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Evaluation of the Fussy Baby Network Advanced Training: Final Report

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Executive Summary

This is the final report of findings and implications from an evaluation of an advanced training for home visitors in an infant mental health-based approach called the FAN (Facilitating Attuned INteractions). The FAN approach was developed by Erikson Institute's Fussy Baby Network (FBN). Training in the FAN approach was delivered to home visitors and supervisors at nine Healthy Families America (HFA) programs, over an 18-month period. A tenth HFA program served as a no-training comparison site for the nine intervention programs.

FAN training teaches home visitors to focus on parents' concerns, to read parents' cues for engagement, and to use the strategies of the FAN approach to match their interactions to what parents indicate they can most use in the moment. Building parenting capacity and self-efficacy by supporting parents, rather than doing for parents, is another goal of the approach. The approach also teaches home visitors to notice, understand, and regulate their own responses to families, all vital components of reflective practice. Reflective supervision, which benefits both practitioners and program participants by helping practitioners manage stress and emotions, is also an essential part of the FAN approach (Bernstein & Edwards, 2012; Watson & Neilsen Gatti, 2012; Watson, Neilsen Gatti, Cox, Harrison, & Hennes, 2014).

The training in the FAN approach began with a 2-day, in-depth foundational training in the core principles. This core training was followed by ongoing review and consultation one to two times per month for 12 months, during which home visitors and supervisors received direct interactive support in mastering the use of the strategies of the approach. This period was followed by 6 months of monthly "booster" sessions to reinforce what was learned. Staff also received support from on-site infant mental health consultants and developmental specialists.

Using a quasi-experimental, mixed methods design, the evaluation sought to understand the impact of the training on home visitors' practices from the perspectives of home visitors, supervisors, and program

participants. We expected to see improvement over time in the quality and consistency of implementing and using the approach and in the skills and comfort levels of home visitors and supervisors as they improved their understanding of the approach across the implementation period. Once staff completed the year-long training, we also expected to see differences in mothers' experiences with the program, their relationships with home visitors, and measures of their functioning (parenting stress, maternal self-efficacy, and depression).

Beginning before the onset of training and continuing through the full 18-month training period, we observed and assessed staff engagement and skills through surveys, interviews, and focus groups. Home visitors and supervisors completed a survey before the start of the core training and also completed a survey every 6 months once FAN training began. We conducted in-person focus groups with home visitors and individual interviews with supervisors and consultants at 9 and 18 months after the start of training. In addition, with the assistance of home visitors, we recruited two samples of families with infants from 2 weeks to 9 months of age. One sample of mothers was interviewed at two points in time (4 months apart) before the start of the training. The other sample was also interviewed at two points in time, but the first interview occurred 12 months after the start of the training process and then again 4 months later. The use of different samples pre- and posttraining was necessary to create a contrast between families who were (or were not) exposed to the training intervention, and between their experiences in the home visiting program.

Findings from staff surveys, focus groups, and interviews indicated that a large majority of home visitors implemented the FAN training model in their practice. The quality of the implementation varied depending on several factors, including program support and staff's previous experience and training (younger, less experienced home visitors found it easier to adopt and implement the approach than older and more experienced staff). It also took time to learn the model and put into practice however, we also learned that some of the core concepts of the approach were easier to learn and implement than others. The training was most helpful to home visitors in understanding and regulating their own feelings during visits and in helping them to see the parents' perspectives. Home visitors felt that the approach was particularly valuable in stressful situations, helping them to think clearly rather than react. Home visitors reported being more comfortable in holding and exploring parents' negative feelings rather than avoiding or quickly jumping to reassure.

In addition to the positive impact that the FAN training had directly on home visitors' approach to home visits and their families, we also learned from staff's reported experiences with training that FAN training was perceived as being too long. The lengthy duration of training and staff's challenges in implementing some aspects of the training was also impacted by staff turnover and program participant attrition.

Parents' narratives about their home visiting experiences in interviews supported our finding that home visitors were able to use the FAN concepts in their home visits. Interviews with parents also suggested that the use of the FAN approach changed the structure and dynamics of the home visit. However, we also observed that when comparing the responses of mothers in the posttraining sample with those in the pretraining sample and mothers at the comparison site, there were no significant differences in ratings on a standardized measure, the Working Alliance Inventory (WAI). One reason might be the fact that ratings of the relationship with their home visitors were very positive at the Time 1 interview, so even modest improvements at Time 2, 4 months later, could be difficult to detect in our sample. This was the case in terms of the WAI total score as well as the scores on two of the three subscales that make up the instrument. On the Bond subscale, which assesses confidence in the home visitor, mutual appreciation, and trust, mothers' and home visitors' ratings were more similar in the intervention group after training than they were in the comparison group. In addition although most mothers reported talking about problems with their infants' crying, sleeping, or feeding with their home visitors, in the intervention group, the posttraining sample of mothers was more likely to discuss infant sleep problems with their home visitor than the pretraining sample of mothers.

In terms of the potential impact of the FAN approach on standardized measures of maternal functioning, there were no significant differences between the pretraining and posttraining samples or between the comparison program and the posttraining sample in maternal self-efficacy and depression. All samples showed modest increases in self-efficacy and modest decreases in depression. In the posttraining sample, in contrast to the pretraining and comparison samples, parenting stress increased over time. One possible explanation could be related to the focus on mindfulness and reflective capacity in the FAN training, leading to the mothers' increased ability to acknowledge the stress they were experiencing. The FAN provides the home visitor with the framework and the skills to notice cues of intense affect and facilitate a conversation about the parent's feelings. Given that there was only a difference of 4 months between the Time 1 and Time 2 interviews with mothers, this is not surprising.

Based on what we learned from both staff and parents, we recommended a shorter training period, clearer training goals and expectations, and flexibility and individuation within each program. In terms of further research, this evaluation also highlighted the need for a longer-term intervention period than the 4-month period in this study to allow for change in parenting to occur.

Introduction

This is a final report of the evaluation of the implementation of an advanced training in the Facilitating Attuned INteractions (FAN) processes developed by the Fussy Baby Network, located at Erikson Institute in Chicago, Illinois. The FAN approach was designed to enhance the skills of home visitors who work with vulnerable families of young children. The Fussy Baby Network based the FAN model on principles of infant mental health, to support families who experience stress related to caring for a young child. For example, a recent analysis indicates that the FAN model increases parenting self-efficacy in parents with excessively crying infants when compared to families with excessively crying infants who did not receive services using the FAN model (Gilkerson, Burkhardt, & Hans, 2016). The FAN includes five core processes, illustrated and described below in Figure 1.[1] Four of the processes are ways in which home visitors can engage families to address urgent concerns. The fifth process, Mindful Self-Regulation, acknowledges that home visitors also experience emotions and need to regulate them in their interactions with high-risk families. The five core processes are not necessarily linear, as portrayed in the figure, but dynamic; during a single visit or over a period of multiple visits, home visitors may use all of the processes at different points in time, depending on what parents indicate they need.

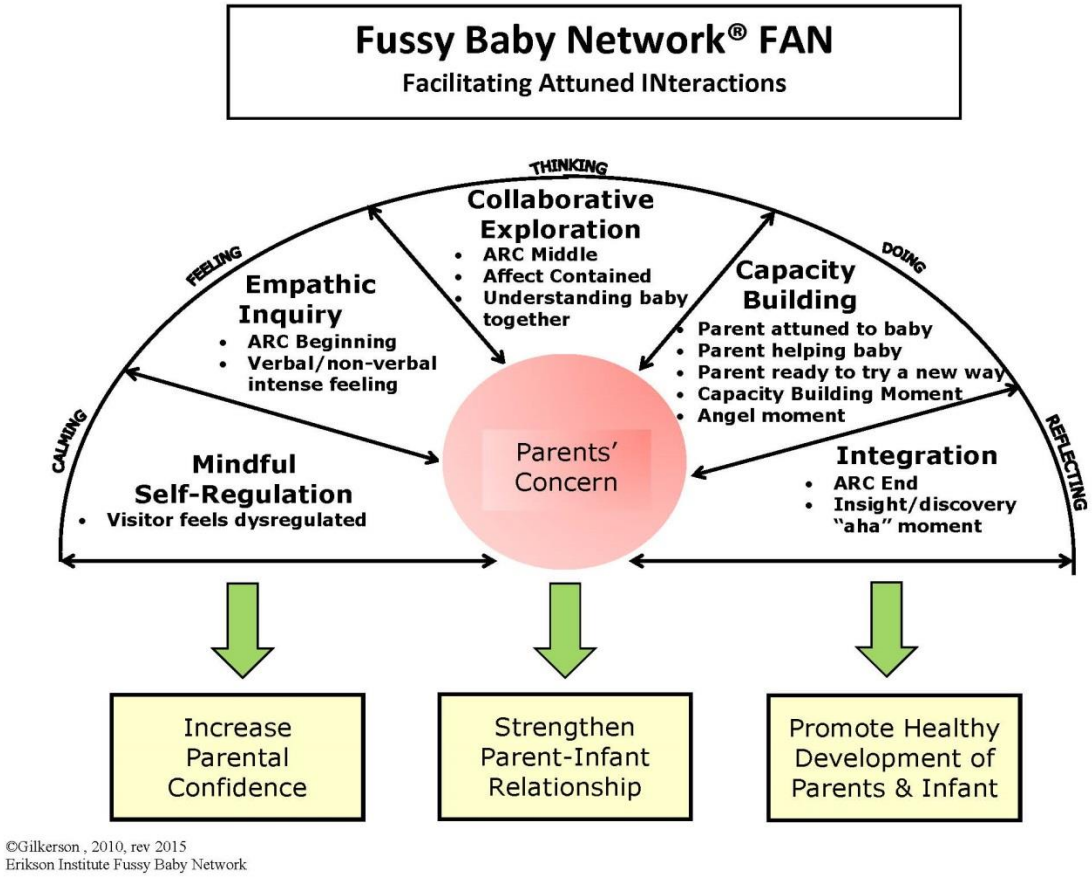
The FAN training teaches home visitors to focus on parents' concerns, to read the parents' cues for engagement, and to use the strategies of the approach to match their interactions with what parents indicate they can most use in the moment. Building parenting capacity and self-efficacy by *supporting* parents, rather than *doing* for parents, is another goal of the approach. The approach also teaches home visitors to notice, to understand, and to regulate their own responses to families, all of which are vital components of reflective practice. Reflective supervision, which has been found to benefit both

[1] Used with permission of the Fussy Baby Network at Erikson Institute.

practitioners and program participants by helping practitioners manage stress and emotions is also an essential part of the FAN approach (Bernstein & Edwards, 2012; Watson & Gatti, 2012, 2014),.

Infant mental health specialists were supported by the Fussy Baby Network and provided consultation to the staff of nine credentialed Healthy Families America (HFA) programs in Illinois. HFA is one of 14 home visitation program models that a federal review considered evidence-based (Avellar, Paulsell, Sama-Miller, & Del Grosso, 2014).

Figure 1. Components of the Fussy Baby Network FAN Approach



FAN Training (The Intervention)

The addition of the FAN strategies as an enhancement to credentialed HFA home visiting programs was implemented through a staged process. Home visitors and supervisors at five Wave 1 programs received the training during 2013–14 and staff at four Wave 2 sites received the training during 2014–15.[2] The

[2] Infant mental health consultants and developmental specialists participated in the training, and in one case, the program director also attended. Doulas participated in the training at some programs but were not part of the evaluation

training for both waves began with a 2-day, in-depth training in the core FAN principles.[3] Program supervisors received an additional day of training prior to attending the 2-day training with their home visitors. The core training was followed by ongoing review and consultation for another 12 months during which home visitors and supervisors received direct, interactive support in mastering the use of FAN strategies either twice or once a month. This 12-month period was followed by 6 months of monthly "booster" sessions to reinforce the principles learned. The key components of the training were the following:

- On-site, program-based delivery, involving both home visitors and supervisors
- Orientation leadership training
- Introductory 2-day core training for home visitors and supervisors, and additional supervisor training
- Twice a month on-site ongoing trainings for 12 months
- Twice a month on-site leadership support for 12 months
- Monthly leadership support calls
- FAN reflection learning tools for home visitors
- Addition of two part-time support staff, an infant mental health consultant (IMHC) and a developmental specialist (DS)[4]

Research Questions and Study Design

The evaluation was designed to examine the effects of the FAN training on home visitors' practices from the perspectives of home visitors, supervisors, and program participants. We expected to see continuing improvement over time in the quality and consistency of implementation and use of the FAN processes as home visitors and supervisors increased their understanding, skills, and comfort with the approach. Once staff completed the year-long training, we also expected to see differences between two samples of mothers—one interviewed before training and one interviewed after training—in their experiences with the program, their relationships with home visitors, and measures of their functioning (parenting stress, maternal self-efficacy, and depression). Specific research questions for the study are the following:

- Do home visitors demonstrate increased skills in working with families, job satisfaction, mindfulness, and reflective practice?
- Do supervisors demonstrate an increased ability to mentor home visitors in using the FAN approach in home visits?

[3]The training for Wave 1 sites occurred in May and early June 2013; the training for Wave 2 sites occurred in January 2014.
[4] Five programs in the study already had an IMHC on staff, while the others hired new staff. At three programs, one individual served as both the IMHC and the Developmental Specialist.

- Are home visitors and supervisors more satisfied with the supervisory relationship after FAN training than before?
- What are the effects of home visitors' use of the FAN approach on their relationships with families and maternal well-being?

The evaluation of the FAN training used a quasi-experimental, mixed-methods design, in which nine of ten HFA programs participated in one of two staggered training and implementation groups. One program served as a comparison site, which did not receive training. To assess effects of training on program staff and program participants, we collected data from two primary groups, program staff and program participants. The procedures for each sample were the following:

1. **Program staff**. We monitored staff engagement and skills repeatedly, beginning with surveys of home visitors and supervisors before the FAN training took place and continuing with four posttraining surveys. The posttraining surveys were administered every 6 months through the 18-month implementation. The surveys included questions about the staff's emerging skills with the FAN approach, their experiences with the FAN training itself, their ability to use the FAN concepts in their work, and their job satisfaction. The surveys also included two standardized self-report measures to assess relationships between home visitors and supervisors and mindfulness, as follows:

   - **Supervisory Working Alliance Inventory**. The Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990) is designed to "measure some properties of the relationship in supervision" and consists of three subscales in the supervisor version: Client Focus, Rapport and Identification. The home visitor version consists of two subscales: Client Focus and Rapport. The SWAI provides a seven-point Likert scale ranging from 1 or "never" to 7 or "always."
   - **Mindfulness Questionnaire**. The Five Facets of Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Baer, Samuel, & Lykins, 2011) consists of five independently developed mindfulness questionnaires that, based on a factor analysis, represent elements of mindfulness as conceptualized in the psychological literature. The five facets are: Observing, Describing, Acting with Awareness, Non-Judging of Inner Experience, and Non-Reactivity to Inner Experience. For this study we used the two scales from the measure that most aligned with the concepts in the FAN, Acting with Awareness and Non-Reactivity to Inner Experience.

   In addition to the surveys, we conducted in-person focus groups with home visitors at each of the program sites at two time points, 9 and 18 months after FAN training. The focus groups lasted about 60 minutes. Home visitors discussed supervisory relationships, job satisfaction, sense of efficacy, a new HFA training that became available midway through the study, challenges to learning the FAN,

and the impact of FAN training on their work. Each of the program supervisors participated in two interviews, one at 9 months and the second at 18 months after the FAN training. The interviews were conducted in person or by telephone. Supervisors were asked about how they were using the FAN in their supervision, how their home visitors were learning the FAN, and their overall opinion of the training. Lastly, consultants to each of the programs were also interviewed twice, at 9 and 18 months after FAN training, in person or by telephone. Consultants served primarily as informants about how the staff were applying what they were learning in the FAN training, as well as how the home visitors were using these specialists in their work with families.

2. **Program participants**. To understand how the FAN training affected the home visiting experiences of program participants as well as their maternal well-being, with the assistance of home visitors, we recruited two samples of mothers with infants 2 weeks up to 9 months of age. The first sample of mothers, the pretraining sample, was interviewed at two time points separated by 4 months (Time 1 and Time 2) before the FAN training began. The second sample, the posttraining sample, was interviewed 12 months after the start of the FAN training (Time 1) and 4 months later (Time 2). The use of different samples pre- and posttraining was necessary to contrast families who were and were not exposed to the FAN strategies, and their experiences in the home visiting program.[5] The Time 1 interviews were conducted in person, usually at the mother's home but occasionally at the program office, while the second interview was conducted by telephone. Lasting approximately 60 minutes, these interviews focused on the mothers' experiences and their relationships with their home visitors, as well as on their maternal health and well-being, and infant health and regulatory issues (crying, feeding, and sleeping). The interviews consisted of a mix of open-ended, semi-structured questions, some structured items, and three standardized measures of maternal functioning.[6] These three measures are briefly summarized below:

    - **Parenting Stress Index–Short Form**. The Parenting Stress Index Short Form (PSI-SF; Abidin, 2012) is a widely used self-report instrument designed to measure the relative degree of stress in a parent-child system and to identify the sources of distress. The 36 items in the PSI-SF assess total stress and stress in three individual areas: (1) stress that parents might be experiencing in their role as a parent (Parental Distress); (2) the extent to which parents believe that their child does not meet their expectations and finds interactions not satisfying (Parent-Child Dysfunctional

[5] We originally planned a group comparison design in which the Wave 2 program staff would serve as a nonintervention comparison group for the Wave 1 program staff during the period that they were not receiving training, but this design assumed a much shorter training and implementation period. A pilot study indicated that training and implementation is a longer process. Thus, we added a 10th program to the evaluation in February 2014, which served as a no-training comparison site.
[6] Mothers received an incentive of 20 dollars for each interview.

Interaction); and (3) how easy or difficult the parent perceives the child to be (Difficult Child). The PSI-SF also contains a validity scale, Defensive Responding, on which a score of 10 or lower indicates that the parent may have been responding defensively. The PSI-SF has been validated to measure and predict the child's current and future emotional and behavioral adjustment, as well as parenting behavior.

- **Edinburgh Postnatal Depression Scale**. The Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) is a 10-item, commonly used screening tool to identify symptoms of depression in the postnatal period and mothers who should be offered a referral for follow-up evaluation. The scale instructions ask the mothers to recall how they have been feeling in the past seven days. Examples of the questions are: "I have been able to laugh and see the funny side of things" and "I have been so unhappy that I have had trouble sleeping." The instrument has a 4-point Likert-type scale ranging from "most of the time" to "hardly ever." Scores can range from 0 to 30. The EPDS is appropriate for use with mothers up to one year postpartum.
- **Maternal Efficacy Questionnaire**. The Maternal Efficacy Questionnaire (MEQ; Teti & Gelfand, 1991) assesses mothers' sense of parenting competence or self-efficacy. This 10-item questionnaire, developed for mothers with infants ages birth to 13 months, addresses mothers' feelings of efficacy in relation to specific domains of infant care, as well as one item assessing feelings of efficacy as a parent in general. Items are scored (and then averaged) as 1, "Not good at all"; 2, "Not good enough"; 3, "Good enough"; or 4, "Very good," for a total average score between 1.0 and 4.0.
- **Working Alliance Inventory**. The short form of the Working Alliance Inventory (WAI; Horvath 1994; Short form by Tracey and Kokotovic [1989], modified by Santos [2005] for home visiting) is a 12-item self-report instrument for measuring the quality of the alliance between the worker and the client. In this study, home visitors were administered the worker version and parents were administered the client version. Each rated different aspects of their relationship on a 7-point scale, from 1, "never" to 7, "always." The scale contains three subscales: Bond, Task, and Goal. The Bond subscale measures the home visitor and participant perceptions regarding the other in terms of liking each other, confidence in their ability to do the job (or make the changes needed), mutual appreciation, and trust. The Task subscale is more action-oriented, assessing the home visitor and participant perceptions of what needs to happen to reach service goals, establish relative priorities, and, if necessary, obtain a new perspective on how to proceed. The Goal subscale measures home visitor and participant perceptions of their agreement on service goals, ability to develop mutual goals, and agreement on the change needed to achieve program

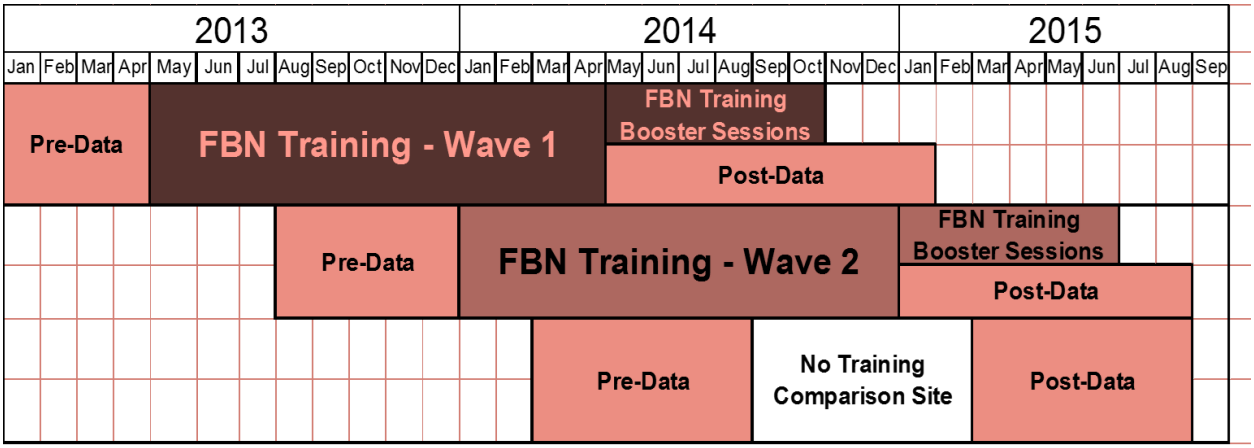
objectives. Subscale scores are a sum of the 4 items contained within each subscale. Agreement is represented by the difference between the home visitor score and the parent score on each subscale, and agreement within 4 points is considered "alliance."

Finally, FAN trainers from Erikson Institute were individually interviewed once at the end of the training period. These interviews lasted approximately 60 minutes and consisted of a series of open-ended questions designed to learn about the trainers' experiences as a trainer and their impressions of how the program staff they trained adapted to the use of the FAN.

At about the same time that we started data collection for Wave 2, we added the tenth HFA program that served as a nontraining comparison group. The timeline for data collection in relation to the FAN training for Wave 1, Wave 2, and Comparison sites is shown in Figure 2.

Copies of survey, interview, and focus group protocols are available upon request.

Figure 2. Data Collection Timeline for Evaluation of FAN Training



Context for the Evaluation

In order to fully appreciate the evaluation, it is useful to consider the economic and program contexts in which the FAN training was implemented. These contexts provide a framework through which to view the participating programs' ability to implement the full program model. First of all, the FAN training began during a time of concentrated federal and state attention on home visiting and on improving the capacity of communities to implement high-quality, evidence-informed programming. The evaluation also began as Illinois, and the rest of the country, was slowly recovering from an economic recession that began around 2008, which greatly increased the needs of families and decreased the resources communities had to meet their needs. Programmatically, the HFA national office revised and disseminated a new HFA program model, called Integrated Strategies for Home Visiting (ISHV), and provided new training to all HFA programs in the state approximately halfway through the FAN training

and evaluation.[7] As we will discuss later, though the new approach is compatible with the core concepts of the FAN, the timing of the ISHV training made it difficult for staff to learn and figure out how to integrate the two training approaches.

Overview of this Report

This report draws primarily from interviews and surveys conducted over a two-and-a-half year period, starting in January 2013, with surveys and interviews of staff and participants in ten HFA programs. It also includes an analysis of administrative data on frequency and length of participation in HFA program services during the study period. In the next chapter, we describe the sample of programs, staff, and mothers who participated in the study. In the third chapter, we present findings related to the implementation of the FAN approach and changes in the practices of staff and in parents' home visiting experiences as a result of training. We also discuss the factors that affected implementation of the approach. In the fourth chapter, we explore potential outcomes of the approach for program participants. The final chapter summarizes our findings and discusses implications for future training and professionalization of the home visiting workforce to improve service quality and family outcomes.

[7] The ISHV training dates varied, but occurred after the first focus group for four of the Wave 1 programs and before the first focus group for the fifth Wave 1 program and the four Wave 2 programs.

Sample Characteristics at Baseline

The 10 programs that participated in the evaluation were all credentialed HFA programs located in one of three regions of Illinois: urban Chicago, suburban/collar counties, and rural/downstate areas. Six of the programs were sponsored by multisite social service agencies, three were offered by county health departments, and the comparison site was located in a community-based behavioral health care center. At the onset of the study, the size of the programs' home visiting staff ranged from as few as three to as many as eight full-time staff.[8] Caseload sizes varied somewhat, depending on the participants' levels of service, but averaged 14 to 15 families per home visitor. All of the programs gave preference to first-time mothers, low-income mothers,[9] and younger mothers (teens and mothers in their early 20s). The racial and ethnic backgrounds of program participants varied by region of the state, but consisted largely of white, black, and Hispanic families. About a third were reported to be Spanish-speaking, foreign-born participants.

Characteristics of Program Staff

Across the nine programs that received training, a total of 52 home visitors and 14 supervisors were on staff during the 6-month pretraining period. The baseline sample of program staff included 45 home visitors and 12 supervisors who completed at least one pretraining survey. (See Table A-1 in Appendix A for additional information about survey response rates.) Because of the considerable attrition of staff during the evaluation period, it was necessary to form a subsample of home visitors who could be followed over time to assess change. There were just 23 home visitors who remained with the study until

[8] Three of the sites employed one or two doulas as part of their home visiting staff. Each program also had one or two supervisors.
[9] As defined as being within 0 to 200% of the Federal Poverty Line.

the end of the 18-month training and also completed at least one pretraining survey,[10] the posttraining Time 1 survey, and the final posttraining Time 4 survey. For the most part, their baseline characteristics were similar to those of the larger sample, though a higher percentage of Wave 1 programs was represented (65%) because of greater attrition among the Wave 2 programs.

Home Visitors

Tables below present demographic and other baseline information for the 45 home visitors who responded to at least one pretraining survey, as well as for the subgroup of 23 home visitors who remained with the study until the final, fourth posttraining survey. As shown in Table 1, all of the home visitors participating in the FAN training evaluation were female and about two-thirds (66%) were under the age of 40 years old. The sample was racially and ethnically diverse; 42 percent of the full sample described themselves as white, 35 percent as Hispanic, and 14 percent as black. The racial/ethnic composition of the home visitors differed between the two waves of programs: Wave 1 home visitors were more likely than those in Wave 2 to self-identify as white; a majority of Wave 2 home visitors self-identified as Hispanic. These differences correspond to differences in the racial/ethnic composition of the families served by the Wave 1 and Wave 2 programs.

Table 1. Demographic Characteristics of Home Visitors at Baseline, by Wave

Home Visitor Characteristics		Wave 2 (*n* = 22)	Full Sample (*N* = 43)	Subsample[a] (*n* = 23)
Age, %				
20–29 years	33	46	40	30
30–39 years	24	27	26	26
40–49 years	24	14	19	22
50–59 years	14	9	12	13
60 years or older	5	5	5	9
Race and/or Ethnicity**, %				
White	52	32	42	44
Hispanic	10	59	35	30
Black	29	0	14	13
American Indian	5	0	2	4
Multiple races and/or ethnicities	5	9	7	9

**Chi-square tests indicated racial and ethnic differences between Waves 1 and 2 are statistically significant at $p < 0.01$.
[a] Subsample refers to the home visitors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.

Home visitors in Wave 2 had higher levels of education than home visitors in Wave 1, which might reflect the younger age of the Wave 2 staff. All of the Wave 2 home visitors had either a Bachelor's or

[10] There were three home visitors who did not complete a pretraining Time 1 Survey (1 from Wave 1 and 2 from Wave 2) so we moved their pretraining Time 2 survey data to pretraining Time 1 survey data and added a separate Demographics survey to pretraining Time 1 survey. It also should be noted that two home visitors did not respond to the demographic and other background questions on the survey; thus, we can only report some information for 43 home visitors.

Master's degree compared to only two-thirds (66%) of home visitors in Wave 1. Home visitors in both waves have similar educational interests; about one-third studied social work or social welfare and less than one-quarter studied psychology. Just five home visitors in the full sample reported that they were currently enrolled in an advanced educational program.

Table 2. Education and Experience of Home Visitors at Baseline, by Wave

Background Characteristic	Wave 1 (*n* = 21)	Wave 2 (*n* = 22)	Total (*N* = 43)	Subsample[a] (*n* = 23)
Current level of education*, %				
High school diploma	14	0	7	9
Some college; no degree	10	0	5	9
Associates degree	10	0	5	9
Bachelor's degree	57	71	64	50
Advanced degree	9	29	18	23
Area of study[b], %				
Social work/social welfare	24	33	29	26
Psychology	18	19	18	11
Child development	6	5	5	5
Early childhood education/education	6	0	3	5
Other or multiple areas of study	46	43	45	43
Currently enrolled in educational program, %				
Yes	10	15	12	5
Years working with families with young children				
Mean (SD)	8.5 (5.43)	6.8 (4.40)	7.6 (4.95)	7.8 (4.59)
Range, *n*	<1–20	0–15	0–20	<1–17
Prior experience delivering home-based services to families				
Yes, %	43	50	46	38
Years of experience delivering home based services to families[c]*	*n* = 9	*n* = 10	*n* = 19	*n* = 8
Mean (SD)	7.3 (6.30)	2.4 (1.41)	4.7 (5.00)	5.2 (4.58)
Range, *n*	1–20	0–15	1–20	1–15

[a] Subsample refers to the home visitors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.
[b] Five home visitors did not respond to this question.
[c] Means based on responses of those who reported have prior experience.
Chi-square tests indicated educational differences between Waves 1 and 2 are statistically significant at $*p < 0.05$.
ANOVA tests indicated mean years of experience between Waves 1 and 2 are statistically significant at $*p < 0.05$.

The home visiting staff as a group had a wide range of experience in home visiting. More than half of the baseline sample had no experience delivering services to families in their homes prior to their current positions. At baseline, home visitors in both waves had, on average, 7.6 years of experience working with families with young children, with home visitors in Wave 1 having slightly more experience (8.5 years vs. 6.8 years). A slightly greater proportion (50% vs. 43%) of Wave 2 home visitors had prior experience

delivering home-based services to families. On the other hand, of those with prior experience delivering home-based services to families, Wave 1 home visitors had significantly more years of experience: 7.3 years vs. 2.4 years, on average. The average years of experience for the home visitor subsample was slightly higher (5.2 years) than the average for the full sample (4.7).

Most (88%) of the home visitors had received other training during the past year. About two-thirds of all home visitors had attended training on domestic violence and two-thirds had attended training on adult mental health problems or depression. About half had attended training on substance abuse and less than half attended the Happiest Baby on the Block training (see Table 3). Less than one-third (29%) attended the adult learning challenges training. On average, both waves of home visitors had attended just over two trainings during the past year.

Table 3. Trainings Received by Home Visitors by Wave in Year Prior to Baseline

Training Indicator	Wave 1 (*n* = 21)	Wave 2 (*n* = 22)	Total (*N* = 43)	Subsample[a] (*n* = 23)
Number of trainings attended in previous year				
Mean *(SD)*	2.3 *(1.79)*	2.4 *(1.40)*	2.3 *(1.60)*	2.7 *(1.63)*
Range, *n*	0–5	0–5	0–5	0–5
None, %	26	9	18	9
1 training, %	13	23	18	22
2–3 trainings, %	26	45	35	26
4–5 trainings, %	35	23	29	43
Topics of trainings attended, %[b]				
Domestic violence/partner conflict	70	67	68	73
Adult mental health problems/depression	62	71	67	70
Substance abuse	50	50	53	57
Adult learning challenges	20	38	29	41
Happiest Baby on the Block	52	26	40	48

[a] Subsample refers to the home visitors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.
[b] Two home visitors noted other trainings: "attachment, ethics, child sexual abuse, compassion fatigue, et al." and "CBFana."

Most of the home visitors in the study worked full time or an average of 38.5 hours per week. Although caseloads averaged between 14 and 15 families, the number of families on home visitors' caseloads varied from as many as 26 to as few as two (i.e., supervisors who carried a small caseload).[11] Wave 2 home visitors were much more likely to speak Spanish in their visits than Wave 1 home visitors (50% vs. 14%), reflecting the fact that Wave 2 programs serve more foreign-born families than Wave 1 programs.

[11] When asked to break their caseloads down by level of service, Wave 2 home visitors reported having a higher percentage of families on Prenatal/Postnatal Level 1 (weekly visits), Level 2 (visits twice a month), Level 3 (visits once a month), and Level 4 (quarterly visits) than Wave 1 home visitors. Wave 1 home visitors reported a higher percentage of families on Prenatal/Postnatal Level 1 (weekly visits) and on Creative Outreach.

Because the FAN training was initially developed to help home visitors work with high-risk families, especially those whose young children were experiencing regulatory problems in calming, feeding, or sleeping, we were interested in how home visitors assessed the needs of their families. When asked how many families on their caseloads have mental health issues, most (91%) reported that they had at least "a few" families with mental health issues. Only 17 percent, however, said that "many" or "almost all" of their families had mental health issues.

All of the home visitors reported receiving weekly supervision, with most sessions lasting at least 90 minutes. About a quarter of the sample reported supervision sessions of 60 minutes, and in one case, 30 minutes at a time. When asked about the supervision they received, all of the home visitors reported that the supervision they received before the start of the FAN training addressed administrative issues, program issues, and clinical issues "fairly well" or "very well." Based on responses of home visitors to the SWAI (see Table 4), supervisory relationships were very positive. On average, home visitors responded "often" or "very often" to all of the items in the assessment. Two of the highest rated items were: "My supervisor is tactful when commenting about my performance" and "My supervisor welcomes my explanations about my client's behavior." The item, "I feel free to mention to my supervisor any troublesome feelings I might have about him/her," elicited a wide range of responses and had the lowest mean rating.

Job Satisfaction

Along with the potential of the FAN training to improve relationships with supervisors, another area the evaluation explored was job satisfaction. Thus, in the pretraining survey, home visitors were asked seven questions around job satisfaction to which they responded using a 4-point scale ranging from 1 or "very dissatisfied" to 4 or "very satisfied." As shown in Table 5, all responses were solidly in the 3, or "satisfied," range with minor, nonsignificant variations among the items.

Table 4. Home Visitors' Responses to Supervisory Working Alliance Inventory (SWAI) at Baseline

SWAI Indicator	Full Sample (*N* = 42) Mean (*SD*)	Subsample[a] (*n* = 23)[b] Mean (*SD*)
My supervisor welcomes my explanations about my client's behavior	6.6 (0.67)	6.5 (0.73)
My supervisor is tactful when commenting about my performance	6.4 (1.11)	6.4 (0.78)
I feel comfortable working with my supervisor	6.3 (0.95)	6.3 (0.92)
My supervisor encourages me to talk about my work with clients in ways that are comfortable for me	6.3 (1.07)	6.2 (0.95)
My supervisor helps me talk freely in our sessions	6.3 (1.07)	6.3 (0.71)
My supervisor treats me like a colleague in our supervisory sessions	6.2 (1.16)	6.0 (0.93)
My supervisor stays in tune with me during supervision	6.1 (1.22)	6.1 (0.99)
In supervision I am more curious than anxious when discussing my difficulties with clients	6.0 (0.89)	5.8 (0.91)
My supervisor encourages me to take time to understand what the client is saying and doing	6.0 (1.25)	5.9 (1.49)
My supervisor helps me work within a specific plan with my clients	6.0 (1.23)	5.8 (1.35)
When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client	6.0 (1.19)	6.0 (1.19)
My supervisor encourages me to formulate my own interventions with the client	6.0 (1.08)	5.9 (1.06)
I understand client behavior and program strategies similar to the way my supervisor does	6.0 (1.05)	5.9 (0.97)
In supervision my supervisor places a high priority on our understanding the client's perspective	5.9 (1.45)	5.9 (1.38)
My supervisor helps me stay on track during our meetings	5.7 (0.37)	5.7 (1.42)
My supervisor's style is to carefully and systematically consider the material I bring to supervision	5.5 (1.45)	5.5 (1.47)
I work with my supervisor on specific goals in the supervisory session	5.4 (1.55)	5.5 (1.34)
I feel free to mention to my supervisor any troublesome feelings I might have about him/her	5.4 (1.86)	5.4 (1.78)
Rapport [c]		
Mean (SD)	6.1 (0.94)	6.1 (0.78)
Range, *n*	2.8–7.0	4.2–7.0
Client Focus		
Mean (SD)	5.8 (1.21)	5.7 (1.32)
Range, *n*	1.1–7.0	1.1–7.0

[a] Response scale: 1, Never; 2, Rarely; 3, Occasionally; 4, Sometimes; 5, Often; 6, Very Often; and 7, Always.

[b] Subsample refers to the home visitors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.

[c] Note: "Rapport" refers to the supervisee's perception of support from the supervisor. "Client focus" refers to the supervisee's perception of the emphasis the supervisor placed on promoting the supervisee's understanding of the client. In calculating the Rapport subscale, we did not include the "My supervisor makes the effort to understand me" item because the wording was changed in the middle of the study to "My supervisor makes the effort to understand my concerns about my participants' behavior."

Table 5. Home Visitors' Job Satisfaction at Baseline[a]

Job Satisfaction Indicator	Full Sample (*N* = 44) Mean (SD)	Subsample (*n* = 23)[b] Mean (SD)
The support you receive from coworkers	3.6 (0.54)	3.5 (0.51)
Cultural sensitivity in your program	3.5 (0.51)	3.5 (0.51)
The supervision you receive	3.4 (0.63)	3.4 (0.58)
Being valued for your work	3.3 (0.71)	3.4 (0.58)
The quality of training you receive	3.3 (0.73)	3.1 (0.76)
Your workload	3.0 (0.64)	3.0 (0.69)
Opportunities for professional development	3.0 (0.78)	3.0 (0.77)

[a] Responses are based on a 4-point scale: 1, Very dissatisfied; 2, Dissatisfied; 3, Satisfied; and 4, Very satisfied.

[b] Subsample refers to the home visitors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.

Self-Assessed Mindfulness

Table 6 shows the mean scores on the two subscales of the Five Facets of Mindfulness Questionnaire (FFMQ), used in this study before FAN training. Higher scores on this instrument indicate greater mindfulness on the part of the respondent. The first subscale, Act with Awareness is defined as "being attentive and engaging fully in one's current activity," and had a mean rating of 33.4 at pretraining Time 1. The highest score possible on the subscale is 40. The second subscale is the Non-Reactivity to Inner Experience subscale, which is described as "being able to perceive emotions without reacting to them, without becoming dysregulated." The highest possible score on this subscale is 35. At pretraining Time 1, home visitors' ratings resulted in a mean score of 24.7. The scores for the subsample were the same as that for the full sample for both the Act with Awareness subscale and the Non-Reactivity to Inner Experience subscale.

Table 6. Home Visitors' Self-Assessment on the FFMQ Mindfulness Questionnaire at Baseline[a]

FFMQ Indicator	Full Sample (*N* = 45)	Subsample (*n* = 22)[b]
I perceive my feelings and emotions without having to react to them	3.5 (0.98)	3.4 (1.00)
When I do things, my mind wanders off and I'm easily distracted	3.7 (0.88)	3.9 (0.92)
I do not pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted	4.4 (0.62)	4.5 (0.51)
I watch my feelings without getting lost in them	3.7 (0.99)	3.8 (0.94)
I am easily distracted	3.9 (1.08)	4.0 (1.15)
I find it difficult to stay focused on what's happening in the present	4.3 (0.84)	4.3 (0.88)
When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it	3.8 (1.13)	4.0 (1.09)
In difficult situations, I can pause without immediately reacting	3.9 (0.92)	3.9 (0.92)
It seems I am "running on automatic" without much awareness of what I am doing	4.3 (0.77)	4.3 (0.70)
When I have distressing thoughts or images, I feel calm soon after	3.1 (1.21)	2.9 (1.19)
I rush through activities without being really attentive to them	4.3 (0.77)	4.2 (0.85)
When I have distressing thoughts or images I am able to just notice them without reacting	3.4 (0.89)	3.4 (0.92)
When I have distressing thoughts or images I just notice them and let them go	3.3 (1.14)	3.3 (1.08)
I do jobs or tasks automatically without being aware of what I'm doing	4.2 (0.89)	4.0 (1.00)
I find myself doing things without paying attention	4.1 (1.01)	4.1 (0.94)
Act with Awareness subscale		
Mean (SD)	33.4 (4.79)	33.4 (4.91)
Range, *n*	21–40	22–40
Non-Reactivity to Inner Experience subscale		
Mean (SD)	24.7 (4.88)	24.7 (4.82)
Range, *n*	11–35	15–34

[a] Responses on the Five Facets Mindfulness Questionnaire (FFMQ) are based on a 5-point scale: 1, Never or very rarely true; 2, Rarely true; 3, Sometimes true; 4, Often true; and 5, Very often or always true.
[b] Subsample refers to the home visitors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.

Supervisors

Twelve supervisors participated in the study at some point in time and completed at least one of the two pretraining surveys, but only seven remained with the study from the pretraining period through the final data collection point.[12] These seven supervisors became the group of supervisors we were able to follow over time, from the time of the first pretraining survey to the time of the fourth posttraining sample. Table 7 presents background characteristics for the 12 supervisors who responded to these survey questions and for the responding supervisors in the subsample. As in the home visitor sample, there was considerable variability among the supervisors in terms of their age and experience. All of them had had previous experiences as home visitors before becoming supervisors, with years ranging from one to 25 years.

Table 7. Supervisor Characteristics at Baseline[a]

Home Visitor Characteristics	Full Sample[a] (*n* = 11)	Subsample (*n* = 7)[b]
Age		
30–39 years old, %	46	50
40–49 years old, %	18	17
60 years or older, %	36	33
Race and/or Ethnicity		
Black, %	18	17
White, %	73	83
Hispanic, %	9	0
Current level of education		
Bachelor's degree, %	55	50
Master's degree, %	45	50
Number of trainings attended in previous year		
Mean (SD)	2.8 (1.82)	3.0 (2.31)
Range, *n*	0–6	0–6
Years working with families with young children		
Mean (SD)	12.9 (6.84)	13.5 (5.51)
Range, *n*	2–20	8–20
Years of experience as a home visitor		
Mean (SD)	11.0 (7.89)	9.8 (6.11)
Range, *n*	1–25	3–20
Current Role		
Supervisor and Home Visitor, %	25	29
Supervisor only, %	75	71

[a] Twelve supervisors completed one or both of the pretraining survey, but only 11 provided demographic and other background information. For the subsample that was followed over time, only six answered demographic and other background questions.
[b] Subsample refers to the supervisors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.

[12] Of the 14 supervisors (7 in Wave 1 and 7 in Wave 2) who were there when we administered the pretraining Time 1 survey, 12 (86%) completed the survey. One staff member was both a supervisor and a home visitor, but we did not know about her supervisory role so we only sent her the home visitor survey for both of the pretraining surveys. One other supervisor did not complete a pretraining Time 1 survey but did complete a pretraining Time 2 survey. Her pretraining Time 2 information was included in all analyses in this report. By the end of the study, there were 12 supervisors in the sample, but four of them were recent hires or promotions and so were not supervisors at the start of the study.

Table 8. Supervisors' Views of Supervision at Baseline

Indicator	Full Sample (n = 11)	Subsample (n = 7)[b]
Number of home visitors in the program supervised this month		
Mean (SD)	4.3 (1.42)	5.1 (0.69)
Range, number of home visitors, *n*	1–6	4–6
Hours spent in each supervision session, on average		
Mean (SD)	1.7 (0.29)	1.8 (0.32)
Range, hours	1.3–2.0	1.25–2.0
Primary way you provide supervision to staff now		
Regular individual supervision with each home visitor, %	63	100
Regular group supervision, %	16	43
Unscheduled supervision, %	32	71
Type(s) of supervision you provide to staff		
Administrative/monitoring, %	58	86
Educational, %	47	57
Reflective, %	63	100
Clinical, %	21	14
In supervision how well do you address…		
Administrative issues		
Somewhat well, %	17	14
Fairly well, %	58	57
Very well, %	25	29
Program issues		
Somewhat well, %	33	14
Fairly well, %	50	71
Very well, %	17	14
Clinical issues		
A little, %	9	17
Somewhat well, %	18	33
Fairly well, %	55	33
Very well, %	18	17
Processing home visitors' feelings and reactions to work with families		
Somewhat well, %	17	14
Fairly well, %	42	29
Very well, %	42	57
How often you have had the opportunity to talk with a supervisor and process your own reaction to the work you do[b]		
Less than once a month, %	33	29
Once a month, %	0	0
Twice a month, %	17	29
Weekly, %	50	43
Ways you meet with your supervisor		
Individually, %	63	100
With other supervisors, %	11	14
Type of supervision with your supervisor		
Administrative/monitoring, %	63	100
Educational, %	21	29
Reflective, %	37	71
Clinical, %	11	14

[a] Individuals providing supervision to supervisors include: another coordinator, immediate boss, program director/manager (n = 3), site director.

[b] Subsample refers to the supervisors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.

Consistent with the responses of home visitors to the SWAI (see Table 9), supervisors also reported positive relationships with home visitors.

