Barriers and Facilitators of Service Use by Low-income Families with Young Children: A Brief Report from the Palm Beach County Family Study

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During the last 3 decades, considerable progress has been made in understanding the ecological and cultural context for children's development and, in particular, the harmful effects of poverty and its correlates on family functioning and child development (e.g., Bronfenbrenner, 1979, 1986; Brooks-Gunn, 2003; Gomby, 2005; Olds et al., 2007). This knowledge has informed a variety of early intervention strategies designed to diminish the effects of poverty on children's development and readiness for school. In particular, comprehensive, integrated systems of health, education, and social services are increasingly viewed as a promising means of supporting healthy family functioning and child development in low-income, at-risk families (Brooks-Gunn, 2003; Gomby, 2005; Olds et al., 2007; Reynolds, Ou, & Topitzes, 2004).

"Sometimes things don't work out how they are supposed to work out, so either you try again or you try another solution."

– Debra, 22-year-old unmarried mother of two preschoolers [1]

This growing body of evidence prompted the Children's Services Council (CSC) of Palm Beach County, over a decade ago, to undertake a long-term initiative to build an integrated system of care to promote and support the healthy development of children, with a focus on the first 5 years of life. The primary goals of the Palm Beach County system of care are to increase the number of healthy births, to reduce the incidence of child abuse and neglect, and to increase school readiness, as indicated by the number of children who enter kindergarten ready to learn (Children's Services Council, 2007). These goals assume that strengthening the system of community supports and services available to families will enhance their ability to raise their children in healthy ways and, in turn, improve children's development and well-being. As a result of better family functioning and improved child health and development, it is also expected that children will be more ready for school, families will be better able to support their children in school, and families will be less likely to need more intensive mental health, child welfare, and juvenile justice services.

To implement their goals, CSC and its partner organizations focused their system-building efforts in selected low-income communities—the Targeted Geographic Areas (TGAs)—that have higher than average rates of child maltreatment, crime, and other risk factors. As shown in Table 1, the system is made up of a range of programs and systems to support children at different stages of their development.

In order to obtain the benefits that services might provide, however, families must use them. Despite the promise of early intervention programs and systems like the CSC system of care, research tells us that their effects are often modest at best (Brooks-Gunn, 2003; Gomby, 1999, 2005). An important factor in the effects of voluntary prevention and early intervention programs is engaging families in services long enough to obtain the benefits that high-quality services can provide (e.g., Daro, McCurdy, Falconnier, & Stojanovic, 2003; Olds, Saddler, & Kitzman, 2007; Raikes et al., 2006; Roggman, Cook, Peterson, & Raikes, 2008).

Table 1. Overview of Programs and Systems Supported by CSC	
Program/System Name	**Program Description**
Maternal Child Health Partnership (MCHP)	A network of health and social services for high-risk pregnant women and mothers, which includes universal risk screening before and after birth; targeted assessment and home visitation; and coordinated services for families experiencing medical, psychological, social, and environmental risks that negatively impact pregnancy and birth outcomes
Early Care and Education	Initiatives to identify and provide services for children with developmental delays and to improve children's school readiness, and a quality improvement system for child care programs
School Behavioral Health Programs	Programs designed to improve children's adjustment to school and enhance their school success by identifying social-emotional and other developmental problems and providing referrals and interventions to respond to these problems
Afterschool Programs	A network of afterschool programs for elementary and middle-school youth supported by Prime Time, an intermediary working to improve the quality of school-based and community programs

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[1] All names in this report are pseudonyms.

This brief presents findings from a 6-year longitudinal study of a sample of high-risk families living in the TGAs and the factors that affect their use of services that are available to them (see Box 1). Mothers were recruited to be in the study from two Maternal Child Health Partnership (MCHP) programs shortly after giving birth. To be in the study, mothers had to be at least 16 years old and speak English, Spanish, or Haitian Creole, the three most frequently spoken languages in the county. A majority (76%) were not married, although many lived with a partner. Less than half (42%) had graduated high school. Fifty-three percent of the mothers were Hispanic, 40 percent were black, and the remaining 7 percent were of other racial/ethnic backgrounds. A majority (71%) were living at or below the poverty line. For about half of the mothers, the recently born infant was their first child; the other half had one or two older children.

