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Understanding Perceptions of Child Maltreatment Risk: A Qualitative Study of Early Head Start Home Visitors

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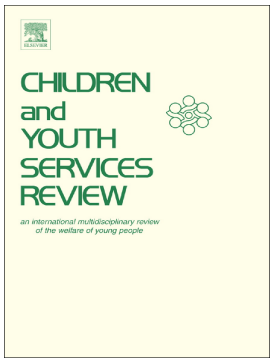

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Understanding Perceptions of Child Maltreatment Risk: A Qualitative Study of Early Head Start Home Visitors

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Abstract

Infants and toddlers enrolled in Early Head Start are at increased risk for child maltreatment. Within Early Head Start, home visitors are in a unique position to identify the families most likely to experience maltreatment by identifying characteristics and behaviors of children, caregivers, families, and environments that are of concern. However, research has demonstrated that home visitors are often ill-equipped to identify and address risk factors such as parental mental health concerns, substance abuse, and domestic violence. Further, little is known about how home visitors understand and perceive risk for maltreatment and identify vulnerable families. The study sought to identify how Early Head Start home visitors understand maltreatment, perceive risk for maltreatment, and work with families identified as at-risk. Qualitative interviews exploring identification of risk for maltreatment were conducted with fourteen Early Head Start home visitors and supervisors. Results indicate variable understanding of maltreatment. Home visitors identified numerous factors they believe suggest elevated risk for maltreatment and described variable approaches to working with families at risk. Findings provide rich information about the role that home visitors play in maltreatment prevention within Early Head Start. Directions for effectively training home visitors to engage families and deliver program and community-based services in a manner that reduces risk for and prevents maltreatment are discussed.

Keywords: Early Head Start, home visitors, child maltreatment, risk factors, qualitative

1. Introduction

Child maltreatment has been identified as a pervasive social problem and a public health issue (Institute of Medicine [IOM] & National Research Council [NRC], 2013). Although there is no single definition of maltreatment, acts typically considered to be maltreatment include physical abuse, sexual abuse, emotional abuse, and neglect (IOM & NRC, 2013). Other acts that have been considered maltreatment include exposure to domestic violence, exposure to drugs or alcohol, and lack of supervision (U.S. Department of Health and Human Services [U.S. DHHS], 2017). Maltreatment and its associated consequences pose a direct threat to the mission of Early Head Start (EHS) as defined in the Head Start Program Performance Standards, which is to (1) promote school readiness by enhancing cognitive, social, and emotional development; (2) build positive parent-child relationships; and (3) improve family well-being (U.S. DHHS, 2016). Early experiences of abuse and neglect are associated with impairments in cognitive development, emotional well-being, language and communication skills, physical health, and school readiness (e.g., Cicchetti & Toth, 2000), which directly interfere with child and family well-being.

EHS is a nation-wide, federally funded early intervention program that provides multidisciplinary services for low-income pregnant mothers and children birth through three. There are three program options available to participants in EHS. Service delivery models include center-based care, home-based care, and combination options that include both center- and home-based care. Home-based programs require a minimum of 48 90-minute visits with the primary caregiver per year, so home visitors have frequent and consistent interaction with families (U. S. DHHS, 2016). The current study focuses on the home-based program option.

Recent estimates have suggested that approximately 9.2 per 1,000, or .009% of children in the United States experience substantiated maltreatment (U.S. DHHS, 2017). Of these

children, 91.6% experience abuse and neglect perpetrated by their parent or caregiver. Children in the birth to three age group, the population served by EHS, experience the highest rates of maltreatment (U.S. DHHS, 2017). It is at this young age that adverse life experiences can be particularly harmful (e.g., Shonkoff & Garner, 2012). Maltreatment profoundly impacts a child's development and is associated with numerous, persistent detrimental outcomes, including neurophysiological, cognitive, and behavioral deficits (Cicchetti & Toth, 2005). These consequences of child maltreatment directly interfere with the identified goals of EHS as defined in the program's mission (U.S. DHHS, 2016). There is a critical need to reduce threat to child competence and healthy family functioning by preventing maltreatment in this population. The developmental-ecological model and the bioecological model are frameworks through which the etiology of child maltreatment can be understood (Belsky, 1993; Bronfenbrenner, 1979, 2006). These frameworks situate factors that increase risk for maltreatment within the child and the child's interactions with the immediate and broader environment. The presence of and interaction between risk factors place children and families at increased risk for maltreatment.

