

Nurturing Families Network 2007 Annual Outcome Evaluation Report

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Nurturing Families Network 2007 Annual Outcome Evaluation Report

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Nurturing Families Network 2007 Annual Outcome Evaluation Report

Executive Summary

In this year's evaluation report, we provide descriptive and outcome information on families who received services in 2006, including 1,312 families from the Nurturing Connections program, 1,291 from the Nurturing Home Visiting program, and 400 from the Nurturing Parenting Groups. These programs, funded and managed by the Connecticut Children's Trust Fund, are components of the Nurturing Families Network (NFN), which is designed to provide a system of continuous care to promote positive parenting and reduce incidences of child maltreatment.

Nurturing Connections provides telephone support and referral services for first-time mothers screened as low-risk for child maltreatment. High-risk families are enrolled in the home visiting program, which provides weekly home visitation and case management services. The Nurturing Parenting Groups are community-based parenting education and support groups for families at various risk levels. There are currently thirty-three NFN program sites statewide, ten of which are located in Hartford.

Because of the large Hartford expansion that occurred in May 2005, we highlight our evaluation of Hartford NFN programs that began enrolling families in May 2005 as part of the Hartford expansion. We do so by separating Hartford sites from the 23 other statewide sites in our outcome analyses. We also report on a statewide NFN staff survey that we conducted at the end of 2006. The survey describes social-demographic characteristics of all NFN program staff as well as their assessments of a wide range of program-related matters.

In 2006, 5,472 first-time mothers, approximately one-third of all first-time births in the state, were screened using the Revised Early Identification Screen (REID). Two-thirds scored at low-risk and were therefore eligible for the Nurturing Connections program. Most parents in this program were over 25 years of age and were white. Contacts were successfully made with 928 families after they left the hospital in 2006, and, on average, families received between 3 and 4 calls. A total of 614 referrals were made, mostly to Infoline, WIC, the Mom's Program (a parenting group), and the Department of Social Services (DSS), and a little less than two-thirds of families complied with these referrals. Referral compliance, however, was considerably lower this year than last (62% vs. 95%), which is a perplexing finding program leaders may want to examine further.

Mothers scoring high-risk on the REID screen are eligible for NFN home visiting services and a little more than one-fourth (27%) of these families ended up in the program. On average, these families stayed in the program for 18 months and received two home visits per month. Pre and post-observations indicated that parenting dispositions were changing over time in ways that should promote more positive parenting, and that families were learning about and using community resources more

effectively. We also found significant educational and employment gains made among mothers remaining in the program, even though these gains often did not mitigate financial burdens. Fathers did not appear to be making the same educational and employment gains, and were less likely to be involved with their children over time.

Social-demographic characteristics and risk profiles of families enrolled in the Hartford expansion did not differ much from NFN families statewide, with the exception that Hartford families were much more likely to be nonwhite. Hartford mothers were also a little more likely to be single and never married and to enter the program with an “acute” status (indicating untreated substance abuse, domestic violence, or mental health problems), but these differences were quite small. Like the statewide group, Hartford families received, on average, two home visits per month. For the most part, outcomes were similar as well. Hartford families showed particularly impressive gains on the rigidity subscale of the Child Abuse Potential Inventory, suggesting that their attitudes and beliefs about their children are becoming more realistic and less intolerant. They also demonstrated increases in their knowledge and use of community resources. They did not, however, show improvements in educational attainment or employment during the first year, which differed sharply from statewide NFN mothers.

We also report on additional outcome measures which are part of our enhanced research design in Hartford. We recorded over 1000 community referrals that home visitors made since program inception in May 2005, with a 63 percent compliance rate. We were surprised, however, that so few of these referrals were made for mental health, domestic violence, or substance abuse services, given the high rate of families reported as “acute” in 2006 alone. Mothers’ depression scores did not change during the first six months or one year of program services. Finally, self-reported child disciplinary practices suggested that most mothers were using non-disciplinary forms of discipline in their children’s first year of life, while one-third reported using milder forms of “corporal punishment.”

We combined statewide and Hartford families for our analysis of child abuse and neglect reports filed with the Department of Children and Families (DCF). These data were encouraging. We continued to see a decline in reports made and substantiated on NFN families, and the overall state rate was comparable to, and in some cases better than, similar populations receiving home visiting services across the country. As before, we found that substance abuse, domestic violence, and poor mental health were common themes among NFN families reported to DCF, and commend program leaders and staff for developing tighter program regulations and practices around these issues through their “Families with Acute Problems” policy.

Between October and December 2006, we surveyed all NFN home visiting program staff across the state. We found slightly more than one-half of home visitors to be Hispanic and, even though most supervisory staff were white, 42 percent of program managers and 20 percent of supervisors were also Hispanic. Surprisingly, there was not much variation in median age between staff levels. The overwhelming majority of staff were parents themselves and many had been single parents at some point in their lives, including nearly two-thirds of home visitors. As expected, educational achievement varied by

position, with 92 percent of clinical supervisors and 77 percent of managers holding graduate degrees, while over one-half of home visitors had completed at least a bachelor's degree.

Overall job satisfaction was high across all three groups. Higher satisfaction ratings were reported on their relationships with families and with one another, and in their development of professional skills and knowledge on the job. Lower ratings were reported on income and on the amount of paperwork required, and, for home visitors, on opportunities for career advancement.

In self-assessments of effectiveness, home visitors felt that their expertise was most evident in providing parenting skills and in building relationships with families. A smaller percentage considered themselves effective in resolving family crises and in assisting families to become self-sufficient, and they considered themselves least effective in building relationships with community providers. Clinical supervisors' self-assessments of effectiveness were high across all survey items; however, they did seem to indicate particular strengths in their clinical work with home visitors and in assisting home visitors to solve crises among NFN families. They considered their review of case files and the monthly home visits they conduct jointly with home visitors to be less effective. Program managers considered themselves most effective in building relationships with community providers and least effective in building relationships with legislators.

Staff inter-ratings were also very high, indicating that staff have developed an appreciation for one another's roles within the program.

Overall, program reviews and self-assessments on the staff surveys were quite positive, suggesting that, at present, the NFN program is functioning well, effectively managing cultural differences, and promoting a strong collective identity.

The Nurturing Parenting Groups make up the third component of the Nurturing Families Network. While there are varying curricula tailored to different populations, and while groups run for varying lengths of time, all groups provide parenting information, support, and an opportunity for parents to learn how to nurture themselves and their children. Most participants were women and were racially and ethnically diverse. Participants' ages followed a bimodal distribution, with the program drawing heavily from the 16 to 19-year-old age group, but also the over 30 age group. There were statistically significant changes in the desired direction on pre and post-tests, suggesting that, overall, parents displayed healthier parenting attitudes and more age appropriate expectations of their children upon completion of the groups.

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In this year's evaluation report, we provide descriptive and outcome information on 1,312 families from the Nurturing Connections program, 1,291 from the Nurturing Home Visiting program, and 400 from the Nurturing Parenting Groups, all of whom received services during the 2006 calendar year. These programs, funded and managed by the Connecticut Children's Trust Fund, are components of the Nurturing Families Network (NFN), which is designed to provide a system of continuous care to promote positive parenting and reduce incidences of child maltreatment.

Nurturing Connections provides telephone support and referral services for first-time mothers screened as low-risk for child maltreatment. High-risk families are enrolled in the home visiting program, which provides weekly home visitation and case management. The Nurturing Parenting Groups are community-based parenting education and support groups for families at various risk levels. There are currently thirty-three NFN program sites statewide, ten of which are located in Hartford.

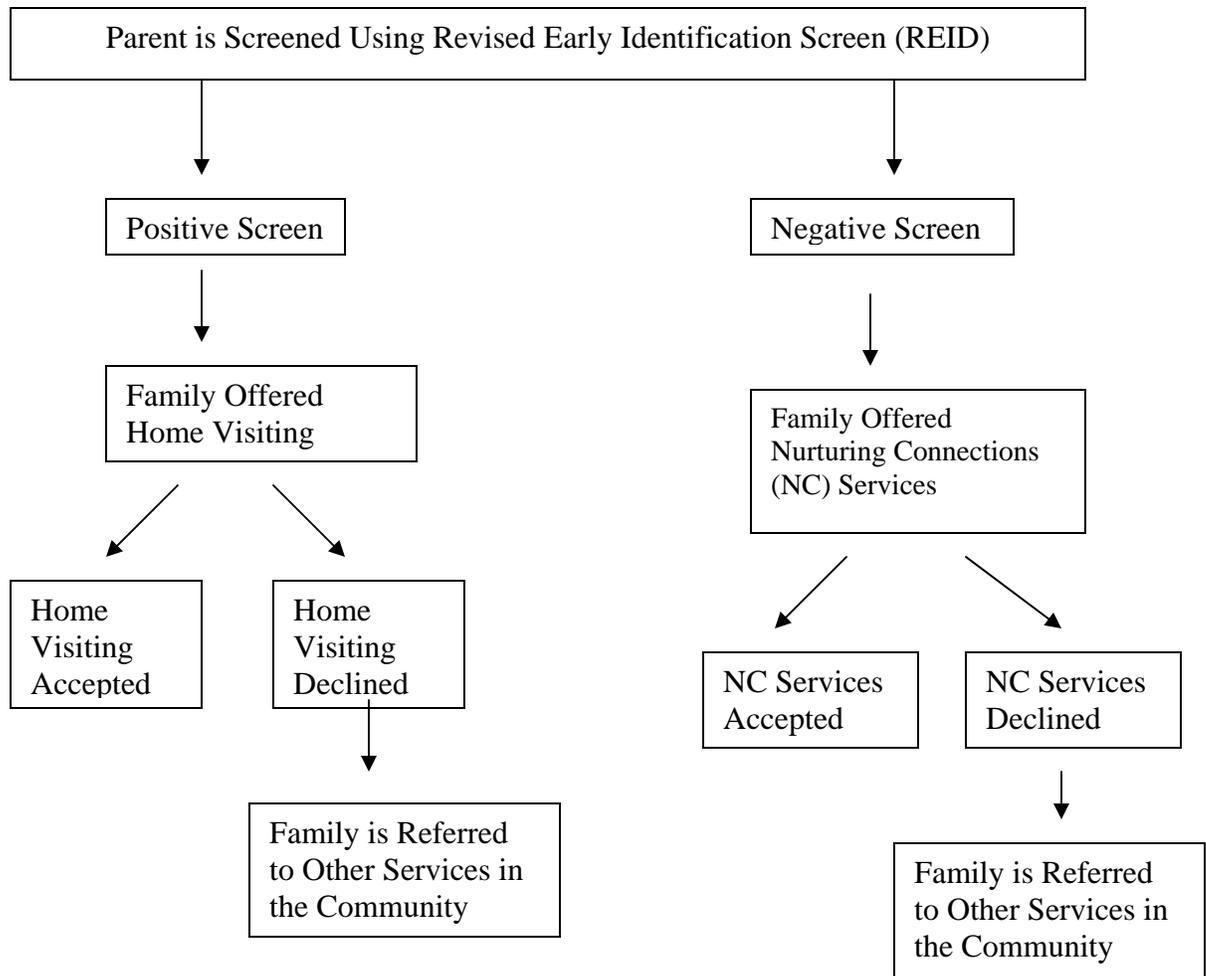
As we did last year, we highlight our evaluation of Hartford NFN programs that began enrolling families in May 2005 as part of the Hartford expansion. We do so by separating Hartford sites from the 23 other statewide sites in our outcome analyses. In this report, we also report on a statewide NFN staff survey that we conducted at the end of 2006. The survey describes social-demographic characteristics of all NFN program staff as well as their assessments of a wide range of program-related matters.

The organization of the report is as follows. We first discuss the Nurturing Connections program – the gateway into NFN. We then turn our attention to home visiting, beginning with a description and outcome analysis of families enrolled in statewide programs, followed by a similar analysis of families enrolled in the Hartford expansion. We combine these two groups in our subsequent analysis of child abuse and neglect reports made to the Department of Children and Families (DCF). We then discuss the results of our statewide staff survey. In the final section, we analyze outcomes for parents participating in the Nurturing Parenting Groups.

Overview of the NFN System

The NFN is a system designed to provide a continuum of services for families in the state. The flowchart in Figure 1 illustrates how families enter the NFN system and the various pathways they may follow. All NFN services are voluntary and, thus, there are many steps at which families can either refuse services or be referred to other community services.

Figure 1. Nurturing Families Network Flowchart



**** The Nurturing Parenting Group can be offered to any parent in the NFN system at any time ****

An important programmatic change was made at the end of 2006 and is reflected in the flowchart. Program leaders decided to streamline the intake and referral processes into the NFN home visiting program. There used to be two eligibility criteria to enter the home visiting program; the Revised Early Identification (REID) Screen and the Kempe Family Stress Checklist (Kempe). The REID screen consists of 17 items that research has shown increases the probability of child maltreatment. If someone had a positive screen, meaning they were high-risk, they were then referred for an in-depth interview using the Kempe assessment. The Kempe has now been eliminated as part of the eligibility requirement, and instead the program will rely exclusively on the REID to discriminate between high-risk and low-risk families. The policy change occurred for two reasons: one, the REID screen has shown a high degree of validity in predicting high-risk assessments on the Kempe, with 93 percent of those scoring at high-risk on the REID in 2004 and 2005 also assessing high-risk on the Kempe. Two, the time lapse between the administrations of the two screens has sometimes resulted in losing contact with families or in families' diminished interest in the program. The Kempe will still be administered to obtain in-depth information on families' backgrounds and current risk factors, but the scores will no longer be used to determine program eligibility.

Nurturing Connections

Nurturing Connections is the primary gateway into the Nurturing Families Network (NFN). The Nurturing Connections sites are located at 25 of the 29 hospitals throughout Connecticut as listed below:

Hartford Hospital
St. Francis Hospital (Hartford)
StayWell Health Center (Waterbury)
Waterbury Child Guidance Clinic in collaboration with St. Mary's Hospital
Norwalk Hospital
Bridgeport Hospital
Manchester Memorial Hospital
Rockville General Hospital (Vernon) in collaboration with Eastern Connecticut Health Network
Lawrence and Memorial Hospital (New London)
Yale-New Haven Hospital
Danbury Hospital in collaboration with Families Network of Western Connecticut
Sharon Hospital in collaboration with Family Strides
Charlotte Hungerford Hospital (Torrington) in collaboration with Family Strides
Stamford Hospital in collaboration with Family Centers, Inc.
Backus Hospital (Norwich)
Hospital of Central Connecticut (formerly New Britain General Hospital)
Middlesex Hospital (Middletown)
Meriden Community Health Center in collaboration with Midstate Medical Center
St. Vincent's Hospital (Bridgeport) in collaboration with Child Guidance Center of Greater Bridgeport
Day Kimball Hospital (Putnam)

Griffin Hospital in collaboration with VNA of South Central Connecticut
 Windham Hospital in Willimantic in collaboration with Generations Health Care Inc.
 Bristol Hospital
 St. Raphael’s Hospital (New Haven) in collaboration with Coordinating Council of
 Children in Crisis
 Greenwich Hospital in collaboration with Family Centers Inc.

The primary function of the Nurturing Connections program is to screen first-time parents to determine their risk of child maltreatment and to refer them to appropriate services. Staff typically screen first-time parents in hospitals, clinics, and community agencies. If a family screens negative, or low-risk, they are offered Nurturing Connections services. These families receive weekly phone calls from a staff member or volunteer, who provides emotional support to the parents, answers any questions they may have about their children’s development, and refers them to community resources as needed. If a family screens positive, or high-risk, they are eligible for home visiting services.

The REID screen contains 17 items, as listed in Table 1, that research has shown increases the probability of child maltreatment. In order to screen positive on the REID, a person must have either (a) three or more characteristics, or (b) two or more characteristics if one of them is item number 8, 11, 14, or 15, or (c) have 8 or more unknown characteristics.

Table 1. REID Screen Items

1. Mother is single, separated, or divorced
2. Partner is unemployed
3. Inadequate income or no information
4. Unstable housing
5. No phone
6. Education under 12 years
7. Inadequate emergency contacts
8. History of substance abuse
9. Late, none, or poor prenatal care
10. History of abortions
11. History of psychiatric care
12. Abortion unsuccessfully sought or attempted
13. Adoption sought or attempted
14. Marital or family problems
15. History of, or current depression
16. Mother is age 18 or younger
17. Mother has a cognitive deficit

In 2006, 5,472 first-time parents were screened using the REID (approximately one-third of all first-time births in the state¹), with two-thirds scoring negative. Most of these families were offered Nurturing Connections services and around two-thirds accepted, as shown in Table 2 below.

Table 2. Program Outcomes for Families Scoring Low-Risk on the REID in 2006

Negative Screens (N=3,605)	#	%
Offered Nurturing Connections	2,851	79%
Accepted Nurturing Connections	1,861	65%

Prior to the recent policy change described above, families scoring positive on the REID were offered a Kempe assessment to determine program eligibility. As shown in Table 3, a little less than one-half of parents offered the Kempe accepted and 87 percent scored positive on the assessment. In the end, 27 percent of positive REID screens ended up in the NFN home visiting program.

There are a variety of reasons for why eligible parents do not enroll in home visiting, including that programs may be full and unable to take new families or that parents may simply not want someone in their home every week. Some of these families are then referred to the Nurturing Connections program, even though this program is not designed to address the needs of high-risk families. As shown in Table 3 below, 22 percent of high-risk families were offered Nurturing Connections -- a decrease from last year (33%) -- and most accepted.

