

Critical Element #6

Supporting the parent(s) and the parent-child
interaction and child development

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Supporting the Parents and the Family
Policy	Programs efforts focus on increasing knowledge and understanding of child development, reducing parental stress and increasing parental self-confidence.
Site specific reference	6
Effective date	July 2001
Revised date(s)	June 2007
Appendices	

Rationale:

While a secure attachment (which is supported in the development of positive parent-child interaction) provides a child with resiliency against a wide spectrum of risk factors, its development often requires support in the form of increased knowledge and understanding of child development, parental stress reduction, increased empathy for the child, and increased parental self-confidence. For this reason, the program focuses efforts on all four of these areas.

Basis for Working in Partnership with Families

Healthy Families New York Program services are family centered, based on the belief that parents, not home visitors or agencies, hold the strongest potential to help their children grow and develop with healthy, functional capacities. A fundamental belief of the program is that families are capable of change, are best able to know what changes need to be made, best able to choose solutions that fit them and best able to decide what support they choose to receive in making their family the best it can be.

Healthy Families New York offers flexible, collaborative services to families, identifying and building upon family strengths and competencies, and respecting family values, beliefs, and culture.

The FSW addresses the needs of all family members and builds on family strengths by routinely exploring accomplishments with parents and what is going well. Services focus on teaching parents about child development, fostering positive parenting skills, and promoting healthy parent-child interactions and encouraging self-sufficiency. Families are assisted with establishing their own goals and identifying and accessing resources (i.e., child development, social, medical, employment, and housing services).

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Review of Initial Assessment
Policy	The FSW, the supervisor and the participant family discuss strengths and address issues identified in the initial Kempe Assessment. These discussions are documented in participant and supervisor files, as appropriate. Referrals for current issues identified on the Kempe of domestic violence, substance abuse or mental health are made within 6 months of enrollment. All three parties use the Kempe for service planning during the course of services offered to families.
Site specific reference	6-1.A, B
Effective date	June 2007
Revised date(s)	
Appendices	

Rationale:

To assure that supervisors and home visitors use the initial assessment in service planning and that they refer back to it during the course of services offered to families to ensure that presenting risks have been discussed, re-evaluated as needed, and addressed, and to ensure that family strengths are used in service planning and in on-going work with each family.

Procedures:

Supervisors and Home visitors

1. Each program develops a system that ensures that the issues and strengths identified in the initial assessment are discussed and reviewed by and between the supervisor and the home visitor.
2. Many programs also include the FAW and/or FAW Supervisor in these initial discussions.
3. This discussion is documented in a consistent place such as supervisor logs and/or the back of the Pre-Intake Activity Form.
4. The assessment is reviewed with the supervisor to look for *potential* strengths, challenges, and goals. The discussion and documentation include efforts to understand the stresses experienced by the family and how the home visitor may begin to address issues that place families at-risk for negative outcomes. These efforts also include highlighting the strengths that families self-identified and those identified by workers during the assessment process so that both stresses and strengths are a part of the service planning.

5. Each program develops a system to assure that the issues identified on the Kempe are revisited over time, including the frequency of the review. If domestic violence, substance abuse, or mental health is identified as a current issue on the Kempe Assessment of an enrolled participant, a referral is made within 6 months of enrollment. There is a Kempe PC1 Issues report in the MIS to help assure that these referrals have been made in a timely fashion. This report tracks only referrals made for Primary Caregiver 1 (PC1) however, referrals are made for any family members, when appropriate. Programs are encouraged to print this report on a regular basis. (see Performance Target MLC7 where programs report these referrals on a quarterly basis.)
6. During supervision, supervisors will engage FSWs in discussion of issues that were brought up on the assessment, especially as they relate to IFSP development. Supervisors also strategize with FSWs how to raise these issues in appropriate, effective and sensitive ways i.e. culturally sensitive, recognizing potential safety concerns for families and workers.
7. Supervisors will discuss with FSWs that the information on the assessment has been voluntarily disclosed by the family, and to be aware that each new family likely knows the FSW has seen or discussed the content of the Kempe assessment and is likely expecting that the FSW will raise and provide help or support for issues identified on the Kempe.

