

# Connecticut Home Visiting Plan for Families with Young Children

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Connecticut Office of  
**Early Childhood**

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Submitted by:

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## Introduction

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Families with young children in Connecticut face a multitude of challenges that negatively affect parenting, maternal and child health, child development, and school readiness. Connecticut has high rates of poverty, unemployment, homelessness, crime, domestic violence, maternal depression, child maltreatment, substance abuse, and teen parenting. The number of children living in poverty in Connecticut continues to remain stubbornly high, increasing 17 percent since 2008. Children living in poverty are at greater risk for developmental and behavioral problems, health issues, learning disabilities and cognitive delays. Poverty substantially increases the chance a child will be abused and neglected. Poor children are more likely to become involved with the child protection and juvenile justice systems, and those living in high-risk communities tend to do poorly in school and struggle through the school years.

Adverse childhood experiences have a lasting and profound impact on the lives of children and many families need support to ensure a great start for their young children and their families. Home visiting programs in Connecticut are designed to provide families with precisely that support. The State and Federal investments in home visiting must be expanded upon and better coordinated to create a *system* of home visiting that effectively meets the needs of families and children.

The Office of Early Childhood was recently created by the governor and legislature to improve and coordinate the policy and administration of early childhood programs. The Office of Early Childhood is a natural hub for the home visiting system because much of the funding for home visiting programs has already been brought under one roof including: Nurturing Families Network, Early Head Start, Nurse Family Partnerships, School Family Connection, the Head Start Collaboration Office, and some Parents as Teachers and Child First programs through the Maternal Infant and Early Childhood Home Visiting funding. At the Office of Early Childhood, developing a home visiting system will naturally build upon other systems development efforts for early childhood.

## Legislation

Public Act 13-178, signed into law June 24, 2013, calls for a comprehensive plan to meet the mental, emotional and behavioral health needs of children in Connecticut. This act includes the requirement for the Office of Early Childhood, through the Early Childhood Cabinet, to deliver recommendations to coordinate the state's home visiting programs by December 1, 2014. This report recommends specific investments and actions to be taken to create a coordinated home visiting system that effectively serves families and children

by improving the experiences of families seeking or accepting home visiting support, increasing administrative efficiency and effectiveness, and building a foundation to continuously improve quality of programs.

Public Act 13-178 calls for specific recommendations for the coordination of home visiting services that serve young children of families experiencing, or likely to experience, poverty, trauma, violence, teen parenthood and health challenges, including, mental, emotional or behavioral health or substance use issues. According to the statute, the recommendations should address, at minimum:

1. A common home visiting referral process;
2. Core competencies and training for home visiting staff;
3. Core standards and outcomes for programs, and a monitoring framework;
4. Coordinating cultural competency, mental health, childhood trauma, poverty, literacy and language acquisition training being provided for home visiting and early care providers;
5. Development of common outcomes;
6. Shared annual reporting of outcomes, including identifying gaps in services, pursuant to C.G.S. 11-4a;
7. Home-based severe depression treatment options for parents of young children;
8. Intensive intervention, including relationship-focused intervention, for children experiencing mental, emotional or behavioral health issues.

### **Workgroup**

The Office of Early Childhood convened a workgroup with state administrators from many disciplines and agencies including the Department of Children and Families, the Department of Mental Health and Addiction Services, The Office of the Child Advocate, the Department of Social Services, the Department of Public Health, and the Commission on Children. The workgroup also included representation from home visiting programs serving families with young children (prenatally through age eight) to ensure robust discussion to generate meaningful and practical recommendations for next steps in creating a coordinated system of home visiting within early childhood. The recommendations reflect agreement within the gathered stakeholders of the field on each topic area outlined in legislation. The process set a foundation and common goals for ongoing collaboration and dialog between home visiting programs which have traditionally been separated by funding, program type, or agency.

### **Impact**

When acted upon, these recommendations will help state agencies and home visiting programs work together to achieve increased administrative and operational efficiency, improve program quality and impact, and improve the experience of families and children.

Increased Administrative and Operational Efficiency and Effectiveness: The administration of the home visiting system and programs will become more efficient. Existing infrastructure and best practices in the state will be shared by all programs to gain maximum return on investment. For example:

- Existing individual investments in the Child Development Infoline at United Way 211 will be better coordinated to significantly improve the service for more impact.
- Shared training will improve the quality of programs while minimizing duplication of effort.
- Existing outreach practices of individual programs (such as visiting all birthing hospitals to refer to Nurturing Families Network) will be retooled to serve all home visiting programs with minimal added expense.

Improved Quality and Impact through Partnerships: While the Office of Early Childhood has responsibility for a large number of early childhood programs, these recommendations reflect the understanding that developing stronger partnerships between preventive and intervention home visiting programs as well as across agency boundaries will help to enhance the quality of all programs. The Office of Early Childhood's commitment to create a home visiting consortium will provide the structure to ensure that programs have the opportunity to share best practices, collaborate, develop shared investments, and monitor the impact and effectiveness of all programs together.

Improved Family Experience: Individual home visiting programs are already responsive to family needs. The recommendations included in this report reflect a vision of creating a home visiting *system* that is also designed with the needs of families in mind that is easy to navigate, provides adequate access to the most appropriate supports, and treats families with respect in every process.



# Part One

## Imagining a Home Visiting System

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## Guiding Principles

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The following statements will guide the development of the home visiting system in Connecticut.

- Children's earliest experiences have a major impact on their development.
- Home visiting is an effective approach to strengthening families across multiple generations.
- All aspects of the home visiting system must be family-centered, strength-based, trauma-informed, multi-generational, relationship-based, and family-driven. Services and supports should be provided without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.
- Families should have access to an array of effective, community-based care, services and supports for children and their families that address their emotional, social, educational, developmental, and physical needs.
- The diversity of Connecticut's home visiting programs is a strength of the system, enabling the form and intensity of the service to match the priorities and level of need of the child and family as the child's age and the family's need for services evolves over time.
- Home visiting programs should be evidence-based, evidence-informed or use promising practices to ensure the effectiveness of services and improve outcomes for children and their families.
- A strong financial base will allow for access to affordable high-quality home visiting programs to meet the needs of all families.
- Programs should be coordinated and collaborative so families do not have to go without needed services because of gaps or disconnects in the system.
- The coordinated system should include all home visiting programs.
- The Connecticut system for home visiting programs is an important component of the service landscape that supports families with young children.
- All state agencies should collaborate in support of a comprehensive early childhood and family support services system.

## What Is Home Visiting?

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Home visiting programs provide critical support to families with young children. Home visiting programs are designed to be effective at promoting child wellness and development, strengthening families, and preventing child neglect, maltreatment, and abuse. Professional home visitors build relationships with families to provide resources, treatment, screening, parenting information, and support during pregnancy and throughout the child's first eight years in places where the families are already caring for their children, most often the home. Programs build on family strengths and provide individual support focused on both the child and the caregivers. This design and approach makes home visiting uniquely effective for families with young children: it is intimate, convenient, contextual, and supportive. For this report, home visiting programs that primarily serve children prenatally to age eight have been included.

*Home visiting programs are designed to be effective at promoting child wellness and development, strengthening families, and preventing child neglect, maltreatment, and abuse.*

## Who Is Home Visiting For?

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Connecticut home visiting programs are tailored for and provided to families who can most benefit from additional support while they are raising young children. Support is provided to the people in a child's life who play a critical role in their growth and development and who are responsible for creating a nurturing environment. This can include expectant mothers, parents, grandparents, foster parents, and child care providers. Typically home visiting is offered to families in poverty or who face barriers to children's healthy growth and development. Programs also serve families who face specific challenges which put families and children at risk such as a preterm birth, a child with developmental delays or behavioral concerns, or adults with substance use problems.

*Typically home visiting is offered to families in poverty or who face barriers to children's healthy growth and development.*

## Why Invest in Home Visiting?

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Early childhood home visiting is an effective prevention strategy that improves outcomes for young children and parents. Research has shown that adverse childhood experiences have a significant impact on long-term adult mental and physical health<sup>1</sup>. Research also shows that the earlier in a child's life home visiting support is provided, the greater the potential for having long-lasting positive results. High quality, research-based home visiting programs have been shown to:

- improve healthy child development across all domains (language development, cognition, physical development, social and emotional development, etc.)
- prevent child injuries, child abuse, neglect, and maltreatment; and
- improve pregnancy birth outcomes and preconception, prenatal, and inter-conception care;
- reduce emergency department visits and hospitalization;
- improve school readiness and attendance and decrease the grade retention and achievement gap;
- reduce crime and domestic violence;
- improve maternal and child health including maternal depression;
- improve family economic self-sufficiency and life skills;
- improve the coordination of and referrals to other community resources and supports.

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<sup>1</sup> <http://acestudy.org/>

## What Is the Cost of Doing Nothing?

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### Preterm Births

- **\$26.2 billion** annual costs nationwide associated with premature births (which make up 7 percent of births in Connecticut in 2013)<sup>2</sup>
  - The *additional annual cost* per infant born preterm is **\$51,600**.

### Child Abuse and Neglect

- **\$124 billion** total lifetime economic burden of all maltreated children in the US in 2008.<sup>3</sup> **39 percent** of child abuse cases occur in the first four years of life and evidence-based home visiting can reduce the incidence of child maltreatment by **50 percent**. The majority of maltreatment cases are neglect, resulting from extreme poverty.
  - The *lifetime cost* of one victim of maltreatment due to adverse health, mental health and economic consequences of maltreatment is **\$210,012**.

### Special Education

- **\$1.7 billion** annual cost of special education services in Connecticut and only 10 percent of costs paid for by Federal funds. Special education funding makes up over **21 percent of total education spending** in Connecticut and costs are growing at an average of 5 to 6 percent per year.<sup>4</sup> 50 percent of children who received home visiting services through the Birth to Three System did not require special education services when they entered kindergarten.
  - The *annual cost* per child for special education in Connecticut is approximately **\$16,000**.

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<sup>2</sup> Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes; Behrman RE, Butler AS, editors. Preterm Birth: Causes, Consequences, and Prevention. Washington (DC): National Academies Press (US); 2007. 12, Societal Costs of Preterm Birth. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK11358/>

<sup>3</sup> <http://www.cdc.gov/violenceprevention/childmaltreatment/consequences.html>

<sup>4</sup> CT Conference on Municipalities Public Policy Report, November 2012, Education Finance in Connecticut

## What Home Visiting Programs are in Connecticut?

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There are many programs in Connecticut that provide regularly scheduled services to families in their homes. For the purposes of this report, the following programs have been included because they serve families with children under age eight and provide the *majority* of their services in a family's home (or other environment of their choice).

The home visiting programs in this report represent different sectors of the field. The bulk of home visiting programs in the state are open to any family provided they meet eligibility guidelines. Several home visiting programs within the Department of Children and Families (DCF) are available only to families facing allegations or substantiations of abuse and neglect. While recommendations to improve the quality of programs and improve program coordination and the experience of families are designed to be relevant to DCF programs, several recommendations such as those regarding referrals, marketing, and reporting are not appropriate. Connecticut is known for its research and innovation in developing effective home visiting programs and there are several home visiting programs that are only available in select communities. While these programs have valuable insights and contributions for the field and will be included in collaborative initiatives, they do not yet serve a large number of families in Connecticut.

### **Large, Statewide Home Visiting Programs**

- Birth to Three
- Child First<sup>5</sup>
- Early Head Start
- Family Resource Centers (Parents as Teachers)
- Nurturing Families Network (Parents as Teachers)
- Young Parents Program

### **Department of Children and Families Home Visiting Programs**

- Caregivers Support Team
- Integrated Family Violence Services
- Intensive Home Based Services- Family Based Recovery
- Level 4 Positive Parenting Program (Triple P)
- Child First

### **Developing, Regional, or Pilot Home Visiting Programs**

- Family School Connection
- Minding the Baby
- Nurse Family Partnership
- Parents as Teachers (MIECHV)
- Nurturing Families Network: Fathering (MIECHV)

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<sup>5</sup> Child First is partially funded by DCP but not restricted to DCF families.

## A Vision for a Coordinated Network of Home Visiting Programs in Connecticut

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All families should have access to high quality, home-based services and supports they need. Home visiting programs should be fully coordinated with each other and with other systems of care such as health, mental health, early childhood services, and early care and education. When the vision of a home visiting system becomes a reality:

**Families** will voluntarily welcome the support provided without stigma because:

- families are respected as partners;
- support is available for all parents and primary caregivers;
- the support provided is non-judgmental, culturally appropriate, builds upon family strengths; and
- the support provided is of value to the family.

**Programs** will be part of a coordinated network that ensures:

- a diverse set of programs are available to meet a broad range of family and child needs;
- sufficient funding is allocated to state agencies for home visiting programs and that funding is used to provide appropriate supports for the needs of all families and children;
- services are easy to access, follow the family, are well-coordinated, and adapt over time to changing needs of families in Connecticut; and
- programs are staffed by people who are well trained and represent the culture and languages of families served.

**The State of Connecticut** will invest in high-quality home visiting programs at a level that matches the demonstrated need for services because home visiting programs:

- have a significant positive collective impact on families and Connecticut as a whole; and
- help prevent the need for costlier services.

# Part Two

## Recommendations for Action

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## Recommendations for Action

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Connecticut has an opportunity to make a huge positive impact on the lives of children and families in Connecticut by carrying out the recommendations described below to create a coordinated home visiting system. These recommendations include practical ways to improve coordination of home visiting programs and strengthen key infrastructure of the system for referral, trainings, coordination, and reporting. Their potential impact relies both on working more collaboratively as well as investing in key areas, and represent the next steps required to improve the home visiting system in Connecticut. When implemented they will achieve increased administrative efficiency, improved program quality, and improved experiences for the families and children seeking or receiving support. In the long term they will increase transparency to the legislature, improve access to home visiting programs for families, and foster meaningful collaboration across home visiting programs.

The Office of Early Childhood is pleased to submit to the legislature these recommendations based on insights from discussion and assessment. Additionally, the Office of Early Childhood is prepared to take on a key role in their implementation going forward. The recommendations are grouped into home visiting system development goals which are based on the requirements of legislation.

## Recommendation #1

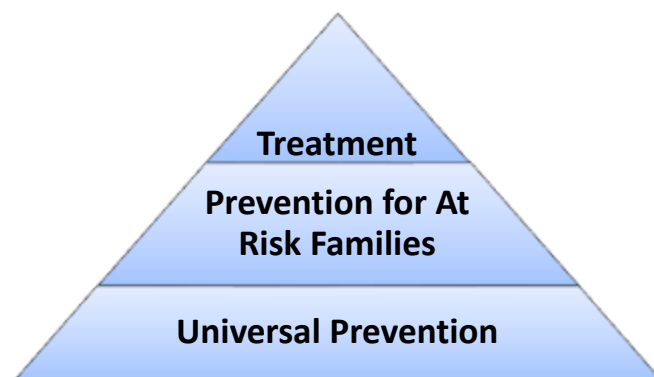
### Ensure Families Have Access to Appropriate Home Visiting Services

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Families benefit most when they are matched with home visiting programs that are well suited to support them in meeting their needs and circumstances. Families should have access to a several home visiting programs that vary in their areas of emphasis ranging from addressing developmental delays to supporting families with a history of abuse or neglect. In a well-developed two generational home visiting system, all home visiting programs, early care and education settings, services for parents and other early childhood services such as pediatric primary care are connected with each other to achieve optimal outcomes for children and their caregivers. All home visiting programs should work closely with one another to meet the needs of the child and caregivers.

In Connecticut, the needs of families vary greatly and there is a broad portfolio of programs that deliver services in the home tailored to meet these needs. However, home visiting programs are not universally accessible to families. Connecting families to the most appropriate program for them is often complicated by capacity and eligibility limitations. For each family, there is a different set of home visiting programs available.

The public health Pyramid Model<sup>6</sup> for child welfare services is a framework for describing different levels of intensity of program intervention.<sup>7</sup> The Pyramid Model can also be used to differentiate home visiting programs and provide a framework to discuss the needs and gaps of the system. The pyramid categorizes services according to three levels: treatment, prevention for at-risk families, and universal prevention.



The home visiting programs in Connecticut can roughly be categorized into the levels of the Pyramid Model as shown in the table below. However, many home visiting programs serve families at more than one level and provide support for families at risk as well as treatment

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<sup>6</sup> Hunter, Catherine, 2011. "Defining the Public Health Model for the Child Welfare Services Context." Australian Institute of Family Studies. Web. 10 September 2014. <https://www3.aifs.gov.au/cfca/publications/defining-public-health-model-child-welfare-servi>

<sup>7</sup> There are a number of pyramid models that talk about dosage and intensity. The Center on Social and Emotional Foundations for Early Learning's model (CSEFEL) is another pyramid model that has a social emotional focus.

for families. For emphasis, they have been categorized according to their primary approach and focus in the table on the next page.

