Intervention Processes in a Head Start Home-Visitation Program: Treatment Challenges, Strategies, and Dissemination

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Background

Over the past four decades, a growing body of empirical literature has linked child maltreatment to myriad short- and long-term psychological and interpersonal problems (e.g., DiLillo, 2001; Kendall-Tackett et al., 1993). As early as the 1970s, recognition of these long-term adverse consequences and high prevalence rates prompted prevention research, and sparked the proliferation of home-visitation programs designed to prevent child abuse. Home-visitation programs provide regular contact and address a variety of issues such as the parent-child relationship, parenting skills, education on child development, parental psychological distress, and lack of social support (Asawa, Hansen, & Flood, 2008). Further, home-based programs seek to eliminate common barriers to services (e.g., lack of motivation, lack of health insurance, transportation difficulties; Thompson, 1995).

In the U.S., home-visitation programs are the most common early childhood intervention programs designed to prevent child maltreatment (Peddle et al., 2002), and home visitation was recommended by the U.S. Task Force on Community Preventive Services as an effective strategy for preventing child maltreatment (Hahn et al., 2003). Indeed, initial randomized trials of home-visitation effectiveness suggested positive impact in preventing child abuse as measured by decreased hospitalizations for injury (Gray et al., 1979) and fewer substantiated Child Protective Services (CPS) reports (Olds et al., 1986). However, while current in-home interventions, such as Lutzker's SafeCare program, have shown promise (Gershater-Molko et al., 2003), recent randomized trials of other nationally-recognized home-visitation prevention programs suggest that these programs are ineffective in preventing child maltreatment (e.g., Duggan et al., 2004; Landsverk et al., 2002).

Challenges

Overall, the mixed results in outcomes of these programs is likely due, at least in part, to the variety of challenges in implementing mental health services outside of traditional clinical settings (Table 1). This presentation summarizes challenges that practitioners face when conducting cognitive-behavior therapy with parents via Head Start home-based services. Challenges include gaining and maintaining access to families who are often referred by other parties, and motivating and engaging clients throughout the treatment process. There are also important contextual challenges to consider, such as helping clients distinguish mental health providers from other professionals who conduct in-home visits (e.g., family advocates), and limiting distractions that are common to a home setting (e.g., phone calls, child care).

An overarching challenge to the implementation of home-visitation programs is funding. With limited financial resources and access to transportation by families to attend mental health services within traditional clinical settings, practitioners may either seek reimbursement or burden the cost of transportation to provide in-home services. In addition, practitioners may also burden the cost for the use of assessment measures that need to be utilized in order to monitor progress. The goal of replicating a traditional clinical setting within a home environment, may present additional challenges. Through the Head Start program, other professionals (e.g., family advocates, nutritionists, nurses, and speech therapists) also routinely provide home-based services to these families. Thus, it is important to immediately establish a professional relationship with the family, which essentially defines how the role of a mental health provider is qualitatively different from other providers. In addition to providing therapy, the parent should be informed about the role of assessment throughout treatment. Furthermore, the family should have the option to complete assessment measures between sessions rather than during the home-visit. While clients in a traditional clinical setting may attend a session solely to complete paperwork, this is often not practical for practitioners attending a home-visit.

Contextual challenges to providing in-home services must also be carefully considered. While distractions are often minimized in traditional clinical settings, through policies such as no cellular phones in session or the availability of childcare, often these factors are present within the clients' home and need to be addressed. By emphasizing psycho-education about therapy in early sessions, the practitioner should convey the importance of minimizing distractions (e.g., television, radio, and phone calls). In addition, when necessary and feasible, the practitioner should arrange childcare in order to effectively conduct therapy with the parent. It may be helpful for the practitioner to schedule a home-visit with the family advocate, who may be able to provide childcare while meeting their own responsibilities. Given this option, it is imperative that client confidentiality is maintained (i.e., ensuring that the advocate remains in a separate room while therapy is provided to the parent). Further, while the presence of other family members may be minimized in traditional clinical settings, this may be a challenge that should be addressed early in treatment.

