Minnesota's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Expansion Project Evaluation

Final Report
June 24, 2015

University of Minnesota

CEED
Center for Early Education and Development

Acknowledgements

The authors would like to thank all the supervisors, home visitors, infant mental health consultants, and administrators who provided so much information for this evaluation. They tirelessly took measures, filled out surveys, and talked to us. We are grateful.

We would also like the thank Jill Hennes, Maren Harris, and Candace Kragthorpe, at the Minnesota Department of Health for their guidance throughout the study. We are grateful for their patience, insights, and help.

We also want to thank our consultant at the beginning of the study, Dr. Mary McEathron, and our partner for the last part of the evaluation, Dr. Randi Nelson. Thank you also to Dr. Michael Harwell, our statistical consultant. Other CEED colleagues provided valuable input and support for the evaluation activities, Dr. Mary Harrison and Beth Menninga, whom we deeply thank. We thank Doug Moon, research assistant, as well.

We thank our advisory board who provided many insights along the way: Daniel Runion, Hennepin County; Ma Her, Ramsey County; Christine Andres, Kanabec County; and Dr. Megan Cox, Minnesota Department of Education.

This evaluation study was made possible by the Affordable Care Act of 2010 as the creator of the Maternal, Infant, Early Childhood Home Visiting Program (MIECHV), with funding and administration from the US Department of Health and Human Services: Health Resources and Services Administration (USSDHHS/HRSA), HRSA Grant #D89MC23539, and was conducted in partnership with the Minnesota Department of Health (MDH).

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I. Introduction

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

II. Background

Use of reflective practice (also referred to as reflective supervision, reflective consultation and reflective facilitation) is growing rapidly, spanning multiple programs and fields of study. Reflective practice is theorized to improve intervention efficacy, staff morale, and ultimately child outcomes. Although programs now employ reflective practice in home visiting, early childhood special education, and other fields as part of their commitment to competency-based interventions, further evidence is needed to define the capacity programs and staff need to provide and sustain reflective practice. Evidence is also needed to determine that implementing reflective practice results in the intended outcomes described above.

Reflective practice is a form of ongoing professional development that is characterized by a group of observable behaviors within interactions between supervisors/facilitators and supervisees. These behaviors are indicative of a set of essential elements of reflective practice that foster supervisor and practitioner self-awareness, reflective functioning, perspective-taking and problem solving and that result in self-report of improved self-regulation, increased job satisfaction and reduced burnout. Reflective practice, as implemented in this project, is grounded in attachment theory (Heller & Gilkerson, 2009), which maintains that the quality of children's earliest relationships can have a significant positive or negative effect on their life course. Also central to this approach is the belief that learning and development take place within the context of relationships (Marsili & Hughes, 2009; New Mexico Association for Infant Mental Health, 2008). This view of development posits that those caring for infants and young children, as well as those supporting these care-giving adults (i.e., home visitors), learn and attain competence through nurturing relationships with other adults. In reflective practice, the supervisor uses gentle inquiry to explore the practitioner's emotional experience related to the issues of concern and to explore the internal experiences of the child, parent and practitioner (Neilsen-Gatti, Watson, & Siegel, 2011). The supervisor creates a safe place where the practitioner can openly verbalize

thoughts and feelings about the child, parent and situation. In this process, the supervisor and practitioner explore the dynamics of the work and share the practitioner's responsibility in working intimately with children and their families. In a "tiered" system of reflective practice, the supervisor is offered the opportunity to experience the same type of supportive relationship through reflective practice provided by a mentor (e.g., another supervisor, infant mental health consultant, supervising peer, etc.).

The importance of the impact of relationships on all developmental domains has been brought to the foreground. This includes relationships between parent and interventionist, as well as parent and child. Ongoing professional development in the form of reflective practice supports the work of interventionists by fostering reflective functioning and facilitating a greater understanding of the impact of interactions and emotions in their work with families. This may lead to a broader and deeper range of intervention approaches and a better choice of intervention based on a deeper understanding of individual and family needs (Watson & Neilsen-Gatti, 2012).

In 2009, with funding from the Administration of Children and Families, MDH developed and began to implement an individualized reflective practice mentoring process for a cohort of eight volunteer supervisors. The goal of this mentoring process was to promote supervisors' capacity in reflective supervision of their home visiting staff, as well as to raise awareness and competence in home visiting staff related to the provision of relationship-based, reflective interventions to families receiving home visits. At the end of the training process, respondents, including both supervisors and home visitors, reported positive impacts, including an increase in their self-ratings on specific reflective practice-related capacities.

A. Contribution to the Home Visiting Knowledge Base

This evaluation furthers the exploration of reflective practice infrastructure, implementation, capacity-building, and its impact. This evaluation is unique in that it is one of a few studies that examine state-wide implementation of reflective practice. Up to this point in time, the bulk of literature regarding reflective practice exists in the clinical mental health field and the multidisciplinary field of infant mental health. The literature base on reflective practice is theoretical and/or presented through personal accounts and case studies. There is virtually no body of either qualitative or quantitative research that addresses reflective practice.

Minnesota has developed a focused and defined approach for implementing reflective practice, which involves mentoring from MDH, the use of Infant Mental Health Consultants working with local program staff, reflective supervision for home visitors and supervisors, and case consultations. Evaluation findings about this approach provide valuable knowledge to the field about the process of building reflective practice infrastructure capacity in a state.

B. Minnesota's Reflective Practice Professional Development Intervention

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

Two national, home visiting models were approved by the state of Minnesota for implementation of MIECHV: Nurse Family Partnership (NFP) and Healthy Families America (HFA). In Nurse Family Partnership, first time mothers are enrolled while pregnant and visited in their homes. Professional nurses provide prenatal visits once a week for the first four weeks, then every other week until the baby is born. Postpartum visits occur weekly for the first six weeks and then every other week until the baby is 21 months. From 21-24 months visits are monthly. Ongoing professional development is provided to nurses through weekly, one hour sessions with a supervisor and case conferences with other home visitors and the supervisor, which are held every two weeks for one and a half to two hours (Nurse Family Partnership, 2010).

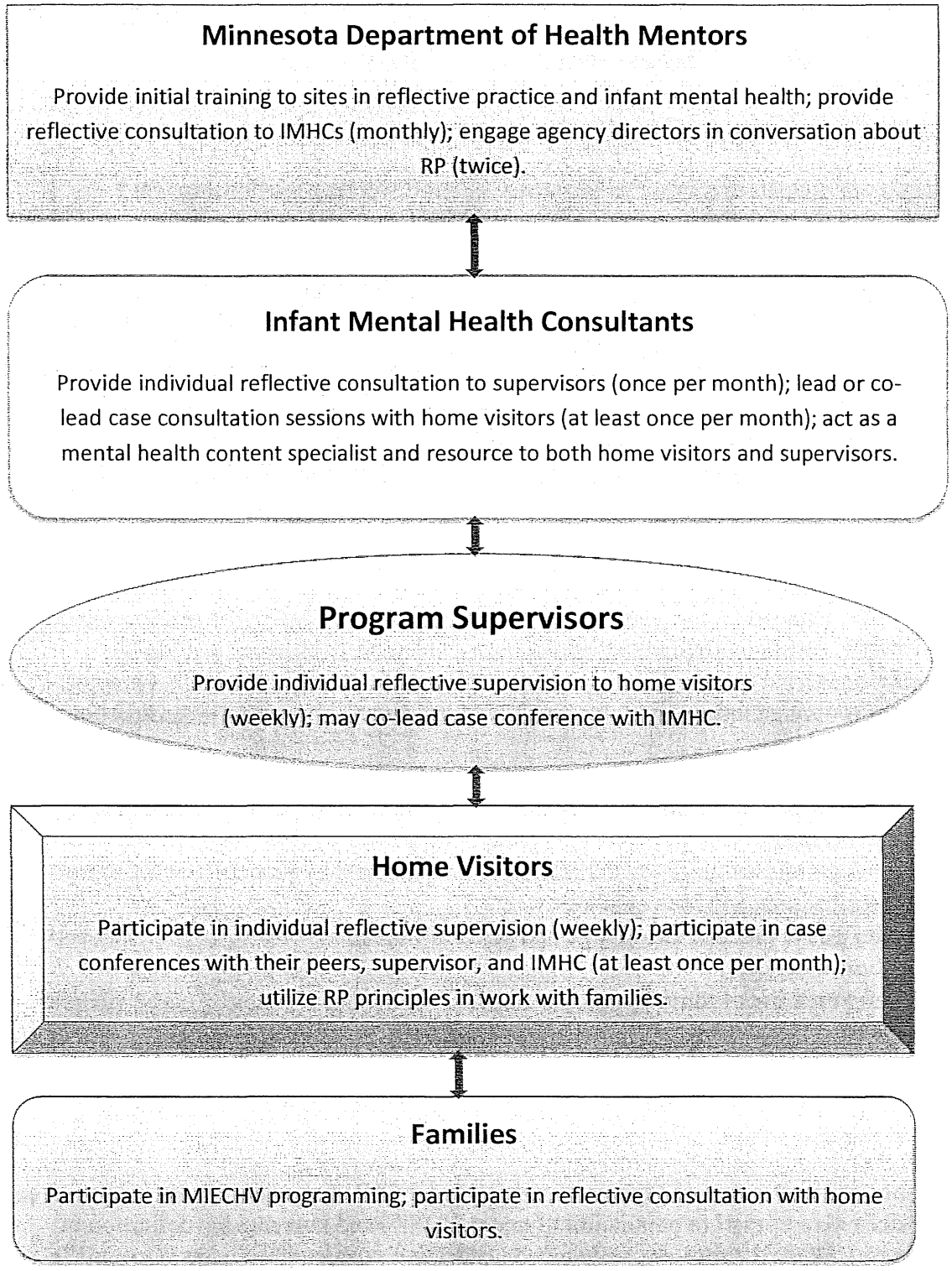
In Healthy Families America (2015), services are initiated prenatally or after birth, with weekly home visits to families with multiple stressors for at least two years by a trained professional. Services may be extended until the child is of school age. Home visitors participate in reflective supervision as support for their work. Although HFA is less explicit about the amount of supervision, MDH, as part of MIECHV, requires weekly reflective supervision and biweekly case conferencing (Personal communication, Jill Hennes, MDH, May 2015).

Funded sites could choose to use either or both of the models. Because this evaluation was not focused on differences between these models, there is no distinction made between models within this report. Both NFP and HFA are referred to simply as the "model(s)."

Figure 1 provides a visual representation of the MDH reflective practice capacity-building approach within the MIECHV Expansion Grant. The tiered delivery structure supports parallel processing of reflective practice elements through the use of:

1. Two MDH staff members, referred to as mentors, who provide initial training in infant mental health and reflective practice. These mentors provide reflective consultation to Infant Mental Health Consultants monthly and also provide reflective consultation to supervisors as needed;
2. Infant Mental Health Consultants, who provide ongoing individual supervision to supervisors, facilitate case conferences, and act as mental health content specialists and resources to home visitors and supervisors;
3. Supervisors, who provide reflective supervision to home visitors and work with the IMHC to facilitate case conferences; and
4. Home visitors, who receive reflective supervision, participate in case conferences, and who then use reflective practice principles in their work with families.

Figure 1. Minnesota's Tiered Delivery Model for Reflective Consultation


Minnesota Department of Health Mentors
Provide initial training to sites in reflective practice and infant mental health; provide reflective consultation to IMHCs (monthly); engage agency directors in conversation about RP (twice).
Infant Mental Health Consultants
Provide individual reflective consultation to supervisors (once per month); lead or co-lead case consultation sessions with home visitors (at least once per month); act as a mental health content specialist and resource to both home visitors and supervisors.
Program Supervisors
Provide individual reflective supervision to home visitors (weekly); may co-lead case conference with IMHC.
Home Visitors
Participate in individual reflective supervision (weekly); participate in case conferences with their peers, supervisor, and IMHC (at least once per month); utilize RP principles in work with families.
Families
Participate in MIECHV programming; participate in reflective consultation with home visitors.

C. Overview of the Evaluation Plan

The Minnesota evaluation plan began with an analysis of the overall state support of local programs for capacity-building in reflective practice. Simultaneously, over the course of the project, a series of tools were used to look at:

- whether participants reported the existence of good working relationships for implementing reflective practice — between MDH staff and local supervisors and in turn between local supervisors and their home visitors;
- whether there was growth in the use of reflective processes within reflective practice sessions conducted between MDH staff and local supervisors and in turn between local supervisors and their home visitors;
- whether the individual supervisor or home visitor perceived him/herself as changing internally—becoming more reflective—over the course of the project; and
- whether supervisors and home visitors participating in reflective practice reported a decrease in burnout and increase in improved perceptions about their accomplishments at work.

III. Design

The purpose of the evaluation was to determine the effectiveness of reflective practice mentoring provided by MDH staff in increasing the infrastructure capacities to support and sustain reflective practice in local home visiting programs. Both a process and a quasi-experimental impact evaluation were included. The plan considered influential elements of infrastructure capacity building including:

- state supports for implementation of reflective practice in local home visiting programs;
- beliefs and attitudes toward reflective practice held by program administrators, supervisors, and home visitors;
- reflective practice knowledge and skills of both home visiting supervisors and home visitors;
- reported use of reflective practice in their work with families by home visitors; and
- reduction in reported burnout and an increase in feelings of competence and successful achievement in their work by both home visiting supervisors and home visitors.

Overall, 19 sites across the state of Minnesota received MIECHV Expansion Grant funding. Ten sites met the definition of rural (a population of under 30,000) and nine met the definition of urban or suburban. Of the 19 sites, six were new to reflective practice (labeled as "Group 1"), and 13 had varying levels of prior experience with reflective practice (labeled as "Group 2"). Approximately 34 supervisors and 140 home visitors participated at these sites (numbers are approximate because of changes in personnel over time). Two MDH mentors led the

infrastructure capacity building, with ten Infant Mental Health Consultants serving the various agencies across the state.

Funding for reflective practice capacity building, an expansion of the MIECHV grant, was awarded to MDH in 2012. The original proposal projected that the implementation of the reflective practice infrastructure would last three years. However, due to several administrative delays, the actual implementation of the intervention did not start across all sites until September 2013 and took place over 18 months.

A. Infrastructure Capacity Building: Process Study

The design of this evaluation considered infrastructure capacity building at all levels of implementation: state, agency sites, and home visiting. As such, evaluation questions examined the following aspects of infrastructure: state supports and resources; beliefs and attitudes of site-level administrators, supervisors, and home visitors; knowledge and skills of supervisors and home visitors; reported use of reflective practice in work with families; and reduction of feelings of burnout and increase in professional efficacy in supervising and doing the work of home visiting. The goals of the process evaluation were to: 1) study the strength of relationships between factors that both influence implementation of reflective practice and are affected by adoption of reflective practice (e.g., mindfulness skills, burnout, reflective leadership, supervisor-home visitor interaction, and therapeutic alliance); 2) to understand perceptions about the intervention; and 3) to inform program efforts in order to improve overall programming.

B. Research Questions

The following section presents the reflective practice evaluation study's research questions that guided the process study including: rationale, measure, sample, methodology, and analysis.

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

Rationale. For the implementation of reflective practice to be successful and institutionalized, program sites and participants needed sufficient support to implement it. Thus, this question directly addressed whether support was sufficient and if not, what would be helpful. The question tapped all levels of the system, including state, site, and delivery.

Tools. In partnership with MDH staff, the CEED Evaluation Team (Stout, Watson, and Bailey) developed two different, yet similar versions of a survey (known as the "CEED survey"); one for supervisors (see Appendix A) and one for home visitors (see Appendix B). This survey was administered once in August 2013 and again in January 2015. The survey examined supervisors' and home visitors' perceptions of reflective practice sessions led by state-level and local supervisors and of support for implementing reflective practice in practice, among other things.

The CEED Evaluation Team also designed semi-structured interview protocols for each role (e.g., MDH Mentor (see Appendix C), Supervisor (see Appendix D), and home visitor (see

Appendix E). The interview protocol for the MDH mentors queried progress in fostering reflective practice capacity in both local supervisors and home visitors. A similar, but adapted semi-structured interview protocol asked local supervisors about their experience of being mentored and the impact of state support for improving their capacity to mentor home visitors.

Sample. The interview sample included MDH mentors, 28 local supervisors, and 60 home visitors, and the CEED Survey sample included 25 supervisors and 66 home visitors.

Methodology. This question was answered through interviews with state-level reflective practice mentors, local supervisors, and home visitors. The interviews with the MDH mentors and supervisors were conducted once in October/November 2013, following completion of training at all sites by MDH. The survey for supervisors and home visitors was given at the beginning of the grant period, August 2013 and before the end of the grant period in January of 2015.

***Research Question 2a:* Do local home visiting supervisors, who participate in reflective practice sessions with state mentors, gain new knowledge and skills in reflective practice?**

Rationale. After MDH mentors delivered training, home visiting supervisors became the bridge to the home visitors in the field. Supervisors' knowledge of and ability to incorporate reflective practice individually and in a group is a vital link to practice; thus any institutionalization of reflective practice depended on supervisors' implementation. We interviewed MDH mentors about their perception of the learning and knowledge that occurred from training and ongoing mentoring. We also asked the supervisors about their perceptions of the acquisition of reflective practice knowledge and skills. Supervisors also took a measure of mindfulness.

Tools. The Kentucky Inventory of Mindfulness Skills (KIMS) (Baer, Smith, & Allen, 2004) is a 39-item self-report measure for the assessment of four different mindfulness factors (observing, describing, acting with awareness, and accepting without judgment). Supervisor, Home Visitor, and Infant Mental Health Consultant Interview Protocols (see Appendices C-G). CEED Survey.

Sample. The interview sample consisted of MDH mentors (n=2) and home visiting supervisors (n=28). The KIMS sample consisted of 16 supervisors.

Methodology. We administered the KIMS at the beginning (April/May 2013), middle (December 2013/January /February 2014), and end (January 2015) of the grant period to measure home visiting supervisors' growth in reflective capacity as evidenced by the four scales of the measure.

We conducted semi-structured interviews with MDH mentors midway (February 2014) and at the end (February 2015) to obtain their perceptions of local home visiting supervisors' change in knowledge and skills. We interviewed site supervisors in October/November 2013 and at the end of the study in December 2014/January 2015.

There were also items on the CEED Survey that asked about knowledge and skills.

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

Rationale. If we expect home visitors to use reflective practice in the field, they should have it modeled in their work with supervisors. Home visitors are the contact point for families. Because of the difficulty of this work and the differing backgrounds and experience of the home visitors, skill levels with reflective practice could vary greatly. Thus, the evaluation tracked changes from the beginning of the Expansion Grant Project to the end, with the hope of showing improvements in knowledge and skills.

Tools. KIMS, Supervisor Interview Protocol (see Appendix D), Home Visitor Interview Protocol (see Appendix E).

Sample. The sample for the KIMS included 51 home visitors. For the interviews, we used a purposeful sample (Patton, 2002) in order to have representation from both groups and all sites. We interviewed 60 home visitors, with saturation occurring about midway through the interviews.

Methodology. We administered the KIMS at the beginning (April/May 2013), middle (December 2013/January 2014/February 2014), and end (January 2015) of the grant period to measure home visitors' growth in reflective capacity as evidenced by the four scales of the measure.

We conducted semi-structured interviews with MDH mentors midway (February 2014) and at the end (February 2015) to obtain their perceptions of home visitors' change in knowledge and skills. We interviewed site supervisors in October/November 2013 and at the end of the study in December 2014/January 2015, and we asked about growth in knowledge and skills for home visitors. We interviewed home visitors once, towards the end of the grant, January 2015.

There were also items on the CEED Survey that asked about knowledge and skills.

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

Rationale. Leadership is essential for new practices to be implemented and institutionalized; leaders' experience with and support of the Expansion Grant activities are important to determine in order to develop and maintain policies and practices that will sustain the intervention.

Tools. Zero to Three's Leadership Self-Assessment Tool (Parlakian, R., & Seibel, N. L., 2001). Administrator Interview Protocol (see Appendix F).

Sample. Agency administrators at all 19 funded sites.

Methodology. Directors completed the Leadership Self-Assessment (pre/post) to measure potential change in program directors' beliefs and attitudes about reflective leadership. Because our initial measurement data on this measure had no variability (i.e., all participants scored high in leadership), we did not give it a second time at the end of the grant. We conducted semi-structured interviews at the beginning (September/October 2013) and toward the end of the grant period (December 2014/January 2015) with the 19 agency heads to obtain their perceptions of reflective practice as professional development and its impact on their programs.

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

Rationale. The change literature notes that some people adopt innovations quickly, others need more time, and a third group is skeptical and resists change (Fullan, 2007). Because of the varied ways in which people respond to changing their practice, time and persistence are required for an innovation to take hold and to be institutionalized. Evaluation can provide feedback about response to change, particularly in attitudes and beliefs, that can inform the implementation process.

Tools. KIMS, Working Alliance Inventory-Short Revised (WAI-SR) (Munder, Wilmers, Leonhart, Linster, et al., 2010), which examines the relationship between supervisors and MDH staff and supervisors and home visitors. Beliefs and attitudes are developed within the context of working relationships. Supervisor Interview Protocol.

Sample. Twenty-nine home visiting supervisors across 19 sites.

Methodology. We administered the WAI-SR with the KIMS to measure the therapeutic alliance between local supervisors and the home visitors they supervise. The focus for this measure was on: (a) agreement on the tasks of reflective practice, (b) agreement on the goals of reflective practice, and (c) development of an affective bond.

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

Rationale. This question reflects the home visitor experiences related to the overall question of change in beliefs and attitudes.

Tools. KIMS, WAI-SR, Maslach Burnout Inventory (MBI) (Maslach, Jackson, & Leiter, 1996), which assesses professional burnout in human service, education, business, and government professions. The MBI contains three sub-scales: emotional exhaustion (EE) which measures feelings of being emotionally overextended and exhausted by one's work; depersonalization (DP) which measures an unfeeling and impersonal response toward recipients of one's service, care treatment, or instruction, and personal accomplishment (PA) which measures feelings of competence and successful achievement in one's work

Sample. Fifty-one home visitors took the three measures over three different time periods (beginning, middle, and end of the grant period). Interviews were conducted with a sample (described under RQ2b) of home visitors toward the end of the granting period.