We begin with a summary of findings related to families' use of CSC early childhood services and a range of other services during the first 5 years following the birth of a child. Next, we examine in more detail mothers' service experiences, focusing on the factors that either facilitate or inhibit their use of services. We then report findings and implications about the relationship among service use and experiences, family characteristics, and maternal and child outcomes.

Use of Formal Services in Early Childhood

A fundamental goal of the service system in Palm Beach County is to enhance the availability and coordination of services and supports for at-risk families and children during the early childhood period. Four-fifths of study participants received maternal and child health services from the MCHP around the time of the birth of their child, typically between 3 months preceding and 6 months following the baby's birth. Approximately one-quarter of mothers who qualified for intensive care coordination received services, for an average duration of 9 months post-partum. Mothers who received more days of service were more likely to have particular risk characteristics and needs, e.g., multiple children, a child with special needs, and physical/mental health needs of their own.

Nearly all (94%) of the study mothers reported receiving assistance with basic family needs in year 5 of the study. Health care, food assistance, dental care, and child care assistance were the most frequently received services (see Table 2). Service use changed over time. Although the two most frequently used areas—health care and food assistance—declined, service use in

Table 2. Percentage of Study Families Using Service areas, 2005-2009 (*n*=310)					
Program Name	**2005**	**2006**	**2007**	**2008**	**2009**
Healthcare for children or mother	75	95	94	89	86
Food support (Food Stamps, Women, Infants, and Children [WIC], food pantry)	89	87	68	70	72
Parenting information	73	23	11	5	8
Dental care for children or mother	22	27	26	55	59
Childcare subsidy	17	27	28	40	41
Transportation help	17	16	7	5	7
Paying rent or bills/housing voucher	11	10	10	11	15
Employment assistance	5	5	3	5	9
Housing or emergency shelter	5	10	10	11	11
Mental health/substance abuse program	2	2	3	8	11
Legal assistance	2	2	6	7	6

Table 3. Percentage of Study Families Using Public Income Supports, 2005-2009 (*n*=310)					
Program Name	**2005**	**2006**	**2007**	**2008**	**2009**
Women, Infants, and Children (WIC)	84	79	56	50	52
Food Stamps	37	46	35	38	47
Earned Income Tax Credit (EITC)	18	23	19	22	35
Social Security Insurance (SSI)	11	8	9	7	11
Temporary Assistance for Needy Families (TANF)	7	8	3	2	2
Rent voucher	4	4	5	6	11
Unemployment Insurance (UI)	3	2	1	3	9

these areas remained relatively high throughout the study. However, there was a striking decline in the use of formal services for parenting information after the first year, perhaps because mothers were no longer connected to the MCHP system, a primary source of such information after the birth of their child. With respect to specific public income support programs, it is noteworthy that despite the low-income status of the study families, with the exception of the WIC program, less than half of the sample used these services (see Table 3).

Consistent with the changing needs of children and families as they grow, use of dental care assistance and child care subsidies increased considerably in years 4 and 5. In the first 2 years of the study, at least half of the focal children were cared for by their parents at home and less than 10 percent in center-based care. By the fifth year of the study—the year before the children were to enter kindergarten—just 39 percent were cared for by their parents at home, while 34 percent were in a center-based program.

Families' Experiences with Services

We expected that mothers in the study would use services differently and that we would see changes in service use over time. Our findings confirmed these expectations. However, we also found many families had unmet needs for services or were not using services available to them. To help us understand how families became engaged in the service system and the factors

that encouraged or discouraged their use of services, we conducted in-depth qualitative interviews over time with 50 of the 531 low-income families in the study. These interviews revealed information about a range of topics, including mothers' daily routines, how they cared for their children, the support they received from family members and friends, the services they used, and their aspirations for their children.

From these interviews, we discovered a range of factors that seemed to encourage or discourage the use of services; we refer to these factors as "facilitators" or "barriers," depending on how they influenced service use. It should be noted that encountering a barrier did not mean the mother had a negative experience with services. Similarly, encountering a facilitator did not mean a positive experience took place. Mothers' experiences with services may be independent of the factors that facilitate or hamper their use. For example, Bayle, a 23-year-old unmarried mother of four children, while in the midst of applying for food stamps complained that the application process was a "headache." Six months later, when she and all of her children were receiving food stamps, she concluded, "But it is worth it when you need it." Sandra, a 20-year-old mother of one child, told us, "It's help, it's a lot of help. But it's just the stuff you gotta do to get help."

