

Homefriends Final Report

I. Introduction: Brief Description of Project

A. Background information

Studies indicate that children with multiple disabilities are more likely to be abused than children who do not have disabilities (Sullivan and Knutson, 2001; Sullivan and Knutson, 1998; Benedict, White, Wulff and Hall, 1990). In 1992, incidences of child abuse and neglect in the U.S. were 1.7 times greater for children with disabilities than children without disabilities. Thirty-seven percent of maltreatment to the disabled children was attributed to their disability (Jones, 1995). A study conducted in Omaha, Nebraska also found that children with disabilities were three times more likely to be reported for maltreatment than children without disabilities. Also, the study indicated that children with disabilities were more likely to have multiple reports of maltreatment than children without disabilities (Sullivan and Knutson, 2001).

Factors that are associated with maltreatment toward disabled children include: inadequate parenting skills, low educational attainment, depression, lack of self-esteem, lack of social support, substance use, poor living conditions, low income and lack of resources (Jones, 1995; Dore & Harnett, 1992; Coohy, 1995). One solution proposed to solve this problem is the promotion of home-based (or visitation) services (Leventhal, 2001). Home visitation services provide a professional (i.e., nurse) or another member of the community (paraprofessionals) to visit the family's home and aid the primary caretaker with parental skills and access to resources (Leventhal, 2001). Studies have found that when high-risk families participate in home visitation programs, the primary caregivers were more likely to have positive outcomes such as lower levels of parental stress and a decreased report of maltreatment (Olds, Eckenrode, Henderson, Kitzman, Powers, Cole, Sidora, Morris, Pettit & Luckey, 1997; Miller & Wittaker, 1988; Lines, 1987).

Experts have indicated that in-home visitation programs, families respond better to paraprofessionals than professionals (Dore & Harnett, 1995; Leventhal, 2001). Leventhal (2001) stated: "A potential strength of having paraprofessionals as home visitors is that they can ally with the families and, compared with nurses, may be accepted more readily by high-risk families."

Paraprofessionals that have been used in home visitation programs vary due to the selection of the volunteers. Empirical evidence have shown that the type of paraprofessionals used in these programs do have an effect on the caretakers especially in the African-American community. Rhodes, Ebert & Fischer (1992) found that young, highly stressed, African-American mothers who were assisted with a "natural mentor" (defined as a nonparent/nonpeer support figure) in their social support network, had lower depression scores than those not assisted with a mentor. The mentors described in this study were older women (average age = 45 years). Many were described as "playmothers."

Staples (1993) explains the importance of elders in the African-American community and suggests that in African families any adult may act as a "father" or "mother" to the child. The

elders pass information to the child through oral communication. The bond between child and elder is essential in preserving traditions and other vital information. This suggests that elderly citizens are a rich resource to the African-American community and that they can be used in other communities and populations as well.

The Homefriends program is a home visitation program that uses African-American elderly citizens as mentors to aid families who are at risk of or have been reported for child abuse and neglect. Also, most of the families in the program have at least one child with a special need. The mentors mostly focus their attention on the child with the special need and assist the parent with parental skills and community resources that would benefit the whole family. The mentors visit the families on a weekly basis.

The Homefriends program is designed to enhance support systems with children with special needs who are abused or neglected or at risk for abuse or neglect. This program has four key components: mentoring (connecting families with older volunteer mentors from their neighborhoods), parent support groups (providing peer support and engaging parents in ongoing projects that build and maintain skills and self-esteem), and concrete services (providing families with needed basic items such as food, clothing, educational materials and toys).

B. Program Model

The Homefriends program was a collaboration between Temple University's Center for Intergenerational Learning (CIL) and the Supportive Child-Adult Network (SCAN). It was a modification of CIL's highly successful Family Friends program, which engages older volunteers as supportive friends to children with disabilities and their families. Homefriends was designed to enhance support systems of families living in West and Southwest Philadelphia with children with special needs and/or who are at risk of neglect or are neglected. There are three key program components: connecting families with older (55+) mentors from their neighborhoods, coordinating parent support groups, and involving community businesses and social services in obtaining concrete services for families.

- 1) Each year approximately 20 older volunteers (55 years+) were recruited, trained and supervised to support 20 families. They visited families in their homes on a weekly basis, provided social/emotional support, modeled positive parenting, offered respite, and connected families with community resources. During the initial trust-building phase of mentors' involvement with families, SCAN also provided their SCOH intervention (Services to Children in their Own Home). After families exited SCAN's caseload, mentors continued their visits indefinitely and took on more "advocacy" roles.

- 2) Parent support groups were created to facilitate peer support, educate, and engage parents in ongoing projects that build and maintain skills and self esteem.

- 3) An advisory committee comprised of local businesspeople, school personnel, service agency representatives, and program participants, was created to assist with program planning. The committee helped develop a Concrete Services Bank with food, clothing, appliances, and assistive technology to distribute to families in the program.

The Philadelphia Health Management Corporation conducted an independent process and outcome evaluation.

C. Collaborative efforts

In this section of the report we will address the primary collaboration underscoring the entire Homefriends effort, that between the Center for Intergenerational Learning (CIL) at Temple University and the Supportive Child Adult Network (SCAN), Inc.

Strengths:

1. Solid Program Structure:

Each agency had a clear role in the overall program structure. CIL was primarily responsible for recruiting, training, supervising and providing ongoing support to the older adult mentors. SCAN was primarily responsible for the identification, screening, and ongoing support to families. The two agencies worked jointly on training the mentors, matching mentors with families, and providing ongoing support to the mentors.

2. Unique Expertise:

In this collaboration, SCAN was clearly far more experienced in working with multi-problem families who were experiencing or at risk of child abuse and neglect. CIL had greater expertise working with children with special needs and in coordinating mentoring programs in general, and specifically mentoring programs involving older adults as mentors.

3. Communication

From the outset of the program, mechanisms for ongoing and thorough communication were instituted. During the first meeting between the collaborating agencies, we discussed the individual "styles" of each agency, our perceived strengths and weaknesses, our past experience with collaboration (what went well and what could have been improved) and our respective hopes and suggestions for the five-year collaboration. We developed a memorandum of understanding that outlined our separate and shared responsibilities. Program staff met on a weekly basis for the first 6 months of the project and then on a monthly basis for the remainder of the project, and agency Executive Directors attended program planning meetings twice a year where challenges were discussed. The Family/Mentor Coordinator and the Program Coordinator communicated several times a week to discuss and problem solve issues for the entire duration of the project.

4. Conscientious Management of Interagency Conflict

As in any collaboration we experienced conflict. Fortunately, this was anticipated and we communicated often enough so that there was ample opportunity for and openness to discussion. We simply talked about the issues. When individuals were at fault, they apologized and as a group we agreed upon how to solve the problem and preempt similar problems from arising in the future.

Weaknesses:

1. Concerns about Program Structure:

The benefits of interagency collaborations notwithstanding, there were times when we wondered whether certain aspects of the program would be more effective if they were in-house within one agency. For example, if the Program Coordinator, who was the primary person in contact with the mentors, worked at SCAN instead of CIL, she could have immediate access to the family case workers when problems arose. Since the caseworkers were mostly in the "field," they were very difficult to reach for both the mentors and program staff. An alternative to this arrangement would have been to change the job description of the Family/Mentor coordinator to include some of the Program Coordinator's responsibilities and to become a full-time position. In this way, she would have been better able to track down case workers when needed.

D. Special Issues

Staff Characteristics

Over 90% of the families served by this project were African American. We had a commitment to hiring as many African American staff as possible. As it turned out, all of our direct service staff were also African American. Almost all of the mentors were also African American. We believe this facilitated mutual understanding, the trust-building process, and provided the children and parents role models they could identify with and aspire towards.