Table 3. Program Outcomes for Families Scoring High-Risk on the REID

Positive Screens (N=1,867)	#	%
Offered Kempe Assessment	1,335	72%
Accepted Kempe Assessment	618	46%
Positive Kempe Scores	538	87%
Offered home visiting services	535	99%
Accepted home visiting services	525	98%
Initiated home visiting services	511	97%
Offered Nurturing Connections	403	22%
Accepted Nurturing Connections	361	90%

Nurturing Connections Program Participants and Services

As discussed above, Nurturing Connections staff provided phone support and referrals to mostly parents who screened low-risk on the REID. The majority of parents in this program were over 25 years of age and were white (see Table 4 below).

¹ This estimate is based on the number of first-time births (17,912) in the state in 2003, the last year data were available.

Table 4. Family Characteristics of Nurturing Connections' Families in 2006

Mother's Age (N=1,141)	
Under 16 years	<1%
16-19 years	10%
20-22 years	16%
23-25 years	14%
26-30 years	30%
Over 30 years	30%
Mean Age	27 years
Mother's Race/Ethnicity (N=1,128)	
White	62%
Hispanic	19%
African American	9%
Native American	<1%
Asian	3%
Multi-racial	<1%
Other	7%
Father's Age (N=450)*	
Under 16 years	0%
16-19 years	4%
20-22 years	10%
23-25 years	11%
26-30 years	26%
Over 30 years	50%
Mean Age	31 years
Father's Race/Ethnicity (N=1,006)	
White	62%
Hispanic	19%
African American	9%
Native American	0%
Asian	3%
Multi-racial	<1%
Other	7%

* Fathers dates of birth are not always included on hospital charts which are often used to complete intake screens, therefore, the N for this variable is considerably smaller than the others.

As we can see from Table 5, Nurturing Connections staff made an average of 3½ calls to each family. Eliminating the families whom staff were unable to contact after they left the hospital, they reached a total number of 928 families who started services in 2006 and provided 614 referrals, mostly to Infoline, WIC, Mom's Program (a parenting group), and Department of Social Services (DSS) (together about one-fourth of all referrals). Referral compliance, however, was considerably lower this year compared to last (62% vs. 95%), a perplexing finding that may warrant some examination by program leaders.

Table 5. Services Received by Nurturing Connections Families in 2006

Mean Length of Time in the Program (N=1,192)	2.4 months
Mean Number of Calls Attempted per Family (N=1,198)	6.3
Mean Number of Contact-Calls per Family (N=1,190)	3.5
Reasons families Left the Program (N=1,183)	
Graduated/met goals	33%
Not available for calls	35%
Refused further services	7%
Family moved	3%
Phone disconnected/out of service	0%
No time for calls	5%
Family non-compliant	3%
Left without explanation	3%
Other	12%
Number of Referrals to Community Resources	
Infoline	47
WIC	45
HUSKY	9
Nurturing Group	14
NFN Home Visiting	15
Care 4 Kids	5
Mom's Program (parenting group)	39
Department of Social Services	31
La Leche League	13
Help Me Grow	7
Other ²	389
Total	614
Rate of Follow-up on Referrals (N=546)	62%

NFN Home Visiting

Since NFN's program inception in 1995, a total of 4,078 families have received home visiting services. Removing the 387 families who have enrolled in Hartford sites since the 2005 expansion and who will be reported on later, Table 6 provides the breakdown of the remaining 3,691 families by site. The newest statewide sites, added in 2006, are at Bristol Hospital, Family Centers in Greenwich, and at the Coordinating Council on Children in Crisis in New Haven.

² The majority of the referrals categorized as "other" were made to a wide range of local community agencies/programs.

Table 6. Home Visiting Sites and Families Served

Site	First Year Offered Services	Total Number of Families Served	Currently Active Families
Hartford VNA*	1995	421	36
Waterbury Child Guidance	1995	361	54
So. Central VNA (New Haven)	1996	277	41
Bridgeport	1996	455	67
Manchester	1996	324	46
New London	1998	153	22
Yale/New Haven	1998	199	39
Danbury	1998	213	35
Torrington	1999	217	54
Willimantic	1999	144	33
Norwalk	2000	122	27
Norwich	2000	154	35
New Britain	2000	115	28
Stamford	2000	101	44
St. Francis*	2000	79	10
Meriden	2002	85	34
Middlesex	2002	79	31
StayWell (Waterbury)	2002	114	35
Putnam	2005	45	26
Greenwich	2006	17	10
Bristol	2006	28	20
4C's/St. Raphael's (New Haven)	2006	11	10
Total		3,691**	737

* These numbers reflect families who began services before the Hartford expansion occurred in 5/24/05

** The total number served at NFN excludes 23 families who received services at more than one site

At the end of December 2006, there were 737 families active at these program sites. On average, families stayed in the program for 18 months. Specifically, 82 percent were still in the program after three months, 65 percent after six months, 44 percent after one year, 25 percent after two years, 15 percent after three years, and 10 percent after four years.

When families leave the program, we ask home visitors to document the reason why the family left and to assess their attitude toward program services. As shown in Table 7, nearly one-half of all program exits were due to families moving out of the service area or to home visitors being unable to locate the mother, usually because she is not home during visits, has changed her phone number without notification, and/or changed residences.

Table 7. Reasons Families Left NFN Home Visiting in 2006 (N=362)

Family moved out of service area	20%
Unable to locate mother	25%
Discharged, family was noncompliant	1%
Family refused further services	11%
Mother is working or in school full-time, no time for home visits	12%
Goals were met/family graduated	14%
Baby removed from home by DCF	4%
Discharged, family was not appropriate for the program	2%
Other family member did not approve of services	1%
Other	10%

Home visitors assessed almost one-half of exited families as having a willing and readily accepting attitude when they left the program. One-quarter were considered reluctant or minimally compliant, and another 4 percent were noted as unwilling or hostile. Home visitors also characterized 71 percent of families as having benefited at least somewhat from program services. To view these data, please see Appendix A.

Risk Profiles

The subscales on the Kempe assessment provide a more nuanced risk profile of participating families. As described in Table 8, a little more than one-half of mothers scored at severe risk on the Childhood History of Abuse/Neglect subscale. However, these data should be interpreted carefully. A severe rating includes mothers who were severely beaten, abandoned, or sexually abused as children, but also mothers who were raised by more than two families or by a family without a nurturing model. We have sharpened our data collection on this in Hartford and are able to discern these differences among families there (see pp. 24-6).

The other three items with high percentages of severe ratings included Multiple Stresses, which examines family stress related to living situations, housing, relationships, and financial status, and two multiple construct items: Low Self-Esteem/Social Isolation/Depression and the History of Crime/Substance Abuse/Mental Illness. Certainly, these data confirm that the program is reaching vulnerable families.

Table 8. Mothers' Scores on the Individual Kempe Items Among 2006 Families

	0	5	10
1. Childhood History of Abuse/Neglect (N=786)	22%	21%	57%
2. History of Crime, Substance Abuse, Mental Illness (N=788)	39%	28%	32%
3. CPS History (N=772)	86%	6%	8%
4. Low Self-esteem/ Social Isolation/ Depression (N=794)	11%	43%	46%
5. Multiple Stresses (N=795)	8%	34%	58%
6. Potential for Violence (N=773)	68%	13%	19%
7. Unrealistic Expectation of Child (N=775)	51%	38%	12%
8. Harsh Punishment (N=741)	75%	19%	6%
9. Negative Perception of Child (N=747)	81%	15%	4%
10. Child Unwanted/ Poor Bonding (N=789)	14%	68%	18%

To augment our family risk profiles, we also presented data on the prevalence of families who were defined by the program as “acute families” in Table 9 below. At the end of 2005, the Continuous Quality Improvement (CQI) Team³ passed the “Families with Acute Problems” policy, which provides guidelines for working with families experiencing any of the following three conditions: unaddressed mental health problems, untreated substance abuse, or domestic violence. The policy states that these families may be enrolled in the program under the discretion of program managers and supervisors, but that an action plan must be developed and adhered to in order for the family to remain in the program. If an “acute condition” develops while families are participating in the program, the same procedure applies – an action plan must be developed and adhered to. If participants do not follow the action plan, they will be discharged from the program and referred to more appropriate services in the community.

We began collecting data on the prevalence of acute families in January 2006, discerning whether the family was identified as “acute” when they entered the program or at some later point. As we see, it was extremely rare for families to be identified as acute when they enrolled, even though a little more than one-fourth were later identified as such.

Table 9. Prevalence of Acute Families in 2006 (N=342)

	%
Acute when entering the program	2%
Acute at any time in 2006	29%

³ The Continuous Quality Improvement (CQI) Team is charged with creating and revising policies that govern the services of NFN and with overseeing program practices.

To examine the validity of two risk measures that we use in our study, we tested whether there was a relationship between scores on the Child Abuse Potential Inventory (CAPI)⁴ and the Kempe, and a family “becoming acute.” As shown in Table 10, we found statistically significant relationships in both cases, reinforcing the importance of these risk measures in our research.

Table 10. Analysis of Risk Measures by 2006 Acute-Families

	Not Acute in 2006	Acute in 2006
Entry CAPI Abuse score	(N=197) 131.1	(N=50) 159.6*
Mother’s total Kempe score	(N=237) 37.3	(N=56) 44.1***

* p<.05 **p<.01 ***p<.001

Social-Demographic Profiles of Statewide NFN Participants

Like our risk measures, social-demographic characteristics, recorded at the time NFN families enter the program, also demonstrate high levels of family vulnerability. These statewide profiles exclude families enrolled during the Hartford expansion, which we will discuss later. As we see in Table 11, nearly one-half of mothers were teen moms; very few were married, and maternal grandmothers were more likely to be living in the homes than fathers.

⁴ The Child Abuse Potential Inventory (CAPI) is a self-report standardized instrument designed to measure someone’s potential to maltreat children. See Milner, J.S. (1986) *Child Abuse Potential Inventory: Manual (2nd Edition)*. Psytec Corporation. Webster, NC.

Table 11. Social Demographic Characteristics of Home Visiting Participants in 2006

Families Screened Prenatally (N=342)	40%
Mother's Marital Status (N=811)	
Single, never married	84%
Married	13%
Divorced, separated, widowed	3%
Mother's Race/Ethnicity (N=804)	
White	32%
African American	18%
Hispanic	43%
Other (includes multi-racial)	7%
Mother age at Baby's Birth (N=728)	
Under 16 years	7%
16-19 years	42%
20-22 years	22%
23-25 years	11%
26 years and older	19%
Median Age	20 years
Maternal Grandmother Living in the Household (N=773)	39%
Father Living in the Household (N=773)	36%
Father's Involvement With Child (N=583)	
Very involved	55%
Somewhat involved	15%
Sees child occasionally	7%
Very rarely involved	3%
Does not see baby at all	21%

Dividing mothers into two groups by age, we see in Table 12 that 77 percent of younger mothers had not completed high school, but only 46 percent were still enrolled in school. Among older mothers, 71 percent had a high school degree or its equivalency and 28 percent were employed (15% full-time) around the time of their child's birth.

Table 12. Mothers' Life Course Data

	19 and younger	20 and older
Mother's Education	(N=341)	(N=354)
Eighth grade or less	10%	10%
More than 8 th grade, less than high school	67%	19%
High school degree or GED	18%	40%
Some vocational training or college	5%	26%
College degree or graduate work	1%	4%
Mother Enrolled in School	(N=345)	(N=365)
Yes	46%	5%
Mother's Employment Status	(N=347)	(N=366)
Mother not employed	87%	72%
Mother employed	13%	28%
Employed full-time	4%	15%
Employed part-time job or occasional work	9%	13%
Mother Employed Prior to Pregnancy	(N=318)	(N=332)
Yes	31%	66%

Because few fathers were living in the homes, we relied on mothers to provide information about them, and when fathers were not involved in the mothers' or children's lives, it was difficult, if not impossible, to obtain this information. Still, the data presented in Table 13, on fathers we were able to document, add to our profile of vulnerable NFN families. Among younger fathers, only 17 percent had completed a high school degree or a GED, and only 38 percent were still in school. A little more than one-half of older fathers had a high school degree or a GED. Full-time employment rates were also low, with one-fifth of younger men and around one-half of older men working at full-time jobs. Further, 10 percent of fathers were incarcerated at the time of the mother's program entry and a little less than one-half had an arrest history.

Table 13. Fathers' Life Course Data

	19 and younger (N=88)	20 and older (N=247)
Father's Education		
Eighth grade or less	5%	8%
More than 8 th grade, less than high school	78%	35%
High school degree or GED	15%	36%
Some vocational training or college	2%	18%
College degree or graduate work	0%	3%
Father Enrolled in School	(N=94)	(N=288)
Yes	38%	4%
Father's Employment Status	(N=91)	(N=297)
Father not employed	56%	25%
Father employed	44%	75%
Employed full-time	20%	53%
Employed part-time job or occasional work	19%	15%
Working more than one job	0%	2%
		All Fathers
Fathers With an Arrest History (N=443)		42%
Father Currently Incarcerated (N=547)		10%

Program Dosage

Program services consist mostly of home visits and, on average, a family receives two visits per month, as shown in Table 14. Families may also receive visits outside of the home or they may attend program events; however, these contacts are minimal.

Table 14. Frequency of Home Visits Per Month

	2006
Average # of attempted home visits	2.6
Average # of completed home visits	2.1
Average # of office/out of home visits	0.2
Average # of NFN social events attended	0.1
Total # of visits completed	2.4

Program Outcomes

In this section we provide results from pre and post-test protocols that measure changes in areas of participants' lives that the program is attempting to impact. Because we do not use a random-control design, we cannot say with any degree of certainty that these changes are attributable to the program intervention. For instance, changes may occur for a variety of other reasons, including exposure to other environmental influences or simply to parental maturity, which we cannot discern without a randomly-generated comparison group. Therefore, any changes we identify below are suggestive, not

definitive, claims of program efficacy. As before, the data below exclude families enrolled during the Hartford expansion.

Community Life Skills Scale

The Community Life Skills (CLS) scale is a self-report standardized instrument that measures someone’s knowledge and use of resources in his/her community. The CLS produces an overall score as well as scores on six subscales: Transportation, Budgeting, Support Services, Support Involvement, Interests/Hobbies, and Regularity/Organization/Routines. Scores on the CLS range from 0-33, with higher scores indicating more effective use of community resources. These data include one year outcomes dating back to July 2004 when we began using the instrument, and are presented in Table 15.⁵

Table 15. Mean Scores on the CLS at Program Entry and One Year (N=136)

	Program Entry	One Year
Transportation	3.2	3.5**
Budgeting	2.9	3.5***
Support services	4.2	4.6***
Support/Involvement	3.8	4.9***
Interests/Hobbies	2.6	2.7
Regularity/Organization/Routines	6.1	6.6**
Total	22.8	25.7***

* p<.05 **p<.01 ***p<.001

We documented statistically significant changes on the total CLS scale, as well as every subscale with the exception of one, concerning the use of resources to satisfy personal interests or hobbies. These outcomes suggest that families in the program increased their awareness of and access to community services, and that parents were likely to budget their money more carefully and to have more social contacts with friends, family, and community organizations.

Child Abuse Potential Inventory

The Child Abuse Potential Inventory (CAPI) is a self-report standardized instrument designed to measure someone’s potential to maltreat children. The CAPI is a widely used and well-researched instrument and has been used as an outcome measure to assess home visitation programs in several states. The CAPI produces an overall Abuse score as well as six subscales scores: Distress, Rigidity, Unhappiness, Problems with Child and Self, Problems with Family, and Problems from Others. NFN mothers complete the CAPI at program entry and then annually. In Table 16, we present outcome data on the CAPI at one and five years for all families who have ever participated in NFN (formerly called Healthy Families), with the exception of families enrolled in the Hartford expansion. Data from the two, three, and four year data points are located in Appendix B.

⁵ The sample size at the two year administration (N=18) was too low to report this year.

Table 16. Mean Scores on the Child Abuse Potential Inventory

	Entry	1 Year (N=955)	Entry	5 Year (N=130)
Distress	88.5	76.7***	93.2	57.2***
Rigidity	25.4	19.6***	31.1	15.6**
Unhappiness	15.5	16.9**	17.0	15.7
Problems with Child & Self	1.3	1.7**	1.4	2.0
Problems with Family	11.7	11.4	10.4	8.6
Problems from Others	12.3	11.5**	12.9	8.9***
Abuse (Total)	155.9	138.8***	163.2	108.1***

* p<.05

**p<.01

***p<.001

Outcome data on the CAPI have remained fairly consistent over time. These data indicated that families significantly reduced their risk for maltreatment over the course of their participation in the program. Families active in the program for at least one year showed statistically significant change on the overall Abuse scale as well as the Distress, Rigidity, and Problems from Others subscales. As before, we also saw significant changes in the undesired direction on the Unhappiness and Problems with Child and Self subscales. This increase, however, was no longer significant at the two, three, and five year data points. Families in the program for five years showed significant changes on the overall Abuse scale as well as the Distress, Rigidity, and Problems from Others subscales.

Most encouraging, the average total score dropped over a five year period from 163 to 108. When viewed in relationship to the scale’s normative score, based on scores from a cross-section of the “general population,” this change is impressive.⁶ The normative mean is 91 with a standard deviation of 75. This means that the average score for the NFN high-risk group of mothers remaining in the program for five years dropped from just under one standard deviation of the normative mean to close to the mean itself (91 vs. 108). This is particularly impressive when we consider that the mothers who remained in the program for 5 years had a higher CAPI score at program entry than mothers at the 1 year data point, suggesting that they were higher risk at program entry.

