The Nurturing Families Network

Policy and Practice Manual

2007 Edition

Prepared by the
State of Connecticut
Children's Trust Fund

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FOREWORD

Acknowledgments

The Connecticut Nurturing Families Network (NFN) policy manual has benefited from the insight and involvement of the hundreds of staff who have worked for the program, the thousands of families who have participated, and the many others who have given their time, energy and expertise to this important work.

The Children's Trust Fund would like to especially thank the members of the Continuous Quality Improvement Team who came together over the past several years to address policy and practice issues and questions within the program. Their wisdom and concern for the families guided their work. The result of their effort is reflected in the strength-based, family-centered practice that is central to the Nurturing Families Network.

We would also like to recognize the important contribution of the University of Hartford Center for Social Research for its rigorous evaluation of the program. The University has provided critical information that has helped us to strengthen the program and learn from our experience. Our thanks go to Dr. Tim Black, Principle Investigator, and to Meredith Damboise, M.A., Research Associate, and others who have contributed to the research.

None of the work of the Nurturing Families Network could be possible without the leadership and guidance of the Children's Trust Fund Council, and the hard work and dedication of the entire staff of the Children's Trust Fund; thank you.

We want to thank Healthy Families America, Healthy Start Hawaii, Dr. John Leventhal, Dr. Stephen Bavolek, Dr. Henry Kempe and Dr. David Olds for their contributions to the field of child abuse and neglect and their inspiration for the development of this prevention model.

We would also like to thank the Connecticut General Assembly and the Governor for their ongoing commitment to the program. In particular we would like to recognize Representative Jack Thompson, Senator Toni Harp and Representative Bob Farr for their critical leadership and support for the development of the Nurturing Families Network.

In addition we would like to recognize all of the agencies, organizations and institutions that have provided Nurturing Families Network services to thousands of families in communities throughout Connecticut.

Children's Trust Fund

Welcome to the Nurturing Families Network!

You are now an integral part of a statewide network of dozens of neighborhood-based community centers and hundreds of caring family service professionals making a real difference in the lives of Connecticut's children and families.

The Nurturing Families Network helps first-time parents manage the myriad of challenges that come with bringing a child into the world. Many of the families in the Network, in addition to caring for a new baby, are also addressing issues related to poverty, social isolation, mental health, substance abuse and domestic violence.

As a Nurturing Families Network family service provider, you will be provided with the training, technical assistance and resources of a program that has a demonstrated track record of helping to break the tragic cycle of child abuse and neglect.

The Nurturing Families Network is unique. How? Because it focuses on providing services *before* a parent's first child is even born – therefore, before a crisis occurs. This preventive approach is a hallmark of Children's Trust Fund programming and is crucial to the success of the Nurturing Families Network. The majority of child protection services, critical as they are to the welfare of Connecticut children, all intervene *after* a child has been abused, neglected or identified with a mental health issue or other problems.

Research has shown that the Nurturing Families Network can help program participants become nurturing parents and self-sufficient members of society. The program successfully identifies, engages and assists parents who are at risk of harming their children while reducing the incidence and severity of abuse and neglect.

You are now part of this exciting initiative to give Connecticut children a safe, nurturing start in life. This policy manual is the first step toward program implementation. In it you will find a wealth of information, insight and resources. We hope and trust you will find it a useful and indispensable resource.

On behalf of Connecticut's families, welcome to *our* family.

Karen Foley-Schain

Karen Foley-Schain, M.A., M.Ed., LPC
Executive Director, Children's Trust Fund

What is the Children's Trust Fund?

The state of Connecticut General Assembly created the Children's Trust Fund in 1983 to coordinate efforts and funding for programs designed to prevent child abuse and neglect. This initiative was part of a national movement to establish such funds in all 50 states. The Trust Fund was established as a state agency in 1997.

The Trust Fund prevents child abuse and neglect by supporting local efforts that help families and communities ensure the healthy growth and development of children.

Since its inception the Trust Fund has developed or funded more than 200 family service programs and initiatives statewide. Signature programs of the Trust Fund include:

- **Nurturing Families Network,** a statewide program that assists parents – particularly high-risk parents – with the challenges of parenthood. The program engages and supports parents before their first child is born through intensive home visiting, group-based parent education and information and support. The Nurturing Families Network serves more than 5,000 Connecticut families per year and is available in 25 of the state's 29 birthing hospitals.

- **Family Empowerment Initiatives** include eight prevention programs that assist high-risk groups of parents with children of varying ages. The programs are located in settings where families may be addressing other issues – schools, substance abuse treatment centers, prisons, domestic violence shelters, child guidance clinics, hospitals, community centers and public housing projects.

- **Connecticut Family Development Institute** offers a series of training programs that provide essential skills to those who help Connecticut families become self-reliant.

- **Help Me Grow**, a program that identifies young children at risk for developmental and behavioral problems and connects them to community resources.

- **Kinship Fund** awards small grants to orphaned or abandoned children living with court-appointed relative guardians. The Trust Fund provides funding to eight probate courts to administer the program.

- **The Parent Trust Fund** encourages strong parent participation in all aspects of community life by offering leadership training in communities across Connecticut. This effort has led to parent involvement in schools, the inclusion of parents on boards and advisory committees, in legislative and other advocacy activities, and at conferences and forums.

- **Shaken Baby Syndrome** prevention program, modeled on the Dias program, educates parents about the dangers of shaking a baby though a statewide collaborative with hospitals and community based initiatives.

- **The Childhood sexual abuse** prevention program is an innovative, offender-focused approach that encourages adult and community responsibility for preventing abuse.

Funding

Federal and state resources, as well as private funding, sustain the Children's Trust Fund. The Trust Fund is the lead agency in Connecticut for the federal Community-Based Grants for the Prevention of Child Abuse program under the Child Abuse Prevention and Treatment Act.

Governance

A 16-member interdisciplinary board known as the Children's Trust Fund Council governs the Children's Trust Fund. The Council includes the Commissioners from the Departments of Children and Families, Public Health, Social Services and Education, as well as parents, a pediatrician and legislatively appointed individuals from the business community and the child abuse prevention field.

Policy Statement

The components of the Nurturing Families Network, the scope of services provided by each component and the policies, procedures, practice guidelines and documentation requirements are subject to change.

Female pronouns ("she," "her") are used for home visitors because at this time all home visitors are female. All NFN program contractors are equal-opportunity employers.

THE NURTURING FAMILIES NETWORK

January 2007

INTRODUCTION

Nurturing Families Network

Mission

The mission of the Nurturing Families Network is to work in partnership with first-time parents facing the challenges of parenthood by enhancing their strengths, providing education and creating community connections.

Vision

The vision of the Nurturing Families Network is that every child will be raised within a nurturing environment.

Guiding Principles

- Developing a trusting and productive relationship between the program staff and the family is the foundation for strengthening a vulnerable young family.

- Consistent and reliable contacts are the most effective way of establishing a supportive and helpful relationship between the program staff and the family.

Program Objectives

- To offer all Nurturing Families Network program services voluntarily and at no cost to families.

- To initiate Nurturing Families Network services prenatally whenever possible, or at birth or within three months of the birth of the baby.

- To provide parents with prenatal and postnatal information that uses specific curricula for families based on the needs of the parents and the age of their child or children.

- To document the nature and scope of family needs by using standardized assessment tools such as the Revised Early Identification Screens (REID)and Kempe Family Stress Checklist Assessment.

- To supplement the Nurturing Families Network program with a network of community resources to meet the needs of families.

- To limit the number of families each staff member works with so each staff member has enough time to prepare and provide quality programs.

- To provide all Nurturing Families Network staff with intensive training specific to their roles within the Network, as well as on going clinical supervision at their sites.

- To deliver all Network services in a culturally competent manner, and offer all staff opportunities to address issues of diversity.

- To establish an advisory committee at all sites within the agencies that includes past program participants, professionals and community members, and other interested parties.

Program Description

The Nurturing Families Network has three primary components: Nurturing Connections, Nurturing Parenting Group and Intensive Home Visiting. All components of the Nurturing Families Network provide parent education, help in managing problems, a 24-hour phone line and referrals to appropriate agencies, but the nature and intensity of the services they provide and the complexity of the problems they address vary significantly.

Nurturing Connections

Screening

The Nurturing Connections program conducts universal screening of all pregnant and first-time parents. The Nurturing Connections Coordinator usually carries out this responsibility. The screening involves either a scan of medical records and/or a face-to-face interview with the parent(s) for several risk factors. The screening tool used is the Revised Early Identification Screen (REID). A memorandum of agreement with the maternity unit or clinic reflects this level of involvement with patients and/or their records.

Parents determined by the screening to be at lower risk of being abusive or neglectful are offered a second function of the Nurturing Connections program: parent support and education or other community services.

Parenting Support

The Nurturing Connections program seeks to provide all new families with critical information about health care and child care before the baby is born or while the mother and baby are still in the hospital.

The program is less intensive than the home visiting program and is designed to serve a less high-risk population.

Nurturing Connections provides information on:

- Prenatal care, including signs and symptoms that might indicate the need to seek medical care, preparing for child birth, and selecting a pediatrician.

- The Husky program, contacts for pediatric care, schedules for immunizations and well baby visits.

- Physical needs and capabilities of infants as well as information on accident prevention and the dangers of shaking a baby.

- Teaching parents about the capabilities and needs of children as they grow.

The program provides ongoing contact and parenting support for a minimum of three to six months after the baby is born.

Nurturing Connections has been shown to be an effective service for parents at all levels of risk for maltreatment.

Home Visiting

The home visiting program is free and offered on a voluntary basis to first-time parents. The families are identified prenatally whenever possible or shortly after the child's birth.

The program supports new families by linking them to a host of community services and providing timely and appropriate parenting education. The program has been effective in reducing the incidence of child abuse and neglect and in enhancing the relationship between parents and children. The program has also been successful in helping parents finish school, secure employment and obtain medical care.

The home visiting program is based on the concept of "family-centered practice." This practice is designed to engage families as partners. Program participants are offered weekly home visits for up to five years. At any time the frequency of the visits can be changed based on the family's needs and preferences. The home visitor and the family work together to create an action plan that meets the needs and desires of the family – drawing on the family's strengths, community resources and the skills of the home visitor.

The program staff members:

- Use approved curriculum
- Create activities to extend or facilitate learning
- Link families to community resources
- Conduct developmental screening

The first objective of the home visitor is to establish a relationship with the family. Often this is accomplished by addressing immediate and concrete needs identified by the family such as food, diapers and transportation. The second objective is to establish a plan for assisting the family that includes both case management and parent education.

Home visitors assume the broad role of teacher, supporter, advocate, child development specialist and liaison to the larger community. Home visitors are trained to have extensive knowledge and skills, including an understanding of child abuse and neglect, the ability to conduct a developmental screening, parenting and home management skills, and the ability to

access community resources. Home visitors work with each family to ensure a connection to a primary medical care provider.

Home visitors act as an empowering agent of change within the family system. This essential aspect of their work is primarily based on their personal ability to accept and communicate without judging.

Nurturing Parenting Group

The Nurturing Parenting Group program provides a positive group experience for families. The program is designed to address four distinct patterns of behavior highly correlated with abusive and neglectful parents.

- Inappropriate developmental expectations.
- Lack of empathy.
- Strong belief in corporal punishment.
- Reversing parent/child roles (i.e. excessive demands and needs for emotional support from the infant or toddler).

RESEARCH AND EVALUATION

Research and Evaluation

The Children's Trust Fund's development and oversight of the Nurturing Families Network is rigorous and on going. As a part of this effort the Trust Fund has contracted with the University of Hartford's Center for Social Research to evaluate the Nurturing Families Network.

The University began evaluating the program at its inception in 1996. It continues to assess both the Network's processes and outcomes. These evaluations examine:

- Enrollment, engagement and retention rates for families served.
- Progress of families using instruments such as the Child Abuse Potential Inventory, Adult-Adolescent Parenting Inventory 2 and the Parenting Stress Index.
- Child abuse and neglect rates for participants.
- Changes in family circumstances, including completion of high school, degree of social isolation, financial difficulties, employment and household arrangements.
- Changes in parenting attitudes, knowledge of child development and parenting practices.

The following is a summary of the key findings:

- Research has shown that the program is successful not only in identifying, engaging and assisting parents at risk of harming their children, but also in reducing the incidence and severity of abuse and neglect.
- After one year of program participation families involved in the program are at significantly less risk for maltreatment, are less likely to choose inappropriate abusive behavior toward their children and are less likely to feel upset and frustrated. Families who participate in the program for more than one year gain even greater benefits in these areas.
- Families who participate in the program make significant gains in education, employment and self-sufficiency.
- Parents gain skills and knowledge, become more responsive and spend more time with their children. Parents also have more realistic expectations about their children and their roles and responsibilities as parents.
- The immunization rate for 2-year old children on Medicaid whose families are involved in the program is 93 percent compared to 73 percent for 2-year olds with similar demographic background.
- The percentage of mothers establishing independent households increased from 53 percent to 93 percent in the second year of program involvement.
- 84 percent of referrals made to specialized services are accepted. This rate is much higher than in programs offering case management/referral services alone.

Implementation Studies

In addition to program outcome analysis, the University of Hartford Center for Social Research has conducted several in-depth program evaluations which explore the dynamics that impact the families enrolled and staff who provide services in the NFN. Following are excerpts of three such evaluations: Process Evaluation, Life Stories and an Ethnography

Insight into a Working Site

Through research, network meetings and conversations with on-site staff, the Children's Trust Fund has learned a great deal about the dynamics of the Nurturing Families Network and the nature of the relationship between the home visitor and the program's target population. This insight and knowledge have had a profound impact on program design, policy, training and practice.

Program research has delved into fundamental questions such as whether professional knowledge and practice can meaningfully improve the lives of families, and whether professional knowledge and practice have relevance to the life of the family. University of Hartford research has suggested that the key to program success is the home visitor's ability to "broker" the professional culture to the family culture, and vice versa. This role is described below.

When a Site Functions Well, the Role of "Cultural Broker" Is Embraced

Professionalism, rather than being avoided as a barrier to connecting with families, is identified and embraced as essential to establishing the appropriate boundaries between the home visitor and family and to facilitate a productive relationship. Home visitors follow the Nurturing Families Network model and parenting curriculum to offer valuable guidance and assistance to families.

While the initial bond with families is based almost exclusively on empathy, home visitors actively seek to make the transition toward a more professional role based on their knowledge and authority in the skill of parenting. Consequently, there is a firm commitment on the part of home visitors to "do curriculum," that is, to focus at least a portion of home visits on parenting education. They believe that curriculum education is relevant and that it provides the most effective means of using professional standards to enhance the home visitor's relationship with the family.

Home visitors know that their professional supervisors genuinely share a deep concern for community families. Therefore, home visitors can openly share impressions and information about families, secure in their belief that by doing so, they are helping, rather than betraying, the families.

Home visitors strive to achieve bi-cultural competence as paraprofessionals. This competence complements their willingness and desire to embrace the role of cultural broker. The home visitors believe both in the efficacy of the Nurturing Families Network program and in the commitment of their professional supervisor to improving the lives of families.

When a Site Does Not Function Well, the Role of the "Cultural Broker" Is Not Embraced

When this happens, home visitors reject professionalism as a viable role. They see it as a barrier to forging meaningful connections to community families. They view the Nurturing Families Network model and curriculum as irrelevant or even antithetical to needs of community families. Consequently, they ignore it in home visits and it provides no means to develop professional boundaries between the home visitor and the family.

When these professional boundaries are not established, the home visitor becomes simply a friend and mentor. This encourages mistrust of professional authority and of the programmatic procedures. When the home visitor allies with the families and the community and casts the Nurturing Families Network into the role of "outsider," she will not seek bi-cultural competence and will not achieve genuinely reciprocal communication.

Such mistrust and alienation makes the home visitor unable and/or unwilling to interpret or "broker" professional culture to community culture and simultaneously unwilling to interpret or "broker" community culture to professional culture, as she seeks to protect her families from the negative judgment of professional authority. Instead of serving as cultural brokers, home visitors find themselves marginalized and less able to achieve program goals.

Life Stories

In 2004, the Children's Trust Fund announced the results of a detailed two-year study of the Nurturing Families Network entitled "Life Stories of Vulnerable Families in Connecticut: An Assessment of the Nurturing Families Network Home Visitation Program." Following is the Executive Summary of the study as prepared by the University of Hartford Center for Social Research.

Executive Summary

This study was designed to learn about the Nurturing Family Network home visitation program from the perspectives of participants themselves. The University of Hartford began designing the study in the summer of 2001 and conducted interviews with 171 mothers and 48 fathers between January 2002 and March 2003, spending between three and four hours with each interviewee in two audio-taped sessions. The report is the culmination of the analysis of over 20,000 pages of transcripts that tell the life stories of vulnerable first- time mothers in Connecticut participating in the program. In their own words, these mothers tell us about their daily struggles and triumphs as well as the role of home visitors in helping them raise a healthy child.

Patterns of Vulnerability

While each mother has a unique story, there are nonetheless patterns or shared characteristics. Based on their pregnancy stories, researchers developed a typology of mothers' vulnerabilities. Four main groups are discussed: 1) cognitively impaired mothers; 2) young- young mothers who delivered their first child between the ages of 13-16; 3) mothers living in cultures of crises with extremely chaotic family histories and/or behavioral problems; and 4) mothers in less distress (MILD), where vulnerabilities are not as severe.

Researchers identified several patterns in the pregnancy stories of cognitively impaired mothers, who make up 12 percent of the sample.

- The pregnancies were often wanted, even when they were unexpected.
- The mothers tended to be older (in their 20s) and often had had previous pregnancies.
- The parents of the mother were not always enthusiastic about the pregnancy.

Twenty-three percent of mothers in the sample fell into the category "young-young " mothers – that is, mothers who delivered their first child between the ages of 13 and 16. The narratives researchers report for the young-young mothers focus on:

- Mothers who were victims of statutory rape.
- Mothers (and families) who normalize teen pregnancy.
- Mothers researchers categorize as "good girls" because they have no history of violent behavior or extensive substance abuse and were doing well in school.
- Mothers researchers label "bad girls" because of a history of truancy, violent behavior, substance abuse and promiscuity.

Roughly a third of the mothers researchers interviewed were living in cultures of crises, representing the third type of vulnerable family. Those living in cultures of crises have a continuous set of problems that multiply and expand, interact and overlap. It is the continuous nature of the crises that creates the "culture." In the extreme cases, hospitals, jails, and death are a part of the narratives; in the less extreme cases, the mothers living in cultures of crises are unable to establish functional everyday routines because of problems with work, relationships or health. Some manage the crises better than others because they have more emotional, psychological and material resources; others do not have the resources to do anything more than deal with the most immediate crisis. This is especially true for those who are cognitively and psychologically impaired, who are extremely poor, and who have scarring histories of child abuse. In these cases, mothers' life trajectories lurch from one crisis to the next, and each life event carries with it the potential for crisis.

Researchers identified the following themes in the stories of mothers living in cultures of crises.

- Violence: violent parents, violent spouses, violent neighborhoods and violent behavior on the part of the mother; their narratives often include stories about police, courts and jails, as well as the Department of Children and Families, foster homes and juvenile centers
- Poverty: inadequate housing, insufficient food, problems with transportation and health care, utilities being turned off, evictions, sanitation problems, bug and rat infestations
- Substance abuse: violence, criminal activity, courts, prisons and treatment centers
- Psychological problems: high rates of mental illness, depression, co-dependency, anxiety and stress-related illnesses

- Medical problems: disabilities that are often a consequence of poverty, abuse and inadequate health care, including asthma, diabetes, botched deliveries and children with low birth rates, respiratory problems and complications from deliveries

Researchers use the acronym MILD (mothers in less distress) to describe the last group of mothers because they did not have extremely traumatic childhoods, are not currently encumbered with debilitating problems and were not young young mothers. Their needs are not as overwhelming as the needs of the other mothers in the program.

The MILD group consists of several subgroups, defined by particular conditions:

- Spanish-speaking immigrant mothers who are isolated linguistically.
- Mothers who are socially isolated.
- Mothers with histories of mental illness now managed with medicine and therapy.
- Working poor families.
- Mothers with a history of substance abuse but no current abuse or problems.

Engaging Mothers through Home Visitation

Given the above description of family vulnerabilities among first-time mothers, researchers next asked the questions: How are mothers engaged by the NFN home visitation program? To what extent do home visitors address these vulnerabilities? How do their personal biographies intersect with home visitation? Participation in the NFN program is entirely voluntary. Mothers must demonstrate a threshold of needs and vulnerabilities to qualify. Nonetheless, mothers must have some initial motivation for accepting the services, and usually this motivation stems from some recognition of their family vulnerabilities or their parenting insecurities. But initial motivation does not always become engagement in the program. Mothers may be open to the program, but at the same time they must be convinced in the early stages of their participation that the program is worth their time and effort. Researchers have developed a second typology to describe the ways in which these relationships become organized, and, as before, they rely on the mothers to teach them what works for them in the context of home visitation. After reading carefully the mothers' stories of program involvement, researchers identified four general ways that home visitors connect with mothers: as baby experts, advocates, friends and fictive kin.