EHS Family Service Workers, hereafter referred to as home visitors, are in a unique position to identify the presence of risk factors in the families they serve and ameliorate those risk factors through ongoing intervention. However, the existing literature on EHS does not address the role of home visitors in maltreatment prevention. This reflects the fact that maltreatment prevention is not a primary program aim within EHS. While current EHS policies require programs to have methods of identifying and reporting actual or suspected instances of maltreatment, the guidelines do not include training in the identification of risk prior to actual occurrence of maltreatment (U.S. DHHS, 2016). This is reflected in research findings suggesting that home visitors may be ill-equipped to identify and address factors that are highly associated

with maltreatment, such as parental mental health concerns, substance abuse, and domestic violence (Azzi-Lessing, 2011; Tandon, Mercer, Saylor, & Duggan, 2008).

1.1. Factors that Increase and Decrease Risk for Maltreatment

Risk factors for maltreatment are characteristics that elevate the risk of – but do not necessarily predict - child maltreatment (IOM & NRC, 2013). More specifically, risk factors can be considered observable vulnerabilities that suggest that families may be at risk for maltreatment in the future. To prevent the numerous detrimental outcomes associated with maltreatment, it is critical to understand the complex and diverse set of factors that occur within a child's developmental-ecological context that are interrelated and interact to increase risk (e.g., Belsky, 1980; Belsky, 1993; Cicchetti & Toth, 2005; Hecht & Hansen, 2001; IOM & NRC, 2013). Specifically, risk factors exist within a child and caregiver, in addition to characteristics of and interactions with the child's caregiver, family, and broader environment (Belsky, 1993).

Characteristics or behaviors of children have been identified as factors that increase the likelihood of maltreatment. For example, developmental disabilities, behavioral problems, or physical health needs have been associated with increased risk for both physical abuse and neglect, in addition to placing children at greater risk for serious injury from an abusive act (Belsky, 1993; IOM & NRC, 2013; Palusci, 2011; Urquiza & McNeil, 1996). It is thought that these characteristics place increased demands or stress on caregivers, which can reduce the ability to provide adequate care (Belsky, 1993). In addition, caregiver depression, substance abuse, and age have been associated with elevated risk of maltreatment (Asawa, Hansen, & Flood, 2008; Belsky, 1993; Hecht & Hansen, 2001; National Academy of Sciences, 2013). Maternal depression, in particular, has been linked to physical abuse and neglect (IOM & NRC, 2013). Other stressors that caregivers face include single parenthood, instability in employment,

and low educational attainment (Brown, Cohen, Johnson, & Salzinger, 1998; Ha, Collins, & Martino, 2015), which have been associated with increased risk for physical abuse and neglect.

Within the child's family, numerous factors have been found to elevate risk of maltreatment, including family instability (Ha et al., 2015), poor parenting practices and limited understanding of child development (Daro & Cohn-Donnelly, 2002; Hecht & Hansen, 2001), infrequent interaction (Urquiza & McNeil, 1996), less supportive and responsive caregiving (Belsky, 1993; Brown et al., 1998), and violence between caregivers (Graham-Bermann, 2002; Palusci, 2011). Prior involvement with Child Protective Services (CPS), particularly a history of substantiated cases, also increases risk (Duffy, Hughes, Asnes, and Leventhal, 2015).

Characteristics of the broader environment have been associated with increased likelihood of maltreatment. National prevalence data indicate that young children living in poverty are at increased risk for neglect and physical abuse (Belsky, 1993; IOM & NRC, 2013; Sedlak et al., 2010). A substantial body of literature has explored environmental risk factors in the context of neighborhoods (Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007; Maguire-Jack, 2014; Molnar et al., 2016), including family support, neighborhood violence, neighborhood childcare burden, social disorganization, and low neighborhood quality. Maltreatment is also more likely to occur in families with inadequate housing and who are receiving public assistance (Palusci, 2011). Similarly, families that lack informal social support are also at increased risk for maltreatment (Spilsbury & Korbin, 2013).

