Region X Innovation Grant

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Growing Together to Support Our Home Visiting Workforce

Region X Home Visiting Workforce Study

RESEARCH BRIEF #4

The Health and Well-Being of the Region X Home Visiting Workforce

Design: Butler Institute for Families, Graduate School of Social Work, University of Denver

Butler Institute for Families
Graduate School of Social Work
University of Denver, Craig Hall
2148 S. High Street
Denver, CO 80208-7101

University of Colorado Denver
School of Education and Human Development
1380 Lawrence Street
Denver, Colorado 80204

Public Consulting Group
148 State Street, 10th Floor
Boston, Massachusetts, 02109

Special thanks to: Laura Alfani, Washington Department of Children, Youth, and Families; Nina Evers, Washington Department of Children, Youth, and Families; Judy King, Washington Department of Children, Youth, and Families; Kerry Cassidy Norton, Oregon Health Authority; Benjamin Hazelton, Oregon Health Authority; Drewallyn B. Riley, Oregon Health Authority; Sherrell Holtshouser, Alaska Division of Public Health; Kristin McKie, Idaho Department of Health and Welfare; Erin Bruce, Idaho Department of Health and Welfare; members of the workforce study working group, and all members of the Region X home visiting workforce.

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Table of Contents

This research brief is the fourth in a series that is part of the *Region X Home Visiting Workforce Study* funded by the *Region X Innovation Grant* at the Washington Department of Children, Youth, and Families, in partnership with The Alaska Division of Public Health, The Idaho Department of Health and Welfare, and the Oregon Health Authority. The study was designed to identify the current strengths, gaps, and unmet needs in the home visiting workforce in Region X to inform workforce recruitment, retention, and professional development efforts. For more information about the study, please see *The Region X Home Visiting Workforce Study: Introduction.*[xvi]

Key Findings

On average, home visitors and supervisors rated their overall health as "good" or "very good." Supervisors rated their health significantly higher than home visitors.

Healthy eating (52%) was more common than regular exercise (25%), and more than half (51%) of the workforce was dissatisfied with their body weight.

Tobacco use was lower among the home visiting workforce (7%) than the general population (16%).

Approximately one in ten (9%) home visitors and supervisors screened positively for depression. Rates of depression were significantly higher in Alaska (14%) and Washington (12%) than Oregon (5%).

More than half (63%) of the workforce reported at least some difficulty paying bills during the year; home visitors reported greater difficulty than supervisors.

Leadership and coworker support, reflective supervision, and self-care were commonly identified stress management techniques.

Most of the workforce reported having a primary care doctor (81%) and access to mental health support (80%) and attending regular check-ups (66%). However, 17% reported health care barriers, which were more common among home visitors than supervisors.

Most of the workforce (81%) reported at least one Adverse Childhood Experience (ACE). One-third (33%) of home visitors and supervisors experienced four or more ACEs. In comparison, recent population estimates in Alaska,[i] Oregon,[ii] and Washington[iii] indicate 15–17% of residents have four or more ACEs.

Introduction

A thriving workforce is key to achieving the goals of home visiting. Home visitors work with families to help them accomplish their goals, foster healthy parent-child relationships, and support children's development.[iv] In order for home visitors to successfully support the health and well-being of families, they themselves must also be healthy and well.[v]

There are various facets of an individual's health and well-being, including physical, mental, and economic.[vi] A past study of the Head Start and Early Head Start workforce in Pennsylvania revealed several pressing health concerns, including high prevalence of depressive symptoms, obesity, and other adverse health indicators.[vii] Furthermore, the lack of economic well-being among the early childhood workforce is well-documented, with many professionals experiencing economic insecurity.[viii] Although there is some indication that the health and well-being of the early childhood workforce, broadly, are cause for concern, less is known about the status of the home visiting workforce specifically.

Aside from understanding the well-being status of home visitors, it is also helpful to know what healthy practices they engage in and what health care services they access. There is clear consensus on the benefits of a healthy diet, regular exercise, avoiding tobacco, and receiving preventive health care services.[ix] Furthermore, stress management and self-care are important in high-stress occupations, like home visiting, because stress can lead to occupational burnout.[x] One type of stress that is important to consider in the context of home visiting is secondary traumatic stress which results from helping or wanting to help a traumatized or suffering person.[xi]

Finally, it is important to understand the extent to which home visitors may have experienced trauma during their own childhood, known Adverse Childhood Experiences