Beyond the Pyramid Model, home visiting programs can be further differentiated through other factors such as<sup>8</sup>:

- *Primary risk factors or issues* the home visiting strategy is designed to address.
  - For example Nurturing Families Network addresses families at risk of child abuse or neglect, Child First addresses children who have experienced trauma or who have emotional or behavioral problems, Early Head Start promotes school readiness for families below the federal poverty line, and Birth to Three supports families with children with developmental delays.
- *Education, training and discipline of the staff.* Programs employ different levels of professionals who deliver home visiting programs.
  - For example, Nurse Family Partnership employs registered nurses and Child First employs licensed Master's level mental health clinicians to provide home visiting programs.
- *Evaluated program content and outcomes.* Some programs have research that demonstrates different positive outcomes achieved as a consequence of program participation.
- *Frequency of visits.* Programs may visit families with different frequencies
  - For example, Minding the Baby recommends weekly visits until the child is 12 months while other programs visit families several times a week.
- *Length of program participation.* The length of program participation may vary according to the intended population, goals, and objectives of the intervention.

For example, a program designed to reduce the risk of abuse and neglect may begin prenatally with the goal of providing support to the family until the child enters kindergarten. Another program designed to support healthy birth outcomes may begin during pregnancy and extend through the first year or two of the baby's life. A program designed for children with developmental, emotional and behavioral problems may begin any time in the first five years of life.

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<sup>8</sup> These examples are drawn from the Arizona home visiting Plan.

## Home Visiting Programs in Connecticut in Pyramid Model

Level	Description	Home Visiting Programs (with Primary Focus)
<u>Treatment Indicated (Tertiary)</u> :	<p>Programs specifically designed to treat, prevent recurrence of, and reduce the long-term implications of an identified problem such as:</p> <ul style="list-style-type: none"> <li>developmental delays, emotional or behavioral programs, significant healthcare needs of children</li> <li>maternal depression, substance use</li> <li>attachment problems between parent and child</li> <li>child abuse or neglect</li> </ul>	<ul style="list-style-type: none"> <li>Birth to Three (developmental delays)</li> <li>Caregivers Support Team (child abuse and neglect)</li> <li>Child First (emotional and behavioral problems, child abuse and neglect, maternal depression, attachment)</li> <li>Integrated Family Violence Services (child abuse and neglect)</li> <li>Intensive Home Based Services (child abuse and neglect)</li> <li>Minding the Baby (maternal depression)</li> <li>Positive Parenting Program (Triple P Level 4) (child abuse and neglect)</li> <li>Young Parents Program (substance use)</li> </ul>
<u>Prevention/ At Risk (Secondary)</u> :	<p>Programs specifically designed to help prevent specific negative outcomes for the child, parent, or family from occurring for families who have risk factors such as:</p> <ul style="list-style-type: none"> <li>poverty</li> <li>maternal depression</li> <li>marital discord or family violence</li> <li>parental drug or alcohol use</li> <li>teen parenthood</li> <li>homelessness</li> </ul>	<ul style="list-style-type: none"> <li>Early Head Start</li> <li>Family Resource Centers (Parents as Teachers)</li> <li>Family School Connection</li> <li>Nurse Family Partnership</li> <li>Nurturing Families Network (Parents as Teachers)</li> <li>Parents as Teachers (MIECHV)</li> </ul>
<u>Universal (Primary)</u> :	<p>Strategies designed for whole communities or populations to enhance social factors that can reduce negative outcomes in the population as a whole.</p>	<p>There are no universal home visiting programs in Connecticut. There are referral and information projects that target every parent with young children, however, such as:</p> <ul style="list-style-type: none"> <li>Help Me Grow</li> <li>Child Development Infoline</li> <li>Public Information Campaigns</li> </ul>

NOTE: The home visiting programs are described and compared in more detail in Appendix C. This table represent the primary purpose and design of programs. Several programs have other goals and address other tiers of intensity.

**Recommendation #1 Goals:****1.1 Secure additional funding from all available sources to expand capacity of the existing home visiting system to meet the needs of families and children throughout CT.**

There is currently insufficient funding to serve the needs of children and families with appropriate home visiting services. In the first years of a child's life, the foundation for future growth and learning is established and development happens quickly. The window of opportunity for effectively meeting the needs of a family is short and an eight month wait for services can have a significant impact. With expanded capacity, home visiting programs could meet the needs of more families at the right moment. For example:

- Birth to Three must tell families of children with mild developmental delays to monitor their child's development and return if the child falls further behind,
- Child First, a home visiting program that serves many of the most vulnerable children and families has wait lists, and
- Nurturing Families Network must refer the family to other local services when the need exceeds program capacity.

Legislators and state agencies should work together to secure and provide additional funding to increase the capacity of the home visiting system. Potential sources include:

- Connecticut State General Fund
- Interagency collaborative funding (including OEC, DCF, DSS, SDE, DDS, DPH, DMHAS, federal Early Head Start)
- Federal grant funding
- Medicaid funding
- Social Impact Bonds or Pay for Success
- Private funding

**1.2 In particular, fund additional home visiting system capacity to serve parents with depression, mental illness or cognitive limitations, children experiencing emotional or behavioral health issues, trauma, or who have mild developmental delays.**

Approximately 45 percent of mothers in a home visiting program were found to be suffering from depression.<sup>9</sup> Lack of transportation and child care, scheduling conflicts, and

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<sup>9</sup> Ammerman, Putnam, et al., in press, *Child Abuse & Neglect*

concerns about stigma, contribute to the fact that many new mothers do not access care for depression, mental illness, or cognitive limitations. Additionally, the root causes of depression are often related to other stressors such as trauma, lack of basic needs, or physical health. All programs should have the responsibility for either providing or attempting to refer caregivers to services for their depression if they are not already receiving appropriate care. The following investments in capacity would begin to address the need for additional treatment level services.

- a. *Expand the capacity of home visiting programs able to treat families experiencing mental, emotional, or behavioral health issues holistically.* In addition to supporting families with other pressing concerns such as meeting basic needs, programs should also have the capacity to treat families experiencing mental, emotional, or behavioral health issues. Nurturing Families Network and Minding the Baby have the ability to treat maternal depression in the home. Child First employs licensed, Masters level mental health clinicians to treat young children with emotional and behavioral problems and maternal depressive symptoms. None of the services of these programs, however, are yet at scale with sufficient capacity to treat every family presenting with needs.
- b. *Expand the use of Medicaid funding to pay for in-home maternal depression intervention.* Recent Medicaid billing changes have opened the door for in-home therapy that could support parents with a two-generation, trauma-informed, psychodynamic approach or cognitive behavioral therapy, for example. Additional funding is needed to develop this workforce and embed those services in the home visiting system.<sup>10</sup>
- c. *Expand the eligibility of the Birth to Three System to serve children who are experiencing mild developmental delays.* Currently only children experiencing significant delays in development<sup>11</sup> are eligible for Birth to Three Services.

### **1.3 Establish governance and collaboration infrastructure to guide home visiting system development and implementation**

The Office of Early Childhood is committed to working with other state agencies to govern the system of state funded home visiting programs and convene the field for further collaborative work. The Strengthening Families Protective Factors are used across the country as a framework to improve child well-being and help to keep all families strong

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<sup>10</sup> Nurturing Families Network has already begun a pilot to develop a cohort of therapists trained and ready to provide in-home treatment.

<sup>11</sup> Significant delays is currently defined as 2 standard deviations below the mean in one area of development or 1.5 standard deviations from the mean in two areas.

and on a pathway of healthy development. The Strengthening Families approach has also served as a framework for cross-sector collaboration in other states. This framework is well suited for use in home visiting cross agency collaboration. The Connecticut Department of Children and Families has embraced Strengthening Families as a fundamental reform in how it conducts its child welfare services<sup>12</sup> and is already using it for collaboration with Head Start.

*Governance:* The Office of Early Childhood will partner with other state agencies to regularly assess the available funding, the statewide unmet need for services and system-wide process and outcome performance measures. When funding allows, the Office of Early Childhood and other state agencies will monitor the quality of programs funded using tools such as external, third-party program evaluations and maintain public-private partnerships to coordinate state and private funding.

*Collaboration:* The Office of Early Childhood will design and establish a collaborative working group to promote the ongoing development and improvement of the home visiting system. For the purposes of this report it will be called “The home visiting consortium.” To ensure robust dialog from many perspectives the consortium membership will be comprised of a representative cross section of the field including representation from other state agencies and representatives of individual home visiting programs. Its design will be based on a successful system quality improvement model in place for Nurturing Families Network (see description below- A Sample Collaboration Structure) that has created a forum for system-wide dialog and improvement. When established, the home visiting consortium will:

- promote cross-agency and cross-program collaboration;
- capture feedback on the performance of the system;
- help identify potential improvements of the system;
- foster collaborative learning, open dialogue and problem solving;
- help implement many of the recommendations of this report;
- develop an implementation plan for select recommendations; and

*The Strengthening Families approach has served as a framework for cross-sector collaboration in other states and could serve as an effective outcomes framework in Connecticut.*

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<sup>12</sup> <http://www.ct.gov/dcf/cwp/view.asp?a=4247&q=500504>



- build system-wide partnerships and linkages with other service systems such as parent support for domestic violence, homelessness, adult depression, pregnancy, food security, justice system involvement, substance use, and healthcare.<sup>13</sup>

To foster local collaboration and coordination between home visiting programs, the Office of Early Childhood should do the following, as funding and confidentiality regulations allow:

- Provide support for local planning and collaboration between programs, particularly at the case management level.
- Develop a transactional data system within the Early Childhood Information System that will allow, within the rules of confidentiality, linkages to other publicly-funded early childhood programs and other state agencies.

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<sup>13</sup> Such as WIC, SNAP, HUSKY, The Mobile Crisis Intervention Team, or The Recovery Specialist Voluntary Program (RSVP).

## **A Sample Collaboration Structure: The Continuous Quality Improvement Team<sup>14</sup>**

The Children's 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 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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<sup>14</sup> Excerpt from (Foley-Schain, Finholm, & Leventhal, 2011)

## Strengthening Families Protective Factors Framework

The foundation of the Strengthening Families approach are five interrelated protective factors that studies show are related to the promotion of family strengths and optimal child development. Research also shows that when these Protective Factors are well-established in a family, the likelihood of child abuse and neglect diminishes. (Center for the Study of Social Policy, September 2014)

- **Concrete Support in Times of Need:** Identifying, seeking, accessing, advocating for, and receiving needed adult, child, and family services; receiving a quality of service designed to preserve parents' dignity and promote healthy development; helping connect families to needed economic supports to achieve self-sufficiency.
- **Knowledge of Parenting and Child Development:** Understanding the unique aspects of child development; implementing developmentally and contextually appropriate best parenting practices; successfully enrolling children in high quality early care and education programs.
- **Parental Resilience:** Managing both general life and parenting stress and functioning well when faced with stressors, challenges, or adversity; the outcome is positive change and growth; identifying maternal depression and ensuring services that help parents achieve improved mental health and wellness.
- **Social and Emotional Competence of Children:** Providing an environment and experiences that enable the child to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
- **Social Connections:** Having healthy, sustained relationships with people, institutions, the community, or a force greater than oneself.

## Recommendation #2

### Strengthen the Referral Infrastructure

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Families who need support should be able to find and access the program or programs they need easily. An effective referral system is critical to achieving this.<sup>15</sup> While there are many investments in referral and intake infrastructure already in place, they are not sufficiently funded or coordinated adequately to allow them to reach all families in Connecticut. Additional funding to bolster intake and referral supports is required as well as additional collaborative efforts to improve existing investments.

A strong referral system for families entering voluntary home visiting programs should have the following characteristics:

- Families hear about home visiting programs from people they trust.
- The first engagement is recognized as critical to develop trust. Families feel heard and do not feel judged; it facilitates the development of trust.
- Families are routinely screened by people who are appropriately trained in making referrals.
- Multiple channels for families to enter the home visiting system. There is no “wrong door” – that is considered unacceptable for system entry.
- The Child Development Infoline provides a central clearinghouse for referrals and entry into programs. The staff is knowledgeable about each program and makes recommendations to families appropriately.
- Programs regularly refer families to other home visiting programs when appropriate by using the central clearinghouse for referrals at the Child Development Infoline.
- Families do not have to tell their story repeatedly in order to obtain services, and data is shared with family permission.
- Relevant data about the family and child is housed within the Early Childhood Information System to facilitate sharing of information, within the limits of confidentiality, among publicly-funded programs serving the child and the family.

#### **Recommendation # 2 Goals:**

##### **2.1 Improve public awareness, knowledge, and perception of home visiting programs.**

- a. *Conduct a marketing campaign for home visiting to increase awareness of services available.* While home visiting is an effective and welcome support for most families

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<sup>15</sup> Referrals should include the DCF home based programs, if age eligible and voluntary.

who use it, there is inadequate knowledge of its availability, which is a barrier to families accessing home visiting programs. The system would benefit from information campaigns that include clear messages about exactly what is provided to families and by whom, the benefits of home visiting, and what the process is for making referrals.

- b. Develop a menu of home visiting programs that will help match families with the most appropriate program.* A menu of programs built on the pyramid public health model that clearly highlights the differentiating features of each program should be created to be available for families and to facilitate referrals. This should include comparisons of programs that explain characteristics of programs such as the population to be served, the location on the public health pyramid, eligibility requirements, or the expected impact or outcomes for families.

## **2.2 Expand and strengthen the capacity of referral infrastructure: Child Development Infoline (CDI)**

Child Development Infoline is a part of United Way's 211 system that provide information and referral, care coordination, and data analysis for Connecticut's social services. Currently Child Development Infoline (CDI) serves as a centralized access point for home visiting services, including Birth to Three, Nurturing Families Network, Maternal Infant and Early Childhood Home Visiting programs (Parents as Teachers, Early Head Start, Child First, and Nurse Family Partnership), and other programs. It provides information through its toll-free 1-800-505-7000 number, as well as via a prompt on the 2-1-1 menu. Child Development Infoline also provides referral and information for Help Me Grow, a referral, screening and monitoring system for children's development. Individual home visiting programs also currently conduct their own outreach and receive referrals directly.

*Families who need support should be able to find and access the program or programs they need easily. An effective referral system is critical to achieving this.*

United Way's expertise and infrastructure have been identified in PA 14-115 as a key building block to develop a behavioral health referral infrastructure and many state agencies already rely on United Way 211 for integrated resource and referral support. The following are recommendations to build on and strengthen this important existing investment.

- a. *Increase Call Volume Capacity.* Expand the call volume capacity of CDI and promote use of the directory more widely as a referral resource.
- b. *Develop a Home Visiting Transactional module within the Early Childhood Information System.* The module should be designed to allow interaction between the participating home visiting programs and CDI in which new referrals could be entered by either. All enrolled children would obtain a State Assigned Student Identification (SASID) through the SASID Manager maintained by the State Department of Education. That unique identifier will allow longitudinal tracking of children as well as the information that the same child is enrolled concurrently in multiple publicly-funded early childhood programs to promote the possibility of better coordination among programs serving the same child or family. Along with the other types of early childhood programs contained in the ECIS, data can be matched to data held by other state agencies such as Public Health, Children and Families, and Department of Social Services so that aggregate information can be returned to programs and analyzed by the OEC. All data sharing and data matching would have to occur within the allowable framework of the Family Educational Rights and Privacy Act (FERPA) and, where applicable, the Health Insurance Portability and Accountability Act (HIPAA).
- c. *Improve the referral process of CDI and 211 staff for home visiting programs.*
  - Modify 211's protocol for other types of calls to ask if there are young children in the house. For example, for calls about housing or substance use where there are young children in the house, 211 should routinely connect the family to CDI for a possible connection to a home visiting program if there is a perceived need and the caller is interested.
  - Train the 2-1-1 call center staff on the home visiting services to increase transfers of appropriate families to CDI for services. Ensure that the CDI staff is knowledgeable about every home visiting program in order to effectively refer to all available programs.
  - Create a standard CDI protocol where referrals should be made based on a gentle exploration of issues to gather information.<sup>16</sup> An algorithm or matrix of available home visiting programs should be developed to assist with triaging referrals to the most appropriate home visiting program by age, level of need, and type of home visiting service. Develop additional referral methods such as a home visiting referral form available for providers to fax, email, or submit online.
  - Document when a program is not available to meet the family's needs to serve as a mechanism for showing the need for additional services. When programs do not

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<sup>16</sup> Perhaps an early identification of strengths, critical issues, and families' goals and risks

have capacity to serve families, make referrals for other parenting support programs, case management, behavioral health services, the Help Me Grow system to monitor developmental and behavioral concerns through Ages and Stages, and mail general information on specific topics including pregnancy related information and general child development information.

