Executive Summary: June 24, 2015

Background:

The Center for Early Childhood Education and Development (CEED) at the University of Minnesota, as a subcontractor to the Minnesota Department of Health (MDH), evaluated one innovative strategy implemented within Minnesota’s Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Expansion Grant Project. This strategy—reflective practice consultation and mentoring—is seen as a critical means of supporting the day-to-day work of home visitors and increasing their skills in serving families and children who are at-risk. Through the MIECHV Expansion Grant Project, MDH sought to increase the capacity of local home visiting programs to utilize reflective practice in their work with families and children. This report includes findings and related implications for reflective practice consultation and mentoring within the state of Minnesota.

The Affordable Care Act of 2010 created the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) to respond to the diverse needs of children and families in communities at risk (US Department of Health and Human Services, 2015). Minnesota’s at-risk communities served by MIECHV were identified by MDH, who conducted a needs assessment that was completed in September of 2010. Minnesota counties were assessed in the areas of maternal and newborn health (i.e., inadequate prenatal care, substance exposures, inter-birth intervals, breastfeeding), child injury (i.e., maltreatment and emergency department visits), and economic self-sufficiency (i.e., uninsured, low maternal education, Medicaid births, unemployed). Those Minnesota counties found to be at the highest risk were invited to participate in the MIECHV Program.

Two national, home visiting models were approved by the state of Minnesota for implementation of MIECHV: Nurse Family Partnership (NFP) and Healthy Families America (HFA). Funded sites could choose to use either or both of the models. Because this evaluation was not focused on differences between these models, there is no distinction made between models within this report. Both NFP and HFA are referred to simply as the “model(s).”

The MDH reflective practice capacity-building approach within the MIECHV Expansion Grant featured a tiered delivery structure supports parallel process of reflective practice elements through the use of:

Two MDH staff members, referred to as mentors, who provide initial training in infant mental health and reflective practice. These mentors provide reflective consultation to Infant Mental Health Consultants monthly;

Infant Mental Health Consultants, who provide ongoing individual reflective consultation to supervisors, facilitate case conferences, and act as mental health content specialists and resources to home visitors and supervisors;
Supervisors, who provide reflective supervision to home visitors and work with the IMHC to facilitate case conferences; and Home visitors, who receive reflective supervision, participate in case conferences, and who use a reflective approach in their work with families.

**Design:**

The purpose of the evaluation was to determine the effectiveness of reflective practice mentoring provided by MDH staff in increasing the infrastructure capacities to support and sustain reflective practice in local home visiting programs. Both a process and a quasi-experimental impact evaluation were included. Overall, 19 sites across the state of Minnesota received MIECHV Expansion Grant funding. Ten sites met the definition of rural (a population of under 30,000) and nine met the definition of urban or suburban. Of the 19 sites, six were new to reflective practice (labeled as “Group 1”), and 13 had varying levels of prior experience with reflective practice (labeled as “Group 2”). Approximately 34 supervisors and 140 home visitors participated at these sites (numbers are approximate because of changes in personnel over time). Two MDH mentors led the infrastructure capacity building, with ten Infant Mental Health Consultants serving the various agencies across the state.

**Sample:**

Two mentors from MDH are the foundation for the infrastructure. Several months into the evaluation, Infant Mental Health Consultants were hired to augment the role of the MDH mentors in the field. Each site had an IMHC who provided reflective supervision on a monthly basis to supervisors and either led or co-led the case consultation for the site.

Supervisors provide reflective supervision individually to home visitors as required by both the Nurse Family Partnership and Healthy Families America models. Supervisors and home visitors also met together monthly in a case consultation group, to which an Infant Mental Health Consultant was added.

Of the 25 supervisors who completed the CEED Survey, ages ranged from 25 – 64, with 44% in the 45-54 years age category. One reported as Asian and 24 as White. Fifteen had a Bachelor of Science or Arts degree and 10 had a post-graduate degree. Sixteen supervisors trained in public health, two are registered nurses, four are social workers, one is a psychologist, and two are both public health nurses and RN’s. Eight supervisors reported a mix of professional training including combinations of RN and PHN, infant/child development studies, sociologist, business degree, and arts degree.

Seventy-two percent of supervisors reported three or more years of experience with reflective practice with 12% having more than 10 years of experience. N terms of years providing reflective supervision, five responded with less than a year, and the majority fell in the 1-5 year range, evidencing that although they may have participated in reflective practice, providing reflective supervision is newer to them.

Of the 66 home visitors who completed the survey, one was under 25 years of age, 25 were in the 25-34 age range, 13 were in the 35-44 age range, 16 were in the 45-54 age range, and 11 were in the 55-64 age range. Two were Hispanic or Latino, and 66 reported themselves as White.

