



Addressing Parents' Mental Health in Home Visiting Services in Public Housing

Marla McDaniel
URBAN INSTITUTE

S. Darius Tandon
NORTHWESTERN
UNIVERSITY
FEINBERG SCHOOL
OF MEDICINE

Caroline Heller
URBAN INSTITUTE

Gina Adams
URBAN INSTITUTE

Susan J. Popkin
URBAN INSTITUTE

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Many families living in public and assisted housing communities¹ face extreme challenges. From juggling scarce resources to raising families in communities often devastated by violence, families report tremendous stress (Scott et al. 2013). The legacy of segregation and failed federal and local housing policies has left these communities mired in the worst, most destructive kind of poverty (Turner, Popkin, and Rawlings 2009). At rates far higher than national averages, many families in public housing struggle with poor physical health and/or untreated depression, anxiety, trauma, or other mental health problems. Endemic community violence, high incarceration rates, and residents weakly attached to the labor force exacerbate the challenges and contribute to high rates of intimate partner violence and alcohol or drug addiction. Children growing up in these conditions of concentrated disadvantage (Sampson 2012) also suffer poor consequences to their health and development (National Research Council and Institute of Medicine 2000).

Our work in public and assisted housing communities in Chicago, IL, and Portland, OR, as part of the Housing Opportunities and Services Together (HOST) project, suggests that home visiting could be a particularly valuable strategy for supporting highly distressed parents and children in these communities. Home visiting programs employ trained home visitors to deliver structured in-home educational and developmentally appropriate support and resources to families with children under age 6. Research shows that well-designed and rigorously evaluated programs have positively affected children's health and development and made them more ready for school. For parents, the benefits have included more effective parenting practices and better economic well-being and health (Avellar et al. 2014).

BOX 1

About This Brief

This brief offers strategies for service providers in public and assisted housing communities to develop strong home visiting services for highly distressed families battling challenges such as depression, substance abuse, or domestic violence. It also provides information on one strategy in particular—the SCRIPT model—that gives concrete instructions for better serving families' mental health and other needs in home visiting programs. The brief also offers insights into how the model's framework could be adapted to allow local communities to respond to their community's particular needs, challenges, and contexts.

Although home visiting has helped families, when we examine the research further we see programs often have difficulty reaching very vulnerable adults and children. Families at high risk for depression or other mental health problems may have trouble engaging or continuing with home visiting services (Daro et al. 2003). Others who engage less include young or first-time parents, parents with less education, and families who do not own their own homes, are lower income, or reside in more violent communities (Daro et al. 2003; Goyal et al. 2014; McCurdy et al. 2006; McGuigan, Katzev, and Pratt 2003; Tandon et al. 2008; Wagner et al. 2003). Parents struggling with substance abuse or domestic violence also participate less (Ammerman et al. 2010; Daro et al. 2003; Duggan et al. 2009; Eckenrode et al. 2000). We find that many parents living in public and assisted housing, particularly in the HOST sites, fit these profiles (Scott et al. 2013).

This brief is the second in a two-part series about public and assisted housing communities' unique service delivery context and ways to adapt home visiting services to better reach high-need families (box 1). The first brief (McDaniel et al. 2014) discusses key aspects of high-quality home visiting program content, delivery, and infrastructure that program planners interested in public and mixed-income communities may want to consider as they seek to adapt home visiting services for resident families (McDaniel et al. 2014). The first brief reflects insights from a meeting in October 2013 of 16 home visiting experts and key resident service staff from the Chicago Housing Authority and Home Forward, the housing authority of Portland, OR.

This second brief focuses on one particularly challenging aspect of home visiting in public and assisted housing communities: serving parents with untreated mental health needs. The participants in the 2013 meeting recognized that many families in the HOST communities have undiagnosed and untreated mental health problems and that home visiting programs are not always well-equipped to screen parents for these risks or to connect parents to treatment. When parents' risks are not addressed, families tend to engage less, and benefit less, from the resources home visitors can offer (Daro et al. 2003). In this brief we examine an approach some home visiting programs in non-public housing settings have used to better incorporate mental health treatment in their home visiting

services overall, and we consider ways program planners and administrators in public and assisted housing communities might customize the strategy to work most effectively in their communities.