- d. *Increase the data analysis role of CDI.* Use the CDI's database of requests and the availability of home visiting programs for system governance, capacity planning, and gap analysis.
- e. *Establish a Help Me Grow/CDI Liaison at Office of Early Childhood* who could assist with marketing, as well as maintaining relationships with the home visiting programs to ensure a smooth referral process and offer resource information to the programs.

### **2.3 Increase the local, community-based, grassroots referrals to home visiting programs.**

- a. *Engage and train community leaders and service providers to refer to home visiting programs.* Build the capacity of community leaders (parents, health care professionals, early care and education staff, substance use counselors, social workers, pastors, WIC office staff, etc.) who have established and trusted relationships with families within their communities to assist in referring to home visiting programs. Ensure they can communicate the value of home visiting and know how to use CDI to refer a family. Nurturing Families Network already has outreach infrastructure in place to visit birthing hospitals to speak with new mothers. This practice could be expanded upon and shared by home visiting programs, for example.
- b. *Ensure home visiting staff persons refer to other home visiting programs as appropriate.* Ensure all home visiting programs have a process as part of their intake/referral protocol to identify if an additional or different home visiting program. Ensure home visiting staff persons have sufficient knowledge of other home visiting programs and know how to use CDI to make a referral. Maintain a feedback loop to inform the referring organization of the success of the referral, as confidentiality rules allow.
- c. *Create an easier basic intake process shared by all programs.* Explore the use of a swipe card for conveying personal data for individuals that can be used across the system (similar to cards issued by the Department of Social Services) or create a uniform intake/referral form of basic family information to be used by all home visiting programs and CDI to make referral.

*Increase the local,  
community-  
based, grassroots  
referrals to home  
visiting programs*

## Recommendation #3

### Establish a Core Set of Competencies and Coordinate Training

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In order to develop an appropriately skilled workforce for home visiting programs, sufficient resources should be allocated to ensure the workforce is well trained. Training and professional development support should be available for all home visiting staff on the core competencies they are expected to have. Once developed, these core competencies can be used to identify opportunities for shared training and workforce development. Shared training on topics such as cultural competency, mental health, fatherhood engagement, early child development, childhood trauma, proper nutrition, safety in the home, mandated reporting (DCF), poverty, the needs of expectant mothers, developmental delays, parent education, literacy and language acquisition would benefit most programs. This shared training will complement, not entirely replace, other training requirements by the programs. For example, some home visiting programs required clinically trained professional staff to deliver a more specialized service (such as therapeutic intervention).

*Core competencies describe the skills, knowledge, values and disposition (what to do and how to do it) staff in every program should have.*

#### **Recommendation # 3 Goals:**

##### **3.1 Create a central training institute to support home visiting program that builds on existing resources.**

The Office of Early Childhood is currently developing a quality improvement system for the early care and education field which will have the capability and infrastructure to support training, coaching, mentoring, and networking statewide. Additional funding should be allocated so this system can be expanded to include the content, capacity, and expertise to support home visiting programs. This will allow the state to provide trainings and quality improvement support efficiently and effectively to achieve core competencies.

The current high level design of this central training institute builds on and coordinates existing strengths in Connecticut while increasing quality, adding capacity, and expanding offerings. State agencies should agree to allow all home visiting programs access to their training resources as resources allow. The Office of Early Childhood should identify and publicize the available trainings and trainers with expertise to provide training, mentoring, or coaching to home visiting staff. This could be done by building on existing infrastructure, such as the Office of Early Childhood Workforce Registry.



This includes building on resources such as trainings provided by Childcare 211, the Nurturing Families Network, the Infant Mental Health Association's Regional Education Service Centers, and DPH's focus on developmental delays through the Maternal and Child Health Services Block Grant- Children and Youth with Special Health Care Needs.

### **3.2 Develop core competencies that align across all early childhood disciplines and services.**

The Office of Early Childhood, with the help of the home visiting consortium, will help develop a set of core competencies for home visiting roles to increase the ability to share training and professional development resources across home visiting, health, and early care and education. Common expectations for what skills and knowledge home visitors should have does not replace the requirements of specific home visiting programs, however. Clinical programs in particular, will have many additional competencies required.

Developing core competencies for home visitor roles will require an evaluation of existing home visiting competencies and roles and the knowledge and skills desired for each role. To be successful, this process should be thorough and well planned with support from national leaders in professional development and workforce initiatives (such as the National Center on Child Care Professional Development Systems and Workforce Initiatives Center). This process will be managed by the Office of Early Childhood's staff with expertise in Core Competency development.

The Office of Early Childhood will use a framework to ensure that as core competencies are developed, they are aligned between the early care and education, health, and home visiting fields. This framework will help ensure that there are shared expectations for the most essential knowledge and skills of staff working with young children and families, regardless of the specific service or setting. For example, potential sources to establish common frameworks are:

- Nebraska's Early Childhood Integrated Skills & Competencies for Professionals as an example a high-level framework. (See Appendix for Nebraska Example)
- The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards) adopted by the Connecticut Commission on Health Equity.
- The Office of Early Childhood teacher role Core Knowledge and Competencies

### **3.3 Conduct an analysis of the home visiting workforce.**

The Office of Early Childhood, with help from the home visiting consortium and Department of Children and Families, should research the size, makeup, and skills of the existing home visiting workforce<sup>17</sup> and assess the statewide need for training and workforce development. In particular, the workforce should be assessed for its ability to serve non English speaking families.

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<sup>17</sup>Could include demographics, educational backgrounds, and types of occupations.

## **Recommendation #4**

### **Ensure Program Standards Promote High-Quality Programs**

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Many home visiting programs in Connecticut already have robust program standards, particularly those which rely on evidence-based models. Programs use standards to ensure that high quality services are delivered in a particular way with fidelity to the evidence-based model. For evidence based programs, the fidelity to model is required in order to conduct research and maintain funding.

The few states that have adopted common program standards are those which have only one or two home visiting program models. Adopting common standards for Connecticut's diversity of programs which range from clinical to education-based models would negatively impact the strengths of Connecticut's existing system. However, there are always opportunities for programs to improve their standards of practice and a long-term approach of sharing best practices and moving slowly towards common standards would be more appropriate. Typical program standards include:

- Initial assessment/screening
- Intake procedure
- Written service plan/goals
- Staffing plan
- Frequency and duration of visits
- Staff qualifications and appropriate competencies for all staff, including supervisors
- Professional development for staff including supervisory oversight and monitoring, clinical consultation and supervision, technical assistance, and training
- Data gathering, analysis, quality monitoring, and continuous program improvement
- Feedback collected from those receiving services
- Ongoing, periodic assessment/outcome measurements
- Confidentiality expectations
- Program exit procedure, including assessment and connection to other services
- Partnership expectations including MOUs and referral relationships with community partnerships; measures of successful referrals for other services

#### **Recommendation #4 Goals:**

##### **4.1 Build on strong existing program standards.**

The home visiting consortium could be used to support a process of quality improvement and learning to encourage programs to share best practices and improve standards and policies where appropriate. Additional funding should be available to conduct research on programs that have not had the opportunity or benefit of a formal evaluation. The program

standards that govern programs' operations are as diverse as the home visiting models. While standardizing them could jeopardize their ability to serve the needs of the families they are designed to support, creating a forum for dialog and reflection on program improvement will strengthen all programs.

## Recommendation #5

### Develop Outcome Measures and Report on Progress

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The vision is to create a reporting system that will drive quality, provide information to decision-makers, and enhance transparency while adding minimal administrative burden on home visiting programs. There is an opportunity to better measure the collective impact of the home visiting programs in Connecticut on children and families. All home visiting programs support families raising young children and help them navigate the varied challenges they face. A core set of common outcomes and process measures that span most, if not all, programs should be developed to show the collective impact of home visiting programs on children and families. Where possible, programs that have additional positive impacts on child outcomes beyond the common outcomes should also be reported.

The individual home visiting programs in Connecticut already report frequently on outcomes and process to various funders. Programs report to the Office of Early Childhood, the Department of Children and Families and to Federal agencies (for Birth to Three, MIECHV, and Early Head start). Additionally state agencies generate regular analyses of funded efforts, Results Based Accountability reports on selected home visiting programs. The Children's Report Card already reports on population-level data.

The most valuable *additional* report would contain information on the home visiting field as a developing system and should be presented to legislators annually in the Results Based Accountability (RBA) framework. This high-level Results Based Accountability model should ideally:

- locate the home visiting system in the broader early childhood system,
- track indicators,
- identify strategies/partners, and
- report on 1) individual programs, 2) groups of programs in Pyramid Model tiers, and 3) all home visiting programs as a system collectively.

At the system level, the home visiting consortium will pursue these high level strategies and seek to monitor performance towards their achievement:

- Ensuring access to home visiting services utilizing the pyramid model of public health services: universal prevention, prevention targeted to families at risk, and intervention for children and families
- Ensuring high quality services and programs through fidelity to evidenced-based models, program improvement, and sharing best practices

- Accountability and performance measurement, including common outcome measures based on the Strengthening Families Five Protective Factors. Potential common measurement tools are provided in Appendix D.
- A strong intake and referral system
- Core competencies for all staff in every home visiting program, along with ongoing, system-wide training and professional development

## Reporting on Home Visiting System

Report Type	Report Audience	Population Level	Example Questions
Children's Report Card	Legislature and Public	All families with young children	What are the rates of abuse and neglect?  Are children arriving at school ready to learn?
<b>Results Based Accountability (Proposed NEW)</b>	Legislature  Federal Government, Funders, State Agencies, Public	All <i>vulnerable</i> families with young children  All families <i>actually served</i> by programs	How many families would benefit from home visiting services? Where are they?  What percent of the targeted population is being served by home visiting programs or have access to a home visiting program appropriate for their needs?  How well are the programs serving the needs of families?  Are families satisfied with the support provided?
Program Annual Reports Progress Reports	Funders (private, State, Federal)	Families served by specific programs	What is the outcome of services provided by this program?

## **Recommendation #5 Goals:**

### **5.1 Finalize Results Based Accountability Population level Framework**

The proposed Results Based Accountability model summarized in the schematic in Appendix E will locate the home visiting work within the larger early childhood and youth systems. At the population level, our result statement -- Connecticut's young people grow up in stable environments, safe, healthy, and ready to lead successful lives -- is the result of the Children's Report Card of the Committee on Children, also adopted by the Governor's Nonprofit Health and Human Services Cabinet as one of six cross-agency human services results for Connecticut state agencies. The home visiting programs in Connecticut contribute to all four domains of the Children's Report Card result: stable and strong families, safe children, healthy children, and children prepared for success in school and life.

With home visiting programs' focus on families with children birth through age eight, home visiting programs will be tracking and reporting on many of the same headline and secondary indicators as the Children's Report Card. The headline indicators are:

- Percent of children in single parent homes living in poverty
- Percent of children assessed for or suffering from abuse or neglect
- Percent of low birth weight babies
- Percent of children with developmental delays
- Percent of children entering kindergarten who need substantial instructional support<sup>18</sup>

### **5.2 Pursue a data and research agenda for unavailable critical indicators**

Like the rest of the early childhood and youth systems, the home visiting system has a large and growing Data Development Agenda for critical indicators of child and family wellbeing that neither the home visiting consortium nor state agencies can yet report. This agenda includes:

- Percent of young children with multiple risk factors for maternal, birth, and infant outcomes and child health and development outcomes
- Rate of maternal depression
- Percent of children with emotional, behavioral, or mental health problems

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<sup>18</sup> NOTE: An improved Kindergarten Entry Assessment is currently being developed by the Office of Early Childhood in partnership with seven states. It is slated for launch in 2016 and reliable data on kindergarten entry will not be available until then.



- Percent of families with low levels of Protective Factors of the Strengthening Families model: concrete support in times of need, knowledge of parenting and child development, parental resilience, social and emotional competence of children, and social connections

### **5.3 Convene a study committee to develop performance and outcome measures for the home visiting system.**

The Office of Early Childhood will convene a study committee through the home visiting consortium to participate in the development of outcome and performance measures and then continue to meet regularly to work collaboratively to analyze data and improve performance. The study committee should be representative of all of the home visiting programs and the key partners. Although each program will need measures specific to its families, services, and funders' requirements, there is a need to:

- develop cross-program common measures that can be used to help guide the implementation of the home visiting system,
- measure our collective impact on the customers of the system,
- help determine the need for changes to the strategies we are pursuing and improvements in the services, and
- minimize the additional administrative burdens on programs where possible.

The Office of Early Childhood is committed to a collaborative process with program providers so the resulting measures are useful for program management and improvement, as well as for system accountability. The measures adopted will be used collaboratively by state funders and providers to analyze performance and design improvement actions. A meaningful subset of these measures would go into a Results Based Accountability report to the legislature.

The performance and outcome development process should follow a national best practice for outcomes measure development used by Court Support Services. The process included developing a data system and convening a standing study committee that includes both internal system administrators as well as contracted service providers. The development process was completed over five years and resulted in meaningful measures adopted by programs with minimal additional burden and full stakeholder support. The approach will also be guided by the recommendations of Governor's Nonprofit Health and Human Services Cabinet on incorporation of performance measures into Purchase of Services contracts that demonstrate the contribution of the program to population results.

#### **5.4 Begin annual Results Based Accountability reporting on the home visiting system to the legislature from the Office of Early Childhood in 2017.**

Although it is premature to identify specific performance measures in this report, the kinds of Results Based Accountability measures the home visiting consortium will consider include the following. What will be reported to the legislature is a meaningful subset of tracked measures.

*Performance measures* to be developed for system performance on penetration, target populations, geographic reach, system process functions.

##### How Much

- Number of families and children served, disaggregated by relevant demographics, characteristics, and geography
- Number of programs, services provided, and home visits by number of family risk factors
- Funding by program and system-wide

##### How Well

- Percent of eligible families served by number of family risk factors
- Percent of families completing services
- Percent of families receiving appropriate dosage of home visits based on family risk factors
- Percent of mothers screened for depression
- Percent of children screened for health, mental health, and developmental delays
- Percent of staff who meet system standards for competency
- Percent of programs implementing evidence-based models with fidelity
- Percent of programs implementing system protocol for referral, including cross-program data sharing
- Percent of programs implementing system standards for services
- Percentage of programs rated high on self-assessment tool that determines how well programs are implementing strategies to strengthen families:  
<http://www.cssp.org/reform/strengtheningfamilies/2014/HOME-VISITING-PROGRAM-SELF-ASSESSMENT.pdf>
- Percent of families satisfied with quality of services provided along multiple dimensions, including cultural competence, respect, and inclusion in decision making

*Outcome Measures* to be developed for the system to measure the impact on children and families

Better Off

- Percent of children served with health, mental health, or developmental delays receiving appropriate treatment
  - Percent of children showing improvement in each: health, mental health, or developmental delays
  - Percent of mothers served with depression receiving appropriate treatment or showing improvement in depressive symptoms
  - Percent of children served ready for kindergarten<sup>19</sup>
  - Percent of children served scoring at grade level on K-3 assessments
  - Percent of families served rated high on the five protective factors, e.g., rates of healthy births and maternal care, abuse and neglect, economic stability, ED utilization, utilizing the Protective Factors Survey, <http://friendsnrc.org/protective-factors-survey> , or similar tool
- Percent of families satisfied with various outcomes achieved through home visiting programs
- 

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<sup>19</sup> NOTE: An improved Kindergarten Entry Assessment is currently being developed by the Office of Early Childhood in partnership with seven states. It is slated for launch in 2016 and reliable data on kindergarten entry will not be available until then.

## Conclusion

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The Office of Early Childhood is pleased to submit this report in response to the legislative mandate described below. The recommendations reflect robust, cost effective, and practical next steps and identify a clear path forward. This effort, prompted by legislation, reflects another step forward toward creating a fully coordinated system of home visiting that is integrated into Connecticut's behavioral health, family support, early care and education, health, and comprehensive early childhood service systems. The Office of Early Childhood recognizes the need for continued efforts to build on these initial recommendations. The Office of Early Childhood is committed to improving the coordination and administration of the home visiting system in the coming years.

# Part Three

## Data on Need and Capacity

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## **Home Visiting in Connecticut: Defining the System Need and the Capacity**

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### **Introduction**

Home visiting programs across the state provide an array of services that can lead to positive family and child outcomes. Home visiting programs have positively impacted many lives; however, it is also evident that many children and families in need still lack access to appropriate services.

This section provides a picture of the existing need for home visiting in Connecticut by presenting high level data on outcomes and risk populations who may benefit from home visiting services. General population data and the estimated capacity of home visiting programs in Connecticut are also included. Although home visiting programs have been successful in helping many families and children, more work needs to be completed to expand home visiting access to children and families in Connecticut.

Data in this section is based on data first presented in the Department of Public Health *Statewide Needs Assessment for Maternal Infant and Early Childhood Home Visiting Programs* (2010) report. Select data points in this section were also included based on discussions in the home visiting workgroup meetings, which convened from July to November 2014. Data for this section was gathered on a statewide basis. Detailed breakdowns of the data are available from the different sources listed.

