

## BECOMING NEAR INFORMED

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We recommend that agencies considering or planning to bring NEAR into home visiting first address each of the suggestions and concepts below.

### NEAR EDUCATION

Implementation science tells us that for an intervention to be successful, all layers of the organization must be informed, involved and committed to the process. Bringing NEAR science into home visiting will require all staff involved to have education about NEAR. We recommend that all staff also complete their own ACE histories privately, without sharing the score. Completing a personal ACE history is an important process for staff to have a felt experience of what home visitors will be doing with families. Having this experience will facilitate team cohesion and support for each other. It is possible that a significant portion of staff will have high ACE scores. We suggest the agency move toward trauma-informed practices as a way to support staff and clients.

### REFLECTIVE SUPERVISION

Before introducing NEAR into the work, we recommend that home visiting programs have established ongoing, quality reflective supervision (RS). RS is required by all evidence-based home visiting models. There are different models of RS, but there are some shared goals and processes. RS provides critical emotional support to staff who carry a heavy burden of secondary trauma and high expectations for improved family outcomes. RS builds staff capacity to deliver services to families with safety, integrity, quality and fidelity; it provides a model for the home visitor of how to be with the client and family. Quality RS requires a trusting relationship built by regularity, predictability and mutual respect. Becoming reflective is a developmental process and is best supported when both the supervisor and supervisee are committed to the process and bring attitudes of curiosity, empathy, openness and self-awareness. While a home visitor might carry a caseload of 25 families, a supervisor or manager might carry all 100 families in the program through her provision of RS. Ideally, the provider of RS will also have her own reflective support.

Resource: *S. Scott Heller & L. Gilkerson (Eds.), A Practical Guide to Reflective Supervision. Washington DC: Zero To Three.*

### DIMENSIONS OF SAFETY

The most common type of safety discussed in the majority culture in the United States is physical safety, yet that is not the only kind of safety we should consider as we infuse NEAR Science into home visiting.

Physical safety, psychological safety, social or relational safety and moral safety are all important capacities that we need to foster in ourselves and the environments we create, as well as in the families we serve.

Physical safety means that the physical environment is protective – designed in a way that prevents problems before they arise.

Psychological safety refers to the ability to be safe with oneself, to rely on one's own ability to self-protect against any destructive impulses coming from within oneself or deriving from other people, and to keep oneself out of harm's way. This ability to self-protect is one of the most shattering losses that occurs as a result of traumatic experience, and it manifests as an inability to protect one's boundaries from the trespass of other people. Another loss is a sense of self-efficacy, which is having the ability to relate to the world on one's own terms without abusing power and without being abused by it. A sense of personal safety is achieved as the injured individual learns how to be effective in protecting herself from violations of personal and psychological space.

A socially safe environment is one that is free from abusive relationships of all kinds. People are not isolated but are connected in a network of support. Emotion is successfully managed and the level of emotional intelligence is high. The past can be looked at, dealt with, and finally left behind. There is tolerance for diverse opinions, beliefs and values but what ties everyone together is a shared belief in the importance of being safe. Boundaries are clear and firm, but flexible.

Moral safety includes giving attention to the question, "Are we helping, or are we hurting?" Organizations and groups that invest in reflection, honest appraisal, open dialogue and principle-centered practice promote moral safety.

Resource: *Sanctuary Model* <http://www.sanctuaryweb.com/safety.php>

## CLIENT-CENTERED

A client-centered, goal-oriented approach to working with families is based on viewing challenges or problems as an opportunity for growth. Being client-centered is deeply knowing the client has the ability to make changes and to move forward. The client-centered home visitor focuses on the client's positive achievements, however large or small, to encourage continued movement toward the goal. The client sets her goal through the home visitor's facilitated exploration of possibilities. The home visitor, while focusing on solutions, does not ignore or make light of challenges but acknowledges them with openness and belief in the client. The home visitor offers partnership in moving toward the goal. Key concepts: The client is the expert on her life. Focus on strengths. Only a small change is needed. Assume her intentions are for the best.

Resource: *Solution-Focused Brief Therapy* [http://www.sfbta.org/about\\_sfbt.html](http://www.sfbta.org/about_sfbt.html)

## RELATIONSHIP-CENTERED

Home visiting prioritizes the relationship between the home visitor and the caregiver as the primary tool to support engagement and learning, and to motivate the parent to reflect on and make positive changes in the family environment. A central goal of this relationship is to ensure a strong and safe attachment relationship between the caregiver and child. Attachment processes interact with and impact brain development, epigenetics, and physical and socio-emotional health and development. Our attachment relationships in infancy are the foundation for all emotionally intimate relationships throughout the life span: familial, romantic and parental.

Attachment is a biologically driven process intended to keep the species alive.

- The young child survives, stays safe and develops by engaging with a protective parent.
- A child adapts to his or her family as a way to keep the parent engaged and protective.

In healthy families, the adults prioritize the infant's needs and change their life to care for and protect the infant. In families who are coping with a lifetime of overwhelming stress, the parents are sometimes so focused on survival that the infant's needs for protection and nurturing are unmet. ACEs can be experienced by the very young child as life-threatening because their survival depends on a protective relationship. Attachment theory posits that the infant feels, "I must be unlovable if my own parents don't protect and care for me." If this is the constant relationship environment, without protective relationships and experiences, the child internalizes these experiences and views herself as inadequate, unworthy, shameful and lacking adequate self-regulation; she experiences the world as unsafe. Note that ACEs research has all of childhood in the same category, though we know some periods of development are more vulnerable.