The information in this brief is provided in two sections:

- The challenges of mental health services in home visiting and the steps suggested by the Screening, Referral, Individualized Prevention, and Treatment (SCRIPT) framework that has been developed to address these challenges.²
- Insights from the HOST sites (Chicago, IL, and Portland, OR) on ways they might customize the SCRIPT framework in their communities and collaborate with an appropriate home visiting provider.

The brief concludes by highlighting some of the key issues this work raises.

Enhancing a Home Visiting Program’s Mental Health Services: The SCRIPT Framework

This section describes the limitations of some home visiting programs around mental health screening, referrals, treatment, and monitoring and discusses how the SCRIPT framework is designed to address these weaknesses.

Home Visiting Program Limitations around Mental Health

Research identifies several challenges that affect how well home visiting programs serve clients with mental health needs. These challenges, which range from limited capacity to recognize and serve the needs to limited capacity to refer and monitor families’ progress in treatment, may include the following:

- *Recognizing mental health needs.* Screening for mental health problems and other risks is not universal across programs and varies widely across the country (Ammerman and Tandon 2012). Although the Maternal, Infant, and Early Childhood Home Visiting³ initiative has greatly increased the number of home visiting programs now conducting screening for maternal depression, it attends less to screening for other risks such as substance abuse or domestic violence.
- *Serving families with subclinical mental health needs.* Mental health treatment is less readily available to parents with subclinical mental health concerns (e.g., presence of depressive symptoms not severe enough to be classified as clinical depression). And current reimbursement structures do not easily allow adults without a clinical diagnosis to receive mental health services even though elevated depressive symptoms have been associated with many of the same negative health outcomes as clinical depression (Cuijpers, de Graaf, and van Dorsselaer 2004; Wagner et al. 2000). When home visiting programs come in contact with a

parent with subclinical needs they may not have the capacity to provide mental health services or know available, affordable referral options (Ammerman et al. 2010).

- *Having a standard process for referring clients to outside agencies.* The home visiting program may refer clients to outside agencies if the home visiting agency itself does not have the capacity to provide intensive or ongoing mental health services. A variety of outside agencies, such as smaller community-based organizations or agencies that are part of larger behavioral health systems or safety net systems (e.g., community health centers, including federally qualified health centers) could provide depression treatment to parents. However, few home visiting programs have a standardized process for making such referrals.
- *Having a standard process for monitoring clients' progress with outside agencies.* Home visiting programs may not have standard processes for monitoring clients' engagement with outside referral agencies, though such attention and follow-up could improve families' success with services. Considerable research shows individuals, particularly lower-income adults, are unlikely to start or continue participation in community-based mental health, substance abuse, or domestic violence services (Mayberry, Horowitz, and Declercq 2007; Song, Sands, and Wong 2004; US Institute of Medicine Committee, Crossing the Quality Chasm 2006), but that better coordination between main providers and the referral agency can help.

The SCRIPT Model

Developed with funding from the National Institute of Mental Health, the SCRIPT model is a tool home visiting programs can use to identify and respond to the psychosocial risks of maternal depression, substance abuse, and domestic violence. The model works to address many of the gaps identified above by giving programs a series of recommendations on (1) screening clients for depression, substance abuse, and domestic violence; (2) building internal capacity to address these psychosocial risks; (3) developing partnerships with outside agencies; (4) referring clients to these outside agencies when necessary; and (5) monitoring clients who are referred to outside agencies.⁴

The SCRIPT model encourages home visiting programs that already focus on one or more of these areas to pay close attention to the complexities of mental health screening, referral, and monitoring of clients. For home visiting programs not currently focused on these areas or that recognize inefficiencies in how they handle them, the SCRIPT model recommends strategies for screening, referral, and monitoring clients' progress. For housing authorities that wish to bring home visiting services to vulnerable residents, the SCRIPT model may provide a useful framework for identifying and addressing residents' complex psychosocial challenges.

