Culturally-Specific Strategies for Improving “Evidence-Based” Early Childhood Home Visiting for Foreign-Born Families

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“Every person is like all other people, some other people and no other person”

Kluckhorn&Murray, 1948

Section 1: Introduction

Why are early childhood experiences a public health concern?

Early childhood, spanning roughly from conception to age 5, is a period of foundational growth and development, which ‘sets the stage’ for health and wellness across the lifespan. Our understanding of this unique phase of life is rapidly maturing and is re-shaping public health policy and practice. Early childhood is an extremely opportune time to invest in core public health efforts, described as "preventing disease, prolonging life and promoting health", (Winslow, 1920). The goal of many early childhood public health efforts and policies is primary prevention, in which, although adverse conditions may exist, factors that negatively impact health have not yet played out.

Early childhood has long been recognized as a key period for brain development. Even as the vast complexity of the brain and the neurological system remains largely unknown, scientific discoveries have opened the door to critical knowledge of how both individual experiences and family environments shape infant brain development. Neurobiologists have demonstrated how high stress experiences and family environments, during infancy, can alter foundational brain architecture. The hormone, cortisol, concentrates in the blood as stress levels rise, and is now thought to play a role in triggering genetic switches that re-map how infant brains develop. High cortisol levels, a response to neglect, harsh handling, or abusive interactions with caregivers, can trigger adaptive brain architecture, built to sustain hyper-vigilance and reactivity- a persistent ‘fight or flight’ response. These children can develop
erratic and sometimes aggressive behavior or become emotionally and socially withdrawn. Due to their physical and emotional dysregulation, they are at risk for harsh discipline and rejection at home, in school and in community settings from a very early age. Once they are school age, these children may experience disproportionately high rates of social rejection, suspensions, expulsions, school dropouts, substance abuse, and criminality/institutionalization. This path from harmful early childhood experiences to poor individual and community-level health outcomes is accompanied by enormous impacts on society.

The traditional frame for understanding child development has focused on the “nature vs. nurture” balance. In this frame a child is born with potential, based on genetic inheritance, which is only fully realized by nurturing reinforcement. We are now aware of how the behavior of genes themselves shapes development and overall health. Epigenetics is the study of gene expression—that is, the variable behavior of genes and their influences on living organisms. Epigeneticists have discovered some of the ways early childhood stress triggers not only adaptations in brain development, but genetic ‘switches’ in cells throughout the body, causing physiologic changes that alter blood pressure, heart rate, mood, and metabolism across the lifespan. Not only does early experience affect a child’s ability to regulate sleep and hunger, it also seems to predispose the child to diabetes in adulthood. Longitudinal studies have borne out the long-term implications of childhood stress, including a shortened life-expectancy.

The longitudinal Adverse Childhood Events (ACE) Study reveals how risks related to health, and socioeconomic well-being are associated with stressful childhood events and environments. This research project of the Centers for Disease Control and Prevention and Kaiser Permanente recruited over 17,000 volunteers (Kaiser patients) between 1995-1997. Participants provided detailed personal histories from childhood. They completed surveys and routine health
screenings, which continue to be analyzed, and have produced over 100 scientific papers to date. Adverse Childhood Experiences scores, commonly referred to as ACEs, are arrived at through a basic yes/no count of events in childhood (Figure 1) such as being struck, sexually assaulted, or left alone (Feletti, V. et al, 1998). Each “yes” scores as 1 “ACE” in the total score. ACES have been shown to be reliably associated with not only lifetime risk of chronic diseases, but also early death (Felletti, V. et al, 1998).

**Figure 1: ACES Questions**

**Finding Your ACE Score While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured?

3. Did an adult or person at least 5 years older than you ever...Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

4. Did you often or very often feel that...No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other?

5. Did you often or very often feel that...You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Did a household member go to prison?
The “ACE Pyramid” (Figure 2) represents the conceptual framework for the understanding of the way these childhood experiences underpin child development, health behavior, social conditions, the development of disease and a shortened lifespan. This framework was the basis of the original “Adverse Childhood Experiences Study” (ACES) conducted between 1995-1997 (Felitti et al, 1998). The “ACE Pyramid” demonstrates the hypothetical connection between individuals who experience adverse events in childhood, and an accelerated progression toward an “early death”. Since 1997, medical and social research have continued to seek answers explaining the relationship of early experiences to events across the lifespan. In the

**Figure 2: The ACE Pyramid**

Adverse Childhood Experiences: Impacts Throughout the Lifespan


2013 CDC report, “Adverse Childhood Experiences: Looking at How ACES Affect Our Lives and Society” found that individuals with 6 or more adverse childhood events listed in Figure 1 have expected lifespans that are 20 years
shorter than those with an ACE score of zero. The original ACE Study also hypothesized and confirmed that individuals with high ACES would be more likely to engage in substance use, and experience unemployment, homelessness, arrests and incarceration. Such lifestyle risks and socioeconomic experiences are seen as part of the progression to “early death” in this model. Individuals with elevated ACEs, but without subsequent health behavioral risks and social conditions have also been shown to also be at risk for a shortened lifespan. This framework notes “scientific gaps” in how ACEs result in “social emotional and cognitive impairment” and subsequently predispose individuals to “health risk behaviors”. Science has addressed these gaps in the past 15 years, as discussed here. These gaps might be better labeled today as “science-policy gaps”. We now understand how emotional development is built into the architecture of young children’s brains, wired to the central nervous system, and how physical health across the lifespan to be impacted by early experience. We are still trying to identify effective policy strategies that prevent ACEs and promote a trajectory of health. We are still asking how public administrators can use what we know about ACEs to reduce the suffering, loss of life quality and morbidity, as well as the societal costs associated with adverse childhood experiences.

ACES data has been used to calculate the lifetime financial costs (Fang, Brown, Florence, Mercy, 2012, p. 156). While child welfare and criminal justice system costs might be more directly associated with the occurrence of child abuse, these alone do not generate the most significant impacts on our economy. The full economic burden to the US economy, also includes associated health care costs and lost productivity due to school failure, unemployment and incarceration. These lifetime costs were estimated in 2011 to cost the US economy as much as $585 billion dollars (Fang, Brown, Florence, Mercy, 2012, p. 156). This finding led the Centers
for Disease Control, (CDC), to conclude in 2012 that “compared with other health problems, the burden of child maltreatment is substantial”.

It is important to consider why, despite the apparent linearity of the ACE conceptual model, not all individuals with a history of ACEs progress to the most serious outcomes, although they are at risk. Early childhood public health prevention efforts seek to both reduce the occurrence and the impacts of ACES, and to discover the resiliency factors that might improve individuals’ health trajectory. Promising areas of exploration include understanding how to mitigate high parenting stress related to parents’ ACES; discovering how to create optimal conditions for infant attachment in high stress families, and identifying and supporting parent and child resiliency factors associated with positive child outcomes.

Just as we are coming to understand the challenging neurobiological effects of adversity, or stress, we are also gaining useful information about the supportive neurobiology formed through more nurturing conditions such as parent-child attachment. For example, early interactions between infants and caregivers have been found to activate the abundant “mirror neurons” that are present in infants’ brains. These highly specialized cells ‘wire’ infant brains for interaction with the adults who care for them. This has been demonstrated in observations of calm face-to-face activities between infants and familiar caregivers, in which elevations in oxytocin and vasopressin are observed in both infant and in caregivers. Oxytocin can produce pleasant feelings of joy and calm. Vasopressin lowers blood pressure and reduces feelings of irritability. These primitive neurological responses relax the parent and the child. Parents who engage in regular, calm, face-to-face engagement with their infant not only feel less stressed and
more confident, their infants grow to be more developmentally on-track in cognitive development and self-regulation.

Parents with high ACE scores can face extreme challenges calming themselves and their infants, and in feeling competent and supported. When these parents also bear the substantial burdens of poverty, historical and current racial discrimination and other forms of bias, or added layers of responsibility such as a family members’ illness or disability, these challenges are multiplied. What is it that allows parents with these overwhelming challenges to succeed despite them? Specific “protective factors” have been shown to mitigate the effects of ACEs on parenting behavior. These are the primary focus of ECHV interventions. Promotion of (1) parental resilience, (2) social connections, (3) knowledge of parenting and child development, (4) concrete support in times of need, (5) and early support for child social and emotional competence, have been found to help parents navigate adversity, (Center for Study of Social Policy, 2014). These findings are also reflected in well-established public health promotion approaches that require the empowerment of individuals and communities-through social support, access to needed information and resources, and influence over outcomes.