Research has also identified protective factors that serve to mitigate the impact of risk factors, though literature has been mixed with regard to the role of protective factors in preventing maltreatment itself (IOM & NRC, 2013). Some protective factors include presence of social support, two parent households, and access to resources such as housing and employment

(U. S. DHHS, 2004). Cicchetti and Toth (2005) described the likelihood of maltreatment as a balance of both risk and protective factors, though previous literature has demonstrated mixed findings related to actual maltreatment prediction (e.g., Dubowitz et al., 2011; MacKenzie, Kotch, & Lee, 2011). Despite the lack of predictive validity, there is value in identifying both risk and protective factors within the context of an intervention. Because of the opportunities for targeting and ameliorating risk within the context of this existing intervention, this study focuses solely on the identification of risk factors.

1.2. Risk within Early Head Start

Children enrolled in EHS are at elevated risk for maltreatment compared to their peers, in part because of the factors that contribute to the eligibility and selection of participants in EHS. Children in the birth-to-three age range (i.e., those served by EHS) experience the highest rates of maltreatment (U.S. DHHS, 2017). Federal regulations also require that at least 90% of enrolled families have annual household incomes below the federal poverty guidelines (U.S. DHHS, 2016). Further, federal guidelines require EHS provide 10% of enrollment slots to children with developmental disabilities. Other risk factors, such as homelessness and receiving government assistance (i.e., TANF, or Temporary Aid for Needy Families), make families eligible for participation in EHS under the Eligibility, Recruitment, Selection, Enrollment, and Attendance (ERSEA) standards (U.S. DHHS, 2015a). In addition, children in the foster system are categorically eligible for EHS (U.S. DHHS, 2015a).

There is limited research evidence identifying that children enrolled in EHS experience maltreatment at rates higher than the general population. A study of maltreatment rates across EHS program models found that over the 13-year study period, 15.8% of the sample had experienced maltreatment, with 5% having experienced maltreatment during the birth through

three range alone (Green et al., 2014). An unpublished doctoral dissertation examining maltreatment within an EHS home-based program found that 7.8% of the sample had experienced court-substantiated maltreatment in the six years following program enrollment (Hubel, 2014). These rates are higher than those found in two longitudinal studies of the general population. Brown et al. (1998) found a maltreatment rate of .07% in a longitudinal study of residents in upstate New York, while Sidebotham, Heron, & the ALSPAC Study Team (2006) found that 2.1% of children in a large-scale cohort study in the United Kingdom were involved in a maltreatment investigation, with only .8% of cases resulting in substantiation. Thus, the presence of risk factors, along with the high prevalence of maltreatment, make young children and families enrolled in EHS an appropriate group for services designed to prevent maltreatment.

1.3. Home Visitation as Maltreatment Prevention

Home visitation first emerged as a policy option in 1992, designed to target low-income families who experience complex, interrelated difficulties and disorganized lifestyles that may interfere with program participation (Bilukha et al., 2005; Daro & Cohn-Donnelly, 2002). Home visitation attempts to reduce barriers through regular contact with families in their own homes, eliminating the need for transportation and increasing parent engagement by providing individualized services to families (Korfmacher et al., 2008; Raikes et al., 2006).

Home visitation is considered a primary prevention strategy for child maltreatment (Merritt, Maguire-Jack, & Negash, 2018). There is a substantial body of literature supporting the effectiveness of home visiting programs specifically designed to prevent maltreatment, such as Nurse Family Partnership (e.g., Olds, 2006) and Healthy Families America (e.g., DuMont et al., 2010). Participation in early childhood home visiting programs has consistently led to reductions in risk for maltreatment, though findings have been mixed related to prevention of maltreatment

itself (Mikton & Butchart, 2009). A meta-analysis of 21 studies of home visitation programs found a median 39% reduction in abuse and neglect for children enrolled in home visitation programs (Bilukha et al., 2005). In a meta-analysis of 60 studies, Sweet and Appelbaum (2004) found a significant decrease in potential for child abuse and neglect following participation in home visitation programs.

Limited research has evaluated maltreatment prevention within EHS, despite the clear potential of the program (Fantuzzo, McWayne, & Bulotsky, 2003). The first longitudinal study of maltreatment prevention within EHS found promising results related to child welfare encounters and substantiated CPS reports (Green et al., 2014). Despite this limited research evidence, participation in EHS has significantly reduced risk factors that have been associated with maltreatment. For example, parents who received EHS services have been found to be more emotionally supportive than parents who did not receive EHS services, and children tend to display fewer behavioral problems after completing EHS (Love et al., 2001). Chazan-Cohen et al. (2007) also found that EHS was effective in reducing levels of maternal depression. It is clear that EHS has the ability to decrease the presence of risk factors associated with maltreatment, which may in turn prevent maltreatment occurrence in the future.