(ACEs), because past trauma can be reactivated in the context of home visiting.[xii] ACEs include child abuse or household dysfunction (e.g., exposure to substance abuse, mental illness, household violence, etc.), and have been linked to increased risk of several chronic health conditions later in life.[xiii] Recent studies of ACEs among human service providers, which includes home visitors, found 70% experienced at least one ACE,[xiv] and individuals with higher ACE scores may be more likely to pursue human service careers.[xv] To avoid reactivating past trauma, restorative cultures can be created within workplaces, which promote positive relationships, reflection, shared values, and self-care.[xvi]

Research Questions

The purpose of this research brief is to address the following questions based on a sample of home visitors and home visiting supervisors ("the workforce") in Region X:

1. How do home visitors and supervisors rate their personal health and well-being, including economic well-being?

2. What healthy practices does the workforce engage in?

3. To what extent do home visitors and supervisors access health care services?

4. To what extent has the workforce experienced Adverse Childhood Experiences?

Sample

The sample used for this research brief includes 468 home visitors who provide home visiting services directly to families and 161 home visiting supervisors, 29% of whom have a caseload of families they serve. These home visitors and supervisors were drawn from 148 programs in Alaska, Idaho, Oregon, and Washington, collectively known as Region X. Within the sample, 202 (43.2%) home visitors and 76 (47.2%) home visiting supervisors work in home visiting programs that receive MIECHV funding. Thirty-eight percent of programs in the sample reported receiving MIECHV funding. This brief also includes data from a sub-group of 12 home visitors and 7 supervisors who participated in follow-up interviews. For more information about the sample and the measures used for this study, please see *The Region X Home Visiting Workforce Study: Introduction.*[xvii]

Results

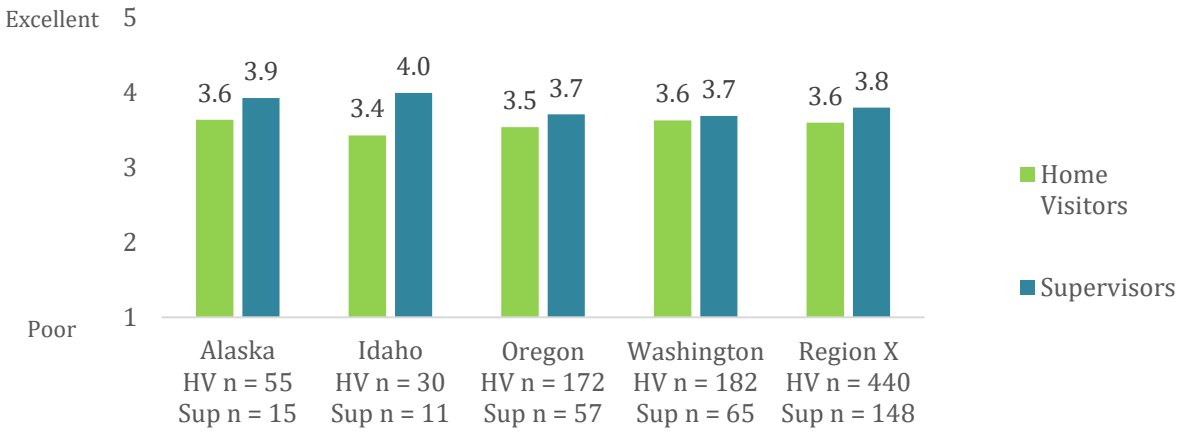
Research Question 1: How do home visitors and supervisors rate their personal health and well-being, including economic well-being?

As described in the introduction to this brief, health and well-being includes physical health, mental health, and economic well-being. This section describes how home visitors and supervisors rate various aspects of their own health and well-being.

OVERALL HEALTH

When home visitors and supervisors were asked to rate their overall health, more than half (57.7%) indicated their health was "very good" or "excellent." An additional 34.4% rated their overall health as "good," while the remaining 7.9% rated their health as "fair" or "poor." Figure 4.1 shows the overall health ratings of home visitors and supervisors, respectively, by state. Means ranged from 3–4, indicating average ratings of "good" to "very good." Home visiting supervisors rated their health significantly higher than home visitors.[1] Specifically, 65.5% of supervisors rated their health as "very good" or "excellent" compared to 55.0% of home visitors. There were no significant differences in overall health ratings by state.

