

Connecticut Appropriations Committee RBA Template Part II, Program/Agency/System Accountability Summary

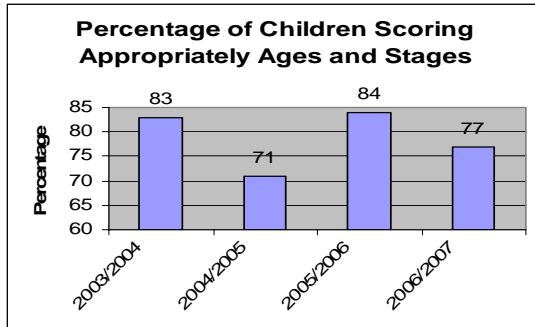
Program: Parents in Partnership Programs (PIP), Department of Children and Families

Quality of Life Result: All Children will begin Kindergarten with the knowledge, skills and behaviors needed for success in school.

Program Purpose: Ensure the safety, physical and emotional health, and development of children age 0-6 years old who have been or are at risk of abuse and neglect

Performance Measure 1

Percent of children developing typically as measured by Ages and Stages.

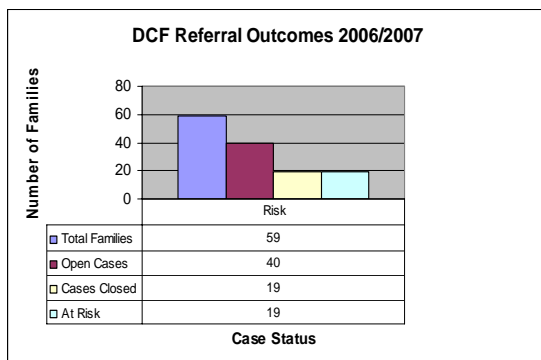


Story Behind Measure 1

Data for 2006/2007 indicates that the PIP programs served a total of 123 children. At the time of data collection, 109 children had completed the Ages and Stages screening (89%). The remaining 11% of the children were in process of screening. Of the 109 children screened, 25 children were identified in need of additional evaluation by either Birth to 3 or the Local Education Agency (if the child was over age 3). Of these children, 100% were eligible for services and were enrolled in developmentally appropriate programs.

Performance Measure 2

Percent of parents experiencing increased stability.

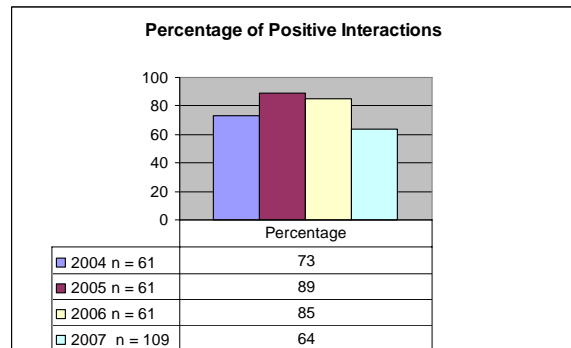


Story Behind Measure 2

As a result of PIP involvement, 19 of 40 open DCF cases, or 48%, were closed as a result of parents completing their goals, improving interactions with their children, and demonstrating an elimination of abusive and neglectful behavior. An additional 19 parents at-risk of DCF referral received parenting support resulting in no new referrals to DCF.

Performance Measure 3

Percent of parents engaging in positive interactions.



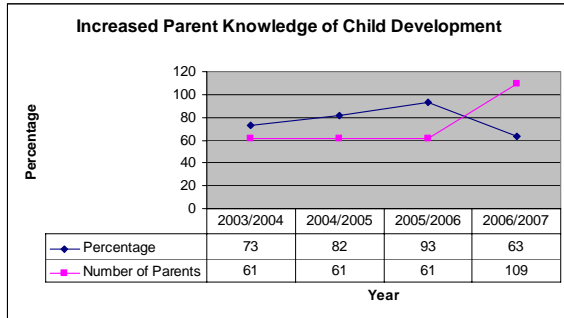
Story Behind Measure 3

Data indicates that 70 of the 109 parents (64%) made significant improvement maintaining positive interactions with their children as measured by the HOME Scale. Interactions were characterized by more episodes of positive behavior management, less commanding, and increased parental engagement in mutually enjoyable interactions with children.

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Performance Measure 4

Percentage of parents demonstrating increase in knowledge of child developmental stages as applied to their children



Story Behind Measure 4

109 parents were served in 2006-2007. Of these, 63% demonstrated significant increase in their knowledge of child development as measured by their ability to identify their children's next major milestone and select appropriate activities to promote this milestone.

Turning the Curves: What do you propose to do over the next two years and why?

1. Decrease maternal depression, parental stress, poverty, and housing instability through the development of an Individual Family Support Plan which outlines goals, strategies, timelines and community links resulting in self-sufficiency. *
2. Document increase in parental knowledge of child development using

the Knowledge of Infant Development (KIDI) and other evidence-based tools.