Life Course Outcomes

Home visitors complete an updated questionnaire annually on each family remaining in the program, from which we derive life course outcomes. Like before, we present one and five year outcomes on all families ever participating in NFN below (excluding families in the Hartford expansion). See Appendix C for two, three, and four year outcomes.

⁶ The normative score is based on a sample of parents whose data were collected at various parent-teacher organizations, Departments of Social Services, Developmental Education Centers, and other community agencies. The sample was mostly white (83%) and married (76%). The median age of parents was 32 and parents had completed an average of 14 years of school.

Dividing mothers into two groups by age, Table 17 provides outcomes for teen mothers and Table 18 for older mothers. Rates of high school or GED completion and employment significantly increased over the first year among young mothers. Among mothers who were enrolled in high school or a GED program at program entry, more than one-half were still in school after one year. For the remainder, approximately the same percentage had left school as had completed their degree.

Table 17. Teen Mothers' Life Course Outcomes

Mothers 19 and younger: One Year Data			
	N	Entry	1 Year
Mothers with at least a high school/GED education	665	21%	30%***
Mothers in school	673	43%	42%
Mothers employed	680	13%	37%***
Mothers employed full-time	530	4%	12%***
Mother enrolled in high school or GED program at program entry (N=222)			
-- completed their degree		18%	
-- completed their degree and enrolled in college		4%	
-- still in high school or a GED program		49%	
-- in a vocational or other school		6%	
-- dropped out of high school or GED program		23%	

Among older mothers there were no significant changes in education attainment after one year, but employment rates doubled, with one-half of older mothers employed and one-third employed full-time. We also see that the number of mothers in school doubled during the first year of program participation; furthermore, of the 51 mothers who were not enrolled in school at program entry, but were at one year, more than one-fourth were enrolled in college and a little more than one-half in a vocational or other type of school, excluding high school or GED program.

At five years, increases in the percentages of high school or GED completion and employment were both statistically significant. For mothers who had been in high school or a GED program at the time of program entry, 69 percent had completed their degrees and 25 percent had continued on to college.

Table 18. Older Mothers' Life Course Outcomes

Mothers 20 Years and Older			
	N	Entry	1 Year
Mothers with at Least a High School Education	459	71%	70%
Mothers Employed	489	24%	49%***
Mothers Employed Full-Time	361	16%	34%***
Mothers in School	483	7%	14%***
Type of school			
High school/GED		22%	17%
College		40%	34%
Vocational school		10%	25%
Other		28%	23%
Mothers Enrolled in School at One Year But Not at Program Entry (N=51)			
Type of school at one year			
High school or a GED program		18%	
College		29%	
Vocational/other school		53%	
All Mothers: 5 Year Data			
	N	Entry	5 Year
Mothers with at Least a High School Education	157	39%	63%***
Mothers Employed	161	14%	56%***
Mothers employed full-time	123	6%	53%***
Mothers in School	155	31%	18%**
Type of School			
High school/GED		76%	11%
College		2%	50%
Other		22%	14%
Vocational school		0%	25%
Mother Enrolled in High School or GED Program at Program Entry (N=35)			
-- completed their degree		69%	
-- completed their degree and completed some college		14%	
-- completed their degree and enrolled in college		11%	
-- reenrolled in GED program		3%	
-- completed their degree and enrolled in a vocational or other school		9%	
-- dropped out of high school or GED program		31%	

Home visitors' perception of mothers' social isolation was also significantly less at one and five years as shown in Table 19. Perceived financial difficulties declined modestly,

meeting our test for statistical significance at one year, but not at five years. Use of government assistance reflected continued financial burdens among this population. While TANF use declined, most likely attributable to state time limits, food stamp use actually increased at both one and five years and Medicaid use remained high as well. These data are sobering, because they suggest that despite improvements in education and employment, many families remain poor or near poor.

Table 19. Mothers' Outcomes in Social Isolation and Financial Difficulties

	Program Entry	One Year	Program Entry	Five Years
Mothers socially isolated	34% (N=1,177)	16%***	31% (N=157)	13%***
Mothers with financial difficulties	65% (N=1,183)	60%**	59% (N=156)	53%
Receiving Medicaid	78% (N=733)	80%	90% (N=70)	86%
Mothers living independently	49% (N=1,106)	55%***	59% (N=148)	80%***
Mother receives TANF	33% (N=1,074)	34%	55% (N=117)	24%***
Mothers receiving food stamps	35% (N=1,071)	43%***	50% (N=118)	55%
Mothers receiving WIC	88% (N=1079)	88%	90% (N=115)	85%

* p<.05 **p<.01 ***p<.001

Finally, in Table 20, we see that fathers' involvement with their children decreased significantly, with only one-half of fathers at least somewhat involved with their children after five years. In contrast to the mothers, there were no significant increases in fathers' educational achievements or rates of employment after one or five years.

Table 20. Life Course Outcomes for Fathers

	Program Entry	One Year	Program Entry	Five Years
Father very/somewhat involved w/ child	70% (N=1,008)	64%***	69% (N=134)	51%**
Fathers with at least a high school education	48% (N=727)	49%	47% (N=76)	51%
Fathers employed	65% (N=839)	67%	72% (N=88)	70%
Fathers in school	14% (N=836)	8%***	14% (N=91)	2%**
Fathers with financial difficulties	58% (N=659)	54%	58% (N=71)	42%
Fathers socially isolated	15% (N=627)	11%**	9% (N=68)	9%

* p< .05 ** p <.01 ***p <.001

Our 2006 data demonstrate that NFN home visiting continues to reach some of the most vulnerable families in the state. On average, these families stay in the program for 18 months and receive 2 home visits per month. Pre and post-observations indicate that parenting dispositions change over time in ways that should promote more positive parenting and that families are learning about and using community resources more

effectively. We also see educational and employment gains made by mothers remaining in the program, even though these gains often do not mitigate financial burdens. Fathers do not appear to be making the same gains and are less likely to be involved with their children over time.

Hartford Home Visiting Programs

There are ten sites currently operating in the city of Hartford. Two of the sites, Hartford VNA and St. Francis Hospital, began in 1995 and 2000 respectively, while the additional eight sites began serving families in May 2005. As presented in last year’s report, we use an enhanced research design for Hartford sites.⁷ Our primary reason is to more closely examine the consequences of home visiting in an urban community with extensive poverty. In this section of the report, we present descriptive, process, and outcome data on families at the eight new Hartford sites and the two older sites enrolled since the expansion.

As we see in Table 21, there have been 1,674 initial screens completed in Hartford since May 25, 2005, of which one-half were positive. Of all the mothers who screened positive (or high-risk) on the REID, 45 percent entered the home visiting program. This is considerably higher than the statewide sites (27%), most likely due to the greater availability of program slots.

Table 21. Program Outcomes for Families Scoring High-Risk on the REID in Hartford

	#	%
Total number of REID Screens Completed	1,674	—
Positive REID Screens	844	50%
– Offered Kempe Assessment	770	91%
– Accepted Kempe Assessment	474	62%
Positive Kempe Assessments	401	85%
– Offered home visiting services	401	100%
– Accepted home visiting services	395	99%
– Initiated home visiting services	381	96%

In Table 22 we see that there is considerable variation in the total number of families served across Hartford sites and in the number currently active, which at the end of 2006 ranged from 8 to 27.

⁷ See Black, T, Damboise, M., Figueroa, M., Fuller-Ball, D., Lamkins, K., & Erdmans, M. (2006) *Nurturing Families Network 2006 Annual Evaluation Report*. Center for Social Research, University of Hartford, West Hartford, CT.

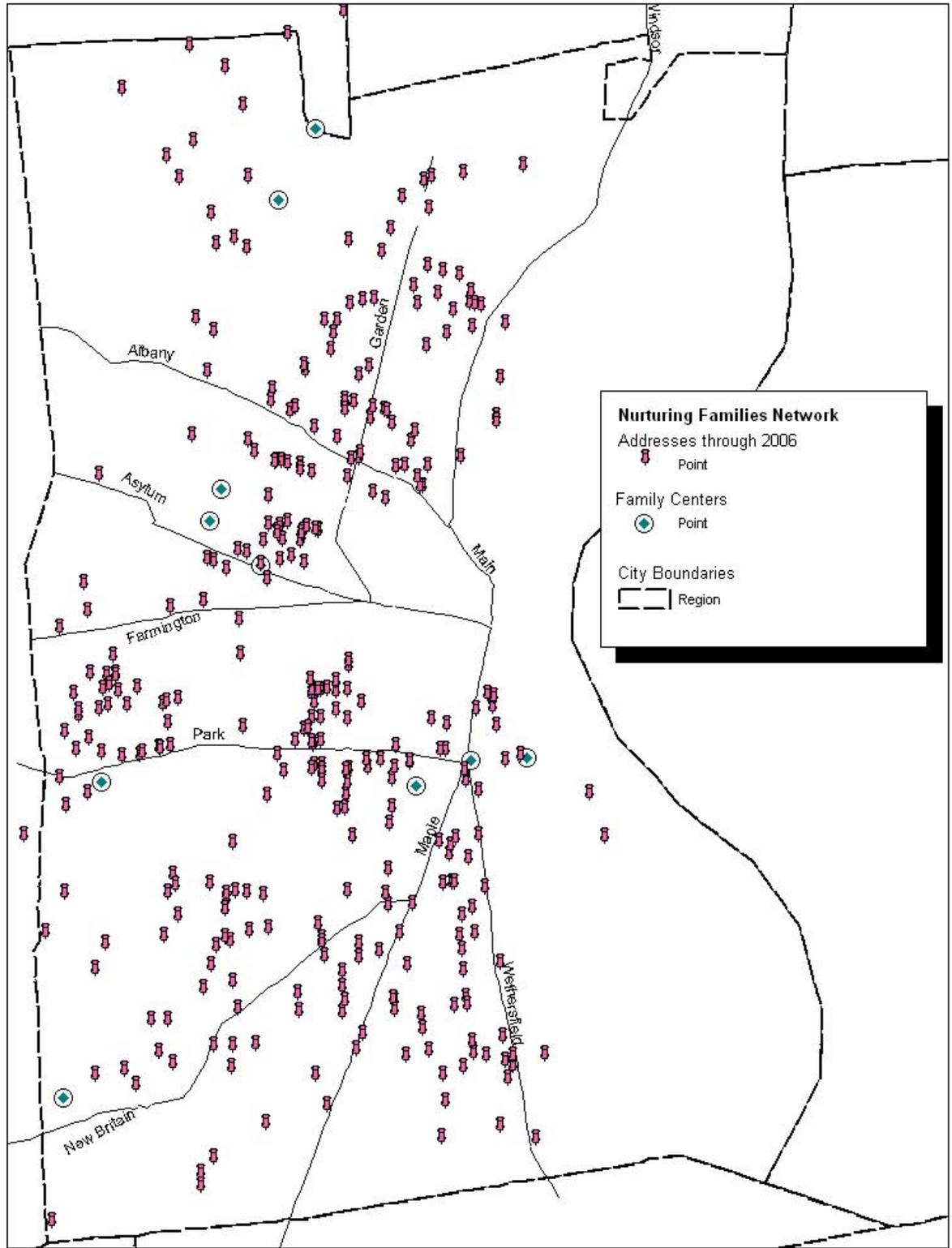
Table 22. Number of Families Served at Each Site in Hartford

	Total #	Active as of December 31, 2006
Asylum Hill	24	8
El Centro	35	22
Hispanic Health Council	29	17
MIOP	56	26
Parkville	40	23
RAMBUH	34	15
Southside	55	26
Trust House	34	15
St. Francis Hospital*	52	27
Hartford VNA*	28	21
TOTAL	387	200

* Numbers reflect families starting 5/24/05 and after

In Figure 2, we present a map with the locations of all the families who have participated in the program since the expansion. The map indicates that, despite the variation in site enrollments, families are enrolling in the program from all parts of the city.

Figure 2. Residential Locations of Hartford NFN Families



Of the 387 families who have participated in the Hartford NFN program since May 2005, 200 were still active on December 31, 2006. Families leaving the program received services an average of five months. As we see in Table 23, families leaving the program tended to be a transient population – one-half left because they either moved out of the service area, moved to another location without notifying their home visitors, or were no longer at home during visits and were unreachable by phone.

Table 23. Hartford Families’ Reasons for Leaving the Program (N=189)

Family moved out of service area	19%
Unable to locate mother	31%
Discharged, family was noncompliant	0%
Family refused further services	26%
Mother is working or in school full-time, no time for home visits	18%
Goals were met	0%
Baby removed from home by DCF	1%
Discharged, family was not appropriate for the program	1%
Other family member did not approve of services	0%
Other	6%

Home visitors were able to document caregivers’ attitudes toward program services for about three-quarters of families who left the program. Among those, around one-half were considered willing and readily accepting of services when they left and were believed to fully understand the relationship between risk factors and their impact on their children. Home visitors believed that 24 percent had greatly benefited from the program and another 46 percent had benefited somewhat.

Table 24. Hartford Home Visitors' Assessment of Caregiver Attitudes at Program Exit

	All	Unknown Responses Removed
Attitude of Caregiver at the End of Services	N=188	
Willing, readily accepting	38%	51%
Reluctant, minimally compliant	30%	41%
Unwilling, hostile	6%	8%
Don't know	26%	---
How Well Did Caregiver Understand the Relationship Between Risk Factors and Their Impact on Their Child's Life?	N=189	
Fully understood relationship	32%	47%
Partially understood relationship	27%	39%
Did not understand relationship	10%	15%
Don't know	31%	---
How Did Caregiver View the Program Services as Helping Them to Better Care for Their Children?	N=189	
Fully understood value of services	28%	38%
Partially understood value of services	33%	45%
Did not understand value of services	12%	17%
Don't know	28%	---
How Motivated was the Caregiver to Address Their Risk Factors?	N=187	
Very motivated	12%	16%
Somewhat motivated	28%	36%
Motivated very little	26%	34%
Not motivated at all	10%	13%
Don't know	24%	---
To What Extent Did the Family Benefit From Services?	N=188	
Benefited greatly	21%	24%
Benefited somewhat	39%	46%
Benefited very little	13%	15%
Did not benefit at all	13%	15%
Don't know	14%	---

Risk Profiles of Hartford NFN Families

As described earlier, the Kempe is scored across 10 items, with each item scored either a 0 (no/low risk), 5 (moderate risk), or 10 (severe risk), to indicate presence and severity.

Table 25. Hartford Mothers' Kempe Scores on Individual Items

	0	5	10
1. Childhood History of Abuse/Neglect (N=377)	26%	26%	49%
2. History of Crime, Substance Abuse, Mental Illness (N=377)	46%	35%	19%
3. CPS History (N=377)	89%	4%	7%
4. Low Self-esteem/ Social Isolation/ Depression (N=377)	7%	60%	34%
5. Multiple Stresses (N=377)	6%	34%	61%
6. Potential for Violence (N=376)	73%	11%	15%
7. Unrealistic Expectation of Child (N=377)	50%	42%	8%
8. Harsh Punishment (N=375)	81%	12%	7%
9. Negative Perception of Child (N=377)	84%	13%	3%
10. Child Unwanted/ Poor Bonding (N=377)	6%	79%	16%

Each of these items, however, includes a larger set of criteria from which judgments are made, and these criteria provide a much better description of risk. As part of our enhanced research design in Hartford, we recorded and will discuss these data on families who scored in the severe range (see Table 25).

Nearly one-half of Hartford mothers were identified as experiencing severe forms of abuse or neglect as children. One-third of mothers were raised by parents who were alcohol or drug addicted, while another one-third were victims of severe beatings. One-half of mothers who scored in this range had been raised by *more* than two families and 39 percent had been removed from their homes or abandoned by their parents.

The fourth item in Table 25 contains multiple constructs – low self-esteem, social isolation, and depression. Most of the 34 percent of mothers who were assessed at the severe range were considered socially isolated (65% reported that they rarely saw other people and, when they did, they didn't find it enjoyable). A little more than a one-quarter (27%) who scored at this level said they couldn't name any lifelines and that they had a history of limited coping skills (26%). Also, as we can see in the table, 6 out of 10 mothers scored at the moderate level on this item, but these data mostly reflected that the mothers had not finished high school or were unemployed and not seeking work.

A little less than two-thirds of mothers indicated severe levels of multiple stresses (item 5). Around one-half of these mothers described extremely stressful living situations and perpetual crises that they felt unable to handle. A little more than one-fifth were in relationships characterized by constant conflict.

Item 10 is a particularly good example of why it is important to look more closely at the defining criteria of the Kempe items, rather than accept them by the meanings implied in their titles. Nearly 8 in 10 mothers scored in the moderate range on the Child Unwanted/Poor Bonding scale because they had a child out-of-wedlock. This criterion alone accounts for most mothers in the NFN program. The primary reason that 16 percent scored at the severe level was because they indicated that the baby was unplanned and

viewed as coming at a bad time in the mother’s life, a likely response among teen mothers. The item is intended to raise important concerns about parent-child bonding, but it does not mean that the child is unwanted or that poor bonding has occurred, as the title may imply.

Looking at the prevalence of risk in a different way, we also see in Table 26 that 10 percent of families are entering the program experiencing an acute condition – a substance abuse, domestic violence, and/or mental health problem – and that another 16 percent are identified as encountering one or more of these problems after they enrolled.