Figure 4.1. Mean scores of "overall health" by role and state

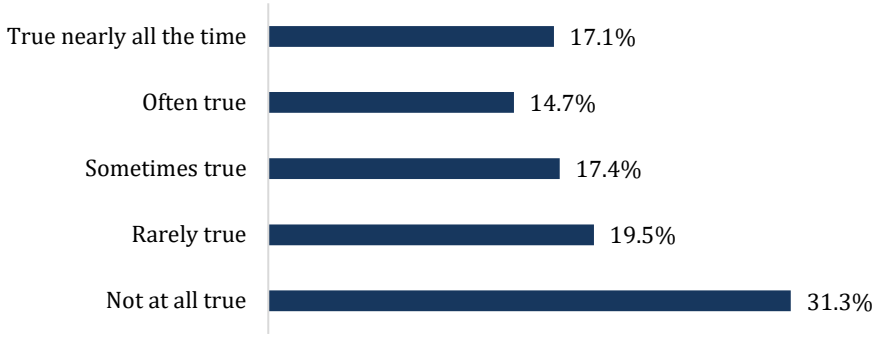


[1] $t(586) = 2.09$, $p = .04$

BODY WEIGHT

Although the workforce tended to rate their overall health favorably, they expressed dissatisfaction with their body weight. Half (50.8%) of the workforce disagreed with the statement "I am at my ideal body weight (plus or minus 5 lbs)." Specifically, 31.3% felt this statement was "not at all true" and an additional 19.5% felt this statement was "rarely true." The overall distribution of responses can be found in Figure 4.2. No significant differences were found by position or by state.

Figure 4.2. Home visitor and supervisor responses to the statement "I am at my ideal body weight" (n = 585)

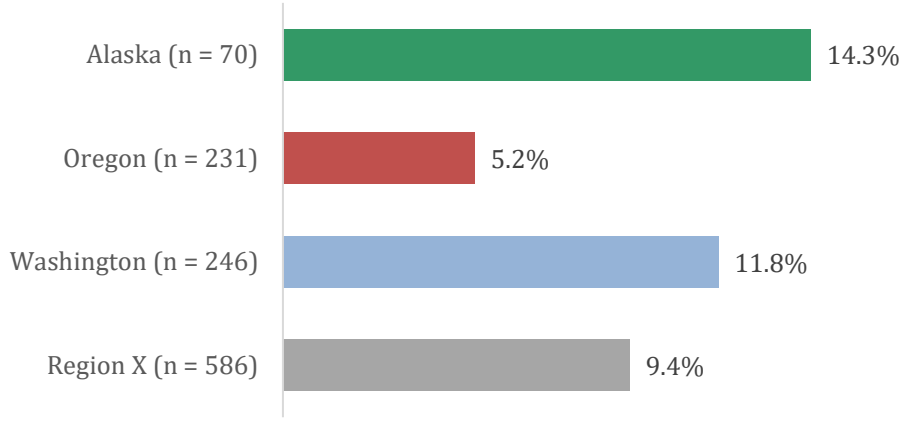


MENTAL HEALTH: DEPRESSION

Overall, 9% of the workforce screened positively for depression based on the Patient Health Questionnaire-2 (PHQ-2) scale.[xviii] Note, a positive screen for depression on the PHQ-2 does not necessarily indicate clinical depression, which is a diagnosis that must be made by a clinician. Figure 4.3 shows the percentage of home visitors and supervisors, collectively, who screened positively for depression by state. Data from Idaho were suppressed due to sample size. There were statistically significant differences by state,[2] but not by job role. Rates of depression were significantly higher in Alaska[3] (14.3%) and Washington[4] (11.8%) than Oregon (5.2%.)

[2] χ^2 (3) = 8.45, p = .04
[3] χ^2 (1) = 6.55, p = .01
[4] χ^2 (1) = 6.59, p = .01

Figure 4.3. Proportion of home visitors and supervisors screening positively for depression by state

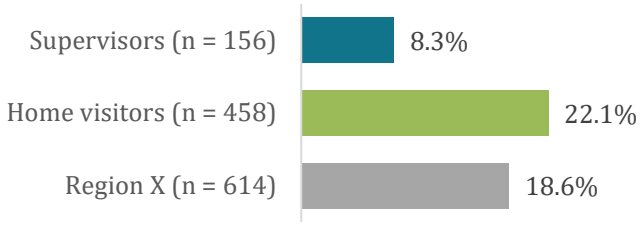


Past work (from 1980 to 2012) estimates clinical depression among the early childhood workforce ranging from 6–27%;[xix] a study of home visitors found roughly 20% had clinically significant symptoms.[xx] Although stigma and bias make it difficult to estimate the true incidence of depression among the workforce, depression rates in the present study are consistent with rates observed in past work.

ECONOMIC WELL-BEING

Two items were used to assess economic well-being: not having enough money left at the end of the month and difficulty paying bills in the past year. Overall, 18.6% of home visitors and supervisors reported "not having enough money left at the end of the month to make ends meet." As shown in Figure 4.4, home visitors were significantly more likely to report not having enough money to make ends meet compared to supervisors.[5] There were no significant differences by state.