Methodology. Methods were similar to those used for RQ 3b.

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

Rationale. As stated before, home visitors are the linchpin for improving outcomes for infants who are at-risk within Minnesota. As home visitors use reflective practice in their work with families, they model the process for the caregivers. Thus, we needed to determine if reflective practice was being used by home visitors and how it was being used.

Tools. CEED survey, Home Visitor Interview Protocol.

Sample. We drew a purposive sample of home visitors as described in RQ2b.

Methodology. We utilized semi-structured interviews, conducted near the end of the grant period (January 2015) to gain perspectives of home visitors regarding their experience using reflective practice.

Research Question 5a: **Do home visiting supervisors report less burnout and increased competence and successful achievement in their work?**

Rationale. Working with at risk populations is difficult and can lead to burnout. Reflective practice is a way of connecting with practice that teaches calm in the midst of challenging situations. If learning reflective practice and implementing was successful, participants should have experienced less burnout.

Tools. KIMS, MBI, WAI-SR, Supervisor Interview Protocol.

Sample. Home visiting supervisors (n=31)

Methodology. Home visiting supervisors completed the Maslach Burnout Inventory (MBI) as part of one questionnaire that included the KIMS, WAI-SR, and MBI. Administration was at three intervals as described above. Supervisors were also asked about burnout in their interviews.

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

Rationale. Learning a new skill can be stressful, as is working with families and infants who are at-risk. The underlying assumption the reflective practice goal of the Expansion Grant Project is

that reflective practice implemented with families will improve reflection by families about their roles and actions as infant caretakers (parents) (this was not measured). This is difficult work and turnover, particularly of home visitors, can be high. On the other hand, if the innovation is successfully adapted, the innovative tool of reflective practice has the potential to improve the knowledge, skills, and attitudes of both home visiting supervisors and home visitors, which in turn should improve outcomes for families and infants. Feedback about feelings of burnout and competence will inform future implementation for MDH.

Tools. MBI, Home Visitor Interview Protocol.

Sample. The sample included 60 home visitors with representation from every site and group.

Methodology. Home visitors completed the Maslach Burnout Inventory (MBI) as described above with the other measures.

C. Infrastructure Capacity Building: Impact Study

For the second part of the evaluation, an impact study was implemented using an interrupted time-series design. Time-series designs enable development of knowledge about an intervention in situations in which randomized controlled trials are not possible or would be premature. Time series studies are well-suited to initial evaluations that want to refine delivery of an intervention (Biglan, Ary, & Wagenaar, 2000). The 19 sites for the Expansion Grant Program were at different levels of implementation. Some sites started implementing reflective practice in 2008, and six sites had not used reflective practice at all. With a time-series study, the growth in reflective practice at these six sites that were new to reflective practice was measured. Results may be used to inform implementation by other states about the process and growth in reflective practice skills and knowledge.

The purpose of the impact study was to describe the growth in reflective practice as a result of the intervention. We employed a time-series design (Glass, 1997; Wholey, Hatry, Newcomer, 2010) using the six sites in Minnesota that are new to reflective practice. The Kentucky Inventory of Mindfulness Skills (KIMS), the Working Alliance Inventory Short Revised (WAI-SR), and the Maslach Burnout Inventory (MBI) were the three measures that provided the time series data. As a result of reflective practice training and implementation, it was hypothesized that:

1. Scores on the KIMS will increase;
2. Scores on the WAI-SR will increase; and
3. Scores on the MBI emotional exhaustion and depersonalization scales will decrease while scores on the personal accomplishment scale will increase.

Stated as research questions:

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

Tools. KIMS, WAI-SR, and KIMS.

Sample. There were six sites new to reflective practice, and these were the sites for the impact study. Because the sample of supervisors was too small, only the home visitors were part of this study. Fifty-one home visitors responded to the three measures that were part of the Measures Survey.

Methodology. The three measures were administered to the home visitors four times prior to delivery of the reflective practice training and start of reflective practice implementation. These administrations were once per month from March 2013 to June 2013. Although it was desirable to have more time between the four measures, doing so would have seriously hampered these new sites in implementing Expansion Grant activities.

Following the administration of the intervention (i.e., onsite training on reflective practice and infant mental health), the measures were given at bi-monthly intervals seven more times. Including the four administrations prior to the intervention, the home visitors in the impact study completed the measure for a total of 11times. The two month intervals were designed to be often enough to capture change but not too often to be contaminated by practice. While it is sometimes important to have the same interval for both pre- and post-measurement to minimize the threat of confounding due to a treatment x time interval interaction, in this case it was necessary to speed up the pre-measures in order to both complete a time-series design during the grant period and to allow sites to implement in a timely manner. Reflective practice takes time to adopt and should not be sensitive to different time intervals for the post-test compared to the pre-tests.

IV. Analyses

Descriptive statistics based on the total number of responses were part of reports generated by Qualtrics, an online survey system. Interviews were transcribed and analyzed using NVivo qualitative data analysis software (QSR International Pty Ltd. Version 10, 2012). Additional quantitative analyses were completed using the Statistical Package for Social Sciences (SPSS Inc.; version 22). Quantitative data were analyzed for group differences using the repeated measures analysis of variance (RM-ANOVA), when possible. Hierarchical Linear Modeling was used to study individual differences for the Impact Study. The analyses of the interviews and

surveys were compared to each other in order to identify commonalities, discrepancies, and to provide descriptive information for all research questions.

A. Process Study Analyses:

Descriptive statistics (e.g., frequencies, means, percentages, etc.) were conducted on data gathered from the CEED surveys completed by all home visitors and supervisors.

RM-ANOVA tests were conducted on data collected from all home visitors (i.e., both group 1 and group 2) on the three different measures (i.e., WAI-SR, KIMS, and MBI) across three time periods (at the beginning, middle, and end of the evaluation period). RM-ANOVAs were also conducted on the three sub-scales of the MBI (emotional exhaustion (EE), depersonalization (DP), and lack of personal accomplishment (PA)). There were a total of 51 home visitors who completed all three measures surveys.

RM-ANOVA tests were conducted on data collected from supervisors on the three different measures (i.e., WAI-SR, KIMS, and MBI) across three time periods (at the beginning, middle, and end of the evaluation period). RM-ANOVAs were also conducted on the three sub-scales of the MBI (emotional exhaustion (EE), depersonalization (DP), and lack of personal accomplishment (PA)). There were a total of 17 supervisors who completed all three Measures Survey.

The CEED survey was analyzed using SPSS. Analyses were conducted to look for potential relationships between demographic variables and self-reported knowledge and skills, beliefs and attitudes, and training. A total of 68 home visitors and 26 supervisors completed the survey.

Interview data were analyzed through bricolage (Kvale and Brinkman, 2008; Patton, 2002) or ad hoc (Miles & Huberman, 1994) techniques. Bricolage or ad hoc techniques rely less on systematic categorization and conversation analysis and more on weaving back and forth with the data, working from an overall impression, going back to interesting passages, sometimes counting statements about different responses to a particular issue, suggesting metaphors for key understandings, noting patterns and themes, seeing plausibility, making comparisons, and building a logical chain of evidence. Reflective practice requires a set of skills, as noted previously—self-awareness, reflective functioning, perspective-taking, etc.—which makes this type of analysis consistent with the intervention.

A. Impact Study Analyses:

RM-ANOVA tests were conducted on data collected from group 1 home visitors on the three different measures (i.e., WAI-SR, KIMS, and MBI) across the 11 time periods (4 prior to the intervention and 7 after the intervention). RM-ANOVAs were also conducted on the three sub-scales of the MBI (emotional exhaustion (EE), depersonalization (DP), and lack of personal

accomplishment (PA)). There were a total of eight home visitors who completed all 11 measures surveys.

Additionally, hierarchical linear modeling analysis was conducted for two levels of findings.

V. Demographic Information:

In order to better understand the findings, we first describe the respondents in greater detail. Two mentors from MDH are the foundation for the infrastructure. Several months into the evaluation, Infant Mental Health Consultants were hired to augment the role of the MDH mentors in the field. Each site had an IMHC who provided reflective supervision on a monthly basis to supervisors and either led or co-led the case consultation for the site. These consultants had some or all of the following qualifications:

- Licensed mental health professional in community;
- Earned the Minnesota Association for Infant and Early Childhood Mental Health (MAIECMH) Endorsement or meets all of the qualifications for endorsement as an Infant Mental Health Specialist at Level III or an Infant Mental Health Mentor (Clinical) at Level IV;
- Supervised experience working with children ages birth to three and their parents;
- Completed coursework in areas such as infant and toddler development, family-centered practice, cultural sensitivity, family relationships and dynamics, assessment and intervention; and
- Experienced in receiving and providing reflective supervision.

Supervisors delivered reflective practice individually to home visitors as required by both the Nurse Family Partnership and Healthy Families America models. Supervisors and home visitors also worked together monthly in a case consultation group, which, as stated, also had an IMHC.

Of the 25 supervisors who completed the CEED Survey, ages ranged from 25 – 64, with 44% in the 45-54 years age category. One reported as Asian and 24 as White. Fifteen had a Bachelor of Science or Arts degree and 10 had a post-graduate degree. Sixteen supervisors trained in public health, two are registered nurses, four are social workers, one is a psychologist, and two are both public health nurses and RN's.

Supervisors were asked to report the years participating in reflective practice (see Table 1). Note that 72% have three or more years of experience with 12% having more than 10 years of experience. They were also asked about their years of providing reflective supervision. Five responded with less than a year, and the majority fell in the 1-5 year range (see Table 2), evidencing that although they may have participated in reflective practice, reflective supervision is newer to them.

Table 1. Supervisors' years of participating in any type of reflective practice

# Years of Participating	#/% of Supervisors

Less than 1 year	8% (2/25)
1-2 years	20%5/25
3-5 years	28% (7/25
5-10 years	32% (8/25
More than 10 years	12%(3/25

Table 2. Supervisors' total number of years providing reflective supervision

# Years of Participating	#/% of Supervisors
Less than 1 year	20% (5/25)
1-2 years	36% (9/25)
3-5 years	28% (7/25)
5-10 years	16% (4/25)
More than 10 years	0% (0/25)

Of the 66 home visitors who completed the survey, one was under 25 years of age, 25 were in the 25-34 age range, 13 were in the 35-44 age range, 16 were in the 45-54 age range, and 11 were in the 55-64 age range. Two were Hispanic or Latino, and 66 reported themselves as White. In terms of education, one reported having some college, five have an Associate of Arts degree, 46 have a Bachelor of Arts or Science and 14 have post-graduate degrees. Forty-three home visitors are trained as public health nurses, six as RN's, two as LPN's, four as social workers, one as a community health worker, one as a marriage and family therapist, and one as a parent educator. Eight supervisors reported a mix of professional training including combinations of RN and PHN, infant/child development studies, sociologist, business degree, and arts degree.

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

The home visitor group was bifurcated in terms of experience, with 29 home visitors reporting ~~three years~~ or less experience and 20 reporting more than 10 years of experience. Nine home visitors had 4-6 years of experience, and eight had 7-10 years of experience. In terms of experience with reflective practice, five home visitors had less than one year, 35 had 1-2 years of experience, ten had 3-5 years of experience, 12 had 5-10 years of experience and three had more than ten years of experience (See Figure 2).

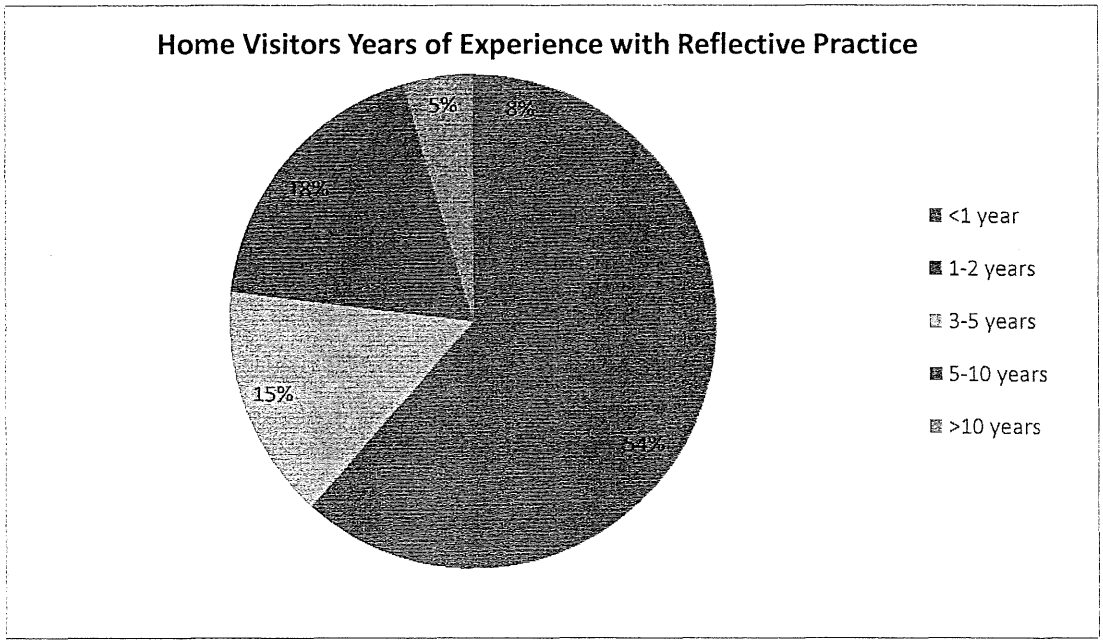


Figure 2: HV years of Experience with Reflective Practice

VI. Overall Quantitative Findings

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

For the initial leadership measure, it was expected that directors whose sites had participated longer in the intervention would differ on the leadership measure and in their interviews from those who had participated a shorter amount of time or who were new to the intervention. Analysis of the Leadership Measure indicated no variability among the respondents.

VII. Findings: Process Study

In this section, we provide findings to answer each research question.

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

Home Visitor Interview Findings

Home visitors were asked questions that pertained to the larger research question: Are state supports sufficient for implementing reflective practice in local programs? The home visitors were nearly evenly split in their opinions about the amount of training in reflective practice they have received. Roughly half of them reported that the amount of training they had received was about right, whereas the other half indicated that it was too little and in some cases came too late.

Some spoke of their interest in having additional or "refresher" training in reflective practice and on motivational interviewing, for instance. Others mentioned mental health as a topic about which they would like more training. And others voiced their opinion that it was difficult to receive so much training and try to incorporate different aspects of the models into their work at the same time.

- *I really appreciate the training. It's just a lot to take in. Even considering, like, two years, you know, that's a long time. But it's just you know, because on top of that, we're trying to maintain our caseload and go out and visit people. And so it's been hard in that respect;*
- *I think it's about right. But as I said, I would — I think it would be good to have this be an ongoing thing periodically. Which we have been doing so far;*
- *I guess I would say it was too little. You know because by the time we were trained, we were into the grant, like, about a year; and*
- *But we've had so many trainings on so many things with the MIECHV that I understand why we haven't. And we do have a good start on it, I believe.*

Some home visitors had specific ideas about the type of further training they would like to receive:

- *You know, maybe a training of — a little bit to provide a better understanding of the purpose of reflective practice would have been helpful. I now believe that I understand it, but it's a very different practice. You know, it's not — it's atypical for most work setting to take time to just reflect. I have not encountered that in all my years as a professional until now; and*
- *...I would — like, my assumption or knowledge about what I'm supposed to be getting out of the sessions is a place for me to unload on maybe my views or judgments of families. And then, like how that's making my emotions— or maybe how that's changing my nursing approach. How my perceptions of our interactions — me and the family — are affecting my nursing. And then also affecting me emotionally.*

The **issue of fidelity** in implementing was raised. This was in response to the question about what additional training, if any, home visitors would like to receive.

- *You know, it's one of those, "I don't know what you don't know." So I don't know if we need more or not. I guess we've never had anyone sit in on a reflective practice and say, yes, that's really good, or is it really doing what it needs to do.*

When asked if there were other types of support that they would like, the majority of home visitors replied that they couldn't think of any or they mentioned challenges at the local level that were largely due to local situations outside of sate influence.

Supervisor Interview Findings

Supervisors were asked about additional training they would like to receive and state supports were sufficient for implementing and sustaining reflective practice in local programs. The

supervisors expressed a wide range of responses. Preferred training topics included foundational training in reflective practice for new supervisors and "refresher" training in reflective practice.

- *I would like it if someone like [Maren] and those sort of thing started doing a bit more -- because I feel like, if it started, there was maybe workshops on this or things like that, maybe when it started. You know, for these new supervisors that are coming in, where is that kind of intro to reflective supervision. And what is this like, and what do you do when it goes poorly, and what do you do when it goes well, and . . .;*
- *I would be interested in just a training devoted to more on reflective practice, even basics I've already heard. Because I think -- kind of refresher or new skills would be wonderful; and*
- *Because even if you've been doing it a while, you know, you go to one of those, and after doing it a while, you hear something different than when you did the first time. Just like motivational interviewing. Kind of, every time you hear it, you're like, oh, wait. That resonates with me differently. And that would be, I think, really nice.*

Many mentioned that they would like to have the **opportunity to participate in an ongoing group for supervisors** who are providing reflective supervision to help them advance their knowledge and assist them in meeting challenges of their reflective work. One supervisor was specific in saying that more help with group facilitation/group process and case conference facilitating would be helpful.

- *I think -- from what I feel like is more of a realistic sense of what it's like to be a supervisor doing this, especially around the mentoring and monitoring side of things or the, you know, mix of reflective and administrative. Just to kind of think about what it is really to do those both. Being able to kind of think about this reflective piece while you still have to be an administrator and a supervisor with, you know, power when we're talking about reflective practice...So how do you -- and I mean, it's a topic that comes up a lot, but it would be nice to figure out a way to have support around that with -- I don't know, whether it's a group or whether it's a training or just a time to talk about it. And it would have to be small, and it would have to be, you know, a group that you trusted anyway. But it just seems like that would be a positive thing to think about as you're growing the skills. Because I think there's some real art to deciding which tool you use sometimes.*

Some supervisors reported that they felt they did not need additional supports to implement reflective practice in their programs.

- *But, no, I feel like I have enormous support from both MDH and from the infant mental health consultant; and*
- *I feel that we are -- in Minnesota, we have been given so many opportunities for, you know, continuing education and information about infant mental health, and now we've had the maternal mental health information. And it's just been -- we're very fortunate here in Minnesota.*

Those who said they would find additional resources helpful identified the following ideas:

- greater administrative support;
- guidance and access to relevant topics, journal articles, bibliographies and other literature they could use to increase their knowledge and skills; and
- having someone within their program who was trained (and endorsed) as an infant mental health specialist and reflective supervisor.

An additional issue that was raised concerned **universal access to consultation** for home visitors, including those who are not delivering services through one of the evidence-based models. As one supervisor put it:

- *I mean, I supervise for three nurses are -- do that specifically, and I have, like, seven other nurses who don't do -- who do family home visiting not in the model. And I kind of wish that they would have some -- I mean, I am reflective with them, but I wish that they had more opportunities for case consultation with the infant mental health consultant and stuff like that. Because I kind of feel like whether they're in the model or they're not, they still need to be reflective, and families should have that. So I guess I would say that I wish that it was across all home visiting programs.*

Supervisors, as was the case with home visitors, were concerned about ways to ensure fidelity to the models, including the use of reflective practice.
Supervisors identified two crucial factors regarding sustaining the use of reflective practice in local programs over time. The first is internal to the programs and is simply a firm commitment on the part of staff to reflective practice as an integral component of the work.

- *But I also think that you have to have a supervisor who wholly, truly, 100% believes in it;*
- *I think the commitment that everybody gives to it. You know, the value that everybody sees and the commitment we all have to continue it; and*
- *Mm-hmm. It takes your executive director, your supervisors above you. It takes all of the administrative entities to buy into it and see the value in it as well. It takes the funding sources buying into it and knowing that maybe your FTE needs to be a little bit bigger to accommodate for those kind of things. And then it -- you know, the people that do the direct work to have a sense of it or an experience of it and find value in it as well.*

The second crucial component identified by the supervisors is **communication about reflective practice—and about home visiting in general.**

- *I think we have to advocate for it and be able to articulate it, like you said earlier. We have to articulate what this is. You know, like, why it is important;*
- *I think people need to understand the importance of it and almost to experience it or see the -- how nurses benefit from it. You know, to hear some of the stories that nurses hear and deal with, and how do you come away with that and take that -- and not take that home to your own bed at night? That makes a difference; and*
- *I'm not going to say that, you know, the powers that be -- our county commissioners or above us really understand reflective practice or what we do. And so that's always a*

challenge for our supervisor to support us. And yet, she has to answer to the board when looking at staffing and other issues;

- *...educating the stakeholders, or, you know, the one that are making the decisions. I don't think they really understand what home visiting is and what reflective practice is.*

Infant Mental Health Consultant Findings

Infant Mental Health Consultants were asked three interview questions pertaining to resources: 1) What resources would help them in providing consultation to agencies, supervisors and home visitors? 2) What ideas do you have for trainings on reflective practice /reflective supervision? and 3) What will it take to institutionalize reflective practice statewide?

Infant mental Health Consultants did not specifically name resources that would help them in their work, except those pertaining to training. In terms of training, IMHCs mentioned access to a basic level of reflective practice training and infant mental health training. This needs to be available on an ongoing basis, so that when there is turnover, there's not a lag time for the home visitor to receive training. Once basic training access is in place, IMHCs had several ideas for other trainings that they believe home visitors and supervisors need. Two mentioned having a case conference group for supervisors only. Several also noted that after a new hire has been in the field a while, there should be follow-up training. Other topics that were mentioned for training included: unique issues of premature babies, maternal depression, maternal mental health, chemical substance abuse, adolescent parents, adult and infant attachment, genograms, cultural understanding, and mindfulness.