The SCRIPT model is designed to be flexible and congruent with different home visiting models in different settings. The model achieves this flexibility by providing home visiting programs with "key considerations" rather than prescribed approaches. Programs using the SCRIPT model modify it to fit their unique contextual and cultural needs. In the remainder of this section we highlight SCRIPT's core components: screening, referrals or in-house services, and monitoring.

SCREENING

Understanding the extent and nature of a client’s depression, substance use, or experiences with domestic violence is essential to appropriately manage and link clients with prevention and treatment services. To effectively determine whether a client could benefit from such services and supports, the SCRIPT model recommends programs systematically screen parents for mental health risks as part of their standard operating procedures.

Home visiting programs can use many tools for screening, and most are available in both English and Spanish and have been used extensively with low-income, diverse populations [for more information about these tools, see Boyd, Le, and Somberg (2005); Burns, Gray, and Smith (2010); Nelson, Bougatson, and Blazina (2012)].

Since home visiting programs should address psychosocial risk factors as soon as possible to properly attend to the issues, SCRIPT suggests programs screen new clients within one month. The SCRIPT model also recommends that programs standardize the screening process and be mindful of how and when they administer screening tools because depression, substance use, and domestic violence are often sensitive issues to discuss.

Evidence points to critical periods when certain risk factors are more likely to appear. For example, three to six months after giving birth is a common time frame when new mothers may experience postpartum depression. Consequently, the SCRIPT model recommends that home visiting programs rescreen clients for depressive symptoms, as well as substance use and domestic violence, at that time.

Beyond selecting the appropriate screening tool and deciding when to screen (and possibly rescreen) clients, programs should consider other logistical issues. These issues include (1) conducting appropriate training for staff on the use, scoring, and interpretation of screening tools; (2) providing feedback to clients on the results of the screening tool, including sharing results with clients who screen “negative” for not requiring further evaluation or treatment; and (3) entering results of screening into administrative databases.

REFERRALS

This section examines the following three issues related to mental health in home visiting, particularly as they relate to the SCRIPT model:

- Providing referrals versus providing services in house,
- Preparing clients for referral, and
- Understanding the role of the home visitor supervisor in the above situations.

Providing referrals versus providing services in house

The SCRIPT model emphasizes that home visiting programs need to know their capacity to either serve the client directly or to refer the client to an outside agency. The screening process will guide a program in determining which clients require additional services for mental health, substance abuse, or domestic

violence. Importantly, a client requiring these additional services does not necessarily need to be referred to an outside agency. In fact, many communities have challenges connecting clients with outside agencies because of long waiting lists, no available service providers, or logistical barriers to clients' access (e.g., cost, transportation).

Home visiting programs can develop their own capacity to address clients' depression, substance use, and domestic violence in two main ways. One way is for programs to train and support home visitors to discuss these issues with their clients. Although most home visitors receive training on these topics when they are hired and through occasional professional development sessions, programs may need to enhance these trainings and sessions by offering them more frequently to ensure home visitors have the tools and resources to initiate and engage clients in more in-depth conversations about these topics.

A second way for a program to develop its capacity to address clients' needs is to implement its own interventions with families. For example, Tandon and colleagues have integrated a brief group-based cognitive-behavioral intervention—the Mothers and Babies Course—into home visiting programs aimed at preventing postpartum depression (Tandon, et al. 2014). Other efforts to integrate mental health services into home visiting programs have successfully treated women experiencing major depression (Ammerman et al. 2013; Beeber et al. 2013). Additional work is also underway attempting to respond to perinatal women experiencing domestic violence (Sharps et al. 2013).

Beyond serving clients in house, the other approach is to refer clients to outside agencies. SCRIPT recommends that programs working with outside agencies establish a memorandum of understanding (MOU) with each outside agency. An MOU is a formalized statement of the mutual expectations of two agencies. Although not a legally binding document, an MOU represents a signed commitment on the part of two or more parties to conduct interagency business in a specified manner. An MOU can specify aspects of the referral and monitoring process developed in collaboration between a home visiting program and an outside agency.