The ACE Study traces a path from adversity to ill health and from childhood stress to adult struggles with social functioning and parenting. Modern science has helped us to begin understanding the physical, physiological and genetic influences of infants’ social-emotional environments. These research findings have moved parental stress and infant attachment to the forefront of public health and education policy and practice. Early childhood parenting support is now viewed as one of the best long-term investments in community health these systems can make.
What is Early Childhood Home Visiting (ECHV)?

Early childhood home visiting (ECHV), as it’s name suggests, occurs within the intimate space where most early parent-child interactions occur—the family home. Science tells us that the relationships children have with their caregivers play critical roles in regulating stress hormone levels during early childhood. The primary goal of ECHV programs is to improve parent-child relationships, and support infant attachment as the foundation of lifelong health and development. Early childhood home visiting is an approach to mitigating parental risks and promoting resiliency through a combination of supports, resources and interventions, that can be individualized, yet retain core components linked with demonstrated or expected outcomes. Some ECHV programs prioritize serving families with specific parenting risks evidenced by involvement in the child welfare system, family violence or depression.

Evidence-based ECHV models, such as the Nurse Family Partnership (NFP); Early Head Start (EHS); Parents As Teachers (PAT); and Healthy Families America (HFA) are prevention-focused. They have been the subject of numerous large, case controlled studies, and meta-analyses, such as the 2012 PEW meta-analysis of ECHV programs and the 2013 federal Home Visiting Evidence of Effectiveness (HomVee) study (James Bell Assoc., 2012; Home Visiting Research Network, 2013). These studies have validated specific ECHV program models and service components. The HomVee, specifically identified “evidence-based” ECHV programs which significantly reduce or mitigate parental risk factors and strengthen parenting behaviors and the trajectory of child development. These program models receive priority for federal funding through the Affordable Care Act, and most other public funding streams. The President’s 2015 budget proposes to expand the availability of “evidence-based” ECHV programs by providing a substantial new investment of $15 billion through FY 2023.
E. Carroll: Improving “Evidence-Based” ECHV

In Multnomah County, over $5 million in local public funding annually is invested annually in programs providing ECHV.

Are ECHV programs “evidence-based” with foreign-born families?

Immigrant and refugee families and families with diverse cultural backgrounds have unique strengths, but they also face unique challenges and have unique service needs. Many foreign-born parents have experienced significant adverse childhood experiences that are not referenced by the ACE study, such as loss of homeland, terror, torture, multiple displacements, prolonged hunger or starvation, and violence committed by governments or soldiers. In addition, immigrants and refugees are often subject to new societal conditions, stressors and daunting barriers including cultural and language isolation and discrimination that contribute to health and socioeconomic disparities. The protective factors that allowed these families to reach the US are often difficult to recreate and may be significantly different that those needed to resettle in the US.

As Multnomah County Health Department faced a series of funding decisions related to culturally-specific investments in ECHV in 2013, it became clear that research into the unique cultures and early experiences of children of foreign-born US parents is limited. Cultural differences in service needs and outcomes have not been adequately examined through the Healthy Families Oregon (HFO) statewide evaluation and MIECHV Needs Assessments. Early childhood literature does not address concrete questions such as: How does ECHV program model ‘X’ benefit cultural group ‘Y’? Even the most widely referenced program evaluations describing “evidence-based best practices” in ECHV programs, such as the federally-funded HomVee study, have not produced data specific to successes (or failures) attaining intended outcomes with culturally specific populations. Although ECHV programs have been developed to
reduce important disparities, imprecise demographics used in evaluation and research prevent a thorough understanding of their success in this regard, (Hepburn, K.S., 2004, p. 11). Public health data, commonly includes broad racial categories, and a few languages, rarely including cultural sub-groups or country of origin/foreign-born status, thereby failing to elucidate these communities’ needs for intervention services. Oregon is beginning to address these data and research gaps in the legislative process through a bill that will require expanded demographic data to be collected by the Oregon Health Authority and Oregon Health and Human Services agencies (HB2134). Development of new policies and infrastructure for data collection across systems, along with appropriate reporting and research protocols, however, are likely many years away.

It is surprising that these persistent data and research gaps have not received more attention, given that families headed by foreign-born parents accounted for over 75% of the growth in the US child population in the last decade (Fortuny, K., 2010, p. 1). In 2012, over 4.5 million US children aged 0-8, had foreign-born parents (Park, M. & McHugh, M., p 11). While data is sparse and measurements inconsistent, there is agreement among data sources that at no time in history has the US been home to a more ethnically and linguistically diverse adult or child population. Along with this diversity comes unique challenges. A 2008 study of low-income working families, revealed English language learners (ELLs) accounted for 59% of all “poor” and “low income” families nationally (Fortuny, 2008, p 1). In 2012, The Migration Policy Institute conducted a national, state-by-state study of the conditions of families headed by foreign-born parents. The table below (Figure 3) shows a clear relationship between parents’ foreign-born status and low income, low education and language barriers. They found that 18% of Oregon parents of children 0-8 years old were foreign-born, with 95% having limited English proficiency, 53% with low income, and 45% with low educational attainment, (Figure 3).
Figure 3:
US and Oregon Parents with Young Children (age 0-8)
2012 Income, Education and English Proficiency Comparisons


<table>
<thead>
<tr>
<th></th>
<th>All US Parents</th>
<th>Foreign-Born US Parents</th>
<th>Foreign-Born US Parents in Category</th>
<th>Foreign-Born Oregon Parents</th>
<th>Foreign-Born Oregon Parents in Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Parents</td>
<td>22,258,200</td>
<td>4,584,600</td>
<td>21%</td>
<td>49,000</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Low Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7,769,700</td>
<td>2,067,400</td>
<td></td>
<td>26,300</td>
<td></td>
</tr>
<tr>
<td>Share of Total</td>
<td>35%</td>
<td>45%</td>
<td>27%</td>
<td>53%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Low Educated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,388,800</td>
<td>1,070,500</td>
<td></td>
<td>12,800</td>
<td></td>
</tr>
<tr>
<td>Share of Total</td>
<td>11%</td>
<td>23%</td>
<td>45%</td>
<td>26%</td>
<td>45%</td>
</tr>
<tr>
<td><strong>Limited English Proficient (LEP)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,394,600</td>
<td>2,146,200</td>
<td></td>
<td>24,200</td>
<td></td>
</tr>
<tr>
<td>Share (%)</td>
<td>11%</td>
<td>47%</td>
<td>90%</td>
<td>49%</td>
<td>95%</td>
</tr>
</tbody>
</table>

The diversity of this generation of Americans will surely come to be recognized as its greatest asset. But at the moment children of color and those with foreign-born parents in Multnomah County are too often on un-equal footing with their white, US born peers in school success, health outcomes and child welfare involvement. MCHD is committed to a process for understanding how to best deploy ECHV and other resources in a manner that addresses
known risk factors and inequities using both “evidence-based” and culturally-specific approaches informed by literature, experience and community inputs.

This Capstone provides the research needed to begin considering how “evidence-based” ECHV programs can be designed to better meet the specific needs of immigrant and refugee families. In section 2 the research question will be more clearly defined. The methodology and findings of a targeted literature review and community-based research will also be described. Section 3 will present conclusions, recommendations, next steps and leadership lessons-learned for developing the approaches needed to assure immigrant and refugee parents in Multnomah County have access to effective supports to ensure optimal and equitable outcomes for their young children.
Section 2: Research Question, Methodology and Findings

Background

In 2013 a question surfaced regarding whether Multnomah County Health Department, (MCHD) should continue to utilize its well-established Healthy Families America (HFA) program as a primary ECHV approach to serving immigrant and refugee families. This was the result of significant changes to this ECHV model over time. In 2001, Multnomah County first received State funds to develop the infrastructure for a “Healthy Start” ECHV program. Healthy Start funds enhanced community-based screening and funded 3 new contracts to community based organizations (CBOs) with capacity to serve 600 families per year with ECHV, 125 of these service slots were dedicated for immigrant or refugee families. The Healthy Start model was seen as a good fit for diverse communities, because its required components could be flexibly delivered by the CBOs, based on their service population’s needs. This changed significantly in 2007 when the state program joined the national Healthy Families America (HFA) Network and adopted the rigorously standardized national HFA home visiting model. For the past 7 years MCHD and the CBOs have continuously re-shaped the program to “evidence-based” standards and policies for screening, eligibility, program focus and content, performance standards, data collection, and governance.