Echoed across these three questions from the IMHCs was a conviction that reflective practice training needs to reach more people across agencies.

- *Helping people understand the importance of it [reflective practice], I think, is needed, too, so they will allow individuals working with others the time to think about their cases and to reflect upon them; and*
- *If people are getting it at that level (policymaker administrative level), then they're having experiences, you know, that validate the importance of the practice and then it's more likely to be supported and, you know, kind of played out down the line.*

Related to the belief that more professionals need training in reflective practice, there is also the belief that there needs to be a change of mindset about reflective practice. For example:

- *I also think changing the mindset that if you talk about feelings that you're weak. I think that's part of the struggle;*
- *I think, from the higher-ups to have an understanding of the benefit. Because, you know, we can do what we can do from the bottom up; and*
- *Also to wrap their heads around what it is. Because I still think that they're (administrators and boards) a little bit skeptical, not skeptical of the process, but just wondering if it's necessary.*

Program Administrator Interview Findings

Program administrators were asked about the adequacy of resources to implement reflective practice. A majority of them stated that they feel they have adequate resources.

- *Yes, we have. And I think it's partly -- you know, my manager really endorses it. And so we've had the financial resources. And that's the main resource I would say. But she also endorses, you know, the particular -- the quality of the particular individuals that we've found that help provide that for the program; and*
- *The MIECHV, you know, expansion grant dollars that carved out the money are probably the most beneficial thing that we could have had. It would be a lot harder to decide where that funding would come from if we didn't have that identified specifically. And that would be -- you know, we definitely would scale back in terms of our use of the consultant. It's not cheap, but the amount factored into the MIECHV grant has provided us really good access to what we need.*

Some administrators, however, indicated that without MIECHV to support it, **continuation of reflective practice may be at jeopardy**:

- *With the MIECHV grant, we have (sufficient financial resources). If we did not have that grant, that would probably be something that would be very challenging to keep;*
- *Right now, yes. And it's because of MIECHV. I do get nervous if we don't get the MIECHV again, how we would be able to fund this work; and*
- *Well, I think we have had -- we've had what we needed within the grant for the direct people that are working in the program. And we were able to, like I say, we have been able to do a few additional things, which has been great. But, you know, without the monies and funds, I -- well, it's just hard, you know. It's so hard to get approved to go to things unless it's -- like, it is almost helpful if it's part of your grant, you know, where you have to do it because it's part of the grant. And that at least gets people trained. But, you know, without that -- without the funding, it's really hard to access some of those trainings. That's the way it is, you know.*

Some administrators voiced their desire for more training.

- *Because there is a lot of money in MIECHV to -- or in the extension MIECHV for reflective practice. But it all goes toward consultation and not toward training for reflective practice. I do feel like there's plenty of money for the infant mental health consultant. But it has been a challenge for scheduling, on both ends, not just . . . It is -- and I do think we are trying to figure -- we are working with her to figure out a way how maybe creatively that we can use some of that, including maybe some training on her end for us. We also -- time is the challenge, too, especially when we start looking at other programs. So who is going to do it if people haven't been trained? You know, we have to have someone who's trained in reflective supervision to provide it and -- to the other programs. And we're just very -- we haven't had people trained, it costs money, and then the time involved is the challenge.*

Access to state-sponsored training was another issue raised by administrators. This is an issue for programs in rural areas in particular.

- *I think the other barriers to the training is offering it in more areas of the state. Bring it closer to us. I mean, I would be more than happy to host something here in (our town). We've got a wonderful training area. You know, bring it right out here. And, you know, we always look at the fact that we can send -- if something is in (our town), I can make arrangements to send my entire staff. But if something is in (one of the towns farther away), that's a whole different ballgame. And farther away than that, then I have to choose.*

Some administrators talked of their **commitment to continuing reflective practice**, no matter what happens with state support for it.

- *Yes, I do. I think -- you know, grateful for the expansion grant, obviously. Because, you know, I don't think it would have gotten off the ground without it. You know, it would have been kind of a hard sell. So I think, if nothing else, it's a jumping board to -- you know, okay, we've gone this far. We don't want to go backwards. But I feel like Jill up at MDH has just been wonderful whenever we have a question or anything. And I felt the way that the MDH kind of tiered it off where she was with us at the initial part of the grant and helped us actually find a contractor, it just -- it really went so smoothly. Instead of saying, this is something you need to do. You're on your own. Go find somebody. It is just -- I just really felt that it was well done; and*
- *I think we're really fortunate, absolutely, yeah. I know that that's not true across the state, but yeah, absolutely. We've been very -- and, you know, certainly the MIECHV funding has helped, and it gave us the boost that we needed, I think, to be able to see what we needed to do. And if it's at all possible to continue to build it into the budget going forward, MIECHV or not, we will.*

Conclusion

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

b. Research Question 2a: Do supervisors, who participate in reflective practice sessions with state mentors, gain new knowledge and skills in reflective practice?

CEED Survey Findings

Because the CEED Survey that was given as a baseline at the beginning of the project showed little variability, we revised the items to ask more directly about change over the length of the grant. Table 3 shows how supervisor respondents reported change in their knowledge of reflective practice over the grant period. Adding up the columns for "My knowledge has greatly increased" and "My knowledge has somewhat increased," shows that supervisors in general believe they have increased their knowledge. Percentages from these two columns range from 84-96%.

Table 3. Supervisors' perceived change in knowledge of reflective practice over grant period

Reflective Practice Principle	My knowledge has greatly increased.	My knowledge has somewhat increased.	My knowledge has stayed about the same.
Create a safe, trusting relationship	24% (6/25)	60% (15/25)	16% (4/25)
Attend to parallel process	44% (11/25)	44% (11/25)	12% (3/25)
Pause and reflect	36% (9/25)	48% (12/25)	16% (4/25)
Explore different perspectives	40% (10/25)	52% (13/25)	8% (2/25)
Consider behavior in the context of relationships	32% (8/25)	64% (16/25)	4% (1/25)
Explore thoughts and feelings	40% (10/25)	48% (12/25)	12% (3/25)
Pay attention to self-regulation and co-regulation	40% (10/25)	52% (13/25)	8% (2/25)
Maintain a clear sense of roles and boundaries	28% (7/25)	56% (14/25)	16% (4/25)
Value the importance of repair in relationships	36% (9/25)	48% (12/25)	16% (4/25)
Pay attention to my experience and how it influences my practice	44% (11/25)	48% (12/25)	8% (2/25)
Develop collaborative relationships	36% (9/25)	48% (12/25)	16% (4/25)
Keep the baby in mind	52% (13/32)	40% (10/32)	8% (2/25)

Supervisors also report increased use of the knowledge and skills for reflective practice. Table 4 indicates that most supervisors (72%-96%) perceive themselves as somewhat or greatly increasing in use of reflective practice skills

Table 4. Supervisors' perceived change in use of reflective practice over grant period

Reflective Practice Principle	My use has greatly increased.	My use has somewhat increased.	My use has stayed about the same.
Create a safe, trusting relationship	24% (6/25)	48% (12/25)	28% (7/25)
Attend to parallel process	44% (11/25)	44% (11/25)	12% (3/25)
Pause and reflect	48% (12/25)	40% (10/25)	12% (3/25)
Explore different perspectives	36% (9/25)	60% (15/25)	4% (1/25)
Consider behavior in the context of relationships	44% (11/25)	48% (12/25)	8% (2/25)
Explore thoughts and feelings	44% (11/25)	44% (11/25)	12% (3/25)
Pay attention to self-regulation and co-regulation	36% (9/25)	48% (12/25)	16% (4/25)
Maintain a clear sense of roles and boundaries	28% (7/25)	52% (13/25)	20% (5/25)
Value the importance of repair in relationships	44% (11/25)	44% (11/25)	12% (3/25)
Pay attention to my experience and how it influences my practice	44% (11/25)	48% (12/25)	8% (2/25)
Develop collaborative relationships	32% (8/25)	60% (15/25)	8% (2/25)
Keep the baby in mind	40% (10/32)	48% (12/32)	12% (3/25)

Although some change over time was evidenced on the CEED survey, a chi-square analysis of the data did not yield any significant relationships with demographic data. This may be because some cell counts were simply too low. At this time, the data do not suggest significant differences by demographics.

Supervisor Interview Findings

The most prevalent theme for the question on knowledge and skills was the skill of slowing down and listening, known within the reflective practice literature as "**pause and reflect.**" In general, supervisors are aware of the importance of slowing down the dialogue and processing with the home visitor, and that when they do slow down, the home visitor is able to see the issue differently. For example:

- *If you stay open to it, and you wonder with this family, that's where it'll come into play. And you listen, because it's really not about supervision. It's about listening;*

- *I am listening more and talking less, and I'm trying to consciously do that; and*
- *Slowing down is very useful. . I'd say our consultant is especially skilled in helping us slow down and really look at the core of the issue so that we're not too quick to react with the peripheral things, like the concrete stuff. But to really slow down and look at the meaning of what's happening.*

A second and related theme is "**wondering, not fixing.**" This is the skill of creating a safe environment for wondering and exploring so home visitors and families can find their own understandings. Adults are more likely to act when they take ownership of/play a role in developing a solution. For example:

- *I'm curious by nature, so being curious with them about why clients react a certain way or reflecting with a nurse on how to change behaviors is -- it's challenging, but it's very interesting. And because I'm curious, it -- you know, I can -- you know, I'm really curious why and, you know, get the nurse to start thinking about why; and*
- *We're spending more time wondering.*

In terms of more broad skills and knowledge, there were a cluster of responses around several important reflective practices, notably, reflective functioning, parallel processing, focus on the baby, and a theme we call **"going deeper."** Related to reflective functioning, supervisors noted their efforts to wonder so that the home visitors are able to explore the perspectives of the family and baby.

- *Being able to explore -- kind of look back and explore and look forward at the same time, but look back and explore our experiences to learn from them. And maybe not even learn from them isn't really the goal. Sometimes it's just being in the moment and being able to look at it from different perspectives.*

Both supervisors and home visitors use the term parallel processing, evidencing their awareness of the chain of processing that, in theory, is passed to the mother and family.

- *And we're spending more time thinking about parallel process. I'm -- more deliberately than I have been, bringing parallel process to the attention of the nurse.*

Equally evident throughout all the data is the focus on the baby.

- *A lot of times, with some of the families we see, they have a hard time focusing on the children or focusing on -- and so with reflective practice, we bring it back to that relationship between the mother and the child or children and help them focus on that.*

Finally, the theme of **going deeper** connects many of these skills and knowledge. Going deeper for these respondents involved both looking for causes in the behaviors in families and also looking at one's own behavior for understanding one's response to situations. Additionally, supervisors recognize that going deeper is part of being reflective and that it is a skill at which they want to improve. Responses evidence both the need for going deeper and the challenge of doing so. For example:

- *That's kind of my challenge, especially now, I'm working with newer people that haven't done much reflective. It is really, how do you get them to reflect, not just tell a*

monologue, a story, you know. And so I think it comes down to asking those questions. I mean, I think I do it, but I just feel like I have a long ways to go in that;

- *And sometimes when they are having a hard -- or myself, either one of us, are having that harder time with going a little deeper, how do I -- how do I help that along and make it easier; and*
- *The digging deeper. Like, once I get them to kind of open up. . . how do I take it to that next step and get to that next level? How did baby respond when Mom did this or, you know, and then how do I elicit more past that? Because I'll just sometimes get a couple answers, and it's, you know, how do we take that conversation to the next step.*

Other responses that did not necessarily cluster around themes support the finding that there's been growth in knowledge and skills. These include having a trusting, safe environment; acknowledging boundaries; seeing different perspectives (reflective functioning); compassion for families; and needing to understand both infant and adult mental health. Clearly, these professionals over the past two years have embraced the knowledge and skills required to practice with a reflective orientation.

Infant Mental Health Consultants Interview Findings

Infant Mental Health Consultants were asked two questions pertaining to knowledge and skills: 1) What knowledge and skills seem to be of the greatest concern to supervisors; and 2) What reflective practice skills and knowledge are most needed by supervisors? Interestingly, IMHCs and supervisors agreed about what skills and knowledge are needed by supervisors. The most important was **supervisory skills** related to reflective practice.

- *Both of my supervisors struggle with how to structure their one-on-one time and how to make that time reflective;*
- *How to manage time, how to manage boundaries; and*
- *Really helping her think about each nurse and where they're at in their reflective and home visiting process.*

Supervisory skills can also address management issues. There are concerns about balancing conventional supervision with reflective supervision which were evident in the following comments:

- *They are really struggling right now with how to be reflective in their management role; and*
- *All of them have some issues that they're dealing with in terms of managing a few people who are not doing their work adequately, and so they want to do that in a way that's not punitive but growth-producing.*

A second skill mentioned often was that of **self-regulation**. Supervisors are confronted with so many difficult issues that they often must model self-regulation while they are teaching it:

- *So I think that you need some confidence in yourself that you won't get all crazy when the nurse comes in all crazy about something. So you need to be regulated;*
- *They are figuring out their limitations and then figuring out how to help each other; and*

- *I work a lot empowering her, encouraging her assertiveness skills. . . what she uses me for most is (sic) some staffing issues with some of the nurses that she uses me to kind of just bounce things off of. She talks about her frustration because she can't really talk about that with anyone else.*

Other skills IMHC mentioned include listening: *listening and partnering with each other without giving advice, without telling people what to do; and listening is about being present in the moment and about listening without your own ideas getting in the way.* And the importance of support for being a supervisor was also listed by the IMHC.

Conclusion.

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

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

CEED Survey Findings

Because the CEED Survey that was given as a baseline at the beginning of the project showed little variability, we revised the items to ask more directly about change over the length of the grant. In terms of knowledge and skills, home visitors' perceptions are similar to those of supervisors (see Table 5). Most reported that their knowledge has either greatly increased or somewhat increased as a result of implementation of MIECHV funding the past two years.

Table 5. Home visitors' perceptions of change in knowledge and skills of reflective practice over grant period

Reflective Practice Principle	My knowledge has greatly increased.	My knowledge has somewhat increased.	My knowledge has stayed about the same.
Create a safe, trusting relationship	35% (23/66)	44% (29/66)	21% (14/66)
Attend to parallel process	38% (25/66)	48% (32/66)	14% (9/66)
Pause and reflect	41% (27/66)	45% (30/66)	14% (9/66)
Explore different perspectives	42% (28/66)	41% (27/66)	17% (11/66)

Consider behavior in the context of relationships	41% (27/66)	42% (28/66)	17% (11/66)
Explore thoughts and feelings	39% (26/66)	42% (28/66)	18% (12/66)
Pay attention to self-regulation and co-regulation	44% (29/66)	42% (28/66)	14% (9/66)
Maintain a clear sense of roles and boundaries	27% (18/66)	44% (29/66)	29% (19/66)
Value the importance of repair in relationships	33% (22/66)	38% (25/66)	29% (19/66)
Pay attention to my experience and how it influences my practice	32% (21/66)	51% (33/66)	17% (11/66)
Develop collaborative relationships	33% (22/66)	44% (29/66)	23% (15/66)
Keep the baby in mind	44% (29/66)	41% (27/66)	15% (10/66)

The skills of "pay attention to self-regulation and co-regulation" and "keep the baby in mind" have the highest scores for an increase in knowledge. Less so is "create a safe, trusting relationship" suggesting that home visitors may have already been creating that environment in their work or that they need to pay more attention to building relationships. Additionally, knowledge has stayed about the same for "maintain a clear sense of roles and boundaries" and "value the importance of repair in relationships." It may be that home visitors already had a sense that they were doing these things or, again, that they need more practice in this area.

As with supervisors, we also asked the extent to which home visitors saw a change in their use of these skills and knowledge over the grant period. Table 6 reports their perceptions for this question.

Table 6. Home visitors' perceptions of change in use of reflective practice over grant period

Reflective Practice Principle	My use has greatly increased.	My use has somewhat increased.	My use has stayed about the same.
Create a safe, trusting relationship	32% (21/66)	39% (26/66)	29% (19/66)
Attend to parallel process	33% (22/66)	48% (32/66)	18% (12/66)
Pause and reflect	38% (25/66)	44% (29/66)	18% (12/66)
Explore different perspectives	33% (22/66)	48% (32/66)	18% (12/66)
Consider behavior in the context of relationships	38% (25/66)	44% (29/66)	18% (12/66)

Explore thoughts and feelings	39% (26/66)	41% (27/66)	18% (12/66)
Pay attention to self-regulation and co-regulation	39% (26/66)	42% (28/66)	18% (12/66)
Maintain a clear sense of roles and boundaries	21% (14/66)	47% (31/66)	30% (20/66)
Value the importance of repair in relationships	27% (18/66)	45% (30/66)	27% (18/66)
Pay attention to my experience and how it influences my practice	37% (24/66)	49% (32/66)	15% (10/66)
Develop collaborative relationships	29% (19/66)	45% (30/66)	26% (17/66)
Keep the baby in mind	44% (29/66)	38% (25/66)	18% (12/66)

These findings support the inference that home visitors may perceive themselves as already "creating a safe, trusting relationship" and "maintain(ing) a clear sense of roles and boundaries," as well as "valuing the importance of repair in relationships." Also showing less change is "develop collaborative relationships" which may evidence that many home visitors already had these relationships in their agencies and work or that further work is needed. Home visitors also showed change in use in "keep the baby in mind." The other two skills, "pause and reflect" and "consider behavior in the context of relationships," also show increased use.

Related to a change in skills and knowledge over the grant period is the level of adoption that home visitors perceive in their work. Table 7 provides their perceptions about the extent to which they have adopted these principles in their work. Clearly, home visitors see themselves as adopting the principles of reflective practice in their work with families and in their collaboration with their supervisors and colleagues in case conferencing.

Table 7. Home Visitors' perceptions of level of adoption of reflective practice principles

Home Visitors' Adoption of Reflective Practice Principles	**Not yet in practice**	**Emerging**	**Fully implemented**
In my case conference group?	5% (3/66)	38% (25/66)	58% (38/66)
Individually with my supervisor?	5% (3/66)	38% (25/66)	58% (38/66)
Working with families?	2% (1/66)	55% (36/66)	44% (29/66)

Home Visitor Interview Findings

Interview findings for home visitors about knowledge and skills to some extent mirror those of the supervisors but they also provide insights to their responses on the survey. **Pause and reflect** was one of the most frequent expressions used throughout interviews, and the power of this skill is evident in interview data.

- *The pausing and the reflecting -- you know, the asking the questions, keeping the baby in mind. You know, what's it like for each person.*

Home visitors spoke about pause and reflect in terms of both their own personal processing of their work and their processing with families. For example, in terms of their own personal processing:

- *So for me to be calm and being aware of my own self, really that's a skill that I think, you know, we've learned through the reflective practice of just minding what we're doing to help model that for them;*
- *And then I've learned a lot about myself, too, where a lot of times, the frustration is with me. You know, and a lot of times, in regards to the progress that a family is making or not making, I guess I should say. So then, I don't know, kind of figuring out, like, how to process everything and, you know, take a deep breath and maybe just step back from it for a little bit; and*
- *Stepping back and taking a deep breath. So I'm learning, I guess, to pause and kind of assess the situation. Where normally, I guess I would call myself a quick-draw [chuckles] and jump to conclusions.*

And, in terms of working with families:

- *Rather than just saying the first thing that comes to mind, or not pausing, or getting angry with -- not with the client, but, like, if they're angry, I'm angry, too, and we're both angry, and we're not getting anywhere. But instead to, like, reflect on that and help someone come down from the emotions;*
- *Trying to be okay with those moments of silence and giving clients opportunities to speak up or maybe to say something that might be on their mind that they're thinking. Yeah, just trying to be more active in my listening and allowing for those pauses, the reflection; and*
- *Because I am a teacher, and I tend to be impulsive sometimes. And so I've learned to curb that and be really comfortable with quiet. And then I've also really tried to practice summarizing what I hear them saying and reflect back to them. You know, tell me if this is right. I hear you saying da da da da da. And so that's kind of a new way of practicing.*

Interview data support the finding in the survey data of an increase in developing and using the skill of **keeping the baby in mind.**

- *And it helps bring back really what this baby's experiencing and how you can see it through the baby. You know, they talk about the -- can't think of the word, but, like, the evidence or, you know, the baby can show you what is going on that family;*
- *The pausing and the reflecting -- you know, the asking the questions, keeping the baby in mind. You know, what's it like for each person; and*

- *I think just a lot of pointing out cues of baby, like, really being intentional of pointing it out. And trying to make this connection for parents and explicitly saying it for them.*

Less evident in the CEED Survey responses is another theme similar to that of supervisors, going deeper. For home visitors, going deeper is related to self-regulation, which explains and supports the data from the CEED Survey, in which home visitors noted an increased knowledge of self-regulation.

- *Or I'm digging deeper into, maybe, my own experiences and why I'm reacting the way I'm reacting. And maybe getting -- understanding better so that you have some type of resources to move forward in a more intentional way; and*
- *I need to implement some strategies to regulate myself, whether that be breathing, relaxing my muscles, being in tune with what's going on with my body so that I can tune into that other person.*

Considering both the CEED Survey and interview responses, there is evidence that, taken as a whole, home visitors are changing in their knowledge and skills about reflective practice. Of note is that three of the four items that concern relationships (e.g., create a safe, trusting relationship, consider behavior in the context of relationships, value the importance of repair in relationships, and develop collaborative relationships), showed the least change in both knowledge growth and change in practices over the grant period. This suggests that home visitors are either comfortable with the relationships they are building or that there is work to be done in terms of building relationships. Since the two models are relationship-based interventions, sorting this out is of vital concern for future implementation of MIECHV.

Infant Mental Health Consultants Interview Findings

Similar to the questions about supervisors, IMHC were asked about what skills and knowledge are of concern to home visitors and what skills and knowledge do they think home visitors need. Instead of the answers aligning, as they did with supervisors, there were obvious differences between what concerns home visitors have and what consultants think they *should* be concerned about.