In terms of education, one reported having some college, five have an Associate of Arts degree, 46 have a Bachelor of Arts or Science and 14 have post-graduate degrees. Forty-three home visitors are trained as public health nurses, six as

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 RN’s, two as LPN’s, four as social workers, one as a community health worker, one as a marriage and family therapist, and one as a parent educator.

Fifty percent or 33 home visitors worked with families in the Twin Cities metropolitan area. Seven worked with families in cities with a population greater than 30,000 people, 11 were in towns between 30,000 and 6,000 people, and 15 were in towns with a population of less than 6,000 people.

The home visitor group was bifurcated in terms of experience, with 29 home visitors reporting three years or less experience and 20 reporting more than 10 years of experience. Nine home visitors had 4-6 years of experience, and eight had 7-10 years of experience. In terms of experience with reflective practice, five home visitors had less than one year, ten had 3-5 years of experience, 12 had 5-10 years of experience and three had more than ten years of experience.

Infrastructure Capacity Building Findings: Process Study

The goals of the process evaluation were to: 1) study the strength of relationships between factors that both influence implementation of reflective practice and are affected by adoption of reflective practice (e.g., mindfulness skills, burnout, reflective leadership, supervisor-home visitor interaction, and therapeutic alliance); 2) to understand perceptions about the intervention; and 3) to inform program efforts in order to improve overall programming.

The process study used mixed methods including interviews, four measures, and a CEED/MDH-developed survey. The four measures included the Kentucky Inventory of Mindfulness Skills (KIMS) (Baer, Smith, & Allen, 2004); the Leadership Self-Assessment (Parlakian & Seibel, 2001); the Maslach Burnout Inventory (MBI) (Maslach, Jackson, & Leiter, 1996) and the Working Alliance Inventory-Short Revised (WAI-SR) (Munder Wilmers, Leonhart, Linst, et al., 2010). Respondents in Group 2 completed both the Measures and CEED Surveys in late July 2013, May and June of 2014 and a final time in January 2015.

There were no significant results for any of the above measures. Results are based on analysis of the CEED Survey and interviews. Below are the findings for each evaluation question.

Research Question 1: Are state supports sufficient for implementing reflective practice in local programs?

There was a general sense among home visitors, program supervisors, infant mental health consultants, and program administrators that state supports have been adequate to implement reflective practice. Although many said that training, in addition to financial support, was adequate at this time, they voiced interest in continuing training opportunities. They noted that access to initial training and ongoing or refresher training needs to be readily available. They believe that training supports both fidelity to the models and commitment to reflective practice. Training recommendations were tied to the expressed concern about whether programs will be able to sustain reflective practice if MIECHV or other funding for it is discontinued.

Research Question 2a: Do supervisors, who receive reflective consultation with IMHCs, gain new knowledge and skills in reflective practice?

Supervisors, in their own words, evidence knowledge and understanding of the skills and knowledge needed to lead a reflective supervision conversation—taking the time to pause and reflect with a wondering orientation that allows the conversation and processing to go deeper. At the same time, a supervisor must balance RS with traditional supervisory
expectations and be the one who manages others. Clearly, their desire to balance reflection and supervision evidences their own deep processing of the responsibilities, knowledge, and skills of being a reflective supervisor.

**Research Question 2b:** Do home visitors, who participate in reflective practice sessions with their supervisors, gain new knowledge and skills in reflective practice?

Data suggest that home visitors are familiar with the skills and knowledge of reflective practice. What is less clear is whether they are able to put these fully into practice. For example, although home visitors believe *pause and reflect* is a key skill for their practice, in light of IMHCs interviews and the CEED Survey, how that pause and reflect is being used in the field is not clear from the data. The theme of *going deeper* relates to the need for further understandings about how home visitors are building relationships. The fact that they see a need to look deeper at what is going on is another suggestion that the skills of reflective practice are being gradually built but not fully in place yet.

**Research Question 3a:** Do agency heads change their expression of support for reflective practice throughout the course of participating in the grant activities?

Looking at agency support from both administrator and supervisor interviews provides a compelling argument that support for MIECHV has been strong throughout the intervention. There is no evident change in either direction. Again, keep in mind that agencies that applied for this funding probably already had a belief in the value of evidence-based programs.

**Research Question 3b:** Do local home visiting supervisors report positive change in their beliefs and attitudes about reflective practice?

Throughout all the data, there is a compelling narrative that supervisors, home visitors, infant mental health consultants, and agency administrators believe in reflective practice. There have also been obstacles (e.g., distance, individual differences) to address in order to effectively implement reflective practice.

**Research Question 3c:** Do home visitors report positive change in their beliefs and attitudes about reflective practice?

