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SPECIAL REPORT
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Nurturing Families Network Leading the Way in Connecticut:

Where we've been, what we've learned, where we're going

Connecticut's Nurturing Families Network Program

The Nurturing Families Network (NFN) program, funded by the Connecticut Children's Trust Fund, is a statewide system of continuous care designed to promote positive parenting and reduce incidences of child maltreatment. The program focuses on high-risk, first-time mothers and starts working with them at or before birth. The program is offered to parents in the service areas of all 29 birthing hospitals in the state.

This paper chronicles the evolution and expansion of Connecticut's Nurturing Families Network, including key stages of evaluation research and impact on program development. It describes participating families, their needs, and explains how NFN's home visiting model creates positive change in families identified as high risk for poor parenting. It also describes how NFN has responded to programmatic issues and changes over time, and how NFN is prepared to address the questions and issues that still remain. In addition, the location of NFN relative to other national home visiting models is examined, and program strengths are highlighted.

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NFN Program Components

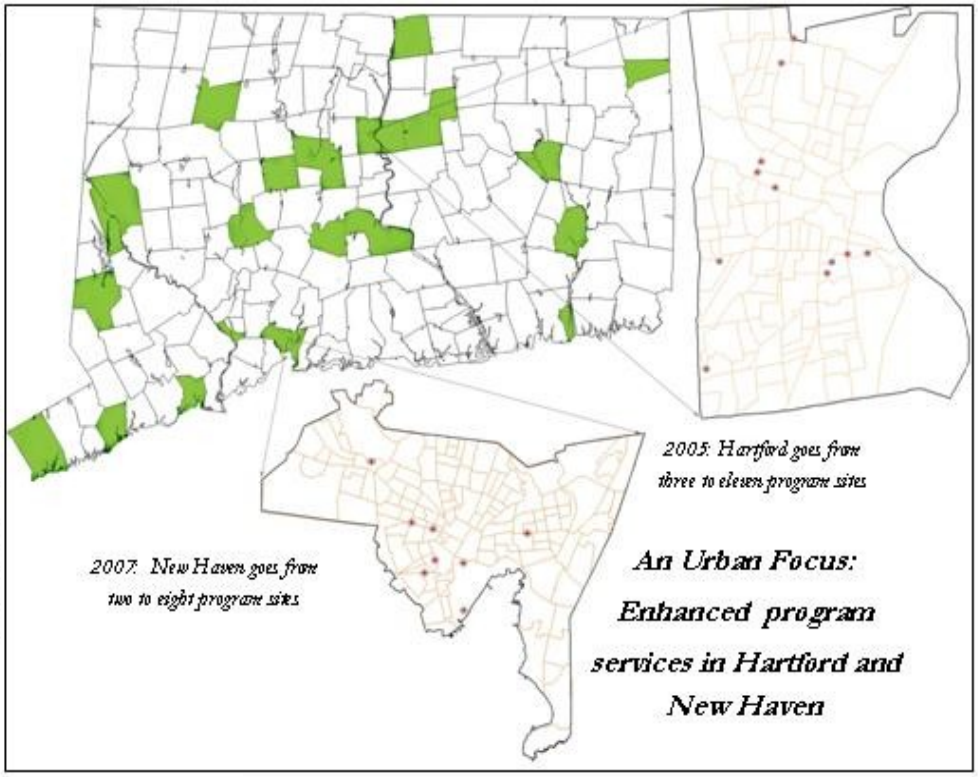
NFN's mission is to work in partnership with first-time parents by enhancing strengths, providing information and education, and connecting them to services in the community when needed. It is made up of three components: Nurturing Connections, Nurturing Parenting Groups, and Nurturing Home Visiting Program.

- *Nurturing Connections* is the gateway into NFN. Staff are responsible for performing the initial screening for identifying parents at low risk or high risk for poor parenting and child maltreatment. Nurturing Connections staff also provides telephone support and referral services for low-risk mothers.
- *Nurturing Parenting Groups* are community-based parenting education and support groups offered to all families at various risk levels, including all parents who enter the NFN system and parents in the community.
- *Nurturing Home Visiting* program provides high-risk families intensive parent education and support in the home and also helps to link families with needed resources and assistance for up to five years.

Chronology and Evolution of Program

When Connecticut's Home Visiting Model was initiated, the only program strategies that existed for child abuse and neglect in the state at that time were treatment-focused, i.e., *after* the fact. The charge of Connecticut's Children's Trust Fund was to develop effective strategies for *preventing* child abuse and neglect. Parent education alone was not enough, case management alone was not enough. Intensive services were called for and a national home visiting model (Healthy Families America) was adapted. Since that time (1995) the program has evolved from two to a total of forty-two program sites in the state. Along the way, much has been learned; there have been various stages of development, and the program model has morphed through several evolutions.

Program sites are located in every geographic area of Connecticut and in all 29 hospitals



From the start the goal has been to provide universal screening of all first-time mothers in Connecticut. Towards these efforts, in 2000 the Children's Trust fund combined home visiting with two other program components under the rubric of "Healthy Families Initiative:" a screening component located in all participating hospitals and a community-based parenting group to reach out to all family members. In 2003 the Children's Trust Fund made the decision to discontinue the national model and the Healthy Families Initiative became Connecticut's Nurturing Families Network. The Network is now a statewide *system* designed to provide a *continuum of services* to first-time mothers. It is operating out of all 29 birthing hospitals and thus has the infrastructure for going to scale in Connecticut. Even as the program has expanded and the number of families being served has substantially increased, program evaluation continues to show many positive program aspects and outcomes. Rates of substantiated abuse (< 2% during 2006), as related to other studies of home visiting models across the country, indicate we are making an impact.