In terms of the home visitors concerns, IMHCs identified self-regulation, adult mental health, and understanding the line between therapy and home visiting as the main ones. Self-regulation was blurred with mindfulness, or being in the moment. As one IMHC noted: *I think one of the skills that everybody is really struggling with is turning all these ideas and concepts actually into kind of in-the-moment work. What is it? What does it look like in the moment? What's it look like between the parent and child?* The consultant recognized that the home visitor must translate training and curriculum into something that needs to happen in the moment between parent and child and at the same time, trying to understand what is happening.

Second, IMHCs noted that home visitors are concerned about adult mental health, which also blends with concern that they are being expected to do therapy when they are not therapists.

- *The complexity of the mental health of the families they're working with is profound. And they're wanting both information and opportunity to understand and think about what the*

implication is there for the babies and the relationship between the caregiver and the baby;

- *There seems to be some anxiety about reflective practice crossing a line into being therapeutic. They kind of go, whoa, that's just—is that my job to go deeper?*
- *I would say maternal mental illness is huge;*
- *They're concerned about mental health issues and what are they going to do if something comes up;*
- *Increasingly they're asking for help in understanding mental illness; and*
- *It seems to be working with adult mental health that comes up a lot.*

Although, according to IMHC, home visitors are concerned about self-regulation and adult mental health, these same consultants have different ideas about what is needed by home visitors. Relationship-building combined with better cultural awareness were prominent in most interviews. In terms of relationship-building, IMHCs observed that home visitors need to shift their beliefs in order to be more effective. For example:

- *Understanding that a mental health diagnosis is part of a disability. It's not something that many times parents can make significant changes in. You can't pull yourself up by the bootstraps;*
- *It's not that you (the parent) might get better at depression or less anxious, but you'll always be depressed and anxious to a certain degree;*
- *The ability to be with people who are struggling and without going after making, fixing it or making them feel better. That is so challenging. . . I think that's the big one; and*
- *Really about mental illness. About understanding about the mother's mental health or, you know, the family's mental health and how that's reflected with the baby.*

Infant mental Health Consultants spoke about culture broadly, including both diversity and understanding the culture of poverty and living with multiple risk factors:

- *We carry our middle class values with us, and sometimes we don't understand. We need to be more curious about why people do things versus judgmental;*
- *There's a whole bunch of, you know, haves and have-nots. And there is a huge culture, you know, there's a rift between folks, middle class people who have worked and, you know, and there's not a lot of joining with people of poverty. There's a true divide. Breaking down of this cultural, you know, kind of norm that's been there for generations is going to take some time; and*
- *Just developing a little bit of empathy or seeing outside of what their own belief system is and being able to see the perspective of somebody else or somebody else's family.*

IMHC identified knowledge and skills about building better relationships and understanding mental health and cultural differences as two important areas that need addressing. By doing so, home visitors can bridge these differences and truly use the relationship as the intervention. In the CEED Survey, the reader should note, home visitors were less concerned about building relationships, and yet doing so is clearly more important than they realize. Again, MDH is advised to work further in helping home visitors develop relationships with the clients they serve.

Conclusion

Interviews suggest that home visitors are familiar with the skills and knowledge of reflective practice. What is less clear is whether they are able to put these fully into practice. For example, although home visitors believe **pause and reflect** is a key skill for their practice, in light of IMHCs interviews and the CEED Survey, how that pause and reflect is being used in the field is not clear from the data. It might be a way of distancing when adult mental health issues or issues of poverty are not understood, which would prevent the relationship-building that is foundational to the interventions. On the other hand, regardless of the reason for pausing and reflecting, learning to do so is foundational to reflective practice. The theme of going deeper relates to the need for further understandings about how home visitors are building relationships. The fact that they see a need to look deeper at what is going on is another suggestion that the skills of reflective practice are being gradually built but not fully in place yet.

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

Administrator Interview Findings

Administrators were interviewed at the beginning and end of the grant period and were asked about changes in knowledge and skills, changes in agency culture, changes in beliefs and attitudes, and the degree to which they support reflective practice. Their answers support other themes throughout this report that will be discussed later. For example, both supervisors and administrators note that there are **individual differences** in how people adopt new ideas.

- *It's like you can't teach old dogs new tricks;*
- *A couple of others initially might have viewed it as more of an annoyance; and*
- *There's always those individuals where—I don't know if it just doesn't come easy to them or they still don't buy into it.*

But although there are these people slower to adopt the intervention, there's also a theme of **acceptance**.

- *It's just getting to be a more familiar topic. And I think more people's minds are opening up to. . . maybe this isn't a passing trend; and*
- *So I think, for the most part, it's been very well accepted and embraced. It's the -- again, it's that dissonance for some of the nurses who have -- who it is really a change of practice and a way of being for them that they can't quite make that shift yet.*

At the same time, there's a general perception that nurses and supervisors as a whole are receptive to reflective practice, and there was another theme of worry that **without funding reflective practice could go away** (although the models mandate it).

- *I know that all of the nurses appreciate being able to talk to somebody about their families. All of the nurses are very busy. And if there wasn't time that was set aside to do reflective practice, I don't know that they would have efficient or effective reflective practice with anybody. You know, you grab a five- or 10-minute chat with a fellow nurse*

here or there, but to sit down for an hour and a half is critical, crucial time that I think they need, that without it being scheduled, I don't think would happen; and

- *You know, nurses are pretty black-and-white and pretty much, we're just going to do this job. [laughs] And so people were a little skeptical about, well, what? And we have to take the time to do what? And they have really embraced it. . . As a matter of fact, with, you know, always the questions about funding, we have actually talked about, okay, so what if funding goes away. You know, how important do you think this is? And every single one of them said, oh my goodness, don't get rid of her. You know, find the money somewhere. So, I mean, they have really embraced it.*

Answering questions about the adequacy of training in skills and knowledge, administrators were split, with some believing it has been adequate but others wanting more. Agencies outside the Twin Cities noted some travel difficulties not just with getting the training that is needed but also with implementing case consultations. Another person remarked that there was a *flurry early on* but that ongoing access to training, especially when there are changes in personnel, has been more difficult to access. Some noted that home visitors need to use the skills in the field to be able to learn them. Also identified was the need for a way to address timely training for new hires. Throughout the interviews, several administrators and others noted the importance of the IMHC. Administrators noted:

- *I think it's -- yeah, I think from a training perspective, it's one of those things that you just have to -- after you kind of have the foundation, you just gotta do it. You just gotta practice it. And then it becomes more second nature. You know, can you ever have enough training? Probably not. But the reality is, I think that, once you have the foundation and understand the basic skills, it either becomes a part of who you are or the dissonance remains, you know; and*
- *I think it's a skill that you continue to develop. And I think it's critical that there's some kind of ongoing training. I think some of it -- you know, you almost need to be -- to have some training and then allow yourself to use that and probably -- so I'm not saying that ongoing training wouldn't be good. But probably more than anything, it's that support that, you know, (NAME) provides to the nurses and that, you know, I think the infant mental health specialist provide to the nurses and to (NAME).*

In terms of beliefs and attitudes, administrators were measured. They tended to believe that reflective practice is a good practice in accordance with the models and that this belief had not changed appreciably over the grant. This is not surprising in that these sites all applied for the funding, suggesting that sites saw the need for reflective practice or they would not have applied.

Interviewers asked all administrators to identify their level of support for reflective practice given four alternatives— fully support, support, somewhat support, or do not support at this time. All administrators indicated fully supporting reflective practice. One person noted: *Is there a rating beyond fully supportive?* A couple noted that financial support is different than philosophically supporting the practice and that without MIECHV funding, they might not be able to "support" it financially. Overall, administrators presented a positive picture of agency support for reflective practice.

Supervisor Interview Findings

In order to more clearly understand the extent of agency support, we asked supervisors about agency priorities. Overall, supervisors believed that reflective practice was a priority in their agencies; however, there was some uncertainty at some sites about whether it will continue if the funding source from MIECHV goes away. A couple supervisors noted that although reflective practice is mandated by the programs, staffing is thin so that having time to do reflective supervision weekly is sometimes compromised. Supervisors also mentioned that agencies understand that reflective practice is a mandated part of the two programs but noted that reflective practice is not necessarily evident in other programs. In some sites, however, support is so strong that there are efforts to bring reflective practice into other programs and to build a culture that has reflective practice as part of it.

Support

- *Our agency understands that they are part and parcel and very important pieces to evidence-based programs;*
- *We've found our own money to supplement this so that we can provide it to all 70 of our staff members, not just the 12 or 15 that we have in MIECHV; and*
- *I think they absolutely honor it and value it.*

Funding Concerns

- *Some see it as just a financial burden and an extra thing that we possibly could cut if we had to cut something out of it. . . so it's going to be interesting. I'm hoping and praying for MIECHV funds to continue for a while.*

Support is "Thin"

- *Your commissioners and other people aren't necessarily supportive of getting staff. So, you know, you are spread pretty thin;*
- *That's always a challenge for our supervisor to support us. And yet, she has to answer to the board when looking at staffing and other issues; and*
- *I would say my agency wants to do it. . . but they haven't made any changes in terms of capacity for supervision.*

Trying to spread it to other non-MIECHV programs

- *We've found our own money to supplement this so that we can provide it to all 70 of our staff members, not just the 12 or 15 we have in MIECHV; and*
- *I'm doing reflective supervision with those staff who haven't had—there's no requirement—model driven requirement for that to happen, but we're kind of expanding.*

Conclusion

Looking at agency support from both administrator and supervisor interviews provides a compelling argument that support for MIECHV has been strong throughout the intervention.

There is no evident change in either direction. Again, keep in mind that agencies that applied for this funding probably already had a belief in the value of evidence-based programs.

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

Supervisor Interview Findings

Because the first round of data collecting did not produce many comments about beliefs, supervisors were asked specifically about their beliefs and attitudes about reflective practice in the final interviews. Evaluators asked supervisors what they initially thought and what they thought as the end of the project drew near. The most evident theme was that of Support, but that support took two paths, one was **Support <u>for</u> the intervention**, which is evident in their comments about how they felt going into reflective practice. Support for the intervention involved the belief that the work with families is more effective when home visitors have reflective supervision. The other was **Support <u>of</u> home visitors**, which evolved as supervisors implemented reflective practice. Support of home visitors is exactly what it says—many supervisors believe that reflective practice provides support for the emotional stress of being a home visitor.

Support for the intervention

- *I think it's been good. I think initially it was hard to -- I think, sometimes, for some people to schedule regular -- that that was important, that you need to reschedule it. It has to happen every week. You know, it was more, like, well, if I can fit it in, we'll do it. Putting a value to it, I guess would be the word;*
- *I think it's an extremely useful practice. And I have talked with my supervisor about whether we could implement it with all of our home visitors; and*
- *The clients aren't going to get the best experience with their worker if they're not being reflective about themselves and their work.*

Support of home visitors

- *I get to hear a lot more, not just about the families, but about the nurses and how they feel about the work now, too, because we have that time to talk about that, too. So I feel like I do know them a lot better now, personally and professionally. Because, you know, everybody has that part of their lives, too. So we do touch on how they're doing in their personal life as well. And I think this time really gives us the opportunity to get to know each other in that way;*
- *It's just a very supportive—supportive way of nurturing and professionally developing your staff;*
- *I would say it's offering support to home visitors;*
- *The best part of my workday is the time I spend with the nurses in reflection . . . to enhance the skills and abilities of the people who are working with families under very difficult situations. I mean, we're talking bedbugs, we're talking scabies, we're talking icy steps that aren't shoveled, we're talking people who don't have gas money to get to*

work. . . There's lots of challenges that the families are facing, and the nurses are standing—the home visitors are standing right by them. . .and its' my job, I feel, to help, to stand by the nurse as she's standing by the family. And support her; and

- *You're consistently supported, and you get to share things. You don't have to hold them all the time, go home and hold them in your head.*

Although the change in expression of support does not directly answer the question of support, it provides evidence of how understanding the effects of reflective practice can be articulated throughout one's work.

A second theme in the questioning about beliefs and attitudes was the perception that there are **individual differences** in how nurses responded to reflective practice. For the most part, supervisors reported that there are staff that find reflective practice more difficult than others. They also observed that these staff are not as effective with families, and as supervisors, they look for ways to deliver reflective practice to address the difficulties of working with home visitors who aren't as receptive to reflective practice. For example:

- *How do I really build that reflectiveness in somebody who maybe isn't that way by nature? And how do I do that? How do I get someone more reflective? Because it comes more naturally to me to be self-reflective and to reflect and go to people to get that. And some people aren't as comfortable or don't have that;*
- *I can see how it affects, like, their relationships with the families in terms of -- I mean, I have to coach them to kind of improve; and*
- *There's a piece of it that can be innate to some people, and then there's a learned portion of it. And I don't know if it comes as naturally to me as it does to other people. And so I have to work to be really intentional about it. So I felt woefully unprepared.*

Another related a personnel issue that she had to handle. She noted: *I am thankful that I wasn't just an administrative supervisor, but that we literally had that time every week or it would have been way harder for me to have those hard conversations.*

There were many other relevant comments to the beliefs and attitudes that developed over the course of the grant. Supervisors noted that in order to do this work, you must learn to be a good listener. Another noted: *The experience of reflective practice kind of brought me back to hopefulness about staying in nursing.* Another noted that you must believe in reflective practice in order to make parallel processing happen. One barrier that is mentioned one or two times for every question is the difficulty of traveling long distances in order to meet one-on-one or within the case conference. The temptation to reschedule is big when distance and driving are involved. A supervisor noted: *Not being in the same office is a huge barrier to this overall process.*

Infant Mental Health Consultants Interview Findings

Infant mental health consultants spoke about **support** as the most prevalent belief. They tended to combine **support for** (reflective practice) with **support of** (home visitors). For example:

- *(They) are super supportive of reflective practice. They find it really helpful for themselves. They find it really helpful for the staff. And they are big proponents of people using that process;*
- *They do not see it as a luxury. They see it as a necessity for their work. They both have talked often about how they've grown professionally through the process; and*
- *I think they value (it). They've come to value it in a way that is able to help sustain their employees, their nurses and be more supportive.*

At the same time, there were some comments that RS is a *forced discipline.*

- *It imposes a structure that sometimes is resisted, even when you're recognizing the value of it. . . day to day pressures have people thinking, oh, I could use that hour or two hours differently; and*
- *I think they look at it positively although they're always, you know, it takes that commitment and scheduling.*

Also mentioned a few times was that supervisors need RS as a form of *self-care.*

Conclusion

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

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

Home Visitor Interview findings

Home visitors expressed a range of initial beliefs and attitudes about reflective practice that can be divided into three general themes. A large number of them reported that they **didn't know what it was** and what would happen during reflective practice sessions. A second theme that emerged among some of the home visitors was **hesitation and apprehension** about having to participate in reflective practice. A third type of response among the study participants was one of **anticipation and enthusiasm** about having the opportunity to participate in reflective practice.

Part of "not knowing" what reflective practice was included confusion about the goal or purpose of the time spent participating. One home visitors said that she thought, when she first heard about it, "that's weird." Another said that she "didn't expect a lot to happen" during the reflective sessions. "I thought it would be something I'd just get through and it would go away."

Many home visitors were hesitant about participating in reflective practice. Initially some found it uncomfortable. One home visitor said she felt the process was "stilted" at first while they were learning how to do it. Another said, "It was a little bit intimidating, a little too personal for the workspace." Some didn't see the benefit of it — of "just talking about the work." Some had the

impression that it was about performance evaluation or about administrative issues related to their work.

- *Like, is this going to be therapy? Do I have time to meet every week with my supervisor and then an additional meeting on top of everything else to do case consultation? Yeah, I mean, it makes sense, but at the same time, I was just like, ehhh...that's emotional. That sounds very vulnerable.*

Some home visitors entered the experience of reflective experience with some knowledge about it and some positive expectations about what it would be like.

- *...I had heard of it and definitely liked supervision and liked, you know, the concepts around that and thought it was really important. And so I really appreciated that about the job when I started. It was— I felt like I was receiving support in a way that I had never received before. And it made it very clear that it was something that worked for me.*

Those who had already experienced reflective practice held positive beliefs and attitudes going into the reflective practice funded by the MIECHV project. They expressed views such as "it's important," "it's not new to me," and "it's part of the work." Others described it as support for practice; guidance in processing and problem-solving and conducting more in-depth discussion of cases and improving practice and emotional support for home visitors.

- *I had a little experience with it in another position. So coming into here, it wasn't a new concept for me. But I expected it to allow for thought processes to take place, to have somebody to bounce ideas off of, to have somebody guide me when I got stuck on things, and a place to just kind of really hash out feelings and concerns and thoughts; and*
- *This job has been my dream job....part of the reason I really wanted to be a part of this program was because I knew reflective supervision was a part of the work.*

Home visitors reported that their beliefs and attitudes about reflective practice changed after having experienced it. This was especially true of those for whom reflective practice was new. The themes that emerged from this line of exploration were: how **positive and important** reflective practice is, that it **provides support for the work**, and that is **provides support for the home visitor**.

There were many **positive** expressions of how the home visitors now value the reflective process. They said that after experiencing it for a while it became more relaxed and natural to participate in it, that it makes sense to them and they now believe it's **important** and effective.

- *I just think that this works;*
- *It's very important, and I use it a lot, not only at work, but in my personal life as well;*
- *I feel that it is very, very important...I've really realized the importance of it in this field of work;*
- *I really like going now. When I first started, I was kind of, "what's the point of this? I don't really understand. And now that I've learned a little bit more and feel more comfortable...;*

- *And it took me a little while to kind of put that all together and see why that's so important, that you know, I reflect with the supervisor, and that helps me reflect with that family, with that mom;*
- *Now that I've been able to use it and see how it works and be a part of it...I can't even imagine a job or being a home visitor that — that a program that doesn't implement reflective practice;*
- *For me, this, like, has been, like this dream job. Like, exactly what I went to school for, and I'm able to — everything I believe in and think that this is how we should be, you know, in prevention and intervention programs with families; and*
- *I don't think that that I would have been able to have done this job for as long as I have if I didn't have that support and ability to be able to talk and share about what's going on and for it to be the norm.*

Home visitors who expressed the belief that it **provides support for the work** say that it is a way to improve practice by increasing their skills, knowledge and insight.

- *I think it's a way for me to think differently;*
- *I think it's a great opportunity for people to be more intentional about their practice, be more aware of themselves and how they're doing their work;*
- *It's just — it gave me more knowledge and insight on how I can help them with what I have to give with not being a social worker or a counselor;*
- *I've learned to listen;*
- *It's more about excellence in our practice and continually, you know, reflecting on what we're doing so that we can be better and better every time we go into the homes and just come in with a fresh perspective and not be (stagnant) in our relationships with the clients;*
- *I feel even stronger about the impact of reflective supervision and how much it adds to my ability and my talents, my — I guess just how I can be with families;*
- *I see how it works with how she's doing it for me, and it's giving me those words and these phrases and that tone to approach my clients; and*
- *There is a component of it where you are examining, you know, yourself and you're challenging yourself to look at your own practice and what that looks like and feels like currently and how you can better that.*

On a cautionary note, one participant voiced the belief that it is important to strike a balance between reflecting and implementation.

- *So in all honesty, sometimes I feel like, "Wow, I've already been reflecting adequately, and now I need to be implementing more."*

The third theme in home visitors' current beliefs and attitudes encompasses **support for the home visitors** themselves. This was expressed by comments including the following:

- *I think it's really important to have that support...(you) need to know that you're not alone, that other people deal with the same things and, you know, if you're having a bad day, you have someone that can just kind of hear you out. Because I think this work is not understood. And people just don't get the intensity of it;*

- *I think it's really been — it's really helped my, you know, mental health, my emotional health, in dealing with some of the, you know, challenging circumstances that our clients are going through;*
- *Like I said, now, looking back, towards the end, and having somebody that kind of made me feel like I could get over some of my obstacles that I was holding back, not understanding certain things, questioning my ability to do my job. Made me feel an understanding of, you're doing just fine. You know, you're doing your job;*
- *I think it's a validation to what I've always been doing;*
- *And it works to help people to always renew their empathy and there, you know, curiosity about why this person is behaving in this way. Why, you know, did they make that decision?*
- *I think it's a necessary part of the home visiting process. I think before, I carried a lot of my work with my families into my own home. And I try to take it off before I walk in the door. But there was never really a mechanism to do that. And the reflective supervision has become that mechanism, or that tool; and*
- *I think that without it, I would probably go crazy. Because I think if you can't talk with somebody about some of these situations, then you carry that around with you. And it's nice to decompress with somebody and they help normalize your feelings sometimes, too.*

Several home visitors expressed opinions about implementation of reflective practice. One noted that, for those living in rural areas where they work at a distance from their supervisor, schedules and weather conditions can affect accessibility to supervision when it is needed. Another home visitor emphasized that it requires *the right person to facilitate it* and while another said that *it takes time to do it well.*

Supervisor Interview Findings

Much of the data gathered from home visitors regarding their beliefs and attitudes were **confirmed by comments from their supervisors**. Some of the same themes emerged from the supervisors.

The first theme about initial beliefs and attitudes, that the home visitors **didn't know what it was** and what would happen during reflective practice sessions, was echoed by supervisors:

- *It's getting better. In the beginning a few of them, you know, were just kind of questioning...what are we doing this for?...what's the point of it? We kind of do this in our office already. Sometimes, you know, I really don't have time for this this week. Can we skip this? But as time has gone on, attitudes, I feel, have changed a little bit.*

Supervisors said that they noted the second theme regarding initial beliefs and attitudes — **hesitation and apprehension** about having to participate in reflective practice:

- *I think it was pretty intimidating when we first started out, that they felt like they were on the hot seat. But we talked, you know lately, and I have heard from them that they do feel that it's not quite so much for that....that it is getting a little bit better; and*
- *I think it's been good. I think initially it was hard to -- I think, sometimes, for some.*

Supervisors confirmed that home visitors' beliefs and attitudes about reflective practice changed after having experienced it. The same themes emerged from this line of exploration.