The reasons for joining the national HFA Network were originally described as two-fold: to improve program outcomes by incorporating “evidence-based best practices” across all sites in Oregon; and to position the program to compete more successfully for funding with other “evidence-based” models such as the Nurse Family Partnership program and Early Head Start. Despite the tremendous work required for accreditation, the promise of better outcomes, better
Evidence of outcomes and increased program funding gained strong support from community leaders ten years ago has been worth the effort. An HFA re-accreditation in 2012 confirmed a high level of quality and consistency across the statewide program and locally. Membership in the national HFA network subsequently helped Healthy Families Oregon to receive significant federal MIECHV investments.

In late 2013, as Multnomah County prepared to issue a new Healthy Families RFP, as required by county policy, program administrators took the opportunity to explore more strategic distribution of all ECHV programs to address the continuing social and health inequities experienced by families in Multnomah County. Administrators asked the following question: Does the Healthy Families program still fit the needs of immigrant and refugee families? Is there enough commonality in the shared immigrant and refugee experience to make this sub-group approach relevant, or are even more culturally specific approaches needed? Has tight standardization of the HFA model turned it into a program that is too rigid to be culturally adapted to immigrant and refugee families? If so, for whom is it too rigid and specifically how? Additionally, if it is found that Healthy Families is not the right program, administrators sought recommendations for a new approach. This Capstone project was created to address these questions.

**Research Question:**

The questions posed by administrators of the ECHV programs in 2013 provide the basis for the research question at the center of this capstone paper. This paper seeks to answer the following: **Is the “evidence-based” Healthy Families America, (HFA),**
program an effective ECHV program for achieving optimal and equitable early childhood outcomes for immigrant and refugee families?

The research conducted to answer the Capstone question is organized into the following three sections: a literature review describing “evidence based” ECHV, a review of culturally-specific literature pertaining to family services and local community-based research utilizing a telephone survey, focus groups and stakeholder interviews.

**Literature Review: The Rationale for “Evidence-Based” Early Childhood Home Visiting**

What are “evidence-based” early childhood home visiting (ECHV) programs intended to do?

Home visiting is an approach to delivering early childhood services to families and to children. The components of this approach differ by program and are shaped by various strategies believed to enhance effective outcomes (Kahn, J. & Moore, K., 2010). Alvarado and Kumpfer describe the goals of these strategies as improving the ratio of risk factors to protective factors, by, for example, improving relationships, discipline and supervision of children, (Alvarado, R. & Kumpfer, K., 2000, p. 1). “Evidence-based” is an important designation given to ECHV program models, indicating there is scientific evidence of their effectiveness in one or more outcomes that have been identified as important to maternal or child health, welfare or educational progress. These outcomes typically include: reduction in reported child abuse incidence; increases child pre-literacy skills and decreases in the incidence of low birth weight. In 2009, the Office of Planning, Research, and Evaluation at the U.S. Administration for Children and Families, (Dept. of Health and Human Services) contracted with Mathmatica Policy Research
to embark on a national review of ECHV program models and determine which had “evidence of effectiveness”. The completed review, Home Visiting Evidence of Effectiveness (2013), was used to allocate nearly all of the $1.5 billion federal funds allocated by the Patient Protection and Affordable Care Act (ACA) Maternal, Infant, Early Childhood Home Visiting (MIECHV) program, (P.L. 111-148). In the 2014, the Department of Health and Human Services (DHHS) advised Congress to increase these investments in ECHV tenfold, to $15 billion. Their recommendation stated that the further expansion of “evidence-based”, early childhood home visiting services would, “ensure that our most vulnerable Americans are on track from birth, and that later educational investments [will] rest upon a strong foundation”(P.L. 111-148).

The influence of US mainstream values, such as the ‘American melting pot’ ideal, seems to have allowed ECHV developers to work under the assumption that once a program has been shown to be “evidence-based”, it can broadly claim to benefit recipients. Karol Kumpfer and her colleagues were among the first group of researchers to identify a problem with “generic” ECHV content, developed with only “white, middle class values” in mind, (Kumpfer, K. et al, 2002, p. 241). They postulated that this generic assumption was reinforced by the commercial intent of program developers to make their products widely marketable. It may make less ‘business sense’ to produce language/culturally-specific ECHV programs, as these would be unlikely to receive the “evidence-based” label needed to assure high sales volume. Curry-Stevens (2011) also points out that since government dollars also “follow numbers”, and census and other government data obscures true counts of immigrant communities and communities of color, these groups receive inequitable access to government-funded resources, which would include ECHV (p.183). The motivation to produce “evidence-based” products, together with undercounting immigrant communities, can thereby “misrepresent and negate the experiences and very identity of [these]
E. Carroll: Improving “Evidence-Based” ECHV

communities of color” by not only underfunding their needs, but applying mainstream interventions with unknown outcomes (Curry-Stevens, et al, 2011, p. 183).

Over the past few years, early childhood research and reports on ECHV have acknowledged the possibility that the fastest growing child population in the US, those with foreign-born parents, might require something different to achieve an optimal and equitable start. However, to date no “evidence-based” ECHV program models have been developed as alternative options. A newly-released report, by the Migration Policy Institute’s National Center on Immigrant Integration Policy argues that this failure constitutes “a violation of federal civil-rights provisions” (Park, M., & McHugh, M., 2014, p. 3). A national, legislatively-mandated, ECHV research project, “The Mother and Infant Home Visiting Program Evaluation” (MIHOPE), will evaluate ECHV programs funded by MIECHV (Michalopoulos, C, et al, 2015). It promises to address the “insufficient evidence of effectiveness in subgroups”, through large, multi-site, case-controlled participant samples. The newly enrolled study population is 35% Hispanic, 31% non-Hispanic Black and 34% non-Hispanic White. As promising as this research may be, language and cultural barriers to foreign-born parents may not be fully addressed. These barriers include study materials, such as consent forms and surveys supplied only in English and Spanish, program participants’ fear of government-sponsored research, and research questions that do not reflect culturally-specific concepts. In short, it is still very unclear how valuable this unprecedented study will actually be in addressing the Capstone question.

What can we learn from “evidence-based” ECHV research about serving foreign-born families?

Immigrant and refugee families share many known risks with their US-born counterpart
families to whom ECHV services are directed, including poverty, low educational attainment and high stress. The fact that parents with the highest number of risk factors for poor health, child welfare and education outcomes have been found to benefit the most from home visiting interventions suggest that immigrant and refugee families will benefit from these ECHV services. (Paris, R. & Bronson, M., 2006, p. 39; Alvarado, R. & Kumpfer, K., 2000).

Paris and Bronson (2006) found that immigrants, in particular, have been shown to benefit from ECHV participation (p.39). Gringer and Smith (2006) found this was especially true if the parents are low-acculturated, non-English speaking, and older (Gringer & Smith 2006). More recently, James Bell Associates (2012) performed a powerful meta-analysis to examine if specific improvements in parenting behaviors, child safety and maltreatment outcomes could be linked to specific ECHV components and service delivery strategies. Particularly effective components and strategies identified included reinforcing parent responsiveness to infant cues and educating parents about social-emotional, physical and language development, including how to create a stimulating home environment. Understanding developmental norms and expectations and non-violent discipline and behavior management were also effective. Programs modeling parental stress management, home management, and problem solving; as well as those linking families to public assistance, concrete supports and alternate caregivers, were found to be more effective in promoting intended outcomes. Of particular relevance to this Capstone project was the finding that providing home visits in a language other than English was found to enhance the effectiveness of ECHV components, as did matching Home Visitors with families by race/ethnicity. Supporting families’ social networks was also a successful strategy.

In summary, “evidence-based” research suggests that ECHV programs are a good fit for immigrant and refugee families, although research that examines outcomes of these programs
have not produced an approach to determining the culturally specific ‘fit’ of particular programs. Foreign-born parents experience the risks generally targeted by ECHV programs. Further, delivery of ECHV programs to foreign-born parents in particular has been found to be a particularly effective strategy. The finding that “relationship style” is critical to ECHV engagement also supports the desirability of cultural specificity in evidence-based ECHV service delivery. There is a lack of research that focuses specifically on the best way to deliver “evidence-based” ECHV programs to foreign-born families and how they can and should be adapted.

**Literature Review:** How should ECHV programs be adapted for foreign-born families?

Immigrant and refugee participants are excluded from many types of research due to study materials being only available in English, and more often English and Spanish only (Falicov, p. 219). This is no less true in ECHV “evidence-based” research. As noted above, this has resulted in an absence of information that would enable us to understand how ECHV content and delivery may benefit, or even harm, immigrant and refugee families.

