EVIDENCE-BASED PROGRAMS FOR EXPECTANT AND PARENTING TEENS

PROFILE GUIDE

OPA OFFICE OF POPULATION AFFAIRS

TABLE OF CONTENTS

INTRODUCTION

The Evidence Based Programs for Expectant and Parenting Teens Profile Guide provides detailed information about several interventions targeting young parents and expectant teens, including program overview, program components, implementation requirements and guidance, and citations for reviewed studies. The interventions included in this guide were identified through the Positive Adolescent Futures Study, a systematic review of programs for teen parents. These programs have rigorous evidence of effectiveness in improving teens' academic outcomes, reducing repeat pregnancy or birth, or increasing contraceptive use.

The following programs are included in the guide:

- AIM 4 Teen Moms
  [Data source: Teen Pregnancy Prevention Evidence Review]
- Computer-Assisted Motivational Interviewing Plus Home Visiting
  [Data source: Administration for Children & Families Home Visiting Evidence of Effectiveness]
- Early Head Start
  [Data source: Administration for Children & Families Home Visiting Evidence of Effectiveness and https://eclkc.ohs.acf.hhs.gov/programs/article/early-head-start-programs]
- Early Intervention Program for Adolescent Mothers
  [Data source: Administration for Children & Families Home Visiting Evidence of Effectiveness]
- Healthy Families America
  [Data source: Administration for Children & Families Home Visiting Evidence of Effectiveness and https://www.healthyfamiliesamerica.org/]
- New Heights
  [Data source: Asheer, S., Burkander, P., Deke, J., Worthington, J., and Zief, S. (2017). Raising the Bar: Impacts and Implementation of the New Heights Program for Expectant and Parenting Teens in Washington, DC. Washington, DC: U.S. Department of Health and Human Services, Office of Adolescent Health.]
- Nurse-Family Partnership
  [Data source: Administration for Children & Families Home Visiting Evidence of Effectiveness and https://www.nursefamilypartnership.org]
- Taking Charge
  [Data source: Data from Harris, M. & Franklin, C. (2010). *Taking Charge: A School-Based Life Skills Program for Adolescent Mothers. Taking Charge: A School-Based Life Skills Program for Adolescent Mothers* (pp. 1-240). New York: Oxford University Press.]
- Teen Options to Prevent Pregnancy
  [Data source: Teen Pregnancy Prevention Evidence Review]

Some programs that were included in the Positive Adolescent Futures Study have been omitted from his guide. They are as follows:

- Community-Based Family Resource and Support Program: The program is no longer in operation.
- Three Generations: This intervention was only a research trial and there is no implementation information available.
- Dollar-a-Day Program: The program was originally implemented more than 20 years ago and there is *very* limited information available.
- New Chance: The program is no longer active, and no current developer or contact information is available.

For some programs, while a full profile was not developed, limited information has been provided in Appendix A. These programs are as follows:

- CenteringPregnancy Plus HIV Prevention
- Learning, Earning, and Parenting Program
- Pathways Teen Mother Support Project

For additional information about the Positive Adolescent Futures Study, please contact the Office of Population Affairs.

AIM 4 TEEN MOMS

I. PROGRAM OVERVIEW

DEVELOPER(S)

Dr. Leslie Clark, Ph.D.; Irene Lim, LCSW; Frances Cordero, MPH; Mona Desai, MPH; Children's Hospital of Los Angeles.

PROGRAM SUMMARY

AIM 4 Teen Moms seeks to reduce rapid repeat pregnancies by helping teen mothers define specific life aspirations, engage in planning to successfully achieve them, and consider the role of contraception in their lives. The 10-week program consists of six 1-hour individual sessions, one 90-minute group session at the half-way point, and another 90-minute group session at the end of the program. It is delivered in teens' homes and/or community-based locations by trained facilitators (called advisors).

TARGET POPULATION

The program is designed for new teen mothers who are 14 to 20 years old and have at least one child. It has been evaluated with Hispanic and African American teens who were 15 to 19 years old and had one child, in Los Angeles County, CA.

PROGRAM SETTING

The program was designed for and evaluated in participant homes (for individual sessions), and in community-based locations (for group sessions).

Contact and Availability Information

AIM Service Center
Children's Hospital Los Angeles
5000 Sunset Blvd., 7th floor
Los Angeles, CA 90027
Phone: 323-361-3126
Email: aim@chla.usc.edu

Sample of curriculum available for review prior to purchase: Yes

Adaptation guidelines or kit available: No

Languages available: English and Spanish (pending)

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

AIM 4 Teen Moms, a positive youth development program, encourages teen mothers to envision positive futures for themselves and to identify the practical steps necessary to achieve their long-term goals. The program's goal is to reduce rates of unprotected sex. The program aims to achieve these goals through a range of potential mediating factors—for example, encouraging participants to think about their future educational and career aspirations, motivating them to pursue their aspirations, and providing them with the information needed to make informed decisions about effective contraceptive methods. In the long-term, the program aims to reduce rates of unprotected sex leading to fewer repeat pregnancies and teen births.

PROGRAM CONTENT

AIM 4 Teen Moms is based on the Theory of Possible Selves, which states that a person's motivation is determined by a balance of positive and negative ways people see themselves in the future. Individuals who are able to imagine both possible positive and negative futures are more likely to work toward their life goals and achieve future success.

AIM 4 Teen Moms emphasizes control over one's future, connects present actions and reproductive choices with future achievements, and defines motherhood as an identity strength rather than a stigma. Drawing on the Theory of Possible Selves, Promotion-Prevention Motivational Orientations, and youth development principles, AIM 4 Teen Moms identifies and builds on teen mothers' hopes for their future and elicits their motivations for attaining adulthood goals.

The program consists of five main core elements:

1) Thinking about a positive possible future.
   Through activities, and discussion, youth envision a positive future and set goals to achieve it.
2) Present actions to achieve future success.
   Youth learn communication skills, how to identify their own strengths, as well as needed resources and experience a sense of success through engagement in personal and group activities.
3) Safeguarding one's future.
   Youth are encouraged to safeguard their future through risk reduction.
4) Creating a reproductive life plan.
   The curriculum incorporates knowledge of different methods of contraception and conceptualizes family planning as part of a larger holistic reproductive health agenda. Youth create a personalized reproductive life plan.
5) Motherhood as an identity strength.
   The program acknowledges motherhood as a driving force that motivates many young mothers to succeed in life. Youth are encouraged to consider parenting as adding to the strengths and experiences useful to succeed rather than as a limiting factor in their life.

The program covers the core elements through six individual sessions and two group sessions:

Session 1 – My Future and My Legacy
Session 2 – My Aspirations and Approach to Family Planning
Session 3 – My Aspirational Resume and Birth Control
Session 4 – Planning and Presenting Myself to the World
Group 1 – Claiming my Future
Session 5 – Relationships in My Life
Session 6 – Putting it All Together
Group 2 – Celebration

PROGRAM METHODS

The program sessions involve a sequenced series of activities designed to build on the life experiences of program participants and support positive youth development.

For the home visits, trained program facilitators (advisors) schedule times to meet with participants in their homes or another location and deliver the six sessions over a roughly 10-week period. The sessions involve a mix of interactive discussion, structured activity worksheets, brainstorming, and role-playing. The two group sessions take place in central community-based locations and bring together small groups of program participants near the middle and at the end of the 10-week program. These sessions reinforce the information provided during the home visits, address realities of teen motherhood, and give participants an opportunity to receive feedback and support from a network of peers.

Participants begin by identifying their future aspirations and choosing a career path to focus on for the purposes of the program. In later sessions, participants write aspirational resumes, draw timelines of their life, and engage in planning for future success. Participants also develop a reproductive life plan that aligns with their present experiences and future goals. Throughout these activities, the participant workbooks require participants to identify current and future achievements, sources of support, and potential detours or roadblocks to their goals. Near the end of the program, each participant compiles a personal portfolio containing the work they accomplished during the program.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

AIM 4 Teen Moms is a 10-week program consisting of:

- Six 1-hour individual sessions, generally delivered in participants' homes.
- Two group sessions, delivered in community-based locations.

STAFFING

Advisors must be comfortable discussing contraception with teens and interacting with teen mothers on a one-on-one basis.