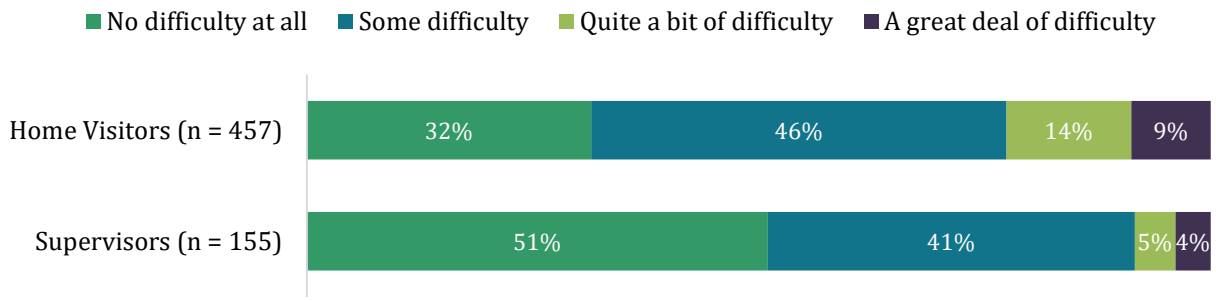
Figure 4.4. Percent of respondents who have difficulty making ends meet by job role



[5] χ^2 (1) = 14.48, $p < .001$

In terms of the second indicator of economic well-being, 63.6% of home visitors and supervisors reported at least some difficulty paying bills in the past year. Specifically, 7.5% reported "a great deal of difficulty," 11.4% reported "quite a bit of difficulty," 44.6% reported "some difficulty," while 36.4% reported "no difficulty at all." Again, there were statistically significant group differences by job role, with home visitors having greater difficulty paying bills compared to supervisors.[6] There were no significant differences among state comparisons. Figure 4.5 shows the distribution of responses among home visitors and supervisors for Region X, respectively.

Figure 4.5. Home Visitors' responses regrading "difficulty paying bills in the past year"



In sum, this suggests much of the workforce has at least some difficulty maintaining their economic well-being, especially home visitors.

Research Question 2: What healthy practices does the workforce engage in?

This section describes the healthy practices of home visitors and supervisors, specifically, eating well, exercising, not using tobacco, and managing stress.

EATING WELL

About half (51.7%) of the workforce reports eating a healthy diet "often" or "nearly all the time." Of the remaining half, 31.6% report "sometimes," 10.4% report "rarely," and 6.3% report "never" eating a healthy diet. There were no statistically significant differences by state or role.

[6] t (610) = -4.80, p < .001

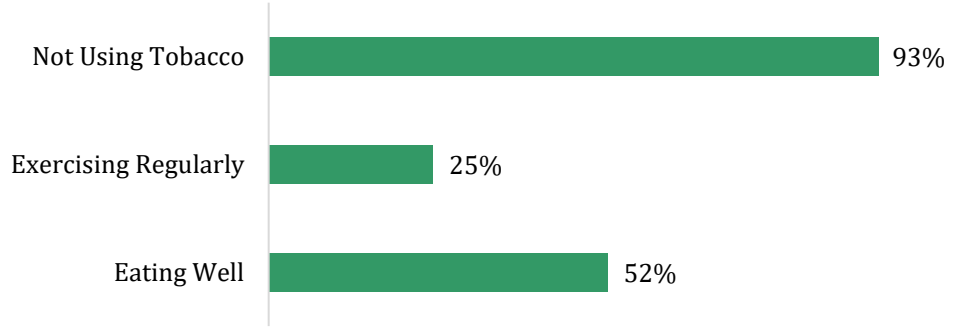
EXERCISING

Regular exercise (at least 30 minutes most days) was less common than healthy eating. One quarter (25.1%) of the workforce reported regularly exercising "often" or "nearly all the time," followed by 30.2% reporting "sometimes," 29.2% "rarely," and 15.5% "not" exercising regularly. There were no statistically significant differences in exercise by state or role. Interestingly, more experienced home visitors and supervisors exercised more regularly than less experienced staff.[7] Exercise habits did not vary significantly by age.

NOT USING TOBACCO

Nearly all of the workforce (93%) report not using any form of tobacco. Additionally, 86% report not living with anyone who uses tobacco. Tobacco use is lower among the home visiting workforce (6.8%) than the general population (15.5%).[xxi] There were no statistically significant differences in tobacco use by state or role.

Figure 4.6. Proportion of home visitors and supervisors engaging in healthy behaviors



MANAGING STRESS

During interviews, home visitors and supervisors were asked to reflect on how they manage the stress of their profession. Several strategies were often discussed, including reflective supervision, coworker support, and various self-care practices. More detail, including specific examples, are shown below.