Table 9. Supervisors' Responses on Supervisory Working Alliance Inventory (SWAI) at Baseline

SWAI Indicator	Full Sample (*n* =12) Mean (*SD*)	Subsample[a] (*n* = 7) Mean (*SD*)
I make an effort to understand my home visitors' concerns about their participants	6.6 (0.50)	6.6 (0.53)
I welcome my home visitors' explanations about their participants' behavior	6.3 (0.49)	6.3 (0.49)
My home visitors appear to be comfortable working with me	6.3 (0.78)	6.0 (0.82)
I encourage my home visitors to talk about the work in ways that are comfortable for them	6.2 (0.72)	5.9 (0.69)
I am tactful when commenting about my home visitors' performance	6.2 (0.72)	6.1 (0.69)
In supervision, I place a high priority on understanding the participant's perspective	6.0 (0.95)	6.0 (1.15)
I encourage my home visitors to take time to understand what participants are saying and doing	5.8 (0.72)	5.9 (0.69)
I stay in tune with my home visitors during supervision	5.9 (0.67)	5.7 (0.49)
During supervision, my home visitors talk more than I do	5.9 (0.90)	5.7 (0.95)
I encourage my home visitors to formulate their own plans with their participants	5.6 (0.79)	5.7 (0.49)
I facilitate my home visitors' participation in our sessions	5.5 (0.80)	5.7 (0.76)
In supervision, my home visitors are more curious than anxious when discussing their difficulties with participants	5.4 (1.00)	5.4 (0.79)
During supervision, my home visitors seem able to stand back and reflect on their own experience	5.4 (1.00)	5.0 (0.58)
My home visitors consistently implement suggestions made in supervision	5.4 (0.51)	5.3 (0.49)
I help my home visitors stay on track during our meetings	5.3 (0.75)	5.3 (0.76)
My home visitors understand participant behavior and program strategies similar to the way I do	5.3 (0.65)	5.3 (0.76)
My home visitors identify with me in the way they think and talk about their participants	5.3 (0.75)	5.3 (0.76)
In supervision, I expect my home visitors to think about/reflect on my comments to them	5.1 (1.00)	5.0 (1.15)
I help my home visitors work within a specific plan with their participants	5.0 (1.04)	4.9 (1.35)
When correcting my home visitors' errors with a participant, I offer alternative ways of intervening with that participant	4.8 (1.06)	4.9 (0.69)
My home visitors work with me on specific goals in the supervisory sessions	4.5 (1.24)	4.1 (1.46)
My style is to carefully and systematically consider the material that my home visitors bring to supervision	4.4 (1.68)	4.3 (2.06)
I teach my home visitors through direct suggestion	4.0 (0.95)	3.6 (0.79)
Rapport		
Mean (SD)	6.0 (0.37)	6.0 (0.37)
Range, *n*	5.71–6.71	5.71–6.57
Client Focus		
Mean (SD)	5.0 (0.55)	4.9 (0.68)
Range, *n*	4.00–5.89	4.00–5.89
Identification		
Mean (SD)	5.6 (0.44)	5.4 (0.37)
Range, *n*	5.00–6.43	5.00–6.00

[a] The SWAI uses a 7-point response scale: 1, Never; 2, Rarely; 3, Occasionally; 4, Sometimes; 5, Often; 6, Very Often; and 7, Always. "Rapport" refers to supervisors' efforts to build a bond or relationship with the home visitor. "Client focus" refers to the degree to which supervisors encourage focused efforts on goals and tasks expected to benefit clients. Identification refers to the extent to which supervisors believe home visitors identify with the supervisors' goals and strategies for working with families.

[b] Subsample refers to the supervisors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.

Job Satisfaction

For the most part, supervisors were "satisfied" with all aspects of their positions (see Table 10). They gave the item that pertained to their "influence on the program" the highest rating and "your workload," "your influence on home visitors' parent-child interactions," "administrative responsibilities and paperwork," and "opportunities for professional development" the lowest rating.

Table 10. Supervisors' Job Satisfaction at Baseline[a]

Job Satisfaction Indicator	Full Sample (*n* = 12) Mean (SD)	Subsample[a] (*n* = 7) Mean (SD)
Your influence on the program	3.3 (0.45)	3.3 (0.49)
Cultural sensitivity in your program	3.2 (0.58)	3.0 (0.58)
Your interactions with home visitors	3.2 (0.58)	3.0 (0.58)
The support you receive from coworkers	3.2 (0.58)	2.9 (0.38)
The supervision you administer	3.1 (0.29)	3.1 (0.38)
Being valued for your work	3.1 (0.29)	3.0 (0.00)
The quality of training you receive	3.1 (0.67)	3.1 (0.69)
Overall job satisfaction	3.0 (0.00)	3.0 (0.00)
Your workload	2.9 (0.29)	2.9 (0.38)
Your influence on home visitors' parent-child interactions	2.9 (0.29)	2.9 (0.38)
Administrative responsibilities and paperwork	2.9 (0.29)	2.9 (0.38)
Opportunities for professional development	2.9 (0.67)	2.9 (0.69)

[a] Responses are based on a 4-point scale ranging from 1, Very dissatisfied; 2, Dissatisfied; 3, Satisfied; to 4, Very satisfied.
[b] Subsample refers to the supervisors who completed a pretraining survey and posttraining surveys at Time 1 and Time 4.
[c] For these three items *n* = 6

Mindfulness Self-Assessment

Because we added the standardized measure of mindfulness to the surveys at the time of the Wave 2 pretraining survey, we had no pretraining data for the Wave 1 supervisors on this measure. Partly because of staff turnover, the sample of supervisors who responded to this assessment was very small—just six supervisors from one of the pretraining surveys and two from post-Time 4 (see Table 11). Consistently over the course of the evaluation, supervisors were asked to respond to 15 items from the FFMQ that make up two subscales: Act with Awareness and Non-Reactivity to Inner Experience.

In both our full sample and our subsample, we found that the item "I do not pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted" had the highest mean score while "I perceive my feelings and emotions without having to react to them" had one of the lowest mean scores. This suggests that, prior to the training, the supervisors demonstrated room for improvement in mindfulness around awareness of behavior as well as acknowledging and letting go of emotions without reacting.

Table 11. Supervisors' Responses to the FFMQ Mindfulness Questionnaire at Baseline[a]

FFMQ Indicator	Full Sample (n = 6)[b] Mean (SD)	Subsample (n = 2)[b] Mean (SD)
I do not pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted	4.5 (0.55)	4.5 (0.71)
I find it difficult to stay focused on what's happening in the present	4.3 (0.82)	4.5 (0.71)
I am easily distracted	4.3 (0.52)	4.0 (0.00)
It seems I am "running on automatic" without much awareness of what I am doing	4.2 (0.98)	4.5 (0.71)
I do jobs or tasks automatically without being aware of what I'm doing	4.2 (0.75)	4.0 (0.00)
I find myself doing things without paying attention	4.2 (0.75)	4.0 (0.00)
I rush through activities without being really attentive to them	4.2 (0.41)	4.0 (0.00)
I watch my feelings without getting lost in them	4.0 (0.00)	4.0 (0.00)
In difficult situations, I can pause without immediately reacting	3.8 (0.75)	3.5 (0.71)
When I do things, my mind wanders off and I'm easily distracted	3.7 (0.82)	3.5 (0.71)
When I have distressing thoughts or images I am able to just notice them without reacting	3.7 (0.82)	4.0 (0.00)
When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it	3.5 (1.22)	4.0 (0.00)
When I have distressing thoughts or images I just notice them and let them go	3.5 (0.55)	3.5 (0.71)
When I have distressing thoughts or images, I feel calm soon after	3.4 (0.89)[c]	3.0 (1.41)
I perceive my feelings and emotions without having to react to them	3.2 (0.41)	3.5 (0.71)
Act with Awareness subscale		
Mean (SD)	33.5 (4.51)	33.0 (1.41)
Range, n	27–39	32–34
Non-Reactivity to Inner Experience subscale		
Mean (SD)	24.8 (1.79)[c]	25.5 (0.71)
Range, n	23–27	25–26

[a] Responses on the Five Facets Mindfulness Questionnaire (FFMQ) are based on a 5-point scale: 1, Never or very rarely true; 2, Rarely true; 3, Sometimes true; 4, Often true; and 5, Very often or always true.
[b] This measure was only provided at pretraining Time 1 to supervisors in Wave 2, hence the small sample size.
[c] n = 5

Again, the Act with Awareness subscale is comprised of eight items so the highest score one could earn on this subscale is 40. The responses of the larger sample of six supervisors resulted in a mean of 33.5 and the score for the subsample of two supervisors was a comparable mean of 33.0. A higher score on this subscale indicates that supervisors rated themselves highly on their capacity for "being attentive and engaging fully in one's current activity." The Non-Reactivity to Inner Experience subscale is made up of seven items, and the highest score possible is a 35. The responses of the six supervisors in our full sample

resulted in a mean score a mean of 24.8 and those of the two supervisors in the subsample resulted in a score of 25.5. A higher score on this subscale indicates an ability to avoid reacting to one's inner experience and to allow thoughts and feelings to come and go without getting caught up in them.

Characteristics of Program Participants

Two samples of mothers were recruited from the nine program sites and the no-training comparison site, a pretraining sample and a posttraining sample. Eligible mothers were those whose infants were between 2 weeks and 9 months of age. Across the nine training programs, with the assistance of home visitors, we recruited and interviewed a total of 217 mothers for the study at Time 1, 129 in the pretraining sample and 88 in the posttraining sample. The decrease in sample size at posttraining was primarily because of staff turnover and families dropping out of the home visiting program, which meant that there were fewer mothers eligible for the study. Of the 217 mothers interviewed at Time 1, 155 (71%) also completed a Time 2 interview—94 in the pretraining sample and 61 in the posttraining sample—and therefore constituted the sample of mothers in programs where the FAN training was delivered. At the nontraining comparison program, 24 mothers completed both Time 1 and Time 2 interviews, 13 in the so-called pretraining sample and 11 in the posttraining sample (see Table 12).

Table 12 displays demographic and other characteristics of mothers in the study. Mothers across all of the programs ranged in age from 14 to 41 years, with a mean age of 22 years (*SD = 4.87*) at the Time 1 interview. Thirteen percent were teen mothers younger than 18 years of age. Over two-thirds of participant mothers were in a relationship at the time of the first interview, and more than two-thirds had a high school education or less. Infants ranged in age from 2 weeks to 9 months old, with a mean of 4.4 months of age (*SD = 3.0*). Eighteen percent of participants were interviewed in Spanish.

The vast majority of mothers were receiving income supports including WIC and Medicaid. Comparing the participants in pretraining and posttraining samples, we found few differences in participant demographics. No significant differences were found between the two samples in terms of maternal age, educational attainment, race/ethnicity, marital status, employment status, infant age, and service use (see Tables 12 and 13). The only difference was in the area of housing and living circumstances: pretraining participants were more likely to live in the home of a parent or other family member than posttraining participants ($p < 0.001$).

To estimate the level of adversity faced by the mothers in this evaluation, a risk index score was calculated based on the 5-Item Risk Index (Administration for Children and Families, 2002), which consists of the following demographic risk factors: (1) receipt of public assistance, Supplemental

Nutrition Assistance Program (SNAP), or Supplemental Security Income (SSI); (2) being unemployed and not in school; (3) lacking a high school diploma or GED; (4) being a teen at the birth of the first child; and (5) having single parent status at the time of enrollment. We aggregated these factors and classified participants as low risk (0, 1, or 2 factors), medium risk (3 factors), or high risk (4 or 5 factors).[13] The mean risk scores for the pretraining and posttraining samples are presented in Table 12, as well as the percentage of "high-risk" participants in each sample. Twenty-seven percent of the pretraining sample and 16 percent of the posttraining sample were in this demographic high-risk sample.[14] Because of the small sample at the comparison site, the comparison site participants were not included in this high-risk subgroup analysis.

Time 1 to Time 2 Attrition

Of the 251 participants at the 10 program sites who were interviewed at Time 1 (151 in the pretraining sample and 100 in the posttraining sample), 71 participants did not complete a Time 2 interview. The reasons for nonparticipation at Time 2 did not differ between the pretraining and posttraining samples. About half (48%) of the attrition resulted from numerous unsuccessful attempts to reach participants, and the other half had either dropped out of the program (32%) or moved out of the service area (20%). There were no statistically significant differences between the group of mothers who only completed the Time 1 interview and the group who completed both interviews with respect to the age of their infant, infant regulatory problems, infant health, maternal health, maternal education, maternal race, maternal employment status, maternal relationship/marital status, depression, parenting self-efficacy, perspective on their home visitor as measured by the Working Alliance Inventory (WAI), or risk index score.

However, those who only completed Time 1 interviews were younger (M = 20.7 (*3.32*)) than the those who completed both interviews, (M = 22.8 (*5.26*), $t(249) = 3.16$, $p = 0.002$). In addition, those who only completed Time 1 interviews participants scored higher on the Parent-Child Dysfunctional Interaction subscale of the Parent Stress Index Short Form (M = 19.3 (*5.76*)) than those who completed interviews at both times (M = 17.6 (*5.33*), $t(247) = 2.12$, $p = 0.035$). No other differences were found between the groups.

[13] For 32 of the participants, employment and education data were missing. With two of the five items on the Risk Index missing, participants were considered high risk if they met all three of the remaining criteria: SNAP recipient, mother was a teen at the birth of first child, and mother is unmarried.

[14] There was variability among the 9 programs in the study. Twenty-eight percent of Wave 1 pretraining participants and 9 percent of posttraining participants were in this demographic high risk sample. In Wave 2, 16 percent of pretraining participants and 21 percent of posttraining participants were high risk.

Table 12. Demographic Characteristics, Mother and Infant Participants at Baseline, Pretraining and Posttraining[a] Samples

Characteristic	Waves 1–2 Pretraining (*n* = 94)	Waves 1–2 Posttraining (*n* = 61)	Comparison Pre (*n* = 13)	Comparison Post (*n* = 11)
Mother age	22.6 (5.68)	23.4 (5.02)	21.4 (3.85)	23.0 (4.12)
Under 18 years, %	15	5	8	0
18–20 years, %	39	28	46	45
21–23 years, %	20	36	31	18
24–26 years, %	6	15	8	18
27–29 years, %	9	7	0	9
30 years or older, %	11	10	8	9
Mother race/ethnicity				
Black, %	22	23	0	9
White, %	29	25	92	91
Hispanic, %	36	44	0	0
Other/Multiracial, %	5	2	8	0
Unknown/Missing data, %	7	7	0	0
Mother marital status				
Married, %	13	15	15	9
Partnered, %	54	56	54	73
Single, %	32	25	3	18
Divorced/Separated, %	1	3	23	0
Unknown/Missing data, %	0	2	8	0
Mother Employment Status				
Employed full time, %	16	16	23	0
Employed part time/seasonal, %	15	16	15	18
Not employed, %	45	51	46	36
Unknown/missing data, %	24	16	15	45
Highest level of education				
Less than high school diploma, %	30	18	23	36
High school diploma/GED, %	40	36	54	45
Some college/no degree, %	17	25	8	9
Associate's degree/certificate, %	7	16	0	9
Bachelor's degree or higher, %	5	3	0	0
Unknown/Missing data, %	0	2	0	0
Infant Age in months, Mean (SD)	4.4 (3.02)	4.5 (2.97)	5.0 (3.54)	4.9 (2.70)
2 weeks—1 month, %	28	30	31	18
2–3 months old, %	21	15	23	18
4–5 months old, %	18	25	0	18
6–7 months old, %	16	15	8	27
8–9 months old, %	17	16	38	18

Note: All numbers in tables are percentages unless otherwise specified.

[a] This table describes only the samples of mothers who completed both Time 1 and Time 2 interviews.

Table 13. Mothers' Household Situations and Service Use, Pretraining and Posttraining Samples

Characteristic	Waves 1–2 Pre (*n* = 94)	Waves 1–2 Post (*n* = 61)	Comparison Pre (*n* = 13)	Comparison Post (*n* = 11)
Housing arrangement				
Rent, %	78	62	69	55
Own, %	17	7	23	9
Temporary, %	5	15	0	0
Lives with family (no cost), %	0	15	0	36
Unknown/Missing, %	0	1	8	0
Moved between T1 and T2, *n*	33	28	31	45
Number of people living in household	4.6 (1.75)	5.0 (3.28)	4.0 (1.54)	3.8 (1.25)
2, % (mother and infant)	6	3	8	9
3, %	29	26	46	64
4, %	16	28	38	9
5, %	19	18	8	9
6+, %	30	23	0	9
Services Received				
WIC, %	96	97	95	100
Medicaid, %	98	95	100	100
Food stamps/LINK card, %	57	54	100	91
TANF, %	14	5	50	64
EHS/HS, %	3	0	17	36
HFA Program Participation[a]				
Received one or more prenatal visits, %	60	50	57	100
Postnatal status in programs				
Participants active in program at 3 months postpartum, %	96	98	100	100
Participants active in program 6 months postpartum, %	88	96	86	67
Participants active in program 9 months postpartum, %	81	83	71	50
5-Item Risk Index score[b]	2.5 (*1.10*)	2.4 (0.91)	N/A[c]	2.7 (*1.01*)
High risk, %	27	16	25	20

[a] Participant status as "active" at 3, 6, and 9 months postpartum and percent of sample who received any home visits prenatally were obtained from HFA program records in Cornerstone database for 8 of the 10 programs in the study, 7 training sites and the comparison site. Two other programs use another data system.

[b] The risk index score is based on the 5-Item Risk Index developed by the Administration for Children and Families (2002). It contains the following demographics risk factors: (1) receipt of public assistance, SNAP, or SSI; (2) being unemployed and not in school; (3) lacking a high school diploma or GED; (4) being a teen at the birth of the first child, and (5) having single parent status at the time of enrollment. "High risk" indicates that a mother has 4 or 5 of these factors.

[c] We did not obtain employment and education data for the Comparison presample, so we could not calculate the risk index. The 25 percent high risk indicates the proportion of mothers who have all three of the other factors: receipt of public assistance, SNAP, or SSI; being a teen at the birth of the first child; and being a single parent at the time of enrollment.

Mother and Infant Health and Well-being at Baseline

Maternal Functioning

Depression. Although previous research has found clinically elevated levels of depression in 28 to 61 percent of mothers in home visiting programs (Ammerman, Putnam, Bosse, Teeters, & Van Ginkel, 2010), participants in the present study generally reported low levels of depression. Depression scores at Time 1—an average of about 4 months postpartum—were relatively low (see Table 14), compared to other similar samples. In the first year postpartum, MIECHV participant Edinburgh Postnatal Depression Scale (EPDS) scores began at a mean of 5.4 (*SD= 5.29*) and ended at a mean of 4.8 (standard deviation 5.23).[15] In a study with Hispanic, black, and white adolescent mothers, Anderson (2010) found a mean score of 5.8 (*SD* = 4.33) on the EPDS at 3 months postpartum. Postpartum studies of adult mothers in non-clinical populations have found mean scores from 4.4 (*SD* = 4.45; Mason, Briggs, & Silver, 2011) to 7.0 (*SD* = 5.24; O'Hara et al., 2012). Thus, the mean score of 3.7 in this sample is lower than anticipated.[16] Furthermore, just a small proportion of mothers in this sample met the clinical cutoff of 13 or higher. A study based in Brazil with approximately one-quarter of the sample teen participants noted highest sensitivity and specificity with a cutoff score of 10 for the EPDS (Santos et al., 2007). Because about one-third of the participant sample in the present study were teens, a cutoff score of 10 was used to indicate mild to moderate depressive symptoms. As displayed in Table 14, less than 10 percent of participants met the cutoff score of 10. The prevalence of postpartum depression in the general population of mothers is estimated to be between 13 (O'Hara & Swain, 1996) and 19 percent (Gavin et al., 2005), based on meta-analyses of a number of studies, hence the rate of depression reported in the present study was unexpectedly low in this sample of young, low-income mothers.

To test for systematic variance, we compared group means on the EPDS at Time 1. When pretraining and posttraining samples were combined, mothers in the comparison group scored higher on the EPDS (*M* = 5.9 (5.17)) than did mothers in the intervention group (*M* = 3.7 (*3.89*,), $t(27.2) = 2.06$, $p = 0.049$).[17] Depression scores at Time 1 were not associated with maternal education, marital status, age, employment status, or infant age, but depression scores did vary by race/ethnicity, $t(166) = 2.57$, $p = 0.011$. White participant mothers tended to report a greater number of depressive symptoms (*M* = 5.0, *SD = 4.40*) than black and Hispanic participant mothers (*M* = 3.4, *SD = 3.69*). This finding is consistent with

[15] Edinburgh Postnatal Depression Scale mean scores in the first year postpartum across MIECHV home visiting program participants were obtained through communication with MIECHV researchers in Illinois and from the Summary Report for MIECHV Maternal Depression (Center for Prevention Research and Development, Institute of Government and Public Affairs, University of Illinois).

[16] To confirm the validity of the depression data, we obtained administrative data from a sample of sites and compared participant scores on the EPDS in our study with scores obtained by the home visitors during the same time frame for the same participants. The scores were significantly correlated ($r = 0.61$, $p < 0.001$) and did not significantly differ, $t(40) = 1.54$, $p = 0.132$.

[17] Levene's test found unequal variances, hence the modified degrees of freedom.

the conclusions of a literature review on racial disparities in the diagnosis and treatment of depression, which found lower rates of treatment for depression for black and Hispanic mother than for white mothers (Simpson, Krishnan, Kunik, & Ruiz, 2007). Research also shows that Hispanic and black women with depressive symptoms are less likely to report these symptoms than white women, which may reflect cultural differences in perceptions of mental health treatment and expectations for motherhood (Backes Kozhimannil, Mah Trinacty, Busch, Huskamp, & Adams, 2011; Borowsky et al., 2000).

Table 14. Mother and Infant Health and Well-Being Pretraining and Posttraining Samples at Baseline

Health Indicators	Training Programs		Comparison Program	
	Pre (*n* = 94)	Post (*n* = 61)	Pre (*n* = 13)	Post (*n* = 11)
Mothers' Health				
Health rating	3.4 (0.93)	3.5 (0.91)	3.3 (1.25)	3.4 (1.12)
Poor, %	1	2	8	9
Fair, %	13	7	15	9
Good, %	41	48	38	27
Very good, %	30	28	15	45
Excellent, %	15	16	23	9
Edinburgh Postnatal Depression score Mean (SD)	3.7 (3.85)	3.7 (3.98)	4.8 (5.02)	7.3 (5.23)
Scored 10–12, %	4	2	1	25
Scored 13+, %	2	7	1	17
Maternal Self-Efficacy Questionnaire score	3.6 (0.31)	3.6 (0.33)	3.6 (0.26)	3.7 (0.29)
Parenting Stress Index–Total score	63.6 (14.80)	63.2 (16.50)	69.0 (10.20)	67.5 (19.03)
Parental Distress	24.7 (6.77)	24.9 (8.17)	25.8 (6.56)	26.6 (7.87)
Parent-Child Dysfunctional Interaction	17.7 (5.00)	17.3 (6.09)	18.0 (3.74)	19.1 (5.65)
Difficult Child	21.3 (5.97)	21.1 (6.56)	25.2 (6.35)	21.8 (6.51)
Child's Health				
Health rating	4.5 (0.71)	4.6 (0.64)	4.2 (1.01)	4.7 (0.47)
Poor, %	0	0	0	0
Fair, %	0	0	8	0
Good, %	13	8	15	0
Very good, %	23	25	23	27
Excellent, %	64	67	54	73
Infant sleep problem, past week, %	47	54	38	36
Number of days in past week	1.2 (1.93)	1.5 (1.97)	1.0 (2.00)	1.1 (2.12)
Talked to anyone about sleep, %	65	70	62	45
Talked to HV about sleep, %	50	65	54	45
Infant crying problem, past week, %	38	48	31	9
Number of days in past week	1.0 (1.77)	1.5 (2.09)	0.4 (0.65)	0.4 (1.21)
Talked to anyone about crying, %	51	48	69	27
Talked to HV about crying, %	41	35	54	27
Infant feeding problem, past week, 5	15	26	8	0
Number of days in past week	0.5 (1.45)	0.8 (1.65)	0.2 (0.83)	0.0 (0.0)
Talked to anyone about feeding, %	85	81	69	55
Talked to HV about feeding, %	62	68	69	45
Mother initiated breastfeeding, %	79	89	69	64
Number of weeks breastfed at Time 2	6.0 (7.85)	8.7 (8.06)	8.5 (9.50)	7.0 (9.31)

Parenting Stress. Parenting stress is another indicator of maternal functioning. The majority of participant mothers (73%) scored in the normal range on the Parenting Stress Index Short Form (PSI-SF) at Time 1, while 26 percent scored in the low range (15th percentile or lower), less than 1 percent scored in the high range (85th through 89th percentiles), and none scored in the clinical range (90th percentile or higher). The subscale scores were all generally in the normal range as well: 3 percent scored in the clinical range and 1 percent in the high range on Parental Distress; 1 percent scored in the clinical range and none in the high range on Parent-Child Dysfunctional Interaction; and none scored in the clinical or high range on the Difficult Child subscale.

On the Defensive Responding scale, a score of 10 or lower indicates that the parent may have been responding defensively, and 17 percent of mother participants in this sample met this criterion. A score at or above the 95th percentile on the Parent-Child Dysfunctional Interaction subscale indicates an elevated risk for abuse, a level at which one mother in this sample scored. This mother also indicated on the EPDS that she thought of self-harm. Thus, the emergency protocol was used in which the program supervisor and home visitor were contacted immediately following the interview, resulting in the home visitor referring her to mental health services.

Maternal Self-efficacy. We also measured maternal self-efficacy, a mother's belief in her ability to successfully care for her child (Teti & Gelfand, 1991). Participants generally reported high levels of maternal self-efficacy at Time 1, with an overall mean score of 3.6 (*SD = 0.32*) on a scale of 1 (not good at all) to 4 (very good). Maternal race/ethnicity, education, age, and employment status were not associated with maternal self-efficacy levels, yet maternal self-efficacy did differ by marital status: single mothers rated their maternal self-efficacy (M = 3.7 (*0.24*)) higher than married mothers (M = 3.5 (*0.35*), $F(3, 173) = 1.78$, $p = 0.031$.) Maternal self-efficacy was inversely related to depression ($r = -.37$, $p < 0.001$) and parenting stress ($r = -.42$, $p < 0.001$), which has been reflected in previous research (e.g. Burkhardt, 2014; Cutrona & Troutman, 1986; Leahy-Warren, McCarthy, & Corcoran, 2012; Teti & Gelfand, 1991).

Infant Health and Well-being

Participant mothers were asked to rate both their own health and their infants' health on a scale from 1, "poor," to 5, "excellent." Mothers tended to rate their infants' health higher than their own, although they rated their own general health between "good" and "very good," on average. Infant health was rated relatively high, with almost two-thirds rated as being in "excellent" health, and none was rated in "poor" or "fair" health.

To better understand maternal perception of infant behavior, participant mothers were asked the number of times in the past week infant crying, sleeping, or feeding had been a problem or upsetting. About 50

percent reported sleep had been a problem, 42 percent reported a crying problem, and about 20 percent said feeding had been a problem in the past week. Of the participant mothers who reported that they had talked to anyone (doctor, home visitor, friend, family, etc.) about their infants' behavior, the majority said that they had spoken with their home visitor (see Table 14).

Assessing the relationship between infant regulatory problems in the past week (crying, sleeping, feeding) and parenting stress revealed that the frequency of problematic infant behavior was significantly correlated with PSI Difficult Child subscale scores, ranging from Pearson's r of 0.18 to 0.27 ($p < 0.03$)[18], at both Time 1 and Time 2. Interestingly, maternal report of infant crying problems in the past week were associated with Parent-Child Dysfunctional Interaction at Time 1 ($r = 0.18$, $p = 0.014$), indicating that the frequency of problematic crying perceived by the mother was related to her perception that the infant was not meeting her expectations and her interactions with her infant were not reinforcing her as a parent (Abidin, 2012). At Time 2, Parent-Child Dysfunctional Interaction was associated with infant feeding problems ($r = 0.15$, $p = 0.048$). This correlation may be related to the age of the infant at Time 2: infants were an average of 8 months old, a time when feeding challenges tend to appear from the child's need for control and exploration (Brazelton & Sparrow, 2006). Feeding problems may have been unexpected by the mother at this age, leading the mother to interpret the feeding problems as a sign of rejection from her child.

Baseline Relationships with Home Visitor

Participant mothers and home visitors each rated their perception of their relationship on the 12-item Working Alliance Inventory (WAI) at the time of our interviews with mothers.[19] Home visitors and mothers rated aspects of their relationship, scored in 3 subscales: Task, Bond, and Goal. Table 15 displays the mean total and subscale scores. With respect to the totals, ratings were near the high end of the scale, with the highest possible total score of 84. The mean total score at Time 1 was 78.6 for the pre-training sample and 78.2 for the post-training sample in the group of programs that received training; the comparison program total scores were only slightly lower. Home visitors' ratings of their relationships were also high, although not as high as those of parents.

The extent of the agreement between parents and home visitors is represented by a difference between the home visitor score and the parent score of 4 points or fewer. Overall, approximately two-thirds of mother-home visitor pairs agreed within 4 points at Time 1 (62% in Task, 72% in Bond, and 71% in Goal), with

[18] Details of the correlational analyses are available by request.
[19] The WAI was part of each interview we conducted with mothers. Following each interview, we sent an online survey to the home visitor and asked her to fill out the WAI for the individual who was interviewed. Home visitors were quite responsive to these requests; of the 249 WAIs completed by the mothers, 226 home visitors completed a WAI (91% response rate).

47 percent of mother-home visitor pairs showing agreement within 4 points on all three subscales at Time 1. Possible total scores ranged from 12 to 84, and possible subscale scores ranged from 4.0 to 28.0. Because of the high means and limited range in scores for both the mothers (range of 40 to 84) and home visitors (range of 36 to 84), we also calculated mother-home visitor agreement within 2 points.

Table 15. Working Alliance Inventory Scores, Parents and Home Visitors, at Baseline (Time 1)

WAI Scores	Training Programs		Comparison Program	
	Pre (*n* = 94)	Post (*n* = 61)	Pre (*n* = 13)	Post (*n* = 11)
Parent WAI Scores				
Total Score	78.6 (5.68)	78.2 (6.82)	75.6 (9.30)	72.4 (14.4)
Task Score	26.1 (2.47)	25.9 (2.87)	24.3 (3.90)	24.0 (5.08)
Bond Score	26.9 (2.20)	26.9 (1.94)	26.8 (1.64)	25.1 (5.54)
Goal Score	25.7 (2.60)	25.4 (3.04)	24.5 (4.05)	23.4 (5.26)
Home Visitor WAI Scores				
Total Score	71.9 (8.53)	70.8 (7.38)	69.0 (8.11)	70.8 (7.78)
Task Score	23.8 (3.29)	23.1 (3.07)	22.7 (2.78)	24.2 (2.69)
Bond Score	24.7 (2.91)	24.5 (2.77)	24.2 (3.27)	23.4 (3.59)
Goal Score	23.4 (3.63)	23.2 (2.84)	22.1 (4.13)	23.2 (3.07)
Task Score—Agreement within 4 points, %	67	61	31	67
Bond Score—Agreement within 4 points, %	77	72	62	44
Goal Score—Agreement within 4 points, %	75	68	62	67
Task Score—Agreement within 2 points, %	38	37	31	56
Bond Score—Agreement within 2 points, %	44	46	54	44
Goal Score—Agreement within 2 points, %	52	41	23	22

Summary of Findings

Across the nine intervention programs, the home visiting staff were racially and ethnically diverse and had a wide range of experience in home visiting. Just under half had previous experience delivering home-based services. At baseline, home visitors tended to have relatively positive feelings about their job and about their relationships with their supervisors. On a standardized measure of mindfulness, both the home visitors and supervisors demonstrated room for improvement in terms of awareness of their behavior and ability to acknowledge and let go of emotions without reacting.

Collectively, mothers in the study ranged in age from 14 to 41 years, with a mean of 22 years; 13 percent were teens younger than 18 years of age. Their infants ranged from 2 weeks to 9 months, with a mean age of 4.4 months. Less than a third had more than a high school education. Most mothers were receiving income supports, including WIC and Medicaid. Mothers generally scored in the normal range on

measures of maternal functioning, with many scoring low on parenting stress and depression. Less than one-quarter of them were considered high risk, based on their employment, education, age, use of public services, and marital status. Mothers tended to perceive their relationship with their home visitor as positive at the Time 1 interview. Over half of mothers reported problems with infant sleep, crying, or feeding in the past week, and if they spoke with anyone about these issues, they tended to discuss them with their home visitor.

Learning and Implementing the FAN: The Views of Home Visitors

As described earlier, we gathered information about learning and implementation of the FAN approach from multiple sources, both quantitative and qualitative. First, we surveyed home visitors and supervisors a total of four times every 6 months following the initial training. The first administration of the survey occurred about a month after the intensive core training, and the second administration 6 months after that. The final survey (post-Time 4) occurred shortly after the end of all consultation and "booster" sessions. Second, we conducted focus groups with home visitors at their program's central office at two points in time, 9 months and 18 months after the initial, core training. Across the nine programs that received FAN training, a total of 40 home visitors participated in the first focus group and 38 participated in the second focus group (32 of whom were also in the first focus group).[20] There was overlap between the focus group participants and the survey respondents in the subsample that we followed over time, but not all participants in the focus groups completed the pretraining, posttraining Time 1, and posttraining Time 4 surveys. Specifically, 20 of the 40 home visitors who participated in the Time 1 focus groups and 22 of the 38 participants in the Time 2 focus groups are represented in the survey subsample.

We conducted individual interviews with supervisors on a similar time schedule. Fourteen supervisors were interviewed 9 months after the core training, and 11 of these 14 were also interviewed 18 months after the core training. All 7 of the supervisors in the subsample that completed the pretraining,

[20] The comparison program staff were surveyed and interviewed on the same schedule as the programs that received training; however, these data are not included in this report.

posttraining Time 1 and posttraining Time 4 surveys participated in the 9-month interview, while 6 of the 7 participated in the 18-month interview.

A third source of information was the interviews conducted with two different samples of program participants, one group which was interviewed before training and one which was interviewed 12 months after the core training. These posttraining interviews with mothers also provided evidence of the extent to which home visitors applied the FAN core processes with their families. However, for ease of presentation, the interview findings are discussed in a later chapter on parents' experiences with home visiting.

All of the data collection with program staff and participants—the surveys, focus groups, and individual interviews—were designed to obtain information about the staff's perceptions of the training and the FAN approach, changes that occurred in their knowledge and skills over the 18-month implementation period, and the extent to which home visitors were able to use the approach in their work with families. These three components of our data collection align with conceptual frameworks in the literature for professional development that include reactions to training, learning or changes in knowledge and skills as a result of training, and the application of knowledge and skills (e.g., Desimone, 2009; Dunst, 2015; Kirkpatrick & Kirkpatrick, 2006). In this chapter, we begin with the results from the surveys of home visitors, with a focus on the subsample of staff we were able to follow over time from the pretraining period to the end of the 18-month training.[21] We then provide selected findings from the analysis of focus groups with home visitors conducted at 9 and 18 months after the core training.

Home Visitors' Attitudes, Knowledge, and Practices: Quantitative Results

Experiences with Training

On all of the posttraining surveys, we asked home visitors about their thoughts of the FAN training (see Table 16). We found that at the time of the post-Time 1 survey, almost three-quarters (71%) of home visitors felt that there was the "right amount of ongoing training" but by the time of the post-Time 4 survey, the majority (73%) felt that there "was too much ongoing training." This was a significant difference at $p < 0.05$. Home visitors were asked six questions directly related to the FAN trainers which

[21] Although our analysis was limited by the size of our staff sample at each time point to looking mainly at differences between pre-Time 1, post-Time1, and post-Time 4, we were nonetheless interested in trying to understand when shifts in understanding or use of the FAN processes might have happened during the 18-month training and consultation period. Thus, we also compared home visitors' responses to selected survey items relevant to learning the FAN processes for any who completed two consecutive surveys, i.e., Time 1 and Time 2, Time 2 and Time 3, and Time 3 and Time 4. These results can be found in Appendix A (Tables A-3 through A-13).

were scored on a 4-point scale ranging from 1 or "strongly disagree" to 4 or "strongly agree." The FAN trainers were appreciated by the majority of home visitors.

Table 16. Home Visitors' Perspectives on Amount of FAN Training and Trainers (*N* = 23)[a]

Indicator	Posttraining, Time 1 %	Posttraining, Time 4 %
Reactions to the amount of ongoing training*		
There is not enough ongoing training	0	5
There is the right amount of ongoing training	71	23
There is too much ongoing training	29	73
The FAN Trainers. . .		
Are easy to relate to		
Disagree/strongly disagree[b]	5	14
Agree	73	52
Strongly agree	23	33
Are knowledgeable about children and families		
Disagree/strongly disagree	5	5
Agree	68	59
Strongly agree	27	36
Explained FAN concepts in a way I could understand		
Disagree/strongly disagree	5	5
Agree	48	55
Strongly agree	48	41
Helped me apply FAN concepts to my work with families		
Disagree/strongly disagree	10	9
Agree	57	55
Strongly agree	33	36
Were prepared and organized for trainings		
Disagree/strongly disagree	5	5
Agree	55	59
Strongly agree	41	36
Helped me to improve my skills in working with families		
Disagree	23	10
Agree	55	67
Strongly agree	23	24

[a] Not all respondents answered every question; between 17 and 22 of the 23 respondents answered individual items.
[b] Very few respondents "disagreed" or "strongly disagreed" with these statements, so we collapsed the two categories.
*Paired sample *t*-tests indicated that time-to-time difference in views of the amount of training was statistically significant ($p < 0.05$)

Finally, home visitors were asked their views about the usefulness of various aspects of the training (see Table 17). Overall, home visitors regarded most of the learning activities as either "somewhat" or "fairly" useful; at the same time, the survey responses indicated a wide range of views. The FAN review sessions held with supervisors were noted as being "useful" by just 18 percent of home visitors at post-Time 1, but by post-Time 4, 40 percent of home visitors noted that it was "useful" (although this difference was not statistically significant). Home visitors rated the usefulness of the developmental specialist and the infant

Table 17. Home Visitors' Perspectives on Usefulness of FAN Training Activities and Tools for Learning (N = 23)[a]

FAN Learning Activity/Tool	Posttraining, Time 1	Posttraining, Time 4
2-day Core Training		
A little/not at all useful, %	23	15
Somewhat useful, %	27	10
Fairly useful, %	27	40
Very useful, %	23	35
Mean (SD)	3.5 (1.18)	3.9 (1.27)
On-site trainings twice a month		
A little/not at all useful, %	27	40
Somewhat useful, %	23	30
Fairly useful, %	23	25
Very useful, %	27	5
Mean (SD)	3.5 (1.26)	2.9 (1.09)
Using the model with 2 families		
A little/not at all useful, %	27	20
Somewhat useful, %	27	30
Fairly useful, %	23	40
Very useful, %	23	10
Mean (SD)	3.4 (1.22)	3.4 (0.94)
Completing the FAN Learning Tool after visits		
Not at all useful, %	14	25
A little/not at all useful, %	19	35
Somewhat useful, %	29	10
Fairly useful, %	24	20
Very useful, %	14	10
Mean (SD)	3.0 (1.28)	2.6 (1.36)
FAN Review Sessions with supervisor		
A little/not at all useful, %	22	25
Somewhat useful, %	39	35
Fairly useful, %	28	25
Very useful, %	11	15
Mean (SD)	3.2 (1.06)	3.3 (1.12)
Contact with Infant Mental Health Consultant		
A little/not at all useful, %	24	26
Somewhat useful, %	24	16
Fairly useful, %	41	32
Very useful, %	12	37
Mean (SD)	3.4 (1.00)	3.8 (1.21)
Contact with Developmental Specialist		
A little/not at all useful, %	31	16
Somewhat useful, %	16	16
Fairly useful, %	37	26
Very useful, %	16	42
Mean (SD)	3.2 (1.36)	3.9 (1.24)
Use of FAN during supervision		
A little/not at all useful, %	41	26
Somewhat useful, %	29	21
Fairly useful, %	24	42
Very useful, %	6	11
Mean (SD)	2.9 (0.97)	3.3 (1.19)

[a] Not all respondents answered every question; between 17 and 22 of the 23 respondents answered individual items.
[b] With two exceptions, few respondents answered "not at all useful," so response was combined with "a little useful" for most items.
*Paired sample t-tests indicated that the following time-to-time differences were statistically significant: Understand FAN Approach Post1 v. Post4 ($p < 0.01$); On-site trainings Post1 v. Post4 ($p < 0.01$); FAN Learning Tool Post1 v. Post4 ($p < 0.05$).

mental health consultant (IMHC) higher at post-Time 4 than at post-Time 1, which likely reflects increasing understanding of how these professionals could assist them in their work with families over the18-month learning and implementation period. Home visitors also perceived somewhat greater value in the 2-day core training and use of the FAN during supervision at post-Time 4 than at post-Time 1. None of these increases were significant.

Home visitors' views of the usefulness of the on-site trainings twice a month declined from a mean of 3.5 (between "somewhat" and "fairly" useful) at post-Time 1 and a mean of 2.9 ("somewhat useful") at post-Time 4. They also rated the completion of the FAN learning tool after visits as "somewhat useful" at post-Time 1 but gave it a lower rating at post-Time 4. Both of these decreases in usefulness were significant: on-site trainings at $p < 0.01$ and the FAN learning tool at $p < 0.05$, and likely reflects some fatigue with the training activities near the end of training.

Learning and Use of the FAN Approach

Home visitors also responded to a series of questions about various aspects of the FAN itself. At the time of the post-Time 1 survey, just under one-quarter (23%) of home visitors reported that they understood the FAN approach "very well," but by the time of the post-Time 4 survey, half reported that they understood the FAN approach "very well," which was a statistically significant increase in understanding at $p < 0.01$. Almost one-quarter of home visitors reported using the ARC questions with "most of their families" or "all of their families" at the time of the post-Time 1 survey; this increased to over two-thirds (69%) by the post-Time 4 survey, although the use of the ARC questions remained steady with less than half of home visitors (45% at post-Time 1 and 41% at post-Time 4) reporting that they used those questions on either "most visits" or "every visit."

When asked about their comfort levels with the FAN core processes, home visitors indicated that they were most comfortable with Mindful Self-Regulation (MSR) and Empathic Inquiry at both post-Time 1 and post-Time 4 (see Table 18). Less than one-third of home visitors (30%) reported that Collaborative Exploration was a core process with which they felt "most comfortable" at post-Time 1, but by post-Time 4, more than half (61%) reported that this core process was one with which they felt "most comfortable." Capacity Building and Integration were processes that were comfortable for a smaller percentage of home visitors at both time points.

When asked to compare the home visits they conducted using the FAN approach to those home visits in which they did not use the approach, 60 percent of home visitors at post-Time 1 reported that the visits were very similar, while71 percent of home visitors at post-Time 4 reported that the visits were very similar.

Table 18. Home Visitors' Knowledge and Use of FAN Approach over Time (*N* = 23)[a]

Knowledge and Use Questions	Post-Time 1 %	Post-Time 4 %
At this time how well do you feel you understand the FAN approach?		
Not well at all	0	0
A little	14	0
Somewhat well	32	9
Fairly well	32	41
Very well	23	50
At this time with how many families are you using the ARC questions?		
None of my families	5	18
One family	5	9
My two "Fussy Baby" families	67	5
Most of my families	24	64
All of my families	0	5
At this time how often are you using the ARC questions on your visits?		
None of my visits	5	14
A few of my visits	23	18
Some of my visits	27	27
Most visits	36	36
Every visit	9	5
Which FAN core processes do you feel most comfortable with?[b]		
Empathic Inquiry	78	70
Mindful Self-Regulation (MSR)	61	74
Collaborative Exploration	30	61
Capacity Building	13	39
Integration	22	22
Which FAN core processes do you feel you would like to further develop in your work with families?[b]		
Empathic Inquiry	4	13
Mindful Self-Regulation (MSR)	17	17
Collaborative Exploration	44	22
Capacity Building	44	30
Integration	61	26
None	13	17
How do the visits in which you use the FAN approach compare to your other visits		
The FAN visits are very similar to my other visits	60	71
The FAN visits are somewhat different from my other visits	35	29
The FAN visits are very different from my other visits	5	0

[a] Between 21 and 23 respondents answered each question.
[b] Multiple responses allowed.

Home visitors were asked to assess their skill levels on six items relevant to the FAN training beginning with the post-Time 1 survey.[22] As Table 19 shows, there were significant differences between post-Time 1 and post-Time 4 in home visitors' ratings of their skills in all aspects of the FAN approach.

Table 19. Self-assessed Skills of Home Visitors in the FAN Approach[a] (N = 23)

Aspect of FAN Approach	Posttraining, Time 1 Mean (SD)	Posttraining, Time 4 Mean (SD)
Reading parents' cues for engagement during home visits***	2.9 (1.41)	4.5 (0.60)
Matching my interactions based on parents' cues***	3.1 (1.31)	4.4 (0.58)
Exploring parents' concerns together before finding solutions***	2.9 (1.41)	4.4 (0.59)
Recognizing my own feelings during visits with families**	3.5 (1.12)	4.5 (0.60)
Maintaining focus on parenting throughout the visit***	2.5 (1.47)	4.3 (0.70)
Encouraging the parent to lead the visit and help set our agenda***	2.7 (1.45)	4.3 (0.72)

[a] Responses are based on a 5-point scale: 1, Not at all skilled; 2, A little skilled; 3, Somewhat skilled; 4, Skilled; and 5, Very skilled. Time 1 occurred 1 month after the core foundational training and Time 4 occurred 18 months after the core training.
* Paired sample *t*-tests indicated no significant time to time differences.

Starting with the post-Time 1 survey for Wave 2, we also asked home visitors to assess their own change in skill level over the past 6 months on the same items noted above (see Table 20). At post-Time 1, which was one month after the core training, Wave 2 home visitors assessed themselves as having "changed a little" on all six items. At post-Time 4, when both Wave 1 and Wave 2 responded to these questions, home visitors perceived change in their skills over the previous 6 months in all six items, assessing themselves as having changed "a little" to "somewhat."

Table 20. Self-assessed Change in Home Visitors' Skills over Time (*N* = 23)[a,b]

Aspect of FAN Approach	Posttraining, Time 1 Mean (SD) (*n* = 8)	Posttraining, Time 4 Mean (SD) (*n* = 22)
Exploring parents' concerns together before finding solutions	2.4 (1.19)	3.0 (1.09)
Recognizing my own feelings during visits with families	2.4 (1.19)	3.0 (1.09)
Encouraging parents to lead the visit and help set our agenda	2.4 (1.19)	2.8 (1.26)
Matching my interactions based on parents' cues	2.4 (0.74)	2.7 (1.16)
Reading parents' cues for engagement during home visits	2.3 (0.71)	2.6 (0.95)
Maintaining focus on parenting throughout the visit	2.1 (1.13)	2.5 (1.01)

[a] Responses used a 4-point scale: 1, Did not change at all; 2, Changed a little; 3, Changed somewhat; and 4, Changed a lot.
[b] This item was added to the Post-Time 1 survey for Wave 2 only, so the sample is much smaller.
*Paired sample *t*-tests indicated no significant time-to-time differences.

[22] Although we added these items to the pretraining survey for Wave 2, we dropped them from the analysis because of the small sample and because the terms would not have been familiar enough to the staff at the time of the pretraining survey for us to feel confident in the way they interpreted them in responding.