E. Funding information

In addition to the five-year \$150,000 grant we received from OCAN, ACYF, we received local grants from Philadelphia's SCOP (Support Community Outreach Project), the Philadelphia Department of Health, Maternal & Child Health, Health Partners HMO, and numerous in-kind donations from community groups, schools, older adult organizations and individuals.

F. Evaluation information

The Temple University, Center for Intergenerational Learning (CIL) contracted with an outside agency, Philadelphia Health Management Corporation (PHMC), to conduct the Homefriends Program Evaluation. CIL and PHMC evaluation staff maintained close personal and phone contact throughout the project. PHMC staff attended monthly staff meetings and attended program workshops and activities. The Research Assistant (RA) was present at all Mentor Workshops, Parent Support Groups, picnics and parties. At each event, she took copious notes.

II. Was the Project Successful in Attaining its Implementation Objects? (Process Evaluation)

A. Statement of project's implementation objectives.

1. Grant Work Plan

Specific objectives included to: 1) *Decrease social isolation of targeted families*; 2) *Decrease parental stress*; 3) *Improve parenting skills of caregivers*; 4) *Improve caregiver attitudes and response to their children with disabilities/chronic illness*; 5) *Increase caregivers' knowledge and access to community resources*; and 6) *Increase community's response to the needs of targeted families and their children*.

2. Staffing

The Center for Intergenerational Learning (CIL) had overall administrative responsibility for the project. CIL subcontracted with Supportive Child Abuse Network (SCAN) to involve families from their caseload. CIL also subcontracted to Philadelphia Health management Corporation (PHMC) to conduct the independent evaluation. A steering committee composed of the Principal Investigator, the Project Director from CIL, the Program Coordinator from CIL, the SCAN Family Mentor Coordinator and the Program Evaluator, met regularly to oversee the major activities of the project. Strategies for involving community businesses and social services in supporting families, recruitment of volunteers and criteria for selection of families were determined by this committee. The steering committee also planned the parent support groups, training of volunteers, and special events. The breakdown of project responsibilities was as follows:

Nancy Henkin, Ph.D., the Principal Investigator from CIL, had overall responsibility for the success of the program. She managed the collaboration, convened the advisory committee, and oversaw the operation of the program evaluation.

Vivian Drayton, MSW, LSW, Executive Director, SCAN, Inc., shared responsibility for the overall success of the program with the P.I. She co-convened the Advisory Committee, supervised the Family/Mentor Coordinator, and participated in all program planning.

Adam Brunner, M.Ed., the Project Director from CIL, supervised the Program Coordinator and oversaw the training and volunteer in-service meetings.

Abby Laniya, M.Ed., the Program Coordinator, recruited, screened, and trained the older volunteers. She worked with the SCAN Family/Mentor Coordinator to match and provide ongoing support to them. She also assisted the SCAN Coordinator with parent support groups. The PC also organized the program's special events and worked with PHMC to coordinate the evaluation. Finally the PC had chief responsibility for developing the Concrete Services Bank.

Andrea LaBoo, M.Ed., SCAN, Inc., the Family/Mentor Coordinator, worked closely with SCAN staff to identify, screen and then match interested families, she organized and co-conducted parent support groups, managed the family's transition when exiting SCAN's caseload, assisted the PC with the ongoing support of volunteers, coordinated the post-test evaluation to families, and provided resource referral to comparison group families after they exited SCAN's caseload.

Kathleen Coughy, Ph.D., PHMC, was the head evaluator. PHMC conducted the program evaluation and administered it with the assistance of CIL and SCAN staff.

Francine Smith, secretary from CIL, provided the administrative support for the program. She typed, responded to calls, ordered supplies and assisted with event coordination.

2. Target population

The City of Philadelphia has the highest incidence of child abuse/neglect in the state of Pennsylvania. In 1991, there were 4,891 reported cases of child abuse and neglect. In

Philadelphia, 2,249 (or 46% of these cases) were substantiated through investigation. The Homefriends program recruited families from those referred to SCAN from the Philadelphia Department of Health and Human Service (DHS). The DHS cases represent 250 SCAN families with approximately 700 children. The cases selected from the DHS caseload for this project came from two levels: those identified in need of early intervention to prevent neglect and those who are chronically neglectful. More than 90% of SCAN's families reside in West Philadelphia. Particularly striking is the fact that more than half of all children in West Philadelphia live in poverty.

Approximately 25 families per year with approximately 93 children (125 families and 372 children over the five years) from SCAN's caseload were served by the Homefriends program. The families SCAN serve are primarily low-income, African-American and female-headed. Yearly, SCAN serves 400 families with over 1,000 children and makes and 50 have been identified as families with substantial substance abuse issues. Consistent with the national data, more than half of SCAN's referrals are for neglect only and not abuse. A survey of SCAN's caseload revealed 169 children with the following diagnosed special health care needs in the following order of prevalence: developmental delay (52), asthma (18), non-organic failure-to-thrive (16), organic failure-to-thrive (14), cardiac (9), seizure disorder (8), birth defects (7), learning disabilities (7), hypertension (5), elevated lead levels (5), gastro-esophageal reflux (4), arthritis (3), cerebral palsy (3), sickle cell (2), metabolic disease (2), retardation (2), and the remaining problems with an incidence of one case – cystic fibrosis, neurofibromatosis, cleft palate, HIV/AIDS, Attention Deficit Disorder, severe brain damage, spina-bifida, chronic lung disease, eczema, cranial stenosis and tuberculosis.

The Homefriends Program recruited 98 West Philadelphia families from SCAN's caseload. A description of the families is in section D.1.

3. Collaboration With Other Agencies and Organizations.

Our most significant collaboration occurred with agencies that sat on our Advisory Board. Those agencies included: the Philadelphia Department of Human Services, Keystone Mercy Health Plan (the largest HMO provider for low-income families in Philadelphia), Northeastern Hospital, Friends Select School, a Temple University Sorority, the Southwest Senior Center, the Haddington Multi-Services Senior Center, the Family Resource Center in West Philadelphia, CHOP (Children's Hospital of Philadelphia), and the African American Clergy Association of Philadelphia.

Each agency collaboration differed in the breadth of its relationship and activities. For instance, the Southwest Senior Center provided continuous mentor recruitment support throughout the entire project. It also offered space to the project for a number of special events. Temple University Sorority and FRIENDS' SELECT SCHOOL were mainly involved in donating toys to the project's Holiday party. The Keystone Mercy Plan representative was largely of help offering suggestions for mentor recruitment and providing small donations for project support.

B. Research Questions for the Implementation Evaluation

The following eight questions are addressed to evaluate the Implementation of the Homefriends Program:

1. Who are the families that received Homefriends' services?
2. Who are the mentors that participated in the Homefriends program?
3. Where were the Homefriends' services conducted?
4. What Homefriends' services were provided?
5. What was the duration of mentor services?
6. How were the Homefriends' mentors recruited and matched with the involved families and what were the successes and obstacles in recruiting mentors and matching them with families?

C. Methods used in the Implementation Evaluation

1. Data Collection

The data collected to answer the implementation questions were collected from the following data sources:

Q.1. Data sources: 1). SCAN Referral forms. These forms included a brief description of the family and the needs and issues of the family. 2). Baseline survey. This survey contained questions about demographic characteristics, health, residential status and family status.

Q.2. Data source: Mentor (pre and post) surveys- the pre survey asks specific questions about the mentor's background (i.e., previous community service) and what services (goals and activities) the mentor plans to conduct with the family. The post survey asks specific questions about the activities the mentor conducted with the family.

