

Mothers' Experiences in and Perspectives on Evidence-Based Home Visiting Programs

A Qualitative Sub-Study from the Mother and Infant Home Visiting Program Evaluation (MIHOPE)



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Overview

INTRODUCTION

Home visiting is a service delivery strategy with decades of research supporting these interventions as a lever to improve a range of outcomes in the early childhood years. However, prior research has found that engagement in home visiting programs varies widely among families enrolled. Though engagement is multi-faceted and operationalized differently across studies, one important aspect of engagement is the relationship between the home visitor and the parent. Indeed, earlier quantitative research has found a positive association between mothers' reports of the quality of their relationships with home visitors and program retention or other participation outcomes. Qualitative research has also found that one of the reasons mothers cite for early attrition is that they did not trust or lost trust in their home visitor, a finding that aligns with the broader literature identifying trust as a key aspect of relationship quality. Yet despite the potential importance of trust between home visitors and parents, it is not always clear *how* trust and strong working relationships with home visitors are built.

This report explores one aspect of family engagement, which is how mothers with low incomes who participated in evidence-based home visiting programs perceived their experiences and relationships with home visitors, with a particular focus on building trusting relationships. In doing so, it represents one of few published studies that brings to light the client or participant side of home visiting, using the mothers' own words. It uses qualitative information collected from semi-structured interviews with 74 mothers who were part of the Mother and Infant Home Visiting Program Evaluation (MIHOPE). MIHOPE is the national evaluation of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program in its early years. The interviews and findings are based primarily on mothers' reflections on their home visiting experiences about 3.5 years after services ended, although nine mothers were still involved in home visiting at the time of the interviews.

RESEARCH QUESTIONS

Five main themes were identified and are discussed in detail in the report:

1. Why did mothers decide to enroll in home visiting?
2. How did home visiting help mothers in the long-term participation group?

3. How was trust with home visitors built among long-term participators?
4. Why did mothers in the lower participation groups discontinue services?
5. What were the long-term participation group mothers' reflections on their experiences in home visiting when services ended?

PURPOSE

This report summarizes the results of a qualitative interview-based sub-study conducted among a sample of 74 program group mothers who received home visiting from evidence-based programs that were part of MIHOPE. It builds upon earlier reports published from MIHOPE, particularly the implementation research report, which presented findings from qualitative interviews with home visitors about how they describe their work and relationships with mothers. The overarching goal of the in-depth interviews with mothers was to shed light on why and how families engage for the time they do, including the role of the home visitor-parent relationship in a family's engagement.

KEY FINDINGS AND HIGHLIGHTS

- **Although earlier research has found that alignment between a parent's goals when enrolling and a home visitor's emphasis on those goals is predictive of sustained participation, the majority of the mothers interviewed did not recall having clear expectations or an understanding of what home visiting entailed.** While most mothers reported that they wanted to be a good parent, they did not have more specific outcomes or goals in mind when enrolling in home visiting beyond this. For example, some mothers said they enrolled in home visiting because they were young, facing motherhood for the first time, and were scared. This suggests that it may be important to understand that not all mothers have clarity about specific objectives when they enroll.
- **The ways in which trust with home visitors is developed appeared to vary across mothers who were long-term participators in the programs.** For example, while most mothers reported appreciating how their home visitors were non-judgmental and did not push them on behavioral change, a minority of mothers stated that they liked when their home visitor took a more directive, straight-talk approach with them. While some mothers said that trust was built because their home visitors helped in direct, tangible ways, a few mothers reported appreciating how their home visitor left the onus of following through on activities on the mother. These findings suggest that particular strategies that resonate with some mothers may not resonate as well with others.

- **Mothers in the lower participation groups were a smaller part of the overall interview sample, but the reasons for their discontinuation of services largely align with the prior literature on early attrition.** Some mothers in this study and others have noted that their life circumstances and stressors, including having to balance work or schooling and childcare or dealing with personal issues such as poor physical or mental health, did not allow them the capacity to stay engaged in home visiting. Other mothers described how they felt that they could and did figure things out on their own, meaning without a home visitor, with some stating that they had good social support systems.

METHODS

The study team conducted in-depth interviews with 74 program group mothers from across six states who had received at least one home visit from a local program included in MIHOPE. The interview protocol was semi-structured in nature, which ensures consistency in the topics covered across respondents while allowing interviewers the flexibility to probe particular experiences in more depth. The interviews were conducted in person from May through November 2019, lasted up to 1.5 hours, and took place when the study child was 4.5 years old on average, several years after the mothers had joined the study and received their first home visit.

Although the study team was aiming for representation across different participation patterns based on quantitative measures of duration and dosage, mothers with lower participation in home visiting were more likely to have outdated contact information and were less likely to respond to contact attempts than mothers who were long-term participators. The findings are largely based on the experiences of mothers who participated in home visiting for an extended period of time (at least 10 months, but often one year or longer). As a qualitative inquiry with a sample of mothers who were mostly long-term participators in home visiting, the findings may not be generalizable to other mothers in the MIHOPE sample or the broader population of mothers who participate in early childhood home visiting programs.

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The Authors

Executive Summary

In 2019, almost one in five children under the age of 6 lived in poverty.¹ Poverty and its associated stressors puts these children at greater risk of encountering adverse experiences that negatively affect their development. One approach that has helped parents and their young children is home visiting, which provides individually tailored support, resources, and information to expectant parents and families with young children. Many early childhood home visiting programs aim to support the healthy development of infants and toddlers and work in particular with families with low incomes, to help ensure their well-being.

Despite the promise of this early intervention approach, prior research has found that families vary widely in their engagement with home visiting programs.² Though engagement is multi-faceted and operationalized differently across studies, one important aspect of engagement is the relationship between the home visitor and the parent.³ Indeed, earlier quantitative research has found a positive association between mothers' reports of the quality of their relationship with home visitors and program retention or other participation outcomes.⁴ Qualitative research has also found that home visitors view the strength of the home visitor-parent relationship to be foundational to engagement and, ultimately, to improving targeted outcomes.⁵ Additionally, qualitative research has found that one of the reasons

¹KIDS COUNT Data Center, "Children in Poverty by Age Group in the United States," website: <https://datacenter.kidscount.org>, 2021.

²Kate Guastaferro, Shannon Self-Brown, Jenelle R. Shanley, Daniel J. Whitaker, and John R. Lutzker, "Engagement in Home Visiting: An Overview of the Problem and How a Coalition of Researchers Worked to Address This Cross-Model Concern," *Journal of Child and Family Studies* 29, 1 (2020): 4–10.

³Thomas Saïas, Emilie Lerner, Tim Greacen, Alessandra Emer, Antoine Guédeney, Romain Dugravier, Florence Tubach, Susana Tereno, and Nicole Guédeney, "Parent-Provider Relationship in Home Visiting Interventions," *Children and Youth Services Review* 69 (2016): 106–115.

⁴Heather Girvin, Diane DePanfilis, and Clara Daining, "Predicting Program Completion Among Families Enrolled in a Child Neglect Preventive Intervention," *Research on Social Work Practice* 17, 6 (2007): 674–685; Jon Korfmacher, Beth Green, Mark Spellmann, and Kathy R. Thornburg, "The Helping Relationship and Program Participation in Early Childhood Home Visiting," *Infant Mental Health Journal* 28, 5 (2007): 459–480.

⁵Jennifer Anne Fraser, Marie Hutchinson, and Jessica Appleton, "Nurses' Experiences of Home Visiting New Parents in Rural and Regional Communities in Australia: A Descriptive Qualitative Study," *Journal of Children's Services* 11, 3 (2016): 204–216; Kathleen M. Hebbeler and Suzanne G. Gerlach-Downie, "Inside the Black Box of Home Visiting: A Qualitative Analysis of Why Intended Outcomes Were Not Achieved," *Early Childhood Research Quarterly* 17, 1 (2002): 28–51.

mothers cite for early attrition is that they did not trust or lost trust in their home visitor.⁶ Yet despite the potential importance of trust between a home visitor and parent, it is not always clear *how* trust and strong working relationships with home visitors are built, especially among families where fear and mistrust of health or social service providers may be common.⁷

This report describes the experiences of 74 mothers who participated in evidence-based home visiting programs that received Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program funding and were part of the larger national evaluation of MIECHV—the Mother and Infant Home Visiting Program Evaluation or MIHOPE. The MIECHV Program is administered by the Health Resources and Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS). The findings describe how mothers perceived their experiences and relationships with home visitors, including the ways that trust was built, as well as their reflections on how the program did or did not affect their family’s well-being. As a qualitative sub-study that centers parents’ voices, this report represents one of few published studies to date that brings to light the client or participant side of home visiting, using the mothers’ own words. The interviews took place about 3.5 years, on average, after home visiting services ended, although nine mothers were still involved in home visiting at the time of the interviews.

OVERVIEW OF THE MOTHER AND INFANT HOME VISITING PROGRAM EVALUATION

MIHOPE, which was launched in 2011 by ACF in collaboration with HRSA, was designed to provide information about whether families and children benefit from MIECHV-funded early childhood home visiting programs as they operated from 2012 to 2017, and if so, how. MIHOPE is a randomized controlled study that included 88 local programs implementing one of four evidence-based models: Early Head Start–Home-based option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. Women included in MIHOPE had been identified by a local home visiting program as eligible and interested in home visiting services, were pregnant or had children under 6 months old, were 15 or older, and spoke English or Spanish well enough to provide informed consent and complete a survey.

To provide reliable estimates of the effects caused by home visiting programs, women who enrolled in the study were randomly assigned to a MIECHV-funded local home visiting program or a control group

⁶Margaret L. Holland, Julie J. Christensen, Laura P. Shone, Margaret H. Kearney, and Harriet J. Kitzman, “Women’s Reasons for Attrition From a Nurse Home Visiting Program,” *Journal of Obstetric, Gynecologic and Neonatal Nursing* 43, 1 (2014): 61–70.

⁷Susan Jack, Alba DiCenso, and Lynne Lohfeld, “Opening Doors: Factors Influencing the Establishment of a Working Relationship Between Paraprofessional Home Visitors and At-Risk Families,” *Canadian Journal of Nursing Research Archive* 34, 4 (2002): 59–69; Sue Kirkpatrick, Jane Barlow, Sarah Stewart-Brown, and Hilton Davis, “Working in Partnership: User Perceptions of Intensive Home Visiting,” *Child Abuse Review* 16, 1 (2007): 32–46.

who received information about other appropriate services in the community. A total of 4,229 families entered the study from October 2012 to October 2015. Although a large-scale evaluation that spanned across 12 states, it is important to keep in mind that the results from MIHOPE are specific to the sample of local programs and families included in the study, which are not necessarily representative of all MIECHV-funded programs or the populations served.

MIHOPE estimated the effects of home visiting programs on family and child outcomes around the time children were 15 months of age, and these results were published in a 2019 report.⁸ The report documented some positive effects for families, including improvements in the quality of the home environment, lower frequency of psychological aggression toward the study child, fewer Medicaid-paid child emergency department visits, and fewer child behavior problems. Most estimated effects are similar to, but somewhat smaller than, the average found in past studies of individual home visiting models.

MIHOPE also included a multi-method implementation study, and these results were published in a 2018 report.⁹ The study team found that home visiting programs in MIHOPE were generally well implemented, with appropriate support in place to help home visitors administer the intended services. Consistent with earlier research, families participated in home visiting for less time and received fewer visits than expected by the evidence-based models. Qualitative interviews conducted with home visitors in MIHOPE further revealed that for the families they identified as more challenging to work with, it was difficult to build a trusting relationship and that they were often engaged in crisis management or working with families who were burdened by past and present stressors.

Largely missing from earlier home visiting studies, including prior MIHOPE publications, are the perspectives of the families participating in home visiting programs.¹⁰ This limitation in the literature constrains one's understanding of how home visiting works and, accordingly, how home visiting programs can be improved. The sub-study using in-depth interviews with families was designed to help fill this gap.

⁸For more information, see Charles Michalopoulos, Kristen Faucetta, Carolyn J. Hill, Ximena A. Portilla, Lori Burrell, Helen Lee, Anne Duggan, and Virginia Knox, *Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation*, OPRE Report 2019-07 (Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2019).

⁹For more information, see Anne Duggan, Ximena A. Portilla, Jill H. Filene, Sarah Shea Crowne, Carolyn J. Hill, Helen Lee, and Virginia Knox, *Implementation of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation*. OPRE Report 2018-76A. (Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2018).

¹⁰Diane B. McNaughton, "A Synthesis of Qualitative Home Visiting Research," *Public Health Nursing* 17, 6 (2000): 405–414; Cynthia Thompson, "Learning to Trust in Home Visiting: Mothers' Perspectives," master's thesis, Iowa State University. (2011).

SUB-STUDY METHODS AND SAMPLE

Sampling Frame and Recruitment

Because the sub-study was designed to explore mothers' experiences in home visiting programs, the sampling frame was limited to mothers who had received at least one home visit.¹¹ A key goal of the qualitative interview sub-study was to explore reasons for variation in participation in home visiting as captured by length of time in the program and visit frequency—patterns that were documented and described in the MIHOPE implementation research report.¹² Therefore, the team used a purposeful sampling design in which the interviewers attempted to recruit mothers from three different participation groups identified in the MIHOPE implementation research: (1) early leavers; (2) later leavers; and (3) long-term participators.¹³

Although the study team was aiming for roughly equal representation across the three groups, mothers in the lower participation groups (the early leavers and the later leavers) were more likely to have outdated contact information than mothers who were long-term participators. Mothers in the lower participation groups were also less likely to respond to the interview team's repeated attempts to contact them than the long-term participators, which could also be a function of having outdated contact information (though this is not possible to confirm). When study team members were able to make contact with mothers, most agreed to participate in the interviews, regardless of participation group type. In the end, the majority of mothers interviewed (59 mothers or 80 percent of the qualitative sub-study sample) were part of the long-term participators group. Fifteen mothers, or 20 percent of the qualitative sub-study sample, were part of the lower participation groups.

In selecting the sample, the study team wanted to include mothers who participated in each of the four evidence-based models included in MIHOPE. They also strove for geographic diversity. Both English and Spanish-speaking mothers were recruited. The final sample included 74 mothers who received home visiting services across 28 of the home visiting programs that participated in MIHOPE. These mothers resided in six states: Illinois, Iowa, New Jersey, South Carolina, Washington, and Wisconsin.

¹¹About 17 percent of the program group sample never engaged in home visiting even though they had expressed an interest in the program. These mothers were excluded from the sampling frame for the qualitative interviews.

¹²See Chapter 4, "Patterns of Participation in Home Visiting Among Families," in Duggan et al. (2018).

¹³The early leavers group includes families who participated for shorter durations than other families in the study (between 0.25–4 months in the first year). These families received an average of four home visits. The later leavers group includes families who participated in home visiting between four and nine months and received an average of 14 home visits in the first year. The long-term participators group includes families who participated in home visiting for 10 months or longer and received an average of 27 home visits in the first year.

Data Collection and Analysis

A team of six trained interviewers conducted in-person interviews from May through November 2019. At the time of the interviews, the MIHOPE child was between 3 and 5 years old, and the average age was 4.5 years. The interviews were all audio recorded with the mother's consent and lasted up to 1.5 hours. Participation in the interviews was voluntary, and each mother received a token of appreciation in the form of a \$50 gift card.

The interview protocol was semi-structured in nature, which ensures consistency in the topics covered across respondents while allowing interviewers the flexibility to probe particular experiences in more depth. The interview protocol was generally organized around the following topics:

- background and family context when home visiting began
- how and why mothers enrolled in the program
- the types of activities, topics, and resources that the home visitor covered or provided over the course of visits
- the mother's relationship with the home visitor, including whether and how that relationship changed over time
- the mother's overall reflections of her experiences in the program, including why services ended and the mother's perceptions of whether and how home visiting made a difference in her family's life

All interviews were transcribed and coded in Dedoose, a qualitative analysis software package. Researchers initially coded the interview transcripts across the main topics covered in the interview guide, and coders also identified the need for new (emergent) codes through reviews of early transcripts. The emergent or new codes were subcode additions within a broad topical code, used to capture variation within that topic. The lead author reviewed excerpts across major codes and subcodes and based on that review, categorized the data by themes and explored patterns.

When summarizing the frequency with which the themes were noted among the sample, we use the following convention:

- “most” when about three-fourths or more of mothers responded in a certain way
- “many” or “majority” when more than half responded in a certain way
- “some” when one-fifth to one-half responded in a certain way
- “several” when less than one-fifth of mothers responded a certain way
- “a few” or “a handful” when between three and seven mothers responded in a certain way

Characteristics of the Sample

The qualitative interview sub-study sample of 74 mothers is racially and ethnically diverse, and includes non-Hispanic Black mothers ($N = 26$; 35 percent), non-Hispanic White mothers ($N = 16$; 22 percent), Hispanic mothers ($N = 26$; 35 percent), and mothers who identify as multi-racial or as other race, such as Asian American ($N = 6$; 8 percent).¹⁴ This racial/ethnic diversity mirrors the diversity of the larger program group sample of mothers (both those who received at least one home visit and the entire program group sample).¹⁵ In addition to race/ethnicity, the interview sample was mostly similar to the broader program group sample, including the full sample of program group mothers who received at least one home visit ($N = 1,736$) and the entire program group sample ($N = 2,102$), across a range of other characteristics captured at study entry.¹⁶

There were, however, some ways in which the interview sample was significantly different from both the larger sample of program group mothers who received at least one home visit and the entire program group sample. The percentages of mothers in the interview sample who were first-time mothers (74 percent) and pregnant (82 percent) at the time of study enrollment are larger than for the full sample of program group mothers who received at least one home visit (59 percent and 68 percent, respectively) and the entire program group sample (60 percent and 68 percent, respectively). More mothers in Nurse-Family Partnership programs (39 percent) and fewer mothers in Parents as Teachers programs (14 percent) were part of the interview sample compared to the full sample who had at least one home visit and the entire program group sample.¹⁷ The interview sample also tended to have somewhat higher education levels, were more likely to be employed, reported lower levels of Supplemental Nutrition Assistance Program benefit receipt, and reported higher levels of receipt of disability insurance at study entry than other program group mothers.

¹⁴For simplicity, we will hereafter refer to the sample of respondents who participated in this qualitative interview sub-study on mothers' experiences in home visiting as "the interview sample."

¹⁵Among the full sample of mothers who received at least one home visit ($N = 1,736$), 29 percent are non-Hispanic Black, 25 percent are non-Hispanic White, 38 percent are Hispanic, and 8 percent are multi-racial or another race (such as Asian American). Among the entire program group sample ($N = 2,102$), 31 percent are non-Hispanic Black, 25 percent are non-Hispanic White, 37 percent are Hispanic, and 8 percent are multi-racial or another race (such as Asian American).

¹⁶These findings are described in Chapter 2 of the main report; see Table 2.1 for detailed comparative statistics for the interview sample, the broader program group sample who had at least one home visit, and the full program group sample.

¹⁷Among the full sample of mothers who received at least one home visit ($N = 1,736$), 29 percent were in Nurse-Family Partnership programs and 22 percent were in Parents as Teachers programs. Among the entire program group sample ($N = 2,102$), 29 percent were in Nurse-Family Partnership programs and 23 percent were in Parents as Teachers programs.

