CHAPTER 7

Building Strengths and Resilience among At-Risk Mothers and Their Children

A Community-Based Prevention Partnership

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Research on the developmental impact of adolescent pregnancy has proliferated during the recent past (Coley & Chase-Lansdale, 1998; Zazlow, Dion, Morrison, Weinfield, Ogawa, & Tabors, 1999). Reviews of the research have underscored the multitude of risks of parenting for the development of both the young mothers and their children. However, few studies have offered viable conceptual frameworks for assessing the impact of interactive risk and protective factors. Social programs designed to remediate these risks have often produced disappointing results. There are several reasons for these findings.

First, these mothers often have multiple problems. For example, they may lack education, have inadequate social support, have limited access to transportation, or be living in high-violence neighborhoods. Accumulating risks make it even more challenging for young mothers to access interventions that may alleviate these conditions. Moreover, it is often difficult to assess the benefits of intervention if outcomes are evident only in the long-term (e.g., increased job opportunities that

may only result from school retention). Finally, research has mainly focused on the negative outcomes associated with the stress of adolescent parenting—although there is growing emphasis on the diversity of outcomes, including positive outcomes, in the scientific literature on adolescent mothers and their children (Schellenbach, Leadbeater, & Moore, 2004).

This chapter extends earlier research on risk and protective factors in several unique ways. First, the present work shifts beyond a focus on individuals (usually the mothers) to include dyadic, social, and community levels of analysis. Second, we move from an examination of single risk factors and outcomes to an examination of multiple factors that interact to predict developmental outcomes. Third, we introduce a strengths-based approach and highlight the diversity in outcomes for young mothers and their children. Finally, we assess a community-based, collaborative approach to the development and implementation of a preventive home visitation program for young mothers and their children.

The first unique aspect of the community collaboration was its basis in theory and its focus on an integrated approach to the multiple components of stress that these mothers confront: individual, dyadic, and social contextual. The program was also based on a multisystemic approach to prevention. It targeted not only mothers and children, but also the social systems (staff systems, services systems, community collaborative systems) that contain these mothers and their children.

Previous research on risk and protective factors has been guided mainly by the use of a causal model of cumulative risk and protection to predict single aspects of behavior intervention (Masten & Coatsworth, 1998). For example, additive main effect models suggest that action of an asset on a single positive outcome is measurable as an additive main effect of the outcome (e.g., the presence of a supportive and involved mother of an adolescent has a positive effect when present but no effect when absent). Alternatively, risk and protective factors may interact so that the impact of a specific risk factor depends on another variable that is activated when risk is experienced (e.g., a young mother may have access to a preventive parenting program when she gives birth to a low birthweight infant, but only if the infant is healthy). Preventive assets can also function to avert risk in a child. For example, early and high quality prenatal care is likely to prevent specific types of risk in the child. Although these frameworks have proven useful in understanding the impact of risk on developmental outcomes, transactional models that account for multivariate risk and outcomes are needed to better

understand the function of risk and protective factors in long-term developmental processes.

DIVERSITY OF OUTCOMES FOR ADOLESCENT MOTHERS AND THEIR CHILDREN

Past research has typically emphasized the negative correlates of early pregnancy and parenting. For example, research suggested that girls who became pregnant were more likely to have experienced maternal rejection, have poor self-esteem, and have poor problem-solving skills in comparison to those who did not experience early pregnancy. Adolescents with lower school performance were at greater risk for pregnancy than those with higher school achievement (Moore, Miller, Morrison, & Glei, 1995). Adolescent pregnancy also tended to be associated with a pattern of risk-taking behavior that included substance use, risky sexual behavior, and early sexual activity (Moore et al., 1995). Studies have also reported that early pregnancy tends to be related to behavioral characteristics such as aggression. For example, Underwood, Kupersmidt, and Coie (1996) found that half of the aggressive girls within a group of lower-income, African American adolescents became pregnant, compared to 25% of the girls rated as nonaggressive.

However, evidence of diversity within groups of young mothers is accumulating. The importance of school success, individual personality characteristics, and support are documented in the literature. Mothers who have more positive outcomes following birth tend to be older, on grade level for their age, and more socially competent and involved with their peers (Leadbeater & Way, 2001; Whitman, Borkowski, Keogh, & Weed, 2001).