Preparing clients for referral

Preparing clients for referral is an essential component of an effective referral process. The SCRIPT model recommends home visiting programs, in keeping with a strengths-based focus, use a client-centered approach in preparing a client for referral. This approach includes educating clients about various referral options, which requires the home visitor to have good familiarity with not only one possible referral site, but several possible options. Regardless of whether a client is referred to services within or outside the home visiting program, the process of introducing a referral to a client is a critical and nuanced process.

Another part of a client-centered focus is understanding when a client is ready to receive and act on a referral. The “stages of change” model of behavior change (Prochaska and DiClemente 2005) highlights that an individual's readiness to change her behavior may be at the “not yet ready” or “getting

ready” phase, suggesting that those clients may need more conversation with a home visitor or other trusted individuals before indicating a willingness to follow through on a referral.

A “warm hand-off” by which a client is directly introduced to a new agency is an effective approach in connecting a client with referral sources. In the SCRIPT model, a warm hand-off means having a home visitor accompany a client to the referral agency for the first contact the client has with that agency. Doing so helps confer the trust and rapport the home visiting client has developed with her home visitor on the new agency to which she has been referred.

Along with ensuring the client is ready to be referred, home visitors should also ensure logistical details (e.g., transportation, cost, paperwork) are in order. When referral details are not taken care of properly, a client willing to follow through may become frustrated with the logistical challenges of receiving services from an outside agency and decide that engaging with the services is too cumbersome.

A home visiting supervisor’s role

A third important issue related to referrals concerns ensuring home visiting supervisors are equipped to support a home visitor’s work with families around mental health issues. Home visitors may be less comfortable or skilled in talking with clients about mental health, substance use, or domestic violence relative to other issues the visitors cover during a home visit (e.g., child development). Home visiting supervisors, then, are important to the referral process as they can not only encourage home visitors to have ongoing conversations about psychosocial risk factors, but they can also encourage home visitors to refer clients to resources within and outside their own program. In doing so, part of a supervisor’s role is to help home visitors recognize their own limits with clients and recognize when another individual with more specialized training can step in. Home visiting supervisors should encourage their staff to become aware of the various referral opportunities so staff give clients a “menu” of referral options. Supervisors can also support and validate the process of making warm hand-offs, and they can use reflective supervision to help home visitors work through challenges and possible solutions to their clients’ psychosocial risks (Heffron and Murch 2010; Parlakian 2001).

MONITORING

For home visiting programs that refer clients to an outside agency, SCRIPT recommends several key steps for monitoring a client’s progress. Although some clients may feel ready immediately to receive services for depression, substance use, or domestic violence, others may initiate services more slowly or refrain altogether.

As noted above, the SCRIPT model recommends home visiting programs develop MOUs with outside agencies. One key area for clarification is the program’s expectations around monitoring referrals and outside agency services. Rather than having implicit and/or unsystematic protocols for monitoring, the model suggests programs work with outside agencies to specify items including, but not limited to, the following:

- Who from the two agencies will communicate about a client's progress (i.e., who are the main points of contact)?
- How often will communication take place (e.g., once a week, once a month)?
- What type of information is shared (e.g., number of visits, description of services received)?
- What authorization must a client provide to allow for sharing of information between agencies?
- How will communication take place (e.g., phone, email)?
- How long will communication take place between the two agencies (e.g., indefinitely, until a client reaches a key milestone)?

Many logistical issues can affect how well a client is able to fully engage in services provided by the outside agency (e.g., transportation, hours of operation). Even when the client and home visitor are able to select an outside agency with minimal logistical barriers, home visitors should monitor whether or how these issues influence service receipt or whether unanticipated logistical problems arise.

SCRIPT also recommends home visitors and clients discuss the client's satisfaction with the outside agency's services. Does the client feel the services are helpful? Does the agency help the client overcome any logistical obstacles to receiving services? Clients will likely experience some challenges in receiving services and may not completely embrace the idea of receiving services from the outside agency even after a few contacts with the provider. Although it is not necessarily the place of the home visitor to mandate continued engagement with the outside agency, home visitors can brainstorm potential alternatives and solutions to situations that may have arisen that have left the client less enthusiastic about continuing to receive services from the outside agency. It is also appropriate for home visitors to attempt to troubleshoot some of the challenges a client is experiencing with the outside agency. For example, a client may be reluctant to mention she does not feel a particular staff member at the outside agency is a "good fit" for her.