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Clearly, one of the ways that moms become connected to the program is through their relationships with home visitors as baby experts. Researchers found this to be the case among more confident moms as well as moms who were unsure of themselves. The more confident, more educated moms liked having someone who could access parenting information and who could regularly talk with them about parenting strategies and child development. More often, however, the baby expert role was elicited by moms lacking confidence in their parenting abilities, who strongly wanted to show themselves and others that they could be good moms. This was especially apparent with young young moms.

The second type of relationship between the mother and home visitor centers around the home visitor as an advocate. Moms often feel powerless (and often are 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, which are all rooted in social characteristics that define power in our society, namely, race and ethnicity, social class and gender. Because the home visitor can help the mom overcome some of these power differences, the home visitor-as-advocate can be the basis of a very strong relationship.

As advocates, home visitors must be knowledgeable about services and make contacts within the community. In particular, they help moms who are linguistically isolated, and they teach moms to negotiate their needs with state and medical authorities by coaching them or, in some cases, by directly intervening. For moms suffering with emotional problems, home visitors become important advocates in managing their health needs and in making sure that the child is cared for and safe. Finally, home visitors are advocates for moms who are in need of material resources, especially moms living in extreme conditions of poverty. Both the young young and those living in cultures of crises especially need services and advocacy.

In addition to serving as a baby expert and an advocate, the home visitor often becomes as a friend to the mom. Many moms - in fact the data would suggest the majority of moms - describe their home visitors as friends, some as their best friend, and some as their only friend. Friendship reflects the rapport that home visitors establish with mothers and conveys the emotional intensity of the relationship as well. The vulnerabilities that many mothers in the program experience create the possibility for an emotional connection that becomes friendship.

Friendship is grounded in varying contexts or situations. For several of the mothers, friendship is related to social isolation. For other mothers, friendship is construed as having someone always there to rely on, someone you can trust, someone to keep you on track. Moms often described the home visitor as someone they could speak to in confidence.

While most of the moms researchers interviewed described their home visitors as friends, such friendship is often limited by a working relationship. There are limits on what a home visitor can and should do in the relationship. Moreover, both home visitors and moms do leave the program. This friendship is circumscribed by these program boundaries. From the mothers' stories, however, it is clear that many relationships involve friend-like dynamics, which lays a groundwork of trust and mutual expectation, providing an opening to develop, examine and change parenting practices.

Similar to friendship, the fourth type of connection between the home visitor and moms involves emotional connection. In such cases, moms often perceive their home visitors as mothers or aunt figures, and, in some cases, home visitors become what researchers describe as “fictive kin.” Fictive kin refers to family networks that include individuals who are not related by blood, but rather through their collective efforts to raise children. Some home visitors develop family-like relations with the mom, child and other members of the family.

A maternal-like relationship allows moms to confide in their home visitors what they might not tell anyone else, including family members. For some moms, who have not had good

relationships with their own mothers, the maternal connection provides an opportunity to feel closeness, to experience maternal support and to learn to trust close intimate relationships.

The maternal relationship is an important dynamic that enhances the home visitor's work with many of the moms in the NFN program. In some cases, it shapes the relationship as the home visitor becomes an extension of the family-as fictive kin. In other instances it allows the home visitor to engage a mom who is struggling with emotional problems, physical health issues, doubts about being a good mom or destructive relationships.

In summary, while researchers have identified these four types of home visitor-mother relationships, these types of connections do not occur independently of one another. Home visitors often find that a mom may elicit different types of relationships based upon her needs, and the response by the home visitor will emphasize one of the relationship types described above. But home visitors may also have to move gracefully between roles – being a baby expert at times, a friend at other times, an advocate in some cases, or a mother figure when the situation demands. In fact, the mothers' stories suggest that a good home visitor is one who can excel in each of these roles and adjust to situations according to a given mom's needs. In other words, skilled home visitors patiently adapt to the needs of the mothers as they present themselves, which, to a large extent, allows the mom to dictate who and what the home visitor becomes in the relationship. Different relationship types require different skills, and a good home visitor must learn to master a repertoire of these skills.

Barriers to Participation

The most difficult obstacle for a home visitor to overcome is convincing the mom that she is not from the state Department of Children and Families (DCF). Many moms commented on how nervous they were in the beginning because they feared the home visitor was from DCF. Getting beyond the DCF fears may give a home visitor entree, but she also has to make a good impression on the mom, or at least convince her that she has something to offer. Researchers have seen a myriad of ways that this occurs, but there are instances where it doesn't occur as well, where the chemistry between the home visitor and the mom is not right.

Participants' critiques of the program offer some lessons. While program engagement has a lot to do with the right interpersonal chemistry between a home visitor and a mother, it is clear that certain characteristics can become barriers to engagement. Moms are less likely to be engaged when home visitors don't show up for visits as scheduled, when they are not attentive to or comfortable with children, or when they appear distant or too professional. Moms clearly value home visitors who are friendly, caring, easy to talk to, non-judgmental and dependable. The two most prominent barriers to participation appear to be fears the moms have that 1.) the program is part of DCF and 2.) staff turnover – especially when the mom develops a close relationship with a home visitor who leaves. All programs have learned how to deal with the first issue, but the second one is difficult. Some programs have had a particularly difficult time retaining home visitors. To some extent, this problem is irresolvable – people move on in their careers. Nonetheless, when staff turnover occurs frequently, efforts to address it are important, judging from the stories of the moms researchers interviewed. In many cases, the transition occurs smoothly, but, given the intensity of the relationships that some moms develop with their home visitors, the loss can be devastating. This point exposes one of the contradictions of the program. Program engagement is often rooted in personal relationships that may take on a friend-like or

maternal character. But when home visitors leave the program, the loss can be experienced as betrayal or abandonment. Helping moms to cope with these transitions becomes an essential part of the program.

Father and Partner Involvement

In addition to interviewing NFN mothers, researchers made an effort, whenever possible, to interview the fathers of the children or mothers' partners who are involved with the children. Researchers didn't expect to make contact with many men in the study because mothers tend to be the target of services, but researchers thought that interviewing fathers might supplement what researchers were learning from moms about neighborhoods, jobs, relationships, resources and the NFN home visitation program. Further, it provided a chance to see if fathers are ever directly or indirectly involved in the program. In total, researchers interviewed 46 men – 39 were the biological fathers of the children and seven were partners involved in the children' lives.

Among this small group of fathers, employment was an impediment to participation in the program, 65 percent were employed full time and were therefore rarely home during program visits. Further, many men held traditional gender attitudes concerning child rearing and believed that the program was for mothers, not fathers. Consequently, nearly 40 percent of fathers knew nothing, or else very little, about the NFN program. However, about a quarter of fathers interviewed participated regularly in home visits, while 38 percent had participated in a few of the visits.

Fathers who participated or learned about the program from the mother were overwhelmingly supportive of the program and of their partners' participation in it. Like the moms, they benefited from the expertise of the home visitor concerning child development and parenting. Further, they received referrals from home visitors and at times relied on their advice and counsel as well. Perhaps most important, for this smaller group of men, the home visitors were successful in engaging fathers and showing them that they too could be active participants in their children's development.

Nonetheless, reaching fathers in the context of home visitation will continue to be difficult. Scheduling conflicts, cultural attitudes and the stress that poverty creates for families will continue to undermine these efforts. But as these stories suggest, even when efforts to be inclusive are only moderately successful, the results can be positive, if not transformative for some fathers.

Conclusion

Perhaps the greatest challenge to the art of home visitation is learning how to allow the needs of the mother to determine the relationship. The life stories teach us this important lesson. Home visitors intending to master their craft must hone their skills as baby experts and cultivate their social capital as community advocates; further, they must learn to manage the distance and closeness of their emotional relationships, allowing for empathetic identification of mothers' and children's needs, while maintaining the analytical distance necessary to respond to those needs.

Ethnography

In order to better understand the day-to-day experience and work of the home visitor (home visitor) working with high-risk families in the Nurturing Families Network, the University of Hartford Center for Social Research performed an ethnographic study of paraprofessionals working within the Network in Hartford. The following is an excerpt from this study. *(Please note: In this excerpt, the Nurturing Families Network is referred to as "Healthy Families" and/or "HFC.")*

"…..Finally, researchers asked home visitors how often they found families to be too high risk for HFC (i.e. Nurturing Families Network) services. Although home visitors felt that inappropriate placements in Healthy Families were rare, the most common reason given for why a family was considered too high risk was drug abuse. Other reasons included mental illness or retardation, domestic violence, criminal involvement and violent lifestyles that resulted in guns in the home.

To summarize the results from the survey questionnaire, the profile of home visitors' social-demographic characteristics suggests that most home visitors are mothers, that most have pursued higher education, that they are racially and ethnically diverse, that about half have received public assistance as adults, and that most have had previous job experience related to their work with HFC. As a group, they are very satisfied with their jobs, especially their relationships with families, program managers, supervisors and other home visitors. They are less satisfied with their incomes, their career advancement opportunities within the program and the amount of paperwork that is expected of them. Home visitors are particularly satisfied with the training and support they receive in the program, especially the support they receive from their supervisors and other home visitors. They clearly believe that they have acquired the skills, knowledge and experience to do their jobs well and indicated high levels of effectiveness in a range of services that they provide to families. Similarly, from the open-ended questions, it would seem that the commitments home visitors make to their families and to their own development as effective home visitors are their primary motivations. Moreover, it would appear that herein lies a dynamic that is essential to the success of the paraprofessional model. When home visitors' commitments to and understandings of their communities are fused with their own personal developments as family and child experts, they create meaningful identities and acquire self-value that is central to the program's success. But these dynamics are located within the relational aspects of their jobs, in their relationships with families and supervisory staff and within the uniqueness of the paraprofessional model. It is to these dynamics that researchers now turn.

Ethnographic Study of Paraprofessionals at the Hartford HFC Site

In addition to the survey, researchers conducted a more intensive study of the role of the home visitor at the Hartford site. This analysis will continue in the final year of the study at the other primary sites; researchers began with Hartford because it was one of the first sites to open its doors in 1995. In this section researchers draw upon several data collection strategies. Researchers conducted lengthy interviews with two home visitors from the Hartford site. Further, in an effort to understand the program as it is experienced by the home visitors themselves, a bicultural, bilingual field researcher "shadowed" home visitors in most aspects of their jobs between April and October 1998. This part of the study is what researchers refer to as an ethnography, because it consisted of making observations of home visitors in the everyday context of their work and then subsequently discussing aspects of their work with them in an informal, casual setting. The ethnographic component focused on the work of five home visitors at the Hartford site. Our ethnographer submitted field notes describing her observations of home visits and her discussions with home visitors. The ethnographer also met with families independently of the home visitors on a few occasions. Lastly, the ethnographer met regularly with a member of the evaluation team to discuss her observations and to discuss subsequent field research activities. Since at this point researchers have only made observations at one of the five primary sites, interpretations are considered preliminary and will need to be corroborated in the coming year as researchers continue this part of the study. At present, the analysis highlights three issues: 1) making connections with families; 2) making connections with supervisors; and 3) the paraprofessional role and its utility in community-based social service programs in which researchers explain the concept of "marginality" as it applies to the work-related challenges of home visitors.)

Connecting with Families

Hartford site home visitors play many roles in the context of their work with program participants. But before they can work effectively with a family, they must first find a way to connect with the family, to develop trust and rapport. The Hartford home visitors have a remarkable number of shared experiences with the program participants; for instance, some have migrated from Puerto Rico and most have grown up in Hartford housing projects. They are familiar with communities that must negotiate the effects of concentrated poverty, search for opportunities to derive self-value and struggle with the consequences of being a language and ethnic minority on the U.S. mainland. Interestingly, many of the Hartford home visitors established themselves as caretakers at an early age in large families due to health or emotional problems of parents, loss of parents, family members affected by substance abuse, early teen pregnancies, marital separation, special needs children or racial discrimination. One explained:

> I studied nurses aid and some social work, but I didn't finish social work. My father became very ill, and I had to stop studying so I could take care of him. Even though I'm not the oldest, it's like I am. I took care of him until he died. I almost went back to school last semester, then at the last minute I didn't. I plan to do so sometime soon.

Another described a similar story:

> When I graduated from high school, I went to Bridgeport University to study nursing. I had been there for two years when my mother called me back home because she was too

> ill to care for the rest of the family. So I came home and never finished. I took some courses later on at Capitol Technical but that was interrupted and I have not gone back.

Despite these familial demands, the Hartford home visitors have pulled through, pursued education and training beyond high school and now hold responsible jobs in the very community in which they grew up. Perhaps because they were often cast into caretaker roles in their families at an early age, many were drawn to human service professions where they have found opportunities to make a difference in the lives of young people in their communities. All the home visitors are mothers. Most were, in fact, teen mothers who had themselves benefited from local programs for teen mothers. All are Puerto Rican descendants, primarily raised in Hartford, although with brief experiences of living in Puerto Rico. All are bilingual.

Home visitors show great empathy for participants as they deliver the Healthy Families' curriculum to new mothers in a variety of different circumstances. They focus on both the child's development and the mother's growth in the parenting role. Their empathy for and identification with participants, however, does not appear to stand in the way of the objective assessments and interventions their job requires. The liaison/advocacy aspect of their role is quite broad and varied, because it often responds to all types of participants' needs. They assist participants in interactions with school authorities, medical providers, DCF staff, probation officers, landlords, etc. They also assist with the acquisition of basic necessities -food, clothing, cribs, toys and household items.

> Field note: The home visitor needed to make another quick stop at a client's house to help bring in some furniture. "Sometimes in this job you do a little of a lot. We get clothes, food, furniture and all sorts of stuff for clients. Sometimes it's above and beyond what we expect and sometimes it's not enough."

Our ethnographer's observations of home visitors' home visits afford us an authentic account of their day-to-day challenges in the paraprofessional role. The overriding impression is that the interpersonal skills and flexibility of the home visitors are crucial to providing effective support. But such skills and understanding are difficult to pass along in books, classrooms or even trainings. Rather, they grow from experience and insights that are rooted in empathetic understandings of the lives of participants. Knowing when to push forward, pull back, ask questions, make suggestions, take action or lend a sympathetic ear are among the skills essential to making home visitation effective. It would be misleading to think that a home visit simply involves a paraprofessional arriving at the house, sitting with a mother and going over a range of topics concerning child development and parenting. These families are often burdened by hardships that are difficult for most of us to fathom. Making a home visit requires home visitors to engage and mediate these hardships; it requires that they be prepared for resistance, indifference and ongoing crises. Take, for instance, the Healthy Families' curriculum that promotes an understanding of child development and good parenting practices. Straightforward presentation and discussion of the Healthy Families' curriculum to receptive, involved clients appears to be the exception rather than the rule. Home visitors frequently encounter resistance and inattention from this struggling population. When this occurs, the home visitors do not simply press on, unable or unwilling to deviate from a scripted delivery of information. Rather, they improvise and adapt to the circumstances they encounter — ever vigilant to any opportunity to connect with a client and redirect the interaction toward a positive end. The following field

note illustrates how the home visitor seizes upon opportunities available to engage the mother about parenting issues.

> Field Note: The little girl immediately took to me and interacted very well. She is a bright little girl and responded well to my urges of repetition and naming of items. The home visitor took advantage to point out my interaction to the mother. "See how smart your daughter is. If you read to her and repeat the names of things several times, she ends up saying it." While I was playing with the baby it was obvious that the mother was engaging more in conversation with the home visitor. The home visitor asked about health follow-up and developmental questions regarding the little girl. The client did comment that she has diabetes, and so the home visitor addressed follow up health-care issues with her.

Home visitors regularly display and utilize the pedagogical skills of a veteran educator. In some cases, teachers have to modify lesson plans when students fail to respond to the teacher's intentions or expectations. Recognizing that the learning objectives must take precedence over the means to achieve those ends, the skillful teacher will adapt to the circumstances. When home visitors encounter inattentive, resistant or sluggish clients, they patiently and judiciously adjust their "lesson plans."

> Field Note: At one point the girl's mother [the maternal grandmother] went away and said she needed to dry her hair. The home visitor took advantage of that time and spoke more seriously with the young lady. The home visitor had her get the curriculum and attempted to do a goals definition exercise with her. The young lady was obviously not vested in the exercise and was doing her least to barely get by. [The home visitor changed strategies]. [The mother then] responded well to the home visitor's inquiries about behavior and time spent with her son. They talked about things the baby does. The home visitor gave her positive reinforcement and immediate feedback.

> Field note: The home visitor asked if she took her son with her when visiting friends, and then they engaged in conversation regarding safety issues, healthy routines for the baby and quality time that was stimulating for the baby. The teen tried to avoid the issues mentioned and had a "smart" answer for each comment. The home visitor listened and very calmly reiterated with her the importance of the safety of the youngster and of her strengthening the bond with her son. The home visitor also addressed poor choices regarding what crowd to hang out with, how she was performing in school and some health issues regarding the teen herself. Despite the client's lack of interest, the home visitor reviewed some curriculum material, addressing some of the behaviors that were actually happening. The home visitor reviewed issues regarding appropriate stimulus, safety, nutrition, nurturing and consistency. When she was done, she confirmed an appointment time with the younger teen.

Home visitors recognize that, quite often, the clients who are the most difficult to reach are the ones most in need of assistance. Consequently, they interpret resistance or defensiveness not as a personal rebuke but as a powerful indication of need and a warning sign of potential trouble. Thus, the home visitors work through the frustration they experience and persevere in their attempts to remain somehow connected to even the most resistant clients.

> Field note: Meanwhile the home visitor had approached the subject of feeding with the older teen. The toddler's mom reported that she had cussed out the WIC people who were trying to tell her how to feed her child; (she switched the toddler from formula to cow's milk). At this point the younger teen got into the conversation as well, they were both on the defensive, stating that no one was going to tell them how to raise their kids. The older teen snitched on her sister, revealing that she has fed cereal to the newborn. The home visitor reminded them both about pediatric recommendations regarding infant/toddler feedings, about infants' physical development and the need for proper nourishment. Both teens took the information with little acknowledgement.

With their most troubled clients, home visitors agonize over proper intervention strategies, cognizant that the risks are great. The most difficult situation a home visitor faces is deciding whether to report a family to DCF. A decision to report almost always compromises the rapport and working relationship the home visitor has with the family. In these cases, home visitors consult the professional expertise, experience and objectivity of supervisors as demonstrated by the following.

> Field note: On the way back researchers shared observations and concerns. The home visitor was asked, "Where do you draw the line before you call DCF?" With a big sigh, she replied, "This time I'm worried, my client seems so uninvited. I will call her before I leave for home today. I will discuss this case with my supervisor again....My supervisor and I have [already] discussed this case. It has been a DCF case on and off. The girls grew up in foster homes. Their mother is a [drug] user. They have no respect for DCF, and DCF opens and closes their case. But there is my responsibility and liability involved — I want my supervisor to do another supervised home visit with me regarding this family. They are a mess."

The preceding description of the challenges of home visitors face when they walk into a family's home, mediate crises and engage resistance is an attempt to provide a realistic profile of the day-to-day work of the home visitor. However, it would be misleading to suggest that all participants are usually in crisis or emotional turmoil. Researchers don't want to leave the wrong impression by emphasizing only the difficulties of the home visitor role. Many families are receptive to their home visitors and eager to learn more about their child's development. These families should not be overlooked.

> Field note: The home visitor had asked the young lady to get her curriculum materials and they went over the material pertinent to his next age stage. The young lady read the information aloud, and then the home visitor would further comment on the matter. The young lady was very attentive and from time to time would ask questions or make comments about her baby. At one point her husband came out of the room and the home visitor commented to him that their baby was doing really well. All three interacted really well.

Observations provided by the ethnographer demonstrate the importance and the uniqueness of the home visitor role in a paraprofessional program. The home visitor must find ways to connect with a population often struggling with a range of issues and problems. In order to engage families on issues of child development and parenting, the home visitor must be flexible and adept at creating ways to effectively communicate, assist, demand and comfort. Not only must

the home visitor be willing to learn about new theories in child development and parenting, but she must also possess a genuine capacity for insight, empathy and understanding. Her success depends on the relationship she develops with her supervisor and is also rooted in shared personal and cultural experiences with the population she is serving.

Connecting with Supervisors

Supervision can, at least in the beginning, be a daunting process. Someone is looking over your shoulder, assessing your work and determining your value to the program and to the families. But the supervisory component is no less important than the connections that home visitors make with their families. For this paraprofessional model to work, home visitors have to learn about new theories and practices in child development and parenting and be able to communicate these lessons effectively to their families — they have to become, as one home visitor described, "baby experts." Further, home visitors have to negotiate professional distance with their families and learn to establish boundaries with them, while at the same time using their cultural understandings and personal insights to make connections with them. This is not an easy task, and home visitors often rely on supervisory staff to assist them in becoming both "baby experts" and in establishing necessary boundaries. At the Hartford site, home visitors recognize the benefit of the professional objectivity of supervisors and the need for client situations to be assessed through new eyes.