For the purposes of my literature review, the following research questions were explored.

- Is there value in serving diverse, foreign-born families a “cultural” group, or are their experiences too dissimilar?
- **What makes** foreign-born families a unique ECHV service population?
- What conditions contribute to the “paradox of assimilation”, whereby foreign-born families experience *worsening* health outcomes over time in the US?

These questions were gleaned from conversations with professional colleagues, as this Capstone began to take shape. They seemed important to address because professionals in the
field, including local system partners, are asking them; and because they underlie the basic rationale for *immigrant and refugee* culturally specific services.

Another set of research questions was suggested by my initial literature findings. These included the following:

- What is “acculturative stress”?
- What conditions exacerbate acculturative stress? Are immigrant and refugee cultures and languages *barriers* to acculturation or “protective factors”?
- What is the relationship between acculturation and child development?

Finally, I asked the following series of questions specific to program development:

- How do we achieve cultural responsiveness in ECHV programs?
- What does cultural adaptation of “evidence-based” interventions look like?

Taken together my literature review, these questions helped me identify many of the gaps found in “evidence-based” literature, regarding how and why to make ECHV more culturally-specific.

**Are immigrants and refugees a “cultural” group?**

Castro notes that culture is not synonymous with ethnicity and makes the case for viewing immigrant and refugee families as a distinct cultural group. He uses the term “population segmentation” to describe cultural adaptations made for ethnic or non-ethnic sub-groups within the larger target population, based on *shared experience*. Other examples of non-ethnic sub-groups include teen parents, mothers with autistic children or incarcerated youth. For the purpose of developing interventions, “population segmentation” identifies the “hidden subpopulations”
most in need of service adaptations (Castro, 2010, p 217). This approach stresses consideration of the person’s ecological context, which can inform an intervention well beyond knowledge of that person’s ethnicity alone. Low-acculturated, non-English speaking, and older parents living in poverty, for example, have been shown to benefit more than others receiving interventions with specific supportive elements across cultures (Gringer & Smith 2006). This finding is also reflected in evidence-based and community-based research as well (Castro, 2010, p 228). This “segmentation” approach hinges on the development of clear standards and protocols for flexible customization of program elements that are culturally responsive to each participant.

**What makes foreign-born families a unique ECHV service population?**

The “paradox of assimilation” describes the surprising fact that first generation and less acculturated second generation immigrants, living in poverty and other stressful conditions, often have better birth outcomes than US mothers living in poverty. Evidence suggests this is not apparent in refugee populations (Johnson-Agbakwu, C. et al, 2014, p. 6). Upon arrival in the US, many immigrants exhibit better health than the US-born population. This “healthy immigrant effect” may reflect the good physical and mental health required to pass through immigration filters. This positive “effect” dissipates with increased time and acculturation in the US (Dow, 2011, p. 224). Subsequent generations also tend to experience declines in measurable health outcomes (Perriera, K. & and Ornelas, I, 2011, p. 195). Over time, the health of foreign-born families tends to worsen to match that of the US population. Meta-analyses confirm that mental health also tends to worsen once immigrants and refugees are permanently resettled (Kimayer, L. et al. 2011).

“The acculturative stress” describes the individual impacts of adapting to a new cultural context and set of life circumstances, typically without familiar supports. Acculturation is often
complicated by trauma and the multiple losses inherent in the immigrant and refugee experience before, during and after relocation. Acculturative stress is correlated to depression (Dow, 2011, p.221). Meta-analyses confirm that refugees are at substantially higher risk than the general population for a variety of specific psychiatric disorders, once they are permanently resettled, (Kimayer, L. et al. 2011).

As discussed earlier, children’s cognitive and behavioral development are profoundly affected by parental stress and this is particularly acute when their family’s and their own position within society feels unstable and unsafe (Bateman, W. et al. 2009, p. 452; Perriera, K. & and Ornelas, I, 2011, p. 197). The data below (Figure 4) from the 2014 Casey Race for Results report, demonstrates how parents’ immigrant status is reflected in 4th grade reading scores (http://www.aecf.org, p.11). Reading scores reflect not only exposure to language and books, but social-emotional development as well, which is sensitive to parental stress levels. Within the US-born parents categories, racial disparities are evident in this data, with African Americans meeting 4th grade reading proficiency at a rate of 18% compared with 46% for white children. Latino children met the standard at 25%. When parental immigrant status is added to race, however, 4th grade reading proficiency across racial groups were found to be 2.5-8 times lower. Although Asian children, as an aggregated racial group, achieved the highest reading proficiency rates in both the immigrant and US-born parents groupings, the reduction from 59% for Asian children of US-born parents meeting the standard, to just 15% for those with immigrant parents is dramatic. Even the highest 4th grade reading proficiency rate for children of immigrant parents is lower than all groups with US-born parents. While this data does not identify a cause for these disparities, outcomes are clearly tied to the experience of race and immigrant status of parents, and require a
culturally-informed response that is sensitive to the unique barriers and burdens faced by families of color and immigrant families.

**Figure 4: US Children Meeting 4th Grade Reading Proficiency (2012)**

<table>
<thead>
<tr>
<th>Race</th>
<th>Parents US-Born</th>
<th>Immigrant Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>18%</td>
<td>7%</td>
</tr>
<tr>
<td>Latino</td>
<td>25%</td>
<td>3%</td>
</tr>
<tr>
<td>White</td>
<td>46%</td>
<td>11%</td>
</tr>
<tr>
<td>Asian</td>
<td>59%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Annie E. Casey Foundation (2014)

While ECHV program approaches focus on direct interventions with families and their intersection with resources, literature describing the immigrant and refugee experience points to the need for a much greater focus on the larger context of how systems impact family well-being. Ann Curry-Stevens, working with the Coalition of Communities of Color in Multnomah County, Oregon, produced a series of reports detailing the many struggles faced by recent immigrant and refugee families facing systemic racism, anti-immigrant attitudes, policies and practices that reinforce isolation and unemployment and poverty (2012, 2013, 2014). Differential treatment in housing, health, employment, education and legal systems compound parents’ struggle to support children in reaching critical early benchmarks for success. In 2011 Hernandez also found that across all racial groups, foreign-born parents experience greater rates of poverty than US-born families (p. 107). In a survey of public health literature Dow (2011) found that symptoms of stress and depression are “more likely to be situational, affiliated with post-immigration factors such as discrimination, unemployment and daily hassles” (p. 224). Stress and depression can
lead to disconnection from social networks and can lead parents to feel “alienated and unwelcome” in early childhood settings (Park, M & McHugh, M. 2014, p. 23). Further, legal issues surrounding immigration are uniquely powerful stressors; because they can carry the persistent threat of further family separation and loss. Depression and other parent mental health challenges have demonstrable effects on young children (Schmit, S. et al, 2014, p. 1). Experiences and perceptions of discrimination are also linked to serious physical health effects in children, including high blood pressure and diabetes, as well as social risks, depression, low school performance and lowered expectations for the future (Perriera, K. & Ornelas, I, 2011, p. 200).

Clearly, immigrants and refugee parents face a set of unique circumstances, barriers and pressures that indicate equally unique ECHV and system approaches.

**Are immigrant and refugee cultures and languages barriers to acculturation or “protective factors”***?

*Acculturation* describes the process by which new immigrants become oriented to the mainstream culture of their new homeland, as well as a new ethnic sub-cultures (Castro 2010, p. 218). Unlike assimilation, *acculturation* describes a non-linear process that does not result in the loss of an immigrant’s cultural identity (Johnson-Agbakwu et al, 2014, p 2). Acculturation can involve an enormous set of tasks and lessons, depending on the differences between the new and traditional cultures and the openness of the new cultural and mainstream communities. Evelyn Lee, in her 1997 *Asian Americans: A Guide for Clinicians*, cautions that acculturation has many practical benefits, and is not *always* positive or beneficial to immigrants mental health (Lee, E., 1997). Lee finds “bicultralism” forms a stronger base for immigrant self-esteem and functioning; stressing the retention of native culture along with new US cultural mastery.
What is the relationship between language, acculturation and child development?