KEY FINDINGS

1. Why Did Mothers Decide to Enroll in Home Visiting?

- **Although earlier research has found that alignment between a parent’s goals when enrolling and a home visitor’s emphasis on those goals is predictive of sustained participation, the majority of the mothers interviewed did not recall having clear expectations or an understanding of what home visiting entailed.**¹⁸ While most mothers reported that they wanted to be a good parent, they did not have more specific outcomes or goals in mind when enrolling in home visiting beyond this. This lack of specificity that was found during the interviews aligns with the respondents’ reports from the MIHOPE baseline survey, where “wanting general help or support” was the most common reason for enrolling. This finding suggests that it may be important to understand that not all mothers have clarity about specific objectives when they enroll.
- **For the majority of the younger, first-time mothers, the motivating factor for enrolling was that they were scared and had a lot of uncertainty.** For example, when asked about why she decided to enroll in home visiting, one respondent simply stated, “Well, I was 19 and scared out of my mind.” Because they were worried about being a parent, some of these mothers also described feeling comforted by the idea of someone who would come into the home and check in on them:

You know, when you’re a first [time] mother—like, I was very nervous. I was like, “I don’t want to do anything to mess up this child.” I don’t know. I just wanted for someone to be like, “You know, you’re doing a good job.”
- **Mothers with older children and who had been involved in home visiting before were the most specific in stating that they enrolled to give their children a head start in life.** A few of the non-first-time mothers noted that they had participated in a home visiting program with their older children and benefited from the experience. Because they had been involved in a home visiting program before, it is not surprising that these respondents were the clearest about why they signed up for the program. A few of these mothers seemed to view the program as an educational one, and one that was meant only for their children.

2. How Did Home Visiting Help Mothers in the Long-Term Participation Group?

- **Most of the long-term participators were able to describe concrete ways in which their home visitor improved how they parent.** Examples included home visitors providing advice and help with improving their children’s health and safety-related practices in the home, guidance on how to

¹⁸Lori Burrell, Sarah Crowne, Kristen Ojo, Ryan Snead, Kay O’Neill, Fallon Cluxton-Keller, and Anne Duggan, “Mother and Home Visitor Emotional Well-Being and Alignment on Goals for Home Visiting as Factors for Program Engagement,” *Maternal and Child Health Journal* 22, 1 (2018):43–51.

support their child’s development, and advice on how to communicate with and discipline their children. For example, several mothers recalled how what they learned from their home visitor helped them change how they disciplined their children, particularly by discouraging the use of yelling and spanking. This was noted among both first-time mothers and those who also had older children. One mother who enrolled when pregnant with her fourth child, a daughter, had three older sons and stated:

The way I raised the boys was...I would raise my voice and yell all the time... Whereas with [daughter] I think, even with just some little ages and stages and stuff that we would go through all the time, it would make me think, “Oh, well, this is what they’re developing”...that’s when I kind of realized that we shouldn’t yell.

- **The majority of mothers in the long-term participation group also described the ways in which the home visitor played an important role in providing them with the emotional support they needed.** Although not a frequent theme, several mothers described struggling with depressive symptoms or anxiety and recounted how the home visitors helped them understand their symptoms and encouraged them to get treatment. Most mothers described how the home visitor represented someone in their lives who really listened to them and “always had their back.” Mothers’ narratives of the types of emotional support provided by the home visitors resonates and aligns with how home visitors in the MIHOPE implementation research report described their primary role, which is that of being a cheerleader and an advocate for the mother.
- **Many of the respondents shared positive stories about how their home visitors helped them access any resources or services they needed.** Some mothers recalled home visitors providing them with material goods as well as information about other community service providers. In addition, a few mothers reported that their home visitors also provided validation and encouragement in following up or through. For example, one mother stated that the value of the home visitor wasn’t just in connecting her to developmental services for her son, but that her home visitor reinforced the maternal instinct she had that her son’s language development was delayed when her son’s primary care provider initially dismissed her concern.

3. How Was Trust with Home Visitors Built Among Long-Term Participators?

- **Some mothers recalled having an early degree of trust with home visitors because of the home visitor’s professional background.** Even for mothers who were initially skeptical of their home visitors, they recounted how trust was developed when they could see the benefits of an activity or approach that the home visitor recommended. As one mother stated when recalling the home visitor’s early advice:

I always felt weird talking [to my daughter] in the very beginning, telling [daughter], “Oh, I’m changing your diaper now”...’Cause she’s a baby and it doesn’t matter. But once I did it, I realized how much it can help her...I noticed that.

- **In addition to valuing the home visitor’s professional expertise, some long-term participators explained that they trusted the home visitor because the home visitor was also a mother.** This aligns with an earlier qualitative study of home visitors, in which sharing commonalities and personal experiences about being a parent were identified as key trust-building strategies.¹⁹ That said, most of the mothers we interviewed whose home visitor was not a parent did not seem to think that this was a barrier to trusting their home visitor in the long run.
- **Mothers in the long-term participation group noted that they felt their home visitor truly cared about them, and that this care was evidenced by the home visitor providing the family with direct assistance and needed or useful items.** A common theme was that care was shown by providing the family with tangible items like diapers, baby clothes, toys or car seats, as well as providing active forms of assistance, such as driving them somewhere, making referral calls on their behalf, and filling out paperwork or forms. These findings are notable in juxtaposition with some of the home visitors’ perspectives described in the MIHOPE implementation research report, including a sense of frustration with mothers who they felt used the program mostly for the “things they could get” and not for the educational content.²⁰ Some home visitors in MIHOPE also worried that providing active assistance did not empower families to solve problems on their own. Although more the exception than the rule, one mother mirrored these sentiments of the importance of avoiding over-reliance on the home visitor:

She could lead the horse to water—me being the horse—but I had to do the action. I wanted so badly to just, at that time in my life, to just collapse and have somebody come save me and stuff. And then I’m also extremely resilient, and she knew that, and she knew that I needed to...keep doing this stuff on my own...

- **The majority of mothers stated that the non-judgmental approach home visitors used helped them feel more comfortable and open.** The importance of being non-judgmental aligns with earlier studies of home visitors’ perspectives on trust-building strategies.²¹ Further reflecting this “no judgment zone” theme, several mothers discussed how they especially appreciated that their home visitor did not nag or push them to change behaviors, even if those behaviors were not optimal, which was also a strategy noted by home visitors in MIHOPE. However, while most mothers appreciated the non-pushy approach used by their home visitors, a few mothers seemed to value that their home visitors were straightforward with them and would “tell it like it is.”

¹⁹Jack, DiCenso, and Lohfeld (2002).

²⁰See Chapter 6 in Duggan et al. (2018).

²¹Jack, DiCenso, and Lohfeld (2002); Lucy Paton, Julian Grant, and George Tsourtos, “Exploring Mothers’ Perspectives of an Intensive Home Visiting Program in Australia: A Qualitative Study,” *Contemporary Nurse* 43, 2 (2013): 191–200.

4. Why Did Mothers in the Lower Participation Groups Discontinue Services?

- **Among mothers in the lower participation groups ($N = 15$), the majority described the ways in which they had figured things out on their own both as a reason for discontinuing and in describing what was happening when services ended.** This generally indicated that the mothers felt that they were able to find the information they needed or answers to their questions on pregnancy or parenting by doing their own research or investigating other resources. When describing their circumstances at the time of their pregnancy or the child's birth, some of the mothers also noted having a solid support system. One mother, who only received a few home visits, explained:

I had a lot of support from my family. My friends...my mom, my grandma—they were really supportive. And Google was also really supportive. I also had a pregnancy app, as well, which every week it would actually have a video of the baby and show what was growing, so that helped a lot, too.

- **A few mothers described the ending of services as being driven primarily by their own life circumstances or logistical challenges.** One mother moved out of the area. A handful of others reported that they became too busy or felt overwhelmed, which prior studies have also found is a common reason for early attrition.²² For example, one mother who engaged for a month noted that although her home visitor seemed nice enough and knowledgeable, she was both working full-time and going to school at night and barely had time to spend with her daughter, let alone maintain home visits.

5. What Were Long-Term Participation Group Mothers' Reflections on Their Experiences in Home Visiting When Services Ended?

- **The majority of the long-term participators reported feeling “okay,” “good,” or being able to “do it on my own” when home visiting ended and reflected positively on their time in the program and their current circumstances.** For some mothers, services ended because their child had aged out of the home visiting program.²³ Some other mothers initiated the end of services because they were busy juggling different activities, including work and childcare, and felt they no longer had time for home visiting. These mothers noted that although leaving the program was hard because they had become attached to their home visitor, they were also moving on in clear ways.

²²Holland et al. (2014).

²³As described in Duggan et al. (2018), the intended duration of enrollment varies across evidence-based models. For Early Head Start–Home-based option, services are offered through the child's third birthday. For Healthy Families America, services are offered through the child's third birthday but can also extend to the child's fifth birthday. For Nurse-Family Partnership, services are offered until the child's second birthday. For Parents as Teachers, services are offered until kindergarten entry.

Several mothers, in fact, credited the home visitor for inspiring them to follow their education goals. Finally, a handful of mothers disengaged when their home visitor left the program but, similar to mothers who left for other reasons, they noted that they had gotten as much as they could out of the program.

- **Several mothers, while in the minority among the long-term participators, described still wanting or needing more services of some kind when home visiting ended.** The mothers who reported needing additional help after home visiting ended were still facing challenging situations and felt they could have benefitted from continued support. For a handful of these mothers, not having home visits was described in almost devastating terms. For example, one mother, whose services ended when her child aged out, recounted that her home visitor was “the only friend I had.” Another mother whose child had also aged out and who had faced a lot of childhood trauma broke down in tears when she described the ending of her home visits, noting that her home visitor “was one of my only somebodies.”
- **While several mothers did not view home visiting as having a lasting impact beyond their time in the program, a few mothers noted that they did not fully appreciate the influence of the program until after home visiting ended.** Several mothers in the long-term participation group tended to see the home visitor as providing direct education and support to their children, rather than a broader influence on them as parents. A few mothers, however, described how they only realized and saw the ways in which the home visitor helped them be a better parent after their home visits ended.

DISCUSSION

While most of the research on family engagement in home visiting consists of quantitative analyses of participation patterns, the current sub-study contributes to a small but growing line of qualitative research examining family engagement from the parents’ perspectives.²⁴ In addition, the findings in this report are based on the largest qualitative interview sample to date (to the best of our knowledge) and are drawn from one of the only studies that has been able to examine mothers’ experiences across multiple home visiting program models. It is worth noting that while some differences in program policies were evident in the interviews (particularly the child’s age when the families aged out), the study team did not find notable differences in themes across models.

The interview sub-study also has several limitations. First, the sample isn’t representative of all mothers who were served by MIECHV-funded programs in its early years of operation, so findings aren’t necessarily generalizable to that broader population. In addition, the sample of mothers who were

²⁴Grace S. Hubel, Alayna Schreier, Brian L. Wilcox, Mary Fran Flood, and David J. Hansen, “Increasing Participation and Improving Engagement in Home Visitation: A Qualitative Study of Early Head Start Parent Perspectives,” *Infants & Young Children* 30, 1 (2017): 94–107.

interviewed for this report were more likely to be in the long-term participation group, which is not reflective of the larger sample of program group mothers who received at least one home visit in MIHOPE.

It is important to keep in mind that across the sample of mothers interviewed, most of the information gathered is based on mothers' reflections after service delivery ended (about 3.5 years later, on average), and people's memories can be different from what they would have recounted when services were ongoing or more recently after services ended. Since both perspectives are valuable, future evaluation research could consider investing in efforts to capture parents' experiences, in their own voices, in home visiting concurrently, as well as after services end, in order to trace how their perspectives evolve over time.

Individualizing services, including visit content and connections to community resources, to meet a particular family's strengths, risks, needs, and desires is a key part of what home visitors do.²⁵ This report's findings on the varied ways in which mothers described how trust with home visitors was built highlights how mothers differed in their receptiveness to different strategies or approaches used by home visitors, underscoring how nuanced the home visitor-parent relationship dynamic can be. It also supports the idea that the concept of tailoring includes both the tailoring of content and the tailoring of style and approaches used with a family.

While the importance mothers seemed to place on the emotional support that home visitors provided was not a surprising finding, it was quite striking to hear mothers, though there were only a handful, discuss the end of home visiting in psychologically devastating terms. Unfortunately, it's not clear what types of transition planning occurred or whether other appropriate services even existed in the community (these mothers did not recall being offered additional services after home visiting ended). Our review of the literature did not produce much research on transition planning for families who may be in need of continued support when home visiting ends, as much more emphasis has been paid to identifying and addressing factors associated with early attrition. Better understanding program practices and testing strategies that aim to provide families with a continuum of care and support when home visiting ends and supports are still needed by the family may be an important line of future work.

Prior research has found that home visitor turnover negatively affects family engagement, and there was evidence of this in the present study as well.²⁶ Given the centrality of the home visitor-parent relationship to engagement, it is important to understand how home visitor turnover and departures can be better managed in cases where the home visitor and parent have developed a strong working relationship. Since some amount of turnover is inevitable and may in fact reflect upward career mobility for the home

²⁵Duggan et al. (2018).

²⁶Holland et al. (2014).

visitor, there may be value to identifying tools or strategies that can ease the transition for families when their home visitor leaves.

1

Introduction

In 2019, almost one in five children under the age of 6 lived in poverty.¹ Poverty and its associated stressors puts these children at greater risk of encountering adverse experiences that negatively affect their development. One approach that has helped parents and their young children is home visiting, which provides individually tailored support, resources, and information to expectant parents and families with young children. Many early childhood home visiting programs aim to support the healthy development of infants and toddlers and work with low-income families, in particular, to help ensure their well-being.

Despite the promise of this early intervention approach, prior research has also found that families vary widely in their engagement with home visiting programs.² Though engagement is multi-faceted and operationalized differently across studies, one important aspect of engagement is the relationship between the home visitor and the parent.³ Indeed, across several studies, qualitative research has found that home visitors view the strength of the home visitor-parent relationship to be foundational to engagement and, ultimately, to improving targeted outcomes.⁴ Yet, surprisingly little is known about the point of view of parents who are receiving home visiting services.⁵

This report presents perspectives from mothers who participated in home visiting programs.⁶ In doing so, it represents one of few published studies that brings to light mothers' own words and reflections about their experiences in home visiting programs and their relationships with home visitors. Specifically, this report summarizes the results of a qualitative interview-based sub-study conducted among a sample of 74 program group mothers who received home visiting from evidence-based programs that received Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program funding and were part of the larger national evaluation of MIECHV—the Mother and Infant Home Visiting Program Evaluation or

¹The poverty rate for children under age 6 was 18 percent in 2019, based on estimates from the American Community Survey data (KIDS COUNT Data Center, 2021).

²Guastaferro et al. (2020). Parental engagement in home visiting has been defined and operationalized differently in the literature but broadly can be thought of as the process of parents *connecting with* and *using* home visiting services to the best of their and the program's ability (Hubel et al., 2017; Korfmacher, Green, Spellmann, and Thornburg, 2007).

³Korfmacher, Green, Spellmann, and Thornburg (2007); Saías et al. (2016).

⁴Fraser, Hutchinson, and Appleton (2016); Hebbeler and Gerlach-Downie (2002); Thompson (2011).

⁵Hubel et al. (2017); Thompson (2011); Zapart, Knight, and Kemp (2016).

⁶Fathers may be participants in early childhood home visiting programs as well. However, the sample that we recruited from for the qualitative interviews, who were part of the Mother and Infant Home Visiting Program Evaluation, consisted only of mothers.

MIHOPE. The interviews were semi-structured in nature, and the fieldwork took place several years after mothers enrolled in MIHOPE. The study child's age at the time of the qualitative interviews ranged from 3 years old to 5 years old. The interviews are based primarily on reflections of mothers' experiences after home visiting ended, which occurred about 3.5 years earlier on average, although nine mothers were still enrolled in the program at the time of the interviews.⁷

Most of the mothers were long-term participators in the programs, meaning that they received home visiting services on a regular basis for about one or more years. This is higher than the average participation of about eight months found among the larger sample of program group mothers who received at least one home visit, as was documented in the MIHOPE implementation research report.⁸ The findings are thus largely based on the experiences of mothers who participated in home visiting for an extended period of time and who had positive reflections of the program and the home visitors they worked with. However, the interview sample also includes some mothers whose participation was more limited and of shorter durations (for example, several months). When relevant, we highlight the experiences of these mothers as well, and note the similarities and differences between their experiences and the experiences of mothers who sustained participation over a longer period of time.

OVERVIEW OF THE MOTHER AND INFANT HOME VISITING PROGRAM EVALUATION

While home visiting programs for low-income families have a long history in the U.S., the authorization and continued funding of the federal MIECHV Program brought about a major expansion of evidence-based home visiting programs for families living in at-risk communities.⁹ Alongside this expanded funding, the legislation also required an evaluation of MIECHV in its early years, which became MIHOPE.¹⁰ The overarching goal of MIHOPE is to provide information about whether families and children benefit from MIECHV-funded early childhood home visiting programs as they operated from 2012 to 2017. MIHOPE is a randomized controlled study that included 88 local programs implementing one of four evidence-based models: Early Head Start–Home-based option (Early Head Start), Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. Box 1.1 provides a brief overview of MIHOPE's study design and goals. Though a large-scale evaluation, it is important to keep in mind

⁷For the nine mothers who were still participating in home visiting at the time of the interviews, all of them were receiving services from the same program that they had enrolled in when MIHOPE started.

⁸Duggan et al. (2018).

⁹In 2010, Congress authorized the MIECHV program by enacting section 511 of the Social Security Act, 42 U.S.C. § 711, which also appropriated funding for fiscal years 2010 through 2014. Funds for subsequent fiscal years were appropriated by section 209 of the Protecting Access to Medicare Act of 2014, Pub. L. 113-93 (fiscal year 2015); section 218 of the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015, Pub. L. 114-10 (fiscal years 2016–2017); section 50601 of the Bipartisan Budget Act of 2018, Pub. L. 115-123 (fiscal years 2018–2022); and section 6101 of the Consolidated Appropriations Act of 2023, Pub. L. 117-328 (fiscal years 2023–2027).

¹⁰SEC. 511 [42 U.S.C. 711] (g) (2).

that the results from MIHOPE are specific to the sample of local programs and families included in the study, which are not necessarily representative of all MIECHV-funded programs or the populations served.

As noted in Box 1.1, MIHOPE included a multi-method implementation research study.¹¹ The study team found that home visiting programs in MIHOPE were generally well implemented, with appropriate support in place to help home visitors administer the intended services. This support included training for home visitors, regular supervision, structured parenting curricula, consultants to address specific family needs, and protocols for risk screening and referrals. Although most of the mothers in the program group received at least one home visit, about 17 percent of mothers assigned to the program group never received a home visit, which is consistent with earlier research. Also consistent with earlier research, families participated in home visiting for less time and received fewer visits than expected by the evidence-based models. Specifically, among mothers who received at least one visit, the average length of participation was eight months, even though all four program models expect families to stay enrolled until at least a child's second birthday.¹² While the families in MIHOPE generally faced several socioeconomic and health-related risk factors at study entry, families with relatively more challenges and barriers participated in home visiting programs for shorter periods compared with average families in the study, while families with relatively fewer challenges participated longer. Qualitative interviews conducted with home visitors in MIHOPE further revealed that for the families they identified as more challenging to work with, it was difficult to build a relationship and that they were often engaged in crisis management or dealing with families who were burdened by past and present stressors.

