

The conceptual standards of the Family Support Program reflect a combination of two kinds of programs offered at the Sandoval County Health Commons: prevention and short term interventions in a variety of areas.

Programs at the FSP remain consistent with the literature regarding the definitions of primary, secondary, and tertiary prevention.

**Primary Prevention** targets the general population and offers services and activities before any signs of undesired behaviors may be present; no screening occurs.

**Secondary Prevention** is directed at those who are “at risk” for harmful health behaviors. Secondary prevention efforts are provided before harmful health behaviors occur.

**Tertiary Prevention** is provided after negative health behaviors have occurred, to reduce the impact of negative health behaviors and to avoid future harm. Tertiary prevention is treatment, working with families after harmful health behaviors have already occurred.

## Conceptual Standards

### Family Centered

*Premise #1: Children and families exist as part of an ecological system.*

A central premise of the FSP is that forces within and outside the family shape human development. Since individuals are embedded in a family system, FSP services are always family centered rather than individually centered (Dunst, 1995; Hess, McGowen and Bostko, 2000). Indeed, reviews of effective approaches have indicated that child only, child centered, or parent centered approaches are not nearly as effective as family focused prevention (Kumpfer and Alvarado, 1998, National Institute on Drug Abuse, 1999). Family refers to the adults and other family members most intimately involved in raising the child, not just a conventional constellation of two, natural parents.

Many of the programs offered at the health commons target young families. The FSP recognizes that strengthening the relationships between caregivers and children is the most effective and longest lasting intervention for helping young children. In ‘The Irreducible Needs of Children’ Brazelton and Greenspan, (2000) state that the first of seven irreducible needs for a young child is for **ongoing nurturing relationships**. Every baby needs a warm, intimate relationship with a primary caregiver over a period of years, not months or weeks. This is far more important to emotional and intellectual development than early cognitive training or educational games. If this relationship is absent or interrupted, a child can develop an array of physical problems like childhood obesity and disorders of reasoning, as well as emotional disorders including lack of motivation and attachment behaviors. Infants, toddlers and preschoolers need these nurturing interactions most of their waking hours.

Many services at the FSP are guided by several principles that are rooted in the current research by Brazelton and Greenspan, Strouf and others on the importance of relationships in early childhood development:

- An intervention with a parent on behalf of an infant is effective.
- The quality of the relationship between parent and infant is the single most important variable that will affect the infant's developmental outcome in a variety of domains.
- Services delivered through the parent are more effective and have greater impact than services delivered directly to the infant.
- The relationship that staff builds with the parent is the vehicle for having an impact on the relationship between the parent and the infant.

As a result of these interventions, parents have a much better understanding of their child's behavior, development, and non-verbal cues; they are able to respond appropriately to their child's needs, and they feel a greater sense of competence and satisfaction in their role as parents. In addition, parents become aware of their own issues and behaviors that impede their ability to respond to their child's emotional needs. A combination of education, developmental guidance, psychotherapy and emotional support is used.

Importantly, family focused does not mean that all programs at the health commons target the whole family. Rather, it means that at all prevention programs offered through FSP involve parents and family members at some level.

### **Community Based**

*Premise #2: FSP programs are embedded in their community and contribute to the community-building process.*

Since the cornerstone of the FSP to focus on the entire family in the context of its culture and community, the FSP places a strong emphasis on the delivery of community based, preventative, and comprehensive services, rather than fragmented and problem-specific crisis intervention.

With respect to early intervention, the FSP promotes practices that simultaneously address the interplay between cognitive, social, emotional, and physical issues and it focuses special attention on children on families experiencing cumulative and multiple stressors. The FSP has also placed special emphasis on providing prevention services to lower income families for a number of reasons.

Prevention services offered at the health commons are also community based in order to access the formal and informal supports needed by the family (Weisbourd and Weiss, 1992). FSP programs respond to the needs of local populations, enabling the community to have a genuine sense of ownership.

## **Culturally Sensitive and Culturally Competent**

*Premise #3: The FSP strives to affirm and strengthen families' cultural, racial and linguistic identities and seeks to enhance their ability to function in a multicultural society.*

Whereas cultural sensitivity is an awareness of and tolerance of diversity, cultural competence goes further. Competency is knowledge about the culture that is used to assist participants in programs. It is showing respect for customs and practices, utilizing unique roles of family members and gaining the acceptance of the leaders within the cultural group.