1.4. Role of Home Visitors.

Home visitors are in a unique position to assess the presence of risk factors through regular contact with families in their homes (Pecora, Chahine, & Graham, 2013). Yet, research has shown that the complexity of problems exhibited by at-risk families often surpasses the ability of home visitors, both in identifying problems and addressing them (Chaffin, 2004; Tandon et al., 2008). Even when risks have been identified, home visitors report having little training in how to address factors such as mental health or substance abuse problems, leading

them to feel unprepared for working with families on these issues (Tandon et al., 2008). Home visitors may also be reluctant to discuss concerns because they are uncomfortable addressing sensitive issues, fear it will cause a strain in the relationship, or do not understand how to connect families to available resources (Duggan et al., 2004; Hebbeler & Gerlach-Downie, 2002; Kitzman, Cole, Yoos, & Olds, 1997). Further, EHS guidelines may be unclear as to whether home visitors provide targeted intervention themselves or if they are to refer families to appropriate services. For these reasons, the field sees a persistent request from home visitors for programs to provide more training and support related to identification of risk for maltreatment (Daro, 2009; Gill, Greenberg, Moon, & Margraf, 2007).

1.5. Current Study

Children and families enrolled in EHS are at increased risk for maltreatment given the presence of risk factors that contribute to program eligibility (e.g., U.S. DHHS, 2016). Further, these families experience maltreatment at higher rates than the general population (Green et al., 2014; Hubel, 2014). To date, there has been limited research on how EHS home visitors understand child maltreatment and identify characteristics that may indicate elevated risk for maltreatment among the families they serve. Within the context of an existing intervention, identification of risk may allow for targeted services to ameliorate risk prior to maltreatment occurrence. Increased understanding of how home visitors identify and respond to risk for maltreatment provides direction for improved fit between program services and family needs. The current qualitative study is exploratory and seeks to understand the role of home visitors in maltreatment prevention within EHS. Specifically, we asked the following research questions:

1) How do EHS home visitors understand and define child maltreatment?
2) What factors to EHS home visitors use to identify families at risk for child

maltreatment?

3) How do EHS home visitors work with families they have identified as 'at-risk' for child maltreatment?

Although this study was exploratory, we broadly hypothesized that there would be variability across all research questions, such that home visitors would understand and define child maltreatment to varying degrees, would utilize varying factors to identify families at risk, and would take a variety of approaches to working with at-risk families.

2. Method

2.1. Participants

All home visitors and supervisors (n = 17) employed by the EHS home-based program during a three-month recruitment period were invited to participate in this study. There were no exclusionary criteria. Of the 17 home visitors and supervisors, 14 (82.4%) elected to participate. Home visitors ranged in age from 22 to 57 (M = 36.57, SD = 11.58). All 14 participants were female and 11 (78.6%) identified as White. 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).

2.2. Setting

Participants were recruited from a grantee agency for an EHS home-based program serving a mid-sized Midwestern community and outlying rural areas. Half of the families enrolled in the EHS home-based program during the study period were White. There was an approximately equal number of boys and girls enrolled in the program. The majority of caregivers were female and had never attended college.

2.3. Procedures

The qualitative interview was developed by the lead author for use in this study. A team of doctoral students in clinical psychology carefully reviewed the interview script and gave feedback to ensure clarity. The lead author piloted the interview with three staff members employed by the same agency who served as family engagement specialists for children enrolled in a part-day center-based Head Start program, and thus had experience with a similar population in addition to experience providing in-home services. Changes were made following the pilot interviews to further ensure clarity. For example, the term "risk factor" was replaced by the terms "warning signs" or "red flags". Three central questions guided the final interview, focusing on how home visitors understand and conceptualize maltreatment, factors that lead home visitors to have concern for the families with whom they work, and how they work with families they have identified as at-risk. Interviews used open-ended questioning followed by probes to generate conversation, as recommended by Creswell & Plano Clark (2011). The interview followed three central questions: *(a) What do you consider maltreatment of children?; (b) Warning signs or red flags are characteristics that make children and families more likely to experience maltreatment. Based on your experience working with families, what are warning signs or red flags for maltreatment?;* and *(c) How do you work with families when you have identified warning signs for maltreatment?*