The practitioner may also face the challenge of monitoring and enforcing the length of session, particularly given the presence of distractions and the lack of a visible clock in the client's home. Lastly, a contextual factor that must not be overlooked is the safety of the practitioner. While traditional clinical settings may afford a greater sense of security and safety to the practitioner (e.g., presence of other providers and staff in the building, access to exits, and safety alarms), the practitioner must monitor and address any foreseeable safety concerns (e.g., attending sessions with an advocate or childcare provider, situating oneself closer to the exit, and access to phone). Finally, diversity issues should be considered which may present as challenges to some practitioners. While maintaining respectful cultural practices (e.g., accepting food/beverages, removing shoes in the home), and building rapport with the family, the practitioner must maintain a professional relationship with the client and convey appropriate boundaries and roles when necessary.

Table 1
Summary of Common Challenges for Home-Visitation Programs

- Funding (e.g., transportation, materials)
- Assessment
- Maintaining confidentiality
- Length of session
- Defining role as a practitioner
- Physical distractions (e.g., TV, phone, radio)
- Childcare
- Respecting cultural practices

Strategies for Overcoming Challenges

Some clients receive home-based services in response to their own request; other clients receive home-based services because of a third party referral. In the latter case, a mental health professional may find it necessary to enhance a client's motivation for change and encourage treatment engagement. This can be accomplished by tailoring treatment to a client's stage of change (Table 2).

Clients in an earlier stage of change may benefit from motivational interviewing (Miller & Rollnick, 1991, 2002). Encouraging an early-stage client to simply explore the pros and cons of their current situation provides a non-judgmental setting in which they can talk about what someone else sees as their problem. In addition, reflecting ambivalence may encourage an early-stage client to consider the pros and cons of change, which may enhance their motivation to change. By definition, clients in a later stage of change are ready to – or already trying to – change. These clients will respond better to interventions that facilitate their change process, rather than enhance their already-present motivation to change. In such cases, a mental health professional should consider more intense, action-oriented interventions.

There are other strategies for overcoming obstacles endemic to providing in-home services. First, the mental health professional may need to explain their role. This may involve drawing contrasts between the mental health professional role and the roles of other professionals who conduct in-home visits (e.g., family advocates). Second, in early sessions, it may be helpful to problem-solve with clients about ways to limit distractions (e.g., phone calls, child care). "Ground-rules" should be recorded and enforced in subsequent sessions. Finally, reviewing this information at the outset of each session may prevent obstacles from arising in future sessions.

Moreover, interventions may be more effective when incorporated into multilevel, ecological frameworks (e.g., Bronfenbrenner's Ecological Model, Figure 1) designed to address behavioral change not only in terms of individual experiences, but across family relationships, community environments, as well as cultural and societal norms. Turner and Sanders (2006) claim that the reduction of child maltreatment must be addressed within an ecological or systems-contextual framework, and current literature suggests that programs that address multiple risk factors across various levels of intervention (i.e., child factors, parent factors, immediate context, and broader context) achieve the most dramatic and enduring results (Asawa et al., 2008).

Figure 1. Bronfenbrenner's Ecological Model

Stages of Change

The five stages of change (Prochaska & DiClemente, 1982) are ordered categories along a continuum of readiness to change a particular behavior. The stage model characterizes change as a process that occurs over time, rather than a "now you have it now you don't" phenomenon. A client's stage of change is typically measured at the outset of therapy by the University of Rhode Island Change Assessment (URICA; McConnaughy, Prochaska, & Velicer, 1983), a 32-item self-report instrument. The intensity, duration, and type of intervention should be responsive to the client's stage of change (Prochaska, DiClemente, & Norcross, 1992).

Table 2 describes the stages of change, and gives suggestions for tailoring interventions to a client's readiness for change.

Table 2. Five Stages of Change & Implications for Therapy

Stage of Change	Characteristics	Approaches
1. Precontemplation	• Not presently considering change • Status quo is "good enough"	◦ Validate lack of readiness to make changes ◦ Empowerment – change is client's decision ◦ Explore current behavior's advantages & disadvantages ◦ Psychoeducation
2. Contemplation	• Ambivalent about making changes • Sees advantages and disadvantages to status quo *and* making changes	◦ Validate lack of readiness to make changes ◦ Empowerment – change is client's decision ◦ Reflect client's identification of advantages & disadvantages ◦ Elaborate on identified advantages & Disadvantages
3. Preparation	• Figuring out how to make changes • Predicting consequences of making changes	◦ Identify obstacles to making change ◦ Problem-solve obstacles ◦ Help client understand change as a series of small steps ◦ Validate client's motivation & ability to change ◦ Establish social support
4. Action	• Trying to change • Practicing new behaviors	◦ Reinforce success, normalize failure ◦ Emphasize client's self-efficacy ◦ Encourage client to draw on social support ◦ Focus on long term advantages of change
5. Maintenance	• Habituating to changes • "New behavior" not so new anymore	◦ Reinforce rewards of change ◦ Plan for long-term support (e.g., booster sessions) ◦ Relapse prevention plan ◦ Plan for coping with relapse