Connecticut's Home Visiting Model:
Chronicle of Program Expansion & Participation of all 29 birthing hospitals

1995: Healthy Families Home Visiting model starts

1995: St. Mary's Hospital

1996: Bridgeport Hospital, Griffin Hospital, Manchester Memorial Hospital

1998: Yale/New Haven Hospital, Lawrence and Memorial Hospital, Danbury Hospital 1999: Hartford Hospital, Sharon Hospital, Charlotte Hungerford Hospital, Windham Hospital

2000: St. Francis Hospital, Rockville General Hospital, Stamford Hospital, William W. Backus Hospital, Norwalk Hospital, Hospital of Central Connecticut (formerly New Britain General)

2001: Healthy Families Initiative: A "System" of Care

2002: Waterbury Hospital, Middlesex Hospital, Midstate Medical Center

2003 From Healthy Families Initiative to Connecticut's Nurturing Families Network

2004: Day Kimball Hospital, St. Vincent's Hospital

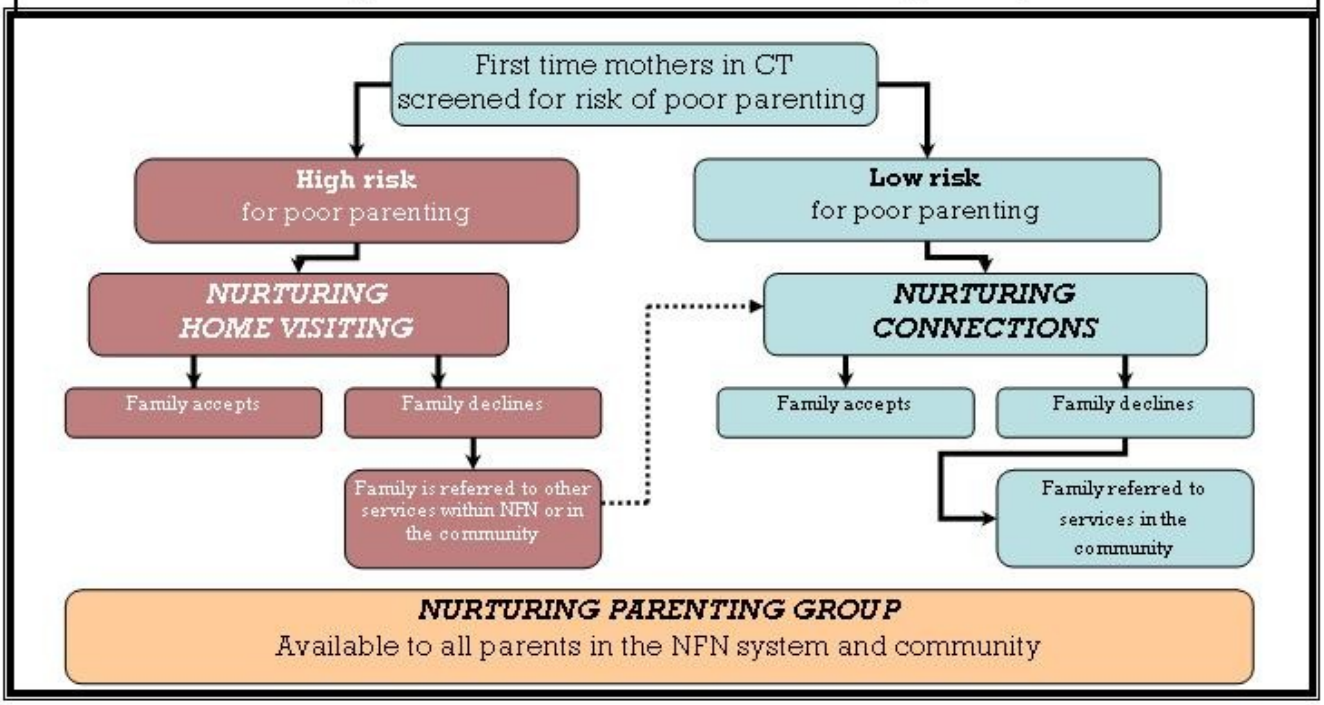
2005: Hartford goes to scale: from 3 to 11 programs

2006: Greenwich Hospital, Bristol Hospital, St. Raphael Hospital

2007: John Dempsey Hospital, Milford Hospital, New Milford Hospital, Johnson Memorial Hospital

2007: New Haven goes to scale, from 2 to 8 sites

Nurturing Families Network: *A Statewide System of Care*

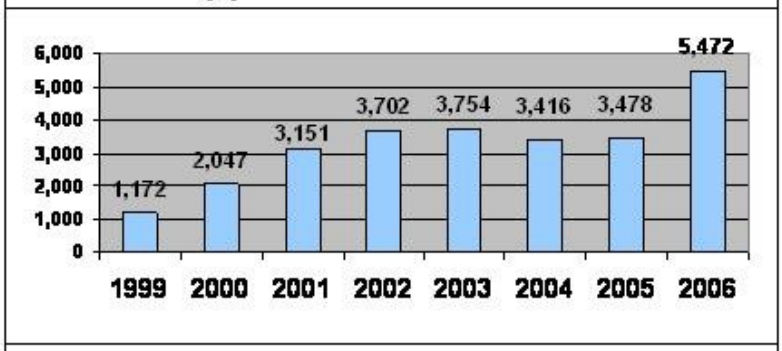


Number of Connecticut families who have been screened and receive home visiting services