The first theme, that reflective practice is **positive and important**, was articulated in many of the supervisors' observations, such as the following:

- *...the feedback I've been getting is that, the more they do it the better they like it...;*
- *...what I've noticed for other home visitors, is that, once they're in here, and we get going, it's definitely a valued time. And I think, more and more, we see it as something we look forward to rather than something in your day that you have to do;*
- *Now we meet an hour and a half every week. And that's a lot of time out of a 40 hour week, and for some people a 32 hour week...I've seen progress in (the home visitors) valuing (the time spent in reflective practice);*
- *...it's become a more protected, valued piece of the work, and other things get cut instead; and*
- *It has to happen every week. You know, it was more, like, well, if I can fit it in, we'll do it. Putting a value to it, I guess would be the word.*

Supervisors confirmed that second theme as well, that reflective practice **provides support for the work**.

- *I've seen several people grow a great deal in their practice and been able to share that with them. And they've found that to be useful. We've seen some families really make some big progress. People that we would have never thought would have been able to make that much progress, who have. And so that's extremely rewarding to the home visitors. So to be able to share with them that satisfaction that they're seeing with the family is valuable feedback to the nurses.*

And the supervisors echoed home visitors' opinions that reflective practice **provides support for the home visitor**.

- *And once in a while they just tell me. I don't – it's unsolicited. I don't know, we're getting lunch of whatever and they would say, "oh I like meeting with my (supervisor) weekly to talk about this or that. So that's been really nice to hear that. Because I know — in the beginning it wasn't always — it wasn't always viewed as something really nice to be going to see your (supervisor) every week.*

Several supervisors commented that they could witness, and be reminded of, the process of introducing home visitors to reflective practice by observing how new team members initially react to the practice and how their comfort with reflection grows over time as they begin to understand how valuable it is to their work.

- *It's been a pretty cool learning experience to kind of see what is feels like at the beginning when you haven't done it before and then kind of interpreting what we're doing.*

Program Administrator Interview Findings

When asked about home visitors' changes the beliefs and attitudes about reflective practice, some administrators from programs that had been implementing reflective practice prior to the MIECHV Expansion Project said that there had not been a significant change in beliefs and attitudes.

- *I wouldn't say I've seen a change. Everyone has been pretty supportive of it, and it's been going on in our agency for, boy, several years now. So I wouldn't say that there's been a change in that. I think everyone is -- I definitely think it's necessary for -- like I said, for the home visitors and the supervisors. So I don't think there's been any change.*

But many administrators confirmed that there had been a change in beliefs and attitudes among staff in their programs.

- *Yes. I think in the beginning, everybody was, like, what is this, and why are we doing this. It was a lot more questioning. And I think now it's become part of kind of the skill set of doing this new evidence-based-type home visiting;*
- *I think that nurses are more receptive to it, and it's a more positive thing to them than when they first started.... It's like you can't teach old dogs new tricks. Experienced nurses. And then it's hard for them to handle someone else stepping in and making suggestions or that type of thing. But I think that has gotten better. I shouldn't say I think. It has gotten better;*
- *I think maybe what I've seen more has been among some of the nurses, the feedback in terms of the value to them and how much they've appreciated having (the infant mental health consultant) available and having the time to reflect on some of their cases more in-depth than what they historically have done, that that's been good;*
- *I've seen a change in that -- again, in the participants. The home visitors that are involved in the reflective practice absolutely love it;*
- *I think they also have gotten better at understanding when they're under stress or when they need to look to the group and/or their supervisor for support. I think they feel -- my sense is that they're freer at asking for support and at sharing with the group things that are bothering them; and*
- *You know, nurses are pretty black-and-white and pretty much, we're just going to do this job. [laughs] And so people were a little skeptical about, well, what? And we have to take the time to do what? And they have really embraced it. As a matter of fact, with, you know, always the questions about funding, we have actually talked about, okay, so what if funding goes away. You know, how important do you think this is? And every single one of them said, oh my goodness, don't get rid of her. You know, find the money somewhere. So, I mean, they have really embraced it.*

Conclusion

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

practice and case consultation provided important support for the work HVs were doing in the field.

g. **Research Question 4.** Do home visitors, who participate in reflective practice sessions, report using reflective practice in their work with families?

Home Visitor Interview Findings

Home visitors were directly asked how participating in reflective practice affected their work in the field. They were also asked about a time when they used a reflective approach with a family. The answers and stories they told were poignant descriptions of the intensity of their work and of the problems the families they serve face. Home visitors gave almost no descriptions that evidenced a directive approach. Many answers suggest that processing with supervisors and in case consultations are at the stage of problem solving for ideas of something they can "try" with the family. That said, home visitors are acutely aware that their relationship with the family is the vital intervention for improving outcomes for babies and families.

Although home visitors talked about a problem solving approach in their professional reflective practice, with families, the skill they most frequently mentioned is the ability to **pause and reflect**. In the context of the research question, the theme of **pause and reflect** constitutes a slowing down, wondering, and not moving quickly to solutions.

Slowing down

- *I think just the ease of being able to sit with a family and to be wherever they are that day;*
- *And so just kind of sitting there and validating and giving her the space to talk about it and then talking about how her life has changed so much and how her baby has come into play and affected the way she feels now about, like, the, you know, previous -- as she calls it, her previous life. She had been living in -- so I think just -- that was a pretty -- she had come full circle and really saw baby as her just change -- and change in life and the reason to live a better, healthier life;*
- *I just yesterday saw a client who is severely depressed. . . I think I asked her, how does that -- because she kind of described her symptoms. . . she just doesn't, like, really want to get out of bed in the morning. She just feels. . . really anxious and. . . really down. She feels like she has a really short fuse. And I said, you know, how does that affect how you relate with the baby;*
  And she's, like, I feel like she comes to me less. . . I feel like I just don't have the energy for her. You know, and I think that just kind of, like, taking the time and thinking; because I'm sure that, you know, when you're in that kind of depression, you're not able -- you're not really aware of what's happening around you. You're so internal. So I think that that was a time that we -- I mean, I don't know if it's going to change anything. But at least she's -- it reframed her thinking for at least that moment.

Wondering

- *we chatted about it for a long time and tried to kind of get at what was the root of this;*

- *but to instead kind of try and have them, you know, look differently at the situation or ask more questions about it. Yeah. So I guess I try and do that most of the time; and*
- *This morning I had a mom who has a 1-year-old who -- the mom was talking about how the 1-year-old and her were -- was throwing tantrums and kind of screaming when she didn't get what she wanted. And so I was able to use reflective -- you know, what do you think she's thinking, why do you think she's acting that way, rather than saying, well, you need to do this when she does that.*

Not moving to solutions

- *I think it does help me to be more reflective with the clients. To try to be reflective with them and ask them questions to make them think about the situation and have them think about their own strategies or their own possible solutions to the -- instead of pointing those things out myself, just saying, oh, you could try this or this or this; and*
- *It makes you, I think, more willing to be more accepting of different things and trying to help them overcome an obstacle by understanding what they need and then trying to teach them a way that'll help with their child -- their relationship between them, versus just automatically thinking, well, she's just doing this because she wants to, you know, not work or stuff like that. It just -- it helps you to prevent forming judgments right away.*

With these skills, home visitors work to have the families or mom come to their own solutions or approaches to the issues they face. In one case described by a home visitor, a mom was given a nebulizer to help her baby's breathing, but the mom had not used it. The home visitor combined skills to help the mother move to using the machine:

- *In the past, I might have just gone right into my nurse mode, you know, and said, oh my gosh, no, you have to be doing this this way, and you got to -- but it was a time when I was just able to stay calm and say, tell me what you know about your baby's sickness. And tell me about this machine. You know, what do you know about how to use this machine. Tell me how you think that machine might help you. And just very non-threatening, you know. And it wound up that she wanted me to show her, and she wanted to use it. She wanted her baby to get better*

A second theme was **relationship building.** Home visitors see that in order to focus on the baby, they need a good relationship with the family. They recognize that the reflective practice skills they implement support building that relationship. For example:

- *It's forming relationships. So it's more of an authentic relationship versus a relationship built on teacher-student-type -- yeah. [chuckles] It goes deeper than just providing knowledge or information to a family; and*
- *But I'm realizing more and more that the process of us sitting side by side and me sharing in learning these things with the family is part of that relationship-building, that going to allow them to want me in their home and to help hear some things that we're learning kind of together that's going to maybe let it in the door than if someone was just preaching advice to them.*

And within a solid relationship, home visitors see the power of their work with families. For example:

- *And then, since having learned what reflective practice looks like, I was able to kind of really dig a little deeper and to find out that there was actually a pretty difficult incident that had occurred earlier on within the week that had made her really upset. And she hadn't been able to process what happened yet. And so she -- after a little while, she was able to feel comfortable enough where she could tell me about the incident, and then we could work through it together and kind of enclose it in a safe space where she could move on with her day and with her kids.*

In answer to the interview questions about working with families, other reflective practice skills and attitudes were mentioned including compassion for families:

- *I can just think of a gal who's really struggled a lot. And I've seen her now -- her little boy is 17 months. And she's been up and down and up and down. And she just is now coming around again. And she -- I know she wants me to come and enjoys our visits. And she was able to express that to me last time, too, that, you know, I've been working on my own mental health, and I've been really working on trying to get better. And, you know, it's just so nice when you will come, but I'm sorry I can't always -- you know, it just doesn't always work for me to [inaudible]come; And so it's been -- you know, some of the people that I work with that are pretty complicated like that, it's helped a lot to try to -- to try to walk in their shoes a little more and see what that might be like. And so I think it's just helped me become a more patient, understanding nurse.*

And persistence:

- *They learn that there are human beings in their life that are reliable and dependable. We show up every week;*
- *They maybe have never met a person who shows up and keeps showing up, no matter if their house is in chaos, no matter if they have 12 dogs. It doesn't matter. We keep showing up every single week; and*
- *That you give them time. You try to -- you keep going back and keep going back and let them know that you want to re-engage with them, that it does work.*

Ultimately, home visitors note that their work should **empower families** to make their own decisions. Home visitors talk about building the self-efficacy in families so that they believe in themselves. Home visitors recognize that many times young mothers and fathers are trying to do things differently from what they experienced growing up, and the only support these young parents have is that of the home visitor. And that's when empowerment becomes so critical. For example:

- *It kind of builds their autonomy and their feeling of self-worth when they kind of come up with the answers and do it on their own. But also having that cheerleader behind them saying that they can do it and giving them that affirmation that they're doing a good job. Again, it goes along with building their confidence, which that leads to their children having better confidence. And so it's a good round -- a good circle;*

- *But I think it really does build more of a trust. And whether they know it or not, maybe they have a sense of empowerment. Because I'm just giving them tools. I'm not trying to fix anything, necessarily. Hopefully, it's -- by me parallel processing with them, they're able to do that and to model with the child; and*
- *I think it just reiterates that they, you know, are the expert in their own life, and they have strengths. And you focus on that. And you kind of reflect that, kind of what you hear. I just think it's -- they end up reaching conclusions that you would have never assumed or never guessed that they could have reached.*

Conclusion

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

h. Research Question 5a. Do home visiting supervisors report less burnout and increased competence and successful achievement in their work?

Supervisor Interview Findings

Supervisors see their role as facilitating home visitors in relieving stress by **providing a safe place** to express stress (venting) in both individual supervision and case consultation.

- *I think it's the biggest stress reliever to know that you have somebody that is going to be present and listen to you and help you think through things so that the stress will hopefully level out or be a little bit less. . . there's a collaborative partner there that at least will help hold some of that stress and some of those hard things with you that you don't have to be in it alone.*

Supervisors also understand that relieving stress can lead to being able to see the situation in another way, a **different perspective**.

- *A safe place to try to find new perspectives that are helpful to, like, calm down stress and sort of normalize some of the emotion or understand where some of that emotion is coming from helps a lot. Or you can go away with maybe some strategies to deal with the stress.*

In line with reflective practice theory is the viewpoint that stress can be shared in a safe environment, but the goal is **not to fix** anything. A focus on "fixing" can compete with finding the meaning and cause of a behavior. In accordance with reflective practice theory, when the home visitor, in partnership with the client, understands the meaning and cause of a behavior, then the client will be empowered to change it.

- *And again, not always moving to strategy. . . to trust that, just by being reflective, that that is strategy enough -- enough to kind of help them process it and kind of move forward, too. So, like, I can't fix it, either. But I can listen. And I mean, I can't fix it if it's not -- you know, like, if it's safety of the child -- you know, I mean, anything like that. But some things are a process. Like, I can't fix Mom's mental health.*

Maslach Burnout Inventory Findings

Although our analysis did not find any significant change in burnout as measured by the Maslach Burnout Inventory, the scores themselves, as compared to norms for social service workers indicate that supervisors experience a greater than average level of burnout. These higher burnout scores are not mitigated by higher scores on the personal accomplishment sub-scale of the MBI.

Conclusion

Interviews show how important support provided in a safe environment is to the work of a supervisor. Supervisor interviews also evidence that supervisors are using the skills of reflective supervision, such as finding another perspective and not trying to "fix" things. Data from the Maslach Burnout Inventory, however, suggest that these supervisors are experiencing significant burnout without the compensating sense of personal accomplishment. Reflective practice alone may not be enough to prevent burnout in supervisors. This is something to consider as MDH goes forward with reflective practice.

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

Home Visitor Interview Findings

The strongest theme was that reflective practice makes home visitors feel **not alone** in facing the difficulties associated with their work. The second most prevalent and also related theme was **feeling supported** by either the case consultation group or by the supervisors.

- *It also sometimes makes things feel less stressful because you know that it's not just you. You're not by yourself;*
- *Just kind of knowing that you're not the only person feeling this way. You're not the only person who experience that;*
- *Being with other home visitors that, in and of itself, is supportive, because they're having the same type of stress and interactions—heaviness that's going on in our families; and*
- *I think home visiting can be a lonely job some days. And so it's—you feel supported when you have that dedicated time to talk about some of the challenges.*

Another strong theme was that of **venting**. **Venting** serves two purposes. It helps the home visitor *get this off my chest and kind of de-escalate,* but at the same time *allows (me) to air it out and . . . sometimes when I'm just saying things out loud, I get the answers to what I want to do or how I could proceed without any input from the other person,* **a different perspective**. Although venting or getting something off one's chest relieves stress, it is not necessarily reflective. In the

words of an MDH mentor, *it can sometimes be a distraction away from working with the families.*

Although home visitors used the term ***venting*** in their interviews, it is not a term associated with reflective practice. Rather, *containment* is the major, intentional practice of reflective practice. Feelings are expressed and *contained. Containing* feelings keeps them from becoming overwhelming, and the individual(s) is more able to stay self-regulated.

Although families were not interviewed for this project, home visitors were asked about how they believe a reflective approach helps families. A reflective skill, parallel processing, was evident in some responses and is specifically, though indirectly, related to burnout. Some home visitors reported reflective practice with families helps them not to feel so isolated in making the changes they need to make to focus on their baby. Many families with risk have not had persistent sources of support in their lives, and they need this support to learn a new way of being with their baby.

- *Many people have not, in their life, had a lot of people be reflective with them. So they're unable to do that with their young infants;*
- *No one's every asked them. No one in their life would ever ask them; and*
- *Many of these folks really haven't had anyone to come and support them and affirm them and you, know, remind them of what they're doing. . doing a good job with this.*

Another parallel with families is the importance of a **trusting, safe environment.** Interviews evidenced that home visitors felt that reflective practice, both with their supervisors and in case consultations, provides an environment that allows them to de-stress. In parallel, home visitors also noted that their work with families is to provide a **safe environment**.

- *Supervision. . . is a safe place to talk about it. . .a place to explore it and wonder about it and think about it;*
- *I think it is the opportunity to present your frustrations in a safe space. . and know that it's not taken lightly;*
- *Going back to that family I was talking about. . . using reflective practice didn't make them feel targeted. . . we're on the team together. It's okay to feel vulnerable. It's a safe place to have those emotions; and*
- *I think the biggest thing it does for families that are at-risk is that it creates an opportunity to build trust, where before, there wasn't any.*

Burnout is mitigated by feelings of **personal accomplishment** in one's work. Another of the strongest themes about reflective practice was that sense of **personal accomplishment**.

- *It just makes me feel like my job is accomplishing something;*
- *It just helps, I think, endure long-term in this program while still enjoying it;*
- *It's really nice to have something to hold onto and say, you did good;*
- *It's helped me grow as a person, too; and*
- *I mean to me, it makes my work meaningful and fascinating, to be honest.*

Maslach Burnout Inventory Findings.
Although our analysis did not find any significant change in burnout as measured by the Maslach Burnout Inventory, the scores themselves, as compared to norms for social service workers indicate that both home visitors and supervisors experience a greater than average level of burnout. These higher burnout scores are not mitigated by higher scores on the personal accomplishment sub-scale of the MBI.

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

VIII. Findings – Impact Study

There were no findings of significance, and some of the models had trouble being fitted. Findings for the Working Alliance Inventory are shown in Table 8. Linear slopes varied across Home Visitors.

Table 8. Final estimation of fixed effects Working Alliance Inventory

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
For INTRCPT1, π_0					
INTRCPT2, β_{00}	76.142518	3.890836	19.570	47	<0.001
YRSRECOD, β_{01}	-1.257822	1.042538	-1.207	47	0.234
PTRECODE, β_{02}	-0.955724	1.939503	-0.493	47	0.624
For TIME slope, π_1					
INTRCPT2, β_{10}	-3.613890	1.833085	-1.971	47	0.055
YRSRECOD, β_{11}	0.968815	0.491169	1.972	47	0.054
PTRECODE, β_{12}	1.118551	0.913756	1.224	47	0.227

Statistics for the current model

Deviance = 991.400404
Number of estimated parameters = 10

The significant B00 tests whether the mean WAI score for the initial measurement differs from zero, which is not meaningful for these purposes. The average linear Time slope is almost significant or significant if you "stretch" .05 and would mean that on average WAI scores decrease 3.61 points per year. If Years as a HV is treated as significant then more experienced HVs are associated with weakening the Time slope.

For the Kentucky Inventory of Mindfulness (KIMS), there was no variation in linear slopes across HVs, so only predictors of the initial measurement are modelled (See Table 9 below). There are no significant effects.

Table 9. Final estimation of fixed effects for the KIMS

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
For INTRCPT1, π_0					
INTRCPT2, β_{00}	116.475197	10.199480	11.420	44	<0.001
DEGRECOD, β_{01}	2.393987	4.616323	0.519	44	0.607
YRSRECOD, β_{02}	-0.625389	1.339047	-0.467	44	0.643
PTRECODE, β_{03}	-4.005308	2.806508	-1.427	44	0.161
For TIME slope, π_1					
INTRCPT2, β_{10}	1.062500	0.572976	1.854	139	0.063

Statistics for the current model

Deviance = 1021.969656
Number of estimated parameters = 7

For the Maslach Burnout Inventory (MBI), linear slopes varied across HVs (See Table 10 below). There were no significant effects.

Table 10. Final estimation of fixed effects MBI

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
For INTRCPT1, π_0					
INTRCPT2, β_{00}	86.243767	12.001238	7.186	50	<0.001
DEGRECOD, β_{01}	0.040722	5.260798	0.008	50	0.994
YRSRECOD, β_{02}	-0.155885	1.520957	-0.102	50	0.919
PTRECODE, β_{03}	-2.222755	2.906438	-0.765	50	0.448
For TIME slope, π_1					
INTRCPT2, β_{10}	0.879559	5.760262	0.153	50	0.879
DEGRECOD, β_{11}	-0.106993	2.525037	-0.042	50	0.966
YRSRECOD, β_{12}	-0.218403	0.730017	-0.299	50	0.766
PTRECODE, β_{13}	0.007846	1.395010	0.006	50	0.996

Statistics for the current model

Deviance = 1201.562734
Number of estimated parameters = 12

For the MBI, Emotional Exhaustion scale, linear slopes varied across HVs, and there were no significant effects (See Table 11 below.

Table 11. Final estimation of fixed effects MBI, Emotional Exhaustion

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
For INTRCPT1, π_0					
INTRCPT2, β_{00}	29.919015	10.446956	2.864	50	0.006
DEGRECOD, β_{01}	0.155378	4.579471	0.034	50	0.973

YRSRECOD, β_{02}	-0.044460	1.323978	-0.034	50	0.973
PTRECODE, β_{03}	-1.788385	2.530024	-0.707	50	0.483
For TIME slope, π_1					
INTRCPT2, β_{10}	4.299096	4.974856	0.864	50	0.392
DEGRECOD, β_{11}	-0.757995	2.180751	-0.348	50	0.730
YRSRECOD, β_{12}	-0.612000	0.630480	-0.971	50	0.336
PTRECODE, β_{13}	-0.236348	1.204801	-0.196	50	0.845

Statistics for the current model

Deviance = 1169.835216
Number of estimated parameters = 12

For the MBI – Depersonalization Subscale, there were no significant effects (See Table 12 below).

Table 12. Final estimation of fixed effects MBI – Depersonalization Scale

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
For INTRCPT1, π_0					
INTRCPT2, β_{00}	6.454373	2.601840	2.481	50	0.017
DEGRECOD, β_{01}	1.025609	1.140528	0.899	50	0.373
YRSRECOD, β_{02}	-0.440908	0.329740	-1.337	50	0.187
PTRECODE, β_{03}	-0.189849	0.630109	-0.301	50	0.764
For TIME slope, π_1					
INTRCPT2, β_{10}	0.320753	1.407184	0.228	50	0.821
DEGRECOD, β_{11}	-0.202597	0.616846	-0.328	50	0.744
YRSRECOD, β_{12}	0.107572	0.178337	0.603	50	0.549

PTRECODE, β_{13}	-0.166025	0.340789	-0.487	50	0.628

Statistics for the current model

Deviance = 735.856457
Number of estimated parameters = 12

Finally, for the MBI – Personal Accomplishment Scale, there was no variation in linear slopes across HVs (so only predictors of the initial measurement are modelled, and there were no significant effects (See Table 13 below).