PROGRAM MATERIALS AND RESOURCES

The following materials are provided with the AIM 4 Teen Moms intervention package:

- Advisor Handbook
- Implementation Manual and Technical Assistance Guide
- Monitoring and Evaluation Guide
- VB Game Kit (Session 2 and 6)
- Role-Play Scenario Cards and Communication Style Cards (Group 1)
- Advisor USB Drive, including:
  - Advisor tools: Continuity Sheet, Directory of Images, and Group Evaluation
  - Templates: Group 1 Reminder, Group 1 Sign in sheet, Resume, Certificate of Accomplishment, Certificate of Appreciation
  - For Youth: Quotes/Affirmations, Birth Control Sheets, and Web Ticket Guide

ADDITIONAL NEEDS FOR IMPLEMENTATION

AIM 4 Teen Moms Licensing Requirements:
All agencies who implement AIM 4 Teen Moms must sign a license agreement, granting them the right to implement and/or adapt AIM 4 Teen Moms under the terms outlined by Children's Hospital Los Angeles. All agencies must sign this contract prior to having advisors (facilitators) trained and implementing AIM 4 Teen Moms. An associated annual license fee of $2000 for each site must be paid as part of the licensing agreement.

Youth-specific materials:
There are a total of six items that must be purchased for each individual teen participating in AIM 4 Teen Moms.
To be purchased from the AIM Service Center:

- Participant Workbook
- Key Chains (Session 1)
- Portfolios (Session 6)
- Participant USB Drive (Session 6)

The next two items can be ordered from the Career Game website. For more information on how to order the booklets and Web Ticket, go to www.careergame.com to purchase:

- The Career Game booklet (Session 1)
- Web Ticket (Session 1)

The following materials are not included in the package and will need to be acquired before implementing AIM 4 Teen Moms. These should be included within your budget:

- CDC Developmental Milestones Brochure (available for free) (http://www.cdc.gov/ncbddd/actearly/freematerials.html)
- Arts/Crafts Kit (e.g., markers, stickers, scissors, etc.)
- Birth Control Kit (e.g., sample Implanon, birth control pills, etc.)
- Office Supplies (e.g., clear labels, construction paper, card stock, etc.)
- Handheld Mirror (Session 5)

Advisors also need access to a computer and a printer with the ability to access the internet.

FIDELITY

The developer provides the following guidelines to providers related to implementing AIM 4 Teen Moms with fidelity:

- Participants should attend at least five out of seven sessions (not counting the celebration group session).
- All participants must complete Session 1 and Session 2.
- All individual sessions must be conducted one on one.
- All facilitator staff must be certified through the AIM Service Center with the 3-day training.
- AIM 4 Teen Moms facilitator fidelity monitoring sheets may be used for assessing advisor (facilitator) performance for each individual and group session as appropriate.

Regular meetings between the intervention director or program supervisor and advisors are recommended to ensure consistency and fidelity in implementing the AIM 4 Teen Moms program.

TRAINING AND STAFF SUPPORT

Staff Training

Staff delivering AIM 4 Teen Moms are expected to attend a 3-day in-person required training before beginning implementation. The training is based on the theory, approach, research findings, and core elements underlying AIM 4 Teen Moms and on the content of the Advisor's Handbook. Training participants have the opportunity for hands-on practice of program activities. In addition, advisors should be knowledgeable in birth control methods and comfortable in talking about methods with teens. Certification to be an AIM 4 Teen Moms advisor (facilitator) requires the successful completion of the 3-day training provided by the AIM Service Center (email: aim@chla.usc.edu). Technical assistance is available by contacting the AIM Service Center (email: aim@chla.usc.edu)

ALLOWABLE ADAPTATIONS

Modifications of the legacy worksheet are allowed to increase the suitability to the target population with whom it is being used (e.g., Native American, Asian and Island Pacific teen mothers), such as by adding images of individuals that look similar in characteristics to the participating youth. Additional information adaptations is provided at the in-person, required training.

IV. REVIEWED STUDIES

Covington, R., et al. (2015). *Interim Impacts of the AIM 4 Teen Moms Program*. Princeton, NJ: Mathematica Policy Research.

Covington, R. D., Luca D. L., Manlove J., and Welti, K. (February 2017). *Final Impacts of AIM 4 Teen Moms*. Washington, DC: U.S. Department of Health and Human Services, Office of Adolescent Health.

COMPUTER-ASSISTED MOTIVATIONAL INTERVENTION (CAMI)-PLUS HOME VISITING

I. PROGRAM OVERVIEW

DEVELOPER(S)

Faculty and staff of the University of Maryland Schools of Medicine and Social Work, the Johns Hopkins University School of Medicine, and the University of Pittsburgh School of Medicine.

PROGRAM SUMMARY

CAMI-Plus seeks to prevent rapid subsequent births among adolescent mothers. The program beings approximately 6 weeks after birth and continues quarterly for 2 years. Participants receive motivational interviewing with a counselor to help increase motivations to use contraception and decrease subsequent pregnancy within two years. Participants also receive home visitations.

TARGET POPULATION

African American adolescent mothers, ages 12-18.

PROGRAM SETTING

Home-based.

Contact and Availability Information

Beth Barnet, MD
University of Maryland
Family Medicine
29 S. Paca St., Lower Level
Baltimore, MD 21201
Email: bbarnet@som.umaryland.edu

Sample of curriculum available for review prior to purchase: No

Adaptation guidelines or kit available: Yes

Languages available: English

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

This program is based on the Transtheoretical Stages of Change model and aims to reduce the percentage of adolescents who have another child within 2 years.

PROGRAM CONTENT

Every quarter, the adolescents complete the computer-based survey assessing their sexual relationships, contraceptive intentions and plans, and current pregnancy prevention practices and participate in a motivational interview with a CAMI counselor.

PROGRAM METHODS

Using a laptop computer, participants answer a series of questions about their current sexual relationships along with their intentions and behaviors toward contraceptive use and condom use. A computer algorithm produces each participant's stage of change (transtheoretical model) for contraceptive use and condom use, which then ranks their risk for pregnancy and sexually transmitted infections. Based on these findings, a 20-minute individualized motivational interviewing session then takes place with a counselor. These sessions allow the counselor to help increase participant's motivation to use contraception and not become pregnant for at least 2 years after giving birth.

Additionally, participants receive biweekly or monthly home visitation sessions, which include parent training and case management. Home visitation sessions are delivered through use of a curriculum, which is based on social cognitive theory and developed specifically for African American adolescent mothers.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

Each CAMI session lasts about 1 hour and includes the computer-based survey and the 20- to 30-minute motivational interview. In addition, participants receive biweekly or monthly home-based parent training and case management services to help the participants address issues related to housing or childcare, for example. The 16-module curriculum, designed specifically for African American adolescent mothers, draws on social cognitive theory and covers topics such as child development and discipline. The home visits are initiated prenatally at about 32 weeks gestation.

STAFFING

Counselors are African American paraprofessional women residing in the same communities as participants.

PROGRAM MATERIALS AND RESOURCES

Laptop computers loaded with the CAMI software are required to deliver the intervention. In addition, CAMI counselors are required to video or audio record sessions that are then reviewed by the motivational interviewing consultant.

ADDITIONAL NEEDS FOR IMPLEMENTATION

Staff should have knowledge and training in motivational interviewing and knowledge of adolescent health issues, contraceptive methods, and condom use.

FIDELITY

During preservice training, each counselor is videoed delivering a session. The interview is assessed using the Motivational Interviewing Process Code, and the counselors are required to achieve a level of motivational interviewing proficiency. CAMI counselors complete service delivery forms to document completion of contacts, content of contact, and contact time and location. No fidelity standards information is available.

TRAINING AND STAFF SUPPORT

Counselors receive up to 2½ days of training on the Transtheoretical Stages of Change model, motivational interviewing, and the protocols.

Training materials are included in a program replication kit that is available through Sociometric Corporation's Program Archive on Sexuality, Health, and Adolescence , a collection of replication kits for implementing programs designed to reduce teenage pregnancy, HIV/AIDS, and other sexually transmitted infections in adolescents.

Technical assistance is not available.

ALLOWABLE ADAPTATIONS

Another arm of this intervention was developed, CAMI, which did not include home visitations.

IV. REVIEWED STUDIES

Barnet B., Liu, J., DeVoe M., Duggan A. K., Gold M. A., & Pecukonis E. (2009). Motivational Intervention to Reduce Rapid Subsequent Births to Adolescent Mothers: A Community-based Randomized Trial. *Annals of Family Medicine*, *7*(5): 436-445.

NURSE-FAMILY PARTNERSHIP

I. PROGRAM OVERVIEW

DEVELOPER(S)

Nurse-Family Partnership National Service Office

PROGRAM SUMMARY

The Nurse-Family Partnership (NFP) is designed for first-time, low-income mothers and their children. It includes one-on-one home visits by a trained registered professional nurse to participating clients. The visits begin early in the woman's pregnancy (with program enrollment no later than the 28th week of gestation) and conclude when the woman's child turns 2 years old. NFP is designed to improve (1) prenatal and maternal health and birth outcomes, (2) child health and development, and (3) families' economic self-sufficiency and/or maternal life course development.