Literature widely supports fostering English language learning (ELL) along with the retention of the native languages of immigrant families (Hernandez, D., 2011). The numerous advantages of speaking the dominant language of your home community are obvious. Language is more than a tool or an information delivery system, however. Retaining one’s native language and teaching it to children born in the US can support acculturation. Each language is a unique system for encoding “symbols, meanings, forms of problem-solving, and adaptations that also facilitate the group’s survival” (Harwood 1981 and Thompson 1969 as cited by Castro, F.G. 2010, p. 216). Language provides group members with “a sense of peoplehood, unity, and belonging, a collective identity or ethnicity” (p. 216). The 2001 Poretz & Rumbaut longitudinal study of immigrants in 13 countries, including the US, suggests adolescents who develop this type of bilingual fluency “adjust” more successfully than children with “other acculturation profiles” (Henandez, D., 2011). The “adjustment” measures examined by the study included self-esteem, educational attainment and performance, career expectations, reduced MH symptoms, higher satisfaction with life and less anti-social behavior.

Castro describes cultural development in early childhood as occurring simultaneously with physical and social-emotional development, and as enhancing family resiliency (Castro, F.G., 2010, p. 216). From age 0-5, parenting language and activities provide some of the most important ways in which culture is embedded in the growing child; bonding and attuning them to their family and community; an important source of resilience throughout life. (Castro, F.G. 2010, p.216).
What does cultural adaptation of “evidence-based” interventions look like?

Filipe Castro authored a comprehensive literature review, exploring culture, acculturation and the cultural adaptation of “evidence-based prevention interventions” used in clinical psychology (2010). Castro cites Betancourt’s definition of a cultural group as one sharing a “collective system of values, beliefs, expectations, and norms, including traditions and customs, as well as sharing established social networks and standards of conduct that define them as a cultural group” (Betancourt & Lopez, 1993, as cited by Castro F.G. 2010, p. 216). This definition highlights the depth and breadth of culture and the potential for many unique differences to be encountered when engaging across cultures. He draws distinctions, however, between surface cultural adaptations that simply translate materials and provide activities attendant to “observable and superficial” aspects of participants’ culture. Rather, he identifies the need for cultural adaptations that acknowledge how culture shapes our understanding of core concepts, such as family, respect and health (Castro 2010, pg 216). Interventions high in “cultural relevance” provide understandable content that is matched to the linguistic, educational, and/or developmental needs of families; and is “interesting and important” and applicable to everyday life (Castro et al, 2004, p. 218).

Effective cultural adaptations require that “evidence-based” interventions change, “based on deeper cultural, social, historical, environmental and psychological factors that influence the health behaviors of a targeted population” (Castro, F.G., Berrera, M., and Streiker, L.K.H., 2010, p 216). Individual or family factors that require customization should include language preferences and fluency, degree of acculturation and differential acculturation within families and the effects of trauma and relocation histories (Alvarado, r. & Kumpfer, K., p. 242). For example, programming that addresses Latino families might include a focus on extended, multi-
generational family relationships; spirituality, religion and metaphysical beliefs; and provide opportunities for social gathering. Critical to this approach, Alvarado and Kumpfer find, is maintaining fidelity to the “evidence-based” dosage of core components with families. These components should be adapted “affectively” and not reduced or eliminated (Alvarado, R. & Kumpfer, K, 2000, p. 244). Also noted is the general lack of training and research guiding cultural adaptations in clinical and home visiting contexts.

An evaluation of a Boston ECHV program for immigrant and refugee mothers with severe trauma histories identified supporting *culturally-specific parenting practices* as a critical program adaptation. Paraprofessional program staff, who by design were all refugees and mothers, were hired based on their shared cultural backgrounds and experiences with the families served. They encouraged mothers in the program to maintain traditions, and establish new cultural communities where their familiar cultural practices were understood and celebrated. Traditions provided comfort and relief; “food for the heart”, and were described as restoring confidence to these deeply traumatized mothers (Paris, R. & Bronson, M, 2006, p 41). Program staff also modeled playing, soothing and stimulating babies, in ways that fit the mothers’ cultural framework. Daily routines involving both cultural and new life skills was stressed. Unless there was a concrete danger to a cultural practice, these practices were generally supported, even when they were not the choice of US experts in child health and development.

In summary, a multiplicity of personal impacts and social inequities are experienced by immigrants and refugees, produced by language isolation, systemic barriers and discrimination; coupled with the loss of traditional lifestyles and community supports. This fuels parent stress and contributes to the declining resilience and poor health outcomes of many new US immigrant families over time. New immigrants must be supported in retaining language and cultural
practices that have historically provided family resiliency while they navigate new environments. A well-developed sense of bi-culturalism in immigrants is associated with improved outcomes, and should be considered a resiliency factor. Families benefit when served with a culture- and language-matched Home Visitor, who respects traditional family functioning and sensitively introduces new information and skills at a pace the family can manage. Home Visitors should also be prepared to advocate for families’ needs within service systems, to reduce the burden of cultural and language barriers and discrimination on vulnerable families.

Community-Based Research: Mapping local practice and gathering community expertise

Methodologies:

The research methodology applied to the community-based research informing this Capstone project consists of three-parts: [1] a county-wide ECHV mapping project, (telephone survey), to identify local immigrant and refugee ECHV providers; [2] a series of 3 focus groups with immigrant and refugee –identified professionals and para-professionals working in Multnomah County; and [3] additional stakeholder interviews within this target group.

ECHV Mapping Project Methodology

The ECHV Mapping project was conducted prior to the focus groups in order to shed light on existing local ECHV programs that serve immigrant and refugee populations, including where they were located, priority outcomes, populations served and service models and other program components in use. In early 2013, in order to document the providers in the ECHV ‘community’, and identify programs serving immigrant and refugee families, a detailed inventory of home
visiting programs was made. Staff from the major ECHV programs in the county were recruited to complete this project, including: the Portland Children’s Levy, Multnomah County SUN Schools and MCHD staff, with support from the Portland State University Center for the Improvement of Early Childhood Outcomes. The project involved conducting a guided conversation by telephone, with a representative of each ECHV program identified. Standardized questions were asked and responses were gathered into a “Multnomah County ECHV Inventory”. The conversational process also collected inputs that were helpful in shaping the focus group content. The inventory identified the quantity of families served, and many other program features, including: culturally specific and “evidence-based” models and curricula used, programs offered to immigrant and refugee families and other sub-groups; and staff demographics, languages, and the availability of interpreter services.

Focus Groups and Stakeholder Interview Methodology

The focus groups and stakeholder interviews conducted for this Capstone project addressed the original research question: **Is the “evidence-based” Healthy Families America (HFA) program an effective ECHV program for achieving optimal and equitable early childhood outcomes for immigrant and refugee families?** In order to gather input from community members who were unfamiliar with the HFA model, however, the research question was broadened to include more commonly understood aspects ECHV program delivery. These included: building relationships with families; conducting screenings and assessments; ECHV program services; and evaluating program outcomes.

The focus groups and stakeholder interviews conducted were comprised of participants who currently lived and/or worked in Multnomah County, and who self-identified as having moved to
the US from an Asian, African or Slavic country. Ironically, in order to facilitate discussion, it was determined that the participants would all need to speak English! Therefore, the participants were further defined as (1) conversationally English-speaking, and (2) providers of home- or community-based services to immigrant and refugee families. Participants included family physicians, ECHV program home visitors, including nurses, and supervisors, Community Health Workers, language interpreters, and refugee support agency staff.

Participants were gathered through word-of mouth and an open email invitation circulated to at least 40 potential participants, resulting in 17 attending one of the three groups (4 Slavic, 8 Asian, 5 African). Attendance was challenging, given the busy schedules of the target group, so an additional 12 immigrant and refugee providers of medical, public health, home visiting, social work and interpretation services provided 1:1 stakeholder interviews. In all, the focus groups and stakeholder interviews reached 29 participants from the following cultures: Bosnian, Burmese, Cambodian, Mien, Romanian, Russian, Somali, Thai, Tongan, and Vietnamese. These participants also described serving a much a larger number of cultural groups, from which they drew their responses. Several participants had experience providing the HFA model.

