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# An intensive mental health home visiting model for two at-risk early childhood populations

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ABSTRACT

This study examined proximal outcomes of a mental health home visiting model for two populations at risk for child maltreatment: families with young children referred by child protective services (CPS) and at-risk pregnant women (Prenatal) referred by community agencies. Family- and caregiver-level outcomes were measured using the Family Assessment Form (FAF). Families ($n = 215$) showed significant improvement in all eight family functioning factors over the course of their participation in mental health home visiting services. Initially, CPS-referred families ($n = 84$) scored higher on the FAF measure of Interactions between Caregivers, indicating greater conflict between caregivers in the family. Prenatal referred families ($n = 131$) were at greater risk initially on Housing. Prenatal-referred families demonstrated greater risk reduction on measures of Supports to Caregivers, Developmental Stimulation, Caregiver Personal Characteristics and Housing. In addition, all families demonstrated significant improvements in functioning on 11 of 12 items comprising the Caregiver Personal Characteristics factor. Overall, CPS-referred families scored at higher risk on items reflecting externalizing problems, while Prenatal-referred families showed greater improvement on items reflecting internalizing problems. This model was successful in reducing risk factors and promoting protective factors for CPS-referred and Prenatal at-risk families. Implications and future directions are discussed.



## 1. Introduction

Home visitation models are designed to promote parenting practices and positive child development within the milieu of the natural home environment. From The Child Welfare Information Gateway (n.d.), home visitation strategies, "…offer a variety of family-focused services to expectant parents and families with new babies and young children. They address issues such as maternal and child health, positive parenting practices, safe home environments, and access to services." Home visiting programs may differ in their focus or the scope of their services, but most provide some type of parenting education and support, child abuse prevention, maternal health support, and early intervention services for children and families.

While home visitation has existed in some capacity for years, it has recently been highlighted in the United States with the passage of the Patient Protection and Affordable Care Act (ACA). Connected with the ACA, in 2010, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program was established (Home Visiting Evidence of Effectiveness, n.d.), and is administered by the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). This program provides states with funding through HRSA to establish evidence-based home visiting programs for at-risk pregnant and parenting women, children 0–5 years of age, and their families. As the first nationwide program promoting home visitation service models, MIECHV aims to increase the number of families they can serve and broaden the impact of home visitation on at-risk children and families. Prior to MIECHV, Stolzfus and Lynch (2009) estimated that 400,000 to 500,000 families in the United States were receiving services through early childhood home visitation, while the Pew Center on the States' Research (2010) showed at least one state-administered home visitation program being operated in 46 of 50 states with a total of 119 programs. The MIECHV program has expanded from an investment of $100 million in fiscal year 2010 to $400 million in fiscal year 2015 (Health Resources and Services Administration Maternal and Child Health, 2015). It has been described as a highly innovative and effective government program (Rodrigue & Reeves, 2015).

### 1.1. Overview of home visitation models for families with young children

The scope and focus of home visitation programs vary related to the program goals and/or needs of the communities they serve. Some programs are universal in scope, designed to reach all new parents, while

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others target specific groups at risk for negative outcomes. Some programs target specific goals, such as improving birth outcomes (e.g., Issel, Forrestal, Slaughter, Wiencrot, & Handler, 2011), mental health outcomes (e.g., Tubach et al., 2012), or dietary and nutritional outcomes (e.g., Haire-Joshu et al., 2008). A common focus is the promotion of positive child development and reduction of child maltreatment (e.g., Duggan et al., 2004; Geeraert, Van den Noortgate, Grietens, & Onghena, 2004; Olds, Henderson, Chamberlin, & Tatelbaum, 1986). General overviews of existing home-visitation models and their effectiveness can be found in Olds and Kitzman (1993), MacLeod and Nelson (2000), Sweet and Appelbaum (2004), Azzi-Lessing (2013), and most recently in the Home Visiting Evidence of Effectiveness (HomVEE) review of the effectiveness of common home visitation models (Avellar, Paulsell, Sama-Miller, & Del Grosso, 2014; see also Avellar & Supplee, 2013). The HomVEE review (2014) identified twelve programs that meet DHHS criteria (HomVEE, n.d.) for an evidence-based early childhood home visiting model.