Table 26. Prevalence of Acute Families in Hartford in 2006 (N=195)

	%
Acute when entering the program	10%
Acute at any time in 2006	26%

Social-Demographic Profile of Hartford NFN Families

Social-demographic profiles of Hartford mothers shown in Table 27 were fairly similar to the profiles of statewide mothers presented earlier, with the exception that all but 2 percent were nonwhite.

Table 27. Social-Demographic Characteristics of Hartford Mothers⁸

	N	%
Entered Program Prenatally	234	62%
Mean Mothers' Age at Baby's Birth	237	20
Median Mothers' Age at Baby's Birth		20
Mother's Age at Baby's Birth		
Under 16		4%
16-19 years		40%
20-22 years		32%
23-25 years		13%
26-30 years		7%
Over 30 years		4%
Mothers' Marital Status	366	
Single, never married		93%
Married		5%
Married, but separated		1%
Widowed		1%
Mother's Relationship to Father of Baby	355	
Partner/boyfriend		64%
No relationship		31%
Married		4%
Married, but separated		2%
Mothers' Race/Ethnicity	362	
Hispanic		59%
African American		28%
White		2%
Multi-racial		3%
Other		8%

Educational levels also did not vary much between Hartford mothers and the statewide population – 84 percent of younger mothers and 31 percent of older mothers had not completed high school compared to 77 percent and 29 percent of the statewide groups respectively. Unemployment rates between the two groups were almost identical (87% for both groups of younger mothers; 70 vs.72% for older mothers).

⁸ The discrepancy in the number of cases in these analyses is primarily due to the high percentage of mothers in the program who are prenatal, so the Ns for information on children are lower.

Table 28. Hartford Mothers' Life Course Data by Age at Baby's Birth

	19 and younger	20 and older
Mother's Highest Level of Education	N=158	N=204
No formal schooling	0%	1%
8 th grade or less	13%	4%
Less than high school	71%	26%
High school diploma	8%	28%
GED	2%	6%
Some college	5%	21%
College degree	0%	4%
Post secondary vocational training	1%	6%
Graduate work	0%	1%
Unknown	1%	4%
Mother Employed During the Year Prior to Pregnancy		
	N=160	N=204
No, was not seeking work	71%	28%
No, but was seeking work	8%	8%
Yes	17%	57%
Full-time	7%	28%
Unknown	4%	7%
Mother Currently Employed		
	N=158	N=204
No	83%	64%
No, but seeking work	4%	6%
Yes	10%	22%
Full-time	3%	13%
Yes, but on maternity leave	2%	5%
Yes, under the table	0%	1%
Unknown	1%	1%
Mother Currently Enrolled in School		
	N=160	N=203
No	43%	89%
Yes	56%	11%
High school or GED program	43%	4%
Unknown	2%	1%
Mother Enrolled in School At Time of Pregnancy		
	N=81	N=182
No	33%	72%
Yes	56%	22%
Unknown	11%	6%

We also collected a range of data to assess the degree of vulnerability among Hartford families. Health data provided in Table 29 indicate that 9 percent of NFN children were born with serious medical problems, mostly related to immature lung development.

Relatedly, 11 percent were born prematurely and 12 percent with low birth weight. Virtually all (98%) of the children we documented had a regular pediatrician.

Table 29. Hartford Mothers' Pregnancies and Birth Outcomes

	N	%
Mother smoked cigarettes during pregnancy	218	6%
Mother drank alcohol during pregnancy	219	2%
Mother used illicit drugs during pregnancy	217	5%
Child born with serious medical problems	234	9%
Born Prematurely (before 37 weeks gestation)	192	11%
Born Low Birth weight (under 5 lbs 8 oz)	223	12%
Child has a Pediatrician	237	
Yes		98%
No		1%
Unknown		1%

Home visitors' perceptions of social isolation were similar to the Kempe data. It appears that around one-third of mothers suffered from social isolation. However, data in Table 30 also show that mothers saw several family members and friends on a weekly basis. Our measures of depression suggest that a significant proportion of Hartford NFN mothers may suffer from depression. Home visitors identified 28 percent of mothers to be depressed at around the time of program entry, and were unsure about another 18 percent. Using a standardized measure, the Center for the Epidemiologic Studies scale (CES-D), 44 percent of mothers' scores indicated "a clinically significant level of psychological distress" in the mothers' lives (which is 24 percent higher than the general population's score on the scale).⁹ Of course, neither of these are clinical diagnoses of depression, but they are indications of high levels of distress among Hartford NFN mothers.

⁹ Radloff, L. S. (1977) The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.

Table 30. Observed Social Isolation and Depression of Hartford Mothers

	N	%
Observed Social Isolation of Mother	362	
No		55%
Yes		35%
Unknown		10%
Mean Number of Relatives Mother Sees per Week	348	3.54
Mean Number of Friends Mother sees per Week	317	1.95
Mean Number of People Mother Can Count on in Times of Need	341	2.96
Home Visitor Report of Depression		
Mother Ever Experienced Depression	365	
No		54%
Yes		28%
Unknown		18%
Mother Ever Received Treatment for Depression	364	
No		64%
Yes		17%
Unknown		19%
Observed Current Depression	364	
No		69%
Yes		13%
Unknown		19%
Mother Currently in Treatment for Depression	359	
No		78%
Yes		6%
Unknown		16%
CES-D Depression Scale	238	
Mean score		15.7
% above cutoff score		44%

Poverty is of course a problem among this population of mothers. As the data in Table 31 show, mothers themselves made little money and were, therefore, likely to live with others. Only 21 percent of fathers were living in the household, while nearly one-half of mothers were living with the child's maternal or paternal grandmother. Only 11 percent of mothers lived by themselves at the time of program entry, although 28 percent were living independently of family with non-family members. About one-half of mothers' households were receiving food stamps, even though the use of cash assistance was considerably lower. Home visitors considered 71 percent of mothers to have financial difficulties.

Table 31. Hartford Family Household and Financial Circumstances

Mothers' Average Unassisted Income (N=358)		All Mothers	Unknown and Not Applicable Responses Removed
Under \$5,000		6%	38%
\$5000-\$9999		3%	18%
\$10,000-\$14,999		2%	11%
\$15,000-\$24,999		4%	23%
\$25,000-\$34,999		2%	11%
Unknown		10%	
Not employed		74%	
Types of Government Assistance Received by Mother and by Household (N=352)			
	Mothers	Others in Household	
TANF	14%	7%	
WIC	67%	17%	
Food stamps	32%	22%	
SSI	4%	6%	
SSDI	2%	4%	
General Assistance	10%	4%	
Section 8	3%	12%	
No government assistance	14%	31%	
Unemployment compensation	1%	0%	
Worker's compensation	0%	<1%	
Unknown	8%	32%	
Mothers Covered by Medical Insurance (N=341)			
		87%	
Children Covered by Medical Insurance (N=179)			
		93%	
Observed Financial Difficulties (N=365)			
No		20%	
Yes		71%	
Unknown		9%	

Table 31. Hartford Family Household and Financial Circumstances (Continued)

	Mothers	Others in Household
Mean Number of Adults Living in the Household (N=347)	1.8	
Relationship to Adults Living in the Household (N=357)		
Mother is only adult		11%
Father of baby		21%
Mother's spouse (not father of baby)		3%
Mother's partner (not father of baby)		3%
Maternal grandmother		45%
Maternal grandfather		9%
Paternal grandmother		4%
Paternal grandfather		2%
Mother's siblings		20%
Father's siblings		4%
Mean Number of Other Children Living in the Household (N=342)		
	0.9	
Mothers Living Independently of Family (N=351)		
- in apartment or rental unit	27%	
- in home owned by mother and/or father	1%	

As shown in Table 32, about one-half of fathers were very involved with their children at the time of birth, while around one-quarter were not involved at all. Fathers' potential for contributing to the financial well-being of their families appeared limited. For fathers we were able to document, about one-half had less than a high school education or its equivalent, and only about one-half were employed. Only one mother was known to be receiving formal child support, even though 17 percent received some informal support (See Table 33 below)

Table 32. Hartford Fathers' Relationships with Mothers and Children

Father as a Primary Caregiver	Children born
	(N=169)
Very involved	47%
Somewhat involved	18%
Sees child occasionally	5%
Very rarely involved	2%
Not involved at all	27%
N/A- child not born yet	---
Unknown	
Father has Custody of Child (N=241)	31%

Table 33. Hartford Fathers' Life Course Data

	ALL	Unknown Responses Removed
Father's Highest level of Education	(N=358)	(N=236)
No formal schooling	1%	1%
8 th grade or less	3%	4%
Less than high school	30%	46%
High school diploma	20%	31%
GED	2%	3%
Some college	7%	11%
College degree	1%	2%
Post secondary vocational training	1%	2%
Graduate work	1%	1%
Unknown	34%	---
Father Currently Employed	(N=354)	(N=269)
No	35%	46%
No, but seeking work	1%	2%
Yes	40%	52%
Full-time	23%	30%
Yes, but under the table	1%	1%
Unknown	24%	---
Does Mother Receive Child Support From Father	(N=148)	
No	63%	
Yes, informal support	17%	
Yes, formal support	1%	
Mother lives with father or mother is prenatal	9%	
Unknown	10%	

Program Dosage

As shown in Table 34, families were seen in the home, on average, twice a month. The 68 percent completion rate of attempted visits, however, was noticeably lower than the statewide rate (81%), suggesting that Hartford families may be more difficult to contact on a regular basis.

Table 34. Frequency of Home Visits Per Month in Hartford

	2005	2006
Average # of attempted home visits	3.1	2.9
Average # of completed home visits	2.1	1.9
Average # of office/out of home visits	0.2	0.2
Average # of NFN social events attended	0.1	0.2
Total # of visits completed	2.4	2.3

Hartford NFN Program Outcomes

Community Referrals

In Table 35, we see the home visitors have made over one thousand referrals to families for community services since the program's inception in May 2005 – indeed, an impressive number. About two-thirds of referrals were complied with. Most referrals were for housing needs and education and employment services. There were surprisingly few referrals, however, for domestic violence services and none for substance abuse. Adding the 30 referrals for mental health services, the total number (32) fell far short of the number of families who were identified with acute conditions (51) in 2006 alone. At the very least, this discrepancy should be addressed in network meetings and in future research.

Table 35. Number and Type of Referrals Made to Hartford Families

	#	%	Compliance Rate
WIC	47	4%	62%
DSS	98	9%	68%
Social Security	6	1%	67%
Food needs	56	5%	55%
Doctor/medical services	90	8%	69%
Housing needs	248	22%	71%
Legal needs	10	1%	80%
Household needs	51	5%	76%
Early intervention/day care	56	5%	61%
Mental health/counseling	30	3%	57%
Crisis intervention	9	1%	44%
Parenting class/program	41	4%	63%
Domestic violence	2	<1%	0%
Substance abuse	0	--	--
Employment/education	188	17%	53%
Department of Children & Families	7	1%	43%
Recreation	28	2%	25%
Cultural/religious	6	1%	67%
Other	154	14%	62%
TOTAL	1127	100%	63%

Child Abuse Potential Inventory-Rigidity Subscale Outcomes

The Child Abuse Potential Inventory Rigidity Scale (CAPI-R) is a self-report scale that measures the rigidity of attitudes and beliefs about the appearance and behavior of children. The subscale is based on the theoretical assumption that rigid attitudes and beliefs lead to a greater probability of child abuse and neglect. Hartford parents complete the CAPI-R at program entry, six months, and then on annual anniversaries of their start-date in the program. Data, presented in Table 36, indicate that parents, active in the program for six months and one year, showed a statistically significant decline in rigid

parenting attitudes. According to the author of the scale, this means they are less likely to treat their children forcefully in order to conform to rigid expectations.¹⁰

This is an important finding, especially when we place the scores in context. The pre-test mean score of 32.6 was extremely high on this scale – more than 2 standard deviations above the normative score (12.5) and considerably higher than the statewide pre-test mean score (24). Continued decline on this scale – as we have seen statewide – would be an important contribution, we believe, towards reducing the potential for child abuse. We might also note that based on pre-test mean scores for the two groups (six months and one year), higher risk families were staying in the program longer.

Table 36. CAPI-Rigidity Subscale Outcomes in Hartford

	Pre- Test Mean	Post-Test Mean
Six month outcome (N=114)	32.6	25.8***
One year outcome (N=46)	35.5	26.9***

* p < .05 ** p < .01 ***p < .001

Center for the Epidemiologic Studies Depression Scale Outcomes

As mentioned earlier, we use the Center for the Epidemiologic Studies Depression scale (CES-D) to assess the prevalence of depression in our sample. This measure was selected mostly as a mediating or control variable, rather than an outcome variable, since we do not know if it is reasonable to expect program services to have a direct effect on depression. Effects might be seen in a few different ways. First, regular, consistent support from a home visitor may reduce stress that may be associated with depression. Or, second, the ability of home visitors to identify depression and refer mothers for effective treatment may also reduce it, especially more clinical forms of it. We did not, however, see any significant change on our depression measure at six months or one year, as reported in Table 37.

Table 37. Hartford CES-D Outcome Data at Six Months (N=95) and One Year (N=41)

	Pre-Test Mean	Post-Test Mean
Six month outcome (N=95), % above cutoff	17.2 (54%)	16.5 (48%)
One year outcome (N=41), % above cutoff	16.0 (44%)	17.2 (44%)

* p < .05 ** p < .01 ***p < .001

Community Life Skills Scale Outcomes

As discussed earlier, the Community Life Skills (CLS) scale is a self-report standardized instrument that measures someone’s knowledge and use of resources in his/her community. Scores on the CLS range from 0-33, with higher scores indicating more effective use of community resources. As reported in Tables 38 and 39, statistically

¹⁰ Milner, J.S. (1986) *Child Abuse Potential Inventory: Manual (2nd Ed.)*

significant improvement on the overall scale was found at both six month and one year administrations, with particular improvement in the area of Budgeting and Support Services, suggesting that families are budgeting their money more carefully and establishing more supportive relationships in their neighborhoods. Support/Involvement scores were also significant at one year, indicating that mothers had more supportive relationships with friends and family and were more likely to have people to rely on in case of an emergency.

Table 38. Mean Scores on the CLS at Program Entry and Six Month (N=114)

	Program Entry	Six Month
Transportation	3.2	3.3
Budgeting	2.6	3.1**
Support Services	4.1	4.4**
Support/Involvement	3.9	4.4
Interests/Hobbies	2.5	2.5
Regularity/Organization/Routines	6.3	6.4
Total	22.6	24.1**

* p< .05 ** p <.01 ***p <.001

Table 39. Mean Scores on the CLS at Program Entry and One Year (N=45)

	Program Entry	One Year
Transportation	3.2	3.4
Budgeting	2.6	3.5***
Support Services	4.0	4.5**
Support/Involvement	3.7	4.5**
Interests/Hobbies	2.4	2.5
Regularity/Organization/Routines	6.2	6.2
Total	22.0	24.5**

* p< .05 ** p <.01 ***p <.001

Life Course Outcomes

As we see in Table 40, there was a significant decrease in home visitor’s perceptions of mothers’ social isolation after six months and one year in the program, but no significant change in their perceptions of families financial difficulties. There were increases in TANF and food stamp use as well -- statistically significant at six months – which is, in part, attributable to over one-half of NFN children being born after program entry.

Table 40. Hartford Mothers' Outcomes in Social Isolation and Financial Circumstances

	Program Entry	Six Months	Program Entry	One Year
Mothers socially isolated	32% (N=125)	17%**	37% (N=46)	13%*
Mothers with financial difficulties	80% (N=122)	80%	83% (N=46)	74%
Mothers living independently	60% (N=126)	62%	52% (N=46)	76%**
Mother receives child support from father of baby (formal or informal)	10% (N=71)	7%	8% (N=26)	4%
Mother receives TANF	11% (N=134)	25%**	14% (N=51)	25%
Mothers receiving food stamps	33% (N=134)	49%**	41% (N=51)	43%
Mothers receiving WIC	76% (N=134)	85%**	76% (N=51)	75%

* p < .05 ** p < .01 ***p < .001

As shown in Table 41, we did not find any significant improvements in mothers' educational attainment or employment rates at six months or one year. This finding differs from statewide mothers, for whom we see statistically significant improvement in both education and employment at one year.

Table 41. Hartford Mothers' Outcomes in Education and Employment

	Program Entry	Six Months	Program Entry	One Year
Mothers with at least a high school education	40% (N=137)	41%	36% (N=50)	42%
Mothers enrolled in school	35% (N=136)	38%	29% (N=51)	41%
Mothers employed	23% (N=134)	21%	24% (N=51)	27%
Mothers employed full-time	8% (N=134)	7%	8% (N=51)	10%

* p < .05 ** p < .01 ***p < .001

Life course data on fathers recorded in Tables 42 and 43 did not change much either. Employment and educational rates remained relatively the same, as did fathers' involvement with mothers and children.

Table 42. Life Course Outcomes for Fathers

	Program Entry	Six Months
Fathers with at least a high school education	44% (N=80)	45%
Fathers employed	55% (N=94)	52%
Fathers employed full-time	12% (N=94)	7%
Fathers in school	20% (N=89)	12%
Fathers with financial difficulties	80% (N=50)	72%
Fathers socially isolated	14% (N=42)	10%

* p < .05 ** p < .01 ***p < .001

Table 43. Hartford Family Relationship Outcomes

	Program Entry	Six Months	Program Entry	One Year
Mothers involved in romantic partnership with father	95% (N=87)	95%	92% (N=36)	83%
Fathers very or somewhat involved with their child	73% (N=56)	70%	76% (N=21)	71%
Fathers living in the household	24% (N=127)	27%	25% (N=51)	24%

* p< .05

** p <.01

***p <.001

Outcomes from Conflict Tactics Scale-Parent-Child Version

This year, we introduce a new measure, one that is widely used in family evaluation research, the Parent-Child version of the Conflict Tactics Scale (CTS-PC). The CTS-PC is a self-report measure that assesses how often parents used specific acts of discipline (both violent and nonviolent) with their children in the past year and assesses parental discipline in the areas of nonviolent discipline, psychological aggression, physical assault, and neglect.¹¹ Hartford program participants complete the CTS-PC around their children’s first birthday and at subsequent birthdays. Although our N is still small at this point, we present CTS-PC data from the 33 parents who completed the instrument at the one year time period in Table 44.