TARGET POPULATION

NFP is designed for first-time, low-income mothers and their children. Mothers may invite fathers and other family members to participate in home visits. NFP requires a client to be enrolled in the program early in her pregnancy and to receive a first home visit no later than the end of the woman's 28th week of pregnancy. Services are available until the child is 2 years old.

PROGRAM SETTING

Home-based.

Contact and Availability Information

Nurse-Family Partnership National Service Office
1900 Grant Street, Suite 400
Denver, CO 80203
Phone: (866) 864-5226
Fax: (303) 327-4260
Email: info@nursefamilypartnership.org
Website: www.nursefamilypartnership.org

Sample of curriculum available for review prior to purchase: Yes

Adaptation guidelines or kit available: No

Languages available: NFP materials are available in English and Spanish. Additionally, in service areas with high concentrations of immigrants, local agencies offer services, curricula, and materials in other languages and may employ interpreters.

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

NFP is designed to (1) improve prenatal and maternal health and birth outcomes, (2) improve child health and development, and (3) improve families' economic self-sufficiency and/or maternal life course development.

PROGRAM CONTENT

Nurse home visitors provide the NFP intervention through the nursing process, clinical assessment, and individualized goal setting with the client. Nurses use visit-to-visit guidelines to support clients' goals and meet the individual needs of families.

PROGRAM METHODS

The NFP model includes one-on-one home visits between a registered nurse educated in the NFP model and the client.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

NFP nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. After the child's birth, client need determines the visit schedule. Clients are assessed using the Strength and Risk Framework at enrollment, after the child's birth, and regularly throughout the program. The results determine the visit schedule and where the visits will be held, the client's home or another location. Visits may increase or decrease depending on the client's strengths, risks, and identified need. Home visits typically last 60 to 75 minutes. NFP National Service Office (NSO) recommends that programs begin conducting visits early in the second trimester (14–16 weeks gestation) and requires programs to begin visits by the end of the 28th week of pregnancy. Clients graduate from the program when the child turns 2 years old.

STAFFING

Four staffing positions must be in place at implementing agencies: (1) nurse home visitors who conduct home visits with families, (2) nursing supervisors who supervise nurse home visitors, (3) an administrative assistant who manages data entry and other administrative tasks, and (4) other administrative staff whom agencies deem necessary to facilitate NFP implementation with fidelity.

PROGRAM MATERIALS AND RESOURCES

NFP NSO provides reference materials (including handbooks, home visit guidelines, online documents, and CD/DVDs) to nurse home visitors and supervisors attending training sessions. Required forms are incorporated into the data collection system.

ADDITIONAL NEEDS FOR IMPLEMENTATION

NFP NSO requires implementing agencies to use a web-based data system to enter data, including staff and client characteristics, maternal and child health information, and home visit documentation. Implementing agencies receive reports through a web-based business intelligence portal.

FIDELITY

NFP NSO monitors data entered into the data collection system to ensure that the program is meeting fidelity benchmarks. The NFP NSO reports data to agencies to assess and guide model implementation; agencies may download these reports at any time and use them to monitor implementation trends. Nurse consultants also monitor program performance and provide support for quality improvement, as needed, to meet fidelity benchmarks. Nurse consultants establish an annual plan for integrating trends and suggest improvements in operational efficiency, clinical processes, and quality improvement.

TRAINING AND STAFF SUPPORT

NFP NSO requires that nurse home visitors complete three core education sessions, in both distance and in-person training formats. The sessions take place over a 9-month time frame. Nursing supervisors must complete the same core education

sessions as the nurse home visitors. Additionally, they must complete four introductory education sessions designed for supervisors, including two in-person sessions. Supervisors are provided with topical, web-based team meeting modules to use based on the training needs of their nursing teams. Additionally, the NFP NSO nurse consultant guides supervisors with creating professional development plans for each nurse home visitor, and to utilize the expertise of other professionals in their communities to meet unique team learning needs. Agencies and supervisors also have access to reports that facilitate program monitoring and support quality improvement. Training materials are available through NFP NSO and are provided to attendees during introductory education sessions.

ALLOWABLE ADAPTATIONS

Dr. David Olds at the Prevention Research Center at the University of Colorado [(303) 724-2893] oversees adaptations and requests for enhancements to the model.

IV. REVIEWED STUDIES

Eckenrode, J., Campa, M., Luckey, D. W., Henderson, C. R., Cole, R., Kitzman, H., et al. (2010). Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial. *Archives of Pediatrics & Adolescent Medicine*, 164(1), 9–15.

Eckenrode, J., Zielinski, D., Smith, E., Marcynyszyn, L. A., Henderson, C. R., Kitzman, H., et al. (2001). Child maltreatment and the early onset of problem behaviors: Can a program of nurse home visitation break the link? *Development and Psychopathology, 13*(4), 873–890.

Hanks, C., Luckey, D., Knudtson, M., Kitzman, H., Anson, E., Arcoleo, K., & Olds, D. (2011). *Neighborhood context and the Nurse-Family Partnership.* Unpublished report submitted to the U.S. Department of Justice.

Hicks, D., Larson, C., Nelson, C., Olds, D. L., & Johnston, E. (2008). The influence of collaboration on program outcomes: The Colorado Nurse-Family Partnership*. Evaluation Review*, *32*(5), 453–477.

Holland, M. L., Christensen, J. J., Shone, L. P., Kearney, M. H., & Kitzman, H. J. (2014). Women's reasons for attrition from a nurse home visiting program. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *43*(1), 61–70.

Holmberg, J. R., & Olds, D. L. (2015). Father attendance in nurse home visitation. *Infant Mental Health Journal*, *36*(1), 128–139.

Holmberg, J., Luckey, D., & Olds, D. (2011). *Teacher data for the Denver Year-9 follow-up*. Unpublished report submitted to the U.S. Department of Justice.

Ingoldsby, E., Baca, P., McClatchey, M., Luckey, D., Ramsey, M., Loch, J., et al.(2013). Quasi-experimental pilot study of intervention to increase participant retention and completed home visits in the Nurse-Family Partnership. *Prevention Science*, *14*(6), 525–534.

Jacob-Files, E., Rdesinski, R., Storey, M., Gipson, T., Cohen, D. J., Olds, D., & Melnick, A. (2014). Should home-based contraceptive dispensing become a routine part of public health nurse practice? Review of nurse perceptions*. Public Health Nursing, 32*(6), 702–710.

Kitzman, H., Olds, D. L., Sidora, K., Henderson, C. R., Hanks, C., Cole, R., et al. (2000). Enduring effects of nurse home visitation on maternal life course: A 3-year follow-up of a randomized trial. *Journal of the American Medical Association*, *283*(15), 1983–1989.

Kitzman, H. J. A., Cole, R. A., Yoos, H. L. A., & Olds, D. A. (1997). Challenges experienced by home visitors: A qualitative study of program implementation. *Journal of Community Psychology*, *25*(1), 95.

Kitzman, H. J., Olds, D. L., Cole, R. E., Hanks, C. A., Anson, E. A., Arcoleo, K. J., et al.(2010). Enduring effects of prenatal and infancy home visiting by nurses on children: Follow-up of a randomized trial among children at age 12 years. *Archives of Pediatrics & Adolescent Medicine*, *164*(5), 412–418.

Kitzman, H., Olds, D. L., Henderson, C. R., Hanks, C., Cole, R., Tatelbaum, R., et al. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. A randomized controlled trial. *Journal of the American Medical Association*, *278*(8), 644–652.

Korfmacher, J., Kitzman, H., & Olds, D. (1998). Intervention processes as predictors of outcomes in a preventive home-visitation program. *Journal of Community Psychology*, *26*(1), 49–64.

Nguyen, J. D., Carson, M. L., Parris, K. M., & Place, P. (2003). A comparison pilot study of public health field nursing home visitation program interventions for pregnant Hispanic adolescents. *Public Health Nursing*, *20*(5), 412. doi:10.1046/j.1525-1446.2003.20509.x.

O'Brien, R., Moritz, P., Luckey, D., McClatchey, M., Ingoldsby, E., & Olds, D. (2012). Mixed methods analysis of participant attrition in the nurse-family partnership. *Prevention Science*, *13*(3), 219–228.

Olds, D. L. (2002). Prenatal and infancy home visiting by nurses: From randomized trials to community replication. *Prevention Science*, *3*(3), 153–172.

Olds, D. L. (2008). Preventing child maltreatment and crime with prenatal and infancy support of parents: The Nurse-Family Partnership. *Journal of Scandinavian Studies in Criminology and Crime Prevention*, 9(Suppl1), 2–24.