3. Incorporate language and literacy based practices with families to assure that children are ready to succeed in school at age five.
4. Collaborate with early care and education settings to ensure that children 3 through 5 receive high quality preschool care and education. *

*No-cost/low-cost action steps.

Key Budget Information	
Total Current Program Year Funding	\$505,290
Funding as Percent of All Funding for Population Result	
Program Funding As Percent of Total Agency Budget	.006%
Funding Distribution	
Total Federal Funds	0
Total State Funds	\$505,290
Capital Projects Subtotal	0
Other Funding	0
Percent of Total Current Funding Contracted to Third Parties	100%

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Program: Parents in Partnership Programs (PIP)/Department of Children and Families

Program Purpose: Ensure the safety, physical and emotional health, and development of children age 0-6 years old who have been or are at risk of abuse and neglect in order to ensure their readiness for school at age 5.	
Contribution to Population Result: Through the provision of supports to parents children will reach kindergarten with the knowledge, skills, and behaviors needed for success in school (Ready by Five, Fine by Nine, 2006).	
Key Budget Information (<i>Dollars reported in millions</i>)	
Total Current Program Year Budget	\$505,290.00
Funding as Percent of All Funding for Quality of Life Result	
Program Funding as Percent of Total Agency Budget	.006%
Budget Distribution:	
Federal	
State	
General Fund	\$505,290.00
Capital Project Funds	
Other State Funding	
Other Funds (Not Federal or State)	
Percent of Total Current Funding Spent on Direct Service	91%

Basic Program Facts

The Parent in Partnership Program was developed in the late 1980's based on a strength-based model of prevention/intervention for families of children with disabilities. The model originated in Tennessee and was referred to as the Regional Intervention Program (RIP). The Connecticut adaptation identified families of young children who were either clients of the Department of Children and Families due to a history of abuse and neglect, and therefore were mandated to participate in a parenting program; or who were perceived to be at risk of future abuse and neglect of their young children. The programs were initially entitled Preschool Intervention Programs. During the 1990's, the program's name changed to the Parent in Partnership (PIP) programs to reflect more accurately the partnership developed by service providers and their clients. There are four PIP projects in the state. They continue to focus on prevention/intervention. Since 1988, they have served approximately 2,369 families. Programs are funded at different levels and therefore vary in the numbers of families they can serve. Individual program capacity ranges from 25 to 65 families at any single point in time.

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The PIP model emphasizes active engagement of parents in promoting their children's development by identifying needs and strengths within families and developing Family Support Plans, which identify parent goals, child developmental goals, and parent/child interaction goals. Individualized services are available through home visits, center-based playgroups and parent educational classes. Goals of the program are to:

1. Promote optimal infant and child health development by increasing parental information about child development and early care and education, which will assist them in making decisions which promote their children's cognitive/problem solving skills, language, social/emotional and physical development.
2. Promote the health and safety of children by increasing positive interactions and positive methods of discipline while decreasing episodes of reported neglect or abuse.
3. Assist families to increase self-sufficiency through the provision of case management services which result in permanent housing, increased educational attainment, and economic self-sufficiency.

All families receive case management services designed to link them with other community services which assist them in accomplishing their personal goal. Services may include linkages to medical providers, including dentists, primary care physicians, prenatal clinics and mental health support. Family self-sufficiency is achieved through referral and collaboration with WIC, housing authorities, GED, higher education and job training programs, financial planning, and employment and early care and education settings. A strong emphasis is placed on identifying the developmental needs of children and the health and mental health needs of parents.

Current families participating in PIP have a complexity of characteristics not easily resolved during short-term crisis oriented programs. The history of PIP involves working closely with family preservation programs and IICAPS programs as families transition from the intensive family service to less intensive community-based services which provide continued support to ensure long term sustainable results. Currently, PIP programs serve a total of 109 families, with 123 children specifically targeted for intervention. Although specific children are targeted for intervention, the entire family system, including numerous siblings, are included in the service. Participating families include the following characteristics:

- 59 families have current DCF involvement - 32 for neglect and 8 for abuse, with an additional 19 families with past DCF involvement or considered at risk of DCF referral;
- 82 families live at or below 185% of the poverty level;
- 32 parents receive care and counseling for substance use;