> Field note: I feel that sometimes, because we're in there so much, we may be missing something, because they're just coming in, something that has become like normal to us, can be picked up by them [the supervisors]. They're more objective because they're not in there all the time.

The relationships among home visitors in Hartford and between home visitors and supervisors are remarkably supportive. References to a "family-like atmosphere" are common, with supervisors often viewed as parental figures and the supervisory home visitor as the oldest sibling. Several home visitors have known one another since childhood and an easy camaraderie seems to relieve the pressure and anxiety of what is clearly a high stress job. They watch over each others' welfare and are sensitive and aware of each others' personal lives as well as work-related issues.

At the Hartford site, home visitors have three levels of direct supervision. The supervisory home visitor, who has been promoted from within the program, is the immediate supervisor. She conducts home visits, makes assessments and consults. The program supervisor, who holds an MSW, is at the next level administratively. She supervises with a focus on mental health issues and clinical/social needs and home visits and consultation. The program director, whose graduate training is in nursing, has final responsibility on decision-making within the program. She supervises with a focus on pediatric needs and child development issues, conducts home visits and is also available for consultation.

Supervisors availability is excellent - frequently at least one supervisor is in the office and are accessible by phone or pager. They are actively involved in all aspects of home visitor responsibilities and are well informed about everyone's cases. Consequently, cases receive extensive review and discussion from a variety of personal and professional perspectives. The tension and inconsistency one might expect from having to respond to the expectations of three

direct supervisors are minimal. While only the supervisory home visitor is Puerto Rican, the program supervisor and director speak Spanish and have extensive experience working with Hartford's Latino population. They are sensitive and knowledgeable regarding issues of cultural diversity and appear to be comfortable checking with the home visitors when their greater familiarity with cultural differences is relevant to a client issue. This is an important observation.

For the supervisory relationship to work effectively, communication has to go in both directions. Home visitors must feel comfortable talking about their families, seeking suggestions, examining mistakes, exposing their educational limitations, contributing to decisions and staking out positions regarding their families' welfare. Supervisors, on the other hand, need to have confidence in the perspectives of home visitors, be open to learning about an ethnic population with whom they have less familiarity, and take seriously the conflicts that occur when attempting to integrate parenting strategies within a culture that may be resistant to some of these ideas. Much discussion centers on the issues of discipline, feeding and spoiling the child and on the emotional and spatial organization of familial and kin networks. When communication goes in both directions, when professionals and paraprofessionals are open to what one another has to offer, then strategies, compromises and new ideas emerge as the two parties work toward resolving problems occurring in their families' lives. In Hartford, the relationship between supervisory staff and home visitors appears to illustrate well the effectiveness of two-way communication and the benefits of working together. In discussing these processes, a number of comments were illustrative.

> Field note: [When there's disagreement], it's discussed. And you put down your feelings about it and then the supervisor puts down her feelings about it. We had situations where our supervisors will write something on a supervised sheet on a home visit, and we don't agree with it. And we will bring it back to them and say, you know, I don't think that's right. And it's discussed, and then, if the supervisor agrees with you, it's taken out. If not then you put down how you felt about it....I think they're very open. They take everything into consideration. Sometimes they'll say, “Let me think about it and I'll get back to you." And they always do get back to us. So I think they are open.
>
> ...there's been a couple of incidences where we've felt we had to correct them [supervisors] in some way, or we disagreed...But for the most part, I feel that we have really good relationships, and they are there when we do need them and they'll try to offer some kind of guidance or support in some way... With [the supervisors] it's more like goal-oriented [and] following through. Education's a big thing [for them]. With us, it's more like we're realistic. We know what our moms are going to do and not do for the most part...Sometimes [the supervisors] might not realize how hard it is to follow through...in the home, because lots of things are going on and they don't get to see that part very often.
>
> I feel that sometimes they really want me to push things on a certain client and sometimes I really feel that that's not the way to go. And usually they tell me, well, you know that family best, or you know that mom best. You've been working with her; you should know how far you can push.
>
> [Do they know the families] as well as we do? No. Because they don't know their everyday issues and their everyday struggles and we do. We can understand a little more

> about where they're coming from. [Sometimes] they're trying to struggle, and they just can't do it....as the worker, I have to explain what the situation is in the home and that she's truly doing the best that she can with what she has, and there's no other way.

These two links in the paraprofessional model - the home visitor - client link and the home visitor-supervisor link - are essential to the effectiveness of the program. But these links are not easy to facilitate. Making strong connections with families and with supervisors creates tensions, misunderstandings and conflicts that have to be negotiated and managed. The home visitor is indeed the backbone of the program, for she is the person who must learn to manage these tensions and turn them into productive practices. She is the one straddling two cultures - the professional and the community culture; this is a unique role, and it is not an easy one to perform on a daily basis.

The Significance of Managing Marginality

"Marginality" is often referred to as one's position on the border of two different cultural worlds. This is an experience shared by members of many immigrant ethnic groups, particularly second - generation immigrants, whose identities are often derived both from the influences of their traditional ethnic group but also from the accommodations made to dominant mainstream culture. At times, the marginal individual, while engaging in frequent and sustained primary contacts in both of those cultural worlds, is fully a member of neither. While the reference point for marginality has traditionally been ethnicity, it could also, researchers believe, refer to the culture of professionalism. Furthermore, while marginality is often regarded negatively, with emphasis on its inherent problems and contradictions, researchers maintain that the marginality of the paraprofessional role in Healthy Families is actually crucial to the home visitors' ability to provide effective interventions.

Home visitors operate at the border of two distinctly different cultural worlds with different (unclear) attendant roles. The paraprofessional in a community-based social service program must balance the demands of a professional culture with the often contradictory demands of a community culture. The role expectations of professional culture stress the need to maintain objectivity and emotional distance from clients in order to establish an authority based on expertise, educational training and credentials. The role expectations of the community culture to which the paraprofessionals remain attached offer an alternate route to authority. As "insider" members of the community, home visitors can achieve an authority derived from trust. Trust evolves from an empathic camaraderie wherein clients perceive that you've "walked in their shoes," faced their problems and, succeeded so consequently you can mentor them through difficult circumstances. One home visitor elaborates:

> I really think that me being a teenage mother has a lot to do with what I can offer my moms, because I'm not just bringing them information — look, researchers say this and that. I can say to her - you know, I made it. I was also a teenage mother; I had one child after another. I know how difficult it is for you to do this and that. I made it - you can definitely make it. So I think that helps a lot for the moms to know that I went through very similar issues that they went through.

Paraprofessionals have the opportunity to establish a rapport with clients as trusted confidants, advisors and mentors, roles that their professional supervisors, seen primarily as formal authority figures and representatives of public agencies, are unlikely to achieve.

> Field note: I honestly feel that this is something that you have to have somewhat lived through it or have experienced it to really understand it. Because a lot of time [professionals] say,"oh, how can they not have any motivation to go to school? How can they not want to better their future for their kids?" And I can relate because I didn't go back to school until I had my second child. Before that, I had no motivation. I was kind of stuck. And they don't see that because they didn't go through that.

Another home visitor makes a similar point:

> We must learn that [building trust] through experience and through seeing these clients and see how their daily lives are. And, little by little, I've learned to respect that, and it's harder for [professionals] because they're not involved in this every day. Because they themselves have not gone through a lot of the issues that these moms have been through.

To maximize their effectiveness with clients, home visitors must be able to cross the boundaries between their dual roles of "outsider" professional and "insider" confidant. This is best accomplished by keeping the boundaries malleable, rather than rigid- in the background, rather than at the forefront of interactions with clients. If the boundaries are flexible they can expand or contract to accommodate the movement of home visitors into the appropriate role for the circumstances encountered. Both client and home visitor are aware that they are not simply friends, but participants in a more formal and instrumental relationship. Only when the client fails to respect that boundary in her behavior or expectations of the home visitor, will the existence of the boundary be gently acknowledged by the home visitor. How adroitly the home visitors manage to walk that tightrope between outsider and insider is crucial to the effective delivery of service. Researchers find much evidence of home visitors' mastery of this difficult challenge. When appropriate to the situation, home visitors assume the insider role and exert influence derived from trust, emotional connection and shared life experiences. But because of their training, knowledge, and expertise as paraprofessionals, they can also assume the outsider role to objectively invoke authority and encourage compliance on certain important issues. Two field notes illustrate the tensions of managing dual roles in which the boundaries blur and defy easy demarcation.

> I think our clients eventually don't see us as a professional, we're always a ... like that's another line we're always fighting against. You know, a person who comes to your house every week and sometimes their whole families won't see them as much as we see them.

> We serve first-time moms, doesn't matter how old they are. With the older ones I just have to prove myself a little more than with the young ones. When I start to share information with them about their children's development and...it starts to happen, then they know I know what I'm talking about.

The home visitors researchers have studied at the Hartford site do indeed find themselves attempting to bridge two disparate cultures. Potentially, the paraprofessional role provides access to two distinctly different avenues to positively influence client behavior. They can bring the

program some of the authority, expertise and respect of professional status (even though they may not be fully credentialed) without some of the drawbacks to effective intervention that are also attached to professional status. Their potential effectiveness is not compromised by the gulf of differential life experience, perceived emotional detachment and judgmental perspective that are characteristic of "full" professionals. This is, however, not an easy position to maintain. Their marginality, the utility researchers have emphasized, exacts a substantial toll in terms of job stress. Home visitors' statements on the difficulty of navigating boundary issues with clients are quite illustrative.

> A lot of our clients become very comfortable with us, like I told you, and from time to time there have been times where I've had to say, you know that's not a good situation and this is what can happen and I have to explain my role to them over again. Because they tend to see you - that this person is there for me and they're very comfortable talking and they forget that there's an office behind us and that there's rules. For example, I've had moms that wanted me to be the godmother of their baby. And they don't understand why we're saying no. They don't understand why that should be a rule.

> Always state what your position is. Even though the program has been explained to this mom. Even though your role has been explained to the mom, always state it again. You let them know from the very beginning what you are there to do. Because you can be taken advantage of very easily. You can be seen as a threat by the family. So I always say, I mean it's me and still once in a while I go over what I'm there to do, even though I've been working with them for a year, two years, three years. Every once in a while I remind them what I'm there to do. Because after a while, they tend to see you as a friend, as part of the family. Which is good, but at the same time, you have to remember to draw that line. I'm here to work with you, not just to sit here and listen to what you have to say.

> The boundaries issue is always in your mind. But when they introduce you to someone they'll say my teacher, my social worker, or the baby's worker. So they do know, even though they feel comfortable with you, they do know that this is a person who is at a paraprofessional level.

It’s stressful for a person to maintain such marginality. Its utility as a strategy of intervention is considerable but bought at a not inconsequential price for the marginalized paraprofessional. Because most home visitors see their paraprofessional position as a transition to professional status and its attendant rewards, they must remain aware of appropriately modeling their behavior to conform to professional standards. But at the same time, they are hesitant to endanger the special trust and confidence of their clients that enable them to provide valuable support services. It is a stressful challenge to confront this paradox on a daily basis.

Nurturing Families Network- 2005 Annual Evaluation Report Summary

Outcome Data by Program Component

Nurturing Connections

- Since 1999, 20,720 first-time mothers have been screened through the Nurturing Connections (NC) program. Sixty-nine percent of all first-time mothers screened negatively (low-risk) on the Revised Early Identification Screen (REID), and were eligible for NC services.
- NC Coordinators and volunteers averaged nine phone call attempts to families, five of which were completed.
- Over the past two years, Nurturing Connections Coordinators/Volunteers made 1830 referrals to families, 95 percent of which were followed-up.

Home Visiting- Statewide

- Since the statewide NFN program's inception in 1995, a total of 3,280 families have recieved intensive home visiting services.
- The average amount of time families stayed in the program was 17 months and families received an average of 2 visits per month.
- Rates of maltreatment for the 410 NFN families checked against the DCF database were three percent. By and large, most reports of maltreatment, both substantiated and unsubstantiated, were categorized as physical or emotional neglect. Almost three-quarters of all substantiated reports were categorized as physical neglect.
- Mothers made statistically significant improvements on the overall Child Abuse Potential Inventory (CAPI) Abuse scale as well as three of the six subscales at both the one year and five year data points.
- After one year in the program, mothers show an increased awareness and use of resources in their community, as measured by the Community Life Skills Scale (CLS).

Home Visiting- Hartford Sites

- Between May 2005 and December 31, 2005, 155 families were enrolled in the ten sites that make up the Hartford NFN program.
- Of the 514 total families screened in Hartford since May 2005, 58 percent screened positively on the REID. Sixty-two percent accepted the Kempe assessment, and 90 percent of them tested positive. Of those who assessed positive, 82 percent initiated home visitation services.
- Families in Hartford received an average of 2.2 home visits per month.
- Since the NFN Hartford began in May through the end of the calendar year, staff have made 291 referrals to families.

Nurturing Groups

- After participating in the Nurturing groups, participants made significant changes in the desired direction on the Parenting Stress Index (PSI) Parental Distress subscale and the AAPI-2 indicating that parents had a greater sense of parenting competence and/or experienced less stress in their parental role.

PROGRAM POLICIES AND PRACTICE STANDARDS

January 2007

PROGRAM DEVELOPMENT AND IMPLEMENTATION

Continuous Quality Improvement Team

Policies for the Nurturing Families Network are developed through the Network's Continuous Quality Improvement Team (CQI). The Continuous Quality Improvement Team gives every staff role a voice. It reviews policies and procedures and recommends policy changes to improve practice, based on feedback and suggestions generated by NFN staff.

Policy recommendations are brought to the CQI for consideration and approval. All approved policies are effective the first day of the next quarter (January 1, April 1, July 1, October 1). After six months of using a policy, the CQI Representative or Alternate can request a policy revision based on the feedback of those they represent.

The Continuous Quality Improvement team provides communication among all staff members, NFN sites, researchers, the Children Trust Fund staff and Children's Trust Fund Council. The CQI representative and alternate are elected by their peers within their network group and attend network meetings on a regular basis. Both the representative and alternate are expected to participate in each CQI meeting and provide feedback to and from their peers and CQI on the policies and procedures discussed and approved at meetings.

Chairs

The CQI team is co-chaired by a designee of the Children's Trust Fund and the University of Hartford. The Co-Chairs are voting members of CQI. Each agency also designates an alternate.

Membership

The Continuous Quality Improvement Team includes a regional representative and alternate for each NFN role:

- Clinical Supervisors
- Family Assessment Staff
- Home Visitors
- Nurturing Connections Coordinators
- Nurturing Group Coordinators
- Program Managers
- Representative from Children's Trust Fund
- Representative from the University of Hartford

The Executive Director of the Children's Trust Fund serves as an ex-officio member of the CQI team.

Criteria for Membership

Membership is open to Nurturing Families Network sites and staff who have one full year of experience with the program.

Newly Elected Members

Each member elected to the CQI team is asked to make a two-year commitment to the CQI team. During their first year, newly elected members are designated as alternates. During the second year of CQI participation, alternates move into the representative position.

A representative's primary responsibility is to uphold and share the views, opinions and concerns of the group they represent.

- Alternate representatives are active participants in the discussions at CQI, but do not vote unless their group's representative is absent.

- Representatives participate in discussions and vote on policy.

- Representatives who miss more than 25% percent of the scheduled CQI team meetings may be asked by the Co-Chairs to resign from their position.

Members at Large

Members at Large are non-voting participants who are allowed to attend CQI meetings and can participate in discussions. Members at Large are not allowed to vote. Members at Large lose their ability to participate in discussions if they miss two consecutive meetings.

Drops-Ins

Drop-Ins are invited to attend CQI meetings and can observe the proceedings. As observers, Drop-Ins are not allowed to participate in the discussions, and they cannot vote. Observers are allowed to comment at the end of the CQI proceedings.

Meeting schedule

Meetings are held on the second Friday of every month from 10 a.m. until 2 p.m. Creative Incentive grants submitted by Nurturing Families Network sites are reviewed in the last hour.

Creative Incentive Grants

The CQI Team awards Creative Incentive Grants to support program innovation. The Grants for up to $250 are used to enhance program services. Sites are encouraged to propose an innovative or creative project that would require funds not covered within their contract award. All Nurturing Families Network sites may apply for these grants. Each site can receive only one grant per year. Applications are available at www.ct.gov/ctf/nfn_forms

Essentials for Site Development

Below is a list of essentials for program success.

Team Work

Developing and operating a successful NFN site requires planning, collaboration and coordination. Every program component and each staff role is dependent on the other. Staff members need to work as a team within their site and with others in the community.

NFN Program Manager

Fundamental to a well-run site is a knowledgeable and involved program manager. A program manager must have strong administrative and organizational skills, be well versed in the duties and responsibilities of each staff role and the ability to represent the interests of NFN within their agency. Additional responsibilities include establishing an advisory committee and engaging in legislative and other advocacy efforts.

Memorandum of Agreement with Birthing Hospital

In order to complete the REID screen the Nurturing Connections staff must have access to medical records and to first-time families while they are receiving prenatal services, staying in the hospital or upon discharge after the birth of their child.

Therefore, all NFN sites that are not located in a birthing hospital must have a Memorandum of Agreement (MOA) with a hospital that assures access.

Community Collaboration

NFN should take the lead in efforts to establish collaborative relationships within their communities to ensure that the varied needs of the participants are met.

Evening and Weekend Hours

NFN programs are encouraged to provide regular evening and Saturday business hours for home visiting and nurturing parenting groups.

Active Advisory Board

Nurturing Families Network sites must have an Advisory Board. The advisory board should include former program participants, professionals, community members and other interested parties. The Advisory Board should meet at least quarterly to discuss program issues and program development.

Opportunities to increase knowledge

The program staff must take advantage of opportunities to increase their knowledge and skills. Program staff is expected to actively participate in community and Nurturing Families Network networking opportunities and training.

Strength based culturally competent practice

Cultural awareness is key to meeting the needs of the families participating NFN. A culturally competent organization is committed to doing what it takes to support their staff to work within the culture of the population it serves. Program staff need to be vigilant in their efforts to learn about different cultures and the issues related to diversity. The office environment should reflect diversity through furniture choice, wall paintings, and décor.

Individualized Program Plans (IPP)

The Individualized Program Plan is the outcome of an annual process to help sites identify and address issues and create strategies for enhancing program service. The sites review evaluation findings and other information to develop the plan. The Children's Trust Fund also provides feedback and makes recommendations to the sites.

Celebrations

Each site should host a celebration at least once a year to recognize the accomplishments of all of the families in the program – even those that may not have met all of the program expectations. Members of the larger community who have provided support or will be providing support to the family once they leave the program should be invited to attend.

Food Service Policy

All food served at site functions must comply with State of Connecticut Department of Public Health Itinerant Food Vending and Catering Food Service Regulation 19-13-B48s. The full text of this regulation is available at **www.dph.state.ct.us.**

Warm line

Each site is required to establish a *warm line* that families can call after business hours. Ideally the *warm line* would operate 24 hours a day. The purpose of the *warm line* is to offer support to parents who need help addressing problems before they develop into a crisis. The NFN staff should be informed of all calls to the *warm line* and follow up with the families on the next business day.

Calendar Distribution

NFN developmental calendars should be distributed to all first-time families parentally or while the mother and baby are still in the hospital. The child development calendar is called " A Star is Born, Memories and Milestones". This calendar can guide and inform the conversations between volunteers and families participating in the Nurturing Connections program. The home visitors can also use the calendar to assist families with scheduling and recording their child's immunizations, well child care appointments and other special moments.

STAFFING REQUIREMENTS

Staffing Requirements

Staffing Plan for Nurturing Connections, Nurturing Parenting Groups and Home Visiting (effective 2005)

- 1 part-time (minimum .20 FTE) program manager
- 1 full-time clinical supervisor who conducts family assessments
- 2 full-time home visitors
- 1 half-time parent group coordinator/facilitator
- 1 part-time (minimum .15 to .20 FTE) children's group facilitator
- 1 half-time connections coordinator (only for sites offering the Nurturing Connections program)

The half-time connections coordinator and half-time parent group coordinator/facilitator positions are often combined into one full-time position. This approach is recommended.

Additional Staffing requirements

Participation in scheduled supervision
Staff members are required to participate in regularly scheduled supervision to review their efforts and address challenges as they arise.

Employing Previous Program Participants

Parents who were recipients of program services are not allowed to become staff at the same program site. They may seek employment in other Nurturing Families Network program sites.

Description of staff positions

Program Manager is responsible for the overall management of the program including staff supervision and training, collaboration with community service providers, program evaluation, advisory board development and managerial matters. The program managers must have a bachelor's degree or master's degree in social work, human services or related social sciences field, and have experience working with vulnerable families.

Clinical Supervisor provides daily supervision and training to the home visitors and other NFN staff. The clinical supervisors must have master's degrees in social work or related human service or social science field, and experience providing clinical supervision and working with vulnerable families. The clinical supervisors conduct the Kempe Family Assessment in the participant's home.

One full time clinical supervisor may supervise no more than five (5) home visitors or five (5) staff including home visitors and other program staff. This rule applies even if one or more of the home visitors or other staff are part-time employees.

The staffs that may report to a clinical supervisor include home visitors, the parenting group coordinator, and the connections coordinator. The children's group coordinator reports to the parenting group facilitator.