Resilience has been defined by Masten and Coatsworth (1998) as "manifest competence in the context of significant challenges to adaptation or development" (p. 205). Competence has been defined as a pattern of effective adaptation in the environment either broadly defined as the achievement of developmental tasks or specifically defined in terms of domains of competence. Developmentally appropriate indicators of competence vary for younger and older adolescents. For younger adolescents, school engagement, academic achievement, and the development of positive peer relationships are all normative tasks. For older adolescents, the successful transition to young adulthood includes high school graduation, post-secondary school training, and economic

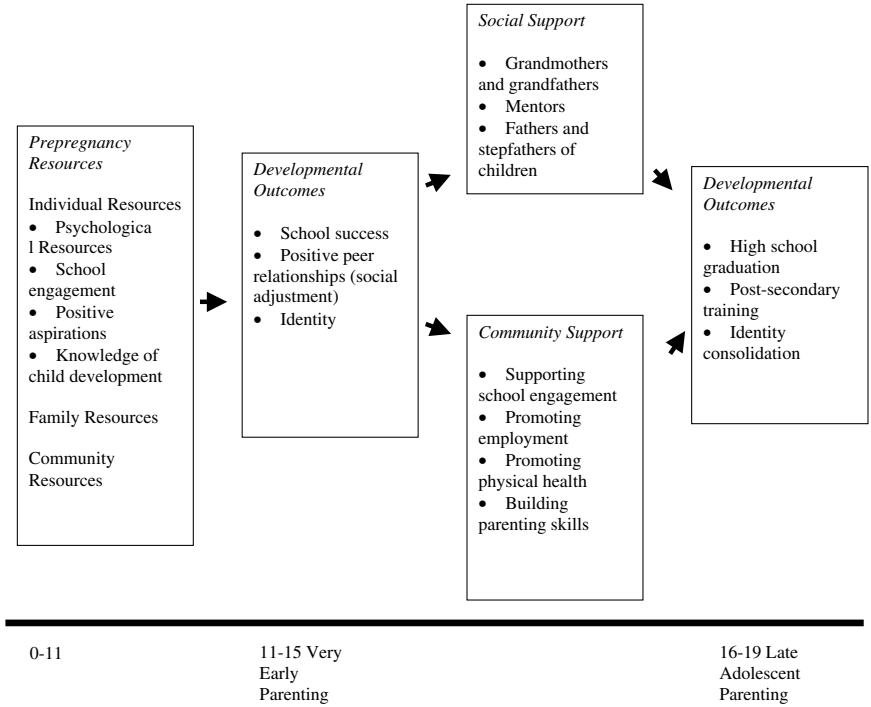

Figure 7-1 A developmental competence model of adolescent parenting.

independence. The competence model for adolescent mothers is depicted in Figure 7-1 (Schellenbach et al., 2004).

A HOME VISITATION PROGRAM TO ENHANCE RESILIENCE AMONG AT-RISK MOTHERS AND CHILDREN

The state of Michigan ranked 39th in indicators of child health and wellbeing, as indicated by high rates of infant mortality and child poverty. These trends were causes for concern in the target Midwestern city. The city had infant mortality rates twice the national average of 9 per 1000, and its residents accounted for 38% of the births to adolescents in the county. The city had the lowest per capita income in the county, and the poverty rate for children under the age of 5 was 39%.

The Healthy Families Oakland Community Partnership

In the early 1990's, Oakland County in general, and the inner-city area of the target city in particular, were primed for a change in its service delivery system. Although numerous service agencies offered support to vulnerable families, there was no unifying connection or bridge among the agencies. Services provided in this traditional way (especially in large communities) are often perceived as confusing to families and difficult to access. Over time, they can become increasingly disjointed, communication between providers becomes limited, and organizations become highly competitive in their respective bids to obtain the scant funding resources that exist to support them. The all-too-frequent results, evidenced in communities throughout the country, are duplication of services to families, failures to assess and connect with families that are harder to reach, and a discouraging inability to improve community-wide indicators of family and child wellbeing.