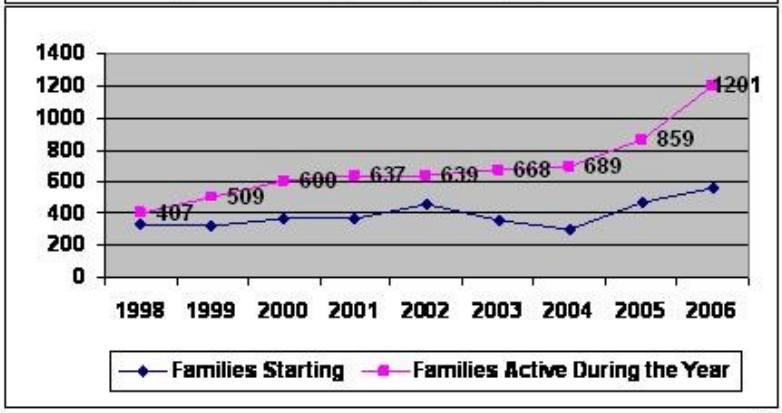
The flowchart illustrates how families enter the NFN system and the various pathways they may follow. Almost 97% of families offered the home visiting program voluntarily accept its services. As the program sites expanded across the state, there has been a comparative increase in screenings and participation in the home visiting program (see graphs on right). The biggest increase occurred with the expansion in Hartford (2005), and a similar expansion is expected over the next one to two years as New Haven increases their services.

There are over 300 family service professionals working for Nurturing Families Network, actively engaging 1,500 to 2,000 families each year. There are dozens of public and private service centers, from neighborhood-based community programs to large hospital and clinic settings.

Number of first time mothers screened : 1999-2006



Nurturing home visiting participation by year since 1998



NFN Stages of Research & Impact on Program Development

Program evaluation and research have been integrated components of Connecticut's home visiting program since its inception in 1995. Descriptive and outcome data have been routinely analyzed, compiled in both yearly and quarterly reports, and used for monitoring changes occurring in areas that the program is trying to impact. By charting program performance in the same areas over time, the performance history also serves as a basis for judgment; that is, prior performance serves as a benchmark for comparing current performance.

Interviews, focus groups, surveys and ethnographic field work have been used to acquire a better understanding of the program intervention, program dynamics, and the characteristics of the families receiving services. Both outcome and process data have been used to inform program development and provide direction for ongoing research and evaluation. This collaborative and interactive effort between practitioners and researchers in assessing program effectiveness and implementation exemplifies pragmatic research that focuses on issues of practical importance and the timely application of knowledge. The comprehensive scope of evaluation completed by the Center for Social Research is listed here:

- **Annual Outcome Evaluations using a pre-post design (1996-2007)**: Assortment of data collection strategies, including baseline questionnaires, monthly data forms, and standardized measures.[1]
- **"Reflections on a program" (1996):** Documented organizational practices and daily activities of the program to inform and refine conceptualization of the program intervention.[2]
- **"Process Evaluation of a Home Visitation Program to Enhance Positive Parenting and Reduce Child Maltreatment" (1998-2000):** Focused on program practices and a theoretical rationale for a paraprofessional model (see p.9). [3]
- **Study Circles (July-October 2001):** An action research design to promote dialogue among practitioners to propose practices, policies, and solutions to concerns identified in the research.[4]

NFN Process and Outcome Measures

- Enrollment, engagement and retention rates
- Kempe Family Stress Checklist
- Child Abuse Potential Inventory
- Adult-Adolescent Parenting Inventory 2
- Rates of child abuse and neglect
- CES Depression Scale
- Parenting Stress Index
- Conflict Tactics Scale
- Community Life Skills
- Changes in parent education, employment, and living circumstances

- **Continuous Quality Improvement (CQI) (2002 and ongoing):** Continuous Quality Improvement Team (CQI) emerged from the Study Circles and is charged with making policy recommendations that govern the services of NFN and with overseeing program practices. All program roles are represented to ensure broad representation.[5]
- **"Life Stories of Vulnerable Families in Connecticut" (2002-2004):** Analysis of 171 interviews with program participants conducted in 2002 and 2003 identified four patterns of vulnerability among mothers at risk for poor parenting (see p.8). [6]
- **Expanded analysis of child abuse and neglect reports (annually since 2004):** Comparison of abuse rates between program sites &with other studies of parents with similarly high risk factors who (1) did not receive an intervention and (2) also received home visiting intervention (see p.10)[7]
- **Hartford NFN: Neighborhood analysis (2005):** Analysis of social and economic context of program and family neighborhoods.[8]
- **Research Team analysis of NFN model (September-December, 2007):** Critical analysis of current NFN program in comparison with national models.

Continuous Quality Improvement Team

Major Policies

- Creative Outreach Policy
- Family Engagement
- Looking for the little steps
- Clinical Supervision
- Length and content of visits
- Working with Significant others
- Families with Cognitive Delays
- Families with Multiple Children Policy
- Families with Acute Problems Policy
- Professional Development Policy

Home Visiting at the National Level: Research Findings Show Challenges

Much of the evaluation and research on Nurturing Families Network has been guided by emerging issues and questions at the national level. Two of the most prominent national models of home visiting are Healthy Families America (HFA), developed by Prevent Child Abuse America in 1992 (the model that was originally adopted by Connecticut), and the Nurse Family Partnership (NFP) model that was established in 1977 as a research-demonstration project. The research on these models has shown mixed results. There has been much debate regarding the relative effectiveness of the NFP (nurse model) versus the HFA (paraprofessional) model. The following sections review key questions and issues that dominate the national scene.

