on the Changes in Child's Future Subdomain of the CPSS

Changes in Child's Future	<u>Frequency of Scores</u>					M	SD	n
	1	2	3	4	5			
*H.S....impact on the the development of my child (Impact).	1	3	14	6	28	4.10	1.11	52
H.S. helped...plan my child/ children's future (Childfut).	4	4	9	15	20	3.83	1.25	52

*Represents questions that were recoded before the data were analyzed.

Appendix A

Questions from the Hawaii Healthy Start Evaluation

Parent Interview

*Warm-up Question: How many children do you have?

*How old are they? (name and age)

*What is your age?

Child 1:

Child 2:

Child 3:

Child 4:

Child 5:

What year did you start Healthy Start?

Which child is in Healthy Start? (reference child to refer to with other questions. If more than one, ask about other children) Name:

Program Information

*1.a. Why did you become involved with the H.S. program? Who is your FSW?

*1.b. What kind of help were you hoping you would get?

*2. Did the program turn out to be different than you expected it to be? How? Can you give me an example?

*3.a. Right now, today, if you could pick the one thing that helped you the most, what would it be? Why? Can you give me some examples?

*3.b. What was a waste of time? Why? (Probe: Was there anything about the H.S. program that was a waste of time? Was there anything about the services that you found unnecessary? or you could do without? Examples?)

4. Is there anything that reminds you of what your FSW told you that you use everyday? Can you tell me some examples?

5. Had you been involved with similar programs in the past? If so, how did they compare to H.S.? (Probe: prior to H.S.)

*6. Have you ever told any of your friends or family members that they should enroll in a H.S. program too? What did you say to them? (if no:) Why not?

7.a. Did your FSW talk to you about how you talk to your child/children? (Give

name of target child) Can you give me an example? (Probe: What did she tell you? Does it work?)

*7.b. Did your FSW talk with you about what sorts of things to do with your child? Can you give me an example? (Probe: What did she tell you? Does it work?)

7.c. Do you go to the beach or the zoo or on special outings, like the museum with your kids? How often?

7.d. What about toys - what kinds of toys does (target child _____) have? Does your child have educational toys? (Probe: Toys with letters, numbers, shapes? Can I see some of them?)

* record player/tape recorder

* toys that teach name of animals

* real/toy musical instrument?

Does child put away toys without help?

7.e. What about reading to your child? Does (target) read? How many books does he/she have? What about songs? like the ABC's, Jack & Jill, Mary had a little lamb, etc.?

* child encouraged to learn pattern speech/numbers? read? (nursery rhymes, TV commercials, prayers, etc.)

* child has books?

Does family buy and read daily newspaper? Subscribe to one?

8. Does your Family Support Worker talk with you about understanding your child's behavior? (Probe: What did she tell you? Does it work?

Can you give me examples?)

9.a. Now, I'd like to ask you about (FSW _____).

How would you describe her (him)?

*9.b. Did you like (FSW's name)? Why?

9.c. Did you ever feel criticized by (FSW's name)?

*9.d. How would you describe your relationship with her/him? That of a friend? a big sister? a mother, or more formal, like a teacher?

10.a. Have you been in contact with the H.S. program and FSW (name) since you

left the program? Why/why not? What was the result? (probe: purpose?)

10.b. Other than H.S. and (FSW's name) have you received any more parenting or family services since you were in H.S.? If yes: Where? Did you like them?

II. Schooling, employment, and fertility information

Now I'd like to ask you about some of the things you are doing now.

*11.a. Are you currently enrolled in school? How long have you been in school? What are you studying to become?

11.b. Have you been in school any other times since you began H.S.? (dates) How long? What were you studying?

*11.c. Do you have plans for anymore schooling? For what? When?

*11.d. Did the H.S. program/FSW's influence your decision about school?

*12.a. Are you currently employed? If "YES," what sort of job do you have? How many hours per week do you work?

12.b. Have you had other jobs since joining H.S. program?

If "YES", obtain brief job description for each job.

How long were you at that job? What sort of work were you doing?

*12.c. Do you have plans for future employment? If YES, When? Where?

12.d. Do you feel that being in Healthy Start helped you with your employment possibilities?

13. a. Have you had more children since (give date started H.S.). How many? How old are they?

*13. b. Do you plan to have more children? Why? How many? When?

III. Parenting Issues

*14. Think back to before you had any children, what did you think it would be like to be a parent? (Probe: Were you looking forward to being a parent? Were you scared about becoming a parent?)

*15. Now that you are a parent, is it different than what you expected? In what ways? Can you give me an example?

16. a. I'd like for you to describe a typical day with your children. (Probe:

Weekday or weekend? Please tell me how does the day start? What kinds of activities do you and (target child) do? Does your family and (target child) eat at least one meal together? What about eating - does (target child) usually eat what you prepare he/she? or does he/she tell what he/she wants?)

