Improving Service Utilization in a Home Visitation Program: Use of Standardized Consultation Following Mental Health Screenings

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Introduction

- Intensive home visitation programs have shown promise for preventing child abuse and neglect while optimizing health and development (Ammerman et al., 2010).
- Home visitors (HV's) are often faced with situations such as caregiver mental health issues, substance abuse, and domestic violence (Tandon et al., 2008) that make it difficult to provide services to families.
- Further, HVs often work with families living in poverty and with children at risk for neglect, abuse, health problems and disabilities. Despite these challenges, little research has been conducted exploring HV self-efficacy in identifying and addressing these issues (Lamorey & Wilcox, 2005).
- The purpose of this study is to evaluate the effects of consultation in addressing two key areas: (a) increasing staff perceived self-efficacy in identifying and discussing risks to healthy child development (e.g., parental mental health issues, substance abuse, environmental concerns, and youth developmental, social, and behavioral concerns) with families, and (b) facilitating staff coordination of services to families in need.

Methods

Participants

- Participants were 10 Family Advocates at a Midwestern Early Head Start Home Based Program (EHS-HB).
- All participants were women, one participant identified as North African while others were European American. The majority of participants held a Bachelor's Degree. Participants ranged in age from 23 to 55 years (M = 34.1, SD = 9.9) and had been working for EHS for an average of 15 months at the project start date.

Measures

- Demographic Questionnaire. Participants provided information related to their gender, age, ethnicity, languages spoken and educational background as well as work-related information such as caseload size, years of service, and prior experience in social welfare or community organizations.
- Support Questionnaire. Designed for the current project, the support questionnaire asks family advocates to rate their perceived support in a variety of work-related areas on a Likert-style scale of 0 (*no support when needed*) to 10 (*always support when needed*).
- Interventionist Practice and Attitudes Scale (IPAS). Adapted from the Evidence-Based Practice Attitude Scale (EPBAS; Aarons, 2004), the EBPAS is a 15-item Likert-style scale designed to assess mental health practitioner attitudes toward adoption of evidence-based practices. Subscales of appeal, openness, requirements, and divergence have alphas of .59 to .90 while total score shows good reliability (alpha = .77). For the current project, higher scores indicate more desirable attitudes and practices.
- Early Interventionist Self-Efficacy Scale (EISES; Lamorey & Wilcox, 2005). The EISES is a 15-item Likert-style scale designed to measure self-efficacy of practitioners serving young children and their families. The EISES provides information related to personal intervention efficacy (alpha = .82) and general intervention efficacy (alpha = .60) as well as an overall self-efficacy score (alpha = .78). Higher scores indicate more self-efficacy.

Design

- Participants were randomly assigned to one of two groups for a 6-month period: Consultation as Usual (CAU) or Standardized Consultation (SC). The CAU group received written feedback on routine mental health screenings designed to assess for risk to healthy child development while the SC group was required to meet with consultants to discuss identified risk factors and develop plans for addressing these factors with families in addition to receiving written feedback.
- Participants in both groups completed the measures outlined above at pre-intervention and mid-point, except for the demographic questionnaire that was completed only at pre-intervention.
- Family service utilization was measured through electronic records indicating referral to services and family follow-through. Information related to identification of need for Child Protective Services (CPS) and receipt of CPS intervention was also recorded.

Intervention

- The University of Nebraska-Lincoln (UNL) Psychological Consultation Center (PCC) maintains an educational partnership with Early Head Start to provide mental health consultation to EHS-HB Family Advocates. A portion of this consultation involves review of routine (administered at initial enrollment and yearly thereafter) mental health screening reports, which include measures of parental depression and child social, emotional, and behavioral development.
- For participants in the SC group, UNL externs scheduled individual meetings to discuss screening results with Family Advocates. During these meetings, externs identified risk factors present for families, reviewed services available to address risk, explored strengths of the family and the family-family advocate relationship, identified barriers to working with families, and discussed plans for presenting results to families.

Table 1

Family Advocate Self-Efficacy as Early Interventionists, Perceived Support, and Attitudes toward Evidence-Based Practices

Measure	Standardized Consultation		Consultation As Usual	
	Baseline *M (SD)*	Mid-Point *M (SD)*	Baseline *M (SD)*	Mid-Point *M (SD)*
EISES				
Personal	48.7 (3.2)	49.5 (2.1)	49.5 (2.1)	51.2 (3.4)
General	22.0 (2.0)	22.0 (4.2)	25.2 (2.8)	25.2 (3.0)
Total	70.7 (5.1)	71.5 (6.4)	72.8 (4.6)	76.4 (4.5)
Support				
Administrative Tasks	7.5 (1.9)	8.33 (1.2)	8.4 (1.1)	8.6 (1.3)
Program Requirements	6.8 (1.7)	9.0 (1.0)	8.4 (1.1)	8.4 (2.3)
Lesson Plans	7.0 (2.8)	7.7 (2.3)	8.6 (1.5)	8.4 (1.5)
Family Safety	8.8 (1.3)	9.0 (0.0)	8.4 (1.9)	8.4 (1.1)
Child Development	9.0 (0.0)	9.0 (0.0)	8.8 (1.3)	8.6 (1.1)
Goals and Expectations	7.5 (1.9)	8.7 (0.6)	8.2 (2.2)	7.8 (1.9)
IPAS				
Appeal	10.6 (.9)	12.0 (1.4)	14.75 (1.9)	12.0 (2.8)
Openness	10.4 (1.8)	8.5 (2.1)	13.0 (1.8)	11.8 (2.9)
Requirements	7.8 (2.7)	7.5 (6.4)	11.3 (1.5)	8.6 (2.3)
Divergence	6.6 (1.1)	6.5 (.7)	5.0 (4.8)	4.8 (3.3)
Total	38.2 (3.3)	37.5 (6.4)	50.0 (9.1)	43.6 (9.0)

Note: EISES = Early Interventionist Self-Efficacy Scale; IPAS = Interventionist Practice and Attitudes Scales.