The FSP acknowledges that increasing access to a variety of health services is crucial in a rural county with a complex mixture of ethnic and cultural elements.

Sandoval County has a rich mixture of rural communities, including several Native American groups, Hispanic people who have lived here for generations, and more recent immigrants including both Anglos and Mexicans. A recent article in *Zero to Three* highlights some of the challenges to increasing access and utilization to maternal and infant mental health services in New Mexico:

The region's strong political and social culture has developed over decades of interaction among these groups and with various government entities. Some of the current difficulty in delivering infant mental health services stems from centuries-old disagreements and distrust among groups. It was not long ago that Native American children were taken from their homes and forced to give up their language and culture, and Hispanic children were punished for speaking their native tongue. Although resentment toward outsiders is a common feature in rural areas, an especially potent residue from generations of distrust lingers here. All of these factors make reaching out to rural areas especially challenging.<sup>1</sup>

In addition to a general culture of distrust especially among Native American and Hispanic populations, demanding travel, unreliable telephone communication, and high rates of drug and alcohol abuse, domestic violence, and teenage pregnancy hamper our population's access of health services.

Indeed, one of the major leanings of the Family Support Program in its first year of operation has been that co-locating several services with a strong, integrated infrastructure is not sufficient in increasing the numbers of families accessing health services.

In part, developing a sense of trust and cultural competency is critical to engage more families in these types of services.

To address the complex cultural and ethnic issues identified above, Sandoval County in conjunction with WIC has developed a strong Community Health Worker Program

---

<sup>1</sup> "Rural Revisited: A Decade and a Half of Practice," Deborah Harris. *Zero to Three*, Vol. 26 NO. 4.

designed to improve access to maternal and infant mental health services with hard to reach families.

As discussed earlier, research and practice show that community health workers have been instrumental in a wide range of activities to improve access to care. Sandoval County community health workers (CHWs) reach out to members of their own neighborhoods, as well as bring community members into the health commons. They have increased Medicaid enrollments substantially at the Health Commons, gathered data essential for changing policy, and initiated services for communities based upon diverse and changing needs.

In the context of WIC and other infant and maternal services offered at the Health Commons, CHWs continuously identify needs often unrecognized by professional staff members because they initiate important relationships with families and provide preventative care and link individuals to health care venues that would otherwise be lost. Our experience and research indicates that legal and undocumented immigrants often delay seeking health services altogether for fear of being deported or being designated as a “public cost.” Sandoval County CHWs work to ensure that community members are not afraid of getting needed services by acting as trusted messengers who clarify immigrant’s rights to health benefits.

CHWs have played a powerful role in breaking down cultural divides that often exist between mental health and early childhood providers and communities of color. They act as linguistic and cultural interpreters and are a vital component of increasing utilization of services. In particular, CHWs have played a prominent role in explaining the benefits of mental health services to populations that are afraid and distrustful of discussing social/emotional issues with outsiders. In this sense, CHW’s have built vital relationships between community providers and the community members. By placing CHW’s at the Health Commons, the FSP has been able to integrate CHW’s with other clinical staff, which has proven to be an effective strategy for reaching a largely rural and culturally distrustful population.

CHW’s will continue to provide these vital linkages through this project. They will continue to increase service access by hosting consumer groups, by providing a range of screenings related to infant and maternal mental health, by co-facilitating playgroups and parenting workshops, and by providing intensive case management services for high risk families. All of these activities create the potential for CHW’s to promote awareness about maternal and infant mental and to educate providers about cultural norms, so that they can better relate to their clients and deliver more appropriate care.

### **Early Start**

*Premise #4: The FSP works with families before negative health behaviors occur.*

The FSP places special focus on working with caregivers and parents before negative patterns develop and produce unwanted or poor outcomes. Research indicates that when

programs and services reach parents early, children benefit. MacLeod and Nelson (2000) found a strong indication that gains made through proactive interventions with families were better sustained and even increased over time. Effective early interventions positively influence the long term parent child relationship and prevent such problems as low birth weight, child abuse and neglect, cognitive impairment, and other problems that prevent children from developing optimally.