Home visitors should also closely monitor the progress a client makes with the outside agency. Assuming appropriate authorizations have been signed to facilitate the sharing of information between agencies, home visitors should inquire about whether the client has changed behavior (e.g., less substance use), exhibited changes in her relationship with an abusive partner, or exhibited changes in depressive symptoms. Because some outcomes may be more long term, home visitors should also inquire whether a client is engaging in any behaviors that are important short-term outcomes, such as increased use of positive coping strategies for stress.

Operating Home Visiting and SCRIPT in Public and Assisted Housing Communities

This section describes public and assisted housing communities' service delivery context. We sought feedback from HOST site partners on how they, as housing authorities, would typically work with an outside service provider such as a home visiting program, and what home visiting partners might need to consider when working with the housing authority and serving its residents. We first describe how home visiting within a public or assisted housing community may be somewhat different than home visiting in other similar low-income neighborhoods. We then discuss SCRIPT in this context and how housing authorities might recommend adapting and implementing it if partnering with a home visiting program. Because SCRIPT is a flexible framework intended to complement and enhance any existing home visiting program, HOST site partners considered how they might approach SCRIPT's recommendations around screening, referrals, and monitoring.

Unique Aspects of Home Visiting in the Public and Assisted Housing Context

Our work with the HOST sites clarifies that service providers should keep in mind several aspects of working in public or assisted housing settings when designing and implementing services there (McDaniel et al. 2014). These considerations include

- *Working with public housing authorities.* Home visiting programs in public and assisted housing communities would likely need to collaborate closely with the housing authority to identify families and referral agencies. In most cases, if housing authorities were initiating the partnership, the housing authority would need to review or potentially adjust its subcontracting arrangements to develop clear partnering procedures with the program.
- *Residents' and program staff's concerns about safety.* Some public and mixed-income housing communities remain quite violent (Hailey and Saxena 2013; Lens, Ellen, and O'Regan 2011; McDaniel et al. 2014; Popkin et al. 2002). Residents' concerns about safety can affect whether and how they choose to engage with services (Hailey and Saxena 2013). Violence could also affect how programs provide their services and arrange to keep their home visiting staff, whose willingness to provide the services may be affected by safety concerns, safe.
- *Residents' needs for privacy and discretion.* Because residents live in close proximity, families may have heightened concerns about maintaining privacy, which may be challenging in a public housing setting. More than in other communities, home visitors may need to assuage clients' concerns about discretion and stigma. Families may have similar concerns about the home visitors' relationship to property management and the housing authority. For example, home visitors could potentially witness or learn information that violates a resident's leasing agreement (e.g., unauthorized residents, unreported employment or income), and families may be reticent to participate in services that could jeopardize their housing. Because discretion

and trust are critical to the home visitor's relationship with families, home visiting programs and housing authorities would need to establish clear boundaries and protocols.

- *Programs' capacity to serve diverse families.* Programs need to be prepared to serve families of different sizes, compositions, and cultures. For example, culturally diverse families may have different goals, speak different languages, and require or respond differently to different approaches (McDaniel et al. 2014). Because a housing authority would likely want and need to serve all eligible households, regardless of size, composition, language, and culture, a home visiting program would need to review and potentially modify its programming to ensure it was inclusive.
- *Communities combating stigma.* HOST sites have described challenges bringing providers into public and assisted housing communities to serve residents. Residents are often doubly stigmatized for being poor and for being of color and/or immigrant. And as mentioned above, providers can also have legitimate concerns about safety. These challenges can affect housing authorities' ability to find providers and also outside agency partners.

Applying SCRIPT in a Public and Assisted Housing Context

Although the considerations discussed in this section are not unique to public and assisted housing communities—home visiting programs often serve and target very low income communities—we suggest the combination of factors, coupled with the defined geographic space and the housing authorities' involvement, make these issues especially salient. Below we discuss how the HOST sites and other housing authorities might consider using SCRIPT, particularly with reference to screening, referrals, and monitoring, to better address families' mental health needs in this context.