Home Visitor and Supervisor Relationships

All of the home visitors reported that they met with their supervisor at least once a week, typically for an hour and a half. The majority of responding home visitors reported that the supervision they received both before FAN training as well as at Post-Time 1 and Post-Time 4 addressed administrative issues, program issues and clinical issues "fairly well" or "very well." We did notice a non-significant dip in satisfaction between the pretraining Time 1 and posttraining Time 1 surveys, but by post-Time 4, the satisfaction levels returned to their pretraining Time 1 levels (see Table 21).

Table 21. Home Visitors' Views of Supervision (*N* = 23)

Quality Indicator	Pre-Time 1 Mean (SD)	Post-Time 1 Mean (SD)	Post-Time 4 Mean (SD)
How would you rate the quality of supervision[a, b]	—	3.6 (1.29)	4.0 (1.02)
In supervision how well do you address[c]:			
Administrative issues	4.2 (0.80)	3.9 (1.31)	4.2 (0.75)
Program issues	4.2 (1.00)	3.8 (1.08)	4.2 (0.81)
Clinical issues	3.9 (0.92)	3.7 (1.24)	4.1 (0.85)
Processing your own feelings and reactions to the work you do with families	4.3 (0.86)	4.0 (1.20)	4.2 (0.87)

[a] Responses to individual items ranged from 20 to 23. Responses used a 5-point scale: 1, Poor; 2, Fair; 3, Good; 4, Very good; and 5, Excellent.

[b] This question was not included on the pretraining survey.

[c] Responses used a 5-point scale: 1, Not at all well; 2, A little; 3, Somewhat well; 4, Fairly well; and 5, Very well.

Home visitors completed a standardized measure, Supervisory Working Alliance Inventory (SWAI), which allows home visitors to rate their relationship with their supervisors. They respond to questions using a 7-point scale ranging from "never" to "always." Two subscales are derived from the 18items asked consistently over the course of the study[23]: Rapport, which is how the home visitor perceives her relationship with her supervisor and Client Focus, which is how the home visitor interprets her supervisor's interest in the home visitor understand her families. Both subscales, as shown in Table 21, varied little among the three time points.

[23] Nineteen items were asked, but one item was rephrased in the middle of the Posttraining Time 1 survey. The published item is "My supervisor makes the effort to understand me" and the revised wording is "My supervisor makes the effort to understand my concerns about my participants' behavior." The published phrasing of this item should be included in the "Rapport" subscale but because of the rephrasing, we left it out of all three calculations of the subscale for consistency.

Table 22. Home Visitors' Views of Relationship with Supervisor: Supervisory Working Alliance Inventory (*N* = 23)

Indicator	Pre-Time 1	Post-Time 1	Post-Time 4
My supervisor welcomes my explanations about my client's behavior	6.5 (0.73)	6.1 (1.25)	6.3 (0.91)
I feel comfortable working with my supervisor	6.3 (0.92)	6.2 (1.22)	6.2 (1.09)
My supervisor encourages me to talk about my work with clients in ways that are comfortable for me	6.2 (0.95)	6.0 (1.50)	6.0 (1.56)
My supervisor helps me talk freely in our sessions	6.3 (0.71)	6.1 (1.17)	6.0 (1.43)
My supervisor treats me like a colleague in our supervisory sessions	6.0 (0.93)	6.1 (0.77)	6.0 (1.40)
My supervisor is tactful when commenting about my performance	6.4 (0.78)	6.2 (1.10)	6.0 (1.32)
My supervisor stays in tune with me during supervision	6.1 (0.99)	5.9 (1.58)	6.0 (1.32)
In supervision my supervisor places a high priority on our understanding the client's perspective	5.9 (1.38)	5.7 (1.42)	6.0 (1.14)
My supervisor encourages me to formulate my own interventions with the client	5.9 (1.06)	6.2 (0.96)	5.9 (1.41)
When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client	6.0 (1.19)	5.8 (1.44)	5.9 (1.35)
I understand client behavior and program strategies similar to the way my supervisor does	5.9 (0.97)	5.7 (1.52)	5.9 (1.18)
My supervisor encourages me to take time to understand what the client is saying and doing	5.9 (1.49)	5.9 (1.49)	5.8 (1.25)
My supervisor helps me work within a specific plan with my clients	5.8 (1.35)	5.6 (1.67)	5.7 (1.46)
My supervisor helps me stay on track during our meetings	5.7 (1.42)	5.6 (1.76)	5.7 (1.35)
In supervision I am more curious than anxious when discussing my difficulties with clients	5.8 (0.91)	5.6 (1.43)	5.6 (1.33)
I feel free to mention to my supervisor any troublesome feelings I might have about her	5.4 (1.78)	5.3 (1.98)	5.4 (1.88)
My supervisor's style is to carefully and systematically consider the material I bring to supervision	5.5 (1.47)	5.3 (1.84)	5.3 (1.62)
I work with my supervisor on specific goals in the supervisory session	5.5 (1.34)	5.4 (1.79)	5.1 (1.58)
Rapport [b]			
Mean (*SD*)	6.1 (0.78)	5.9 (1.15)	5.9 (1.18)
Range	4.2–7.0	2.3–7.0	2.7–7.0
Client Focus			
Mean (*SD*)	5.7 (1.32)	5.6 (1.52)	5.7 (1.27)
Range	1.1–7.0	1.0–7.0	2.9–7.0

[b] *Rapport* refers to the supervisee's perception of support from the supervisor. *Client focus* refers to the supervisee's perception of the emphasis the supervisor placed on promoting the supervisee's understanding of the client. We did not include one item in the Rapport subscale as the wording was changed from "My supervisor makes the effort to understand me" to "My supervisor makes the effort to understand my concerns about my participants behavior" at the time of the Wave 2 post-Time 1 survey.
*Paired sample *t*-tests indicated no significant time-to-time differences.

Experiences with Infant Mental Health Consultant and Developmental Specialist

A component of the training program was the addition of two part-time staff, an infant mental health consultant (IMHC) and a developmental specialist (DS). These specialists were available to all home visiting staff to discuss any concerns that home visitors or parents may have about a child or family or to attend home visits with the home visitors in an effort to better understand a situation or to assist the home visitor in her work with a family. These specialists participated in the FAN training with the home visitors and supervisors and were available to provide additional support for their learning and use of the FAN.

On the pretraining survey, a little more than half (58%) of the subsample of 23 home visitors reported having previous experience with an IMHC and three-fourths of them said the amount of consultation was "adequate" for their needs. Two-thirds described the quality of the consultation as "very good." A somewhat smaller percentage (47%) had previous opportunities to work with a DS. Among this group, 90 percent reported that the amount of consultation was "adequate," although only 40 percent described the quality of the developmental consultation as "very good."

In terms of perceived need for mental health consultation, 30 percent of the 23 home visitors said that they had at least "some" families on their caseloads with mental health issues. When asked on the posttraining surveys about the number of families with mental health issues, however, a somewhat higher percentage (43%) said that at least "some" families have mental health issues on the post-Time 1 survey, and an even higher percentage (58%) reported having at least "some" families with mental health issues on the post-Time 4 survey. It is not clear whether this difference reflects a change in the characteristics of their clients or a greater awareness of mental health issues that might have resulted from the FAN training and the presence of the consultant at the program.

At the time of the post-Time 1 survey, over half (61%) of home visitors reported they had met individually with the IMHC and 52 percent had met with the Developmental Specialist. By the time of the post-Time 4 survey, contact with both consultants had increased, although more so for the IMHC than for the Developmental Specialist. All of the responding home visitors noted that they had met with the IMHC, and 68 percent had met individually with the developmental specialist. The reported frequency of their meetings also increased between post-Time 1 and post-Time 4. As we discuss later, unless the consultants were already on staff at their programs (which was the case for five consultants), it took time to establish themselves, to get to know the staff, and to figure out how they could be most helpful. Thus, the overall increase in use of both consultants partly reflects the increasing awareness of the staff about the consultants' roles and their increasing integration into the program. It might also reflect changes in the concerns of the home visitors about the families on their caseloads. For example, at the time of the post-

Time 1 survey 44 percent of the survey respondents said they had concerns about the development of "a few" of the children on their caseloads compared to 59 percent at the post-Time 4 surveys.

Home visitors, at post-Time 1 and post-Time 4 were asked a series of evaluative questions about each of the consultants using a 4-point response scale. The data shown in Table 23 indicate overall satisfaction with the consultants at both time points, and slightly more positive responses at Time 4 compared to Time 1. There was one statistically significant increase between post-Time 1 and post-Time 4—on the percentage of home visitors responding "strongly agree" to the item "Developmental consultant has helped me resolve my question or problem in working with families with developmental issues."

Home Visitors' Mindfulness Self-Assessment

Table 24 shows the mean scores on two subscales of the Five Facet Mindfulness Questionnaire (FFMQ) before FAN training and again at two time points after training.[24] The first subscale, Act with Awareness, is defined as "being attentive and engaging fully in one's current activity." Scores on this measure decreased over the three time points, from a mean of 35.1 at pretraining Time 1 to a mean of 34.5 at post-Time 1 and then to a mean of 34.1 at post-Time 4. None of these small changes were statistically significant.

The second subscale shown in Table 24 is the Non-Reactivity to Inner Experience subscale, which is described as a measurement of "Being able to perceive emotions without reacting to them, without becoming dysregulated." Scores on this subscale fluctuated over time for the sample of 23 home visitors. Their mean scores dropped between pre-Time 1 and post-Time 1, but then increased at post-Time 4. The increase between post-Time 1 and post-Time 4 was significant at $p < 0.05$. Three individual items also showed an increase over time, all of which are included in the Non-Reactivity to Inner Experience subscale: "I perceive my feelings and emotions without having to react to them," "In difficult situations, I can pause without immediately reacting," and "When I have distressing thoughts or images I just notice them and let them go." Thus, although home visitors did not rate themselves differently over time with respect to their ability to concentrate and fully engage in their activities, they did perceive an increase in their awareness of their feelings and in their ability not to react to them.

[24] The FFMQ measure was not part of the pretraining survey for Wave 1, so the number of respondents was small.

Table 23. Home Visitors' Experiences with Mental Health and Developmental Consultants (*N* = 23)

Statement about Consultant (C)	Infant Mental Health Consultant		Developmental Specialist	
	Post T1	Post T4	Post T1	Post T4
Met individually with C since FAN Training began				
Never, %	39	0	48	32
Less than once a month, %	35	41	26	27
Once or twice a month, %	22	54	17	32
Weekly or more often, %	4	5	0	5
Mean (SD)	2.0 (1.17)	2.8 (0.81)	2.1 (1.71)	3.1 (1.19)
Range of times met with **C**	1–6	2–5	1–7	1–8
C accompanied me on a home visit				
Yes, %	4	0	14	29
C has responded to requests in timely manner				
Disagree/Strongly disagree, %	12	5	8	0
Agree, %	53	52	62	56
Strongly agree, %	35	43	31	44
Mean (SD)	3.2 (0.81)	3.3 (0.73)	3.2 (0.60)	3.4 (0.51)
C has been easy to relate to				
Disagree/Strongly disagree, %	5	10	0	6
Agree, %	58	43	67	44
Strongly agree, %	37	48	33	50
Mean (SD)	3.3 (0.58)	3.3 (0.90)	3.3 (0.49)	3.4 (0.62)
C was knowledgeable in dealing with my request				
Disagree/Strongly disagree, %	6	9	8	6
Agree, %	59	48	62	50
Strongly agree, %	35	43	31	44
Mean (SD)	3.3 (0.59)	3.3 (0.78)	3.2 (0.60)	3.4 (0.61)
C has handled my situation effectively				
Disagree/Strongly disagree, %	12	5	8	6
Agree, %	65	45	69	50
Strongly agree, %	24	50	23	44
Mean (SD)	3.1 (0.60)	3.4 (0.75)	3.2 (0.55)	3.4 (0.61)
C made me feel positive about working with a specialist				
Disagree/Strongly disagree, %	6	5	7	6
Agree, %	67	45	57	44
Strongly agree, %	28	50	36	50
Mean (SD)	3.2 (0.55)	3.4 (0.75)	3.3 (0.61)	3.4 (0.62)
C improved my understanding of mental health/developmental issues				
Disagree/Strongly disagree, %	25	14	7	6
Agree, %	56	43	71	44
Strongly agree, %	19	43	21	50
Mean (SD)	2.9 (0.68)	3.3 (0.83)	3.0 (0.53)	3.4 (0.62)
C helped improve my skills in work with families				
Disagree/Strongly disagree, %	19	9	14	17
Agree, %	50	48	79	44
Strongly agree, %	31	43	7	39
Mean (SD)	3.1 (0.85)	3.3 (0.78)	2.9 (0.66)	3.2 (0.73)
C helped me resolve problem in work with families				
Disagree, %	25	10	7	6
Agree, %	50	48	86	56
Strongly agree, %	25	43	7	39
Mean (SD)	3.0 (0.73)	3.3 (0.66)	3.0 (0.39)	3.3 (0.59)

Note: Not all respondents answered every question; between 16 and 23 respondents answered individual questions.
*Paired sample *t*-tests indicated that the following time-to-time differences were statistically significant: Met IMHC individual Post1 v Post4 ($p < 0.05$) and Developmental Consultant Helped me resolve problem Post1 v Post4 ($p < 0.05$).

Table 24. Change in Home Visitors' Self-Assessments of Mindfulness on the FFMQ over Time[a]

FFMQ Indicator	Pretraining T1[b] (*n* = 8)	Posttraining T1[c] (*N* = 23)	Posttraining T4[d] (*N* = 23)
I perceive my feelings and emotions without having to react to them	3.6 (0.52)	3.7 (0.85)	4.2 (0.70)
When I do things, my mind wanders off and I'm easily distracted	4.3 (0.71)	3.8 (0.92)	3.9 (1.02)
I do not pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted	4.6 (0.52)	4.5 (0.74)	4.5 (0.89)
I watch my feelings without getting lost in them	3.9 (0.99)	3.7 (1.21)	4.0 (1.03)
I am easily distracted	4.1 (1.25)	4.3 (0.98)	4.3 (1.13)
I find it difficult to stay focused on what's happening in the present	4.3 (1.04)	4.5 (0.86)	4.2 (1.23)
When I have distressing thoughts/images, I "step back" and am aware of the thought/image without getting taken over by it	4.3 (0.71)	3.8 (1.21)	4.2 (0.96)
In difficult situations, I can pause without immediately reacting	4.1 (0.64)	3.8 (0.61)	4.4 (0.59)
It seems I am "running on automatic" without much awareness of what I am doing	4.4 (0.74)	4.3 (0.70)	4.3 (*0.91*)
When I have distressing thoughts/images, I feel calm soon after	3.1 (1.25)	3.2 (0.93)	3.6 (1.12)
I rush through activities without being really attentive to them	4.5 (0.76)	4.2 (0.87)	4.3 (0.92)
When I have distressing thoughts or images I am able to just notice them without reacting	3.9 (0.64)	3.3 (1.11)	4.1 (0.69)
When I have distressing thoughts/images I just notice them and let them go	3.9 (0.99)	3.2 (1.08)	3.4 (1.02)
I do jobs or tasks automatically without being aware of what I'm doing	4.4 (0.74)	4.4 (0.82)	4.2 (0.95)
I find myself doing things without paying attention	4.6 (0.52)	4.5 (0.87)	4.6 (0.69)
Act with Awareness sub-scale			
Mean (SD)	35.1 (5.00)	34.5 (5.58)	34.1 (6.32)
Range, *n*	26–40	20–40	18–40
Non-Reactivity to Inner Experience sub-scale			
Mean (SD)	26.8 (3.65)	24.8 (4.70)	28.1 (3.74)
Range, *n*	23–33	15–34	20–34

[a] Responses are based on a 5-point scale ranging from 1, Never or very rarely true; 2, Rarely true; 3, Sometimes true; 4, Often true; and 5, Very often or always true.
[b] Sample size ranged from $n = 8$ because this measure was not part of the Wave 1 pretraining surveys.
[c] Of the 23 respondents, between 20 and 22 answered each item.
[d] Of the 23 respondents, between 19 and 20 answered each item.
* Paired sample *t*-tests indicated that the following differences between post-Time 1 and post-Time 4 ratings were statistically significant: Pause without reacting ($p < 0.01$); Notice without reacting ($p < 0.05$); and Non-Reactivity to Inner Experience Post1 v. Post4 ($p < 0.05$).

Home Visitors' Job Satisfaction

Home visitors were asked seven questions around job satisfaction to which they responded using a 4-point scale ranging from 1 or "very dissatisfied" to 4 or "very satisfied." Over time, all responses were solidly in the 3 "satisfied" range with only minor, non-significant fluctuations.

Table 25. Home Visitors and Job Satisfaction over Time (*N* = 23)[a]

	Pretraining, Time 1 (*N* = 23) Mean (SD)	Posttraining, Time 1 (*n* = 22) Mean (SD)	Posttraining, Time 4 (*n* = 21) Mean (SD)
The support you receive from co-workers	3.5 (0.51)	3.6 (0.59)	3.5 (0.60)
The supervision you receive	3.4 (0.58)	3.3 (0.84)	3.4 (0.68)
The quality of training you receive	3.1 (0.76)	3.2 (0.61)	3.4 (0.68)
Cultural sensitivity in your program	3.5 (0.51)	3.5 (0.60)	3.4 (0.51)
Being valued for your work	3.4 (0.58)	3.2 (0.66)	3.2 (0.51)
Opportunities for professional development	3.0 (0.77)	2.9 (0.77)	3.0 (0.74)
Your workload	3.0 (0.69)	2.9 (0.47)	2.8 (0.63)
Mean of all job satisfaction items	3.3 (0.46)	3.2 (0.40)	3.3 (0.42)

[a]Responses are based on a 4-point scale: 1 = Very dissatisfied, 2 = Dissatisfied, 3 = Satisfied, and 4 = Very satisfied.
* Paired sample *t*-tests indicated no significant time-to-time differences.

In brief, the survey analysis revealed that home visitors experienced increased awareness of and ability to contain their feelings between the post-Time 1 survey, which was administered about a month after the core FAN training, and the Time 4 survey about 18 months later. There were no significant changes over time in terms of home visitors' views of supervision, which were positive overall, or in their ratings of job satisfaction. When asked to assess their skill levels on six practices relevant to the FAN approach, for example, reading parents' cues for engagement and maintaining a focus on parenting during visits, home visitors rated themselves significantly higher on the post-Time 4 survey than on the post-Time 1 survey. As we see below, similar results emerged from the qualitative analysis of focus groups with home visitors.

Qualitative Results from Home Visitor Focus Groups

> We're not there to tell her what to do or help her fix this problem, so now we've learned to ask, "Well, what have you tried, what do you think works, what would you like to try?" type of things. They are always in the front seat and they always feel like they're the expert in their lives so that when something else occurs later, they can remember, "Oh, I can do this," and they'll do it.

The quote above is from an 18-month focus group participant. In this section we present selected findings from 18 focus group discussions with home visitors of the Wave 1 and Wave 2 programs. Nine focus groups were conducted 9 months into the learning and implementation period; the other nine were

conducted 9 months later (i.e., 18 months after the 2-day core training). As noted earlier, a majority of the staff who participated in the first focus group also took part in the second focus group. We begin this section by explaining the changes that home visitors reported in their practices as a result of the FAN training and provide excerpts from the focus groups that illustrate how the home visitors incorporated the FAN approach into their practice. We then discuss factors that influenced learning and use of the FAN approach and some of the challenges home visitors experienced using the approach.

Changes in Attitudes and Practices

Consistent with the survey findings, the home visitors who participated in the focus groups at 9 and 18 months showed gradual learning and implementation of the FAN model and approach. There was a difference in initial receptivity to the approach between home visitors who had had prior experience as home visitors and those who were fairly new to their positions. Experienced home visitors at most (but not all) of the sites tended to question the usefulness of the FAN or did not see how it would improve their practice. More often than not, experienced home visitors were resistant to learning and using the approach at the beginning. Their resistance was the result of various factors, which we discuss later in this section. Although there were variations in how easily they learned or the extent to which they applied the FAN principles and processes, as a general rule, resistance declined over time. Their growing understanding and acceptance also came about for several reasons. These included the ongoing training, the opportunity to try out the approach with their families and see for themselves how it worked, and the ability to reflect on their experiences with other home visitors, their supervisors, and the consultants. In addition, many home visitors began to see positive effects on their relationships with families.

At nine months into the implementation of the FAN approach, home visitors' narratives tended to describe purposeful yet still tentative efforts to incorporate the FAN approach into their practice. At 18 months into implementation, changes in practice seemed more natural and less effortful (although not less intentional).[25] There did not seem to be a particular point in time between the 9- and 18-month focus groups at which there was a shift in attitudes and practice for a majority of the home visitors as each individual took to the concepts and implemented them in their individual ways. Rather, there seemed to be incremental changes over this period in knowledge of, confidence in, and use of the approach. It would be difficult to quantify the amount of change, but at 18 months into the implementation of the FAN approach, there were signs of internalization of several aspects of the FAN approach, perceived benefits

[25] This trend was observed in all but one program. In that one program, it was difficult to overcome initial resistance to the approach in a majority of the staff. We saw only a little progress in learning and implementation by the time of the 18-month focus group. At that time, some of the home visitors at this program reported attempts to use aspects of the FAN approach, particularly MSR and some of the Arc of the Visit questions.

from the use of the FAN approach, and application to practice—aspects that were not apparent in the 9-month narratives. The following excerpt from an 18-month focus group illustrates this progress in learning:

> I just realized just through talking about it in supervision and with staff, that a lot of it just is coming more natural now, and we're doing it without even thinking about it, because when you sit down, and you're like. . . . They ask why are you doing this and this, there might be aspects of it that we're not necessarily using or that we've tweaked that look just more like our own, instead of necessarily like the structure of the Fussy Baby or the FAN, but I think, like we had said even before, a lot of the FAN we had been doing.

We describe some of the differences we noticed when comparing the 9-month and 18-month focus group data and provide more examples that reflect learning and implementation of the core processes and other elements of the FAN approach in Table B-1 in Appendix B.

Overall, after 18 months of training, home visitors reported greater ability to read parent cues, match and regulate their emotions, to encourage parents to lead visits, and to explore client concerns collaboratively, even among home visitors who were resistant to the approach at the 9-month focus group (see Table B-1). Most home visitors reported some improvement in their ability to recognize the agenda of the parent, as opposed to their own agenda, and to consciously allow parents' concerns and interests to guide the topic of conversation during the home visits. By the 18-month focus group, the approach that home visitors took to address client concerns shifted from "doing" for the family or mother or focusing on what the mother has already done to focusing on what the mother believes to be the root cause of problems and ways to problem solve.

Consistent with the survey results, the focus group discussions showed that the easiest concepts to understand and learn were the core processes of MSR and Empathic Inquiry. A majority of home visitors reported improved reflective capacity and ability to recognize their feelings during visits by the time of the 9-month focus group. Most home visitors identified the techniques they learned in training to recognize and manage emotional situations as the primary way in which they have been able to recognize their feelings during home visits. They also discussed how the FAN approach allowed them to be better listeners and seek understanding of the families' perspective. The language of the Arc of the Visit questions facilitated the ability of some home visitors to take the perspectives of families. (This perspective-taking ability might also, in turn, facilitate Collaborative Exploration and problem solving, although home visitors usually did not mention this in particular. We discuss the Arc of the Visit questions in the next section.)

Most home visitors, at all but one of the programs, reported recognizing the parent agenda as distinct from the home visitor agenda and implementing more mother-led visits. They credited the FAN approach with improved communication, trust building with their families, empowering their clients to take the lead in finding solutions and, ultimately, improved relationships with these clients.

After 9 months of training, there was a noticeable difference between veteran and new home visitors in the acceptance of the approach. Experienced home visitors reported trying the FAN techniques and language but not using them uniformly in all visits. These home visitors reported less change in themselves and were less likely to report changes in their clients compared to home visitors that were using the techniques on a wider scale. The differences between more and less experienced home visitors dissipated over time but were still noticeable at the 18-month focus groups.

Along with changes in practices came changes in home visitors' perceptions of their roles. During focus group discussions, experienced home visitors in particular described their view of their role before and after training. Before the training, they saw their role as problem solving, fixing or "doing," for parents. They also reported feeling some pressure to solve problems for parents. For many of the veteran home visitors, this urgency to find solutions for their clients was deeply engrained in their practice. Nine months after the start of training, however, these home visitors expressed a change in their view of their role. As one home visitor commented, "Now we're given the freedom to sit there and listen. We can listen and explore with the mom and it's okay. We can't fix everything." By 18 months of training, more veteran home visitors expressed more often than they had at 9 months the feeling that they finally "had permission" to meet the mother where she was and allow the mother to take the lead in finding solutions. Home visitors also mentioned, as they did at 9 months, the relief they felt in not having to fix things for the family, which reduced their emotional burden during visits: "Not having to know the answer to everything. I think that's the biggest relief by far. If anybody asks me now, [I ask], 'What do you think?'"

The Arc of the Visit

In addition to the core processes, the FAN approach offers a structure called the Arc of the Visit for home visits with a predictable beginning, middle, and end. Typically, for example, a home visitor might start a visit by asking a parent, "What has it been like for you to take care of your baby during the past week?" Midway through a visit, a home visitor might check in with a parent to make sure the visit was meeting her needs, for example, by asking, "Have we gotten to what you most wanted to talk about today?" Finally, towards the end of the visit, the home visitor might ask the parent to describe her baby in three words and ask her what she would like to remember from the day's visit.

Home visitors' reactions to the Arc of the Visit structure and language varied but emphasized the sharp difference between new home visitors and experienced home visitors in receptivity to the questions and

willingness to try them with their clients. As we note later in this section, many home visitors—usually those with little previous experience—perceived the structure, focus, and language of the FAN framework and language as helpful. However, others—usually more experienced home visitors—described the approach as rigid and not effective for engaging clients. They referenced the Arc of the Visit questions in particular. At 9 months into the implementation of the FAN, home visitors from four of the nine programs sites perceived that the FAN tools offered no flexibility or did not flow naturally with their practice. They believed that they did not have permission to adapt the Arc of the Visit questions to their own style in order to elicit the same responses from families. Some home visitors felt uncomfortable or awkward asking questions, and they reported that the families felt uncomfortable or at a loss for words in responding to the questions. In some sites, home visitors described the Arc of the Visit questions as more difficult to use with teen clients and clients who had been in the program for a longer time.

By the time of the 18-month focus group, however, home visitors at most sites seemed to perceive the FAN approach to be less rigid as they became more comfortable making it their own. In at least one program, home visitors reported that they had discussed their concerns about the rigidity of the approach with their trainers and had been given latitude to change the questions to fit their own style and the dynamics and circumstances of the family. In other cases, home visitors made a concerted effort to try the questions, especially with new clients, and over time became more comfortable using them. One home visitor in the 18-month focus group, asked to describe what she had gained from participating in the FAN training, stated that the Arc of the Visit questions had helped in developing trust in her relationship with a family:

> One of the things I got from [the FAN training] is to meet the parents where they are at. I sometimes come in with our agenda I know I have and I want to talk about something specific and parents are in feelings are somewhere else and talk about different topics. I think I have learned to ask the parents in the beginning as well, "What do you want to talk about?" Or in the middle, "I have this to bring but what do you have to say to me?" I kind of learned to do that a little bit on my visits. I think it has opened a door of trust too with the families that are thinking, "Oh, she doesn"t come here for just what she wants but she really cares about what I have to say." At least that"s where I want to be able to be with my families.[26]

[26] For reasons of confidentiality, we do not provide identifying information for the focus group excerpts. Throughout this section and other sections that present qualitative data to illustrate findings, we provide excerpts from the full range of programs where staff provided relevant examples. In other words, unless indicated, examples are not limited to one or two programs or to a small number of home visitors.

The FAN in Action

Home visitors were asked to share stories of using the FAN in their practices at both the 9-month and 18-month focus groups. Below we present just four of many examples from the focus groups that illustrate how the home visitors were using the FAN core processes. In this first example, from a 9-month focus group, we see evidence of Collaborative Exploration and Capacity Building:

> She really wanted her baby just to soothe herself during her naps and have her go to sleep on her own just by putting her in the crib. So we were first talking [and] thinking about what she could do or how that process would look. And then, we were done talking about that, so I knew we had to transition somewhere, so we went into doing. It was the baby's naptime, and I said, "Do you want to try it, now?" And she didn't even say "yes" or "no." She got up, put the baby in the crib, turned off all the lights, closed the door, and then we're still thinking/doing at that time because the baby's not crying. So we had talked about what kind of process she could do. She could just go in, peek in, and close the door, tell her she's okay, peek in, and then, 15 minutes later, the baby was asleep on her own. So I saw that to be very successful. It didn't work after that. I think that was the only time [getting the baby to sleep on her own] worked [but] the [FAN] process that we were supposed to follow was successful.

The following example from another 9-month focus group illustrates a home visitor's use of MSR as well as her ability to build the capacity of the mother:

> I was on a home visit, and the mom was holding the baby, and she needed [to do] something, so she handed the baby to me. And as I was sitting in a chair, the baby started getting fussy. It was really hard for me, I had to use my mindful self-regulation to sit and not get up and bounce the baby and try to soothe the baby. I just kind of sat there and awkwardly held the baby, and mom finished what she was doing. I was like, "I just can't get her settled down." I gave her back to mom, and mom was able to get the baby to stop fussing and crying. I was like, "Look, she just needed her mom."
>
> It was a newborn baby, and mom had really struggled when she had the baby to feel comfortable with the baby. She said the baby was colicky and crying all the time, mom was really stressed out about the baby, and just watching their interactions, the baby just wasn't happy. So when I gave the baby back, she kind of bounced the baby or did whatever she did, and the baby stopped fussing. I was like, "Oh, see, look. She wouldn't stop fussing for me. She just really needed her mom." Before, I definitely would have stood up and bounced that baby, and I would have gotten that baby to stop crying. I don't like crying babies. It was really hard for me to sit there and not do anything for this baby that's fussing, and [thinking], "Am I going to give a crying baby back to mom? How is she going to handle that?" . . . And so when she got the baby to stop crying, it was like this "Ah-ha'" moment.

In the excerpt below, drawn from an 18-month focus group, the home visitor describes her use of Collaborative Exploration in what she said was the first time she had really used the FAN approach:

> A 2-year-old just could not stop throwing tantrums. It was constantly, all the time. The mom and dad, they would just [argue with] each other, and then [the child] would just react, and I was just like, "Hello?" [But] instead of just saying that, I was just like, "Why do you think that she's doing this? What happens before these tantrums start?" They were just like, "Oh, well, yeah". . . but they got to put it together without me pointing it out, and it was just really cool for the whole family. It all clicked with the mom and dad. I don't know if they could change [their behavior], but they knew now what was causing it. It was her reaction to them [arguing] with each other. Maybe they were more aware of it, maybe. Yeah, they put it on themselves, instead of just blaming it on the child. They did recognize it, so it was good.

In the following narrative, we see indications of Empathy Inquiry as well as Capacity Building and, perhaps, Integration,[27] when the home visitor from the 18-month focus group notes at the end that the young mother was talking about her relationship with the baby.

> She had her baby when she was obviously very [young]. And a lot of times like at least the first 6 months, I noticed her leaving the baby a lot with the grandmother and it was really hard. I think this particular mom had some mental health issues and domestic violence with the father of the baby. She was not really always engaging with the baby. I spent a lot of time really trying to model to her, trying to just be there, just be supportive.
>
> I have definitely been able to use the FAN with her and the grandmother because they both have had a lot of intense, emotional stuff going on, just things concerning themselves, the baby. I saw a lot of times, like the FAN, it teaches you to allow them to solve the problems and so it's been helpful for me to step back, and when you step back you really don't know what's going to happen or how. During the course of the whole time, like he's been in the program for 2 years, I've watched her transition from the baby always going to the grandmother to now the baby is always under her, baby is playful. She's interactive with him, she engages with the baby. She, the last time I saw her, was trying to tell me she's so happy. She's also telling me about her relationship with the baby. She's taking her responsibilities seriously so that's one of my extreme stories where I've seen a lot of growth from not wanting to parent [and] not caring.

Factors Influencing Learning and Application of the FAN Approach

Data from home visitors across all programs at both points in time indicated several factors that influenced their learning and adoption of the FAN approach. In addition to the characteristics of the home visitors themselves (e.g., the extent of their previous experience with home visitation, previous reflective capacity, and willingness to change), factors included their perceptions of the value and purpose of the approach, their experiences using the FAN with families and perceptions of its benefits for families,

[27] We found fewer examples of the core process of Integration in the data from the focus groups than the other core processes, which is consistent with the staff survey findings that this is a concept that is harder to learn and not used as often.

experiences with the FAN training and rapport with the trainers, and the support of supervisors and consultants.[28]

Perceptions of the FAN Approach

Structure, Focus, and Language. Across all groups, a majority of home visitors agreed that the FAN approach has helped their practice become more focused on the mother or the mother-child dyad and provided more structure to their home visits. For some, the terminology and language introduced by the FAN approach helped home visitors frame and process their work as well as connect with and engage clients in a new, positive way. The following excerpts are from 9-month focus group participants:

> I think that it helps to make my visits more structured, so when I do have to focus on the baby for most of the visit, it makes it easier to do that because I start off with maybe asking about parenting and the baby, whereas before I might have come in, hey, what's going on, and that opens them to talking about [other things—boyfriends, the baby's daddy].

> I think it's helpful just in the aspect of—with certain families, it's more helpful than other families. Some families, it's nice to have that structure [which] kind of keeps your boundaries, and it kind of keeps maybe things on track because some [parents] get so far off track [talking about issues not parent-child focused], that it's like, "No, let's rein it back in." It's nice to have that check-in question, and it's nice to have certain checkpoints during the visit.

Home visitors reiterated the value of the FAN approach for structuring the home visits at the 18-month focus group, although less frequently.

> I would say that the visits, I guess I could always say they have more of a structure now. It's like there's an order, we start with the baby and then anything that mom wanted to talk about and then the wrap up discussing what they learned or anything that stood out to them. For a lot of them, they even have started to expect me to ask the 3 words to describe the baby. I've had a couple of them say, "I thought about this before you came." Yeah, I would just say it's, there's more of a structure and a flow to it.

There were differences observed in the tenure of a home visitor and their perception of the FAN structure. Staff who were newer in their role were more likely to report embracing the FAN approach. These staff stated that the FAN Training has provided them with needed training for their position as well as a helpful framework. While veteran home visitors were more likely to express skepticism about the value of the approach after 9 months of training, after 18 months of training, most home visitors perceived the

[28] There were other factors, which we do not address here, that we speculate also had an impact on learning and implementation. These included characteristics of the program site, other research and professional development activities occurring at the same time as the FAN training, and the introduction of the new HFA Integrated Strategies curriculum.

approach as helpful, in particular the terminology of the Core Processes, Arc of the Visit language or MSR strategies.

There were mixed views about the Arc of the Visit questions. As with other aspects of the FAN, new home visitors found it easy to put into practice than home visitors with more experience. Some of the variations in receptivity to and use of the questions had to do with how strictly or flexibly the questions were presented by the trainers. Some home visitors, especially during the 9-month focus groups and especially veteran home visitors, talked about the FAN approach as being "too rigid." Others felt free to vary the language of the questions, as illustrated by the following excerpt from the 18-month focus group:

> So the questions that [the trainers] want us to ask, I'll ask them all the way at the end because that's just not the way that my visits flow. That's not how it goes. But I mean each and every [core] process that we usually do, like for me, I know that, for my clients, I like to do a lot of doing for them—not with them, so that helped a lot, knowing that there's a process to follow to get to doing is very helpful.

A new home visitor in the 9-month focus group, who was taking on a client from another home visitor, reported that it was easy for the parent to adapt to the Arc of the Visit question about what it had been like for her to be a parent:

> [Using the ARC questions] has been easy because I don't know anything different. One of [another home visitor's] clients is going to be one of my clients. We went in last week for the first visit with me there. She had already seen [the other home visitor] for 2.5 years. I took her hand and asked, "What's it like being a mom?" and she answered. It wasn't awkward or anything. Then we asked again this week and she's like, "Is this a thing?" I said, "We're just curious." She's like, "Okay that's fine."

A Sense of Sameness. A common theme across most of the nine sites at both time points, but especially at the time of the 9-month focus groups, was a sense of sameness between the FAN concepts and home visitor's practice prior to training. This theme was particularly salient among more experienced home visitors. Even though most agreed that the terminology of the FAN core processes and the Arc of the Visit questions were new, they described the FAN concepts as aligned with their previous practice. Although one might think a sense of sameness would facilitate learning, for home visitors who were hesitant to make the effort to learn a new approach to their work, this sense of sameness was a point of resistance. Because home visitors believed that they were already doing quality home visits, they often failed to recognize the contribution of the approach and described training as unnecessary or a waste of time. Changing the way they conduct visits, and the language that they use in their interactions with mothers, was challenging.

This sense of sameness was expressed in the following excerpts from two 9-month focus groups:

> The overall, I mean, the information, yes, it is good and it does work, mainly because that's how you relate to your participants and that's how you bond and build that relationship with them, but it's all information that I've already heard before, so, I agree with [the FAN approach].[29]

> One time we sat and mapped out a home visit and all the things that went on, and was like, oh yeah, we did this and did this and did this and did this, and so you probably went over at least four of the FAN things within a home visit. You weren't very conscious of it, but it's like, "Oh, OK, I've done that and I did this," so we do it. I think we probably do it unconsciously, we just now have a formal name for [what we do].

This perspective was especially dominant among staff from five of the nine programs; four of the five were also programs in which home visitors reported having difficulty building rapport with trainers. For these home visitors, this perception of "sameness" seemed to delay acceptance and use of the FAN approach at 9 months. These home visitors reported trying the approach with some families but did not see the value of the approach. After 18 months of training, there was a shift in these home visitors, with some resistant home visitors describing how their gradual adoption of the approach in their visits was related to a shift in mindset about the value of the FAN approach. Several home visitors who reported not seeing the value of the approach at 9 months described how the approach has helped them become more reflective at 18 months. Although they continued to be resistant to using some of the core processes and the Arc of the Visit questions, they were beginning to recognize that the FAN approach offered a unique framework and language for thinking and talking about home visits. It called home visitor's attention to aspects of the relationship that they were not attending to in the same way before, such as the way they problem solve with families, taking more of the mother's perspective into account, exploring to figure out mother's perspective and recognizing the mother's agenda as distinct from the home visitor's agenda.

Perceived Change in the Home Visitor's Role. Home visitors at two of the nine sites expressed concern initially about the "therapeutic" orientation of both the new HFA guidelines and FAN Training, which they thought was altering the scope of home visitor profession. They worried that the emphasis on a reflective posture and Empathic Inquiry might induce a surge of mental health needs—in the words of one worker, "opening a can of worms"—that they were not professionally trained to handle. As another home visitor explained, "That's not why I started this job. . . I am not a therapist. . . . Like I said with everything evolving, it's just things are changing, and we're expected to do a little bit more than maybe some of us feel comfortable doing." One of her colleagues added, "We're definitely not trained on it, and we're not paid for it. I'm not paid to be a counselor or a therapist, because I would be getting paid more." Although

[29] Again, these excerpts represent different focus groups, but for confidentiality reasons, we do not identify the programs associated with them.

this was a minority view that seemed to dissipate for most people over time, it is a view that should be addressed in the training and learning process.

Training Process, Tools, and Requirements

Length and Intensity of Training. As reported earlier, the results of the surveys of home visitors indicated that when asked about the FAN trainers, staff at most of the programs responded positively about their relationships with the trainers, their knowledge about children and families, and their ability to explain the FAN concepts and help the staff apply them to the work with families. However, over time, staff seemed to become fatigued by the sheer amount of training. About a month after training, most home visitors thought there was just "the right amount" of ongoing training, but by the end of training, most thought there was "too much" ongoing training. The findings were supported by findings from the focus groups.

When discussing the training process, home visitors raised the following issues most often: the amount of paperwork, the repetitive nature of trainings, perceived rigidity of the approach, and not enough opportunities to talk about real families and issues. The amount of paperwork, more specifically the burden imposed by a large amount of paperwork, was mentioned at all nine program sites. Home visitors from seven of the nine programs describe the training as repetitive at 9 months, and home visitors at four programs described it as repetitive at 18 months. In this regard, there was a sense that perhaps too much time was spent on some of the "easier" core processes (e.g., MSR and Empathic Inquiry) and not enough time on the other core processes. Home visitors at four programs also stated that they would have liked the flexibility to use the training as a place to talk about their actual clients or examples that more accurately mirror the population they work with and the issues their families face.

The reaction that the training was too long and, in some cases, repetitive was driven partly other demands on home visitors' time. Factors that made the training time burdensome included the regular paperwork required by HFA, the fact that staff were also learning new HFA documentation requirements as part of the new HFA standards (as all programs attended the new HFA training during the 18-month ongoing FAN training), the pressure to keep caseloads high to meet capacity requirements, and unplanned conditions such as harsh winter weather that led to the cancellation of home visits that then had to be rescheduled. In all nine program sites, home visitors questioned the amount of paperwork required during the FAN Training. Home visitors who accepted as well as those who did not accept the approach both described paperwork as being burdensome. This paperwork was typically described as redundant of the logs that they were already required to complete and added to their already heavy workload, particularly by 18 months into training. Although home visitors recognized the value of paperwork when learning the

approach initially, many no longer saw the usefulness of the paperwork near the end of the ongoing training period.[30]

While the length of training did not consistently translate into negative attitudes about the FAN approach, these perceptions were common across the programs and their staff, regardless of the pace at which they learned and applied the approach. The view that the amount of time dedicated to training was too much was especially prevalent among older, more experienced home visitors, but was sometimes expressed by newer home visitors. "For us [newcomers], I think [the training] was good, but I still think it was too much," a home visitor commented at the 18-month focus group. Another home visitor admitted that she had a "bad attitude" towards the approach because of the amount of time dedicated to training and including paperwork, even after conceding that she would probably "remember [the FAN] training more than any other training" she had ever had. Still other home visitors confessed that after the training was completed they would need to continue practicing the FAN approach in order to retain what they learned. In an 18-month focus group, one participant expressed the view that although everyone in her office was using the FAN, "I think I'll need a lot more practice doing it. I definitely don't know how perfect we are at it." In another 18-month focus group, a home visitor said, "Just recently, it's starting to feel really like—or we're noticing it—that we're doing it [FAN] more." Another home visitor at the same program added, "I don't think I'm going to have it all quite yet in the next year."

Experience with Trainers

The relationship that home visitors had with their trainers could either facilitate or challenge their acceptance and adoption of the FAN approach. Sites that reported having good rapport with their trainers were more likely to report finding the FAN approach useful in to their work. Conversely, staff with poor rapport with their trainers were slower to adopt the approach and were less likely to describe it as useful 9 months into training. Out of the nine program sites, three reported a lack of rapport with trainers, at some point during the 18-month training. Home visitors at two of the program sites were particularly outspoken about their struggle with trainers and training.[31] The mismatch between trainers and home visitors slowed the development of rapport between trainers and the staff, and, in turn, slowed learning and implementation of the FAN approach.

Staff at these four programs were more likely to perceive the FAN approach as rigid because the trainers were not flexible. (This was the view of most of the home visitors at one program site, and of individuals

[30] Staff at one program complained about not receiving feedback on this paperwork, which was a source of frustration for them.

[31] In these two programs, adjustments were made in the training process and/or in the trainers assigned to them, which seemed to alleviate some of the discontent among the staff.

but not the majority at the other three programs.) Three home visitors, from different program sites, invoked images of a "cookie-cutter" or "mold" to convey the fact that they were finding it difficult to accept, let alone learn, the FAN approach because of its seemingly rigid structure that did not fit into their practice. As one of them explained, "[The trainers] keep telling us to do things [their] way, but [their] way doesn't fit everybody. It's not a cookie-cutter." The staff from this group of programs also noted that although their trainers meant well, they did not convey confidence in the value of the approach, which dampened their motivation to learn.

In addition, some of these home visitors felt that trainers treated them as novices in their own field. Staff at two programs especially expressed the desire for trainers to tailor the sessions to the abilities of individual home visitors. They reported the trainers were spending too much time on some topics and not reading when the home visitors were ready to move to another issue. Over time, changes were made in the training process that improved the learning and implementation of the FAN at these sites.

Despite the challenges of these four programs, staff at four other programs reported having built a strong rapport with trainers. One program stood out because, at the time of the 18-month focus group, all of the home visitors recalled with enthusiasm about when they suddenly gained a better understanding and appreciation for the FAN approach. This happened when their trainer, who already had strong rapport with the staff, instinctively used the Empathic Inquiry and Collaborative Exploration with a home visitor who reported an upsetting experience with a family in her practice. This incident allowed home visitors to see the "FAN in action" and the benefits drawn from the use of the FAN approach. In turn, this facilitated the use and adoption of the FAN approach into their practice. At the 18-month focus group, it was clear that the incident had affected all of the staff. They continued to discuss the experience long after it happened. One member of the focus group commented, "If everybody could have something like that, a teaching moment, but it would probably have to be authentic in order to be that. It was very spontaneous but, man, it changed the whole experience for me going forward." Another home visitor commented, "It went from theory to seeing it!" A third home visitor shared her memory of the emotions the experience elicited for her:

> I was so in that moment with [the trainer]. I was crying and I can still cry from that. I remember looking at [the trainer] and seeing her tears. I remember thinking . . . I'm experiencing what our clients experience. That is why she has [such good] relationships because I can feel her concern. She wasn't saying anything. I can still remember that.

Staff at another program similarly praised their trainers for their ability "modeling some behaviors that [we] can do with our participants." They also felt that trainers were effectively listening to them and understanding their feelings. According to one home visitor, "I think they really listen to us and, like, we

have FAN moments there, where they hear our feelings about things and just how they react to us, [we know they understand]."

Using the FAN Approach with Families

Home visitors' experiences as they tried the FAN approach with families similarly influenced their adoption, or resistance, of the core processes. Some saw the usefulness of the approach as limited during particular situations or with certain clients, for example, during crisis situations or with clients with mental health challenges. Some home visitors also reported that it was harder to shift their approach with families that had been in the program for some time, in particular introducing the Arc of the Visit language with these families.[32] As mentioned earlier, reactions to the Arc of the Visit questions were mixed. As described above, staff at three program sites complained about the rigidity of the Arc of the Visit questions and said they would not work with their families, especially parents who wanted their home visitors to "do" for them and with whom they had already established a routine. Thus, veteran clients again found it most difficult to transition to the Arc of the Visit language.

Home visitors who appeared to struggle to incorporate the new language seemed particularly concerned about how their clients perceived the change. They stated that their clients did not understand why they were asked the same questions every visit. Others said that asking their clients to use three words to describe their baby is not a question that they find useful or appropriate, as it causes some mothers to become self-conscious and simply respond with "I don't know" or say the same three words at every visit. These home visitors said that they would rather report on how mothers described their baby during the course of the visit without prompting rather than directly asking the mother to provide three words.