Table 2

Family Advocate Self-Initiated Consultations by Group

Variables	Standardized Consultation	Consultation As Usual	
	Total (Median)	*Total (Median)*	F
Number of Consults Initiated	2 (0)	11 (2)	5.98*
Minutes Spent In Consults	25 (0)	265 (30)	26.271**
	Total (%)	*Total (%)*	
Topics Addressed			
Behavioral Concerns	1 (50%)	3 (23.1%)	
Developmental Delay	0 (0%)	0 (0%)	
CHAT Concerns	0 (0%)	0 (0%)	
Elevated CES-D	0 (0%)	0 (0%)	
Parental Stress	0 (0%)	6 (46.2%)	
History of CPS Involvement	1 (50%)	1 (7.7%)	
Current CPS Involvement	1 (50%)	7 (53.8%)	
Caregiver Mental Illness	0 (0%)	7 (53.8%)	
Caregiver Substance Use/Abuse Issues	0 (0%)	1 (7.7%)	

Note: CHAT = Checklist for Autism; CES-D = Center for the Epidemiological Study of Depression Scale; CPS = Child Protective Services. * = $p < .05$; ** = $p < .01$.

Table 3

Family Outcomes Including Service Referral and Engagement and CPS Involvement at Mid-point

Variable	Standardized Consultation *n (%)*	Consultation As Usual *n (%)*
Risk Level		
Low	23 (57.5)	12 (33.3)
Moderate	15 (37.5)	19 (52.8)
High	2 (5.0)	4 (11.4)
Referred for Services	11 (27.5)	9 (25.0)
Engaged in Services	8 (20.0)	9 (25)
CPS Need Identified	2 (5.0)	7 (19.4)
CPS Intervention	2 (5.0)	7 (19.4)

Results

- Chi-square analyses and independent samples t-tests indicated no significant differences on ethnicity, languages spoken, education level, time working for EHS-HB, or age between groups.
- Means and standard deviations for assessment scores are listed in Table 1.
- Two-by-two ANOVA (Group x Time Point) revealed no significant differences between groups at pre-intervention or mid-point on the six perceived support items or EISES personal, general and total scales. Nor were there significant within group differences on these measures between time points.
- Participants in the CAU group had significantly more self-initiated consultations and spent significantly more time in self-initiated consultations compared to the SC group (Table 2).
- Table 3 provides information on family level outcomes. Independent samples t-test indicated that participants in the SC group had significantly more families identified as low risk compared to the CAU group, $F(73) = 1.984$, $p = .045$. In regard to number of referrals, family engagement in services referred, CPS need identified and CPS intervention received, the groups did not differ significantly.

Challenges Encountered

- During data collection, EHS-HB revised procedures to screen only at initial enrollment therefore eliminating yearly re-screens. This change drastically reduced the number of mental health screenings administered during the current project. Screenings only took place during enrollment at the start of the program year (August 17, 2012).
- While screenings are completed within 45 days of enrollment, office logistics prevented efficient coordination between Family Advocates and UNL externs, drawing out time between screen and report as well as report and consult. For the reasons stated above, only 5 standardized consultations for a total of 29 minutes were completed during the first three-months of the project.

Remaining Data Collection

- Post-intervention data will be collected in January 2013. These data will include the IPAS, EISES, and Support Questionnaire information as well as family level outcome data (e.g., referral, engagement, CPS need, and CPS intervention). Data regarding Family Advocate self-initiated consultation and standardized consultation data will be continually collected until the project end-date in January 2013.

Discussion

- As expected, groups did not differ significantly after random assignment on demographic or dependent variables.
- Interestingly, there were fewer self-initiated consultations for participants in the SC group. Although only 5 standardized consultations were completed, these consultations may decrease the need for self-initiated meetings.
- Contrary to hypotheses, participation in the standardized consultation group was not associated with higher self-efficacy or perceived support in the workplace. Groups also did not differ in service referrals, engagement, CPS needs identified or CPS intervention. This may be due to the limited number of standardized consultations completed.
- Given that groups did not differ on demographic variables, it is also not clear why those in CAU reported higher scores on openness and overall positive attitudes toward evidence-based practices.

Lessons Learned and Future Directions

- Although investigators gained approval from EHS-HB management, they were not made aware of pending changes to screening procedures. Future projects may include broad caseload consultation rather than consultation regarding mental health screening reports.
- Considering time lags in the transmission of paperwork as well as coordination of meetings with home visitors, researchers should allot for a longer intervention period (12-18 months rather than 6).
- Despite these limitations, researchers anticipate home visitor self-efficacy and family service engagement to increase as consultants continue to collaborate with family advocates in exploring families' needs and strengths.