The study team also examined the effects of home visiting on the full sample of families (program and control group families) when children were around the age of 15 months.¹³ There were some positive effects for families, and most estimated effects are similar to, but somewhat smaller than, the average found in past studies of individual home visiting models. Estimated effects were statistically significant for 4 of the 12 confirmatory outcomes: the quality of the home environment, the frequency of psychological aggression toward the child, the number of Medicaid-paid child emergency department

¹¹Duggan et al. (2018).

¹²As described in Duggan et al. (2018), the intended duration of enrollment varies across evidence-based models. For Early Head Start, services are offered through the child's third birthday. For Healthy Families America, services are offered through the child's third birthday but can also extend to the child's fifth birthday. For Nurse-Family Partnership, services are offered until the child's second birthday. For Parents as Teachers, services are offered until kindergarten entry.

¹³Michalopoulos et al. (2019).

Box 1.1. Overview of MIHOPE

The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is the legislatively mandated evaluation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. The MIECHV Program is administered by the Health Resources and Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS). MIHOPE was launched in 2011 by ACF in collaboration with HRSA. MDRC conducted the study in partnership with James Bell Associates, Johns Hopkins University, Mathematica Policy Research, the University of Georgia, and Columbia University.

MIHOPE is studying the four evidence-based models chosen by 10 or more states in their fiscal year 2010–2011 plans for MIECHV funds. These models are Early Head Start–Home-based option, Healthy Families America, Nurse–Family Partnership, and Parents as Teachers. Women included in MIHOPE had been identified by a local home visiting program as eligible and interested in home visiting services, were pregnant or had children under 6 months old, were 15 or older, and spoke English or Spanish well enough to provide informed consent and complete a survey.

To provide reliable estimates of the effects caused by home visiting programs, women who enrolled in the study were randomly assigned to a MIECHV-funded local home visiting program or a control group who received information about other appropriate services in the community. From October 2012 to October 2015, a total of 4,229 families entered the study.

MIHOPE estimated the effects of home visiting programs on family and child outcomes around the time children were 15 months of age. Results included most outcome areas that the legislation that authorized the MIECHV Program indicated the program should affect: (1) prenatal, maternal, and newborn health; (2) child health and development, including child maltreatment; (3) parenting skills; (4) crime or domestic violence; (5) family economic self-sufficiency; and (6) referrals and service coordination. Findings from this MIHOPE impact analysis were published in 2019.*

MIHOPE also collected extensive information about home visiting service implementation to describe the families served, the policies and support in place for home visitors to provide services, the quantity and content of the actual services provided to families, and the ways those services varied. Findings from the MIHOPE implementation analysis were published in 2018.†

For more information on MIHOPE, see U.S. Department of Health and Human Services (2022).‡

*Charles Michalopoulos, Kristen Faucetta, Carolyn J. Hill, Ximena A. Portilla, Lori Burrell, Helen Lee, Anne Duggan, and Virginia Knox. 2019. *Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Evaluation*. OPRE Report 2019-07. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

†Anne Duggan, Ximena A. Portilla, Jill H. Filene, Sarah Shea Crowne, Carolyn J. Hill, Helen Lee, and Virginia Knox. 2018. *Implementation of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation*. OPRE Report 2018-76A. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

‡U.S. Department of Health and Human Services. 2022. “Mother and Infant Home Visiting Program Evaluation (MIHOPE), 2011-2025.” Website: www.acf.hhs.gov/opre/research/project/maternal-infant-and-early-childhood-home-visiting-evaluation-mihope.

visits, and child behavior problems.¹⁴ No statistically significant effects were found on the eight other confirmatory outcomes including: parental receipt of education or job training services; parental supportiveness; health insurance coverage for the child; number of Medicaid-paid well-child visits; child receptive language skills; new pregnancy after study entry; frequency of minor physical assault; and any Medicaid-paid health care encounters for injuries or ingestions. However, for 9 of the 12 confirmatory outcomes, program group families fared better than control group families on average, which is unlikely to have occurred for the study sample if the home visiting programs made no true difference in family outcomes. Results for several exploratory outcomes suggest home visiting may improve maternal health and that home visiting might also reduce household aggression.

MOTIVATION FOR CONDUCTING QUALITATIVE INTERVIEWS WITH PROGRAM GROUP MOTHERS

Largely missing from earlier studies of home visiting, including prior MIHOPE publications, are the perspectives of the families who participate in home visiting programs.¹⁵ This limitation in the literature constrains one's understanding of how home visiting works and, accordingly, how home visiting programs can be improved.¹⁶ For example, a multi-level quantitative analysis that examined the predictors of family attrition from home visiting noted that the first few months of program participation appear to be a sensitive period for drop-outs among families.¹⁷ The authors speculated that building a trusting relationship with the mother at the beginning of the services would thus be an important step towards improving long-term participation among mothers.

Other studies have provided support for the idea that building trust is important for program retention.¹⁸ For example, quantitative research has found a positive association between mothers' reports of the quality of their relationship with the home visitor and higher participation levels.¹⁹ A qualitative investigation of early attrition in a Nurse-Family Partnership site found that one of the reasons that mothers dropped out was because they lost trust in the program or did not want to continue engagement after the first home visitor with whom they had bonded left the agency.²⁰ Yet, despite the potential importance of trust between a home visitor and parent, it is not always clear *how* trust and strong

¹⁴Confirmatory outcomes were selected by the study team as the main outcomes by which to assess the effectiveness of home visiting programs in MIHOPE, based on the evidence that existed before the impact analysis was conducted, the policy relevance of various outcomes, and the quality of the tools available to measure those outcomes. These outcomes are generally ones where previous studies had consistently found favorable effects or that have objective measures that come from observations or direct child assessments.

¹⁵McNaughton (2000); Thompson (2011).

¹⁶Jack, DiCenso, and Lohfeld (2002); Thompson (2011).

¹⁷Brand and Jungmann (2014).

¹⁸Heaman, Chalmers, Woodgate, and Brown (2006); Jack, DiCenso, and Lohfeld (2002); Woolfolk and Unger (2009).

¹⁹Girvin, DePanfilis, and Daining (2007); Korfmacher, Green, Spellmann, and Thornburg (2007).

²⁰Holland et al. (2014).

relationships with home visitors are built, especially among families where fear and mistrust of health or social service professionals may be common.²¹

By interviewing parents in an in-depth manner about their participation in home visiting programs, some researchers have begun to shed light on why and how families engage for the time they do, including the role of the home visitor-parent relationship in a family's engagement. Separate studies of parental engagement in an Early Head Start program and a Nurse-Family Partnership program both found that barriers to sustained engagement cited by parents included logistical challenges with maintaining visits while also working full-time, doing housework, and providing care for their children.²² These parents tended to view home visits as one more "to-do" or stressor as opposed to seeing the home visitor as someone who could help alleviate the stressors in their lives.

Another theme from prior research is that there are sometimes misalignments between a parent's expectations and understanding of the program and the home visitor's expectations and intentions. For instance, a study of a Parents as Teachers program noted that while parents tended to view home visits as akin to tutoring sessions for their children (rather than visits that were geared toward providing information or support to the parent), home visitors believed they were modeling and showing the parent how to interact with their children and support their child's development outside the home visits.²³ This lack of alignment between the home visitors and parents, the authors posited, was a likely explanation for why the accompanying impact evaluation of this program found no effects on parenting behaviors.

This line of qualitative-based research on family engagement, while outweighed in the home visiting implementation literature by quantitative metrics and analyses of dosage and duration of program participation, underscores the importance of asking parents for their perspectives. Doing so can help illuminate why broader patterns exist and illustrate the sometimes complicated dynamics between home visitors and parents.²⁴ The present sub-study was designed to further extend the field's understanding of mothers' perspectives and reflections of their time in home visiting programs. The remainder of this report is organized as follows:

²¹Kirkpatrick, Barlow, Stewart-Brown, and Davis (2007); Thompson (2011); Woolfolk and Unger (2009).

²²Hubel et al. (2017); Holland et al. (2014).

²³Hebbeler and Gerlach-Downie (2002).

²⁴Prior studies that have explored mothers' narratives about their engagement in (or attrition from) home visiting include: Hebbeler and Gerlach-Downie's (2002) study of mothers and home visitors in a Parents as Teachers program (U.S.); Holland et al.'s (2014) study of mothers in a Nurse-Family Partnership program (U.S.); Hubel et al.'s (2017) study of parents in an Early Head Start program (U.S.); Paton, Grant, and Tsourtos' (2013) research on mothers in an intensive nurse home visiting program (Australia); and Zapart, Knight, and Kemp's (2016) study of mothers in a nurse home visiting program (Australia). Thompson's (2011) unpublished master's thesis is also an excellent qualitative investigation of mothers' perspectives on their relationships with home visitors in rural (unspecified models) home visiting programs (U.S.).

- 1. Who participated in the qualitative interview-based sub-study?** The MIHOPE study team's approach to sample selection and recruitment and a description of the interview participants is provided in Chapter 2.
- 2. Why did mothers decide to enroll in home visiting?** Chapter 3 describes mothers' recollections of why they decided to enroll in a home visiting program and provides context on their lives and expectations when home visiting services started.
- 3. How did mothers describe and perceive the services home visitors provided during their time with the program?** Chapter 4 focuses on the interview findings from the long-term participation group mothers and summarizes the different ways in which they described how their home visitors helped them.
- 4. For mothers who were long-term participators in home visiting, how was trust with their home visitors built?** Chapter 5 continues the focus on long-term participators and summarizes key themes around mothers' descriptions of how trust with their home visitors was developed.
- 5. For mothers who were in the early leavers or later leavers participation groups, why did they discontinue services?** Chapter 6 describes the circumstances of the lower participation group mothers, with a particular focus on understanding the reasons for why they ended home visiting earlier than the rest of the sample.
- 6. What were the mothers' reflections on their experiences in home visiting when services ended?** Chapter 7 presents additional reflections from the long-term participators about their families' circumstances when services ended and their thoughts on the ways in which home visiting made a difference in their lives.

The final chapter provides a discussion of the study's strengths and limitations, as well as potential implications based on the main findings.

2

Sample and Methodology

This chapter describes the sampling approach used to recruit mothers who were part of the program group in the Mother and Infant Home Visiting Program Evaluation (MIHOPE) to participate in in-depth interviews about their experiences in home visiting. It further describes the characteristics of the 74 mothers who ended up participating in the interviews. These interviews were conducted between May and November 2019, which was four to six years after the mothers had first entered the study and began to receive home visiting services. This chapter also describes ways in which the sample of interview respondents are similar to and different from the larger program group sample in MIHOPE.

SAMPLING PLAN

Because the interview sub-study was designed to explore mothers' experiences in home visiting programs, the sampling frame was limited to mothers who had received at least one home visit.¹ A key goal of the qualitative interviews was to explore reasons for variation in participation in home visiting as captured by length of time in the program and visit frequency—patterns that were documented and described in the MIHOPE implementation research report and that are summarized in Box 2.1.² Specifically, the team used a purposeful sampling design in which the interviewers attempted to recruit

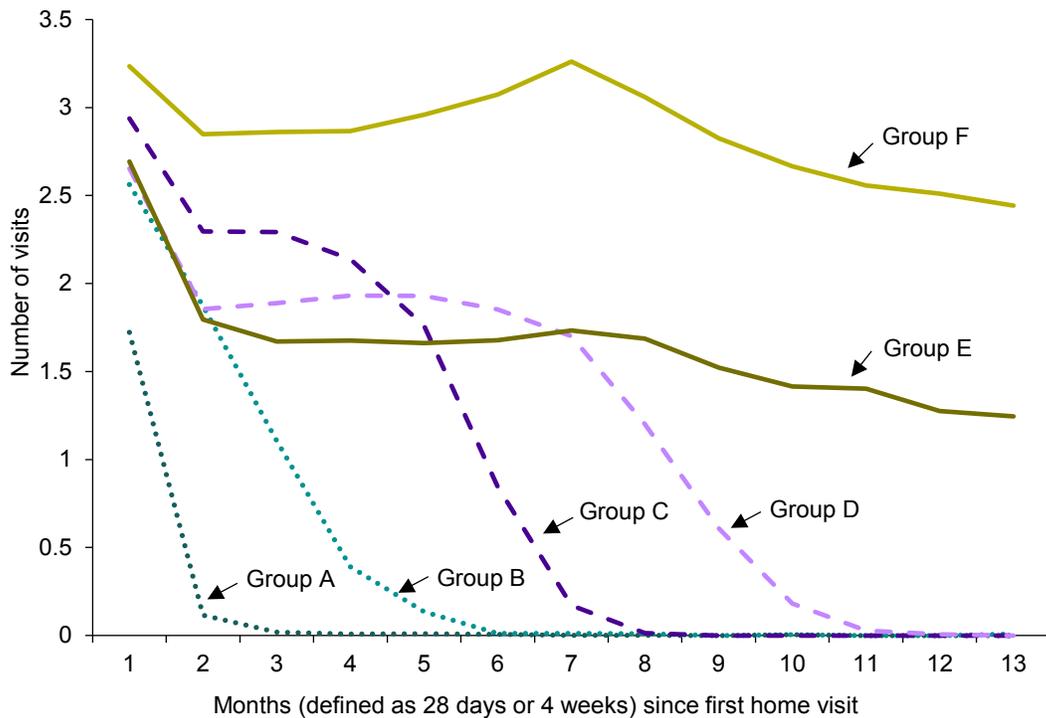
¹As described in Chapter 1, about 17 percent of the program group sample never engaged in home visiting even though they had expressed an interest in the program. These mothers were excluded from the sampling frame for the qualitative interviews.

²Duggan et al. (2018). Detailed service delivery data on the frequency of visits, duration of contact, and the content of visits (including topics discussed and referrals made) were based on family service logs that were completed weekly by home visitors for the families assigned to the program group and who had received at least one home visit. Most of the analyses based on the family service logs summarized in the MIHOPE implementation research report were restricted to families who had the potential to be enrolled in home visiting for one year. Because the family service log data were completed as part of MIHOPE (and not for programmatic purposes), the log data do not provide a complete picture of a family's overall participation in a program if that family participated longer than one year.

Box 2.1. Patterns of Participation in Home Visiting Found Among Program Group Families in MIHOPE

Across the home visiting literature, a family's participation in a program is often measured and monitored by two key indicators: (1) duration or the length of time a family participates in home visiting, and (2) visit frequency or the number of visits received. Accordingly, in the MIHOPE implementation research report, the study team presented data on several measures of participation, such as the average number of months families were in a program, and visit frequency, such as the average number of visits received.*

In addition to these more standard metrics, the study team also examined overall patterns of participation over the first year of services for the program group families who received at least one home visit. The analysis, called a trajectory analysis, takes into account both duration and visit frequency to identify common patterns of participation found among the sample.† Six distinct patterns of visit trajectories emerged, as shown below.



SOURCE: MIHOPE weekly family service logs.

NOTES: The lines denoted by Groups A, B, C, D, E, and F show the common patterns of participation, or visit trajectories, among MIHOPE families that received at least one home visit. Groups A and B comprise the early leavers; Groups C and D comprise the later leavers; and Groups E and F comprise the long-term participants.

Although six groups were uniquely identified, families' participation patterns tended to fit into one of three broad types of participation:

- Early leavers: Families whose initial visits were followed soon after by a steep decline in participation, then no participation.** Groups A (15 percent of the sample) and B (13 percent of the sample) received 1.7 and 2.6 visits on average, respectively, during the first month of participation. Then their participation drops sharply, with the vast majority no longer participating six months after enrollment.

(continued)

Box 2.1. (continued)

- **Later leavers: Families whose initial visits dropped to a plateau, then whose participation declined sharply to nonparticipation within the first year.** Families in Groups C (7 percent of the sample) and D (10 percent of the sample) received 2.9 and 2.7 visits on average, respectively, during the first month. Families in Group C settled into a somewhat stable pattern of about two visits per month on average for the next four months, but then their participation dropped. Families in Group D settled into a somewhat stable pattern of just under two visits on average per month through the seventh month, with a drop thereafter.
- **Long-term participators: Families whose visit patterns settled into a relatively stable pattern over the period.** Families in Groups E (38 percent of the sample) and F (16 percent of the sample) exhibited a sustained pattern of home visiting participation across the first year, compared with the early leavers or later leavers. Families in Group E received 2.7 visits on average during the first month, then averaged between 1.2 and 1.8 visits per month for the remainder of the year. Families in Group F started with 3.2 visits on average per month and maintained a high level of participation overall, dropping to about 2.5 visits on average per month a year later.

These three participation groups became part of the stratified sampling frame the qualitative interview sub-study team used to recruit respondents for the semi-structured interviews.

[†]Additional measures and a fuller discussion of the home visiting services received among the program group sample in MIHOPE can be found in Chapter 4 of the MIHOPE implementation research report (Anne Duggan, Ximena A. Portilla, Jill H. Filene, Sarah Shea Crowne, Carolyn J. Hill, Helen Lee, and Virginia Knox. 2018. *Implementation of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation*. OPRE Report 2018-76A. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services).

[†]To identify these patterns, the study team first calculated the number of home visits received by month for each family who had at least one visit. The team then analyzed the data to ascertain the presence of distinct patterns or “visit trajectories.” A technical appendix to the MIHOPE implementation research report provides more detail on the trajectory analysis (Carolyn J. Hill, Eric Cohn, Samantha Xia, and Ximena A. Portilla. 2018. *Implementation of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation: Technical Appendix for Chapters 4 and 5*. OPRE Report 2018-76B. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services).

mothers from three different participation groups in order to capture a variety of experiences in home visiting. These groups included: (1) early leavers; (2) later leavers; and (3) long-term participators.³

Although the study team was aiming for roughly equal representation across the three participation groups, we soon realized as we began to conduct outreach and recruitment that mothers in the lower participation groups (both the early leavers and the later leavers) were more likely to have outdated contact information than mothers in the highest participation group (long-term participators). Mothers in the lower participation groups were also less likely to respond to the interview team’s repeated attempts to contact them than the long-term participators, which could also be a function of having outdated information (though this is not possible to confirm). When study team members were able to make

³The early leavers group includes families who participated for shorter durations than other families in the study (between 0.25–4 months in the first year). These families received an average of four home visits. The later leavers group includes families who participated in home visiting between four and nine months and received an average of 14 home visits in the first year. The long-term participators group includes families who participated in home visiting for 10 months or longer and received an average of 27 home visits in the first year.

contact with mothers, most agreed to participate in the interviews, regardless of participation group type. Thus, in the end, the majority of mothers interviewed (80 percent) were part of the long-term participators group.

In selecting the sample, the study team also wanted to include mothers from each of the four evidence-based models included in MIHOPE and strove for geographic diversity. Both English and Spanish-speaking mothers were recruited, although the majority of respondents (92 percent) spoke English as their primary language. The final sample included 74 mothers who received home visiting services from one of 28 home visiting programs that were included in MIHOPE. At the time of the interviews, these mothers resided in six states: Iowa, Illinois, New Jersey, South Carolina, Washington, and Wisconsin.