Participants were asked to respond to 4 areas of inquiry: **building relationships with families; conducting screenings and assessments; common ECHV program components; and evaluating program outcomes.** For each area of inquiry participants were probed to discuss cultural adaptations, successes, service barriers and recommendations for program, staffing and system improvements, (The full focus group script is Appendix A).
Findings:

ECHV Mapping Project Findings

The HV mapping project collected standardized, quantitative program information into a “Multnomah County HV Inventory”, a database that has been used to create visual reports describing this service array. The process of telephoning each program staff also allowed for some qualitative data gathering. The Inventory found English speaking and Spanish speaking Latino families are widely served throughout the County in both “evidence-based” ECHV programs and culturally specific Latino programs. Programs providing a limited number of Slavic, Asian and African ECHV openings generally utilized research-based parent education curricula, and less intensive, or primarily center-based services, within culturally based service models. One “evidence-based” ECHV program was found to serve diverse immigrant and refugee families, including Ethiopian and Somali families, but only if the parents were able to communicate in English. Materials such as parent education handouts were available in limited languages. While a few “evidence-based” programs did have one or two staff that spoke Vietnamese or Russian, the model and materials used were not translated or culturally adapted. Interpretation was found to be available in theory, but not generally in practice, and was thought to be too time and cost intensive for ECHV programs. Family members were utilized as interpreters in some instances. While a few mainstream programs responded that they could provide in-person, telephone and computer interpretation on-demand; but when asked how many times they had actually provided these services in the past year, the response was consistently “never” or “rarely”. The Healthy Families immigrant and refugee program appears to be providing the majority of “evidence-based” ECHV services through a culturally diverse immigrant and refugee team, in Multnomah County. Still, even this diverse team of 5 Home Visitors serves many families cross-culturally and through interpreters. In summary, the
Inventory revealed inconsistencies in how immigrants and refugees were served with regards to staffing, language interpretation, translated or culturally-specific materials, and ECHV models utilized. Coordination or alignment of the limited ECHV program openings available for immigrant and refugee families was found to be a missing system component.

Community-Based Focus Groups and Stakeholder Findings

A set of surprisingly consistent themes along with a list of more culturally-specific considerations emerged from the focus groups and stakeholder interviews. These responses did not always align with the questions posed, which, in retrospect, required participants to possess too wide a scope of knowledge of the HFA model. Measuring and evaluating program outcomes, for example, was barely touched. Focus group responses are organized below according to the 3 areas of inquiry: **building relationships with families; conducting screenings and assessments; common ECHV program components.** The 4th area of inquiry, **evaluating program outcomes** did not receive much response, likely because it was the least aligned with the participants direct service perspectives. Participants and stakeholders were permitted to take discussions ‘off-script’, introducing new topics they felt strongly about. Following is a summary description of the discussions, which most directly addressed the research questions:

*Building Relationships with Families*

*There was a preference for staff who speak the same language as families and have a strong commitment to the cultural group specifically, beyond a specific program goal or function.* Focus group participants and stakeholders interviewed had clear opinions about who
should provide home-based services to immigrant and refugee families. Their recommendations largely mirrored recommendations found in evidence-based and culturally-specific research. Staff should deeply understand cultural taboos, preferences and frameworks for relating, and use these with skill. They should understand and respect family hierarchy, including gender roles.

*Conversely, serving one’s own community, although desirable, was also noted to produce intense demands on staff.* Stakeholders noted that serving families from within their own cultural community presents challenges regarding professional boundaries. They confided that when they say “no” to a family, fail to sufficiently engage elders due to time constraints, or try to stay within the ‘job description’, families let them know their behavior is not appreciated. They may find subsequent home visits “forgotten” for a few weeks—an indication that they had failed to balance their complex professional and cultural expectations.

*Workers must be flexible and responsive to the whole family,* and sometimes the community, to build relationships with the identified program participant. One stakeholder, a Somali interpreter and social worker, described balancing her work with accompanying expectations to join in community rituals such as cooking for new moms in her community for 7 days after the birth of a baby, translating and reading mail for participants’ neighbors, and representing her community in many meetings and on boards. Medical and social work professional guidelines might advise stronger boundaries between work and personal time, but immigrant and refugee communities do not operate with these Western concepts. Members may lose personal and professional credibility if they set “professional” limits. Becoming a recognized community “helper”, interpreter, resource, or bridge can be overwhelming at times, even though it is also rewarding; and is a unique pressure felt by these workers in their community.
Culturally-specific and language-specific work force development strategies are needed. The work force development solutions proposed for these staff challenges include hiring ‘natural helpers’ who are comfortable navigating complex cultural and community dynamics, supporting appropriate levels of staffing throughout systems to meet community’s needs, careful attention to staff ‘burn-out’ and vicarious trauma, and improved access to English Language Learning (ELL) services to increase the number of community members capable of formally and informally helping others to navigate systems. Another work force development strategy discussed by multiple stakeholders was the development of staff training and client materials in all of the languages served. Home Visiting staff are disadvantaged when they attend training in English, and leave with only English materials, having no opportunity to internalize the learned information in the language and cultural context in which they will be applied. Providing the training, materials, and rehearsal opportunities in the languages and cultural frameworks providers will be utilizing in service delivery is seen as a way to raise quality and consistency in the services offered to immigrant and refugee families.

Government programs draw suspicion. Many focus group participants and stakeholders expressed community-held fears of government and providing information that is personal or could be used against them in the future. This supports community-based staffing and suggests that stressing a service is based on “nationally-recognized” models or is part of a “statewide system” of supports can be counter-productive.

Nurses and medical staff, from any cultural background, were generally more trusted than child welfare or mental health staff. Multi-disciplinary teams were seen as an ideal way to increase cultural access to all of the needed specialties a family might require with the fewest barriers and the least time spent coordinating across systems. Home Visitors were viewed as
multi-talented and highly skilled, but additional mental health, medical and nutritional supports were often needed. Immigrant families, similar to US-born parents, prefer fewer, stronger relationships with coordinated service providers.

*Screening and Assessment:*

*Rushing disclosure of sensitive information, or any information, is counter-productive and may alienate families.* Screening and engagement strategies that allow for appropriate pacing of relationship before providers request sensitive information are viewed as absolutely essential. One stakeholder succinctly expressed this with the adage, “No business gets done until the third cup of tea”. An African focus group participant explained that families fear judgment and seek *community*, not systems or services, for a sense of safety. Service providers must stretch their professional role to meet this need for relationships to be effective. “I need to have that personal connection to trust. You are dealing with my life. My life, you know? So you have to act like that.”

*Trust and relationship must take priority over prescribed assessment time frames.* Screening and engagement are periods during which EBHV programs gather a great deal of information through an assortment of standardized assessments. This required evaluation component - a “baseline” of information against which to measure program outcomes, may help focus service delivery, if participants respond openly. Focus group participants shared that immigrant and refugee families generally find the process inappropriate and confusing, given the lack of relationship. Many questions asked, regarding interpersonal violence, mental health and the supportiveness of family members, are considered deeply shameful and taboo and might be difficult to discuss at any time. Home visitors who share families’ cultural values also express their own discomfort in breaking from cultural standards for respectful conversation, in order to
complete required assessments after one or two meetings. Focus group participants and stakeholders shared that while participants may respond to questions they find disrespectful or confusing because “they want to respect you”; they are unlikely to respond honestly, often under-reporting their troubles because, “it helps the relationship” to avoid unpleasantness (Asian); because it is mistimed with regard to relationship building (African); or the true purpose of the questions is unknown and therefore distrusted (Slavic). Workers expressed that going through the motions of completing assessment paperwork “gets in the way” of relationship-building early on. They comply with these requirements, however, to retain program funding for the community.

*Acknowledged families experiences with discrimination and honor hierarchy within communities and families.* Immigrants and refugees are aware of being judged for their differences, and as a result may not share information until a relationship and trust are built. Also there may just be a slower cultural pacing to interactions than Western service models assume will be the case. Hierarchical family systems and religious beliefs in Asian, African and Slavic cultures require sensitivity to elders, envoys, and leaders. In some cases a specific cultural leader is the community gatekeeper, and must vet the screening requirements and approve of the services provided. Other times it is a trusted provider who signals to a family that information or resources can be trusted. Sometimes family elders must approve services based on a perception of the provider’s level of cultural respect, which also takes time to ascertain.

*Common ECHV Program Components:*

- **Components of home visiting must be expanded and customized to immigrant and refugee realities.** Immigrant and refugee staff delivering EBHV services to their cultural communities must provide the same content and program elements to all participants. In addition, they must also deliver an array of services, lessons and methodologies to keep immigrant and
refugee families interested and engaged. All participants spoke about new immigrant and refugee families’ need to learn about local customs, resources and systems. They find themselves constantly modeling how to function in the new country, how to interact with systems and providers, and adapt to culture change. From explaining how to “use” American housing, (re: appliances, refrigeration, heat, locks, screens, new food items, etc.) to helping families navigate immigration, health, housing, employment and childcare systems, these Home Visitors (and other service providers) are often delivering an expanded scope of supports. Helping a family read mail, bills, summonses and paychecks or tax forms happens at most visits. Those working in EBHV programs find this added layer of work makes it a constant challenge to fit required program content into the normally scheduled 60-90 minute visit. Possible supports mentioned included additional program staffing, such as a “resource specialist” available all day by phone and more comprehensive and lasting federally funded refugee assistance.