All home visitors and supervisors employed during the three-month recruitment period were invited to participate in the study. Semi-structured interviews assessing the understanding and identification of risk for maltreatment were conducted with 14 home visitors and supervisors. Supervisors were included in this study to increase the number of participants and ensure data saturation; each supervisor had previously been a home visitor. Because the lead author had previously worked with this program in a clinical role, interviews were conducted by

a member of the project staff with basic training and experience in interviewing and information gathering techniques who had not previously worked with the home visitors or supervisors. Each interview lasted between 45 minutes and one hour and was conducted in a private space at the agency. At the completion of the interview, participants received $25 in reimbursement for their time. Interviews were audio recorded with the permission of the participant and transcribed into Microsoft Word documents. All identifying information was redacted during transcription.

2.4. Data Analyses

Analyses were conducted using Dedoose, a qualitative data analysis tool that employs a web-based interface for efficient data coding and database searching retrieval. Dedoose incorporates the identification and exploration of coding patterns in qualitative data to be automated via program-generated tables and user-defined output. The lead author reviewed all interviews and conducted a content analysis using the process described by Miles and Huberman (1994). Analysis followed an inductive process such that themes are derived from the data itself. First, the coders reviewed all interviews and engaged in data reduction; the data were coded into small, meaningful units of analysis and operationalized in an iterative fashion. Data display was then used to review coded text segments and identify themes and patterns prior to drawing overall conclusions. Inductive thematic saturation was reached when additional data did not lead to the inclusion of new codes and themes (Saunders et al., 2017). Important quotes related to the primary interview questions were identified throughout the coding process. Data were analyzed and themes identified separately by central question. A graduate research assistant was trained to code interviews in Dedoose using the coding scheme. Five interviews (38%) were randomly selected to be independently coded by the research assistant. Reliability across codes ranged from 77 to 100%, with an average across codes of 97.3%. Codes with reliability below 90% were

reviewed to reach consensus; approximately 1% of codes required consensus. All interviews were re-coded by the lead author using the modified coding scheme.

3. Results

3.1. What do you consider maltreatment of children?

Home visitors were provided an opportunity to identify types of maltreatment; specific maltreatment types identified by home visitors were then probed for further detail. All home visitors identified at least one form of maltreatment. A majority of home visitors specifically identified *Physical Abuse* as a type of maltreatment. Within this category, over half of the home visitors described hitting a child and some referenced spanking as a potential form of physical abuse. Over half of home visitors specifically identified *Neglect* as a type of maltreatment. When probed further, nearly all home visitors described failure to provide basic needs for a child as a type of maltreatment. Half of the home visitors identified *Emotional Abuse* as a type of maltreatment. Within this category, nearly half described lack of attention or engagement from a caregiver. Half of the home visitors also 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. Finally, fewer than half of the home visitors identified *Exposure to Domestic Violence* as a type of maltreatment. Within this category, some included failure to protect a child from exposure to violence. No other types of maltreatment were identified by home visitors.

3.2. What are red flags or warning signs for maltreatment?

Home visitors identified a number of red flags that indicate that maltreatment may be more likely to occur in the future. Home visitors identified characteristics specific to children, caregivers, families, and broader environments, consistent with the contexts described by Belsky (1993). Participants identified a total of 86 risk factors (Table 1). Some variables were subsumed under broader categories.

Home visitors identified a variety of child behaviors and characteristics. Many home visitors described how developmental, physical, and mental health challenges may lead to increased risk of abuse or neglect. One clear theme was the perception that these challenges would increase stress and frustration experienced by caregivers, which could eventually lead to maltreatment. For example, one participant noted "Probably children who act out, children who have, like autism or Attention-Deficit/Hyperactivity Disorder (ADHD), any other physical or mental health issues. Children who have colic because parents can get frustrated pretty easily when they cry a lot." Another home visitor identified child behavior problems as a risk factor and explained why it might eventually lead to maltreatment:

> The defiant behavior, the kids that always say 'no' back to the parents, the ones that don't listen…Just kids that don't listen to you or follow your directions. Just typical behavior of tantrums and not understanding how to take care of their tantrums, or to redirect or guide them to different activities.

The most commonly identified risk factors reflected the role of the parent, identifying characteristics of caregivers that would lead them to be concerned about potential risk for maltreatment. Specifically, home visitors discussed parental mental health problems and parental stress. One home visitor noted:

> 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.

