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Commentary

Building a statewide home visiting program from 2 to 42 sites: A state agency's perspective

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Introduction

In 1995, based on emerging research across the US and a tragic case in Connecticut (Gomby, Larson, Lewit, & Behrman, 1993; Kauffman, 1996; Tuohy, 1992; Office of the Child Advocate, 2001) that highlighted the need to prevent child abuse, the Connecticut Children's Trust Fund, now a division of the State's Department of Social Services, launched a major initiative to develop a universal home visiting program throughout the state. Through the home visiting program the Trust Fund sought to identify at-risk parents and provide them with effective services. The goal of these services was to address the risk factors that made parents vulnerable to child abuse and neglect and, ultimately, to reduce the number of children substantiated by the child welfare system as abused or neglected.

Although much has been written about home visiting programs (Donelan-McCall, Eckenrode, & Olds, 2009; Howard & Brooks-Gunn, 2009; Leventhal, 2005; MacMillan et al., 2009), little has been written about the perspectives of state agencies that fund and direct such programs. The purpose of this commentary, therefore, is to describe the Trust Fund's strategy to develop the statewide program and describe how it was expanded from 2 to 42 sites. Chief among these strategies were efforts to gain the support of the state legislature, to develop a partnership with academic centers that would conduct carefully designed research to provide data and feedback to inform and refine practices as the program developed, and to put in place an infrastructure to ensure an effective program model that could be adapted based on advances in the field and findings from the Trust Fund's research in Connecticut.

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Building legislative support

The Trust Fund sought to build legislative support for a statewide, comprehensive, state-of-the-art home visiting program. The Trust Fund recognized the need to educate state legislators to ensure that funding would be provided, increased, and sustained. To do this the Trust Fund sought the support of influential legislators on key committees. In 1995, the Trust Fund introduced the legislators and other state policy makers to leaders working in the field of home visiting. The group was briefed on the concept of home visiting, the need for the prevention program, and the results. Policy makers said they were impressed and encouraged by what they heard.

With the support of legislators, the Trust Fund secured funding for the first 2 home visiting sites. At this time, the state legislature passed Sec. 17a-56 of the Connecticut state statutes (17a-65, Establishing Nurturing Families Network) that charged the Children's Trust Fund with establishing "the structure for a state-wide system" for a home visiting program. In addition, the legislation required the Trust Fund to develop a training program, standards, and protocols for the statewide system. It also called for a data system to document the impact of the program, including the incidence of child abuse and neglect, risk profiles, and demographics of the families participating in the program.

Key to the Trust Fund's legislative strategy was linking a program site to each of the state's 29 birthing hospitals. This strategy allowed for the possibility that vulnerable mothers giving birth anywhere in the state would have access to the home visiting services, that home visiting services would become a standard of care at all of the state's birthing hospitals, and that there would be a broad base of legislative support from throughout the state for this effort. The Trust Fund worked to educate legislators about the impact of abuse on children, the difference between prevention and protection, and the benefits of home visiting, which were documented in national literature and in our own research (for example, Damboise, Hughes, & Black, 2009).

Over the next several years, the Trust Fund provided testimony on legislative bills to expand the home visiting program, held briefings at the state capitol, published newsletters, and circulated evaluation findings on the successful outcomes of the program. The Trust Fund also held community forums about the program. Community leaders who were interested in the program were encouraged to talk with their local hospital administrators and legislators about obtaining state funding for it. Community leaders held breakfasts for legislators, participated in "Legislative Day" events at the capitol, and encouraged local supporters and the families participating in the program to advocate for continued and expanded funding. In addition to these activities, advisory committees were established at the program sites. The committees included influential members of the community who met with legislators, testified at hearings, and increased the profile of the home visiting program.

Through these efforts the Trust Fund's budget for home visiting grew from $300,000 for 2 sites in 1996 to roughly $10 million for 42 sites over the next decade. Today the program provides services in the catchment area of all 29 birthing hospitals with expanded programs in 2 urban areas, Hartford and New Haven. In 2008, 8,499 first-time mothers were screened at these hospitals, and 1,716 families received regular home visiting services from 125 home visitors (Damboise et al., 2009).