Randomized control design & evidenced-based practice

Not surprisingly, one overriding debate concerns evidence-based practice. Evaluations that are conducted with an experimental design that includes a randomly assigned control group are seen as the "gold" standard in assessing social service programs. For example, the popularity of home visiting has been driven by the program with the strongest evidence of success: the Nurse Family Partnership model. In a series of rigorous experimental designs, the NFP showed demonstrable results in both parenting and child outcomes .[9] However, evidence-based practices identified during a demonstration project that is conducted under optimal conditions may not be as effective when used in everyday settings where the conditions, funding and support may be less than optimal. Randomization studies on programs that have been brought "to scale" are not only much more difficult to conduct but there is less control over program implementation, staff training and supervision. For instance, in one review, replication of the NFP program resulted in variation in attrition rates and maternal and child outcomes across sites.[10] Inconsistent findings from multi-site randomized trials of Healthy Families America home visitation have raised important questions about the challenges of program implementation, the population being served, and home visitor qualifications.[11]

Program implementation & quality assurance

One of the more salient findings from two randomized trials on the Healthy Families Hawaii and Healthy Families Alaska programs is that service delivery and outcomes, varied considerably across program sites.[12,13] This underscores the importance of studies and evaluation that focus on the quality and consistency of program implementation. No matter how carefully evaluated a program is, all home visitation models face the challenge of ensuring program quality as the model is replicated in new sites and adapted by various organizations within diverse communities. Current emphasis in home visitation evaluation research is on establishing a data management infrastructure that provides agencies with regular reports on process and outcome measures that readily facilitate improvement in implementation.[14]

Who receives services versus who delivers services

Much debate regarding the relative effectiveness of the NFP (nurse) model versus the HFA (paraprofessional) model mainly focuses on who delivers services. Randomized control studies of programs that utilize paraprofessionals as home visitors have had mixed results. This includes a study that compared outcomes in paraprofessional home visiting with nurse home visiting and found paraprofessional effects to be approximately half the size of those produced by nurses.[15] Not surprisingly, the efficacy of the paraprofessional model was called into question. However, a follow up study looked at outcomes 2 years after the program ended and found that although there were greater effects for *children* in nurse-visited families, there were greater effects for paraprofessional-visited *mothers*.[16] An important study on Healthy Families New York (paraprofessional model) found significantly positive outcomes for two participant subgroups as compared with a control group: a "prevention" subgroup (first-time mothers versus mothers who have already engaged in abuse) and a "psychologically vulnerable" subgroup.[17]

Credentials & professionalism of the home visitor

The experience and training requirements for home visitors have also been the source of much debate.[18] Typically paraprofessionals come from the community that they serve. The assumption is that given their community ties and similar backgrounds to the parents, they will be able to easily reduce family resistance to professional services and more easily form a rapport. Historically, paraprofessionals had little formal education or training beyond what was offered by the program. For example, in the study that compared outcomes of paraprofessional-provided services with nurse-provided services, researchers deliberately refrained from hiring anyone with a college education. However, as of 2003, 37% of HFA home visitors nationally had bachelor's degrees, and an additional 39% had some college experience.[17] Nonetheless, several studies have cited the challenges of a paraprofessional model. Strong identification with families and working in contexts characterized by scarcity can make it difficult for the home visitor to find a coherent role, and in some cases, they may become "protector" of the community and families and question the usefulness of curricula and other program tools.[11,19]

Mental health, Substance abuse, Domestic violence, Father involvement

The need to enhance home visiting services in managing mental illness, substance abuse, and intimate partner violence is well documented. Home visiting programs, whether delivered by nurse practitioners or paraprofessionals, are often challenged by the clinical and social issues that many parents present.[9,16,20-23] The high prevalence of maternal depression and trauma history in home visiting populations and the challenges that they present for home visitation are a relatively new programmatic and research focus. One promising study examined the impact of in-home therapy concurrently with home visiting services and found substantial reduction in symptoms of depression from pretreatment to post-treatment.[11,21] In addition, as programs increasingly see positive outcomes for children and mothers, there is growing interest in developing support and services for fathers in program activities as well.[12,23]