Olds, D. L., Henderson, C. R., Kitzman, H., & Cole, R. (1995). Effects of prenatal and infancy nurse home visitation on surveillance of child maltreatment. *Pediatrics*, *95*(3), 365–372.

Olds, D. L., & Korfmacher, J. (1998). Maternal psychological characteristics as influences on home visitation contact. *Journal of Community Psychology*, *26*(1), 23–36.

Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association*, *278*(8), 637–643.

Olds, D. L., Henderson Jr., C. R., Chamberlin, R., & Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, *78*, 65–78.

Olds, D. L., Henderson, C. R., & Kitzman, H. (1994). Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25 to 50 months of life? *Pediatrics*, *93*(1), 89–98.

Olds, D. L., Henderson, C. R., Cole, R., Eckenrode, J., Kitzman, H., Luckey, D., et al. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized controlled trial. *Journal of the American Medical Association*, *280*(14), 1238–1244.

Olds, D. L., Henderson, Jr., C. R., Tatelbaum, R., & Chamberlin, R. (1988). Improving the lifecourse development of socially disadvantaged parents: A randomized trial of nurse home visitation. *American Journal of Public Health*, *78*, 1436–1445.

Olds, D. L., Hill, P. L., O'Brien, R., Racine, D., & Moritz, P. (2003). Taking preventive intervention to scale: The Nurse-Family Partnership. *Cognitive and Behavioral Practice*, *10*(4), 278–290.

Olds, D. L., Holmberg, J. R., Donelan-McCall, N., Luckey, D. W., Knudtson, M. D., & Robinson, J. (2014). Effects of home visits by paraprofessionals and by nurses on children follow-up of a randomized trial at ages 6 and 9 years. *JAMA Pediatrics*, *168*(2), 114–121.

Olds, D. L., Ingoldsby, E. M., Luckey, D. W., Knudtson, M. D., & Loch, J. M. (2015). Cluster randomized controlled trial of intervention to increase participant retention and completed home visits in the Nurse-Family Partnership. *Prevention Science*, *16*(6), 778–788.

Olds, D. L., Kitzman, H. J., Cole, R. E., Hanks, C. A., Arcoleo, K. J., Anson, E. A., et al. (2010). Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending: Follow-up of a randomized trial among children at age 12 years. *Archives of Pediatrics & Adolescent Medicine*, *164*(5), 419–424

Olds, D. L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., et al. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. *Pediatrics*, *114*(6), 1550–1559

Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., et al. (2007). Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial. *Pediatrics*, *120*(4), e832–e845.

Olds, D. L., Kitzman, H., Knudtson, M. D., Anson, E., Smith, J. A., & Cole, R. (2014). Effect of home visiting by nurses on maternal and child mortality: Results of a 2-decade follow-up of a randomized clinical trial. *JAMA Pediatrics*, *168*(9), 800–806.

Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., et al. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics*, *110*(3), 486.

Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., et al. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics*, 114(6), 1560–1568.

Sidora-Arcoleo, K., Anson, E., Lorber, M., Cole, R., Olds, D., & Kitzman, H. (2010). Differential effects of a nurse home-visiting intervention on physically aggressive behavior in children. *Journal of Pediatric Nursing*, *25*(1), 35–45.

Stavrakos, J. C., Summerville, G., & Johnson, L. E. (2009). Growing what works: Lessons learned from Pennsylvania's Nurse-Family Partnership Initiative. Philadelphia: P/PV.

Zeanah, P. D., Larrieu, J. A., Boris, N. W., & Nagle, G. A. (2006). Nurse home visiting: Perspectives from nurses. *Infant Mental Health Journal*, *27*(1), 41–54.

TEEN OPTIONS TO PREVENT PREGNANCY (T.O.P.P.)

I. PROGRAM OVERVIEW

DEVELOPER(S)

OhioHealth Community Health and Wellness

PROGRAM SUMMARY

The Teen Options to Prevent Rapid Repeat Pregnancy program provides motivational interviewing, contraceptive access, and social service support over an 18-month period to help at-risk teen mothers develop and adhere to a birth control plan and to prevent rapid repeat pregnancies. The program is delivered by trained nurse educators through home and telephone-based care coordination.

TARGET POPULATION

The program is designed for and was evaluated with females between 10 and 19 years old who are pregnant (at least 28 weeks into their pregnancy) or have just given birth (up to 8 weeks postpartum).

PROGRAM SETTING

Home- and telephone-based.

Contact and Availability Information

Robyn Lutz
Project Director
Phone: 614-566-9085

Sample of curriculum available for review prior to purchase: Yes

Adaptation guidelines or kit available: Yes

Languages available: English

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

T.O.P.P.'s goal is to reduce rapid repeat teen pregnancies and promote healthy birth spacing through home and telephone-based care coordination that encompasses motivational interviewing and access to family planning and other supportive services.

PROGRAM CONTENT

The core component of the T.O.P.P. model is motivational interviewing. The premise of this model is that contraceptive behavior can be changed by empowering a young woman to make her own informed choices about birth control and pregnancy and providing her easy access to birth control. Motivational interviewing is an individualized, client-driven, collaborative form of communication designed to promote individual change. The model encompasses the following:

- Motivational interviewing: 18 monthly one-on-one home and telephone motivational interviewing sessions with a nurse educator focusing on birth spacing and preventing repeat pregnancy, birth control methods and misconceptions about the methods, and future planning for achieving birth control and spacing goals.
- Access to contraception: T.O.P.P. improves access to contraception by offering access to a T.O.P.P. clinic, transportation services, and/or in-person discussion about and distribution of contraceptives.
- Assessment and referrals by a social worker: T.O.P.P. provides participants with access to a social worker who, based on initial psychosocial assessments and case management, can refer participants to services. The theory behind these service referrals is that addressing other barriers that teen mothers may face, such as poverty, trauma, and homelessness, will ultimately help them adhere to a birth control regimen. These components are designed to increase participants' consistent use of contraception, which, in turn, will lead to the program's desired goals of promoting healthy birth spacing and reducing rapid repeat teen births.

PROGRAM METHODS

T.O.P.P. provides monthly home and telephone-based coordinated care supplemented with access to contraceptive services during individual, in-person visits with the teen mothers. During the nurse educators' contacts with participants, they use motivational interviewing, to educate clients about family planning and the value of preventing rapid repeat pregnancies. Educators strive to gently guide the conversation in a manner that educates participants about the health benefits of delaying subsequent pregnancy, provides medically accurate information on various birth control methods (including abstinence), addresses any misconceptions inhibiting contraceptive use, and helps the teens develop a birth control plan.

Follow-up telephone calls provide an opportunity to provide further information on contraceptives, help participants identify and schedule appointments with their OB/GYN or other medical provider, debrief about the participants' appointments, and problem-solve barriers to consistent and continued birth control use. The calls also provide a forum for the educators to address supportive service needs participants may face and refer them to the T.O.P.P. social worker for additional support, as needed.

Participants may also access birth control through the T.O.P.P. clinic if they cannot get into their clinic or medical home. Nurses also provide in-home Depo-Provera shots.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

T.O.P.P. expects that nurse educators will conduct monthly telephone calls with participants over a period of 18 months. Frequency of calls may be greater during the initial program period, and there is no minimum or maximum length for each call. To facilitate initial and continued contraceptive use, the nurse educators make follow-up telephone calls and are also encouraged to conduct home or other in-person visits, if possible, at least one per participant during their time in the program. Ideally, such a visit would be conducted within the first few months after a client's enrollment in T.O.P.P.

STAFFING

T.O.P.P. should be delivered by nurse educators with training in motivational interviewing, obstetrics, gynecology, or maternal and child health. Staff are expected to also be trained in educating clients on the characteristics of different contraceptive options.

PROGRAM MATERIALS AND RESOURCES

The developer has a program tool kit available for purchase. The tool kit includes a program overview, the T.O.P.P. logic model, a chapter on the pedagogy and enabling factors, information on curriculum and program components (including worksheets and patient screening tools), and fidelity guidelines.

ADDITIONAL NEEDS FOR IMPLEMENTATION

Additional in-person training may be needed on motivational interviewing, obstetrics, gynecology, maternal and child health, and/or contraceptive options.

FIDELITY

The T.O.P.P. program relies on ongoing staff training, expert telephone call reviews, and the use of monitoring tools to maximize fidelity to motivational interviewing methods. The T.O.P.P. logic model may be obtained by contacting the developer. Fidelity benchmarks and monitoring tools in the program tool kit available for purchase.