Home Visitors and Families

1. Each program develops a system that ensures that the issues identified in the initial assessment are discussed between the home visitor and participant family.
2. This discussion is documented in the participant file.
3. The discussion and documentation include efforts to understand the stresses experienced by the family and initial plans to address issues that place families at-risk for negative outcomes. These discussions with the family also highlight the strengths that the families had self-identified during the assessment process and those identified by the worker, so that both stresses and strengths are a part of the Individualized Family Service Plan process.
4. At time of assessment, FAWs inform participants how the content of the interview is shared with program staff. This helps the participant to connect the assessment process with the on-going work of the program.
5. At the time of enrollment, the FSW reminds the participant that the FAW has shared the content of the interview. This sets the expectation that it will be an on-going aspect of work with the program, and it may increase the participant's comfort level when the FSW begins to discuss it.

6. The FSW reviews and does follow up on referrals made by the FAW.
7. Some programs have found it helpful to include the FAW in the initial visit by the FSW in order to facilitate discussion of the assessment.
8. During supervision, the FSW supervisor revisits the issues identified on the Kempe in order to provide historical context for what might be happening currently or help the FSW recognize a family's progress compared to what was happening with them at the time of enrollment.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Individual Family Support Plan (IFSP)
Policy	HFNY programs use the IFSP to guide the delivery of program services. The process of developing the plan uses family support practices and is driven by the family in a collaborative effort with the FSW and the FSW supervisor.
Site specific reference	6-2 A-D
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-IFSP worksheet and IFSP -IFSP Rules and Ideas

Rationale:

To ensure that the delivery of services to families is guided by the Individual Family Support Plan (IFSP) and that the process of developing the plan uses family-centered practices. The IFSP serves 4 main functions:

- a. It is a guide for service delivery to ensure families are getting what they need from program services
- b. It is a tool for supporting, assisting and in some instances, teaching, problem-solving skills
- c. It provides recognition of family strengths, competencies, and accomplishments.
- d. When successfully implemented, the IFSP sets the family up for success, thus increasing the tendency to plan and increasing self confidence, self-sufficiency and a sense of self-efficacy

Programs help families identify, plan for and obtain needed services and achieve specific goals they have set. The IFSP should never be viewed as a contract for service provision or a “service plan that the family agrees to.”

Home visitors treat families as partners in this process, eliciting ideas from parents and providing information, but not persuading or pushing an agenda that the family does not share. Home visitors behave in ways that demonstrate respect for the attitudes, values and competence of program families.

The process of developing the plan uses family support practices and is driven by the family in a collaborative effort with the FSW and the FSW supervisor. This collaboration will help to yield IFSPs that are family centered and family directed.

Families and FSWs review and revise the IFSP on a regular basis. The review schedule establishes a timetable for the family and the home visitor to regularly review strengths and accomplishments, parent child interaction and relationships, stressors, needs, and any issues regarding the target child's development. The family reviews and revises goals and the methods by which

they will be addressed, with the FSW acting as a facilitator in the problem-solving process.

Procedures:

Initial IFSP

1. The IFSP is completed within 45 days of intake and may take 2 or 3 visits to complete. After an initial IFSP planning discussion with the Supervisor, that includes the content of the assessment, the FSW collaborates with the family to identify family strengths, competencies and family needs. Some ways that this may be accomplished are:
 - Informal discussion which takes place during home visiting.
 - Activities using a variety of tools (i.e. checklists that identify family strengths and needs)
 - Discussion regarding information gained through the Kempe Assessment or through the Parental Stress Index (PSI) when families have entered the program postnatally.

These conversations and activities are documented by the FSW in the participant record.

2. Goals
 - Goals are specific, measurable (observable), attainable, realistic, time-limited, and stated in the positive.
 - Goals and specific objectives/strategies are developed for both family and parent-child interaction/child development needs.
 - IFSPs contain goals for the parent, the child and the parent-child interaction.
 - Goal setting is an opportunity for the home visitor to discuss with the family issues that impact healthy parenting such as those identified in the initial assessment, healthy lifestyle issues, self-sufficiency, and any other issues identified from other tools used by the program in an open and honest way as well as goals designed around child development and parent child interaction.
 - Typically, at least one child development/PCI goal (ex: help the baby learn to sit up) and one family functioning/self-sufficiency goal (ex: replace SS card so we can apply for a loan) are part of the IFSP.