DATA COLLECTION PROCEDURES AND ANALYSIS

Data Collection

The overarching goal of the in-depth interviews was to learn more about mothers' experiences and life circumstances during the time that they participated in home visiting, including their perceptions of benefits and limitations in the services they received. The interview protocol was semi-structured in nature, which ensures consistency in the topics covered across respondents while allowing interviewers the flexibility to probe into particular experiences in more depth. The core questions of the interview protocol generally fall under the following topics:⁴

- the mother's background and family context when home visiting began
- how the mother found out about home visiting and why she decided to enroll
- the types of activities, topics, and resources that the home visitor covered or provided over the course of visits
- the mother's relationship with the home visitor, including whether and how that relationship changed over time
- the mother's overall reflections of her experiences in the program, including the mother's perceptions of whether and how home visiting made a difference in her family's life

A team of six trained interviewers conducted in-person interviews from May through November 2019.⁵ At the time of the interviews, the MIHOPE child was between 3 and 5 years old, and the average age was 4.5 years. For most of the sample (65 out of 74 mothers), home visiting services had ended an average of 3.5 years before the interviews took place, although nine mothers were still enrolled in the

⁴The Appendix includes a copy of the interview protocol.

⁵One mother was interviewed over the telephone.

home visiting program. The interviews were all audio recorded with the mother's consent and lasted from 60 to 90 minutes. The interviews mostly took place at the respondent's home but in some cases, the interviews were conducted at a different location (including local cafés, diners, libraries, and parks) because that was the preference of the mother.

Analysis

Transcriptions were uploaded and coded in Dedoose software by a team of four coders, three of whom had also been part of the interview team and, thus, had intimate familiarity with the structure and content of the interviews. Each coder was trained in using Dedoose and participated in the development of the initial codebook, which first entailed the development of broad codes that sorted excerpts across the main topics covered in the interview guide and then independent review and more detailed coding of several transcripts by each team member. After independent coding of the same transcripts, the team reconvened to further flesh out the codebook and build consensus across coders. Through applying this working version of the codebook to new transcripts, individual coders then identified the need for new (emergent) codes or for further clarification on the use of existing codes. The emergent or new codes were mostly subcode additions within a broad topical or "parent" code, used to capture variation within that topic. For example, one section of the interview asked the respondent to reflect on her relationship with the home visitor. Within this broad "home visitor-mother relationship" code, the team developed a series of subcodes or "child" codes based on the varied responses. Some mothers noted that they appreciated how their home visitor was an expert or had particular expertise they didn't have whereas others described how they bonded with their home visitor because of shared commonalities. The lead coder was responsible for compiling coders' assessments and for revising the codebook, and then communicating substantive changes in codebook versions to the rest of the team. At the end of the coding process, the parent or main codes roughly followed the different sections of the interview guide, but many subcodes were created to capture the range of responses given by the interview respondents.

Given the complexity of the codebook, inter-rater reliability was not calculated. However, to ensure consistency in coding across transcripts, weekly one-on-one meetings were held between the lead researcher and each coder to review sections of transcripts that had been coded the previous week, including sections where the coder was uncertain about the application of codes. In the end, about 20 percent of excerpts were reviewed by two team members.

After coding was completed, the excerpts across the major codes and subcodes were reviewed by the lead author. From this review, themes began to emerge within each major topic (for example, why mothers enrolled in home visiting). Codes were then reexamined, coded excerpts were categorized into the identified themes, and patterns were further explored. In selecting themes to home in on for this report, we counted the frequency with which a theme was present. It is important to note that counting in qualitative analysis is often not an end result, but a means to an end of describing the

regularity with which an event, perception, or experience was found in the sample's narratives.⁶ Thus, counting helped us identify commonalities of themes as well as divergences from common themes, and to explore those cases in more depth.

When summarizing the themes discussed in this report, the convention we followed was to use:

- “most” when about three-fourths or more of mothers responded in a certain way,
- “many” or “majority” when more than half responded in a certain way,
- “some” when one-fifth to one-half responded in a certain way,
- “several” when less than one-fifth of mothers responded a certain way, and
- “a few” or “a handful” when between three and seven mothers responded in a certain way.

In discerning patterns across themes, we examined whether there were differences based on sociodemographic and other background characteristics (for example, the mother's race and ethnicity, the mother's age when she enrolled, her educational level, whether she was pregnant when she enrolled, and whether she was a first-time mother). These characteristics were examined because prior research indicated that there may be variation in engagement based on these factors.⁷ Because MIHOPE is a cross-model evaluation, we also examined whether there were differences in the reporting of certain themes based on the program model. When patterns are found based on these or other types of characteristics, they are noted in the text; otherwise, there was not a clear patterning of differences.

DESCRIPTION OF THE SUB-STUDY SAMPLE

Because the respondents who participated in the qualitative interview sub-study were part of MIHOPE, in which data from several sources were collected, the team was able to analyze the characteristics of the qualitative interview sample as captured at the time of their entry into the home visiting program and MIHOPE, as seen in Table 2.1. Table 2.1 also shows how the qualitative interview sub-study sample compares to the broader sample of program group mothers who received at least one home visit ($N = 1,736$) and the full sample of program group mothers ($N = 2,102$).⁸ The information shown is primarily based on respondents' self-reported survey responses, although some information is also pulled from family service logs, state vital records, and Medicaid data.

⁶Zapart, Knight, and Kemp (2016).

⁷See, for example, Ammerman et al. (2006); Duggan et al. (2000); Jacobs, Easterbrooks, and Mistry (2005); and McGuigan, Katzev, and Pratt (2003).

⁸For simplicity, we will hereafter refer to the sample of respondents who participated in the qualitative interview sub-study on mother's experiences in home visiting as “the interview sample.”

Table 2.1
Baseline Characteristics of the Qualitative Interview Sub-Study Sample
and MIHOPE Program Group Samples

Characteristic	Qualitative Interview Sample	Ever Had a Home Visit Sample	P-Value ^a	Full Program Group Sample	P-Value ^b
First-time mother (%)	74.3	58.9	0.006	59.5	0.008
Maternal average age (years)	23.8	23.7	0.930	23.6	0.764
Pregnant (%)	82.4	68.0	0.002	68.0	0.002
Maternal race and ethnicity (%)			0.839		0.916
Mexican origin	21.6	24.5		23.8	
Other Hispanic	13.5	13.4		12.7	
Non-Hispanic White	21.6	25.1		24.8	
Non-Hispanic Black	35.1	29.1		30.5	
Other or multiracial	8.1	7.9		8.2	
Primarily speaks Spanish ^c (%)	12.2	15.5	0.418	14.5	0.560
Biological father in the home (%)	47.2	43.3	0.494	41.7	0.337
Relationship status (%)			0.594		0.408
Married to the focal child's biological father	25.0	20.2		18.7	
Living with a partner or spouse	26.4	24.9		24.7	
In a relationship or not living together	23.6	29.9		30.7	
Single	25.0	24.9		25.9	
Maternal highest level of education (%)			0.001		0.000
Less than a high school diploma or equivalent	27.0	41.7		42.4	
High school diploma	28.4	32.3		32.8	
Some college or more	44.6	25.9		24.8	
Mother employed during the past three years (%)	87.7	79.6	0.038	79.4	0.035
Food insecurity (%)	54.1	54.8	0.895	54.0	0.989
Received any public assistance during the past month (%)					
Supplemental Nutrition Assistance Program	48.6	59.5	0.055	59.8	0.049
Disability insurance	25.7	17.9	0.075	18.0	0.082
Temporary Assistance for Needy Families	13.7	19.7	0.185	20.0	0.168
Women, Infant, and Children	73.0	75.8	0.568	74.8	0.706
Health insurance coverage for the mother (%)	91.9	91.3	0.845	91.2	0.841
Substance use before pregnancy (%)	37.8	31.0	0.197	31.2	0.210
Maternal symptoms of depression or anxiety (%)	50.0	42.0	0.156	41.4	0.128
Presence of physical intimate partner violence (%)	20.3	19.1	0.794	18.9	0.762
Experience with battering (%)	8.1	5.9	0.479	5.9	0.482

(continued)

Table 2.1 (continued)

Characteristic	Qualitative Interview Sample	Ever Had a Home Visit Sample	P-Value^a	Full Program Group Sample	P-Value^b
Home visiting model (%)			0.140		0.097
Early Head Start	16.2	15.1		13.5	
Healthy Families America	31.1	34.0		34.4	
Nurse-Family Partnership	39.2	29.0		29.1	
Parents as Teachers	13.5	21.9		23.0	
Sample size	74	1,736		2,102	

SOURCES: Calculations based on the MIHOPE family baseline survey, family service logs, state birth records, and Medicaid enrollment data.

NOTES: Distributions may not add to 100 percent because of rounding. Baseline characteristics for the qualitative interview sub-study sample were collected from December 2013 to August 2015.

^aThe p-value is based on statistical tests of differences between the qualitative interview sample and the sample of program group mothers who received at least one home visit.

^bThe p-value is based on statistical tests of differences between the qualitative interview sample and the full program group sample.

^cThe percentage of Spanish speakers in the interview sample does not match the percentage of interviews conducted in Spanish because some mothers are proficient in both Spanish and English.

As seen in Table 2.1, the interview sample of mothers were young when they entered MIHOPE (average age = 24 years). Mothers who participated in the qualitative interview sub-study are racially and ethnically diverse, with non-Hispanic Black mothers ($N = 26$ mothers; 35 percent), non-Hispanic White mothers ($N = 16$ mothers; 22 percent), Hispanic mothers ($N = 26$ mothers; 35 percent), and mothers who identify as other race (such as Asian American) or multi-racial ($N = 6$ mothers; 8 percent). The age and racial/ethnic composition of the interview sample is similar to the larger sample of program group mothers who received at least one home visit and the full program group sample.⁹

First-time mothers constituted about 74 percent of the interview sample, 59 percent of the sample with at least one home visit, and 60 percent of the full program group. Although MIHOPE included both women who were pregnant and women who had recently given birth, most mothers in the interview sample were pregnant with the study child at baseline (82 percent). This is higher than the sample of mothers with at least one home visit (68 percent) and the full program group sample (68 percent). These differences may partly reflect the fact that, as shown at the bottom of Table 2.1, the interview sample includes more mothers who were randomly assigned to Nurse-Family Partnership programs ($N = 29$ mothers; 39 percent) than the sample of mothers who received at least one home visit (29 percent) and

⁹Assessment of similarities and differences between the interview sample ($N = 74$) and the comparison samples, including the sample of program group mothers who received at least one home visit ($N = 1,736$) and the full program group sample ($N = 2,102$) are based on tests of statistical significance. We considered differences to be statistically significant if the p-value was at the 10 percent level or less, which is consistent with the threshold specified in the study's design and analysis plan (Michalopoulos et al., 2013), and was used in the MIHOPE impact report.

the full program group sample (29 percent). Nurse-Family Partnership is the only model of the four to restrict eligibility to pregnant, first-time mothers.

The interview sample also includes a smaller share of mothers assigned to Parents as Teachers programs ($N = 10$ mothers; 14 percent) than the sample who had at least one home visit (22 percent) and the full program group sample (23 percent). But the percentage of mothers who were randomly assigned to Early Head Start programs ($N = 12$ mothers; 16 percent) and Healthy Families America programs ($N = 23$ mothers; 31 percent) were similar to the sample that had at least one home visit (15 percent and 34 percent, respectively) and the full program group (14 percent and 34 percent, respectively). These differences by model between the interview sample and the other program group mothers—namely the higher shares of mothers in Nurse-Family Partnership programs and lower shares of mothers in Parents as Teachers programs in the interview sample—partly reflects differences in the study team’s sampling frame for the qualitative interviews and the states targeted. While we strove for representation across the four models that was proportionate to the sample of mothers who received at least one home visit, the sampling frame included slightly higher percentages of mothers in Nurse-Family Partnership programs (35 percent) and slightly lower percentages of mothers in Parents as Teachers programs (14 percent) compared to the broader sample of mothers who had at least one home visit (results not shown). In addition, among the sample of mothers who received at least one home visit, mothers who participated in Nurse-Family Partnership programs were somewhat more likely to be in the long-term participators group compared to mothers from the other models (results not shown). Because contact information was better for long-term participators, this might also explain why the interview sample includes more mothers from Nurse-Family Partnership programs.

Across several indicators, the interview sample exhibited socioeconomic and other risks that could affect their children’s health and development. For instance, more than half reported experiencing food insecurity in the year prior to the baseline survey. About half reported elevated symptoms of depression or anxiety at baseline.

On most of the indicators shown in Table 2.1, the interview sample appears to be largely similar to the full sample of program group mothers in MIHOPE as well as the sample of program group mothers who received at least one home visit. The most notable difference between the interview sample and the other samples is the mothers’ education levels: almost half (45 percent) of the mothers in the interview sample had some college education or more when they entered the study compared to 26 percent of the sample who received at least one home visit and 25 percent of the full program group sample. The mothers who participated in the qualitative interviews were also more likely to have been employed in the three years prior to baseline and less likely to be receiving assistance from the Supplemental Nutrition Assistance Program. On these indicators, it appears that the interview sample had lower levels of socioeconomic risk than the other program group mothers. However, mothers in the interview sample were more likely to report receiving disability insurance than the larger sample of mothers who received at least one home visit and the full program group sample of mothers.

Table 2.2 provides additional information on the interview sample's participation in home visiting. The results in this table draw from the MIHOPE baseline survey conducted with families (on their reasons for enrolling in home visiting), the MIHOPE family service log data collected on home visit participation over the first year (which informed the participation group typology), and responses from the qualitative interviews on overall duration of participation and number of home visitors.¹⁰

While mothers participated in home visiting for varying lengths of time, as seen in Table 2.2, more than half ($N = 49$) of the interview sample participated for more than one year. Nine of these 49 mothers were still participating in the program at the time of the interview (which was conducted four to five years after they received their first home visit) and another mother had just graduated from the program when her child turned 5 years old.¹¹ An additional 10 mothers participated for almost a full year (10 to 12 months). These mothers were all part of the long-term participation group ($N = 59$). Eleven mothers interviewed participated in home visiting for less than three months (early leavers) and four mothers interviewed had participated in home visiting for four to nine months in the first year after entering the program (later leavers). Most of the sample reporting working with only one home visitor, but about one-third ($N = 25$) reported that they received services from multiple home visitors.

In the MIHOPE baseline survey, mothers were asked to identify the reasons why they were interested in receiving home visiting services (note that mothers could select multiple reasons for enrolling). The responses seen in Table 2.2 underscore that, despite the survey providing options for specific reasons for enrolling, such as to learn how to have a healthy pregnancy or birth or to improve their child's development, the majority of mothers enrolled for general support and not for help with particular outcomes. Over 40 percent of mothers who participated in the qualitative interviews noted that they wanted to learn how to be a better parent, but again, most were not specific about which aspects of parenting they wanted help with.

¹⁰We relied on mothers' reports provided during the qualitative interviews for assessing their overall length of participation in the program and the number of home visitors they had because the family service log data recording duration information and home visitor turnover for the MIHOPE implementation research report were collected for a limited amount of time.

¹¹For the nine mothers who were still participating in home visiting at the time of the interviews, all of them were receiving services from the same program that they had enrolled in when MIHOPE started. In seven cases, the study child had not yet aged out but would do so when turning 5 years old. In the other two cases, the program reenrolled the mother when she became pregnant with a subsequent child after the study child.

Table 2.2
Participation Measures and Reasons for Enrolling in Home Visiting

Characteristic	Number	Percentage
Participation group type		
Early leavers	11	15
Later leavers	4	5
Long-term participators	59	80
Duration of participation (months)		
0-3	11	15
4-6	2	3
7-9	2	3
10-12	10	14
13-18	6	8
19-24	15	20
25-36	18	24
37 or more/still in home visiting ^a	10	14
Number of home visitors ^b		
One	45	64
Multiple	25	36
Reasons for enrolling in home visiting services ^c		
For additional support/generic help or to learn things	39	59
To get education on or learn how to be a better parent	29	44
To learn how to help her baby learn and develop	8	12
To get referrals or get connected to resources	7	11
To learn how to help her baby be healthy	5	8
To have someone to talk to/reduce the feeling of being alone	4	6
To learn how to have a healthy pregnancy	3	5
To get help with breastfeeding	2	3
To be healthy or improve her physical health	1	2
Sample size	74	

SOURCES: Calculations based on the MIHOPE family baseline survey, family service logs, and qualitative interviews conducted by the study team.

NOTES: Distributions may not add to 100 percent because of rounding.

^aAt the time of the interview, nine mothers were still receiving home visits. These mothers had their first home visit 3.9 to 5.2 years earlier.

^bThis information could not be gathered from all interviews due to recall error, so the numbers do not add to the total sample.

^cAs indicated on the MIHOPE family baseline survey. These reasons are not mutually exclusive.

CONCLUSION

Although the study team attempted to recruit and interview mothers across varying levels of participation in home visiting, the mothers who ultimately were interviewed were primarily long-term participators in home visiting. For the lower participation groups of mothers in MIHOPE, their contact information was more likely to be outdated and they were less likely to respond to contact attempts than long-term participators. The interview sample was racially and ethnically diverse, and most mothers were young and pregnant for the first time when they enrolled in MIHOPE and began home visiting services. The mothers who participated in the qualitative interviews were mostly similar to the full program group sample and exhibited socioeconomic risks such as high rates of food insecurity. On a few indicators, namely higher education levels, employment, and lower rates of receipt of Supplemental Nutrition Assistance Program benefits, the interview sample had lower levels of socioeconomic risk than the other program group mothers. Most of the interview sample, in response to survey questions about their main reasons for enrolling in home visiting, reported needing general support or help, but were not specific about particular outcomes or areas they wanted help with. As described further in the next chapter, these results are mirrored in mothers' narratives of how and why they decided to enroll in home visiting.

3

How and Why Mothers Enrolled in Home Visiting

To contextualize mothers' experiences and perceptions of their time in home visiting programs, mothers were first asked to recall what they were expecting when they enrolled in home visiting and to describe what was going on in their lives. A prior qualitative study of mothers who left a home visiting program early found that one of the reasons was that mothers' expectations of the program did not align with what they felt they ended up receiving, such as the home visitor not being able to provide them with answers to some of their questions or that there wasn't enough flexibility in the scheduling and frequency of visits.¹ In another study, mothers said that they actually knew very little about what home visiting was, and thus had limited expectations.² What did the mothers in MIHOPE know about home visiting and why did they sign up? What was going on in their lives at the time services began? This chapter presents findings on these questions and reflects mothers' best recollections of what was occurring in their lives at the time they enrolled in the program.

MOTHERS' EXPECTATIONS AND REASONS FOR ENROLLING IN HOME VISITING

The majority of mothers interviewed did not recall having specific expectations or a clear understanding of what home visiting was. For example, summing up several mothers' responses to questions about what they were expecting and why they enrolled in home visiting, one mother stated, "So, actually, I didn't even realize what I was signing up for... I just thought with kids, the more help, the better." This idea of generally wanting help aligns with the findings described in Chapter 2, of mothers not having a clear or specific reason for enrolling. Most of the mothers reported that they had heard about the home visiting program from another service provider or from a friend or family member. Even in these cases, where the program was recommended to the mother, mothers recalled generally being told that the home visiting program could help them as a parent and could provide them with resources. Several mothers recalled that they enrolled after someone from the program reached out to them directly, which

¹Holland et al. (2014).

²Thompson (2011).

was typically at a prenatal clinic or at the birth hospital. Only a small number of mothers reported finding out about the program on their own (for example, by looking online for support).

Even though their understanding of what home visiting actually entailed was limited, most of the mothers also stated that they wanted to be a good parent. Mothers varied, however in how they were feeling about being a parent and other contextual factors when they first engaged with home visiting. These factors translated into different motivations for enrolling.

