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Brief motivational interviewing training for home visitors: Results for caregiver retention and referral engagement

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ABSTRACT

Many home visiting programs deliver evidence-based curricula to expectant or new parents to improve child and family outcomes, and home visitors need effective tools to keep families engaged and connected. This study investigated the use of Motivational Interviewing (MI) to keep families connected and engaged in home visiting programs. Using a pre-post training longitudinal design, we evaluated the effect of MI training on: a) knowledge and utilization of MI strategies, b) families completing referrals for community-based support services, and c) retention in home visiting services. Data from home visitors (n = 27) receiving MI training and the caregivers (n = 795) served were analyzed in the study. Training increased knowledge and use of MI strategies, increased completed caregiver referrals, and significantly improved caregiver retention in home visiting. Implications for practice are discussed.

1. Introduction

Home visiting programs often serve caregivers and families who are experiencing multiple maternal and child health risk factors (US Maternal and Child Health Bureau, 2015). Home visitors are not equipped to be all things to a family; that is, they are unlikely to also be trained mental health professionals, domestic violence advocates, and substance use disorder counselors. However, home visitors are uniquely positioned to work with caregivers to identify their needs and goals, develop a plan to meet these needs and reach goals, and provide support in reaching goals. Home visitors need additional tools to be able to meet complex needs of caregivers and their families and to empower caregivers to connect to other community-based services that may meet their needs. Motivational interviewing (MI) is one tool that can be used to support home visitors' collaborative practice with and strengthen caregivers' personal motivation to change or empower follow-through on decisions.

MI has been found to be effective in a variety of social service contexts, including mental health, social work, and psychology settings (Lundahl, Kunz, Brownell, Tellefson, & Burke, 2010). This study investigated the extent to which home visitors in Kansas learned and utilized MI strategies in their practice and the effect of MI training on caregiver receipt and completion of support service referrals, as well as caregiver retention in home visiting services. Retention is important because keeping families retained in evidence-based home visiting services may improve the likelihood of achieving the positive maternal and child outcomes targeted by these services.

1.1. The role of home visiting in improving maternal and child outcomes

Home visiting programs serve pregnant women and families with young children. Such programs are generally voluntary and geared toward preventing child abuse and neglect, supporting positive parenting, improving maternal and child health, and promoting child development and school readiness (Sama-Miller et al., 2016; US Maternal and Child Health Bureau, 2015). Trained professionals or para-professionals visit families and expectant parents in their homes, evaluate families' needs, and offer services and/or referrals to meet those needs. Services might include teaching parenting skills, promoting early learning in the home, providing health and safety information, and conducting screenings for postpartum depression, substance abuse, and/or family violence (US Maternal and Child Health Bureau, 2015). Research on early childhood interventions has found that a range of home visiting programs demonstrate improvements in children's cognitive abilities and achievement as well as behavioral and emotional skills (Karoly et al., 2005; Sama-Miller et al., 2016). Furthermore, families receiving home visiting services enjoy improved health and safety in the form of fewer emergency room visits, hospital stays,

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improved maternal and child health, increased positive parenting, and reduced risk of abuse, maltreatment, and parent arrests (Casillas et al., 2016; Karoly et al., 2005; Sama-Miller et al., 2016). A variety of evidence-based home visiting models are used in Kansas, including Early Head Start, Healthy Families America, Parents as Teachers, Nurse-Family Partnership, and Attachment and Biobehavioral Catch-up. Other services provided in the home setting for families with young children in Kansas include a promising approach program called the Team for Infants Exposed to Substance Abuse (TIES), a universal model offered as part of Title V Maternal and Child Health Services called Maternal and Child Health (MCH) Home Visiting, Infant Toddler Services (Part C, IDEA), and Family Preservation.

Although making referrals is a component of most evidence-based home visiting programs, the U.S. Department of Health and Human Services Administration for Children and Families' Home Visiting Evidence of Effectiveness (HomVEE) review found that the vast majority of home visiting models have not been studied for effectiveness in making linkages and referrals (Sama-Miller et al., 2016). Of the studies that have included some outcome around making referrals or otherwise connecting families with services, most have found that home visiting is associated with increased awareness or use of other community resources (Dodge et al., 2014; LeCroy and Krysick, 2011; Love et al., 2001; Love et al., 2002; Lowell et al., 2011; Olds et al., 1986; Silovsky et al., 2011).

Few studies have examined the factors that improve referral rates and engagement with services. Duggan et al. (2000) found large cross-site variation in linking families to needed community resources. Schwarz et al. (2012) found that families receiving home visiting were more likely to be referred to and receive early intervention services for children with developmental delays. Family engagement is thought to be critical to the success of a home visiting program. Korfmacher et al. (2008) note: “Logically, it makes sense that involvement would function as ‘dosage,’ with those who participate more and who are more highly engaged receiving a stronger ‘dose’ of the services offered by a program” (p. 190). Multiple studies support this general conclusion (Heinicke et al., 2000; Korfmacher et al., 1998; Lieberman, Weston, & Pawl, 1991; Olds et al., 1999; Ramey et al., 1992; Wagner, Spiker, Hernandez, Song, & Gerlach-Downie, 2001; Raikes et al., 2006). However, Korfmacher and colleagues note that this relationship must be interpreted with caution, as higher functioning families may be better able to engage, and/or appear more engaged to providers.