Consistent with the ecological and cultural frameworks of other researchers (e.g., Andersen, 1995; Bronfenbrenner, 1986; McCurdy & Daro, 2001; Weisner, 2002), we found four different but interconnected levels of factors that affect service use—the

Figure1. Levels of Service Barriers and Facilitators

- Individual Factors
- Provider Factors
- Program and Policy Factors
- Neighborhood Factors
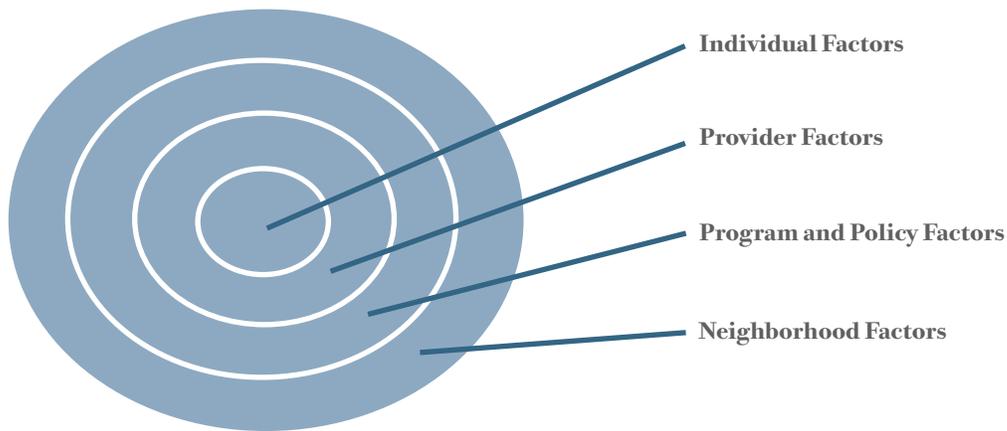
individual, the provider, the program, and the neighborhood level (see Figure 1). At the individual level, we identified factors such as mothers' language and literacy skills, personal enabling resources (e.g., knowledge of services, personal social networks, access to transportation or child care, persistence or ability to advocate for themselves), perceptions of need and desires for children's well-being, personal and family attitudes and beliefs about services, and previous service experiences.

At the provider level, characteristics of provider agencies such as their responsiveness, language skills, and cultural competency of the staff affected service use. At the program and policy level, factors include eligibility and documentation requirements, program structure, availability of translation services, location of services, intake procedures, and length of waiting time to apply for or receive services. Lastly, at the neighborhood level, the data suggest that factors such as neighborhood safety and community transportation systems affect families' access to and decisions to use services.[2]

A number of factors were common to groups of families. Transportation was a commonly mentioned barrier to applying for services as well as to keeping

appointments for services. Hospital social workers and agency care coordinators in the MCHP system were commonly mentioned facilitators, who helped mothers apply for child care/preschool, food stamps, and—in the case of pregnant women—Medicaid for themselves and their children. MCHP providers assisted families with access to concrete resources, e.g., baby care supplies, bus passes, and food, as well as providing emotional support and parenting information. Karol, for example, reported, "[the agency worker] will go get toys, clothes and books, and she'll come visit me to see how I'm doing." And Bayle noted, "Like for Thanksgiving, she [the social worker in the MCHP agency] got me hooked up with a box of food and turkey and things like that. She usually gets me bus passes and little stuff like that." Others described learning about appropriate discipline for their children and activities to stimulate children's language and cognitive development.