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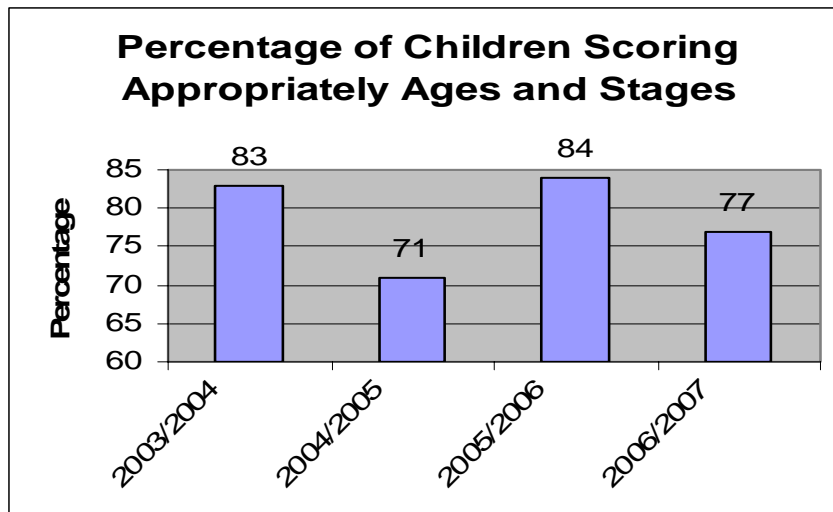
- 36 parents have identified issues of domestic violence as affecting their family life;
- 50 parents have a current mental health diagnosis including maternal depression;
- 22 families are headed by teen parents;
- 24 parents have cognitive challenges;
- 7 families are homeless;
- 46 parents are receiving mental health counseling;
- 32 families have five or more of the above risk factors

The length of time parents typically participate in the PIP program is between 12 and 18 months, although length of participation can be extended due to the depth and breadth of challenges faced by these families.

Performance Measures and Story Behind the Baselines

Performance Measure 1:

Percent of children developing typically as measured by Ages and Stages



Story Behind Measure 1

The graph above presents the percentage of children each year from 2003-2007 who achieved typical developmental milestones as evidenced by monitoring with the Ages and Stages Questionnaires. It is important to note that each year represents different cohorts of children. These cohorts cannot be directly compared with each other. In addition, the data collected from 2003-2006 was based on a proxy measure representing only two of the four PIP programs. Clearly this is less robust data. The 2006/2007 data is highly robust since it accurately reflects data from the four PIP programs.

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The Ages and Stages Questionnaires continue to be a useful developmental monitoring tool for several reasons:

- The use of ASQ as a developmental monitoring tool has been studied extensively and validated on large populations of children.
- The ASQ is able to measure validly and reliably children's development in the domains of : social, emotional, language, cognitive, physical and motor development
- Children who live in situations where there is chronic stress require more frequent monitoring in order to assure that they are achieving milestones which will bring them to Kindergarten ready for a successful school experience.
- The ASQ provides a cycle of frequent monitoring through parent-completed questionnaires provided every four months from B-2 years, and every 6 months thereafter to the age of five years old.
- The ASQ provides an additional comprehensive set of questionnaires dealing only with social/emotional development at each specified age.
- The ASQ questionnaires are available in several languages.
- The ASQ is easy to use with parents. Parents easily engage in completing the questionnaires and enjoy the simple games played with their children.
- The ASQ provides educational value by informing parents about appropriate developmental milestones and behavioral expectations for their children.

As a result of participation in RBA during the 2006 year, all PIP programs were provided training in use of Ages and Stages Questionnaires (See Low Cost Recommendation, P 8, RBA Template, 2006). Data for 2006/2007 indicates that the PIP programs served a total of 123 children. At the time of data collection, 109 children had completed the Ages and Stages screening. It is important to realize that 89% of the children participating in the PIP programs received developmental screening during the current year. The remaining 11% of the children are in process of completing their developmental screens. Since children and families enter and transition from the program continuously, there are always children in the process of completing their screening. It is also important to note that the screening of 109 children identified 25 children in need of additional evaluation by either Birth to 3 or the Local Education Agency (if the child was over age 3). Of these children, 100% were eligible for services and were enrolled in developmentally appropriate programs.

The data is most useful in demonstrating that:

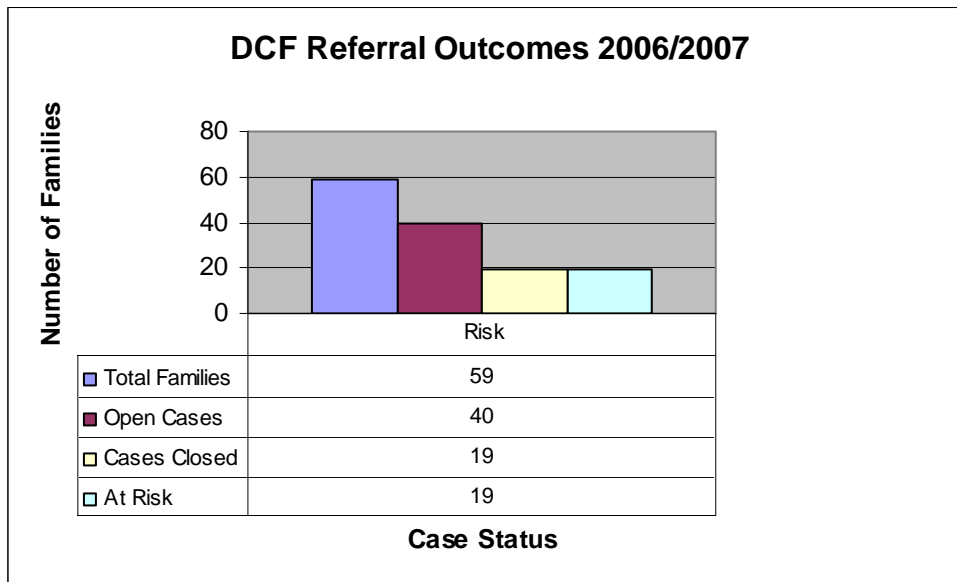
- All PIP programs are monitoring children's development.
- Most children are developing in a typical range despite the number of stressors challenging their parents.