Home Visitor works directly with the families in the home. They may visit the families once a week, provide information to improve parenting skills and teach child development. They also help families' access community resources.

The home visitors may be paraprofessionals or have bachelor's degrees in social work or a related field. They must be knowledgeable about both community services and the experiences the families face. Home visitors should be selected because of their personal characteristics and not solely on their education and employment history. Home visitors should demonstrate a strong ability to work with people at different ages and life stages, living in challenging circumstances and within diverse cultures. Sites are encouraged to hire home visitors who reside in the communities they serve.

Home visitors who meet the credentialing requirements for the senior home visitor position may, in addition to their regular duties, be assigned leadership responsibilities within the home visiting program.

Nurturing Connections Coordinator screens first-time families in the prenatal or postnatal period using a standardized tool to help decide which of the three program components best meet the needs of each family. The nurturing connections coordinator develops referral sources and methods for connecting families to the other components of NFN.

Additional responsibilities include recruiting, training, supporting and supervising volunteers. Coordinators and volunteers provide follow-up telephone calls for a minimum of three to six months after the child is born. The purpose of the calls is to offer parents emotional support and information needed to obtain additional services. The coordinators usually have bachelor 's degrees in Social Work or a related field, experience working with families in crisis, and the ability to work with families from diverse social and ethnic backgrounds.

Nurturing Parent Group Coordinator/Facilitator co-facilitates the Nurturing Parenting Groups and supervises the children's group facilitators. In addition the Parent Group Coordinator recruits, trains and supervises needed volunteers. The parenting group facilitator uses the Nurturing Parenting Program curriculum. The coordinators usually have a Bachelors degree in social work or a related human services or social sciences field and have experience working with families in crisis.

Children's Group Facilitator co-facilitates the Nurturing Children's Group for children whose parents or guardians are participating in the Nurturing Parenting Group. The purpose of the

children's group is to provide developmentally appropriate activities for children. The children's group facilitators must be high school graduates and must have experience working with children and vulnerable families in crisis. The children's group coordinator reports to the nurturing parenting group coordinator.

Family Assessment Staff conducts Kempe assessments following the Nurturing Families Network Family Assessment Worker training. After 1 year of employment, and with the recommendation of the Supervisor, program staff can participate in family assessment training.

JOB DESCRIPTIONS

Nurturing Families Network Program Manager

Supervised By:

Executive Director/Management staff

Job Description:

Program Managers are responsible for the overall operation and management of the program, including staff supervision and training, collaboration with community service providers, community relations and fund raising, client assessments, program evaluation and other managerial matters.

The Program Manager is also responsible for the advisory committee, marketing and representing the program, research, data analysis and quality assurance, strategic planning and providing adequate resources for staff.

Experience/Education Requirements

The program managers are required to have a bachelor's degree in the human services field. A master's degree in a related field is preferred. Previous management experience working with vulnerable families and children is required.

Skills

- Excellent interpersonal skills and ability to communicate effectively with people from diverse social and ethnic backgrounds.
- Strong organizational and management skills to handle varied duties and responsibilities.
- Demonstrated leadership abilities and supervisory skills.
- Legislative and other advocacy skills.
- Analytical skills.
- Community organizational skills.
- Basic computer skills including Word and Excel required.

Credential/License Required

Connecticut state driver's license and automobile liability insurance as required by hiring agency.

Additional Requirements

May require weekend and or evening meetings. May also be required to have program staff make referrals to The Department of Children and Families.

All duties must be implemented in accordance with the hiring agency contract with the Children's Trust Fund, the Nurturing Families Network policies and approved training, hiring agency policies, ethical practice standards and state law.

Nurturing Families Network Clinical Supervisor

Supervised By:

Program Manager

Job Description:

Clinical Supervisors provides daily supervision, support and training to the Home Visitors. They may also provide supervision to the Nurturing Parenting Group coordinators/facilitators and Connection Coordinators.

Clinical Supervisors conduct joint home visits with the home visitors, ensure and maintain up-to-date, complete and confidential client records, facilitate the Professional Development Focus Group in-service training model, and oversee caseloads.

Each supervisor must participate in 30 hours of training annually.

Experience/Education Requirements

The Clinical Supervisors are required to hold a master's degree in social work or in a related social science or human services field. They must have previous supervisory and clinical experience working with vulnerable families.

Skills

- Be comfortable conducting home visits.
- Excellent interpersonal skills.
- Ability to support, teach and advise home visitors and other supervisees
- Understand complex family issues and dynamics
- Strong organizational and management skills to handle varied duties and responsibilities.
- An ability to be creative, innovative and a self starter.
- Basic computer skills including Word and Excel required.

Credential/License Required

Connecticut state driver's license and automobile liability insurance as required by hiring agency.

License in social work, professional counseling or marriage and family therapy helpful.

Additional Requirements

May require weekend and/or evening hours to attend functions or meet with families.

All duties must be implemented in accordance with the hiring agency contract with the Children's Trust Fund, the Nurturing Families policies, hiring agency policies, ethical practice standards and state law.

Nurturing Families Network Home Visitor

Supervised By:
Clinical Supervisor

Job Description:

Home Visitors work directly with the families. They may visit the families once a week, provide information, and use highly regarded curricula to improve parenting skills and teach the families about child development. They also help the families access services from community resources. The Home Visitors may be paraprofessionals or may have bachelor's degrees in social work or a related field. They are knowledgeable about both community services and the experiences the families face.

In addition the home visitors with families develop strength-based action plans to address areas identified as challenges, maintain collaborative relationship with primary care providers and community services, and maintain accurate records of all client contact.

Home visitors who meet the credentialing requirements for the senior home visitor position may, in addition to their regular duties, be assigned leadership responsibilities within the home visiting program.

Experience/Education Requirements

The Home Visitors must have a high school diploma and relevant work experience. Home visitors should have experience working with vulnerable children and families. They must be open to working with families of diverse backgrounds

Skills

- Excellent interpersonal skills and ability to engage families from diverse social and ethnic backgrounds.
- Strong organizational skills to handle varied duties and responsibilities.
- Demonstrated ability to be creative, innovative and resourceful.
- Model parent - child interaction with parents and children.
- Basic computer skills including Word and Excel preferred.

Credential/License Required

Connecticut state driver's license and automobile liability insurance as required by hiring agency.

Additional Requirements

May require weekend and or evening hours to conduct home visits.

All duties must be implemented in accordance with the hiring agency contract with the Children's Trust Fund, the Nurturing Families Network policies and approved training, hiring agency policies, ethical practice standards and state law.

Nurturing Families Network Connections Coordinator

Supervised By:
Program Manager or Clinical Supervisor

Job Description:

Nurturing Connections Coordinators screen first-time families in the prenatal or postnatal period using a standardized tool to help decide which of the three program components best meets the needs of each family.

Nurturing Connections Coordinators are responsible for recruiting, training, supporting and supervising volunteers.

Coordinators and volunteers provide follow-up telephone calls to families for a minimum of three to six months following the birth of their child. The purpose of the call is to give the parents emotional support and information and to help the parents get the additional services they need.

Experience/Education Requirements

The coordinators are required to have an associate degree in human services or comparable education and experience. A bachelor's degree in social work or a related field is preferred. The coordinators must have experience working with vulnerable families.

Skills

- Excellent interpersonal skills and ability to engage hospital staff, families, volunteers and interns from diverse social and ethnic backgrounds.
- Strong organizational and management skills to handle varied duties and responsibilities.
- Strong ability to be creative, innovative and independent.
- Basic computer skills including Word and Excel required.

Credential/License Required

Connecticut state driver's license and automobile liability insurance as required by hiring agency.

Additional Requirements

May require weekend and/or evening hours to attend functions and meet with and supervise volunteers.

All duties must be implemented in accordance with the hiring agency contract with the Children's Trust Fund, the Nurturing Families Network policies and approved training, hiring agency policies, ethical practice standards and state law.

Nurturing Families Network Parenting Group Coordinator

Supervised By:
Program Manager or Clinical Supervisor

Job Description:

Nurturing Parenting Group Coordinators co-facilitate Nurturing Parenting Groups and are responsible for training and supervising Nurturing Children's Group Facilitators and recruiting, training, supporting and supervising program volunteers.

Parenting Group Coordinators use the Nurturing Parenting Program curriculum to provide education and information to parents and guardians to increase parenting skills. As individual needs are presented in the group, the coordinators may make referrals for additional services.

Parenting Group Coordinators are responsible for creating safe nurturing group environments and completion of program and evaluation forms.

Experience/Education Requirements

Parenting Group Coordinators are required to have a bachelor's degree in social work, human or social sciences or comparable education and experience. A master's degree in social work or in human or social sciences preferred. Coordinators must have experience working with vulnerable families.

Skills

- Excellent interpersonal skills and ability to engage staff, families and volunteers from diverse social and ethnic backgrounds.
- An ability to be creative, innovative and independent.
- Strong group facilitation skills.
- An understanding of group dynamics and adult learning styles.
- Strong organizational, supervisory and coordination skills to handle varied duties and responsibilities.
- Basic computer skills including Word and Excel required.

Credential/License Required

Connecticut state driver's license and automobile liability insurance as required by the hiring agency.

Additional Requirements

May require weekend and/or evening hours to facilitate groups and provide supervision to the children's group facilitator and volunteers.

All duties must be implemented in accordance with the hiring agency contract with the Children's Trust Fund, the Nurturing Families Network policies and approved training, hiring agency policies, ethical practice standards and state law.

Nurturing Families Network Children's Group Facilitator

Supervised By:
Nurturing Parent Group Coordinator

Job Description:

Child Group Facilitators co-facilitate the Nurturing Children's Group for children whose parents or guardians are participating in the Nurturing Parenting Group and are responsible for assisting in creating a safe-child group environment, providing supervision and safety of the children and oversight of volunteer involvement in the group.

Child Group Coordinators use the complementary children's age-specific Nurturing Parenting Program curriculum to provide structured, developmentally-appropriate activities for children.

Experience/Education Requirements

Child Group Facilitators are required to have a high school or general education diploma. A bachelor's degree in social work or in human or social sciences preferred. The Child Group Facilitator coordinators must have experience working with vulnerable families.

Skills

- Excellent interpersonal skills and ability to engage staff, children, families and volunteers from diverse social and ethnic backgrounds.
- An ability to be creative, innovative and independent.
- Strong group facilitation skills.
- An understanding of children's developmental stages and learning styles.
- An ability to work as a team player both with the children's and parents' group facilitators.
- Strong skills in organization, oversight and coordination to handle varied duties and responsibilities.

Credential/License Required

None.

Additional Requirements

May require weekend and or evening hours to facilitate groups and participate in supervision.

All duties must be implemented in accordance with the hiring agency contract with the Children's Trust Fund, the Nurturing Families Network policies and approved training, hiring agency policies, ethical practice standards and state law.

Nurturing Families Network Family Assessment Staff

Supervised By:

Program Manager/Clinical Supervisor

Job Description:

Family Assessment Staff assess first-time parents using the KEMPE assessment tool, a validated instrument that is administered in a conversational manner. This tool gathers information within ten domains correlated to risk factors associated with abusive and neglectful parenting. This process is used to provide a more in-depth assessment of a family's needs upon entering the home visiting program.

Experience/Education Requirements

Family Assessment Staff may have bachelor's or master's degrees in social work or the human services field. Family Assessment Staff must have previous experience working with vulnerable families.

Skills

- Be comfortable conducting assessments in the home.
- Excellent interpersonal and interview skills.
- Ability to engage families, demonstrate sound judgment and good decision-making skills
- Understand complex family issues and dynamics and be sensitive to families.
- Strong organizational skills to handle varied duties and responsibilities.
- Excellent oral and written communication skills.
- Realistic expectations about the program mission.
- Basic computer skills including Word and Excel required.

Credential/License Required

Connecticut state driver's license and automobile liability insurance as required by hiring agency.

Additional Requirements

May require weekend and/or evening hours to assess families.

All duties must be implemented in accordance with the hiring agency contract with the Children's Trust Fund, the Nurturing Families policies, hiring agency policies, ethical practice standards and state law.

PROFESSIONAL DEVELOPMENT AND TRAINING

Professional Development Policy for NFN staff

The purpose of the professional development policy is to set standards and guidelines for staff training in order to:

- Prepare the staff to work effectively in their role
- Enhance skills and knowledge of the staff over time

The professional development policy outlines the:

- Required comprehensive training plan for all of the Nurturing Families Network staff.
- Process for recognizing and rewarding the professional growth and development of the staff.
- Credentialed home visitor and credentialed senior home visitors policy

Required Comprehensive Training Plan

Each member of the staff is responsible for completing the *Nurturing Families in Action* training specific to their role. All staff must participate in pre-service and in-service training. Staff participate in additional training based on their role. The Children's Trust Fund and the sites share the responsibility for providing training.

A list of training and requirements by role

Required Training for Program Managers:

- Family Development Training for Supervisors and Leaders

Required Training for Clinical Supervisors:

- Thirty hours of in-service training each year
- Family Development Training for Supervisors and Leaders
- Touchpoints©
- Parents as Teachers: Born to Learn™ Training for Supervisors

Required Training for Home Visitors:

- Family Development Credential (FDC) for Family Workers
- Touchpoints©
- Parents as Teachers: Born to Learn™ Training
  - Prenatal to 3 Years
  - 3 Years to Kindergarten Entry

Optional Training for Connections Coordinators and Parent Group Coordinators who supervise others:

- Family Development Training for Supervisors and Leaders
- Touchpoints©

Optional Training for Connections Coordinators, Family Assessment Staff, Parent Group Coordinators working with families:

- FDC for Family Workers
- Touchpoints©

Description of Training

Nurturing Families in Action: This is an interactive and energetic training based on individual roles of staff within the Nurturing Families Network. During *Nurturing Families in Action* participants have the opportunity to explore the philosophy, practice and procedures that are at the core of NFN. Throughout these hands-on trainings participants learn from peers, develop insight into their work and leave with additional tools to be successful in their role.

Opening Day (mandatory for all participants)

On Opening Day participants spend time discussing the policy and theory that guides the work of the Nurturing Families Network. Staff learns information regarding the Children's Trust Fund mission and the history of home visiting as an intervention strategy. In addition participants learn about attachment theory and understand why it is the foundation of NFN.

Home Visitors Track

Participants will explore NFN policies and establish relationships with colleagues that can support personal growth and development. During this track participants have the opportunity to share experiences and focus on the types of families enrolled in NFN. Participants learn about tools, resources and skills to reinforce their work as a home visitor. Home Visitors learn how to prepare for and conduct a home visit with a family.

Participants are trained in the use of a child development-monitoring tool, Ages & Stages Questionnaire. Training on the Dias model to prevent shaken baby syndrome is also provided.

Clinical Supervisor Track

Participants review their role and responsibilities and the policies and procedures of NFN. Supervisors learn about the Focus Group Professional Development Model of staff development and identify their role in establishing a nurturing environment.

Group Facilitator Track

During this training participants identify the central elements of NFN Children's Group and Parent Group Policy. Participants increase their knowledge and understanding of the relationship between parent and children's group facilitators. The staff explores components of a physically and psychologically nurturing group environment. In addition, staff learn how to use the Nurturing curricula and how to facilitate a group experience. This track is for all parent and children group facilitators.

Nurturing Connections Track

Participants learn about the history and policies of Nurturing Connections while exploring their role as coordinator. They learn how to use the REID assessment tool while developing skills to engage new parents in the program. In addition, staff explore how to recruit, train and retain volunteers to work with families enrolled in the Nurturing Connections program.

Family Assessment Track

Participants gain an understanding of the philosophy behind the KEMPE assessment, how to effectively engage families, and prepare needed documentation. Participants also learn about the specific NFN policies related to the family assessment.

Program Manager Track

This training covers the components of the Program Manager role while exploring the roles of other Nurturing Families staff. Participants discuss concepts central to the NFN program including the cultural broker model. Program managers learn about the importance of contract management and the many challenges that come with implementing the program.

Site Visits

Each participant is required to spend one day visiting an NFN site. The site visit is an opportunity to learn from colleagues at another NFN program.

Family Development Credential (FDC) for Family Workers is an 80-hour, community based, comprehensive skill building training for anyone who works with families. The value of this program is derived from the interactive, experiential learning and completion of a comprehensive portfolio. Topics explored include:

- Communicating with Skill and Heart
- Taking Good Care of Yourself
- Diversity
- Strength-based Assessment
- Home Visiting
- Collaboration

FDC for Family Workers is arranged by or through the Children's Trust Fund and must be completed within two-years of employment. Participants who complete the training and pass an exam earn a Family Development Credential and may apply for and receive six undergraduate credits from Charter Oak College.

NFN Home Visitors are expected to complete all course requirements and earn a credential.

Family Development Training for Supervisors and Leaders compliments the 80-hour FDC training for family-service workers. The course focuses on a strength-based approach to human services.

Family Development Training for Supervisors and Leaders is a 35-hour training that offers practical ways to build organizational capacity in areas of empowerment based supervision, interagency collaboration, strength-based assessment, multicultural competence and professional development. Participants who complete the training receive a certificate.

Parents as Teachers: Born to Learn™ Training

Prenatal to 3 Years

This is a six day training. The training focuses on child development and covers:

- Neuroscience research on early brain development and learning (prenatal through age 3)
- Sequences of early childhood development
- Effective instructional personal visits
- Facilitation of parent-child interaction
- Ideas for parent group meetings
- Ways to provide connection 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: Prenatal to 3 Years award-winning video series, parent handouts, prepared visit plans (for monthly, bi-weekly and weekly visits), and resources for parent educators

3 Years to Kindergarten Entry

The goal of this training is to prepare PAT-certified parent educators to successfully extend the Parents as Teachers program to families with children ages 3 years to the age of kindergarten entry. This two-day training is available only to current parent educators already certified in the Born to Learn Curriculum: Prenatal to 3 Years. The training covers intellectual, language, social-emotional and motor development of children 3 to 5 years old, and covers techniques for facilitating parent-child interaction during personal visits. The curriculum contains 11 units of personal visit plans and parenting information. Training topics include:

- Latest neuroscience information relating to 3- to 5-year-olds
- All elements of literacy, including reading, writing, listening and speaking
- The value of play and the adult's role
- Aspects of motor development, including gross and fine motor skills, nutrition, health and safety development
- Aspects of social-emotional development such as social relationships and attachment
- Aspects of intellectual development such as how children gather and process information
- Parent group meetings that include topics related to development and parenting issues of children 3-5 years old

Pre-service: Arranged by the Sites

Each site is responsible for providing all staff with mandatory training on the following topics within the first 6 months of staff employment. These topics must be covered in addition to any required training offered by the organization.

- Health Education – Pre and Postnatal Health & Well-being
- Workers' Safety and OSHA requirements
- Family Violence (Domestic, Child Abuse & Neglect)
- Mental Health, HIV/AIDS, Substance Abuse/Alcoholism
- Mandated Reporting to DCF
- Communication Skills
- Stress Management and Burnout Prevention
- The Nurturing families Network Policy Manual

Professional Development Focus Group Model

The Focus Group Model is required for the NFN home visiting staff. The training format may be used for Nurturing Connections Coordinators and Nurturing Group Facilitators.

The model, created by the Hartford-VNA Nurturing Family Network site, has three components.

First Component:

- During supervision, key issues and challenges for the home visitors are identified.
- The home visitors and the supervisor agree to focus on one of the issues.

The supervisor locates an expert within the community or the site to come to their site and offer training or information on the particular issue.

Second Component:

Following the training the home visitors decide how they want to bring this information back to the families.

In rare cases, the experts might be invited back to co-facilitate the focus group with the home visitor. However, most often the home visitors will decide to re-design the training and offer it to the families themselves. The home visitors usually hand pick and personally invite a few families they know will benefit the most from the training. The home visitor-led trainings are called focus groups.

In the Hartford VNA experience, the supervisors engaged the children in a nearby room during the focus group. This practice relieved the parents of the need to watch their children while they participated in the group and freed up the home visitors to provide the presentation or facilitate the activity. This also meant that the supervisors were close at hand if they were needed for any reason.

Third Component:

The roles and responsibilities for preparing these focus groups are shared and rotated among the home visitors. This allows all of the home visiting staff to build new skills in leadership, organization and communication. The training is offered quarterly.

Touchpoints©: This is a 16-hour training for healthcare, childcare, education and social service professionals in anticipatory guidance based on the Touchpoints© model.

Eight hours of training focus on communication and the relationship strategies between care providers and parents, as well as care providers and other professionals.

The remaining eight hours of training focus on their families and on using observations as a means to establish plans that support parent/child relationships and promote healthy development.

The Touchpoints© Model

- Stresses prevention through developing relationships between parents and professionals
- Combines knowledge about early child and parent development with the communication skills needed to make connections with parents
- Acknowledges that developing and utilizing relationships is critical to appreciating the significance of cultural, religious and social dynamics for families
- Encourages the professional to focus on strengths in individuals and families, rather than deficits
- Provides insight into the emotional experience of the developing parent
- Departs from traditional service provision in its multidisciplinary approach. By combining the knowledge and perspectives of developmental psychology, education, nursing, pediatrics, psychiatry, and social services, valuable linkages are made to support children and families.