In addition, home visitors across many of the programs reported difficulties applying the FAN approach when a family was experiencing a "crisis," for example, because of mental health issues, domestic or neighborhood violence, or financial problems. Staff from five programs, in particular, provided examples of this challenge, with more examples coming from the 18-month than the 9-month focus groups. Home visitors, especially from two program sites, remarked on the challenge of applying the FAN strategies when parents were not emotionally cooperative and when home visitors were not equipped to handle the

[32] When we discussed this issue with the FAN trainers near the end of the study, they indicated that there might be crisis situations in which a home visitor must take action and find it difficult to apply any of the core processes, but once the situation is under control again, the FAN processes can be used to process what happened.

magnitude of the mental health problems of the families.[33] Some home visitors thought it was more difficult to read the cues of teen parents and use the FAN with them.

Others talked about challenges with families who were experiencing mental health issues or developmental delays, which they did not feel very comfortable or well-equipped to manage. The following excerpts are from home visitors in the 18-month focus group:

> I'm not a therapist. I am here to play with you and your kid, bring an activity, and talk to you about some developmental stuff. I can talk to you about some serious life stuff, but wow. Now you have mental health issues, and now you're talking about hurting yourself or hurting your baby. . . . That brings it to just a whole new level, and I feel like I'm just seeing more [mental health problems and crisis], and I don't have the training to be able to handle that, like I'm not getting that training from anyone, but they're expecting us to go there and meet the mom where she's at. Then when we come back, we're not getting the support to necessarily deal with it, because I kind of need therapy after that. Like I said with everything evolving, it's just things are changing, and we're expected to do a little bit more than maybe some of us feel comfortable doing.

> I think that some of our families are not high functioning and if you have a family that is not high functioning I don't want to jump up but she really needs more direct information. I am not going to ask her too many questions. This is not the way that I approach in this kind of family. I said that the first time that we met with you, I think that this is a great training but all my clients are individual, all of them are different and I am not going to use the same approach for all of them.

In this regard, some home visitors reported struggling with the approach when, as they often described it, parents "stay too long in the same core process," particularly Empathic Inquiry. These home visitors described challenges of moving forward along the core processes of the FAN or knowing how (or when) to transition between areas of the FAN when parents persist in staying in the same core process for an extended period of time. As an 18-month focus group participant said:

> Like, are we still talking about this three weeks later? No. We have to move on. So with that, if you think about three weeks later, no. We need to speed up the process. . . which makes me scared to ask that middle question, because you know it's going to be the same, the exact same can of worms all over again. So it's knowing how to ask it without. . . [making it too long], just kind of making it short, so, "how have you been feeling again?" [But then] it's like, "OK, hour's up. We need to get to our activity."

[33] We had a sense of increasing reports of mental health needs among the Wave 2 programs (and the Comparison site); however, staff in the Wave 1 programs were just as likely to report difficulties working with families with mental health problems or other crises as those in Wave 2 programs.

It was not clear whether some of these challenges reflected where the home visitors were in their stage of learning (for example, their ability to interpret cues of parents that might indicate that the parents were ready to move on)or reflected families not being able or ready to move on. The following excerpt comes from a home visitor in the 18-month focus group who was clearly receptive to the structure of the FAN approach but struggled with knowing when to move from one process to another:

> [The FAN] came out at a really good time to address the whole empowerment thing. What are they going to do when we're gone? I really do like that a lot, the Collaborative Exploration and Capacity Building. I think that's amazing…I think in terms of matching my clients, it has helped me to know. Okay, I can empathize but then what? I can empathize all day long but then where do I go with that? Just having a … framework to try [helps, but] I don't know.

Staff at four or five of the programs also recounted challenges using the FAN approach when grandparents were present during a visit. This was particularly the case when information the home visitors were providing conflicted with the advice of family members, or when a home visitor was trying to build the capacity of a mother to find her own solution to a problem. For example, a home visitor at a 9-month focus group expressed her concern this way: "So when I come in and tell a client, 'You can do more things—go get a job, finish high school, do even a short career,' the moms are like, 'No, she has to stay home, cook, and clean, and do the laundry and find a good man and be happy.'" When this happened, she admitted, she sometimes felt compelled to try to fix the problem by telling parents what do instead of helping the young mother find her own way.

Despite these challenges, home visitors also reported successes in using the approach with families and perceived benefits for families. Seeing the FAN in action helped them appreciate the value of the approach. These are two examples from 9-month focus groups:

> I think this is really good for families. . . especially in [cultures in which] a lot of families, you don't talk about things, you don't talk about your feelings because it's a sign of weakness, especially for somebody who you don't know like that. So I think that this is a great tool to help us come in and kind of share a different world or open up a different aspect to them and kind of let them know that it's OK to talk about how you feel, you know? Like I guess that's one of the things that I really appreciate about the FAN, like its kind of therapeutic abilities so I think it's a great way to come in without saying [this is therapy]. . . which could normalize [therapy], universalize that type of thing, so thanks FAN.

> When you have the participant who's going through a lot or is faced with some type of crisis, we have the tools and we've learned the process to be more empathic and to listen to what they're going through and when they do need help with something, we've learned to let them figure it out and get to a solution, which kind of takes the pressure off of you as a home visitor, and kind of helps you remember that I don't have to solve this, but I've done enough in just listening to them and we all want to empower the people we work with.

Another example is the following excerpt from an 18-month focus group:

> She started talking about how she was frustrated about it and she was expressing that. Then I asked her something like, "How does that make you feel or what do you think about that?" instead of saying, "Well, that really sucks" or something maybe like that a friend would have said. The look on her face when I asked her how she felt, maybe like if I stayed in the empathic inquiry for example. She was shocked that somebody would ask her, "How do you feel about this? Wow. That sounds like it could be really difficult." I think she really enjoyed it. I think that it's a different approach for most of these families, too, as to how people speak to them and how they ask them about parenting. I'm going to say pieces of it will stay with me, yes.

Support of Supervisor and Consultants

The support of supervisors and consultants was another critical factor in home visitors' progress in learning and implementing the FAN approach and core processes. Supervisors influenced the extent of home visitors' "buy-in" to the approach and their ability to learn and then incorporate it into their practice. Home visitors' perception of the role of supervisors in reinforcing the learning and adoption of the FAN approach into their practice was mixed across home visitors and program sites. Some home visitors believed that their supervision had incorporated the FAN approach, as reflected in the following excerpt from a 9-month focus group: "I think a lot comes though supervision, just [her] telling us what we did was good. Or is there a better way? Maybe not her telling us, 'There's a better way that you could've done don't that,' but asking us, 'Do you think there's a better way you could've handle it?' She uses a lot of Fussy Baby with us, too, and it works."

Yet for others, supervision was not perceived as helpful or home visitors reported that their supervisor did not use the FAN approach regularly or with fidelity. Others reported that supervisors were not using the approach during supervision. For example, another home visitor in a 9-month focus group commented, "I don't feel like it's being explored with me, I don't feel like we collaborate, you know what I'm saying." A similar view was expressed by a home visitor in yet another 9-month focus group: "[My supervision] hasn't changed at all. She says, 'Have you done your Fussy Baby homework?' and I say 'No,' and she's like, 'We'll go through it together.' Then we go through it." These home visitors tended to also report using the FAN approach less with their families and having less engagement with the approach.

Two programs, one from each wave, stood out among the nine programs because all of the home visitors from these two programs agreed that their supervisor was heavily invested in the implementation of the approach and that their supervision had incorporated the FAN approach and principles. The home visiting staff from these two programs stressed their high regard for their supervisor and her role in helping them understand and implement the FAN approach. They also reported more tangible changes in supervision, changes that reflect the application of the FAN approach. At an 18-month focus group, one home visitor

said, “I think [supervision is] just so different [now]. Before, it would be literally, ‘Okay. Give me the dates. What did you take out?’ That would be it. Now [after FAN Training], you have more opportunity to talk about the content of the visit.”

Another home visitor participating in the same focus group expressed a similar view, while also acknowledging that the change in supervision was not easy and could be emotionally demanding: “It’s way more than enough, honestly. . . . It’s just the same as being on a two-hour visit. It’s draining. If you’re doing it in your reflective way, it’s much more, I feel, like, difficult and it feels way longer to sit there because you’re really having to be introspective and reflective.” For one of these programs, at the 18-month focus group, a home visitor summarized the importance of her supervisor in overcoming the staff’s resistance to the approach as well as learning and using the FAN approach:

> I tell you what: we would not, as a staff, embrace this whole thing at all if we didn’t have it. A matter of fact, if we didn’t have someone in that position like our supervisor who was on board, we would not be on board. I see other programs how the supervisors talk about it and I realized, okay, that’s why their staff is enjoying it. It was hostile in the beginning. She was all in and everyone grumbling about “how am I going to do this thing.” As a staff, we’ve come around. It has changed our culture, how we do things. We’re at different places in it and how we like it and the parts that we like. For the most part, we would not be in doing it at all if it wasn’t for her.

Six program sites also expressed appreciation for the role of the infant mental health consultant (IMHC) and, to a lesser extent, the developmental consultant, in their learning the FAN. Home visitors reported valuing their feedback on their work with parents and credited them—the IMHC particularly—for reinforcing their understanding of the principles of the FAN approach. In some cases, staff seemed to feel more comfortable with these consultants because they felt less “judgmental.” In the words of one home visitor, “She’s just really understanding about everything that you say, and there’s just absolutely no judgments when you talk to her.” The following excerpts, all from 9-month focus groups, provide other examples of staff views of the consultants:

> [The MHC] was really good about letting us kind of work through it ourselves with the way that she asked questions, and she kind of asked, I think, the—at least for me—she asked the right questions to trigger different ideas. And then if I was stuck with something, then she was able to give me some guidance and ideas, and I think she was awesome to be honest. She was really helpful.

> It's been helpful to have the mental health consultant and the developmental consultant. . . because these [mothers] aren’t getting what they need out in the community, but we as workers have consultants that will guide us to where we might find that resource, or at least to help us understand better what's going on.

> She will guide me through that to see where we were at with that client.. When we're discussing whatever client is, whether it's the new girl or previous other girls, [IMHC] would bring it up. We don't have it in front of us but [IMHC] does use mindful self-regulation. "You guys have got to take care of yourselves. How were you feeling at that time? What was going on?"

In sites where home visitors were not receiving reflective supervision from their supervisor, either because their supervisor was not trained in the FAN approach or chose not to use this approach during supervision, home visitors reported turning to the IMHC for reflective supervision. According to one home visitor at the 18-month focus group, the IMHC in her program "takes us definitely out of our comfort zone, probably, and makes you think more in to the FAN in the few [conversations] that I had with her, than our regular supervisor [does], but she was there to focus on that." In another 18-month focus group, a home visitor shared the following experience with the program's IMHC:

> She's been helpful in a lot of my staffing especially with my families who experienced domestic violence in just helping me process it and reflecting, reflecting on the things that have happened and even sometimes talking about some of the options that they may have. . . . Just dealing with my own feelings with everything, she helped me with another family where the baby was having erratic behavior. Just helping me process things and reflect on it and how certain things impact the baby and how to go over that with mom, she's been pretty good.

Summary

In summary, we found that home visitors reported increased awareness of and ability to contain their feelings between the Time 1 survey, which was administered about a month after the core FAN training, and the Time 4 survey about 18 months later. There were no significant changes over time in terms of home visitors' views of supervision, which were positive overall, or in their ratings of job satisfaction. When asked to assess their skill levels on six items relevant to the FAN training on practices such as reading parents cues for engagement and maintaining a focus on the parent during visits, home visitors rated themselves significantly higher on the post-Time 4 survey than on the post-Time 1 survey.

Focus groups with home visitors and interviews with supervisors revealed shifts in their perspectives before, during, and after the FAN training. Before the training, home visitors saw their role as problem solving for parents. Nine months into the FAN training, however, home visitors reported feeling a sense of freedom to listen and explore with parents and not needing to fix everything. By 18 months of training, home visitors expressed feeling that they could finally meet the mother where she was and allow to take the lead in finding solutions. Home visitors also mentioned the relief they felt in not having to fix things for the family.

Across the programs in the study, there were home visitors who agreed that the FAN approach helped their practice become more focused on the mother or the mother-child dyad and provided more structure to their home visits. At the same time, there were differences in the extent to which they understood, valued, and used the approach, depending in part on the length of their tenures as home visitors and their initial reactions to the structure of the FAN approach. For some, the terminology and language introduced by the FAN approach helped home visitors frame and process their work as well as connect with and engage clients in a new, positive way. There were differences observed in the tenure of a home visitor and their perception of the FAN structure. Staff who were newer in their role were more likely to report embracing the FAN approach. These staff stated that the FAN training has provided them with needed skills for their position as well as a helpful framework. While veteran home visitors were more likely to express skepticism about the value of the approach after 9 months of training, after 18 months of training, most home visitors perceived the approach as helpful.

As we discuss in the next chapter, supervisor interviews provided a different but largely consistent perspective on the training process and the factors that affected the use and adoption of the FAN approach in their program: the supervisor's opinion of and support for the approach; the trainers' ability to deliver the training in a way that built upon existing expertise and concerns of staff; characteristics of the home visitor (e.g., age and experience); the specific training activities and tools; length and intensity of training; and organizational and other contextual factors (e.g., staff turnover, the introduction of the new HFA Integrated Strategies curriculum in the middle of the training process, and competing work demands).

Learning and Implementing the FAN: The Views of Supervisors and Consultants

In this chapter we report findings from interviews and surveys with supervisors and consultants. As mentioned, we conducted individual interviews with supervisors and consultants on a similar time schedule as the home visitor focus groups. In addition, we administered surveys of supervisors at the same time we surveyed home visitors. Although all or nearly all of the supervisors responded to each of our surveys, because of staff promotions and staff turnover at several programs, we could only follow seven supervisors over the time that spanned from a pretraining survey through the first posttraining survey until the last posttraining survey. The sample of supervisors participating in interviews was larger: Fourteen supervisors were interviewed 9 months after the core training, and 11 of these 14 were also interviewed 18 months after the core training. All 7 of the supervisors in the subsample that completed the Pretraining, Posttraining Time 1 and Posttraining Time 4 surveys participated in the 9-month interview, while 6 of the 7 participated in the 18-month interview.

Supervisors' Attitudes, Knowledge, and Practices: Quantitative Results

Here we summarize the main findings from the group of seven supervisors who responded to a pre-training survey and post-training surveys at Time 1 and Time 4.

Views of FAN Training

At the time of the Post-Time 1 survey, which was administered a month after the 2-day core training, just four the seven supervisors responded to survey questions about the amount and process of training and ongoing consultation. Three of the four regarded the ongoing training and consultation, which happened twice a month, as "the right amount" while the other described it as "too much." At post-Time 4, three of the responding supervisors felt that the ongoing training was "the right amount," whereas four thought there was "too much" ongoing training.

On the post-Time 1 survey, all four of the responding supervisors either "agreed" or "strongly agreed" that the trainers were easy to relate to and effective in explaining the FAN concepts in an understandable way and helping both home visitors and supervisors use the concepts in their work. At post-Time 4, five

of seven supervisors "agreed" or "strongly agreed" that the trainers were easy to relate to, while two supervisors "disagreed" with this view. One of the supervisors who disagreed indicated that although the trainers at her program explained concepts in a way that she could understand, they were not explaining them effectively or helping staff apply the concepts in their work with families.

Supervisors were also asked to provide their opinions of the usefulness of various components of the FAN training. As shown in Table 26, at post-Time 1, supervisors gave the highest ratings to the 2-day core training. Although the rating dropped a little by post-Time 4, it was still regarded as "fairly useful." However, at post-Time 4, the IMHC received the highest overall rating in terms of usefulness to helping staff learning the FAN approach. One item, "Use of the FAN during supervision" remained consistent at 4.0 ("fairly useful") at both time points. Mean scores for other training activities and tools decreased between the two times points.

Table 26. Supervisors' Views of Usefulness of Fan Training Activities and Tools

FAN Training Activities and Tools	Post-Time 1 Mean (SD)	Post-Time 4 Mean (SD)
Contact with mental health consultant	4.0 (0.82)	4.6 (0.53)
2-day Core Training	4.8 (0.50)	4.1 (1.46)
Use of FAN during supervision	4.0 (0.82)	4.0 (1.15)
Using the model with 2 families	4.3 (0.50)	3.9 (1.21)
FAN Review Sessions with supervisor	3.8 (1.26)	3.7 (0.76)
On-site trainings twice a month	4.3 (0.50)	3.6 (1.27)
Contact with developmental consultant	4.0 (0.82)	3.4 (1.81)
Completing the FAN Learning Tool after visits	4.3 (0.50)	3.4 (0.98)

Response scale: 1, Not at all useful; 2, A little useful; 3, Somewhat useful; 4, Fairly useful; and 5, Very useful.

Learning and Use of the FAN Processes

In terms of their own knowledge of the FAN, at the time of the post-Time 1 survey, two of the four responding supervisors said they understood the approach "somewhat well" and two said they understood it "fairly well." Three of the four noted that they were most likely to use Mindful Self-Regulation in their supervision of home visitors, and the other supervisor said Integration was the process she used most. By post-Time 4, of the seven responding supervisors, four said they understood the FAN concepts "very well" and three said "fairly well." Just one supervisor said that Mindful Self-regulation was the process she used most, while the other supervisors were divided between Empathic Inquiry and Collaborative Exploration processes in their supervision of home visitors.

In addition, supervisors indicated growing comfort with each of the core processes between post-Time 1 and post-Time 4, with the exception of Integration. They also reported growing appreciation for the usefulness of the FAN during supervision. Three of the seven supervisors described the FAN as "very useful" and two said it was "fairly useful" during supervision. Four of the seven supervisors reported

being "fairly comfortable" leading FAN review sessions on the post-Time 4 survey. Thus, in this small sample of supervisors, there was evidence of increasing understanding of and comfort with the FAN core processes over time as well as increasing use of them, especially Mindful Self-regulation, Empathic Inquiry, and Collaborative Inquiry.[34] None of the supervisors at Time 4 reported using Capacity Building or Integration, and these two core processes were the ones that supervisors indicated they would like to develop their knowledge further.

Finally, at Post-Time 1, just one of four responding supervisors thought that her FAN review sessions in supervision were different from her other supervisory sessions. Two of the four said supervision had changed, although only "somewhat," at most. By the time of the post-Time 4 survey, however, four of the seven responding supervisors said the FAN review sessions differed from other supervisory sessions. Six of the seven reported that their supervision had changed "somewhat," and one said it had change "a lot" since the start of the FAN training.

As shown in Table 27 below, the supervisor's self-assessed skill level on the six items in the table increased between the post-Time 1 and post-Time 4 surveys. Although none of the increases are significantly different, the greatest increase between post-Time 1 and post- Time 4 was on the item "Supporting home visitors around exploring parents' concerns together before finding solutions." The next largest increase was on the item "Supporting home visitors around reading parents' cues for engagement during home visits." Supervisors' self-assessed skills on "helping home visitors recognize their own feelings during visits with families" and "supporting home visitors around matching their interactions based on parents' cues" also changed from 4.0 ("skilled") at post-Time 1 to 4.3 at post-Time 4. They continued to view themselves as "skilled" in the three other areas, although their ratings remained essentially the same between the two time points. Supervisors were also asked for their perceptions of how much they had changed from the start to the end of training. Results in Table 28 indicate they saw the largest increases in their ability to support home visitors in encouraging parents to lead visits, collaborating with parents to explore their concerns, and managing their feelings during visits.

[34]Using a 5-point scale, with 1 indicating "not at all comfortable" and 5, "very comfortable, mean ratings of the seven supervisors of their level of comfort with the core processes at Post-Time 4 were as follows: Mindful Self-Regulation, 4.7 (*0.49*); Empathic Inquiry, 4.7 (*0.49*); Collaborative Exploration, 4.6 (*0.53*); Capacity Building, 4.3 (*0.49*); and Integration, 3.8 (*0.98*).

Table 27. Self-assessed Skills of Supervisor with FAN Processes[a] (*N*=7)

FAN Process	Post-Time 1 (*n* = 5) Mean (SD)	Post-Time 4 (*N* = 7) Mean (SD)
Supporting home visitors around exploring parents' concerns together before finding solutions	4.0 (0.00)	4.6 (0.53)
Supporting home visitors around reading parents' cues for engagement during home visits	4.0 (0.00)	4.4 (0.53)
Helping home visitors recognize their own feelings during visits with families	4.0 (0.00)	4.3 (0.76)
Supporting home visitors around matching their interactions based on parents' cues	4.0 (0.00)	4.3 (0.49)
Helping home visitors regulate and manage their own feelings so they can be fully present during visits	4.0 (0.00)	4.1 (0.38)
Supporting home visitors around maintaining focus on parenting throughout the visit	4.0 (0.00)	4.0 (0.58)
Supporting home visitors around encouraging the parent to lead the visit and help set the agenda	4.0 (0.00)	3.9 (0.69)

[a] Responses are based on a 5-point scale: 1, Not at all skilled; 2, A little skilled; 3, Somewhat skilled; 4, Skilled; and 5, Very skilled. Five of seven supervisors responded at post-Time 1.

* Paired sample *t*-tests indicated no significant time-to-time differences.

Table 28. Supervisors and Self-assessed Change in FAN Skills over Time[a] (*N* = 7)

FAN Skill Area	Posttraining, Time 4 Mean (SD)
Supporting home visitors around encouraging the parent to lead the visit and help set the agenda	3.7 (0.49)
Supporting home visitors around exploring parents' concerns together before finding solutions	3.6 (0.53)
Helping home visitors regulate and manage their own feelings so they can be fully present during visits	3.6 (0.79)
Helping home visitors recognize their own feelings during visits with families	3.3 (0.49)
Supporting home visitors around matching their interactions based on parents' cues	3.1 (0.69)
Supporting home visitors around maintaining focus on parenting throughout the visit	3.1 (0.69)
Supporting home visitors around reading parents' cues for engagement during home visits	2.9 (0.38)

[a] Responses are based on a 4-point scale: 1, Did not change at all; 2, Changed a little; 3, Changed somewhat; and 4, Changed a lot.

*Paired sample *t*-tests indicated no significant time-to-time differences.

Supervision and Relationships with Home Visitors

Supervisors responded to a standardized measure, the Supervisory Working Alliance Inventory (SWAI), using a 7-point scale ranging from 1 ("never") to 7 ("always"). The 23 items on this measure formed three subscales, two of which were similar to those on the home visitor version of the instrument: Rapport (7 items), Client Focus (9 items), and Identification (7 items). Overall, the supervisors' ratings of their relationship with home visitors were slightly lower than home visitors' ratings on a similar instrument, but still positive. Across all three time periods, supervisors gave their highest ratings to items that indicated their efforts to understand their home visitors' concerns about their clients, their tact when commenting on their staff's performance, and efforts to make them feel comfortable when talking with their supervisor.

We found no statistically significant differences in the subscale scores across time when we compared mean scores at pretraining, post-Time 1 and post-Time 4. However, two individual items—"I teach my home visitors through direct suggestion" and "When correcting my home visitors' errors with a participant, I offer alternative ways of intervening with that participant"—showed a significant decrease between ratings at pretraining Time 1 and posttraining Time 4. This decrease suggests that supervisors might have perceived themselves as being less directive with their home visits and less likely to jump in with a suggestion for working with a family, which likely reflects the influence of the FAN approach. Scores for a third item, which states "In supervision, I place a high priority on our understanding the participant's perspective" declined between the pretraining survey and the posttraining Time 1 survey, although the rating was higher at post-Time 4 than at post-Time 1. We do not have a clear explanation for the initial drop, unless it conveys a different interpretation of what it means to understand the participant's perspective. At the same time, we would note that ratings at all three time points were 5.2 or above, reflecting a fairly frequent practice.

Table 29. Supervisors' Views of Relationships with Home Visitors: Supervisory Working Alliance Inventory (*N* = 7)

SWAI Indicator	Pre-Time 1[b]	Post-Time 1[a]	Post-Time 4
I make an effort to understand my home visitors' concerns about their participants	6.6 (0.53)	6.2 (0.84)	6.4 (0.79)
I am tactful when commenting about my home visitors' performance	6.1 (0.69)	5.8 (0.45)	6.4 (0.79)
I welcome my home visitors' explanations about their participants' behavior	6.3 (0.89)	6.4 (0.84)	6.0 (1.00)
I encourage my home visitors to take time to understand what the participants are saying and doing	5.9 (0.69)	5.3 (0.96)	5.9 (1.07)
I encourage my home visitors to talk about the work in ways that are comfortable for them	5.9 (0.69)	5.8 (0.84)	5.9 (0.90)
My home visitors appear to be comfortable working with me	6.0 (0.82)	5.8 (0.45)	5.9 (0.38)
During supervision, my home visitors talk more than I do	5.7 (0.95)	6.2 (0.84)	5.7 (0.95)
In supervision, I place a high priority on our understanding the participant's perspective	6.0 (1.15)	5.2 (0.45)	5.6 (1.27)
I encourage my home visitors to formulate their own plans with their participants	5.7 (0.49)	4.8 (1.30)	5.5 (1.22)
I stay in tune with my home visitors during supervision	5.7 (0.49)	5.6 (0.55)	5.4 (0.79)
In supervision, my home visitors are more curious than anxious when discussing their difficulties with participants	5.4 (0.79)	4.8 (1.26)	5.3 (1.11)
My home visitors identify with me in the way they think and talk about their participants	5.3 (0.76)	4.6 (0.89)	5.3 (1.03)
My home visitors understand participant behavior and program strategies similar to the way I do	5.3 (0.76)	5.2 (0.84)	5.3 (0.76)
I facilitate my home visitors' participation in our sessions	5.7 (0.76)	4.3 (1.71)	5.1 (1.86)
In supervision, I expect my home visitors to think about or reflect on my comments to them	5.0 (1.15)	4.8 (1.26)	5.0 (1.29)
During supervision, my home visitors seem able to stand back and reflect on their own experience	5.0 (0.58)	5.2 (0.84)	5.0 (1.15)
I help my home visitors stay on track during our meetings	5.3 (0.76)	5.0 (0.71)	5.0 (1.00)
My home visitors consistently implement suggestions made in supervision	5.3 (0.49)	5.0 (0.71)	4.7 (1.25)
My style is to carefully and systematically consider the material that my home visitors bring to supervision	4.3 (2.06)	4.2 (1.64)	4.1 (1.57)
My home visitors work with me on specific goals in the supervisory sessions	4.1 (1.46)	3.6 (0.89)	4.1 (0.90)
I help my home visitors work within a specific plan with their participants	4.9 (1.35)	4.0 (1.00)	3.9 (1.35)
When correcting my home visitors' errors with a participant, I offer alternative ways of intervening with that participant	4.9 (0.69)	5.2 (0.84)	3.7 (1.25)
I teach my home visitors through direct suggestion	3.6 (0.79)	3.6 (1.14)	2.9 (1.07)
Rapport			
Mean (SD)	6.0 (0.37)	5.5 (0.68)	5.7 (0.87)
Range, *n*	5.7–6.6	4.6–6.1	4.1–6.6
Client Focus			
Mean (SD)	4.9 (0.68)	4.5 (0.42)	4.5 (0.72)
Range, *n*	4.0–5.9	3.9–4.8	3.1–5.2
Identification			
Mean (SD)	5.4 (0.37)	5.0 (0.55)	5.4 (0.78)
Range, *n*	5.0–6.0	4.3–5.6	3.9–6.0

[a] Just 4 supervisors responded to the SWAI at post-Time 1

[b] Response scale ranged from 1 ("never") to 7 ("always"); frequency labels are not assigned to intermediate ratings.

* Paired sample *t*-tests indicated that the following differences were statistically significant: Direct suggestion Pre1 vs. Post4 ($p < 0.01$); Participant perspective Pre1 vs. Post1 ($p < 0.05$); Correcting errors Pre1 vs. Post4 ($p < 0.05$); and Correcting errors Post1 vs. Post4 ($p < 0.05$).

Experiences with Infant Mental Health Consultant and Developmental Specialist

As shown in Table 21, supervisors' reports of their staff's experiences with the infant mental health consultant (IMHC) and developmental specialist differed. Staff had more contact with the IMHC than the developmental specialist, although the amount of contact with both consultants increased between post-Time 1 and post-Time 4. In addition to meeting with home visitors individually, the consultants were available to join home visitors on home visits. At the time of the first posttraining survey, just 20 percent of supervisors noted that the IMHC went out on home visits, but by the fourth posttraining survey, 57 percent reported that the consultant went on a home visit.

When asked about the effectiveness of the IMHC, there were no significant differences between responses at post-Time 1 and post-Time 4. However, there was a positive trend noted in their responses about the role of the IMHC in helping home visitors "resolve questions or problems in working with families in the area of mental health" and in making them "feel positive about working with a mental health specialist" from post-Time 1 to post-Time 4.

In contrast to the positive trend observed in supervisors' ratings of the value of the IMHC to their staff, there was a negative trend when we compared their ratings of the value of the Developmental Specialist on the post-Time 4 survey with the post-Time 1 survey. One reason might be less perceived need for consultation around developmental concerns than for consultation on mental health issues. But it also is possible that the developmental specialist was not as well integrated into the program as the IMHC.

Table 30. Supervisors' Views of Staff Experiences with Mental Health and Developmental Consultants (*N* = 7)

Statement about Consultant (C)	Infant Mental Health Consultant		Developmental Specialist	
	Post T1	Post T4	Post T1	Post T4
Met individually with staff since FAN Training began				
Never, %	0	43	100	14
Less than once or once a month, %	75	57	0	71
Twice a month or more often, %	25	0	0	14
Mean (SD)	2.3 (0.50)	2.7 (0.76)	1.5 (0.58)	2.0 (0.58)
Range, *n*	2–3	2–4	1–2	1–3
Accompanied staff on one or more home visits				
Yes, %	20	57	25	29
Responded to staff requests in timely manner				
Disagree/strongly disagree, %	25	0	0	29
Agree, %	0	43	50	29
Strongly agree, %	75	57	50	43
Mean (SD)	3.5 (1.00)	3.6 (0.53)	3.5 (0.58)	2.9 (1.35)
Has been easy to relate to				
Disagree/Strongly disagree, %	0	0	0	28
Agree, %	25	29	50	29
Strongly agree, %	75	71	50	43
Mean (SD)	3.8 (0.50)	3.7 (0.49)	3.5 (0.58)	3.0 (1.15)
Was knowledgeable in dealing with their requests				
Disagree/strongly disagree, %	25	0	0	14
Agree, %	0	29	50	43
Strongly agree, %	75	71	50	43
Mean (SD)	3.5 (1.00)	3.7 (0.49)	3.5 (0.58)	3.1 (1.07)
Has handled their situations effectively				
Disagree/strongly disagree, %	25	0	0	28
Agree, %	0	43	50	29
Strongly agree, %	75	57	50	43
Mean (SD)	3.5 (1.00)	3.6 (0.53)	3.5 (0.58)	3.0 (1.15)
Made staff feel positive about working with a specialist				
Disagree/strongly disagree, %	25	0	0	28
Agree, %	25	29	50	29
Strongly agree, %	50	71	50	43
Mean (SD)	3.3 (0.96)	3.7 (0.49)	3.5 (0.58)	3.0 (1.15)
Improved staff understanding of mental health/ developmental issues				
Disagree/strongly disagree, %	25	0	0	28
Agree, %	25	57	75	43
Strongly agree, %	50	43	25	29
Mean (SD)	3.3 (0.96)	3.4 (0.53)	3.3 (0.50)	2.9 (1.07)
Helped improve staff skills in work with families				
Disagree/strongly disagree, %	25	0	0	28
Agree, %	25	57	75	43
Strongly agree, %	50	43	25	29
Mean (SD)	3.3 (0.96)	3.4 (0.53)	3.3 (0.50)	2.9 (1.07)
Helped staff resolve problems in work with families				
Disagree/strongly disagree, %	25	0	0	28
Agree, %	50	50	75	43
Strongly agree, %	25	50	25	29
Mean (SD)	3.0 (0.82)	3.5 (0.55)	3.3 (0.50)	2.9 (1.07)

Not all respondents answered every question. Response rates for individual questions range from 4 to 7 answers.
*Paired sample *t*-tests indicated that no time-to-time differences were statistically significant.

Mindfulness

The final standardized measure that the supervisors completed at all three time points was the Five Facets of Mindfulness Questionnaire (FFMQ). Supervisors were asked 15 items from the FFMQ consistently over the course of the evaluation (see Table 31). Supervisors used a 5-point scale to respond to the questions, ranging from 1 or "never or very rarely true" to 5, or "very often or always true." These 15 items make up two subscales: Act with Awareness and Non-Reactivity to Inner Experience. In our subsample of supervisors we found a significant increase on the Non-Reactivity to Inner Experience subscale between post-Time 1 and post-Time 4 ($p < 0.05$). The other subscale, Act with Awareness, also changed between post-Time 1 and post-Time, 4 moving from a mean score of 30.2 at post-Time 1 to a mean score of 32.2 at post-Time 4. However, this increase was not significant.

Job Satisfaction

Table 32 presents supervisors' satisfaction with a number of aspects of their jobs at three time points, between the pretraining period and the posttraining Time 4 survey. We limit this discussion to the differences between pre-Time 1 and post-Time 4 because just four supervisors responded to these items at posttraining Time 1. First, at post-Time 4 in comparison to pre-Time 1, average ratings were higher (although not statistically significant) on eight of the 12 items, including "the quality of training you receive," "the support you receive from co-workers," and "your interactions with home visitors." This might reflect the influence of the FAN training. On the other hand, several items such as workload, the supervision they provide, and opportunities for professional development, among others, remained fairly stable. In addition, the mean rating of "being valued for your work" was significantly lower at post-Time 4 (2.4) compared to pre-Time 1 (3.0). The reasons for this drop in supervisors' perceptions of being valued for their work are not immediately clear. Findings from the interviews with supervisors did not provide an explanation either.

To conclude this section, the survey analysis suggests that supervisors perceived themselves to be "skilled" in supporting their home visitors in the use of the FAN approach, with ratings of skills increasing between posttraining Time 1and post-Time 4, although not significantly. There was also a modest increase in self-ratings of mindfulness. We turn now to data from the qualitative interviews with supervisors and consultants at 9 and 18 months after the start of training, which strengthen and augment these quantitative results.

Table 31. Supervisors' Mindfulness: FFMQ Responses (n = 6)[a]

Indicator	Post-Time 1	Post-Time 4
I perceive my feelings and emotions without having to react to them	3.8 (0.84)[c]	4.0 (0.00)
When I do things, my mind wanders off and I'm easily distracted	3.7 (0.82)	3.5 (0.84)
I do not pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted	4.5 (0.55)	4.2 (0.75)
I watch my feelings without getting lost in them	3.8 (0.75)	4.0 (0.63)
I am easily distracted	3.5 (0.55)	4.0 (0.71)
I find it difficult to stay focused on what's happening in the present	4.2 (0.41)	3.8 (0.75)
When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it	4.2 (0.75)	4.0 (0.63)
In difficult situations, I can pause without immediately reacting	4.0 (0.63)	4.0 (0.00)
It seems I am "running on automatic" without much awareness of what I am doing	3.8 (0.45)[c]	3.7 (1.03)
When I have distressing thoughts or images, I feel calm soon after	3.7 (1.37)	3.7 (1.03)
I rush through activities without being really attentive to them	4.2 (0.75)	3.8 (0.75)
When I have distressing thoughts or images I am able to just notice them without reacting	3.8 (0.41)	3.8 (0.75)
When I have distressing thoughts or images I just notice them and let them go	3.0 (0.89)	3.8 (0.75)
I do jobs or tasks automatically without being aware of what I'm doing	3.7 (0.52)	3.8 (0.75)
I find myself doing things without paying attention	3.8 (0.75)	3.8 (0.75)
Act with Awareness subscale		
Mean (SD)	30.2 (2.17)[c]	32.2 (3.96)[c]
Range, n	29–34	29–39
Non-Reactivity to Inner Experience subscale		
Mean (SD)	26.4 (4.04)[c]	27.3 (3.56)
Range, n	20–31	23–33

[a] Responses are based on a 5-point scale ranging from 1, Never or very rarely true; 2, Rarely true; 3, Sometimes true; 4, Often true; and 5, Very often or always true. Pre-Time 1 data are not presented because the FFMQ was not on the Wave 1 supervisor surveys, so only one of the seven supervisors completed it.

* Paired sample t-tests indicated that the following time-to-time differences were statistically significant: "Notice them and let them go" Post1 vs Post4 ($p < 0.05$) and Non-Reactivity to Inner Experience subscale Post1 vs. Post4 ($p < 0.05$).

Table 32. Supervisors and Job Satisfaction over Time (*N* = 7)[a]

Aspect of Job	Pre-Time 1 Mean (SD)	Post-Time 1[b] Mean (SD)	Post-Time 4 Mean (SD)
The support you receive from coworkers	2.9 (0.38)	2.8 (0.50)	3.4 (0.53)
The quality of training you receive	3.1 (0.69)	3.0 (0.00)	3.4 (0.53)
Your interactions with home visitors	3.0 (0.58)	3.0 (0.00)	3.4 (0.53)
Your influence on home visitors' parent–child interactions	2.9 (0.38)	3.0 (0.00)	3.3 (0.52)
Your workload	2.9 (0.38)	2.5 (0.58)	3.1 (0.69)
Opportunities for professional development	2.9 (0.69)	3.0 (0.00)	3.1 (0.38)
Your influence on the program	3.3 (0.49)	3.0 (0.00)	3.1 (0.38)
Cultural sensitivity in your program	3.0 (0.58)	3.3 (0.50)	3.0 (0.58)
Administrative responsibilities and paperwork	2.9 (0.38)	2.5 (0.58)	3.0 (0.58)
The supervision you administer	3.1 (0.38)	3.0 (0.00)	2.9 (0.90)
Being valued for your work	3.0 (0.00)	2.8 (0.50)	2.4 (0.53)
Mean (SD) of all job satisfaction items	3.0 (0.00)	2.8 (0.50)	3.1 (0.38)

[a] Responses are based on a 4-point scale: 1,Very dissatisfied; 2, Dissatisfied; 3, Satisfied; and 4, Very satisfied.
[b] At post-Time 1, only four supervisors responded to these items.
* Paired sample *t*-tests indicated that the pre-Time 1 to post-Time 4 difference for "being valued for your work" was statistically significant ($p < 0.05$).

Qualitative Results from Supervisor Interviews

> I will say to a home visitor, "So what has mom tried and what did you say to her to help her?" So I've noticed that we're doing more of that Collaborative [Exploration] just like I'm hearing the workers are doing that with the families. So not just the Fussy Baby families, but they're collaborating with me, they're collaborating with the families on ways they can best support this without giving them the answer. [For example, I might say] "Well, maybe mom wasn't ready to focus on development, and where was mom at that, and how did that transition go?"

The quote above is from an interview with an 18-month supervisor. In this section we draw from 24 individual interviews with supervisors; 13 were interviewed 9 months into the training and implementation period and 11 of them were interviewed again at 18 months.[35] In our individual interviews with supervisors, we discussed the program context for implementing the FAN, the experiences of their home visiting staff with the approach, and the effects of their own learning of the approach on their practices as supervisors.

Overall, the findings from the supervisor interviews strengthen the findings from the focus groups with home visitors in terms of the effects of training on practice and the factors that shaped the learning and

[35] We also interviewed another supervisor at the 18-month time point; however, she was new in her position, so she was not yet very familiar with the FAN approach and did not have a perspective on learning and implementation at her site.

implementation of the FAN approach. Supervisors noted that the implementation of the FAN approach forced them to alter the way they and the home visitors have conducted supervision and home visits. Supervisors observed that home visitors were incorporating many elements and core processes of the FAN approach into their everyday work—albeit not uniformly—including a reflective posture (e.g., being nonjudgmental and listening attentively), reflective responses (e.g., matching and shifting), and most of the core processes (i.e., Empathic Inquiry, MSR, Collaborative Exploration, and Capacity Building). Supervisors also reported changes in what home visitors were reporting about their families. In particular, supervisors observed that families were providing more in-depth information to home visitors, which seemed to have strengthened their relationship with the families.

As we learned from the focus groups, home visitors experienced the FAN training differently across the nine programs. Thus, progress in acceptance and learning of the approach and subsequent changes in practice varied across program sites. In most program sites, supervisors also noted initial resistance to the FAN approach among at least some of their staff, although this resistance usually waned over time as home visitors became more aware of the benefits of the approach and more comfortable using it. Below, we first describe the kinds of changes in practice that supervisors reported in their own work as a result of the training and then turn to the changes that they saw in their staff's practices. We also discuss the key factors that supervisors thought were influencing the learning and adoption of the FAN approach.

Change in Supervisors' Knowledge and Practices

Many supervisors appeared to have incorporated elements of the FAN approach in supervision using a parallel process. As a result, the content of the discussions about supervision has changed in focus and depth: it has become more reflective and collaborative and more focused on the home visitors' concerns. Even some supervisors—notably, experienced and new supervisors at three of the Wave 2 sites—who admitted feeling unprepared to supervise their staff using the FAN approach were tentatively and gradually adopting a reflective posture to their supervision. At her 9-month interview, one of these supervisors told us:

> Reflective supervision has always been a little difficult for me because when I started out there was no training. It was here you're a supervisor. It was more like a case review, what's going on with the family. Definitely I'm really trying. . . I'm still working on that reflective supervision piece. I think more and more it's becoming more natural to me.

The following excerpts from two supervisors at different programs indicate changes in their ability to implement true reflective supervision. The first is a 9-month interview; the second is an 18-month interview.

> [I'm] just continuing to have those conversations with [my supervisee] and explore with her. What would you have done different? Is there something else you could have done or is that really all you could do in that situation? Everybody was safe and everybody was taken care of and tomorrow is a new day. Having her see and realize about herself some of the things that I've seen since the beginning, the strengths. That couldn't have happened by me just continuing to say you're doing a great job. . . . It's been a really fun process to watch.

> I think [my supervision] has changed a lot. I think I had my learning curve where I'm like, "Oh, now I know what I'm doing in supervision, and I know how to respond to their concerns, and just listen more than I talk, and ask more open-ended questions." I think that it really has helped me to think about supervision in the FAN of meeting them where they are.

Furthermore, as a result of the FAN training, supervisors also reported becoming more empathic and more focused on main concerns of their supervisees, as suggested by the following excerpts from two different 9-month interviews:

> Before [supervision] was all focused on families and we spent most of the time furiously writing what was going on with the family and not talking so much about what that felt like as a home visitor and what struggles they may have had, or the things that they were really proud of families and they accomplished.

> [The trainer] also mentioned. . . that wherever the parent is mentioned you could put in home visitor. I was like, that is so true—it was like a light bulb went off for me. I am going to start doing that. . . I do remember just when I was the supervisee saying something similar like I feel like you're my [home visitor] and I'm the mom and I can't figure this out with this mom it's just like well, it is supposed to be a parallel process so I was familiar with that term. It is supposed to look like that, but the light bulb was well, how do I do that because not everybody is going to come here struggling just like a mom would struggle or having oh, I had a great week I got mom figured, blah, blah, blah, what about her baby, like when the baby first figures out how to walk or crawl. That is very easy to see and do parallel process there, but when that's not going on that can be. . . . The ARC approach will definitely help with that.

By focusing more on the home visitors' concerns in supervision, supervisors also believed that supervision was becoming more collaborative. One informant, at her 9-month interview, described herself as "building an environment, atmosphere where they can feel comfortable sharing things that are going well and things that may not be going so well. Really reflecting on their work and thinking together about their families." She added that supervision was becoming more enjoyable for her as well as more comfortable for her staff. Another supervisor, at her 18-month interview, said it has been helpful for her to work together with her staff to figure out a solution to a problem with a family rather than feel that she has to have the solution, "We're always trying to figure out where we are or where the participant is or even getting other staff's input and asking questions [rather than] feeling like 'I have to come up with the

answers.' We all kind of bounce ideas and questions off of one another. I think that is something that has improved."

Although the survey results would suggest that the use of the FAN did not change overall job satisfaction among supervisors, there were some supervisors who believed that it had improved their job satisfaction. A supervisor new to her role told us at her 9-month interview, "I think it has improved my job satisfaction in my current role, because it was not a role that I aspired to, or was looking for. I wasn't necessarily real excited to move into that role." Another supervisor also believed her job satisfaction increased because of the opportunity to learn and see how the work of the program was affecting families. The supervisor said at her 18-month interview:

> I think it increased my feelings of job satisfaction because I think that yeah, I really believed in what we were learning and doing and I saw how I see how it impacted families and staff and I appreciate that the opportunity to take the time for these professional opportunities too, so yeah, I think it's really beneficial.

In reporting these changes in their practices, supervisors also acknowledged that it took time for them to happen. A supervisor, in her second interview 18 months after the core training, stated:

> In the beginning it was difficult trying to remember to step back and keep my feelings in check. So maybe a staff member was having a reaction to a family or a parent that I wouldn't necessarily have. I didn't quite understand, so it was hard in the beginning to, say, step back. "These are their feelings right now. Let's let them vent because sometimes they just need to do that." I probably would have done it that way anyways, but the Fussy Baby approach just helped me realize why it's beneficial for me to just not interject and to try and understand where the worker was coming from. It's gotten easier, definitely, and I feel much more comfortable now.

This informant and other supervisors believed that changes in their practices were a natural consequence of the intensity of and time dedicated to training, as well as the use of some of the learning tools incorporated into the training. They also attributed their shifts in practice to simply realizing the benefits of the FAN approach for their staff and the families with whom they work. Some supervisors, as reflected in the excerpt below, saw it as a way to help home visitors manage their emotions and avoid burnout or, as some supervisors called it, "compassion fatigue." One participant in the 18-month interview said:

> I think [supervision] is extremely important, especially when we are doing it reflectively. It's addressing the mental health of the supervisee. . . to prevent burnout. I knew supervision was a good tool to prevent burnout, but Fussy Baby supervision with this parallel process and being reflective I think is even more effective at that.

Changes in Home Visitors' Practices

In addition to changes they saw in their supervisory practices, supervisors reported several changes in the way in which their staff were working with families. As one supervisor noted in her 9-month interview, "I feel we've gone from being very confused to being like, this is a great thing. The majority of our staff has completely bought into it and really used it with maybe not just the two families [required by the training process]." She noted that home visitors in her program have not only started using some of the process in their home visiting but also "into their time with family and their time with friends. It just like become [sic] their way of being with other people."