In 1992, the national child abuse prevention organization in Chicago, illinois entitled *Prevent Child Abuse* secured funding to form a national network of researchers and practitioners that became known as Healthy Families America. A local collaboration secured funding from the Skillman Foundation of Detroit, Michigan for the Healthy Families Oakland program and developed a unique program that was targeted to serve some of the most needy families in a lower-income, high-risk urban area. A local hospital system, human service agencies, and Oakland University were committed to deliver services and to conduct an initial evaluation of the project. The goal was to improve child health and development and family wellbeing by providing an individualized, structured, and strength-based approach of intensive, long-term, home-based family support to vulnerable new families.

The components of this ongoing program include family assessment services that are provided systematically to all families in the target community to enable the connection of families most in need with intensive home-based support as well as home visits by a specially trained family support specialist. Families receive weekly visits during the initial six to twelve months of the life of the child—and which can be extended if family needs warrant. As family stability improves, visits are tapered to twice monthly, monthly, and then quarterly over a three to five year period.

The service delivery team is comprised of bachelor-degreed and non-degreed family support specialists who provide regular and ongoing home-visiting services to families and are employed with the various human service agencies within the community, master-degreed family assessment specialists who provide initial outreach and connection of

families to the program and who are employed by the hospital, master-degreed infant mental health specialists who augment home-based support to the family when clinically indicated, and master-degreed supervisors who provide centralized support to the entire collaborative ensuring program accountability, professional support, and skill development for all staff.

Healthy Families Oakland adheres to the standards of practice that are grounded in a series of critical elements, which represent current knowledge about implementing successful home visiting. Family support services are intensive, comprehensive, long-term, flexible, and culturally sensitive and begin prenatally or at birth. The objectives are to: a) provide parenting education through use of standardized curriculum materials on child development, health and safety, as well as activities to promote positive parent-child interaction; b) develop parenting skills through parent-initiated goal setting, observation, and guided interventions that build confidence and competence; c) support the parent-child relationship through the development of a consistent, trusting, and caring relationship between the parent and the family support specialist; and d) advocate on behalf of each family and child by providing linkage to health, education, and community services and to do so in such a way that builds the family's ability to advocate for these services on their own behalf. The home visitation program was designed to promote maternal and child health, improve quality of parenting, improve child and maternal well-being, and increase and integrate the level of community collaboration to provide higher-quality and more accessible services to young mothers and their children.

Sustaining and Growing the Partnership

From 1992 to 2002, the Healthy Families Oakland initiative grew from four organization partners to 10, from serving families citywide to countywide, and from one funding source to 22 private foundation and public funding sources. Funding also came from partner organizations and private community donations.

The implementation and decade-long growth of the program required more than what was anticipated in the momentum that propelled the program's launch. It required a willingness on the part of each agency to take risks as well as the steadfast commitment at all levels, from direct services providers to management and administrative leadership. For example, specialists in family assessment, family support, infant mental health, and parent-group facilitation all worked as members of the Healthy Families Oakland team, while employed at 10 different organizations. Centralized support and supervision was provided by one

agency. This required the development of a uniform job description for program positions across agencies. Staff needed to be motivated to increase their contribution to the team and remain engaged with the program, as staff retention is often a challenge in the human services field. When it became evident that the differential salary range for similar positions across agencies was causing some staff to consider moving to another agency, the collaborative partnership agreed on a common salary range to promote stability. Although these system changes may appear minor, the ability and willingness of organizations to alter their systems of staff supervision and human resources and to increase rates of compensation was of paramount importance to the strength and survival of this collaborative.

Evaluating Our Success

While formal evaluation research was not possible at the beginning of the program, a social action research approach was possible. There are many indicators that together suggest the Healthy Families Oakland program has been successful. The collaborative partnership on two occasions (1998 and 2002) underwent an accreditation site visit that required the coordinated involvement of all organizations. Both times, outside assessors recommended and accredited the program and this resulted in securing a four-year national credential as a Healthy Families America program on each occasion.