The data indicated that parents frequently used non-physical discipline methods, including explaining why something was wrong and redirecting bad behavior, during the child’s first year of life. There were also a number of parents who used “psychological aggression,” with more than one-half reporting they had screamed, shouted or yelled at their child at least once. Forty-five percent of parents had threatened to spank their child at least once, but had not followed through with the threat. The only physical means of discipline reported fell into the minor “corporal punishment” category. Thirty-one percent had slapped their child on the hand, arm or leg at least once, and 16 percent at least 3 to 5 times, while 18 percent indicated they had spanked their child at least once. One parent reported she had hit her child on the bottom with an object. No parents reported using any severe or extreme physical punishment on their young children.

Social-demographic characteristics and risk profiles of families enrolled in the Hartford expansion did not differ much from NFN families statewide, with the exception that Hartford families were much more likely to be nonwhite. Hartford mothers were a little more likely to be single and never married, and to enter the program with an “acute” status, but these differences were quite small. Both groups are very representative of Connecticut’s most vulnerable families. Like the statewide group, Hartford families

¹¹ Straus, M.A. (2003) *The Conflict Tactics Scales Handbook*. Western Psychological Services. Los Angeles, CA.

received, on average, 2 home visits per month. For the most part, outcomes were similar as well. Hartford families showed particularly impressive gains on the rigidity subscale of the Child Abuse Potential Inventory, suggesting that their attitudes and beliefs about their children are becoming less rigid and more realistic. They also demonstrated increases in their knowledge and use of community resources. They did not, however, show improvements in educational attainment or employment during the first year, which differed sharply from statewide NFN mothers.

We also reported on additional outcome measures which are part of our enhanced research design in Hartford. We recorded over 1000 community referrals that home visitors made since program inception in May 2005, with a 63 percent compliance rate. We were surprised, however, that so few of these referrals were made for mental health, domestic violence, or substance abuse services, given the high rate of families reported as “acute” in 2006 alone. Mothers’ depression scores did not change during the first six months or one year of program services. Finally, self-reported child disciplinary practices suggested that most mothers were using non-disciplinary forms of discipline in their children’s first years of life, while one-third reported using milder forms of “corporal punishment.”

Table 44. CTS-PC One Year Data (N=33)

	Never	Once	Twice	3-5 Times	6-10 Times	11-20 Times	More than 20 Times	Not in he Past Year But Happened Before
You explained why something was wrong	25%	3%	3%	13%	16%	13%	25%	3%
You put your child in “time out” (or sent the child to his or her room)	64%	9%	9%	3%	6%	3%	3%	3%
You shook your child	100%	0%	0%	0%	0%	0%	0%	0%
You hit your child on the bottom with something like a belt, hairbrush, stick, or some other hard object	97%	3%	0%	0%	0%	0%	0%	0%
You gave your child something else to do instead of what he or she was doing wrong	18%	0%	12%	6%	12%	9%	42%	0%
You shouted, yelled, or screamed at your child	42%	12%	15%	18%	6%	3%	3%	0%
You hit your child with a fist or kicked your child hard	100%	0%	0%	0%	0%	0%	0%	0%
You spanked your child on the bottom with your bare hand	82%	3%	9%	0%	6%	0%	0%	0%
You grabbed your child around the neck and choked him/her	100%	0%	0%	0%	0%	0%	0%	0%
You swore or cursed at your child	88%	3%	3%	6%	0%	0%	0%	0%
You beat your child up	100%	0%	0%	0%	0%	0%	0%	0%
You said you would send your child away or kick him or her out of the house	100%	0%	0%	0%	0%	0%	0%	0%

Table 44. CTS-PC One Year Data (Continued)

You burned or scalded your child on purpose	100%	0%	0%	0%	0%	0%	0%	0%
You threatened to spank or hit your child but did not actually do it	55%	15%	9%	3%	3%	3%	9%	3%
You hit you child on some other part of the body besides the bottom with something like a belt, hairbrush, stick, or some other hard object	100%	0%	0%	0%	0%	0%	0%	0%
You slapped your child on the hand, arm or leg	69%	13%	3%	13%	3%	0%	0%	0%
You took away privileges or grounded your child	76%	0%	6%	6%	3%	3%	6%	0%
You pinched your child	100%	0%	0%	0%	0%	0%	0%	0%
You threatened your child with a knife or gun	100%	0%	0%	0%	0%	0%	0%	0%
You threw or knocked your child down	100%	0%	0%	0%	0%	0%	0%	0%
You called your child dumb or lazy or some other name like that	94%	3%	0%	3%	0%	0%	0%	0%
You slapped your child on the face or head or ears	100%	0%	0%	0%	0%	0%	0%	0%
<i>You put your child in time out (in the past week)</i>	69%	10%	10%	3%	3%	3%	0%	-
<i>You shouted, yelled, or screamed at your child (in the past week)</i>	62%	21%	14%	0%	3%	0%	0%	-
<i>You spanked your child on the bottom with your care hand (in the past week)</i>	82%	7%	4%	0%	7%	0%	0%	-
<i>You slapped your child on the hand, arm or leg (in the past week)</i>	66%	17%	7%	7%	3%	0%	0%	-

Table 44. CTS-PC One Year Data (Continued)

You had to leave your child home alone, even when you thought some adult should be with him or her	100%	0%	0%	0%	0%	0%	0%	0%
You were so caught up with your own problems that you were not able to show or tell your child that you loved him or her	92%	4%	4%	0%	0%	0%	0%	0%
You were not able to make sure your child got the food her or she needed	96%	0%	4%	0%	0%	0%	0%	0%
You were not able to make sure your child got to a doctor or hospital when he or she needed it	100%	0%	0%	0%	0%	0%	0%	0%
You were so drunk or high that you had a problem taking care of your child	100%	0%	0%	0%	0%	0%	0%	0%

State Reports of Child Maltreatment

Each year, program participants are asked to sign a release form that allows us to search the Department of Children and Families (DCF) database to determine whether or not they have been reported for maltreatment during their tenure in the home visitation program. This year, 664 families who participated in the program at any time between July 1, 2005 and June 30, 2006 signed the release, representing 54 percent of all families who were active during that time. Forty percent of families had exited the program before a current release was signed (releases are only good for one year¹²), while only three percent refused to sign.¹³ These data include participants from all NFN sites, including the Hartford sites.

We analyzed demographic and risk data to determine if those who signed the release differed from those who did not. Results of this analysis are presented in Table 45. The families that *signed* the release had significantly higher CAPI Rigidity scores than those who did not. Further, those who signed the release were more likely to be non-white. There were no other significant differences on the other variables. These data increased our confidence that the group excluded from our analysis was not at higher risk than the group that did sign the releases and, if anything, suggested that our sample was at higher risk of having state reports filed on them.

Table 45. Comparison of Mothers Included and Excluded in Analyses of State Child Abuse and Neglect Reports

	Signed DCF Release (N=664)	Did Not Sign DCF Release (N=447)
CAPI Rigidity score	26.6	23.7**
Mother's total Kempe score	39.1	39.5
Mother's age at baby's birth	21.6	21.3
% Mothers with at least a high school degree	47%	43%
% Mothers employed	21%	20%
% Mothers nonwhite	77 %	70% Non-White***

* p<.05 **p<.01 ***p<.001

Similar to previous reports, we analyzed this year's DCF data in three different ways. First, we assessed families reported for maltreatment *at any time during their participation in the program*. Second, we assessed families who were reported to DCF *during their participation between July 1, 2005 and June 30, 2006*. Last, we assessed families who were *active in the program for the entire year, July 1, 2005 to June 30, 2006 and any reports filed during that time*. In each of the three analyses, we compare this year's and last year's data. These data are provided below in Tables 46-48.

¹² The Hartford sites use a different release form which families sign when they enter the program. This release does not expire until the family leaves the program or until the parents revokes consent.

¹³ An additional 3 percent did not sign for other reasons including difficulty reaching the family and staff vacancies.

Our first analysis shows that nearly 16 percent of all families had a DCF report filed at some time during their participation in the program and almost 6 percent had a substantiated report, a decrease from last year.

Table 46. Reports of Child Maltreatment at Any Time During Program Participation

	2004-2005	2005-2006
Total number of families that signed DCF release	410	664
# of families with DCF Report (%)	92 (22.4%)	103 (15.5%)
# of families with multiple DCF reports (%)	40 (9.8%)	33 (5.0%)
# of families with substantiated DCF report (%)	32 (7.8%)	37 (5.6%)
# of families with multiple substantiated DCF Reports (%)	7 (1.7%)	4 (0.6%)
Total number of reports	157	146
Total number of substantiated reports	41	41

In the second analysis, 8 percent of participating families had a report filed between July 1, 2005 and June 30, 2006 and 2 percent had a substantiated report. Again, these data indicate a decrease in maltreatment rates from last year.

Table 47. Reports of Child Maltreatment Made Between 7/1/05-6/30/06

	2004-2005	2005-2006
Total number of families that signed DCF release	410	664
# of families with DCF Report (%)	45 (11.0%)	55 (8.3%)
# of families with multiple DCF reports (%)	7 (1.7%)	7 (1.1%)
# of families with substantiated DCF report (%)	12 (2.9%)	14 (2.1%)
# of families with multiple substantiated DCF Reports (%)	0 (0%)	0 (0%)
Total number of reports	53	61
Total number of substantiated reports	12	14

In our final analysis, we calculated an annualized rate of maltreatment, including only the 256 families who received services for the entire year.¹⁴ DCF reports were filed on 8 percent of these families and substantiated for 2 percent.

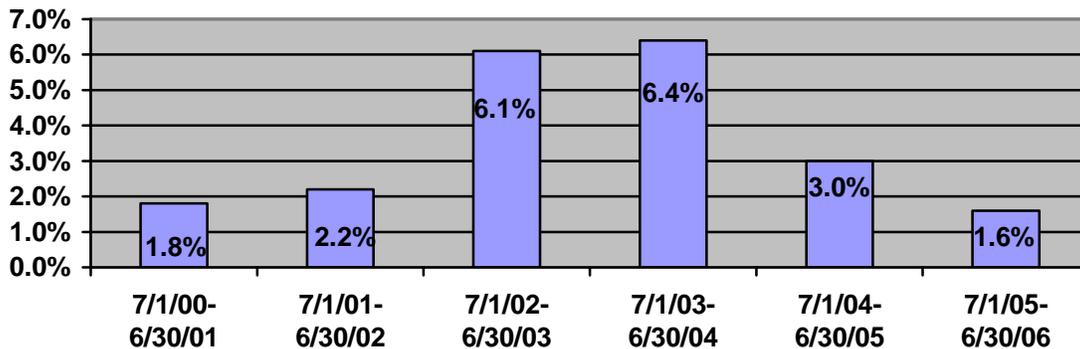
¹⁴ The purpose for this analysis is to standardize the exposure that a family has to the NFN program and to calculate rates that could be compared to state and national rates.

**Table 48. Reports of Child Maltreatment for Families
Active Between 7/1/05-6/30/06**

	2004-2005	2005-2006
Total number of families active entire year 7/1/05-6/30/06	229	256
# of families with DCF report (%) 7/1/05-6/30/06	35 (15.3%)	20 (7.8%)
# of families with multiple DCF reports (%)	6 (2.6%)	3 (1.2%)
# of families with substantiated DCF report (%)	7 (3.1%)	4 (1.6%)
# of families with multiple substantiated DCF reports (%)	0 (0%)	0 (0%)
Total number of reports	43	23
Total number of substantiated reports	7	4

Our rate of child maltreatment for this year's sample is noticeably less than in previous years. Figure 3 shows the annualized rate of maltreatment for the past six years for the NFN population. As shown, there was a spike in the maltreatment rates in the FY 2003 and FY 2004, while the rates in the past two years have declined considerably. Most encouraging, the rate of DCF reports filed on families receiving services for the entire year dropped by nearly one-half.

**Figure 3. Annualized Rates of Maltreatment for the NFN
Population**



In order to create a framework for interpreting these rates, in Table 49, we provide maltreatment rates that have been documented by research on similar home visitation programs across the country. One should keep in mind, however, that eligibility criteria as well as the nature and frequency of services may differ across programs. All rates reported are annualized rates of maltreatment unless otherwise noted in the comments column.

Rates across the country ranged from 1 to 8 percent. This year's annualized rate of 1.6 percent is similar to many studies, while it compares favorably to several studies at the higher end of the range.

Table 49. Rates of Maltreatment Reported in Other Home Visiting Program Evaluation Research

Home Visiting Program	Evaluators and Year Published	Rate of Reported Abuse/Neglect	Comments
Nurse- Family Partnership	Olds (2006)	Elmira- 4%- Nurse visited 8%- Control	Rates of abuse/neglect during the first 2 years of child’s life. They did not look at formal A/N rates for the Memphis or Denver studies. However, the Memphis study they found that during the first 2 years of life, the nurse visited children had 23% less health care encounters with injuries than those in the comparison group.
Healthy Families New York	Mitchell- Herzfeld & Izzo (2005)	8%- Treatment group 6%- Control group	Percentage of families with at least 1 substantiated report after 1 year in the program
Healthy Families Virginia	Galano & Huntington (2004)	1.1%	Percentage of families with at least 1 substantiated report after 1 year in the program
Healthy Families Arizona	Lecroy & Milligan (2003)	1%	Percentage of families with at least 1 substantiated report after 1 year in the program. Only includes families who had at least 4 home visits and were active in the program for at least 6 months during the 1 year time period.
Healthy Families Arizona	Davenport (2000)	1.6%- Healthy Families 1.4% comparison group	Only includes substantiated reports made 6 months after the family started the program.
Healthy Families Jacksonville (Florida)	Edwards et al. (2001)	1%	Percentage of families with at least 1 substantiated report after 1 year in the program
Healthy Families Florida	Williams, Stern, and Associates (2005)	5%	Percentage of families with at least 1 substantiated report after 1 year in the program
Healthy Families Hawaii	Duggan, et al (2005)	0.8%- Treatment 1.1%- Control	Percentage of families with at least 1 substantiated report in the child’s first year of life.
Healthy Families Iowa	Hanson (2006)	4%	Data for fiscal year of 2005 (has ranged from 4%-7% over the past 4 years)
Oregon Healthy Start Home Visiting	Katzev et al (2002)	2.1%	Percentage of families with at least 1 substantiated report during the calendar year 2000.

As presented in Table 50, NFN mothers were perpetrators in 87 percent of all reports and 72 percent of substantiated cases. Fathers were involved in 37 percent of all cases, but in 51 percent of substantiated cases. Families, on average, had been in the NFN program for 15 months when a substantiated report was filed and home visitors made 17 percent of these reports.

As in previous years, domestic violence and drug and alcohol use were common reasons why reports were made. About one-third of all substantiated reports involved domestic violence and another one-third substance use, while one-third of cases also involved a parent with a mental illness or cognitive delay. When we combined these three conditions, (domestic violence, substance use, and mental illness), we found that 55 percent of all reports and 66 percent of all substantiated reports involved at least one of these factors.

Table 50. Relationship of Perpetrator to Child and Frequency of Conflated Factors Identified in State Reports

	All Reports (N=146)	Substantiated Reports (N=41)
Perpetrator of Maltreatment		
Mother only	51%	41%
Mother and father	26%	29%
Father only	10%	22%
Mother and maternal grandmother	3%	0%
Mother and mother's boyfriend	1%	0%
Mother and other family member	3%	0%
Mother and unknown perpetrator	1%	2%
Mother and mother's boyfriend	1%	0%
Maternal grandmother	1%	2%
Other family member	2%	0%
Mother's boyfriend only	1%	2%
Mother, father, and maternal grandmother	1%	0%
Unknown perpetrator	1%	0%
Home Visitor Made Report to DCF	12%	17%
Domestic Violence Involved in Report	22%	32%
Drugs Involved in Report	16%	29%
Alcohol Involved in Report	2%	2%
Parent has Mental Illness or Cognitive Deficit	30%	32%
Child has Mental Illness or Cognitive Deficit	1%	7%
Average Length of Time in Program When Report Occurred	12 months	15 months

As shown below in Table 51, physical neglect was by far the most prevalent type of maltreatment that occurred, accounting for an even higher rate of substantiated cases than last year (95% vs. 73%). According to the Connecticut Department of Children and Families, physical neglect is defined as “the failure to provide adequate shelter, food, clothing, or supervision which is appropriate to the climatic and environmental conditions. Physical neglect may also include leaving a child alone for an excessive

amount of time given the child’s age and cognitive abilities and holding the child responsible for the care of siblings or others beyond the child’s ability.”