Based on the supervisor interviews, most of the program staff were using the FAN approach to some degree by the end of the 18 month implementation period. However, the pace and depth of learning and adoption of the FAN approach was not uniformly experienced. First, some program sites learned and adopted the FAN approach at a faster rate than others. Second, some program sites did not equally adopt all the core processes of the FAN approach. For example, a supervisor at one program site, where more resistance to change was observed, candidly explained that her staff "picked and chose which [core process] was most important [and] grasp[ed] bits and pieces of it." Another supervisor, from a different program site, stressed that use of the FAN approach varied according to staff and their level of resistant in changing their practice. She concluded that for the more resistant staff, "a hybrid Fussy Baby" was adopted whereas for the less resistant staff a "more loyal" version was adopted.

For earlier adopters of the FAN approach, the biggest changes in practice occurred by 9 months into training, with fewer changes in practice reported after 18 months into training. At program sites that were slower to adopt the approach, change in practice was not observed until after 18 months of training. In some ways, these program sites at 18 months into training resembled their counterparts at 9 months into training.

Supervisors were also asked to report on specific changes they had seen in their staff. Most often, they mentioned that the home visitors had become more focused on parents' concerns, on helping families finding their own way by building parents' capacity and confidence and fostering collaborative exploration, on meeting parents where they were at the moment, on seeing the child the parent sees, and on exercising mindful self-regulation. The following excerpts provide examples of how supervisors viewed their staff's increased abilities to meet parents where they are and focus on their concerns. The first excerpt is from a 9-month interview; the second is from an 18-month interview

> [What Fussy Baby] has taught us to do fits anybody that's working with parents, because it gives them a platform or a door that they can introduce their issues or things that's on their mind. . . you kind of go into a home as a home visitor with the goals of your program and the goals of what

> benchmarks you have to achieve in your mind, and sometimes you don't think about, "Oh, they have something that they want to say."
>
> [The FAN training is] really giving the parent more of a voice in the visit. Because I think we give the parent a voice in the world. We advocate for them to advocate for the families, but that's advocating with school or advocating at your doctor's office, advocating outside or inside your home, and now we're working to have them advocate for themselves inside their own home and their own decisions.]

In the following example, from an 18-month interview, a supervisor describes a supervisory session with a home visitor who came to realize that she was more focused on her plan for a family than on the family's concern:

> Finally, after we talked and I'd asked a few questions, [my supervisee] finally said, "You know what, their goal plan wasn't theirs; that goal plan was mine. I wrote that." So at this point she just got to saying, "I think next visit I need to go back and just say that to them. 'I think all this that you told me you wanted to do you're just telling me what I said to you, you thought I said you should be doing.'"

Supervisors also observed changes in home visitors' ability to take a parent's perspective and see the baby the parent sees. The following excerpts are from 9-month interviews:

> It's helped the FSW folk to work to see the baby the mom sees, so instead of coming in with our own idea of what this child can do or what this family can do, it's—we're seeing it from a different lens, and it's helping us talk with the parent about that, and really being on the same page as the parent as opposed to where in our head the parent should be or is.
>
> I think it's given the home visitors that opportunity to do that to keep baby really in mind and really in focus. I think that's really beneficial for everybody. I also think again it has really shifted focus from the home visitor being like the expert and really helping them in that to think of themselves as the expert.

Supervisors also reported that along with this shift in focus, home visitors were also learning to help families find their own solutions to their problems. As one supervisor told us in her 9-month interview, "I've noticed it even more that people are kind of sitting back and asking the families to come up with more ideas as opposed to just chiming in, or being okay with that silence." Other supervisors described the work of her staff with their clients more as a "partnership" or "collaboration." As one informant put it at her 18-month interview, "We no longer became fixers, we became collaborators. I think that's a big difference. . . we saw the bigger benefits of breaking things down and helping mom find her own answer and not jump out and try to fix things."

Just as the home visitors highlighted the importance of MSR in their practice, supervisors also recognize its value, as indicated by the following excerpts. The first excerpt is from a 9-month interview; the second is from an 18-month interview.

> The self-regulation piece [is helpful] because we never realized until now that all this stuff is going on. Sometimes we're going in a house that's not clean, or you're going in the house and it's clean, but they have a cat, and you don't like cats, but you still have to be attentive to mom when you know this cat is lurking around somewhere, and is he going to jump on my lap? Is he going to get near my feet? How do you contain yourself and still be attentive to mom?
>
> With mindful self-regulation, I like that that has been brought to life, because you think there's something wrong with you when somebody is telling you something horrible, and you're going to have to tune out for a minute, and you think, "Oh my gosh. That was horrible. I totally missed what they've just said, because that was so overwhelming. . . . That's a normal thing and that's a good thing. That prevents you from saying you can't talk [like that].

Supervisors also recognized that the transitions in practice led to shifts in perceptions of the home visitor's role. As one supervisor explained at her 9-month interview, "I think the model really encourages us to think about each family's individual strengths and challenges and treats the families as the experts in their family and their child so we don't come in there with this expert teaching hat on." Another supervisor commented at her 9-month interview on the move away from having to solve problems for families, as follows:

> I think it is a definite shift. I think a lot of them were feeling that they needed to solve problems. To give the information so. . . yeah I think it's a shift. I think a lot of cases though they were doing too. I think it's more a shift from really having the families realize and come up with how to handle issues versus the support worker telling them this is what you need to do. I think the whole Healthy Family model has shifted that way.

Internalization and Assimilation of the FAN

As supervisors reflected back on the process of the FAN implementation in their program sites, they also shared insights related to the use, adoption, and internalization of the FAN approach. Supervisors talked about the extent to which the FAN approach has been assimilated into the staff's practice after 18 months and how implementation increased over the course of training. The following supervisor, in the 18-month interview, highlighted these changes in the posture and practices of their staff:

> Well, most of my staff are doing Fussy Baby with all their families. . . learning to recognize their own reactions and learning how to put it in perspective. That learning how to hold what mom is telling me over here and not take it all internally and not mix it with how we think she should react to a situation. I think our parents sense that from us. Not that we've been judgmental, but I think we were able to hold this stuff, without judging, without even get any hint with doing this helpful Mindful Self-Regulation, it just made us a little bit more mature, I guess, of how to handle what's going on with the families.

We also observed changes in practice in program sites where staff exhibited some resistance to change. All supervisors that were resistant to incorporating the approach after 9 months of training reported using and valuing FAN to some extent by 18 months. A supervisor who was skeptical about the FAN approach when we interviewed her 9 months after implementation started, confessed that she "finds [herself] using MSR" and that her staff was using "the FAN not only in their work, but in their personal life, too. When we interviewed her 18 months after implementation started, she said:

> It was a learning process, and I wasn't exactly clear on what does reflective supervision mean for a while. Then once I started to, "Well, Fussy Baby is really good about—the supervisor FAN." I was like, "Oh." Then it had all those wonderful questions on the back. I'm like, "That sounds like something I can ask, and that sounds like something I can ask." Then it helped me get the home visitors to reflect on themselves or on the moment when something happened.

The FAN Terminology. Overall, the FAN terminology was not equally adopted across or within program sites. While some supervisors acknowledged that their staff had yet to "master" the FAN language, others believed that the FAN approach "lingo" has "become part of [their program] culture." More often than not, there was evidence that the new FAN language and structure were fostering better communication among staff. As one supervisor put it, "We're all using the same words for a clearer understanding." This common language, in turn, made supervision easier. As one informant stated, "I feel like the Fussy Baby trainings has given us a common language to use during supervision. They've given us a structure. We don't use the structure of the FAN tools on every supervision, but when we review them it definitely gives us kind of a structure to go through."

At one program site, the supervisor believed that the new common language of the FAN approach played an important role in minimizing disruptions in home visiting because of staff turnover. This is because the FSW who was to take over the cases left by a departed staff person would be using the same approach and language to intervention. Therefore the adjustment of families to a new worker would be less disruptive. In her 9-month interview, she explained the following:

> A lot of times because staff turnover is so high, you have a family and they're working with someone, and it ends, and then they start with a new worker, and it doesn't really seem like that worker picked up where the other person left off, but because the staff is now using the same language, the same behaviors, things like that, I think it really helped in transitioning families from one family-support worker to a new one. Because the things that the family heard with this one or may have gotten that question about, or they're kind of getting the same questions and the same language with the next one, that helps, because if staff turnover is high, you lose families, because they say, "I don't want a new home visitor." Now, they're like, "Oh she asked me the same thing she asked me."

Benefits for Staff: Reducing Staff Emotional Burden

Although home visitors did not directly report an increase in job satisfaction or a reduction in the stress of their jobs, supervisors perceived that using the FAN might help reduce staff's emotional burdens. First, they noted that the FAN approach has lifted the pressure on home visitors of having to cover or "fix" a predetermined list of issues with families. They realized that they were able help their clients meaningfully by tailoring their intervention to what the family needed most in the moment. One supervisor illustrated this claim, saying, "My thinking is that it's a little bit freeing for an FSW because we're not. . . . It takes out the whole element of thinking, 'I got to get this done; got to get this covered.' So, it allows us to go to places mom wants to go." Another supervisor echoed this claim in an 18-month interview:

> When we think about our families in crisis, the ones that we come in and it's all about feelings and how they're feeling, it's hard to feel that you have any news in that situation of, "Well, there's nothing I can do for her but listen to her and listen to what she's going through and how she's feeling about it." Then Fussy Baby gives us that tool of like if that's where she was, if she was in empathic inquiry and you stayed there, then that's all you needed to do. You just needed to hold her feelings and be there with her in that situation. I think that that's how it helped us.

Second, supervisors realized that the use of Mindful-self regulation (MSR) made them and home visitors aware of the signs of burn-out before it would escalate. One supervisor offered a prime example in an 18-month interview:

> I think it's a burnout saver. I think approaching families from this perspective can improve the family's mental health, but then being able to receive the same exact thing when you're in a supervision session with your home visitor, no matter how tough that family was, you're gonna receive the same exactly support that you're giving them. For me, that's one of the main things that could . . . save the home visitor from burnout.

Benefits for Families

In addition to changes in staff knowledge and practices, some supervisors reported positive responses from program participants to the use of the FAN approach. In particular, supervisors observed a shift in the amount and content of information about families shared during supervisory meetings. Home visitors have found that families are willing to disclose more information about themselves and about their concerns. As one supervisor simply put it, the FAN approach has given "parents a voice." Another echoed this view in reference to a FAN strategy to ask mothers to describe their child "in three words" at the end of the visit, as follows: "I think that they're feeling more heard. I think that's probably the biggest [change]. And the other thing is saying those three words about their baby, and you can really see them stop and think."

Several supervisors believed that home visitors were incrementally building trust and strengthening their relationships with families as a result of their increased ability to listen empathically and respond to what parents need at the moment. This belief is illustrated by the following excerpt from an 18-month interview:

> What we provide is just showing up and being there and listening and being a sounding board for them. That's probably one of the best things that we can do. It's not about physical things that we bring in and it's not about—although they may appreciate those, and they have a need for them—of handouts of those things, but just building a relationship with them, addressing relationships that allows us to help them to see their own strengths and to start there and really work at building the capacity that they already have to be parents.

In addition, home visitors' new ways of conducting home visits seemed to be increasing parents' reflective capacity and building their capacity to make decisions and solve problems more independently. The home visit now provides, as one supervisor put it, "a safe place to make a decision and then come back and reflect on it and see." Another supervisor commented that the FAN "is helping them stand and build their confidence because the workers aren't jumping to do things for the client. They're empowering them to find the resources on their own and realize what their own strengths are."

Factors Influencing the Learning and Application of the FAN Approach

When supervisors were asked to comment on the factors that facilitated or interfered with learning and implementing the FAN, they pointed out that changes in practice were a natural consequence of the intensity of and time dedicated to training as well as their staff's ability to remain involved in the training. However, supervisors also mentioned these other factors most often: the supervisor's stance on and support for the approach; characteristics of the home visitor (e.g., age and experience); length of time home visitor has been working with families; training characteristics (e.g., format and content, amount of paperwork, length and intensity of training, and relationship with trainers); and organizational and other contextual factors (e.g., staff turnover, competing work demands, unexpected program stressors). Again, these themes were more evident in some programs than in others.

Supervisor Support for the FAN Approach

Most of the supervisors recognized the importance of their role in encouraging their staff to embrace the FAN approach. Supervisors who provided motivation and instrumental support—through supervision—on the use of the FAN approach seemed to reinforce its use and adoption in their home visiting practices. Many supervisors tried to coax their staff into embracing the FAN approach by sharing their enthusiasm for it. One supervisor said the following to her staff: "It's like when you learn a new skill, you're so excited, 'I got this new skill, and we're going to do it,' and we're doing it, and supervision is happening."

Some of the supervisors also were aware of their role in supporting their staff as they began to have a better understanding of the FAN approach. In the words of one supervisor, this phase was "kind of drinking the Kool-Aid of Fussy Baby."

Supervisors that were new in their role reported finding the FAN approach to be very helpful in the process of learning how to be a supervisor and were open to using the approach as a tool for supervision. Particularly at Wave 2 sites, supervisors that reported feeling unsure about their supervisory responsibilities or anxious about reflective supervision after 9 months of training were fully committed to using the using the approach by 18 months into training. One supervisor stated,

> I went from not really even knowing what reflective supervision is to fully embracing and doing the parallel process with the home visitors. I really want to keep Fussy Baby alive. I want them to use it with their families. I use it with them so it stays fresh in their mind, and they can turn around and use it with their families.

All supervisors were aware that the implementation of the FAN approach in their program encountered some resistance.[36] One of them reported "having a hard time keeping staff motivated in Fussy Baby" and recalled having to "light that fire again" when she noticed that her staff was getting frustrated. Veteran staff in particular expressed greater resistance to the approach because the approach felt unnatural to implement or they encountered resistance from clients when using the approach. As one supervisor described, "It's harder to buy in when it's not something you feel is applicable to you or you can use."

Home Visitor Characteristics and Readiness to Change

Supervisors also observed that receptivity to the FAN approach and progress in learning and using it varied according to staff personality. "You have different staff. You have different personalities, different opinions," said one supervisor. In programs when staff made good progress in learning and implementation, supervisors believed that it was the staff's ability to remain open to and engage in the training over a long period of time that largely drove their growth. The following reflections were shared by two different supervisors during their 18-month interviews:

> Everyone was on this journey, or this progression, everyone kind of moved at a different pace. Some of that had to do with maybe the amount of experience they had in home visiting before. Some of it had to do with their openness to try something new and to truly engage. . . I think in the last nine months it's been much easier than it was prior to that. . . I think the first five months, four to five

[36] At one program, the supervisor was herself resistant to the FAN approach and by most accounts, staff at this program made slower progress in learning and implementation than at the other training sites.

> months, it was very difficult not necessarily to understand, but to really be willing to try something different
>
> [A veteran home visitor] has acknowledged in trainings, saying, "Yeah, maybe I could have done it that other way." That wasn't something that she was willing to accept before, where now we hear her saying, "Yeah, I could have done it that way. I think that that might have worked." So we see some change there, in that she's willing to look for the Fussy Baby way of doing things. There's definitely been improvement.

Many supervisors also noted that home visitors' educational and training background, years of experience in home visiting, and personal characteristics shaped learning and adoption of the FAN approach. For example, a recurring point made by supervisors was that acceptance of the FAN approach was delayed because many of the concepts covered in the FAN approach overlapped with those learned by home visitors in their previous training and educational experiences. Home visitors did not see how the FAN approach differed. According to supervisors, in the beginning of the FAN program implementation, examples of how home visitors typically expressed their views were: "I think we've always done that"; "I've been engaging families for 15 years"; "this stuff we already do"; and "I already know this stuff." On the other hand, for home visitors new to the home visiting field, the incorporation of the FAN approach into their practice seemed to come more naturally. In talking about a new hire, a supervisor reflected, "Maybe it's easier for her because this [FAN approach] is all she knows."

In addition, some supervisors talked about the challenges of adjusting to a "no fixing" approach. As one supervisor explained, "I think Collaborative Exploration was very difficult for some staff, because that felt more like, 'The parents asked me a question and they want me to give them an answer and I'm not; I'm just asking them some more questions.'" In contrast, some supervisors believed that home visitors with counseling background were more adept in incorporating the core processes into their practice.

Experiences Using the FAN with Families. Similar to home visitors, supervisors also commented on the challenge of using the FAN approach with families in which home visitors have already established a routine. Thus, according to some supervisors, home visitors found it easier to use the FAN approach with the new families coming into the program, as reflected in the excerpt below from an 18-month interview.

> I think it's harder for our staff, with the older kids that it's kind of three years of doing the same thing. We can't go on and just change it but starting new with the younger ones and doing that has really changed. . . . I've seen that more. . . "Well, how am I supposed to come in and just change how I'm doing it with families that I've been doing this for this long or my new families that I see weekly, my other ones I'm seeing monthly and I'm supposed to come in and change how I do it and I'm only

there once a month? Is it really doing much? It's more they're really doing it with these new group of people that are getting a new experience.

Characteristics of Training

Format and Content. Some supervisors believed that understanding the FAN approach, as a whole—"seeing the big picture," in words of one supervisor—from the beginning of the training would facilitate the understanding of the different core processes of the FAN approach. Three supervisors from two program sites especially talked about the challenges of fully understanding the model. They complained that just understanding the FAN approach became, at least for a while, the focus of their supervision: "I think initially a lot of our time in supervision was like what do they mean by this? I don't know. I think it's this," one supervisor explained.

Another supervisor made similar remarks: "We were unclear about what it was and it was months before we start that we were told we were going to be doing this." This supervisor went onto describe how this led to initial negative feelings about the training, "Really, how can you expect us to really buy into this or even participate fully or be here present fully when you feel like you're coming at us with something that you don't want us to really know?"

Amount of Paperwork. Completing the FAN learning tool forms was an issue with a majority of the programs, although the topic seemed more prominent in interviews with supervisors in the first wave of programs receiving the FAN training. Often the paperwork was viewed as burdensome because it was one more thing that need to be done along with a variety of other administrative work required by the program. Thus, the majority of the supervisors across the nine programs objected to the amount of paperwork required during FAN training and said it was a source of frustration among home visitors. One supervisor confessed, for example, that "the pressure of, 'Now let's figure out what to write and fill out these forms'" was generating some anxiety among her staff. The burden of the learning tools was less of an issue for supervisors from Wave 2 programs, perhaps because the trainers reduced the amount of training activities that involved paperwork after receiving complaints from Wave 1 program staff.

Length and Intensity of Training. Supervisors' perspectives on the length, frequency, and requirements of training were mixed. On the one hand, they shared that their staff complained about the amount of time dedicated to training. Many agreed that the time they were required to dedicate to training "was too much." Three of the Wave 2 program sites reported that the training felt drawn out and that too much time was spent covering each individual core process. The underlying main concerns identified by most sites was that the staff perceived any incremental time spent on training as time taken away from their work with families.

On the other hand, despite the concerns of their staff about the amount and length of time spent on training, many supervisors recognized the benefits of a long-term training commitment. Some of these supervisors admitted, when reflecting back on the FAN implementation in their program site, that the intensity of the training was necessary in order for them and their staff to learn the new approach and use it in their work with families. The following excerpts from two different 18-month interviews illustrates this ambivalence:

> I feel that it's been a lot and too much to where workers resent going [to the training] and [doing the other] stuff because they don't have time. There's so much stuff we require that this is just another thing that is a burden almost to them. . . . The amount of time we spend on Fussy Baby, I feel it's too much, but I get the benefit of it. So it's that double-edged sword where it's like a yes and no answer.

> I think that Fussy Baby has been the most training they've received. I know that it's not possible to have this type of training model with all of the other training, but this is just the way that it should be done because it just keeps it so present in your mind. It's not just one training that they just go to, and a couple of things from the training might stick to them.

Supervisors themselves struggled with the amount of time spent on training vis-à-vis other demands. In a few cases, supervisors had been recently promoted and were learning new roles while also trying to support home visitors in their learning and use of the FAN. The following excerpt from a 9-month interview illustrates this point.

> I think all the additional responsibilities that were just so new to me, like the administrative side that just took me some time to get used to and comfortable with, especially moving up from being a home visitor to a supervisor. That was difficult, just getting a handle on reporting and balancing encouraging and motivating staff as opposed to micromanaging because I'm panicking about getting things done.

Another area of concern was time management, especially when taking into account co-occurring projects and duties. A few supervisors talked about the challenge of using a reflective approach in supervision when they had to spend time on administrative paperwork. In an 18-month interview, one supervisor expressed her struggle to balance administrative and funding tasks with reflective supervision as follows:

> Just recently, I feel like I have not been [spending enough time] at being reflective with them. It sort of feels rushed this past week and I feel bad about that. Up until just recently, it had been, they check in, we go over their case weight, we do kind of the administrative stuff first, do they have room for more clients, first home visits, any family goal plans that they've done with families and we'll look over those together and the assessment that needs to be reviewed. . . . The second half is kind of like okay tell me what's going, how are you doing with your families, what have your most recent home visits been like, and we would have more time to do the reflective piece of it.

Relationships with Trainers. Overall, most supervisors appreciated the support and feedback they received from the FAN trainers and the quality of the training received. This seemed to be conducive to the learning and adoption of the FAN approach by staff and supervisors alike. For example, one supervisor elaborated on the positive outcomes that came from allowing staff to talk to the trainers about their complaints about the training. She went on to say that trainers discussed with her staff ways to adjust the training to better fit her staff's practice styles. "[The trainer] just stopped and regrouped, and I think that they just appreciated that she was like in tune with them." In a few program sites in which tension was observed between staff and trainers at first, implementation of the FAN approach seemed more challenging. One supervisor, for example, admitted that "there was definitely resistance from the start" but that was alleviated when a change was made in the trainers. "That's when I noticed the big difference and more of an on boarding of 'Yes, we are doing it and we can.'"

Program Contextual Factors

There were many contextual factors that may have hampered learning and adoption of the FAN approach across program sites. Understanding these factors may help planners and trainers adapt their training to the current circumstances of each program site. We noted that some program sites seemed more resistant to implementing the FAN approach than others. In these program sites, there seemed to be several sources of stress that hindered staff's ability to embrace the FAN approach and not see it as "just one more change" the program imposed on them. These sources included the following:

Staff Turnover. Supervisors reported that staff turnover was a source of stress in their program. Six of the nine program sites reported staff turnover and the challenges associated with it. As one supervisor reported, "It's quite a process to hire new staff and get them up to speed and get them to where they need to be." Another said, "It's been a little bit of a roller coaster. We did have one staff person leave, and her caseload got redistributed. Some chose to not continue in the program." A third questioned how to sustain the quality of services with frequent turnover at her program: "I still have the open position that I'm interviewing for, so it's like, it's continuous, so you just wonder if you're really being as effective with the work that you're doing, even though people are changing time and time again."

Supervisors from Wave 2 programs reported that staff turnover was, in part, due to the state's budget situation. In their 18-month interviews they described working in an exceptionally stressful work environment. For example, one shared, "It [has been] a very stressful couple of weeks. Everybody definitely was freaking out, 'What are we gonna do?' We try to keep that also from staff. Staff don't know what's going on." In an 18-month interview, another supervisor, whose staff were aware of the situation, reported:

> I don't think they're living in panic every day, but I think it is on their mind and they know it's a reality. I mean it happened already they didn't fill my position, my previous position, and that was kind of like, "Okay, we'll just wait and see what happens." But then there was a layoff, it became more real, and they know there's the possibility of more to come.

Competing Demands. In addition to the implementation of the FAN approach, supervisors—primarily those at Wave 1 sites—were coping with a variety of concurrent work demands, including program accreditation, other professional trainings, and research projects. At their 9-month interviews, they indicated that it was "a balancing act" trying to cope with a variety of work demands. As one supervisor explained, "All these research projects are tied into the same funding, so it's like, all the money came up and now we have to figure all this stuff out. It is overwhelming." In a 9-month interview, another supervisor reflected on the situation at her program:

> Honestly though, had it been at a time that there weren't like five other research projects going on, and we're in four out of the five of them, and entering another one in the next three months, I think it would've been more. . . the timing part wouldn't have been so overwhelming, and the documentation part.

Unplanned Stressors. Unexpected, stressful events and demands on program staff, such as the implementation of a new database, a move to a new office, or changes program policies and procedures, also contributed to their reactions to the length of the FAN training and capacity to learn. Staff at one program talked about unexpected work demands because of problems with a new management information system software that had been installed. In another case, a program's relocation to a significantly smaller physical space negatively affected the morale of the staff and drastically changed the dynamic of their supervision. One of the supervisors at the program shared her perspective in her 9-month interview:

> We moved to a new building. Fussy Baby started and we really lost a lot of team cohesiveness. I really feel like there's a disconnect. . . . In the past, they would always come to the office first and in the mornings before they gather their stuff to go on their home visits, I could stop and say, "Hey, how did that go yesterday? What about this?" It's gone. You can do it through text, but like I said, it's just so impersonal.

Shift in the HFA Model. Supervisors, predominantly from the Wave 2 programs, reported on the challenges of incorporating the FAN approach into their practice as changes in the HFA model of home visiting were being launched at the same time. Although most supervisors recognized that the new HFA model, Integrated Strategies, was compatible with the FAN in many ways, it introduced some new language and structure that seemed to conflict with what they and their staff were learning through the FAN training. For many, learning the two different models at the same time was confusing. The following

excerpts are taken from the 9-month interviews, which was about the time that most of the Wave 2 programs were being trained to implement the new HFA Integrated Strategies.

> It was really confusing because at the same time we were learning the HFA new approach and it was after years of [the old HFA model] and, I have to say, I was more familiar with the Fussy Baby approach and that reflective piece and meeting families where they were. I was already comfortable with that because I had adopted that and then they throw this like this is going to be the new standard, the new thing.
>
> Although it's been somewhat of a gradual shift [toward the new HFA model], being involved with the Fussy Baby has made it more real and concrete. This is what we're supposed to be doing now and some of the things we used to be doing that we feel very comfortable doing may not be what's best for the family. We want what's best for the families so we. . . we're going to take that. We're going to feel uncomfortable in it for a little bit just to see what's best that may happen.
>
> Some of the challenges are that we have our HFA policies and procedures. Then we have Fussy Baby where sometimes it doesn't completely go together. Where Fussy Baby is telling us if the mom is in feelings, then you stay in empathic inquiry even if it takes you the whole visit. If she's not able to get past the feelings and she stays there, then you stay there with her where empathic inquiry and match the parents where they are. Then with the Healthy Families of Illinois thing, we need to take curriculum to the class. That's part of the policies, the procedures, and this is how you do it. Then it becomes the problem.

Qualitative Results from Consultant Interviews

We also interviewed the IMHCs and the developmental specialists at each of the nine training sites two times, at 9 months and 18 months after the training started. This sample was composed of 17 individuals since one person performed both functions at one of the programs. We found considerable overlap between the views of the IMHCs and the developmental specialists, even though the latter had, as a group, a somewhat harder time figuring out their roles and being integrated into the home visiting programs. Findings from the consultant interviews, for the most part, also supported those from the supervisor and home visitor data. Thus, this section just briefly highlights the main themes that emerged from the consultant interviews.

Changes in Home Visitors' Attitudes and Practices

Consultants observed variations in how long it took for staff to learn and use the core processes and the Arc of the Visit language and structure. Among the core processes, there was general agreement among the consultants that MSR was the easiest for staff to understand and apply. As one consultant put it,

"MSR was the most natural to implement."[37] Even at programs where staff made slow progress in learning and implementing the core processes, consultants noted that MSR was the exception—as one put it, "MSR was helpful to everyone and used across the board." Integration was mentioned most often as the hardest for home visitors to learn, but some consultants also thought Collaborative Exploration was challenging. Although most consultants considered Empathic Inquiry comparatively easy to learn, some consultants commented that it can be difficult because "some home visitors don't feel comfortable with feelings." Although some consultants noticed that home visitors seemed to feel relieved by not having to have answers for every family problem, others reported that staff were having a hard time giving up doing things for the families, or what one informant referred to as "the needing to be needed piece."

Especially at the 18-month interview, consultants were seeing differences in how staff talk about their families. One consultant said, "You can notice a difference between the staff here and the conversations we're having. . . . It's very much more around an infant mental health approach that we come in not as the expert." Another stated that the FAN helped staff "conceptualize some of their work and really recognize some of that they're doing when they're doing it." In her view, the FAN was most helpful as a tool to help staff go back and think about or discuss their experiences. Another consultant, in the 18-month interview, summed up what she felt the home visitors at her program had gained as follows:

> When I look at the whole 18 months, the home visitors have gotten more used to the language and used to using the approach and integrating it into their work, although I think for people who are newer home visitors, that's just all they knew. I think it was easier for them to kind of get when people were in feelings. I think it was more difficult for them to distinguish between exploration and doing and often they really misunderstood reflection.

Factors Influencing Learning and Use of the FAN

Role of the Consultant

As indicated by the staff survey and interview data, it took time for home visitors to start working with the IMHCs and developmental specialists after training started, unless they had already established relationships with staff (as was the case for four IMHCs). Most consultants reported in their interviews that it was challenging to figure out their role at the program and then how to integrate consultation into the FAN model at first. In many cases, they felt a need for more training in the FAN before they could support the staff in learning and applying the new approach. Although they generally found the FAN concepts compatible with their other training and experience, except for one IMHC, they were not

[37] One consultant stated that Capacity Building was easy for home visitors to learn because "that's what they want to do. They want to go in and do that immediately. . . . They feel very comfortable there because that's what they've done before." However, other consultants disagreed in that it was not always easy for home visitors to know when a parent was ready to move to Capacity Building.

familiar with the FAN before the start of the training. At 9 months, one consultant expressed concern about how the program was using the consultants and noted that she needed more specialized training on the FAN at the beginning: "When I started I didn't know the FAN. And I didn't have any extra training around it. I was learning it like everyone else was. This idea that in consultation I might create some FAN moments was lost on me." At 18 months, another consultant commented, "I don't think any of us got good instruction on how consultation fit into the FAN at all. The [home visitors] weren't sure how they were supposed to use consultation." Gradually, however, it appears that the consultants—especially the IMHCs—became more integrated into the training processes. Another consultant who reported at her 9-month interview that it was difficult to integrate the FAN language and processes into consultation, reported at her 18-month interview, "I got better as I got more familiar with the Fussy Baby terminology. I got better at labeling things with that terminology."

A few of the consultants mentioned that the amount of time for consultation was not sufficient. One felt she needed more time for consultation because the home visitors "sometimes had trouble talking about the work [i.e., the FAN concepts] in the group. They'd want to talk about anything else." She added, with some frustration, "It was hard to get them to begin the work. . . . I did the best I could." She said that she would allow for some relationship building time but couldn't spend the whole 45 minutes of her time with them doing that. Another consultant described her time with one of the programs as one of her "less satisfying consultation experiences." She said that the home visitors would tell her that they were "doing this and that," that is, using the FAN, but she did not feel that they did as much as they could have. Another consultant, who expressed a similar view, suggested supervisors could have done more to support the use of the consultants.

Role and Support of Supervisors

Consultants agreed that the support of the supervisor made a difference in the learning and application of the FAN. At the 18-month interview, consultants at two programs in particular noted that the supervisors at their programs were "not on board" with the training, especially at the beginning. One said, "It would've made a difference if the supervisors had been more actively supportive. In one case, the consultant thought the supervisor's nondirective style contributed to her lack of support. In contrast, a consultant at another program described the supervisors as being very strong and the key to success of the training at this site: "The supervisors really embody and represent the idea around relationship-based work, which is part of the reflective practice, which is part of the FAN. . . . They are really support staff in way that they're able to do this really hard work with families really thoughtfully."

Characteristics of Training

Consultants generally thought that it took home visitors time—a good year—for them, as one consultant stated, "to hit their stride" and feel like "Yeah, I really get this. I really see how this is working." At the same time, consultants also observed a "fatigue factor" with trainings twice a month. One consultant thought that the training period could be shortened but that the program should keep consultation because staff need continued support. Another consultant at the 18-month interview thought that too much time was spent on the easier core processes and not enough on more difficult ones:

> The first two, MSR and Empathic Inquiry, it seemed like we spent a long time there. . . . Maybe it was just easier to understand. Maybe it was stuff we were more familiar with. And then the last two, I just didn't feel like we got the same kind of in-depth information and the hands-on kind of training about how to get there that we did with the first two.

Another consultant thought that learning might have happened more quickly if staff had been given time to talk about their families and "how to use the model with families or more time for the FSWs to be able to talk about their experience with families during the training."

Echoing the findings from home visitors and supervisors, consultants observed that learning the FAN approach was much more difficult for veteran staff than for new staff. They also reported that having to learn the new HFA Integrated Strategies curriculum almost at the same time was a challenge, which, according to one consultant, was "a problem that doesn't get a lot of support from the top."

Staff Reactions to Training. As noted, consultants were also aware of initial resistance on the part of many staff, typically those with previous experience as home visitors, to learning a new approach. One consultant reported that staff at her program were reluctant to use Arc of the Visit and other reflective questions because they felt "phony" or too scripted. Although the consultant has encouraged the staff to put these questions in their own language, they still did not want to ask these questions. She thought that the Arc of the Visit could have been better integrated into the training.

Another consultant, at her 9-month interview, thought that resistance from staff at her program came from a feeling that they were being "insulted" by the idea that they needed more training, as if they were not doing the work the right way. When interviewed at 18 months, this consultant expressed a similar view but described this initial resistance more as anxiety and being overwhelmed by all the changes: "A lot of changes at the same time made them less open." In describing her staff as "just not open to it" in both her 9- and 18-month interviews, a consultant described it as not really meeting the staff where they are in their development: "It's like a little conflict within the parallel in that we're talking about really meeting people where they're at. Then we have this training agenda we have to give to you, and so there's a little bit of a mismatch."

There was a sense from several consultant interviews that the demands of other research projects as well as the administrative tasks of their jobs affected the pace at which staff accepted and learned the FAN concepts. One consultant implied that staff had been promised some program support to manage their additional work load that did not come through: "The program had made promises to the FSWs [home visitors] that, then, after they were awarded the grant, they did not do." She, as well as other consultants, described the home visiting staff as fatigued and overwhelmed by the amount of training and paperwork. Another consultant added that the home visitors at her program were also concerned about what they perceived as a shift from a focus on in their role from facilitating parent-child interaction and play to more of a therapeutic role with the parent.

At the same time, the consultant interviews also made clear that over time, staff were learning, becoming more comfortable with the language and structure of the FAN, and using the FAN with at least some of their families. At her 18-month interview, a consultant summarized the changes that occurred in the home visitors attitudes and practices this way: "They are super excited about it now. They were initially hesitant because they participated in so many trainings and there are so many models they have to integrate and they were hesitant because it is one more things to learn. They see how practical it is, how friendly it is to learn and use."

Summary

In summary, from all three groups of informants—home visitors, supervisors, and consultants—we found that home visitors increased awareness of and ability to contain their feelings. All agreed that MSR was a helpful concept and one that was used across the nine programs. There also were changes in perceptions of the role of the home visitor and in the structure and content of home visits. Both supervisors and consultants reported less pressure to solve problems and "fix everything" for parents and a greater capacity to listen and explore with parents. In addition to the training, they noted several factors the contributed to the home visitors' progress in learning and using the FAN. These included supervisors' and consultants' knowledge and ability to provide support for learning, staff's initial receptivity to the approach, the trainers' ability to deliver the training in a way that built upon existing expertise and concerns of staff, the previous experience and training of the home visitors, and organizational factors (e.g., staff turnover, the introduction of the new HFA ISHV curriculum in the middle of the training process, and competing work demands).

Parents' Experiences and Early Outcomes

Again, assisted by home visitors, we recruited two samples of program participants—a pretraining sample and a posttraining sample—to take part in individual interviews at two time points, about 4 months apart. The interviews, which were a mix of open-ended, qualitative questions and quantitative measures, focused on three broad areas related to the implementation of the Fussy Baby Network® FAN training and the FAN approach with families: (1) mothers' experiences and relationships with their home visitor, (2) maternal health and well-being (parenting self-efficacy, depression, and parenting stress), and (3) infant health and regulatory issues (crying, feeding, and sleeping). Below, we begin with a discussion of the qualitative and quantitative findings about mothers' experiences and relationships with their home visitors, and then look at findings about changes in maternal functioning in the pretraining and posttraining samples.

Home Visiting Experiences before and after Training

Through mothers' narratives in interviews, we were able to capture indications of the effects of the implementation of the FAN core processes and of changes in home visitors' practices after training in the FAN approach. In this section, we compare findings drawn from an analysis of the qualitative portion of the Time 1 and Time 2 interviews with mothers in the two samples (pretraining and posttraining) of participants at the nine programs that received training.[38] In comparing interviews before and after training, we observed differences in the following areas: the format of home visits, the dynamics of visits, the use of (or absence of) the FAN principles and core processes, perceptions of the home visitor, and the mother's relationship with the home visitor. In what follows, we discuss differences in these areas in the

[38] In order to manage the huge amount of data, we began by analyzing all pre- and posttraining interviews with mothers whose home visitors were the same in the pretraining and posttraining samples. We then randomly selected a portion of other interviews to analyze, making sure we had representation from all nine of the programs in the study. In total, we analyzed 204 (65%) of the 310 interviews from the nine programs that received training, 128 in the pretraining sample (which was a larger sample) and 76 in the posttraining sample. We excluded the interviews with mothers at the comparison program from the analysis for this report but will be analyzing them in the future, along with the remaining interviews with mothers at the training sites.

narratives of mothers in the pretraining and posttraining samples that might be attributed to the FAN training.

Home Visit Dynamics: Use of FAN Approach

Comparing the narratives of mothers in the pretraining sample with mothers in the posttraining sample, we observed a number of similarities. First, mothers' reported feelings about their home visitors were, with a small number of exceptions, quite positive in both the pretraining and posttraining samples. Furthermore, the content of home visits was relatively the same after training as it was before training. That is, like the pretraining home visits the content of the visits posttraining was usually guided by child development information, screens and assessments such as the Ages and Stages Questionnaire, and infant care information. However, this information was conveyed differently by mothers in the posttraining compared to the pretraining sample. The posttraining narratives indicated subtle differences in the practices of home visitors that seemed to be informed by the principles of the FAN approach. Specifically, we observed four themes in the posttraining narratives, as follows:

Parent-Led

In the posttraining visits, a sense that parents were more involved in setting the agenda for and/or leading the visits emerged more often than in the pretraining visits. Several mothers in the posttraining cohort remarked that their home visitors asked for their permission to hold or play with their baby, a strategy that likely reflects the FAN process of Capacity Building. The following excerpt from an interview with a mother in the posttraining sample illustrates this point.

> They are really good about interacting with them and they are always really good about making sure that I think it's okay for them to do it, so they are not. . . you know, it's my baby, let me play with the baby. They are really good about keeping their distance, which I don't care but some moms would care. It's nice that they think of it that way.

Mothers in the posttraining sample also noticed that visits focused as much around their concerns as around their child. As one mother told us, "It's not just about [baby], it's about me too. From the beginning we've talked about postpartum depression, we've talked about breastfeeding, we've talked about my health, [the baby's] health, just all different things. . . . Everything, anything that would come up." Additionally, home visitors seemed to be asking parents more consciously about the topics and concerns they want to talk about during their home visits, as opposed to just asking perfunctory questions. This same mother in the posttraining sample went on to say:

> I'd tell you, this past year I've been in and out of several different jobs and one of them I had an injury at work and I was pretty upset about it. When she came here one time, I was venting my frustrations on trying to find a job and I get a job and then I get hurt. She listened to me and very

> much took interest to what I was saying. Even though it wasn't necessarily directed towards [baby's] development.

Calm, Unhurried Posture

In focus groups, some home visitors reported that that they learned to "sit on their hands" to help them focus on listening to mothers talk about their feelings and problems without interrupting and jumping in to give advice. There was also evidence of this posture in the accounts of mothers in the posttraining cohort—and its absence in the narratives of mothers in the pretraining cohort. This strategy might also reflect the use of the FAN process of Mindful Self-regulation by home visitors. For example, a mother in the pretraining sample reported a typical conversation with her home visitor as follows: "I'm not just sitting there telling her information, and that's how some counselors it seems like they will just sit there and listen to you talk, but no, she'll let me know information about her and how stuff went her time around. So I like that." In contrast, a mother in the posttraining sample described her interactions with her home visitor in the following way:

> She would come. . . she didn't really say much, like she would just talk about the program. But she will like sit down and talk to you about life and things. I really like her. . . she listens a lot. She's very supportive. . . . The time at the hospital when the nurses came in there being complete asses . . . and I was like snapping off and she was just standing there listening the whole time. . . . Just like going along with me and listening. . . . She helped me talk about it. . . . [She] asks about our problems [feelings], sees how the baby's doing. Asks me how I'm doing.

Attunement

Although mothers in both the pretraining and posttraining cohorts felt that their home visitors listened and supported them well, we caught glimpses of attunement (i.e., feeling connected and understood) when mothers talked about their concerns or problems with their home visitors. As a mother in the posttraining sample simply put it, her home visitor can "tell how I'm feeling, so if I'm upset, mad or sad then she can feel that as well." Another mother relayed the following about her home visitor:

> She listens to me. She definitely supports me, like I said. Even though I did try the breastfeeding but it didn't work out, she didn't make me feel bad like the stupid signs up on the doors showing what breast milk has in it as opposed to formula. She's really good about if I didn't want to do it, she wasn't going to talk about it, but if I did then she would be able to help me. [She was] really educational with giving me the information on the breastfeeding and the alternatives if I didn't and then showing me the pros and the cons of both sides. . . . [But she] never made me feel guilty or pushed me one way or the other.

Use of FAN Core Processes Pre- and Posttraining

In this section, we present evidence of the presence or absence of the five FAN core processes in the narratives of mothers in the pre- and posttraining cohorts. These intervention processes—Empathic Inquiry, Collaborative Exploration, Capacity Building, Integration, and Mindful Self-Regulation (MSR)—work with parents to address their urgent concerns and provide ways to engage with the family around these concerns. The FAN also offers a structure for the visit called the Arc of the Visit that allows the parent to lead the visit and facilitates discussions using the core processes. We were more likely to find indicators of some core processes (Empathic Inquiry, Collaborative Exploration, and Capacity Building) than others (MSR and Integration). This was partly because of the frequency with which Integration occurred (home visitors noted, for example, that they did not use this process as much) and partly because of the difficulty of inferring the use of MSR, which has to do with home visitors' ability to regulate their emotions, from mothers' narratives.

Empathic Inquiry

Empathic Inquiry is a process by which the home visitor recognizes, validates, and often explores the feelings of the parent to provide support for how the parents feels about her child and herself as a parent. It is often a FAN process that home visitors use in starting their visits. Overall, in both pre- and posttraining cohorts, mothers indicated that their home visitors listened to them attentively. For example, a mother in the pretraining cohort told us, "I really feel like she does listen pretty well. . . . I was just really stressed from all that stuff, and she listened to [my concerns]." A mother in the posttraining cohort made a similar point about the way her home visitor listened: "She doesn't pretend that she is listening. If I say something, she is listening, because I know with her answers, and the way she makes a gesticulation or something, so I know she is listening."

However, in the posttraining cohort, there seemed to be a difference in mothers' narratives about their home visitors' posture and practices strategies. Some narratives included aspects of the Empathic Inquiry core process that was largely absent in the narratives of the pretraining cohort. These mothers' narratives conveyed that home visitors listened to them not only attentively but also with acceptance and not interrupting. Home visitors also seemed more predisposed to allowing mothers to talk extensively without jumping in to give an answer, a solution, or advice. The following excerpts in the posttraining sample illustrate this point.

> I was talking to her about how I was struggling with my depression feelings and things like that. She listened and was very understanding about it. She didn't seem judgmental at all. . . . That's not something that I particularly like to talk about and I think that I felt comfortable talking to her about it

> and the way that she responded with listening and being supportive was a really great thing. . . . She never really brings her own opinion in there. She just listens to what we say.
>
> She just came over and she sat and listened to everything. I didn't even know she was listening as hard as she was until she brought me back every single answer to every single question I was asking. . . . She sat for like, I think our visit ran an hour and a half that day. Just sat there and listened to me. Watch me cry.

Mothers' narratives about their home visitors' reaction as mothers talked about their feelings also differed between the pre- and posttraining cohorts. Even though mothers' narratives in both cohorts indicated that their home visitors recognized their feelings, the act of validating and exploring mothers' feelings was more predominant in the narratives of mothers from the posttraining cohort. The following excerpt from the post-FAN cohort provided examples where we captured the presence of Empathic Inquiry intervention strategies used by these mothers' home visitors. In these examples, mothers talked about expressing their emotions, reflecting on them (at times), and feeling understood.

> She's pretty much the reason why I stayed in the program, because I think it would have been anyone else, I don't know if I would have continued, but she was just a good person. I really like her. . . she's great for being there to help me talk through it, and just to listen to how upset I was. Because that's what I wanted to do. Just to talk to somebody that wasn't in it that could just give me their opinion, and to tell me if what I'm saying is childish, or if how I feel is childish, and that things that I'm doing is all right, that it is the mature thing, and it's OK to feel childish.

In comparison, we found only a few examples of Empathic Inquiry in the pretraining cohort. The excerpt below is one of the few:

> Well every time she comes in is like, "How are you doing? Is there—how did it go? How was your days or your couple days ago, your weekend?" Then how do I feel. So we go through that. "How do you feel? How's the baby? How do you feel with the baby? Are you getting used to it or not?" So we do speak about my emotions with the setting and we'll discuss it. . . . Yes, I remember telling her the baby had the runny nose. So she suggested me to call the doctor. Then how did I feel, how did I handle it. So she was going more into detail. So, "How are you handling it or how do you feel handling the baby being sick or anything?"

We also found examples of where Empathic Inquiry was lacking in the posttraining narratives—that is, where home visitors were sympathetic but seemed to suppress, minimize, or normalize mothers' feelings. However, these examples were more prevalent in the pretraining sample whose narratives suggested that home visitors seemed to avoid exploring mothers' feelings, and typically resorted to reassuring mothers by suppressing their feelings, talking about their own feelings, talking them out of their feelings, or jumping in to fix or give an answer. The following excerpt illustrates this lack of Empathic Inquiry in the pretraining sample:

> The first time she came by the house I was feeling depressed. I mean I was so sad, I almost cried when she was here. That week my mother in law was my enemy because she was mad that I didn't want her in the room when I went to deliver the baby. I told [my home visitor] everything and she became my friend. She helped me a lot with this and gave me advice, told me not to worry, that my number one focus should be the baby and that if my mom in law is mad that is because of her own issues and that I should just leave it and focus and me and the baby.