3. Forms

Programs may identify their own IFSP worksheet forms. They contain the following, at a minimum:

- A place for the family's signature (at least two family signature spaces to attend to engagement of both mothers and fathers), the FSW's signature and the supervisor's signature.

- The date the IFSP was developed
 - An area for identifying individual goals
 - An area for identifying the steps toward achieving the goals
 - Dates for completing each of the steps toward completing the goals
 - Dates for completing the goals
 - An area for documenting discussion of the family's strengths as they relate to developing the IFSP (may be documented on a separate sheet or other form if preferred.)
 - Including space for recording pertinent referrals is also suggested.
 - Programs are encouraged to document the discussion of, and/or celebration of successes.
4. All IFSPs (initial and updated) are reviewed and discussed with supervisors.
 5. All IFSPs are signed by the FSW, the Supervisor, and the parents, although it does not need to be all at the same time.
 6. It is recommended that the original IFSP goes to the family and copies are kept in family file and supervisor's binder, according to program protocol. FSWs find it useful to carry a copy in the folder they take for home visits so that it is available for on going conversation.

On-going work with the IFSP

1. Timeframes

- The formal update of the IFSP is frequent enough to insure meaningful and relevant goals are being set. It is reviewed and revised with the family every six months, or more often. The IFSP is to be up-to-date and active throughout the family's work with the program.
- Documentation of this process is recorded in the participant file. (As in #1 in the preceding section on "Initial IFSP") IFSPs may be updated sooner if a family has accomplished goals or decided to change them.
- The FSW and FSW supervisor refer to the IFSP at least every month to assess its continuing appropriateness as a guide for services.
- IFSPs are reviewed with the family and updated at least every six months for families on Levels 1, 2, and 3. If a family is on level 4, the IFSP can be revised annually.
- If a family is on Level X because they have had to temporarily stop receiving services, the IFSP is updated or a new IFSP is completed once services are reactivated.
- If the IFSP was completed prenatally, a new goal for the baby is added soon after the baby is born.

2. Supervisor Role

- Documentation of supervisory discussions is kept according to program protocol (i.e. in supervisor logs) with attention to charting families' progress toward meeting goals, discussion of progress, and how the home visitor will use the IFSP to guide interventions and activities with the family. This documentation occurs at least once a month.
 - Many supervisors find they are able to better integrate the IFSP into discussions about families by maintaining the most current version of each family's IFSP in their supervisor binder.
3. When families do not accomplish goals, it is useful for the FSW, the family and the supervisor to look at whether the family still wants to accomplish that goal, and consider whether the goal has been realistically written and identify what barriers exist before continuing the goal on an updated plan.
 4. Prior to writing a new IFSP, the FSW brings his/her working copy to the home visit to discuss with the family accomplishments over the past six months, stresses, needs, and any issues regarding the target child's development. The family decides if they want to continue to work on items they have not achieved. The FSW and parent(s) will discuss other progress the family has made during the past six months.
 5. An IFSP is considered updated when the FSW and participant have reviewed progress on goals and objectives on the plan, discussed and documented what happened, revised target dates for goals and/or added new goals based on the needs of the family.

Further detail on guidelines and procedures is included in the HFA Training Manual, page 93.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Promotion of Positive Parenting, Knowledge of Child Development and Health and Safety Practices
Policy	Healthy Families New York programs promote positive parenting practices and knowledge of child development and health and safety through observing and supporting parent-child interaction, sharing parent-child activities, use of curricula, and regular developmental screening of target children.
Site specific reference	6-3 A-C
Effective date	July 1, 2003
Revised date(s)	June 2007
Appendices	Home Visit Records

Rationale:

To ensure that programs promote and share information and build skills and share activities regarding positive parent-child interaction, healthy physical and emotional child development, and family health and safety.

Procedures:

1. Program Policies

- Each program develops its own policies to describe how home visiting staff promote and share information regarding positive parent-child interaction, healthy physical and emotional child development, and health and safety information.
- Policies provide details about the types of activities staff are expected to conduct during home visits and how parenting skills are promoted within the context of the child’s development.
- Policies assure that health and safety practices focus on both preventative strategies as well as areas of concern.
- Policies identify the curricula and/or materials used to share information and how frequently this information is shared with families. (See Selection of Curriculum.)