### 1.2. The Partnerships for Families (PFF) model

#### 1.2.1. Framework

Partnerships for Families (PFF), a home visiting model with the goal of preventing child maltreatment, was designed by a workgroup of the child welfare department of a large urban county in California and the commission of a county-wide organization charged with promoting healthy development of children under 5 years of age. The PFF model was based on the Strengthening Families™ Protective Factors Framework, which includes five Protective Factors: Parental Resilience, Social Connections, Concrete Support in Times of Need, Knowledge of Parenting and Child Development, and Social and Emotional Competence of Children (Horton, 2003; see also Center for the Study of Social Policy, 2014). PFF includes an emphasis on direct services to families with young children at risk for child maltreatment. In addition, PFF emphasizes service collaboratives in local communities that represent different providers within the system of care. This initiative targets outcomes at the family, agency, and community levels (First 5 LA, 2005) and uses a strength-based approach. Services under the PFF model were implemented in 2006 by community agencies across the county in nine different service areas (e.g., Reuter & Whitaker, 2010). In the aggregate, PFF has been demonstrated to successfully engage families in services and improve family functioning. In terms of reducing risk for child maltreatment, the children of families engaged in PFF ($n = 6323$) were found to have significantly lower rates of re-referral to child protective services and substantiated allegation of maltreatment compared to children who received no CPS services ($n = 16{,}232$): children from families fully engaged in PFF had a lower percentage of re-referrals (39% vs. 52%), substantiated maltreatment (15% vs. 24%), DCFS case openings (10% vs. 16%), and removals (4% vs. 14%) compared to those who did not receive PFF services (Brooks et al., 2011).

#### 1.2.2. Populations served

PFF serves two specific populations that are highly vulnerable to child maltreatment: (1) families with children 0–5 years of age who were the focus of a child abuse report and investigation by the child welfare department that did not result in an open child protective services case but were rated as high risk, and (2) at-risk pregnant women with current presentation or history of domestic violence, substance abuse or depression referred from the community by prenatal clinics, previous PFF clients, sober living programs for women and children, etc. These two groups of families were the populations of focus for all PFF programs across the nine service areas of the county.

### 1.3. The PFF Mental Health Model

Notable to the rollout of the countywide PFF program was the provision for each service area to adapt the basic model to the unique cultural, linguistic and service needs of its population, as well as the resources available in each community to serve these families. The goal was to provide a responsive system of care for eligible families. In one service area, PFF was implemented as a mental health service model by a community mental health center for children and their families with a long history of collaborating with other agencies and nonprofits to meet the needs of their clients. Thus the PFF Mental Health Model was based on this provider's expertise in early childhood mental health for young children and their families and success in coordinating needed services with its partnering agencies in the community.

#### 1.3.1. Staffing

In contrast to many home visitation models for families with young children that utilize paraprofessionals (see Azzi-Lessing, 2013), the PFF Mental Health Model uses masters' level mental health professionals with early childhood expertise to provide home visiting services. The In-Home Therapists (IHT) serve as the primary providers and contacts for the family. With a full-time Program Resource Specialist on staff and a collaborative of partnering community agencies, the IHT has support in assuring that families are given a "warm hand-off" to needed resources. For purposes of quality and fidelity of the IHTs' services, two hours of professional, clinical supervision is provided weekly for the whole team, and individual clinical supervision and reflective practice facilitation is provided weekly or bi-weekly.

The exclusive use of mental health professionals as home visitors distinguished the PFF Mental Health Model from the other PFF programs in this countywide initiative. In addition, using mental health professionals to provide the full scope of comprehensive, home-based services distinguished the PFF Mental Health Model from traditional mental health programs for children. The IHT combined the functions of therapist, counselor, case manager and/or case coordinator to address the complexity of the family's needs. The model has been described as having the IHT "in front of the curtain" with the family, while supporting staff and community agencies are "behind the curtain" and brought onto the stage by the IHT as needed. Also in comparison to traditional mental health programs, the PFF Mental Health Model is noteworthy in its inclusion of all members of the family, not just the parent and child(ren) but also fathers, grandparents, siblings and other extended family (Center for the Study of Social Policy, 2010). Finally, in contrast to traditional mental health services, there was no need to have an "identified patient" with a specific mental health diagnosis and symptomatology that met "medical necessity." The needs of everyone in the family, from basic needs to mental health needs, were on the table for intervention as needed to strengthen the families.

#### 1.3.2. Intensity and duration

The PFF Mental Health Model consists of a minimum of one home visit per week by the IHT, usually 90 min in duration. It should be noted, that at the time of entry into the program, some families are in crisis and/or have immediate needs for food, clothing and shelter. The IHT makes as many home visits or contacts as required to stabilize the family. Overall, participating families received an average of 35.24 contacts (s.d. = 19.70 contacts) over the course of the service episode. Though the original design called for a six-month program duration, there was allowance for longer services based on the needs of the family. Across all participants, the average length of participation in the PFF Mental Health Model was 271.25 days (std. error = 8.86 days), equivalent to approximately nine months. Kaplan–Meier event history analysis showed that Prenatal-referred families (mean = 290.08 days, std. error = 11.84 days) tended to remain engaged in the program longer than CPS-referred families (mean = 242.63 days, std. error = 12.66 days), log rank $\chi^2(1, 215) = 8.376$, $p < .01$ (median difference = 38 days, CI = 31.08–44.92). This difference was expected in that the Prenatal-referred families could be retained from enrollment during the prenatal period until up to six months after the child's birth. In all cases, the final determination of the length of service was based on