* Is TV used judiciously?

* Does child choose favorite foods?

*16.b. What sorts of things do your children do that really get on your nerves? (Probe: Things that irritate you/gets you angry/ "stresses you out"? (if other children, ask about each of them, doublecheck age!)

*17. What do you do in these situations?

* physical punishment in last week? (Probe: slap hands?)

*18. Is this different or the same as the way you were treated as a child? How? (Probe: Can you give examples?)

19. Are there other ways in which you treat your children that are different from the way you were treated as a child? Can you give me examples?

*20. How did you think you'd be different as a parent if you had not participated in the H.S. program?

21.a. Has anyone ever put you down/criticized you about the way you deal with your children?

21.b. If yes, who was it?

21.c. What happened? (Probe: Can you describe the situation? (refer to person who criticized.)

21.d. How did you feel about it?

22. When you don't know what to do with your children, whose advice do you think about? (Probe: Whose advice do you take?)

(insert list of community resources)

23. Is target child (name) currently in a school program? (like Head Start? or pre-school? DOE) What school? For how long?

23.b. How does (target child name) like it?

23.c. What are (target child name) favorite school activities? (draw, music, etc.)

23.d. Do you put any of his/her art work or projects up around the house?

23.e. Have you met the teacher?

IV. Child Rearing Scenarios

24.a. Infants: Sometimes babies just won't go to sleep. No matter what you do, they just keep crying. What would you do in a situation like this?

24.b. Pre-schoolers (up to age 5): Sometimes when 2 and 3 year old kid are in store with their mothers they see something they want, and if their mother won't get it for them, they will really throw a scene -- screaming, crying, even throwing themselves down on the floor. How would you handle a situation like this?

24.c. All Ages: It seems like all kids talk back to their parents sometimes. Can you tell me about the last time that this happened with one of your children? (Probe: For target child. What did you do?)

Do you have any questions for me?

Thanks for your help and time.

* Questions used for the group discussion with the mothers

Other questions asked at the group discussion with the mothers:

1. How do you feel about the home visits made by your FSWs?

*intrusion

*bad timing/inconvenient

*too many/too few

2. Do you see changes in your life (+ or -) since starting H. S.?

Have your personal values been affected? Do you see progress for your child?

Examples

3. Do you feel this program has made an impact on the way you feel about your children/child's development and your child's future?

Appendix B

The Clients' Perceptions and Satisfaction Survey

Please answer questions 1-4. For the remainder of the questions, respond by circling the number, 1 to 5, that corresponds to your answer. If a particular question does not apply to you or your circumstances, simply write "N/A" beside the question. Thank you again for your participation.

*1. When did you start participating in the Healthy Start Program?

Month _____ Year _____

*2. How many children do you have? _____

*3. Do you plan to have more children? _____ If yes, when (approximate date) do you plan to have your next child? _____

*4. Are you employed? _____

Full-time _____

Part-time _____ Hrs/week _____

*5. I received the help I was hoping to get from the Healthy Start Program.

Almost Never		Sometimes		Almost Always
1	2	3	4	5

6. How often do you feel that your participation in the program is a waste of time?

Almost Never		Sometimes		Almost Always
1	2	3	4	5

*7. I would recommend this program to a friend.

Definitely Not				Most Definitely
1	2	3	4	5

8. I would tell family members that Healthy Start could be helpful and useful for them.

Definitely Not				Most Definitely
1	2	3	4	5

9. The Healthy Start Program has been a source of support for you or your family.

Almost Never		Sometimes		Almost Always
1	2	3	4	5

10. Healthy Start is providing me with support that I would not have received otherwise.

Strongly Disagree		Neither Agree nor Disagree		Strongly Agree
1	2	3	4	5

*11. My FSW tells me helpful things that are useful in everyday situations.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*12. My FSW's home visits are an intrusion on my privacy.

Almost Never		Sometimes		Almost Always
1	2	3	4	5

13. How often are your FSW's home visits inconvenient?

Very Rarely		Sometimes		Very Often
1	2	3	4	5

14. My FSW offers me advice or helps me decide how to handle situations when my child gets on my nerves (if not applicable please circle N/A) N/A

Very Rarely		Sometimes		Very Often
1	2	3	4	5

15. How often does your FSW make positive comments about your abilities as a parent?

Very Rarely		Sometimes		Very Often
1	2	3	4	5

16. My FSW offers help and advice about my other children (answer only if you have more than one child).

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*17. How often does your FSW talk with you about discipline and offer discipline alternatives and ideas.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

18. My FSW gives me opportunities to ask questions about a variety of things.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*19. My FSW criticizes my behavior with my child.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

20. My FSW is critical of my personal behavior.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*21. I feel comfortable talking with my FSW about many issues in my life (personal problems, money issues, etc.).