Q.3. Data source: Mentor weekly report. These reports are brief logs that the mentors submitted to the Homefriends staff. These logs contain information about what happened during each contact with the family (i.e., family activities, discussion of parental goals, family issues, etc.)

Q.4. Data sources: 1) Mentor's in-service meeting notes. These notes are a summary of the information that the mentors shared about their families. The notes included issues that the mentor faced with the families, advice given to deal with these issues and any changes (positive or negative) that the mentor noticed with the families. 2). Homefriends Activity notes. These notes summarize the program activities provided for the families (i.e., Back to school picnics, parent support groups, etc.). The notes included the attendance of families for each activity and the observation of each activity. 3). Focus group. A focus group was conducted near the end of the program to obtain participant's opinions of the program and benefits they received from the program.

Q.5. Data source: Records maintained by the Research Assistant and the Program Coordinator regarding the beginning and end of each Homefriends' mentor/caregiver match.

Q.6. Data Source. The Center for Intergenerational Learning's Homefriends staff.

2. Methods of Data Collection

1. Referral forms were completed by the SCAN caseworkers and were submitted to the Homefriends staff to assess the families' eligibility for participation in the Homefriends Program. If eligible, the forms were submitted to the evaluation staff and a baseline interview was scheduled. The eligible families were subsequently randomly assigned to the intervention or control group.
2. The mentor surveys were filled out by the mentors and were submitted to the Homefriends staff at the beginning of the match and at the end of the match (or nine-months after the match started). After the surveys were submitted to the Homefriends staff, they were submitted to the PHMC evaluation staff and entered into a database.
3. Mentor weekly reports were filled out by the mentors and were submitted to the Homefriends staff on a monthly basis. Once the Homefriends' staff collected the forms, they submitted them to the PHMC evaluation staff, where they were entered into a database for analysis.
4. The Research Assistant took notes at the Mentor In-service meetings. These meetings were held monthly. The research assistant also observed and documented the Homefriends activities. Questions for the focus group with participants were developed by the evaluation and Homefriends' staff. The Research Assistant was present at the focus group and took notes. An employee of the Center for Intergenerational Learning, who was not involved in the Homefriend program, facilitated the focus group.
5. The Research Assistant received information about the matches from the Program Coordinator and developed a database into which all mentor/caregiver data were entered. The Center for Intergenerational Learning staff kept ongoing files on how the mentors were recruited and matched and met once a year with SCAN's Family/Mentor Coordinator to debrief on this subject and synthesize learnings.
6. The Center for Intergenerational Learning staff kept ongoing files on the successes and obstacles encountered in recruiting mentors and matching them with families and met once a year with the SCAN's Family/Mentor Liaison to debrief on this subject and synthesize learnings.

3. Sampling Procedures

The SCAN staff were informed about the Homefriends Program and asked to refer families they felt were appropriate. Once referred, the Homefriends staff reviewed the case to assure that they met the criteria for inclusion. Names of all eligible families were then forwarded to PHMC evaluators who set up interviews to gather baseline data. Once the families were interviewed,

the research staff randomly assigned participants to either the intervention or comparison group and informed the program staff of this selection. Initially, families were randomly assigned according to a table of random numbers; however, more families were assigned to the comparison group than the intervention. As it was deemed important to have a sufficient number of intervention families for analysis, the random selection was then based on odd and even numbers. This allowed for a more even distribution of the families to the study groups.

4. Data Analysis Procedures

Both quantitative and qualitative data are used for the implementation data analysis. The quantitative data are taken from the SCAN referral forms, mentor weekly reports and mentor survey forms. The qualitative data are taken from the mentor weekly reports, surveys and in-services, activity observations and the focus group.

Frequency distributions were developed from baseline data to document the demographic characteristics of the population served by the Homefriends Program and the mentors recruited. Tables were developed to document the number and duration of mentor/caregiver matches. These data were also used in the outcome evaluation. Tests of differences were conducted to compare the implemented program with that which was originally proposed. Finally, qualitative data were analyzed to assess the content of the mentoring services.

D. Implementation Evaluation Findings.

1. Who are the families that were serviced?

Homefriends families lived primarily in the West and Southwest section of Philadelphia, the target area for SCAN, Inc. The families came from two different caseloads at SCAN: the SCOH (Services to Children in their Own Home) program and HIP (Health Intervention Program). SCOH families are referred by the Department of Human Services for either suspected or confirmed child abuse and neglect. HIP families are also referred by DHS, usually because a family member (either the parent or child) has compromised health or a disability or is at high risk for child neglect due to a number of risk factors.

Almost all of the Homefriends' families live in poor, if not, inadequate housing, are single parents (often in unstable or unsupportive relationships), are under, if not, unemployed, are poorly educated, are survivors of foster care or inadequate parenting, are survivors of numerous damaged relationships and a significant number are recovering from substance abuse.

A total of 151 families were referred to the program by SCAN caseworkers. A total of 98 families were ultimately included in the study. Over the five-year period of the program, 53 families dropped out of or were eliminated from the study. Nearly one-third of these families refused to participate and another third were dropped from the SCAN caseload as they could not be located due to inaccurate information. In 13% of the cases, the Homefriends' child was placed in foster care making the family ineligible to participate. A few potential participants were jailed and thus not available and other families were dropped because of drug use or other circumstances that made it unsafe for the mentors to visit. Two parents died during their participation in the project.

Fifty families were assigned to the intervention group while forty-eight families were assigned to the comparison group.

**Table 1- Recruitment for the Homefriends Program
October 1996 through September 2001**

Number of families referred to the program	151
Number of families that were ineligible or dropped from study	53
Number of families in the study	98

Demographic Characteristics of Participants (Table 2)

The participants in the study tend to be young, African-American women. The mean age of the participants is 33 years of age. Nearly all of the participants are female (only three participants are male) and ninety-two percent are African-American. Five caregivers are European-American, one is Latino and two are from other ethnic backgrounds.

Education/Employment/Income. Both study groups have similar education levels of approximately tenth grade. Eight percent of the participants in the intervention group and fifteen percent of the comparison group were employed at baseline. Most of the participants in the intervention group and eighty-five percent in the comparison group report that they receive public assistance (81% and 85%, respectively).

Residential Stability. The majority of the participants had relocated to a new residence at least once in the past three years. Half of the intervention group and sixty-one percent of the comparison group had moved one to two times during the past three years. Fifteen percent of the intervention group and twenty-two percent of the comparison group had moved three to six times in the past three years. Nearly half (49%) of the sample reports living in their current residence less than one year.

Health Status. Nearly half (46.6%) of the intervention group and twenty-nine percent of the comparison group report that they have a chronic health condition. However, in self-reports of health status, fifty-eight percent of the participants in the intervention group report that their health is good or excellent compared to sixty-nine percent of the participants in the comparison group.

Family Status. Seventeen percent of the caregivers were married at the time of the study. On average, the caregiver families had three children in the household. Over half of the Homefriends children (in both groups) are under five years of age. All of the participants had at least one child with a disability and/or chronic illness. Forty percent of the disabilities reported are respiratory (i.e., asthma) or learning disabilities. Over half (56%) of the caregiver families (fifty-three percent from intervention group and fifty-eight from comparison group) have multiple fathers.