Facing Motherhood for the First Time

When describing their situation at the time they signed up for home visiting, the majority of the respondents who were young (in their late teens or early twenties at the time of enrollment) and pregnant for the first time reported being fearful of motherhood and described this time in their lives as one of uncertainty. For example, when asked about why she decided to enroll in home visiting, one respondent simply stated, “Well, I was 19 and scared out of my mind.” Zara, a Black woman who was 23 years old and about five to six months pregnant with her first child when she enrolled, similarly noted that she was afraid.³ She could not remember where she was, but recalls that someone at a local community-based organization told her about the home visiting program and that it helps new parents:

And I was like, “Great, because I’m scared as shit.” [Laughs]... And then the opportunity to have home visits where they would come and go through the stages with me as I was going through the pregnancy, that’s what was really great. It was calming and everything, ’cause I was scared.

Because they were worried about being a parent, some of these mothers also described feeling comforted by the idea of someone who would come into the home and check in on them. One mother, who was a teenager living with her own mother at the time she started home visiting, noted that she signed up for home visiting because she wanted “to have another point of view” besides her mother, but also wanted to see “if I could do this [parenting], like, on my own,” meaning independent of her own mother. Having a home visitor verify that she was mothering on her own was important to her. Another respondent said:

You know, when you’re a first [time] mother—like, I was very nervous. I was like, “I don’t want to do anything to mess up this child.” I don’t know. I just wanted for someone to be like, “You know, you’re doing a good job.”

In this manner, these mothers did not necessarily describe wanting new information or education on how to parent as a primary reason for enrolling, but instead seemed to want to have someone who could provide them with reassurance and validation that they were on the right track. This aligns with how the home visitors interviewed in MIHOPE described their role as one of providing positive reinforcement and

³Pseudonyms are used throughout the report to protect the identity of individuals.

encouragement, which they, in turn, felt was a strategy for empowering the mother and her relationship with her child.⁴

Although more the exception than the norm, a few mothers who were also young, first-time parents expressed more confidence in their ability to raise children. This was largely because these respondents had been heavily involved in taking care of other younger family members growing up. For example, in direct contrast to the examples above, Gabriella, a Mexican-American first-time mother who was 20 years old when she started home visiting, stated that she enrolled because she felt overconfident and wanted to check herself:

I helped raised a bunch of my cousins. There was like 13 younger than me, so I already knew. I basically knew everything, but [I signed up] to kind of just to challenge myself. To find [out], am I really accurate? Do I really know all this stuff?...Because I felt like I was a little overconfident.

Similar to the mothers who expressed fear, the first-time, more confident mothers also went on to say that they wanted reassurance from home visiting about how they were raising their child, even if they had the experience of helping to raise younger kin.

To Get Support for Their Child’s Development

Among non-first-time mothers, a few respondents noted that they had participated in a home visiting program with their older children and benefited from the experience. Because they had been involved in a home visiting program before, it is not surprising that these respondents were the clearest and most specific about why they signed up for the local program in MIHOPE. Most of the mothers with prior home visiting experience stated that they enrolled to give their kids a head start in life. For example, one mother who had been involved with home visiting for her older daughter noted that she enrolled in the same program again because she was looking for early child development support. She further remarked that her older daughter is “just really smart...advanced” and attributed this to her involvement in home visiting. For the child in MIHOPE, the mother went on to say:

It doesn’t matter if I might be inconvenienced or anything like that. That’s how I’ve always felt when it came to their education. It doesn’t matter if I’m workin’. It doesn’t matter what I’m doin’ at the time. Their education is the most important thing.

In contrast to other respondents and as illustrated in the quote above, a few mothers primarily seemed to view the program as an educational one, and one that was meant only for their children, which is

⁴Duggan et al. (2018); see Chapter 6.

similar to the findings from an earlier qualitative study of home visiting programs.⁵ Unlike this earlier study, however, this was more the exception than the norm among the mothers interviewed in MIHOPE.

The majority of mothers with older children who had not been previously involved with a home visiting program described enrolling because they wanted another perspective and advice on parenting, which is similar to some of the first-time mothers. For example, one mother with older children who had not engaged in a home visiting program before explained that there was a 10-year gap between when she had her first child and the child in MIHOPE. She enrolled in home visiting because “a lot changes in 10 years” and she especially wanted someone she could bounce ideas off of and who could answer her parenting questions.

To Get Emotional Support

For some mothers, both first-time mothers and mothers with older children, their primary motivation for enrolling in home visiting was to get emotional support. These mothers wanted parenting help as well, but in contrast to the mothers described thus far, these respondents recounted that they were feeling isolated and lacking support around the time they enrolled. For example, one mother recalled that she and her husband were barely making ends meet when she found out she was pregnant:

I was at WIC, and I got really sensitive and started crying because my husband was the only one working then...and I was just taking it all on and I was crying. And they're like, “You know, we have people that can come and visit so you don't feel so stressed.” So that's how I applied.

Another mom recounted feeling depressed, unsure about the pregnancy, and also that she was alone at the time:

I was not in...a right state of mind. Like I was still...trying to make it [pregnancy] seem like, “Okay, this is not happening.” I wasn't really close to anybody, so I was trying to really just back myself away a little, just so I could see, mentally, what is it I'm gonna do?... And there was actually a booklet at [the local implementing agency], and I said, “I know I'm not the only person like this, so there has to be somebody else that is feeling this way.”

Several mothers spoke of difficult childhoods and wanting the support to do things differently from how they were raised. For example, Annie, a non-Hispanic White mother who was 19 years old and pregnant for the first time when she started home visiting services, recounted an extremely turbulent upbringing, being raised by a mother with (what the respondent said was) narcissistic personality disorder. The relationship was so bad that she ran away from home when she was 15 and started couch surfing with friends. Through work, she saved up enough money to buy a used car and would sleep in her car when

⁵Hebbeler and Gerlach-Downie (2002).

she wasn't able to find a friend to stay with. When she found out she was pregnant, she was referred by her prenatal clinic to the home visiting program and signed up. She recounts:

I was afraid of becoming like [my mother]...And I just told [home visitor] one of my main goals is to just...I just want my son to know that he's loved and he is valued...And like, you know, I just didn't want him to feel the way that I felt when I was growing up.

Other Reasons for Enrolling

In addition to the reasons noted thus far, two mothers stated that they primarily signed up for home visiting to get resources, which included tangible goods like diapers, clothes, or toys. However, these mothers also noted that there were other things going on that seemed to motivate them to enroll. For example, one respondent recounted being at the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) office and being told that the program would help with getting her different things. But she also described feeling down because she had dropped out of college due to the pregnancy, and that she didn't have much going on in her life:

I remember one of the lovely ladies there [at WIC] introduced me...She told me about all the benefits that [son] would be getting and like the car seat, toys, and stuff. I was like, "Wow, that sounds great." And I wasn't working as well. I was just a stay-at-home mom.

Finally, several mothers stated that they did not really have a reason for signing up. While a minority among the larger sample, this smaller group of mothers differed from others in that they did not mention enrolling in home visiting to get help with parenting or resources, even in vague terms. Within this small group, about half were lower participators and quickly dropped out of the program after enrolling. For example, Lauryn, a Black woman who was 20 years old and pregnant for the first time when she enrolled, stated that she was encouraged to participate from someone at her prenatal care provider's office and thought she'd give it a try. But she also explained that she is a "soft person" and has a hard time saying no. She ended up receiving only a few visits. The other half were longer-term participators who, despite not having a clear reason for enrolling, found that they and their children began to benefit from the program and stayed involved.

CONCLUSION

The home visiting models in MIHOPE have outlined logic models for the outcomes they target, and prior research suggests that a program can best create change by aligning services to match a client's specific goals.⁶ However, most of the mothers in the interview sample did not have clear expectations

⁶Duggan et al. (2018); Burrell et al. (2018).

about what home visiting entailed when they signed up for the program. Along with the findings from the MIHOPE baseline survey about reasons for enrolling (described in Chapter 2), these findings from the qualitative interviews suggest that some mothers are not always clear themselves about why they enrolled and what they hoped to get out of home visiting. While some mothers were more specific in that they enrolled to support their child's development, the majority of the young, first-time mothers reported feeling scared and generally wanting help and reassurance with how to parent. Still others could not recall having an overarching or motivating reason for enrolling. However, as described in Chapter 2, most of the sample ended up engaging for long periods of time which suggests that these mothers ultimately saw some benefits to participating in home visiting, even if they weren't always specific or sure about what they were hoping to get out of the program.

4

How Home Visiting Helped Mothers

Despite the varying motivations for enrolling, as described in the previous chapter, most of the mothers in the qualitative interview sample reported receiving wholly or mostly positive benefits from their time in the program. However, there were some exceptions and most of these, as might be expected, were from the experiences of mothers in the lower participation groups (discussed in Chapter 6). Mothers' reflections on the ways in which home visiting positively helped them and their children are summarized in this chapter, and they are based on the narratives of long-term participants only. We focus on these mothers because the data are richest for them, as mothers in the lower participation groups had a harder time recollecting specific ways that home visiting helped them, which is not surprising given that they engaged for shorter durations. The main themes are organized by the broad types of support and education that the sample of long-term participants reported receiving, including guidance on parenting practices, help that supported or improved their own well-being, and assistance with resources.

HELP WITH POSITIVE PARENTING

Many mothers in the long-term participation group were able to describe concrete ways in which their home visitor improved how they parent. Examples include getting advice and help with improving their child's health and safety-related practices in the home, guidance on how to support their child's development, and advice on how to communicate with and discipline their child.

Child Health and Safety

Some mothers—particularly first-time mothers—said that they gained basic knowledge about child safety and health practices from their home visitors that they wouldn't have known otherwise. As one respondent noted:

I was just lost. It was bad. It was just embarrassing. Like I would ask her, "How do you know how much water to put in [the bottle]?" "Oh, it's [the instructions about dilution] on the back of the can." I mean, I didn't even know it was on the back of the can.

Arguably, as with the example quoted, the mother would have figured out what to do without the home visitor. But a few mothers went on to explain that the concrete advice and safety information home visitors provided often opened them up to learning more about parenting. For example, one mother who was a little skeptical of home visiting when she first enrolled described how that changed over time.

I probably wouldn't have been so motivated to find out new things if it wasn't for [home visitor]. Because there was things she told me that I had no clue about. Like a choking hazard [is] don't stick your finger down their throat, it just pushes it in there more. I would totally be the one who would do that.

Another respondent explained that as a teenager who was pregnant for the first time when she enrolled in home visiting, she had some uninformed notions about parenting. She described that the main way the home visitor supported her was to help her grow up:

I feel like it made me a more mature and responsible parent...With the crib, for example, with me having all the toys in there. Because I thought it looked pretty. It's such a warning. For the babies, they cannot have teddy bears and stuffies around them when they're infants. It just made me more responsible in that area...

This same mother and several other mothers also recalled that they were always able to reach out to their home visitor in cases where they didn't know what to do about a health issue with the child, such as when the baby developed a rash or spiked a fever. They noted how this kind of immediate, personal support was different from (and better than) having to call or schedule an appointment with a doctor. For example, Nicole, a multi-racial mother who was 17 years old when she enrolled in home visiting, recalled being scared about her son who was always sick:

He got sick a lot...It turned out to be asthma. And the doctors couldn't prescribe anything. So I asked [home visitor] about how to help him cope with that, because he would be coughing hard. And he has [frequent] reflux. So when he coughed, he'd like throw up and stuff. And so...she definitely helped me find home remedies and stuff that I could do for him, too.

Nicole went on to explain that she was frustrated that the doctors weren't able to do something to help her child and felt that "just because I'm young, they [the doctors] didn't really take me seriously." But she found that she was able to turn to the home visitor who took her concerns seriously and helped her find other ways to help manage the child's health concerns.

Child Development

When interviewers asked mothers to reflect on the topics they discussed with their home visitor over the course of their participation, most mothers consistently described content related to parenting to support child development. This is congruent with the quantitative data from the MIHOPE

implementation research report, which showed that the most frequently discussed topics were on child development and positive parenting behavior.¹ Even the first-time mothers who felt fairly confident about their ability to parent because they had helped raise siblings or other kin and the mothers who already had children reported gaining new insights into parenting.

For example, one respondent who said she had basically raised her brothers noted that “it’s different with your own kid” and recalled her home visitor encouraging her to read to her child or spend some other type of quality time with her child every day, things that she didn’t do when she was taking care of her little brothers. Several mothers also remarked that their home visitors taught them to be more intentional parents. This included paying attention to how their child was feeling, and responding accordingly. When asked for a specific example of this, Zara stated:

Interviewee: So, well [daughter] can be a bit—what do I want to say?—a kid. I don’t even want to say hyper, just a kid and everything. And mommy doesn’t always want to play with dolls. Because this can go on for hours, and I can’t do that no more. [Laughs] But...I don’t want to turn away, and you know that whole statistic [about] how many times a kid hears the word “no”? [Laughs]

Interviewer: Yeah.

Interviewee: So...I would compromise with, like, “Let mommy feel a little bit better and we can play for 30 minutes before you go to bed.” So finding that medium and everything. And it goes to what I was saying, because I don’t always have to say yes. But being intentional about making sure that she knows I’m present, which is me offering, we can do this like 30 minutes before it’s bedtime. I feel like it’s being intentional about letting her know that I’m present.

Interviewer: And you felt like you learned this from having your home visitor?

Interviewee: Yeah.

Communication and Discipline

Another common and concrete way in which mothers recalled how home visiting helped them as parents was in disciplining their children, particularly with discouraging the use of yelling and spanking. This was noted among both first-time mothers and those who also had older children. In fact, when asked how home visiting helped them, a few of the mothers with older children or those who had helped raise their siblings or kin remarked that while much of their parenting behaviors did *not* change, discipline and yelling were areas where they did take away something. For example, Gabriella, who had helped

¹Duggan et al. (2018).

raise her cousins, noted that “I already had my plan, and they [home visitors] just were either reassuring me or telling me what I should tweak a little bit.” But she goes on to state:

Interviewee: ...they did make a very valid point that timeouts are a lot more beneficial...versus spanking them.

Interviewer: Why?

Interviewee: Because a spanking—they will not remember it five minutes later. But if he has to sit for five minutes, and you have to sit him down and say what he did wrong and why we’re not gonna do it no more, it will click in his head.

Interviewer: Wow.

Interviewee: Because I’m like, “[Son], don’t you remember why you got spanked?” And he’s like, “No.” I’m like, “Seriously?” I remember as a child if I got a whopping, I would never do it again. [Son] is like, “I’m gonna fight you back.”

Interviewer: Did you know that already or did they tell you that?

Interviewee: They taught me the timeout thing. I would have never done that. And they say just keep checking back, like, do you know why you’re in timeout? If they can say it, do you know why you’re in timeout? And once they’re able to say it, they got it.

Leah, a non-Hispanic White mother who was 36 years old when she enrolled in home visiting, had three older boys when she had her daughter (the MIHOPE child). She recounted how her involvement in the home visiting program had her reflect more on her daughter’s development and her use of yelling with all of the kids:

The way I raised the boys was...basically, what I learned growing up. How my mom was with us. And that’s how I was with the kids. I mean, I would raise my voice and yell all the time and tell them, “Hey, you’re not supposed to do that!” Whereas with [daughter] I think I, even with just some little ages and stages and stuff that we would go through all the time, it would make me think, “Oh, well, this is what they’re developing.” So...it would always make me think back to the boys. I think that’s when I kind of realized that we shouldn’t yell. Because you know what? Yelling don’t really do much for the kids except teach them how to yell at other people.

HELP WITH MATERNAL WELL-BEING

The majority of mothers in the long-term participation group described the ways in which the home visitor played an important role in providing them with the emotional support they needed. Although less frequently discussed than the parenting changes, some mothers credited home visiting for helping to improve their mental health.

Depression and Anxiety

Several mothers described struggling with depressive symptoms or anxiety and recounted the different ways that home visitors helped them navigate their symptoms. As described in the MIHOPE implementation research report, home visitors are expected to screen regularly for depressive symptoms and connect mothers to services if needed.² One mother stated that she had a history of depression before becoming pregnant. After giving birth, her symptoms returned, as detected by the home visitor:

Interviewee: ...We did some screenings and we talked about points on [the scale] that I had difficulties with. And I had been on antidepressants before and I had stopped them for a couple years. Then I had [son] and then it came, I don't remember when, but it came to a point where it's like, "Yeah, I think you should probably go see a doctor again." So I had gotten back on them [medication] and so, yeah.

Interviewer: So she's the one that did the screening and one of them came back positive.

Interviewee: Yeah. She was like, "Yeah, you might want to go see just see what they want to do and that it's like, okay."

Similarly, Leah noted that she had a history of struggling with anxiety. Through discussions with her home visitor, she realized she needed to get a formal mental health assessment. The home visitor recommended a place for her to go:

I would have to say with sitting and talking to her a lot of times, with different issues that I was having...that would be when I would realize, hey, well, maybe I should go get—like for my anxiety and stuff—I ended up going and getting a mental health evaluation. I didn't end up even thinking about doing that, honestly, until me and her got to talking about different health issues and stuff I was having, and then I decided to go.

²Duggan et al. (2018).

In both of the examples above, it is notable that the mothers had histories of depression or anxiety, which might suggest that they were more open to discussion and were honest with their home visitors about the presence of symptoms. As described in a later chapter, this is not always the case. However, a few other mothers who did not have a prior history of depression stated that they experienced postpartum depression (PPD) and that the home visitor helped them by normalizing their feelings when they exhibited symptoms of PPD. As one mother described:

She basically helped me to know that it's not weird. A lot of women go through PPD. 'Cause I remember it felt like I was weird, I was all by myself kind of thing. It's not weird at all. People go through it. A lot of people don't talk about it but they do go through it.

In an earlier qualitative study of home visitors, home visitors described that while they felt most comfortable and competent addressing parenting behaviors and child health and development topics, there were three areas where they felt less equipped to talk to and support parents: substance abuse, intimate partner violence, and mental health concerns.³ It was thus notable to find that for the mothers who described experiencing poor mental health during their time in home visiting, most also reported feeling supported and encouraged by their home visitor to acknowledge the issue and to seek professional help. Very few mothers reported issues with or discussions about substance use and intimate partner violence dynamics with their home visitor. Those that did discuss these issues with their home visitor recounted that their home visitor provided support, advice, and encouragement to change these dynamics, although the mother was not always willing to follow that advice.

Emotional Support

The majority of mothers did not describe experiences with specific mood disorders, unlike the mothers discussed above. They did however state that home visiting helped with their overall well-being, and the most common way in which this was done was by the home visitor providing emotional and social support. Mothers described how the home visitor represented someone in their lives who listened, someone to talk to, and someone who had their back and would encourage them. Mothers' narratives of the types of emotional support provided by home visitors resonates and aligns with how home visitors in MIHOPE (as documented in the MIHOPE implementation research report) described their role, which is that of being a cheerleader and an advocate for the mother.⁴ For some mothers, especially for those who reported feeling lonely and isolated, regular home visits were something they would especially look forward to.

Even for mothers who were married or living with the child's father or a partner, the home visitor sometimes became someone that they could more easily and safely open up to. As one mother noted, the home visitor provided her with validation and "there is no validation coming from him [husband]."

³Tandon, Mercer, Saylor, and Duggan (2008).

⁴Duggan et al. (2018).