Table 51. Types and Frequency of Child Maltreatment

	All Reports (N=146)	Substantiated Reports Only (N=41)
Physical neglect	85%	95%
Emotional neglect	27%	17%
Physical abuse	12%	10%
Sexual abuse	2%	2%
Medical neglect	2%	2%
Moral neglect	1%	0%
Emotional abuse	2%	5%

*Can be more than one type of maltreatment per report

For each investigation of child abuse or neglect, DCF identifies the type of maltreatment from a set of criteria used to characterize the incident. These characteristics provide a more detailed understanding of the incident. There were 134 characteristics identified for the 41 substantiated cases among the NFN population. Examining these data for physical neglect, we noted that, by far, the most common characteristic identified was inadequate supervision, which accounted for 21 percent of all identified characteristics. Typically, these cases involved mothers not providing enough direct supervision to their children or leaving the children in the care of others who were not properly equipped to watch the children. The following are examples of substantiated physical neglect from this year’s data.

- The mother of the baby lived with her mother and had recently started using crack cocaine. One night, she left the house at 9:30 p.m. without telling anybody, stole some money from her mother, took their car and didn’t come home until early the next morning. She didn’t tell anybody she was leaving, so essentially she left the baby unattended, although he was sleeping the whole time.
- A police officer called in this report for physical neglect against the mother and father, who had an altercation. The father threw the phone book at the mother, threw the phone book through the window, and then spit in her face. The 2-year-old child was present at the time of this argument. The father was arrested. A protection order was granted requiring him to leave the premises. The next morning the mother said she wanted the protection order lifted and the father came back into the house. Both mother and father were already participating in counseling, separately and together. The case was substantiated against both parents for physical neglect.

- This case involved an allegation of physical neglect against the mother of the baby. She had gone to CVS pharmacy with her child, who was 2 at the time, and a friend. The mother and her friend went in to pick up some pictures and they left the 2-year-old sleeping in the unlocked car. Somebody saw the child alone in the car and called the police. It took the police at least 20 minutes to find the mother in the store, so it appeared that the child was in the car for a substantial amount of time. The mother was arrested and was substantiated for physical neglect.

There were four cases of substantiated physical abuse and one case of sexual abuse among families we assessed this year, but because we included reports at any time during their participation in the program, two of the physical abuse cases and the sexual abuse case were described in last year's report.

The following are summaries of the two new physical abuse cases that occurred during the 2006 calendar year.

- The first is a case in which the father of the target child (almost 2 years old) was substantiated for physical abuse, emotional abuse, physical neglect and emotional neglect. The father was home alone with the child and somehow the child was burned. The father said that he was cooking macaroni and cheese and the pot fell off the stove and that the water splashed on the child. The doctors at the hospital said that the child's injuries were not consistent with the father's story. The child had second-degree burns on his feet and ankles and first-degree burns from the chest down to the ankles. They said it appeared that the child's feet and ankles had been submerged in water. The father was subsequently arrested and charged with assault in the first degree, cruelty to a person, risk of injury to a minor, and providing a false statement. The child was eventually returned to the mother, under the conditions that the father was to have no contact with the mother or the child.
- In the second case, the mother was substantiated for physical abuse and emotional abuse. The child, who was 3-years-old at the time, got into the diaper rash lotion and smeared it all over himself. The mother reported that she lost control, kicked him in the butt and smacked him in the face. The same day she had also threatened to commit suicide. It's not clear whether or not she went to the hospital voluntarily, but she checked into the hospital for her mental health issues. She has depression and ADHD, both of which were untreated at the time.

Data on child abuse and neglect rates this year are encouraging. We continue to see a decline in reports made and substantiated on NFN families, and the overall state rate is comparable to and in some cases better than similar populations receiving home visiting services across the country. As before, we see that substance abuse, domestic violence, and poor mental health are common themes among NFN families reported to DCF, and

commend program leaders and staff for developing tighter program regulations and practices around these issues through their “Families with Acute Problems” policy.

NFN Staff Survey

Between October and December 2006, we surveyed all NFN home visiting program staff across the state. The program has grown considerably in the past few years, so acquiring information on staff social-demographic characteristics, basic employment information, satisfaction with their jobs, perceptions of the program, and self-assessments of their effectiveness seemed prudent. The data are presented by three levels of staffing – home visitors, clinical supervisors, and program managers. Since many of the program managers throughout the state are also supervisors, those performing dual roles are included in our supervisor category; whereas, staff serving as solely managers are included in the program manager category. Eighty-three percent (58) of home visitors, 93 percent (27) of supervisors or manager-supervisors, and 68 percent (13) of program managers responded to our survey.

Social-Demographic Characteristics

In Table 52, we see that slightly more than one-half of home visitors were Hispanic and, even though most supervisory staff were white, 42 percent of program managers and 20 percent of supervisors were also Hispanic.¹⁵ Surprisingly there was not much variation in median age between staff levels.

Table 52. Racial and Ethnic Characteristics and Median Age by Staff Position

	White	African American	Hispanic	Median Age
Program Managers	50%	8%	42%	46 years
Clinical Supervisors	60%	8%	20%	39 years
Home Visitors	25%	21%	52%	38 years

All but 14 percent of home visitors and 23 percent of supervisors were parents themselves, and many had been single parents at some point in their lives, including nearly two-thirds of home visitors.

¹⁵ Note that 17% of staff refused to report their race and ethnicity, including 14 home visitors, 2 supervisors and 1 program manager.

Table 53. Family Data by Staff Position

	Ever Received Public Assistance	Staff that Are Parents	Single Parents At Any Time	Mean Number of Children	Median Age Staff Had First Child	Median Age
Program Manager	15%	100%	23%	2	24 years	46 years
Clinical Supervisor	19%	77%	40%	2	29 years	39 years
Home Visitor	38%	86%	62%	2	23 years	38 years

As expected, educational achievement varied by position, with 92 percent of clinical supervisors and 77 percent of managers holding graduate college degrees (see Table 54 below). Among home visitors, over one-half had completed at least a bachelor’s degree, while 14 percent had an associate’s degree and another 24 percent had taken some college courses.

Table 54. Education Achievement and Work-Related Experience by Staff Position

	GED or High School Diploma	Associate’s Degree	Bachelor’s Degree	Graduate Degree	Previous Related Job Experience
Program Manager	0%	0%	23%	77%	92%
Clinical Supervisor	4%	0%	4%	92%	96%
Home Visitor	30%	14%	48%	8%	71%

Employment Information

Median gross income, reported in Table 55, for home visitors was \$565 per week, which translated into an annual salary of just under \$30,000. Supervisor gross weekly pay was \$865 and managers’ \$945.¹⁶ As we will see in the next table, only 27 percent of home visitors indicated that they were satisfied with their income (compared to 41% of supervisors and 75% of managers).

Because we included the eight newer Hartford sites in our calculations of time in positions and at the agency, these data do not adequately reflect the longevity of statewide staff.¹⁷ For instance, removing the new Hartford sites from our calculations, median time in position increased from 2 to 4 years for home visitors, but less dramatically for the other two groups.

¹⁶ This was another question that many staff refused to answer, including 20 home visitors, 10 supervisors and 6 program managers, or 37% of total respondents.

¹⁷ The same was true of income, even though the variations were not very substantial. For instance, median weekly income for home visitors in Hartford was \$531, compared to \$578 for all other statewide sites.

Table 55. Median Employment Statistics by Staff Position

	Gross Weekly Income	Length of Time In Position	Length of Time At Agency	Weekly Hours Worked At Agency	Weekly Hours Worked For NFN
Program Manager	\$945	3.0 years	4.1 years	40 hours	16.0 hours
Clinical Supervisor	\$865	1.1 years	2.1 years	37.5 hours	35.0 hours
Home Visitor	\$565	2.0 years	2.0 years	36.3 hours	35.0 hours

Job Satisfaction

We asked staff to rate their satisfaction on a range of job-related factors, using a 5-point Likert scale with response categories ranging from “Very Satisfied” to “Very Dissatisfied.” For our purposes here, we combined the first two responses – “Very Satisfied” and “Satisfied” – to each item and reported these calculations below as our definition of being satisfied. For a complete report of these data, see Appendix D.

As reported in Table 56, overall job satisfaction was high, ranging from 70 to 100 percent across the three groups. All three also indicated high rates of satisfaction in their relationships with families and with one another, and in their development of professional skills and knowledge on the job.

Table 56. Self-Reported Job Satisfaction By Staff Position

	Home Visitor	Supervisor	Program Manager
Overall satisfaction	70%	84%	100%
Income level	27%	41%	75%
# Hours worked per week	86%	88%	58%
Amount of paperwork required	38%	56%	58%
Opportunities for job advancement	34%	N/A	N/A
Amount of training received	81%	78%	85%
Relationship with program manager	83%	74%	N/A
Relationship with supervisor	90%	N/A	93%
Relationship with other home visitors	95%	N/A	N/A
Relationship with FAW	N/A	82%	100%
Relationship with home visitors	N/A	92%	93%
Relationship with families	97%	89%	N/A
Development of professional skills/knowledge	95%	71%	88%
Personal safety while on the job	69%	69%	N/A
Amount of paperwork required by Univ of Hartford	38%	67%	75%
Usefulness of Univ of Hartford evaluations	43%	62%	88%

Lower rates of satisfaction were reported by home visitors on income, opportunities for career advancement, the amount of required paperwork, and the usefulness of the evaluation. Supervisors also recorded lower satisfaction with income and the amount of paperwork, but less so than home visitors, while managers reported lower satisfaction with hours worked per week and paperwork, even though satisfaction for both of these items was high compared to the other two groups.

NFN Training and Program Materials

Program staff and participants are racially and ethnically diverse, raising important challenges to training protocols and the selection of program curricula. First, we asked staff to assess on a scale 1 to 10, how adequately they felt the core NFN training had prepared them for their jobs. Mean scores increased by job status, as reported in Table 57.

Table 57. Mean Score Rating the Adequacy of NFN Core Training By Staff Position (Scale 1-10)

	Home Visitor	Clinical Supervisor	Program Manager
How adequately did the NFN core training prepare you for your job	6.6	7.7	7.8

As shown in Table 58, the ratings on the cultural appropriateness of program trainings and materials were generally high. As before, these items were based on a 5-point Likert scale, ranging from “Extremely Appropriate” to “Very Inappropriate,” and we combined the first two categories to define “appropriate” in Table 58. Still, because there was less satisfaction on the last item about the cultural appropriateness of program materials, we looked more closely at these data by the racial and ethnic characteristics of staff, irrespective of their staff position, and reported the full range of data in Table 59.

Table 58. Satisfaction with Program Training and Materials By Staff Position

	Home Visitor	Clinical Supervisor	Program Manager
How well do you understand the NFN Model	71%	85%	92%
How well do you feel staff are trained to effectively address the cultural characteristics of families in the program.	56%	63%	85%
How culturally appropriate do you feel the program materials are	51%	48%	69%

As we see, only one staff member considered the materials rarely appropriate, but there was nevertheless variation in responses, with no African Americans and only one Hispanic staff member considering the materials “Extremely Appropriate” compared to 22 percent of white staff. Also, the data show that three-quarters of African American

staff considered the materials only “Somewhat Appropriate.” The fact that few staff found the program materials culturally inappropriate suggests the program has addressed these challenges well, still the variation in responses across racial and ethnic staff underscores the importance of keeping this issue open to communication and future assessment.

Table 59. Cultural Appropriateness of Program Materials by Racial and Ethnic Characteristics of Staff

	White	African American	Hispanic
Extremely appropriate	22%	0%	3%
Appropriate	47%	25%	52%
Somewhat appropriate	31%	75%	42%
Rarely appropriate	0%	0%	3%
Very inappropriate	0%	0%	0%

The Paraprofessional Model

NFN is based on a paraprofessional home visitation model. While the definition of the paraprofessional does vary, generally, it refers to a home visitor who shares cultural characteristics with families, often lives in the same community, is able to connect with families in a more relaxed non-professional manner, and is not likely to have received a college education, or at least not a specialized college education that would have prepared them for working with vulnerable families.

When we asked program managers to assess their satisfaction with and their commitment to the paraprofessional model based on their experiences, they demonstrated a high degree of support for the model, even though there was variation between being very and somewhat committed and satisfied (see Table 60 below).

Table 60. Program Manager Attitudes Towards Paraprofessional Program Model

	Very Satisfied or Committed	Satisfied or Committed	Somewhat Satisfied or Committed	Rarely Satisfaction/Committed and Not Satisfied At All or Not Committed
Satisfaction with paraprofessional model	31%	31%	39%	0%
Commitment to paraprofessional model	46%	23%	31%	0%

A common criticism made of paraprofessional home visitors is that because they have similar living circumstances or similar histories as family members, they tend to value the parts of their job that address family crises and conflicts over parts of their job that require educational or technical skills and knowledge, like teaching a parenting curriculum or making referrals in the community. We asked home visitors to rank-order a

list of program activities that indicated the tasks they spent the most time doing with their families. The results, shown in Table 61, demonstrate that NFN home visitors spent most of their time teaching parenting skills, followed by assisting family members to be self-sufficient and linking parents to community services.

Table 61. Rank Ordered Program Activities Home Visitors Spend The Most Time Doing

1. Teaching parenting Skills
2. Assisting families in becoming self sufficient
3. Linking families to other community services
4. Resolving family crises and conflicts
5. Connecting families to medical services

Addressing family crises and conflicts, which is no doubt an important part of their jobs, was nonetheless ranked fourth out of the five tasks and, therefore, does not seem to be taking up the majority of their time. We also analyzed this question by home visitor educational level, dividing home visitors into three groups, those with a GED or high school diploma only, those with an associate’s degree, and those with at least a bachelor’s degree (see Table 62). While there was some variation on the ranking of the 2nd and 3rd items, all three groups listed resolving family crises as their 4th item. These data challenge this particular criticism of paraprofessionals.

Table 62. Rank Ordered Program Activities Home Visitors Spend The Most Time Doing By Education Level

	High School Diploma or GED	Associate’s Degree	Bachelor’s Degree
Teaching parenting skills	1	1	1
Assisting families in becoming self sufficient	3	2	3
Linking families to other community services	2	2	2
Resolving family crises and conflicts	4	4	4
Connecting families to medical services	5	4	5

We also asked supervisors and managers to assess the effectiveness of home visitors on several factors, listed in Table 63. The answers to these items were given using a 5-point Likert scale, with categories ranging from “Very Effective” to “Very Ineffective.” Again we collapsed the first two categories and reported them in the table (For a full account of these data, see Appendix D). As we see, these ratings were very high across all items and both groups.

Table 63. Assessment of Home Visitor Effectiveness By Supervisory Staff Level

	Supervisors	Program Managers
Worker reliability	78%	93%
Ability to identify problems in the home	95%	85%
Communication with families	91%	100%
Communication with supervisory staff	91%	93%
Motivation to learn new skills	64%	77%
Ability to establish boundaries with families	72%	77%
Willingness to use program curricula	86%	92%
Ability to develop relationships with families	96%	93%

We also asked home visitors to assess themselves on a range of job responsibilities (see Table 64 below). For this variable we report the full range of data on the 5-point scale to illustrate the variation in home visitors’ self-assessments of their work. Overall, home visitors felt that their expertise was most evident in providing parenting skills and in building relationships with families. Interestingly, given the earlier discussion, only 27 percent considered themselves very effective in resolving family crises, while 31 percent considered themselves only somewhat effective. Also, only one-third considered themselves very effective in assisting families to become self-sufficient, while one-fourth considered themselves only somewhat effective.

We believe that these responses are important in two respects. First, they are reality checks. Helping families become self-sufficient and resolving family crises will indeed exceed the capacity of a home visitation program in some cases. External barriers to self-sufficiency are sometimes difficult and complex, and beyond the scope of a home visitor, just as family crises can exceed what a home visitor and a mother together can accomplish. Second, and relatedly, these responses shed light on areas where more systemic changes might be necessary for home visitors to effectively meet family needs.

Table 64. Home Visitor Self-Assessment of Effectiveness

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Providing parenting skills	66%	32%	2%	0%	0%
Building relationships with families	64%	32%	4%	0%	0%
Linking families to community services	43%	51%	6%	0%	0%
Connecting families with medical services	38%	49%	11%	2%	0%
Assisting families in becoming self-sufficient	33%	44%	24%	0%	0%
Resolving families crises and conflicts	27%	42%	31%	0%	0%
Building relationships with community providers	19%	49%	32%	0%	0%

Rounding out the home visitors’ self-assessments, only 19 percent considered themselves very effective in building relationships with community providers, while 32 percent considered themselves only somewhat effective. This may be a responsibility that falls

more under the role of supervisory staff, but it may also be an area in which program leaders will want to target more training.

Supervision and Program Management

We have argued in past reports that the supervisor-home visitor relationship is central to program success and that the supervisory role was poorly developed in the original program model.¹⁸ In the past several years, program leaders have increased the educational and clinical training requirements of supervisors and have required that more of the supervisor’s time be devoted to direct clinical supervision of home visitors. As part of this, supervisors are now required to make monthly home visits with their home visitors. As we see in Table 65, most were doing so, even though 32 percent were still falling short of this expectation. Still, as reported in Table 66, supervisors were considered by their home visitors as very accessible and very helpful.

Table 65. Frequency of Home Visits Made With Supervisor

Weekly	Monthly	Every 3 Months	Twice a Year	Never
2%	67%	24%	4%	4%

Table 66. Home Visitors’ Assessments of Supervisors

	Very Accessible or Helpful	Accessible or Helpful	Somewhat Accessible or Helpful	Rarely Accessible or Helpful	Not Accessible or Helpful
How accessible is your supervisor when you have a concern	83%	14%	3%	0%	0%
How helpful is your supervisor in resolving problems	68%	21%	9%	2%	0%

Program managers’ assessments of supervisors on a range of tasks were also very favorable, with more than 80 percent of managers rating their supervisors as effective or very effective on all items listed in Table 67 below.