The collaborative has also annually measured the quality of the workplace and studied the engagement of all staff (representing all 10 agencies) with assistance from the Gallup Organization. The findings have been highly positive and clearly show the commitment of each organization partner and their staff. The Gallup Organization assesses engagement scores across four stages of an engagement hierarchy (The Gallup Organization, 2000). The program's scores have consistently fallen well into the top quartile in comparison to Gallup's extensive national database. In Gallup's meta-analysis of engagement hierarchy, organizations that rank in the top quartile have higher productivity, better employee retention, increased customer satisfaction, better cost efficiencies, and improved employee safety.

Clearly also indicating its success, the Healthy Families Oakland collaborative has sustained itself and grown in numerous ways. However, even in the face of this maturity and relative funding stability, this is not to say that the process becomes easier. The partnerships continuously require devout attention and energy to resist the regular pull that each agency naturally feels from time to time to return to more traditional, single-agency service delivery systems. The stabilizing force

during these times is a renewed commitment to the purpose of our shared work.

ASSESSING THE EFFECTS OF A COMMUNITY-BASED PREVENTION PROGRAM

The impact of the Healthy Families Oakland program on the families it served was informally assessed and findings suggest positive outcomes. A more formal evaluation would have given more reliable evidence of the value of the program, but this is not always feasible in a broad-based community program—where the use of even a wait-list control group over many years can be seen as a restriction of services that could excessively burden needy individuals. Large-scale, costly comparisons with communities without the program would provide useful comparison through fully-funded large-scale evaluations.

Analysis of the Process of Service Delivery

In an effort to assess the relationship between services and issues raised by the mothers and the topics actually covered during the home visits, concerns were coded from the Home Visit Process Records that were written at each home visit. Concerns were categorized according to maternal life course issues (e.g., employment, housing, and return to school), intrapersonal and interpersonal relationship issues, and instrumental support issues. During the first 3 months of service, mothers raised concerns regarding interpersonal relationships and instrumental support. Mothers began to initiate a focus on their own life course issues between the 6^{th} and 9^{th} month of service.

The types of services provided by each family support specialist to mothers were summarized from home-visit records to check on the validity of the implementation of the model. Four categories were used to check which program components were implemented at home visits: a) use of a standardized curriculum; b) resources and guided intervention to enhance parenting skill; c) emotional support through the development of a caring relationship with the family support specialist; and d) advocacy to provide referrals and links to community services. The summary showed that the family support specialists utilized each component at each of the home visits, but the greatest amount of time was devoted to professional support from the family support specialist to the young mother. The next highest amount of time was devoted to

the use of the standardized curriculum and modeling or guided parenting interventions. Providing advocacy services remained high during the year of participation.

Healthy Families Oakland participants consisted of a sample of 193 mothers and their children who were recruited from two major hospitals in a metropolitan area. The mothers ranged in age from 13 years to 39 years of age. The majority of the participants were young (mean age of 19.6 years), single (95.4%), and low in education. The mean level of educational attainment was 10.6 years at the time of the child's birth. The mothers also tended to be poor, as 89% were below poverty level. There was some diversity in the ethnicity of the sample, with 46.4% Caucasian, 43.7% African-American, 9.4% Latino, and .5% of Asian-American origin.

The infants in the sample (50.7% male) were healthy and of average birth weight (6.86 pounds) and gestational age (38.78 weeks). Scores on Apgar assessments at birth were in the normal range (8.11 at 1 minute following birth, 8.82 at 5 minutes following birth).

Levels of risk and demographic variables within the hospital setting were assessed in individual interviews within 48 hours following birth. The quality of care giving, physical health of the child, and child developmental status were assessed at home visits scheduled when the infant was four months of age. The data collected on the Healthy Start Oakland project were based on a multi-method approach utilizing interviews, standardized assessments, behavioral observations, questionnaires, and self-report data. The variables focus on structural, individual, and dyadic risk and protective factors and the dynamic interplay of these factors in predicting resilient outcomes among the at-risk mother-infant dyads.