TRAINING AND STAFF SUPPORT

Staff delivering T.O.P.P. are required to attend an initial 2-day training retreat focused on motivational interviewing techniques, led by a motivational interviewing expert consultant. Staff also need training regarding the provision of efficacy-based contraceptive counseling.

After the initial training, staff should meet weekly with the training expert during the first program year and continue to do so every other week if research is being conducted. The ongoing technical assistance sessions offer ongoing training, review recent motivational interviewing interactions, and discuss the quality of those interactions. The sessions also provide an opportunity to discuss ways to handle the challenges staff face in conducting motivational interviewing.

ALLOWABLE ADAPTATIONS

The program's toolkit (available for purchase) lists specific activities that are required for fidelity to the T.O.P.P. model, and those that are optional.

IV. REVIEWED STUDIES

Smith, K., et al. (2015). *Interim Impacts of the Teen Options to Prevent Pregnancy Program*. Princeton, NJ: Mathematica Policy Research.

Rotz, D., Luca, D. L., Goesling, B., Cook, E., Murphy, K., & Stevens, J. (July 2016). *Final Impacts of the Teen Options to Prevent Pregnancy Program*. Cambridge, MA: Mathematica Policy Research.

EARLY HEAD START

I. PROGRAM OVERVIEW

DEVELOPER(S)

Office of Head Start in the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS).

PROGRAM SUMMARY

Early Head Start programs provide family-centered services for low-income families with very young children, up to age 3. These programs are designed to promote the development of the children, and to enable their parents to fulfill their roles as parents and to move toward self-sufficiency. Early Head Start programs provide similar services as preschool Head Start programs, but they are tailored for the unique needs of infants and toddlers. Early Head Start programs promote the physical, cognitive, social, and emotional development of infants and toddlers through safe and developmentally enriching caregiving. This prepares these children for continued growth and development and eventual success in school and life.

TARGET POPULATION

Low-income pregnant women and families with children from birth to age 3 years.

PROGRAM SETTING

Home- or center-based services, a combination of home- and center-based programs, and family childcare services (services provided in family childcare homes).

Contact and Availability Information

Administration for Children and Families
Office of Head Start (OHS)
Mary E. Switzer Building
330 C Street, SW, 4th Floor
Washington, DC 20201
Websites:
Office of Head Start
www.acf.hhs.gov/programs/ohs/

Head Start ECLKC
https://eclkc.ohs.acf.hhs.gov/

Sample of curriculum available for review prior to purchase:
Yes

Adaptation guidelines or kit available: None available—If a program chooses to substantially modify a curriculum to better meet the needs of one or more specific populations, the program must (1) partner with early childhood education curriculum or content experts, and (2) assess if the adaptation adequately facilitates progress toward school readiness goals.

Languages available:
Because programs select their own research-based early childhood home visiting curriculum, they can select materials in the languages appropriate for the families they serve. All Early Head Start-Home-Based Option programs are required, through the Head Start Program Performance Standards, to work with families in their primary, or preferred language, whatever language that may be.

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

Head Start/Early Head Start programs establish program and school readiness goals. Program goals support the program's mission to serve children, families, and the community; and they may include goals related to parent, family, and community engagement; finances; service provision; and so forth. School readiness goals are a subset of overall program goals and focus on child development and early learning outcomes in the five essential domains.

PROGRAM CONTENT

Head Start and Early Head Start programs are aligned with the Head Start Early Learning Outcomes Framework: Ages Birth to Five. A research-based curriculum, it is content-rich, providing broad and varied experiences and activities that promote children's learning and development. It invites children to think deeply about what interests them and builds on their prior knowledge and experiences. It also offers a sequence of learning experiences based on children's developmental progressions.

PROGRAM METHODS

Early Head Start programs provide family-centered services for low-income families with very young children to promote the development of the children, and to enable the parents to fulfill their roles as parents and move toward self-sufficiency. Programs may be center-based, home-based, or a combination of the two.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

A program must choose to operate one or more of the following program options: center-based, home-based, family childcare, or an ACF approved locally designed variation. A program that would like to implement a locally designed variation must submit a waiver and request for approval to their HHS official. The program option(s) chosen must meet the needs of children and families based on the community assessment. In center-based programs, trained teachers provide up to 20 hours of childcare and other services each week. In home-based programs, home visitors visit participants weekly. Services are available from pregnancy through the child's third birthday.

STAFFING

Staffing includes directors, fiscal officers, family services managers and staff, health services managers and health managers, education managers, disabilities managers, center-based infant and toddler teachers, center-based preschool teachers, center-based preschool assistant teachers, family childcare providers, child development specialists, home visitors, and coaches. The educational requirements for all positions related to Head Start programs can be found here.

PROGRAM MATERIALS AND RESOURCES

Curriculum materials to support implementation include resources to help education staff understand how to use it (i.e., what to do and how). The materials might also include resources to help education managers and coaches support education staff to effectively implement the curriculum. Curriculum materials vary across curricula and may include: manuals for education managers and staff to support understanding of the curriculum's approach, guiding principles, and teaching materials; guides for education staff to support curriculum implementation, such as lesson plans that describe how to implement specific learning experiences and how to individualize for all children (e.g., dual or tribal language learners); tools that help assess the fidelity of implementation; reflection or self-assessment materials for education managers, coaches, and staff; coaching and other individualized training resources to guide curriculum implementation. An example of the scope and sequence of curriculums can be found here. An example of an Early Head Start program can be found here.

ADDITIONAL NEEDS FOR IMPLEMENTATION

Other considerations for implementation include: safe and effective teaching and learning environments, effective teaching practices, developmentally appropriate learning environments, materials and space for learning, and promoting learning through approaches to rest, meals, routines, and physical activity.

FIDELITY

According to the Head Start Program Performance Standards, Early Head Start–Home-Based Option programs must establish and implement procedures for the ongoing monitoring of their own operations, as well as those of each of their delegate agencies. At least once every program year, Early Head Start–Home-Based Option programs must conduct a self-assessment of their effectiveness and progress in meeting program goals and objectives and in implementing federal regulations. Early Head Start–Home-Based Option programs are monitored for compliance with the performance standards by a team of external consultants according to a schedule based on the program's 5-year funding cycle. The review teams use a monitoring protocol developed by the Office of Head Start to review programs. Other program options are required to maintain implementation fidelity via: program differentiation, program adherence, and quality of program delivery. These three aspects can be observed through the extent to which programs are exhibiting global and individual lesson or activity fidelity. Global fidelity illustrates how consistently a program implements their curriculum over time. Observations for global fidelity must occur three to six times a school year. Individual lesson fidelity measures the fidelity of the individual lessons or activities during the school year. Fidelity can be supported with checklists or protocols; however, it is also important that all teams implement fidelity reviews into their processes.

TRAINING AND STAFF SUPPORT

Standardized training procedures include initial and ongoing training to support education staff as they learn to implement a curriculum with fidelity (i.e., as it was designed to be used). Standardized training procedures provide consistent content (e.g., curriculum approach and guiding principles) and delivery methods (e.g., training length, in-person or virtual) across training sessions. Standardized training procedures vary across curricula and may include: in-person training offered by the curriculum developers, those qualified to train on behalf of the developer, or in-person trainings prescribed by the developer; and training materials to be used by education managers and coaches, such as training scripts, presentations, webinars, and online modules

ALLOWABLE ADAPTATIONS

Adaptations can be made to materials and/or curriculum if they are needed to meet the needs or specific populations; however, these adaptations must be properly assessed and consistent with compliance and effectiveness processes.

IV. REVIEWED STUDIES

Love, J. M., et al. (2001). *Building Their Futures: How EHS Programs Are Enhancing the Lives of Infants and Toddlers in Low-Income Families. Volume I: Technical Report*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation.

Love, J. M., et al. (2002). *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start. Volumes I-III: Final Technical Report [and] Appendixes [and] Local Contributions to Understanding the Programs and Their Impacts*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation.

Vogel, C. A., Y. Xue, E. M. Moiduddin, E. E. Kisker, & B. L. Carlson. (2010). *Early Head Start Children in Grade 5: Long-Term Follow-Up of the Early Head Start Research and Evaluation Study Sample*. OPRE report no. 2011-8. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation.

EARLY INTERVENTION PROGRAM FOR ADOLESCENT MOTHERS

I. PROGRAM OVERVIEW

DEVELOPER(S)

Researchers at the University of California at Los Angeles School of Nursing.