Table 2-Baseline Demographic Characteristics of Homefriends' Caregiver Study Groups

Characteristics	Study Group	
	Intervention N=50	Comparison N=48
AGE (Years)*		
Mean	33.38	30.51
S.D.	10.55	8.57
Range	14 - 59	18 - 59
GENDER (%)		
Female	96.00%	97.90%
Male	4.00%	2.10%
RACE/ETHNICITY (%)		
African American	92.00%	91.70%
Caucasian	6.00%	4.20%
Hispanic	0%	0%
Other	2.00%	4.20%
EDUCATION		
Highest grade completed (mean)	10.78	10.75
SD	1.65	1.55
Range	4 - 12	3 - 12
MARITAL STATUS (%)		
Married	20.00%	14.60%
Divorced	14.00%	6.30%
Widowed	8.00%	4.20%
Single, never married	58.00%	75.00%
EMPLOYMENT STATUS (%)		
Employed	8.00%	15.00%
Unemployed	92.00%	85.00%
PUBLIC ASSISTANCE (%)		
Receive	81.10%	85.40%
Do not receive	18.90%	14.60%
RELOCATION IN THE PAST THREE YEARS(%)		
0 times	35.40%	17.40%
1-2 times	50.00%	60.90%
3-4 times	10.40%	15.20%
5-6 times	4.20%	6.50%
TIME LIVING AT PRESENT RESIDENCE (%)		
1-6 months	28.00%	29.20%
7-12 months	18.00%	22.90%
13-18 months	2.00%	4.20%
19-24 months	6.00%	8.30%
Over 2 years	46.00%	35.40%

* Outliers were excluded from both study groups for research purposes

**CAREGIVERS WITH CHRONIC
CONDITIONS (%)**

Chronic condition	46.60%	29.20%
Of those caregivers w/ chronic conditions:		
Respiratory System	26.10%	35.70%
Heart/Circulatory	13.00%	14.30%
Digestive System	4.30%	0%
Hepatitis/cirrhosis	4.30%	0%
Bone/Muscle problems	8.70%	0%
Diabetes	17.40%	14.30%
Cancer	4.30%	0%
Blood problems	8.70%	7.10%
Skin ulcers/rashes	0%	7.10%
Eye problems	0%	7.10%
Depression	8.70%	7.10%
Panic disorder	4.30%	7.10%
Other	0%	7.10%

SELF-REPORTED HEALTH STATUS (%)

Excellent or Good	58.00%	68.80%
Fair or Poor	42.00%	31.20%

**NUMBER OF CHILDREN
LIVING WITH CAREGIVER**

Mean	2.88	3.25
S.D.	1.53	1.80
Range	1-7	1-9

**FAMILIES WITH MULTIPLE
FATHERS (%)**

Multiple fathers	53.10%	58.30%
Of those families w/ multiple fathers		
2 fathers	61.54%	50.00%
3 fathers	23.08%	17.86%
4+ fathers	15.38%	32.14%

**AGE OF HOMEFRIENDS
CHILDREN (%)¹**

0-5	57.60%	61.23%
6-12	25.90%	28.57%
13+	16.50%	10.20%

¹ Intervention and comparison sample exceeds baseline number because five families requested services for two children per household *instead of one*.

2. Who are the mentors that participated in the program?

A total of 40 senior citizens were recruited for the Homefriends program. Out of those who were recruited, twenty-four became mentors and were matched with the families. All of the senior citizens are African-American; their mean age is 62 years. Nineteen participants are female and five are male. Most (92%) of the mentors had volunteered in other types of community programs previous to Homefriends.

Table 3 – Demographic Characteristics of Homefriends' Mentors

Characteristics	%
	N=24
AGE (Years)	
Mean	62.39
S.D.	6.71
Range	50-75
GENDER (%)	
Female	80.00%
Male	20.00%
RACE/ETHNICITY (%)	
African American	100.00%
MENTORS WHO VOLUNTEERED IN COMMUNITY PROGRAMS	
Programs involving children	50.00%
Programs from church organizations	21.00%
Programs involving the sick	17.00%
Other programs	12.00%

3. Where the Homefriends' services were provided?

A majority of the mentor contacts (69%) were conducted in the families' home. The mentors visited the family's homes on a weekly basis. Nine percent of the contacts were through telephone calls and through social events. A few of the mentors escorted families/caregivers to medical appointments. Others accompanied families to appointments with the family's social worker and attendance at Homefriends' events (i.e., Back to School Picnic, Holiday Party). Contacts also included trips to take the family food shopping, looking at new housing and apartments, attending WIC appointments, and attending family court and school meetings.

4. What Homefriends' services were provided?

Mentor Services

The mentor/caregiver matches began in July 12, 1997 and continued through March 13, 2001. A total of 50 caregivers were matched with mentors. Some matches were discontinued and

caregivers were re-matched with new mentors and a few caregivers were matched with two mentors simultaneously. This latter dual matching was incorporated where the caregivers seemed to have extraordinary problems and needed extra support. In total, 69 matches were made with 50 caregivers.

Table 4 – Description of Matches provided in the Homefriends Program

Number of families matched in the program	50
Number of matches made in the program	69
Number of different types of matches	
Original match	37
Rematches	23
Simultaneous matches	9
Average number of contacts per match	14
Average length of all matches (in months)	10
Length of matches (%) (in months)	
≤ 1 month	29.0%
2-6 months	17.0%
7-12 months	28.0%
13-24 months	13.0%
24 + months	13.0%

On average, the Homefriends Program recruited approximately 19 intervention families and 15 comparison families each year of the program. This is somewhat less than proposed (25 families) however, program start-up took longer than proposed and recruitment for new participants had to be ended nine months prior to the end of the program in order to complete follow-up testing.

Of the 69 Homefriends' mentor/caregiver matches, fifty-four percent (37) of caregivers stayed with their originally assigned mentor. As is indicated in Table 4, the duration of the matches ranges from one month to over 24 months. On average, the length of all matches was ten months; however, nearly one third of the matches ended within one month. Reasons for the short duration of these matches are described below. The average number of contacts was 14 per match. However, this number may under-represent the work of the mentors as the mentors did not always document all contacts. Based on the weekly reports submitted, the mentors provided a variety of services. The content of these services is exemplified in the following quotes.

□ Emotional support to Caretaker

The weekly reports provided descriptive details of how the mentor aided the caregiver with emotional support. The mentors reported that in incidences where the caregiver was distraught over family problems or health problems, the mentor provided a lending ear and aid with solving the problem.

"Today was the second anniversary of (caregiver's) daughter's death. It was so sad, she cried and I had prayer with her and put my arms around her for comfort. I am so glad that I was there for her. We talk about her family."

"Talked to caregiver about her problems. Mostly, I just allowed her to talk and I listened and encouraged her. Told her that she has a lot to deal with, but she's handling it."

"(Caregiver) called saying she needed to talk and needed help. She is no longer employed due to her illness. She has not been able to keep medical appointments for herself or children."

"(Caregiver) is upset and crying. She found a bump in her breast. (Caregiver) had to talk a lot of things out. The Homefriend was able to calm her down."

□ Parental advice to the Caretaker

One of the goals of the Homefriends program was to aid the caregiver with parental skills. Below are some examples of how the mentors approached this goal.

"We talked about how and when to punish the children, such as the use of television. We talked about what to see on television. (Caregiver) states that she turn on the radio on when the program is violent or too sexy."

"(Caregiver) and I discuss children's behavior. We try to arrive at a solution to help (Homefriends' child)."

"Talked to caregiver about how to discipline the grandchildren, setting limits and watching educational TV."

"We discussed how to keep the children clean and personal hygiene for the whole family at home."

□ Educational help for the Homefriends' Child

A majority of the weekly reports submitted mentioned visits and activities that involved the child's education.

"I am teaching the children the alphabet. I played with the children and read to them. We also did some counting numbers. (Caregiver) and I had a

good talk about how she can manage better with the children when she has to go out. We made some plans. We had a good visit."