Data for the section was gathered from several sources including, but not limited to, the Connecticut Department of Public Health, the Connecticut Department of Labor, the Department of Public Safety, and the US Census American Community Survey.

### **General Population Data**

In 2013, 785,342 children ages zero to eighteen lived in Connecticut. Most children lived in households (99.7 percent); however, a small percent of children lived in group quarters<sup>20</sup> (0.3 percent, 2,336 children). The below graph (Figure 1) displays the number of children who lived in Connecticut disaggregated by age group. Currently, most home visiting programs in Connecticut serve children eight years of age and younger. Approximately, 47 percent (365,233 children) of children were eight years of age or younger in 2013.

Figure 1: Percent of Children by Age in Connecticut, 2013

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<sup>20</sup> Group Quarters is a classification term used by the US Census Bureau. Group Quarters is defined as is a place where people live or stay, in a group living arrangement. This is not a typical household-type living arrangement. Group quarters include such places as college residence halls, residential treatment centers, skilled nursing facilities, group homes, military barracks, correctional facilities, and workers' dormitories. For more information, please visit [http://www.census.gov/acs/www/data\\_documentation/documentation\\_main/](http://www.census.gov/acs/www/data_documentation/documentation_main/)

Source: American Community Survey 1 Year Survey

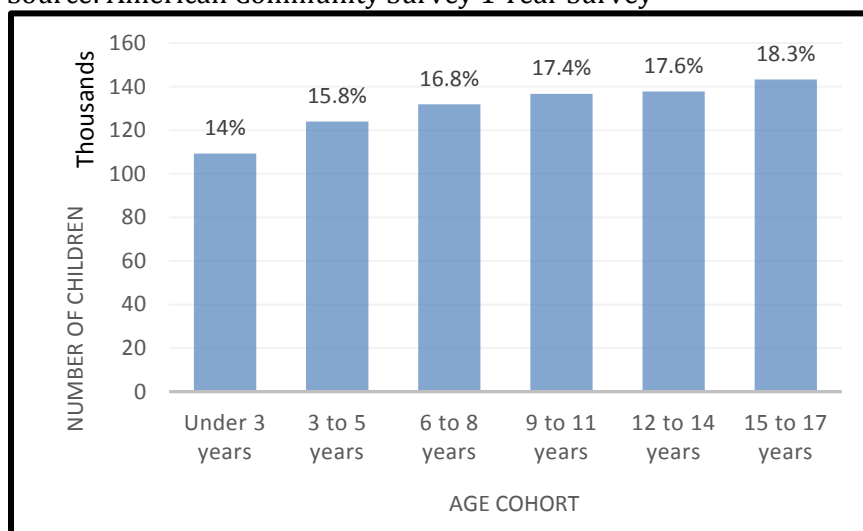


Figure 2 contains the number of women, ages 15 to 50, who gave birth in 2013. Thirty-two percent of women in this age cohort, or 11,504 women, were unmarried; and 68 percent, or 24,400 women, were married.

Figure 2: Women in Connecticut Who Gave Birth in the Last 12 Months, ages 15-50, 2013

Source: American Community Survey 1 Year Survey

	Data	Percent
<b>Total births to Women 15 to 50</b>	35,904	100%
<b>Unmarried women who gave birth</b>	11,504	32%
<b>Married women who gave birth</b>	24,400	68%

Figure 3 contains the number and percent of children in Connecticut who did not receive a home visit in 2012.<sup>21</sup> Eighty-seven percent of children, or the majority of the child population ages zero to three years, did not receive a home visit.

Figure 3: Percent of Children Who Did Not Receive Home Visiting, 2012

Source: Kids Count

	Data	Percent
<b>Children ages 0 to 3 whose parent did not receive a new parent home visit</b>	127,712	87%

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<sup>21</sup> Does not include Birth to Three participation.



## **Family and Child Health and Development Outcomes and Risk Factors**

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The following section is a list of outcomes and risk factors pulled from the DPH Needs Assessment completed in 2010, as well as additional outcomes and risk factors that the home visiting work team determined to be common across the home visiting system. Each outcome and risk factor is paired with a description and an indicator to illustrate the need.

The outcomes and risk factors included in the DPH Needs Assessment consist of standard outcomes and risk factors that have been historically tracked for the home visiting system in Connecticut. It is important to note that this list is not exhaustive; the work team plans to identify more outcomes and risk factors that are common across the home visiting system.

### **Short Term Child Health and Development Outcomes**

- Childhood Neglect and Abuse
- Children with Developmental Delays

### **Child Health and Development Risk Factors and Outcomes**

- |  |  |
|--|--|
| • Early Childhood Poverty                                  | • Tobacco Use During Pregnancy                                     |
| • Low Educational Attainment                               | • Alcohol use during Pregnancy                                     |
| • Teen Parenthood  | • Perinatal/Maternal Depression (Data not available) <sup>22</sup> |
| • Children Affected by Crime (including domestic violence) | • Low Birth Weight and Preterm Birth                               |
| • Asthma   | • Fetal and Infant Mortality                                       |
| • High Blood Lead Levels                                   | • Infant Deaths Due to Neglect or Abuse                            |
| • Homelessness   | • Single Parenthood  |
| • Infants Born into Poverty                                | • Early Language Development                                       |
| • Late or No Prenatal Care                                 |  |

### **Long Term Child Health and Development Outcomes**

- Early Scholastic Achievement
- High School Dropout Rates

### **Short Term Child Health and Development Outcomes**

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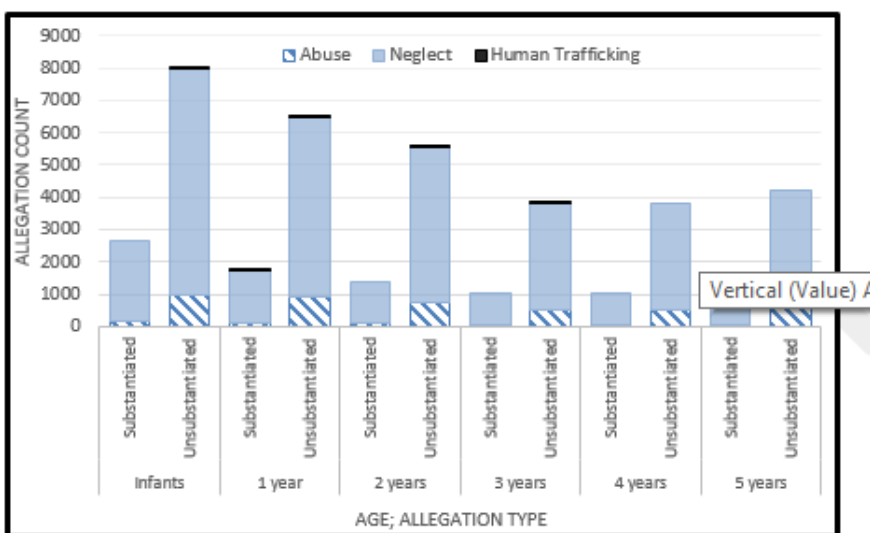
#### **Childhood Neglect and Abuse**

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<sup>22</sup> No data on this risk factor was included in the DPH Needs Assessment.

Child abuse and neglect affects a child's development. In fiscal year 2014, there were a total of 40,747 child abuse and neglect allegations, and 8,894 allegations were substantiated. Neglect was much more frequent than abuse across all age groups. It is important to note that neglect is the form of maltreatment that is most directly associated with poverty. According to the Child Welfare Information Gateway, when compounded with other factors such as substance abuse and financial uncertainty, poverty places a child at a significantly higher risk for neglect.<sup>23</sup> Figure 5 displays the total number of Department of Children and Families abuse and neglect allegations, substantiated and unsubstantiated, by age group.<sup>24</sup>

Figure 5: DCF Child Abuse and Neglect Counts, Fiscal Year 2014  
Source: Connecticut Department of Children and Families



### Children with Developmental Delays

Children who exhibit significant developmental delays are at risk for manifesting developmental challenges later in life. The Connecticut Birth to Three System is a statewide program whose mission is to strengthen the capacity of Connecticut's families to meet the developmental and health needs of infants and toddlers. In fiscal year 2012 the Connecticut

<sup>23</sup> DePanfilis, Diane. Child Neglect: A Guide for Prevention, Assessment, and Intervention. Child Welfare Information Gateway. Web. 20 Nov 2014. <https://www.childwelfare.gov/pubs/usermanuals/neglect/chapterfour.cfm>

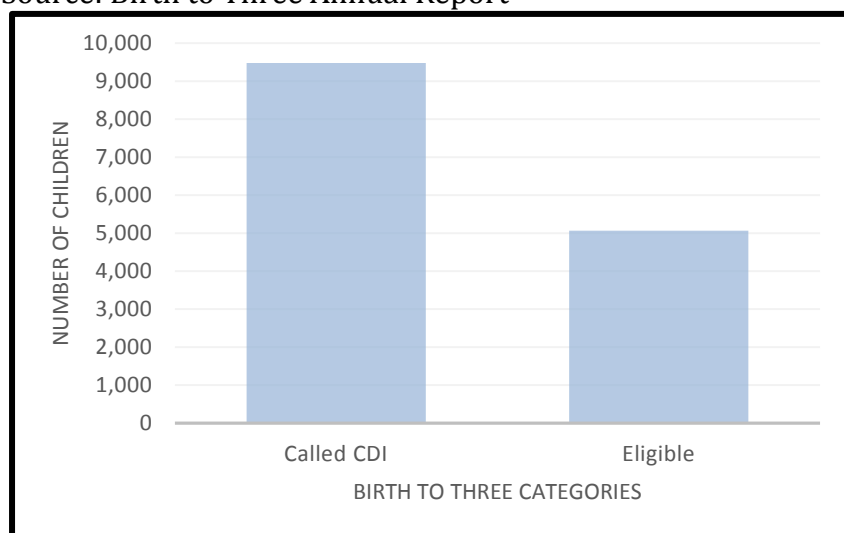
<sup>24</sup> Total abuse and neglect allegations are comprised of different types of abuse and neglect. Neglect breakouts: educational neglect, emotional neglect, medical neglect, and moral neglect. Abuse breakouts: emotional abuse/maltreatment, physical abuse, and sexual abuse/exploitation.

Birth to Three System created a new initiative to help ensure that infants who are eligible for services before the age of one are identified and their families are offered early intervention supports.<sup>25</sup> Birth to Three evaluates children for:

- Problem solving skills (cognitive);
- Understanding and expressing ideas (communication)
- Self-help skills such as eating (adaptive)
- Ability to move well, see, and hear (motor and physical)
- Ability to express feelings and understand other people (social-emotional)<sup>26</sup>

Before the age of three, 12 percent of each Connecticut birth cohort received services provided by Birth to Three. Figure 6 shows the number of calls made to the Child Development Infoline (CDI) which is a statewide hotline for families to connect to the services they need. Of the 9,480 children for whom there was a concern leading to a call, 5,067 were referred, evaluated, and found due to have a significant developmental delay. (Eligible for Birth to Three Services).

Figure 6: Connecticut Birth to Three Service Categories, Fiscal Year 2014  
Source: Birth to Three Annual Report



<sup>25</sup> "Taking First Steps Together: Connecticut Birth to Three System 2012. Connecticut Birth to Three. Web. 14 Nov 2014.  
<http://www.birth23.org/files/ADR/AnnualReportFY12.pdf>

<sup>26</sup> Ibid 6.

## Child Health and Development Risk Factors and Outcomes

### Early Childhood Poverty

The DPH Needs Assessment cites early childhood poverty as a risk factor for child health and development outcomes. Figure 9 displays the number of children in poverty in 2013 by age cohort.

Figure 9: Number of Connecticut Children Living in Poverty, 2013

Source: US Census American Community Survey

Age Group	Total Children
<b>Under 5 years</b>	32,540
<b>5 years</b>	6,199
<b>6 to 11 years</b>	35,095

Figure 10 displays the child poverty trends in Connecticut disaggregated by age group. In all three age categories, the percent in poverty increased over the time period. The percent of children under the age of five was generally higher than the percent of children in poverty in the other age cohorts.

The prevalence and increase of Connecticut children in poverty deserves serious attention. Actionable steps need to be implemented to abate its prevalence. Programs that provide economic supports to families and children are critical in reversing this trend.

Figure 10: Percent of Connecticut Children Living in Poverty, 2005-2013

Source: US Census American Community Survey, 1 Year Survey

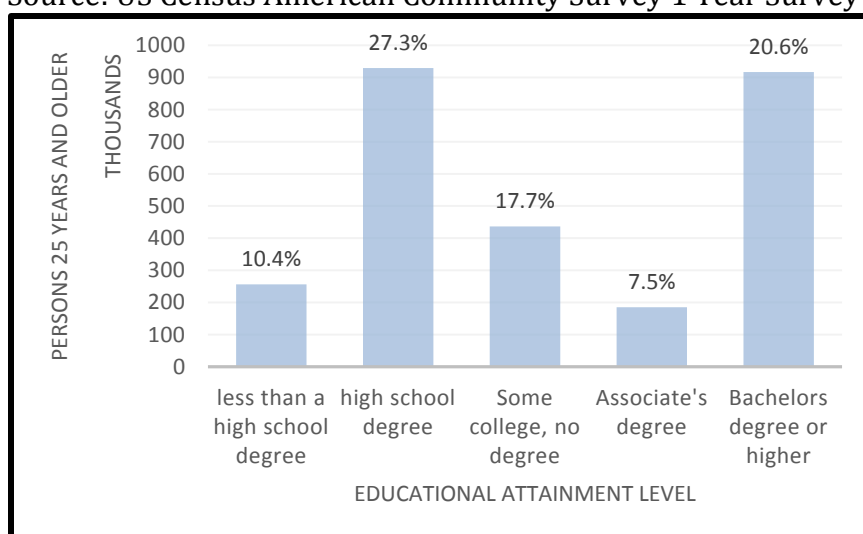


### **Low Educational Attainment**

Figure 7 displays educational attainment levels for Connecticut's population 25 and older in 2013. According to the figure approximately 256,000 individuals, 25 years and older (10.4 percent), obtained less than a high school degree. People who have not obtained at least a high school degree experience difficulty in finding employment, especially during recessionary periods. This often exposes a person to economic insecurity. Home visiting programs attempt to mitigate this by encouraging school readiness and school success, as well as providing families with economic supports.

Figure 7: Educational Attainment for Individuals 25 Years and Older, 2013

Source: US Census American Community Survey 1 Year Survey

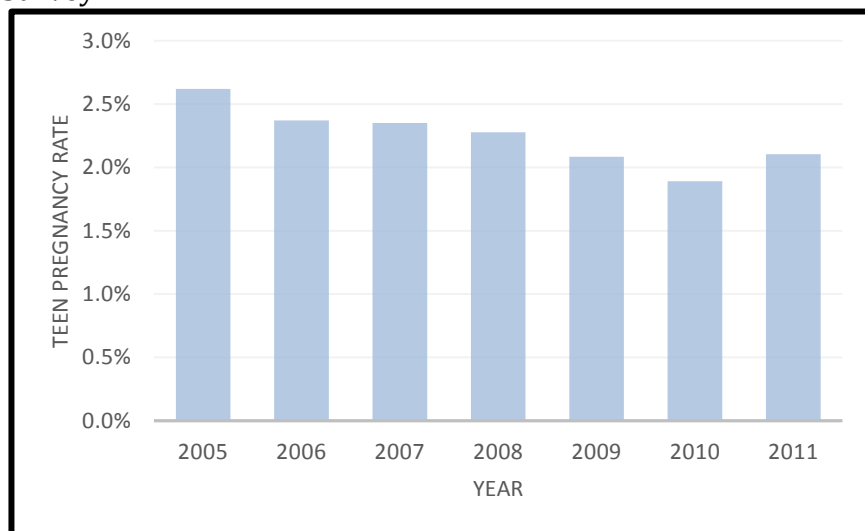


### **Birth to Teenage Mothers**

Teen parenthood is another focus of several home visiting programs in Connecticut. Figure 8 displays the percent of Connecticut teenagers ages 15 to 19 who were pregnant during the years shown. The graph shows that from 2005 to 2010, the rate trended downward. However, in 2011 the rate of teen pregnancy increased to slightly over 2 percent. In 2011, 2,629 teenagers gave birth.

Figure 8: Connecticut Births to Teen Mothers, 2005-2011

Source: Connecticut Department of Labor, IWIP data; US Census American Community Survey



### **Children Affected by Crime**

The DPH Needs Assessment also listed children affected by crime as a risk factor that home visiting programs need to address. Witnessing crimes can be traumatic for a young child, and consequently may affect their mental state and overall development.