Recognizing and rewarding the professional growth and development of the staff

Upon completion of required training and protocols Nurturing Families staff are eligible to become credentialed home visitors. Specific information detailing the requirements follow.

Home Visitor Credential

The purpose of this policy is to define the qualifications and process for obtaining a home visitor credential.

Home visiting credentialing requirements

Training

The training requirements listed below must be completed within two years of employment as a home visitor with the Nurturing Families Network. A certificate will be awarded to each individual who successfully completes all attendance and training requirements. The certificates will indicate the number of training hours completed.

Application

Home visitors who meet the training requirements can apply to the Children's Trust Fund for a credential. The home visitor must submit the following with their application.

- Certificate verifying completion of the training requirements
- Verification of employment requirements
- A recommendation from the clinical supervisor and program manager describing how the home visitor demonstrates the skills and knowledge gained from the training
- Documentation verifying participation in the Professional Development Focus Group in-service training.

Trainings needed with point values to qualify for a Home Visitor Credential.

Points are based on the number of training hours.

Ages and Stages Basic training	3
Ages and Stages Social and Emotional training	3
Diaz Shaken Baby Syndrome prevention	4
Nurturing Families Network core	35
Family Development Credential	80
Touch Points	16
Parents As Teachers (0-3)	35
Parents As Teachers (3- Kindergarten)	16
Professional Development Focus Group Model experience*	82
TOTAL	**274**

Professional Development Focus Group

Facilitation responsibilities	**Points earned**
Home visitor participates in 2 hours of training to gain knowledge	2
Home visitor creates a training opportunity for families	4
Home visitor coordinates, invites families, and facilitates the group experience	8
Total	**14**

Home visitors who co-facilitate a group experience each will earn half or 7 points.

Participation responsibilities	**Points earned**
Home visitor participates in 2 hours of training to gain knowledge	2
Home visitor supports peer in creating a training opportunity for families	4
Home visitor supports peer in facilitating training experience	2
Total	**8**

During the 1st calendar year of employment a home visitor is expected to:		
Participate in three Professional Development Focus Group	(3x8)	24
Facilitate one Professional Development Focus Group	(1x14)	14
First calendar year total		38
During the 2nd calendar year of employment a home visitor is expected to:		
Participate in two Professional Development Focus Group experiences	(2x8)	16
Facilitate two Professional Development Focus Group experiences	(2x14)	28
Second calendar year total		44
***Participation in a Professional Development focus group experience total**	**(38+44)**	**82**

Home Visitor Credential grandfather clause

The two year time limit for completing the training required for home visitors can be waived and a home visitor can receive the Home Visitor Credential by satisfying the following:

- Verification of completion of the training requirements that were in place at the time of employment
- Verification of four years of home visiting experience with NFN as of January 1, 2007
- Verification of participation in *Nurturing Families in Action*, an FDC credential and participation in at least one training required for the home visitor credential
- Participation in one and facilitation of one Professional Development Focus Group

- Recommendation from the clinical supervisor and the program manager describing how the home visitor has demonstrated the skills and knowledge gained from the training in her work

Note: The grandfather clause expires 10/1/07. After that time credentials will be only be issued to home visitors who complete all of home visiting credentialing requirements within two years of employment.

Senior Home Visitor Credential

The purpose of this policy is to define the qualifications and process for obtaining a Senior Home Visitor Credential.

Senior home visitor credentialing requirements

Home visitors with five years of employment with NFN who have obtained a Home Visiting Credential and meet the additional requirements can apply for the Senior Home Visitor Credential.

The training requirements

- One hundred twenty-nine hours of in-service training using the Professional Development Focus Group model

- Completion of three advanced level courses developed and offered by the Children's Trust Fund

Description of Advanced Level Courses

- Self and Others. Focuses on understanding one's own life, history and culture while learning about others including group dynamics, the age and stages of human development.

- Multiculturalism. Explores bias and prejudice in the American experience, forces that perpetuate it and forces for change including history, poverty, religion, spirituality, immigration and others.

- Complex Human Behavior. Explores substance abuse, domestic violence and behaviors related to mental health issues, grief, trauma, teen pregnancy and family planning.

A certificate will be awarded to each individual who successfully completes all attendance and training requirements. The certificates will indicate the number of training hours completed.

Application

The following must be submitted to the Children's Trust Fund:

- Verification of the Home Visitor Credential

- Certificate verifying completion of training requirements
- Recommendation from the clinical supervisor and program manager describing how the home visitor has demonstrated leadership, responsibility, interpersonal and organizational skills, and the ability to transfer knowledge and experience to others
- Documentation verifying participation in the Professional Development Focus Group in-service training

Trainings needed with point values to qualify for a Senior Home Visitor Credential.

Points are based on the number of training hours.

Training	Points earned
Self and Others	45
Multiculturalism	45
Complex Human Behavior	45
Professional Development Focus Group	129
Total	**264**

Professional Development Focus Group

Points are based on the estimated number of hours involved with each aspect of the Professional Development Focus Group. It is expected that during year three, four and five the home visitor will earn additional 129 points for in-service training as follows:

Participate in two Professional Development focus group experiences	(8x2) x 3yrs	48
Facilitate two Professional Development focus group experiences	(14x2) x 3yrs	81
Total		**129**

Senior Home Visitor Credential Grandfather Clause

A home visitor employed by the Nurturing Families Network can be granted the Senior Home Visitor Credential by submitting:

- Verification of completion of the training requirements in place at the time of their employment
- Verification of seven years of home visiting experience with NFN as of January 1, 2007.
- Verification of participation in Nurturing Families in Action training, the FDC credential, and participation in at least one training required for the Home Visitor Credential.
- Participation in one and facilitation of one Professional Development Focus Group Model experience.
- Recommendation from the clinical supervisor and program manager. The recommendation must describe how the home visitor has demonstrated leadership, responsibility, interpersonal and organizational skills, and the ability to transfer knowledge and experience to others.

Note: The grandfather clause expires 10/1/07. After that time credentials will be only be issued to credentialed home visitors who complete all senior home visitor credentialing requirements.

Responsibilities of Senior Home Visitors:

In addition to the duties assigned to a home visitor, a senior home visitor may be assigned additional responsibilities as follow:

- Train newly hired home visitors including peers at their own or other NFN sites
- Facilitate orientation sessions for new staff
- Accompany home visitors during home visits as needed
- Take the lead on site activities
- Develops a specialty within their programs

A 5% pay increase should be given at the time the home visitor receives the Senior Home Visitor Credential and is given additional responsibilities.

CLINICAL SUPERVISION

January 2007

Clinical Supervision

The CQI team has developed the clinical supervisor position with the home visitor in mind. However, this approach can and should be adapted to supervision provided to the parenting group coordinator/facilitator and the connections coordinator.

Research on the Nurturing Families Network shows that clinical supervision is a vital component of the home visiting program. Because families who participate in the program have complicated lives and complex needs, providing services to these families in their homes presents many challenges for the paraprofessional home visitor and the program supervisor.

Clinical supervision is a strategy that can prepare the home visitor to meet the challenge.

Role of clinical supervision

Clinical supervision addresses issues related to family functioning and dynamics as well as to the experience of the home visitor working with the family.

The clinical supervisor assists the home visitor to:

- Develop a fuller understanding of the families they are working with.
- Consider strategies and approaches for engaging and working with individual families.

The clinical supervisor also helps the home visitor become aware of and manage the feelings and frustrations she may be having about her work.

Clinical supervision is a skill. Clinical supervisors must have the experience and background to understand the families' complex needs, circumstances and the challenges faced by the home visitors.

Implementing Clinical Supervision: Administration

The clinical supervisors perform several administrative tasks. They review files and home visiting reports, follow-up on referrals, and make sure that program policies and procedures are being followed. This review can be very time-consuming. Therefore, whenever possible, records should be reviewed prior to the supervisory meeting. This will allow more supervisory time for the issues and questions that surface from the "paper review" as well as for the family issues and other matters the home visitor wants to discuss.

Implementing Clinical Supervision: Professional Development/Education

Clinical supervision provides an opportunity for the supervisor to teach, offer new skills and support the professional development of the home visitor.

The supervisor should listen carefully to what the home visitor is saying about the family. The supervisor should be prepared to ask questions and provide information that will enhance the home visitor's understanding of the family and her role.

The supervisor should:

- Ask questions about the family make-up, dynamics, culture and changing circumstances that may affect the family and the home visits.
- Explore with the home visitor how changes in the life of the family might be affecting how the family interacts with the home visitor.
- Help the home visitor think about how she might need to adjust her approach to reflect and accommodate the needs of the family.
- Help the home visitor seek and identify red flags that might alert her specific problems or circumstances.
- Help the home visitor identify and to address specific problems or circumstances.
- Provide feedback and impressions of the Kempe assessment and to plan the first visit.
- Help the home visitor organize her thoughts and her work with a family over time.

Supervisors should ask home visitors to come to supervision meetings prepared to discuss issues and questions related to the families and their home visits.

Implementing Clinical Supervision: Managing Feelings and Reactions to Families

Working with families with multiple issues can be rewarding – but it can also be stressful and frustrating. Supervisors should be aware of how the workers feel about the work they are doing and the families they are working with. It is important that the home visitors have an opportunity to explore and learn how to manage their feelings. Left unchecked, these feelings can lead a home visitor to lose sight of important boundaries, to distance themselves from families or to burn out.

Clinical supervision can help the home visitor reframe her experience of the family within the context of her role and her knowledge of the family and of human services practice.

In addition to supervision, individual sites can provide supplemental training on a variety of topics that support the professional development of the home visitor.

Frequency and Scheduling of Supervision

Clinical supervision should be available to each home visitor for a minimum of two hours each week. A set schedule – same time and day each week – is recommended.

The clinical supervisor should also be available in the office or by phone to address critical issues and/or questions that arise. The supervisor should designate an alternative staff member who has the authority to make decisions when the home visitor cannot reach the supervisor.

Joint home visits

Once a month, in lieu of the two-hour office meeting, clinical supervision should take the form of a joint home visit. The supervisor should accompany each home visitor on a joint visit to at least two families. Ideally, the supervisor would spend the full day visiting families with the home visitor. If a site has more than four home visitors, the supervisor may join home visitors on site visits on alternating months.

The purpose of the joint visit is to:

- Help the supervisor learn about the issues and needs of the families and stay in touch with the experience of working with families in their homes.
- Give the worker and the supervisor an opportunity to have a shared experience with the family, which can enrich discussions in the future.
- Give the supervisor the opportunity to see the home visitor in the environment with the families.
- Give the supervisor the chance to model skills.
- Break the isolation for the home visitor and the family.
- Make supervisors' visits with the families a normal occurrence so that, in case of a crisis, the supervisor's presence doesn't seem odd or troubling to the family.

Group Supervision

It is required that the Home Visitors and Clinical Supervisor participate in a biweekly meeting to increase teamwork, review NFN policies and procedures, review successes and strategies and community resources, and to provide support for each other and the families they serve. During group supervision, the Home Visitors and Supervisor should also discuss progress on implementing the professional development focus group model and choose a topic for that model for each quarter of the contract year.

Supervisory considerations when assigning cases and/or duties

The work load should be assigned based not only on the availability of the workers, but also on their areas of expertise. However, workers who have strengths in a particular area (and are in great demand) should not be overloaded with highly vulnerable families or consistently more complex and time consuming duties.

When assigning families to home visitors, the supervisor should consider the severity of the family's needs. Families with more complex issues may need to be scheduled for one visit per week.

Likewise, the number of families with complex issues should be considered when assigning families to staff and volunteers in the Nurturing Connection program for telephone support and education and when recruiting families for the Parenting Groups.

The supervisor is responsible for deciding how many families are appropriate for each individual based on the particular needs of the family.

The process and topic covered in clinical supervision as outlined in this document can be adapted to achieve the goals of increased job satisfaction and staff retention.

Required Supervisor's Education Training and Support

To perform this function each site must have a master's level supervisor trained in social work, human services or a related field who has experience in clinical supervision. The clinical supervisor must also have an understanding of the community and the families served by their program.

Clinical supervisors should meet to review and discuss their work with their supervisors at least every two weeks. Supervisors must receive at least 30 hours of training each year. At least 12 hours of the in-service training must be specifically focused on issues and information related to clinical supervision.

During the 30 hours of required annual supervisory training, the supervisor should pursue several opportunities to address cultural awareness through experiential learning.

Clinical Supervisors should focus on learning about the culture of the families during the joint visits with the home visitor and through the Professional Development Model (PDM). Outside training can also be helpful.

NURTURING CONNECTIONS PROGRAM

January 2007

Nurturing Connections

Screening and Volunteer or Staff Telephone Support

The goals of the Nurturing Connections program are to:

- Provide prenatal and post-partum education to families at low risk for abuse and neglect
- Help reduce the social isolation of new families and create connections between the family and their community

To achieve its goals Nurturing Connections program screens first-time parents and connects those at low risk with volunteers or interns while the mother is pregnant or the mother and baby are still in the hospital.

At full capacity, the Nurturing Connections program will provide telephone support to 100 families each year.

The program offers information on a wide range of topics including:

- Prenatal care, information on how to select a pediatrician and preparing for the child's birth
- Husky program, schedules for immunizations and well baby visits
- Physical needs and capabilities of infants, and the needs of children as they develop
- Dangers of shaking a baby, second-hand smoke, sudden infant death, accident prevention and more

Screening First-time Families Program Eligibility

Nurturing Connections Coordinators staff use the Revised Early Identification (REID) tool to screen new mothers prenatally whenever possible or in the hospital at the time of the baby's birth.

Ideally the screener reviews the mother's medical chart to complete the REID. When that is not possible, or when the information on the medical chart is incomplete, the screener meets directly with the mother to complete the screen.

The screener meets with the mother to introduce the NFN program. Mothers with a negative score on the REID are offered Nurturing Connections telephone support and those with a positive score are offered home visiting. The Nurturing parenting Group is offered to all families regardless of their REID score.

While the Connections staff is most likely to encounter mothers at the prenatal clinic and on the maternity ward, they are encouraged to involve fathers in this process whenever possible.

Providing Telephone Support to High Risk Families

- The coordinator, after consulting with her supervisor, may, but is not required to, offer Nurturing Connections to high risk parents in the following circumstances:

  • Mother scores positive on the REID and the home visiting program is full.

  • Mother scores positive on the REID and refuses to participate in the home visiting program.

  • Mother initially agreed to participate in the home visiting program, scored twenty-five points or higher on the Kempe Assessment and declined the home visiting program.

  In these special instances the Nurturing Connections Coordinator or other paid staff member of the agency, instead of a volunteer or intern, must provide services. Every effort should be made to:

- Enroll the mother in Home Visiting if a space becomes available.

- Enroll the mother in the Nurturing Parenting Group.

- Seek more intensive community-based services to assist the mother and the family as needed.

Referral Policy

- Staff and volunteers should explore the mother's interest in referrals to other community agencies.

- The mother may remain in Nurturing Connections while she is participating in other community services.

- If a mother is receiving services through Nurturing Connections or the Nurturing Parenting Group and her circumstances and needs change, the Nurturing Connections coordinator may assist her in enrolling in home visiting services.

- Once the transition is complete and the mother is receiving home visiting services, involvement with Nurturing Connections must be terminated.

- The volunteer is required to contact the Nurturing Connections coordinator immediately if she is concerned about the safety or well-being of the child or the parent. **In case of an emergency, the volunteer must call 911.**

Nurturing Connections Volunteers and Interns Guidelines

Volunteers and interns are expected to participate in a three-hour initial training on the roles and responsibilities of the volunteer, infant development and community resources. They may also be asked to attend additional training required by the agency.

- Volunteers and interns must participate in regularly scheduled monthly meetings to review cases and to obtain additional training.
- Volunteers will be assigned no more than four to seven families at one time. The number will depend on the volunteers' time and the needs of the families on her caseload.
- Volunteers should be asked to make a one-year commitment to the program.
- Interns are required to commit for two full semester(s) to the program.

Duties of the volunteers and interns can include:

- Meeting with the mother at the prenatal clinic, doctor's office or in the hospital. Volunteers must not conduct home visits with parents at any time.
- Providing information and an overview of the program at the initial meeting.
- Providing every family enrolled in the program with a NFN child-development calendar.
- Contacting the family for a minimum of three to six months after the child's birth through telephone calls, mailings or group meetings facilitated by the Nurturing Connections Coordinator.
- Giving families who need extra support and help with parenting skills information on community support services.

Decreasing social isolation through group activities

The Nurturing Connections program offers group activities for the parents and volunteers to come together. These groups are usually educational and social in nature. The groups are usually scheduled monthly or bi-monthly.

The Nurturing Connections participants and volunteers should also be invited to the site's NFN celebration.

HOME VISITING PROGRAM

January 2007

Home Visiting Program

The home visiting program is free and offered on a voluntary basis to first-time parents who have a positive score on the Revised Early Identification (REID) screen. A Nurturing Connections Coordinator usually administers the screen. Families are identified and offered services prenatally whenever possible or shortly after the birth of their child. Families can be enrolled in the program until the child is three months old.

The goals of the program are to:

- Provide timely and appropriate parenting education
- Enhance the relationship between parents and children
- Support new families by linking them to a host of community services

Assessment and Transitioning Families

Assessment Conversation

A trained Family Assessment staff conducts a psychosocial assessment of the parents, usually with the mothers, who screen positively on the REID. The assessment is a key part of the enrollment process. It helps the program staff gain a deeper understanding of the strengths and challenges facing the family.

The assessment ideally takes place in the parents' home. The Kempe Family Stress Checklist (the Kempe) covers ten domains that include family history and risk factors for child abuse and neglect. The assessment is conducted in a conversational manner and takes approximately one hour.

Recording the Kempe Assessment

The staff person completing the assessment must accurately record the information gathered during the conversation and assign a score for each of the ten domains. The total score indicates each parents potential of risk for child abuse and neglect. This assessment reviewed with the Home Visitor.

Beginning the baseline form

The family assessment staff begins filling out the baseline data form. The form must be completed within 30 days from the time a family enters the program. The home visitor can collect any missing information during that time.

Transition the Family

The family assessment staff meets with the home visitor to discuss the results of the Kempe assessment. The information is helpful for planning the first and subsequent home visits.

The family assessment staff informs the supervisor of any special circumstances within the family. The supervisor may choose to participate in the transition meeting. Whenever possible the family assessment staff should join the home visitor for the first home visit.

Initial Home Visit Forms

The home visitor will bring no more than four forms to the initial home visit. The following forms must be included:

- Family Rights & Responsibilities.
- Release of confidentiality forms including those related to the evaluation.
- HIPAA Consent.

An additional form may be added at the discretion of the site.

Documentation Required Program Entry

Home Visiting Baseline Form and Child Abuse Potential Inventory (CAPI)

The baseline data form must to be completed within 30 days from the time a family has their first visit with the Home Visitor. The Home Visitor is responsible for completing the baseline data form.

The information is critical to the research. If this data is not gathered when the families first enter the program, the evaluators will be unable to obtain an accurate picture of the progress parents make while participating in the program.

The CAPI is also a time-sensitive instrument and must be completed within the first 30 days a family enters the program.

Engaging Families

Engaging families in the Home Visiting program is not a simple or straightforward task.

The families served by the program face, and have faced, multiple difficulties and challenges in their lives. Many of the families have had negative experiences with human service agencies and state systems. Many have had difficulty realizing their goals – even with the help of well-meaning providers.

As a result, many of the families entering the program are hesitant to engage with yet another service provider offering help. For a family to feel comfortable opening their door, sharing sensitive information or revealing their goals, they must be approached in a nonjudgmental manner that recognizes their individual strengths, respects the influence of their culture on their parenting style and assumes that they want to be the best parents for their child. Building trust is a process – and it takes time.

While recognizing that every relationship develops in a unique way, we have identified three stages of relationship-building that are fundamental to all relationships. These stages can serve as a "road map" to guide a home visitor through the process of engaging with a family. The time needed for moving through each of the stages will vary from family to family. However, the relationship should progress to stage three during a three-month period of regular home visits. The stages are described below.

Stage 1

*Getting to know each other***.** During this stage the home visitor begins to learn about the family, to form some impressions of the family's circumstances, and to think about how she might best work with the family during the upcoming months.

During this initial stage, the home visitor is beginning to learn about the family's adjustment to the pregnancy or new baby, the interpersonal dynamics of the household and the family's engagement style.

The home visitor is also helping the family to learn about the program, what it has to offer and the services she can provide.

Stage 2

Establishing the purpose of the relationship. During stage two, the home visitor begins to focus on parent-child interaction (PCI), to select and discuss a curriculum and to work on identifying and meeting some of the immediate needs the family may have.

Stage 3

Establishing a mutually trusting relationship. At this stage the home visitor and the family have developed a comfort level that allows for meaningful conversations about issues the family is struggling with and about what the family wants and needs.

The home visitor should carry the Action Plan form to each visit and be prepared to introduce it at the appropriate time.

