



Early Head Start Home Visitor's Identification of Risk for Maltreatment: Implications for Engaging Families and Supporting Behavior Change

Alayna Schreier, Katie Meidlinger, Anne L. Steel, Mary Fran Flood, & David J. Hansen

University of Nebraska-Lincoln



Introduction

Child maltreatment has a profound impact on healthy child and family development and is associated with numerous detrimental outcomes that persist across the lifespan (Cicchetti & Toth, 2005; Shonkoff & Garner, 2012). Infants and toddlers enrolled in Early Head Start (EHS) are at increased risk for child maltreatment due to the presence of numerous risk factors, such as poverty, parental mental health problems, and developmental disability (e.g., Belsky, 1993; Bronfenbrenner, 1979).

Home visitation programs like EHS have been found to be effective in reducing child maltreatment through increased access to at-risk families with the aim of identifying individual needs and providing multidisciplinary, targeted services (Asawa et al., 2008; Daro & Cohn-Donnelly, 2002). As such, home visitors are in a unique position to identify the families most likely to experience abuse and neglect.

However, the goals of EHS aim to promote healthy family functioning and do not identify prevention of maltreatment as a primary program outcome; thus, there is limited knowledge on how EHS and its home visitors identify risk for and prevent maltreatment. The existing literature on risk identification has demonstrated that home visitors are often ill-equipped to identify and address risk factors that are highly associated with maltreatment, such as parental mental health concerns, substance abuse, and domestic violence (Azzi-Lessing, 2011; Tandon et al., 2008). Further, little is known about whether home visitors recognize the association between those risk factors and maltreatment. There is a critical need to understand how home visitors identify the behaviors that constitute maltreatment and the factors that place families at increased risk for experiencing maltreatment. This improved understanding will help to support EHS staff in their ability to connect at-risk families with empirically-supported services that support behavior change, thus preventing child maltreatment.

The current study is the qualitative component of a sequential mixed-methods project examining how EHS home visitors understand maltreatment, determine risk for maltreatment, and refer families identified as at-risk to relevant EHS and community-based services.

Method

Participants

The final sample was comprised of 14 EHS home visitors and supervisors, ranging in age from 22 to 57 ($M = 36.57, SD = 11.58$). All 14 participants were female and 11 (78.6%) identified as White. The remaining three participants were Hispanic or Black. Ten participants (71.4%) had a Bachelor's degree and four (28.6%) attended some college or had an Associate's degree. Participants had between six and 189 months of experience ($M = 52.21, SD = 51.09$).

Procedures

Semi-structured interviews were conducted that focused on three central questions:

- 1) What do you consider child maltreatment?
- 2) What are red flag or warning signs for maltreatment?
- 3) How do you work with a family who you think is likely to experience maltreatment?

Interviews were audiotaped and transcribed. Participants received \$25 in compensation for their time.

Data Analysis

Preliminary analyses were performed using Dedoose, a web-based qualitative data analysis tool. The lead author reviewed all interviews and conducted a content analysis using the process described by Miles and Huberman (1990), from data reduction to data display to drawing conclusions. Important quotes related to the primary interview questions were identified throughout the coding process.

Results

Question 1: What do you consider maltreatment?

All home visitors identified at least one form of maltreatment. Ten home visitors (71.4%) specifically identified "Physical abuse" as a type of maltreatment. Within this category, eight home visitors (57.1%) described hitting a child. Four home visitors (28.6%) referenced spanking as a potential form of physical abuse.

Eight home visitors (57.1%) specifically identified "Neglect" as a type of maltreatment. When prompted further, twelve home visitors (85.7%) described a failure to provide basic needs for a child as a type of maltreatment.

Seven home visitors (50%) identified "Emotional abuse" as a type of maltreatment. Within this category, six home visitors (42.9%) described a lack of attention or engagement from a caregiver.

Seven home visitors (50%) identified "Sexual abuse" as a type of maltreatment. When asked to define sexual abuse, each of these home visitors described inappropriate touching involving a child.

Six home visitors (42.9%) identified "Exposure to domestic violence" as a type of maltreatment. Within this category, three home visitors (21.4%) included the failure to protect a child from exposure to violence.

Question 2: What are red flags or warning signs for maltreatment?