In turn, motivation is thought to be a key factor in family engagement (Institute for Child and Family Wellbeing, 2016; Korfmacher et al., 2008). McCurdy and Daro (2001) identify individual attitudes toward service and willingness to change as key factors in parents' intention to enroll in voluntary family support services, and a strong match between personal and program goals as key factors for retention.

1.2. Engaging families through motivational interviewing strategies

Motivational Interviewing (MI) could be a supportive practice to both help home visitors make and engage families with appropriate referrals and improve family engagement and retention. Many practitioners find that MI is a good fit with home visiting because of its focus on respectful and adaptive communication with clients. MI is a collaborative, person-centered approach to elicit and strengthen a client's motivation to change behavior. It is a non-judgmental, empathetic, and egalitarian approach (Lundahl et al., 2010). Miller and Rollnick (2012) characterize MI as “about arranging conversations so that people talk themselves into change, based on their own values and interests” (p.4), making use of five skills: asking open questions, affirmation, reflective listening, summarizing, and informing and advising. Miller and Rose (2009) recount that “a guiding principle of MI was to have the client, rather than the counselor, voice the arguments for change” (p. 528). This act of hearing reasons that the change is desirable in one's own words, and according to one's own values and goals, seems to be what makes MI effective, increasing personal commitment to change and diminishing resistance to intervention (Forrester, Westlake, & Glynn 2012; Miller & Rose 2009).

MI can change the mindset of the client and also shift the perspective of the service provider. Forrester et al. (2012) note that MI shifts the focus from the client to the interaction between the client and the worker by putting “the spotlight on social worker behavior as both a potential cause of resistance and also our most important tool for reducing resistance” (p. 123). Variations on MI have been found effective in improving pregnant women's motivation to decrease alcohol consumption (Osterman, 2011); improving outcomes related to substance abuse, health-related behaviors, and gambling (Lundahl et al., 2010); improving risky behaviors and client engagement (Lundahl and Burke, 2009); reducing cannabis use among young adults with schizophrenia (Smeerdijk et al., 2012); and improving outcomes for people with co-occurring issues with alcohol and anxiety and/or depression (Baker, Thornton, Hiles, Hides, & Lubman, 2012). Particularly relevant to the present study, MI has been found effective at improving long-term engagement and retention in parent and child mental health programs (Ingoldsby, 2010) and a behavior parent training program with families involved in child welfare (Chaffin et al., 2009).

As in other services, MI is used in home visiting to improve engagement, motivation, and retention. Initial evidence suggests the use of MI in home visiting is effective. A randomized trial found that home visitors who received training on communicating around sensitive topics which included MI were found to have improved communication knowledge, attitudes, confidence, and observed skills, and exhibited fewer instances of persuasion and confrontation (West et al., 2018). These effects diminished over time, which underscores the importance of ongoing reinforcement of MI use (p. 8). Channon et al. (2016) found that nurse home visitors who received MI training were competent in using the skills in visits, but there was variation. Some particular practices – such as the balance of asking questions and providing reflections with offering information – were difficult to achieve within a home visiting model designed to provide specific information. The present study extends research on the use of MI within home visiting by examining the effect of MI training on home visitor and family outcomes.

1.3. The present study

The present study seeks to answer the following questions: 1) to what extent do frontline home visiting staff understand and practice MI strategies after being trained? 2) What is the impact of home visitor MI training on caregiver service referral completion? 3) What is the impact of home visitor MI training on caregiver retention in home visiting services? Below, we discuss each of these research questions and introduce our hypotheses.

1.3.1. Research question 1. To what extent do frontline home visiting staff understand and practice Motivational Interviewing strategies?

The direct impact of MI training should be that it produces changes in home visitors' knowledge and behaviors. We hypothesized that MI training would improve home visitor knowledge of MI (Hypothesis 1a), improve reflective listening skills (Hypothesis 1b), and lead to greater use of strategies consistent with the tenets of the MI approach (i.e., MI-consistent strategies) in home visitor practice, compared to strategies inconsistent with the tenets of the MI approach (i.e., MI-inconsistent strategies) (Hypothesis 1c).

1.3.2. Research question 2: What is the impact of home visitor MI training on caregiver service referral completion?

We hypothesized that MI training for home visitors would increase the percent of service referrals that caregivers completed (Hypothesis 2). We expected home visitors would elicit more change behavior from caregivers by using MI; therefore, caregivers would be more likely to