Reflective supervision. Of the 19 interviews conducted, 16 (84%) mentioned leadership support and/or reflective supervision as a means of managing stress. As discussed in *Brief 3*,

[7] $t(216.03) = -2.24$, $p = .03$

reflective supervision refers to an ongoing, scheduled professional development process that enhances the reflective practice skills of home visitors. Reflective supervision, specifically, was discussed as a stress management technique in 13 (68%) interviews. As demonstrated in the corresponding excerpts, reflective supervision was a stress management technique used by both home visitors and supervisors.

In the excerpt to the right, the home visitor mentioned how reflective supervision allows her to regulate her emotions, "think clearly," and "be present" with families, which are characteristic of mindfulness, a state of being attentive, present, non-judgmental, and accepting.[xxii] Similarly, the supervisor discusses how she has chosen to receive reflective supervision, even though it is not required, because it allows her to process difficult situations.

Coworker support. Talking with coworkers is another stress management technique. In fact, 14 (73.7%) interviews discussed coworker support as a stress management strategy. Similar to reflective supervision and leadership support, coworker support offers an opportunity to be heard while maintaining the confidentiality of the clients.

> I have to process that stuff with my coworkers, because I literally can't talk about it with anyone else, because of the confidentiality. . . . My team is really good about checking in. . . . We all know each other well enough to check in, "Do you need anything? What can I do?" and then [be] really

"I have reflective supervision, and that's probably the main way I [deal with emotional aspects of the work.] I've learned—four years now of reflective supervision—I've really learned how to control my emotions or deal with what's happening inside me at the moment of a visit that a crisis happens so that I can think clearly and be present to the family and then be able to later process it. It's usually talking to a coworker or talking to my supervisor or my regular supervisor. Just talking to someone really helps."

- Home visitor

"Hearing about trauma and these really, really sad stories that can, also, be really hard. But I think I found enough strategies that I've built in to keep that balance for myself because I also make sure that I receive reflective supervision as well. . . . It's not required. But it is recommended. So I know that that's also helped me as a supervisor to be able to continue to have that not only as a home visitor, being able to have reflective supervision but, also then, as a supervisor receiving it as well. So it kind of counters some of those challenges, having a place to be able to process it."

- Supervisor

respectful, whatever the answer is, about maintaining that boundary or helping with whatever.

–Home Visitor

Self-care practices were also commonly discussed as strategies for coping with stressful situations. All but one (94.7%) interview mentioned self-care practices, which include exercise, taking time off, practicing mindfulness, journaling, having hobbies outside of work, and spending time with family and friends. One supervisor shares examples of self-care practices she does both in and outside of work:

> I make sure that I build in self-care on a regular basis. So I have a lot of things that I do outside of work. But, also, when I'm at work I'm really intentional about making sure that I take time for a lunch. That if I'm in my office all day that I'm getting up and that I'm moving around and that I'm going outside. . . . And I build in exercise on a regular basis outside of work. . . . I have noticed throughout the years of doing this program that there are times when I didn't have that built in as much and I could definitely see the impact. And having it built-in allows for having more emotional availability for others to be able to be present and be with them when we're talking about really difficult things.
>
> –Supervisor

Consistent with past excerpts, the above supervisor discusses how her work is positively impacted by her self-care / stress management. Namely, she is more emotionally available and "present" for others. She specifically addresses times when self-care was not a part of her routine and how she "could definitely see the impact."

Some home visitors acknowledged the difficulty of building a regular self-care practice, especially with some of the challenges of the profession. One home visitor shared how difficult and "messy" it is to establish self-care routines, such as practicing mindfulness or art, to "quiet ourselves" and "regulate our own hearts."

Although the majority of self-care strategies that were shared during the interviews were healthy behaviors, a few home visitors also mentioned strategies that may not be healthy if practiced in excess, such as drinking, spending money (i.e., "retail therapy"), or emotional eating.

"[Handling the emotional aspects of the job] is a learning curve. I don't always handle it well. I have been learning to practice more—to do more mindfulness practices and meditation practices. My team has been working collectively on the ways to kind of just regulate our own hearts and systems and quiet ourselves when things kind of tend to get emotional or triggered. . . . I've been trying to develop routines at home as well. That's a practice, right? It's learning. Sometimes, I'm really messy."

- Home visitor

In sum, home visitors and supervisors face various emotionally challenging situations in their work, and they employ a variety of strategies to cope with stress. Many report utilizing healthy strategies, including leadership and coworker support, reflective supervision, and self-care. However, it is important to acknowledge that self-care and stress management are not always easy to do, and some professionals use less healthy coping strategies.