PROGRAM SUMMARY

The Early Intervention Program (EIP) is designed to help young mothers gain social competence and achieve program objectives by teaching self-management skills, techniques for coping with stress and depression, and skills to communicate effectively with partners, family, peers, and social agencies. The program targets pregnant Latina and African American adolescents who are referred to the county health department or another health services agency for nursing care. EIP includes 17 home visits from mid-pregnancy through the child's first year of life. During home visits, public health nurses use a variety of teaching methods to cover five main content areas: (1) health, (2) sexuality and family planning, (3) maternal role, (4) life skills, and (5) social support systems.

TARGET POPULATION

EIP targets pregnant adolescents from underserved minority groups who are referred to the county health department or another health services agency for nursing care. Women are eligible for EIP if they are 14 to 19 years old; at 26 weeks gestation or less; pregnant with their first child; and planning to keep the infant. Expectant mothers who are chemically dependent or have serious medical or obstetric problems are ineligible. Although EIP initially targeted adolescents, young mothers out of adolescence also may benefit from the program.

PROGRAM SETTING

Home-based.

Contact and Availability Information

Deborah Koniak-Griffin, EdD, RNC, FAAN
University of California at Los Angeles, School of Nursing
Box 956919
Los Angeles, CA 90095
Phone: (310) 206-3842
Email: dkoniak@sonnet.ucla.edu

Inese Verzemnieks, Ph.D., RN
University of California at Los Angeles, School of Nursing
5-637 Factor Building
700 Tiverton Avenue
Los Angeles, CA 90095-6919
Phone: (310) 206-9165
Email: iverzemn@sonnet.ucla.edu

Sample of curriculum available for review prior to purchase: Yes

Adaptation guidelines or kit available: No

Languages available: Available in English only.

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

During home visits, nurse home visitors cover five main content areas: health, sexuality and family planning, maternal role, life skills, and social support.

PROGRAM CONTENT

Nurse home visitors implement all aspects of the model using standardized protocols to ensure uniformity. The EIP protocols are organized based on the nursing process and cover each of five content areas: health, sexuality and family planning, maternal role, life skills, and social support. Examples of worksheets used to facilitate learning and behavior change include "Psychological Aspects of Appetite and Food," "Danger Signals During Pregnancy," "Prenatal Rest, Exercise, and Activity," and "I Want to Change." Another worksheet (called "What Do I Do?") is used when the mother needs help solving a problem. Protocols incorporate several teaching techniques, such as examining educational and vocational goals and options, completing problem-solving worksheets, letter writing, and reviewing individualized videotaped instruction and feedback (videotherapy). In addition, nurse home visitors role-model infant caretaking methods from the Neonatal Behavioral Scale for mothers, who then demonstrate the methods for their nurse home visitors and continue to practice after the visits using an assessment form called the Mother's Assessment of the Behavior of Infant.

PROGRAM METHODS

Prenatal visits focus on use of prenatal health care, preparation for childbirth, and self-care during pregnancy. In addition, nurse home visitors conduct four classes focusing on the transition to motherhood, fetal development, parent-child communication, and maternal health. During the postpartum visits, nurse home visitors provide mothers with information on family planning; infant care and development; well-baby health care; education attainment; substance use; mental health issues, such as handling emotions; and referrals for mental health counseling, family planning, and childcare. For example, EIP addresses the prevention of sexually transmitted diseases (such as HIV/AIDs), contraceptive options, school readiness preparations (such as reading to children), and prevention of lead poisoning. Nurse home visitors also help mothers improve communication skills and learn how to assess their infants' needs, respond to infant distress, and interact reciprocally with their infants. To help mothers improve their infant interaction and nurturing skills, nurse home visitors use videotherapy, in which they videotape a mother interacting with her infant and subsequently soliciting the mother's opinion about the quality of the interaction.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

EIP includes home visits from mid-pregnancy through the end of the child's first year. The program includes 17 home visits—two prenatal and 15 postpartum—each lasting 1.5 to 2.0 hours. Postnatal visits occur when the child is 1, 4, and 6 weeks old and at monthly intervals between the child's 2nd and 12th months. In addition, EIP offers four "preparation for motherhood" classes.

STAFFING

Public health nurses from local health departments or nurses from other health service agencies conduct home visits and classes. A supervisor guides and monitors their implementation. In the initial demonstration of EIP, nurse home visitors were employed by the county health department and contracted by the university to deliver EIP services, and the program also employed recruiters.

PROGRAM MATERIALS AND RESOURCES

Protocols contained within standardized manuals guide implementation of EIP.

ADDITIONAL NEEDS FOR IMPLEMENTATION

EIP uses multiple tools to assess maternal and infant well-being and screen for potential risks.

FIDELITY

Fidelity of EIP is documented using prenatal and postpartum forms in which nurse home visitors record the components of care they provide. In addition, an on-site supervisor must be present to guide and monitor their implementation of study protocols. Monitoring by the model developers is also highly recommended.

TRAINING AND STAFF SUPPORT

EIP requires on-site staff training from the model developer and director. No information is available on the current length of preservice training. For the demonstration, preservice training for nurse home visitors was approximately 60 hours. EIP developers train nurse home visitors to use a standardized manual with protocols to guide implementation of prenatal and postpartum services. The EIP model developer and director are available to provide training.

ALLOWABLE ADAPTATIONS

No information available.

IV. REVIEWED STUDIES

Koniak-Griffin, D., Anderson, N. L., Brecht, M. L., Verzemnieks, I., Lesser, J., & Kim, S. (2002). Public health nursing care for adolescent mothers: Impact on infant health and selected maternal outcomes at 1 year postbirth. *Journal of Adolescent Health*, *30*(1), 44–54.

Koniak-Griffin, D., Mathenge, C., Anderson, N. L., & Verzemnieks, I. (1999). An early intervention program for adolescent mothers: A nursing demonstration project. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *28*(1), 51–59.

Koniak-Griffin, D., Verzemnieks, I. L., Anderson, N. L., Brecht, M. L., Lesser, J., Kim, S., et al. (2003). Nurse visitation for adolescent mothers: Two-year infant health and maternal outcomes. *Nursing Research*, *52*(2), 127–136.

Koniak-Griffin, D., Anderson, N. L., Verzemnieks, I., & Brecht, M. L. (2000). A public health nursing early intervention program for adolescent mothers: Outcomes from pregnancy through 6 weeks postpartum. *Nursing Research*, *49*(3), 130–138.

HEALTHY FAMILIES AMERICA

I. PROGRAM OVERVIEW

DEVELOPER(S)

Prevent Child Abuse America (PCA America).

PROGRAM SUMMARY

Healthy Families America's (HFA) goals include reducing child maltreatment, improving parent-child interactions and children's social-emotional well-being, and promoting children's school readiness. Local HFA sites select the target population they plan to serve and offer hour-long home visits at least weekly until children are 6 months old, with the possibility of less frequent visits thereafter. Visits begin prenatally or within the first 3 months after a child's birth and continue until children are between 3 and 5 years old. In addition, many HFA sites offer parent support groups and father involvement programs. Sites also can develop activities to meet the needs of their specific communities and target populations.

TARGET POPULATION

HFA is designed for parents facing challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or previous issues related to substance abuse, mental health issues, and/or domestic violence.

PROGRAM SETTING

HFA sites are implemented by many different types of public and private agencies, including public health, mental health, education, child welfare agencies, Federally Qualified Health Centers, community-based nonprofit health and human service agencies, and stand-alone entities.

Contact and Availability Information

Healthy Families America
National Office Prevent Child Abuse America
228 S. Wabash, 10th Floor
Chicago, IL 60604
Phone: (312) 663-3520
Fax: (312) 939-8962
Email:
mailbox@preventchildabuse.org
Website:
www.healthyfamiliesamerica.org

Sample of curriculum available for review prior to purchase: N/A

Adaptation guidelines or kit available: Yes

Languages available: HFA sites can select a curriculum that is available in the languages spoken by its target population. Many sites implement curricula that are available in English and Spanish

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

HFA aims to (1) reduce child maltreatment; (2) improve parent-child interactions and children's social-emotional well-being; (3) increase school readiness; (4) promote child physical health and development; (5) promote positive parenting; (6) promote family self-sufficiency; (7) increase access to primary care medical services and community services; and (8) decrease child injuries and emergency department use.

PROGRAM CONTENT

The HFA National Office does not require sites to use a specific curriculum; however, it does require that sites use an evidence-informed curriculum with (1) participant/family materials and (2) a facilitator's manual with specific guidelines for delivering the curriculum and a focus on anticipatory guidance. The curriculum should address the HFA goals related to cultivating, strengthening, and nurturing parent-child relationships; promoting healthy childhood growth and development; and enhancing family functioning by reducing risk and building protective factors.