A different participant noted, "It could be how well they handle stress, how do they deal with stressful situations, are they able to walk away from something or are they just kind of let all that

energy exert out onto the child." Another primary theme emerged regarding stressful life events (e.g., job loss, miscarriage, bereavement, divorce) as risk factors. One home visitor described concerns related to how caregivers cope with stressful life events:

> High stress levels. I think that really triggers the emotional response of like that breaking point of when it's gonna happen, and unfortunately all our families have high stress…so that's a big one. And on top of that, like I said the new relationships, break ups, things like that…different jobs, loss of a job where they would be more stressful, overdue bills, anything that can trigger that response of not handling it in the appropriate way or the best way for the child.

Home visitors also identified a parent's prior experiences (e.g., relationship with their own caregiver, experiences of maltreatment in childhood) as a risk factor for maltreatment. One home visitor stated, "I suppose if you know the background of the parent, how they were raised…that could be how they possibly raise their own children because they don't know any better."

Within the broader family context, home visitors identified quality of family interaction and communication as a risk factor. Specifically, home visitors perceived families to be at risk for maltreatment when they observed families struggling with effective communication. One home visitor described, "If you have a family perhaps with poor communication styles, where you are not able to share your feelings or say how you're feeling or have somebody listening to you. I would say – your family time together." Another participant described the parent/child relationship, explaining "…the lack of just emotion of responding to their children. That's a huge concern on the neglect side I should say and the lack of bonding…the lack of interest in sharing about kinda milestones in their child's development." A majority of home visitors identified conflict between caregivers as a potential risk factor for maltreatment. The following quote from

a home visitor is illustrative of these concerns, "If he is, you know, verbally or physically abusive towards the mom, then who knows what he does to the child." Even more broadly, participants described concerns about the relationship between caregivers:

> I think just the relationship factor between parents, looking at how they interact with each other. Maybe they have different parenting styles that could be stress for each other. If one parent does stuff one way and another parent does it another way, that would be stressful within a relationship.

In addition, home visitors identified factors related to access to resources, including homelessness, poor school systems, and other challenges associated with low-income families (e.g., Supplemental Nutrition Assistance Program [SNAP]). Many participants discussed lack of financial resources and the quality of the neighborhood, noting they often occur in combination. One participant explained:

> If they live in a more low-income neighborhood with higher crime rates or more violence. They go to a bad school, if they have a lot of crime that's happening around them, basically just living in a bad neighborhood that doesn't have a lot of money or resources.

There was a common concern among home visitors surrounding issues of culture or immigration. Some home visitors identified that war or unrest in the country of origin would lead to increased parental stress, while others identified practical concerns about language barriers and isolation from family. One home visitor illustrated these concerns:

> People that come from different countries because it's hard when you move from your own place to a different country and you get very sad and you're homesick and I saw people that got very depressed and they were crying all day and they didn't care about

> their kids, and sometimes they said 'Oh I came here because I want a better life for my children, but look where we are and we are alone.'

Finally, some home visitors described the process by which these risk factors may lead to maltreatment in the future among EHS families that face multiple life stressors across different risk contexts. The following quote illustrates this mechanism:

> I think parents focus on, it's a fight or flight mode. They focus on what they need right now and a lot of times education and the ways to…care for your child isn't the priority on the list…I mean they wanna get food on the table, they want the big things first of…living, the needs, so I think that goes, they focus on that and then the children are kind of back a bit.

3.3. How do you work with families when you have identified warning signs for maltreatment?

Nearly all home visitors reported that they typically discuss risk for maltreatment with families. Many home visitors believed that communicating with families about identified concerns was a primary function of their job. Some home visitors explained the importance of identifying areas of concern early, illustrated by the following quote:

> I'm in that home for a reason, not just to come play and have a great time, we wanna change their lives and let them know there's maybe a better way to handle things or there's just another option for them because again, we're mandatory reporters [of child maltreatment] and we make that very clear from the get-go and I would do reminders like throughout the year and just be like, 'Hey, don't want you to forget, this is what I've gotta do,' and in my head I'm like, 'If I can get in there and be a little preventive of anything, then great cause I don't wanna call CPS and totally change the lives of a

family.' If we can nip it while it's small or while I think it's small, then great [be]cause I don't wanna go to the extreme of waiting and waiting until the explosion of a call needs to happen.