Table 13. Final estimation of fixed effects

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
For INTRCPT1, π_0					
INTRCPT2, β_{00}	47.483495	4.089065	11.612	50	<0.001
DEGRECOD, β_{01}	-0.125594	1.788139	-0.070	50	0.944
YRSRECOD, β_{02}	0.285499	0.516972	0.552	50	0.583
PTRECODE, β_{03}	-0.002937	0.987895	-0.003	50	0.998
For TIME slope, π_1					
INTRCPT2, β_{10}	0.018519	0.283777	0.065	157	0.948

Statistics for the current model

Deviance = 917.008403
Number of estimated parameters = 7

VIII. Discussion

The purpose of this evaluation was to examine the infrastructure for reflective practice that is being built across the state of Minnesota within home visiting programs and to determine whether that infrastructure is effective. As such, the task of the evaluation was global and not focused closely on details. It emanated from two assumptions behind reflective practice: 1) that reflective practice improves the work life and work of home visitors, which includes preventing burnout, feeling and being effective, and retaining well-trained, effective home visitors; which results in 2) a partnership relationship with families leading to better outcomes for baby and the

family. In what follows, we first propose a conceptual framework that we developed as we analyzed and synthesized the data (Appendix H). We then consider our findings within both these larger assumptions and the framework.

As we talked with supervisors, home visitors, infant mental health consultants, and MDH mentors, a picture of how home visitors conceptualize their work emerged. The framework describes three approaches to interventions. On the left is the Directive Approach. Note that this is a top down, expert to novice, task oriented approach, and it represents the traditional approach to home visiting as well as a traditional way practitioners are trained to work with clients in pre-service programs. Our data affirm that most respondents in this study no longer view their work as directive. Instead, they have adopted a range of skills and knowledge and a belief system that supports working in a more collaborative way with clients or families. They reported change in how they practice with families. A supervisor noted:

- *I try and use silence more and just wait for them to talk a little more. I try, try, try to remember not to just jump in and fix whatever they're talking about. But instead, ask them some more questions and see where they go with it. I'm more conscious of, you know, what about the baby in all of this. You know, as they talk about clients and, you know, just asking that question about, you know, what's the baby doing in all of this. I guess, you know, those things maybe have changed somewhat.*

Her style is no longer directive but reflective. In the words of a home visitor:

- *It also has helped me to really focus on giving my families credit. Letting them know that they are the experts. That I am just there to support them. And a lot of times, they will – you know, they'll say, well, what should I do? And I'll say, what do you think you should do? How do you think you could move forward with this? Or what have you tried that's worked in the past? You know, just some of the things that just really empower families. So I feel like my families are so much more empowered. I'm not there to fix anything anymore. I'm there to empower them to fix it themselves.*

Although there's been a clear shift from the Directive Approach, there's ample evidence that much of the processing in supervision and case conferencing is Problem-Focused. A Problem-Focused Approach, as represented in Appendix H shifts the hierarchy somewhat in that the interventionist, or home visitor, works together with her supervisor and case consultation group to explore solutions for cases with which she is struggling. The implementation is a "search for what to try." There is strong evidence that much of the processing that's currently taking place in the home visiting programs is in this Problem-Focused Approach. For example:

- *Reflective practice really helps that they, you know, give you a different idea or different approach to try. And a lot of times they work;*
- *I talked to her recently about a family that was—it's very difficult. Where the mom is just not engaging with her kids. There's three of them that are quite young. And the consultant just provided me with some information as to what to try on the next meeting; and*
- *And then we talk about what are the strategies we can use to empower this family to be as successful as they can.*

These responses suggest that there's a search for solutions within the case consultation or with the supervisor. While this approach is more collaborative and exploratory than the Directive Approach, there is still a sense that the interventionist will find the "right" answer and that the change process for the family will happen when they know this "right" answer. In essence, the theory of change is based on knowledge transmission; if the professional shares the right knowledge, the family will function better.

The third approach, and the goal of this infrastructure-building project, is the Reflective Approach. In the Reflective Approach, the supervisor and the case consultation group function as a place for the interventionist, or home visitor, to process her work, to slow down, wonder, and reflect about what might be going on for the family. The group and supervisor "wonder" together and offer different perspectives, but they do not try to "solve" the problem or the case. The home visitor takes both her experience in this process and the new knowledge back to the family and through reflection, asking good questions, and building a relationship, partners with the family to find the meaning and causes behind behaviors. She supports the family in exploring new perspectives and processes, which ultimately, may or may not result in changes in behaviors that are not serving the family well. And throughout all, the focus is on the baby. In this Reflective Approach, the theory of change is that as families develop their own reflective functioning abilities, they will be better able to manage the ups and downs they face. The interventionist is a reflective partner supporting the development of families' reflective functioning capacities. The interventionist, herself, is supported in her own reflective functioning by her parallel process with her reflective supervisor and the reflective case consultation process.

There are many pieces of qualitative data and CEED Survey data that support the claim that the MIECHV program is well on its way to the Reflective Approach to practice. Answers to research questions suggest the support for **Venting, or containment**, which allows the home visitor to get the hard things she sees and the frustrations she experiences off her chest within an appropriate setting:

- *We hold our families. . . there's just times when your caseload is full. . . or that you've got a couple of families that are in crisis, and it just can become so heavy. You need someone else to help you hold it. It's too much to hold by yourself. You need to be able to share that with someone else so that at least you feel like you're not trying to hold the whole thing all by yourself.*

Containment and sharing the load allow the home visitor to:

- *Wonder and question instead of going with initial feelings. So thinking more deeply about it and analyzing it and seeing the situation from multiple perspectives.*

This is, of course, done in a **safe and trusting place**, either the case consultation group or with the supervisor.

- *I can go to my supervisor and . . . I can be vulnerable. And I have someone who can just kind of hear me out; and*
- *And then we can talk about what are the strategies we can use to empower this family to be as successful as they can be. How do we continue to move forward with the family in whatever way this is going to be successful for them.*

The team of case consultation, supervisor, home visitor and family work in partnership with the belief that:

- *People are capable. People can solve their own problems, and people are their own best expert. And that we are just here to support them to figure that out. Some of my families I've now been working with for over two year. And I've seen such amazing growth and confidence. . . my families are just so amazing. It's just amazing that people know they're capable. They know they can do it. And it's just amazing to see.*

These examples illustrate that for these home visitors, through the relationship-based reflective process, they are able to get to the place where they can partner with families in a reflective way. Their descriptions support the idea that having a reflective supervisor who provides safety or containment for the "venting" of authentic emotional responses to challenging work supports a shift in thinking about empowerment of families. As described, this is an expansion from a problem-solving approach and requires a capacity for patience and the provision of the same kind of safe place as families explore their own options. The nature of empowerment requires the provision of this safe and trusting place, and as these home visitors describe, their particular experience using the Reflective Approach supports them to practice in this way.

One final note is that burnout scores were higher than the norms for other social service workers, and these scores were not mitigated by high scores on the personal accomplishment sub-scale of the MBI. This suggests that MDH needs to be aware that reflective practice alone many not sufficiently address burnout in this highly stressful work

IX. Strengths and Limitations

Although the qualitative and CEED Survey data support the claim that the infrastructure over the two years of the grant has improved the use of reflective practice in evidence-based models, the quantitative data are less compelling. There were no findings of significance on any measure employed to empirically gauge change. There are several reasons for this. First, none of the three measures, the KIMS, WAI-SR, or the MBI is a direct measure of reflective practice. They instead measure behaviors that one would expect to change as a person becomes more reflective. But change in practice does not happen overnight, and the length of the intervention was eighteen months from start to finish and even less for some of the new sites that waited for implementation. In a study about case consultation, Harrison (2014) noted that her respondents reported that they did not start to sense a change in themselves until between the second and third year.

Another reason the quantitative data did not show any significance is that there is great variance in the amount of experience with reflective practice at sites, within home visitors, and within supervisors. Some Twin Cities sites have been practicing for eight years or more, while other sites were completely new to reflective practice. Because we analyzed mean scores on the measures, the differences between individual respondents are not evident.

We believe that the quantitative data would support the qualitative findings in time. Studies reported in the implementation science literature (Fixsen et al, 2005) estimate that it takes 2-4

years for a new innovation to take hold, and research using the Concerns-Based Adoption Model (CBAM) (Hord et al, 1987) has also found that it takes about three years for change to become part of practice. Thus, although the grant was initially for three years, in the end, the study lasted eighteen months, a much shorter time frame. Demographic data from the CEED Survey- indicate that 56% of supervisors have two years or less experience with reflective supervision, 30% have three to five years, and only 15% have five to ten years of experience. The figures are similar for home visitors with 62% have two years or less experience, 15% having three to five years, 18% having five to ten years, and 5% having more than ten years. Both home visitors and supervisors with the greatest experience were also mostly in the metro area, where reflective supervision has been in practice at some agencies as many as ten years. These data suggest that many participants are at the beginning stages of either reflective supervision or practice.

A change like reflective practice is often a "two steps forward, one step back" process. A home visitor may grasp at ideas for things to try from her consultation group, but a year later, after building a relationship with a family, may work with the family in a partnership to build the skills for raising an infant to a child. Additionally, there are differences in people's abilities to adopt new practices. For some, reflective practice involves intellectual, behavioral, and emotional shifts in how they build relationships and practice home visiting.

One strength of the study is the use of a mixed methodology, which allowed studying an idea from different points of view. For example, although the CEED Survey might suggest that home visitors are using the relationship as their intervention, interviews suggest that there is still work to do for that to be fully implemented.

Another strength of the study is the sampling process that was used. All agencies had the opportunity to participate. For the interviews, we made sure that every agency had a number of interviews proportional to the amount of staff involved in MIECHV. Every level of the infrastructure was also represented in the interviews, MDH staff, IMHCs, grant administrators, supervisors, and home visitors.

A third strength is the richness of the qualitative interviews, although impossible to adequately show here. Having a rich set of interview data allowed us to see how supervisors and home visitors progressed in their adoption of reflective practice, which mitigates the lack of a reliable and valid measure of reflective practice.

There is ample evidence that MIECHV supports home visitors in their work with families. This study did not set out to measure change in families; however, second hand reports from home visitors provide many examples of how their delivery and embracing of reflective practice help families find new ways of solving their own problems and focusing on the baby. Finally, the evaluation was shared work with all participants in the MIECHV program.

XII. Conclusions and Implications

The main conclusion and one that addresses the purpose of the evaluation is that Minnesota is well on its way to building a sustainable infrastructure for reflective practice. There are numerous examples of practitioners moving away from a Directive Approach and incorporating

more collaboration, as well as working from a Reflective Approach. At the same time, it's difficult to ascertain the degree to which home visitors are building and sustaining the relationships with families that support growth and change in taking care of babies and preschoolers. Additionally, there are questions still unanswered and issues to address that could guide further implementation.

First, professionals implementing the model receive some training from NFP and HFA. For example, supervisors get two hours of training from NFP. The approach to reflective practice also differs within the models. The Minnesota Department of Health provides a one day training with a half day for infant mental health and a half day for reflective practice. These are the basics that most professionals participating in the MIECHV Expansion Project receive, although we had several respondents tell us that they had no training whatsoever. For this evaluation, it was impossible to differentiate who is getting what training.

Additionally, home visitors and supervisors are getting many other opportunities to attend trainings. We tried counting them, but realized quickly that you cannot count them accurately based on interviews. Among the trainings mentioned were Motivational Interviewing, Circle of Security, using genograms, etc. How does all the other training professionals receive influence their capacity for and implementation of reflective practice? Another question is how well professionals integrate these various approaches into practice. Home visiting practice risks becoming much like education with the "practice du jour" menu. Integration of training, we believe, would further strengthen the implementation of reflective practice. In the words of one supervisor:

- *One of the questions I've had for myself has been the integration of reflective practice, reflective supervision, with Motivational Interviewing. . . as it relates to nursing practice. . . When is it important and necessary from a nurse practice perspective to look at more directive interaction? The best examples that I can have in terms of developmental screening for children, for infants, questions about preterm labor and assuring that we follow our best practices in that area. And then how does that blend with reflection, and then how does that blend from a process and a word perspective, motivational interviewing. . . I haven't been aware of anything which grapples with those three variables* (e.g., directive, motivational interviewing, and reflective practice) *in a way that comes out with a finished way of being.*

Additionally, we realize from our interviews that one size cannot fit all when it comes to training and other supports for reflective practice. There are significant differences between metro and rural areas. Metro areas have better and easier access to training and can draw from a much larger pool of trained professionals. Travel to training, to clients, and to reflective practice case consultation or supervision is more difficult in rural areas, and sometimes home visitors have to choose between spending an hour driving to see a client or participating in individual reflective practice or case conferencing. The training needs are also different in sites that have been engaging in reflective practice for a long time. These sites have built a culture of reflective practice, so bringing a new person in is easier, whereas for new sites, the capacity to train someone in house is not yet there.

We suggest developing a tiered intervention model of training that provides a foundational training and different types of training as the person gets more experience. This assumes there is a way to identify what people need and where an individual is in terms of skills and knowledge. A tool such as the Reflective Interaction Observation Scale (RIOS) (Watson et al., 2014) would be invaluable for informing training needs.

One training gleaned as needed includes a basic reflective practice training easily accessible that would help with the issue of staff attrition. This could be online modules with self-testing, videos, and/or frequently scheduled in-person training at specific sites. These would need to be followed-up with support from a mentor as the home visitor works in the field. There could also be some prerequisites for certain types of training, for example, such as having a certain amount of experience before taking Motivational Interviewing.

In terms of the travel difficulties, the use of technology to connect home visitors with training, supervision and case consultation should be considered. We heard many concerns about the problems that distance creates.

Another training issue is gaining expertise at specific reflective practice skills. In a multitude of interview data, people say they want to learn how to "go deeper," to learn how to ask good questions so they can get under the presenting issue to what's really going on. This relates to another identified training need: training not only in infant mental health but also in adult mental health. Home visitors and supervisors see these as foundational to their work.

Finally, we heard a resounding plea for keeping infant mental health consultants available to supervisors and case consultation groups. Respondents see the need for the content training they provide, the supervision they provide to supervisors, and the modeling of reflective practice strategies.

In conclusion, Minnesota is well on its way to an infrastructure for reflective practice within evidence-based home visiting programs. That infrastructure can further benefit from a structured and innovative approach to training, which will sustain and grow the progress that's been made—and grow it for Minnesota's infants, children, and families. As Nicholas Kristof and Sheryl WuDunn note:

- *The greatest inequality in American is not in wealth but the even greater gap of opportunity. One reason the United States has not made more progress against poverty is that our interventions come too late. If there's one over-arching lesson from the past few decades of research about how to break the cycles of poverty in the United States, it's the power of parenting—and of intervening early. . .children's programs are most successful when they leverage the most important—and difficult—job in the world: parenting. Give parents the tools to nurture their child in infancy and the result will be a more self-confident and resilient person for decades to come* (September 14, 2014, pp 1-2).

Appendix A

CEED Survey for Supervisors

Thank you for taking the time to complete this survey on reflective practice. The survey is part of the Evaluation of the Minnesota Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Expansion. We are interested in your knowledge and experience as a MIECHV supervisor within Minnesota. Participation in this project is voluntary and you may choose to not answer or stop participating at any time. The data collected from this survey will be used to inform both the process and impact evaluation of the MIECHV program. The data will be reported in aggregate; you will not be identifiable. The survey takes approximately 15 minutes to complete. We thank you for your time and careful responses.

If you have concerns or questions about this evaluation, please contact Karen Storm (stout010@umn.edu; 612-624-5708) or Ann Bailey (baile045@umn.edu; 612-626-3724) at the UMN Center for Early Education and Development.

Questions about Experience

1. Throughout your career, how many years total have you participated in any type of reflective practice?
    a. Less than 1 year
    b. 1-2 years
    c. 3-5 years
    d. 5-10 years
    e. More than 10 years

2. Throughout your career, how many years total have you provided reflective supervision?
    a. Less than 1 year
    b. 1-2 years
    c. 3-5 years
    d. 5-10 years
    e. More than 10 years

3. For each principle of reflective practice listed below, please indicate whether you've received formal training or not.

Reflective Practice Principle	Received Formal Training
Create a safe, trusting relationship	Yes/no
Attend to parallel process	Yes/no
Pause and reflect	Yes/no
Explore different perspectives	Yes/no

Consider behavior in the context of relationships	Yes/no
Explore thoughts and feelings	Yes/no
Pay attention to self-regulation and co-regulation	Yes/no
Maintain a clear sense of roles and boundaries	Yes/no
Value the importance of repair in relationships	Yes/no
Pay attention to my experience and how it influences my practice	Yes/no
Develop collaborative relationships	Yes/no
Keep the baby in mind	Yes/no

4. For each principle of reflective practice listed below, please rate how much your knowledge has changed over the grant period.

Reflective Practice Principle	My knowledge has greatly increased	My knowledge has somewhat increased	My knowledge has stayed about the same
Create a safe, trusting relationship			
Attend to parallel process			
Pause and reflect			
Explore different perspectives			
Consider behavior in the context of relationships			
Explore thoughts and feelings			
Pay attention to self-regulation and co-regulation			
Maintain a clear sense of roles and boundaries			
Value the importance of repair in relationships			
Pay attention to my experience and how it influences my practice			

Develop collaborative relationships			
Keep the baby in mind			

5. What do you believe has been the most influential source of learning reflective supervision for you? (choose one)
    a. Formal training
    b. Conferences
    c. My supervisor
    d. My peers
    e. Infant Mental Health Consultant
    f. Articles/books
    g. Other. Please explain.

6. For each principle of reflective practice listed below, please rate how much your use of each principle has changed over the grant period.

Reflective Practice Principle	My use has greatly increased	My use has somewhat increased	My use has stayed about the same
Create a safe, trusting relationship			
Attend to parallel process			
Pause and reflect			
Explore different perspectives			
Consider behavior in the context of relationships			
Explore thoughts and feelings			
Pay attention to self-regulation and co-regulation			
Maintain a clear sense of roles and boundaries			
Value the importance of repair in relationships			
Pay attention to my experience and how it influences my practice			

Develop collaborative relationships			
Keep the baby in mind			

7. To what extent do you believe these principles influence your effectiveness as a reflective supervisor?
    a. My use of these principles greatly influences my effectiveness
    b. My use of these principles somewhat influences my effectiveness
    c. My use of these principles does not influence my effectiveness
    d. I cannot answer: Please explain to help us better understand your answer.

8. At this time, how would you rate your level of adoption of reflective practice principles?

	Not yet in practice	**Emerging**	**Fully Implemented**
In the case conference group?			
Individually with the home visitors?			

9. At this time, how would you rate your level of competence in applying reflective practice principles?

	Not yet in practice	**Emerging**	**Fully Implemented**
In the case conference group?			
Individually with home visitors?			

Questions about the Use of Reflective Practice in Case Conferencing and Individual Supervision

The next set of questions is about the use of reflective practice in case conferencing and individual supervision. There are no right or wrong answers. We are simply interested in your experiences and routines.

10. How long have you been leading/co-leading the case conference group?
    a. ___ Less than 1 year
    b. ___ 1-2 years
    c. ___ 3-4 years
    d. ___ More than 4 years

11. How long have you provided individual reflective supervision to home visitors?
    a. ___ Less than 1 year
    b. ___ 1-2 years
    c. ___ 3-4 years
    d. ___ More than 4 years

12. Since implementing reflective supervision, to what extent has your time responding to home visitors' unscheduled needs for support (drop-ins) changed?
    a. My time responding to drop-ins has increased
    b. My time responding to drop-ins has stayed the same
    c. My time responding to drop-ins has decreased

13. Based on your experience, how has learning reflective supervision affected your communication with the home visitors you supervise?
    a. Communication has greatly improved
    b. Communication has somewhat improved
    c. Communication has stayed about the same
    d. Communication has become more difficult
    e. I cannot answer: Please explain to help us better understand your answer.

14. Based on your experience during the grant period, how helpful is the individual reflective supervision you provide to home visitors' work?
    a. Not at all helpful
    b. Somewhat helpful
    c. Helpful
    d. Very helpful
    e. I am not providing any reflective supervision

15. Based on your experience during the grant period, how helpful are reflective case conference groups to home visitors' work?
    a. Not at all helpful
    b. Somewhat helpful
    c. Helpful
    d. Very helpful
    e. I am not providing case conferencing

16. The organization that I work for supports the use of reflective practice

a. Agree
b. Disagree
c. I don't know

Questions about the Use of Reflective Practice with Home Visitors

17. How comfortable are you in using reflective practice in your supervision of home visitors?
    a. Not at all comfortable
    b. Somewhat comfortable
    c. Comfortable
    d. Very comfortable

18. How competent do you feel using reflective practice in your supervision of home visitors? ("I feel knowledgeable and have practiced my skills")
    a. Not at all competent
    b. Somewhat competent
    c. Competent
    d. Very Competent

19. How well do you believe you are incorporating reflective practice in your supervision of home visitors?
    a. Fully incorporating reflective practice
    b. Use often
    c. Use occasionally
    d. Not using. Please explain to help us better understand the barriers to using reflective practice.

Perceptions about Knowledge and Skills

20. In describing your individual reflective supervision sessions with the home visitors, please rate the following

Typically, in individual supervision. . .	**Do Not Agree**	**Somewhat agree**	**Agree**	**Strongly Agree**
We create a safe place to explore the home visitors' feelings about their work				
There is a respectful give and take between myself and the home visitors				

I can hold the home visitors' thoughts and feelings without trying to fix them				
I help the home visitors think about how their assumptions and experiences influence their practice				
I collaborate with the home visitors to solve problems of practice				
I make it safe to talk about situations that are not going well				
I provide uninterrupted focus on the home visitors' work with families during the individual meeting time				
Home visitors are receiving the right amount of reflective supervision to support them in their work				
My relationship with the home visitors provides a model for how I hope they work with families				
I guide the home visitors to explore the perspectives of everyone involved				
We don't forget about the baby				

21. In describing your case conference reflective practice sessions, please rate the following statements.

Typically, within the reflective case conference. . .	**Do Not Agree 1**	**Somewhat agree 2**	**Agree 3**	**Strongly Agree 4**
The group members listen carefully to the presenter.				
The group doesn't forget about the baby.				
The group explores meaning and perspective(s) about what is presented.				
Group members ask thoughtful questions about the case presentation.				
The group explores the meaning of the cultural contexts of the families.				
Group members hold solutions until the presenter is ready.				
Group members feel safe expressing strong feelings.				
The group listens with the goal of deeper understanding.				