2. Skill building and information sharing with families to promote positive parent-child interaction and child development skills.

a. Frequency:

- Programs attempt to include time spent promoting positive parent-child interaction and optimal child development on all visits whether or not a family is experiencing crisis. There may be some exceptions to this; however, the goal is to include it on all visits.

- Interventions to promote positive parent-child interaction are a part of the FSW's daily routine with all families. These interventions may consist of discussion and observation of infant cues, calling attention to the child's emotions, introducing interactive games or activities, making positive comments that shape and reinforce desirable parent-child interactions, and education about key issues related to attachment such as: brain development, empathy, the development of trust, and fostering the development of self-esteem in children.
- b. Documentation
- Programs document both observations of parent-child interaction and child development as well as what information is shared with families. Curriculum use is clearly documented to indicate what content was shared with families. Most effective documentation practices would also include a description of the family's response to the information and/or activity.
 - Programs develop tools, checklists, resources, and specific methods to document the home visitors' observation and assessment of parent-child interactions (i.e. home visit records).
 - Programs identify and use checklists or other tools to guide parents in understanding their infant's development. Programs develop tools, checklists, resources, and use specific curricula and other flexible methods to support parents learning about child development and positive parenting.
- c. Staff/team meetings and supervision: Managers and Supervisors utilize some portion of all staff and team meetings, and individual supervision to help staff assess and improve their efforts to support parents in promoting positive parent-child interaction and child development (i.e. through case presentations and discussions). The content of these meeting and supervision discussions is documented in minutes and in supervisor logs.
3. Health and Safety Practices
- Health and safety information includes prevention strategies and also addresses any issues observed in the home. These strategies are discussed in supervision.
 - Content shared with families includes health and safety issues such as smoking cessation, SIDS, shaken-baby syndrome, baby-proofing, safe sleeping practices, breast feeding materials and other safety issues.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Selection of Curriculum
Policy	Healthy Families New York programs use parenting and child development curricula approved by OCFS, and other tools and resources to provide families with information about positive parenting practices, child development and health and safety skills.
Site specific reference	6-3 A-C
Effective date	June 2007
Revised date(s)	
Appendices	

Rationale:

To ensure that programs identify and use parenting and child development curricula, tools and other resources to provide families with information about positive parenting practices, child development and health and safety skills.

Guidelines

The use of parenting and child development curricula approved by OCFS establishes an organized, sequential method by which the programs support parents in obtaining the information needed to learn positive parenting and child development and facilitates the promotion of parenting skills within the context of the child’s development.

A variety of curricula are available for review through the Healthy Families New York Resource Library.

Programs select a core curriculum for home visiting in which all Family Support Workers and Supervisors are trained. Programs use other curricula as supplements or alternatives to the core curriculum, and while these can be selected at programs' discretion, materials should address the promotion of positive parent-child interaction, child development and health and safety for children prenatally to five years of age. Curricula may also address the psycho-social well-being of parents.

The following curricula are currently approved as core curricula:

Partners for a Healthy Baby. Florida State University Center for Prevention and Early Intervention Policy. 1- 850-922-1300.

Parents as Teachers.

Parents as Teachers National Center, Inc.
10176 Corporate Square Drive, Suite 230

St. Louis, Missouri 63132
Phone: (314) 432-4330

P.I.P.E.(Partners in Parenting Education)
<http://www.howtoreadyourbaby.org/index.html>

Healthy Babies...Healthy Families: San Angelo Curriculum

Healthy Families San Angelo
200 South Magdalene Street
San Angelo, Texas 76903
325-658-2771
www.hfsatx.com

For Supplementary curricula, three are currently recommended:

Partners for Learning Curriculum and Activity Cards. Isabelle Lewis, Joseph Sparling & Craig Ramey. Kaplan Press. 1-800-334-2014.

Helping Babies Learn: Developmental Profiles and Activities for Infants, and Toddlers. Setsu Furono, et. al. Communication Skill Builders. Tuscon, Arizona. 1-800-866-4446.