The DPH Needs Assessment called for collecting data on the number of children who had an incarcerated parent in Connecticut as a proxy for children affected by crime. However, data on incarcerated parents in Connecticut was not available when the Needs Assessment was completed and is still not available. However, the Connecticut Department of Safety collects data on the number of child victims and the number of domestic violence offenses with children involved or present. Figure 11 displays the number of child victims in 2011.

Figure 11: The Number of Child Domestic Violence Victims, 2011

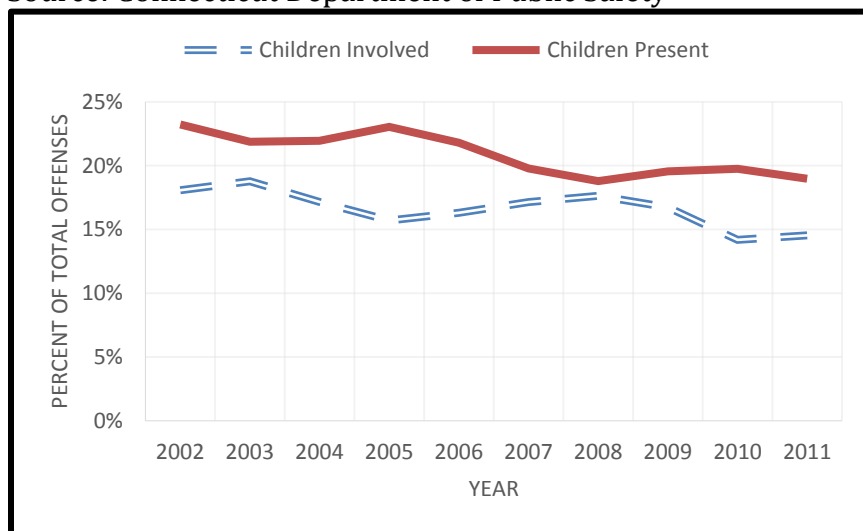
Source: Connecticut Department of Public Safety

Child victims	Data
<b>0 -1 years</b>	155
<b>2 to 5 years</b>	216
<b>6 to 9 years</b>	199

Figure 12 displays Connecticut domestic violence offenses from 2002 to 2011 with children involved and present. Overall, both trends are generally decreasing overtime. However, the percent of offenses with children involved or present is staggering. In 2011, in 19 percent of offenses (3,888 offenses) children were present and in 14.5 percent of offenses children were involved (2,979 offenses). Domestic violence incidents can severely affect a child; therefore it is imperative to address this risk factor.

Figure 12: Connecticut Domestic Violence Offenses with Children Involved or Present, 2002-11

Source: Connecticut Department of Public Safety



### **Asthma and High Blood Lead Levels**

The prevalence of asthma and high blood lead levels was also listed as risk factors that can negatively impact a child's overall health and development.

According to the Centers for Disease Control and Prevention (CDC), any lead amount present in a child's blood is harmful. Lead exposure has been shown to affect a child's IQ, ability to pay attention, and academic achievement.<sup>27</sup> Further, once a child has been exposed to lead, the effects cannot be reversed. In Connecticut, medical providers are mandated to conduct blood level testing for children ages 9 to 72 months.<sup>28</sup> In 2012, 75,569 children under the age of six, or approximately 40 percent of children under the age of six

<sup>27</sup> What Do Parents Need to Know to Protect Their Children? Centers for Disease Control and Prevention, 2014. Web. 14 Nov 2014. < [http://www.cdc.gov/nceh/lead/ACCLPP/blood\\_lead\\_levels.htm](http://www.cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm) >

<sup>28</sup> Hung, Tsui-Min. "Childhood Lead Poisoning in Connecticut: 2011 Surveillance Report." Connecticut Department of Public Health. Web 14 Nov 2014.

[http://www.ct.gov/dph/lib/dph/environmental\\_health/lead/pdf/CY\\_2011\\_Surveillance\\_Report\\_11-6-2012.pdf](http://www.ct.gov/dph/lib/dph/environmental_health/lead/pdf/CY_2011_Surveillance_Report_11-6-2012.pdf)

in Connecticut, were tested for lead. Figure 13 shows the number of children in 2012 who had blood levels greater than 5 mg/dl.

Figure 13: Number of Children with High Blood Lead Levels, 2012

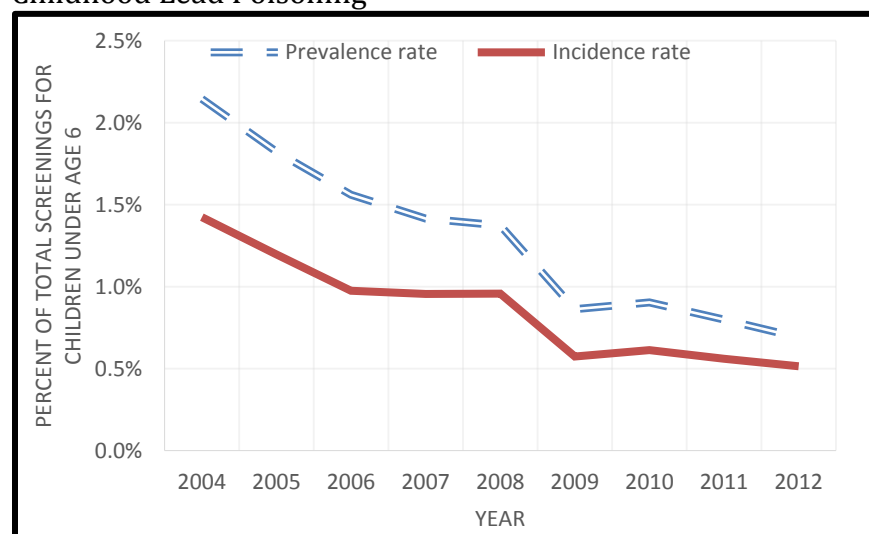
Source Connecticut Department of Health, Annual Disease Surveillance Report on Childhood Lead Poisoning

	Data	As a Percent of Screenings
<b>greater or equal to 5 mg/dl</b>	2,261	2.9%
<b>greater or equal to 15 mg/dl</b>	196	0.25%
<b>greater or equal to 20 mg/dl</b>	107	0.14%

Figure 14 shows the prevalence and incidence of lead blood levels in children under the age of six over time. The prevalence and incidence, as a percent of screenings, dropped over this time frame.

Figure 14: Prevalence and Incidence of Lead Levels over 10 dl of Children under Age Six, '04-2012

Source: Connecticut Department of Health, Annual Disease Surveillance Report on Childhood Lead Poisoning



Asthma can also adversely affect a child's health. Asthma can be triggered by air pollutants, dust mites, mold, and tobacco smoke among other factors. Common symptoms of asthma



include wheezing, breathlessness, and coughing.<sup>29</sup> Figure 15 displays the number of children by age cohort affected by asthma in 2010.

Figure 15: Asthma Prevalence by Age Cohort, 2010

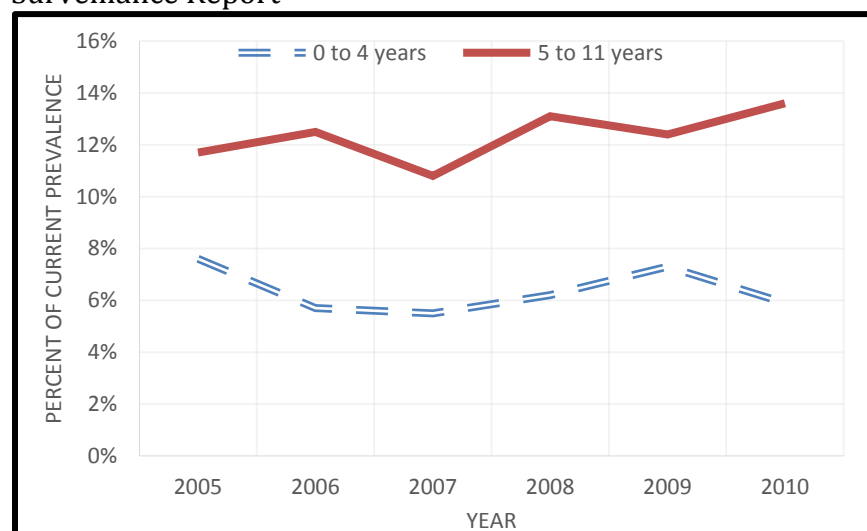
Source: Connecticut Department of Public Health

	Data	Percent
<b>0 to 4 years</b>	11,907	5.9%
<b>5 to 11 years</b>	43,212	13.6%

Figure 16 shows the prevalence of asthma among two age cohorts: zero to four years of age, and five to 11 years of age. The prevalence among children five to 11 years of age generally increased over the time period displayed. The prevalence rate of asthma in children under the age of five decreased slightly.

Figure 16: Current Prevalence of Asthma by Age Cohort, 2005-2010

Source: Connecticut Department of Health, The Burden of Asthma in Connecticut: 2012 Surveillance Report



<sup>29</sup> *Learn How to Control Asthma*. Centers for Disease Control and Prevention, 2014. Web. 14 Nov 2014.  
<http://www.cdc.gov/asthma/faqs.htm>

## **Homelessness**

According to the Connecticut Coalition to End Homelessness, there were approximately 754 children (55.7 percent of homeless shelter population) living in Department of Social Services (DSS) funded emergency shelters in the third quarter of 2013.<sup>30</sup>

According to the American Psychological Association, outcomes associated with children who are homeless include hunger, poor physical and mental health, and interrupted or delayed schooling.<sup>31</sup> Several home visiting programs in Connecticut work with children in these circumstances in attempts to prevent the listed outcomes associated with homelessness.

Figure 17: DSS Funded Emergency Shelter Population, 3<sup>rd</sup> Quarter of 2013

Source: Connecticut Coalition to End Homelessness

	Data	Percent
<b>Total persons</b>	1,354	100.0%
<b>0-2 years</b>	261	19.3%
<b>3-5 years</b>	177	13.1%
<b>6-13 years</b>	316	23.3%

## **Infants Born into Poverty**

The DPH Needs Assessment lists infants born into poverty as a risk factor for maternal, birth, and infant outcomes. Figure 18 displays the number of women who gave birth in Connecticut who had incomes below the poverty line in 2013.

Figure 18: Connecticut Women, Ages 15 to 50, Who Gave Birth in the Last 12 Months by Poverty Level<sup>32</sup>, 2013

Source: American Community Survey, US Census Bureau

	Data	Percent
<b>Women who had a birth in the past 12 months</b>	35,889	100.0%

<sup>30</sup> The population living in DSS emergency shelters is not the entire population universe of the homeless in Connecticut.

<sup>31</sup> *Effects of Poverty, Hunger, and Homelessness on Children and Youth*. American Psychological Association. Web. 14 Nov 2014. <http://www.apa.org/pi/families/poverty.aspx>

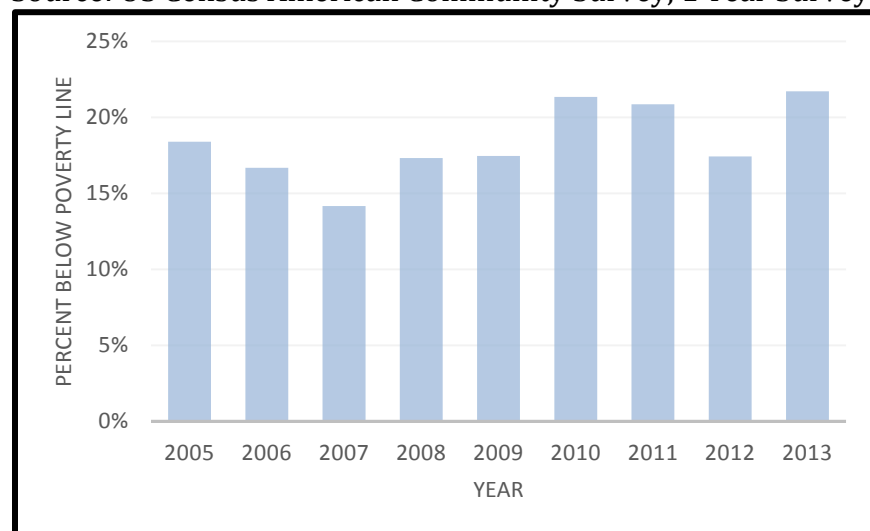
<sup>32</sup> Women 15 to 50 years for whom poverty status is determined (differs from 2013 total birth estimate).

<b>Women who gave birth, below the poverty level</b>	7,796	22%
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Figure 19 displays the percent trend overtime. The figure shows a steady rise in the percent in poverty. In 2013, the percent of women in poverty who gave birth peaked at 22 percent (7,796 women) indicating a persistent trend in need of reversal. Many home visiting programs aim to reduce the number of families and children in poverty by providing critical economic supports in times of need.

Figure 19: Percent of Women, Ages 15 to 50, Who Gave Birth with Incomes below Poverty Line, 2005-'13

Source: US Census American Community Survey, 1 Year Survey, 2005-2013



### **Late or No Prenatal Care**

Late or no prenatal care was also listed as a risk factor contributing to maternal, birth, and infant outcomes in the DPH Needs Assessment. Figure 20 displays the number of births in Connecticut associated with late or no prenatal care in 2011.

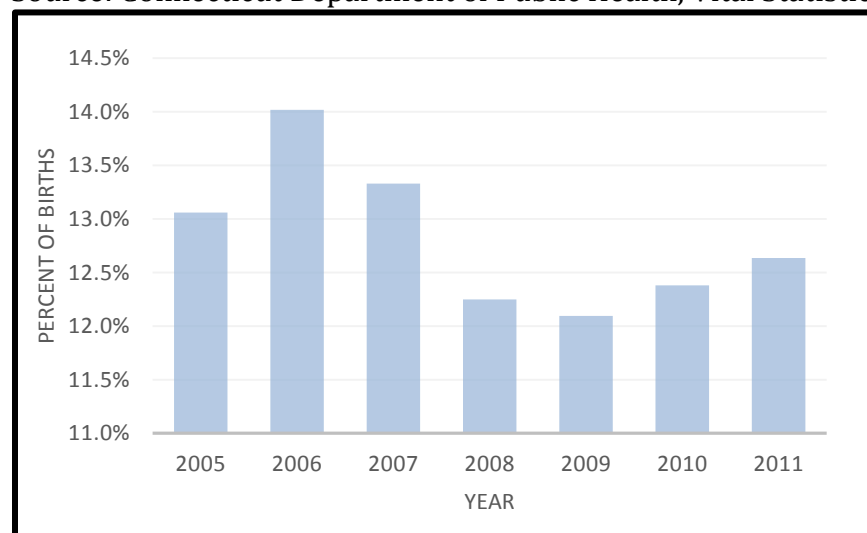
Figure 20: Late or No Prenatal Care<sup>33</sup> in Connecticut, 2011  
 Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
<b>Total births</b>	37,277	100.0%
<b>Late or no prenatal care</b>	4,800	12.9%

Figure 21 displays the trend in the percent of births associated with late or prenatal care. From 2006 to 2009, there was an observable decrease in the percent of births associated with late or no prenatal care. However in 2010 and 2011, the percentage increased again. There were 4,800 births associated with late or prenatal care in 2011.

Prenatal care can be an important resource for pregnant mothers and their families. During prenatal care, mothers and families are informed on the steps needed to increase the chances of a healthy delivery, such as which substances to avoid, and vitamin intake.<sup>34</sup> If more mothers participate in prenatal care in Connecticut, it should improve positive birth outcomes.

Figure 21: Percent of Connecticut Births Associated with Late or Prenatal Care, 2005-2011  
 Source: Connecticut Department of Public Health, Vital Statistics



## **Tobacco and Alcohol Use during Pregnancy**

<sup>33</sup> Late prenatal care is defined as prenatal care beginning in the second or third trimester of pregnancy.

<sup>34</sup> *What is Prenatal Care and Why is it Important*. National Institute of Child Health and Human Development, 2013. Web. 14 Nov 2014. [www.nichd.nih.gov/health/topics/pregnancy](http://www.nichd.nih.gov/health/topics/pregnancy)

According to the Centers for Disease Control and Prevention (CDC), smoking during pregnancy can lead to several pregnancy complications, such as premature birth, Sudden Infant Death Syndrome (SIDS), placenta damage, and low birth weight.<sup>35</sup> Further, alcohol usage can lead to premature delivery, and developmental problems in children.<sup>36</sup>

Figure 22 shows the incidence of tobacco and alcohol consumption during pregnancy in Connecticut. In 2011, 4.6 percent of births were associated with pregnant women who smoked (2,910 births), and 0.5 percent of births (195 births) were associated with women who consumed alcohol.

Figure 22: Connecticut Births to Mothers Who Smoked During Pregnancy, 2011

Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
<b>Total births</b>	37,227	100.0%
<b>Consumed alcohol during pregnancy</b>	195	0.5%
<b>Smoked during pregnancy</b>	1,729	4.6%

Figure 23 displays the trend in usage by substance type. According to the figure, tobacco and alcohol usage declined from approximately 2004 to 2010, however alcohol use increased in 2011.