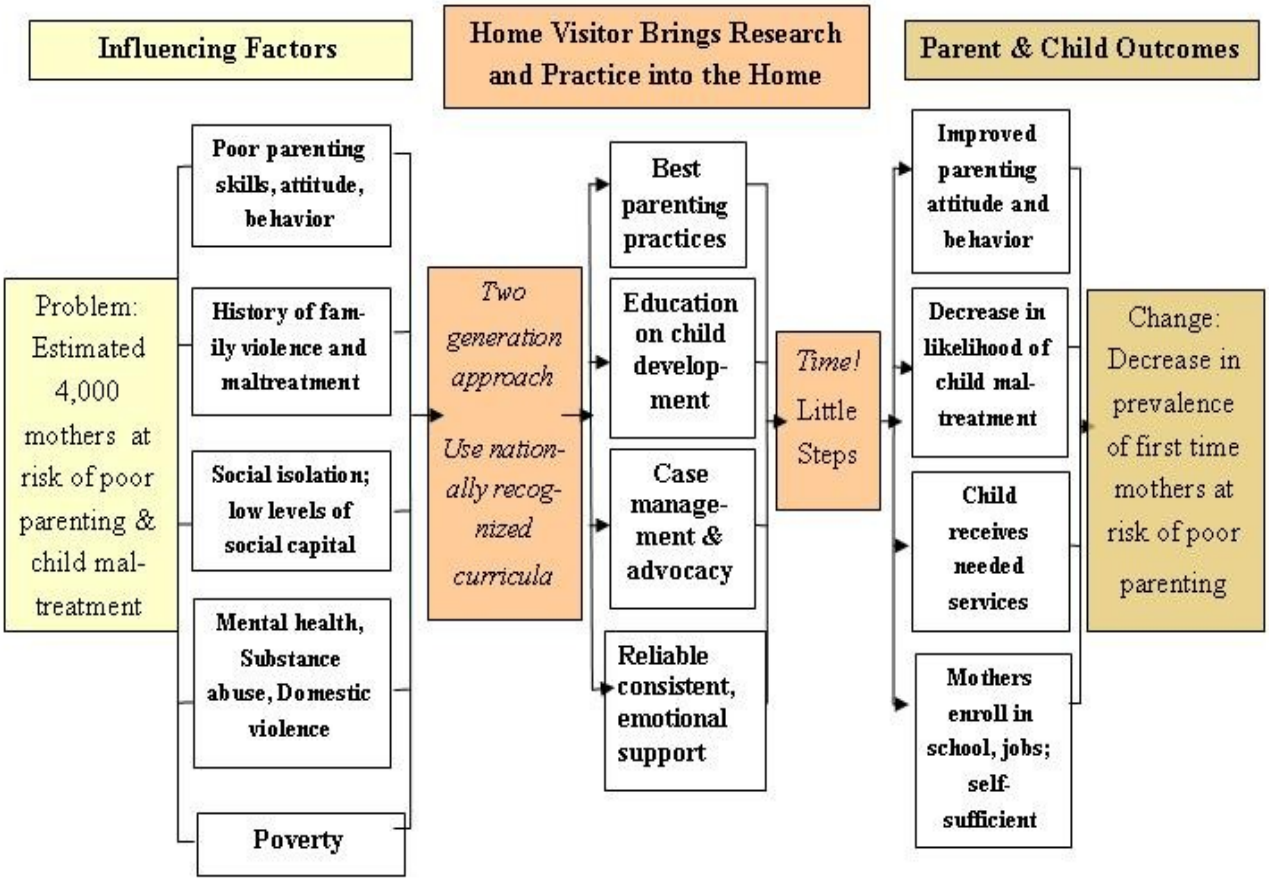
Staff training and supervision

It is well recognized that learning and change take place in the context of the relationship the parent has with the home visitor.[18] Home visitors frequently encounter resistance and inattention from this struggling population and have to patiently attempt to move forward and adapt program practices and goals to the particular contexts of families when and how they can. "The helper has to enter the client's world, not just to gain trust, but to gain 'significance.' At the same time, he or she has to be seen as a new and different figure, one that creates new possibilities and room for change."[24] Regardless of their backgrounds and education, home visitors require a great deal of training and supervisory support. Aspects of program implementation that are especially important are training and support for this relationship to develop in a manner that facilitates change.

Explicit and comprehensive theory of change

The home visitors deliver the content of the program based on their understanding and beliefs about how the program is supposed to work, whether this is explicit or not. Findings from both experimental and qualitative studies highlight the importance of articulating the intervention steps of a program and explicitly stating the links between these steps and the needs of the families and the goals of the program.[25,26] Furthermore, one exploratory study found that even with a well implemented program, where the home visitors were consistent and had a strong sense of what they were trying to do, the change theory was not comprehensive enough to address the multiplicity and complexity of the issues affecting parents.[25]

How Nurturing Families Network Creates Change in CT



To understand how the NFN program works, a model that describes the nature of the problem in Connecticut and how the program intervenes in ways that create change is depicted above. Various data sources are used to describe details of the model including factors related to child abuse and neglect (p. 8), bringing research and practice into the home (p. 9) and program outcomes (p. 10).

Underlying Assumptions for Creating Change

Universal screening and targeted recruitment: The first step in preventing the initiation of child abuse is targeting first-time mothers in situations where risk factors for poor parenting are apparent. The long-term goal of the program is to interrupt the inter-generational transmission of risk and positively shape future parenting behaviors and child outcomes. In Connecticut there are an estimated 4,000 first time mothers each year with at least one significant risk factor for abuse or neglect.[7] Although the goal is to reach families at the prenatal stage, the relationship with all 29 birthing hospitals provides a unique opportunity to facilitate services during the immediate postpartum period.

Two generation approach: Services need to focus on both the parent and the child. The primary purpose of home visits is to address parenting issues using child development and parenting curricula; these visits actually involve much more. Families are often burdened by hardships that are difficult to fathom. Making a home visit requires home visitors to engage and mediate these hardships and requires they be prepared for resistance, indifference, and ongoing crises. Home visitors are advocates for families, interacting with community institutions (e.g., schools, public assistance); they help establish and follow through on goals; they make referrals to community services; they help families negotiate crises; and they spend a great deal of time providing emotional support and positive feedback to the mothers.

The relationship between the home visitor and family is at the heart of the program: The development of a trusting relationship between the home visitor and the family is essential for creating change. However, the relationship is directed by specified roles - home visitor as baby expert, advocate, friend and fictive kin (see p. 9) - that facilitate the creation of a significant relationship, deliver the program content (i.e., child development curricula), and respond to sudden crises.