"I took a book with me to hear (Homefriends' child) read. She reads very well. Homefriends' child and I looked at pictures of what happens in the body when normal and when diabetic."

"We're (mentor and Homefriend's child) still learning numbers, colors and shapes. We read books, sing, play games and colored numbers. (Caregiver) has been joining in on most of the teaching of numbers and games. She's helping (Homefriends' child) learn the shapes."

□ Medical advice to the Homefriends' family

Since this program is targeted to help children with disabilities, the mentors often provided medical advice to the children.

"Discussed medication of (Homefriends' child). New medication seems to be affecting appetite and showing subdued behavior. Suggested further contact with physician to report observations. Discussed Christmas party, gave tokens for transportation."

"Going with (caregiver) and children to health center to pick up referral slip for their appointment to several places. Improving in helping to get the children proper exercise in walking and other outdoor activities."

"Support for (caregiver and child) as they visited the Wills Eye Hospital for follow up eye surgery. (Caregiver) needed information about traveling to and from the hospital."

"(Caregiver) had been ill for the past four days, cramping, muscle pain, aching chest. Did not complete papers for Social Security. Agreed to visit to assist with papers."

"Checking on (caregiver's) medication and doctor's appointments. Discussing all who reside at residence. How the new food stamp system will affect her. Assisting older children with homework and clean-up time for toys."

□ Access to Resources

As noted in the program objectives, another goal of the Homefriends program was to aid the families with community resources.

"We talked about shopping for food and clothing where and how to shop to get bargains, prices and sales for the best bargain for the least amount of money."

"We talked about which company to go to about her heating bill."

"Talked to caregiver about trying to get a house in Frankford."

"Visited (caregiver) encouraged her and showed her love and caring. This time, her mother was sick and (caregiver's) sisters were not helpful. Took her to get some non-perishable foods."

- Inclusion of children and family in social events

Along with the events that the Homefriends staff provided to the families, the mentors also took the family on trips and initiated social events within the family (i.e., family games):

"I brought a game call "Phase 10." The whole family played. They seem to enjoy the game. The eldest (child) seem not to understand the game. It is a game of strategy. Mentor helped him to understand the game."

"I took the boys to the movies to see "Tarzan." The boys displayed very good behavior and good time had by all."

"Today (child) and I went to the Salvation Army recreation center. They have a lot of activities, such as basketball, football, etc. I entered (child) into the program."

"(Homefriend's child) homework was on the subject of Kwanzaa, so we went to the library to learn about Kwanzaa."

"I helped my boy to prepare for kindergarten. He knows his numbers and the alphabet. I knew that all he needed was love. He is not in special education class. He is in a regular class and doing well."

- Parent Support Group

Daytime Parental Support Groups were regularly scheduled throughout the Homefriends Program. A total of four formal support groups were conducted. Attendance at these events was disappointing and suggests some of the difficulties of young parents to attend daytime events. Welfare to work was a key factor impacting parent participation; parents were actively involved in training and/or employment. A total of 16 families attended the meetings. Several of these families attended more than one support group. In response to the poor attendance, program staff decided to combine support groups with special events. The topics at the meetings varied from ways to handle stress, prepare for work, help children through school and other parent-related issues. Those who attended the Support Groups tended to rate the groups as excellent or good. One parent rated one workshop as poor.

- Special Events

Several special events took place for the Homefriends' caregivers and mentors. The events included "Shop Till You Drop" (parents were given imaginary money and could purchase up to 20 items at \$1 cost that included clothes for themselves, their children, and housing supplies) two summer picnics and five holiday parties. Twenty-five families attended the special events. Many

of those families attended several special events. The Holiday Parties usually attracted close to 100 participants.

In addition, caregivers, mentors and children were given coupons to the local water ice vendor and At these events, the caregivers received holiday gifts, back to school supplies, clothing donations, toiletries, and other items. At times, the caregivers would share stories about the things they appreciated about their mentor and what they had done for them. The participants tended to rate these events as excellent or good.

6. How mentors were recruited and matched with families?

Mentors were recruited through:

- a. advertisements in neighborhood newspapers and public service announcements on radio and television.
- b. presentations at Senior Citizen Centers and churches.
- c. flyers distributed at job fairs, Aging Expos and posted in neighborhood stores.
- d. mass mailings to businesses, churches, community agencies.
- e. posting flyers in local businesses, libraries, recreation centers, church bulletin boards, etc.

7. Successes and obstacles in recruiting mentors and matching them with families?

We believe offering mentors a stipend to visit families was an essential part of attracting mentors from poor or working class communities to our program. However, if the stipend were higher, we believe it would have attracted a greater number of mentors. While we were highly pleased with the quality of people that were recruited for the Homefriends program, our numbers were not high. Perhaps we would have recruited a larger number of mentors if we had been more successful in getting high profile articles in the major newspapers or reports on television. Increased publicity and/or the sponsorship of celebrities or government leaders would have also made recruitment easier, we believe.

The two greatest obstacles confronting the recruitment of mentors were that: 1) we were asking mentors to go into private homes, and 2) we were asking them to work with multi-problem families. Each of these facts frightened many potential mentors away. Once mentors became involved, we believe our training and support were strong enough to retain them and maintain their mental health for quite a long time. Only in a few cases did mentors drop out of the program because they were burnt-out or frustrated with their family. This was true in spite of the fact that many families tested mentors to the limit.

Our process of matching families was most successful, we believe, as a result of the skills of staff, Program Coordinator and Family/Mentor Coordinator. Each got to know the mentors/families well, gathered useful information, and applied exceptional intuition in making matches. Several times we found ourselves exclaiming, "We had no idea when we matched them that they had so much in common."

III. Was the Project Successful in Attaining its Participant Outcome Objectives? (Outcome Evaluation)

A. Project Outcome Objectives.

1. Changes that were expected to occur as a result of the project as a whole.

The following five changes were expected among the families who participated in the Homefriends Program.

1. Improved caregiver parenting skills;
2. Increased caregiver knowledge and access to community resources;
3. Decreased social isolation among targeted families;
4. Decreased parental stress;
5. Improved caregiver attitudes and response to children with disabilities/chronic illness;

2. The changes in participants that were expected to occur as a result of specific project components.

Through the mentoring program, families and children with special needs were expected to gain a "friend" to whom they could turn for support and guidance and have more opportunities for recreational and cultural activities. The Homefriends program also provided social activities for the families. Through the mentoring and the social activities, the caregivers were expected to feel less isolated than prior to the program.

Families participating in the program received social and emotional support and a needed break from the responsibilities of caring for a vulnerable child. This support was expected to reduce parental stress.

Homefriends' mentors served as role models, nurturers, advocates and listeners, sharing their experience and compassion with parents who are feeling overwhelmed. Participants also took part in parenting workshops. Through these activities, caregivers were expected to improve their parenting skills and their attitudes toward the Homefriends child.

The mentors and program staff also introduced the caregivers to new resources throughout the community. Therefore, it was expected that the intervention group would increase their knowledge and use of community resources.

B. Outcome Evaluation Research Questions

The following research questions are the basis of the Homefriends' outcome evaluation.

- 1) Do parental skills of the Homefriends' families, compared to the control families, improve significantly between pre and post-test periods?
- 2) Do the Homefriends' families knowledge and access to community resources, compared to the control group, increase significantly between the pre and post-test periods?
- 3) Does social isolation of the Homefriends' families, compared to the control group, decrease significantly between pre and post-test periods?

- 4) Does parental stress of the Homefriends' families, compared to the control group, decrease significantly between pre and post-test periods?
- 5) Do the caregiver attitudes and responses to their children with disabilities/chronic illness of the Homefriends' families, compared to the control families, improve significantly between the pre and post-test periods?

