



Implementation of the Alarm Distress Baby Scale as a universal screening instrument in primary care: feasibility, acceptability, and predictors of professionals' adherence to guidelines



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ABSTRACT

Background: Infant socioemotional development is often held under informal surveillance, but a formal screening program is needed to ensure systematic identification of developmental risk. Even when screening programs exist, they are often ineffective because health care professionals do not adhere to screening guidelines, resulting in low screening prevalence rates.

Objectives: To examine feasibility and acceptability of implementing universal screening for infant socioemotional problems with the Alarm Distress Baby Scale in primary care. The following questions were addressed: Is it possible to obtain acceptable screening prevalence rates within a 1-year period? How do the primary care workers (in this case, health visitors) experience using the instrument? Are attitudes toward using the instrument related to screening prevalence rates?

Design: A longitudinal mixed-method study (surveys, data from the health visitors' digital filing system, and qualitative coding of answers to open-ended questions) was undertaken.

Setting and participants: Health visitors in three of five districts of the City of Copenhagen, Denmark ($N = 79$).
Methods: We describe and evaluate the implementation process from the date the health visitors started the training on how to use the Alarm Distress Baby Scale to one year after they began using the instrument in practice. To monitor screening prevalence rates and adherence to guidelines, we used three data extractions (6, 9, and 12 months post-implementation) from the electronic filing system. Surveys including both quantitative and open-ended questions (pre- and post-implementation) were used to examine experiences with and attitudes towards the instrument. Descriptive and inferential statistical and qualitative content analyses were used.

Results: Screening prevalence rates increased during the first year: Six months after implementation 47% ($n = 405$) of the children had been screened; 12 months after implementation 79% ($n = 789$) of the children were screened (the same child was not counted more than once). Most (92%) of the health visitors reported that the instrument made a positive contribution to their work. The majority (81%) also reported that it posed a challenge in their daily work at least to some degree. The health visitors' attitudes (positive and negative) toward the Alarm Distress Baby Scale, measured 7 months post-implementation, significantly predicted screening prevalence rates 12 months post-implementation.

Conclusions: Adding the Alarm Distress Baby Scale to an established surveillance program is feasible and acceptable. Screening prevalence rates may be related to the primary care worker's attitude toward the instrument, i.e. successful implementation relies on an instrument that adds value to the work of the screener.

What is already known about the topic?

- Identification of socioemotional problems in infants is often held under informal surveillance, but systematic universal screening using a validated instrument is needed to prevent overlooking

children who need further assessment and intervention.

- Even when universal screening programs are implemented, they are often not effective, and screening prevalence rates are often low. A growing, but small, body of literature suggests that this is partly due to low adherence to screening guidelines among the professionals

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responsible for screening.

- The Alarm Distress Baby Scale (ADBB) is a validated screening instrument for identification of socioemotional problems in infants and it is well suited for use in a busy ‘real-life setting’.

What this paper adds

- The ADBB has not previously been implemented as a universal screening instrument in a primary care setting, and this study provides a good starting point for policymakers, planners, and managers who intend to undertake quality improvement initiatives aiming at early detection and prevention of socioemotional problems in infancy.
- This study extends the growing literature on implementation of routine developmental screening into a busy health visiting practice focusing on feasibility and the professionals’ perceptions of using the screening instrument.
- Moreover, this study confirms the often untested assumption that low screening prevalence rates is related to the practitioners’ attitude toward the screening instrument and to the extent to which conducting the screening is perceived as meaningful and positively contributes to his/her practice.

1. Background

An infant’s ability to engage in social interaction is one of the most important indicators of socioemotional development linked to a range of long-term outcomes such as language development, socioemotional competencies, and behavioral, attachment, and autism-spectrum disorders (e.g., Feldman, 2007; Guedeney et al., 2013, 2014). Intervention becomes increasingly more difficult as problems in infancy become more complex and severe with development (e.g., Phillips and Shonkoff, 2000). As such, early identification of socioemotional problems and referral to intervention services is a public health imperative.

Although psychiatric disorders, e.g. behavioral or attachment disorders, are rarely diagnosed in children under the age of two years, recent research has shown that these problems can be reliably detected as early as infancy (0–2 years) (Bagner et al., 2012). Furthermore, early detection of behavioral and emotional problems lead to successful intervention efforts to ameliorate these problems (Bagner et al., 2012; Zeanah and Gleason, 2009). Despite internationally agreed upon recommendations of preventive strategies that target the general population (Bagner et al., 2012), many countries lack a systematic approach to screening and referral for mental health problems in infancy (Huffman and Nichols, 2004).