Culturally-specific mental health approaches are needed to address system barriers.

While mental health may be either a taboo subject, or simply not culturally relevant, participants noted their awareness that the extreme stress of being a recent immigrant or refugee clearly impacts family and individual mood and functioning. One Home Visitor shared that families with extreme trauma do not know how to have fun and struggle to engage in fun and developmentally beneficial activities with children. She tries unconventional mental health approaches such as bringing a karaoke machine to engage the whole family in singing traditional songs from their culture of origin. Sharing her own story, as a Cambodian genocide survivor, she feels helps to assure families that they too can heal in time and become great parents. Several participants also suggested groups and classes away from the home for craft or cooking projects (women) or car
repair or job search classes (men). This strategy provides a less stressful and less direct context for accessing information and supports.

*Patience and sensitive understanding is needed* to provide the repetition of information that many new immigrants and refugees require. This may be due to trauma, stress and disorientation caused by major life changes, and also because much of the new information is far outside prior experience and frameworks, and takes time to absorb. An example provided is the common practice of advising parents to bring their toddler to the dentist for check-ups and sealants—a practice that has no reference point for Russian immigrants. One participant shared that she finds she must carefully explain and repeat why such activities would benefit the family. She also uses “the latest science tells us” approach, not “this is how it is done here”, which shows greater cultural respect.

*Enhanced system capacity and coordination outside of immigrant and refugee service programs is needed.* Participants and stakeholders often feel isolated in caring for families, and often struggle to elicit needed responses from within critical service systems. Often they feel they must accompany their clients to lengthy appointments in order to assure they are properly served and that the family understands the information they receive. Suggestions were made that, “Everyone needs to help these families. We cannot be everywhere”. Coordination for immigrant and refugee families across systems was described as non-existent except perhaps for refugees in the earliest months of their settlement.

*English instruction during home visits is a resource that families desperately need* to become higher functioning in Multnomah County. Many women, in particular, do not leave the home except when absolutely necessary, due to their lack of English language skills or cultural
practices or anxiety. The delivery of home language instruction should also engage all members of a family, from grandparents to toddlers, and be free of cost and trauma informed.

**Focus should be placed on the most vulnerable immigrant and refugee families without local family and community connections.** *Family and community* relationships can shield individuals from the full impact of their adverse conditions and events, and consequently shield children from the effects of unmitigated parental stress and despair. Connection to one’s cultural community in the new homeland is viewed as essential to family survival and strength. Membership in an extended family and cultural community provides shared knowledge, comfort, strength and resources. Other strengths mentioned by participants include:

1. Calm acceptance of life’s challenges: “We can survive anything”

2. Clear gender roles: Cultural traditions of protecting and sheltering women and children can buffer acculturative stress. (These circumstances can also isolate and endanger women who lack community connections, such as “foreign brides”).

3. Traditional family roles: tend to value respect, discourage conflict, support strong family bonds and promote breastfeeding.

4. Religion: Strong, supportive, and sometimes politically active cultural communities promote health and wellness, i.e.: forbidding smoking and alcohol use.

5. Cultural barriers *as strength*: Immigrants and refugees residing in areas of poor housing, crime, traffic, and easy access to poor food, and gambling or sex-related businesses may maintain separation from their immediate community as a strategy for cultural or spiritual survival.
Conclusions:

Conducting the “evidence-based” literature review as a first step provided clear evidence, early on, of the many gaps to be explored to answer the Capstone question: **Is the “evidence-based” Healthy Families America, (HFA), program an effective ECHV program for achieving optimal and equitable early childhood outcomes for immigrant and refugee families?** Had extensive literature been published addressing which programs or service components are considered “evidence-based” with immigrant and refugee families, this project would not have been necessary. This was not the case. Literature on cultural adaptation of evidence-based interventions was also reviewed and this confirmed that the body of ready-to-use literature that might answer the Capstone question was not located ‘on a different shelf’. This review also confirmed observations that the Healthy Families staff have made, regarding areas of cultural ‘fit’ between immigrants and refugee families and components of the program. Community-based research provided the clearest guidance, plugging gaps in knowledge, and steering program administrators and staff toward possible program adaptations that are relevant to local immigrant and refugee families.

Evidence-based research is seen as the ‘gold standard’, producing research based on validated surveys and assessments, ideal for meta-analyses, and powerful enough to identify the program components that improve child outcomes. Larger studies with experimental or quasi-experimental designs, using sophisticated analytics produce easily understood messaging about
why ECHV investments matter. In the past few years, national policy coalitions have successfully lobbied federal and state legislators and used evidence-based research to win billions of dollars in federal funding for ECHV programs, while citing this research. The research to determine an “evidence-base”, by design, has gaps, flaws and limitations, however. The US child population is becoming increasingly language- and culturally diverse, with children with foreign-born parents comprising the fastest growing segment. Yet methodologies for “evidence-based” ECHV research has not kept pace with these dramatic changes. Research study populations continue to be less diverse than the populations receiving the intervention, consistently excluding participants who do not speak English or Spanish. When more diverse participants are included in large studies or meta-analyses, the outcomes are not disaggregated in ways that allow practical application of research findings. Even general data describing the community needs, challenges, strengths and accomplishments of cultural sub-groups are missing. Data collection tools, which record Somali refugees only as “African American” and recent Bosnian refugee as “White” have long been the rule in public health and social science research. For many reasons, including fear, distrust and lack of language access, new immigrants also bypass participation in data collection activities. The result is data that glosses over disparities, and misinforms critical funding decisions. Consequently, we lack the answers needed to make public investments for the best results. This is a lost opportunity to gain timely insight into a whole generation of young families.

Literature targeted by this review described cultural adaptation and culturally specific approaches to parenting interventions, relevant to immigrants and/or refugees. This literature review was critical to developing a deeper understanding of the significance of culture, acculturation, acculturative stress and cultural disparities. Yet this review also failed to produce specific strategies for adaptation of ECHV programs in particular. There were no large culturally
specific studies found that were relevant to the Capstone questions of determining the cultural fit or effectiveness of ECHV programs or components. Further, a lack of translated and validated measures available, and lack of demographic clarity and consistency in most studies, severely limited the ability of researchers to ‘connect the dots’ between studies or perform meta-analysis. Studies of “Asian families”, for example, did not delineate subjects with different countries of origin and language groups, different immigrant generations or number of years in the US, with different levels of English speaking abilities, and acculturation, different socio-economic circumstances and levels of education etc., making the results of research less clear and usable. This is important, considering the shift toward “evidence-based” service models required from most government funders. Determining the specific need for cultural adaptation of these models cannot even occur without better research. Without the kind of validation and funding of “evidence-based” ECHV programs, culturally-specific programs are hampered by a lack of guidance and infrastructure, including tailored curricula, training, and quality assessment standards and relevant data.

Recommendations

Based on the information collected from this study, MCHD should embark on an iterative process of cultural adaptation with our contractors, utilizing quality improvement (QI) methods and tools to identify core program adaptations to the current HFA model that are culturally-responsive to immigrant and refugee families. The application of frameworks of “equity and empowerment” and “cultural responsiveness”, discussed in Section 2, should be applied to this work, to assure that efforts engage appropriate stakeholders and are respectful and relevant to both the staff involved in delivering services and the families served. The community-based
research conducted for this project produced a large number of guiding principles, specific program content guidance and ‘food for thought’. This input, summarized in detail in Section 3, should inform local policies and procedures, contract requirements, service innovation and evaluation of outcomes in a continuous improvement loop. Moving forward, MCHD should seek approval for successful locally adaptations from national HFA model experts, and should utilize these conversations, as well as ECHV conferences and other forums, to build on an emerging national conversation about improving cultural relevance of publicly funded “evidence based, best practice” ECHV standards.

Next Steps

MCHD will retain and adapt the well-established HFA program and existing program infrastructure, including well-established relationships, trained staff and supervisors, data collection and documentation systems, and feedback loops. Although this is the right decision for now, we anticipate the possibility that we may later identify an even more promising culturally-specific ECHV program worth adopting. Retaining the HFA model, while adapting it, will require MCHD to replace state funding for this contract with local funding that carries fewer restrictions. This strikes a balance between our interests in both innovative adaptation and potentially preserving our eligibility for future “evidence-based” funding, because it is possible that local adaptations can be made while preserving the core HFA standards. Meanwhile, re-allocated local funding will qualify as program “matching funds”, allowing MCHD to apply for more funding for other HFA contracts in the community.
Leadership Lessons Learned

This Capstone has empowered me to seize an opportunity to consider whether existing ECHV program practices were culturally responsive and equitable for immigrant and refugee families and communities. The methodology selected, a combination of literature review, local service mapping, focus groups and stakeholder interviews, has informed and shaped how early childhood services are delivered. My research was initially limited by a lack of reliable data and literature to adequately describe foreign-born families and communities, especially English language learners. I discovered how the lack of visibility of these families in relevant research had allowed policy solutions to take shape that were a questionable fit.