The home visitor and the supervisor should discuss the progress of the engagement process in supervision and consider how to best approach a family when the process is not moving smoothly.

The home visitor should use the Family As Partners (FAP) approach outlined in the Family Development Training curriculum for working with a family to identify wants and needs. The approach should also be used to determine who – the family or the home visitor – will be responsible for accomplishing the specific tasks outlined as part of the FAP process.

The home visitor should avoid using the term "goal" when working with the family. The term means different things to different families and has, at times, led to a breakdown in communication between the home visitor and the family. The CQI committee suggests using the terms "wants and needs" instead.

Action Plan

Introducing the Action Plan

Once the home visitor has developed a trusting relationship with the family and discussed the family's resource needs and the parents' hopes for the baby, the Action Plan tool can be introduced to the parents.

In many Nurturing Families Network programs, young moms live with their extended family and not always with the father of the baby. If this is the case, program staff should make an effort to bring the father into the planning process, at least with respect to the child's needs. If the parents are not amenable to mutual planning, the home visitor can take some of these same planning steps with the father on another occasion. If the program has a father involvement worker, the Action Plan can be used by those staff.

In some families, it may be appropriate to involve other family members in the Action Plan planning meeting. Many cultures value the ideas and involvement of older family members or significant others. The home visitor may want to introduce the planning process with the parents first. Once the parents are comfortable with the planning process, the home visitor can ask if there are other important support people the parent would like to involve.

This formal planning process should occur during the first 90 days of involvement with a family, depending on the family's wants and needs.

Here are two examples of how to explain the Action Plan to parents:

- "We have been working together for a month or so, and, at this point in our program, it's time to get specific about what we want to accomplish. Next week we will spend time talking about what you want and ways to accomplish those things. You may want to spend some time this week thinking about what you want to do in the short term."

- "One of the most exciting parts of the Nurturing Families Network program is that we help you figure out what you want, what's important to you and then how to get it! As I mentioned last week, today we're going to talk about your wants and needs – what you want to do, be, share and create. Did you have any thoughts about this during the week?" If the answer is no, the home visitor may suggest talking about what they have already accomplished.

Developing the Action Plan with the Family: Typical Steps in the Process

- Review the concept and philosophy of the Action Plan with the family.

- Ask the family what they think their strengths are and record this information on the Action Plan form. The home visitor may need to do some coaching to begin the process, suggesting strengths that the home visitor has observed.

- Review the services that the Nurturing Families Network program provides to families.

- Keeping in mind the family's strengths, stressors and needs, ask the parents to select a few areas that they would like the home visitor to help them focus on during the next six months. It's probably best to read through the lists on the Action Plan worksheet with the parents, checking off what they want. If the parent(s) has not selected any items related to parenting or child development, the home visitor will explain that discussing parenting and child development and doing activities with the baby is part of the program. The home visitor will then ask the parent to select a couple of items they'd be interested in focusing on. It may be helpful for the home visitor to use the SMART acronym to ensure that the needs and wants the family develops are:

  Specific

  Measurable

  Achievable

  Realistic

  Time-Oriented

- Briefly review the notes regarding concerns addressed in the initial assessment interview with parent(s). To protect parental confidentiality, review this information only with the parent who participated in the family assessment discussion, unless that parent requests you review it with his/her partner. Therefore, you should always bring a blank set of Action Plan forms with you. Remind the parent that these were items that the family assessment worker discussed with her/him in the hospital, clinic, etc. The goal here is to let the parent know that the home visitor is aware of the Family Stress Checklist interview and the stressors that affect her/his family. This will help her/him focus on the family's needs and concerns. It will also help the family to acknowledge difficult issues and incorporate appropriate wants and needs into the Action Plan.

- The home visitor should also ask the family to select approximately four items from the worksheet or to select other concerns not listed but important to the family to focus on during the next six months. These will be written in under the heading "What I/We Want." For each of these items the home visitor and parent(s) will determine how the family will achieve these needs/wants with the support of the home visitor. This will involve a discussion incorporating solution-focused problem-solving techniques. The home visitor will neither "tell" the family how they should achieve these needs/wants nor "do it for them." The home visitor's role is to provide support, guidance and education. The home visitor should review the services available through other agencies and be aware of how she can assist the family in obtaining these services.

- This session also provides an opportunity for the home visitor to find out what services the family is receiving from other providers and record this information on the Action Plan form. This is very important for two reasons: a) the home visitor needs to ensure that

services are not being duplicated, and b) this information may need to be collected for evaluation purposes.

- The home visitor will discuss child-development tracking with the family. The child-development tracking information may be completed prior to the visit and discussed with the family.

- The home visitor should record the family's pediatrician and phone information on the Action Plan form. If the family does not have a medical home, the home visitor should encourage them to establish one as soon as possible. Also, immunization information should be included on the Action Plan form.

- The home visitor should discuss the frequency of home visits over the next six months with the family and fill in this information on the Action Plan form. The frequency of visits is based on the family's needs and availability to participate in the program.

- The parent(s) and the home visitor sign and date the Action Plan.

- The supervisor discuss the home visitors progress in introducing and creating the Action Plan ensuring that items identified on the Kempe Family Stress Checklist have been appropriately incorporated.

Identifying Strengths and Resources

- Whom do you turn to when you need someone to talk to?

- Are there people around to help when you have a problem?

- What do you think your family does better than anything else?

- Has anyone ever complimented you or another member of your family?

- When are you most proud of your family?

- Who would you call if you won the lottery?

- What helps most for your family to survive?

- Who has helped you the most in the past few weeks?

Source: The Children and Families Program of the Florida Department of Health and Rehabilitative Services.

Recognizing Progress: Looking for the Little Steps

Sometimes families have made small gains that are hard to see when the home visitor is so closely involved. Here are a few things to look for:

- The parents are at home and available to talk when the home visitor arrives for a visit.
- The parents ask questions during medical check-ups.
- The parents refer to their goals or to setbacks from their goals and are open to planning their next steps.
- When the home visitor reviews the Action Plan with the family, some progress or change has taken place.
- Significant family members express an interest in the program or in becoming involved with the parents and the child.
- The family has made contact with another program or service provider for additional help.
- The parent takes on a new responsibility related to childcare or household duties.
- The parent asks questions or asks for help during a visit.

Scheduling and Conducting Visits

Weekly Home Visiting Schedule and Case Assignment

The Nurturing Families Network is a weekly home visiting program that can provide services to families for up to five years. Given the varied needs of families and lessening of those needs over time it is expected that home visitors will have a caseload that include scheduled weekly, biweekly or monthly visits.

The following are requirements for the home visitor caseload.

A full-time home visitor should schedule 12 – 15 home visits each week for a total of 48 to 60 home visits per month.

Home visitors must not carry a caseload of more than 25 families at any given time.

- The home visitor should plan to visit each home for one hour.
- Supervisors need to determine, the appropriate number of weekly visits for each home visitor. In determining this number the following should be considered:
  - The level of experience of the home visitor.
  - The amount of driving time involved in seeing each family.
  - The issues affecting the family (i.e., parents with a cognitive delay may require more time and involvement from the home visitor).
- The 12-15 scheduled weekly visits do not need to be three per day. For example, a home visitor may schedule up to four visits per day, leaving one day open for paperwork, workshops, meetings, etc. A home visitor should not schedule more than four visits per day.
- The number of weekly visits does not need to be the same for each member of the site's staff. One home visitor might have 13 weekly visits, while another worker may have 15. The purpose of scheduling visits is to adequately match the needs of the families.
- Some families may request more or fewer visits. Sometimes the home visitor may be the one to suggest moving to more or fewer visits. When a family and home visitor discuss the possibility of changing the visiting schedule, the conversation should focus on what is best for the family (from the family's point of view).
  - For example, some families may request bi-weekly (two times per month) visits. In this case, the average of 15 weekly visits for the month goes down to 14 1/2 per week for that month. The home visitor should stay at 14 1/2 weekly visits until another family established a bi-weekly pattern. Then the weekly home visiting schedule would be 14. At

this time, a home visitor could take on a new family, thus bringing the total back up to 15 weekly visits.

- It is important to note that when families are being seen on a bi-weekly basis, home visitors should go DOWN one-half, not go UP one-half, in their weekly visiting numbers. In the above example weekly visits went DOWN to 14 1/2, and then DOWN again to 14, before a new case was added. The home visitor should not go to UP to 15 1/2.

- When a family and home visitor discuss the possibility of changing the frequency of weekly visits to two times per month, a home visitor should suggest a trial period. This trial period can be one or two months of bi-weekly visits. At the completion of the trial period, the family and worker can discuss the appropriateness of making the bi-weekly visits the new visiting schedule. At this time the family may wish to continue with bi-weekly visits, or may ask to return to weekly visits. The home visitor should remind the family that, if a bi-weekly schedule is preferred, the home visitor will fill that one-half time slot with another commitment. Therefore, both family and home visitor should be aware of the consequences of frequency changes.

- If a family wants to go from bi-weekly back to weekly visits (due to any number of reasons), the home visitor can make this accommodation if there is room on the visiting schedule. If a home visitor does not have room on the schedule, the family can choose one of the following options;

  - The family may see another home visitor who has an opening.

  - The family may choose to wait for their home visitor to have an opening. Telephone check-ins and referral to other services (i.e., Nurturing Group) might be of assistance to the family during that time.

- Some families may wish to be seen one time per month. In such cases, all of the discussions and issues noted above apply.

Determining Visit Frequency

The home visitor and supervisor routinely review family need (stability and functioning) to plan interventions. In these reviews, visit frequency should be based on the same criteria that are used to plan interventions. An increase or decrease in visit frequency depends on the collaborative assessments of the home visitor and supervisor and on the family's wishes. The supervisor may use the following checklist to guide changes in the visit frequency at any point during the family's involvement in the program.

- Assessment of parent-child interaction (empathy/expectations)
- Assessment of family functioning and support
- Parent knowledge of child's needs and expected age-related behaviors, especially childhood milestones that may be stressful times, i.e., learning to crawl and walk, "terrible twos"
- Safety and comfort of physical environment
- Engagement of family in the program, as determined by kept appointments and home visitor assessment of parent interest
- Presence of crisis and family's ability to manage it
- Assessed progress on Action Plan
- Family use of needed community/health resources, i.e., well-child medical appointments, a depressed mother receiving counseling

Creative Outreach Policy

Decisions on the extent and method of creative outreach will be made on a case-by-case basis by the clinical supervisor in consultation with the home visitor at each site.

The supervisor's decision will be guided by what is in the best interest of the family and will take into consideration the home visitors' impressions of the family, including their:

- Readiness and willingness to engage in the program
- Issues or circumstances that led to the family's missed visits or absence
- Receptivity to the worker if she were to call or drop by

Administrative Guidelines

Creative Outreach

- Families on a caseload will begin creative outreach after one scheduled visit is missed. Creative outreach will continue for one month. During this month the home visitor will attempt to reach the family by phone, mailings and home visits.
- After one attempted and failed visit, the site supervisor may choose to assign a new family to the home visitor. The home visitor will routinely be assigned new families after the third failed attempt to visit the family or after a total of six weeks without visits with the family.
- Following creative outreach, families may receive announcements, invitations or other materials from the site as appropriate.

Closed Cases

- A family's case file should be immediately closed when a family says that they do not want home-visits or services from the agency.
- Case files should be closed when the first-born child is five years old, or for extenuating circumstances on a case-by-case basis.
- Case files should be closed if the site receives verification (i.e. returned mail) that the family is no longer reachable or living in the catchment area.

Reopened Cases

- Cases of families that have been closed may be reopened and the families readmitted into the home visiting program anytime the family contacts the site or request services until the first-born child is five years old.

- The supervisor or assessment worker will meet with families requesting to be readmitted to the program to assess their needs and determine whether the services of the home visiting program are still appropriate to meeting those needs.

- Families who are requesting to be readmitted to the program will be offered, at the discretion of the supervisor, the opportunity to:

  - Continue to work with their previous home visitor if they are still employed by the site and have an opening on their caseload.

  - Begin working with a different home visitor if their original worker is not available.

  - Be placed on a waiting list if the site is at capacity and receive a referral to another program that best matches the needs of the family.

Process

The program manager, in consultation with the clinical supervisor and/or the family assessment staff, should devise an internal system for keeping track of closed families and for readmitting families.

For example, if a family calls and requests services, the clinical supervisor or family assessment staff should look through the case file to determine who the family's last home visitor was and whether that worker has an opening. If the worker has an opening, the family should be assigned to their previous worker.

In cases where the first worker has a full caseload or has left the program, the clinical supervisor or family assessment staff should make a home visit to speak with the family to assess the level of need identified and the issues that brought the family back to the program. Staff should then pursue one of the two tracks:

- If the site has openings the supervisor should then assign the family to a home visitor after reviewing the initial and current circumstances of the family.

- If the site is at capacity, the family should be offered a waiting list and other services in the community that best fits the needs of the family.

Families on the waiting list should be contacted as openings become available on the home visitor caseloads.

If a readmitted family finds itself in creative outreach for a second or third time the supervisor should work with the home visitor on strategies for:

- Talking with the family about both the family's needs and the expectations of the program

- Emphasizing the worker's need to have families keep appointments
- Working with the family to resolve the issue of no shows

At no time should a supervisor or home visitor apply undue pressure or coercion to engage the family into the program or use their access to resources or support as power over the family to compel them to comply with visits.

Home Visit Preparation

Home Visitors should spend a minimum of 30 minutes preparing for each home visit. At a minimum, Home Visitors should take the following steps to prepare for each home visit:

- Review home visit record from previous visits
- Choose curriculum to use based on the stage of pregnancy or the child's age/development
- Choose a prenatal or preparation for child's birth activity or age/development appropriate parent-child activity
- Research other curriculum/information if necessary
- Assess whether family needs/wants a referral to a community agency (If so, bring contact info for agency/program and connect with someone at agency)
- Review family's Action Plan so you can discuss progress/next steps
- Determine if ASQ or research instruments are due for family
- Identify family's strengths and determine how to best support family in their successes/accomplishments
- Identify family's risk factors and assess ways to address them using curriculum, referrals or other information

Length and Content of Visits

Home visits should be scheduled for one (1) hour and should not be less than thirty (30) minutes or longer than ninety (90) minutes unless special circumstances warrant additional time. Home visitors must discuss the need for longer visits with their supervisor.

Any visit that lasts less than thirty (30) minutes will not be counted as a visit. In order to count, thirty (30) minute visits must cover all of the essentials of a home visit, including curriculum and parent/child interaction.

Out of home/office visits only count if the Home Visitor and parent spend at least twenty (20) minutes and cover the essentials of a home visit including curriculum and parent/child interaction. Out of home/office visits should augment the home visits and not be a substitute for them. Home Visitors should consult with their supervisors if there are barriers to completing home visits.

Visits of any kind that do not include a focus on curriculum and parent/child interaction will not count.

Working with Significant Others

The social network of parents affects their ability to reach their potential for growth and self-sufficiency. A social network might include grandparents, siblings, aunts, uncles, the baby's father, the mother's boyfriend and others. The Nurturing Families Network will make every effort to encourage the participation of significant others in the program whenever it is appropriate.

Home Visits

When conducting home visits, home visitors should know and follow the guidelines and key principles of engagement. This is extremely important when another family member and/or the live-in boyfriend are present during the home visit. Preparation for the home visit is vital to ensure a successful outcome.

The home visitor should treat each family member with respect and recognize that she is entering the entire family unit even though the focus of her work may be on the mother and the new baby.

Preparation should include:

- Meeting with the family assessment staff to review the assessment and to prepare for the visit – keeping the entire family in mind. Special attention should be paid to individuals who are emotionally and financially connected to the mother.

- Reviewing agency documents to ensure they are family friendly and have appropriate space for additional family member names. Having documents translated into the family's native language will be helpful or necessary to effectively communicate with the family.

Father of the Baby

Family assessment staff should complete a Kempe assessment with the father of the baby if he is available.

Almost 70 percent of the fathers are very or somewhat involved with their children according to the research. This involvement is a strength of the family. Even though only 30 percent of the fathers live with the mother of the baby, the role of the program is to support them, teach them about positive parenting and a healthy relationships, and to make appropriate referrals when necessary.

Boyfriend

The relationship between the mother and her boyfriend is usually important to her. As a result, the boyfriend is significant in the life of the child. It is not uncommon for a boyfriend to live in the household or for the child to call the boyfriend “Dad.”

The boyfriend's life may be complicated. There may be complex interpersonal dynamics between the boyfriend and the father of the baby or other family members.

The home visitor should provide the mother with information and resources that can help her make healthy relationship choices for herself and her baby.

With the mother's permission the home visitor should:

- Discuss and clarify her role with the boyfriend
- Provide the boyfriend with information about healthy relationships, parenting education and child safety

The home visitor should speak regularly with the mother about her relationship with the boyfriend (and others) in order to assess the safety of the child. The home visitor should make appropriate referrals for additional support when needed and discuss any concerns she may have with her supervisor.

Workshops or presentations on the engagement process with fathers, boyfriends, teen parents living with their parents, domestic violence and grandparents are recommended for program staff.

Families with Cognitive Delays and Other Developmental Disabilities

Working with families who are struggling with multiple issues is very difficult. Trying to determine which problem to address first or what problem lies at the root of the other issues is quite challenging.

Research indicates that many families who enter the program suffer from some level of cognitive delay and/or developmental disability. Often developmental challenges are not as clear when the family first enters the program as they are six months to a year later. Many times additional stressors become more obvious as families begin to share more with their home visitors.

Once a home visitor has established a working relationship with the family, she is faced with the challenge of locating and securing the additional outside services needed by the family. Services for this population are very scarce, and existing programs often have very long waiting lists.

When providing home visiting services to families, it is important to:

- Allow enough time for the home visitor to adequately help the family
- Make sure that the home visitor schedules visits weekly and caseloads are appropriate to reflect the additional time needed to work with these families
- Connect families to appropriate outside services when necessary
- Continue to discuss the problems the families face in team meetings and /or individual supervisory sessions

In addition, the supervisors should consult with the home visitors when determining the number of scheduled visits.

Parents with Multiple Children

The purpose of this policy is to provide clarification of the roles, responsibilities and expectations of home visitors when parents already receiving home visiting services have more than one child.

The NFN model and philosophy is based on family-centered practice. The vision of NFN is that every child will be raised within a nurturing environment. Given our vision, guiding principles and commitment to family-centered practice, every child residing in the household is entitled to receive early intervention services/support.

Parents who have more than one child usually need more support to ensure child safety and education while balancing the different developmental needs of each child.

Based on various factors such as multiple children at varying developmental stages, cognitive abilities of parents, behavioral issues or medical conditions, a family can receive more than one visit per week.

The amount of involvement with subsequent children should be determined on a case-by-case basis considering their individual developmental needs.

The minimum services to be provided to each child by the family support worker include:

- Complete the Ages & Stages child-development Questionnaire
- Track immunizations
- Plan activities using curriculum for the targeted child, inclusive of other children
- Provide parents with information and refer them to community resources if they request additional support or if significant developmental delays are identified
- Educate parents on how to promote sibling bonding

Benefits include:

- Enhancing sibling bonding, giving parents the chance to focus on dynamics
- Developing individual opportunities for each child
- Supporting the development of family fun and positive parent-child (family) interaction

Families with Acute Problems

This policy covers a very small number of parents dealing with severe problems. The parent(s) may be experiencing or have recently experienced a psychotic episode, delusional or suicidal behavior, exposure to violence or a crisis related to substance abuse.

The purpose of this policy is to provide guidance when these situations occur and to create a framework for decision-making within each NFN site. The ***Families with Acute Problems*** policy provides sites with several options as follows:

- To secure added support for such families, the NFN site may choose to stay or become involved with a family to stay or become involved with a family with added supports, or to stay or become involved with a family while pursuing efforts to secure added support for the family.

- The NFN sites may also choose ***not*** to stay or become involved with a family when added support is critical but the family declines that support or ***not*** stay or become involved if added support is critical but can not be found, or when the situation is untenable for the home visitor.

Parents Already Enrolled in NFN

The Nurturing Families Network provides intensive support for high risk and hard to reach parents. In addition to caring for a new baby, these families face many challenges that are often compounded by their own histories of substance abuse, mental health issues and domestic violence. The University of Hartford report for 2005 on the NFN program found that:

- More than one quarter of the participating families had a history of substance abuse, about one-quarter of the mothers had a history of psychiatric care, and one third had a history of or current depression.

- One third of the mothers were either prone to violence or living in households where violent episodes were likely to occur.

- The mothers had limited familial and social support, a general discontent with life or destructive coping mechanisms.

- Slightly more than three quarters of the mothers were abused or neglected themselves as children and almost 66 percent had a criminal history, a history of substance abuse and/or a history of mental illness.

- The average score on research instruments for Nurturing Families Network mothers was similar to the average score for samples of known mild physical abusers and of female parents addicted to alcohol.

- Nearly 40 percent of the fathers had substance abuse problems. Eleven percent was incarcerated at the time of baby's birth and 46 percent had a history of arrest.