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- The 2006/2007 data is a more accurate reflection of the "real" numbers of children who are being monitored and referred for early intervention by PIP.
- We should be concerned that 23% of the children in our PIP programs are experiencing developmental delays that are serious enough to make them eligible for early intervention or Local Educational Agency (LEA) programs for children (age 3 and above) with special needs.
- We should explore the connection between number of risk factors in the PIP population of families and the number of children eligible for early intervention services.

Performance Measure 2:

Percent of parents experiencing increased stability.



The Story Behind Measure 2

A major goal of the PIP programs is to stabilize families where there have been reported cases of neglect and abuse. Last year we relied on the measure of parent re-referral rate while participating in the PIP program as an indicator of family stabilization. The data indicated that parent re-referrals while participating in PIP services were very low (4%-6%). Data from 2006-2007 indicated even fewer re-referrals while parents were participating in the PIP program (0%). Concluding that this measure might not be the best indicator of parent/family stability, it was decided to measure progress by the number of DCF cases closed as a result of participation in PIP. When PIP provides services the ultimate goal is to not only stabilize a family but ameliorate and prevent child abuse and neglect. With that in mind, our 2006/2007 data begins to explore that goal by providing a measure of the numbers of DCF cases which were closed as a result of successfully completing the PIP program. Data indicated that the PIP programs

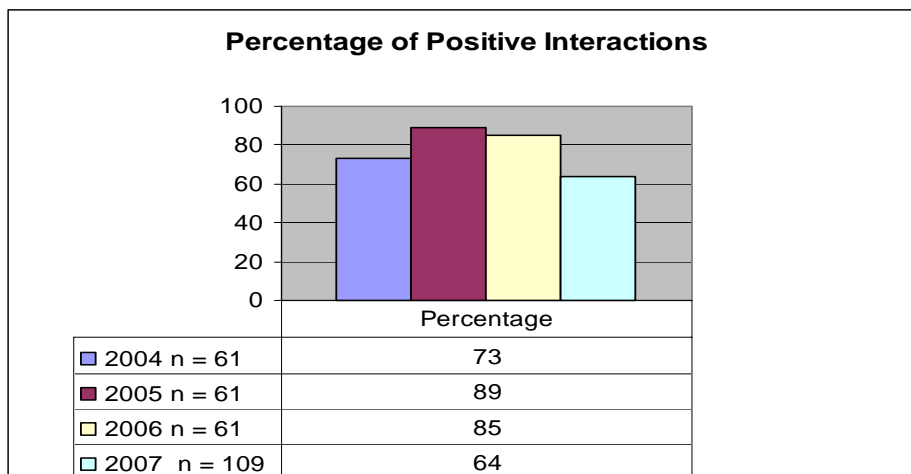
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received collectively 59 referrals from DCF during 2006/2007. This represented 54% of the total number of referrals to the PIP program (59 of 109). Parents were referred for two reasons: an open, active and current DCF case, or history of DCF involvement; or as a parent at risk of future DCF referral as indicated by one or more reports to DCF. Forty families entered PIP programs with current DCF mandated involvement due to either abuse (8 parents) or neglect (32 parents). Nineteen additional parents were referred for parenting support because they were at risk of DCF referral. As a result of PIP involvement, 19 of 40 open DCF cases or 48% were closed as a result of parents completing their goals and improving the health, safety and physical protection of their children. In addition the 19 parents at-risk of DCF referral received parenting support resulting in no new referrals to DCF.

During participation in PIP, each parent developed an Individualized Family Support Plan to address the family’s unique and diverse needs. As a result of participation in RBA during 2006, all PIP programs were provided assistance with developing a common process and format for use in developing Family Support Plans (see Low Cost Improvement Strategy, p. 8, RBA Template, 2006). Goals included parent goals (i.e. education, housing, job training), child developmental goals based on screening using the Ages and Stages Questionnaires, and goals for parent/child interaction. Parents identified individual strengths as well as needs. Parents with open and active DCF cases developed their Family Support Plan in collaboration with PIP staff and the DCF case manager. \

Performance Measure 3:

Percent of parents engaging in positive interactions, discipline and guidance with their children.