The lessons I will take away and apply to similar challenges in the future will include:

1. In order to accurately understand community needs and solutions, data must clearly identify not only the largest single segments of society, but also those who now collectively comprise the highly diverse US majority.

2. “Evidence-based” research findings that exclude significant portions of the community may lead to solutions that unintentionally worsen inequities.

3. When all solutions currently available/funded lack cultural specificity, it is necessary to work directly with the community to assess if and how these solutions might be applied in a culturally responsive manner.

4. Immigrant and refugee communities are diverse, because of the multiplicity of experiences; cultures and languages represented, and include individuals with many
degrees of acculturation to the US. Unique approaches to standardized program models are needed to engage and strengthen these communities.

5. Membership in a cultural community is a critical resource for immigrants and refugees, especially those learning to parent children. Traditional Western 1:1 service delivery approaches miss a critical opportunity to engage and support these communities and strengthen family well-being and resilience.

6. And finally, we are living in a time of expanding cultural diversity, accompanied by persistent inequities. If we are to succeed as a nation, old mindsets that marginalize smaller communities must be discarded. Public administrators must make decisions that reflect our current reality and the nation we are becoming. It is critical that we paint a complete picture with our data and identify, engage and empower all members of society, especially marginalized youth and their families, to find the solutions that will take us toward an optimal and equitable future.

“The design and implementation of early childhood policies and practices must be examined through a cultural lens in order to avoid biased ethnocentric value judgments on the part of providers, avoid inappropriate or intrusive interventions, and guide state-of-the-art practices—which include family centered, child-focused, and individualized care. “ (Hepburn, K. S., 2004).
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Appendix A: Focus Group Format and Questions

Oregon Community Services Study

Direct Service Staff Focus Group Guide

As participants enter, the facilitator will orient them to the refreshments, nametags, and restrooms. Questions 2-5 will appear on a whiteboard or flipchart visible to participants entering the room.

Introduction

Good afternoon. Thank you for coming. My name is [Facilitator’s name] and my colleague is [other RMC Research staff person’s name]. We are both with RMC Research Corporation.

As you may already know, the Oregon Community Services Study is interested in learning more about the delivery of home visiting services and other services for pregnant women and parents of young children. We want to understand what works well and what could work better. Specifically, we are interested in learning from professionals like you who serve families from African, Asian, and Slavic communities in Multnomah County. We will be asking you about your experiences and your thoughts about the needs of families in the communities you serve. We plan to talk with you for 2 hours, so we should be finished by about [time].

During the session, we will call you by the name on your name tag and [other RMC Research staff person’s name] will be taking notes. The use of audiotapes for recording the focus group will also be used to accurately record the ideas and opinions expressed. Names will be omitted from all notes including those transcribed from the tapes.

The feedback provided today will be included in a report describing what services are needed and accessed by the families you serve and to what extent these services are meeting families’ needs. No individual comments will be reported in such a way that anyone could identify who made them.

We are really interested in what each of you has to say. There are no right or wrong answers. Because we understand that talking in a group setting can be uncomfortable we will be encouraging the use of CHAT guidelines to help make the environment safe and welcoming.

- **Confidentiality**—What is said in this room should stay in this room. Please do not refer to the focus group as a place where you heard certain information (even if you do not think the person who said it would mind).
- **Honor**—If someone says something that you disagree with, we ask that you respond respectfully. We are very interested in what everyone has to say, so please try and find a way to express yourself respectfully.
- **Anonymity**—If you choose to talk about actual experiences related to past or current clients, it is important not to name people or include any information that could be used to identify who you may be speaking about.
- **Team Trust**—We ask that you give each other the opportunity to speak. It is important that we let one person finish their thoughts before someone else speaks.
Before we get started, let’s go around and have everyone say their name.

Discussion Topics/Questions:
1. *Let’s start by going around the table and sharing: Approximately what percentage of the clients you serve are:
   a. African immigrants or refugees?
   b. Asian immigrants or refugees?
   c. Slavic immigrants or refugees?

2. *What services do you provide to immigrant or refugee families of African, Asian, and Slavic heritage? [Additional question for home visiting providers: Which home visiting model are you implementing? What is your role in implementing these home visiting services?]

Now I’d like to direct your attention to the four topic areas written on the board. We’re going to discuss your experiences with what has worked well and what hasn’t in each of these areas. Please take a few moments to look them over and reflect on practices you’ve used and adaptations made in each of these topic areas in your work with families of African, Asian, or Slavic heritage. Feel free to jot down a few notes if you think it will help you remember during the discussion. [Pause for individual reflection.]

3. *Building Relationships with Families
   a. What practices have you used or adaptations have you or your agency made in order to build relationships with families you work with of African, Asian, or Slavic heritage?
   b. How well do you think these practices or adaptations have worked? What hasn’t worked well? [Probe: in what ways worked/didn’t work.]
   c. What barriers have you encountered? [Probe for EBHV providers: any model requirements that may present barriers.]
   d. Facilitator probes as needed: Do you have adequate time to build a relationship with immigrant and refugee clients before addressing sensitive issues? Are there subgroups within these immigrant/refugee groups for whom your approach differs from the larger cultural group? Does your approach with new immigrant and refugee families differ from your approach with families who have been here longer?

4. *Conducting Screenings or Assessments
   a. What practices have you used or adaptations have you or your agency made in how you conduct screenings or assessments with families of African, Asian, or Slavic heritage? [Probes: timing, cultural relevance]
   b. How well do you think these practices or adaptations have worked? What hasn’t worked well? [Probe: in what ways worked/didn’t work.]
   c. What barriers have you encountered? [Probe for EBHV providers: any model requirements that may present barriers.]
   d. Facilitator probes as needed: Do the various questions that your organization asks new clients present any problems for the immigrant and refugee families you work with? Are there subgroups within these immigrant/refugee groups for whom you
modify screenings or assessments in ways that differ from the larger cultural group? Does your screening/assessment approach with new immigrant and refugee families differ from your approach with families who have been here longer?

5. **Implementing Program Services**

   a. What practices have you used or adaptations have you or your agency made to make program services culturally responsive (e.g., how often you see families, program content) to families of African, Asian, or Slavic heritage?
   
   b. How well do you think these practices or adaptations have worked? What hasn’t worked well? [Probe: in what ways worked/didn’t work.]
   
   c. What barriers have you encountered? [Probe for EBHV providers: any model requirements that may present barriers.]
   
   d. *Facilitator probes as needed: Does the frequency or amount of time you need to work with immigrant and refugee families differ from other families with small children? How long/how often is optimal? Are there subgroups within these immigrant/refugee groups for whom you modify services in ways that differ from the larger cultural group? Do service needs of new immigrant and refugee families differ service needs of families who have been here longer?*

6. **Evaluating Outcomes**

   a. What practices have you used or adaptations have you or your agency made to evaluate client outcomes of families of African, Asian, or Slavic heritage?
   
   b. How well do you think these practices or adaptations have worked? What hasn’t worked well?
   
   c. What barriers have you encountered? [Probe for EBHV providers: any model requirements that may present barriers.]
   
   d. *Facilitator probes as needed: Are there subgroups within these immigrant/refugee groups for whom your agency modifies evaluation outcomes in ways that differ from the larger cultural group? Do evaluation outcomes for new immigrant and refugee families differ from those of families who have been here longer?*

7. *Do you have thoughts about other changes that could be made to provide culturally responsive services to families of African, Asian, or Slavic heritage? [Probe for EBHV providers: Are you aware of any procedures your model offers for making adaptations or modifications for any specific population groups?]*

8. What kinds of support, training, or resources do you think [home Vs/staff] need to best serve families of African, Asian, or Slavic heritage?

   a. What supports does your organization provide for staff to implement culturally responsive practices? [Probe for EBHV providers: What supports does your national model’s organization provide for staff to implement culturally responsive practices?]
9. Tell us about your experiences with coordination of services across providers in your work with families of African, Asian, or Slavic heritage.
   a. What has worked well in coordination across providers?
   b. How could coordination of services be improved?

10. Is there anything else that you would like to share with us today about home visiting or other community services?