Very Rarely		Sometimes		Very Often
1	2	3	4	5

22. When I need help that is not available from Healthy Start, my FSW helps me find other agencies and resources.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*23. If I have a problem, Healthy Start provides help as quickly as possible.

Strongly Disagree		Neither Agree nor		Strongly Agree
		Disagree		
1	2	3	4	5

24. My FSW talks to me about ways to talk to and communicate with my child/children.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*25. My FSW discusses activities for me to do with my child such as play activities, reading, outings, etc.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

26. How often do you read to your child, sing songs, and/or nursery rhymes.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*27. My child has received much better health care because she/he is enrolled in this program.

Strongly Agree		Neither Agree nor		Strongly Disagree
		Disagree		
1	2	3	4	5

28. I have learned more about the responsibilities of parenting since beginning the Healthy Start Program (if not applicable please circle N/A) N/A

Strongly Agree		Neither Agree nor		Strongly Disagree
		Disagree		
1	2	3	4	5

29. Healthy Start has not changed the way I parent my child.

Strongly Agree		Neither Agree nor		Strongly Disagree
		Disagree		
1	2	3	4	5

30. I realize that some of the ideas I had about parenting before I enrolled in Healthy Start were unrealistic.

Strongly Agree		Neither Agree nor		Strongly Disagree
		Disagree		
1	2	3	4	5

*31. Healthy Start has helped me enjoy my child/children more.

Strongly Agree		Neither Agree nor		Strongly Disagree
		Disagree		
1	2	3	4	5

*32. Have you participated in: A.nurturing classes and/or B. home-based nurturing sessions (FSW teaches in home) C. no nurturing classes/ home-based nurturing sessions (please circle the letter or letters that apply).

*33. If you circled A or B, how did you find the classes?

Not at all Helpful		Somewhat Helpful		Very Helpful
1	2	3	4	5

34. Healthy Start provides information about parenting that I would not have known otherwise.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*35. Do you receive the *Healthy Stages* newsletter?

Yes _____ No _____
 (if you circle NO, go to question #37)

*36. If yes, are the newsletters useful to you?

Not at all Helpful		Somewhat Helpful		Very Helpful
1	2	3	4	5

*37. My FSW gives me information about providing good nutrition for my child.

Very Rarely		Sometimes		Very Often
1	2	3	4	5

*38. I have noticed positive changes in my life since starting the Healthy Start Program.

Strongly Disagree		Neither Agree nor Disagree		Strongly Agree
1	2	3	4	5

39. Healthy Start has not had a positive impact on the development of my child.

Strongly Disagree		Neither Agree nor Disagree		Strongly Agree
1	2	3	4	5

*40. Healthy Start has helped me make plans for my future.

Strongly Disagree		Neither Agree nor Disagree		Strongly Agree
1	2	3	4	5

41. Healthy Start has helped me think about and/or plan for my child/children's future.

Strongly Disagree		Neither Agree nor Disagree		Strongly Agree
1	2	3	4	5

42. How much effort do you feel that you have put forth to accomplish the goals the program has for you?

Very Little Effort		Some Effort		Very Much Effort
1	2	3	4	5

*43. Are you interested in finding employment? Yes _____ No _____
 (if you answered "no" to #43 then go to question #45)

*44. If yes, is the program helpful in finding employment possibilities?

Not at all Helpful Somewhat Helpful Very Helpful
 1 2 3 4 5

45. How much help has your FSW offered in thinking about family planning.

Very Little Help Some Help A Lot of Help
 1 2 3 4 5

46. How often does your FSW force her personal opinions on you concerning your personal activities, birth control choices, family planning, etc.

Very Rarely Sometimes Very Often
 1 2 3 4 5

*47. Are you interested in furthering your education (eg. high school, college, etc.)? Yes _____ No _____
 (if you answered "no," then go to question #1 on the next page)

*48. If yes, how helpful is your FSW in discussing opportunities to further your education?

Not at all Helpful Somewhat Helpful Very Helpful
 1 2 3 4 5

***Signifies the items that were used during the telephone interviews.**

In the following section, we are interested in your specific experience with Healthy Start. Feel free to write as much or as little as you like when answering the following questions. Thanks again.

1. Do you have any suggestions for program improvement?

(2 1/2 inches of space)

2. Feel free to make comments about your overall perceptions of the Healthy Start Program.

(2 1/2 inches of space)

3. Name the one thing that satisfies you the most with the Healthy Start Program.

(2 1/2 inches of space)

4. Name the one thing that satisfies you the least with the Healthy Start Program.

(2 1/2 inches of space)

Appendix C

The Coverletter for the Clients' Perceptions and Satisfaction Survey

Healthy Start Clients,

We need your help. We want to know how you feel about Healthy Start and how we can make it better. This questionnaire will help us understand what you find helpful, what you do not like, and how we can improve the program for you and for future participants. We also appreciate your suggestions and comments. Only you can tell us about the strengths and weaknesses of the program.