Time: The model recognizes that it often takes a very long time for families to have the trust and hope essential to make improvements. It is not unusual for family progress to go up and down for a year before it stabilizes. The more interactions over time, the more opportunities to foster trust based on experiences and perceptions that develop.

Connecticut's Vulnerable Families

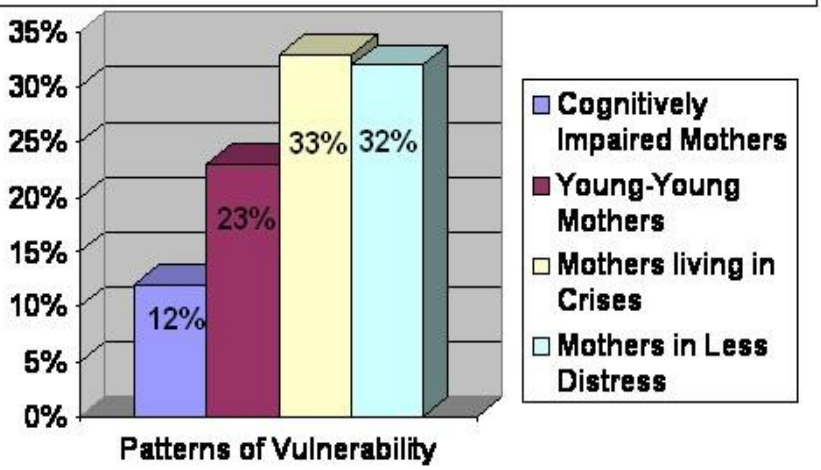
Abusive parents often have inappropriate expectations of children and little awareness of their needs which stems from their own poor self perceptions. They often have little to no knowledge of stages of child development and believe in physical punishment as a proper disciplinary measure. In fact, abusive parents may look to the child to be sensitive to their needs (role-reversal) and are disappointed when the child does not respond to this demand.[27]

We know that abusive parenting patterns are often learned through personal histories of poor nurturing, rejection, family violence, sexual abuse, material deprivation, and a sense of failure. Lack of social support or social isolation is one of the strongest predictors of child abuse.[27]

Factors related to poverty and economic insecurity - scarce resources, minimal social supports, heightened violence - profoundly take a toll on parents' energy, patience, sense of control, and mental health. In turn, depression and other forms of psychological stress affect parent interactions with their children and undermine their ability to focus on their children's needs and respond appropriately.[24]

Analysis of 171 interviews with program participants conducted in 2002 and 2003 identified patterns of vulnerability among mothers in Connecticut who were identified as at risk for poor parenting.[6] These mothers' life stories show the struggles of families throughout Connecticut in large and small cities, in towns and rural areas. Four distinct subgroups were identified, each of which helps to define a mother's struggle with being a first-time mother (see below). These include "cognitively impaired mothers," "young-young mothers," "mothers living in crises," and "mothers in less distress." What is most striking in their stories is the range of vulnerabilities and the complex of needs among these first-time mothers. Moreover, many of the women have multiple vulnerabilities that interact with one another. The vulnerabilities that were identified merge, diverge, and re-emerge across the life course. Clearly a "one size fits all program" is not useful. Perhaps the greatest challenge to the art of home visitation is learning how to allow the needs of the mother to organize the relationship (see p. 9). The life stories teach us this important lesson.

Who Benefits from Nurturing Families Network?



"Cognitively Impaired Mothers" (N=21)	*"Young-Young Mothers" (N=40)*	*"Mothers Living in Crises" (N=52)*	*"Mothers in Less Distress" (N=51)*
• Majority of these mothers had been in special education programs • Learning needs were an evident vulnerability. • Unexpected but desired pregnancies • Older mothers (in their 20s) with previous pregnancies • Parents of the mother were sometimes dubious about the pregnancy.	• These mothers were between the ages of 13 and 16. • Many were victims of statutory rape • Pregnancies were sometimes normalized by families • Most spoke of being "scared" • Immaturity & bonding issues with child were themes • Finishing school was an additional problem	• Violence • Poverty • Substance abuse • Psychological problems • Medical problems	• Linguistic isolation, immigrant status, and economic instability • Social isolation as a result of life transition • History of mental illness and currently receiving treatment • Mothers recovering from substance abuse

Bringing research to practice: The Cultural Broker Model

Interaction between home visitor and family member is the heart of the program

Interaction between home visitor and clinical supervisor is equally important

The home visitors are at the frontlines of the program, bringing the services and program approach into the communities and homes. The organization and direction of the relationship between the home visitor and mother is often guided by the different needs of vulnerable families. It is here where the research is translated into practice.[3] Home visitors have to be able to bridge the knowledge, practices, and philosophies of the professional culture with the needs, concerns, and desires of a population that struggles with a range of issues and problems. They "broker" meaningful communication and interaction between these two distinct cultural worlds. The bridge from community culture to professional culture involves establishing an empathic connection with community families, earning their trust, understanding their lives, and communicating their needs, desires, concerns, and difficulties to professional supervisors. Simultaneously, the bridge from professional culture back to community culture involves taking the knowledge, philosophies, and practices of the NFN model back to community families by demonstrating its value, application, and relevance to their lives. When this process occurs, the home visitor is in the role of cultural broker, acting as the interpreter, facilitating genuinely reciprocal communication between two cultures in which this communication does not normally and naturally occur. Bicultural competence is an ability, a set of skills and a base of knowledge. For these reasons the home visitor's success not only depends on her personal and cultural experiences with the population she is serving, but very much depends on the relationship she develops with her supervisor. Home visitors must rely on clinical supervisors to assist them in becoming "baby experts," in cultivating their social capital as community advocates, and in maintaining the professional objectivity needed for appropriately assessing different situations. Home visitors must believe in the relevance of professional knowledge and practices for the families they are serving, and they must trust that the professional culture, as represented by the clinical supervisor, is committed to improving the lives of families.