More often than not, having a positive experience with a program led to use of the program again for a subsequent pregnancy. However, a handful of mothers who reported positive experiences with a MCHP program did not seek or accept help for their subsequent

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[2] We also recognize that the broader social, economic, and political context—for example, national and state immigration policies; the availability of affordable housing, jobs, transportation systems; and the costs of energy and food—also impact family circumstances, needs, and access to services.

pregnancies. Sandra and Shirley, for example, declined to participate in one of the MCHP programs because they felt they could handle subsequent pregnancies on their own. As Shirley explained, "I felt like I was stable enough to do it on my own, like as far as Pampers and stuff for the baby. I just really didn't call [the agency] back. I don't know why I didn't." Expressing confidence in her parenting knowledge and skills, Sandra told us, "I had really learned a lot from my other [MCHP agency] nurse. She taught me a lot to the point that I really don't think I need anybody else to help me. It's beginner teen moms that really need that program a lot."[3]

At the same time, we found variations within our sample. Parents' beliefs and values about seeking help and using services varied and thus they could be either a barrier to or a facilitator for a mother and her family. For example, mothers were much more likely to seek help for their children than for themselves or adult family members. As Neena explained, "No, since my husband lost his job, there is no insurance. But that is a lesser concern. Just as long as we have it for Enrique [child], it's okay." Tracy expressed a similar view when she told us, "Once Medicaid expires for me I will be uninsured which is fine. I have been uninsured forever. It is just mostly the kids that I am worried about that they will always have insurance.

In addition, a barrier to one mother—for example, having to use a computer to apply for a service—could be a facilitator for another mother. We also observed that, depending on the area of service need and current family circumstances, these factors variably influenced service use. For instance, throughout the study, mothers were more likely to seek help with medical care for their children and with food assistance than other service areas. They also were more likely to seek or receive parenting information during the first year of their baby's life than they were in later years. In contrast, mothers were more likely to seek assistance with child care costs after the first year of their baby's life.

One area in which these variations were especially evident was child care arrangements, where multiple factors came into play. Mothers' employment was the factor most likely to cause families to use out-of-home care for their children; over the first 3 years of the study, the number of mothers who returned to work and arranged for out-of-home care for their children increased. But there were other reasons that parents were progressively more likely to consider nonparental child care arrangements. Families' choices of child care arrangements were also based on mothers' individual preferences and the age and special needs (e.g., speech delays) of the child. Some mothers preferred to keep their children at home until kindergarten: "I think I want to take care of her until she is 5 years old," Julia told us. "I will take better care of her." Others, like Abigail, saw preschool as necessary for getting their child ready for school: "I don't want to push her too much, I just want her to have understanding and not be behind. That's why I sacrifice myself to send her to the daycare to teach her so when she go to kindergarten she is prepared." In general, many mothers in the sample became more open to using out-of-home care around their child's third birthday or when their child had more mastery of language and self-help skills. Sandra reported telling her son, "You're 3 years old now. You know a lot. You go to the restroom on your own. You got to be around other kids. You have to learn more than what you know."

In addition to the older age of the children and mothers' growing comfort with out-of-home care, another factor in child care use was the greater availability of low- or no-cost child care options for older children, such as Head Start and Florida's Voluntary Prekindergarten. At the same time, cost was a significant factor in the type of care used across the years of the study. Many mothers, regardless of their race/ethnicity or nativity, were interested in out-of-home educational experiences for their children. However, they could not afford to enroll their child without financial assistance. Mothers who received subsidies were much more likely to use

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[3] Unfortunately we were not able to follow these mothers during their second pregnancies and child birth to know whether they had, indeed, enough self-sufficiency and confidence that MCHP services were no longer needed or whether they would still have benefitted from these services.

center-based care than mothers who did not receive subsidies.

Thus, service use changed over time for many reasons. Sometimes family circumstances changed, along with their eligibility for public supports. Sometimes families felt they needed fewer services or none at all, or they struggled to complete reapplication processes to maintain services. In contrast to their experiences with other service systems, most mothers reported positive experiences with MCHP care coordination programs. These programs seemed to address mothers' material needs (including help with transportation) and parenting concerns. They also served as bridges to access to other needed social programs that had difficult application processes and unresponsive program staff. Even when their involvement with the MCHP system was relatively short, several mothers valued the care coordination program and relationships with staff enough to accept or seek help from care coordination programs for subsequent pregnancies. This support was particularly important for mothers with lower language and literacy skills, fewer personal resources, and limited social support. These mothers sometimes did not understand program requirements or were intimidated by unfriendly staff.