The Story Behind Measure 3

Proxy data was obtained for the years 2003-2006 from two PIP programs. The data included 61 parents. Data analyzed from this cohort indicated high levels of positive

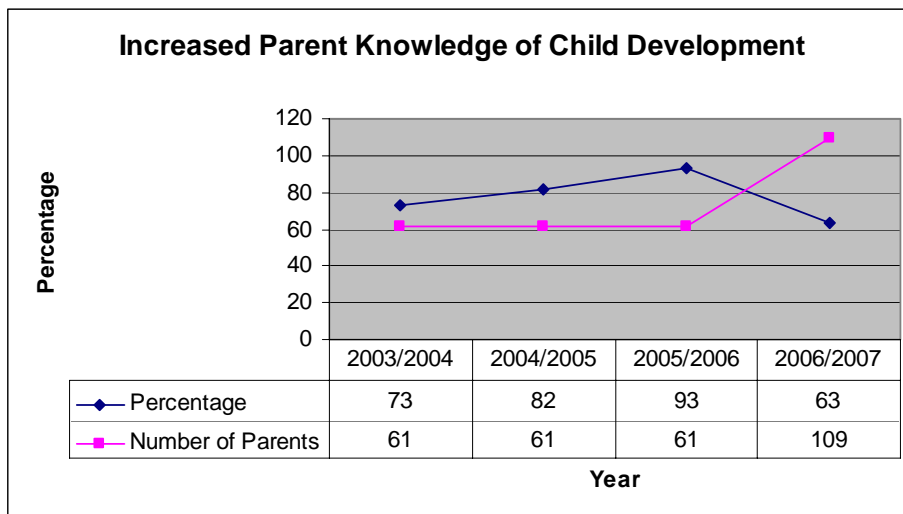
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parent/child interactions after intervention. However, it was difficult to interpret this data for two reasons. First, although the numbers of parents served were the same each year, the cohort of parents was different each year, negatively affecting any ability to compare parents from year to year. Secondly, the two programs used slightly different methods for collecting information about positive parent/child interactions resulting in data that could not be compared.

As a direct result of participation in the RBA process during 2006 (see Low Cost Recommendation, p. 8, RBA Template, 2006), all PIP programs were provided training in the use of Home Environment Scale and the Parent/Child Caregiver Involvement Scale as reliable and valid measures of parent/child interactions. Data from 2006/2007 is a more accurate representation of the improvement in interaction after intervention since it documents change among participants in all four PIP programs using these measures of parent/child interaction. In the 2006/2007 cohort, 109 parents from all four programs were provided information, coaching and support in order to increase the instances of positive interactions they engaged in with their children. Data indicated that 70 of the 109 parents (64%) made significant improvement in maintaining positive interactions with their children as measured by the HOME Scale. Interactions were characterized by more episodes of positive behavior management, less commanding and increased parental engagement in mutually enjoyable interactions with children.

Performance Measure 4

Percentage of Parents demonstrating increase in knowledge of child developmental stages as applied to their children



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Story Behind Measure 4

The graph above indicates the number of parents served and the percentage of parents participating in the PIP program who benefited from the service. PIP programs served 109 parents during 2006-2007. Of those completing their programs, 63 % demonstrated significant change in the knowledge of their own child's development. It should be remembered that this is point in time data. Many participants are still in the process of completing goals; therefore, their results are not available. In addition, while it appears that the percent of parents who have increased knowledge of child development has decreased from past years, it should be remembered that 2003-2006 data dependent on a small cohort of parents used as a proxy measure. This was not truly representative of all parents participating in the four PIP programs. The 2006-2007 data is believed to be a truer reflection of the changes made by the very challenged and complex families served by PIP (see p. 5-6 RBA 2007). Finally, since cohorts of parents differ in strengths, needs and complexity, any downward trend may be attributed to a particularly challenged cohort of parents.

As a result of participation in RBA during 2006, all programs have re-incorporated home visiting as the primary method of providing families with child specific information. The rationale for making this decision is that each family attending PIP has a unique set of complex strengths and needs. Children are born with their own unique birth history, temperament, biological, neurological and physiological strengths and needs. Parents participating in PIP have been exposed to extreme and unique stressors in both number and kind. Many parents participating in the PIP program have failed to benefit from traditional parent education programs where groups of parents meet for 7-10 weeks during a parent education class to address specific topics (i.e. toddler tantrums, sleep, mealtime behavior, toileting).

Parenting programs such as Parents as Teachers or Positive Parenting were developed to enhance foundational information about child development. They were designed to be delivered to middle-income families. These programs do not necessarily account for the needs of people living in poverty, people struggling with mental health challenges or learning challenges, or families with diverse ethnicity, race and language. The information provided, while important and accurate, does not always meet the needs of the parent. It may not be accessible or understandable to families who do not read, or who represent different ethnic and cultural beliefs. In addition, the length of the classes and the amount of information covered in each class may not permit parents the time they need to learn the information presented. Finally, information may not address the unique needs of their children or the environmental situations which challenge many parents today. Many parents cannot generalize the information learned in a class to their home environment.