Research and evaluation

From the beginning the Trust Fund understood the importance of examining program practices and implementation efforts. While many program developers were focused on randomized control trials, the Trust Fund was interested in a wide range of information that could be used to craft a set of best practices and guide the development of the program within the individual sites and within the statewide network of sites.

As the Trust Fund expanded the program across the state, it needed theoretical models as well as outcome data for staff to understand how program goals and policies translated into effective practice in a variety of settings. The staff also needed to understand the ways barriers to successful implementation could be overcome. To administer the program in the "real world" context of large hospitals and small community-based organizations, the Trust Fund needed information about the dynamics of the sites—how they worked and what made them effective. The Trust Fund also needed insight into the families involved with the programs—who they were, why they became involved in the program, and ways in which the service was relevant to their lives.

The need for this type of research has gained recognition among social scientists in the field, particularly as more states have sought to bring programs to scale. As noted by experts in the field such as Lisbeth Schorr, those who design social programs must have at "their fingertips the lessons learned from theory, research and experience enabling them to construct ever stronger hypotheses and evermore effective ways to solve problems" (Schorr & Smyth, 2009). The Trust Fund contracted with the Center for Social Research at the University of Hartford to evaluate the program by focusing on three key domains:

1. Annual data collection to measure program outcomes in areas the program was trying to impact.
2. Ethnographic studies to develop an understanding of home visiting practice, the functioning of the sites, and the families participating in the program.
3. Quality assurance measures to assess individual site performance and the overall performance of the network.

The Trust Fund also contracted with researchers at the Center for the Study of Culture, Health, and Human Development at the University of Connecticut to evaluate its training program for home visitors.

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The Trust Fund and the researchers established regular meetings to discuss and analyze findings. It was not uncommon during these meetings for questions to arise that would lead to further data analysis, discussions with practitioners, and/or the use of new instruments. Often there was agreement between researchers and staff on findings. At other times, however, it was clear that researchers needed more day-to-day experience in the field to develop the solid understanding of the program necessary to interpret study findings. It was a challenge to bring researchers close enough to the practice to do this. To address this need the researchers conducted ethnographic studies in the field, held focus groups with site staff, and interviewed parents participating in the program. The field work helped the researchers to understand more clearly the program from the site perspective and to build relationships and credibility within the network.

In some instances questions were raised by the Trust Fund about the data collection process used by researchers and their subsequent findings. For example, after several discussions with the sites and the researchers, the Trust Fund discovered that a wide range of activity was being reported as a "program offer." The Trust Fund's definition of a "program offer" was a face-to-face conversation with a new parent. Researchers, however, considered a "program offer" to include dropping off packets of information about the program in the hospital room of the mother or mailing informational packets to the mother's home shortly after childbirth. As a result of this misunderstanding, the Trust Fund recognized the need to clearly define the term "offer" and what would be reported under this measure.

Despite these types of challenges, the information collected by the researchers was used to develop a better understanding of the program and to make changes when needed. In one instance, the researchers conducted an ethnographic study of 171 mothers participating in the program and found that the program was working with 4 distinct groups of mothers—each with very different needs (Black, Erdmans, & Dickinson, 2004). Of those in the study, 12% of the mothers had cognitive impairments, 23% of the mothers were between the ages of 13 and 16, and 33% of the mothers were living in ongoing crisis. The fourth group, 32%, was found to be living in some but less distress due to linguistic and social isolation or histories of mental illness and/or substance abuse that were being or had been treated. These findings made it clear that a "one size fits all" approach to services was not appropriate. In response, the program adopted a "case by case" approach to scheduling home visits with families, rather than prescribing a predetermined two or four visits per month for every family. Caseloads were determined by a weekly home visiting schedule based on the needs of the families rather than by visiting a fixed number of families. By using this approach, each home visitor's caseload reflected the number of home visits required for each family.