All responses are confidential. Your replies go directly to the evaluators of the program (at the College of William and Mary), who will summarize the results and give them to the program directors and to your FSWs. Thank you for your help.

**Thank you,
The William & Mary
Evaluation Team,**

**Dr. Joe Galano
Dr. Lee Huntington
Roberta Halsey**

P.S. As a way of saying thank you, everyone who returns a questionnaire will be entered in our "Thank You Lottery." Four lucky winners will receive \$25.00 each. Please print your name at the bottom of this page to be entered into the "Thank You Lottery". Thanks again!

Appendix D

The Domain-Specific Questions Used in the Personal Interviews

1. Support: What kinds of support have you received from Healthy Start and which individuals in H.S. provide these sources of support?

2. Nurturing: Has H.S. helped you to get more information about parenting and child development? Please give some examples.

3. Future: Do you feel this program will affect the future for you and your child? In what ways?

Appendix E

Correlations Between Items on the Overall Support Domain of the CPSS.

Item	1	2	3	4	5	6	7	8	9
Clients (n =68)									
1 Help	..	.26	.26	.27	.26	.26	.57**	.51**	.20
2 Waste		..	1.00**	.95**	.91**	.86**	.13	.08	.84**
3 Friend			..	.95**	.91**	.86**	.13	.08	.84**
4 Family				..	.93**	.87**	.20	.09	.83**
5 Source					..	.94**	.23	.12	.86**
6 Otherwise						..	.23	.09	.75**
7 Everyday							..	.40**	.04
8 Private								..	.27
9 Inconvenient									..

* p < .01

**p < .001

Appendix E Continued

Correlations Between Items on the Overall Support Domain of the CPSS.

Item	10	11	12	13	14	15	16	17	18	19
Clients (n =68)										
1 Help	.03	.12	-.07	.22	.16	.28	.10	.33*	.17	.50**
2 Waste	.40**	.87**	.39**	.15	.84**	-.03	.80**	.32*	.71**	.27
3 Friend	.40**	.87**	.39**	.15	.84**	-.03	.80**	.32*	.71**	.27
4 Family	.42**	.86**	.44**	.22	.85**	-.08	.77**	.29*	.76**	.33*
5 Source	.38**	.82**	.38**	.19	.82**	-.01	.79**	.31*	.75**	.26
6 Otherwise	.43**	.74**	.35**	.25	.74**	.03	.73**	.26	.68**	.24
7 Everyday	.07	.15	.02	.41**	.15	.15	-.00	.34*	.24	.38**
8 Private	-.03	.12	.13	.30*	.21	.30*	-.09	.25	.17	.28
9 Inconvenient	.38**	.82**	.39**	.18	.86**	.00	.80**	.33*	.74**	.20

* p < .01

**p < .001

Appendix E Continued

Correlations Between Items on the Overall Support Domain of the CPSS.

Item	10	11	12	13	14	15	16	17	18	19
Clients (n =68)										
10 Nerves	..	.43**	.41**	.30*	.46**	-.24	.40**	.26	.47**	.14
11 Positive		..	.47**	.18	.96**	-.10	.77**	.40**	.77**	.21
12 Advice			..	.31*	.43**	-.24	.34*	.16	.39**	.11
13 Discipline					.17	.04	.07	.27	.22	.24
14 Questions					..	-.07	.79**	.41**	.82**	.22
15 Critical							.25	.07	-.15	.05
16 Personal								.27	.63**	.11
17 Issues									.37**	.46**
18 Resources										.40**
19 Quick										

* p < .01 **p < .001

Appendix G

Correlations Between Items on the Overall Future Domain of the CPSS.

Item	1	2	3	4	5	6	7	8	9
Clients (n =68)									
Changes		.09	.67**	.29*	.10	.34*	.11	-.16	.41**
Impact			.33*	.85**	.80**	.28	.83**	.62**	.33*
Plansfut				.48**	.35*	.45**	.32*	.07	.53**
Childfut					.77**	.37**	.82**	.53**	.41**
Effort						.30*	.80**	.59**	.24
Possibilities							.33*	.02	.36*
Plan								.64**	.34*
Choice									.06
Edfut									

* p < .01

**p < .001

VITA

Roberta Dean Halsey

Born in Roanoke, Virginia, February 19, 1971. Graduated from Franklin County High School in Rocky Mount, Virginia, June 1989. The author received her Bachelor of Science degree in Psychology, December 1992, from Virginia Polytechnic Institute & State University. This thesis completes her requirements for a Master of Arts degree in Psychology from the College of William & Mary, December 1995.

The author will be moving to Denver, CO to pursue her interest in the field of child development. She hopes to pursue her Doctor of Philosophy degree in this field at a later time.