C. Outcome Evaluation Research Methods

1. Methodology

The outcome evaluation is based on an experimental research design with randomization of families to either an experimental or comparison group. The participants were drawn from the SCAN/DHS caseload. The focus of the outcome evaluation is to assess the extent to which the program objectives have been realized.

SCAN workers informed potential families about the Homefriends program. After the SCAN worker informed the families and the families agreed to participate, a referral was sent to the research staff. After the research staff received the referral, a baseline interview was conducted by trained interviewers. Subsequently, the families were randomly assigned to the experimental or comparison group. At the baseline interview, the families signed a consent form agreeing to participate in the study.

The experimental group received a Homefriends' mentor in addition to their services from SCAN. The comparison group received no mentor, however, they received services from SCAN. Nine months after the baseline interview, a follow-up interview was scheduled. Each family received twenty dollars for participating in the baseline and the follow-up interview.

2. Data Collection

A composite survey instrument was developed to collect baseline and follow-up data for the outcome evaluation. This instrument contained two standard and validated scales and newly developed scale to obtain information to answer the research questions. The combined instrument was pilot tested with families who fit the same profile as the targeted families. The baseline instrument included questions about demographic characteristics of the families. Beyond these demographic questions, the baseline and follow-up instruments were similar and contained two standardized scales: 1) the Parenting Stress Index (PSI, Abidin, 1990), and 2) the Social Support Network Inventory (SSNI, Flaherty et al., 1983) and an index of knowledge and use of community resources developed specifically for the program.

The SSNI is designed to measure the strength of social support networks and requires about 15-20 minutes to complete. Validity testing indicates high alphas for all factors. The last two SSNI questions inquire about a recent stressful event. For this study, that event referred to the child with disabilities and/or chronic illnesses.

The PSI is a parent/caretaker self-report instrument designed to identify caretaker/child systems at-risk and those that are currently dysfunctional. Validity of the instrument is based on ten years

of research. The short form contains 36 questions which are divided into three subscales: 1) Parental Stress Scale, 2) Parent/child Dysfunction Scale and Difficult Child Scale. These subscales each measure an outcome related to three objectives of the Homefriend program.

In addition, to comply with OCAN requests for data for a cross-site analysis, Child Well-Being Scales of both intervention and comparison families were included in the data collection. The SCAN caseworkers were asked to complete the Child Well-Being Scales. This was done at approximately the same time as the baseline and the posttest interviews. The Child Well Being Scales were developed by Magura and Moses (1986). These scales measure the adequacy of various environments (i.e., household, grooming and parenting) of young children. The scales are completed by the SCAN social workers. For the purposes of this study, eight scales were selected: Physical health care, clothing, personal hygiene, household sanitation, physical safety in home, parental approval of children, parental expectations of children and parental teaching and stimulating of children.

3. Data Analysis

The analysis investigates the extent to which of the program objectives of the study were realized. The analysis includes procedures to compare the two study groups and pre and post test measures for each study group.

The outcome analysis included a variety of statistical procedures. Descriptive statistics were initially used to examine the data. Means were calculated for many variables and scales. Correlations were computed and subsequent regression analysis techniques were employed. Qualitative data were also analyzed to identify repeated and specific trends and explanations of the qualitative findings.

4. Issues that affected data collection and analysis

For a variety of reasons, outcome data collection was sometimes impeded. The reasons for the problems in data collection are as follows.

- Shortly after some families were selected for the study, some were dropped from SCAN's caseload and could not be contacted.
- Primary caretakers were sometimes hard to contact due to incorrect information (wrong address, family moved right after selection, wrong phone number).
- Locator follow-up information was sometimes inaccurate, causing a delay in follow-up interviews.
- The follow-up interview window was sometimes longer than nine months due to difficulty locating caretakers' and scheduling appointments.

D. Outcome Evaluation Findings (Table 5, 6)

In the final analysis, some specific, statistically significant improvements are evident among the intervention group that did not occur within the comparison group, including a lack of foster care

placements. However, these improvements are not evident in some of the major scales utilized in the evaluation.

Research Question 1. Do parenting skills among the intervention group, compared to the control group, improve significantly between the pre and post-test periods?

SCAN, Inc. data indicate that during the course of the project, four families in the comparison group had children placed in foster care, and no families from the intervention group were placed. This is a statistically significant finding at the .05 confidence level ($t = 2.043$).

Parenting skills as measured by the Parent-Child Dysfunction Scale did not change significantly for either group during the program. However, in response to specific questions from the PSI scale, improvements were noted for the intervention group. When asked about feeling trapped by parental responsibilities and being able to do new and different things, the intervention group improved significantly while no change occurred among the control group. In addition, beliefs about being a good parent improved for intervention caregivers but did not change for control parents. This change in perceptions of parenting for the Homefriends' group approaches statistical significance ($p = .08$).

An improvement in Parental Teaching and Stimulation of Children as measured by the Child Well-Being Scales, was noted for the intervention group. This improvement is significantly related to the length of the mentoring relationship. The more often a caregiver met with the Homefriends' mentor, the greater the improvement in their score on the Parental Teaching and Stimulation Scale.

Research Question 2. Do Caregivers' Knowledge and Access to Resources, compared to the control group, increase significantly between the pre and post-test periods?

Four categories of resources were examined for this analysis: Childcare, parenting, medical and food resources. Knowledge of food resources increase for both study groups and use of these resources increases for the intervention group ($p = .08$) and declines for the comparison group. The intervention group also gained knowledge of and access to parenting resources while the comparison group reports fewer resources or use of parenting resources at the post-test compared to the pre-test period.

Both the intervention and comparison groups gained insignificant knowledge and access to childcare resources during the course of the program. Very small but insignificant changes are indicated regarding medical resources for both study groups.

Research Question 3. Does social isolation of the intervention group decrease significantly, compared to the comparison group, between the pre and post-test periods?

Analysis of the data from the Social Support Network Inventory indicate that there was very little change in SSNI scores between the pre and post test. Furthermore, both the intervention and comparison groups report fewer people in their support network at the end of the program compared with the beginning. The intervention group, though they report in focus groups and

mentor evaluation questionnaires that they received much support from their mentors, did not include the mentors in their social network. The reasons for this are unclear but may be due to the phrasing of the SSNI question ("Tell me about the five most important people in your life" including only those people over the age of 12 years) and the caregiver's view of who is in and out of their networks.

Research Question 4. Does Parental Stress decrease significantly, compared to the control group, between the pre and post-test periods?

The participants in this study experience high levels of stress as measured by the PSI. At baseline, the participants in both study groups had higher parental stress levels than a normal population as measured by the author of the PSI (Abidin, 1990). Also, the caregivers with chronic health conditions reported significantly higher stress levels than caregivers with no chronic condition.

Additionally, during the program, participant distress levels increased significantly for both the intervention and control groups ($P = .003$ and $.000$, respectively). Examinations of the PSI data indicate that the individual stress levels varied throughout the program. This variability and increase in parental distress are not related to duration or extent of mentoring, numbers of children, whether the participant or the children had chronic conditions, numbers of fathers, social support or any other variables utilized in the outcome evaluation.

Research Question 5. Do Caregivers' Attitudes toward child with disabilities, compared to the control group, improve significantly between the pre and post-test periods?

Attitudes toward the Homefriends' child, as measured by the PSI scale, did not change significantly for either study group between the pre to post-test period.

TABLE 5-Baseline and Follow-up Data of Homefriends' Caregiver Study Groups.