Future Directions

In order to bridge the gap between the stages of change and ecological framework literature, a pilot study is currently in preparation. The study will focus on the individual and microsystem levels of an ecological framework (i.e., individual, family) and tailor an empirically supported treatment (Parent-Child Interaction Therapy) to match each family's readiness to change. Motivational interviewing techniques will be used with families in earlier stages of change, and an more action-oriented interventions and booster sessions will be used with families in later stages of change.

In the initial session, the home-visitation client will complete the URICA to measure current stage of change. If assessment results indicate that the client is in the *precontemplation* stage, then the client's particular precontemplation pattern will be assessed, and appropriate strategies will be utilized (Table 2). Similarly, motivational interviewing techniques will be utilized for individuals in the *contemplation* stage of change. Home-visitation clients in the *preparation* stage will be gradually introduced to available intervention options. For the purposes of this study, individuals in the *action* stage will be invited to participate in a 12-session Parent-Child Interaction Therapy (PCIT). PCIT is an empirically-supported, short-term parent training program for children 2 to 7 years old. Previous research utilizing PCIT has demonstrated its effectiveness in improving parent-child relationships (Eyberg, Boggs, & Algina, 1995), decreasing child disruptive behaviors (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993), increasing child compliance with parental requests (Eyberg & Robinson, 1982), improving parenting skills (Eyberg, 1995), and reducing parent stress levels (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). Lastly, clients in the *maintenance* stage will be encouraged to maintain treatment gains through the use of periodic follow-ups and possible booster sessions.

The motivational factors that predict treatment success at the individual level can later be incorporated into a variety of broader early childhood intervention programs providing services across multiple settings (e.g., home-visitation, school-based programs, community clinics). Interventions such as community-based programs have the potential to achieve the most widespread impact on child maltreatment, but the progress is slow and costly (Daro & Donnelly, 2002). Matching interventions with the client's (or community-based group's) motivation level are likely to decrease attrition rates and costs of services. Individually-based programs (e.g., home and clinic settings) can be effective, but embedding these programs within a larger system would likely lead to pervasive and enduring changes in the prevention of child maltreatment.

Table 3. Five Stages of Change & Therapeutic Techniques

Stage of Change	Treatment Strategies
1. Precontemplation	***Reluctant Precontemplators*** – Those who, through lack of knowledge or inertia, do not want to consider change ❖ Careful listening and providing feedback in empathetic manner ***Rebellious Precontemplators*** – Great deal of knowledge about the problem but do not want to be told what to do ❖ Agreement with the client that no one can force them to change ❖ Providing a list of available options ❖ Encouraging small incremental changes ***Resigned Precontemplator*** – Those who lack energy and investment and have given up on the possibility of change ❖ Instilling hope and exploring barriers to change ❖ Reassure clients that relapse is common and not a failure ***Rationalizing Precontemplator*** – Those who appear to have all the answers to the problem. Believe that their behavior is the result of someone else's problem. ❖ Empathy and reflective listening ❖ Do not argue with these clients ❖ Double-sided reflections are useful
2. Contemplation	❖ Listen for change statements (including expressions of concern, problem recognition, optimism about change) ❖ Offer periodic summaries, using double-sided reflections ❖ Reflect and affirm self-motivational statements ❖ Be patient and persistent with the client while avoiding confrontation
3. Preparation	❖ Assess the level of strength of the client's commitment to change ❖ Gently introduce and creatively develop an effective plan for PCIT ❖ Continue to utilize careful listening and reflections
4. Action	❖ Implementation of a 12-session PCIT intervention ❖ Careful listening and affirmations ❖ Focus and praise successful participation
5. Maintenance	❖ Problem solve difficult situations that may occur in the future ❖ Follow-up contact to provide additional support ❖ Utilize "booster sessions" if necessary