Home visitors, supervisors, and administrators all expressed that beliefs and attitudes about reflective practice had changed, over the course of the grant, to positive support for the intervention. Home visitors noted that initially they were hesitant about the practice and concerned about the degree to which reflective practice discussions would be personal. Supervisors noted the same concern. Both home visitors and supervisors reported that reflective supervision and case consultation provided important support for the work HVs were doing in the field.

**Research Question 4:** Do home visitors, who participate in reflective supervision sessions and case consultation, report using reflective practice in their work with families?

Interview data about the application of reflective practice with families are rich with evidence for the work home visitors are doing. Through a simple but powerful skill of *pause and reflect*, home visitors take the time to wonder, *build relationships* and *empower families* to make decisions for their lives.

**Research Question 5a:** Do supervisors report less burnout and increased competence and successful achievement in their work?
Interviews demonstrated how important support provided in a safe environment is to the work of a supervisor. Supervisor interviews also evidence that supervisors are using the skills of reflective supervision, such as finding another perspective and not trying to “fix” things. Data from the Maslach Burnout Inventory, however, suggest that these supervisors are experiencing significant burnout without the compensating sense of personal accomplishment. Reflective practice alone may not be enough to prevent burnout in supervisors. This is something to consider as MDH goes forward with reflective practice.

**Research Question 5b:** Do home visitors report less burnout and increased competence and achievement in their work?

Interviews show how important support provided in a safe environment is to home visitors. Home visitor interviews also evidence a strong sense of personal accomplishment. Data from the MBI, however, suggest that these home visitors are experiencing significant burnout without the compensating sense of personal accomplishment. Reflective practice alone may not be enough to prevent burnout in home visitors. This is something to consider as MDH goes forward with reflective practice.

**Infrastructure Capacity Building Findings: Impact Study**

For the second part of the evaluation, an impact study was implemented using an interrupted time-series design. Time-series designs enable development of knowledge about an intervention in situations in which randomized controlled trials are not possible or would be premature. Time series studies are well-suited to initial evaluations that want to refine delivery of an intervention (Biglan, Ary, & Wagenaar, 2000). The 19 sites for the Expansion Grant Program were at different levels of implementation. Some sites have implemented reflective practice as part of an evidence-based model for several years, and six sites had not been exposed to reflective practice to our knowledge. With a time-series study, the growth in reflective practice at these six sites that were new to reflective practice was measured.

The purpose of the impact study was to describe the growth in reflective practice as a result of the intervention. The Kentucky Inventory of Mindfulness Skills (KIMS), the Working Alliance Inventory Short Revised (WAI-SR), and the Maslach Burnout Inventory (MBI) were the three measures that provided the time series data. Between 15-11 home visitors responded to the three measures. The research questions were:

1. Does participation in reflective practice mentoring increase scores for home visitors on the Kentucky Inventory of Mindfulness Skills (KIMS)?
2. Does participation in reflective practice mentoring increase scores for home visitors on the Working Alliance Inventory-Short Revised (WAI-SR)? And
3. Does participation in reflective practice training and mentoring contribute to decreased burnout and increased sense of accomplishment for home visitors as measured by the Maslach Burnout Inventory (MBI)?

The three measures were administered to the home visitors four times prior to delivery of the reflective practice training and start of reflective practice implementation. These administrations were once per month from March 2013 to June 2013. Following the administration of the intervention (i.e., onsite training on reflective practice and infant mental health), the measures were given at bi-monthly intervals seven more times. Including the four administrations prior to
the intervention, the home visitors in the impact study completed the measure for a total of 11 times. The two month intervals were designed to be often enough to capture change but not too often to be contaminated by practice.

Quantitative analyses were completed using the Statistical Package for Social Sciences (SPSS Inc.; version 22). Quantitative data were analyzed for group differences using the repeated measures analysis of variance (RM-ANOVA), when possible. Hierarchical Linear Modeling was used to study individual differences for the Impact Study.

**Research questions 1, 2, and 3**

For all repeated measures analysis of variance tests conducted, there were no significant findings. There were no significant changes across time on the scores for the WAI-SR, KIMS, MBI, and MBI sub-scales for group 1 home visitors, group 2 home visitors, or supervisors.

**Conclusion:**

The main conclusion and one that addresses the purpose of the evaluation is that Minnesota is well on its way to building a sustainable infrastructure for reflective practice. There are numerous examples of home visitors and supervisors moving away from a more directive approach and incorporating more collaboration, as well as working from a reflective approach.

A second overall finding is that the type and amount of training needed beyond the basics provided by the models is difficult to determine, but supervisors, infant mental health consultants and home visitors believe there is a need for more training. We suggest developing a tiered intervention model of training that provides a foundational training and different types of training as the person gets more experience.

Finally, interview data from administrators, supervisors, and home visitors indicate that the infant mental health consultants are crucial to the continued implementation of reflective practice. They provide content training in infant and adult mental health, consultation to supervisors, and model a reflective approach in case consultation.

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