Characteristics	Group			
	Homefriends Caregivers N=41		Comparison Caregivers N=40	
	Baseline	Follow up	Baseline	Follow up
NUMBER OF PEOPLE IN SUPPORT NETWORK				
0-2	31.71%	48.78%*	30.00%	62.50%*
3-4	26.83%	24.39%	25.00%	7.50%
5	41.46%	26.83%	45.00%	30.00%
SOCIAL SUPPORT NETWORK INVENTORY (Range=1-5, Higher score = greater support)				
Mean	4.12	4.13	4.10	3.91

* $p < .05$

S.D.	0.93	0.75	0.75	0.71
Range	2.60-8.08	2.73-7.33	2.08-6.31	1.75-4.83
Parenting Stress Index (PSI).²				
(Higher score = greater stress)				
TOTAL DISTRESS SCORE				
Mean	100.13	101.58	92.55	101.06
S.D.	18.19	20.53	18.78	21.97
Range	70-141	64-134	54.00-130.00	51-148
<i>Mean for a normal sample</i>	71.00			
<i>S.D. for a normal sample</i>	15.40			
<i>(Abidin, 1990)</i>				
PARENTAL DISTRESS SCORE				
Mean	28.35	32.68**	24.83	32.91**
S.D.	7.13	8.56	7.49	9.25
Range	17-44	17-57	13-45	13-54
<i>Mean for a normal sample</i>	26.40			
<i>S.D. for a normal sample</i>	7.20			
<i>(Abidin, 1990)</i>				
PARENT-CHILD DYSFUNCTIONAL INTERACTION SCORE				
Mean	33.36	32.66	32.55	33.56
S.D.	6.49	7.33	7.88	6.36
Range	20-47	19-46	18-49	19-49
<i>Mean for a normal sample</i>	18.70			
<i>S.D. for a normal sample</i>	4.80			
<i>(Abidin, 1990)</i>				
DIFFICULT CHILD SCORE				
Mean	38.63	37.55	36.37	36.13
S.D.	8.09	8.42	9.61	8.96
Range	24-57	24-55	18-56	14-56
<i>Mean for a normal sample</i>	26.00			
<i>S.D. for a normal sample</i>	6.70			
<i>(Abidin, 1990)</i>				
CHILDCARE RESOURCES (%)				
Knowledge of resource	39.02%	41.50%	45.00%	60.00%
Received help from a resource	39.02%	39.00%	37.50%	52.50%
PARENTING RESOURCES (%)				
Knowledge of resource	43.90%	57.50%	55.00%	48.60%
Received help from a resource	43.90%	51.20%	50.00%	30.00%

² The number used in the intervention group of the PSI 43 because two families received two mentors for both of their children.

** p < .01

MEDICAL RESOURCES (%)

Knowledge of resource	39.00%	37.50%	27.50%	32.50%
Received help from a resource	36.59%	29.30%	25.00%	27.50%

FOOD RESOURCES (%)

Knowledge of resource	36.60%	51.72%	32.50%	34.40%
Received help from a resource	36.60%	41.40%	20.00%	18.80%

Table 6- Relationship between Pre-post Parental Stimulation Ratings and Mean Months of mentoring

Posttest Parental stimulation rating	Baseline Parental Stimulation rating	Mean months of mentoring
High activity	High Activity	28.67
	Moderate Activity	31.00
	Passive Approach	10.00
	Total	25.40
Moderate Activity	High Activity	4.00
	Moderate Activity	19.45
	Passive approach	18.33
	Considerable deprivation	23.00
	Total	17.70
Passive approach	Moderate activity	3.00
	Passive approach	4.50
	Considerable deprivation	23.00
	Total	7.60
Total	High Activity	18.80
	Moderate activity	17.93
	Passive approach	14.33
	Considerate deprivation	22.50
	Total	17.30

Note: Correlation between Parental Stimulation ratings and length of match is statistically significant (p=.011)

Mentor Evaluation

Homefriends' participant's ratings on a post intervention evaluation form imply that they thought highly of their mentors and enjoyed excellent and good relationships with them.

MENTOR RATINGS BY CAREGIVERS (N=39)

Mentor Qualities	Ratings of Mentor	
	<u>Excellent or Good</u>	<u>Fair or Poor</u>
How would you rate:		
The availability of the mentor	81.60%	18.40%
The ability of mentor to aid Homefriends' child	82.10%	17.90%
Your relationship with the mentor	82.10%	17.90%
The level of respect with which the mentor treated you	100.00%	NR
The overall service the mentor provided to the family	82.10%	17.90%
The level of support the mentor provided	76.90%	23.10%
The amount of time the mentor spent with the family	82.10%	17.90%

All of the Homefriends' caregivers reported that the mentors treated them with respect. In all other categories, approximately four-fifths of the caregivers rated the mentors excellent or good suggesting that the mentors excelled in their ability to relate to the participants and to provide needed services.

When asked about the best thing the caregivers liked about their mentor-mentee relationship, one theme that stood out was that the mentors were supportive.

"I like this mentor best, because she is here for me and my daughter, (she) didn't turn away because of how my daughter acts."

"Mentor was always there when I needed someone to talk to."

"She listens to me and gives me good advice. She's like a second mother."

"She let me voice my opinion, she didn't put me down."

"(Mentor) Respects my opinion and gives me an honest opinion."

"Encourages me to stay on the right path, encourages the children with school."

"The fact that after my mentor talked to me, I was able to come around and make a positive change."

"She was always available to help out with the kids. Pretty much anything I needed, she provided."

Another theme was the mentors' help with the Homefriends' children's education.

"(Mentor) Take(s) time to help with homework, discipline and general interest."

"He (mentor) talked to child, helped him with his homework."

"The mentor helped the kids learn their telephone number, ABC's, numbers, letters and stuff."

"Both of my kids had problems getting homework done. So, when they told me that my mentor would come in and help me with the homework for the children. One is in first grade and the other is in fifth grade. The days she comes in, she helps my youngest, which gives me more time to help my oldest."

Some caregivers admired their mentors "nice personality" and the fact he/she "goes beyond need." There were also comments that the mentors would attend doctor visits, school meetings, family activities and aid with resources.

"Liked him better than those who tried to help child before. Call or converse about child. He would come to school meetings."

"She will come and assist in doctor's visits or whatever."

"He helped me with school and appointments with child."

"(Mentor) did a lot, went back and forth to the clinic with the kids...Went to the Salvation Army for clothing."

E. Discussion.

The findings of the Homefriends' Evaluation indicate that elderly individuals in the African American Community are an asset to young families at risk of child neglect or abuse. The families can benefit from the knowledge and experience of these individuals and they generally appreciate the support that the elderly citizens can offer. However, the support, experience and knowledge of the elderly population may not be enough, in and of itself, to overcome the myriad of problems and stress faced by these young parents.

Studies suggest that for families with multiple problems, multiple services are needed to overcome the many difficulties they face and stabilize their family life. One or two interventions are not enough to address the complex needs of individuals and families such as those in the Homefriends Program. At least one Homefriends' caregiver seemed to be aware of this. When asked why she stayed in the Homefriends Program, she replied:

"Actually, my goal is to get as many services as I possibly can from Childlink, SCAN, CATCH and other family programs. (I want to) make sure that someone goes with me to see a specialist, neurology, behavior and the whole nine yards"

Many of these families do not have relatives or friends to whom they can turn for help. This made the support of the mentors very meaningful and lasting.