Home visitors identified a number of red flags across child, parent, family, and environmental levels. No child factors were identified by more than half of home visitors. The most commonly identified risk factors tended to reflect the role of the parent ($n = 10$), including parental stress, parental mental health problems, and violence in the home. One home visitor noted: "I just think stress is a huge thing that leads to that and just what's going on in the family and how everybody's interacting...mom, dad, relationship or that kind of thing can definitely...I mean if they're not getting along it might be taken out on the kids."

Another home visitor stated: "If you know one parent's dealing with depression, that might be, like, unintentional neglect to the children just because...if they're depressed, they're not gonna be meeting the needs of the kids to be up and aware of what they need if they can't take care of themselves."

In addition, lack of financial resources ($n = 12$) and the quality of the neighborhood ($n = 12$) were also commonly identified as risk factors, often in combination. For example: "Livin' in a bad neighborhood and living in a very poor neighborhood...that sounds kind of like discrimination, but a lot of negative things happen in poor neighborhoods because they don't know any better and don't have the resources to make it better."

Question 3: How do you work with a family who you think is likely to experience maltreatment?

Ten home visitors (71.4%) reported that they typically discuss risk for maltreatment with families while four home visitors (28.6%) reported that they do not communicate with families about concerns.

Home visitors reported that their decision to discuss concerns was based on their understanding of families and their likely reactions, particularly when they felt they had a good relationship. For example: "If it's a family I've just had for four weeks, I sometimes don't think it's the right time to bring it up because it can really cause a bad relationship between me and them that might not get better."

Related to why home visitors may not discuss risk for maltreatment with families, two themes emerged: home visitor discomfort and potential consequences within families. Participants reported concerns about how conversations about risk would be interpreted by families, with many identifying worries about being unintentionally insulting or blaming. For example: "You don't want to insult any, you have to be careful of choosing the discussion that you want to have and not insulting them."

Many participants expressed worry that bringing up concerns would cause risk to worsen, leading to unintentional consequences. One home visitor noted: "You wanna share the information, but you don't want them to not open their door the next, or drop the program."

Home visitors identified the need for additional training specific to working with families when they have identified concerns. For example: "I think a little bit more training on speaking to families initially, because I think it is a very intimidating topic to talk about with families...how do you bring that up to a parent, how do you say 'Oh, excuse me but I have a concern right now and this is what it is.'"

Every home visitor reported that they would discuss concerns about families with their supervisors, and half stated that they would discuss concerns with other home visitors. The most common reason for not discussing concerns with other home visitors were beliefs about confidentiality and family privacy. For example: "You don't want to give away that kinda thing about your family when you know they're gonna see them at playgroup or something and they'll be like 'Oh that's the family that has that going on.' And it's all confidential but they might kinda pick up on who you're talking about."

Discussion

Overall, results indicate a number of training needs in order to improve EHS in serving families at risk for maltreatment and best support behavior change to prevent maltreatment. In regard to definitions of maltreatment, there was variability between home visitors in how they understood what constitutes maltreatment and what risk factors indicate likelihood of maltreatment in the future. Home visitors were unable to identify all types of maltreatment, with the majority only noting physical abuse and neglect. Participants were more likely to identify risk factors at the parent level, but did not typically identify factors at the child level that could contribute to increased parental stress.

Results also suggest that many home visitors communicate concerns to families but may not feel equipped to discuss risk in all situations. Participants identified a particular challenge early in the relationship with families, when they have not yet built trust. Home visitor discomfort addressing sensitive issues and fear that it will cause a strain in the relationship also makes discussing risk for maltreatment more difficult. In addition, concerns about confidentiality appear to be a substantial barrier that reduces EHS home visitors' ability to effectively utilize program resources. Consultation with peers can be a very helpful opportunity to share expertise and advise, particularly given the wide range of experience among home visitors. Clarifying the extent of confidentiality and the role of consultation may enable home visitors to better learn from each other in these particularly challenging cases.

While the qualitative data provide direction for how EHS home visitors can better serve families at risk for child maltreatment, data analysis is not yet complete. A second coder will be utilized to increase credibility. Future research using these data will improve understanding of how home visitors identify risk and can provide additional recommendations for better incorporating maltreatment prevention into work with families.

This presentation was made possible by Grant Number 90YR0082 from the Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Office of Planning, Research and Evaluation, the Administration for Children and Families, or the U.S. Department of Health and Human Services.