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The PIP model of service involves frequent home visiting (minimum weekly visits). Services are delivered where parents live to ensure that: providers account for differences in family environment, identify needs within the home, provide parents essential privacy in which to develop and discuss goals, provide parents opportunities to practice new skills in a meaningful environment, and promote parent/child interaction by removing distractions during instruction. During home visits, weekly goals are discussed, activities are selected and strategies for promoting children's development are demonstrated. Parents receive coaching, feedback and materials suited to their learning needs and the needs of their children. Weekly information is collected regarding the outcomes of the visit.

What steps are needed to improve performance in the next two years and why?

* No-cost/low-cost action steps:

1. PIP programs will survey each parent participant to determine the status of housing stability, economic security, education and job training. Areas of need will become goals of the Family Support Plan. Success in the PIP program will be measured by improved self-sufficiency in order to assess the effectiveness of PIP in reducing risk factors associated with neglect, abuse. *

- Rationale: While neglect and abuse occurs in all socio-economic groups, poverty increases stress in families. Economic security allows families to purchase child care and respite which may ameliorate some of the stress in their lives.

2. Parents participating in PIP will receive information about general child development and specific information about their own child's developmental status in order to promote their child's readiness for school. PIP programs will document increase in parental knowledge of child development using the Knowledge of Infant Development (KIDI), and other evidence-based tools. *

- Rationale: Knowledge of appropriate age/stage related information as well as the unique characteristics of one's child assists parent to create appropriate expectations of their child which may promote insights into children's behavior and the appropriate responses to difficult, stage related behaviors.

3. PIP programs will incorporate language and literacy based practices with families during play groups and home visits with the intent of assuring that their children are ready to succeed in school at age five.

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- Rationale: All children served by PIP have the right to arrive at school ready to succeed. Success in School is dependent on early and rich language experiences which begin as soon as an infant is born.

4. PIP programs will assure that children of parents participating in PIP who are ages 3 through 5 are ready for school success at age five by linking them with high quality early care and education settings including Head Start and School Readiness Programs.*

- Rationale: 75% of children in Connecticut have a preschool experience. This is directly related to the economic circumstances of their parents.

Appendix A: Data Development Agenda

1. Document Individual Child/Family Success.

When attempting to determine whether anyone is better off as a result of participating in a variety of services a program may offers, it is important to determine two aspects of the service: Did the service do what it was intended to do? and, How did the client feel about the service, the way it was delivered and whether the service was appropriate to the client's needs? Some information gathering is best done using objective, valid and reliable instruments which can demonstrate changes over time. Other information can be gathered through observation or surveys. Research has demonstrated the importance of responsive, nurturing parent/child relationships, the importance of parental knowledge of child development in creating accurate expectations, and the importance of recognizing and treating maternal depression in optimizing very young children's development. In addition, it is important to assist parents with creating and maintaining calm and supportive home environments. Finally, children cannot develop optimally unless their needs for medical care and nutrition are met. All PIP programs will therefore gather the following information for analysis:

- Parental satisfaction surveys. Parental satisfaction is an important measure of a successful program. Each survey will determine parental satisfaction with the following elements: the actual services provided and their importance and relevance to the parent, parental perception of being valued during the planning process,, parents feelings about relationships with professionals (respect, dignity, equity), parents feeling of success in both parenting and improved quality of life as a result of the supports and services provided.
- Pre/post data child/caregiver relationship. Parents referred to PIP often have a history of abuse or neglect. They frequently come from biological families where their own needs for nurturance have not been met. They are often ill-equipped to provide responsive, nurturing parenting because due simply to a lack of knowledge and experience. One goal of the PIP programs is to provide parents with a different and more positive example of parenting. Parent/Caregiver relationships are assessed pre and post intervention using the

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Parent/Caregiver Involvement Scale (Farran, Jay & Comfort, 1981) Changes in the manner of interaction are documented. The expected outcome is a reciprocal, child-focused nurturing and responsive interaction.