¹⁸ See Black, T. & Markson, S.L. (2001) *Healthy Families Connecticut: Process Evaluation of a Home Visitation program to Enhance Positive Parenting and Reduce Child Maltreatment*. and Diehl, S. (2001) *Healthy Families Study Circles project: July 11-October 10, 2001*.

Table 67. Program Managers' Assessments of Clinical Supervisors

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Worker reliability	54%	39%	0%	0%	8%
Communication with the home visitors	54%	39%	0%	0%	8%
Communication with families	39%	54%	0%	0%	8%
Motivation to learn new skills	77%	15%	0%	0%	8%
Ability to clinically supervise home visitors	69%	15%	8%	0%	8%
Ability to develop relationships with families	62%	31%	0%	0%	8%

Finally, we also asked supervisors to assess themselves on a range of job responsibilities. As reported in Table 68, more than 75 percent of supervisors considered their work effective or very effective on all listed items. In short, with the exception of falling somewhat short on making regular monthly home visits, the assessments of clinical supervisors were exceptional across all three groups.

Table 68. Clinical Supervisors' Self-Assessments

	Very Effective	Effective	Somewhat Effective	Often Ineffective
Reviewing families' case files	23%	58%	19%	0%
Performing clinical supervision with home visitors	54%	38%	8%	0%
Performing administrative supervision with home visitors	35%	54%	8%	4%
Doing joint visits with home visitor	26%	52%	19%	4%
Assisting home visitors in dealing with families' crises	67%	26%	7%	0%
Overseeing the completion of paperwork	22%	63%	11%	4%
Completing Kempe assessments	55%	36%	9%	0%

The same is true when we turn the spotlight on program managers. Supervisors appeared quite pleased with their program managers' accessibility and helpfulness (Table 69) and program managers generally gave themselves high effectiveness ratings on virtually all items listed in Table 70. Managers considered themselves most effective in building relationships with community providers and least effective in building relationships with legislators.

Table 69. Clinical Supervisors’ Assessments of Program Managers

	Very Accessible or Helpful	Accessible or Helpful	Somewhat Accessible or Helpful	Rarely Accessible Or Helpful	Not Accessible or Helpful at all
How accessible is your supervisor when you have a concern	59%	27%	14%	0%	0%
How helpful is your supervisor in resolving problems	55%	27%	18%	0%	0%

Table 70. Program Managers’ Self-Assessments

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Reviewing families’ case files	14%	71%	14%	0%	0%
Performing supervision with clinical supervisor	39%	62%	0%	0%	0%
Writing/revising contract with CTF	40%	60%	0%	0%	0%
Writing/revising contract with other funders	33%	55%	11%	0%	0%
Overseeing the completion of paperwork	14%	71%	14%	0%	0%
Building relationships with community providers	62%	15%	15%	8%	0%
Building relationships with legislators	15%	15%	39%	23%	8%

Program Protocols and Technical Assistance

One important role played by the Children’s Trust Fund is to provide ongoing technical assistance to program sites. We asked supervisors and managers how often they utilized technical assistance and how helpful they found it to be. As reported in Table 71, supervisors were much more likely to request technical assistance, but were less likely to find it helpful. While 45 percent of supervisors found the assistance helpful or very helpful, close to one-fifth of supervisors considered it “rarely helpful” (see Table 72 below).

Table 71. Frequency of Requested Technical Assistance From CTF by Supervisory Level

	At least once a month	At least quarterly	At least twice a year	Once a year	Less than once a year
Program Managers	17%	17%	42%	8%	17%
Clinical Supervisors	10%	60%	15%	0%	15%

Table 72. Satisfaction with Technical Assistance by Supervisory Level

	Very Helpful	Helpful	Somewhat Helpful	Rarely Helpful	Not Helpful At All
Program Managers	30%	40%	30%	0%	0%
Clinical Supervisors	9%	36%	36%	18%	0%

In 2003, CTF reorganized communication networks and decision-making practices throughout the state to include all staff in the process. Staff are divided into three regions – the northeast and southwest regions of the state and Hartford. Home visitors in the northeast and southwest meet on a quarterly basis, while the Hartford group meets monthly. Supervisors and program managers inside and outside of Hartford meet every other month with their respective groups. One representative and one alternate are then elected from each group to participate on the program’s policy-making body, the Continuous Quality Improvement (CQI) team. One representative and one alternate from the research team and all CTF staff also participate on CQI, but all groups, including CTF, have only one vote on the committee.

Because all supervisors and managers are expected to attend network meetings, we questioned them about the frequency of their attendance and the usefulness of the meetings. As we see in Table 73, attendance was high among both groups, and while no one found the meetings unhelpful, there was some variation on how helpful the meetings were perceived to be, ranging from very to somewhat helpful.

Table 73. Network Meetings Attendance by Supervisory Level

	Attend Every Meeting	Attend Most Meetings	Attend Some Meetings	Do not Attend Meetings At All
Program Managers	46%	54%	0%	0%
Clinical Supervisors	56%	37%	4%	4%

Table 74. Assistance of Network Meetings by Supervisory Level

	Very Helpful	Helpful	Somewhat Helpful	Rarely Helpful	Not Helpful At All
Program Managers	23%	39%	39%	0%	0%
Clinical Supervisors	20%	35%	45%	0%	0%

The last issue we report on from the survey has to do with the appropriateness of families enrolled in the program. In the past few years, there has been a concern that some of the families entering the program are multi-problem families that are beyond the reach of the program intervention. As we discussed earlier, the program’s “acute policy” was passed at the end of 2005 to address this concern. In Table 75, we report how frequently staff felt that families enrolled in the program were inappropriate for services. Home visitor and supervisor responses were very similar – a little less than one-half of each group found families to be either sometimes or often inappropriate – and these are the staff more likely to be intimately involved in families’ lives.

Table 75. Frequency in Which Families are Viewed as Inappropriate for Home Visiting Services by Staff Position

	Always	Often	Sometimes	Rarely	Never
Home Visitors	0%	11%	32%	50%	7%
Clinical Supervisors	0%	8%	40%	44%	8%
Program Managers	0%	0%	15%	77%	8%

NFN staff surveys indicated that overall job satisfaction was high across all three groups. Higher satisfaction ratings were reported on their relationships with families and with one another, and in their development of professional skills and knowledge on the job. Lower ratings were reported on income and on the amount of paperwork required, and, for home visitors, on opportunities for career advancement.

In self-assessments of effectiveness, home visitors felt that their expertise was most evident in providing parenting skills and in building relationships with families. A smaller percentage considered themselves effective in resolving family crises and in assisting families to become self-sufficient, and they considered themselves least effective in building relationships with community providers. Clinical supervisors’ self-assessments of effectiveness were high across all survey items; however, they did seem to indicate particular strengths in their clinical work with home visitors and in assisting home visitors to solve crises among NFN families. They considered their review of case files and the monthly home visits they conduct jointly with home visitors to be less effective. Program managers considered themselves most effective in building relationships with community providers and least effective in building relationships with legislators.

Staff inter-ratings were also very high, indicating that staff have developed an appreciation for one another's roles within the program.

Overall, program reviews and self-assessments on the staff surveys were quite positive, suggesting that, at present, the NFN program is functioning well, effectively managing cultural differences, and promoting a strong collective identity.

Nurturing Parenting Groups

The Nurturing Parenting Groups make up the third component of the Nurturing Families Network. These groups are based on the Nurturing Program, developed by Stephen Bavolek.¹⁹ All sites that run a Nurturing Connections program, with the exception of St. Francis Hospital, also run Nurturing Parenting Groups. There are varying curricula tailored to different populations, including Birth to Five, Nurturing for Prenatal Families, Nurturing for Parents of Children ages 5-11, and Nurturing for African American Families. Most NFN sites use the Birth to Five or the Nurturing for Prenatal Families curriculum. Groups run for differing lengths of time, but all provide parenting information, support, and an opportunity for parents to learn how to nurture themselves and their children. In most groups, staff also provide meals and/or snacks and a structured program for children. Groups are held in various settings including hospitals, schools, and community centers. In this year's report, we present data on all groups (in the statewide and Hartford sites) that began in 2006.

Social-Demographic Data

Social-demographic characteristics of program participants across all 61 groups are presented in Table 76. Most participants were women, and while they were racially and ethnically diverse, 4 out of 10 were Hispanic. Participants' ages followed a bimodal distribution, with the program drawing heavily from the 16 to 19 age group, but also the over 30 age group. Relatedly, around one-third of participants were employed and a little more than one-third enrolled in school. Seventy percent reported involvement with a partner, although only 24 percent were married.

¹⁹ Bavolek, S.J., McLaughlin, J.A., Comstock, C.M. (1983) *The Nurturing Parenting Programs: A Validated Approach for Reducing Dysfunctional Family Interactions*. Final Report NIMH.

Table 76. Nurturing Parenting Group Family Characteristics

Participant's Gender	N=447
Male	13%
Female	87%
Participant's Age	N=427
Under 16 years	5%
16-19 years	34%
20-22 years	11%
23-25 years	9%
26-30 years	13%
Over 30 years	27%
Mean Age	26 years
Mean Number of Children Participant Has	N=445
	1.2 children
Participant's Race/Ethnicity	N=446
Hispanic	44%
White	32%
African American	15%
Multi-racial	5%
Asian	1%
Other	3%
Language Participant is Most Comfortable Speaking	N=445
English	63%
Spanish	18%
English and Spanish	18%
Other	1%
Participant's Employment Status	N=440
Not employed, not seeking work	35%
Not employed, but seeking work	30%
Employed full-time	16%
Employed part-time	15%
Occasional work or more than one job	4%
Participant Enrolled in School	N=439
No	61%
Yes	39%
High school	23%
College	3%
GED Program	2%
Vocational school	1%
Other type of schooling	9%
Partner's Marital Status	N=434
Single, never married	68%
Married	24%
Separated	3%
Divorced	5%
Widowed	1%

Table 76. Nurturing Parenting Group Family Characteristics (Continued)

Does Participant Have a Partner	N=289
No	30%
Yes	70%
Partner enrolled in group	16%
Mean # of Adults Living in the Household	N=431
	1.8 adults

Program Participation

Nurturing Groups run for differing lengths of time depending on the curriculum used. The longer groups (such as Birth to Five) operate for 24 weeks, while the shortest groups (such as Prenatal) run about nine weeks. In order to present a standardized measure of program participation, we documented how many sessions parents attended in relation to how many sessions were offered. We have attendance data on 365 group participants from 2006. As we see in Table 77, about one-fifth had perfect attendance, which compares favorably to last year (21% v 14%) and around one-half attended at least 75 percent of all sessions offered.

Table 77. Nurturing Group Attendance Rates (N=365)

% of Group Sessions Attended	%
Less than 25%	13%
25%-49%	9%
50%-74%	22%
75%-99%	35%
100%	21%
Mean # of Sessions Attended	9 sessions

Program Outcomes

We employed two different outcome measures for the Nurturing Parenting Groups: The Parenting Stress Index-Short Form (PSI-SF) and the Adult-Adolescent Parenting Inventory 2 (AAPI-2). The PSI-SF, designed to measure parenting and family characteristics that fail to promote normal development and functioning in children, was used for all Nurturing Parenting Groups other than the prenatal groups. The PSI-SF also identifies parents who are at-risk for dysfunctional parenting. Parents completed the PSI-SF during the first and last group sessions.

Scores on each subscale of the PSI-SF range from 12-60, with lower scores indicating more healthy parenting attitudes. Scores on the Total Stress scale range from 36-180. As reported in Table 78, there were statistically significant changes in the desired direction on all scales. In general, these scores indicated that parents were experiencing greater parenting competence and less stress in their parental roles.

Table 78. Parenting Stress Index-Short Form Outcomes (N=88)

	Pre	Post
Parental Distress	31.1	27.1***
Parent-Child Dysfunctional Interaction	23.2	21.0**
Difficult Child	30.2	26.4***
Total Stress	83.5	73.4***

* p>.05 ** p<.01 *** p<.001

The PSI-SF is not appropriate for prenatal groups; therefore, we used the AAPI-2 to assess group outcomes. Statistically significant improvements were recorded, as shown in Table 79, which suggest that, overall, parents displayed healthier parenting attitudes and more age appropriate expectations of their children upon completion of the groups.

Table 79. Adult-Adolescent Parenting Inventory-2 Outcomes (N=429)

	Pre	Post
AAPI-2 Total Score	139.4	149.0***

* p>.05 ** p<.01 *** p<.001

Appendix A: Statewide Exit Data

Attitude of Caregiver at the End of Services (N=354)

Willing, readily accepting	49%
Reluctant, minimally compliant	26%
Unwilling, hostile	4%
Don't know	21%

How Well Did Caregiver Understand the Relationship Between Risk Factors and Their Impact on Their Child's Life? (N=361)

Fully understood relationship	44%
Partially understood relationship	25%
Did not understand relationship	8%
Don't know	23%

How Did Caregiver View the Program Services as Helping Them to Better Care for Their Children? (N=359)

Fully understood value of services	45%
Partially understood value of services	26%
Did not understand value of services	6%
Don't know	23%

How Motivated Was the Caregiver to Address Their Risk Factors? (N=328)

Very motivated	32%
Somewhat motivated	31%
Motivated very little	10%
Not motivated at all	8%
Don't know	20%

To What Extent Did the Family Benefit From Services? (N=357)

Benefited greatly	45%
Benefited somewhat	26%
Benefited very little	10%
Did not benefit at all	5%
Don't know	14%

Appendix B: Statewide CAPI Outcome at Two, Three, and Four Years

Mean Score on the CAPI at Program Entry and Two Years (N=562)

	Program Entry	Two Years
Distress	87.9	64.6***
Rigidity	25.1	16.7***
Unhappiness	15.3	16.1
Problems w/ child & self	1.4	1.6
Problems w/ family	11.4	11.0
Problems from others	11.7	10.5**
Abuse (Total)	151.8	121.8***

* p>.05 ** p<.01 *** p<.001

Mean Score on the CAPI at Program Entry and Three Years (N=310)

	Program Entry	Three Years
Distress	85.6	65.3***
Rigidity	26.0	16.2***
Unhappiness	15.7	17.4
Problems w/ child & self	1.5	1.9
Problems w/ family	10.6	10.2
Problems from others	11.6	10.0**
Abuse (Total)	150.7	121.8***

* p>.05 ** p<.01 *** p<.001

Mean Score on the CAPI at Program Entry and Four Years (N=193)

	Program Entry	Four Years
Distress	85.8	67.7**
Rigidity	27.2	16.7**
Unhappiness	16.1	19.0*
Problems w/ child & self	1.6	2.2*
Problems w/ family	10.4	10.9
Problems from others	11.9	9.7**
Abuse (Total)	151.9	126.8**

* p>.05 ** p<.01 *** p<.001

Appendix C: Statewide Living Circumstances Outcomes at Two, Three, and Four Years

Changes in Living Circumstances between Program Entry and Two Years

	N	Entry	2 Years
Mothers with at least a high school education	653	42%	52%***
Mothers employed	685	17%	51%***
Mothers employed full time	518	8%	29%***
Mothers in school	677	26%	22%*
Mothers with financial difficulties	675	65%	57%***
Mothers socially isolated	669	34%	20%***
Father very/somewhat involved w/ child	572	70%	59%***
Fathers with at least a high school education	390	53%	50%
Fathers employed	452	67%	70%
Fathers in school	448	13%	5%***
Father abuses alcohol	286	13%	15%
Father abuses drugs	292	16%	21%
Fathers with financial difficulties	355	57%	54%
Fathers socially isolated	327	12%	9%
Receiving Medicaid	374	79%	85%*
Mothers living independently	638	53%	82%***
Mother receives TANF	592	37%	32%*
Mothers receiving food stamps	592	37%	44%**
Mothers receiving WIC	590	89%	89%

Changes in Living Circumstances between Program Entry and Three Years

	N	Entry	3 Years
Mothers with at least a high school education	402	40%	55%***
Mothers employed	420	15%	53%***
Mothers employed full time	324	8%	39%***
Mothers in school	417	26%	19%**
Mothers with financial difficulties	417	65%	51%***
Mothers socially isolated	407	34%	17%***
Father very/somewhat involved w/ child	345	72%	59%***
Fathers with at least a high school education	250	46%	52%
Fathers employed	267	67%	72%
Fathers in school	263	14%	6%**
Father abuses alcohol	173	12%	14%
Father abuses drugs	172	15%	21%
Fathers with financial difficulties	203	56%	48%
Fathers socially isolated	188	13%	9%
Receiving Medicaid	209	79%	85%
Mothers living independently	383	56%	79%***
Mother receives TANF	368	37%	26%***
Mothers receiving food stamps	368	38%	47%**
Mothers receiving WIC	306	87%	86%

Changes in Living Circumstances between Program Entry and Four Years

	N	Entry	4 Year
Mothers with at least a high school education	259	38%	53%***
Mothers employed	271	15%	58%***
Mothers employed full time	204	6%	45%***
Mothers in school	266	28%	12%***
Mothers with financial difficulties	266	65%	53%**
Mothers socially isolated	265	35%	18%***
Father very/somewhat involved w/ child	232	72%	58%***
Fathers with at least a high school education	154	49%	50%
Fathers employed	167	71%	70%
Fathers in school	170	11%	3%**
Father abuses alcohol	111	9%	14%
Father abuses drugs	119	14%	21%
Fathers with financial difficulties	132	60%	44%**
Fathers socially isolated	123	11%	11%
Receiving Medicaid	114	82%	86%
Mothers living independently	250	60%	80%***
Mother receives TANF	229	42%	22%***
Mothers receiving food stamps	228	40%	46%
Mothers receiving WIC	227	85%	84%