Risk and Protective Factors

The hospital record screen consisted of a checklist for the presence or absence of specific psychosocial and mental health factors that are associated with poor parenting and negative child outcomes. Screening was based on an 18-item review of current social contacts and emotional health (e.g., family supports, family problems) and history of mental distress (e.g., substance abuse or depression). Mothers are referred to the second level of the screening process if records indicate risk on any 2 of the 18 items or if the records indicate that the mother meets any of the following criteria: a) single parent; b) late or no prenatal care; or c) mother considered an abortion for the present birth.

The second tier of the assessment involves an in-person interview of the mother. The Family Stress Checklist (Orkow, Murphy, & Nicola, 1985) is a structured interview which assesses the parent's perceptions of his/her strengths and needs in 10 specific areas: childhood experience; lifestyle, behaviors and mental health (including substance use history); previous contact with protective services; coping skills and social support system; stresses; anger management; expectations of children's developmental milestones and behaviors; plans for discipline; perception of child; and bonding and attachment. Each factor is assigned a "0" if no risk is present, a "5" if mild risk is present, and a "10" if severe risk is present. Total scores range from 0 to 100; a total score of 25 or over indicates that the mother is at high risk for problems in parenting. Typically, data indicate that approximately 50% of those interviewed are offered services, or 20% of all mothers originally screened, are offered services.

Four-Month Postpartum Follow-Up Measures

The Child and Maternal Health Record was a tool used by Family Support Specialists to record whether the mother is linked to a primary care physician, immunizations, well-child care visits, and sick-child care visits.

The HOME Scale (The Home Observation Measure of the Environment) (Caldwell & Bradley, 1985) was used to assess the quality of the child's caregiving environment. The scale is an observational and report measure completed during a home visit by the trained family support specialist. The HOME consists of six subscales including responsivity, acceptance of child behavior, organization of the environment, parental involvement with the child, provision of play material, and opportunities for variety. The HOME Scale is widely used and accepted home observation and parental report measure.

The MSSI (Maternal Social Support Index) was used to assess the mother's social support system. Twenty questions are used to tap seven categories of support: help with daily tasks, visits with relatives, individuals the mother can count on in time of need, emergency child care, satisfaction/communication with male partner, community meetings, and community group work involvement. The MSSI has strong test-retest reliability after 9 months and good internal consistency (Pascoe, Ialongo, Horn, & Reinhardt,1990).

The Ages and Stages Questionnaire (Squires, Potter, & Bricker, 1995) was used to assess the development of the infants. Each questionnaire includes 30 items that assess development in five domains: communication, gross motor skills, fine motor skills, problem solving, and personal-

social development. Reading level of each questionnaire ranges from fourth to sixth grade. For each of the items, trained staff members assist parents in an observation of whether or not the child performs the specific behavior, coded "yes"; performs the specific behavior on an occasional basis, coded "sometimes"; or does not yet perform the behavior, coded "not yet."

Characteristics of the Families and Findings

The total scores and subscale scores for *risk and protective factors* are depicted in Figure 7-2. Major risks that were reported included multiple family crises and stresses, lack of support and coping skills, and substance abuse or history of depression. Many mothers also reported problems in bonding and attachment to their infants, as well as coping and self-esteem issues. Twenty-four percent of the sample scored within the extremely high-risk domain on an item of the Family Stress Checklist.