Characteristics of CT Home Visitors

- *#1 Priority:* Interpersonal skills and experience to engage families in constructive relationships
- Writing & analytical skills
- Education level (2007 data)

  GED/HS diploma: 30%
  Associates degree: 14%
  Bachelor's Degree: 48%
  Graduate Degree: 8%

"[Home visitor] is a real nice person. She is always laughing. When she comes over I laugh. Anybody can see that. I laugh when she's over. I change...my whole personality changes to a different person just because she is around." - - Participating mom

Life story interviews with NFN mothers in 2002 and 2003 provided an opportunity for mothers to describe their program experiences and perspectives.[6] They articulated what they valued most about their relationships with their home visitors.

Home Visitor as Baby Expert

Many vulnerable mothers are noticeably grateful to home visitors who can help them do what many fear they might not do well: raise a healthy child. Relationships with home visitors often get organized primarily around the quest to prove to themselves and others that they can indeed be good mothers. In fact, at all sites, the focus on child development is central to program services and often becomes the organizing dynamic around which mothers make connections with home visitors.

Home Visitor as Advocate

Moms often feel powerless in interactions with medical authorities, state authorities, landlords, school principals, and the like. Their powerlessness stems from a combination of poverty, language and educational limitations, and diminished self-images. Because the home visitor can correct some of the asymmetry caused by these power differences, the home visitor-as-advocate can be the basis of a very strong relationship.

Home Visitor as Friend

The vulnerabilities that many mothers in the program experience create the possibility for emotional connection that very often gets articulated as friendship. Friendship needs to be combined with the roles of baby expert and advocate in order for the home visiting practice to be most effective. Friend-like dynamics, however, lay a groundwork of trust and mutual expectation, providing an opening in which to develop, examine, and change parenting practices.

Home Visitor as Fictive Kin

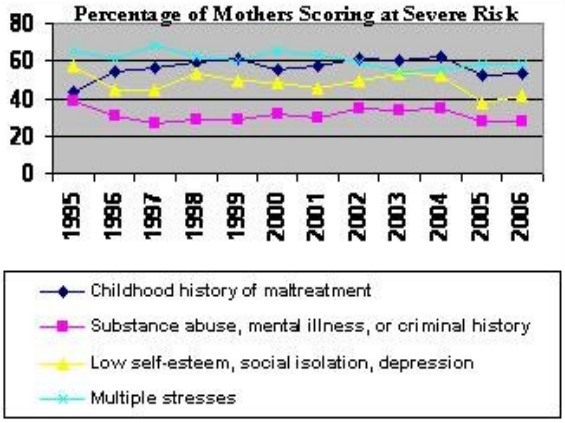
"Fictive kin" refers to a concept taken from anthropology in which family networks include individuals who are not related by blood but through their collective efforts to raise children. Becoming part of the child's life often earns the home visitor her place in the family.

Is Connecticut making a difference?

The program has consistently reached a vulnerable population, has provided them with intensive services, and has overall yielded positive results:

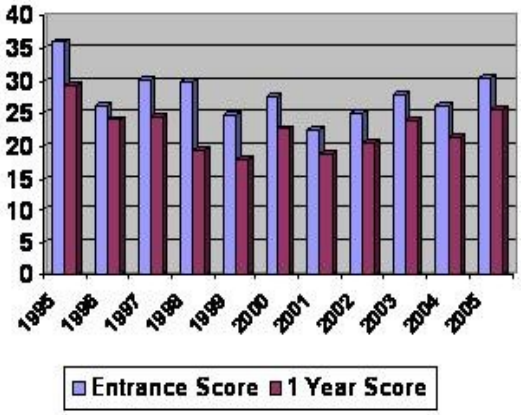
- The program has done an excellent job of identifying and recruiting a high-risk population.
- Mothers who remain in the program for one year show significant improvements in parenting attitudes.
- There are low rates of child abuse and neglect among program participants.
- The program has done an excellent job of linking families to services in the community.
- Mothers who remain in the program for one or two years often achieve educational and employment goals.

Home visiting staff are enrolling high-risk mothers into the home visiting program as measured by the Kempe Family Stress Checklist



For each program year, over one half of these first-time mothers had experienced severe maltreatment as children and one half experienced multiple stresses. On average, about 40% of mothers showed signs of low self-esteem, social isolation, or depression, and about 30% had histories of substance abuse, mental illness, or criminal activity.

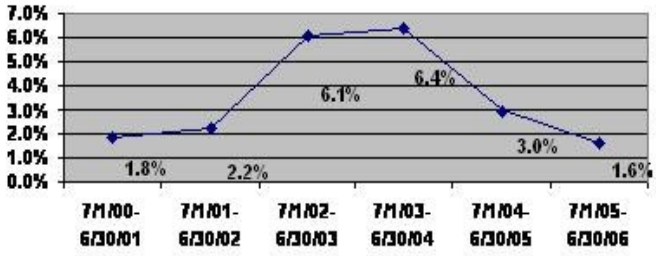
After one year, mothers show significant change on the Child Abuse Potential Inventory (CAPI) Rigidity subscale



The Child Abuse Potential Inventory (CAPI) is a well researched standardized instrument that measures the risk of maltreating children. Mothers have consistently shown significant, positive change on the CAPI Rigidity subscale, indicating that mothers have less rigid expectations of their children and are less likely to treat their children forcefully.