We also noted that a handful of home visitors in the pretraining cohort tried to talk mothers out of their feelings by warning them about the effect of their feelings on their babies. For example, a mother in the pretraining sample noted that her home visitor "reminded me that I mean I have to keep strong for him [baby] and told me how good I was doing, how happy he looked compared to how he was in the hospital." Another mother reported learning from her home visitor that "You have to control yourself first, your moods and everything, so that you can transmit calmness and tranquility to your child. Because if you are stressed out, and you feel that you cannot, then [the baby] is also going to feel what you feel."

Finally, mothers' narratives related to their mental and emotional health were more prevalent in the posttraining cohort. This is consistent with findings from the home visitor focus group analysis from both Wave 1 and Wave 2. Several home visitors across program sites reported that there was an increase in mental health needs. For example, a mother in the posttraining cohort recalled confiding her history of abuse to her home visitor who, in addition to listening with acceptance, was able to refer the mother to a mental health clinic:

> We talked about my emotional health. . . . When I talked to her about the whole sexual abuse and everything, she [home visitor] gave me a minute to get it out and clear my head because I started getting all emotional and stuff. . . . She gives me space to talk about, yeah talk a lot. Yeah, because I'm a talker at times. Well, when I'm comfortable, I'm a talker. Other places I just observe [i.e., don't talk], but overall she does give me that space to bring up any other concerns that I have and everything.

Collaborative Exploration

Collaborative Exploration refers to the way home visitors work collaboratively with a parent to explore a concern about their baby or another matter. The purpose of the process is gain an understanding of the parent's view of the problem or situation and, in turn, develop a shared understanding of the baby or concern. Overall, in the pretraining cohort, home visiting seemed to be driven primarily by the program curriculum and agenda as opposed to being parent-led, which did not always allow for mothers to share and explore their concerns.

For example, a mother recalled that during a home visit her home visitor explained to her how to soothe a fussy baby even though she believed that this was not a source of concern because her baby was rarely

fussy. “She told me when [baby] is fussy for no reason to try to swaddle her and just give her ‘shh’ in her ear, but my baby never does that. She’s not fussy—she’s a good baby.” Other narratives of mothers in the pretraining sample, such as the one below, gave a similar perspective.

> She [home visitor] first goes over what she has to say, and then after that, she’ll ask me if I have any questions or questions about some other subject, and then we’ll start talking about that. . . . One of her [home visitor] goals was to try to get him off the bottle by a year and put him on a sippy cup, and I didn’t feel really comfortable with that.

This home visit format, in which information seemed predetermined, also was reflected in mothers’ narratives indicating that their home visitor “brought something new” every home visit. This new information at each visit seemed to follow the home visitor’s (or the curriculum’s) agenda, which sometimes, but by no means always, repeated information the mother had obtained through another source such as a group at school. As one mother commented, “Every week it’s different—different topic, different conversation. It’s not the same. It’s always changing, yeah.” Another mother reported, “A lot of stuff that she told me I kind of know, but she always teaches me something new every time she comes, but the only reason I know is because I have a group at school where we talk about stuff like this.” Another comment from a member of the pretraining sample makes a similar point:

> I’m like, okay, I know she going to have something new for me to talk about or some information for me. And each time, like I said, she does have new, more information. Each time she comes, she has some type of information to give me and it would be helpful so I know each time I be learning something.

This view seemed to be consistent with mothers’ perception of their home visitors. Many mothers believed that the role of the home visitor was to provide them with information about child development, milestones, infant care, and activities to promote child development. One mother described the role of her home visitor: “This is what you should do, her job really is her job to let me know what [the baby] should be doing.” Several mothers in the pretraining sample reported that their home visitors gave them advice almost every visit: “Like she always telling me to lay him on his stomach. That helps him learn how to crawl and whatever else. Like he’d be teething and such. She’ll be trying to tell me what to do, like most of the time when she visits.”

Perhaps because these mothers equated advice on parenting to information provided around child development and infant care, they believed that their home visitors gave them suggestions of what they “should or not should be doing” according to their child developmental stages rather than “telling them what to do.” However, many mothers—including those who believed that their home visitors did not “tell them what to do”—when describing their interactions with their home visitors expressed themselves in

ways that portrayed their home visitors as "telling me what to do," either explicitly or implicitly. For example, one mother repeatedly told the interviewer that her home visitor "did not tell her what to do". But when this mother further explained her interactions with her home visitor, she described how her home visitor communicated with her by saying: "she [home visitor] want me to do this." Other examples are in the following excerpts from the pretraining sample:

> We talked about her feeding and how I'm putting cereal in her milk. She [home visitor] always puts me on the spot, like, "You're not supposed to do that."
>
> When it's time to put him to sleep she [home visitor] told me to do a routine and . . . she tell me to take him to bed, read him a book, give him a bath, and put him to bed
>
> She [home visitor] wants me to get the baby and read to him in front of her so that she sees. And, she tells me how to hold the book up to the baby so they can be able to see the pictures.
>
> And I was trying to decide if I should go back [to school] in the fall or should I just wait another year. And she [home visitor] is like, "Well, I really think you should go right now. I think you can do it. You're strong. You've handled a job and all this stuff."

As these examples illustrate, although mothers in the pretraining cohort were welcome to request information or ask questions of their home visitors about any topic or concerns, home visitors typically responded without exploring mothers' view of the situation and what they have tried to address their concerns or problems. One mother recalled that upon sharing with her home visitor her concerns dealing with visiting family, her home visitor jumped in to give her "helpful" advice on how she should deal with the her family.

> I have a lot of distance with my family members and I was nervous of them coming down a few months ago and meeting my son for the first time. . . . [My mother] just tries to find the smallest thing [wrong] and to make a big thing out of the smallest things. And I was telling [home visitor] how I felt like that and she was just like, "You know what? You just breathe and you let your mother know that this is your home, not her home, this is your home and that this is what you made a home. And then this is your son and that with your life before had nothing to do with how you live your life today."

Another mother provided a similar example, which looks empowering on the surface but actually seems to be a missed opportunity for the home visitor to explore the mother's view of the problem.

> Sometimes you get desperate and you do not know what to do when a baby cries and cries. And, there, the first thing they say to you is you calm down yourself. To calm down the mother and then try to calm down the baby. Because sometimes I think that mothers try to, um, harm the baby. Because, for example, it cries and cries and they don't know what to do, and they get desperate, and bad things happen. And, like, for example, in the beginning when he was born, he like made a lot of effort like this [gestures]. I thought he was sick. And, I told her when she came, I said to her (my baby

> does like this) and, *she* looked for information to see what he had. And, she told me, "No, it is nothing bad. Don't worry. But, if you want to feel really calm, take him to the doctor."

Again, in cases in which home visitors asked questions to understand the problem, their purpose was not to gain mothers' view of the situation or concern but rather to understand the problem so they could offer a solution to "fix" the problem.

Narratives of mothers in the posttraining cohort shared similarities and differences with those of mothers in the pretraining cohort. Like the pretraining cohort, many mothers in the posttraining cohort reported receiving advice on parenting and information on child development and infant care. There were also some examples, like the one below, of what seemed to be a lack of Collaborative Exploration.

> We say, something like if it's not working, she comes up with an alternative; maybe you can try this or maybe she is reacting like this because of this. I don't think she's ever come out like, you're not doing it right or that's not the way. She always tries to give us ways to improve on our techniques. She gives us suggestions that she knows that improves on what we're doing.[39]

However, overall, the narratives of mothers in the posttraining sample differed in the context for and way in which this information was conveyed. These mothers frequently stressed that their home visitors were not giving them advice or providing information based on the program agenda. Instead, they were usually providing information in response to mothers' requests. Because mothers in the posttraining sample more often experienced visits that were structured around their concerns, questions, and needs, they were asked more frequently about their questions and the topics they wanted to cover or discuss. The following is how one mother described her experience :

> She always ask me at the end of the lesson or visit, she's like, "Is there any subject you want to focus about for next week? Something that you are interested in?" Either way she comes prepared. I always tell her. . . I think there's only been two occasions no, four, that I've said, "Oh, let's talk about this." Like for example I wanted to talk about. . . I don't remember, but I gave her four subjects I wanted to talk about, and we did cover them when she came for her following visit.

In multiple interviews with the posttraining sample, we heard statements similar to the following: "It's nice that I can choose whether we want to actually talk about the topic or not." "She really only gives me advice when I ask. They are really big on 'You're the mom. You can do things how you want.'" Another mother told us, "We always plan the week ahead what we're going to do. She has a checklist and we

[39] We did not attempt to systematically match mothers to programs in this phase of our analysis. However, we did notice that some excerpts showing a lack of Collaborative Exploration in the posttraining sample were from participants in programs in which home visitors in focus groups reported challenges with training and trainers and experienced other external factors. This may have inhibited the implementation of the FAN approach.

check what we want to do for the next time that she comes. And [she asks what I want to talk about] pretty much every single time she comes."

Some of the mothers were unable to fully describe their home visitors' approach, as if it was a new experience. In these cases, mothers resorted to saying "I don't know how to explain it."One mother said, "[Home visitor] doesn't tell me how to do it, it's more like. . . I don't know how to explain that. She'll suggest."

Mothers' narratives in the posttraining cohort also were distinct from those of the pretraining cohort because they included signs of home visitors and mothers *thinking together* about a problem or concern. In the words of one mother, they would be "talking about the pros and cons and kind of brainstorming what outcome would be worth pursuing." Along with not jumping in and giving advice, home visitors were trying to understand mothers' theory of the problem. One mother in the posttraining sample said:

> I didn't feel like my daughter's father was carrying at least half of the weight and it was becoming really frustrating. [Home visitor] was just giving me a bit of advice in terms of telling me to evaluate the situation where it is because I've tried numerous ways of presenting some things to him and eventually I just became annoyed. She was explaining though that I need to take a moment for myself and evaluate the pros and cons of the situation and what I want to move forward with. I really appreciated that.

Additionally, there was some evidence in the posttraining narratives of efforts to not only understand parents' theory of a problem but also helping them find their own solution, for example, by asking questions to get a common understanding of the situation, such has "what have you tried?" We found only a few examples that explicitly captured this aspect of Collaborative Exploration, which seemed to be absent in the pretraining cohort. It is not clear whether this is because it occurred infrequently or because of the difficulty of inferring its presence in the mothers' narratives. The following passages from two mothers in the posttraining sample highlight how some home visitors tried to understand mothers' view of a problem, concern, or situation and help them find their own way:

> She [home visitor] usually tries to get me to answer my own question. I really like that. She'll ask me questions, [and] I'm like, "I know where you going with this." She's like. . . "You know you just answered yourself?" "Right." If I have a concern about something, she'll get me to say something. She'll keep asking questions, and eventually I'll address my own concerns. I'll say, "What, how did you do that?" She's really good at that. . . . Then when I have concerns that I can't just get on the phone and call somebody, I can think in my mind, "Okay, let's walk through this. Let's do what we do at our visits." It's nice to have that idea in the back of my head that, I can get through this on my own. . . . She doesn't judge. She ask you immediately, "Why you do that?" There might be something she doesn't know. Maybe you can explain to her. She doesn't just automatically give me stuff I

should do differently, or stuff I should do that I don't agree with. . . . She asks me a lot of questions. . . . Eventually, I'll come around and [be] like, "Oh wait. I figured it out." It's funny. She definitely ask more questions than giving advice. That's kind of fun, actually. Because it makes me realize that I can answer my own questions. I can figure things out if I really want to on my own.

[The home visitor] asked what I wanted to do. I told her that I felt like I needed to help him [partner] a little. Then she asked me why didn't he want me to help him. I told her because he wanted me to go back to school. Then, she asked me how did I feel about, if it was something I wanted to do, or if it was something he just wanted me to do. Then I told her I've been talking to him that I've been wanting to go back to school, but with the baby and I don't want to leave her with just anybody. Just the concern trying to see who could take care of her while I was in school. Then she asked if we had a plan for childcare, and I was like, "Well, he worked second shift, so he wants me to take morning classes so that he could take care of the baby while I was in class

Capacity Building

Capacity Building is the process by which the home visitor works with the mother to increase her knowledge and capacity to help her child. The goal is to strengthen the mother's confidence, skills, and knowledge and highlight positive parenting moments, while working through concerns or problems related to the baby. It often occurs following or in conjunction with Empathic Inquiry. Capacity Building in the pre-FAN cohort was limited to providing information addressing parents' concern and praising, supporting, and encouraging mothers. Home visitors provided valued information to address a concern or problem voiced by parents to increase their knowledge on child development, infant care, and parenting. However, as discussed in the previous section, parents' narratives offered little indication that home visitors delved into parents' own capacity to explore what they already tried or knew before providing information addressing their concerns or problems. More often than not, capacity building resembled giving advice rather than taking a reflective approach. The following passages from pretraining mothers illustrate this point.

I was telling [home visitor] about how [pediatrician] keeps not liking the fact that he's not up to weight as the chart that she uses. She was really understanding with that and explaining to me that breastfed babies just grow slower and as long as they're meeting their milestones and gaining [weight] and not losing, things like that, that they're okay. So she was definitely really understanding with that and that was helpful so I could take that information and like relay it back to his pediatrician. I think it helped the pediatrician understand, too. So that helped a lot definitely.

A few weeks ago, [baby] was just getting into everything, starting to move around, and I was like, "No, you can't go near the plug." And, she said, "The best thing to do is don't reward them for the good that they do, reward them when they obey on the bad, because later on, if they ever got punished, they'll know that it was better to listen to their parent than it is to do something good and always be praised on it, because then they'll expect it." But, if you praise him and say, "Hey, that was

> a good job that you just did listening to mommy," then they'll understand you and you'll have a better relationship with your child than always giving them what they want.
>
> It's just the times when I ask her, like, "What should I do?" and she's like, "Oh," and she'll say something then. Like if my baby's not on progress and like—'cause right now he still like doesn't want to crawl or like be on tummy time a lot; he still cries about that. She's like, "Oh, you can try this. You can try putting him somewhere or something, giving him toys or something." But yeah, she gives me good advice.

In the pretraining cohort, Capacity Building was also observed in the support and encouragement the home visitors provided to parents about their parenting. Almost all of the mothers indicated that their home visitors usually praised them for their parenting, highlighted what they did or have been doing as a parent, and/or accentuated their positive parenting. The following excepts reflect this perspective.

> I can tell [home visitor] is supportive of my decisions and situations that I'm going through, and why it's important. . . she's kind of helped me notice about myself, like how far I've come, just even with the way I interact with people, but also even with [baby]. He's helped me grow into a better person, because I used to do some pretty bad stuff, and so, she'll talk to me about it and I really do like that.
>
> Just like that it's okay to take a break; [home visitor] makes me feel not bad about stepping out of the room for a minute and, you know—'cause some people would be like, "Oh you shouldn't leave your baby alone ever," but then she was really about like, "Oh, no it's okay; sometimes you need a break, and that's normal and healthy," and all that stuff. So she was really supportive of me staying sane. . . . "Oh, I think you're a really good mommy; you're doing so well, and you're handling this situation really well." She was always really uplifting, kind of; she always tried to make me feel good about the job I was doing as a mom. Because it is hard, you know, and I have a lot of self-doubt sometimes about how I'm raising her and the job that I'm doing; you know, 'cause she cries so much; it's kind of hard not to blame yourself. But she always made me feel like it wasn't my fault and I was doing everything I could, and I was doing a pretty good job as a mom.

Behaviors that are inconsistent with the concept of Capacity Building were similarly observed in the pretraining cohort. Mothers described home visits in which home visitors "took over for them" or "did for them," seemingly unaware of how their attitudes and actions undermined parents' capacity building. Indeed, some mothers' narratives suggested that their home visitors were the main agent leading the activities and interactions taking place during home visits.[40] One pretraining cohort mother said:

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[40] We try to distinguish these examples from examples in which mothers report the administration of the ASQ developmental screening, which is a requirement of the HFA program. For example, a mother related "She [home visitor] puts [the baby] on the floor and she tells me to do it or she does it. She does it like an exam, you could say, an evaluation. And, she says, 'Oh [baby] is doing what she should be doing.'"

> [Home visitor] gives [my husband and me] an example of something to do, we try it, and if it works, we continue doing it. And she'll bring out papers with different games on it and different nursery songs we sing to her, and stuff to do with her, and we'll do it with her, and then when she comes the next time, [home visitor] does it with her

Other mothers' narratives portrayed their home visitors taking over the role of caring and parenting for their child and, unintentionally, robbing parents of the experience of sharing with their child a positive and emotional bond or implying that parents lack the capacity to take the lead. For example, three pretraining mothers said:

> Also like what developmental kind of stuff and physical stuff he's going to go through, and then he woke up and then [home visitor] started playing with him…she started playing with him and once again, she tried to get him to crawl. She's trying to see him crawl because he's stubborn.

> Mostly what I was telling you about was the last visit 'cause I was very surprised that my son was mimicking everything she [home visitor] was doing. He was imitating, in other words, when she would take the blocks and put them into a bowl. He was doing the same thing. And that was the first time I ever saw him do that so I was very surprised how well she was teaching him how to do a little more than what he's been doing. Otherwise basically everything is his and he don't want you to play with his stuff. And when she's here he shares with her, so that's pretty much what they do. Kind of hang out. It's mostly play time really for him. He doesn't know he's learning. He thinks it is play time, but he's really learning.

> [Home visitor] always only plays with him for a while, and tends to always put him to sleep, and then she gets me some handouts, and talks about whatever the handout's on, like a project to work on, or what the month that he's coming into—since six months is I guess kind of more milestone—kind of says what he should start to be doing. No matter what time our visit is, it seems like she always—they'll start playing, and he'll start getting fussy, so she [home visitor] will walk him, and he'll fall asleep. . . . He's worked on those leg muscles and standing, and every time she came over, she would lay him on the ground and help him work to roll over, reassure me just 'cause he's not rolling over yet doesn't mean he's behind or anything like that.

Thus far in our analysis of the mother interviews, there have been just two mothers who described instances in which home visitors explicitly took over for a parent without her permission or approval in a way that concerned the mother. In the excerpt below, a pretraining mother relates two times, apparently rare, when this happened. In both instances, the mother did not feel comfortable expressing her concern:

> The only, only, only ever time where I was like "ooh" [expressing concern] was when—I think it was her first or second or third visit with us—he was a newborn, and she [home visitor] put him on the hardwood floor. . . . She was teaching us how to swaddle him, and she laid his head on the hardwood floor, and I was just like, "Oh, my god, my baby.". . . And then one time, [home visitor] stuck a Cheerio in his mouth, and I didn't really want him to start Cheerios yet. And he started choking on it,

> and I got scared, and I was a little upset, but I mean I kind of just let it go. She hasn't done anything recently.

This example also reflects a more general theme in our interviews with mothers, which is the belief that their home visitors are expert in child development and therefore should take the lead in pointing out to parents their child's developmental milestones.

Even though the information from home visitors can reassure parents that their child is developing normally, the belief that it can only come from the home visitor may contribute to undermining parents' capacity and confidence. For example, when one mother confessed that she rather have her home visitor making the decisions about home visit topics—"I prefer for her to tell, for her to tell me and then, well, I understand"—and when another two claimed that their home visitors was usually "right," it also revealed that home visitors may have unintentionally reinforced the notion that these mothers lack the ability to think for themselves.

Mothers' narratives in the posttraining cohort also indicated that home visitors were eager to provide information addressing parents' questions, concerns, and problems. However, we observed a difference in many of the narratives in the posttraining cohort. These narratives not only described home visitors addressing their questions and concerns but also reflected postures tied to the FAN approach. Home visitors seemed to build capacity by gently coaching parents, encouraging parents to make decisions on their own (i.e., "helping parents find their own way"), tapping into parents' capacity and ability (i.e., "you have the ability to figure out what you or your child need"), encouraging parents to observe their child development achievements and milestones, and taking opportunity of capacity building moments. One example appears in the previous section on Empathic Inquiry in which a mother reports on the ways her home visitor tries to get her to answer her own questions. The following examples from the posttraining sample also reflect these strategies.

> [Home visitor] never really gave me no opinions on how to take care of my baby because she basically like. . . she basically was asking me how would I react as a parent and I would tell her and she would give me these little flashcards and ask me what was more important to me and stuff like that so she would ask me that, your priorities are set straight, they are good priorities, you want more for your baby than yourself. . . I could say when I was going through this little thing. . . I would just basically ask her is there something that she thinks I should think I should look into, or if she thinks I should just leave it alone. Basically, she just supported me and then she's just like, "Whatever you decide to do, just go ahead and do it."

> [Home visitor] is very understanding and she just tries to give me some different ideas that I can [choose]. . . . Sometimes I would put him on his side, I don't know, I guess it's just something that my mom would always tell me that the baby should tilt them to the side a little bit because you don't

> want them to, if they spit out or whatever, that way it doesn't stay in their throat. I asked her about it and she said it was basically that some people say one thing, some people say another thing, but it all depends on what you feel more comfortable doing with your child. She [home visitor] let me know that whatever I feel comfortable with and whatever the baby feels comfortable with too. . . . Making me feel comfortable and knowing that really the decision is up to me and what I want to do, or how I want to go about things with my son.
>
> She [home visitor] gives you an option, choice, and that's what I like, especially because I don't like the whole pushiness. You're going to do it my way or no way. She's just really great. . . . She [home visitor] never asked, but I seen her looking at [baby], because I never really thought to ask or whatever if she wanted to, and I seen her looking at [baby] really cute like, so it was like, "You want to hold her?" And she was like, "Yeah." Because she could have asked me at any time, but I don't think she felt that that was right or something, and just be like, "Hey, can I hold her?" But of course she should have known, yeah, you can hold her.
>
> There was times where I have questions about the diapers. . . like when do I transition them to the next number. When she got rashes I didn't know, because my doctor wasn't answering, and both his parents were working; both my parents were working, I didn't know who to go to so I was able to message her and ask her, I was like, "She has rashes, am I supposed to take her to the emergency?" And then she was like, "You know your baby more than me and anyone," she said, "You think that they're severe or she's not herself, then take her."

Overall, mothers in both the pretraining and posttraining cohorts seemed to be the recipients of home visitors' support and encouragement; both groups typically reported receiving praise highlighting what they are doing right and stressing the positive aspects of their parenting. However, we captured a slight variation in the narratives of about four mothers from the posttraining cohort in terms of how they described their home visitor's support. These mothers' narratives suggested that home visitors complimented and supported them in the context of their *own accounts and realization* of their parenting accomplishments and initiatives, as oppose to home visitors complimenting them on what they noticed them doing. The passages below seem to describe this behavior:

> She's [home visitor] very good at it. She notices when I'm actually making strides to take action on certain things, like that example I just gave here and everything, because originally, when they used to come over, I would always be holding her. She would always be in my arms, and gradually I got to the space where I was able to just put her down and she'll be fine and everything, and also let her father step in and take her. She commended me on that piece.
>
> I actually taught her [home visitor] a thing. I went to the doctor and I told them my daughter was eating cereal and they were appalled and they were able to explain to me why they don't give babies food before they're six months and I was able to share that with [home visitor]. Now she can share it

> with the young women at the program around food. That was good. We both found out something new.

Furthermore, in contrast to mothers in the pretraining cohort, some mothers in the posttraining cohort expressed feeling more "confident" because of the support and encouragement from their home visitors. The following examples speak to this perspective:

> Anytime I tell her [home visitor] he's advanced or a new skill that he's gotten, she tells me, "Good job." She tells me I'm doing a great job every visit. She tells me I'm doing a great job as a mom, so she's pretty encouraging. She [home visitor] tells me that I'm doing really well with talking with him. It's when she sees something if I tell her something about how I'm grabbing his hands and stuff like that she'll just give me a little confidence boost and tell me good job.

> I've learned to just be more confident in mothering stuff, as well as the small things, like baby massaging. . . . Because I'm always very critical of myself, and right now I tend to receive a lot of criticism or a lot of advice on my family's end, and what to do and how to take care of my son. Having her [home visitor] here to just reassure me that I'm doing a good job, even with my own decisions, is very comforting.

Finally, another distinction, albeit subtle, between the pretraining and posttraining cohorts was the manner adopted by the home visitors in the posttraining cohort when offering parents support and encouragement. A group of mothers in the posttraining cohort, when talking about the ways in which their home visitors support their parenting, expressed themselves very thoughtfully with expressions that seemed to align with the FAN principles. These mothers' narratives conveyed that their home visitors sought to strengthen their confidence (i.e., "you understand your baby/child," "you are able to help your child/baby") and to nourish the emotional bond they shared with their child when lending their support. For example, a mother related that her home visitor said "just how good I am at knowing [the baby's] cues, when he's tired, when he's hungry, when he's sleepy. I can just look at him and know exactly what he needs at that very moment." The following passages from posttraining samples also reflect these characteristics of the home visitors' manner:

> He [baby] was sitting up and trying to pull himself up on something. After it happened I comforted the baby and she was like, "I love that you always give him his space to become independent and to do what he wants to do." Then right afterwards something happened, I think he looked at me and he smiled or something. She said, "You can tell the bond between you guys is really well, and you're doing such a great job." That just kind of reminds me of that I'm doing a great job when my son can look at me and smile.

> When I was feeding [baby] cereal, at first I was nervous or scared. I know about, how do I do this? How I do that? Am I giving her too much? Am I giving her too little? How do I know if she ate too

> little or too much? When I was feeding her, [home visitor] was just, "Oh wow, look at you. Look at Mommy, she knows what she's doing now."

Integration

The Integration core process seeks to build a parent's capacity to reflect on what she learned from a visit or on how she sees her child or to create a coherent story about a stressful experience in her life. We rarely found examples of Integration in either of the pretraining or posttraining interviews with mothers, which is consistent with the information we collected from staff focus groups and interviews.[41] First, Integration does not occur in every visit. Second, it was challenging to elicit information from parents on how their home visitors prompted and helped them reflect on the visit, on themselves, and on their child. Parents usually talked about what they learned with their home visitors and home visiting program. We suspect that Integration might be captured in mothers' narratives about how they have changed or what they have discovered in themselves or their child as a result of their participating in the home visiting program. This component of the analysis is still in progress and therefore the findings reported here are brief and still preliminary.

One indicator of Integration was mothers' reports that their home visitors asked them to describe their child "in three words" at the end of the visit, although only a handful of mothers mentioned this feature in the interviews analyzed to date. One example is the following:

> She [home visitor] asked me to describe her [child] in three words. I described her as she's inquiring, she's stubborn and she's a very happy baby. We checked in about doctor visits and her shots. We checked in about stages she is in terms of eating [certain] foods and she was just reminding me to pay attention to the labels on the foods that'll tell me what stage the food is for. That was helpful.

We also captured glimpses of Integration when mothers reflected on what they had learned about themselves or their child as a result of their home visitors' visits. On example is the excerpt presented in the section on Capacity Building in which a mother described a visit when a mother picked up her crying baby and although he stopped crying, the mother was pessimistic about her ability to soothe him the next time he cried. However, she reported that her home visitor kept saying she did what was good for him at that moment. Other examples that seem to reflect the process of Integration are the following:

> I would like to raise her a little bit differently, learning her ABCs and stuff, or reading very well, better than I can. That's part of my learning disability, I couldn't count past 10. Certain things like that, I would like to teach her a little bit more. Teach her numbers past 10, or let her sing the ABCs or something, let her read better than I can. . . I have seen different ways of me taking care of my child. I

[41] The FAN trainers also told us that Integration process is harder for families to do and may not occur in every visit.

> have seen her grow so much. I've seen myself, too. I feel confident that okay, I know that [home visitor]'s coming next week. I'm going to tell her about this.
>
> Sometimes. I think sometimes. . . I think she [home visitor] really helps me realize. . . Like I said in the beginning, she helps me answer my own concerns. I think a lot of times, it's like "Oh wait, I get it now." We were talking about, in the future I can't always protect [my daughter]. We talk a lot about how to deal with things in future. When she does go to daycare. I can't be there to watch her every two seconds. It's just little things that worry me. She helped realize that those are going to help the baby in the long run.

Mindful Self-Regulation

Mindful Self-Regulation (MSR) is the process by which the home visitor monitors, regulates, and understands her own reactions in an interaction with a parent and is able to maintain a calm engaged presence—or regain balance in the moment if she becomes dysregulated. As discussed previously, home visitors frequently talked about the usefulness of the MSR process and provided numerous examples of how they applied it in their work with families. As noted earlier, some home visitors talked about "sitting on their hands" to help them attend to what mothers were saying and refrain from jumping in to give advice. However, we rarely saw direct examples of MSR in the posttraining cohort. Mothers rarely talked about the emotional reactions of their home visitors.

One example from an interview with a mother in the posttraining cohort that suggests the home visitor was regulating her feelings is the following: "She's very calm. She doesn't get up in arms like if I was talking to one of my friends or even my mom about it or something. It causes more heightened emotion but she's like a person of reason and she's a third party who isn't emotionally invested in it." Another mother in the posttraining cohort shared her view that the home visitor was trying to keep her calm: "Last week was [really hard] because I had to move out so I talked to her about my baby because I was really worried because I had to move out of a place that I lived in. She was just trying to keep me calm and not to panic about the situation and [give me] tips for my baby."

Two factors may have contributed to this apparent lack of MSR in mothers' narratives. First, the challenge of perceiving home visitors' affect when mothers are dysregulated. Second, the challenge interviewers experienced eliciting this kind of information from mothers. As we continue to analyze mothers' interviews, particularly with regard to their perception of and relationships with their home visitor, we may learn more about how they experience their home visitor's affect.

To summarize, we observed differences in the narratives of mothers in the pretraining and posttraining cohorts in the format and dynamics of home visits and in the use of the FAN approach and core processes. Our findings to date are briefly outlined in Table B-1 in the Appendix.

Relationships with Home Visitor before and after Training

As suggested in the previous section, most of the study mothers seemed to have a good relationship with their home visitors. In both pre- and post-FAN training cohorts, mothers overall believed they had a close, personal relationship with their home visitors and, typically, described their home visitor as caring, helpful, compassionate, friendly, and trustworthy. Mothers also perceived their home visitor as being knowledgeable about child development and infant care and resourceful in helping getting parents linked to community resources and social services (e.g. housing, food, health care, and child care). These mothers also felt that their home visitors genuinely cared about them and that they could relate to them.

Additionally, the relationship between mothers and their home visitors seemed stable over the 4 months between the Time 1 and Time 2 interviews. Mothers reported that it took different lengths of time to get comfortable with their home visitor. Some seemed to establish rapport almost from the beginning of the relationship, while others took a little longer to evolve. Those who reported not having an immediate rapport with their home visitor, however, mentioned getting comfortable over time as they get to know their home visitors. Table B-2 in the Appendix provides examples of the main themes that emerged from the analysis of the interviews with mothers, which show the similarities between the views of the pre- and posttraining samples.

The Working Alliance Inventory

These findings from the qualitative interviews with mothers were consistent with the results of a standardized measure of the relationship between mothers and their home visitors, the Working Alliance Inventory (WAI). With this measure, we were interested in mothers' overall ratings of their relationships with home visitors as well as the extent to which there was alignment between their ratings and those of their home visitors in three subscales—Task, Bond, and Goal. As reported in Table 15, mothers' ratings of their relationships with their home visitors were very positive at the Time 1 interview. They were similarly positive at the Time 2 interview.

No differences between pretraining and posttraining sample scores on the WAI were found. We also found no differences between the intervention and comparison groups on the number of subscales in agreement in pretraining or posttraining at either Time 1 or Time 2. In the pretraining sample, the WAI total score was not significantly different between intervention and comparison groups. In posttraining, the WAI total score was higher in the intervention group (M = 78.2, *SD = 6.82*) than in the comparison group (M = 72.4, SD = 14.2, $t(71) = 2.11$, $p = 0.038$). However, this difference between the intervention and comparison groups was due to the lower posttraining WAI scores in the comparison group (see Table 15)—the intervention group scores remained constant from pretraining to posttraining. The WAI Bond

subscale—which assesses participant confidence in the home visitor's ability to do the job, mutual appreciation, and trust—was also higher in the intervention group (M = 26.9, *SD = 1.94*) than in the comparison group (M = 25.1, *SD = 5.54*,, $t(71) = 2.00$, $p = 0.050$) following the training, but again this was due to the decrease in comparison group WAI Bond scores posttraining. These differences were not found in the pretraining sample.[42]

In terms of the alignment between mothers and their home visitors, the differences between a mother's and a home visitor's subscale scores were calculated, and if the absolute value of the difference between their scores was 4 points or fewer, they were considered to be in agreement. Overall, approximately two-third of mother-home visitor pairs agreed within 4 points at Time 1 (see Table 15). In the posttraining sample, the difference between the mother rating and the home visitor rating of their bond at Time 1 (WAI Bond subscale) was smaller in the intervention group (M = 3.13, *SD = 2.34*) than in the comparison group (M = 5.72, *SD= 4.66;* $t(63) = 2.64$, $p = 0.011$). In other words, mothers and their home visitors in the intervention group were more aligned in their perspectives of their bond with one another than mothers and their home visitors in the comparison group.

Participant mothers were asked about their infants' behavior and the frequency with which crying, sleeping, feeding had been a problem. Maternal perception of infant behavior and regulatory problems and to whom they reached out to discuss these problems were analyzed by group. Of the participant mothers who spoke with anyone about their infants' crying, sleeping, or feeding, the majority discussed it with their home visitors (see Table 14). In the intervention group, the posttraining sample of mothers were more likely to discuss infant sleep problems with their home visitor than the pretraining sample of mothers ($\chi^2 = 6.27$, $p = 0.012$).

Another indication that the parent-home visitor relationship may have been stronger in the posttraining intervention sample compared to the comparison sample is the difference in the program retention rates. By 9 months postpartum, the proportion of participants in the posttraining intervention group who remained active in the home visiting program was greater than the proportion of participants in the posttraining comparison group who were still active in the program (see Table 13; $\chi^2 = 3.75$, $p = 0.026$). This difference was a result of a decline in participant retention in the comparison program posttraining.

[42] WAI Task scores were higher in the intervention group (M = 26.1, SD = 2.47) than comparison (M = 24.3, SD = 3.90, $t(105) = 2.25$, $p = 0.027$) in pretraining,. The same pattern was found posttraining as well, yet the difference did not reach significance because of the small sample size, $p = 0.078$. This finding indicates that participants at the intervention sites generally tended to feel that they and their home visitor establish priorities together and agree on the tasks needed to reach their goals, more so than the comparison participants. Because this was true prior to the training, this difference is not related to the training.

Although this finding appears promising, we believe it should be followed up with further study with a larger sample to better understand the meaning of this difference.

Changes in Maternal Functioning

> Well I guess I could say that they're, maybe they're more open with me. Dealing with families, talking about emotion and things like that is something that, you just don't do it. They're not taught to do that. Vulnerability's just, is not a characteristic that you're supposed to have but I think, I think maybe with the FAN approach they've learned, or they're now able to talk about it more openly. — Home visitor, 18-month focus group

Again, all 10 programs identified eligible families and assisted with recruitment of two samples of participant families at each site: one pretraining sample and one posttraining sample. Each participant mother was interviewed twice, referred to as Time 1 and Time 2 interviews. (Some participants were lost to attrition by Time 2 but those families were excluded from this analysis.) Repeated measures analysis of variance was conducted for each maternal functioning variable, with pre-post groups and intervention-comparison groups as the between-subjects factors and the change in maternal functioning scores from Time 1 to Time 2 as the dependent variable.

Parenting Stress

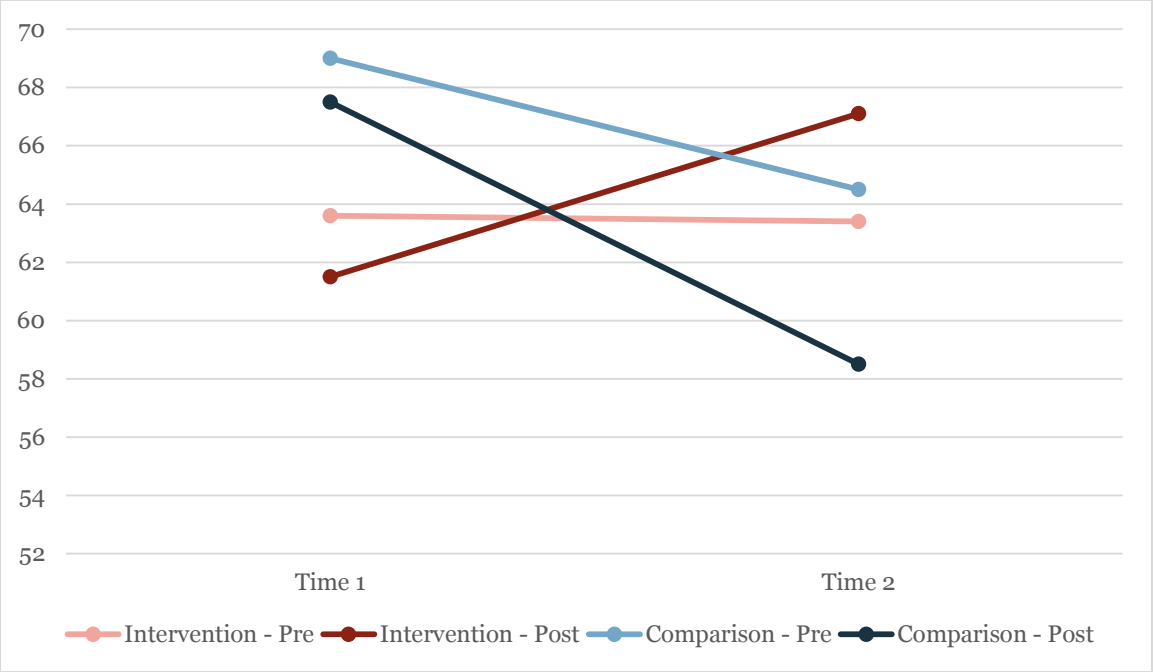
Prior to conducting repeated measures analysis of variance on parenting stress, correlational analyses were performed on Parenting Stress Index Short Form (PSI-SF) Total Score and subscale scores and all continuous demographic variables. Maternal education was correlated with both PSI-SF Total Score (r = -0.21, p = 0.021) and Parental Distress subscale scores (r = -0.22, p = 0.008). No other demographic variables were associated with parenting stress.

The change in PSI-SF Total Score from Time 1 to Time 2 was analyzed in a repeated measures analysis of variance, with pre-post groups and intervention-comparison groups as the between-subjects factors and maternal education added as a covariate. We hypothesized that parenting stress would decrease over time in the intervention posttraining group at a greater slope than in the comparison pre- and posttraining groups and the intervention pretraining group. The repeated measures ANOVA revealed that the slope did not differ in the pre- and posttraining samples between groups,[43] but the Time 1 to Time 2 change in PSI-SF Total Score was significantly different between the intervention group and the comparison group overall (see Figure 3). In the comparison group, parenting stress decreased from Time 1 to Time 2 both pretraining and posttraining. In the intervention group, however, parenting stress did not change from

[43] $F(1, 142) = 2.79$, $p = 0.097$, partial $\eta^2 = .019$. For partial eta squared, an effect size of $\eta^2 = 0.01$ is considered small, $\eta^2 = 0.06$ is considered medium, and $\eta^2 = 0.14$ is considered large (Cohen, 1969).

Time 1 to Time 2 in the pretraining sample, while increasing from Time 1 to Time 2 in the posttraining sample.

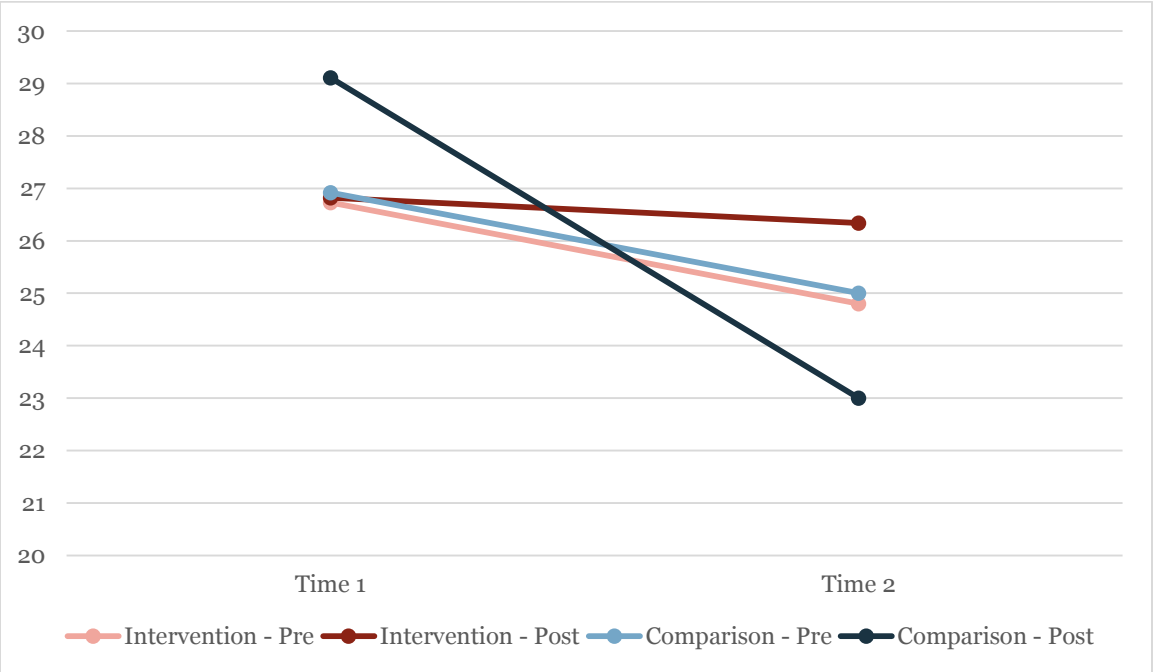
Figure 3. PSI-SF Total Score



$F(1, 142) = 9.57$, $p = 0.002$, partial $\eta^2 = .063$

To better understand this increase in parenting stress in the posttraining intervention group, we explored the PSI-SF subscales. Change in Parental Distress was not different between pre- and posttraining samples, ($F(1, 142) = 2.66$, $p = 0.11$, partial $\eta^2 = .018$), but the change in Parental Distress over time was different in the intervention group as compared to the comparison group (see Figure 4). Pretraining, all samples looked similar: Parental Distress decreased from Time 1 to Time 2. Posttraining, Parental Distress in the comparison sample decreased over time, but in the intervention group did not change from Time 1 to Time 2.

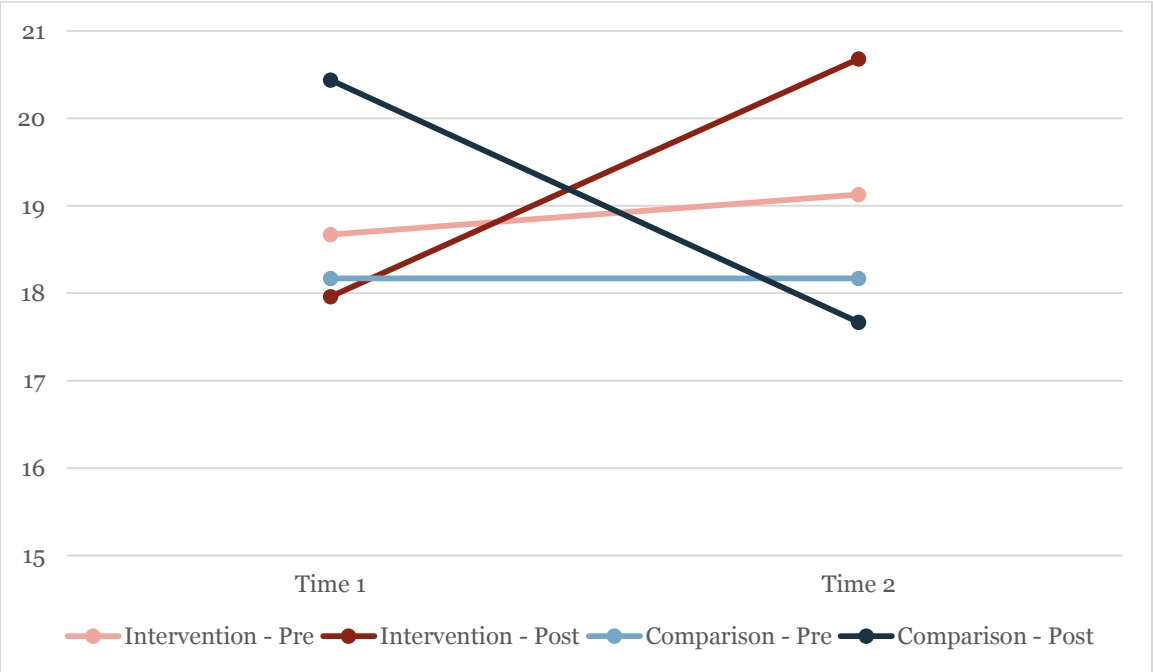
Figure 4. PSI-SF Parental Distress Subscale



Change in Parental Distress over time was different in the intervention group as compared to the comparison group, $F(1, 142) = 5.35$, $p = 0.022$, partial $\eta^2 = 0.036$.