* p>.05

** p<.01

*** p<.001

Appendix D. Full Staff Survey Results by Position

Home Visitors

Income and Length of Employment

Mean gross weekly income (N=38)	\$576
Mean length of time employed in position (N=55)	3.3 years
Mean length of time employed at agency (N=56)	4.4 years
Mean hours worked at agency (N=58)	35.6
Mean hours worked for NFN (N=56)	35.0

Home Visitor Satisfaction with:

	Very Satisfied	Satisfied	Somewhat Satisfied	Dissatisfied	Very Dissatisfied
Overall satisfaction with job	25%	45%	27%	4%	0%
Income level	3%	24%	40%	21%	12%
The number of hours worked per week	29%	57%	7%	5%	2%
Amount of paperwork required	2%	36%	26%	28%	9%
Opportunities for career advancement	9%	25%	23%	28%	16%
Amount of training received	30%	51%	16%	4%	0%
Relationship with program manager	43%	40%	12%	5%	0%
Relationship with supervisor	51%	39%	9%	2%	0%
Relationship with other home visitors	49%	46%	5%	0%	0%
Relationship with families	66%	31%	3%	0%	0%
Development of professional skills and knowledge	55%	40%	5%	0%	0%
Personal safety while on the job	22%	47%	21%	7%	3%
Amount of paperwork required by UHA	10%	28%	38%	19%	5%
Usefulness of UHA evaluation	14%	29%	35%	19%	3%

Training and the NFN Model

On a Scale of 1 to 10, How Adequately Did the NFN Core Training Prepare You for Your Job? (N=53)	6.6
How Often Do You Receive Additional In-Service Training? (N=52)	
Weekly	8%
Monthly	56%
Every 3 months	27%
Twice a year	8%
Yearly	2%
How Well Do you Understand the NFN model? (N=58)	
Understand very well	71%
Understand somewhat	26%
Understanding is vague	2%
Do not understand at all	2%

Satisfaction with Program Materials

How Well Do You Feel Staff are Trained to Effectively Address the Cultural Characteristics of Families in the Program? (N=58)	
Extremely well trained	16%
Well trained	40%
Adequately trained	36%
Inadequately trained	9%
Very poorly trained	0%
How Culturally Appropriate Do You Feel the Program Materials Are? (N=58)	
Extremely appropriate	10%
Appropriate	41%
Somewhat appropriate	43%
Rarely appropriate	5%
Very inappropriate	0%

Frequency of and Satisfaction with Supervision

How Often Does Your Supervisor Accompany You on a Home Visit? (N=55)	
Weekly	2%
Monthly	67%
Every 3 months	24%
Twice a year	4%
Never	4%
How Accessible is Your Supervisor When You Have a Concern? (N=58)	
Very accessible	83%
Accessible	14%
Somewhat accessible	3%
Rarely accessible	0%
Not accessible at all	0%
How Helpful is Your Supervisor in Resolving Problems? (N=56)	
Very helpful	68%
Helpful	21%
Somewhat helpful	9%
Rarely helpful	2%
Not helpful at all	0%
Are There Aspects of Your Supervision That You Would Like to Change? (N=57)	
No	88%
Yes	14%

Home Visitor Activities

Are There Regular Opportunities for You to Discuss Job Related Problems and Concerns with Other Home Visitors? (N=43)	
No	14%
Yes	86%
If Yes, How Helpful are the Other Home Visitors in Working With You to Resolve Job Related Problems/Concerns? (N=38)	
Very helpful	40%
Helpful	40%
Somewhat helpful	21%
Rarely helpful	0%
Not helpful at all	0%
Home Visitor Rank Order Assessment of the Activities They Spend the Most Time On: (N=45)	
1. Teaching parenting skills	
2. Assisting families in becoming self-sufficient	
3. Linking families to other community services	
4. Resolving family crises and conflicts	
5. Connecting families to medical services	
Home Visitor Rank Order Assessment of Age Groups of Mothers They Feel Most Effective Working With (N=45)	
20-25 years old	
17-19 years	
26 years and older	
16 years and younger	
How Often Do You Feel a Family is Too High-Risk for NFN Services? (N=56)	
Often	11%
Rarely	32%
Sometimes	50%
Never	7%

Home Visitor Self-Assessment of Effectiveness in: (N=47)

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Providing parenting skills	66%	32%	2%	0%	0%
Building relationships with families	64%	32%	4%	0%	0%
Linking families to community services	43%	51%	6%	0%	0%
Connecting families with medical services	38%	49%	11%	2%	0%
Assisting families in becoming self-sufficient	33%	44%	24%	0%	0%
Resolving families crises and conflicts	27%	42%	31%	0%	0%
Building relationships with community providers	19%	49%	32%	0%	0%

Home Visitor Demographics

Mean Age (N=38)	37 years
Median Age (N=38)	38 years
Race/Ethnicity (N=44)	
Hispanic	52%
White	25%
African American	21%
South American/Brazilian	2%
Other Languages Spoken Fluently (N=49)	
Spanish	51%
Other	4%
None	45%
Home Visitor is a Mother (N=49)	86%
Mean # of Children (N=41)	2 children
Mean Age When Home Visitor Had First Child (N=40)	23 years old
Home Visitor Ever a Single Mother? (N=42)	62%
Highest Level of Education (N=50)	
GED	4%
High school diploma	2%
Some college	24%
2 year Associate's degree	14%
4 year Bachelor's degree	32%
Some graduate courses	16%
Graduate degree	8%
Had Previous Job Experienced Related to Home Visiting (N=49)	71%
Ever Received Public Assistance (N=45)	38%

Supervisor Staff Survey Results- N=27

Income and Length of Employment

Mean gross weekly income (N=17)	\$877
Mean length of time employed in position (N=23)	3.0 years
Mean length of time employed at agency (N=23)	5.3 years
Mean hours worked at agency (N=23)	36.8
Mean hours worked for NFN (N=23)	34.9

Supervisor Satisfaction with:

	Very Satisfied	Satisfied	Somewhat Satisfied	Dissatisfied	Very Dissatisfied
Overall satisfaction with job	28%	56%	12%	4%	0%
Income level	22%	19%	33%	22%	4%
The number of hours worked per week	42%	46%	12%	0%	0%
Amount of paperwork required	15%	41%	19%	26%	0%
Amount of training received	41%	37%	22%	0%	0%
Relationship with program manager	37%	37%	21%	5%	0%
Relationship with FAW	53%	29%	18%	0%	0%
Relationship with Home Visitors	46%	46%	8%	0%	0%
Relationship with families	48%	41%	11%	0%	0%
Development of professional skills and knowledge	15%	56%	19%	7%	4%
Personal safety while on the job	27%	42%	23%	4%	4%
Amount of paperwork required by UHA	15%	52%	22%	11%	0%
Usefulness of UHA evaluation	27%	35%	27%	12%	0%

Training and the NFN Model

On a Scale of 1 to 10, How Adequately Did the NFN Core Training Prepare You For Your Job? (N=22)	7.7
How Often Do You Receive Additional In-Service Training? (N=24)	
Weekly	0%
Monthly	42%
Every 3 months	46%
Twice a year	8%
Yearly	4%
How Well do you Understand the NFN Model? (N=26)	
Understand very well	85%
Understand somewhat	15%
Understanding is vague	0%
Do not understand at all	0%

Satisfaction with Program Materials

How Well Do You Feel Staff are Trained to Effectively Address the Cultural Characteristics of Families in the Program? (N=27)	
Extremely well trained	26%
Well trained	37%
Adequately trained	30%
Inadequately trained	9%
Very poorly trained	0%
How Culturally Appropriate Do You Feel the Program Materials Are? (N=58)	
Extremely appropriate	10%
Appropriate	41%
Somewhat appropriate	43%
Rarely appropriate	5%
Very inappropriate	0%

Frequency of and Satisfaction with Supervision

How Accessible is Your Supervisor When You Have a Concern? (N=22)	
Very accessible	59%
Accessible	27%
Somewhat accessible	14%
Rarely accessible	0%
Not accessible at all	0%
How Helpful is Your Supervisor in Resolving Problems? (N=22)	
Very helpful	55%
Helpful	27%
Somewhat helpful	18%
Rarely helpful	0%
Not helpful at all	0%

Technical Assistance and Appropriateness of Families

How Often Do You Attend Supervisor Network Meetings (N=27)	
Attend every meeting	56%
Attend most meetings	37%
Attend some meetings	4%
Do not attend meetings at all	4%
How Helpful are the Network Meetings (N=20)	
Very helpful	20%
Helpful	35%
Somewhat helpful	45%
Rarely helpful	0%
Not helpful at all	0%
How Often Do You Seek Technical Assistance From CTF? (N=20)	
At least once a month	10%
At least quarterly	60%
At least twice a year	15%
Once a year	0%
Less than once a year	15%
How Helpful is Technical Assistance From CTF? (N=22)	
Very helpful	9%
Helpful	36%
Somewhat helpful	36%
Rarely helpful	18%
Not helpful at all	0%
How Often Do You Feel a Family is Too High-Risk for NFN Services? (N=25)	
Always	0%
Often	8%
Sometimes	44%
Rarely	40%
Never	8%

Assessment of Own Effectiveness in: (with not applicable responses removed)

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Reviewing families' case files	23%	58%	19%	0%	0%
Performing clinical supervision with home visitors	54%	38%	8%	0%	0%
Performing administrative supervision with home visitors	35%	54%	8%	4%	0%
Doing joint visits with home visitors	26%	52%	19%	4%	0%
Assisting home visitors in dealing with families' crises	67%	26%	7%	0%	0%
Overseeing the completion of paperwork	22%	63%	11%	4%	0%
Completing Kempe assessments	55%	36%	9%	0%	0%
Building relationships with community providers	33%	56%	7%	4%	0%

Mean Number of Hours Supervisors Spend per Week Doing the Following (N=21)

Compiling and reviewing paperwork	5.5
Reviewing families' case files	3.7
Consulting with your program manager	2.2
Performing individual supervision with home visitors	7.2
Building/maintaining relationships with community providers	2.8
Non NFN related work	2.4
Other	6.8

Supervisor Assessment of Home Visitor Effectiveness in: (N=23)

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Worker reliability	39%	39%	22%	0%	0%
Ability to identify problems in the home	30%	65%	4%	0%	0%
Communication with the families	26%	65%	4%	4%	0%
Communication with supervisory staff	36%	55%	5%	5%	0%
Motivation to learn new skills	32%	32%	32%	5%	0%
Ability to establish boundaries with families	29%	43%	29%	0%	0%
Willingness to use program curricula	41%	45%	14%	0%	0%
Ability to develop relationships with families	52%	44%	4%	0%	0%

Supervisor Demographics

Mean Age (N=22)	40 years
Median Age (N=22)	39 years
Race/Ethnicity (N=25)	
Hispanic	20%
White	60%
African American	8%
Jamaican	8%
Multi-racial	4%
Other Languages Spoken Fluently (N=25)	
Spanish	24%
Other	12%
None	64%
Supervisor is a Parent (N=26)	77%
Mean # of Children (N=20)	2 children
Mean Age When Supervisor Had First Child (N=19)	29 years old
Supervisor Ever a Single Parent? (N=20)	40%
Highest Level of Education (N=26)	
GED	0%
High school diploma	0%
Some college	4%
2 year Associate's degree	0%
4 year Bachelor's degree	0%
Some graduate courses	4%
Graduate degree	92%
Had Previous Job Experienced Related to Clinical Supervision (N=25)	96%
Ever Received Public Assistance (N=26)	19%

Program Manager Staff Survey Results N=13

Income and Length of Employment

Mean gross weekly income (N=7)	\$945
Mean length of time employed in position (N=23)	3.1 years
Mean length of time employed at agency (N=23)	6.2 years
Mean hours worked at agency (N=23)	37.1
Mean hours worked for NFN (N=23)	16.6

Program Manager Satisfaction with:

	Very Satisfied	Satisfied	Somewhat Satisfied	Dissatisfied	Very Dissatisfied
Overall satisfaction with job	46%	54%	0%	0%	0%
Income level	33%	42%	8%	17%	0%
The number of hours worked per week	25%	33%	25%	17%	0%
Amount of paperwork required	8%	50%	17%	25%	0%
Amount of training received	39%	46%	15%	0%	0%
Relationship with supervisor	85%	8%	8%	0%	0%
Relationship with FAW	75%	25%	0%	0%	0%
Relationship with home visitors	62%	31%	8%	0%	0%
Development of professional skills and knowledge	50%	33%	8%	8%	0%
Amount of paperwork required by UHA	17%	58%	25%	0%	0%
Usefulness of UHA evaluation	33%	50%	8%	8%	0%

Training and the NFN Model

On a Scale of 1 to 10, How Adequately Did the NFN Core Training Prepare You for Your Job? (N=11)	7.8
How Well Do You Understand the NFN Model? (N=13)	
Understand very well	92%
Understand somewhat	8%
Understanding is vague	0%
Do not understand at all	0%

Satisfaction with Program Materials and Program Model

How Well Do You Feel Staff are Trained to Effectively Address the Cultural Characteristics of Families in the Program? (N=13)	
Extremely well trained	23%
Well trained	62%
Adequately trained	15%
Inadequately trained	0%
Very poorly trained	0%
How Culturally Appropriate do you Feel the Program Materials Are? (N=13)	
Extremely appropriate	23%
Appropriate	46%
Somewhat appropriate	31%
Rarely appropriate	0%
Very inappropriate	0%
How Satisfied Are You With the Paraprofessional Model of Home Visitation? (N=13)	
Very satisfied	31%
Satisfied	31%
Somewhat satisfied	39%
Rarely satisfied	0%
Not satisfied at all	0%
How Committed Are You to the Paraprofessional Model of Home Visitation? (N=13)	
Very committed	46%
Committed	23%
Somewhat committed	31%
Rarely committed	0%
Not committed at all	0%

Technical Assistance and Appropriateness of Families

How Often Do You Attend Program Manager Network Meetings (N=13)	
Attend every meeting	46%
Attend most meetings	54%
Attend some meetings	0%
Do not attend meetings at all	0%
How Helpful are the Network Meetings (N=13)	
Very helpful	23%
Helpful	39%
Somewhat helpful	39%
Rarely helpful	0%
Not helpful at all	0%
How Often Do You Seek Technical Assistance From CTF? (N=12)	
At least once a month	17%
At least quarterly	17%
At least twice a year	42%
Once a year	8%
Less than once a year	17%
How Helpful is Technical Assistance From CTF? (N=10)	
Very helpful	30%
Helpful	40%
Somewhat helpful	30%
Rarely helpful	0%
Not helpful at all	0%
How Often Do You Feel a Family is Too High-Risk for NFN Services? (N=13)	
Always	0%
Often	0%
Sometimes	15%
Rarely	77%
Never	8%

Assessment of Own Effectiveness in: (with not applicable responses removed)

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Reviewing families' case files	14%	71%	14%	0%	0%
Performing supervision with clinical supervisor	39%	62%	0%	0%	0%
Performing administrative supervision with home visitors	22%	67%	11%	0%	0%
Writing/revising contract with CTF	40%	60%	0%	0%	0%
Writing/revising contract with other funders	33%	56%	11%	0%	0%
Overseeing the completion of paperwork	14%	71%	14%	4%	0%
Building relationships with community providers	62%	15%	15%	8%	0%
Building relationships with legislators	15%	15%	39%	23%	8%

Program Manager Assessment of Home Visitor Effectiveness in: (N=13)

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Worker reliability	39%	54%	0%	8%	0%
Ability to identify problems in the home	31%	54%	15%	0%	0%
Communication with the families	31%	69%	0%	0%	0%
Communication with supervisory staff	54%	39%	8%	0%	0%
Motivation to learn new skills	46%	31%	23%	0%	0%
Ability to establish boundaries with families	23%	54%	23%	0%	0%
Willingness to use program curricula	46%	46%	8%	0%	0%
Ability to develop relationships with families	62%	31%	8%	0%	0%

Program Manager Assessment of Supervisor Effectiveness in: (N=13)

	Very Effective	Effective	Somewhat Effective	Often Ineffective	Very Ineffective
Worker reliability	54%	39%	0%	0%	8%
Communication with the home visitors	54%	39%	0%	0%	8%
Communication with the families	39%	54%	0%	0%	8%
Motivation to learn new skills	77%	15%	0%	0%	8%
Ability to provide clinical supervision to home visitors	69%	15%	8%	0%	8%
Ability to develop relationships with families	62%	31%	0%	0%	8%

Program Manager Demographics

Mean Age (N=12)	44 years
Median Age (N=12)	46 years
Race/Ethnicity (N=12)	
Hispanic	42%
White	50%
African American	8%
Other Languages Spoken Fluently (N=12)	
Spanish	50%
Other	0%
None	50%
Program Manager is a Parent (N=13)	100%
Mean # of Children (N=13)	2 children
Mean Age When Program Manager Had First Child (N=13)	24 years old
Program Manager Ever a Single Mother? (N=13)	23%
Highest Level of Education (N=13)	
GED	0%
High school diploma	0%
Some college	0%
2 year Associate's degree	0%
4 year Bachelor's degree	0%
Some graduate courses	23%
Graduate degree	77%
Had Previous Job Experienced Related to Program Management (N=13)	96%
Ever Received Public Assistance (N=13)	15%