- Developmental screening and monitoring using the Ages and Stages Questionnaire. In order for children to reach kindergarten ready to succeed they must meet the typical milestones along the way. Therefore, it is necessary and most important to provide periodic developmental screening and monitoring. All children between the ages of birth and six years old within each family served will be monitored using the Ages and Stages Questionnaire for the duration of the family's participation in PIP. Once the family transitions from PIP all children under the age of six within the family children will be enrolled in the statewide Help Me Grow Program. Each PIP program will report on the results of their Ages and Stages monitoring including: number and status of children monitored, the number of referrals for specialized services, and the number of families who follow-up with the recommended services.
- Home environment. PIP programs assist families reach goals in many areas primarily through a home visiting program. While in the home parents are encouraged to provide a safe, healthy, and stimulating environment. The HOME Scale is used to analyze this environment. All PIP programs will collect pre-post assessment of the home environment. Pre assessment information will be used to guide development of parts of the Family support Plan. Post data collection will provide an analysis of changes that have occurred.
- Child Development Knowledge. Most DCF families referred to the PIP program have been referred due to child neglect. Parents frequently neglect or abuse their children because they do not have accurate expectations of the child based on the child's level of development. Expectations can be either too high or too low, interfering with the optimal development of the child. Knowledge of child development is critical in assisting parents form realistic expectations and in providing parents with age and stage related information. The KIDI (Knowledge of Infant/Toddler Development) assesses parental knowledge. It is offered as a pre-post assessment existing and improved child development knowledge.
- Pre/post levels of parental. The Parenting Stress Index (Abidin). All families experience stress, but some families experience more stress due to poverty, number and ages of children, job insecurity, food insecurity and homelessness. The Parenting Stress Index is designed to help families identify their source of stress. Once identified, goals can be incorporated into the Family Support Plan. Action steps and strategies are introduced to

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alleviate stress. Pre-post measurement of stress is an indicator of successful participation in a program

- Pre/post maternal depression. Maternal depression interferes with mother child relationships. In young infants and toddlers lasting effects can be seen in insecure and impaired attachment. It is of critical importance to identify women who are depressed or at risk of depression. By identifying and treating maternal depression, children's emotional health can be supported. Maternal depression will be determined by pre/post assessment using the Center for Epidemiology Studies - Depression Scale (CES-D). Women with significant, clinical findings will be referred to appropriate community services.
- Document child physical health/mental health - immunizations - well child visits. Children cannot be ready for kindergarten if their health needs including medical, dental, and nutritional needs are not met throughout their early childhood. PIP programs will collect and report pre-post data about immunizations, well child clinics and dental visits to ensure the health of participating children.

2. Develop a method of site-based data collection that is linked with DCF Central Office and DCF LINK System as appropriate and as determined by the Decision Support Unit.

Appendix C, Information and Research Agenda

- Develop a system of tracking outcomes for children who have participated in PIP, perhaps as part of the PSIS system
- Research methods of expanding the number of PIP programs through additional funding
- Explore the connection between number of risk factors in the PIP population of families and the number of children eligible for early intervention services.
- Explore relationship between numbers of stress factors present in a family and child referral for B-3 services or LEA services Among the best predictors of future learning, behavioral and cognitive disabilities is the presence of extreme levels of stress in families. If we can begin to identify children living in high stress situations, we may be able to work with them and their families on stress reducing strategies to promote their healthy development.

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Appendix D, Partners and Their Roles

- **Community Providers include:** mental health providers, clinics, hospitals, pediatricians, substance abuse treatment centers, employment agencies, homeless shelters, Local Educational Agencies, Head Start, School Readiness Programs, day care providers, physicians, dentists, and local housing authorities. Collaborative relationships are developed with individuals and agencies on a local and statewide level. PIP relies on these individuals as both a source of referrals and as resources with which to connect families requiring services.
- **Community Networks and Councils.** PIP Directors and staff participate in local community networks and councils. These networks and councils offer an opportunity to increase awareness of the program and services it offers families and children, to learn more about the cultures and beliefs of families in the geographical area, and to provide community providers opportunities to share information and receive referrals. During the past twenty years PIP has partnered with agencies to support local efforts at obtaining additional programs through cooperative grant writing.
- **State Agencies.** PIP Directors and staff invite state agency representatives from area offices that provide financial assistance, housing assistance, child care, nutrition supplement, and transportation to parent support and information groups. Representatives of these agencies provide information and training to parents and staff alike enabling parents to learn the eligibility criteria and skills necessary to apply for assistance; and enabling staff to gain critical, current information that assists them in promoting family advocacy. The training and technical assistance is generally offered at not cost to the program. Developing relationships with representatives of DSS, DCF, WIC, Head Start, DMHAS and SDE is critical to supporting families.

Appendix E, What Works

Brain development occurs most rapidly during the first few years of life. At birth a child's brain contains 100 billion neurons ready to code and record information from all the baby's senses and early experiences. By age 3, the brain achieves 80-85 percent of its adult size and its architecture includes a trillion connections between neurons.