- Of the fathers, four percent were considered to be at low risk for child maltreatment, 36 percent at moderate risk, 48 percent at high risk and 12 percent at severely high risk for child maltreatment.

- Ninety-one percent of the mothers scored at moderate or severe risk on the multiple stressors subscale including relationship problems, financial distress or frequent job losses or moves.

Crisis:

Sometimes these problems create a crisis in life of the family. In some instances these problems threaten a parent's ability to function effectively or become unmanageable for the home visitor. In many of these situations more help is needed than the home visitor can provide.

In some instances it is clear that the child's well being has been endangered or that the child has suffered abuse and / or neglect as a result of the problem. In these situations the staff should follow the NFN policy regarding reports to DCF.

In other cases the child is not in immediate danger and the parent has functioned appropriately given the situation or DCF has refused to accept the case. In these cases, the home visitor should take all appropriate and necessary immediate action including:

- Calling 911, the police or other emergency service.

- Informing the supervisor. The supervisor must inform the program manager.

- Following appropriate site policies.

- Creating, with the family, a crisis plan to prevent the reemergence of the crisis or to keep the situation from developing into a crisis.

Following the crisis:

Following the crisis the home visitor and, as warranted, her supervisor should meet with the parent(s) to discuss and assess the situation, the intensification or onset of the crisis, and the need

for additional services, supports or resources. The outcome of this discussion must be documented in a crisis plan. The plan should reflect any or all of the specific needs or preferences of the parent(s) while addressing the issue at hand.

When the crisis plan is agreed upon, the parent(s), with the assistance of the home visitor and/or supervisor, will arrange for the additional services. This agreement and the crisis plan should become a key part of the ACTION PLAN.

Parents may refuse additional services. However, if the parents refuse and the clinical supervisor and home visitor have determined that the services are essential for the parents' continued involvement in NFN, the home visitor and clinical supervisor may choose to:

- End services to the family and close the case. The family may re-enter NFN, within the standard 5-year timeline, if the family has put the previously identified services in place and there is an opening in the NFN program.

- Transfer the parent(s) to another service or program that would be more appropriate.

If the parents are willing to accept additional services and none are available, the supervisor or the home visitor may end services to the family as outlined above or continue to work with the family while searching for appropriate services.

The home visitor or supervisor should contact 211 for assistance and request a search of available services in the geographic area to address the specific problem or problems identified.

The parents, with the assistance of the home visitor and/or supervisor, should call the providers on the list to locate an appropriate and available service and to schedule a first meeting.

While crisis planning for prenatal and postnatal parent(s) is similar, there are some differences to keep in mind.

Parents presenting with acute problem prior to enrollment in NFN

Prenatal Intake – Expectant Parents

When a family assessment staff determines that expectant parents have acute problems and it is clear that more help is needed than the home visitor can provide, the family assessment staff should inform her supervisor.

The family assessment staff should ask the referral source or the hospital social worker to develop a treatment plan with the expectant parents and to find additional services to augment the NFN home visiting program.

Admission into NFN may be contingent upon securing additional services for the parent and the parents' agreement to participate.

If the family assessment staff and the supervisor determine that additional services are essential for the parents' involvement in NFN, the family assessment staff or the supervisor must explain this to the referral source.

If the parent refuses the additional services, the family assessment staff and supervisor may decide not to accept the parent into NFN. In this case, the referral source would maintain the responsibility for referring the parents to another service or program that would be more appropriate.

When the parents agree to the additional services and the treatment or crisis plan it should become a key part of the Action Plan.

Post-Natal Intake - At the Time of Birth

When a family assessment staff determines that new parents have acute problems and it is clear that more help is needed than the home visitor can provide, and a referral to DCF has been ruled out or rejected, the FAW should inform her supervisor.

The family assessment staff should ask the hospital social worker or other referral source to develop a crisis plan with the family and find additional services to augment the NFN home visiting program.

The family assessment staff may inform the referral source about the services available through 211. The family assessment staff or supervisor may also participate in the search.

Admission into NFN may be contingent upon securing additional services for the parents and the parents' agreement to participate in the services.

If the family assessment staff and the supervisor determine that additional services are essential for the parents' involvement in NFN, the family assessment staff or the supervisor must explain this to the referral source.

If the parents refuse the additional services, the family assessment staff the supervisor may decide not to accept the parents into NFN. In this case, the referral source would maintain the responsibility for referring the parents to another service or program that would be more appropriate.

When the parents agree to the additional services and the crisis plan, it should become a key part of the Action Plan.

Please cross-reference this policy with the NFN "Policies for working with the Department of Children and Families" policy, which is also included in the NFN manual.

Working with Families after the Death a Child

The purpose of this policy is to provide guidance to sites following the death of a child in the NFN home visiting program.

This policy refers to those situations where a child in the family dies. The goal of the program should be the successful termination of services with the family.

With the guidance of the Supervisor the focus of the home visitor's work with the family should include:

- Offering support

- Assessing the need for alternative services and exploring and linking families to services and resources

The focus of the Clinical Supervisor working with the home visitor should include

- Providing direction and consultation regarding the process and plan
- Applying Clinical Supervision techniques to the process

The termination process should be completed as soon as possible and within ninety days. The time frame should be determined on a case-by-case basis in consultation with the Supervisor.

If there is more than one child in the family, home visiting services should continue.

If the primary child dies, the family may remain in the program and continue to receive services until the next oldest child is five (5) years old.

NURTURING PARENTING GROUP PROGRAM

January 2007

Nurturing Parenting and Children's Groups

Introduction

The Nurturing Parenting Group and Children's Groups are curriculum-based, experiential classes designed to promote positive parent-child relationships and reduce isolation.

Nurturing Parenting Groups are designed to offer community residents opportunities to participate in the groups free of charge. Parents with multiple children are eligible to participate in the groups.

The goals of the Nurturing Parenting Group

- Enrich the life and assure the healthy growth and development of families.
- Provide families and others responsible for the care of children with information and resources on topics and issues of interest to them.
- Assist families in breaking the sense of isolation that often comes with parenting.
- Prevent child abuse and neglect by supporting parents and providing opportunities for group members to share and connect with one another as resources and supports long after the group experience has ended.

The goal of the Nurturing Children's Group

- To provide a safe, enriching and nurturing environment for infants, toddlers and young children while their parents are participating in the Nurturing Parenting Group.

Program Eligibility

This service is provided at no cost to families. Families currently involved with the Department of Children and Families (DCF) due to an investigation or an open case due to a substantiation of abuse or neglect should not be enrolled in the Nurturing Parenting Group. If a family *becomes* involved with DCF as a result of a substantiated case of abuse and neglect, they are welcomed and encouraged to continue with the Nurturing Parenting Group; (refer to Working with the Department of Children and Families policy in this manual).

Accessing Services

Families can access the Nurturing Parenting Group in several ways:

- Self referral, Hospitals, schools and community agencies may refer families directly to the Nurturing Families Network site.

- The Nurturing Connections Coordinator may also offer and introduce the group during face-to-face interviews with first-time parents in the hospital.

- The Nurturing Families Network Home Visiting program may offer and introduce the group to the families they serve.

Contractual Requirements

Each site must provide 30 weeks of group to fulfill its contractual obligations in providing Nurturing Groups.

- Two long-duration groups (20+ sessions each group).

- Three shorter-duration groups (usually 10 sessions per Prenatal or You Make the Difference).

- A combination a long and shorter duration group. For example, one 20 +session group (such as Birth to Five) and one 10-session group (such as Prenatal or You Make the Difference).

Curricula

Nurturing Families Network sites must choose curricula from Dr. Stephen Bavolek's series or the *You Make the Difference (YMTD)* curriculum. The Bavolek's series includes:

- Nurturing Program for Prenatal Families.
- Nurturing Program for Parents and Their Infants, Toddlers and Preschoolers.
- Nurturing Program for Parents and Their School-Age Children 5-11 years.
- Nurturing Program for Parents and Adolescents.
- Nurturing Program for Teenage Parents and Their Families.
- Nurturing Program for Foster and Adoptive Parents.
- ABC's for Parents.
- Crianza con Carino.
- Nurturing Program for Parents of children with Special Learning Needs.
- Nurturing Program for African-Americans.
- Nurturing Program for Families in Substance Abuse Treatment and Recovery.
- Developing Nurturing Skills K-12 School-Based Curriculum.

The *You Make the Difference (YMTD),* 9 week curriculum focuses on increasing the parents' ability to connect with their child by teaching 1) how to allow the child to lead; 2) how to adapt to sharing the moment; and 3) how to add new experiences and words.

Written approval by the Children's Trust Fund is required prior to the use of any curriculum that is not a part of Dr. Stephen Bavolek's series or *You Make the Difference (YMTD).*

Facilitators must be certified through the Hanen Center prior to using the You Make the Difference (YMTD) curriculum.

Procedures and Program Requirements

Procedures for the parent groups:

- Group curricula must be selected based on the needs of the community.
- A parenting group must have at least 6 individuals committed to participating to begin.
- At least three (3) weeks prior the start of parenting group the start up form must be submitted to the Children's Trust Fund indicating the number of volunteers recruited to assist with the groups.
- No more than 16 adults may be enrolled in each group. Groups larger than 16 must hire an additional group facilitator or offer another group.

Procedures for Children's groups:

- Each site must have a paid, trained employee as the leader of the Children's Group.
- Open communication between group leader(s) and the children's parents must be fostered at each session.
- While leaving flexibility to the individual sites, it is important to recognize the Children's Group should end no later than 7:30 p.m.
- Parents are required to give written permission for their children to participate in all of the groups' activities, including meals and snacks. If a parent chooses not to give permission, the parent will need to provide other arrangements for their children, including food.
- All parents must deliver their children to the playgroup area.
- All parents must pick their children up from the playgroup area.
- Volunteers are never to walk through the hospital/agency with children alone.
- Group environments should maintain high standards of cleanliness, particularly in eating and napping areas.
- In the Children's Group room, **emergency** telephone numbers <u>must</u> be posted and there <u>must</u> be an accessible phone.
- Procedures for diaper changing need to be in place and discussed at initial session (if applicable). Parents must change their children's diapers.

- Parents must take their children to the bathroom.

- The Children's Group will follow the Children's Group curriculum compatible with the Parenting Group curriculum selected. The curriculum should focus on the following:

  - Enhancing motor skill development.
  - Encouraging cooperation and teamwork.
  - Fostering positive social interaction and social skill development.
  - Learning positive forms of age-appropriate play.
  - Appropriate children's activities should be complementary to parents 'group activities.

- There must be enough trained adults available to provide adequate supervision of every child.

- For infants and children, the ratio of adults to children must be no more than 1 to 4.

- Two adults must be in the room at all times with a child. No adult is permitted to stay alone with a child.

- Regardless of age, there are times when some children may require more adult supervision.

- A children's group room should:

  - Be well-lit and ventilated.
  - Be child-oriented, clean and orderly.
  - Have various spaces to accommodate age ranges of group members.
  - Have all toys washed and disinfected regularly.

The following procedures apply to the facilitation of groups:

- Home visitors must not be assigned responsibilities to facilitate or function as volunteers for either the parents or children's group.

- Nurturing Group is a multifaceted process. Therefore we recommend that all groups are co- facilitated with other staff members, volunteers or interns who meet the minimum group facilitation requirements.

- Group facilitators must receive training in health and safety issues.

- Food allergy and dietary restrictions must be gathered and documented at the time of intake.

- Groups can offer "potluck" dinners at annual or special occasions with the parents' knowledge.

- Nurturing Group coordinators should attend the Network meetings (held approximately 6 times per calendar year).

- The Children's Trust Fund will offer training opportunities for Nurturing Parenting Group Facilitators.

- Each Nurturing Group's lead facilitator must be a paid staff person. The lead Nurturing Parenting Group facilitator must have a bachelor's degree with sufficient experience facilitating groups or a minimum of three years experience facilitating psychosocial educational groups**.**

- Active recruitment for new group members ceases at the start of the group**.**

- The Nurturing Parenting Groups are closed to observers.

- The Nurturing Parenting Group is closed to new members after the third week and/or at the discretion of the Nurturing Group facilitator.

While each site is encouraged to be creative, there are some basic policies that all groups must be aware of and should plan:

- Sites must have an orientation prior to the beginning of each group, or at the first group session. At the orientation key issues such as food allergies, the special strengths or challenges of the children and the expectations of the group facilitators and parents are shared and discussed.

- All groups will be conducted in accordance with existing fire and health department standards.

- There must be an *evacuation* plan. This plan must be posted, visible and shared with all group facilitators. Parents and volunteers should be informed of this plan at the first group session.

- Supplies to handle accidents and emergencies must be available.

Nurturing Parent Group participants should be invited to site celebrations.

WORKING WITH AGENCIES THAT MANDATE SERVICES

January 2007

Policies for Working with Agencies that Mandate Services

The CQI team has developed the policies for working with an agency that mandates services with the Department of Children and Families (DCF) in mind. However, this approach can and should be adapted to working with other agencies who mandate services such as probation, parole, the courts and others.

Policies for Working with the Department of Children and Families (DCF)

Working with a family and DCF when a case is opened and the family has been previously enrolled in the program

Nurturing Families Network staff are mandated reporters. The Nurturing Families Network recognizes and accepts that some families who enroll in a prevention program will require intervention and DCF involvement.

The Nurturing Families Network will support the role of DCF in protecting the safety of the child. NFN will continue to promote positive parent-child interaction, healthy growth and development, and to enhance family functioning by building trusting relationships, teaching problem solving skills and improving the family's support system.

The Nurturing Families Network will continue to work with a NFN-enrolled family following these guidelines:

- The Nurturing Families Network is always a voluntary service and cannot be stipulated as part of a mandated treatment plan or as an alternative to a Department of Children and Families investigation or ongoing oversight and intervention related to child abuse or neglect.

- If there is one child in the family and that child is removed from the parents' care for a period of more than three months, the parents will be discharged from the program. The home visitor will assist the parent with referrals.

- Foster children, who are first-time parents, can participate in the Nurturing Families Network programs.

- Parents who live with other individuals, who are being investigated or receiving oversight and /or services for allegations of abuse and or neglect, but are not themselves under investigation or substantiated for abuse or neglect can participate in Nurturing Families Network programs.

- Nurturing Families Network staff will work with DCF to develop a treatment plan. DCF will maintain responsibility for monitoring the plan and determining if the goals are met.

- Nurturing Families Network action plans will include intervention and referrals for services. The Nurturing Families Network will not assume responsibility for providing the services or making sure that the services are obtained.
- The Nurturing Families Network will honor any legal interventions including "no contact" orders.
- The Nurturing Families Network will:
  - Require a release of information allowing NFN and DCF to discuss the case and exchange information.
  - Request a meeting with DCF and the family within two weeks of the start of an investigation and /or transferring of the case for oversight and services for issues of abuse and/or neglect. The purpose of the meeting will be to clarify roles and responsibilities.
  - Document all contacts with DCF which will be included in the family's case file. The family will have access to the file.
  - Maintain contact with the DCF worker to discuss the well-being of the child and the status of the case.
  - At the close of the case, receive from DCF a summary indicating how the risks to the child/children were reduced or eliminated.

Screening and Assessment: Criteria for Assessing Appropriateness of the Nurturing Families Network at the Time of the Child's Birth

- Because the Nurturing Families Network is a prevention program, only one percent of the Nurturing Families Network caseload can be involved with DCF at the time of program enrollment.
- When substantial risk factors, abusive or neglectful behaviors are present, a DCF report is indicated. The Nurturing Families Network, a voluntary prevention program, is not an appropriate referral in this case.
- It is not appropriate to give families the choice of the Nurturing Families Network or a report to the Department of Children and Families. If enough risk factors are present, a report to DCF must to be made.
- Foster children, who are first time parents, can participate in Nurturing Families Network programs.
- Parents who are victims of statutory rape can participate in the Nurturing Families Network programs.

Approved by the Children's Trust Fund and the Department of Children and Families and each of the current Nurturing Families sites – October 19, 1998.

Compliance with Mandated Reporting Requirements

Program Managers are responsible for ensuring that each staff member has been trained and is well versed their responsibilities as mandated reporters including the DCF operational definitions of abuse and neglect. All program managers should contact the DCF office in his or her area to request mandated reporting training. DCF policies and procedures can be obtained at www.dcf.state.ct.us.

DOCUMENTATION TOOLS AND CONTACT INFORMATION

DOCUMENTATION TOOLS AND CONTACT INFORMATION

Please read the information below carefully.

This section of the policy manual contains:

- Recommended Program Curricula and Supplies
- Overview of Current Program Forms Required
- Documentation Your Work
- Explanation of Site Ratings
- Current Evaluation logs:
  - Nurturing Connections forms and Purpose
  - Home Visiting Research Requirements and Due Date Hartford and New Haven Regions
  - Home Visiting Research Requirements and Due Date Northern and Southern Regions
  - Nurturing Group Research Requirements and Due Dates

To obtain the forms go to the Children's Trust Fund web site at www.ct.gov/ctf/nfn_forms and click on either:

- Hartford and New Haven Regions
- Northern and Southern Regions

Curriculum Name	Program	Description	Supplies Cost	Training cost	Total cost	Ordering information
A Star is Born, Memories and Milestones Calendar	*Nurturing Connections and Home Visiting*	Child development calendar	*$2.35 each*	N/A	*Dependent of amount ordered*	*Contact the Children's Trust Fund*
Parents As Teachers	*Home Visiting*	*Two curricula, Prenatal to three years and three years to kindergarten. Provides information and activities in the areas of child development and child brain development, starting during the pregnancy until Kindergarten.*	*$295.00 per home visitor and $75.00 per Supervisor* *Note: 1st year only Prenatal to three years curriculum is required.	$625/home visitor/ per curriculum	*Prenatal-three years=$1915* *Three years to kindergarten=$1840* *Note: Add an additional $1180 when ordering curricula both English and Spanish.* *Grand total=$4935.00*	*Once the registration form is submitted to PAT the manual is ordered and is provided on the first day of training.*
Partners for a Healthy Baby	*Home Visiting*	*Four colorful multicultural curricula (Before baby arrives, 0-6 months, 7-12 months, and 13-18 months) Provides information and activities in the areas of parents and child's physical, intellectual, emotional and social well being.*	*$125.00 per curriculum per home visitor and ($10.00/packet/ curriculum handouts - you will need one per family)*	N/A	Curricula in English and Spanish=$1750. Handouts in English and Spanish=$900. *Grand total=$2650.00*	*FSU Center for Prevention and Early Intervention Policy, 1339 E. Lafayette St. Tallahassee, FL 32301, 850-922-1300 (phone), 850-922-1352 (fax) ww.cpeip.fsu.edu <http://www.cpeip.fsu.edu>.*

The above total cost is based on ordering both English and Spanish versions of all curricula and materials for two home visitors and groups with fifteen families each.

Healthy Babies…Healthy Families	*Home Visiting*	Three curricula Prenatal Dad, Dad's San Angelo Birth to36 months ,Mom's and Birth to 36 months. Provides child gender specific material with simple wording and pictures.. Master copies of the curricula purchased can be replicated.	*Cost for: Prenatal Dads= $249.00* *Each is Birth to 36 months curriculum =$599.00*	N/A	*Grand total = $5788.00*	*Healthy Families San Angelo, 200 South Magdalen Street, San Angelo, Texas 76903, telephone (325) 658-2771 or Fax (325) 658-6438l:teri_covert_hfsa@msn.com or http//hfsatx.com/order/print*
Little Bits curriculum	*Home Visiting*	*Five curricula, for Little Bits for Mommy to Be, Birth to eighteen months moms, Little bits for Dads (Birth to eighteen months), Eighteen to forty eight months, Little bits of wisdoms (Birth to three years). Written as if the child is speaking to the parent.*	*The cost is $90.00 for each stage*	N/A	*Grand total= $900.00*	*SHD Enterprises, P.O. Box 2205, Lakeland, Florida 33806-2205, telephone (863) 816-2507, (fax) 863-853-3724.*
Ages and Stages Questionnaires (Basic)	*Home Visiting*	*Child development screening tool, which can be reproduced, that Home Visitors will complete during visits with the families at identified developmental stages.*	*$190 per boxed questionnaires and user's guides*	N/A	*Grand total=$190.00*	*Call 1-800-638-3775, 410-337-8539 (fax) or www.brookespublishing.com <http://www.brookespublishing.com>*

The above total cost is based on ordering both English and Spanish versions of all curricula and materials for two home visitors and groups with fifteen families each.