Over the course of the study, we observed frequent changes in the study families' ecological and cultural circumstances (e.g., financial status, health status, employment, child care needs, and household composition). These changes took place as children were growing and learning. As their children grew, mothers needed to know less about taking care of a newborn and more about dealing with a child who was moving to the toddler years. At the same time, mothers also had more children. As new stressors emerge, the range of support once enjoyed by mothers becomes outdated. Mothers who had terminated MCHP services or public benefits did not always have an easy way to return to this kind of support, unless they became pregnant again. This suggests the importance of extending the MCHP system to provide additional points of entry for mothers of young children (between 2 and 4 years old) to increase children's access to adequate care and subsequently enhance children's outcomes. A short

intervention program may not be enough to support and inform a family's parenting practices during a child's toddler years while a family's ecological and cultural circumstances are changing. In this sense, programs may be more efficient if they work towards improving short-term outcomes (e.g., birth outcomes) rather than long-term outcomes (e.g., school readiness). A longer program format may also enhance a family's access to other social programs, as well as help to ensure mothers are accessing health care throughout their reproductive years (which, in turn, increases the likelihood of receiving prenatal care early in a new pregnancy).

Conclusions and Implications

Consistent with other research (e.g., McCurdy & Daro, 2001), these findings highlight the challenges of engaging families in voluntary programs. The demographic characteristics of families living in the TGAs are the ones associated with poor developmental and educational outcomes for children. Therefore, CSC's strategy of identifying families who need services and targeting services to families in high-poverty areas remains a sound one for reaching children most at risk of not succeeding in school. However, to benefit from services, families must use them. Service use varied widely among the low-income families in this study. Many families who were eligible for—and might have benefited from—CSC-funded and other services were either not receiving them or not using them enough to obtain intended benefits.

Although foreign-born mothers were more likely to receive MCHP services, when compared to U.S.-born mothers, they used fewer services outside of the MCHP system overall. Given that the MCHP system was successful in engaging foreign-born mothers, there may be ways that CSC can positively impact how other publicly-funded services are provided to eligible foreign-born families as well as eligible U.S.-born families who are harder to reach with services. Raising public awareness of families' literacy, educational, and social needs—as well as their service needs—could be helpful. CSC might also consider ways to more widely share its

knowledge of and experience in training service providers in culturally appropriate approaches.

Study findings make clear that the emerging system of care in Palm Beach County is successfully providing needed MCHP services to many at-risk families around the birth of a child It appears, moreover, that unlike other formal services used by the study families, the MCHP has more flexibility to adapt to the diverse circumstances and daily routines of the families they serve. At the same time, there were challenges in keeping some of the mothers engaged in these services for as long as they were eligible. There also were challenges in identifying and addressing new service needs, linking mothers to other services once they left the MCHP system, and tracking service use over time as their children got older. Based on these findings, we offer several recommendations to improve service access and use in the TGAs in general and strengthen the CSC system of prevention and early intervention services in particular, as follows:

Expand entry points for MCHP services. Based on findings about the relationship between mothers' mental health and children's development, and given the need for continued services during children's toddler years, we recommend that there be multiple entry points to services for families once their children "age" out of the services available during the postnatal period. Consideration might also be given to providing more entry points for parents; for example, even if a child does not screen as being at-risk, if a mother is at-risk because of poor physical or mental health, this could pose risks for the child. Medical providers should be engaged to do more screening of mothers and children and make referrals to community-based agencies if they do not qualify for formal Early Intervention services.

Enhance training of service providers. One strategy to keep families engaged in services is to improve the knowledge and responsiveness of service providers.

This could be achieved by enhancing training in approaches that are culturally appropriate and family strengths-based, including instruction in ways to gauge the special needs of families. Although it might not be possible to directly impact service delivery in agencies not funded by CSC, it might be possible to raise awareness of the families' literacy and educational needs, in addition to their service needs. Families can be intimidated by program requirements, and staff who are trained to help families through the process in a respectful way could reduce duplication of paperwork and client and staff frustration in the future, as well as making families feel more positive about seeking and accepting help.