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<sup>35</sup> *Tobacco Use and Pregnancy*. Centers for Disease Control and Prevention, 2014. Web. 14 Nov 2014.

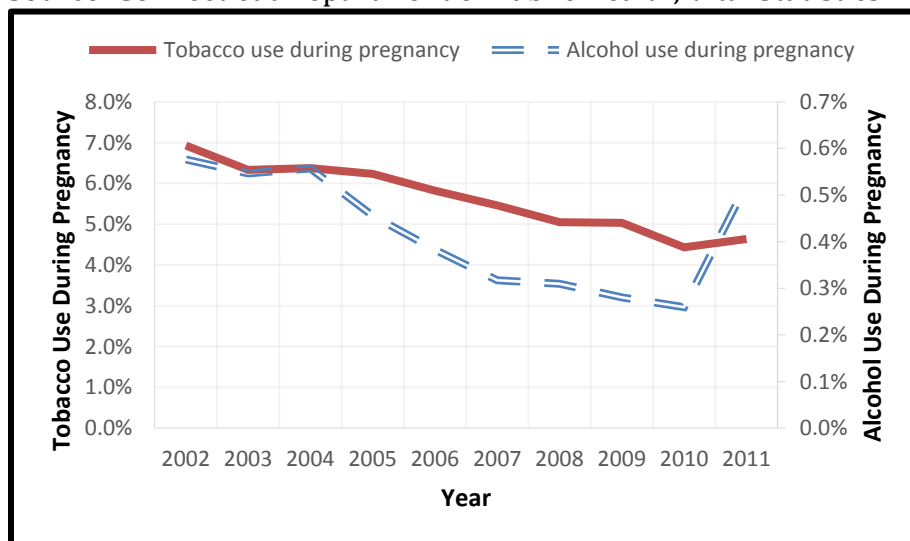
<http://www.cdc.gov/reproductivehealth/tobaccousepregnancy/>

<sup>36</sup> *Alcohol and Pregnancy*. US National Library of Medicine, National Institute of Health, 2014. Web. 14 Nov 2014.

<http://www.nlm.nih.gov/medlineplus/ency/article/007454.htm>

Figure 23: Alcohol and Smoking Prevalence among Mothers, as a Percentage of Total Births, 2002-2011

Source: Connecticut Department of Public Health, Vital Statistics



### **Perinatal/Maternal Depression**

Perinatal and maternal depression is a significant risk factor affecting family and child healthy development. Maternal depression has been linked to a myriad of factors such as genetic predisposition and situational factors. Research has also shown that mothers who live in poverty are more likely to experience depression. Maternal depression can negatively impact birth outcomes, and can affect a child's behavioral, cognitive, and social and emotion functioning.<sup>37</sup>

It is estimated that 12 percent of women experience depression in a given year, and post-partum depression is estimated to affect between five to 25 percent of pregnant mothers.<sup>38</sup> Maternal depression data is not currently available for Connecticut. Nevertheless, maternal depression should be acknowledged and its risk factors should be monitored. Many home visiting programs in Connecticut work with mothers who have depression.

### **Low Birth Weight, Preterm Birth, and Fetal and Infant Mortality**

In 2013, there were 35,904 women, ages 15 to 50, who gave birth and resided in Connecticut. Several home visiting programs work with pregnant mothers in attempts to

<sup>37</sup> Knitzer, Jane, et al. "Reducing Maternal Depression and Its Impact on Young Children toward a Responsive Early Childhood Policy Framework." National Center for Children in Poverty. (2008). Web 14 Nov 2014.

<[http://www.nccp.org/publications/pdf/text\\_791.pdf](http://www.nccp.org/publications/pdf/text_791.pdf)

<sup>38</sup> Ibid 2.

decrease the possibility of negative birth outcomes, such as low birth weight, and fetal and infant mortality. Figure 24 displays the number of infant and fetal deaths in 2011.

**Figure 24: Connecticut Fetal and Infant Mortality, 2011**

Source: Vital Statistics, Connecticut Department of Public Health

	Data	Rate
<b>Fetal deaths</b>	209	5.6 per 1000 births
<b>Infant deaths</b>	194	5.2 per 1000 births

Figure 25 displays the number of fetal and infant deaths from 2002 to 2011. There has been an overall reduction in the number of infant and fetal deaths, however the number of fetal deaths increased from 2009 (188 deaths) to 2011 (209 deaths).

**Figure 25: The Number of Fetal and Infant Deaths, 2002-2011**

Source: Department of Public Health, Vital Statistics

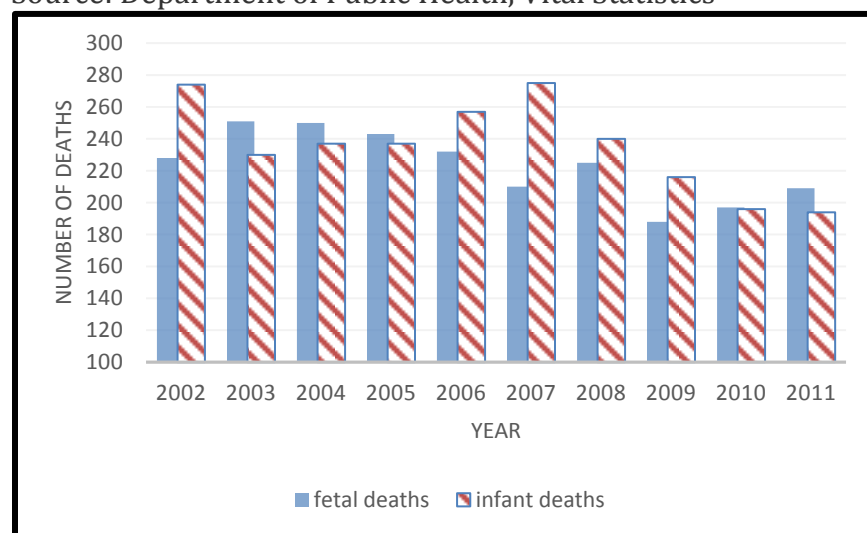


Figure 26 displays the number of low birth weights and preterm births in 2011.

Figure 26: Connecticut Preterm Births and Low Birth Weights, 2011

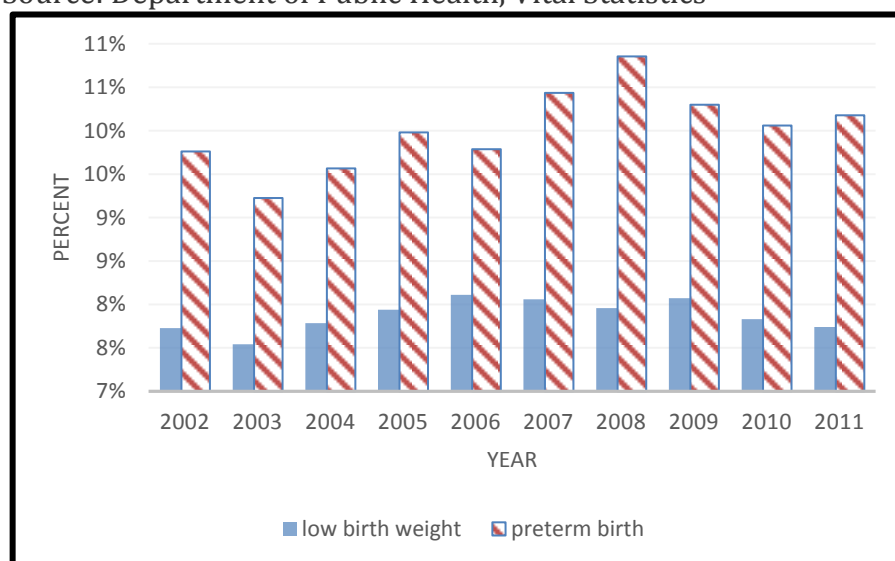
Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
<b>Total births</b>	37,277	100%
<b>Low birth weight (&lt;2500g)</b>	2,885	8%
<b>Before 37 weeks gestation</b>	3,794	10.1%

Figure 27 displays the trend in preterm births and low birth weights. From 2003 to 2008 there was a percent increase in both low birth weights and preterm births. However, after 2008, there was a general decline in both. In 2011, there were 2,885 low weight births and 3,794 pre-term births.

Figure 27: Low Weight Births and Preterm Births as a Percent of Total Births, 2002-2011

Source: Department of Public Health, Vital Statistics



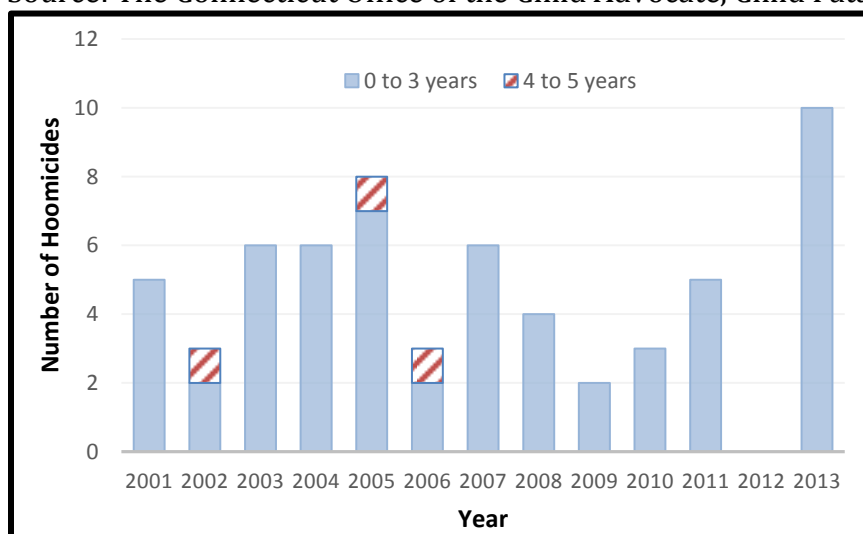


### **Infant Deaths Due to Neglect or Abuse**

Several home visiting programs in Connecticut also attempt to impact infant death due to neglect and abuse. The Office of the Child Advocate recently released a report investigating deaths of children in 2013. In 2013, there were 82 child fatalities. Fifteen percent of the 2013 child fatalities were determined to be accidents, and 12 percent resulted from homicide.

Figure 28 displays the number of child homicides for children, ages zero to five, over the time frame of 2001 to 2013. In 2013 there were ten child homicides, which is the highest over the 2001 to 2013 time frame. According to the report, seven children died from abusive head or blunt force trauma, two children died of gunshot wounds, and one child died as a result of homicidal asphyxia.

Figure 28: Connecticut Homicide Data, Children Ages Zero to Five, 2001-2013  
Source: The Connecticut Office of the Child Advocate, Child Fatality Report.



### **Single Parenthood**

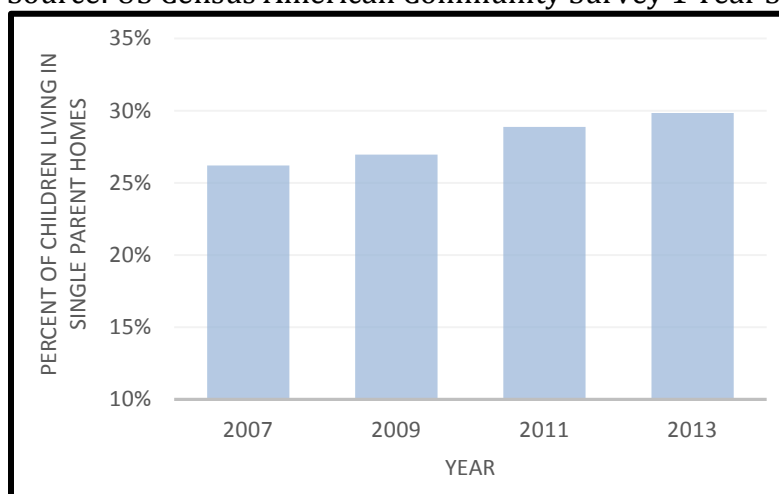
Single parenthood is associated with child neglect. One particular study found that the probability of child neglect was 87 percent higher if a child lived with only one parent. One factor is that a single parent, or caregiver, may spend less time with a child because the parent, or caregiver, may need to allocate more time to completing household tasks. In a

multiple caregiver or parent arrangement, household tasks can be distributed to more people, thus freeing up time that can be spent with a child.<sup>39</sup>

In 2013, 212,501 children lived in single parent households (30 percent of all Connecticut children). The percent of children living in single parent households has steadily increased over time. Figure 29 displays the percent of children living in single parent households in Connecticut.

Figure 29: The Percent of Children Living in Single Parent Households, 2007-2013

Source: US Census American Community Survey 1 Year Survey



### **Early Language Development**

In their first 24 months of life, children learn by listening to sounds of the family culture and language. Infants need exposure to words and books to assist in their language development.<sup>40</sup> Although there is no specific data that tracks the language development of infants and toddlers in Connecticut, there is data on the extent to which parents read to their children, and thus expose them to language. Figure 30 shows this data for Connecticut. From 2011 to 2012, approximately 13 percent of children ages one to five were read to by their family members less than three days per week (27,000 children).

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<sup>39</sup> DePanfilis, Diane. *Child Neglect: A Guide for Prevention, Assessment, and Intervention*. Child Welfare Information Gateway. Web. 20 Nov 2014. <https://www.childwelfare.gov/pubs/usermanuals/neglect/chapterfour.cfm>

<sup>40</sup> "Statewide Needs Assessment for Maternal, Infant, and Early Childhood Home Visiting Programs." (2010) Connecticut Department of Public Health. Web. 20 Nov 2014. [http://www.ct.gov/dph/lib/dph/family\\_health/home\\_visiting/needs\\_assessment\\_complete\\_091510.pdf](http://www.ct.gov/dph/lib/dph/family_health/home_visiting/needs_assessment_complete_091510.pdf)

Figure 30: Children Ages 1 to 5 whose Family Members Read to Them Less than 3 Days per Week, Various Years

Source: Child Trends analysis of data from the U.S. Department of Health and Human Services

	Data	Percent
<b>2003</b>	27,000	12%
<b>2007</b>	20,000	10%
<b>2011 - 2012</b>	27,000	13%

## Long Term Child Health and Development Outcomes

### Early Scholastic Achievement

One of home visiting's areas of focus is early scholastic achievement. Home visitors aim to prepare children and families for school readiness and success through a variety of methods.

Educational institutions often use a standardize test to evaluate a student's academic level. Students in Connecticut are tested at different intervals throughout their academic careers. One test administered is the Connecticut Mastery Test (CMT). Students are first tested in third grade and are tested in critical learnings areas: writing, reading, and mathematics. It is important to note that the CMT can be an indicator of early scholastic achievement, but it is not an absolute determination of a child's cognitive ability. Figure 31 displays the number and percent of children in third grade who did not meet the CMT goal in the 2010-2011 school year.

Figure 31: Children in Connecticut below Goal in Third Grade, Connecticut Mastery Test, 2010-2011 School Year

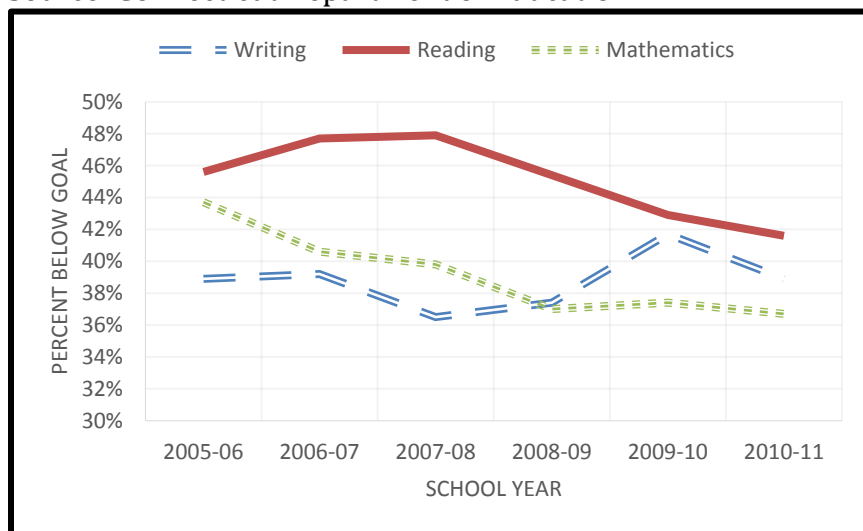
Source: Connecticut Department of Education

	Number tested	Number below goal	Percent
Writing	39,124	15,219	38.9%
Reading	37,964	15,793	41.6%
Mathematics	38,377	14,084	36.7%

Figure 32 displays the percent of 3<sup>rd</sup> grade children tested who did not meet the CMT score goal from the 2005-2006 school year to the 2010-2011 academic year. Overall, the number of children who did not meet the goal declined during this time period. However, in the 2008-2009 school year there was an increase in the number of students who did not meet the writing goal.