Another mother remarked on how she relied heavily on her social network during the first year of parenting in particular, which included her extended family and her husband. But she also noted how the home visitor was different:

Just knowing that I had someone there to talk to if I felt like, oh, I couldn't talk to my husband or my parents...to ask her questions and know that she wasn't gonna judge me and she wasn't gonna make me feel bad about whatever decision I made. She was there to encourage me. And sometimes family members do that, they just discourage you. Because the stuff that they say...they don't really think and they don't really know.

Thus, while it was common for mothers without partners or strong social networks to remark that they relied on the home visitor for that emotional connection, the examples above illustrate the unique role that the home visitors played in mothers' lives, even for those who had partners, family, or friends nearby.

HELP WITH RESOURCES

Interviewers also asked specifically about whether and how home visitors helped mothers access any resources or services they needed, and the majority of respondents shared positive stories about how their home visitor helped in this regard. Some mothers recalled home visitors providing them with material goods, such as diapers, baby clothes, car seats, books, and toys, as well as providing information and connections to other community service providers:

She always helped with diapers...and we talked about education. We did WIC, she helped me with the application...Because I didn't know what to do, what paperwork to take. I didn't know anything. She even showed me how to apply for food stamps. She knew I was going to need that...And like even the resources, like, if I ran out of milk, she had got me into the right person to help me when we was like, well, we don't have an appointment right now...

In addition to connecting moms to resources in the community, home visitors also provide validation and encouragement in following up or through on those services. For example, one mother described how her home visitor helped connect her to a speech therapist for her son. She went on to state that the value of the home visitor wasn't just in connecting her to services but that her home visitor reinforced the maternal instinct she had that her son's language development was delayed and encouraged her to push for getting those services.

Finally, although less commonly noted, a few mothers recounted times when home visitors helped them with their own educational and employment goals. When asked about whether she received help with her education or employment, Nicole, the young mother of the child with asthma, recounted:

She definitely helped me, because I wasn't employed when she was first coming. So she gave me pamphlets on hiring and places to get hired, so where I could apply. And so Snagajob—she gave me that information. Snagajob is like where you can go and put in your zip code, and then a bunch of areas pop up where they're all hiring. So then you can click on them and fill out an application, which was very helpful. And then once I got a job, she helped me, like, because I wanted to save money to move out [of my parents' house]. So she helped me find basically a plan on how to save money and stuff like that.

In another example, a mother noted that after giving birth and having a good experience breastfeeding her child, she became very interested in becoming a nurse and wanted to specialize in lactation consultation. Her home visitor, who was a nurse, encouraged her to pursue a career in nursing, provided guidance on local nursing programs and scholarships, and eventually wrote her a letter of recommendation for nursing school. At the time of the interview, this mother was completing her coursework and referred to her home visitor as her mentor and role model.

CONCLUSION

The stories recounted in this chapter, based on the experience of mothers who participated in home visiting for extended periods of time, illustrate the concrete ways in which home visitors worked with mothers to address different concerns, ranging from child health and safety practices, parenting to support child development and discipline, and their own emotional well-being. The areas that mothers recalled their home visitors helping them with largely align with the topics that the home visitors in MIHOPE reported discussing most frequently across visits, including child development, positive parenting behaviors, child preventive care, and mental health and stress.⁵ Also in line with the quantitative data collected in MIHOPE on visit content, very few mothers reported discussing intimate partner violence concerns or substance use with their home visitors. It is unknown from the interview data whether these more challenging types of topics were not discussed because the interview sample of mothers did not have these concerns or because the mother did not want to talk about them (with either the interviewer or the home visitor). It is likely that if a mother does not trust her home visitor she will not open up about these or other serious concerns.⁶ In the next chapter, findings are presented that explore the question of how trust is built from the perspectives of long-term participants.

⁵Duggan et al. (2018).

⁶Thompson (2011).

5

How Trust is Built in the Home Visitor-Mother Relationship

At the core of the positive experiences summarized in the previous chapter rests a trusting relationship between the home visitors and the mothers who were long-term participators. This chapter describes how trust is built from the perspectives of mothers who were in the long-term participation group. An earlier study, focused on home visitors' perspectives of trust-building, found that home visitors reported using several strategies, including bonding and building rapport with the child first; taking a non-directive, non-judgmental approach; sharing personal experiences and demonstrating commonalities; and providing practical assistance in the early visits to show mothers that the services they provide can have an immediate impact.¹ Very few home visiting studies have examined the issue of trust and how it is developed from the viewpoints of mothers. The interview protocols included a section that asked mothers to describe their relationship with the home visitors, from their initial perceptions and interactions to the end of their time in the program. Notably, the protocols did not include explicit questions about the concept of trust. Yet, through the analysis of qualitative codes on the nature of their relationship with their home visitor and how the relationship evolved over time, an overarching theme of mothers' describing the building of trust emerged. Specific findings within this theme are presented in this chapter.

BEING AN EXPERT, BECOMING A FRIEND

Some mothers recalled having an early degree of trust with home visitors based on the home visitor's professional background, including training as a nurse or social worker or as someone who studied child development. These mothers were particularly drawn to and valued the expertise that the home visitor brought to the table from the beginning. For example, one mother noted that "I have friends who have babies, but it's nothing like hearing it from a professional, like a nurse nurse." Another mother with a home visitor who had a bachelor's degree in child development similarly noted that she trusted that her

¹Jack, DiCenso, and Lohfeld (2002).

home visitor “knew what she was doing. I felt like she knew about the children and what they needed, especially coming from a child development background.”

In contrast, several mothers appeared to be more dubious of their home visitors in the beginning, but they also seemed to trust the home visitor’s guidance and expertise enough to try out a strategy that they didn’t at first understand. Over time, they started to see the benefit for themselves, which then served to reinforce and strengthen the mother’s trust in the home visitor. As one respondent recounted:

Anything that I did, I always saw a positive outcome with it...Even if it was things where I’m like, “Why would I need to do that?” ... I always felt weird talking [to my daughter] in the very beginning, telling [daughter], “Oh, I’m changing your diaper now.”... ’Cause she’s a baby and it doesn’t matter. But once I did it, I realized how much it can help her. Or even little games to play with her where I’m like, “What’s the point of that? She already does that.” But then she would just advance so much more. I noticed that.

In cases where mothers were drawn to the home visitors’ expertise or developed more trust by seeing the benefits to implementing the home visitor’s advice, some mothers also described how their relationship with their home visitor evolved to become one where the home visitor was considered a friend, and sometimes, even a family member:

I feel like with her, she was always like...she knew what she was doing, so that’s why I was able to like trust her, you know, talking about everything. She, like, after a point— she wasn’t a stranger anymore. It was like she was my friend.

SHARING COMMONALITIES AND FOLLOWING UP

While some mothers underscored the value they placed on the home visitor’s skills and professional background, other mothers explained that they trusted the home visitor because the home visitor was also a mother. As a fellow parent, the home visitor had personal experience to bring to the table. This finding aligns well with a prior qualitative study of home visitors, described above, which found that home visitors would disclose something based on their personal experiences and emphasize what they shared in common with their clients as strategies to establish trust and build rapport.² For example, one of the mothers we interviewed stated that one of the reasons she and her home visitor got along so well (this mother noted that the home visitor had become a close friend) was because they often would spend time during the home visits swapping parenting stories and laughing about the antics of their children.

²Jack, DiCenso, and Lohfeld (2002).

As a point of comparison, Maya, a Mexican-American mother who was 20 years old and pregnant with her first child when she started home visiting, stated that she didn't always trust her home visitors (she had three), especially because two were not mothers. She explained:

I don't think there was anything we disagreed on, really. I think...what did make it hard sometimes is they would tell you something that they themselves haven't experienced it. That would kind of be the hard part of trusting it. How can you know for sure it's going to work?

Further underscoring this theme, Maya noted that she dropped out shortly after her second home visitor, whom she had bonded with and who was also a mother, left the program. This home visitor transferred Maya to a colleague and that third and last home visitor was not a parent. At the same time, it is notable that Maya had persisted with her first home visitor, who was also not a parent, for seven months of visits, despite her skepticism about getting parenting advice from someone who wasn't a mother. Her participation seemed to be driven by the fact that she had moved to a new area, without friends or family nearby, as her husband had recently changed jobs. With her first home visitor, Maya reported that she appreciated the emotional support the home visitor provided, even if they did not share motherhood as a commonality.

This is not to say that home visitors must be parents in order to develop trust with their clients. Most of the mothers we interviewed whose home visitor was not a parent did not seem to think that this was a barrier to trusting their home visitor in the long run. One of the specific strategies that seemed to help build trust in these situations was when home visitors would be clear when they didn't know the answer to something, but then they would also follow up on the mother's questions or concerns at the next visit. As one mother explained:

What she used to tell me is like, "Look, I'm not a mom, so I don't know this answer, but I can find it for you, or I'll look for it." And she used to bring stuff...and ask, "Do you have any questions?" And [I'd say] "Yeah, I have questions about this and this and that." So she would bring printouts about the information the next time that she found. So, sometimes, she told me, "I don't know this stuff, but I can bring you something if I research this stuff."

This strategy of the home visitor acknowledging when she needed to go find more information on a topic and following through with research and resources was used by home visitors more broadly, including by home visitors who were also parents but didn't know the answer to a question or a topic. The consequence of the counterpart to this example—of home visitors not following up—was highlighted in another study that examined mothers' reasons for early attrition from home visiting. In this study, mothers reported disengaging because their home visitor did not meet their expectations, which was evidenced when home visitors were not able to answer a question and then did not subsequently help

the mother find the requested information.³ Together, these findings illustrate that while home visitors do not necessarily have to share commonalities with the mother, including being a parent, in order to build trust, it is important that home visitors demonstrate a level of commitment to following through.

SHOWING CARE

Mothers who described having a good relationship with their home visitors also noted that they felt that their home visitor truly cared about them and their child. When asked for examples of how mothers felt this care, a common theme was that care was shown through providing the family with needed or useful items. For example, one mother said that her home visitor “treated her like family.” When asked to expand upon what this meant, she recounted a time when the home visitor brought her a free vacuum cleaner (the program was giving these out to certain families):

She’s just brought in like different little things. Like, she found out that I was sweeping my floor all the time. Well, the reason I wasn’t using a vacuum was because they put this cheap carpet in here, so it pulls up constantly. ... Well, one time she showed up with a Shark vacuum and she’s like, “So these were going out to ten different people and I picked you.” It seems like she picks our family for a lot of things. “Try this and see if it’s gonna pull up your carpet.” Oh! That’s been like one of the best things ever.

Similarly, another mother recalled that her home visitor:

...always made sure that I had what I needed. She always made sure I had a bus ticket if I need to get on the bus, if I needed any kind of transportation money, any kind of gift cards for the baby to get me what I needed to get. Anything that I needed, she would help me.

These findings match what the earlier research from the perspective of home visitors has found, where the provision of practical assistance in the early home visits has been noted as a strategy that home visitors use to build trust.⁴ These findings are also notable in juxtaposition with some of the home visitors’ perspectives on the provision of material goods discussed in the MIHOPE implementation research report.⁵ Some home visitors expressed frustration and wariness of mothers who they felt used the program mostly for the “things they could get” and not for the educational content. The mothers’ perspectives, however, underscore that when home visitors provided goods or direct assistance to the mothers, mothers interpreted that as a sign of caring, and this fostered their trust in the home visitor.

³Holland et al. (2014).

⁴Jack, DiCenso, and Lohfeld (2002).

⁵Duggan et al. (2018).

Several mothers noted that another way that home visitors showed that they cared was by advocating for the mother and playing an active role in helping them with a resource. For example, one mother described a situation where she was becoming very frustrated with her prior landlord, who would continuously call her about bills that she said had already been paid. It was the home visitor who eventually got on the phone with the landlord and got him to stop sending the bills and calling the mother. This action, as interpreted by the mother, showed that the home visitor “had my back.” Other mothers described how their home visitor would drive them to places, make calls to referral sources on their behalf, and fill out paperwork and forms for them. On the one hand, mothers clearly valued this support and this kind of practical assistance cemented the trust they placed in their home visitor. On the other hand, some home visitors interviewed in MIHOPE worried that such active assistance on their part did not empower or teach families to solve problems on their own.⁶

Although she was more the exception than the rule, one mother mirrored some of the home visitors’ sentiments regarding the importance of avoiding over-reliance on the home visitor. In contrast to the examples above, this mother described the ways in which her home visitor supported her by *not* acting on her behalf:

She was kinda that person who...she could lead the horse to water—me being the horse—but I had to do the action. So, she would try as much as possible to set me up for whatever it was that I needed. I had to be the one to go act on it. I had to drive to the place with the resources or whatever it was...That’s the thing. She let me come halfway, you know? ... And she knew I was that person where I needed to do that, because she recognized that...I wanted so badly to just, at that time in my life, to just collapse and have somebody come save me and stuff. And then I’m also extremely resilient, and she knew that, and she knew that I needed to...keep doing this stuff on my own somewhat, because after she was gone, it was like, I was on my own.

NO JUDGMENT ZONE AND STRAIGHT TALK

The majority of mothers stated that one of the things that helped them feel more comfortable and open toward their home visitors was the non-judgmental approach used, which again aligns with earlier studies of home visitors’ perspectives on trust-building strategies.⁷ In describing how her relationship with the home visitor changed over time, one mother said:

It [the relationship] just slowly developed, I guess. I went from being nervous and not knowing what was going to happen to being like, okay, I understood what the visits were going to be like. And I knew she was going to be more of a support person than

⁶Duggan et al. (2018).

⁷Jack, DiCenso, and Lohfeld (2002); Paton, Grant, and Tsourtos (2013); Zapart, Knight, and Kemp (2016).

someone who was going to judge me—like, “Well, you’re not drinking two glasses of milk each morning?” [Laughs]...It was like a no judgment zone.

Further reflecting this “no judgment zone” theme, several mothers discussed how they especially appreciated that their home visitor did not nag or push them to change behaviors, even if those behaviors were not optimal. For example, a handful of mothers noted that they were smokers, including Leah (the mother with anxiety). Leah reported that her home visitor didn’t bother her about this, and remarked that this was one of the reasons she liked her home visitor so much. As another mother explained, “Cause you always hear it from the doctors, and it’s like, Oh my God. Would you just stop sometimes?” Breastfeeding was another behavior where a few mothers reported that while the home visitor encouraged the mother to breastfeed, they also supported the mother’s decision to not do it or to wean early.

Interestingly, the home visitors interviewed in MIHOPE similarly noted the importance of not judging or nagging the families they worked with, and they highlighted these same exact areas—smoking and breastfeeding—as particular behaviors that they did not like to push mothers on.⁸ As described in the MIHOPE implementation research report, home visitors stated that if they pushed too much or too hard on a behavior that the family was not open to changing, they felt that they risked the family dropping out of the program altogether.

While most mothers appreciated the non-pushy approach used by their home visitors, a few mothers seemed to value that their home visitors were straightforward with them and would “tell it like it is.” For instance, in describing her relationship with her home visitor, Asha, a Black mother who enrolled in home visiting when she was 31 years old, shortly after giving birth to her son, stated that by the end of their time together, the home visitor “was like an older sister” to her. Expanding on this analogy, Asha noted that her home visitor:

...was always very supportive but she also wouldn’t sugar-coat stuff for me...She’d be like, “Look. I’m not trying to be mean or disrespectful but this is what it is. This is the reality of the situation. This is what you’ve got to do ‘cause these are the potential consequences if you don’t get this done.” So for me that works better than “You just try” or “You just do what you gotta do.” No. “If you don’t do this, then this is what’s gonna happen.”

GOING ABOVE AND BEYOND

A final, but less common, theme when it comes to understanding how trust was built was several mothers’ perception that home visitors went above and beyond for them. For instance, while the majority of mothers noted that they appreciated that their home visitor was flexible with scheduling visits, a few

⁸Duggan et al. (2018).

mothers described how their visitors went out of their way to be helpful. One mother reported that there was a time when she got very busy with work and had to cancel a lot of the scheduled visits. It appears that the mother knew or was told that she might get dropped from the program if she didn't maintain visits, and so appreciated that her home visitor kept her in the program despite her cancellations. Others reported that they could call or text their home visitor at any time, and the home visitor would respond. Mothers described this as a more unusual act (for a social service provider) but one that reassured them.

CONCLUSION

The specific ways in which the long-term participators described how home visitors were able to build trust with them largely align with the earlier literature that has examined this concept from the perspectives of home visitors. Common strategies included identifying shared commonalities, following up on topics where the home visitor may not know the answers to questions off-hand, maintaining a non-judgmental and non-pushy approach, and providing material resources and practical assistance early in the relationship. This chapter, however, also identified additional approaches that mothers described as helping them develop trust, which have not often been discussed in the prior literature. For example, it appears that the majority of mothers valued and placed inherent trust in the expertise of the home visitors. Yet some prior research, including the interviews conducted with home visitors in MIHOPE, has found that home visitors may downplay their expertise because they feel it interferes with focusing on and fostering the parents' strengths and abilities.⁹ In addition, while less commonly noted, some approaches—including home visitors using straight talk and efforts to minimize over-reliance on the home visitor—were notable in that they appeared to be in direct contrast to some of the other trust-building strategies documented in this chapter and found in the prior literature.

⁹Duggan et al. (2018); Hebbeler and Gerlach-Downie (2002).

6

Why Lower-Participation Group Mothers Discontinued Home Visiting

The findings summarized thus far are primarily based on mothers who participated in home visiting for a sustained period of time—from 10 months to several years. But for some mothers interviewed ($N = 15$), their engagement in home visiting was shorter and sometimes considerably so (lasting only one to three visits). This section explores the circumstances behind the experiences of mothers in the early leavers group ($N = 11$) who participated for three months or less, and those who were in the later leavers group ($N = 4$), which includes mothers who participated anywhere from four to nine months.

Specifically, this chapter describes the reasons mothers in the two lowest participation groups discontinued services earlier than longer-term participators, and how they were feeling when services ended.¹ In addition to the smaller sample size upon which the findings in this chapter are based, it is important to recognize that the mothers we interviewed and the reasons they gave for discontinuing services may differ from other mothers in the lower participation groups. As described in Chapter 2, early leaver mothers and later leaver mothers were more likely to have outdated contact information than other mothers. This is consistent with the finding from the MIHOPE implementation research report that mothers who moved more than once in the year before entering the study participated in home visiting for shorter periods of time than other mothers.² Early leavers and later leavers were also less likely to respond to the interview team's repeated attempts to contact them than the long-term participators, which could also be a function of having outdated information (though this is not possible to confirm). The mothers who we were able to interview may thus represent a less transient group of mothers among the broader sample of early leavers and later leavers. Because their experiences with home visiting were limited and from several years ago, some mothers had a hard time remembering details about the program.³ While the findings in this chapter reflect fuzzier memories and are based on a smaller and

¹Initially, the study team examined the data for differences between the early leavers and the later leavers, particularly as compared to the themes found among the long-term participation group. Although the sample size is very small, the narratives of the four mothers in the later leavers group were more similar to those of the early leavers than those of the long-term participators, which is why this chapter summarizes findings across the two groups.

²Duggan et al. (2018).

³Several mothers, in fact, confused the MIHOPE survey and assessment team, who conduct on-going interviews and in-home observations as part of the evaluation, with the home visiting program that they had initially enrolled in.

potentially select sub-sample, they are presented to shed some light on these mothers' particular experiences, which were largely distinct from the rest of the sample.