Growing Great Kids. Great Kids, Inc. 1-800-906-5581.
<http://www.greatkidsinc.org>

The following criteria are considered when selecting a home visiting curriculum:

- Materials and/or the training that aids the worker in using the materials in a relevant, interactive manner.
- Materials include activities on parenting, child development and health and safety.
- Materials include information and activities for promoting healthy birth outcomes.
- Materials should have a strong focus on the emotional as well as physical well-being of babies and young children.
- Materials guide home visitors to promote parenting skills within the context of the child's development.
- Materials on health and safety practices include preventative strategies.
- Materials are culturally and linguistically responsive to the community (i.e. have a multi-cultural focus, are available in Spanish and/or French, or other language relevant to the target community.)
- Materials that will be seen by families should be attractive to the target community, conveying the message that families are important. Materials and the manner in which they are used must be strength-based.

- Curricula that can be supported by specialized training on its use and implementation should be given priority.
- Curricula should come with positive recommendations from those who have used them.
- Cost should not be prohibitive.

* Note: All materials used with families should be reviewed by a supervisor prior to use with a family to ensure curricula is relevant and consistent with HFNY practices.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Developmental Screening
Policy	All target children are screened using the Ages and Stages Questionnaire (ASQ) to determine developmental progress and/or to identify possible delays. HFNY programs administer the ASQ at designated intervals. Should a delay be suspected, all target children receive referrals and/or follow-up.
Site specific reference	6-5, 6-6, 6-7
Effective date	July 1, 2003
Revised date(s)	June 2007
Appendices	ASQ cover sheet (MIS)

Rationale:

To ensure that target children are regularly screened to determine developmental progress and/or identify possible developmental delays, and that when a delay is suspected, children receive appropriate referrals and/or follow-up.

Administering the Tool:

1. All Healthy Families New York programs implement a policy stating that they use a standardized tool, the Ages & Stages Questionnaire (ASQ), to determine and record developmental progress and/or to identify possible delays.
2. The ASQ is completed at the following intervals: 4, 8, 12, 16,20,24,30, 36, 48, and 60 months with optional intervals at six and eighteen months.
3. Premature babies have their ASQs completed on their corrected date of birth, (CDOB) up to but not including the 24-month assessment.
4. The purpose of the ASQ is thoroughly explained to the parent. The ASQ must be completed jointly by the parent and Family Support Worker. Ideally, the ASQ is done by the parent, with guidance from the FSW. A child development specialist reviews the completed ASQ and the FSW gives feedback and follow-up activities to the family.
5. Each program site employs a child development specialist, on staff or on a consultant basis, to consult with staff, to review ASQs, and provide child development training.
6. All FSWs are trained in the implementation of the ASQ, procedures for referral, follow-up, and data collection prior to administering the tool.

Scoring:

1. It is encouraged that scoring be done in conjunction with the parent. However, this decision should remain within the discretion of the FSW. All scores are explained thoroughly to the parent. In those cases where the score falls below the cut-off level, parents should be reminded that the ASQ is not

an IQ test. It is only meant to indicate if further developmental assessment and evaluation may be needed.

2. If a child scores under the cut-off in any area, a referral to the county Early Intervention Program must be made for further assessment. The family does not have to accept the referral.
3. If a child falls within the “suspicion” range, the developmental activities are presented and discussed with the parents. The child’s score and potential implications and remedies should be explained to the parent. These children will have their development monitored closely by the FSW and discussed with the child development specialist at regular meetings. The child development specialist may recommend that a referral for further evaluation be made.

Documentation:

1. Referrals to Early Intervention (EIP) are documented by marking #13 on the ASQ coversheet. The outcome of the referral is documented by marking #14. FSWs also document the referral on the Referral Tracking sheet.
2. Even if a different party has made a referral to EIP, FSWs will follow the procedures in #1 concerning the ASQ coversheet.
3. Programs document in participant records when screens are not being administered (i.e. child already involved with Early Intervention Services.)
4. To assure appropriate follow-up, programs routinely print and review the MIS report of all children who scored below the cut-off on the ASQ and what their status is with EIP.
5. Participant files include the completed score and summary sheets of the ASQ. Some programs keep a participant’s ASQs in a separate binder.
6. Programs are encouraged to document when a family declines early intervention services and document the home visitor’s efforts to engage the family in continued discussion about these services. It is not uncommon for families to feel worry and fear over a delay in their child’s development. Home visitors will be sensitive to these feelings. If the family has declined a referral to early intervention, the FSW will plan with supervisor and family activities to address areas of delay while continuing to find ways to discuss an EIP referral when it seems appropriate.
7. On a quarterly basis, programs report on the number and percentage of children who demonstrate age appropriate developmental milestones or need to be referred for further evaluations/service is delays are detected. (See Performance Target HD7).