SPECIAL CONSIDERATIONS AROUND SCREENING

Both study sites agreed with the importance of systematically screening for depression, substance use, and domestic violence. As each site thought about their communities, however, they highlighted two issues that were particularly relevant for their contexts.

First, both sites emphasized the time it might take a home visitor to gain a family's trust (particularly for families who may have seen many providers come and go). Although SCRIPT recommends screenings occur within a month's time, sites suggested that home visitors may need more time to build the necessary rapport with some families. With SCRIPT, this is a flexible recommendation, but it still requires some systematic procedures and planning by the provider.

Second, site partners in Portland raised questions about screening in different languages, as many parents in the Portland site are neither native English nor Spanish speakers. Consequently, a home visiting provider in Portland would need (1) a plan for screening families who speak other languages and (2) the capacity to serve or refer families who speak neither English nor Spanish. Related to questions about language, the Portland site partners also discussed staffing requirements and the importance of having staff who reflected the community's racial, ethnic, cultural, and language diversity.

SPECIAL CONSIDERATIONS AROUND REFERRALS

Study site partners highlighted two issues around the referral process in SCRIPT. First, they recognized that referrals to some outside agencies may be difficult in their communities. If outside agencies are far away, the home visiting programs may have to develop their own services and internal capacity or find providers willing to come on-site to deliver services. The Chicago site is particularly isolated, which makes this one of the more important considerations in planning and identifying programs for this site. The partners agreed with the SCRIPT recommendation to develop MOUs with potential partner agencies, and they discussed the viability of dedicating administrative space on site.

Second, during the SCRIPT discussion about referrals and the home visiting supervisor's role, study partners emphasized the supervisor's role in helping the home visitors cope with highly distressed families. Partners considered the risk of "secondary trauma" to home visitors and how home visiting programs would need a plan for their supervisors to recognize and support home visitors' own exposure to stress.

SPECIAL CONSIDERATIONS AROUND MONITORING

Both sites agreed that SCRIPT's monitoring component was important, and neither site had specific questions or observations about SCRIPT's recommendations in that area. Partners were, however, interested in the service duration of both the home visits and the SCRIPT component. Given some families' serious needs, the partners discussed the length and potential sustainability of services after the home visits end. SCRIPT lasts as long as the selected home visiting model, so it varies by program. Typically, home visits are most intensive between the first 6 to 12 months after a child's birth, particularly for evidence-based home visiting models focused on pregnant women and newborns.⁵ Among these home visiting models, participation and visits often wane as the child grows or the family's needs decrease. Currently, the SCRIPT model does not have formal recommendations for how long to sustain the referrals and monitoring components; their duration may need to be worked out among community partners, the home visiting provider, and the referral agencies.

Conclusions

To be effective, home visiting services should both support parents' ability to stabilize their lives and strengthen their ability to give their children the strong start all children need. This brief offers strategies for service providers in public and assisted housing communities to develop strong home visiting services to highly distressed families battling challenges such as depression, substance abuse, or domestic violence. It provides information on one strategy—the SCRIPT model—that gives concrete instructions for better serving families' mental health and other needs in home visiting programs, while also providing insights into how the model's framework could be adapted to allow local communities to respond to their community's particular needs, challenges, and contexts.

The information in this brief is intended to help enhance home visiting services for families in public and assisted housing communities. But it is only a first step. To know whether these strategies work,

communities should implement and evaluate their programs to understand whether the services work effectively, for whom, and under what circumstances.

As researchers continue to study home visiting, we underscore a large challenge facing service providers wanting to serve families in public and assisted housing communities. Although there is growing recognition by researchers, housing authorities, and policy makers that supportive services to families in public and assisted housing contexts are important (Bratt 2008; Theodos et al. 2012), funding is not easily available to support such services. We note some exceptions, including several innovative housing authorities that have “Moving to Work” status, allowing them to dedicate some funds to services and helping them create more robust resident service programs (Bowie 2004; Bratt 2008; Kleit and Page 2014; Popkin 2013; Popkin and McDaniel 2013). Also, some housing authorities have partnered with other agencies to bring more services to their residents. For example, the Healthy Start in Housing program in Boston, MA, serves public housing residents and is colocated in the community, though few researchers have studied these colocated programs and how they might benefit residents (Allen, Feinberg, and Mitchell 2014).