FIGURED THINGS OUT

In the majority of the 15 cases, mothers described the ways in which they had figured things out on their own, both as a reason for discontinuing and in describing what was happening when services ended. Figuring things out meant slightly different things to different mothers but generally indicated that the mother felt that she was able to find the information she needed or answers to her questions by doing her own research or investigating other resources. However, figuring things out “on my own” did not mean that a mother was alone. In fact, when describing their circumstances at the time of their pregnancy or the child's birth, some of the mothers reported having a solid support system that sometimes included the baby's father and friends, but most often included extended female kin (mothers or grandmothers), and they stated that they were able rely on their network to get the support they needed.

For example, one mother described feeling well supported by her existing social network. She had enrolled in home visiting because “I wanted to see what they could offer in terms of resources.” It was unclear why she stopped, as she did not seem to remember even getting a visit. But she further explained that:

I had a lot of support from my family. My friends...my mom, my grandma—they were really supportive. That's about it. And Google was also really supportive...If I had questions about labor, just like how would I know I was in labor, the difference between real contractions and Braxton Hicks, just like really more early pregnancy symptoms. I also had a pregnancy app, as well, which every week it would actually have a video of the baby and show what was growing, so that helped a lot, too.

Another mother, who could not recall why she decided to enroll in home visiting in the first place and only engaged for one or two visits, described herself as someone who had always been independent. When asked about whether she had wanted help with parenting, she said:

I don't need no guidance...I mean, I've always been smart. I never really needed much help growing up, or I was always kind of the one that was always level-headed. I never really got into trouble. So I just rely on those good instincts that my mom and dad instilled in me, and just I grew with it. It comes naturally.

In both of these cases, the mothers did not appear to have regrets about their limited participation in the program, and they also discussed the ways in which, at the time of the interview, they felt comfortable with how they were parenting and how their children were developing.

PROGRAM ENDED SERVICES

In a handful of the early-leaver cases, mothers reported that they would have liked to engage in the program more, but that the program had essentially ended their services. In one case, the program reportedly closed. In the other two cases, the mothers said that they were basically dropped, meaning that the home visitors stopped coming, and they did not understand why services had ended. When interviewers asked if anyone from the program ever followed up or connected with them again, they reported no.

It is not clear why this happened, but these two mothers said that they were genuinely interested in the home visits. One of these mothers, however, felt that she was okay without the program because she had been engaged in home visiting with her first child. This mother was mainly interested in getting resources and the child-centered activities the home visitor would bring or do. The other mother was more upset and explained that she felt she could have used and benefited from the services. She had been receiving home visits for a month, and then described the end of services as a break-up:

Like, a lot could change in a month...A lot more things could happen in the whole family dynamic, little things like that, and it was like, "Damn, so now I gotta research everything myself..." and I guess that...they forgot about me. It was like, "Ooh, I'm already into it, already ready, like you've got me all giddy about it." Then we broke up. I got dumped [Laughs].

While this case was unusual among the sample, another study, described earlier, also found that a few mothers reported that services ended because their home visitor stopped coming to see them and they were not sure why.⁴

LOGISTICAL CHALLENGES

A few mothers described the ending of services as being driven by their own life circumstances or logistical challenges. For example, one mother moved out of the area. A handful of others reported that they became too busy or felt overwhelmed, which has also been found as a reason for early attrition in other studies.⁵

One respondent who engaged for a few months noted that although her home visitor seemed nice enough and knowledgeable, she felt that the timing was not right. She explained that she was both working full-time and going to school at night, and she barely had time to spend with her daughter, let alone maintain home visits. Another mother had engaged in home visiting for about three or four months.

⁴Holland et al. (2014).

⁵Holland et al. (2014); Hubel et al. (2017).

She was different from some of the other lower participation group mothers in that she reported really enjoying the program. However, she has fibromyalgia and reported that she was in a considerable amount of pain, which made engagement in the visits difficult, and so she ended her home visits.

REGRET OVER NOT CONTINUING WITH SERVICES

Finally, a handful of mothers in the lower participation groups expressed regret that they had not engaged longer in the program. One mother recounted that she had basically emotionally shut down around the time that she was in the home visiting program (she engaged for about three months):

And I just shut the door, you know? I made that [isolation] become reality...And growing up isolated from everybody in that time, raising my kids, seeing that what I'm doing...What I am doing is what's hurting us and what's making me not make it...I can say that now that I'm older, I understand that I like the program and I like what [program] is doing here. I didn't understand at first. I don't think I was trying but now I do and it makes a lot of sense.

This mother had a history of mental health issues and as illustrated in the quote, would revert to self-isolation as a coping mechanism. At the time of the interview, she stated that she would like to reconnect with some services, especially to help her improve her mental health.

CONCLUSION

Mothers in the lower participation groups articulated different reasons for why they left the program early. Although the findings in this chapter are based on a smaller sample and this sample is select in the sense that we were able to reach them (which was, as noted in Chapter 2, generally more challenging for the lower participation group mothers), it appears that the majority of mothers in these groups left because they felt they were able to handle parenting on their own. Some of these mothers reported having a good support network, while others felt that they were able to find the parenting information they needed through other means. In a handful of cases, the program closed or the home visitor stopped coming, and these mothers stated that they would have continued to participate in home visiting if they could have. Finally, a few mothers reported becoming too overwhelmed, busy, or unable to sustain their engagement because of other factors in their lives. With these mothers, some expressed a sense of regret at not continuing with services.

7

Mothers' Reflections on Home Visiting When Services Ended

Having described the circumstances surrounding the end of home visiting for mothers who were in the lower two participation groups, this final, substantive chapter summarizes how longer-term participators described their families' circumstances at the time home visiting services ended.¹ This chapter also describes additional reflections by long-term participation group mothers on the ways in which home visiting had a lasting impact and the ways in which it was more limited.

CIRCUMSTANCES SURROUNDING THE END OF HOME VISITING

Feeling "All Right"

The majority of the long-term participators reported feeling "okay," "good," or being able to "do it on my own" when home visiting ended, and reflected positively on their time in the program and their current circumstances. For example, Asha stayed with the home visiting program for about two years. Although she could have stayed in the program longer, she ended services after she signed her child up for preschool and also noted that she had the support of her mother, who had recently moved to be closer to her. Reflecting on the whole of her time in the program, she stated:

In the beginning it was more just 'cause I needed her [home visitor] more. Obviously, I needed her a lot more in the beginning but towards the end she's like [coming] once, twice a month. We'd catch up, see how we were doing, everything's good. And especially towards the end I really didn't need her as much then 'cause I had my mom, but also I was at that place where I was okay. I had all the resources I needed. I was working good enough that I could take care of all the bills. I was good.

¹For the nine mothers who were still receiving services, their reflections are about their current and prior years of experience in home visiting. Seven of these mothers were nearing the end of services because the MIHOPE child would age out soon, and so in many ways, they were reflecting on their time in the program as it comes to a close. For two mothers, it was not clear when services would end because they had reenrolled in the program for a child who was born after the MIHOPE child.

For some mothers, services ended because their child had aged out of the program. While many of these mothers reported a lot of sadness at not being able to see their home visitor regularly anymore, they also felt that their situations were okay. For other mothers, they initiated the end of services because they were busy juggling different activities, including work and childcare, and felt they no longer had time for home visiting. Similar to the mothers whose children had aged out, the ending of home visiting was hard because they had become attached to their home visitor but they were also moving on in clear ways. A few mothers, in fact, credited the home visitor for inspiring them to follow their educational goals. For example, as described in Chapter 4, one mother decided to go back to school and become a nurse partly based on her positive experiences with her nurse home visitor. Another mother recounted the following:

The home visiting program, it opened up my eyes to that importance of what happens between birth and five, and that's how it [an interest in child development] started. And then when [son] got into the center, I became involved, and then when he got moved from the infant room to the toddler room, I was asked to be on the policy council...

She further went on to say that her time in home visiting had a “huge ripple effect” on her, and the program inspired and helped her get her Child Development Associate credentials. As a young, single mother who had an unexpected pregnancy, she went on to describe the value of the emotional support her home visitor provided, in addition to helping with her education and employment goals:

When you have people like that in your corner, you realize that...I never would have thought I could reach goals that I had as a child because of the way my circumstances were...but they've showed me that you can. And when you have the right support in your corner, you can accomplish anything.

Several mothers ended services because their home visitor left the program, but like the other mothers described, they too felt that they were in a better place than when they started and had gotten what they needed from the program. For example, one mother said she ended services when her home visitor, who she had worked with for about 2.5 years, told her she was leaving the program. While she would have continued to engage with the program longer if her home visitor were not leaving, she stated:

So I actually ended up quitting the program around that two-and-a-half year mark or so. Not because of anything that I wasn't getting from them, it was because I was getting busier at work...And so I was trying to find the best way to juggle [parenting, school and activities with kids, and work]...And so I just decided that [program] maybe had given me as much as I could get at that point in time. ... It wasn't anything about the program. I would have continued just to BS with [home visitor]. [Laughs].

Still Wanting or Needing Services

As with the cases above, several mothers had become emotionally bonded to their home visitor and when the home visitor left or quit her job, these mothers ended their engagement with the program. These cases are different, however, because the mothers described still wanting or needing more services of some kind. For example, one mother had been involved with two home visitors over the course of about two years, and had bonded to both. She described why she ended up leaving the program:

I believe at that time I think I was trying to balance a job too and I think I had ended up dropping out of school. I had just lost my car and I was like...You know what? I think I was slipping back into depression a little bit and I didn't want to be around someone new and then have them see me like that...[Home visitor] ended up being like an extended part of the family 'cause she was with us for a long time. And then, for them to say, "Nope. She's not going to be there anymore but we can send someone else." I'm like, I don't want anyone else. So that's how it ended.

In this case, the return of the mother's depression (she had a history of depression, which her home visitor had talked with her about) combined with her home visitor leaving triggered her to end services. Yet given the mother's mental health history and other circumstances (losing her car and dropping out of school), she may have also benefited from continued support.

For a handful of mothers, the lack of having the home visitor was described in almost devastating terms. One mother, whose services ended when her child aged out, recounted that her home visitor was "the only friend I had" and that she was the only person who could empathize with the pain the mother had gone through. This pain included having lost several close family members, having grown up in a community where she witnessed a lot of violence, and also being in an emotionally unhealthy relationship with the baby's father.

Annie, who, as recounted in Chapter 3, had run away from home at 15 and had a history of childhood trauma, broke down in tears when she described the ending of her home visits (her child had also aged out). Annie noted that she had a lot of abandonment issues, which largely explained why losing her home visitor also felt traumatic to her. She was also a mother who was managing a lot of concerns, including a mental health disorder and a history of alcohol abuse:

Most people have somebody. I mean, most people—everybody, almost—has somebody. I'm just a rare situation where I didn't have anybody. And she was one of my only somebodies other than my counselor, you know? [Starts crying] So, if I would've just had her maybe a little bit longer, maybe I would've been supported enough in my emotions and someone to vouch for me. ... It really sucked, because I felt like I had all these great services, but I have a lot of abandonment issues. And I also have been abandoned a lot in my life...for someone who's dealt with abandonment

issues and then I finally have a support person for that long, and then just for them to leave?

Finally, several other mothers noted that they felt they needed more help, but often with specific things. For example, one mother stated that she needed help with getting her child access to a speech therapist (she was having a hard time finding resources and also stated the doctors were not helpful). This mother noted that her home visitor would have been able to help her in this circumstance. Another mother said that she still had many questions on child development, especially as her children were more verbal and active than when they were infants, and remarked “I feel more stressed now than before.”

FURTHER REFLECTIONS ON THE LIMITS AND PROMISES OF HOME VISITING

In several of the respondents’ narratives reflecting on their experiences, there were also instances when home visiting seemed to play a more limited, although still positive, role in mothers’ lives. In a handful of other cases, mothers noted that while they were not always open to what the home visitor was saying during their time in the program, they could now see ways in which they could have benefited from the home visitor’s advice.

Home Visiting Helped on the Margins

Several of the long-term participation group mothers, when compared to the rest of the long-term participators interviewed, appeared to view the home visitor’s role in more circumscribed ways. As described in Chapter 3 on reasons for why mothers enrolled in home visiting, the mothers who tended to see the home visitor as providing direct education and support to their children only, as opposed to a service provider who was supporting them or the whole family, did not describe additional ways that home visiting made a difference in their lives. For instance, one mother called the home visitor “a teacher for her kids” and also liked having someone to talk to but did not think that much else in her life changed. These mothers appear to be very similar to the mothers in another study, reviewed earlier, who viewed the home visitors as tutors for their children and not necessarily as providers who were teaching them skills or instilling parental behavior change.² However, while that earlier study found this to be a main theme expressed by the majority of the mothers, this was not commonly mentioned by the mothers interviewed for this study. Most of the long-term participators seemed to get much more out of the program as described throughout this report. A few long-term participators also noted that they mostly benefited from the information and support home visitors provided during pregnancy and in preparation for birth, but they felt that they needed the home visitor less after they gave birth. That said, they enjoyed the home visits enough to continue with services.

²Hebbeler and Gerlach-Downie (2002).

Mothers Who Did Not Always Open Up

The findings in Chapter 5 described how trust was built between home visitors and mothers, but a few mothers also described how they had a harder time opening up to their home visitor or being open to the suggestions the home visitor was making. It is not readily apparent why these mothers were less willing to open up than other mothers in the higher participation group, or why they did not discontinue the program, like the lower-participation group mothers who did not build a strong relationship with their home visitor.

This lack of openness, these mothers reflected, meant that they could have benefited more than they did while in the program. They also made clear that while the home visitor asked the right questions or suggested resources, they were not ready to make changes. One mother who described having mental health concerns was asked about whether her home visitor had talked about this with her or tried to connect the mother to resources in the community. The mother said that it was discussed but went on to say:

I don't believe I was open to referrals. I mean now I'm open to it but back then I wasn't. I didn't want to go talk to a psychiatrist or a therapist. I didn't want to talk to someone because in my mind I was confirming that I was crazy. And I remember [home visitor] telling me like it's not crazy if you go, like you're not crazy if you go talk to someone. So, I mean, I believe it was talked about but it wasn't ever...we're not going to push it on you.

In another example related to mental health, Maya, who was wary of home visitors who were not parents themselves, reflected during the interview that she was probably suffering from postpartum depression, but that she did not answer the screening questions truthfully when her home visitor would ask her about whether she was experiencing depressive symptoms. While she reports feeling better now, she also reflected upon how hard a time that period after birth was for her:

Interviewee: I think that's one of the things where I wasn't open as I should have [been] because I felt like I really did struggle with it, but she would ask me, and I would take a test, and I would come out fine, but I felt like when she would leave, it would be harder to cope.

Interviewer: And when you took those tests...you wanted to seem fine?

Interviewee: I said I was fine, yeah. I think if I would have been honest, I would have been on the scale. And I think, even for myself, it took me a while to come to terms with...okay, I am struggling.

Planting Seeds

One of the themes from the home visitor interviews in MIHOPE was that of planting seeds.³ Home visitors stated that with some families, the best one could do was plant seeds of ideas and suggestions for behavior change, with the understanding that one might not ever see those changes take place during their time with a family. The hope was that these ideas would germinate and take hold at some later point. It was therefore interesting to hear a few mothers voice the understanding that home visiting helped them grow, and how that growth sometimes emerged later:

It did have an immediate impact, but the biggest impact didn't come until the stress relief kind of came later. And then those thought-provoking moments were there for me to go glean back on and be like, now that I'm not in survival mode, everything that they ever worked with me on is kicking in. It kicked in over time, and it's still kicking in...So, for instance, the school situation when they encouraged me [to go back to school]. I wasn't interested back then, but now that I'm not in survival mode anymore, all of that encouragement and stuff is there. And even the eating, nutrition, and development. I'm trying to limit their screen time. I'm trying to make sure they're on a balanced diet, all the things I never cared about before.

Again, this was a rare theme to find among the sample, even among the long-term participator group of mothers. But it suggests that at least for some mothers, the home visitors' advice and information can have a lasting influence, even if it was not always taken or adopted in the moment.

CONCLUSION

For the majority of the long-term participators, the mothers seemed okay with home visiting services ending, albeit sad to not see their home visitors regularly. This group of mothers included those whose children had aged out of the program, those who had transitioned their child to care at another setting and were working more, as well as those who decided to discontinue services when their home visitor left the job. Though saying goodbye to the home visitor, whom they had become attached to and trusted, was described as a source of sadness and loss, these mothers described being in a better place than when they had started services. For a smaller group of mothers, it appears that they were not ready for services to end. Particularly for a few mothers, who recounted having traumatic childhood histories or complex concerns, the home visitor's departure was described as a new wound and type of abandonment. While several mothers described the role of home visiting in circumscribed and more limited ways, a few other mothers, perhaps with the benefit of time and hindsight, described how they only now realized and saw the ways in which the home visitor helped them be a better parent.

³Duggan et al. (2018).

Conclusion

As part of the large-scale implementation study that was embedded within the Mother and Infant Home Visiting Program Evaluation (MIHOPE), a rich amount of data, both qualitative and quantitative, was collected and analyzed. Detailed findings were presented in a comprehensive report published in 2018.¹ In addition to identifying varying levels of participation in home visiting programs, as measured by the length of time families spent in programs and the number of visits received, the implementation research report also summarized themes from interviews conducted with home visitors who described how they viewed their relationships with families, strategies they used to promote positive child and family outcomes, and both the rewarding and challenging aspects of their work.

This interview-based sub-study, conducted with a subsample of mothers who enrolled in MIHOPE and began receiving home visiting services four to six years earlier, presents an important but largely understudied perspective in the home visiting literature. As a qualitative inquiry with a sample of mothers who were mostly long-term participators in home visiting, the findings may not be generalizable to other mothers in the MIHOPE sample nor the broader population of mothers who participate in early childhood home visiting programs. That said, the in-depth interviews conducted with mothers echoed themes that were expressed by the home visitors interviewed in MIHOPE and have been found in the small but growing literature that has documented mothers' experiences in home visiting programs.² At the same time, the interviews with mothers also uncovered some themes that diverge from some of the earlier literature and the home visitors' perspectives analyzed in MIHOPE. Collectively, the findings in this report and the earlier literature thus underscore the complex and varied circumstances of the population served by home visiting and the different ways in which mothers viewed the program.

In this final chapter, we review the key findings of the report and the ways in which it builds upon the existing research, including findings from the MIHOPE implementation research report. We also discuss the study's strengths and limitations, and we conclude by outlining the potential implications of the report's key findings.

¹Duggan et al. (2018).

²Hebbeler and Gerlach-Downie (2002); Holland et al. (2014); Hubel et al. (2017); Paton, Grant, and Tsourtos (2013); Thompson (2011); Zapart, Knight, and Kemp (2016).