Existing assessment procedures for infant socioemotional development include parent- or caregiver-report questionnaires, observational coding procedures, and diagnostic classification systems. Questionnaires and observational coding procedures have demonstrated sound psychometric properties for use in infancy (for a systematic review, see Bagner et al., 2012). Observational coding procedures provide more objective and detailed information than questionnaires, however, they are more time consuming, and it has been discussed whether observation-based methods are feasible in primary care settings (Bagner et al., 2012).

The first critical step in identification and intervention is high-quality, universal screening, i.e., screening of all infants, not just those with suspected problems (e.g. Pinto-Martin et al., 2005; American Academy of Pediatrics, 2006). Developmental screening refers to the standardized use of a validated screening tool at established time points to distinguish children at risk for developing problems from those who are not (Glascoe et al., 2013). In contrast, developmental surveillance refers to an informal, ongoing process that provides a broad clinical picture based on parental concerns, continued monitoring of developmental history, observations of the child, and input from other professionals when necessary (American Academy of Pediatrics, 2006).

The American Academy of Pediatrics cautions that without systematic use of a validated screening tool, children at risk will be missed. This is consistent with results from other screening studies, not limited to the infant mental health domain, that have demonstrated that formal screening programs are far more effective than general health surveillance (Evins et al., 2000; Miller et al., 2011; Wickberg and Hwang, 1996).

However, when formal screening programs have been established, they are often not effective, and implementation studies have reported very low screening prevalence rates, despite recommendations for universal screening (Rice et al., 2014; King et al., 2010; Sand et al., 2005). Similarly, a growing literature has demonstrated that health care professionals responsible for screening often do not adhere to screening guidelines (Allen et al., 2010; King et al., 2010; Arunyanart et al., 2012; Aylward, 2009; Guerrero et al., 2010). For example, it was reported that only 23% of pediatricians consistently used a standardized developmental screening tool despite official guidelines that all children should receive a developmental screening (Sand et al., 2005). Failure of successful implementation has been linked to time constraints, inability to adequately train health care professionals, lack of reimbursement, unfamiliarity with the screening instrument, the health care professionals’ fear of having a positive screen, poor communication with parents, and viewing the screening instrument as burdensome and useless (King et al., 2010; Pinto-Martin et al., 2005, for a review, see Gellach, 2016).

Regardless of the cause, the existing literature highlights a gap between research and practice resulting in poor implementation of research-based methods in practice, which in turn results in under-detection of infants in need (Blase et al., 2012; Fraser, 2013; Guerrero et al., 2010). Although the ultimate goal is to improve outcomes for infants with socioemotional problems, such research also stresses the need for studies investigating factors important for successful implementation of universal screening for socioemotional problems in infancy as well obstacles that cause low adherence to screening guidelines among health care professionals. In other words, to successfully transfer research-based knowledge on infant mental health factors to practice, research must focus on specific implementation outcomes and so-called ‘drivers of implementation’ (Fixsen et al., 2009).

1.1. The current study

Our study evaluated the process of implementing a systematic screening program for socioemotional problems in an established developmental surveillance program, i.e., the public health home visiting program of the City of Copenhagen, Denmark. In the City of Copenhagen, the home visiting program includes six routine visits during the first postpartum year: three visits during the first three weeks, a visit at two months, at four-six months (for new parents only), and at eight-ten months. Home visits typically last 60 min. The service is widely used and well-accepted among parents: over 99% of all Danish families receive the regular home visits (Dansk Sygeplejeråd, 2010). The home visits are conducted by health visitors: specialized nurses who have completed the “Advanced Nurse Health Visitor Education Program”. As a prerequisite, nurses must have at least 24 months of relevant work experience, e.g., pediatric nursing, infant psychiatric nurse, or neonatal nursing. Health visitors measure and weigh the baby, guide and support parents in matters of breastfeeding, physical and mental health, family dynamics, parent-child attachment, and coordinate with other health care services.

In 2015, the Alarm Distress Baby Scale (ADBB; Guedeney and Fermanian, 2001) was added to the public health visiting surveillance program in Copenhagen. The ADBB is a well-validated screening tool designed to identify infant socioemotional problems in primary care settings, such as in the context of routine pediatric examinations or during routine well-infant visits. More specifically, the ADBB assesses

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