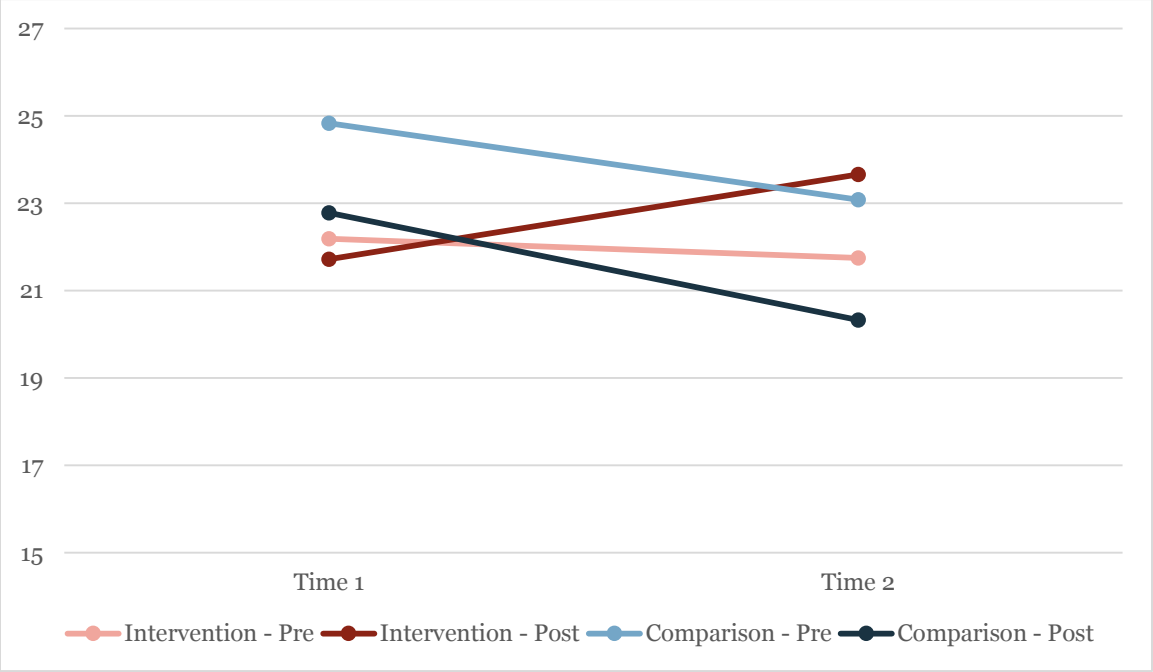
Changes from Time 1 to Time 2 in both Parent-Child Dysfunctional Interaction and Difficult Child subscales were significantly different in the intervention sample compared to the comparison sample, but the differences between pretraining and posttraining samples between groups were not significant (see Figure 5 and Figure 6). This suggests that either the change in maternal functioning is related to the programs, or the sample size was insufficient to provide the power needed to demonstrate a pre-post difference in these subscales with this small effect size.

Figure 5. PSI-SF Parent-Child Dysfunctional Interaction subscale



Change from Time 1 to Time 2 on Parent-Child Dysfunctional Interaction subscale was significantly different in the intervention sample compared to the comparison sample, $F(1, 174) = 5.04$, $p = 0.026$, partial $\eta^2 = 0.028$.

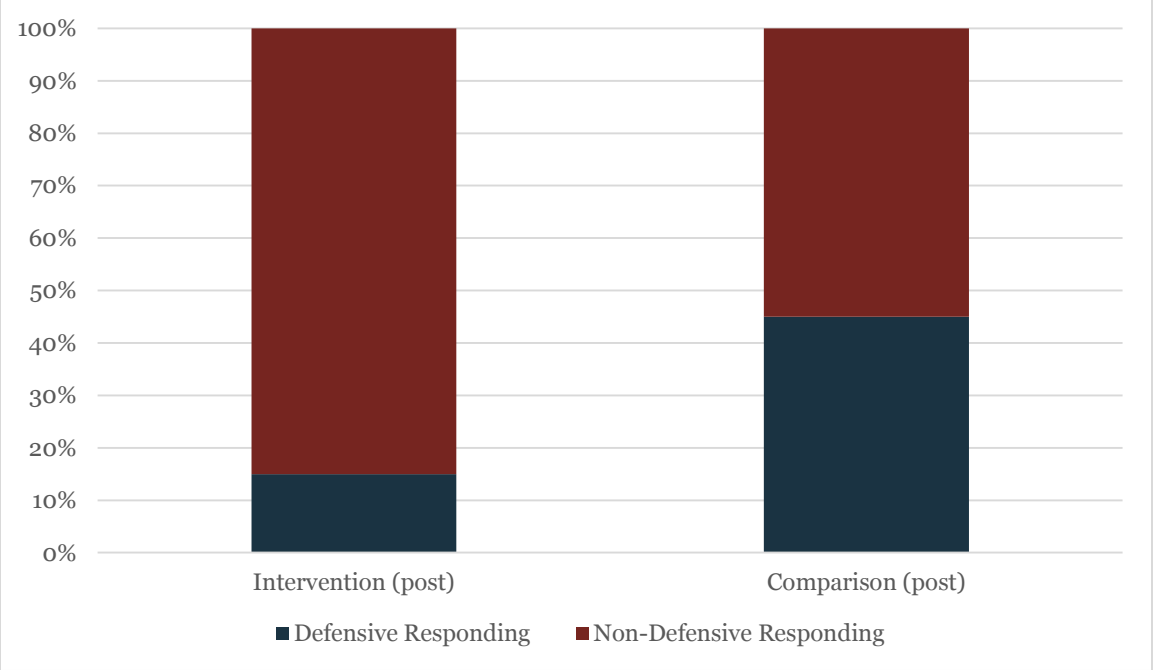
Figure 6. PSI-SF Difficult Child subscale



Change from Time 1 to Time 2 on Difficult Child subscale was significantly different in the intervention sample compared to the comparison sample, $F(1, 174) = 5.27$, $p = 0.023$, partial $\eta^2 = 0.029$.

The PSI-SF also provides a Defensive Responding score, and a score of 10 or lower indicates potential defensive responding. The proportion of those who responded defensively did not differ by pre-post, intervention or comparison group, risk level, maternal age, education, employment, marital status, or housing. When race and ethnicity were analyzed with defensive scores, we found significant differences by race/ethnicity. White mothers were more likely (45%) to respond defensively then Hispanic (10%) or black (10%) mothers ($\chi^2 = 4.68$, $p = 0.030$). When we compared the intervention group and the comparison group, no group differences were found in the pretraining samples, while in the posttraining samples the comparison group had a higher rate of defensive responding at Time 2 (45%) than the intervention group at Time 2 (15%), $\chi^2 = 5.61$, $p = 0.018$ (see Figure 7).[44]

Figure 7. PSI-SF Defensive Responding in Intervention and Comparison, Posttraining at Time 2



$\chi^2 = 5.61$, $p = 0.018$

[44] Because those who responded defensively may not have been accurately reporting their stress levels, we decided to run the models again excluding those who met the criteria for Defensive Responding. With this subsample ($N = 147$), maternal education was no longer related to PSI-SF Total Score or any subscale scores ($r = -0.13$, $p = 0.16$), so maternal education was not included as a covariate in the models. Excluding the defensive responders, the change in parenting stress from Time 1 to Time 2 was different pre-post and varied by intervention and comparison group, $F(1, 143) = 4.34$, $p = 0.039$, partial $\eta^2 = 0.029$. While parenting stress decreased over time in the pretraining samples and in the posttraining comparison group, stress increased over time in the posttraining intervention group. For Parental Distress, the change over time was different pre-post and varied by intervention and comparison group, $F(1, 143) = 3.84$, $p = 0.05$, partial $\eta^2 = 0.026$. Changes from Time 1 to Time 2 in both Parent-Child Dysfunctional Interaction and Difficult Child subscales were different in the intervention sample compared to the comparison sample [PCDI: $F(1, 143) = 4.38$, $p = 0.038$, partial $\eta^2 = 0.030$; DC: $F(1, 143) = 4.24$, $p = 0.041$, partial $\eta^2 = 0.029$], but not different pre-post.

In the posttraining sample, parenting stress increased from Time 1 to Time 2. Although the increase in reported parenting stress between Time 1 and Time 2 in the posttraining sample was unexpected, we would note first that the measured level of parenting stress is still within a normal range of stress. Because this increase was not observed in the pretraining sample or in the comparison sample, the rise in parenting stress in the families whose home visitors received the FAN training could be the result of the focus on mindfulness and reflective capacity in the FAN training and the atmosphere the trained home visitors create during the visits. Mindfulness and an open, reflective posture by the home visitor provides a safe environment for the parent, one in which they might feel more comfortable engaging in difficult discussions about negative emotions. The five experiences that should comprise a therapeutic environment are attachment, containment, communication, inclusion, and agency (Haigh, 2003). Although home visitors are not therapists, they can provide a therapeutic environment, and this atmosphere promotes a sense of safety and acceptance (HFA Best Practice Standards, 2014). Reflective supervision is a component of the FAN training, which facilitates reflection in the home visitors. Reflective capacity is "essential to professional competence in the infant–family field" (Weatherston, Weigand, & Weigand, 2010, p. 22).

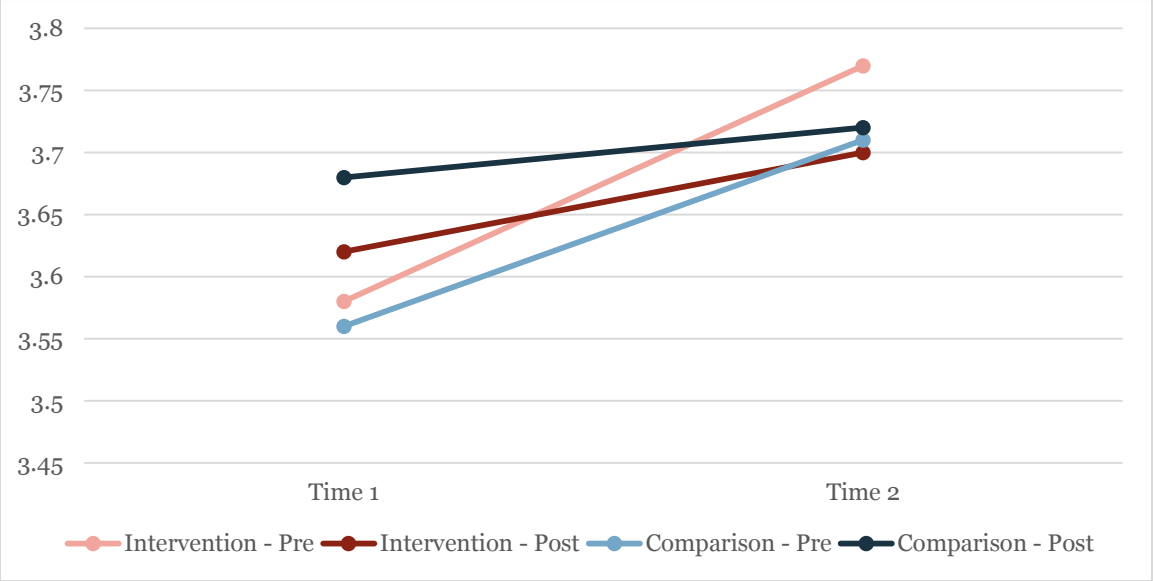
Furthermore, the home visitors who received the FAN training may have modeled reflective functioning for the parents, facilitating parents' increased reflective capacity. "Parenting is a fraught and complex enterprise, and without developed capacities for reflective functioning, parents are vastly more prone to impulsivity, disorganization, and dysregulation in relation to their child" (Slade et al., 2005, p. 76). A recent study that looked at the influence of parental reflective functioning found that parents who are more reflective are more likely to acknowledge the stress that they are experiencing, as compared to parents with lower levels of reflectivity (Twomey, 2012). Hence, mothers whose home visitors received the FAN training may have reported higher levels of parenting stress over time because, as the home visitor and mother built rapport and the home visitor provided a reflective and safe atmosphere, these mothers were able to acknowledge the stress they were experiencing. Finally, the core process of the FAN referred to as "Empathic Inquiry" provides the home visitor with the skills and confidence to explore the mother's feelings. Whereas prior to the FAN training the home visitors may have been hesitant to ask about mothers' emotions because it might open "that can of worms," the FAN encourages home visitors to observe for any cues that the mother is experiencing intense emotions, ask about her feelings, and provide an opportunity and for the mother to share affect she is experiencing. The apparent elevated levels of parenting stress in the posttraining intervention group may indicate an increase in the mother's

awareness and acknowledgement of her stress, a more accurate representation of the parent's experience, whereas the pretraining sample and comparison group may have underreported their stress.[45]

Maternal Self-efficacy

Participant mothers generally reported relatively high levels of maternal self-efficacy at Time 1, with a mean score of 3.6, between "good enough" (3.0) and "very good" (4.0). As found in other research (e.g., Porter & Hsu, 2003), maternal self-efficacy increased over time, as parents tend to feel more confident about their parenting capacity with experience (see Figure 8). Correlational analysis revealed a positive association between infant age and maternal self-efficacy (r = .41, p < 0.001.) Thus, infant age was added to the model as a covariate, and still maternal self-efficacy increased from Time 1 to Time 2 when infant age was controlled (F = 24.37, p < 0.001, partial η^2 = 0.141). However, the change in maternal self-efficacy did not differ between the pre- and posttraining samples or between intervention and comparison groups.

Figure 8. Maternal Self-efficacy



Maternal self-efficacy increased from Time 1 to Time 2 for all groups, F = 13.54, p = 0.001, partial η^2 = 0.263.

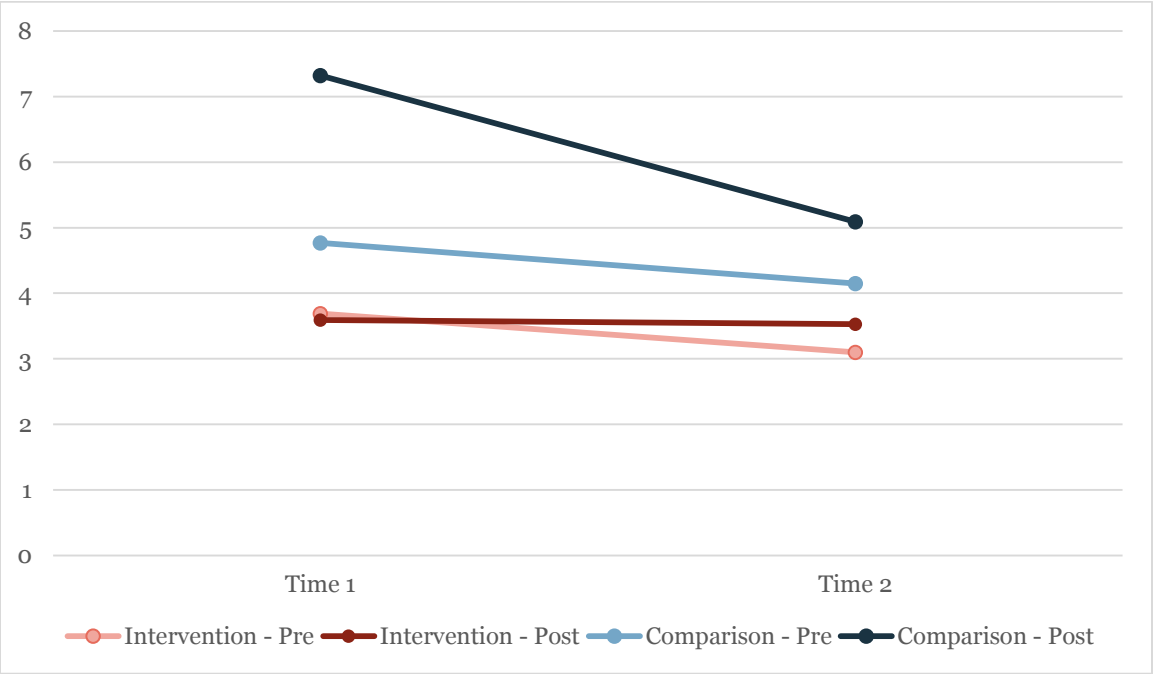
[45] Futures without Violence, a national group doing research in states on domestic violence levels, has worked closely with the Wisconsin home visiting system. In that state they are finding higher rates of reported domestic violence than in other states. It is also a state that has intentionally added reflective supervision, infant mental health consultation, and the FAN approach in home visiting programs. Program staff believe the rates are higher because home visitors and parents are not afraid to have the conversation about domestic violence and, as a result, staff are learning more about what is actually happening (verbal communication with Linda Gilkerson, FBN director). Analogously, the higher parenting stress around the parent-child relationship might relate to the effect of the FAN approach in helping home visitors listen to parents' concerns and see the baby the parent sees. If this is the case, it is likely that the 4-month period between Time 1 and Time 2 was not a sufficient amount of time to see the extent to which home visitors, using the FAN approach, are able to help mothers work with the stress around their child.

Depression

As was discussed in Chapter 2, the Time 1 scores on the Edinburgh Postpartum Depression Screen (EPDS) were lower than anticipated, with a mean score of 3.7. A report of maternal depression levels in MIECHV home visiting programs presented a mean EPDS score of 5.03 (*SD* = 5.16) for the first score in the first year postpartum (Center for Prevention Research and Development, 2014). A *t*-test comparing their mean Time 1 depression score with the mean Time 1 score in our sample revealed a significant difference between scores, ($t(388) = 2.73$, $p = 0.007$), indicating that the depression scores in the present study were lower than typical depression scores in this population. In previous research, postpartum depression has been found more often in the first 3 months than at later points in the first year postpartum (Cooper, Campbell, Day, Kennerley, & Bond, 1988; Kumar & Robson, 1984; Wolfson, Crowley, Anwer, & Bassett, 2010). In the present study, however, no difference in depression levels between Time 1—which occurred at an average of 4 months postpartum—and Time 2—which occurred at an average of 8 months postpartum—was found. In addition, no relationship between infant age and depression scores was found. Because the depression scores obtained in this study were comparable to the depression scores obtained by the home visitors for the same participants, and the depression scores for this sample tended to be lower than in the population of mothers in home visiting programs in Illinois, it is reasonable to conclude that the mothers who volunteered to participate in our study may have experienced fewer depressive symptoms than the overall group of mothers in home visiting in Illinois.

When we compared the intervention and comparison groups and the pre-post samples, no group differences were found in the change in depression over time ($F(1, 174) = 2.10$, $p = 0.149$, partial $\eta^2 = 0.012$). When the intervention and comparison groups were analyzed independently, no change in depression from Time 1 to Time 2 was found in the intervention group ($t(154) = 1.41$, $p = 0.16$). However, mothers in the comparison group showed a decrease in depression from Time 1 to Time 2, ($t(23) = 2.39$, $p = 0.025$). This significant difference in the comparison group was a result of the elevated mean depression score in the comparison "posttraining" group at Time 1, which was higher than the other groups and time points in the study (see Figure 9). (Note: paired *t*-tests were run for the pre and post samples separately for the intervention and comparison groups as well, and none of the Time 1 to Time 2 changes was significant for any of the pre or post samples.)

Figure 9. Depression



High Risk Sample Subgroup Analysis

We also are interested in understanding change in maternal functioning for different groups of mothers. As described in chapter 2, we calculated a risk index score for each of the study mothers based on the 5-Item Risk Index (Administration for Children and Families, 2002) and classified participants as low (having 0, 1, or 2 factors), medium (3 factors), or high risk (4 or 5 factors).[46] As shown in Table 13 in Chapter 2, 27 percent of participants in the pretraining cohort and 16 percent of participants in the posttraining cohort were in this demographic high-risk sample. (Because of the small sample at the comparison site, the comparison site participants were not included in this high risk subgroup analysis.)

In addition to these demographic risk factors, some mothers in this study could also be classified as "high risk" in their maternal functioning. Participants were included in the maternal functioning high risk group if they scored outside the normal range, either high or defensive, on at least two of the three maternal functioning measures. Mothers who scored in the high range on the PSI-SF (85th percentile or higher) or scored defensively on the PSI-SF (10 or below on the Defensive Responding scale) were considered at high risk for parenting stress. A score of 10 or above on the EPDS or a score of 0 (defensive) was

[46] For 32 of the participants, employment and education data were missing. With 2 of the 5 items on the Risk Index missing, participants were considered high risk if they met all 3 of the remaining criteria (SNAP recipient, mother was a teen at the birth of first child, mother is unmarried).

considered high risk for depression. For maternal self-efficacy, a score in the lowest 10th percentile (< 3.19) or the highest score (4.0; defensive) was considered high risk for maternal efficacy.

When we added the 25 participants who were classified as high risk in maternal functioning (scored high or defensively on 2+ maternal functioning scales) to the 30 participants in the demographically high risk group, some participants fell into both categories, thus the total in the high risk combination group (demographic and maternal functioning) was 42 participants in Waves 1 and 2.

Parenting Stress

Within this high risk combination group, we compared the change in parenting stress from Time 1 to Time 2 between the pretraining and posttraining samples. The change in parenting stress (PSI-SF Total Score) over time was different in the pretraining sample compared to the posttraining sample ($F(1, 37) = 4.46$, $p = 0.04$, partial $\eta^2 = 0.11$). In Wave 1, parenting stress increased over time in the pretraining sample and decreased in the posttraining sample. On the other hand, in Wave 2, parenting stress decreased over time in the pretraining sample and increased in the posttraining sample.

When we analyzed the subscales of the PSI-SF, the change in Parental Distress over time did not differ pre–post ($F(1, 37) = 0.72$, $p = 0.40$, partial $\eta^2 = .02$). However, the change in Parent-Child Dysfunctional Interaction (PCDI) was different in the pretraining sample compared to the posttraining sample and differed by wave ($F(1, 37) = 5.07$, $p = 0.03$, partial $\eta^2 = 0.12$). In Wave 1, PCDI increased from Time 1 to Time 2 in the pretraining sample and decreased over time in the posttraining sample. In Wave 2, PCDI remained the same over time in the pretraining sample, yet increased in the posttraining sample.[47] In the Difficult Child (DC) subscale, the change from Time 1 to Time 2 was different in the pretraining sample compared to the posttraining sample and differed by wave ($F(1, 37) = 4.61$, $p = 0.04$, partial $\eta^2 = 0.11$). Like the PCDI subscale, DC subscale scores in Wave 1 again increased from Time 1 to Time 2 in the pretraining sample and decreased over time in the posttraining sample. In Wave 2, DC decreased over time in the pretraining sample and increased in the posttraining sample. Thus, the patterns in parenting stress over time tended to differ by Wave in this high risk subsample.

Maternal Self-efficacy

We compared the change in maternal self-efficacy over time between the pretraining and posttraining samples in this high risk subsample. The change in maternal self-efficacy from Time 1 to Time 2 examined pre-post and by wave did not reach statistical significance ($F(1, 38) = 2.88$, $p = 0.098$, partial η^2

[47] The Parent-Child Dysfunctional Interaction subscale scores were higher at Time 1 in the High Risk group (M = 20.0, SD = 6.05) than for the Low-Medium Risk group, (M = 17.1, SD = 5.08, $F(1, 152) = 8.02$, $p = 0.005$).

= 0.070). Overall, maternal self-efficacy generally increased over time both pretraining and posttraining in the high risk subsample in Waves 1 and 2 ($F(1, 38) = 10.77$, $p = 0.002$, partial $\eta^2 = 0.221$).

Depression

We compared the change in depression over time between the pretraining and posttraining samples in this high risk subsample. Changes in depression from Time 1 to Time 2 did not show any trends in the high risk subsample.

Summary

Overall, we found both similarities and differences in mothers' narratives about their home visits and their relationships with their home visitor between the cohort of mothers interviewed before the start of the FAN training and the cohort interviewed 12 months after training. On the one hand, the vast majority of mothers in both groups reported positive relationships with their home visitors. On the other hand, narratives in the pretraining cohort often centered on the kinds of advice and suggestions they received from their home visitors, rather than narratives about what circumstances preceded the advice-giving. This might reflect processes like Collaborative Exploration to understand mothers' perspectives and how they might solve a problem before offering suggestions to address mothers' concerns.

The mothers in this study tended to report low levels of parenting stress and depression and high levels of maternal self-efficacy, overall. Reporting low levels of parenting stress and depression may be indicative of the "survival mode" in which these impoverished mothers often live (Payne, DeVol, & Dreussi Smith, 2006). Before a sense of belongingness—which involves trust and open communication—can occur, both physiological and safety needs must be met (Maslow, 1943). Many families in poverty have unmet physiological needs, such as food and housing, and a majority have unmet safety needs, such as community violence, domestic violence, transgenerational trauma, and financial insecurity. Although addressing and treating mental health and well-being challenges can improve other risk factors for families, mothers experiencing high levels of parenting stress or depression who are also facing physiological and safety issues may not feel they are in a place to focus on or even acknowledge these struggles.

Comparison site mothers did not show a significant difference between pre and post for change in any maternal functioning variable. In the intervention group, the only maternal functioning variable in which a difference was found between pretraining and posttraining was parenting stress: parenting stress did not change over time in the pretraining sample but appeared to increase over time in the posttraining sample. The posttraining sample may have experienced increased reflective capacity from their home visitors' reflective practice, and the home visitors recognizing, validating, and/or exploring emotions through Empathic Inquiry may have provided the atmosphere and opportunity for the mother to acknowledge and

openly communicate her struggles. It is possible that once she began to discuss with her home visitor her emotions and the stress she was experiencing, she found that she received support and validation, and she was willing to discuss these same feelings in the interview with the evaluation team.

Hence, mothers whose home visitors received the FAN training may have reported higher levels of parenting stress over time because, as the home visitor and mother built rapport and the home visitor provided a reflective and safe atmosphere, these mothers were able to acknowledge the stress they were experiencing. Indeed, as discussed earlier, supervisors noticed a shift in the amount and content of the information about families that home visitors shared during supervisory meetings. They suggested that the FAN approach has given "parents a voice" and home visitors a framework for noticing and talking about their emotions. As a result, families are more willing to disclose more information about themselves and about their concerns. Thus, mothers in the posttraining intervention group may be more accurately reporting their experience of parenting stress, whereas the pretraining sample and comparison group may have been underreporting their stress. Future research evaluating the impact of the FAN approach on program participants should aim to follow parents for a longer period of time with three data collection points, measuring the change in parenting stress after the increase at the second data point and whether the parenting stress decreases significantly by Time 3.

Conclusions and Implications

This is the final report of a 3-year evaluation of an advanced training for home visitors in the FAN approach that is based on infant mental health principles. Training was delivered to home visitors and supervisors at nine Healthy Families America (HFA) programs over an 18-month period. A tenth HFA program served as a no-training comparison site. FAN training teaches home visitors to focus on parents' concerns, to read parents' cues for engagement, and to use the strategies of the approach to match their interactions to what parents indicate they can most use in the moment. Building parenting capacity and self-efficacy by *supporting* parents, rather than *doing* for parents, is another goal of the approach. Other important components of the approach are enhancing supervisors' reflective practice in working with home visitors and teaching home visitors to attend to, understand, and regulate their own responses to families.

The training began with a 2-day, in-depth foundational training in the FAN core processes for all staff, with a half-day of additional training for supervisors. The initial training was followed by ongoing review and consultation sessions that lasted 90 minutes, one or two times per month for 12 months, during which home visitors and supervisors received direct interactive support in mastering the use of the strategies of the approach. After the 12-month follow-up period, monthly "booster" sessions were offered to reinforce what was learned. Staff also received support from on-site infant mental health consultants and developmental specialists.

Using a quasi-experimental design, the evaluation sought to understand the impact of the training on home visitors' practices from the perspectives of home visitors, supervisors, consultants, and program participants. Considering the findings from all of these sources, we found that there was a change in the knowledge, comfort levels, and skillfulness of home visitors and supervisors with the FAN approach across the 18-month implementation period. There was also evidence of changes in the structure and content of their home visits, as well as the relationships between home visitors and families.

Key findings from the study include the following:

- Before the training, home visitors saw their role as problem solving, or "doing," for parents and felt pressure to find solutions for parents' problems and concerns. Nine months into the FAN training, home visitors perceived a change of their role, feeling a sense of freedom to listen and explore with parents and not feeling as though they needed to fix everything. After 18 months of training, home

visitors realized that they could meet the mother where she was at in the moment and allow her to take the lead in finding solutions. They also mentioned a sense of relief in not having to fix things for the family.

- There were differences among home visitors in terms of their receptivity to the FAN approach and the Arc of the Visit language and structure, as well as the pace of their learning and application, as a function of their previous experience as home visitors. Generally, home visitors who were new to the profession found it easier to learn and adopt the approach. More experienced home visitors tended to be initially resistant to the approach in part because they did not see a need for improvement and in part because their initial perception was that the FAN approach was "the same" as what they were already doing with families. Although it was not always clear what aspects felt the same, it might have been difficult, for example, for some staff to distinguish "exploring problems to help a mother find her own way" (Collaborative Exploration) from "exploring problems to provide advice."
- Several factors affected the progress that home visitors made in learning and incorporating the FAN core processes into their work. These included the amount and quality of support from supervisors and consultants, and the ability of trainers to establish rapport with the staff, build on their existing knowledge, and address their concerns during training. Not surprisingly, it also was easier to incorporate the FAN concepts into visits with new program participants than with those who had been with the program for longer period of time and with already established routines. Learning and implementing the approach were also affected by organizational and other contextual factors, such as competing work demands (e.g., administrative paperwork), staff turnover, and the introduction of the new HFA Integrated Strategies curriculum in the middle of the FAN training process. Staff at most of the programs expressed feeling overwhelmed and fatigued at one point or another by the lengthy training.
- Parents' narratives about their home visiting experiences in interviews supported our finding that home visitors were able to use the FAN concepts in their home visits. Interviews with parents also suggested that the use of the FAN approach changed the structure and dynamics of the home visit. In particular, narratives of mothers in the posttraining sample revealed many more examples of the Empathic Inquiry, Collaborative Exploration, and Capacity Building processes than in the pretraining sample.
- When comparing the responses of mothers in the posttraining sample with those in the pretraining sample and mothers at the comparison site, there were no significant differences in ratings on a standardized measure, the Working Alliance Inventory (WAI). One reason might be the fact that ratings of the relationship were very positive at the Time 1 interview, so even modest improvements 4

months later at Time 2 would be difficult to detect in our sample. Mothers' ratings of their relationships with their home visitors were very positive at both time points in all groups, not only in terms of the WAI total score but also the scores on the instrument's three subscales. At the same time, mothers' and home visitors' ratings on the Bond subscale items were more similar in the intervention group posttraining than they were in the comparison group, which suggested that mothers and home visitors in this group were more aligned in their perceptions of their relationships.

- There were also other indications in the quantitative data of stronger relationships between mothers and home visitors in the posttraining sample. Most of the participant mothers who reported problems with their infants' crying, sleeping, or feeding discussed these problems with their home visitors. In the intervention group, however, the posttraining sample of mothers was more likely to discuss infant sleep problems with their home visitor than the pretraining sample of mothers.
- In terms of the potential impact of the FAN approach on maternal functioning, standardized measures of maternal self-efficacy and depression showed no significant differences between the pretraining and posttraining samples or between the comparison group and the posttraining sample. All groups showed modest increases in self-efficacy and modest decreases in depression over time, consistent with our expectations.
- In the posttraining sample, in contrast to the pretraining and comparison groups, parenting stress increased over time. One possible explanation could be related to the focus on mindfulness and reflective capacity in the FAN training, leading to the mothers' increased ability to acknowledge the stress they were experiencing. The FAN provides the home visitor with the framework and the skills to notice cues of intense affect and facilitate a conversation about the parent's feelings.

Training and Evaluation Challenges

As noted above, there were a number of factors that influenced what home visitors took away from the training and the pace at which they learned and incorporated aspects of the approach into their work. Organizational factors, particularly the turnover of home visitors and supervisors, also influenced the impact of the training and our ability to assess the impact. A majority of programs experienced staff turnover at various points in the study, with well over half of the staff leaving or changing their positions overall. (Turnover was especially high at the Wave 2 sites.) This meant that even with a relatively good response rate to surveys, it was difficult to follow the same staff members over the full study period. We also were aware that staff were receiving different amounts of training that were hard to capture and assess in relation to their progress in learning. Staff also reported feeling burdened by the FAN training activities because of the amount of administrative paperwork and by having to learn the new HFA curriculum at the same time as the FAN. In addition, several of the training sites were involved in other

research projects that had their own sets of requirements. These factors posed challenges for the trainers and consultants who were working with the program staff to build their capacity to work with high-risk families.

It is also important to acknowledge the limitations and challenges of using staff self-reports to assess change in knowledge and practice and using mothers' narratives of their home visiting experiences, rather than direct observation, as a way to assess home visitors' practices. For example, mothers often talked about what they had learned from their home visitor or the advice or guidance she provided, but did not always describe the process by which they learned or received the advice. Thus, we could not always be certain from the mothers' accounts whether home visitors used Empathic Inquiry, Collaborative Exploration, or Capacity Building processes (or some combination) before offering suggestions to address their concerns. On the other hand, the mothers' narratives yielded numerous examples of these three core processes that supported the staff self-reports. In addition, mothers' narratives allowed us to learn about their experiences from their point of view—something that we could not have done as easily through direct observation.

Implications and Recommendations

Despite the challenges of implementing and evaluating a long-term advanced training to improve the skills of home visiting staff working with high-risk families, study findings clearly indicate home visitors and supervisor's practices changed. Home visitors increased their ability to read parents' cues, focus on their concerns, and explore solutions to problems with them instead solving problems for them. There was also evidence of an increase in mindfulness, particularly the ability to regulate their emotions while listening empathically to the concerns and needs of parents. The visits were more parent-led, more focused on parenting, and more collaborative. Findings from staff's reported experiences with the lengthy FAN training and implementation also revealed some challenges to practice change, including staff turnover and program participant attrition, and ways to improve the FAN training structure. As discussed below, recommendations include a shorter training period, clearer training goals and expectations, and flexibility and individuation within each program.

Future Research

Finally, the evaluation also showed a need for a longer follow-up study of home visitors' and supervisors' beliefs and practices to understand to what extent the training "sticks" and what core processes are sustained in their work. Additional research might help us to understand at what points there are shifts in staff's learning, what kind of ongoing support or coaching is most helpful to learning, and what kinds of organizational factors facilitate or interfere with learning. We also think there is a need to follow mothers for a longer period of time than was possible in this study to understand the impact of the approach on

their functioning and well-being, their relationships and parenting skills, and, in turn, the well-being of their children.

For example, we speculate that the increase in reported parenting stress by mothers in the posttraining sample might be the result of home visitors using the FAN core process to create a safe space for mothers to talk about their concerns. It is possible that once she began to discuss her emotions and the stress she was experiencing with her home visitor, the mother found that she received support and validation, and she was willing to discuss these same feelings in the interview with the evaluation team. As a result, mothers in the posttraining intervention group may be more accurately reporting their experience of parenting stress, whereas the pretraining sample and comparison group may have been underreporting their stress. If we were able to follow the mothers for a longer period of time, we could test our hypothesis that we would first see an increase in parenting stress, as the mother and home visitor build rapport and the mother confides in the home visitor, followed by a decrease in parenting stress, as the home visitor supports the mother in working through her concerns and struggles.

Training and Support Strategies

The training developed by the Fussy Baby Network was designed to enhance the skills of home visitors and meet the needs of busy practitioners by offering on-site, job-embedded training and consultation, and additional support for learning from supervisors, an infant mental health consultant, and a developmental specialist. The training was intentionally designed to be implemented over a period of time based on the assumption that the concepts are not easy to learn all at once, require application and reflection to learn, and that individual concepts build on one another and are interconnected. It included learning tools to help home visitors reflect on their interactions with families, ideally with their colleagues and supervisors, as well as their trainers. These general characteristics of the training are consistent with recommendations in the literature of effective professional development (e.g., Desimone, 2009; Dunst, 2015; and Weston, 2005).

Although most staff—supervisors as well as home visitors—recognized that they learned more than they could have in a shorter training period, they still suggested shortening the training because it was hard to juggle the demands of training with all of their other responsibilities. Because learning was so varied between and within the programs in the study, it is not clear what length of time would be best; also this factor is one of many that affected receptivity to and ability to learn and apply the approach. The results of the 9-month interviews suggested that many concepts were becoming established by that time, although they were firmer at 18 months than they were at 9 months. Further, despite the relief that many home visitors felt when the training was over, several recognized that they would need more practice in it to maintain or solidify their skills. Staff also asked that written requirements be reduced or eliminated

altogether, given the already heavy administrative requirements of their jobs. Based on these findings, one suggestion is for written learning tools to be completed during the on-site training or to replace or incorporate them into existing paperwork.

As noted by home visitors, supervisors, and consultants alike, there was initial resistance to learning the FAN approach that stemmed from several concerns: (1) the length of the training; (2) the perceived burden of additional paperwork; (3) the sense of rigidity of the Arc of the Visit structure (a concern of primarily veteran home visitors); and, (4) the repetitive nature of the training (for some home visitors). Other concerns stemmed from perceptions or beliefs that could have been, perhaps, addressed by trainers or supervisors in the early stages of training. One was a sense, most often among experienced home visitors, that the training implied that they were not already doing a good job and perhaps needed to be "fixed"; a sense that the FAN was no different from what they were already doing; a sense that the approach was too "rigid" or had to be strictly followed; and a concern, especially at two of the nine programs, about the "therapeutic" orientation of the training, which they thought was altering the scope of their home visitor work. They did not feel comfortable handling the emotions or mental health issues that they thought might emerge from the approach nor, in some cases, did they think they were being appropriately compensated for performing the role of a counselor or therapist. Although all of these concerns tended to dissipate over time, they nonetheless created some resistance that would not have interfered with learning if addressed directly and earlier in the training process.

In terms of addressing these concerns in future training, it is important to clarify what home visitors should expect from the FAN training at the outset of the training. Home visitors complained about the approach being repetitive and no different than their current strategies. Therefore it would be helpful to let the participants know that because the concepts are complex and interrelated, some of the training may seem repetitive in order for them to become familiar and comfortable with the approach. It may be also helpful to discuss the differences and similarities between the FAN approach and home visitors' current home visiting intervention strategies to help home visitors overcome the impression that what they are learning in training is no different than what they already know. Relatedly, home visitors talked about not having a clear definition of the FAN approach and its purpose. This suggests that both when implementing the FAN training and during the course of training, trainers should clearly define the FAN approach and what it aims to achieve. This strategy might help to reduce initial resistance and keep staff engaged since it is hard for staff to get a full, comprehensive view at the beginning.

Many home visitors perceived the FAN Model—especially the Arc of the Visit questions—as rigid. Some felt that they did not have the latitude to change the questions to fit their style or their home visiting circumstances. Therefore, explaining the purpose of the Arc questions might be more helpful than asking

them to use them verbatim. That may give home visitors who craved it the latitude to change the questions to fit their style, established family dynamics, and any other circumstances. Other suggestions are to have home visitors *first* practice the approach with newer clients and then use the approach with families with whom they have already established routines, adjusting the questions according to the family's circumstances. If that is not possible, trainers might inform home visitors to expect a gradual change in practice in terms of families' reactions or that, regardless of how new their clients are, some parents might not be used to "thinking for themselves" at the beginning.

Although training and consultation were offered on-site and presumably individualized to a certain extent, there was still a sense from the focus groups and interviews that the trainings could have been more tailored to the experiences and needs of the individual program staff. This might have helped address some of the concerns about the "sense of sameness" or sense that the approach would not work with their clients. A home visitor from a 9-month focus group provided the following suggestion:

> And when they come in, it seems like they have—and maybe that's just the way it's supposed to go as far as them having like week one, week two, like activities and topic—but maybe if they could do like an orientation period, not just like a one-meeting orientation but a period of getting to know the workers and skill levels and then design kind of like the curriculum—whatever—based off of that versus kind of like one-size-fits-all because we do have different levels of experience as far as the program. So like, you know, like they were saying they were newer to the program, so as far as she was starting—week or so, so this is all she knows versus where our training came from.

Home visitors across program sites suggested a more "hands-on" approach to training. This would address, in part, their concerns about the challenges in applying the FAN approach in their work practice. Most of the suggestions provided by home visitors were related to creating opportunities to apply the approach during training with examples from their own home visiting experiences. As one home visitor explained, "I do think that it could've been more personal for all of us that once a month we would've been just, it's your turn (to talk about your visit). I think you would've been paid more attention as to how your visit is going and how that plugs into FAN." Similarly, another home visitor in the 18-month focus group talked about the importance of training materials reflecting the kinds of clients her program serves:

> We watched some videos that were not teenagers, so that was kind of out of line for us, a little bit, but even if we submitted our own confidential stories and made them into vignettes, so it wasn't personalized [to] us, where I'm going to share a story, and then be pinpointed for 10 minutes to explore it more in front of everybody, where if we can all just submit something and they can just randomly pick, I don't have to admit that it's my family.

Some home visitors also suggested allowing enough time to apply core processes in their practice before resuming their training sessions in order to help them have a better understanding about their experience

in applying the approach. One home visitor in the 18-month focus group explained this suggestion: "We've only done [the FAN] in visits for two weeks. I mean until the next time they [trainers] come. Like it's really—you've only had two weeks to even implement what we talked about." The home visitor continued,

> I think like, even looking back now, I kind of wish that we would have even done more of like a narrative [instead of paperwork]. . . and then gone through that and figured out what steps of the FAN did I use. I feel like that would have been very beneficial for me. . . . Instead of trying to figure it out sometimes on my own, like where was I here, where was I there? I feel like it would be even more beneficial. . . I guess because it would be real, and you could talk through it.

Moreover, the experience of one program site in which the trainer unexpectedly applied the principles of the FAN during training proved to reinforce as much the value of the FAN approach as understanding of its concepts. As one home visitor from this group put it: "It went from theory to seeing it." This suggests finding more ways for the trainers to model the approach and use it in a way that home visitors can experience it for themselves.

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Appendix A. Additional Quantitative Tables

Wave 1 and Wave 2 Survey Completion Rates

Table A-1. Raw Counts of Completed Home Visitor Surveys, Excluding Comparison Site (N = 67)

	Pre-Survey 1	Pre-Survey 2	Post-Survey 1	Post-Survey 2	Post-Survey 3	Post-Survey 4
Completed	42	43	38	32	31	32
Did not complete	10	9	5	9	8	8
Completion Rate	81%	83%	88%	78%	79%	80%

Table A-2. Raw Counts of Completed W1 & W2 Supervisor Surveys, excluding Comparison Site (N = 18)

	Pre-Survey 1	Pre-Survey 2	Post-Survey 1	Post-Survey 2	Post-Survey 3	Post-Survey 4
Completed	13	14	13	11	10	10
Did not complete	2	2	1	1	1	1
Completion Rate	87%	88%	93%	92%	91%	91%

Survey Responses of Home Visitors across Time (Post-Time 1 vs. Time 2, Time 2 vs. Time 3, and Time 3 vs. Time 4)

Because there was considerable variability in which staff responded to each of our pretraining and posttraining surveys (largely the result of staff attrition), it was necessary to choose a limited sample of 23 home visitors to follow over the entire time span of the evaluation. With this sample, however, we were only able to analyze differences between Pre-Time 1, Post-Time 1, and Post-Time 4. Nonetheless, we were interested in trying to understand when shifts in understanding or use of the FAN processes might have happened during the 18-month training and consultation period and thought it would be valuable to look at differences between consecutive surveys for the same home visitors. Thus, we also compared home visitors' responses to selected survey items for any home visitor who completed two consecutive surveys, i.e., post-Time 1 (administered 1 month after training) and Time 2 (6 months after Time 1), Time 2 and Time 3 (6 months after Time 2), and Time 3 and Time 4 (6 months after Time 3). In the tables in this appendix we have included time-to-time analyses of how home visitors responded to the questions

about self-assessed skills, the two SWAI subscales, the two FFMQ sub-scales, and the job satisfaction items. It is important to note that the samples included in these tables are different from the sample we used to look across the span of time that started with the pretraining phase and continued through the 18-month training and consultation period. In addition, the samples for each comparison below differ because of differences in the number of individuals who responded to the survey at each time point. Thus, the sub-sample of home visitors who completed both the post-Time 1 and post-Time 2 surveys (e.g., Table A-3) is a different sample than those who completed the post-Time 2 and post-Time 3 surveys (Table A-4).

Skills in the FAN Approach

These tables suggest that the subsample of home visitors who responded to both the post-Time 1 and post-Time 2 surveys assessed themselves as having rather significant increases in all of the skills related to the FAN approach between those two time points (see Table A-3). By comparison, any differences in self-assessed skills by home visitors who responded at both Post-Time 2 and Time 3 (see Table A- 4) and by those who responded at both Post-Time 3 and Time 4 (see Table A- 5) were more modest.

Table A-3. Self-assessed Skills of Home Visitors in the FAN Approach between Post-Time 1 and Time 2[a] (*n* = 21)

Skills Statement	Posttraining, Time 1 Mean (SD)	Posttraining, Time 2 Mean (SD)
Reading parents' cues for engagement during home visits***	3.0 (1.40)	4.5 (0.51)
Matching my interactions based on parents' cues***	3.2 (1.21)	4.4 (0.50)
Exploring parents' concerns together before finding solutions***	3.0 (1.40)	4.3 (0.73)
Recognizing my own feelings during visits with families**	3.6 (0.98)	4.5 (0.60)
Maintaining focus on parenting throughout the visit**	2.6 (1.47)	4.0 (0.74)
Encouraging the parent to lead the visit and help set our agenda**	2.9 (1.55)	4.2 (0.77)

[a] Responses are based on a 5-point scale: 1, Not at all skilled; 2, A little skilled; 3, Somewhat skilled; 4, Skilled; and 5, Very skilled. Time 1 occurred 1 month after the core foundational training and Time 4 occurred 18 months after the core training.
* Paired sample *t*-tests indicated significant time-to-time differences of all items at * $p < 0.05$, ** $p < 0.01$, and *** $p < 0.001$

Table A-4. Self-assessed Skills of Home Visitors in the FAN Approach between Post-Time 2 and Time 3[a] (n = 22)

Skills Statement	Posttraining, Time 2 Mean (SD)	Posttraining, Time 3 Mean (SD)
Reading parents' cues for engagement during home visits	4.1 (0.56)	4.4 (0.49)
Matching my interactions based on parents' cues	4.2 (0.50)	4.2 (0.43)
Exploring parents' concerns together before finding solutions	4.0 (0.76)	4.0 (0.69)
Recognizing my own feelings during visits with families	4.5 (0.67)	4.5 (0.51)
Maintaining focus on parenting throughout the visit	4.0 (0.72)	4.1 (0.75)
Encouraging the parent to lead the visit and help set our agenda	4.2 (0.66)	4.1 (0.61)

[a] Responses are based on a 5-point scale: 1, Not at all skilled; 2, A little skilled; 3, Somewhat skilled; 4, Skilled; and 5, Very skilled. Time 1 occurred 1 month after the core foundational training, and Time 4 occurred 18 months after the core training.
*Paired sample *t*-tests indicated that the Post-Time2 and Time 3 differences in "reading parents' cues for engagement during home visits" was statistically significant at *** $p < 0.001$.

Table A-5. Self-assessed Skills of Home Visitors in the FAN Approach between Post-Time 3 and Time 4 (*n* = 24)[a]

Skills Statement	Posttraining, Time 3 Mean (SD)	Posttraining, Time 4 Mean (SD)
Reading parents' cues for engagement during home visits	4.3 (0.48)	4.4 (0.58)
Matching my interactions based on parents' cues	4.3 (0.44)	4.3 (0.70)
Exploring parents' concerns together before finding solutions*	4.0 (0.69)	4.4 (0.71)
Recognizing my own feelings during visits with families	4.4 (0.50)	4.5 (0.59)
Maintaining focus on parenting throughout the visit	4.1 (0.74)	4.3 (0.69)
Encouraging the parent to lead the visit and help set our agenda**	4.0 (0.64)	4.4 (0.66)

[a] Responses are based on a 5-point scale: 1, Not at all skilled; 2, A little skilled; 3, Somewhat skilled; 4, Skilled; and 5, Very skilled. Time 1 occurred 1 month after the core foundational training, and Time 4 occurred 18 months after the core training.