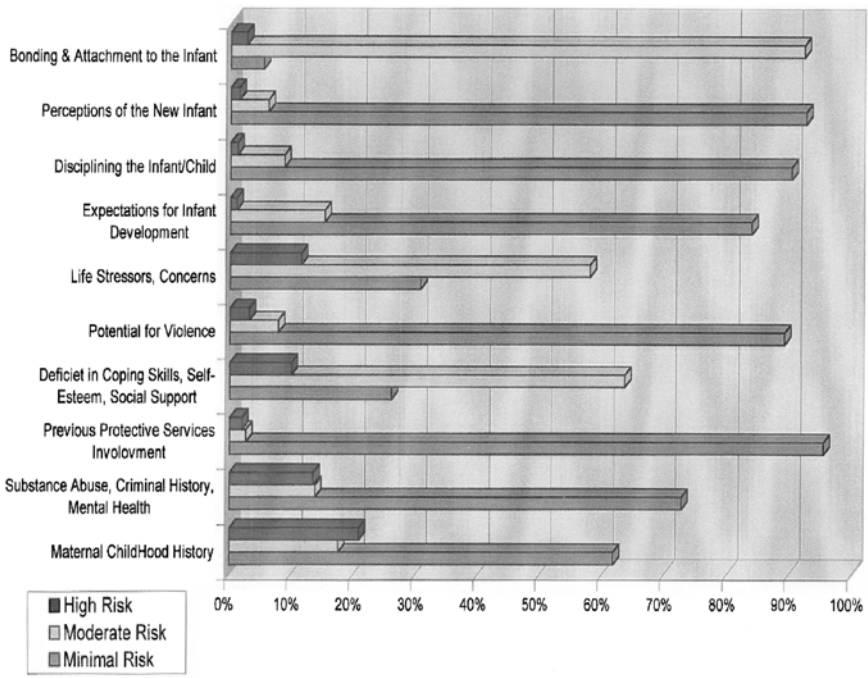

Figure 7-2 Distribution of level of risk across Family Stress Checklist risk scales: Initial assessment subscale scores.

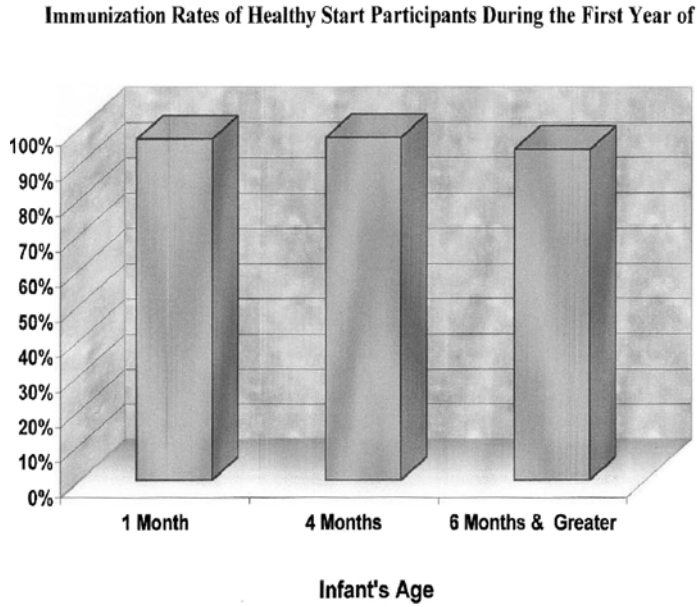

Figure 7-3 Analyses based on total number of open and closed cases during reported month intervals.

The results indicated that the mothers were responsible for many of the household and parenting tasks such as paying bills, housework, preparing the child for bed, and feeding the child. In 33.9% of the cases, the mothers received assistance with these tasks. Most (84%) of the mothers reported that they received instrumental support (food, money, and clothing) from their relatives. Young mothers believed that they could depend on a partner for instrumental support; however, only 15% of the mothers reported that they received instrumental support from their partners. Moreover, many of the young mothers (47.4%) believed that their partners would be able to provide care on a regular basis; however, individuals who provided childcare were most often neighbors (63.2%) or relatives (36.8%).

Health-promotion behaviors were assessed as: engagement in the preventive health care system through successful linkage to the primary health care physician, successful compliance with immunization schedule of the National Academy of Pediatrics, and decreased use of emergency room care. The Health Record for each child was typically completed through the use of a hospital-based computerized recording system to improve the accuracy of the data collection. Data indicated

that 100% of the participants were successfully linked to a primary care physician within the system, and 99% of the sample were up-to-date on well-child care visits (documenting engagement with the preventive health care system) and on immunizations at 1 month and 4 months of age. The use of emergency room care was low during the first year of life (6.2 visits) compared to the mean number of visits for a comparable group (21 visits per year).