"I probably gained about 40 pounds since I took this job. Now, I'm losing it, so emotional eating, I think, is one way [I deal with stress]."

- Home visitor

Research Question 3: To what extent do home visitors and supervisors access health care services?

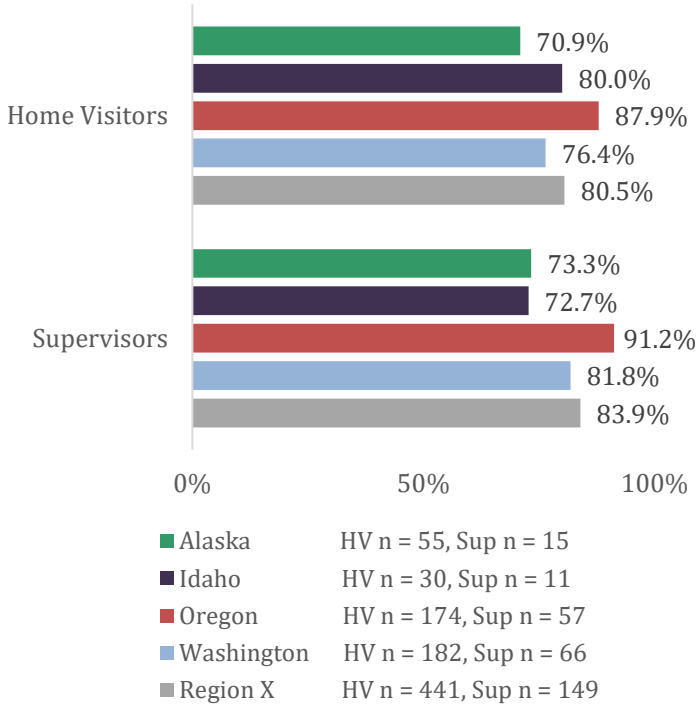
This section describes the extent to which home visitors and supervisors access health care services, including primary care and mental health services, as well as the extent to which they experience barriers to access.

ACCESSING PRIMARY CARE

Most (81%) of the workforce reports having a primary doctor or health care provider. There were no statistically significant differences by job role; however, there were statistically significant differences by state. Figure 4.7 shows the percent of home visitors and supervisors, respectively, who report having at least one primary care doctor. Accessing primary care was more common in Oregon than in Alaska[8] and Washington.[9]

Across Region X, 65.7% of the workforce reports visiting a doctor within the past year for a routine checkup. There were no statistically significant differences by job role or state.

Figure 4.7. Percent of respondents who have a primary care doctor



MENTAL HEALTH SERVICES

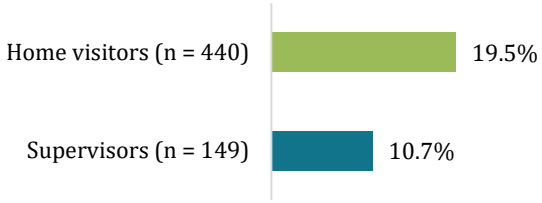
Similar to primary care, most (80%) of the workforce reported having easy access to a behavioral or mental health specialist. There were no statistically significant differences by job role and state.

[8] χ^2 (1) = 12.44, $p < .001$
[9] χ^2 (1) = 10.15, $p = .001$

BARRIERS TO ACCESS

Despite the majority of professionals reporting access to primary care and mental health services, 17% of the workforce said they needed to see a doctor in the last year but could not because of cost or distance. There were statistically significant differences by job role, but not by state. As shown in Figure 4.8, home visitors experienced health care barriers to a greater extent than supervisors.

Figure 4.8. Percent of respondents who experience barriers to health care access by job role



Access to Health Care

81% have at least one primary doctor / health care provider

80% have easy access to a behavioral or mental health specialist

17% needed to see a doctor in the last year but could not because of the cost or distance

n = 589–590

Research Question 4: To what extent has the workforce experienced Adverse Childhood Experiences?

ADVERSE CHILDHOOD EXPERIENCES

Survey respondents were given the option to report their ACE scores. Approximately three quarters of the workforce (75.7%) reported ACE scores (74.8% of home visitors and 78.3% of supervisors). Of those who responded, the majority (81.1%) experienced at least one Adverse Childhood Experience (ACE) prior to age 18, which could have included abuse, neglect, poverty, substance abuse, divorce or separation, domestic violence, mental illness, or parent incarceration. The distribution of ACE scores can be found in Table 4.1. There were no statistically significant differences by job role and state.