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Parental Stress Index
Policy	To assess families' situations and changes over time with respect to several parenting indicators, all HFNY families are provided the Parenting Stress Index to complete at the appropriate intervals.
Site specific reference	N/A
Effective date	June 2007
Revised date(s)	
Appendices	PSI cover sheet (MIS)

Rationale:

HFNY Programs use the Parental Stress Index (PSI) in order to identify and assess the stressors of parenting and assess families' situation over time with respect to various parenting indicators. This policy establishes guidelines for administering the PSI.

1. General Guidelines:

- a. The PSI is copyright protected and each copy is purchased by HFNY.
- b. The PSI is administered to primary caretaker one. (PC1). The program may additionally administer the tool to the child's other parent or to a significant other, however the Management Information System only requires completion of the tool for the PC1. (See the *Parenting Stress Index Professional Manual, Psychological Assessment Resources, Inc.* for further information on interpretation, validity, etc.)
- c. The PSI is answered with the target child in mind. For multiple births, the parent identifies one target child for the initial and all subsequent PSIs.
- d. The PSI is best completed in the presence of the FSW, whenever possible. Any exceptions are made at the discretion of the supervisor.
- e. In order to ensure the most accurate reflection of the parent's feelings, the PSI is completed during one home visit.
- f. FSWs encourage parents to answer all questions openly and honestly without fear of being judged or criticized.
- g. Each program site develops internal protocols for discussing the PSI. Typically, if the score does not warrant immediate attention, the FSW and Supervisor will discuss the results during weekly supervision, and review the results with the family in a supportive, non-judgmental manner within two weeks of administration. (See below for "Referral Criteria" for results requiring more attention.)
- h. The tool is administered on the following schedule:

First Administration:

 - a. Prenatal at intake: within one month of the target child's date of birth
 - b. Postnatal at intake: within one month of intake

After First Administration:

 - Age of target child: 6 months, 1 year, 2 years, 3 years, 4 years, and 5 years

- At discharge from the program
- i. Programs report on items related to the PSI on a quarterly basis. (See performance targets PCI2-6.)

2. Responsibilities of the FSW

- a. Attend training on administering the PSI prior to administering the tool to families. This training may be a formal training, an in-service, or may be delivered directly by a supervisor or co-worker. It is important that the training contain opportunities for the FSW to practice administering the tool with a supervisor or experienced peer. This practice also includes opportunities to introduce and describe the reasons for administering the tool to families.
- b. Dates are planned for administering the PSI so that it is completed within the window period.
- c. If the window period is missed, the PSI is still administered at the next opportunity.
- d. Upon scoring the tool, the results are reviewed with the supervisor prior to discussing them with the family.
- e. The results of the PSI are submitted to the MIS.
- f. The results of the PSI are incorporated into IFSP discussions with supervisors and families.
- g. Referrals are provided and documented as appropriate.
- h. Discussions about the PSI are documented in home visit notes.
- i. The PSI is maintained in the participant file, or a separate file, according to individual program protocol.

3. Responsibilities of the Supervisor:

- a. Attend training on how to administer the PSI to families.
- b. Provide opportunities for role-playing how to administer the PSI during supervision of FSWs if needed.
- c. Shadow the FSW when administering the tool to ensure that it is being administered correctly and effectively.
- d. Assist FSWs to establish due dates for the PSI, to ensure it is administered within the window period.
- e. Review the scoring and work with the FSW to develop a plan for incorporating the results in follow-up work with the family.
- f. Document the discussion of follow-up in supervisor notes.
- g. Ensure that the PSI is included in the participant file or separate file according to program protocol, and that documentation regarding it is included in home visit notes and the IFSP, when appropriate.

4. Referral Criteria

- a. Defensive Responding: A Defensive Responding score of 10 or less indicates that the individual may be responding in a defensive manner, and caution should be exercised in interpreting the remainder of the scores.