Policies to address the various circumstances of the families were also developed. These included policies for working with mothers in crisis, working with mothers who were dependent on others, and working with mothers with cognitive delays or other developmental disabilities. The policies provided guidance to program staff working with mothers in these circumstances and created a framework for decision making within the program. The Trust Fund's current research efforts focus on addressing maternal depression in the mother's home and engaging fathers within the current home visiting model.

Developing an infrastructure for effective implementation

The Trust Fund needed to build an organization with and among the sites to address the issues identified by the researchers, interpret data, and inform policy. To do this, the Trust Fund established the Continuous Quality Improvement Team (CQI), which included representatives and alternates from each of 4 regions in the state. The members were elected to represent their staff role and serve on the CQI for 2 years. The team met on a regular basis. It functions as a "mini-Congress" where program implementation questions, problems, and quality assurance issues are addressed.

The CQI team meetings provided a vehicle for thoughtful and consistent discussions between the Trust Fund, researchers, and program administrators, as well as supervisors of the home visiting program and front-line staff. The CQI team gave every staff member a voice. The discussions and subsequent policy recommendations were essential to bringing research and practice together, to developing a collective understanding of the model, and to helping staff adhere to its practices. Discussions with the CQI team helped clarify the philosophy behind intervention strategies and helped illuminate policies and practice standards by considering them within the context of real life situations that needed to be addressed in the field. For example, the CQI team has developed policies and practice standards for the role of the clinical supervisor, staff training and the credentialing of home visitors, and an in-service training model that connects issues and challenges raised in clinical supervision with professional development.

Program staff at all levels had much to contribute to the development of the model, policies, and practice. Through the CQI team, program staff were able to review research findings, evaluate and test policy recommendations, and help make changes to improve practice. This process also enabled the Trust Fund to scrutinize the research findings and to bring new ideas and innovation to the program by keeping it dynamic and responsive to challenges involved in home visiting while maintaining fidelity to critical areas of the program. The Trust Fund staff was responsible for managing the CQI team, chairing the meetings, staffing the sub-committees, drafting the policies, and facilitating the flow of information throughout the network. To implement new policy and program changes, the Trust Fund staff worked with staff at the program sites to provide training, examine program outcomes and make recommendations. Trust Fund staff also worked with on-site staff to solve problems.

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Conclusions

The Children's Trust Fund has established an approach that serves as an incubator of new ideas, effective programming, and public-private partnerships. Research has shown that families participating in the home visiting program have low rates of substantiated abuse and neglect, 1.3–4.4% per year over the last 4 years (Damboise et al., 2009). These results are lower than those in high-risk groups identified using the identical screening instrument (Murphy, Orkow, & Nicola, 1985; Stevens-Simon, Nelligan, & Kelly, 2001) and in high-risk groups in Connecticut (Stewart & Black, 2001).

Key to the success of this program was legislative support; ongoing, rigorous evaluations of important aspects of the program and the vigorous efforts of everyone involved to apply the research to practice and program development. Overall, the research was vital to understanding and adapting the home visiting to the needs of families in the program. The research findings helped the Trust Fund assess, and, when necessary, change the way it administered and coordinated sites across the state. The research findings also helped the Trust Fund develop best practice, set standards, and measure outcomes at each site.

Going forward, the Children's Trust Fund's goal is to expand the program to reach all first-time parents in Connecticut at risk of abusing or neglecting their children. In Connecticut there are roughly 10,000 children born into poor families each year with 1 or more risk factors for subsequent abuse or neglect. Of these 10,000 children, about 5,000 are born to first-time parents. The Nurturing Families Network is reaching only about 2,000 of these at-risk families. Like most states, Connecticut is facing a very challenging economic situation at this time, and so, for now, the Trust Fund's efforts are focused on preserving the vital services that are in place with an eye toward resuming its expansion efforts when the state's fiscal picture improves.

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