From Neurons to Neighborhoods: The Science of Early Childhood Development (2000) published by the National Research Council and Institute of Medicine of the National Academies provides the following conclusions, all heavily grounded in and strongly supported by science (evidence-based).

- The traditional “nature versus nurture” debate is simplistic and scientifically obsolete.
- Early experiences clearly influence brain development, but a disproportionate focus on “birth to three” begins too late and ends too soon.
- Early intervention programs can improve the odds for vulnerable young children, but those that work are rarely simple, inexpensive, or easy to implement

Consequently, the FSP asserts that it is imperative to begin working with families at the time of the birth of their first child (Guteman, 1997, Kumpfer and Alvarado, 1998). Some FSP programs even begin parentally because pregnancy is generally a time when many women are eager to learn about effective infant and toddler care and parenting.

### **Developmentally Appropriate**

*Premise #5: The developmental processes that make up parenthood and family life create needs that are unique at each stage in the life span.*

Understanding stages and developmental tasks is crucial to effectively responding to the needs of participants. There are developmental considerations for all participants, be the children, parents, teens, other family members, or caregivers. Child development refers to the ages and stages a child goes through physically, emotionally, socially, and intellectually. For instance, parenting is a developmental process wherein the parents’ skills and abilities change over time. And families go through various stages. Changes parents and families experience are related to the age and developmental stages of children, the transitions that families experience, and an individuals’ aging process. Thus, all prevention work at the FSP includes information about human development and skill building in human development for teens, parents and caregivers are essential elements of the FSP.

### **Empowerment and Strength Based Approaches**

*Premise #6: Enabling families to build on their own strengths and capacities promotes healthy behaviors.*

All persons have strengths. The FSP empowers participants by identifying and building on their capabilities and competencies. The FSP seeks to create opportunities for

competencies to be learned or displayed, taking advantage of resources and supports already utilized by the family. It builds on the positive functioning of participants rather than labeling the family as “broken” and “needing to be fixed.” The model is premised upon participants and families becoming less dependent on professionals. The FSP measures success based upon participant’s increased sense of self-efficacy. All programs place a heavy emphasis on utilizing motivational interviewing techniques to assess for a family’s readiness to make behavioral changes and to help families move along the change continuum.

The FSP also places special emphasis on being relationship-focused with participants. FSP prevention programs pay special attention to how we establish our relationships with participants. According to Kelly and Zuckerman, participant-provider relationships give participants the opportunity for felt empathy and felt security. Such relationships are often built over time and the intent is to enter into the world of the participant, to gain an understanding of their circumstances and experiences, and to get a picture of their world.

Staff members are encouraged to listen, observe, reflect, and instruct. A relationship based framework asks staff members to step down from their roles as experts and the role of identifying a problem and prescribing to the participant how to fix it is moved to the background. Instead, our focus is on supporting and assisting participants in our role as caregivers. When the staff member is removed from the role of the expert, participants are able to build on their own competencies and abilities to nurture their children and make positive behavioral changes.

Some of the basic elements to forming mutuality in staff-participant relationships include: recognizing and respecting unique characteristics, responding sensitively, showing empathy, and using repair within the encounter if going in the wrong direction.

The emotional connection between a staff member and participant is similar to the connection that Pawl suggested in developing a meaningful connection with a child: “When a child is held in mind, the child feels it, and knows it. There is a sense of safety, of containment, and, most important, existence in that other, which has always seemed to me vital...it seems to me that one of life’s greatest privileges is just that—being held in someone’s mind” (Pawl, 1995).

Hirshberg described the essential process of engaging with parents in ways that let the parent know that we will engage in the same act of connection, offering to hold the parents and the baby in our own mind as fully and completely possible. He further comments that while it is easy for providers to get caught up in all “the technical procedures and paperwork, the diagnostic and developmental considerations and complications, and the frantic scheduling and juggling of times and needs” it is easy to lose sight of the purpose—to create a safe space for families to share their stories, to listen carefully and thoughtfully, and to connect with families emotionally (Kelly and Zuckerman, 2003).