- b. Parental Distress (PD) Domain: When the PD scale is the highest among the three subscales it is recommended that further exploration be conducted. There may be signs or indications of the presence of depression, lack of social support, conflict with the child's other parent, etc. Appropriate referrals like parenting classes and parental support groups designed for helping to improve the parent's self-esteem and sense of parental competence are recommended.
- c. Parental-Child Dysfunctional Interaction (PCDI) Domain: High scores in the PCDI may indicate an impaired relationship between the parent and child (i.e. child does not meet parent's expectations). Very high scores suggest potential for child physical abuse and neglect. Intensive services and support (i.e. preventive services and Level 1-SS, etc.) are recommended. Prompt intervention and additional assessment is required in these cases.
- d. Difficult Child Domain (DC): High scores in the DC often indicate a need for professional assistance. If the DC domain is above the 90th percentile and the other two domains are below the 75th, then a referral for parent education with a focus on behavioral management should help the situation.
- e. Total Stress: The Total Stress Score provides an indication of the overall level of parenting stress an individual is experiencing. It reflects the stresses reported in the areas of personal parental distress, stresses derived from the parent-child interaction and the stresses that result from the child behavioral characteristics. It does not include stresses associated with other life roles and life events. A Total Stress score above a raw score of 90 (at or above the 90th percentile) indicates significant levels of stress. Individuals scoring above this level should be referred for closer diagnostic evaluation and professional assistance.

Timing and Families not Accepting Referrals

- a. If upon completion of the PSI, any domain or total stress is outside the normal range, appropriate referrals or resources are ideally offered within 3 days. The FSW will follow up with the family, ideally within a week after the service referral is offered to see if the family has engaged with a referral or resource and/or to offer additional support and information.
- b. If it is determined that the family is in need of referral and resources but does not accept such service, the FSW works with his/her supervisor to explore how to proceed. The FSW documents that the family did not accept the referral in the participant record and on the service referral form.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Breast Feeding
Policy	Programs work toward having 30% of Healthy Families New York primary caretakers breast feeding the target child for at least 3 months from the birth of the child.
Site specific reference	6-3A-B
Effective date	July 1, 2003
Revised date(s)	June 2007
Appendices	HFNY Target Child Identification and Birth Outcomes HFNY Follow-Up Form (MIS)

Rationale:

Healthy Families New York recognizes breast feeding as the ideal method of feeding and nurturing of infants and recognizes breastfeeding as primary in achieving optimal infant and child health, growth, and development, in addition to providing many proven health benefits for mothers.

Guidelines:

The HFNY initiative supports the American Academy of Pediatrics policy statement on breast feeding. Each site develops its own policy regarding how to support and implement this policy. Minimally, sites will provide basic training on breast feeding for all new staff within 6 months of hire with annual updates for existing staff. This training will provide current, evidence-based and culturally responsive lactation information.

To promote breast feeding, programs implement the following, as appropriate in their communities:

- During both the prenatal and postpartum periods, enthusiastically encourage new mothers to breastfeed. Relay the numerous benefits to both the child and mother to ensure that all parents make an informed decision regarding infant feeding.
- Inform parents of breast feeding resources available in their community.
- Consider the benefits of having a certified lactation consultant available to staff and whether some staff may be interested in becoming certified lactation consultants.
- Make office space conducive to breast feeding whenever possible.
- Utilize educational materials that recognize breast feeding as the normal and preferred method of infant feeding.
- Avoid providing incentives that undermine breast feeding (i.e.: formula gift packs)
- Avoid posters, pamphlets, handouts, calendars and other materials provided by formula supplement corporations.

- Establish seamless lactation support programs between hospitals and communities that may include the establishment of participant breast feeding support groups.

Documentation:

- Staff document the family’s chosen feeding method on the TC Identification and Birth Outcomes Form (MIS).
- There is an optional (local use only) “Feeding Method” field on the TC Identification and Birth Outcomes form. Programs may elect to have staff complete this section for their own use.
- Staff document how long the family breast fed on the Follow-Up form (MIS).
- On a quarterly basis, programs report on the number and percentage of babies who are breast fed (See Performance Target PCI1.)