Table 4.1. **Distribution of ACE scores by job role**

# of ACES	Total Workforce	Home Visitors	Supervisors
0	18.9%	17.1%	23.8%
1	16.8%	16.3%	18.3%
2	16.0%	16.6%	14.3%
3	14.9%	14.3%	16.7%
4+	33.4%	35.7%	26.9%

As shown in Table 4.1, one-third of the workforce had four ACEs or more, which, based on data from the original ACE study, substantially increases risk of chronic health problems.[xxiii] Table 4.2 shows, by state, the average ACE scores, as well as the percent of respondents reporting ACE scores of four or more. Please note, select cells are suppressed due to sample size. Among the general population surveyed in the original study, approximately half (52%) of respondents experienced at least one ACE, and fewer than one in ten (6%) reported four or more ACEs.[xxiv] More recent population estimates in Alaska,[xxv] Oregon,[xxvi] and Washington[xxvii] indicate 15–17% of residents have four or more ACEs.

Table 4.2. **Average ACE scores and ACE scores of 4+ by state and job role**

	Alaska			**Idaho**			**Oregon**			**Washington**		
	Home Visitor n = 43	Sup. n = 14	State n = 57	Home Visitor n = 28	Sup. n = 9	State n = 37	Home Visitor n = 132	Sup. n = 46	State n = 178	Home Visitor n = 147	Sup. n = 57	State n = 204
Average	3.1	2.8	3.0	2.5	1.6	2.3	3.2	2.8	3.1	3.0	2.4	2.9
% with 4+ ACEs	39.5%	--	35.1%	28.6%	--	27.0%	36.4%	30.4%	34.8%	35.4%	26.3%	32.8%

During interviews, the workforce reflected on how their childhood experiences influence their current work with families. Often, home visitors and supervisors reflected on how their own adverse childhood experiences allow them to have empathy and compassion for some of the challenging situations facing families, and how it motivates them to help families who are experiencing similar situations.

To summarize, the majority of the home visiting workforce in Region X experienced Adverse Childhood Experiences, and roughly 33% of the workforce experienced 4 or more ACEs. Based on interviews, these experiences motivated career decisions and a desire to help families, and inspired empathy and compassion among home visitation professionals.

> "I did have a brother that did partake in drugs, and so I saw what that can do to a family . . . how it took a toll on the community. . . . I kind of wanted to do something that gave back. . . . Everybody makes mistakes. . . . How do we fix it instead of punishing? And I think that's kind of where I wanted to come into home visiting, is I know that most of our families in our caseload are at-risk families, and so I knew there had to be someone that's out there that would understand and not be judging and just kind of give them that support that they need just to get over the hump and be successful in the long run."
>
> - Supervisor

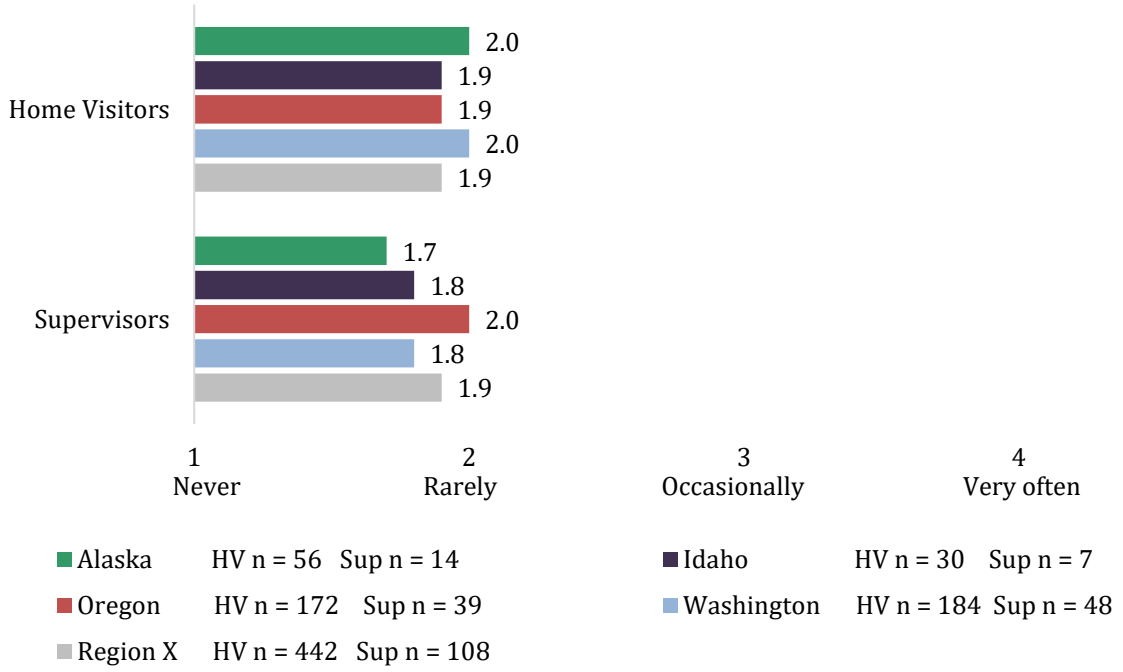
SECONDARY TRAUMATIC STRESS

Given how common ACEs are among the home visiting workforce in Region X, it is important to understand secondary traumatic stress. Four items from the Secondary Traumatic Stress Scale (STSS)[xxviii] were administered ($\alpha = .68$), specifically:

- It seems as if I am reliving the trauma(s) experienced by my families
- When I think about my work with some of my families or are reminded of them, it upsets me
- I avoid people, places, or things that remind me of my work with families
- I want to avoid working with some of my families

Overall, the mean for home visitors and supervisors was 1.92, which coincides with "rarely" experiencing secondary traumatic stress. For home visitors, scores ranged from 1.00 to 3.25, and supervisors' scores ranged from 1.00 to 4.00. Figure 4.9 shows the mean secondary traumatic stress scores by role and state. Note, there were no significant differences by role or state. In sum, the workforce does not report experiencing high levels of secondary traumatic stress.

Figure 4.9. Mean scores of secondary traumatic stress scale by role and state



Policy Considerations

This brief broadly explored Region X home visiting professionals' perceptions of their own health and well-being. Based on these findings, the following policy considerations are proposed.

Cultivate Supportive Workplaces

Restorative cultures that promote relationships, reflection, shared values, and self-care are particularly important for individuals who have experienced trauma.[xxix] In the Region X sample, eight in ten workers reported experiencing at least one Adverse Childhood Experience, and one in three workers reported significant trauma (4 or more ACEs.) In order to avoid reactivating past trauma, the workforce needs opportunities to reflect,

process emotions, cultivate mindfulness, and take care of themselves. During interviews, many home visitors and supervisors discussed using reflective supervision to process emotions and, ultimately, be more mindful in their interactions with families. In fact, past work has shown that home visitors who were more mindful had higher quality relationships with families.[xxx] Additionally, self-care was identified as a stress management technique during interviews and must be supported in the workplace.[xxxi] Self-care at work can include taking periodic breaks, taking vacations, seeking out supportive colleagues, and reserving work tasks for designated hours. Workplace cultures that support self-care could encourage staff to engage in healthy activities and set and monitor self-care goals, and supervisors can model positive practices (i.e., limit e-mails to working hours, take vacations themselves, etc.). It is apparent through past Region X work, such as *NEAR@Home: Addressing ACEs in Home Visiting by Asking, Listening, and Accepting*, that understanding ACEs is recognized as important, especially in supporting families.[xxxii] We recommend this work continue with special attention to creating restorative cultures that support the home visiting workforce.

Support and Incentivize Health and Wellness

Consistent with the previous recommendation, health and wellness should be supported and incentivized. Region X should continue to provide opportunities for physical and mental health care and support, which was received by most of the workforce. It is important to note that approximately one in five workers experienced barriers to health care related to cost and/or distance. More information is needed to determine possible solutions, such as creating or contributing to health savings accounts (for financial barriers) or promoting tele-health options (for geographic barriers). Interestingly, the home visiting workforce in Oregon reported significantly higher rates of primary care access and also reported significantly lower rates of depression. Given that depression is highly treatable,[xxxiii] it is possible that access to primary care increases the likelihood that a variety of health conditions, including depression, will be detected and treated. Furthermore, exercise appears to be an area in need of improvement among the Region X workforce. Only one in four workers engage in regular exercise, and over half are not pleased with their body weight. To the extent possible, efforts should be made to incentivize exercise (e.g., set self-care goals related to exercise, provide gym memberships, hold walking meetings, host fitness classes, share information, etc.).

Foster Financial Well-Being

Finally, much of the workforce indicated at least some degree of difficulty maintaining their economic well-being. To increase financial stability, efforts should be made to increase wages, especially among home visitors, who experience the most economic instability. In fact, wages were identified as the second most common reason for turnover (see *Brief 3*), suggesting that increasing wages may promote retention. In addition, it may also be beneficial to share information and resources related to financial well-being on topics such as strategies for saving money, paying off or avoiding debt, retirement planning, and the

like. Integrating financial counseling into human service professions, like home visiting, may not only benefit the workforce, but also the families they serve.[xxxiv]

In conclusion, the home visiting workforce must be supported in order to be supportive of families. This report indicates that there are many great things already happening in Region X to support the workforce, including reflective supervision and access to health care services; nevertheless, there is still much to be done to ensure all workers are thriving across domains of health and well-being.

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