Demographics:

1. What is your age? (Drop-down box)
    a. Under 25
    b. 25-34
    c. 35-44
    d. 45-54

e. 55-64
f. 65+

2. What is your ethnicity?
    a. Hispanic or Latino
    b. Not Hispanic or Latino
3. What is your race?
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islander
    e. White
    f. Multiracial:

4. What is the highest level of education you have completed?
    a. Some college or Certificate Program
    b. Associate of Arts degree
    c. Bachelor of Arts or Science
    d. Post graduate degree
5. In what year did you last receive a degree?
6. What is your professional training? (check all that apply)
    a. Public Health Nurse
    b. Registered Nurse
    c. Licensed Practical Nurse
    d. Social Worker
    e. Community Health Worker
    f. Psychologist
    g. Marriage and Family Therapist
    h. Parent Educator
    i. Other_____

7. In what type of community are the majority of families you serve located?
    a. Twin Cities Metropolitan Area
    b. Cities with populations greater than 30,000 people (e.g., St. Cloud, Duluth, Moorhead, Mankato, Rochester, etc.)
    c. Towns with populations less than 30,000 but more than 6,000 people (e.g., Austin, Brainerd, Detroit Lakes, Owatonna, Winona, etc.)
    d. Towns with populations less than 6000 people (e.g., International Falls, Wadena, Morris, etc.)

8. What is the total number of years you have worked as a supervisor? (Drop-down box)
    a. Less than one year
    b. 1-3
    c. 4-6
    d. 7-10
    e. Over 10 years

9. Prior to becoming a supervisor, how many years were you a home visitor?
    a. I was not a home visitor prior to becoming a supervisor.
    b. Less than 1 year
    c. 1-3 years
    d. 4-6 years
    e. 7-10 years
    f. Over 10 years

Please share any additional comments about your experience with reflective practice. (TEXT BOX)

Thank you for completing this survey.

Appendix B

CEED Survey for Home Visitors

Thank you for taking the time to complete this survey on reflective practice. This follow-up survey is part of the Evaluation of the Minnesota Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Expansion. We are interested in your knowledge and experience as a MIECHV provider within Minnesota. Participation in this project is voluntary and you may choose to not answer or stop participating at any time. The data collected from this survey will be used to inform both the process and impact evaluation of the MIECHV program. The data will be reported in aggregate; you will not be identifiable. The survey takes approximately 15 minutes to complete. We thank you for your time and careful responses.

If you have concerns or questions about this evaluation, please contact Karen Storm (stout010@umn.edu; 612-624-5708) or Ann Bailey (baile045@umn.edu; 612-626-3724) at the UMN Center for Early Education and Development.

Questions about Experience

1. Throughout your career, how many years total have you participated in any type of reflective practice?
    a. Less than 1 year
    b. 1-2 years
    c. 3-5 years
    d. 5-10 years
    e. More than 10 years

2. For each principle of reflective practice listed below, please indicate whether you've received formal training or not.

Reflective Practice Principle	Received Formal Training
Create a safe, trusting relationship	Yes/no
Attend to parallel process	Yes/no
Pause and reflect	Yes/no
Explore different perspectives	Yes/no
Consider behavior in the context of relationships	Yes/no
Explore thoughts and feelings	Yes/no
Pay attention to self-regulation and co-regulation	Yes/no
Maintain a clear sense of roles and boundaries	Yes/no
Value the importance of repair in	Yes/no

relationships	
Pay attention to my experience and how it influences my practice	Yes/no
Develop collaborative relationships	Yes/no
Keep the baby in mind	Yes/no

3. For each principle of reflective practice listed below, please rate how much your knowledge has changed over the grant period.

Reflective Practice Principle	My knowledge has greatly increased	My knowledge has somewhat increased	My knowledge has stayed about the same
Create a safe, trusting relationship			
Attend to parallel process			
Pause and reflect			
Explore different perspectives			
Consider behavior in the context of relationships			
Explore thoughts and feelings			
Pay attention to self-regulation and co-regulation			
Maintain a clear sense of roles and boundaries			
Value the importance of repair in relationships			
Pay attention to my experience and how it influences my practice			
Develop collaborative relationships			
Keep the baby in mind			

4. What do believe has been the most influential source of learning reflective practice for you? (choose one)
    a. Formal training
    b. Conferences
    c. My supervisor
    d. My peers
    e. Infant Mental Health Consultant
    f. Articles/books
    g. Other. Please explain.

5. For each principle of reflective practice listed below, please rate how much your use of each principle has changed over the grant period.

Reflective Practice Principle	My use has greatly increased	My use has somewhat increased	My use has stayed about the same
Create a safe, trusting relationship			
Attend to parallel process			
Pause and reflect			
Explore different perspectives			
Consider behavior in the context of relationships			
Explore thoughts and feelings			
Pay attention to self-regulation and co-regulation			
Maintain a clear sense of roles and boundaries			
Value the importance of repair in relationships			
Pay attention to my experience and how it influences my practice			
Develop collaborative relationships			
Keep the baby in mind			

6. To what extent do you believe these principles influence your effectiveness as a home visitor?
    a. My use of these principles greatly influences my effectiveness
    b. My use of these principles somewhat influences my effectiveness
    c. My use of these principles does not influence my effectiveness
    d. I cannot answer: Please explain to help us better understand your answer.

7. At this time, how would you rate your level of adoption of reflective practice principles?

	Not yet in practice	**Emerging**	**Fully Implemented**
In my case conference group?			
Individually with my supervisor?			
Working with families?			

8. At this time, how would you rate your level of competence in applying reflective practice principles?

	Not yet in practice	**Emerging**	**Fully Implemented**
In my case conference group?			
Individually with my supervisor?			
Working with families?			

Questions about the Use of Reflective Practice in Case Conferencing and Individual Supervision

The next set of questions is about the use of reflective practice in case conferencing and individual supervision. There are no right or wrong answers. We are simply interested in your experiences and routines.

9. How long have you participated in your case conference group?
    a. ___ Less than 1 year
    b. ___ 1-2 years
    c. ___ 3-4 years
    d. ___ More than 4 years

10. How long have you received individual reflective supervision?

a. ___ Less than 1 year
b. ___ 1-2 years
c. ___ 3-4 years
d. ___ More than 4 years

11. Based on your experience during the grant period, how has reflective practice affected communication with your supervisor?
    a. Communication has greatly improved
    b. Communication has somewhat improved
    c. Communication has stayed about the same
    d. Communication has become more difficult
    e. I cannot answer: Please explain to help us better understand your answer.

12. Based on your experience during the grant period, how helpful is the individual reflective supervision you receive in your work?
    a. Not at all helpful
    b. Somewhat helpful
    c. Helpful
    d. Very helpful
    e. I am not receiving any reflective supervision

13. Based on your experience during the grant period, how helpful is case conferencing in your work?
    a. Not at all helpful
    b. Somewhat helpful
    c. Helpful
    d. Very helpful
    e. I am not participating in case conferencing

14. The organization that I work for supports reflective practice
    a. Agree
    b. Disagree
    c. I don't know

Questions about the Use of Reflective Practice with Families

15. How comfortable are you in using reflective practice in your work with families?
    a. Not at all comfortable
    b. Somewhat comfortable

c. Comfortable
d. Very comfortable
e. I am not using reflective practice with families.

16. Based on your experience, how well do you believe reflective practice has affected the communication with families?
    a. Communication has greatly improved
    b. Communication has somewhat improved
    c. Communication has stayed about the same
    d. Communication has become more difficult
    e. I cannot answer: Please explain to help us better understand your answer.

17. How effective do you believe reflective practice is in helping the families you serve?
    a. Not at all effective
    b. Somewhat effective
    c. Effective
    d. Very effective

Perceptions about Knowledge and Skills

18. In describing your individual reflective practice sessions with your supervisor, please rate the following

In your typical individual reflective supervision experience. . .	**Do Not Agree**	**Somew hat agree**	**Agree**	**Strongl y Agree**
My supervisor provides a safe place to explore my feelings about my work				
There is a respectful give and take between my supervisor and me				
My supervisor can hold my thoughts and feelings without trying to fix them				
My supervisor helps me think about how my assumptions and experiences influence my practice				
My supervisor collaborates with me to solve problems of practice				
My supervisor makes it safe to talk about situations that are not going well				
My supervisor provides uninterrupted focus on my work with families during the individual meeting time				
I am receiving the right amount of reflective supervision to support me in my work				
My relationship with my supervisor provides a model for how I want to work with families				

My supervisor guides me to explore the perspectives of everyone involved				
My supervisor and I don't forget about the baby				

19. In describing your case conference reflective practice sessions, please rate the following statements.

In general as a reflective practice group. . .	**Do Not Agree 1**	**Somewhat agree 2**	**Agree 3**	**Strongly Agree 4**
The group members listen carefully to the presenter.				
The group doesn't forget about the baby.				
The group explores meaning and perspective(s) about what is presented.				
Group members ask thoughtful questions about the case presentation.				
The group explores the meaning of the cultural contexts of the families.				
Group members hold solutions until the presenter is ready.				
Group members feel safe expressing strong feelings.				
The group listens with the goal of deeper understanding.				

Demographics:

10. What is your age? (Drop-down box)
    a. Under 25
    b. 25-34
    c. 35-44
    d. 45-54
    e. 55-64
    f. 65+
11. What is your ethnicity?
    a. Hispanic or Latino
    b. Not Hispanic or Latino

12. What is your race?
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American

d. Native Hawaiian or Other Pacific Islander
e. White
f. Multiracial:

13. What is the highest level of education you have completed?
    a. Some college or Certificate Program
    b. Associate of Arts degree
    c. Bachelor of Arts or Science
    d. Post graduate degree
14. In what year did you last receive a degree?
15. What is your professional training? (check all that apply)
    a. Public Health Nurse
    b. Registered Nurse
    c. Licensed Practical Nurse
    d. Social Worker
    e. Community Health Worker
    f. Psychologist
    g. Marriage and Family Therapist
    h. Parent Educator
    i. Other_____
16. In what type of community is are the majority of families you serve located?
    a. Twin Cities Metropolitan Area
    b. Cities with populations greater than 30,000 people (e.g., St. Cloud, Duluth, Moorhead, Mankato, Rochester, etc.)
    c. Towns with populations less than 30,000 but more than 6,000 people (e.g., Austin, Brainerd, Detroit Lakes, Owatonna, Winona, etc.)
    d. Towns with populations less than 6000 people (e.g., International Falls, Wadena, Morris, etc.)
17. What is the total number of years you have worked as a home-visitor?
    a. Less than one year
    b. 1-3
    c. 4-6
    d. 7-10
    e. Over 10 years

Please share any additional comments about your experience with reflective practice. (TEXT BOX)

Thank you for completing this survey.

Appendix C

MDH Mentor Interview Protocol

Good morning/afternoon. Thank you for agreeing to participate in the MIECHV Expansion Grant Evaluation interview. My name is [FILL IN YOUR NAME]. The interview will take between 45-60 minutes.

The purpose of this interview is to gather information on the Minnesota MIECHV expansion grant. The focus of the evaluation is to determine if the current infrastructure and available resources effectively support the implementation of reflective practice within Minnesota. This information will be used by CEED and the Minnesota Department of Health to guide the support and infrastructure of reflective practice use in public health home visiting.

I encourage you to share your points of view. There are no right or wrong answers to the questions I will ask. Your answers to the questions will remain confidential, meaning that your individual answers will not be shared with anyone outside of CEED. The information gathered will be analyzed for themes and then shared with the Minnesota Department of Health in the form of a report. There will be no identifiable information shared, meaning that your name will not be tied to your comments.

You have the right to stop participating at any time during the interview with absolutely no penalty. You also have the right to call or email me at any time after the interview and ask me to remove parts of your interview or the entire interview. I'll be recording this interview today so that I can actively listen to you and so I can accurately capture the conversation. Do you have any questions or concerns before we begin?

Last spring we met and talked with you about your responsibilities specific to the MIECHV expansion grant. This interview is a follow up to that interview. Some of the questions will be similar.

1. As MIECHV has been implemented, have your role and responsibilities as an MDH mentor changed at all? Can you give me an example?

2. What formal training have you provided to sites (e.g., introduction, goals, structure, etc.) over the grant period?

3. In your opinion, has there been adequate knowledge and skills training for the Group 1 supervisors and home visitors to fully implement reflective practice?
    a. Do you believe that is too little, too much, or about the right amount of formal training?

b. How, if at all, would you change the formal reflective practice training opportunities for Group 1?
c. Is this training sufficient to meet the requirements of the home visiting models? Please explain.

4. In your opinion, has there been adequate knowledge and skills training for the Group 2 supervisors and home visitors to fully implement reflective practice?
    a. Do you believe that is too little, too much, or about the right amount of formal training?
    b. How, if at all, would you change the formal reflective practice training opportunities for Group 2?
    c. Is this training sufficient to meet the requirements of the home visiting models? Please explain.
5. How, if at all, have your own skills and knowledge of reflective practice changed over the grant period?

6. In your role as a MDH mentor, what challenges have you experienced during the grant period, if any?
   **Since the purpose of the grant to look at infrastructure, be sure to probe about any challenges related to infrastructure, support of supervisors and administrators, suspicions from the field about the purpose of reflective practice, etc.

7. How often do you provide mentoring on reflective supervision? Individually? In the case conference?
    a. Has the amount of mentoring on reflective supervision increased, decreased, or stayed about the same over the grant period?
    b. Has the quality (e.g., depth of discussion, use of reflective practice principles, etc.) of the mentoring changed over the grant period?

8. Have you seen a change in the beliefs and attitudes of home visitors, supervisors and/or administrators about reflective supervision and practice?
    a. What changes can you describe?
    b. Have you observed reflective practice improvement in the Group 1 sites? Please explain.

   *If they don't know, that's OK.

9. Do you believe the implementation of reflective practice is influencing the work environment within agencies?
    a. How has this changed over the course of the year? Provide examples.

b. Have you observed changes in the work environment for the sites in Group 1? Please explain.

*If they don't know, that's OK.

10. What were your expectations of the Infant Mental Health Consultant?
    a. How important is the role of the IMHC in supporting supervisors and home visitors at Group 1 sites? Supporting evidence-based home visiting at Group 1 sites?
    b. How important is the role of the IMHC in supporting supervisors and home visitors at Group 2 sites? Supporting evidence-based home visiting at Group 2 sites?
    c. What specific skills and knowledge, if applicable, do you think supervisors and home visitors are learning from the Infant Mental Health Consultant?
    d. What feedback, if any, have you received from supervisors or administrators regarding the Infant Mental Health Consultants?

11. What is your vision for the use of reflective practice within the agencies? How, if at all, has this changed during the grant period?

12. What do you believe are the effects, if any, of reflective practice on program outcomes?

13. Do you believe that agencies have had the resources (e.g., financial, access to Infant Mental Health Consultants, paperwork support, etc.) necessary for implementing reflective practice?
    a. What support, if any, have you received from MDH to implement reflective practice?
    b. What barriers, if any, are there to full implementation of reflective practice?

14. What do you believe it will take to sustain reflective practice within an agency? Statewide?

Appendix D

Supervisor Interview Protocol

Good morning/afternoon. Thank you for agreeing to participate in the MIECHV Expansion Grant Evaluation interview. My name is [FILL IN YOUR NAME]. The interview will take between 45-60 minutes.

The purpose of this interview is to gather information on the Minnesota MIECHV expansion grant. The focus of the evaluation is to determine if the current infrastructure and available resources effectively support the implementation of reflective practice within Minnesota. This information will be used by CEED and the Minnesota Department of Health to guide the support and infrastructure of reflective practice use in public health home visiting.

I encourage you to share your points of view. There are no right or wrong answers to the questions I will ask. Your answers to the questions will remain confidential, meaning that your individual answers will not be shared with anyone outside of CEED. The information gathered will be analyzed for themes and then shared with the Minnesota Department of Health in the form of a report. There will be no identifiable information shared, meaning that your name will not be tied to your comments.

You have the right to stop participating at any time during the interview with absolutely no penalty. You also have the right to call or email me at any time after the interview and ask me to remove parts of your interview or the entire interview. I'll be recording this interview today so that I can actively listen to you and so I can accurately capture the conversation. Do you have any questions or concerns before we begin?

With MIECHV Expansion Grant funding, MDH has been supporting the statewide implementation of reflective practices in home visiting. Last fall, we asked you about your role as a supervisor using reflective practice. In this interview, we will be asking you follow up questions about your experience as part of the expansion project.

1. What training, if any, have you had in the last year as part of the MIECHV expansion project? What training do you still want?
2. Reflecting on the past year, how would you now describe your role as a supervisor who provides reflective supervision to individual home visitors?
    a. How has your role changed, if at all? What are you doing that's different? What are you doing that's the same?
    b. How much time, if any, are you spending on management/administrative responsibilities during the individual reflective practice sessions?
3. Please talk about your role in case conferencing now.

   a. How, if at all, has your role changed over time? What are you doing that's different? What are you doing that's the same?
   b. How much time, if any, are you spending on management/administrative responsibilities during the case conference?
4. What feedback do you receive from the home visitors about the reflective practice sessions?
5. Have you seen a change in how home visitors talk about/approach their work with families since the implementation of reflective practice? Please give an example.
6. What were your initial beliefs about implementing reflective practice? What are your beliefs about implementing reflective practice now? (What did you expect to happen?)
7. How would you describe reflective practice to a colleague?
8. In what aspects of reflective practice do you feel skilled? What areas, if at all, are challenging for you?
9. Please describe the support you are receiving from Infant Mental Health Consultant (IMHC).
   a. What specific skills and knowledge are you learning from the IMHC?
   b. Is the amount of time he/she spends with you about right? Please explain.
   c. Is the amount of time he/she spends with your team in the case conference about right? Please explain.
   d. How does the support of the IMHC affect the quality of the interactions with home visitors, if at all? Please explain.
   e. Are there additional supports you'd like but currently don't have?
10. Can you please describe your working relationship with the IMHC? How do you share the work, if at all? Has your working relationship changed over the course of the expansion grant? How?
   a. What value does the IMHC add to the practice of reflective practice? What value do they add for your individual practice? What value to the work of the agency?
11. How has the practice of reflective supervision affected your knowledge of home visiting?
12. In what ways, if any, is reflective practice helpful in dealing with any stressful aspects of your work?
13. How does practicing reflective supervision influence engagement with your work, if at all?
14. How does reflective supervision and practice fit into the priorities of your agency?
   a. Please share an example.
15. What will it take to sustain reflective practice within an agency? Statewide?
   a. How have, if at all, your perceptions changed about sustainability across the implementation of MIECHV?

Appendix E

Home Visitor Interview Protocol

Good morning/afternoon. Thank you for agreeing to participate in the MIECHV Expansion Grant Evaluation interview. My name is [FILL IN YOUR NAME]. I work at the CEED, which is the Center for Early Education and Development at the University of Minnesota. The interview will take approximately 60 minutes.

The purpose of this interview is to gather information on the Minnesota MIECHV expansion grant. The focus of the evaluation is to determine if the current infrastructure and available resources effectively support the implementation of reflective practice within Minnesota. This information will be used by CEED and the Minnesota Department of Health to guide the support and infrastructure of reflective practice use in public health home visiting.

I encourage you to share your points of view. There are no right or wrong answers to the questions I will ask. Your answers to the questions will remain confidential, meaning that your individual answers will not be shared with anyone outside of CEED. The information gathered will be analyzed for themes and then shared with the Minnesota Department of Health in the form of a report. There will be no identifiable information shared, meaning that your name will not be tied to your comments. If we use a quote from this interview, we will say, "a home visitor said," and not tie your name to your quote.

You have the right to stop participating at any time during the interview with absolutely no penalty. You also have the right to call or email me at any time after the interview and ask me to remove parts of your interview or the entire interview. I'll be recording this interview today so that I can actively listen to you and so I can accurately capture the conversation. Do you have any questions or concerns before we begin?

With MIECHV Expansion Grant funding, MDH has been supporting the statewide implementation of reflective practices in home visiting. Last fall, we asked supervisors about their use of reflective practice. In this interview, we will be asking you questions about your experience as part of the expansion project.

1. What training in reflective practice, if any, have you had in the last two years as part of the MIECHV expansion project?
    a. What training do you still want?
    b. Do you believe the amount of training has been "about right," "too little," or "too much?"
2. What have been the most helpful ways for you to gain reflective practice skills and knowledge (e.g., empathic listening, pausing, self-regulation, etc.)?

3. What aspects of reflective practice are you aware of right now? (e.g., parallel processing, creating a safe space, focusing on the baby, pause and reflect, maintain a clear sense of roles and boundaries)

4. What aspects of reflective practice is your team working on right now? (e.g., parallel processing, creating a safe space, focusing on the baby, pause and reflect, maintain a clear sense of roles and boundaries)

5. How does participating in reflective supervision support your own learning?
    a. Please provide an example.

6. How does participating in reflective practice with your colleagues and the Infant Mental Health Consultant (IMHC) support your learning? Please provide an example
    a. What specific skills and knowledge are you learning from the IMHC?
    b. Is the amount of time he/she spends with your team in the case conference about right? Please explain.
    c. How does the support of the IMHC affect the quality of your interactions with your supervisor, if at all? Please explain.
    d. Are there additional supports you'd like but currently don't have?

7. How would you describe reflective practice to a colleague?

8. What were your initial beliefs about implementing reflective practice? What did you expect to happen?
    a. What are your beliefs about implementing reflective practice now?
    b. What has influenced your beliefs about reflective practice?

9. How does reflective supervision compare to your prior experiences with supervision?

10. How, if at all, has reflective practice, both individual and case conferencing, influenced your work as a home visitor?
    a. What reflective practice skills, if any, are helpful with your work as a home visitor?
    b. How does your knowledge of infant mental health influence your work as a home visitor?