KEY FINDINGS

- **Although earlier research has found that alignment between a parent’s goals when enrolling and a home visitor’s emphasis on those goals is predictive of sustained participation, the majority of the mothers interviewed did not have clear expectations or understandings of what home visiting entailed.**³ While most mothers reported that they wanted to be a good parent, which has also been found across several earlier studies, they did not have specific outcomes or goals in mind when enrolling in home visiting beyond that.⁴ This lack of specificity could reflect the fact that the interviews took place several years after mothers enrolled in home visiting; however, the qualitative findings align with the respondents’ reports from the MIHOPE baseline survey, where wanting general help or support was the most common reason for enrolling. This suggests that it may be important to understand that not all mothers have clarity about specific objectives when they enroll. For some, the motivating factor for enrolling was that they were young, facing motherhood for the first time, and were scared. Other mothers, especially those with older children and who had been involved in home visiting before, were the most specific about wanting to give their children a head start and improve their development.
- **Despite fielding the interviews several years after mothers began to receive home visiting, most of the mothers in the long-term participation group were able to recall specific examples and describe concrete ways that their home visitors helped them.** Their examples align with the three types of activities that broadly define a typical home visitor’s activities: providing education (particularly around child health and safety practices, child development, and communication and discipline), providing emotional support, and providing resources. An earlier qualitative investigation found that home visitors saw their role of providing emotional support as more important than their information sharing role, and some of the home visitors in MIHOPE similarly described their primary role as that of being a cheerleader and source of support for the family rather than as an educator.⁵ While the home visitor’s ability to provide the mother with emotional support and encouragement was highlighted by the women we interviewed, the descriptions from the long-term participators also illustrate that these roles—of providing support and providing information or direct education—are not incompatible and that both are important to mothers.
- **Similarly, mothers in the long-term participation group valued and appreciated the expertise that home visitors have.** In fact, when home visitors were able to demonstrate their expertise, this helped several mothers who initially viewed their home visitor with skepticism to learn to trust in their home visitor. For mothers who had prior experience with home visiting, they enrolled again because they had first-hand knowledge of the type of expertise the home visitor brought to the table. This finding contrasts with some earlier research conducted among home visitors (including those in

³Burrell et al. (2018).

⁴Hebbeler and Gerlach-Downie (2002); Hubel et al. (2017); Thompson (2011).

⁵Hebbeler and Gerlach-Downie (2002).

MIHOPE), which has described how some home visitors intentionally try to play down their expertise, in order to be on a more equal footing with their clients and as a strategy to empower the parent.⁶ As described by home visitors, they do not want parents to feel that someone is coming into their home in an authority position and telling them how to raise their children. But for some mothers, the expertise and guidance of the home visitor was precisely what they were drawn to.⁷

- **The ways in which trust with home visitors is developed appeared to vary across mothers in the long-term participation group.** For example, the majority of mothers stated that they appreciated how their home visitors were nonjudgmental and that they did not push mothers when they did not want to do or change something. This theme is congruent with the home visitors in MIHOPE who noted that they did not like to push mothers to change behaviors that the mothers did not seem to want to change and used positive reinforcement approaches.⁸ However, a minority of mothers stated that they liked when their home visitor took a more directive, straight talk approach with them. Similarly, while the majority of mothers noted that trust was built with their home visitor partly because she helped them in direct, tangible ways (for example, by bringing material goods like diapers or baby clothes, talking directly to referral partners, or filling out application forms), a handful of mothers in the long-term participation group said that they valued how their home visitor left the onus of following through on activities to the mother. Taken together, these findings suggest that particular strategies that resonate with some mothers may not resonate as well with others, and that home visitors could consider how to tailor the approaches they use to match a family's preferences.
- **Mothers in the lower participation groups were a smaller part of the overall interview sample, but the reasons that they discontinued services largely align with the prior literature on early attrition.** For example, mothers in this study and others have noted the ways in which their life circumstances and stressors, including having to balance work or schooling and childcare or dealing with personal issues such as poor physical or mental health, did not allow them the capacity to stay engaged in home visiting.⁹ Other mothers described the ways in which they felt that they could and did figure things out on their own, meaning without a home visitor, with some stating that they had good social support systems.¹⁰

STUDY STRENGTHS AND LIMITATIONS

In addition to asking mothers directly to reflect on their experiences with home visiting, which has not often been done in prior research, the findings in this report are based on the largest qualitative interview

⁶Duggan et al. (2018); Hebbeler and Gerlach-Downie (2002).

⁷Hebbeler and Gerlach-Downie (2002).

⁸Duggan et al. (2018).

⁹Holland et al. (2014); Hubel et al. (2017).

¹⁰Holland et al. (2014).

sample to date, to the best of our knowledge. This report also represents one of the only studies that has been able to examine mothers' experiences across multiple home visiting program models, and it is worth noting that while some differences in program policies were evident in the interviews (particularly the child's age when the families aged out), the study team did not find notable differences in themes across models.

The fact that we interviewed mothers several years after they had initiated home visiting services was a source of initial concern among the interview team, as we worried that mothers would not be able to recollect some of the details of their time in the program. However, perhaps because most of the sample consisted of long-term participation group mothers, the memories of home visiting were still relatively fresh. In fact, it was notable how a few mothers, with hindsight and time, had developed a deeper understanding of what their home visitors were trying to impart, and that only after coming out of "survival mode" (brought on by becoming a parent to a new, young child) were they able to internalize or follow through on some of what the home visitor was saying.

The qualitative interview sub-study also has several limitations. In addition to limitations to generalizability that apply broadly to qualitative studies, the sample of mothers interviewed for this report were more likely to be in the long-term participation group, which is not reflective of the larger sample of program group mothers who received at least one home visit in MIHOPE. As noted, it was more challenging to reach mothers in the lower participation groups because their contact information, including phone numbers, email addresses and mailing addresses, were outdated. This is likely not an accident since the implementation analysis examining predictors of participation found that mothers who were more likely to leave home visiting early were also more likely to have moved more than once in the year prior to the start of the study and had other characteristics that prior research has found can negatively affect child well-being (specifically, in addition to being more likely to have reported moving more than once in the year prior to the study, mothers who participated for shorter durations were statistically significantly more likely to be younger, to not live with the child's biological father, to rate their health as poor, and to exhibit higher levels of relationship avoidance).¹¹ As the home visitors described in the MIHOPE implementation research report, families who were facing numerous and acute crises or stressors were among the most challenging to serve and keep engaged in the program. At the same time, some mothers in the long-term participation group also appeared to face numerous challenges and somehow were both interested in the program and managed to stay engaged. Unfortunately, it is not possible to know with certainty why these mothers were able to maintain engagement and others were not.

Although recall problems ended up not being a large concern with the long-term participators, the time that had elapsed for mothers in the lower participation groups and their last contact with the home visitor was an even greater number of years, and some did have a hard time remembering details. For example, a few mothers couldn't clearly remember if they even received a home visit or confused the MIHOPE

¹¹Duggan et al. (2018).

field staff (who conduct follow-up interviews and assessment in the home) with receiving home visiting from the local program they were randomly assigned to.

It is important to keep in mind that across the entire sample of mothers interviewed, most of the information gathered is based on the mothers' reflections after service delivery ended, and people's memories can be different from what they would have recounted at an earlier time. Since both perspectives are valuable (that is, understanding what mothers are experiencing while they are in home visiting as well as their reflections after services end), future evaluation research could try to capture mothers' experiences, in their own voices, in home visiting concurrently as well as after services end in order to trace how their perspectives evolve over time. Finally, the findings presented in this report are one side of the story and do not reflect the experiences and intentions of the home visitors, just as the findings from the home visitor interviews presented in the MIHOPE implementation research report do not reflect the experiences and intentions of mothers.¹² In addition, some of the concerning events described, such as the stories of home visitors disappearing and not contacting the mother, are not possible to verify.

FURTHER DISCUSSION

Individualizing home visiting services, including visit content and connections to community resources, to meet a particular family's strengths, risks, needs, and desires is a key part of what home visitors do.¹³ This report's findings on the varied ways in which mothers discussed how trust with their home visitors was built highlights how mothers differed in their receptiveness to different strategies or approaches used by home visitors, underscoring how nuanced the home visitor-parent relationship dynamic can be. It also supports the idea that tailoring includes both the tailoring of content and the tailoring of style and approaches used with a family. As demonstrated through the mothers' narratives, the tailoring of approach to match a family's circumstances means that while some mothers will value when their home visitors play a more active role in helping them with resources, others may value being encouraged to do things for themselves. While most mothers we interviewed appreciated the non-judgmental and non-pushy approach their home visitors embraced, others responded to a more directive style.

Alongside other studies, this report found that the provision of material resources and direct assistance is important to some mothers, and may be particularly helpful as a strategy for building trust early in the relationship.¹⁴ While providing goods may not be something all programs can afford for all families, even small items, like second-hand baby clothes or board books, were appreciated by mothers and served as proof that the home visitor cared about their families. Particularly for families who approach home

¹²Duggan et al. (2018).

¹³Duggan et al. (2018).

¹⁴Jack, DiCenso, and Lohfeld (2002).

visiting with more skepticism, providing these resources early on may be a simple and effective way to start to gain trust.

While the importance of the emotional support that home visitors provided was not a surprising finding, it was quite striking to hear mothers, though there were only a handful, discuss the end of home visiting in psychologically devastating terms. Whether because their child had aged out or because the home visitor they had bonded to left (or both), for mothers with histories of trauma, the end of services was described as a new source of trauma. Unfortunately, it is not clear what types of transition planning occurred or whether other appropriate services even existed in the community (these mothers did not recall being offered additional services after home visiting ended). Our review of the literature also did not produce much research on transition planning for families who may be in need of continued support when home visiting ends, as much more emphasis has been placed on identifying and addressing factors associated with early attrition. Better understanding program practices and testing strategies that aim to provide families with a continuum of care and support when home visiting ends and supports are still needed by the family may be an important line of future work.

Prior research has found that home visitor turnover negatively affects family engagement, and there was evidence of this in the present study as well.¹⁵ Given the centrality of the home visitor-parent relationship to engagement, it is important to understand how home visitor turnover and departures can be better managed in cases where the home visitor and parent have developed a strong working relationship. Since some amount of turnover is inevitable and may in fact reflect upward career mobility for the home visitor, there may be value to identifying tools or strategies that can ease the transition for families when their home visitor leaves. There are also clear impediments to retaining a skilled home visiting workforce that have been noted in the literature, such as the stressful nature of the work (including secondary trauma) and low pay.¹⁶ At the same time, there is increased interest and investment in identifying and building the evidence on professional development and support strategies that can help retain and support a skilled home visiting workforce, while working within these broader challenges. Such strategies could not only help home visitors balance the sometimes difficult nature of their work, but, at least based on the narratives of the mothers interviewed for this report, could foster sustained engagement, especially among families where developing trust with a social service provider did not come easy.

¹⁵Holland et al. (2014).

¹⁶Sandstrom et al. (2020).

Appendix A

Interview Protocol

This appendix includes the broad topics and specific questions that the MDRC team developed and used to conduct semi-structured interviews with a sample of program group mothers involved in the Mother and Infant Home Visiting Program Evaluation. Approval of this protocol was secured through the Office of Management and Budget Number 0970-0402.

LEAD-IN QUESTIONS:

- Tell me what it is like to be a mom
 - PROBE: What's been hard about your experience? What's been good? Surprising or unexpected?

A. Family context when home visiting began; How and why mothers enrolled

- 1) How did you first come to know about [PROGRAM NAME]?
 - PROBE: Can you walk me through how you came to find out about the program?
- 2) Thinking back to that time when you first learned about and were interested in the program, describe what was going on in your life.
 - Probe on pregnancy and childbearing history
 - Probe on relationship with child's father and family context, household environment, community context, and perceptions of their social support system
 - Probe on age, education, and employment history of the mother at this time
 - Probe on perceptions of relative disadvantage or advantage—where do they think they fall or how they think they are doing compared to how well other people are doing in their community
 - Probe on the mother's perceptions of her own upbringing
- 3) How come you were interested in participating in the program?
- 4) What did you think the home visitor was going to do with you and your child?
 - Probe on expectations of the outcomes or issues that the mother was hoping the program would address
 - Probe on expectations of the content of services (e.g., education about certain topics, referrals, or linkages with other services)
 - Probe on expectations of frequency or intensity of services
 - Probe on expectations of duration of services

B. Experiences with the home visiting program; Visit structure and content

- 5) Please walk me through the first time you met with your home visitor. What do you remember talking about or doing with the home visitor?
 - NOTE: If the mother describes mainly doing paperwork or filling out forms, ask about what they remember about the content of those forms. Then use questions below to ask generally about the early interactions (first few visits, or first month of home visiting).
 - PROBES:
 - What types of things do you remember the home visitor doing or focusing on?

- How did she explain the program to you?
 - How did these things (what she said and what she did in the first home visit) match up with what you were expecting?
- 6) I'd like to learn more about the types of activities that the home visitor did with you and your child over the course of your visits.
- a. First, what was a typical home visit was like?
- PROBES:
 - How did the visit usually begin?
 - What did the home visitor ask about? What did she/he talk about?
 - What did you ask the home visitor about?
 - How much time was spent on talking about the child?
 - How much time was spent with the home visitor interacting directly with your child or guiding you in doing activities or interacting with your child?
 - How much time was spent talking about issues going on with you?
- b. Thinking about all the visits you had with the home visitor, what did she/he work with you or your child on over the time that you saw her/him? Can you describe the different things she/he did or said over the time that you saw her/him?
- NOTE: If family saw multiple home visitors, ask about each home visitor.
 - PROBE on specific outcome areas to capture service delivery across domains. If the family had minimal contact (e.g., one or two visits), ask the respondent to recall, to the best of her ability, what was done or discussed during those early visits, and probe as well on the following areas:
 - Healthy child development (e.g. different stages of language development, motor skills, social-emotional well-being)
 - Parenting skills (e.g., how to create a strong bond, types of activities to do with child, how to discipline child, limit setting, responding to child cues)
 - Child's health (e.g., healthy pregnancy and birth, getting or maintaining insurance coverage, taking child to well-child visits, when to use the emergency room, healthy sleeping, eating, and growth, household safety)
 - Your own physical health (getting or maintaining insurance coverage, postpartum check-ups, birth spacing or family planning, smoking, substance use)
 - Your own mental health (awareness and screening for depression or anxiety, mental health history, dealing with childhood trauma)
 - Interpersonal dynamics with your partner or the baby's father (e.g., relationship quality, co-parenting, use of verbal or physical aggression)
 - Your education and employment goals (both short- and long-term)
 - The types of material resources you and your child needed, such as food, transportation, income support, child support, child care, or housing.
 - Help with getting access to other professional services, like doctors, therapists, child development experts, substance use treatment, or relationship counseling.

C. Perceptions of how home visiting helped with parenting and well-being; Navigating parenthood outside the program

FOR RESPONDENTS WHO WERE IN LATER LEAVERS and LONG-TERM PARTICIPATORS GROUP:

- 7) How would you describe the ways in which your involvement with the home visiting program helped you with being a parent? With your overall well-being?
- PROBES:
 - How do you think it changed the way you parent your child? For example:
 - The way you interact with your child (e.g., bond with child, talk to child, engage with child in different activities, pay attention to what child is doing)
 - The way you set limits with child or discipline child
 - Ways (that is, activities or things to do, things to watch out for or take care of) to help make sure your child is or stays healthy
 - Ways to make sure that your child is developing normally (e.g., their language development, their brain functioning, their motor skills, their emotional health)
 - How do you think it changed your own physical health? Mental health? With your education and employment goals?
 - How did the home visitor help you with family, including your relationship with the baby's father or your partner? Your relatives? Friends or other people you may rely on for help or emotional support?
 - How often were you able to follow through on the things (activities, referrals) the home visitor had recommended you do? What were some of the barriers to following through?
 - What types of activities or things did you work on with the home visitor and continue to use or do after the home visiting program ended? How come?
 - How realistic or practical did you think the advice that the home visitor gave you was? (NOTE: Ask for specific examples of when advice was realistic and when it was perceived as not being realistic)
- 8) How did the home visiting program help you get access to the other services that you or your family might have needed, like food assistance, cash assistance, education or job training, employment help, health care, therapy or counseling, transportation, or housing?
- For issues that the respondent noted needing some help with, PROBE on what the process was for receiving that help, the role the home visitor or the program played, what the barriers were, and what strategies were used. If relevant, also probe on their experiences with the quality of services provided.
 - PROBE also on areas where the respondent needed help, but wasn't able to access help (NOTE: have respondent narrate circumstances)
- 9) Were there other persons (family, friends, or professionals) or other programs or resources that you relied on for help with being a parent during this time? Please describe how you relied on these individuals or resources and what this looked like.
- NOTE: Clarify whether these individuals or resources were accessed through the home visitor or the program versus independently accessed by the parent.

FOR RESPONDENTS WHO WERE IN EARLY LEAVERS GROUP:

- 10) Who or what types of programs or resources did you find yourself relying on to help you with being a parent during the early years of [CHILD]'s life? Maybe you looked for advice from a

doctor or health care provider, got involved or received services from someone else in the community, relied on your family and friends? Please describe how you relied on these individuals or resources and what this looked like.

- PROBE on whether and how they sought out advice, guidance, or support on:
 - Parent-child interactions
 - Child discipline
 - Child health
 - Child development
 - Mother's own health and emotional well-being, including past trauma
 - Interpersonal and other relationships with partner, spouse, family, or friends
 - Mother's education or employment opportunities
- PROBE on how they navigated parenting "on their own," if they respond that they did not rely on any particular individual or resource.

11) A lot of families with young children need help with different things to make ends meet, like food assistance, cash assistance, education or training, employment help, health care, therapy or counseling, transportation, or housing. Were there particular issues that you felt you needed or could have used some help with in the first few years of [CHILD]'s life?

- For issues that the respondent noted needing some help with, PROBE on what the barriers were and what strategies were used to get access to help. If relevant, also probe on their experiences with the quality of services provided.
- PROBE on areas where the respondent needed help, but wasn't able to access help (NOTE: have respondent narrate circumstances).

D. Relationship with home visitor and how that changed over time

12) How would you describe your relationship with your home visitor?

- NOTE: If family saw multiple home visitors, ask about experience with each home visitor.
- PROBES:
 - What was it like in the beginning or when you first started to work with her?
 - How did the relationship change over time?
 - What was it like at the end of your time in the program?
 - Would you have liked the relationship to be different? How? Why?

13) In what ways did your time and interactions with the home visitor match what you were expecting to happen?

- PROBES:
 - Expectations and actual experiences with content of services
 - Expectations and actual experiences with dosage (length of home visits, frequency of visit, length of participation)
 - Expectations and actual experiences with expertise or knowledge of home visitor
 - Expectations and actual experiences with getting access to material resources
 - Expectations and actual experiences with getting referrals and services from other community providers

E. Duration of participation and reasons for ending services

14) How long did you end up seeing the home visitor(s)?

- PROBES:
 - Whether participation was steady (e.g., maintained one or two visits a month) or was more irregular (would go for a month or two without any contact)
 - How the family came to follow the particular pattern they report

15) Can you describe how come the home visits ended?

- PROBES:
 - What was going on with you and your family at that time?
 - How were you feeling about your child's health and development?
 - How were you feeling about your own health (physical and emotional)?
 - What about your education or work?
 - Relationship with your partner/spouse, the child's father, other family members, friends?

F. Closing thoughts on family situation and opinions on program improvement

16) How would you sum up your experiences and situation now as a parent?

17) What do you think your life will look like a year or two from now? Five years? Ten years?

- PROBE: In what ways did your involvement with the home visiting program influence the way you think about your (and your child's) future?

18) If you had a friend that was pregnant or recently gave birth to a baby—someone who reminded you of yourself a few years ago—what would you tell her about [PROGRAM NAME]?

19) Based on your experience—both in the program and knowing what you know as a parent—how would you change the program? What do you think could be done to improve the program?

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Costs of Evidence-Based Early Childhood Home Visiting

Results from the Mother and Infant Home Visiting Program Evaluation

2022. Phaedra S. Corso, Justin B. Ingels, Rebecca L. Walcott.

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