*Paired sample *t*-tests indicated that the difference between post-Time 3 and Time 4 in "exploring parents' concerns together before finding solutions" was statistically significant at *$p < 0.05$ and in "encouraging the parent to lead the visit and help set our agenda at **$p < 0.01$.

Home Visitors' Relationships with Supervisors

Between Post-Time 1 and Time 2, home visitors who responded to the SWAI at both time points reported a statistically significant increase in perceived support from their supervisors. Although there was a small increase in perceived support among those who responded to both the post-Time 2 and Time 3 surveys, it was not statistically significant. On the other hand, there was a small decrease in perceived support between post-Time 3 and Time 4 for all home visitors who responded to the survey at these times. There also was a small decrease in client focus, which refers to home visitors' perceptions of the emphasis supervisors place on promoting their understanding of their clients.

Table A-6. Home Visitors' Views of Relationship with Supervisor: Supervisory Working Alliance Inventory (SWAI) between Post-Time 1 and Post-Time 2 (n = 21)[a]

Subscale	Post-Time 1 Mean (SD)	Post-Time 2 Mean (SD)
Rapport [b] *	5.2 (1.23)	5.7 (0.58)
Client Focus	5.5 (1.66)	5.8 (1.17)

[a] The sample sizes for the individual times that make up each subscale ranged from 16 to 18 home visitors.

[b] *Rapport* refers to the supervisee's perception of support from the supervisor. *Client focus* refers to the supervisee's perception of the emphasis the supervisor placed on promoting the supervisee's understanding of the client. We did not include one item in the Rapport subscale as the wording was changed from "My supervisor makes the effort to understand me" to "My supervisor makes the effort to understand my concerns about my participants' behavior" at the time of the Wave 2 Posttraining1 survey.
*Paired sample *t*-tests indicated that the Post-Time 1 and Time 2 differences in Rapport were statistically significant at * $p <$ 0.05.

Table A-7. Home Visitors' Views of Relationship with Supervisor: Supervisory Working Alliance Inventory between Time 2 and Time 3 (n = 22)[a]

Subscale	Post-Time 2 Mean (SD)	Post-Time 3 Mean (SD)
Rapport [b]	5.7 (0.52)	5.9 (0.58)
Client Focus	6.2 (0.91)	6.3 (0.67)

[a] The sample sizes for the individual times that make up each subscale ranged from 15 to 20.

[b] *Rapport* refers to the supervisee's perception of support from the supervisor. *Client focus* refers to the supervisee's perception of the emphasis the supervisor placed on promoting the supervisee's understanding of the client. We did not include one item in the Rapport sub-scale as the wording was changed from "My supervisor makes the effort to understand me" to "My supervisor makes the effort to understand my concerns about my participants behavior" at the time of the Wave 2 Posttraining1 survey.
*Paired sample *t*-tests indicated no significant time to time differences.

Table A-8. Home Visitors' Views of Relationship with Supervisor: Supervisory Working Alliance Inventory between Time 3 and Time 4 (n = 24)[a]

Subscale	Post-Time 3 Mean (*SD*)	Post-Time 4 Mean (*SD*)
Rapport [b]		
Mean (*SD*)	5.7 (*0.82*)	5.5 (*0.97*)
Client Focus		
Mean (*SD*)*	6.2 (*0.90*)	5.8 (*1.12*)

[a] Sample sizes range from 20 to 22.

[b] *Rapport* refers to the supervisee's perception of support from the supervisor. *Client focus* refers to the supervisee's perception of the emphasis the supervisor placed on promoting the supervisee's understanding of the client. We did not include one item in the Rapport subscale as the wording was changed from "My supervisor makes the effort to understand me" to "My supervisor makes the effort to understand my concerns about my participants behavior" at the time of the Wave 2 Posttraining1 survey.
*Paired sample *t*-tests indicated that the Post-Time3 and Time 4 difference in Client Focus was statistically significant at *$p <$ 0.05.

Mindfulness

With respect to self-assessed mindfulness, there were small positive changes in the responses of home visitors in each of the samples between post-Time 1 and Time 2 and between Time 2 and Time 3, although only the difference between post-Time 2 and Time 3 on the Non-Reactivity subscale was statistically significant. There was essentially no change in self-reported mindfulness in the sample who responded to the survey at post-Time 3 and Time 4.

Table A-9. Change in Home Visitors' Self-Assessments of Mindfulness between Post-Time 1 and Time 2 (*n* = 21) [a,b]

	Posttraining T1[c] Mean (SD)	Posttraining T2[d] Mean (SD)
Act with Awareness sub-scale	32.4 (6.39)	32.8 (6.04)
Non-Reactivity to Inner Experience sub-scale	24.7 (5.12)	26.1 (4.71)

[a] Responses are based on a 5-point scale ranging from 1, Never or very rarely true; 2, Rarely true; 3, Sometimes true; 4, Often true; to 5, Very often or always true.
[b] Sample size ranged from 17 to 18 home visitors.
*Paired sample *t*-tests indicated no significant time-to-time differences.

Table A-10. Change in Home Visitors' Self-Assessments of Mindfulness between Post-Time 2 and Time 3 (*n* = 24)[a,b]

	Posttraining T2[c] Mean (SD)	Posttraining T3[d] Mean (SD)
Act with Awareness sub-scale	34.3 (6.00)	34.1 (7.50)
Non-Reactivity to Inner Experience sub-scale*	25.5 (3.87)	27.7 (5.04)

[a] Responses are based on a 5-point scale ranging from 1, Never or very rarely true; 2, Rarely true; 3, Sometimes true; 4, Often true; to 5, Very often or always true.
[b] Sample size ranged from 17 to 20 home visitors
*Paired sample *t*-tests indicated that the following time-to-time differences were statistically significant at * $p < 0.05$, ** $p < 0.01$, and *** $p < 0.001$.

Table A-11. Change in Home Visitors' Self-Assessments of Mindfulness between Post-Time 3 and Time 4 (N=21)[a,b]

	Posttraining T3[c] Mean (SD)	Posttraining T4[d] Mean (SD)
Act with Awareness sub-scale	36.7 (3.33)	36.6 (3.80)
Non-Reactivity to Inner Experience sub-scale	27.9 (4.58)	27.7 (3.60)

[a] Responses are based on a 5-point scale ranging from 1, Never or very rarely true; 2, Rarely true; 3,Sometimes true; 4, Often true; to 5,Very often or always true.
[b] Sample size ranged from 18 to 21
*Paired sample *t*-tests indicated that the following time-to-time differences were statistically significant at * $p < 0.05$, ** $p < 0.01$, and *** $p < 0.001$.

Maternal Functioning Tables

Table A-12. Maternal Functioning[a] at Time 1 and Time 2 by Wave and Pre-Post

Sample	Wave 1		Wave 2		Comparison	
	Pre	Post	Pre	Post	Pre	Post
	n = 50	*n* = 32	*n* = 44	*n* = 29	*n* = 13	*n* = 11
PSI-SF T1	62.1 (14.27)	63.2 (17.40)	65.0 (13.56)	60.2 (13.50)	69.9 (10.08)	72.3 (17.34)
PSI-SF T2	63.4 (14.09)	68.2 (15.99)	63.3 (15.04)	66.7 (12.48)	66.3 (20.07)	61.0 (16.29)
PSI-SF mean change T1–T2 (SD)[b]	-1.2 (14.37)	-3.5 (16.10)	1.8 (11.03)	-5.6 (13.99)	4.5 (15.98)	9.0 (16.60)
MEQ T1	3.6 (0.31)	3.6 (0.34)	3.6 (0.31)	3.7 (0.31)	3.6 (0.26)	3.7 (0.29)
MEQ T2	3.8 (0.21)	3.7 (0.19)	3.8 (0.21)	3.7 (0.29)	3.7 (0.19)	3.7 (0.25)
MEQ mean change T1–T2 (SD)[c]	-2.7 (3.38)	-2.0 (3.20)	-2.4 (3.92)	-0.3 (4.28)	-1.5 (3.30)	-0.4 (2.33)
EPDS T1	4.0 (3.64)	4.0 (4.06)	3.3 (4.08)	3.3 (3.93)	4.8 (5.02)	7.3 (5.23)
EPDS T2	3.9 (3.53)	3.7 (4.39)	2.2 (3.24)	3.4 (5.59)	4.2 (4.34)	5.1 (4.09)
EPDS Mean change T1–T2 (SD)[d]	0.1 (3.15)	0.2 (4.53)	1.2 (2.76)	-0.1 (3.41)	0.6 (1.94)	2.2 (3.42)

[a] Maternal functioning measures were the Parenting Stress Index-Short Form (PSI-SF), the Maternal Self-efficacy Questionnaire (MEQ), and the Edinburgh Postnatal Depression Screen (EPSD).
[b] Repeated measures ANOVA with maternal education added as covariate, between subjects factors: pre-post, Intervention-Comparison, $F(1, 143) = 4.34$, $p = 0.039$, Effect size: partial $\eta^2 = 0.029$
[c] Repeated measures ANOVA with between subjects factors: pre-post, Intervention-Comparison, $F(1, 171) = 0.001$, $p = 0.982$, Effect size: partial $\eta^2 = 0.000$
[d] Repeated measures ANOVA with between subjects factors: pre-post, Intervention-Comparison, $F(1, 174) = 2.10$, $p = 0.149$, Effect size: partial $\eta^2 = 0.012$

Table A-13. PSI-SF Subscale Scores at Time 1 and Time 2 by Wave and Pre-Post

Sample	Wave 1		Wave 2		Comparison	
	Pre	Post	Pre	Post	Pre	Post
	n = 50	*n* = 32	*n* = 44	*n* = 29	*n* = 13	*n* = 11
Parental Distress T1	24.4 (7.34)	24.3 (7.51)	24.9 (6.13)	25.3 (8.86)	25.8 (6.56)	26.6 (7.87)
Parental Distress T2[a]	23.5 (6.48)	25.3 (7.82)	23.6 (6.14)	25.5 (8.42)	24.0 (9.47)	21.6 (8.32)
Parent-Child Dysfunctional Interaction T1	17.4 (5.37)	17.5 (7.22)	17.9 (4.59)	16.9 (4.55)	18.0 (3.74)	19.1 (5.65)
Parent-Child Dysfunctional Interaction T2[b]	18.1 (5.63)	19.6 (5.23)	18.5 (5.00)	20.1 (6.21)	17.7 (6.16)	17.0 (4.86)
Difficult Child T1	20.5 (6.39)	21.9 (6.65)	22.2 (5.39)	20.1 (6.34)	25.2 (6.35)	21.8 (6.51)
Difficult Child T2[c]	21.3 (5.41)	23.1 (5.20)	21.2 (6.37)	22.3 (5.16)	22.9 (6.49)	19.9 (4.89)

[a] Repeated measures ANOVA with maternal education added as covariate, between subjects factors: pre-post, Intervention-Comparison, $F(1, 142) = 2.66$, $p = 0.105$, Effect size: partial $\eta^2 = 0.018$
[b] Repeated measures ANOVA with between subjects factors: pre-post, Intervention-Comparison, $F(1, 174) = 1.93$, $p = 0.166$, Effect size: partial $\eta^2 = 0.011$
[c] Repeated measures ANOVA with between subjects factors: pre-post, Intervention-Comparison, $F(1, 174) = 0.19$, $p = 0.664$, Effect size: partial $\eta^2 = 0.001$

Appendix B. Qualitative Methods and Tables

Our overall approach to analyzing the qualitative data from home visitor focus groups, supervisor and consultant interviews, and mother interviews was informed by "grounded theory" (e.g., Glaser & Strauss 1967; Lincoln & Guba 1985; Miles & Huberman 1994; Patton 2002), which systematically identifies and compares concepts and themes in narrative data, usually termed "the constant comparative method." We examined interview transcripts and summary notes line by line to see what ideas and patterns the data reflected, then we developed codes for the data based on the ideas and patterns. The interview topics provided an initial guide for analysis, but we also looked for the emergence of other themes and meanings that were not in the original protocol. In the coding process, we tried to capture both the representational meaning, or the content of what was said, and the presentational meaning, or how it was said, that is, individuals' use of language and narrative style (Freeman, 1996). As we identified concepts, we compared and contrasted them with previously identified concepts and grouped similar concepts together in categories. Throughout the process, we wrote memos to document relationships among concepts and categories and emerging ideas and patterns.

Our goals in the analysis and interpretation of the qualitative data were to both understand the experiences of our informants (program staff and program participants) as individuals in the context of their daily circumstances and to compare and synthesize the narratives of all individuals to develop descriptions of "typical" or "composite patterns" of staff's experiences with training and mothers' experiences with home visiting. The analytic methods involved a simultaneous process of deduction and induction. Below we briefly discuss how we managed and analyzed the large quantity of data we collected from parents. Additional information on our analytic approach with these data or with the data from the staff interviews and focus groups is available from the authors.

Analysis of Parent Interview Data

Data Reduction

We analyzed all of the qualitative data we collected from interviews and focus groups with staff. In order to manage the amount of data we collected through interviews with parents, however, it was necessary to reduce the amount of data and the topics that we analyzed. We created our analytic sample by selecting

all parents with both Time 1 and Time 2 interviews whose home visitors were the same in both the pretraining and posttraining samples because we were most interested in change in staff over time. We then randomly selected a portion of other interviews to analyze to make sure we had appropriate representation from all nine of the programs that received FAN training. In total, we analyzed 204 (65%) of the 310 interviews from the nine programs that received training, 128 in the pretraining sample (which was a larger sample) and 76 in the posttraining sample.[48] We further reduced the data in our analytic sample by selecting the portions of the data that were most pertinent to our primary research questions, which had to do with understanding how the FAN training impacted home visitors' skills and the experiences of parents with home visiting. Thus, we made the decision to code and analyze the portions of the data about parents' experiences and relationships with their home visitors, evidence that home visitors were using the FAN approach and core processes in their visits, and potential outcomes of the FAN approach on parents before and after the FAN training.

Learning the FAN Approach

Because the evaluation's questions and purpose sought to understand the extent to which home visitors and supervisors were learning and incorporating the FAN approach into their practice, it was necessary for the qualitative analysts to understand the FAN concepts and core processes. Analysts participated in a one-day training on the FAN approach and read the instructors' training manual. Analysts also participated in monthly project meetings with the FAN training staff and had additional periodic communication with the staff to discuss the FAN approach concepts emerging from data as a way to gauge the analysts' interpretation of the FAN approach and its principals reflected in the parents' narratives. These steps were outlined prior to data analysis because without an understanding of the FAN approach and its strategies and purpose, the ability to recognize and capture the FAN concepts, terminology, and language embedded in the parents' narratives would be very limited.

Codebook Development and Coding

We initially developed a codebook based on the core components and strategies of the FAN approach including the five FAN basic core processes (Empathic Inquiry, Mindful Self-Regulation; Collaborative Exploration, Capacity Building, and Integration); the principles and strategies underlying the core processes; the non-desirable strategies (i.e. FAN mismatches) outlined in descriptions of the core processes; and the desirable outcomes the FAN approach seeks to achieve as a result of home visitors use of the model in the practice of home visiting. This predetermined list of codes was defined according to

[48] We excluded the interviews with mothers at the comparison program from the analysis for this report but will be analyzing them in the future, along with the remaining interviews with mothers at the training sites.

the concepts of the FAN approach and was aimed to capture both the absence and presence of these concepts before and after home visitors were trained. In the parents' narratives, the purpose was to compare before and after training to look for any change in parents' discourse that could be attributed (or not) to the FAN training. Our preliminary codes also allowed us to code parents' urgent concerns and potential outcomes under the FAN Integration core process. Although we started with this structured codebook, we also allowed for other codes to emerge from the data, for example, elements that would not be limited to the implementation of the FAN approach. These additional codes were created under four major categories derived from our interview protocol: (1) description and content of home visits; (2) relationship between home visitors and parents; (3) parents' perception of home visiting program, (4) parents' perception of their home visitors.

Approach to Data Analysis

We framed our analysis for this first phase of the analysis of parent data in two ways. First, as mentioned, we reduced our sample without jeopardizing representability. Second, we determined our priorities for coding topics based on the FAN approach and the primary research questions addressed in the interview protocol. These strategies also helped to focus and reduce the amount of data to be analyzed, without limiting the data context. We interpreted the presence and absence of the FAN approach and strategies by taking into account the context in which they emerged within participants' description of what transpired during home visits. For example, when parents expressed feeling more confident in their parenting skills, they often talked in the context of their home visitor providing encouragement and support or in the context of feeling more knowledgeable about infant care and child development. This approach to analysis in which we tracked the contexts of emerging themes was particularly pertinent to understanding the differences and similarities between the pretraining and the posttraining cohorts and identifying in what ways the FAN approach was absent or present within parents' narratives.

The final codebook included both the predefined code list and any new themes or codes that emerged from the broad categories listed the codebook. Thus, the codebook included both narrow (i.e., each of the FAN core processes) and broad (e.g., *parent perception of home visitor*) categories. The relative flexibility enjoyed within an imposed analysis framework allowed us to borrow techniques from both data-driven (Glaser & Strauss, 1967) and theory-driven approaches. The theory-driven approach was guided by our research purpose to track the use of the FAN concepts and strategies from parents' narratives. In this sense, our plan for analysis were determined prior to data collection and textual data was to be interpreted with a framework at hand. We used content analysis, albeit sparsely, as a support tool and an analytical choice for the verification of terms associated with the FAN approach.

Within this circumscribed framework, we also used thematic analysis. We read data to allow new codes and themes to emerge and we tracked the relationship between codes and themes. For example, after applying the code "*Parent relationship with home visitor*" several times while reading and re-reading the interviews, we pulled together all its corresponding textual data for further reading and interpretation and identified the theme "*genuinely care*" and "*can relate to*" that had emerged. This process was repeated for every theme which emerged.

For a deeper and more meaningful interpretation of coded data, we used discourse. For each core FAN concept coded, we tried to capture both the content of what was said, and how it was said, that is, parents' use of language and narrative style or what Freeman (1996) calls presentational meaning. This approach was especially important because the way parents expressed themselves verbally did not always explicitly uncover the FAN concepts. Therefore it was important to look not only at what parents said, but how it was said. For example, a parent in our posttraining sample repeatedly told the interviewer that her home visitor "does not tell her what to do". This statement could have been interpreted as reflecting the presence of Collaborative Exploration. But when this parent described her interactions with her home visitor, she revealed that her home visitor was actually taking the lead in finding solutions for her and "telling her what to do," although disguised as a suggestion; thus, with additional context and a close reading of how the parent expressed herself, we determined that there was no evidence of Collaborative Exploration. As part of this analysis of parents' narratives, we also looked at the parents' choice of pronoun ("she" versus "we" and "she" versus "I") when describing their interactions with home visitors. Typically parents who used "I" and "we" to describe their interactions with home visitors, revealed signs that the FAN was being applied by their home visitors as opposed to parents who more often described their interactions using the pronoun "she."

Data Management and Report Outputs

Transcripts were entered into a qualitative software program—Atlas.ti—to facilitate data management and the systematic analysis and coding of the interviews. We then pulled together various coded data (e.g. FAN basic concepts before and after training; Relationship between home visitor and families; Perception of home visiting program) using the Atlas.ti report outputs function and organized the data in thematic tables using Excel. The tables allowed for the reading of the data across time, across cases, and before and after the FAN training for each of the FAN basic concepts. This approach provided a way to estimate the frequency of the presence or absence of the FAN principles and strategies as well as a way to identify in what ways the FAN concepts were expressed within the context of the parents' narratives.

Integrity and Reliability Checks

There are a number of analytical challenges when coding a large quantity of qualitative data, starting with the quality of the data. As with any large undertaking of qualitative data collection, there is a learning curve. We found that overall the quality of the data improved over time as interviewers became more familiar with the protocol and were able to employ more in-depth probes to elicit information that would allow us to detect each parent's home visitor's approach to home visiting. At the same time, there were some later interviews that were much less rich than earlier ones. Thinking critically during a qualitative interview by moving beyond superficial or common sense meanings or what sociologists refer to as "making the familiar strange" is usually a challenge when conducting a large number of interviews. It may lead to interviewers' fatigue and less frequent probes for additional information because it is more difficult to see what is and is not familiar. It may give the interviewer and also the analyst an illusion of saturation of information, when there is still more to learn.

Likewise, our qualitative research analysts also improved their understanding of the FAN concepts as coding and analysis progressed over time and this was confirmed by research team discussions around the approach. Therefore, we were aware that coding became more focused and accurate over time. We addressed this challenge by going back to review the coding of early documents to ensure the level and accuracy of coding were similar throughout the coding process. In addition, in early coding, three analysts coded a sample of interviews. Next, we created report outputs of coded data generated by Altas.ti for group discussions around their interpretation. Although we relied on one primary analyst for the coding and analysis of the interviews, we held regular research team discussions to assess the interpretation of parents' narratives related to the FAN core processes and concepts to address potential bias.

In addition, we were well aware of the potential for bias when coding for the absence and presence of the FAN concepts in the pre and posttraining cohorts. One way to avoid this type of bias would have been to blindly code all the interviews without the prior knowledge of parents' who were interviewed before and after their home visitors received the FAN training. This analytical approach, nonetheless, was not a viable option because we could not afford to wait for at least a year until we had all the pre and posttraining data. Therefore we had to start reading, coding and analyzing the pretraining sample. To mitigate this bias, however, we randomly selected a small sample of five interviews from both the pre- and posttraining sample to be coded by two additional analysts. We then discussed the interpretation of the coded texts with our research team. The interpretation of the recoded texts was compared to the documents that were not blindly coded. We found only a couple of inconsistencies. Also, during the process of systematically organizing the quotes according to the identified FAN concepts, we arranged the coded data sets without a label indicating the origin of their sample cohorts (pre or posttraining).

These documents were reviewed by two analysts and followed by research team discussions around the interpretation regarding the presence or absence of the FAN concepts. Again, we only found a few inconsistencies. We speculate that few inconsistencies were found because of ongoing team discussions around the interpretation of the FAN concepts within parents' narratives during coding and analysis write-ups.

Finally, when applicable, we triangulated our data to look for corresponding themes in the home visitors and supervisors' focus group and interview data. For example, programs in which we observed greater internalization of the FAN approach among staff appeared to be linked to parents' narratives, which provided evidence that their home visitors were incorporating the FAN concepts in their practice. Conversely, programs in which we observed more resistance to the use of the FAN approach were linked to parents whose narratives lacked the FAN concepts.

The full report provides numerous examples of common themes reflected in the staff and parent data. In the tables below, we provide additional excerpts from the staff and parent narratives along with a summary table of differences in parents' home visiting experiences before and after training.

Table B-1. Themes in Home Visitors' Narratives of Practice Associated with the FAN Approach

Themes	Illustrative Excerpts from Home Visitor Focus Groups	
	Time 1 **(9 months into implementation)**	**Time 2** **(18 months into implementation)**
Reading parents' cues/ meeting parents where they are/matching	When I really sat with her. . . and let her have that **angry moment versus saying,** "Okay, I can keep talking about it, but where you are gonna do? What are you gonna do?" **That was me skipping ahead**, but she wasn't ready, so sitting with her kind of allowed her to engage further with me, and so to move us forward a little bit. So I think about, yeah, **like six to eight months ago, it feels like it started to really make difference in the visit**. No, they're not in a place to fix it and having an understanding of **where parents are at in** fixing things and how they're feeling about thing [is helpful]. W**e're still exploring**. We're still asking questions. **I'll read her cues, and being able to read those cues of when she's ready to move into on capacity building**. I think that's going to be more of what I carry with me [from the FAN training]. For me, it's having a better understanding of how to read the parents, what they want. **Are they ready to move forward with finding a solution, or am I just sitting here listening?** I think just in general, **I'm going to definitely implement that in all my visits**, and I already do.	Especially when we talked about cues, like she said, there are times that it can be cultural. Where it's not that they're not ready to do. It's just maybe they're embarrassed to do or they're shy to do or need that little extra push. When it comes to cues like that, I think I'm on it [FAN training] has been really good at **helping me realize where someone else is, versus where you are**. I jumped to doing a lot. I've noticed a change in the visits. I don't think they have consciously noticed a change, but when I started, it was very parent-child activity, and so it was always, "Let's have the child there, because we always do an activity." **And over the course of time we're matching mom,** and we're staying in these other areas [i.e., core processes]. It's good that we have a way to label everything. It keeps me focused in my visits about where my parents are and holding me back from always doing, doing, doing. I've gotten better at just sitting with their feelings and talking with them about that. I feel the training has overall helped me relate with my parents a little bit more.
Encouraging parents to lead visit/focusing on parents' concerns/ listening	I feel like it's helped a lot with my parents and with my clients. In terms of, it helps more, guiding them to think on their own, than us finding the answer for them. I have a tendency to kind of just give them the answer. It's just how I am. . . but I always want to be the one helping and guiding. So, this has really helped me step back and ask the questions to get them thinking to answer their own questions. That's helped me a lot. [I am now realizing] that most of the time I thought "why don't my clients get it? Why don't my clients get it?" Like the information you provide and then you're doing it and giving	With the Arc of the Visit questions I hear more about what they are thinking instead of what I am thinking. It's more of them than on me. I am not there to fix their problems. I am there to help them see what they can do. She started talking about how she was frustrated about it and she was expressing that. Then I asked her something like, "How does that make you feel or what do you think about that?" instead of saying, "Well, that really sucks" or something maybe like that a friend would have said. The look on her face when I asked her how she felt, maybe like if I stayed in the empathic inquiry for example. She was

Themes	Illustrative Excerpts from Home Visitor Focus Groups	
	Time 1 **(9 months into implementation)**	**Time 2** **(18 months into implementation)**
	it and repeating it, and some of the handouts that talk about the same thing, you know? That's my agenda. **That's not their agenda.** They're not thinking that that's what they want to do and this is because I'm telling them. . . . How do you train this little boy. . . He's going to be four years and he's not potty-trained. They're now acknowledging that that's not their priority. In every visit. I listen more. I don't try to rescue them. I try to listen more to what they have to say.	shocked that somebody would ask her, "How do you feel about this? Wow. That sounds like it could be really difficult." I think she really enjoyed it. I think that it's a different approach for most of these families, too, as to how people speak to them and how they ask them about parenting. I'm going to say pieces of it will stay with me. Yes. I think that what I got from everything is one of the things I got from is to meet the parents where they are at. I sometimes come in with our agenda I know I have and I want to talk about something specific and parents are in feelings are somewhere else and talk about different topics. I think I have learned to ask the parents in the beginning as well, "What do you want to talk about?" Or in the middle looking at, I have this to bring but what do you have to say to me? I kind of learned to do that a little bit on my visits. I think it has opened a door of trust too with the families that are thinking, "Oh, she doesn't come here for just what she wants but she really cares about what I have to say." At least that's where I want to be able to be with my families.
Exploring parents' concerns together/ helping them find their own solutions	We were [doing] more of the doing than helping them explore and figure out those feelings. We'll label them in helping them see the interactions that they're really having with their children. It was hard at the beginning just to step back and let them try. . . . Like she said, not to jump in and say this. . . but little by little, and having the Fussy Baby and then the new changes for the program with the same approach, I feel like I would do much better work. The whole thing about the collaboration or where you think **they're trying to think through the process and maybe they can come up with an answer to the problem as opposed to me trying to hand it to them.** I incorporate this in working with them, because I don't have their answers. And I remind myself	All these red flag stood up for me I was like, "No, let's explore why she wants this." I would have never thought that she doesn't want her baby to grow. I was thinking of other reasons why it would be and would be "Why don't you want her to crawl on the floor?" She opened up to me about that. I was "Wow." That definitely helped me understand. We definitely did the doing initially, helping her to get the order of protection, following through with that type of stuff, but now with processing the feelings, now that it's been a month or two, I'm staying with mom where she's at and how she's feeling about the relationship because culturally her family expects her to stay with her abuser. . . [And thinking] of what mom is feeling in that moment and definitely connecting to where

Themes	Illustrative Excerpts from Home Visitor Focus Groups	
	Time 1 **(9 months into implementation)**	**Time 2** **(18 months into implementation)**
	that I don't have their answers and that I need to allow them to sometimes figure out how we want to do something**.** I don't have to fix it now. Mom came up with it herself, **where before I might have told her what I thought the solution was.** **I do a lot of capacity building with her [a client] and a lot of collaborative exploration**, and she always is like, **"Remember what we talked about last week?** I tried that, and it's happening this week." She's so excited about those things, and I'm like, "Sweet."	she is. She was definitely doing in the beginning but now she's wanting to process and she's wanting to feel supported and that's what we're really trying to focus on. If they have a question or a concern about something that's happening, I feel as though they feel comfortable enough to ask, "What do you think about this?" Or "Do you know of anything?" Then I might bring over a referral or some information and then from there they follow up. So it's something that's a collaboration with the both of us instead of just them or [me].
Recognizing and regulating feelings during visits	[I am] using the whole FAN process, having that better understanding, **and like the mindful self-regulation, just being more aware of my feelings during visits.** I think the MSR I use every day. If I feel like I'm getting stressed by their stress, I've learned ways to cope with that through the mindful self-regulation.	Once I was able to channel my own [feelings], it helped me to be able to slow down with the participants and help them problem solve better. When it comes to wanting to do the doing, I realize when a parent asks me a question, I feel pretty anxious about it. I feel I need to give them an answer. It helped me set myself back and say "You know what? Take your time. You don't have to know **everything.** Why are you getting so anxious about it, and process everything." I feel once I was able to channel my own MSR, it helped me to be able to slow down with the participants and help them problem solve better. I think it probably has helped me. . . . The MSR, probably with burnout. Probably helped me with that. I really do use the mindful-self-regulation.

Table B-2. Summary of Parents' Home Visiting Experiences before and after FAN Training

Aspect of Home Visit	Pretraining	Posttraining
Visit Format	Addresses parents' concerns Asks parents if they have questions or provides the opportunity to talk about their concerns but is more centered on the topic of the day Visit main focus is on child developmental milestones and development (age and stages) Curriculum: Pre-determined	Addresses parents' concerns Asks parents if they have questions or provides the opportunity to talk about their concerns beyond home visiting agenda Visit seemed to be either planned or changed its course given parents' needs at that moment Some narratives suggest that visit is parent led ("they take my opinion into the home visits") Only a few mothers mentioned the ARC of engagement questions when prompted Curriculum: Flexible/ Meeting parent where they are at/ home visitors are not rigorous about agenda content
Visit Dynamics	Providing Education/information/suggestions	Providing information/education with signs of reflective posture, understanding feelings, and working together. Communication seemed less perfunctory and more reflective and unhurried ("sitting on one's hands").
Use of FAN Core Processes	Limited to providing suggestions. Limited evidence of FAN principles (i.e. reflective posture, addressing parents' concerns, attunement) – FAN core processes are lacking	Evidence of FAN core processes (Empathic Inquiry, Collaborative Exploration, Capacity Building, and Integration) and principles (reflective posture, addressing parents' concerns, parent-led visit, attunement)

Table B- 3. Themes in Mothers' Narratives about their Relationships with Home Visitors

Theme	Pretraining Excerpts	Posttraining Excerpts
Genuinely Cares	She actually cares about me. She actually tell me—like she offered me—she ask me do I need a baby stroller, some clothes, what do I need for him, and I tell her, and she'll get it.	It's a two-way conversation it's not just. . . . It's not that she's just here just because she has to be.
Can Relate to	She's caring, very outgoing. And, I don't know, she's very I guess realistic. Like, you know, I feel like I could relate to her on anything	She was sincere, because she actually went through the same thing that I went through, with her son. She said that she felt the same way, she didn't connect with her child, and she felt like she didn't want him either. It actually made me feel better to know that somebody else went through the same thing, and overcame it.
Get Personal	So even when I asked simple things about what I could use to be like in labor, like she got something that was extra personal	That I can talk to her about anything, that she's always extremely friendly and open with me. Not only do I share things with her, but she's shared a few things with me too. She's shared some personal experiences with me, not that she brings her personal business to me home. But, if I'm. . . I said, have you ever done this, or has this ever happened. She's shared some stories with me.
Reliable/ Trustworthy	And she's someone I could really depend on. Like if call her or want to ask her a question in text, I be like, "Oh, I need to know about this a little bit more." She could like call me and call me back and text me or tell me from a presence of—so yeah, she's pretty reliable.	She said that if I needed anything, if I needed anybody to listen to or anything that I can talk to her as well and that is all going to be confidential, she's not going to tell anybody. I think that part that's when I started feeling a lot more comfortable around her, just knowing that I could count on her for help if I needed, or just needed somebody to listen to.

Appendix C. Administrative Data Study of Participation in HFI Home Visiting Programs

Program retention is one potential indicator of client satisfaction or the value of home visiting services for clients. Clients are less likely to withdraw from relationships that they value, so it could be expected that positively valued service relationships might lead to less early termination and longer durations of participation in services. Other factors, such as agency staffing patterns and client mobility, can also influence retention, but we presume that the perceived value of the program to the client is the main influence on how long they stay with a program. To explore the potential effect of FAN training on client participation and retention we analyzed available HFI data stored in the IDHS Cornerstone database.

We examined the enrollment and participation histories for clients served by any programs taking part in the FAN training evaluation that had data in Cornerstone. We were able to obtain data for eight of the 10 programs in the study, three Wave 1 programs, four Wave 2 programs, and the Comparison program almost to the end of June 2016. (The Cornerstone data allow tracking of enrolled client experience for most agencies providing HFI services in Illinois, but not all; data for two of the Wave 2 programs were stored in another database.) Our analyses were limited by a combination of small sample sizes and relatively short periods of observation, especially for Wave 2 programs. That is, we were able to acquire full data for a period of 18 months beyond the enrollment of infants in the Wave 1, Wave 2, and Comparison programs pretraining samples, and 12 months beyond the enrollment of infants in the Wave 1 posttraining sample. However, we could only acquire full data for 9 months beyond the enrollment of infants in the Wave 2 and Comparison program posttraining samples.

Participation: Comparing Clients in FAN Training Sites and Other HFI Programs

We decided to focus our administrative data study on all of the clients of programs that participated in the FAN training (rather than only the ones who participated in interviews for the evaluation), based on the assumption that any client could have received about equal benefit from the training. In our first analysis, we compared clients in the group of seven programs which received FAN training with all other HFI programs in Cornerstone (which, in this case, included the Comparison group in the study). Although

similar training and information may have reached staff at some of these sites, our analysis compares seven programs (three Wave 1 and four Wave 2) to the 44 programs that did not receive FAN training.

Table C- 1 describes basic home visiting patterns for clients in the training and non-training programs. We separated all groups into 6-month entry cohorts to support examination of changes in the program indicators over time. The main variable of interest was the number of home visits the average client received and the proportion of the recommended visits (as determined by IDHS guidelines for each level-of-care classification) that actually occurred. These indicators combined the joint influences of client cooperation with agency fidelity to the home visiting model. The table also reports the average active duration of HFI enrollments and the average amount of inactive time that clients experienced.

The main findings in Table C- 1 are in the summary rows. The clients in all of the programs which received FAN training combined have a higher average number of visits (23.0) and a higher ratio of completed visits (0.81) than do the programs without FAN training (20.9 and .70). In contrast, the non-training programs have slightly longer average enrollment durations and less inactive time while enrolled than the programs that received FAN training. These differences are not necessarily the result of the FAN training and might just reflect different characteristics of the agencies that were selected for this training.

We followed each of these subgroups over time by looking at the experience of sequential entry cohorts. This allows the data for the FAN training programs to be examined for groups of clients who entered before the training was implemented, while the training was being delivered, and after the training was received. In this way, the pretraining cohorts serve as a partial comparison group, and the posttraining cohorts should demonstrate any measurable effects of the training on duration and amount of home visiting. For the Wave 1 and Wave 2 cohorts, the approximate training periods are indicated by the boxes that overlay each table. (The table for cohorts in the non-training programs has no such box.) In each of these tables, the final row is shaded to indicate that the values are artificially small, by an unknown amount, because of partial censorship of our observations. This means that some of the client cases were still active when the final data pull was made from Cornerstone (in June 2016), so some of their visits and part of the completed duration could not be included in the analysis.

Although there is some variation in these indicators across entry cohorts, there is nothing systematic, except that they reflect the overall group differences described above. There are some interesting anomalies that defy clear explanation. Notably, the Wave 1 sites see a marked drop in average visits for the cohorts that entered during training. Any theories that might describe this, however, must also explain why the Wave 2 sites show increased average visits for the cohorts that entered while they were engaged in FAN training.

Table C- 1. Home Visiting Participation of HFI Clients in 7 FAN Training Programs and 44 Other HFI Programs

	N clients	N Visits	Ratio of completed visits to prescribed		N weeks active	N weeks inactive	
	Sum	Mean			Mean	Mean	
Wave 1 Sites (	250	21.6	0.81		29.2	4.1	
Wave 2 Sites (	210	24.7	0.82		32.7	2.7	
Total	460	23.0	0.81		30.8	3.5	
Wave1 sites by entry date							
2012_1	37	20.1	0.87		26.6	3.6	
2012_2	38	26.9	0.76		34.8	3.9	
2013_1	32	25.8	0.87		32.7	3.1	
2013_2	41	22.5	0.80		29.4	4.1	training
2014_1	29	16.5	0.79		23.9	3.6	period
2014_2	28	24.2	0.93		32.5	5.2	
2015_1	32	18.0	0.71		27.6	6.2	
2015_2	13	12.5	0.74		19.7	2.3	
Wave2 sites by entry date							
2012_1	34	27.3	0.76		37.8	1.0	
2012_2	33	23.8	0.80		32.5	1.5	
2013_1	32	25.7	0.82		34.1	3.8	
2013_2	34	25.2	0.87		33.2	3.0	
2014_1	15	29.9	0.83		39.4	1.9	training
2014_2	22	27.2	0.80		33.5	3.1	period
2015_1	26	22.7	0.83		28.9	4.2	
2015_2	14	11.1	0.85		14.9	3.3	
Clients in other HFI	1,889	20.9	0.70		35.2	2.8	
Other HFI by entry date (no training)							
2012_1	43	20.9	0.92		51.4	9.9	
2012_2	279	21.9	0.66		40.7	4.1	
2013_1	268	24.2	0.73		42.0	2.2	
2013_2	269	22.9	0.71		37.9	2.9	
2014_1	266	21.5	0.65		35.5	2.8	
2014_2	250	22.2	0.70		34.8	3.1	
2015_1	272	17.5	0.65		29.1	1.5	
2015_2	242	15.7	0.80		22.6	1.7	

Note: Shaded cells are likely to be artificially low due to censoring, as data observations ended in spring 2016.

Duration and Number of Visits: Comparing Pretraining and Posttraining Clients

Table C- 2 compares the duration of HFI enrollments for clients in both Wave 1 and Wave 2 programs. One potential marker of client benefits from support services is longer program retention. Presumably, clients are less likely to withdraw from relationships that they value, so it could be expected that positively valued service relationships might lead to less early termination and longer durations of service spells. Other factors, such as agency staffing patterns and client mobility, can also influence retention, but we presume that the importance of benefits to the client is the main influence on how long they stay with a program.

The tables should be read across rows to see the gradual decrease in the size of each cohort over time. Looking at the percentage table, we see that the first Wave 1 cohort (2012-1) had 62 percent remaining involved in HFI after 6 months, 54 percent after one year, and 35 percent after two years. By definition, these numbers decrease from left to right as clients exit from HFI. Comparisons should be made vertically, which shows the elapsed duration after a set period of time for every cohort. As before, the periods of training are indicated with boxes. The final section of Table C- 2 shows percentage differences, subtracting the Wave 2 percentage for each cell from corresponding Wave 1 percentage. For some reason, the second (posttraining) Wave 1 and first (pretraining) Wave 2 cohorts show that, for these times only, Wave 1 clients exited from HFI much faster than Wave 2 clients. This time period includes the full year of training for Wave 1 sites, and the half-year before training and the first half-year of training for the Wave 2 sites. An explanation of why Wave 1 clients were more likely to leave than Wave 2 clients during this period of time is not clear.

Visit Fidelity: Comparing Pretraining and Posttraining Clients

The final table in this section, Table C- 3, compares exit patterns among the FAN training programs to those from the non-training programs that are used as a comparison. Overall, these show that clients in the FAN training programs do tend to remain enrolled in HFI longer than those from the comparison programs. However, two factors mitigate the usefulness of this observation. First, the programs showed a tendency towards longer durations before FAN training was implemented as well as afterwards, suggesting other factors might be affecting retention. Second, the unusual performance of the second (posttraining) Wave 1 and first (pretraining) Wave 2 cohorts, observed in the previous table, continue to show here. For these two sets of half-year entry cohorts, the difference observed in both prior and following years is not present. In this one period that is mostly during FAN training, the programs show poorer retention and shorter duration.

Table C- 2. Amount of Visitation in 8 HFI Programs

	Number enrolled	Number remaining active: at 3 mos	at 6 mos	at 9 mos	at 1 year	at 18 mos
Wave 1						
Pre Training	37	35	30	29	26	24
Post Training	22	22	22	20	16	5
Wave 2						
Pre Training	59	57	54	49	42	33
Post Training	32	31	30	25	6	
Comparison						
Pre Training	7	7	6	5	5	4
Post Training	6	6	4	3	0	

	Number of client visits completed during interval: 0-3 mos	3-6 mos	6-9 mos	9-12 mos	12-18 mos	18-24 mos
Wave 1						
Pre Training	331	296	250	208	305	266
Post Training	201	192	170	111	114	27
Wave 2						
Pre Training	504	488	463	370	471	322
Post Training	207	266	203	153	24	
Comparison						
Pre Training	49	64	62	42	57	15
Post Training	51	45	30	14	0	

	Average number of visits per client completed during interval: 0-3 mos	3-6 mos	6-9 mos	9-12 mos	12-18 mos	18-24 mos
Wave 1						
Pre Training	8.9	8.5	8.3	7.2	11.7	11.1
Post Training	9.1	8.7	7.7	5.6	7.1	5.4
Wave 2						
Pre Training	8.5	8.6	8.6	7.6	11.2	9.8
Post Training	6.5	8.6	6.8	6.1	4.0	
Comparison						
Pre Training	7.0	9.1	10.3	8.4	11.4	3.8
Post Training	8.5	7.5	7.5	4.7	-	

	Average number of visits per client per monthl: 0-3 mos	3-6 mos	6-9 mos	9-12 mos	12-18 mos	18-24 mos
Wave 1						
Pre Training	3.0	2.8	2.8	2.4	2.0	1.8
Post Training	3.0	2.9	2.6	1.9	1.2	0.9
Wave 2						
Pre Training	2.8	2.9	2.9	2.5	1.9	1.6
Post Training	2.2	2.9	2.3	2.0	0.7	
Comparison						
Pre Training	2.3	3.0	3.4	2.8	1.9	0.6
Post Training	2.8	2.5	2.5	1.6	-	

Notes: Darkly shaded Cells are fully CENSORED because of insufficient time in study period for these observations to be completed. Yellow cells are PARTIALLY censored: some observations had time to occur, others did not. These numbers would be expected to increase with more time of observation.

Table C- 3. Levels of Engagement and Visit Fidelity to HFI Model

Entire History tracked for each participant

	Number of clients enrolled	Level of Care Spells: Avg. N spells	avg weeks elig visit	avg weeks not elig	percent time elig visit	Actual vs. Expected visits, given level of care: Avg. N visits completed	Avg. N visits expected	Pct of exp visits completed
Wave 1								
Pre Training	37	5	93	14	87	58	65	89
Post Training	22	11	49	21	70	42	39	108
Wave 2								
Pre Training	59	4	81	14	85	53	66	80
Post Training	40	3	41	11	79	31	40	78
Comparison								
Pre Training	7	3	66	16	80	46	57	81
Post Training	7	2	29	21	58	24	32	76
Combined	172	4.5	67	14	83	46	54	85

Entire History tracked for each participant (participants with no eligible spells dropped)

	Number of clients enrolled	Level of Care Spells: Avg. N spells	avg weeks elig visit	avg weeks not elig	percent time elig visit	Actual vs. Expected visits, given level of care: Avg. N visits completed	Avg. N visits expected	Pct of exp visits completed
Wave 1								
Pre Training	37	5	93	14	87	58	65	89
Post Training	22	11	49	21	70	42	39	108
Wave 2								
Pre Training	58	4	81	14	85	53	66	80
Post Training	39	2	41	11	79	31	40	78
Comparison								
Pre Training	7	3	66	16	80	46	57	81
Post Training	6	2	29	21	58	24	32	76
Combined	169	4.6	68	14	83	47	55	85

History for each participant during first year of life (before first birthday)

	Number of clients enrolled	Level of Care Spells: Avg. N spells	avg weeks elig visit	avg weeks not elig	percent time elig visit	Actual vs. Expected visits, given level of care: Avg. N visits completed	Avg. N visits expected	Pct of exp visits completed
Wave 1								
Pre Training	37	3	39	3	93	29	38	76
Post Training	21	9	36	9	80	30	33	91
Wave 2								
Pre Training	54	2	43	2	96	31	43	72
Post Training	37	2	38	3	93	27	38	71
Comparison								
Pre Training	6	2	44	1	98	30	47	64
Post Training	6	2	34	1	97	23	37	62
Combined	161	3	40	3	93	29	39	75

Conclusion

The examination of retention and duration using administrative data in Cornerstone produced inconclusive results. For the Wave 1 participants, more of the pretraining cases terminated early compared to the posttraining cases. For example, all of the posttraining clients were still involved with HFI at 6 months, while almost one-quarter of the pretraining clients had left their programs. This evidence might point towards a positive influence of FAN training. The results for Wave 2 participants are not as clear, with both pre and posttraining groups showing very similar patterns of case duration. The comparison group is too small to sustain a valid pre and posttraining comparison.

The other issue with all of these indicators, especially those for the Wave 2 and Comparison participants, is that the elapsed time of observation was too short to observe the retention patterns of the client cases. An observation of case duration is termed "right-censored" when the final closing event is not observed because it had not yet occurred during the period when data were gathered. Overall, 31 percent of all cases were right-censored for duration. This is not equally distributed across groups. The Wave 1 cases had the least censorship, and the Wave 2 cases the most. The Wave 2 posttraining group had the most censorship, with final duration unobserved for one-half of all clients. Valid comparison of these data, especially for Wave 2 and the comparison program clients, must be deferred until a longer period of observation is available.

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