11. What do you believe are the effects of applying reflective practice skills in your work as a home visitor?

a. Describe a time when you consciously used a reflective approach with the family/caregiver. What happened?

12. How does reflective practice impact your feelings about your effectiveness in your work, if at all?

13. In what ways, if any, is reflective supervision helpful in dealing with any stressful aspects of your work?
    a. In what ways, if any, are case conferences helpful in dealing with any stressful aspects of your work?

14. How does a reflective approach support the growth and change of at-risk families, if at all?

15. How does reflective supervision and practice fit into the priorities of your agency?
    a. Please share an example.

16. What will it take to sustain reflective practice within an agency? Statewide?

Appendix F

Infant Mental Health Consultant Interview Protocol

Good morning/afternoon. Thank you for agreeing to participate in the MIECHV Expansion Grant Evaluation interview. My name is [FILL IN YOUR NAME]. I work at the CEED, which is the Center for Early Education and Development at the University of Minnesota. The interview will take approximately 45 minutes.

The purpose of this interview is to gather information on the Minnesota MIECHV expansion grant. The focus of the evaluation is to determine if the current infrastructure and available resources effectively support the implementation of reflective practice within Minnesota. This information will be used by CEED and the Minnesota Department of Health to guide the support and infrastructure of reflective practice use in public health home visiting.

I encourage you to share your points of view. There are no right or wrong answers to the questions I will ask. Your answers to the questions will remain confidential, meaning that your individual answers will not be shared with anyone outside of CEED. The information gathered will be analyzed for themes and then shared with the Minnesota Department of Health in the form of a report. There will be no identifiable information shared, meaning that your name will not be tied to your comments. If we use a quote from this interview, we will say, "an Infant Mental Health Consultant said," and not tie your name to your quote.

You have the right to stop participating at any time during the interview with absolutely no penalty. You also have the right to call or email me at any time after the interview and ask me to remove parts of your interview or the entire interview. I'll be recording this interview today so that I can actively listen to you and so I can accurately capture the conversation. Do you have any questions or concerns before we begin?

Last fall, we asked all the IMHCs about their role in supporting reflective practice. In this interview, we will continue to ask you questions about your experience as part of the MIECHV expansion project.

15. Please remind me, for what sites/agencies are you providing consultation?

16. Please describe your role as the infant mental health consultant. How has this changed, if at all, throughout the grant period?
    a. Does your role vary from site to site? If so, please describe your differing roles.
    b. On what topics have you been asked to provide consultation?
    c. Are you providing both individual and case conferencing consultation? To whom are you providing this?

17. In your role as an infant mental health consultant, how do you support your continuing education in reflective practice and infant mental health?

18. How would you describe reflective practice to someone who knew nothing about it?

19. As part of the grant, the Infant Mental Health Consultants are expected to provide reflective supervision to MIECHV supervisors.
    a. How often are you providing mentoring or support?
    b. Has the amount of time spent consulting with the supervisor(s) changed over the period of the grant?
    c. What skills and knowledge seem to be of the greatest concern to the supervisor(s)?

20. What reflective practice skills and knowledge are most needed by supervisors?

21. Please describe a typical case conferencing session.
    a. With how many case conferencing groups are you working?
    b. Who leads the group? Has that changed over the grant period?
    c. Has the amount of time you spend in the case conference changed over the grant period?
    d. What skills and knowledge seem to be of the greatest concern to the home visitors?

22. What reflective practice knowledge and skills do you feel are most needed by home visitors?

23. What beliefs and attitudes are you hearing from supervisors regarding reflective practice?

24. What beliefs and attitudes are you hearing from home visitors regarding reflective practice?

25. What do you think supervisors gain by participating in reflective practice?

26. What do you think home visitors gain by participating in reflective consultation?

27. What is your perception of how supervisors are implementing reflective practice with home visitors? Please provide an example.

28. What is your perception of how reflective practice is being implemented by home visitors with families? Please provide an example.

29. What resources, if any, would help you in providing consultation to agencies, supervisors, home visitors?

30. What ideas do you have for trainings on reflective practice/reflective supervision? Do you have any recommendations for specific groups—supervisors, home visitors, administrators? Who should provide the training? What training, if any, do you believe MDH could be providing on reflective practice?

31. What will it take to institutionalize reflective practice statewide?

Appendix G
Agency Administrator Interview Protocol

Good morning/afternoon. Thank you for agreeing to participate in the MIECHV Expansion Grant Evaluation interview. My name is [FILL IN YOUR NAME]. I work at the CEED, which is the Center for Early Education and Development at the University of Minnesota. The interview will take between 30-40 minutes.

The purpose of this interview is to gather information on the Minnesota MIECHV expansion grant. The focus of the evaluation is to determine if the current infrastructure and available resources effectively support the implementation of reflective practice within Minnesota. This information will be used by CEED and the Minnesota Department of Health to guide the support and infrastructure of reflective practice use in public health home visiting.

I encourage you to share your points of view. There are no right or wrong answers to the questions I will ask. Your answers to the questions will remain confidential, meaning that your individual answers will not be shared with anyone outside of CEED. The information gathered will be analyzed for themes and then shared with the Minnesota Department of Health in the form of a report. There will be no identifiable information shared, meaning that your name will not be tied to your comments. If we use a quote from this interview, we will say, "an administrator said," and not tie your name to your quote.

You have the right to stop participating at any time during the interview with absolutely no penalty. You also have the right to call or email me at any time after the interview and ask me to remove parts of your interview or the entire interview. I'll be recording this interview today so that I can actively listen to you and so I can accurately capture the conversation. Do you have any questions or concerns before we begin?

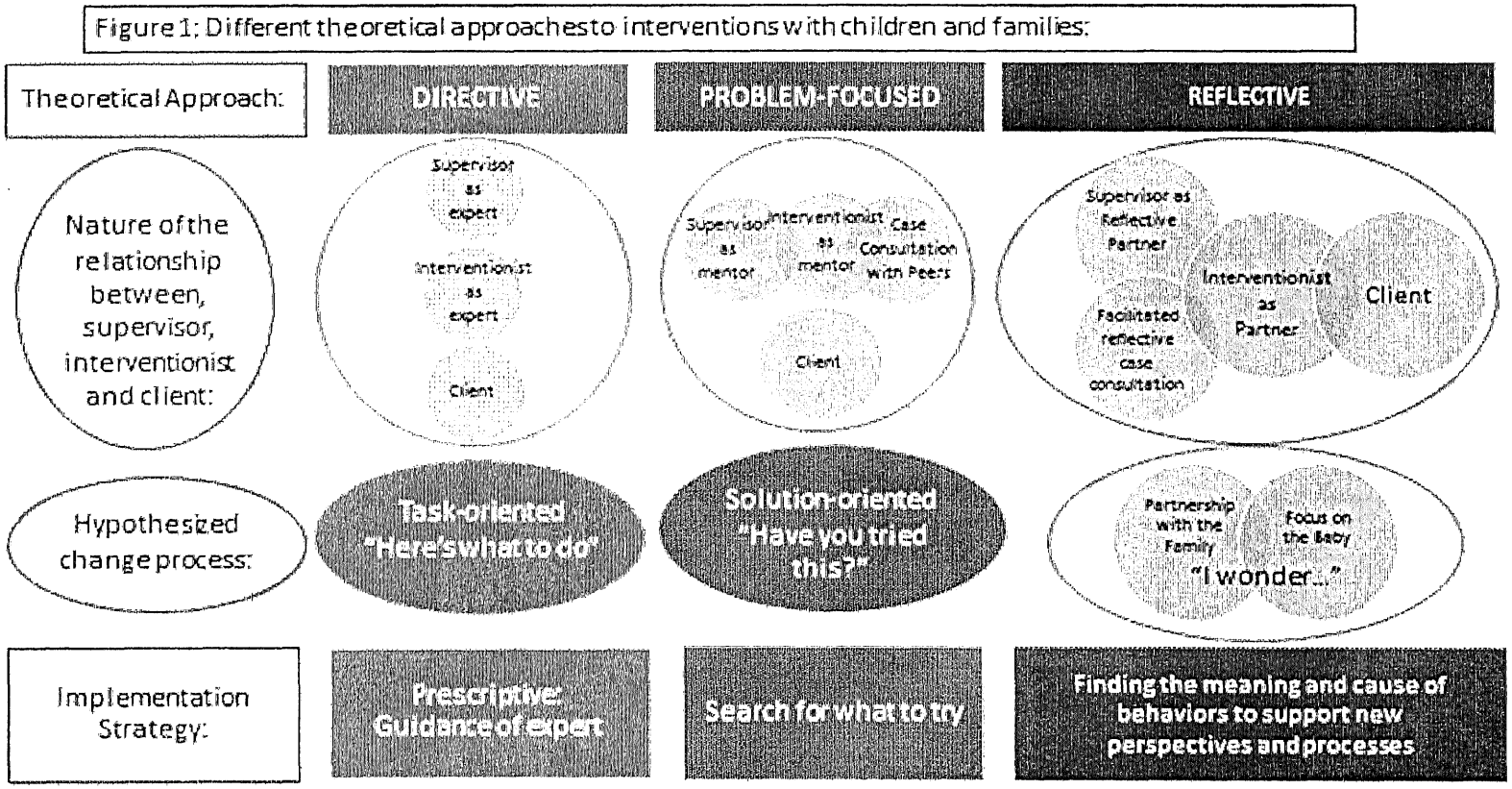
Last fall we met and talked with you about your responsibilities specific to administering MIECHV expansion grant. This interview is a follow up to that interview. Some of the questions will be similar.

1. As MIECHV has been implemented, have your role and responsibilities for it at the agency changed at all? Can you give me an example?
   a. Comparing your work with MIECHV to last fall, is it taking up less, about the same, or more of your time? (What reasons do you think explain this?)
2. Have you had any new training or experience in reflective practice/supervision since last year?
   a. If so, can you please describe it?
   b. If not, do you want further training in reflective practice?

3. Do you believe the implementation of reflective practice is influencing the work environment at your agency?
    c. How has this changed over the course of the year? Provide examples.
    d. Does the use of reflective practice affect people in other programs within your agency? If yes, how?
4. Have any of your responsibilities supervising staff who use reflective practice changed over the course of the grant?
    a. How comfortable are you in using reflective practice in your role as an administrator?
5. What were your expectations of the Infant Mental Health Consultant?
    a. How important is the role of the IMHC in supporting supervisors and home visitors? Supporting evidence-based home visiting?
    b. What specific skills and knowledge, if applicable, are you learning from the IMHC?
6. Have you seen a change in beliefs and attitudes about reflective supervision and practice? What changes can you describe?
7. Has there been adequate knowledge and skills training for the supervisors and home visitors to fully implement reflective practice?
    a. What else would you like to see added for training, if anything?
8. If you had to rate your own support of reflective practice, would you say you "fully support, somewhat support, or do not support reflective practice at all?" How are you supporting the use of reflective practice within your agency?
9. What is your vision for using reflective practice within your agency? How, if at all, has this changed during the grant period?
10. What do you believe are the effects, if any, of reflective practice on program outcomes?
11. Do you believe your agency has had the resources (e.g., financial, access to IMH providers, etc.) necessary for implementing reflective practice?
    a. What support, if any, have you received from MDH staff?
    b. What barriers, if any, are there to full implementation of reflective practice?
12. What do you believe it will take to sustain reflective practice within your agency? Statewide?

Appendix H

Reflective Practice Conceptual Framework



Appendix I
Related Findings from CEED Survey

Table 1. Home Visitors' responses to whether they Received formal training, n=66

Reflective Practice Principle	Yes	No
Create a safe, trusting relationship	55	11
Attend to parallel process	52	14
Pause and reflect	54	12
Explore different perspectives	52	14
Consider behavior in the context of relationships	54	12
Explore thoughts and feelings	57	9
Pay attention to self-regulation and co-regulation	53	13
Maintain a clear sense of roles and boundaries	59	7
Value the importance of repair in relationships	48	18
Pay attention to my experience and how it influences my practice	54	12
Develop collaborative relationships	53	13
Keep the baby in mind	60	6

Table 2. Supervisors' responses to whether they received formal training, n=26

Reflective Practice Principle	Yes	No
Create a safe, trusting relationship	24	2
Attend to parallel process	24	2
Pause and reflect	22	4
Explore different perspectives	24	2
Consider behavior in the context of relationships	24	2
Explore thoughts and feelings	24	2
Pay attention to self-regulation and co-regulation	21	5
Maintain a clear sense of roles and boundaries	24	2

Value the importance of repair in relationships	21	5
Pay attention to my experience and how it influences my practice	23	3
Develop collaborative relationships	23	3
Keep the baby in mind	24	2

Table 3. HVs' responses to most influential source of learning reflective practice, n=67

Type	Number/Percent
Formal training	7/10%
Conferences	7/10%
My supervisor	26/39%
My peers	14/21%
Infant Mental Health Consultant	31/46%
Articles, books	4/6%
Other ("life experience," "doing it")	4/3%

Table 4. Supervisors' responses to most influential source of learning reflective practice, n=26

Type	Number/Percent
Formal training	2/8%
Conferences	0/0%
My supervisor	2/8%
My peers	2/8%
Infant Mental Health Consultant	20/77%
Articles, books	3/12%
Other ("all," "receiving it" "doing it")	4/15%

Table 5. HVs' responses to extent to which principles influence effectiveness

Extent	Number/Percent
Greatly influences my effectiveness	55/82%
Somewhat influences my effectiveness	11/16%
Cannot Answer ("Just started")	1/1%
Do not influence my effectiveness	1/1%

Table 6. Supervisors' responses to extent to which principles influence effectiveness

Extent	Number/Percent
Greatly influences my effectiveness	22/85%
Somewhat influences my effectiveness	4/15%
Cannot Answer	0/0%
Do not influence my effectiveness	0/0%

Table 7. HVs' level of adoption, n=67

	Not yet in practice	Emerging	Fully Implemented
In the case conference group?	3	26	38
Individually with my supervisor	4	25	38
Working with families	1	37	29

Table 8. Supervisors' level of adoption, n=26

	Not yet in practice	Emerging	Fully Implemented
In the case conference group?	0	15	11
Individually with the home visitors?	0	14	12

Table 9. HVs' perceived level of competence in applying RP principles, n=67

	Not yet in practice	Emerging	Fully Implemented
In the case conference group?	3	39	25
Individually with my supervisor	4	35	28
Working with families	2	45	20

Table 10. Supervisors' perceived level of competence in applying RP principles, n=26

	Not yet in practice	Emerging	Fully Implemented
In the case conference group?	1	20	5
Individually with home visitors?	0	19	7

Table 11. HVs' length of time participating in case conference group, n=66

Length of Time	Number/Percent
Less than 1 year	7/10%
1-2 years	40/60%
3-4 years	6/9%
More than 4 years	14/21%

Table 12. Supervisors' length of time leading/co-leading case conference group, n=25

Length of Time	Number/Percent
Less than 1 year	7/28%
1-2 years	12/48%
3-4 years	4/16%
More than 4 years	2/8%

Table 13. HVs' length of time receiving individual RS, n=66

Length of Time	Number/Percent
Less than 1 year	5/8%
1-2 years	37/56%
3-4 years	9/14%
More than 4 years	15/23%

Table 14. Supervisors' length of time providing individual RS

Length of Time	Number/Percent
Less than 1 year	5/19%
1-2 years	10/38%
3-4 years	7/27%
More than 4 years	4/15%

Table 15. HVs' beliefs about effects of reflective practice on their communication with families

Level of Improvement	Number/Percent
Communication has greatly improved	29/44%
Communication has somewhat improved	25/38%
Communication has stayed about the same	10/15%
Communication has become more difficult	0/0%
I cannot answer (Just started, haven't used)	2/3%

Table 16. HV's beliefs about effects of reflective practice on communication with supervisor

Level of Improvement	Number/Percent
Communication has greatly improved	27/41%
Communication has somewhat improved	28/42%
Communication has stayed about the same	9/14%
Communication has become more difficult	0/0%
I cannot answer (New to role, just started)	2/3%

Table 17. Supervisors' beliefs about effects of reflective practice on communication with home visitors

Level of Improvement	Number/Percent
Communication has greatly improved	13/50%
Communication has somewhat improved	13/50%
Communication has stayed about the same	0/0%
Communication has become more difficult	0/0%
I cannot answer	0/0%

Table 18. HVs' perceptions of helpfulness of reflective supervision for their work

Level of Helpfulness	Number/Percent
Very helpful	38/58%
Somewhat helpful	11/17%
Not at all helpful	0/0%
Helpful	15/23%
I am not receiving reflective supervision	2/35%

Table 19. Supervisors' perceptions of helpfulness of reflective supervision for HV's work

Level of Helpfulness	Number/Percent
Very helpful	13/52%
Somewhat helpful	1 or 4%
Not at all helpful	0/0%
Helpful	11/44%
I am not providing reflective supervision	0/0%

Table 20. HVs' perceptions of helpfulness of case conferencing for their work

Level of Helpfulness	Number/Percent
Very helpful	44/67%
Somewhat helpful	8/12%
Not at all helpful	0/0%
Helpful	14/21%
I am not receiving reflective supervision	0/0%

Table 21. Supervisors' perceptions of helpfulness of case conferencing for HVs' work

Level of Helpfulness	Number/Percent
Very helpful	14/54%
Somewhat helpful	0/0%
Not at all helpful	1 or 4%
Helpful	11/42%
I am not providing reflective supervision	0/0%

Table 22. HVs' perception of their comfort in using reflective practice with families

Level of Comfort	Number/Percent
Very comfortable	24/36%
Somewhat comfortable	10/15%
Not at all comfortable	1/2%
Comfortable	30/45%
I am not using reflective practice with families	1/2%

Table 23. Supervisors' perception of their comfort in using reflective practice in their supervision of home visitors

Level of Comfort	Number/Percent
Not at all comfortable	0/0%
Comfortable	12/48%
Very comfortable	8/32%
Somewhat comfortable	5/20%
I am not providing reflective supervision to HVs	0/0%

Table 24. HVs' perception of the helpfulness of reflective practice for families

Level of Effectiveness	Number/Percent
Very effective	34/52%
Somewhat effective	9/14%
Not at all effective	0/0%
Effective	23/35%

Table 25. Supervisors' perception of competence in using reflective supervision with home visitors

Level of Competence	Number/Percent
Not at all competent	0/0%
Somewhat competent	9/35%
Competent	10/38%
Very competent	7/27%

Table 26. HVs' methods for staying in touch with families

Method	Number/Percent
I text with the families	44/67%
I email with the families	0/0%
I telephone the families	11/17%
I only stay in touch with families through home visits	1 or 2%
Other (text and phone-6, all of the above-3, letters-cards-1)	10/15%

Table 27. Supervisors' perception of how well they are incorporating reflective practice in their supervision

Level of Incorporation	Number/Percent
Fully incorporate	9/35%
Use often	17/65%
Use occasionally	0/0%
Not using	0/0%

Table 28. HVs' perceptions of their reflective supervision sessions, n=65

Reflective Supervision Principle	Do Not Agree	Some-what agree	Agree	Strongly Agree
My supervisor provides a safe place to explore my feelings about my work	40	16	8	1
There is a respectful give and take between my supervisor and me	40	19	6	0
My supervisor can hold my thoughts and feelings without trying to fix them	30	21	9	5
My supervisor helps me think about how my assumptions and experiences influence my practice	28	23	11	3
My supervisor collaborates with me to solve problems of practice	37	19	8	1
My supervisor makes it safe to talk about situations that are not going well	40	17	8	0
My supervisor provides uninterrupted focus on my work with families during the individual meeting time	30	23	9	3
I am receiving the right amount of reflective supervision to support me in my work	35	18	6	6
My relationship with my supervisor provides a model for how I want to work with families	36	16	8	5
My supervisor guides me to explore the perspectives of everyone involved	31	21	11	3
My supervisor and I don't forget about the baby	41	18	6	0

Table 29. Supervisors' perceptions of reflective supervision session, n=26

Reflective Supervision Principle	Strongly agree	Agree	Some-what agree	Do not agree
We create a safe place to explore the home visitors' feelings about their work	22	4	0	0
There is a respectful give and take between myself and the home visitors	23	3	0	0
I can hold the home visitors' thoughts and feelings without trying to fix them	9	13	4	0
I help the home visitors think about how their assumptions and experiences influence their practice	8	18	0	0
I collaborate with the home visitors to solve problems of practice	13	13	0	0
I make it safe to talk about situations that are not going well	19	7	0	0
I provide uninterrupted focus on the home visitors' work with families during the individual meeting time	12	12	2	0
Home visitors are receiving the right amount of reflective supervision to support them in their work	11	13	2	0
My relationship with the home visitors provides a model for how I hope they work with families	13	13	0	0
I guide the home visitors to explore the perspectives of everyone involved	11	14	1	0
We don't forget about the baby	15	10	1	0

Table 30. HVs' perceptions of case conferencing sessions, n=66

Response	Strongly Agree	Agree	Somewhat agree	Do not Agree
The group members listen carefully to the presenter.	42	17	7	0
The group doesn't forget about the baby.	42	21	3	0
The group explores meaning and perspective(s) about what is presented.	41	20	4	0
Group members ask thoughtful questions about the case presentation.	42	19	5	0
The group explores the meaning of the cultural	29	24	12	1

contexts of the families.				
Group members hold solutions until the presenter is ready.	22	26	14	4
Group members feel safe expressing strong feelings.	30	25	10	1
The group listens with the goal of deeper understanding.	40	19	5	1

Table 31. Supervisors' perceptions of case conferencing sessions, n=26

Response	Strongly Agree	Agree	Somewhat agree	Do not Agree
The group members listen carefully to the presenter.	17	9	0	0
The group doesn't forget about the baby.	14	12	0	0
The group explores meaning and perspective(s) about what is presented.	12	13	0	1
Group members ask thoughtful questions about the case presentation.	12	13	0	1
The group explores the meaning of the cultural contexts of the families.	11	12	3	0
Group members hold solutions until the presenter is ready.	4	15	7	0
Group members feel safe expressing strong feelings.	8	17	0	1
The group listens with the goal of deeper understanding.	12	13	0	1

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