"You can't trust your family, (moans of agreement throughout the group) but you can trust your mentor. Whatever you tell them, it is confidential unless you give them the right or sign a paper saying that they can tell someone else. But, you tell your family one thing and it goes around and around and the stories get changed and it is nothing but confusion. I have a jealous family. Because I was out in the street, nowhere else to go with my kids and they all had homes. Then when the DHS worker put me in Section 8, that's how we got a home. So, I, like I say, it's trust. Sometimes people say they can't trust a lot of people. It takes a long time for me to trust someone, but once you gain that trust, I don't think you ever lose it, especially if it is someone you rally like and care about."

Yet, as the mentors sought to bring structure and support to the mentors, they were met with resistance along with appreciation. The caregivers needed and wanted their support but did not always appreciate their consistency.

"I know we came to the program for the stability but they (the mentors) are so consistent and stable that it bothers you and sometimes you want to say 'can't you just ease up this one time?' but they just keep you going and going and going. You understand what I am saying? They're very consistent where it can be nerve wrecking"

The focus group leader asked this caregiver if she thought that the mentors should be more flexible. She responded:

"No, no. I am just saying that it's (consistency) a good thing, but it gets on your nerves at times."

F. Summary

The Homefriends program was based on a successful model in which adults 55 and older mentored families that have children with special needs. What is different about the original model is that the families involved are more organized and in less crisis than the Homefriends families. Homefriends families tended to have histories of unhealthy relationships, therefore, they were slow to trust and in some cases were resistant to the mentor's caring and interest. They also tended towards disorganization; for example, they would schedule a mentor to come at a specific time and date and not be there. They were struggling with issues of addiction and domestic violence, therefore they could be secretive with their mentors or consciously keep the mentors away so they would not find out. In addition, most of the Homefriends families were on welfare. During the period of the program, they were forced to attend training and find work, a major undertaking for many of them. As a result of these complicated issues, matching and maintaining matches were particularly challenging and labor intensive. We learned that the existing structure of the program was not necessarily the most efficient, and we also questioned whether this type of intervention was best suited to such multi-problem families. Based on our experience with the original model, it may be that this intervention is most appropriate for higher functioning families that possess certain risk factors and need support in order to not spiral into a crisis.

On the other hand, based on the fact that four children in the control group were placed in foster care and no children in the intervention group, this program did save the system money. If the cost of placing a child in foster care for a year is estimated at \$40,000/year, then this program saved the foster care system at least \$120,000. Considering that there were also other positive outcomes from the research, it may be determined that this program was cost-effective.

Another issue affecting this model relates to the use of older adults as mentors. A byproduct of utilizing adults 55 and older is that they are more highly at risk of health problems due to the ravages of aging. Several of our volunteers were over the age of 70. There were many cases in which either the mentor's health or that of his/her spouse prevented him/her from visiting or continuing to visit a family. This is an unavoidable reality. On the other hand, because most of our mentors were retired, the issue of work or raising a family did not impinge upon their ability to either commit to or consistently visit a family. Their life experience and their availability and flexibility made them an invaluable resource to vulnerable families. Any future programs that plan to make use of older adults as volunteers simply need to take into account that health can be an issue that can at times affect consistency or longevity of commitment. In general, we believe that our mentors were exceptionally committed and consistent.

G. Recommendations

If the federal government decides to replicate a similar model, we recommend one of two possible staffing changes: either that the staff person who is responsible for supervising the mentors be housed in the same agency that provides direct service to families or that the person

in the role of the Family/Mentor Coordinator work full-time. The mentors (and their supervisor) need direct access to the people who are working with the families. If the Program Coordinator worked at the child welfare agency, this would have occurred, or if the Family Mentor Coordinator worked full-time, they would have been more accessible to the Program Coordinator and better able to track down the family caseworkers. It would be ideal if mentors could sit in on team meetings where their families' issues are being discussed. However, this was not feasible in this study due to confidentiality issues.

Notwithstanding the latter point, we feel strongly that the interagency collaboration was invaluable to the success of this project. The quality of staff at CIL, their experience in directing mentoring programs, the fact that they are not in the child welfare system and therefore not crisis oriented, had much to do with the success of this program.

We believe that this model would not have worked with such multi-problem families if the families were not receiving a range of other supports. SCAN, Inc., the agency serving families through this project, was offering families resource referral, parent education, financial assistance, psychological services, and childcare support. If these services were not in place, the mentors would have felt lost at sea. In several cases where the families were discontinued from SCAN's caseload but the mentoring continued, the mentors felt overwhelmed and in a few cases burned-out.

Since we were committed to exploring the specific value of utilizing adults 55 and over to support families, we did not actively recruit younger volunteers. We would recommend that an intervention be studied in which an intergenerational corps, of volunteers from the ages of 25-85, be tried in the future.

The last challenge has to do with the fact that this program was an experimental study. Many willing and cooperative families that requested and wanted a mentor were placed in the control group and therefore were ineligible. In addition, some of the families placed in the intervention group lost interest in receiving a mentor. In spite of this, program staff expended unusual effort trying to sustain the matches. Without the constraint of a control group study, the Homefriends service would have reached a much larger number of families and achieved greater outcomes.

Bibliography

- Abidin, Richard R., Parenting Stress Index, Short Form, University of Virginia. 1990.
- Benedict, M., White, R., Wulff, L., and Hall, B. (1990). Reported maltreatment in children with multiple disabilities. Child Abuse and Neglect, 14, 207-217.
- Coohey, C. (1995). Neglectful mothers, their mothers, and partners: The significance of mutual aid. Child Abuse and Neglect, 19(8): 885-895.
- Dore, M.M., and Harnett, J.M. (1995). The role of the volunteer in family-preservation services. Families in Society: The Journal of Contemporary Human Services, 49, 67-75.
- Flaherty, Joseph A., Garviria, M., & Pathak, D.S. (1983) The measurement of social support: The Socials Support Network Inventory. Comprehensive Psychiatry, 24, pp. 521-529.
- Jones, D. (1995). Risky situations: Vulnerable children. Working with families who have children, ages birth to five, who are at risk of maltreatment with a focus on disabilities. (ERIC Publication No. ED384196 pp. 1-28). Minneapolis, MN : PACER Center Inc.
- Leventhal, J.M. (2001). The prevention of child abuse and neglect: Successfully out of the blocks. Child Abuse and Neglect, 25(4), 431-439.
- Lines, D.R. (1987). The effectiveness of parent aides in the tertiary prevention of child abuse in South Australia. Child Abuse & Neglect, 11, 507-512.
- Magura, S. and Moses, B.S. (1986). Outcome Measures for Child Welfare Services. Washington, D.C.: Child Welfare League of America.
- Miller, J.L., and Whittaker, J.K. (1988). Social services and social support: Blended programs for families at risk of child maltreatment. Child Welfare, 67, 161-174.
- Olds, D.L., Eckenrode, J., Henderson, C.R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L.M. & Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen year follow-up of a randomized trial. Journal of the American Medical Association, 278(8), 637-643.
- Rhodes, J.E., Ebert, L., and Fischer, K. (1992). Natural mentors: An overlooked resource in the social networks of young, African-American mothers. American Journal of Community Psychology, 20(4), 445-459.
- Staples, R., (1993). Black families at the crossroads: Challenges and prospects. San Francisco: Jossey-Bass Inc.
- Sullivan, P.M. and Knutson, J.F. (1998). The association between child maltreatment and disabilities in a hospital-based epidemiological study. Child Abuse and Neglect, 22(4), 271-288.

Sullivan, P.M. and Knutson, J.F. (2000). Maltreatment and disabilities: a population-based epidemiological study. Child Abuse and Neglect, 24(10), 1257-1273.

Telleen, S., Herzog, A., and Kilbane, T.L. (1989). Impact of a family support program on mothers' social support and parenting stress. American Journal of Orthopsychiatry, 59, 410-419.