Figure 32: Percent of Children in Connecticut at or Above Goal, Connecticut Mastery Test, 2005-2011

Source: Connecticut Department of Education



### **Outcome: High School Dropout Rates**

According to research, students drop out of high school for several reasons including life events such as pregnancy or family economic reasons; and behavioral reasons.<sup>41</sup> Several home visiting programs in Connecticut focus on school readiness and providing families with economic supports to positively impact outcomes such as the high school dropout rate. Figure 33 displays Connecticut high school dropouts as a percent of total enrollment in 2011.<sup>42</sup>

Figure 33: Connecticut High School Dropout Rate, School Year 2011

Source: Information for Workforce Investment Planning, Connecticut Department of Labor

	Data	Percent
<b>High school enrollment</b>	170,255	100%
<b>High school drop outs</b>	4,377	2.6%

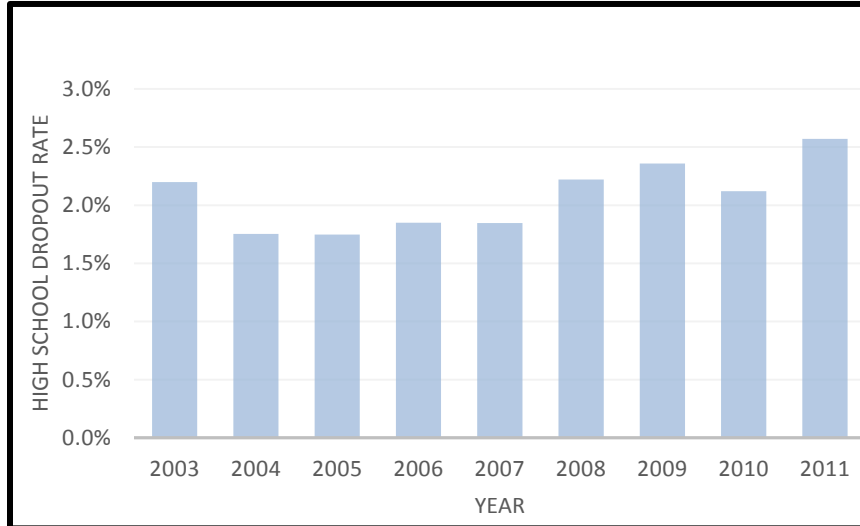
<sup>41</sup> Balfanz, Robert. "What Community Can Do to End its Dropout Crisis?" Center for Social Organization of Schools, John Hopkins University. Web. 14 Nov 2014. [http://web.jhu.edu/CSOS/images/Final\\_dropout\\_Balfanz.pdf](http://web.jhu.edu/CSOS/images/Final_dropout_Balfanz.pdf)

<sup>42</sup> Referring to 2010-2011 academic year.

Figure 34 displays a steady dropout increase and a rate peak in 2011 at 2.6 percent (4,377 students).

Figure 34: Connecticut High School Dropout Rate, 2003-2011

Source: Connecticut Department of Labor, IWIP data



## Home Visiting Capacity in Connecticut

During this study, a list of major home visiting programs that provide services in Connecticut was compiled. Each program differs in terms of the service offered and the model used, however all have the common goal of supporting families and their children in order to reach positive outcomes such as healthy births, family well-being, and healthy child development.

The number of children served by these programs was also collected to gain a sense of the overall current capacity of the system. Altogether, home visiting programs in Connecticut served approximately 18,607 children in fiscal year 2014 (Figures 35 and 36).

When compared against the risk populations outlined above, home visiting programs do not appear to have the capacity to meet the need of the different populations in need of supportive services. If the capacity of home visiting programs is expanded to meet the need, more positive outcomes for children and families could be reached in Connecticut.

Figure 35: Connecticut Home Visiting Programs, Number of Children Served in Fiscal Year 2014

Source: Home Visiting Work Team

Capacity	Estimated Children Served in FY 2014
Birth to Three	9,686
Nurturing Families Network (Parents as Teachers)	2,336
Family Resource Center (Parents as Teachers)	1,132
Child First*	985 <sup>43</sup>
Parents as Teachers (MEICHV)	690
Early Head Start	549
Family School Connection	169 <sup>44</sup>
Nurse Family Partnership (MIECHV)	107
Minding the Baby	36
Early Childhood Parents in Partnership	Not available
Young Adult Services Young Parents Program	Not available
<b>Total experiences with Home Visiting Programs (may be duplicative)</b>	<b>15,690</b>

\*Also serves DCF involved families.

<sup>43</sup> Estimate of children served based on the number of families served.

<sup>44</sup> Estimate of children served based on the number of families served.

Figure 36: Department of Children and Families Home Visiting Programs  
 Source: Home Visiting Work Team

Capacity	Estimated Children Served in FY 2014
Positive Parenting	1,558
Integrated Family Violence Services	856
Caregivers Support	260 <sup>45</sup>
Intensive Home Based Services: Family-Based Recovery	204
<b>Children served by home visiting</b>	<b>2,878</b>

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<sup>45</sup> Estimate of children served based on the number of families served.



# Part Four

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## Appendix A: Recommendations Development Process

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The Office of Early childhood assembled and managed an inter-agency and multi-program work team to ensure the development of recommendations for designing a home visiting system were practical and amenable to the field as well as ambitious. Work team members shared documents, gathered for monthly meetings, and provided input and insight at every stage of the development of recommendations. The result of this time and energy is a set of recommendations that are agreed upon by the leaders in the field in Connecticut and set the stage for future trusting, collaborative, and lasting partnerships and collaborative work. The full list of work team members is included at the start of the report.

Workgroup support and data analysis support was provided by the Connecticut Economic Resource Center, Inc.: Bob Santy, Alissa DeJonge, Carmel Ford, and Pat McLaughlin. Additional input and feedback provided by individual contributors such as Marcia Hughes, Bennet Pudlin, and Kristina Stevens.

The recommendations were shared in draft form with the public for feedback. Two focus groups and an online survey were able to gather very thoughtful reactions and suggestions from over 75 home visitors and program administrators in the field. Overwhelmingly, the response to the draft recommendations was positive. Many stakeholders suggested additional recommendations or emphasis and their ideas were incorporated into the report with few exceptions.

### Work Team Members:

Maggie Adair	Mickey Kramer
Cathy Battista	Pam Langer
Marcie Cavacas	Catherine Lenihan
Nancy DiMauro	Darcy Lowell
Doug Edwards	Judith Meyers
Mary Farnsworth	Mary Peniston
Karen Foley-Schain	Lynn Skene Johnson
Linda Goodman	Janet Storey
Linda Harris	Grace Whitney
	Zimmerman, Elaine

## **Appendix B: Nebraska's Universal Competencies**

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### **Nebraska's Universal Competencies**

#### **Universal Competency 1**

Appreciates and recognizes the impact and role relationships play in the context of all learning, growth and change including, but not limited to, relationships between the child & other children, parent & child, parent & professional, professional & child, or professional & professional.

#### **Universal Competency 2**

Respects and accepts a family's expertise regarding their family system and children. Encourages family involvement and collaboration in all plan development and implementation from a strengths based approach.

#### **Universal Competency 3**

Recognizes the role culture plays in a family life and respects how it impacts their view of the world and choices in raising a family.

#### **Universal Competency 4**

Demonstrates core knowledge and the ability to infuse knowledge into practice in the areas of resiliency, child development, social-emotional development, attachment (healthy development of and impact of loss, stress or trauma), infant mental health principles, brain development, and the impact of risk factors on family and child development.

#### **Universal Competency 5**

Identifies the benefits of using a child and family's natural environments and routines for learning and demonstrates the ability to increase the consistency, predictability, and engagement qualities of these areas.

#### **Universal Competency 6**

Recognizes the value of play, language and literacy in learning and the development and nurturing of relationships.

#### **Universal Competency 7**

Demonstrates empathy for all individuals and the ability to see from the child's perspective (thinking about how the adult's actions are interpreted through the eyes of the child).

**Universal Competency 8**

Demonstrates awareness of the developmental phases and behaviors of a family and the ability to support the family to navigate effectively through transitions.

**Universal Competency 9**

Recognizes the components of quality observation and assessment and uses the information to inform practice.

**Universal Competency 10**

Is active in one's own professional development plan – seeking advancement of knowledge for application to service provision.

**Universal Competency 11**

Identifies the benefits of quality reflective supervision, demonstrating the ability to reflect on one's own bias, and personal reactions to working with children and families.

The following tables represents potential alignment of existing Connecticut frameworks and competencies to the universal competencies of Nebraska using Universal Competency 4 as an example.

<b>Home Visiting</b>	<b>Parents as Teachers/MIECHV</b>	<b>Nurturing Families Network</b>	<b>CT AIMH Credential</b>	<b>Child First</b>	<b>Early Head Start</b>	<b>Certificate in Infant Toddler Care</b>	<b>Birth to Three System</b>
<p>Home visitors receive intensive training specific to their role to understand the essential components of family assessment and home visiting.</p> <p>The home visitor develops knowledge and awareness of the signs of depression, trauma, homelessness, domestic violence, and/or mental illness.</p> <p>The home visitor develops a basic knowledge of health, mental health, child development, and disabilities to ensure service coordination.</p>	<p>Life Skills Progression Training</p> <p><b>Core Competency Child and Family Development</b></p> <p>Parent Educators are knowledgeable about child and parent development and are skilled in fostering positive parent-child interactions.</p>	<p><b>PAT Core Competency Child and Family Development</b></p> <p>Plus</p> <p><b>Home Visitor Credential</b> KEMPE Training Life Skills Progression Training Nurturing Families In Action Training Touchpoints Training</p>	<p><b>Competency: Thinking</b> Skill area; Analyzing information, solving problems, exercising sound judgment, maintaining perspective, planning and organizing</p> <p><b>Competency: Theoretical Foundations</b> Knowledge Areas: pregnancy &amp; early parenthood, infant &amp; young child development and behavior, infant/young child and family-centered practice, relationship-based practice, family relationships and dynamics, attachment, separation and loss, cultural competence.</p>	<p><b>Child First Learning Collaborative Curriculum</b></p> <p>Learning Session 1</p> <p>Online Learning 1</p> <p>Module II: Infant and Child Development</p> <p>Module III: Caregiver Development</p> <p>Module IV: Attachment and Relationships</p> <p>Module V: Assessment</p>	<p><b>Relation Based Competencies</b></p> <p><b>Family Well-Being and Families as Learners,</b> Enhances the parent-child relationship, and supports parents' role as the first and lifelong educators of their children.</p> <p><b>Coordinated, Integrated and Comprehensive Services</b> Acts as a member of a comprehensive services team so that family service activities are coordinated and integrated throughout the program.</p>	<p><b>Core Competencies</b></p> <p>Identify the developmental domains and explain their interrelation with early learning and development.</p> <p>Know how to form strong attachments with a baby and why a strong attachment is important.</p> <p>Demonstrates an understanding of how infants and toddlers grow and develop socially, emotionally, physically, and cognitively in order to create realistic expectations and provide quality early learning experiences for infants and toddlers.</p>	<p><b>All staff must meet Birth to Three Personnel Standards</b></p> <p><b>The Infant Toddler Family Specialist Credential (ITFS)</b> <b>indicators of practice relate to knowledge and practice in the areas identified in this competency.</b></p> <p><b>Providers are encouraged and supported to become endorsed by CT AIMH in infant mental</b></p>

## Appendix C: Program Descriptions

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### **Birth to Three**

**Services:** Focus of services is on supporting the parents and caregivers of infants and toddlers by providing research-based interventions that promote the child's development in the areas of communication, social-emotional, motor, adaptive and cognitive skills. Licensed and certified staff work with caregivers in the home or community settings using daily activities as the natural setting for introducing and practicing new developmental skills.

**Demographic Served:** Infants and toddlers from birth to three years old who exhibit significant developmental delays or have confirmed medical diagnoses with a high likelihood of experiencing developmental delay.

**Intervention Level:** Tertiary intervention (intervention).

**Location served/location sites:** Home- and childcare-based supports provided statewide. There are 43 agencies including specialty programs for children with autism spectrum disorders or who are deaf or hard of hearing.

**Fiscal Year 2014 Children and Families Served:** 9,686 children.

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### **Child First**

**Services:** Services include child development; child-parent psychotherapy; attachment; parenting; brain development; executive functioning, impact of trauma; toxic stress and ACEs; parental challenges - depression, substance use, domestic violence; emotional regulation; community resources.

**Demographic Served:** Serves children, prenatal to six years. Program serves pregnant mothers, first time mothers, families with multiple children, foster families, families at any income level, families with substance abuse issues, families with depression or other mental health issues, families living in homeless shelters/non-traditional households, families with domestic violence issues, families with incarcerated parents, fathers, teen parents, children who have experienced, trauma, abuse and neglect, and have developmental delays and mental health issues.

**Intervention Level:** Secondary intervention (prevention) and tertiary intervention (intervention).

**Locations served/location sites::** Site locations throughout the state including Greater Bridgeport, Hartford, New Haven, Norwalk, New London County, Middletown, New Britain, Stamford, Windham County, Ansonia/Derby, Bloomfield, Bristol, Danbury, East Hartford, and Meriden.

**Fiscal Year 2014 Families Served:** 985 families.

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### **Early Head Start**

**Services:** Educational services in addition to comprehensive prenatal and child development services. Services focus on areas including health, mental health, oral health, family support and education, fatherhood & grandparent supports, community resources.

**Demographic Served:** Children ages zero to three years. Program serves pregnant mothers, first time mothers, foster families, families at any income level, fathers, teen parents, and children with mental health issues.

**Intervention Level:** Secondary intervention (prevention).

**Locations served/location sites:** services are available statewide with program sites in Bridgeport, Colchester, Danbury, Griswold, Groton, Manchester, Middletown, Montville, New Haven, New London, Norwich, Stamford, Torrington, Vernon, Waterbury, and Windham.

**Fiscal Year 2014 Children and Families Served:** 500 children and 500 families (estimated).

---

### **Family Resource Center**

**Services:** Family Resource Center is a home visiting program that provides child development and parental education services. Several Family Resources utilize the Parents as Teachers home visiting model.

**Demographic Served:** Served children zero to five years. Program serves pregnant mothers, first time mothers, families with multiple children, foster families, families at any income level, and families with substance abuse issues.

**Intervention Level:** Primary intervention (community/population education and promotion).

**Location served/location sites:** Program sites are located in Bridgeport, Danbury, Enfield, Greenwich, Hartford, Manchester, Meriden, Middletown, Milford, New Britain, New Haven, New London, Norwalk, Norwich, Putnam, Stamford, Torrington, Vernon, Waterbury, and Windham.

**Fiscal Year 2014 Children Served:** 1,132 children.

---

### **Family School Connection**

**Services:** Family School Connection a home visiting program for families of school aged provides parenting education, information on child development and connection to resources with the goal to improve parenting practices , reduce the incidence of child abuse and neglect and help parents become more involved in the their child's education. The four targeted areas of intervention include: nurturing parenting, healthy families, parent life outcomes and school preparedness. Family School Connection uses the Nurturing Skills for School Aged Children Parenting curricula.

**Demographic Served:** Family School Connection services children ages three to eight years old. Family School Connection services first-time and non-first time parents and caregivers, families of any income level, families in homeless shelters, and families with incarcerated parents. .

**Intervention level: Intervention Level:** Secondary intervention (prevention).

**Locations served/locations sites:** There are location sites in Middletown, New Haven, and Norwich.

**Fiscal Year 2014 Families Served:** 169 families.

---

### **Minding the Baby**

**Services:** Services provided include parental reflective functioning coaching and parent education including skills, information and activities for enhancing attachment, child development. Direct mental health care provided for mothers & infant/parent dyadic care provided for family. Health care information and referrals, parent life course, parent self-efficacy skills, and case management.

**Demographic served:** Program serves pregnant mothers, first time mothers, families at any income level, families with mental health issues, families living in homeless shelters, families with domestic violence issues, fathers, and teen parents.



**Intervention level:** Primary intervention (community/population education and promotion), secondary intervention (prevention), and tertiary prevention (intervention).

**Location served/location sites:** New Haven

**Fiscal year 2014 children and families served:** 34 children and 36 families.

---

### **Nurse Family Partnership**

**Services:** Nurse Family Partnership is home visiting program that services low-income, first-time moms so that they receive the care they need to have a healthy pregnancy, and can provide responsible and competent care for their children, and become more economically self-sufficient. Services provided include assessment, education, and prevention.

**Demographic Served:** Serves children zero up until their second birthday. Program serves pregnant mothers (up to 28 weeks gestation), first time mothers, low-income families only, and teen parents.