Responsive, nurturing, language-rich parent-child interactions provide the essential context in which the child's brain architecture and knowledge expands (Ready by Five & Fine by Nine, 2006). All children must learn to manage stress in order to be successful. Tolerable stress is the way that we help children achieve this goal. The environment in which a child develops is critical to this process. Research shows that children who are

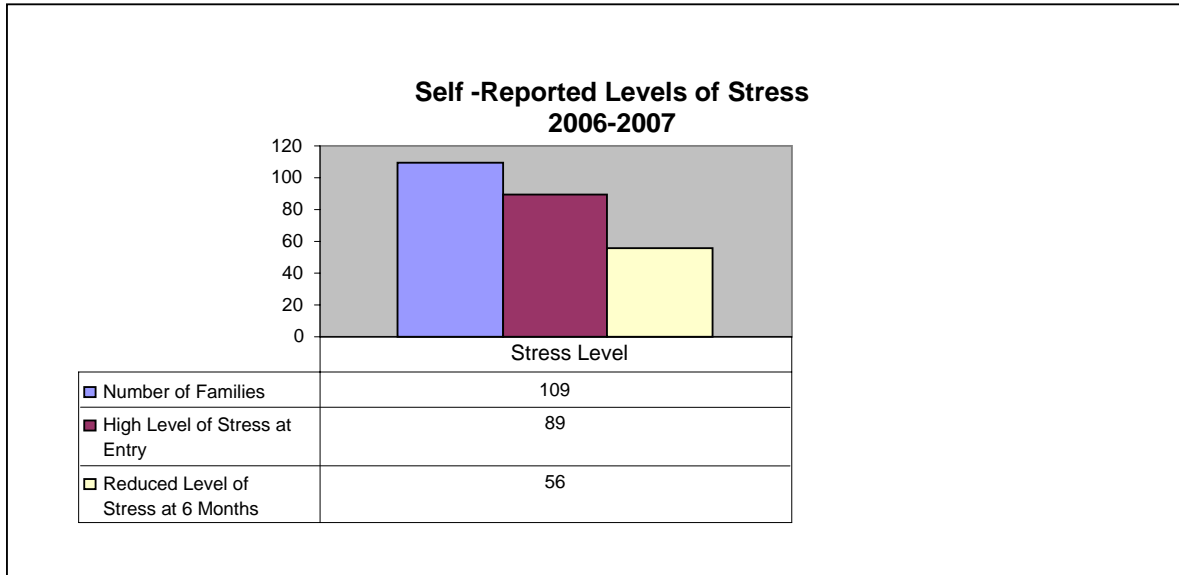
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not touched, stimulated, or played with during this time have brains that are 20-20% smaller than normal. All learning first occurs within the context of relationships. Secure attachments result when infants and young children engage in positive, satisfying relationships with those who care for them. Positive, responsive relationships form the basis of all future learning in the domains of language, cognition and social-emotional development and are of critical importance.

Positive interactions are defined as those interactions where both parent and child experience mutual pleasure. These interactions occur during play but also during times when young children are being nurtured, guided and disciplined. During healthy parent child interactions discipline is given in the form of guidance and is not punitive in nature. Limits are clearly set in a warm and responsive manner appropriate to the child's age. There is generally a limited amount of commanding and demanding and concomitantly an increased amount of explanation. Several instruments are utilized to explore parent /child interactions.

Parents who live in stressful environments, have mental health challenges, or have a history of distorted, insecure and abusive parenting themselves often have difficulty engaging in positive interactions with their young children. Their lack of child development knowledge coupled with their own complex environmental, social and emotional needs produces increased uncertainty and increased and often unmanageable stress in their lives. An environment of this nature may result in children who have elevated levels of stress. Stress may become toxic to their development remaining elevated rather than returning to a normal level. Toxic stress in early childhood is associated with persistent effects on the nervous system and stress hormones that can damage the developing brain architecture and lead to lifelong problems in learning, behavior and both physical and mental health (Shonkoff, 2006).

Connecticut Appropriations Committee RBA Template
Part II, Program/Agency/System Accountability



Families who neglect and abuse their children often are families who experience one or more of the following: difficult child, chaotic family dynamics, poverty, under-education, under-employment, domestic violence, substance use and multi-agency involvement. These families tend to experience far greater stress than typical families. Poverty, under-education and job insecurity increase stress on parents and thus on their children. The PIP programs assess individual needs of families and children, develop action plans based on identified strengths, and create goals with families. Services are individualized to achieve greater stability and decrease the stress in families. This can mean connecting families to food stamps, WIC or to medical facilities. For many families referrals are made for counseling. In addition, all families have opportunities to attend classes and center-based programs that help them learn to care for and support the development of their children. Participation in PIP may mean assisting a mother access child care while she attends school, or assisting with locating and paying for child care. One measure of greater stability is fact that the family is able to maintain their family unit without re-referral to the Department of Children and Families. The graph above demonstrates that during 2006/2007 self-reported levels of stress decreased for 56 of 89 parents or 63% of the parents participating in the program who reported high levels of stress. While self-report is useful, it is very important to measure stress levels and stress level reduction using a standardized tool. During the 2007/2008 year all PIP programs will participate in training in the Use and interpretation of the Parenting Stress Index, a reliable and valid tool measuring changes in parent levels of stress,.