PROGRAM METHODS

HFA includes (1) screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences; (2) home visiting services; and (3) routine screening and assessment of parent-child interactions, child development, and maternal depression. In addition, many HFA sites offer services such as parent support groups and father involvement programs. HFA encourages local sites to implement additional services such as these that further address the specific needs of their communities and target populations.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

HFA sites offer at least one home visit per week for the first 6 months after the child's birth. After the first 6 months, visits might be less frequent. Visit frequency is based on families' needs and progress over time. Typically, home visits last 1 hour. HFA sites begin to provide services prenatally or at birth and continue through the first 3 to 5 years of the child's life. Each local site determines—usually based on available funding—if services will be extended beyond 3 years.

STAFFING

HFA has four primary staff positions: (1) family support staff who conduct home visits with families; (2) family resource staff who conduct family and child assessments and sometimes screen families for enrollment in the program; (3) supervisors who provide administrative, clinical, and reflective supervision to family support and family resource staff; and (4) program managers who oversee program operations, funding, quality assurance, and evaluation.

PROGRAM MATERIALS AND RESOURCES

The *Healthy Families America Site Development Guide* (rev. 2014) is a guidebook that provides information for sites on planning, developing, and implementing an HFA site. The HFA Best Practice Standards (rev. 2017) offer specific guidelines on HFA model implementation. The HFA National Office provides sample service delivery forms.

ADDITIONAL NEEDS FOR IMPLEMENTATION

The HFA National Office recommends that affiliated sites use an appropriately designed data system to manage and report the participant services they provide; site, community, and staff characteristics; funding sources; agency collaborations; and preliminary outcomes information. The HFA National Office requires sites to report aggregate information on family characteristics, services, and outcomes in the web-based HFA site tracker system, which is free to affiliated sites.

FIDELITY

To validate adherence to the HFA model, sites must comply with accreditation requirements, which involves conducting a site self-assessment; undergoing a peer-review site visit that is conducted by at least two external, nationally trained peer reviewers; and meeting a minimum 85% threshold of adherence to the HFA Best Practice Standards (rev. 2017).

TRAINING AND STAFF SUPPORT

HFA core training is a mandatory 4-day seminar delivered by nationally certified HFA trainers. Supervisors and program managers attend a fifth day focused on administrative, clinical, and reflective supervision. The training (1) prepares program staff to provide services specific to their job responsibilities; (2) integrates strategies for use with families with unresolved trauma; and (3) describes the HFA critical elements and the best practices of family-centered and strength-based service provision. The HFA National Office requires that direct service staff, supervisors, and program managers receive this training within the first 6 months of employment. Program managers are also required to participate in a 3-day in-person HFA implementation training focused on how to implement the HFA model with fidelity. The HFA National Office requires sites to provide orientation training that includes information about the challenges faced by the community's families, the local resources available to support those families, and staff safety and confidentiality.

Affiliated sites are offered more than 38 hours of distance learning modules and/or recorded webinars that meet all of the mandatory training requirements within 3, 6, and 12 months of hire. Training materials are available through the HFA National Office. Nationally certified HFA trainers provide the HFA core training. Additionally, HFA supports the development of in-state training capacity and offers a train-the-trainer process. National and state trainers are required to be recertified every 5 years. Training is coordinated through the HFA National Office, except in states with in-state training capacity, and is made available both locally and regionally. Technical assistance is available from the HFA National Office by implementation specialists via phone, email, and on-site (when requested).

ALLOWABLE ADAPTATIONS

HFA sites may implement enhancements to the model, as long as those enhancements do not compromise the site's fidelity to the model as established in the HFA Best Practice Standards (rev. 2017). For example, some sites have included clinical staff to address substance abuse and depression. Any adaptations or proposed changes that compromise the site's fidelity to the HFA model require a formal adaptation request, and any approval of such are the sole discretion of the HFA National Office and PCA America.

IV. REVIEWED STUDIES

Jacobs, F., Easterbrooks, M.A., Goldberg, J., Mistry, J., Bumgarner, V., Raskin, M., et al. (2016)."Improving Adolescent Parenting: Results from a Randomized Controlled Trial of a Home Visiting Program for Young Families. *American Journal of Public Health 106*(2), 342–349.

Ownbey, M., Ownbey, J., and Cullen, J. (2011). The Effects of a Healthy Families Home Visitation Program on Rapid and Teen Repeat Births. *Child and Adolescent Social Work Journal, 28*(6), 439–458.

NEW HEIGHTS

I. PROGRAM OVERVIEW

DEVELOPER(S)

The program was initiated at Anacostia High School and Cardozo High School in Washington, DC. With federal funding, the original program supported staff at each school who primarily helped parenting students complete Temporary Assistance for Needy Families–related paperwork. Over time, the program transition to new leadership in the District of Columbia Public School central office and evolved in both scope and structure.

PROGRAM SUMMARY

The New Heights Program is a school-based service delivery program that supports expectant and parenting District of Columbia Public School students (young dads and young moms). The program focuses on supporting the academic, physical, and socioemotional needs of its participants through case management services, educational workshops, advocacy, academic support, and program incentives.

TARGET POPULATION

Expectant and parenting high school students.

PROGRAM SETTING

School-based.

Contact and Availability Information

Adia Burns, MSW
Manager, New Heights Program
Office of Equity
District of Columbia Public Schools
1200 First Street, NE, 11th Floor
Washington, DC 20002
Phone: (202) 442-5040
E-mail: adia.burns@k12.dc.gov

Sample of curriculum available for review prior to purchase: No

Adaptation guidelines or kit available: No

Languages available: English

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

New Heights seeks to improve attendance, increase graduation rates, improve/maintain the health of these students and their children, prevent subsequent pregnancies, and prepare students for higher education or joining the workforce.

PROGRAM CONTENT

New Heights' key feature is placing a dedicated staff person, a coordinator, in every school. They lead program delivery in each school, delivering the program's multiple components tailored to the needs of their students. Each coordinator serves as a free resource for their school, assessing the academic and personal needs of participating students and helping them identify concrete strategies and achievable goals to meet those needs.

PROGRAM METHODS

Coordinators are responsible for integrating four main components into the regular school day: (1) advocacy, (2) targeted school-based case management, (3) weekly educational workshops, and (4) incentives. Taken together, these components aim to help expectant and parenting students identify their strengths to overcome barriers, become self-sufficient, and achieve educational success.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

Core components are as follows:

- Advocacy – coordinators educate school staff and empower expectant and parenting students to ensure that they receive the necessary accommodations to attend and complete school.
- Case Management – the program includes one-on-one targeted and tailored support to help students meet their academic goals. Coordinators monitor and promote academic progress and help students manage logistical and personal challenges to ensure that they can attend school daily.
- Educational Workshops – held at least three times per week, lunchtime workshops provide supplemental education on relevant topics, such as parenting skills, career and financial planning, prenatal care, early childhood development, and healthy relationships.
- Baby Bonus Bucks – a system of in-kind incentives that students can earn when they meet personal goals and use toward purchasing items, such as maternity and baby supplies. These incentives are designed to improve attendance, grades, and class participation.

Program activities, such as the workshops and one-on-one meetings with coordinators, are voluntary and expected to occur before, between, or after regular classes, such as during lunch period or when students have free time during the school day.

STAFFING

The coordinators are trained staff employed by the district who operate primarily out of a dedicated office or classroom space in each school. Coordinators must be collaborative, experienced, skilled, and possess a can-do spirit. Experience in social work or counseling is helpful.

PROGRAM MATERIALS AND RESOURCES

Coordinators receive a toolbox consisting of extensive training, ongoing professional development, guidance manuals, and a system of supports.

ADDITIONAL NEEDS FOR IMPLEMENTATION

The program also serves as the point of contact with community partners and public services, facilitating the exchange of information and access to resources, such as transportation support and childcare.

FIDELITY

No information available.

TRAINING AND STAFF SUPPORT

Coordinators receive ongoing monitoring and one-on-one feedback from the program manager.

ALLOWABLE ADAPTATIONS

No information available.

IV. REVIEWED STUDIES

Asheer, S., Burkander, P., Deke, J., Worthington, J., and Zief, S. (2017). *Raising the Bar: Impacts and Implementation of the New Heights Program for Expectant and Parenting Teens in Washington, DC. Washington, DC: U.S. Department of Health and Human Services, Office of Adolescent Health.*

TAKING CHARGE

I. PROGRAM OVERVIEW

DEVELOPER(S)

Mary Beth Harris, Ph.D., adjunct associate professor at University of Southern California Suzanne Dworak-Peck School of Social Work and Cynthia Franklin, Ph.D., Stiernberg/Spencer Family Professor in Mental Health and associate dean for doctoral education in the Steve Hicks School of Social Work, University of Texas at Austin.