**Intervention Level:** Secondary intervention (prevention).

**Location served/location sites:** Nurse Family Partnership serves families in New London and Middlesex Counties.

**Fiscal Year 2014 Children and Families Served:** Not available at time of report

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### **Nurturing Families Network**

**Services:** Nurturing Families Network (NFN) home visiting program provides parenting education, information on child development and connection to resources with the goal of promoting positive parenting and reduce the incidence of child abuse and neglect. The four targeted areas of intervention include: nurturing parenting, healthy families, parent life outcomes and school readiness. The Nurturing Families Network utilized the Parents as Teachers home visiting model.

**Demographic Served:** First time parents starting prenatally whenever possible, or shortly after the child's birth including parents living in homeless shelters/non-traditional households, low-income families, families with an incarcerated parent, teen parents, and parents with high risk indicators. Nurturing Families Network works with families of children ages zero to five years.

**Intervention Level:** Secondary intervention (prevention).

**Locations Served/location sites:** There are location sites in Bloomfield, Branford, Bridgeport, Bristol, Danbury, East Hartford, East Haven, East Windsor, Enfield, Groton, Hamden, Hartford, Hebron, Killingly, Manchester, Meriden, Middletown, Milford, New Britain, New Haven, New London, North Branford, Norwalk, Norwich, Plainfield, Plainville, Plymouth, Putnam, Stafford, Stamford, Stonington, Stratford, Tolland, Torrington, Vernon, Waterbury, West Hartford, West Haven, Windham, Windsor, and Winchester.

**Fiscal Year 2014 Children Served:** 2,200 children

---

### **Nurturing Families Network (NFN) Fathering Home Visiting**

**Services:** NFN Fathering Home Visiting provides parenting education, information on child development and connection to resources delivered by male home visitors to father's or a man who becomes significantly involved with a child and mother enrolled in the NFN program. The four targeted areas of intervention include: nurturing parenting, healthy families, parent life outcomes and school readiness. The Nurturing Families Network utilized the Parents as Teachers home visiting model.

**Demographic served:** Serves children zero to five years old. Program serves prenatal fathers or men who become significantly involved with a mother enrolled in the NFN program, first time fathers and fathers with multiple children, fathers and with high risk indicators, including fathers that live in shelters/non-traditional households. Nurturing Families Network works with families of children ages zero to five years.

Nurturing Families Network serves families with children ages zero to five years.

**Intervention Level:** Secondary intervention (prevention)

**Locations served, location sites:** There are sites located in Hartford, New Haven and Torrington.

**Fiscal Year 2014 Children and Families Served:** 136 children.

---

### **Parents as Teachers (MIECHV)**

**Services:** Maternal Infant Early Childhood Home Visiting Program provides education and connection to community resources to improve health, wellbeing and parenting outcomes of pregnant and parenting families who are at risk for poor health outcomes.

**Demographic Served:** First time and non-first time parents, starting prenatally whenever possible, or shortly after the child's birth including parents living in homeless shelters/non-traditional households, low-income families, families with an incarcerated parent, teen parents, and parents with high risk indicators. Maternal Infant Early Childhood Home Visiting works with families of children ages zero to five years.

**Intervention Level:** Secondary intervention (prevention).

**Locations Served/location sites:** There are 14 site locations: Bloomfield, four in Bridgeport, East Hartford, East Haven, Manchester, Meriden, New Britain, Norwich, Torrington, West Haven and Windham. Locations served also include North Branford, Vernon and Winchester.

**Fiscal Year 2014 Children and Families Served:** 652 children.

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### **Parents as Teachers- Fathering (MEICHV)**

**Services:** Maternal Infant Early Childhood Home Visiting Program provides education and connection to community resources fathers to improve health, wellbeing and parenting outcomes of pregnant and parenting families who are at risk for poor health outcomes.

**Demographic Served:** First time and non-first time fathers, starting prenatally whenever possible, or shortly after the child's birth including fathers living in homeless shelters/non-traditional households, low-income fathers, teen fathers and fathers with high risk indicators. Maternal Infant Early Childhood Home Visiting works with fathers of children ages zero to five years.

**Intervention Level:** Secondary intervention (prevention).

**Locations Served/location sites:** There are 14 site locations: Bloomfield, four in Bridgeport, East Hartford, East Haven, Manchester, Meriden, New Britain, Norwich, Torrington, West Haven and Windham. Locations served also include North Branford, Vernon and Winchester.

**Fiscal Year 2014 Children and Families Served:** 99 children.

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### **Young Adult Services Parents Program**

**Services:** NA

**Demographic served:** NA

**Intervention level:** NA

**Location served/location sites:** NA

**Fiscal year 2014 children and families served:** NA

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## **Programs of the Connecticut Department of Children and Families**

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### **Caregivers Support**

**Services:** Multifaceted intervention addressing caregiver and child needs. Services including caregiver support, referrals, and life skills.

**Demographic Served:** Serves families with children zero to eight years of age. Serves families with multiple children, foster families, families at any income level, families with substance abuse issues, families with depression and other mental health needs, and fathers.

**Intervention Level:** Primary intervention (community/population education and promotion).

**Location served/location sites:** Serves families statewide with program offices in Hartford, Manchester, Windsor, New Britain, Torrington, Waterbury, Middletown, Windham, Norwich, Milford, Bridgeport, Danbury, Norwalk, and Stamford.

**Fiscal Year 2014 Families Served:** 260 families.

---

### **Integrated Family Violence Services**

**Services:** This primarily is an in-home service for families where domestic violence has been identified. The program focuses on all family members including the child, the parent who is the survivor of domestic violence & the batterer. Services provided include parent support and education, care coordination, and parent-child psychotherapy intervention.

**Demographic served:** Serves children ages zero to eight years. The program serves pregnant mothers, first time mothers, families with multiple children, foster families, families at any income level, families with domestic violence related issues, children who have experienced abuse and neglect.

**Intervention Level:** Tertiary intervention (intervention).

**Location served/location sites:** Location sites are located in Bridgeport, New Haven, Norwich, Hartford, and Waterbury.

**Fiscal Year 2014 children and families served:** 856 children served and (396 families served).

---

### **Intensive Home Based Services (Family-Based Recovery)**

**Services:** Provides services on substance abuse (Reinforcement Based Treatment); and parent and child services (real time parent-child interactions, DVD reviews of sessions, safety planning, drug testing, vouchers, basic needs, legal issues, social club, outreach, collaboration with DCF).

**Demographic served:** Serve children from birth to three years. Program serves first time mothers, families with multiple children, families of any income level, families with substance abuse issues, families with depression and other mental health related issues, and children with developmental delays.

**Intervention Level:** Tertiary intervention (intervention).

**Location served/location sites:** Statewide with program sites in New Britain, Meriden, New Haven, Bridgeport, Mansfield, Norwich, Waterbury, Manchester, and Hartford.

**Fiscal year 2014 children and families served:** 204 children (204 families).

---

### **Level 4 Positive Parenting Program (Triple P)**

**Services:** Positive Parenting focuses on parental education using the Level 4 Triple P curriculum.

**Demographic served:** Serves children ages zero to 17 years of age. Program serves demographics such as first time mothers, foster families, and families at any income level.

**Intervention level:** Tertiary intervention (intervention).

**Locations served/location sites:** Program serves families statewide.

**Fiscal year 2014 children and families served:** 1,558 children (1,558 families).

## Appendix D: Potential Common Measurement Tools

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### MEASURES OF CHILD DEVELOPMENT

**Ages & Stages Questionnaire, 3<sup>rd</sup> Edition** (ASQ-3, Squires & Bricker, 2009) - The ASQ-3 is used to screen infants and young children for developmental delays through parent-completed questionnaires. Questions are written at a 6<sup>th</sup> grade level, and the instrument is available in English and Spanish. Interpretation of the results can be done by a professional or trained paraprofessional, and support materials include a User's Guide and online introductory webinar. The instrument's test-retest reliability coefficient is .92, and internal consistency estimates range from .51 to .85. The concurrent validity coefficient is .86. The ASQ-3 has high sensitivity (.86) and specificity (.85).

**Ages & Stages Questionnaire: Social Emotional** (ASQ:SE, Squires, Bricker & Twombly, 2002) - The Ages and Stages Questionnaire: Social Emotional is a screening instrument that is also used for progress monitoring, intervention planning and research. The ASQ:SE is available in English and Spanish, and it measures seven behavioral areas: self-regulation, compliance, communication, autonomy, affect, adaptive functioning and interpersonal interactions. Reliability results are acceptably high to strong, including an internal consistency of .82 and test-retest result of .94. Both concurrent and predictive validity results are considered high to strong. The instrument has adequate sensitivity (.65 to .79) and high specificity.

**Brief Infant-Toddler Social Emotional Assessment** (BITSEA, Briggs-Gowan & Carter, 2006) The Brief Infant-Toddler Social Emotional Assessment is a brief screening instrument for evaluating social-emotional problems and competence in children ages 12 months to 3 years. Positive BITSEA screenings during toddlerhood have been linked to language/learning and/or social-emotional problems, as reported by kindergarten teachers (Carter, Briggs-Gowan, & Davis, 2004). Used mostly for screening and research to quickly identify possible developmental delays, the BITSEA contains 42 items that are drawn from a pool of items within the more in-depth Infant Toddler Social Emotional Assessment (ITSEA). If social-emotional and competency delays are identified, the BITSEA can be followed by the 166-item ITSEA for a more comprehensive assessment. Test-retest reliability (.85 to .87), inter-rater reliability (.61 to .68) and internal consistency (.65 to .80) are acceptably high to strong results. Predictive validity is .71, and concurrent validity has moderate results. The instrument has high sensitivity (.80 to .99) and high specificity (.80 to .90).

## MEASURES OF MATERNAL DEPRESSION

**Beck Depression Inventory** (BDI-II, A. Beck et al., 1961) is the most widely used screen for depression. It has been extensively used in clinical trials of treatments of depression (Gloaguen et al., 1998), and has been used with postpartum women. Its psychometric properties are well documented and acceptable (A. Beck et al., 1996).

**Edinburgh Postnatal Depression Scale** (EPDS, Cox et al., 1987). The EPDS was developed for screening postpartum women in outpatient and home visiting settings. It has been utilized among numerous populations/languages. It has also been effective for identifying symptoms of major depression at prenatal (Murray et al., 2007), for post natal adolescents (Anderson, 2010) and in at least one study it was effective in identifying depression in fathers in the postnatal period (Edmonson et al., 2010). It consists of 10 questions that can usually be completed in less 5 minutes.

**Center for the Epidemiologic Studies Depression (CES-D) scale** (Radloff, 1977): The CES-D is a 20-item, self-report scale of depression intended for conducting research in the general population. It has internal reliability estimates of between .84 to .90.

## MEASURES OF SOCIAL SUPPORT

**Interpersonal Support Evaluation List** (ISEL; Cohen & Hoberman, 1983). The ISEL is a widely used measure of social support that has been utilized with multiple clinical and nonclinical populations. This 40-item measure consists of statements regarding the availability of tangible and emotional support that are endorsed using a 4-point scale. The ISEL has excellent reliability and validity (Cohen & Hoberman).

**Social Network Index** (SNI; Cohen et al., 1997). The SNI consists of 12 items that document the size of social network. It can be used in conjunction with or independent of social support as measured by the ISEL.

## MEASURES OF PARENT-CHILD INTERACTION

**Parenting Stress Index-Short Form** (PSI-SF, Richard R. Abidin): The PSI-SF is a self-report instrument designed to evaluate the magnitude of stress in the parent-child system. The PSI-SF is a brief version of the Parenting Stress Index which that consists of 36 items from the original 120-item PSI. The instrument's internal consistency and test-retest coefficients have been found to be between .80-.91 and .68-.85 among the scales (Abidin, 1995).

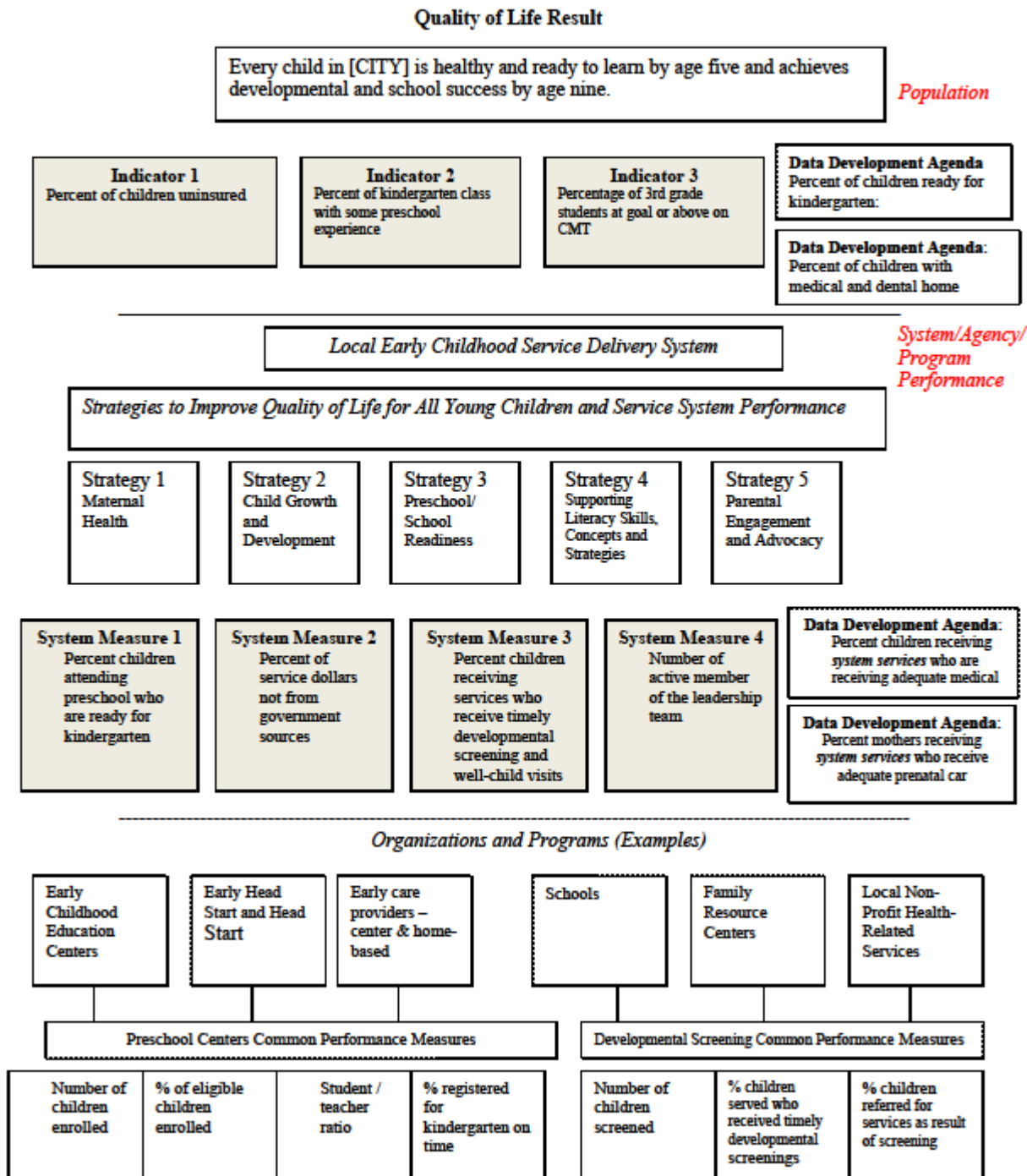
**The Home Observation for Measurement HOME Inventory (HOME)** (Caldwell & Bradley, 1984) . The HOME is a standardized instrument designed to *measure the quality of the stimulation in the home environment*. The HOME is comprised of six subscales; 1) Parental Responsivity, 2) Acceptance of Child, 3) Organization of the Environment, 4) Learning Materials, 5) Parental Involvement, and 6) Variety in Experience. The HOME Inventory has been highly correlated with later child development and intellectual measures. The reliability coefficient for the HOME is .89 and averages .70 for the six subscales.

**Infant/Toddler HOME Inventory (IT-HOME, Caldwell & Bradley):** The IT-HOME is a version of the Home Observation for Measurement of the Environment (HOME) Inventory. The IT-HOME is designed for use during infancy (birth to age three). It is designed to measure the quality and quantity of stimulation and support available to a child in the home environment. The focus is on the child in the environment, child as a recipient of inputs from objects, events, and transactions occurring in connection with the family surroundings (Totsika & Sylva, 2004). It is composed of 45 items clustered into six subscales: Parental Responsivity, Acceptance of Child, Organization of the Environment, Learning Materials, Parental Involvement, and Variety in Experience.



## Appendix E: Results Based Accountability Example Schematic

### III. Cohort 1 RBA Schematic



## Works Cited

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- Foley-Schain, K., Finholm, V., & Leventhal, J. M. (2011). Building a statewide home visiting program from 2 to 42 sites: A state agency's perspective. *Child Abuse & Neglect*, 283-286.