Ages and Stages Questionnaires Social and Emotional	*Home Visiting*	*A secondary developmental screening tool, which can be reproduced, completed by Home Visitors if a child's scores on the basic test reflect a concerns in this area.*	*$125 per boxed questionnaire and user's guide.*	N/A	*Grand total = $125.00*	*Call 1-800-638-3775, 410-337-8539 (fax) or www.brookespublishing.com <http://www.brookespublishing.com>*
Nurturing Parenting	*Group*	*One time materials purchase to use with the prenatal and Birth to 5 programs: Implementation manual multicultural parenting education guide and a video:" I'm only doing this for your own good" and Nurturing Touch Introduction to the Art of Infant Massage*	*$164.90*	N/A	*Grand total= $164.90*	*www.nurturing parenting.com*
Nurturing Parenting	*Prenatal and Birth to 5 Home Visiting and group*	*1 package of 15 nurturing books for babies and children, 1 package of 15 red, white and bruises*	*$240.00 per 15 participants per program*	N/A	*Grand total =$480.00*	*www.nurturing parenting.com*

The above total cost is based on ordering both English and Spanish versions of all curricula and materials for two home visitors and groups with fifteen families each.

	programs					
Nurturing Parenting	*Prenatal Groups*	*2 Facilitators manuals, 15 parent handbooks, parenting videos, and parent and facilitators certificates (20 per package) certificate resource materials, instructional aids, videos, games.*	*$424.90*	N/A	*Grand total = 424.90*	*www.nurturing parenting.com*
Nurturing Parenting	*Birth to five Groups*	*2 Facilitators manuals, 15 parent handbooks, parenting videos: Set of Nurturing Touch Videos for Infants, Toddlers, and preschoolers. Alternatives to spanking: Red, White and Blue, and parents, children and facilitators certificates (20 per package and instructional aids.*	*$895.95*	N/A	**Grand total=895.95**	*www.nurturing parenting.com*
Nurturing Parenting	*Birth to five Home visiting*	*Home Visitor manual*	*$45/ home visitor*	N/A	**Grand total=$90.00**	*www.nurturing parenting.com*
XXXXXXXXX	*XXXXXX*	*XXXXXXXXXX*	*XXXXXXXXX*	XXXXXX	XXXXXXXXXX	*XXXXXXXXXXXXXXXXXXXXXXXX*
Cumulative cost					***$16,518.75***	

The above total cost is based on ordering both English and Spanish versions of all curricula and materials for two home visitors and groups with fifteen families each.

NFN Program	Form	Completed by	Timeframe of completion	Where kept
Nurturing Connections	Intake (includes the REID)	Connections Coordinator	Entry	Parents record Copy sent back to Coordinator form site to informed Connections of the outcome of the referral to a site Copy of front page submitted to researchers
Home Visiting	Intake (includes the REID)	Supervisor – check re-entry and record the re-entry date on the form	Re-entry into program	Parents record Copy of front page submitted to researchers
Nurturing Connections	Connections Family Summary	Connections coordinator and volunteers	Conclusion of services	Parents record Copy submitted to researchers
Home Visiting	Kempe Family Stress Checklist (Narrative and scoring) **(Hartford only)**	Family Assessment Worker	Completed within one week of the Kempe Family Stress Checklist conversation	Parents record Copy submitted to researchers
Home Visiting	Home Visiting Family rights, responsibilities, and confidentiality policy	Home Visitor	Initial home visit with family(with Family assessment Worker)	Parents record

NFN Program	Form	Completed by	Timeframe of completion	Where kept
Home Visiting	Home Visit Record	Home Visitor Reviewed and signed by Supervisor	After each contact with family	Parents record
Home Visiting	Authorization to Release Information	Home Visitor	One per agency/ individual prior to (initial)contact to receive and exchange information- renewal required at least once yearly	Parents record
Home Visiting	Home Visiting Baseline Data Form Expanded baseline form **(Hartford)**	Started by the family Assessment Worker Completed by the Home Visitor	Within first month family enters program At 6 months of program entry Annually for date of program entry	Parents record Copy submitted to researchers
Home Visiting	Authorization to use or disclose (release) health information for a research study **(used for Hartford sites only)**	Home Visitor	Program entry	Parents record Copy submitted to researchers
Home Visiting	Community Life Skills scale(CLS)	Home Visitor	Program entry At 6 months of program entry Annually for date of program entry	Parents record Copy submitted to researchers
Home Visiting	Center for Epidemiological Studies Depression Scale (CES-D) **(Hartford only)**	Parents	Program entry At 6 months of program entry Annually for date of program entry	Submitted to researchers Copy I the parent's record Note: Efforts are taken to insure that the parent's responses are

NFN Program	Form	Completed by	Timeframe of completion	Where kept
				not used as a clinical factor when providing services to the families.
Home Visiting	Child Abuse Potential Inventory (CAPI)**(STATEWIDE)** Child Abuse Potential Inventory –Rigidity scale(CAPI-R) (**HARTFORD)**	Parents	Program entry At 6 months of program entry Annually for date of program entry	Submitted to researchers Copy retained in parents record
Home Visiting	Conflict Tactics Scale	Home Visitor	One year after child's birth	Submitted to researchers Copy retained in parents record
Home Visiting	Monthly activity log Expanded monthly activity log **(Hartford)**	Home Visitor	Monthly	Submitted to researchers by 10th of the following month. Retain a copy for Home Visitor's and Clinical Supervisors records
Home Visiting	Individual Family Support Plan	Parents and home visitors	Within initial 90 days of program entry 6 month intervals	Copy retained in parents record

NFN Program	Form	Completed by	Timeframe of completion	Where kept
Home Visiting	Ages and Stages Questionnaire	Home Visitor	4, 6,8,12,16,18,20,24,30,36,42,48,54,60 month	Copy retained in parents record
Home Visiting	DCF Release Form	Parents sign	Within initial 2 months of program entry Annually	Submitted to researchers Copy retained in parents record
Home Visiting	Exit Status Form	Home Visitor	Upon family leaving the program	Submitted to researchers Copy retained in parents record
Parenting Group	Parenting Group Start – Up/ Ending Form	Parent Group Coordinator	3 weeks prior to group start	Start up form submitted to researchers, Children's Trust Fund and Child Development Info line Ending form submitted to researchers
Parenting Group	Group Baseline data form	Parents	Program entry	Submitted to researchers Copy retained for site record

NFN Program	Form	Completed by	Timeframe of completion	Where kept
Parenting Group	Enrollment form	Parent Group Coordinator	Program entry	Submitted to researchers Copy retained for site record
Parenting Group	Parenting Stress Index (PSI)	Parents with children	First group session	Pretest-submitted to researchers within 2 weeks of completing Post-test submitted to researchers within 2 weeks of group completing
Parenting Group	Adult-Adolescent Parenting Inventory (AAPI-2)	Prenatal parents	First group session	Pretest-submitted to researchers within 2 weeks of completing Post-test submitted to researchers within 2 weeks of

NFN Program	Form	Completed by	Timeframe of completion	Where kept
				group completing
Parenting Group	Attendance	Parent Group Coordinator	After last group session	Submitted to researchers
Parenting Group	Exit status form	Parent Group Coordinator	After last session attended when family leaves before graduation	Submitted to researchers Copy retained for site record
Nurturing Connections Home Visiting Parenting Group	Creative Incentive Grant Application	Program Supervisor **Note: site Program Manager signature required**	Once per year	Submitted to Continuous Quality Improvement team Copy retained for site record
Nurturing Connections Home Visiting Parenting Group	Quarterly work plan status report	Preparer **Note: Site Program Manager must also sign report if they were not the report preparer**	January-March is due April 30th April-June is due July 31st July-September is due October 31st October-December is due January 31st	2 copies (1 with original signatures) financial expense forms submitted to the Children's Trust Fund. Copy retained for site record

Documenting Your Work

Sites must develop a system that ensures the:
- Confidentiality of all records
- Timeliness and accuracy of all documents

Data for each month must be submitted no later than the tenth day (10th) of the following month to the researchers. The timeframes established for completing each form allows the University of Hartford the ability to evaluate the progress of families in each of the Nurturing Families Network programs.

In addition to completing the evaluation tools and research documents staff should keep records that document all contact with families. These records should include:

- Purpose of the meeting or visit, the topics discussed and the family's response to the information
- Observation regarding the interaction among the adults in the household
- Observations of the child
- Observations of the interactions among parents, caregivers and the children
- Concerns expressed by the family and/or requests for assistance
- Challenges in working with the family and how the challenges were or will be addressed and the plan for future visits and other efforts

General guidelines for documenting information:

- Limit taking notes while you are meeting with the family. Most forms can be completed when you return to the office.

- If you must complete a form with the family, and as appropriate, have the family fill in the information.

When recording events and contacts with and on the behalf of all families is important to:

- Note all individuals present and/or spoken to during the contact.

- Make sure to comply with state laws. Families are entitled, and in some case others, to review records and files at any time.

- Record only the information necessary to allow the reader to understand what was seen, heard and/or said during contacts with or about the family.

- Be objective when recording information about a family's circumstance. Record only facts, observations and verifiable information. Avoid letting your personal feelings, prejudices or interpretations influence what you write.

- If you are aware of any information that leads you to suspect that a child might be at risk for abuse or neglect speak with your supervisor immediately. Your supervisor can assist you in developing a plan to increase the safety of the child and documenting the information.

Explanation of Site Ratings

The University of Hartford rates each site's compliance in completing the evaluation materials within the established timeframes. The rating system is comprised of five components to the rating: tracking system, data completion and submission, form usage, response to data requests, and communication.

A site that receives a 5:

1) Has and uses a system for tracking due dates for instruments
2) Consistently submits all required data that is completed within the due dates
3) Always responds to researchers data questions in a timely manner
4) Always uses the most updated forms
5) Keeps in good communication with the researchers if issues arise

A site that receives a 4:

1) Has and uses a system for tracking due dates for instruments
2) Consistently submits most required data that is completed within the due dates
3) Often responds to researchers data questions in a fairly timely manner
4) Always uses the most updated forms
5) Often keeps in good communication with the researchers if issues arise

A site that receives a 3:

1) Has, but does not correctly use a system for tracking due dates for instruments
2) Sometimes submit data that is incomplete or completed too late, or does not submit some data at all
3) Does not consistently respond to researchers data questions in a timely manner
4) Sometimes does not use the correct forms
5) Sometimes keeps in good communication with the researchers if issues arise

A site that receives a 2:

1) Does not use a system for tracking due dates for instruments
2) Consistently submits data that is incomplete or done too late, or does not submit some data at all
3) Does not respond to researchers data questions in a fairly timely manner or does not respond at all
4) Often does not use the correct forms
5) Does not keep in good communication with the researchers

A site that receives a 1:

1) Does not use a system for tracking due dates for instruments
2) Consistently submits data that is incomplete or done too late, or does not submit any data at all
3) Does not respond to researchers data questions at all
4) Consistently uses old (not updated) forms
5) Does not keep in communication with the researchers at all

Per the Nurturing Families Network contracts sites that fail to comply with these reporting requirements can be fined up to $1,000.00. Refer to the contract for additional information.

NURTURING CONNECTIONS FORMS AND PURPOSE

NFN- Nurturing Connections Research Requirements and Due Dates

FORM	Who Completes?	When Is It Completed
Intake (Negative screens and positive screens not referred for home visiting)	NC Coordinator	After the family enters Nurturing Connections or Refuses Nurturing Connections
Nurturing Connections Family Summary	NC Coordinator	Within a family stops receiving Nurturing Connections Phone Calls

NFN- Home Visiting Research Requirements and Due Dates (Hartford and New Haven Regions)

FORM	Who Completes?	PROGRAM ENTRY (needs to be completed within 30 days of the start date)	MONTHLY	6 Month (needs to be completed within 30 days of the 6 month anniversary of the start date)	1 YEAR (needs to be completed within 30 days of anniversary of the start date)	2 YEAR (needs to be completed within 30 days of anniversary of the start date)	3 YEAR (needs to be completed within 30 days of anniversary of the start date)	4 YEAR (needs to be completed within 30 days of anniversary of the start date)	5 YEAR (needs to be completed within 30 days of anniversary of the start date)	EXIT
Intake	FAW	X								
Baseline	FAW/Home Visitor	X		X	X	X	X	X	X	
Child Abuse Potential Inventory Rigidity (CAPI-R)	Family	X		X	X	X	X	X	X	
Community Life Skills Scale (CLS)	Family & Home Visitor	X		X	X	X	X	X	X	
Center for Epidemiologic Studies Depression Scale (CES-D)	Family	X		X	X	X	X	X	X	
Conflict Tactics Scale-Parent Child Version (CTS-PC)	Family				X (Done at the child's 1st birthday)	X (Done at the child's 2nd birthday)	X (Done at the child's 3rd birthday)	X (Done at the child's 4th birthday)	X (Done at the child's 5th birthday)	
Monthly Contact Log	Home Visitor		X							
Exit Status Form	Home Visitor									X

** DCF Release Form is collected annually, usually around September (All sites)

NFN- Home Visiting Research Requirements and Due Dates
(Southern and Northern Region Sites)

FORM	Who Completes?	PROGRAM ENTRY (needs to be completed within 30 days of the start date)	MONTHLY	1 YEAR (needs to be completed within 30 days of anniversary of the start date)	2 YEAR (needs to be completed within 30 days of anniversary of the start date)	3 YEAR (needs to be completed within 30 days of anniversary of the start date)	4 YEAR (needs to be completed within 30 days of anniversary of the start date)	5 YEAR (needs to be completed within 30 days of anniversary of the start date)	EXIT
Intake	FAW	X							
Baseline	FAW/Home Visitor	X		X	X	X	X	X	
Child Abuse Potential Inventory (CAPI)	Family	X		X	X	X	X	X	
Community Life Skills Scale (CLS)	Family & Home Visitor	X		X	X	X	X	X	
Monthly Contact Log	Home Visitor		X						
Exit Status Form	Home Visitor								X

NFN- Nurturing Group Research Requirements and Due Dates

Name of Form/Instrument	Who Completed	When Is It Completed
Nurturing Group Attendance Form	Completed by group facilitator	Turned in at the end of each group
Exit Status Form- Group	Completed by group facilitator on families participating in the group services only if they leave the program before graduation	Submitted with the post-test data after the group ends
Group Baseline Form	Completed by group participants	Completed at program entry (orientation or 1st group session). Should be sent within 3 weeks of beginning of group.
Parenting Group Start-Up Form	Completed by group facilitator and mailed before group starts {this form is also sent to CTF}	Should be mailed before the group starts
Parenting Stress Index* (outcome instrument for larger groups)	Nurturing group parents (NOT used for prenatal groups)	Should be administered in the first and last group session. Should be sent within 3 weeks of beginning and end of group.
AAPI-2* (outcome instrument for prenatal group)	Prenatal group participants and for prenatal moms in the larger groups	Should be administered in the first and last group session. Should be sent within 3 weeks of beginning and end of group.

* These forms are copy written and cannot be photocopied. Please get copies from the University of Hartford.

Nurturing Families Network
Connecticut Directory, November 2006

Children's Trust Fund 450 Capitol Avenue Hartford, CT 06106	(860) 418-8765	

University of Hartford Center for Social Research 461 Farmington Avenue Hartford, CT. 06105	Meredith Damboise (860) 523-9644 damboise@hartford.edu	

Bridgeport (3)		
Bridgeport Child Guidance Center 180 Fairfield Avenue Bridgeport, CT 06604	Noraleen Dunphy (203) 394-6529	Intensive Home Visiting (in collaboration with Bridgeport Hospital and St. Vincent's Medical Center)
Bridgeport Hospital 267 Grant Street Bridgeport, CT 06610	Monica Fox (203) 384-3752	Nurturing Connections Nurturing Parenting Group (in collaboration with Bridgeport Child Guidance Center)
Bristol (1)		
The Parent and Child Center at Bristol Hospital 9 Prospect Street Bristol, CT 06010	Kimberly Carmelich (203) 585-3481	Nurturing Connections Nurturing Parenting Group

Danbury (1)		
Families Network of Western CT, Inc. 5 Library Place Danbury, CT 06810	Susan Giglio (203) 791-8773	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with Danbury Hospital)
Hartford (11)		
Asylum Hill Family Center 896 Asylum Avenue Hartford, CT 06105	Anyango Smith (860) 244-9944	Nurturing Parenting Group Intensive Home Visiting
El Centro de Desarrollo y Reafirmacion Familiar 80 Jefferson Street Hartford, CT 06106	Ara Gena Martinez (860) 524-6853 Ext 687	Nurturing Parenting Group Intensive Home Visiting
Hartford Hospital 80 Seymour Street Hartford, CT 06102	Laura Dean (860) 545-3131	Nurturing Connections Nurturing Parenting Group
Hispanic Health Council for Women's and Children's Health 175 Main Street Hartford, CT 06106	Grace Damio (860) 527-0856 Ext 274	Nurturing Parenting Group Intensive Home Visiting
Maternal Infant and Outreach Program 131 Coventry Street Hartford, CT 06112	Evelyn Guzman (860) 543-8834 Ext 7035	Nurturing Parenting Group Intensive Home Visiting
Family Life Education 39 Grace Street Hartford, CT 06010	Julia Candela-Gonzalez (860) 233-9700	Nurturing Parenting Group Intensive Home Visiting
RAMBUH Family Center 2 Holcomb Street Hartford, CT 06112	Brenda Lammie (860) 547-1426 Ext 7431	Nurturing Parenting Group Intensive Home Visiting

Hartford (continued)		
St. Francis Hospital & Medical Center 114 Woodland Street Hartford, CT 06105	Jesusita dePedro (860) 714-6968	Nurturing Connections Intensive Home Visiting
Southside Family Center 15-21 Newfield Avenue Hartford, CT 06106	Joyce Bosco (860) 953-0113	Nurturing Parenting Group Intensive Home Visiting
Trust House Family Center 155 Wyllys Street Hartford, CT 06106	Anne Brown (860) 278-8387	Nurturing Parenting Group Intensive Home Visiting
VNA Health Care – Hartford 103 Woodland Street Hartford, CT 06105	Migdalia Belliveau (860) 493-7359	Intensive Home Visiting (in collaboration with Hartford Hospital)
Lower Naugatuck Valley (1)		
VNA of South Central CT 1 Long Wharf Drive New Haven, CT 06511	Pamela Lorenzo (203) 777-5521 Ext 2301	Intensive Home Visiting (in collaboration with Griffin Hospital/Derby and Milford Hospital)
Manchester (1)		
Manchester Memorial Family Development Center 71 Haynes Street Manchester, CT 06040	Elizabeth Conklin (860) 646-1222 Ext 2538	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting
Meriden (1)		
Community Health Center of Meriden 134 State Street Meriden, CT 06450	Kimberly Paluska (203) 237-2229	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with MidState Medical Center)
Middletown (1)		
Middlesex Hospital Center for Behavioral Health 28 Crescent Street Middletown, CT 06457	Eileen Lader (860) 344-6426	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting

New Britain (2)		
The Hospital of Central Connecticut 100 Grand Street New Britain, CT 06050	Jennifer Hernandez (860) 224-5900 Ext 6623	Nurturing Connections Nurturing Parenting Group
New Haven (2)		
Coordinating Council for Children in Crisis, Inc. 131 Dwight Street New Haven, CT 06511	Cheryl Burack (203) 624-2600 Ext 303	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting
Yale-New Haven Hospital Dept. of Social Work 20 York Street New Haven, CT 06510	Melissa Rowe (203) 688-5996	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting
New London (1)		
Lawrence & Memorial Hospital 365 Montauk Avenue New London, CT 06320	Christina Garabedian (860) 442-071 Ext 2457	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting
Norwalk (1)		
Family & Children's Agency 9 Mott Avenue (mail only) 149 Water Street (site) Norwalk, CT 06850	Tiffany McCarthy (203) 604-1230 Ext 312	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with Norwalk Hospital)
Norwich (1)		
Families First/Madonna Place 240 Main Street P.O. Box 825 Norwich, CT 06360	Linda Kane (860) 886-6600 Ext 116	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with Backus Hospital)
Putnam (1)		
Day Kimball Hospital 320 Pomfret Street Putnam, CT 06260	Ellen Madigan (860) 928-6541 Ext 2012	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting

Sharon (1)		
Family Strides 350 Main Street, Suite D Torrington, CT 06790	Jacky Dieli (860) 482-3236 Ext 50	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with Sharon Hospital)
Stamford (1)		
Family Centers, Inc. Greenwich Hospital P.O. Box 7550 Greenwich, CT 06836	Rose Marie Turner (203) 324-3167	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting
Family Centers, Inc. 60 Palmers Hill Road Stamford, CT 06902	Helma Gregorich (203) 324-3167	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with Stamford Hospital)
Torrington (1)		
Family Strides 350 Main Street, Suite D Torrington, CT 06790	Jacky Dieli (860) 482-3236 Ext 50	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with Charlotte Hungerford Hospital)
Vernon/Rockville (1)		
Eastern Connecticut Health Network Rockville Hospital 31 Union Street Vernon, CT 06066	Elizabeth Conklin (860) 646-1222 Ext 2538	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting
Waterbury (2)		
Child Guidance Clinic of Greater Waterbury, Inc. 36 Sheffield Street Waterbury, CT 06704	Tracy Radden (203) 575-0466 Ext 105	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting
Staywell Health Center 232 North Elm Street Waterbury, CT 06702	Christine Bianchi (203) 756-8021 Ext 3018	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with Waterbury Hospital)

Willimantic (1)		
Generations Family Health Center, Inc. 1315 Main Street Willimantic, CT 06226	Debra Crane (860) 450-7471 Ext 214	Nurturing Connections Nurturing Parenting Group Intensive Home Visiting (in collaboration with Windham Hospital)