Coping with unsafe attachment and ACEs can lead to similar behaviors: risk-taking, impulsivity, substance use, mental illness, and unsafe and revolving relationships. Thinking about clients in the context of ACEs and attachment helps us better understand a client's behavior. Home visitors can be flexible and adaptive in interpreting and responding to the client's behaviors. For the ACE survivor with an unsafe attachment history, the experience of being with someone who can think about her and see her as an important and capable person might be difficult and scary. The opportunity to be heard, understood and accepted by the home visitor can be a powerful experience for the ACE survivor in developing healthier and more flexible coping and adaptive strategies.

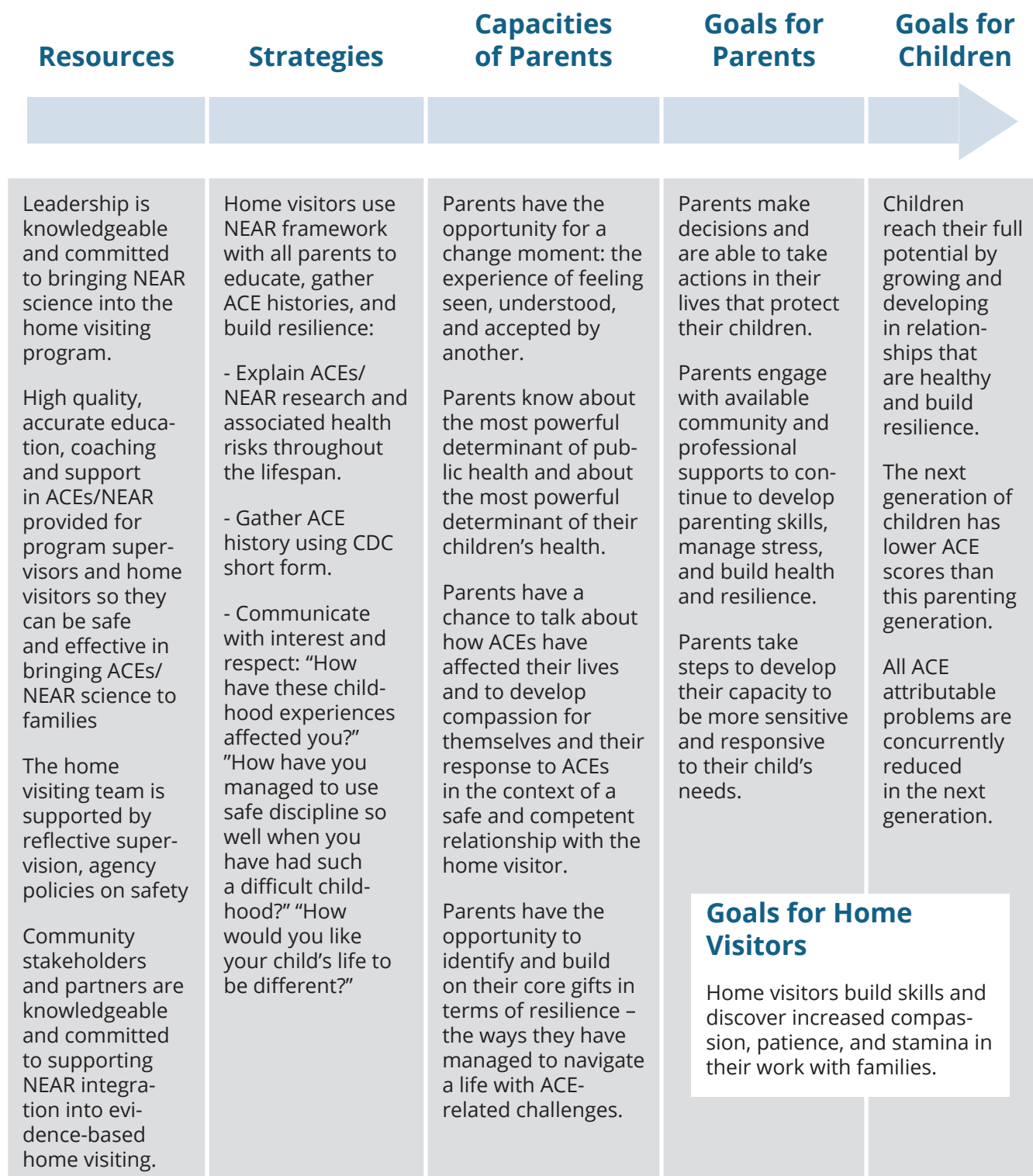
With different stages of development and a widening circle of relationships come potential opportunities for adapting a more flexible, balanced way of relating. The Core Elements section of this toolkit guides the home visitor with safe, empathetic and therapeutic strategies to support the home visitor and the client in developing a safe relationship.

Home visitors carry a heavy responsibility for program goals and outcomes, as well as the responsibility to improve outcomes for each individual and family. Bringing NEAR processes into the practice helps home visitors find compassion, patience and stamina to:

- Meet the client where she's at
- Stay engaged with her even when she is acting difficult
- Understand that what might appear to be small steps of change are really leaps forward
- Develop with her accommodations that will ease ACE-related challenges in her life, and help her better protect her children from ACE accumulation.

Resource: *Patricia McKinsey Crittenden, Raising Parents: Attachment, Parenting and Child Safety. Willan Pub., 2008*

## Theory of Change for Integrating NEAR Science in Evidence-Based Home Visiting



**Goals for Home Visitors**

Home visitors build skills and discover increased compassion, patience, and stamina in their work with families.