Annualized rates of child maltreatment within the NFN home visiting program have decreased for the past two years and the annualized rate for 7/1/05 - 6/30/06 dropped to 1.6%, an almost 100% reduction from the previous year. However, in 2002, there was a marked increase (see graph). Analysis of reports concluded that issues surrounding domestic violence, substance use, and mental health were prevalent in our sample of perpetrators.[1,7,8] These maltreatment rates were compared with the rates reported in two studies with similar high-risk mothers not receiving home visitation services: in the first study, 25 % of the children in the high-risk group had been maltreated[28] and in the second study 22% of mothers had maltreated their children.[29] These rates are almost four times as high as the NFN rates (5.4% for a two year rate). We continue to monitor rates of maltreatment as well as details of reports.[7] Our analysis of the 2005-2006 data indicate that 95% of substantiated reports of maltreatment involved physical neglect and one-third of substantiated reports involved a parent with a mental illness or cognitive deficit.

Rates of Child Maltreatment among NFN Participants



Program Model Drives Program Training and Clinical Supervision

NFN in Action[30] - ***M***ission, policies, program model & implementation, practice of home visiting
- ***A***ttachment theory, Ages & Stages developmental monitoring, shaken baby syndrome
- ***S***creening, assessment, engaging families, nurturing group curricula

Parents as Teachers: Born to Learn Training[33,34]

Six-day training based on neuroscience research on early brain development and learning

Topics (prenatal to3):

Sequences of early childhood development
Effective instructional personal visits
Facilitation of parent-child interaction
Ideas for parent group meetings
Ways to connect to community resources
Service to diverse families
Red flags in areas of development
Hearing, vision, and health
Recruitment and program organization
The Born to Learn Curriculum (video series, parent handouts, prepared visit plans, and resources for parent educators)

Topics (3 year to kindergarten):

Two-day training

All elements of literacy, including reading, writing, listening and speaking
Value of play and adult's role
Aspects of motor development
Aspects of social-emotional development
Aspects of intellectual development
Parent group meetings: topics related to development and parenting issues for age group

Family Development Credential[31]

80-hour community-based training

Topics explored:

Communicating with skill and heart
Taking good care of yourself
Diversity
Strength-based assessment
Collaboration

Introduction to Nurturing[27]

Two-day training

Identifying patterns of abusive parents

Inappropriate expectations
Lack of empathy
Strong belief in physical punishment
Parent child reversal
Power and Independence

Touchpoints[32]

16-hour training in anticipatory guidance

***Topics* explored:**

Communication and relationship strategies
Prevention through developing relationships
Significance of cultural, religious, & social dynamics
Focus on strengths
Emotional experience of developing parent
Multidisciplinary approach

Implementation of clinical supervision[30]

- Weekly case reviews
- Joint home visits
- Group supervision
- Professional development & education

Clinical Supervisor listens, ask questions, provides feedback

- Helps home visitor think about how to adjust her approach to reflect and accommodate the family
- Helps the home visitor identify red flags that might alert her to specific problems
- Helps the home visitor identify and address specific problems or circumstances
- Provides feedback and impressions of the family assessment & plan for first visit
- Helps home visitor to organize her thoughts and her work with a family over time

What Distinguishes NFN from other Program Models?

*L*ike most programs, Nurturing Families Network has moved through several developmental stages with periods of transition and growth followed by periods when the program plateaued before moving to the next stage. Unlike many programs, however, change has largely resulted from carefully designed research to inform and refine program practices. From the beginning researchers worked closely with practitioners and front-line workers using their expertise and observations to gain insight into emerging issues. When cumulative research identified practice and policy issues, aggressive steps were taken to make changes. In 2000 a series of committees were established to review program roles, training, and supervision.[4] From this process a vision of a "new home visiting program" was created. In 2002 a Continuous Quality Improvement (CQI) Team was instituted as a forum for developing policy and protocols and for monitoring program fidelity. All of this activity served as a catalyst for breaking away from the national model and, in 2003, the Healthy Families Initiative became Connecticut's Nurturing Families Network. Since that period of transition, there has been significant improvement in parenting curricula, training, and supervision. The program model for creating change uses the most recent science on child development and parenting practices with high-risk families but also incorporates an understanding of the experiences and belief systems of the families, home visitors, and clinical staff, and the nature and importance of their interaction.

Next Steps:

*I*n response to the research on national home visitation programs, Connecticut's research-practitioner model has taken specific steps to (1) monitor program implementation and understand the nature of the intervention; (2) articulate a model that links the intervention steps with the needs of the family and the goals of the program; and (3) use the change model to drive the quality and content of staff training and clinical supervision. Even as the program has expanded statewide and the number of families being served has substantially increased, program evaluation continues to show positive outcomes. Rates of substantiated abuse (<2% during 2006), as related to other studies of home visiting models across the country, suggest we are making an impact in Connecticut.[22]

*A*t this new plateau in the program, NFN continues to look toward the research at both the national and local level for direction and next steps in order to:

- build capacity for screening and serving all first-time mothers in the state of Connecticut;
- conduct a pilot project for therapeutic treatment of depression in home visitation;
- strengthen the program focus on fathers;
- focus research and analysis on child outcomes; and
- focus research on the home visitor's qualifications, educational level, training, and characteristics.

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SPECIAL REPORT

Nurturing Families Network
Leading the Way In Connecticut:
Where we've been, what we've learned, where we're going

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