Help families stay involved in or become reconnected to services over time as needs change. Service use by study families varied for many reasons, including perceptions of need, access to other resources, difficulties with reapplication processes, or actual improvements in their circumstances. The decline in use of formal services for parenting information after the first year might reflect increased confidence in parenting skills, but could also indicate a lack of connections to other services and supports once mothers leave the MCHP. As children grow, new developmental stages are likely to bring parents new challenges and questions and make them more open to services to help with parenting. These periods might be "touch points" when parents are more receptive to services but the formal structures to help them engage or re-engage in services may not exist.[4]

Make the location and timing of services convenient for families. Program locations, office hours, and excessive waiting times can pose significant barriers for families, especially if they have transportation or child care problems. Home visits, traveling service vans, and child care- or school-based programs are good alternatives to office visits, especially if they are open during evenings and on weekends. As employers may be

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[4] Dishion and his colleagues also suggest that "developmental transition points such as toddlerhood, school entry, and early adolescence offer unique opportunities for health promotion and risk reduction because child and family behaviors reorganize at these points" (Dishion et al., 2008). They also recommend that interventions be family centered and ecologically focused, as well as embedded in existing service systems.

reluctant to allow families unpaid time off for appointments with teachers, doctors, or service agencies, it may be more feasible to persuade health care providers, schools, and service agencies to expand locations and hours of services to make them more convenient for families.

Explore other forms of information and communication about services. During the time of this study, CSC expanded their use of other vehicles (such as radio, television, faith-based organizations, and public libraries) to disseminate information to reach families with limited education or literacy skills, families not receiving information through relatives or friends, and families who were not already using other services like child care. The local offices of federal benefit programs were also channels for disseminating information about CSC-funded programs. Increasing the knowledge of health care providers about community-based services and encouraging them to refer families to these services might also better inform families and make them more willing to use services.

Strengthen relationships between the CSC system of care, health care, and other community supports and services. This study suggests the importance of an ecological and systems approach to serving families and children, which recognizes that children grow up in a family context and families need support—and a range of services—in raising their children. They also need help navigating the complexity of the service system and making transitions from one service to another (e.g., when children "age out" of one system and into another). Providing services and referrals through child care programs is one way to reach families who use these services. However, this approach will not reach many mothers who are not working, who are either not eligible or who are on a waiting list for a child care subsidy, or who prefer other child care settings. This suggests that CSC might need to work even more collaboratively with other service providers (such as WIC, primary care providers, public health clinics, and community-based organizations) to reach its target families. The study also highlighted an increase in mothers' reliance on medical and child care providers for parenting information after the infancy period. This demonstrates that improving the knowledge these professionals have about parenting and parenting supports in the community, and tools for assessing child development, maternal functioning, and service needs.

Box 1. The Palm Beach County Family Study

A central question for CSC and other stakeholders in Palm Beach County concerns the effectiveness of the system. Is the service system functioning and being used by families as expected? Is it achieving its intended outcomes? To help to answer these questions, CSC commissioned Chapin Hall to conduct a longitudinal study to better understand the characteristics and needs of families the system is intended to serve, how they use services in and outside the system, and how service use is related to child well-being, family functioning, and children's readiness for school. In developing the study, we were guided by an ecological framework, which emphasizes the different contexts in which children develop, including family, neighborhood, and the policies that affect the services and systems they experience.

The study used a mixed methods approach that included analysis of administrative data on service use and key outcomes for all families with children born in the county during 2004 and 2005. The data covered the time from birth until the children entered kindergarten. Data were also collected through annual in-person and telephone interviews with a sample of 531 mothers who gave birth to a child in the county during 2004 and 2005 for 5 years. A 3-year qualitative study was conducted, involving in-depth interviews and observations of forty of these families. Mothers were recruited through two maternal child health programs that were part of the Maternal Child Health Partnership (MCHP).

To ensure we had enough mothers who were likely to use services, we over sampled mothers that the MCHP screened at-risk around the birth of their child. As a result, mothers in our sample had more risk characteristics than other mothers in the county. For example, 17 percent were teen mothers, 72 percent were not married (although many were living with a partner), 41 percent had graduated high school, and 57 percent were foreign-born. Of the 531 mothers who participated in initial interviews soon after the birth of the focal child, 310 were interviewed all 5 years.

Improve data systems and other sources of information on service availability, use, and need. The MCHP database is an important source of information on the types of services families receive in the system, referrals made to providers outside the system, and how families enter and leave the system. Additional sources of information on the location of services, community needs for services, and the outcomes of referrals would assist funders and service providers in planning and monitoring how the system is working to ensure families get connected to the services they need.

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