Analyses of the Effects of Co-Occurring, Multi-Level Risk and Protective Factors

Since one of the major goals of the project was to improve the quality of parenting of the at-risk mothers, several analyses were conducted to assess the relationship of structural, familial, and individual risk and protective factors influencing quality of parenting. Identification of the relative influence of these variables could provide information about the variables that affect program outcomes. Structural variables of educational attainment, income, age, and employment status were derived from the demographic record. Data on intrapersonal risk and maternal coping skills and depression were obtained from the standardized risk assessment administered within 48 hours of birth. Quality of parenting was derived from the HOME scale administered in the mothers' homes 4 months following birth.

In multiple regression analyses, a model using both structural and intrapersonal variables was significant, with income, parent coping skills, and maternal depression independently predicting quality of parenting. Overall, mothers with higher income, better coping skills, and lower levels of depression at time of birth showed higher quality of parenting 4 months following birth.

Perhaps not surprisingly, given that the sample included infants who were healthy at birth, 95% exceeded the cutoff point for positive development on the screening tool (the ASQ) at four months of age. However, based on a developmental competence model of adolescent parenting, parental resources (personal coping skills or maternal depression) and community support (average contact hours with Healthy Families Oakland) were expected to predict developmental outcomes (ASQ scores) at 4 months of age. The results of the multiple regression were significant. However, the influence of contact with the program varied by risk status of the mother. Mothers who had lower risk (more positive coping skills) received average contact and had infants with higher developmental scores. Mothers who were at higher risk (fewer coping skills) received higher than average contact but had infants with lower developmental scores.

DISCUSSION AND IMPLICATIONS

The mothers who participated in this strengths-based community prevention program showed high levels of preventive health-promotion behaviors, as well as enhanced parenting and home environment. Anecdotally, positive gains in the health-promotion behaviors showed in the transition from a more crisis-oriented and distrusting approach to a preventive and trusting approach among the young mothers. Indeed, all of the mothers succeeded in linking to a primary care physician for their preventive health care needs and the mothers were highly successful in achieving age-appropriate immunizations (99%–100%). Moreover, the limited use of emergency room care and the regular use of office-visit medical care were important to providing more effective and earlier medical intervention. Decreased use of emergency room care also results in more cost-effective use of the medical care system.

Mother–infant adaptation was influenced by both structural and intrapersonal variables. Consistent with previous research indicating the negative effects of poverty associated with parenting (McLoyd, 1990), the quality of parenting in this sample was influenced by an individual's economic resources, despite their program involvement. Moreover, personal variables such as the coping skills of the mother also influenced the quality of parenting. In addition, exploratory analyses indicated that the risk level of the mother influenced her interaction with the community-based prevention program and its success in enhancing the children's early development. Programs need to be sensitive to the needs of subgroups of mothers with specific intrapersonal and structural profiles that can interact with program variables to affect outcomes.

Many prevention programs for young mothers focus on a deficits-based approach regarding knowledge, motivation, skills, or support. The findings from this community-based prevention program suggest that a strengths-based approach that builds on the personal resources of the mother and the goals that she has for herself and her child can be effective in influencing positive outcomes for her child. Although all of the mothers in the prevention program were lower income, single, and experiencing personal risks, it was evident that diversity existed within the group. Using a strengths-based model of adolescent competence, individual differences in personal attributes were explored. Higher levels of personal coping skills were related to more positive outcomes for the participants. These findings are consistent with results from previous research suggesting that maternal personality characteristics influence participant outcomes in home-based intervention programs (Olds et al., 1999). Future research should assess the contribution of the individual

characteristics of the infant (such as premature births or low birth weight) to program use and outcomes.

The findings also have important implications for funding agencies and public policy programs. These organizations need to rely more on comprehensive programs that address goals for both the mothers and the children within a strengths-based perspective. The Healthy Families Oakland program was effective in increasing community collaboration from 4 partners to 10 partners over a 4-year period and in expanding the number of mothers served from city-wide to county-wide. Finally, the program has been successful in institutionalizing services and increasing funding sources from a single source to more than 22 public and private sources of financial support. In summary, the success of this community-based program demonstrates what can be accomplished within a decade-long, university-community collaboration. The collaboration was successful because of the strong commitment to sustained effort and because of the unique strengths of each of the partners in joining to accomplish a mutual goal: to make a difference in the lives of these young mothers and their children.

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