PROGRAM SUMMARY

The Taking Charge curriculum is a solution-focused, cognitive-behavioral brief group intervention designed to help pregnant and parenting female students stay in school. School achievement and subsequent graduation are believed to be the first steps for adolescent mothers toward establishing lives of self-sufficiency. The primary goals of Taking Charge are school achievement through increased attendance, improved grades, and positive life outcomes. The program curriculum was designed within a developmental and strengths-based framework, so school professionals can intervene with young mothers and enhance their social problem-solving skills and active coping strategies that will enable them to manage the challenges they encounter across four critical life domains: education, personal relationships, parenting, and employment/career.

TARGET POPULATION

Pregnant and parenting women ages 15-19 years old.

PROGRAM SETTING

Public Schools, alternative schools, and other school-based settings.

Contact and Availability Information

Cynthia Franklin, Ph.D., LCSW
Stiernberg/Spencer Family
Professor in Mental Health
University of Texas at Austin
School of Social Work
1 University Station D3500
Austin, Texas 78712
Phone: 512-471-0533
Fax: 512-471-9600
Email: cfranklin@mail.utexas.edu

Sample of curriculum available for review prior to purchase: Yes

Adaptation guidelines or kit available: No

Languages available: English

II. PROGRAM COMPONENTS

PROGRAM OBJECTIVES

- To increase the adolescent mother's use of problem-focused coping strategies, while decreasing her use of avoidance or passive adaptation to deal with problems across the four critical life domains of education, parenting, personal relationships, and employment/career.

- To increase the competent use of social problem-solving skills across the four critical life domains of education, parenting personal relationships, and employment/career.
- To increase an adolescent mother's school achievement through improved grades and attendance. School achieve ment and subsequent graduation is believed to be adolescent mothers' first step toward establishing a life of self-sufficiency.

PROGRAM CONTENT

The Taking Charge group curriculum is a multimodal, brief, cognitive, behavioral curriculum. This manualized intervention was developed within a developmental and strengths-based, solution-focused framework, utilizing the strengths and resources, and life goals and developmental tasks of adolescent mothers.

PROGRAM METHODS

Group sessions are structured to follow a similar format throughout. The following describes activities for the three segments of each session.

First 25 minutes: While participants are eating lunch or snack, leaders engage the group in a discussion. Topics of discussion vary from session to session but may include the problem-solving process, the particular goal domain for the session, or participant experiences with tasks between sessions.

*Next 30 to 40 minutes***:** With the exception of the first two sessions, the group remains together or divides into two groups designated by the leaders. During this time participants work the problem-solving process, beginning with identifying their goal and ending with two specific tasks that they plan to perform before the next session.

Final 10 to 15 minutes: Leaders respond to concerns and questions, present points-earned reports, summarize the session, and identify topics and activities for the next session. At two sessions (three sessions in a 12-session intervention) small incentive gifts are presented during this time.

III. IMPLEMENTATION REQUIREMENTS AND GUIDANCE

PROGRAM STRUCTURE AND TIMELINE

The curriculum includes a group meeting once a week for 8 weeks, with each session lasting 60 to 90 minutes. The group session format has three segments. The first segment involves a group discussion led by the group leader on various topics, including participants' personal experiences with tasks completed between sessions. During the second segment, participants work through the five-step problem-solving process in which they identify their goals and carry out specific tasks toward each goal before the next group meeting. The third segment includes any questions or concerns participants may have for the group leader, and a summarization of the session.

Incentives are built into the curriculum to motivate participants to fully engage in the group activities and individual tasks. The primary incentive is a point system. Compliments and positive feedback from group leaders and members are also used. Points can be earned each week by attending school, attending group sessions, completing tasks, and finishing school homework. Points are accrued throughout the 8 weeks of group sessions toward an award in the end. Awards vary according to available resources but may include gift certificates, small gifts such as movie passes, and participation in an off-campus field trip.

STAFFING

Group leaders should designate as Leader One or Leader Two for the purpose of following treatment manual instructions. Treatment manual directions assume that Leader One is on the school staff or is someone who has day-to-day contact with group participants. Leader Two is assumed to be a former adolescent mother, a community agency staff member, a student intern, or a volunteer.

PROGRAM MATERIALS AND RESOURCES

Manual: Harris, M.B. & Franklin, C. (2007). *Taking Charge: A life skills group curriculum for adolescent mothers*. New York: Oxford University Press.

ADDITIONAL NEEDS FOR IMPLEMENTATION

The incentives used in the program cost $200–$300.

FIDELITY

No information is available.

TRAINING AND STAFF SUPPORT

Training is available from the program developers.

ALLOWABLE ADAPTATIONS

Although Taking Charge has only been studied as an 8-week group intervention, feedback from participants and leaders suggests a 12-week intervention may be effective, even desirable. The group can be extended easily to 12 sessions by allowing 2 weeks rather than one, for each goal domain. Sessions one, two, 11, and 12 of a 12-week group are identical to those of an 8-week group. Sessions where goals and tasks are identified and performed are given 2 weeks for each goal area, rather than one.

IV. REVIEWED STUDIES

Harris, M. B. & Franklin, C. G. (2003). Effects of a cognitive-behavioral, school-based, group intervention with Mexican American pregnant and parenting adolescents. *Social Work Research*, 27*(2)*, 71–83.

Harris, M. B. & Franklin, C. G. (2009). Helping adolescent mothers to achieve in school: An evaluation of the Taking Charge group intervention. *Children & Schools*, 31*(1)*, 27–34.

APPENDIX A

CENTERINGPREGNANCY PLUS HIV PREVENTION

CenteringPregnancy Plus HIV Prevention was tested by Yale researchers during 2001-2006 as an intervention that combined the existing CenteringPregnancy model with HIV prevention materials. Through randomized, controlled trials, it was shown to have favorable outcomes among young moms. The Centering Healthcare Institute opted not to incorporate the HIV prevention component into the program. Yale University, creators of the HIV component, does not offer any training on those materials, though they are available online.

CenteringPregnancy, offered through the Centering Healthcare Institute, has changed significantly since the Yale University research was conducted, and the original HIV prevention materials would not correspond with the CenteringPregnancy programs at this time. While CenteringPregnancy is not specific for teens, many locations that have adapted it to work with this population. Additional information about CenteringPregnancy can be found here.

LEARNING, EARNING, AND PARENTING PROGRAM

The Leaning, Earning, and Parenting (LEAP) program is a mandatory program in the state of Ohio pursuant to Ohio Revised Code 5101:1-23-50**. The LEAP program** promotes school attendance in pregnant and parenting teens (under age 20) on welfare. The design was intended to improve academic outcomes for participants to eventually produce improved employment outcomes and consequent reductions in welfare dependence. LEAP provides a financial incentive for teens to enroll in school or a GED program, as well as a financial incentive for every month in which they stayed in school. Additionally, LEAP provides a case manager for each participant and, if approved by that case manager, the program also provides childcare and transportation assistance.

The following are reviewed studies of this program:

- Bloom, D., Fellerath, V., Long, D., & Wood, R. G. (1993). *LEAP: Interim findings on a welfare initiative to improve school attendance among teenage parents.* New York, NY: Manpower Demonstration Research Corporation.
- Long, D., Gueron, J. M., Wood, R. G., Fisher, R., & Fellerath, V. (1996). *LEAP: Three-year impacts of Ohio's welfare initiative to improve school attendance among teenage parents.* New York, NY: Manpower Demonstration Research Corporation.
- Bos, J. M., & Fellerath, V. (1997). *LEAP: Final report on Ohio's welfare initiative to improve school attendance among teenage parents.* New York, NY: Manpower Demonstration Research Corporation.

PATHWAYS TEEN MOTHER SUPPORT PROJECT

Funded by the Center for Substance Abuse Prevention, Pathways Teen Mother Support Project was a randomized field trial of a comprehensive, community-based intervention for pregnant and parenting teens with a family income at or below 175% of the federal poverty level living in a four-county area of South Carolina. The programs objectives included: (1) reduce drug, alcohol, and tobacco use; (2) reduce repeat pregnancy and increase family planning; (3) improved academic and work-related achievement; and (4) increased indicators of well-being for the teen mother (e.g., parenting, problem solving, and self-control; perceived social support; sense of meaning and purpose; self-efficacy). The program involved individualized case management, home visits, small groups, and family group decision making. Materials and information for hierarchical case management, family group decision making, life skills training, microenterprise training, and other program elements are available at no cost upon request, as well as additional information. Contact program developer James R. McDonell, MSW, Ph.D. at jmcdnll@clemson.edu.

This publication was supported by Award No. HHSP233201500036I from the Office of Population Affairs (OPA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.