

Appendix 5

ABCDII Gaps/Barriers to Interventions at the Demonstration Sites

The goal of the ABCDII Project was to ensure that children and families identified at well-child exams would receive referrals and services that were appropriate to their needs. Children and families were identified for a variety of needs, specific to healthy mental development, physical development, family stress, and parental depression. In most cases, physicians and nurses referred families to the local Care Coordinator for a referral to services.

In January of 2006, the Care Coordinators were asked to collect data about the barriers faced when referring families for services. Particularly, they were asked to document when a needed or recommended service was not available, and why. Because the two Coordinators at the demonstration sites are effective and experienced, they didn't always see barriers up front – they saw ways around barriers, Asking them to collect data about barriers at the first level of referral challenged their way of doing business.

The rural site found few barriers, likely because they had few referrals. (The rural Care Coordinator did not collect data on the referrals that did not have barriers.)

- At the rural site, two children were referred to a child psychiatrist, but none was available.
- One child was referred for a developmental evaluation and transportation was a barrier.
- One child was referred to the Children at Home program, but it did not exist in their area.

The urban site found more barriers, because they had more referrals and more of a variety of programs as referral sources. The majority of barriers were related to either the parent's unavailability or the parent's non-interest in the referral.

- 54 instances involved transportation as a barrier (2 for Promise Jobs, 2 for the Community Mental Health Center, 23 for other child Health programs, 7 for WIC, 1 for Early ACCESS, 9 for dental or lead, and 10 for a well child exam.)
- 4 cases faced the barrier of “no such program exists or provider not available”. (1 for the Children at Home program, and 3 for private psychiatrist).
- 6 referrals faced a cultural/language barrier. (3 for other Child Health Program, 2 for well-child exam, and one for Early ACCESS).
- In 32 cases the barrier was either the parent being unreachable (after three attempts or more) or the parent being uninterested in the program. These included 2 referrals to home visiting programs, 1 referral to a support group, 2 to FaDDS, 2 to PROMISE jobs, 7 to VNA parenting programs, 1 to a private psychologist, 1 to a private psychiatrist, 1 to Early ACCESS, 9 to respite care, 1 to Head Start, 2 to CCRR, 2 to Empowerment respite services, 1 to WIC, and 1 to dental or lead exams.

The urban site's Care Coordinator also collected data on referrals that were made without barriers. There were a total of 57 referrals made without barriers.

Appendix 5

- 1 – telephone helplines
- 10 – General Home Visiting
- 1 – Support groups
- 4 – FaDDS
- 4 – Parents as teachers
- 7 – VNA Parenting
- 1 – lead program
- 16 – other child health program
- 1 – Head Start
- 2 – CCR&R
- 2 – Empowerment respite services
- 1 – WIC
- 2 – Early ACCESS
- 1-1Dental/lead exam
- 1 – employment/workforce development
- 1 – AEA
- 2 – emergency room

These data were collected from late January until mid-June 2006. The data show that the most likely barrier for families weren't related to cost, but to the family's themselves being unreachable by the Care Coordinator, or being unwilling to avail themselves of services.

The new IDPH Healthy Mental Development Initiative project sites will collect similar data regarding barriers and gaps. Those projects will share their data with the state HMD Coordinator, as well as their local stakeholders.