Beyond the examples above, most housing authorities have relatively little funding for supportive services that could be used for the kinds of two-generational services we discuss in this brief. For example, the US Department of Housing and Urban Development rarely provides direct funds for services, and the two programs that do—HOPE VI and Choice Neighborhoods—require that these “community supportive services” emphasize moving residents toward self-sufficiency (Popkin et al. 2004, 2010). The department’s other efforts are also almost exclusively focused on employment. The Family Self-Sufficiency program provides housing authorities with limited funding for a service coordinator to help participants set goals and save toward purchasing a home or paying tuition,⁶ and the Resident Opportunities and Self Sufficiency program also provides limited support for service coordination to link residents to employment services.⁷ As a result, on-site services for families focused on adult stability and children’s development are not commonplace.

This brief describes early stages of our work-in-progress identifying and bringing research-based strategies to public and assisted housing communities to support them in their efforts to design and implement effective home visiting services. Especially when families are coping with violence or depression, the daily struggles to manage can affect a parent’s desire and capacity to engage with services, or sometimes literally open the door to them. Because these challenges may also make it difficult to reach children in the household—especially infants, toddlers, and other preschool age children—enhanced home visiting that attends to parents’ mental health in a framework like SCRIPT can potentially strengthen families while also bringing needed resources to children who may not otherwise be reached.

Notes

1. By public and assisted housing communities the authors are referring to public housing developments and mixed-income housing communities with public housing units.

2. Tandon, S. Darius, Karen Edwards, Tamar Mendelson, Deborah F. Perry, and the SCRIPT Advisory Board, "Development of a Protocol for Screening, Referral and Monitoring of Home Visiting Clients Exhibiting Psychosocial Risk Factors," 2014.
3. The Maternal, Infant, and Early Childhood Home Visiting initiative, enacted as part of the Affordable Care Act in 2010, provides federal funding to states to implement and evaluate evidence-based home visiting programs that target at-risk communities. At least 75 percent of this funding must be used for evidence-based home visiting models, and up to 25 percent can be used to evaluate promising models. See National Conference of State Legislatures, "Maternal, Infant and Early Childhood Home Visiting Programs (MIECHV)" (<http://www.ncsl.org/research/health/maternal-infant-and-early-childhood-home-visiting.aspx>).
4. Tandon, S. Darius, Karen Edwards, Tamar Mendelson, Deborah F. Perry, and the SCRIPT Advisory Board, "Development of a Protocol for Screening, Referral and Monitoring of Home Visiting Clients Exhibiting Psychosocial Risk Factors," 2014.
5. These conclusions are based on the authors' review of the US Department of Health and Human Services' "Home Visiting Evidence of Effectiveness" website (<http://homvee.acf.hhs.gov/implementations.aspx>).
6. See US Department of Housing and Urban Development, "Family Self-Sufficiency (FSS) Program" (http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/fss).
7. See US Department of Housing and Urban Development, "About the Resident Opportunities and Self Sufficiency (ROSS) Grant Program" (http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/ph/ross/about)

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About the Authors

Marla McDaniel is a senior research associate in the Center on Labor, Human Services, and Population at the Urban Institute. Her research focuses on family resources, social policies, race, and their influence on child and adult health and well-being. Before joining the Urban Institute, she was a postdoctoral fellow at the Columbia University School of Social Work. She received her doctorate in human development and social policy from Northwestern University.

S. Darius Tandon is an associate professor in the Department of Medical Social Sciences and the associate director of the Center for Community Health at the Northwestern University Feinberg School of Medicine. His research focuses on the prevention of mental disorders and promotion of positive mental health among vulnerable populations, and he has done work with home visitation programs that serve perinatal women. He received his PhD in community psychology and prevention research from the University of Illinois at Chicago.

Caroline Heller is a research associate in the Center on Labor, Human Services, and Population at the Urban Institute. She contributes to research focused primarily on early childhood, including early childhood education, child care and home visiting.

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