Not all home visitors shared that they would discuss concerns with families. 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, or would cause the family to shut down and cease talking to the home visitor or even participating in the program. One home visitor described, "Like if no matter how you tried to do it, if it was gonna come off really bad and then something might happen because you brought it up." Another 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 reported that their decision to discuss concerns with families was based on their beliefs about how the family would react, identifying greater comfort when home visitors 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." When home visitors did decide to discuss concerns with enrolled families, they tended to approach the conversations broadly. This is illustrated by one participant, who explained "I've made comments, like not directly, but kind

of talked about it in a broader term of this is good for children everywhere. It's not so much focused on 'your children need this.'" Home visitors were also likely to engage in broad discussion along with the provision of resources or education. Another home visitor described:

> I would definitely bring out some parent education. I wouldn't necessarily, I'd make it broad and say, 'I'm just sharing this with my families' and not target them specifically but just kind of talk about like different ways of discipline like instead of spanking, do this or talk about positive reinforcement, give them resources of places that can help if there's a specific thing that they're having an issue with.

Home visitors also reported connecting families to available resources designed to ameliorate the area of concern. For example, one participant explained that they "…give some resources that can help if there's a specific thing that they're having an issue with such as housing or they need food or lack of clothes or parental counseling or just sharing resources with them." The importance of connecting families to resources is illustrated in the following quote:

> We build up these mechanisms, those support systems, I mean, it comes down to that. Because I'm only gonna be in their life for a short period of time, so I need them to find an outside resource, besides me, I'm nice, but I need them also to find the community resources.

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 family privacy. For example, one home visitor described:

> 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.

Home visitors also identified training needs related to working with families when they have identified concerns. For example, one participant suggested, "Just attending more trainings about specifically what to do in certain situations. Maybe having a list of warning signs where we can see them and know, um, yeah, just trainings and lists." Another home visitor described the need for training on initiating those conversations:

> 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.'

Participants also noted that this training should occur more frequently to become more comfortable with these topics. This is illustrated by the following quote:

> It's that continuous training…I feel like we need to do more training or as family educators, just…even DHHS, like I heard there was a training maybe a month ago or so for CPS talking about what are typical calls they get, what are signs, what are things that would make you call, and I think to have kinda those examples of what it is we're looking for, cause again, if maybe your background that you grew up with, you were in not a very good home and so it might seem normal, but what does, everybody's standard is different, so it's kinda like let's get on the same page. I know you can't have a book that has everything laid out for you, but I think the more we talk about it and the more trainings you attend, the better idea, you know what to look for and the way things could be looking.

4. Discussion

To effectively identify risk for maltreatment, home visitors must first understand what constitutes maltreatment. Home visitors were asked to identify types of maltreatment. Results indicated variability between home visitors. Home visitors identified a total of five types of maltreatment: physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic violence. No single home visitor identified all five types of maltreatment, and no single type of maltreatment was identified by all home visitors. Although it is a concern that home visitors did not consistently identify maltreatment subtypes, this lack of definitional agreement is reflected in variations in legal statute across states (U.S. DHHS, 2015b). Similarly, maltreatment types measured in large scale national studies of child abuse vary as a result of this lack of agreement (e.g., U.S. DHHS, 2017). The majority of home visitors focused primarily on physical abuse and neglect. It was particularly notable that only half of all home visitors identified sexual abuse as a type of maltreatment. Physical abuse and neglect may be more readily visible than sexual abuse among these young children, which could account for this lack of focus by home visitors. This is consistent with large scale studies finding that sexual abuse occurs less frequently than both physical abuse and neglect (e.g., U.S. DHHS, 2017). It is also possible that this result is a function of the interview structure, such that maltreatment types were not probed unless home visitors identified them independently. Home visitors may be aware of all maltreatment types noted in this study and could identify them if specifically asked, but were unable to generate all types from memory.

Related to risk identification, home visitors identified 86 factors (described to participants as “warning signs” or “red flags”) they believe could indicate elevated likelihood of future maltreatment. Any risk factor identified by a home visitor was included in the list; consensus was not required. Results again indicated substantial variability among home visitors in

understanding what risk factors may increase likelihood of future maltreatment. Home visitors were widely observant of risk and identified a substantial number of risk factors that have been strongly linked to maltreatment in the literature, including child physical and mental health problems, caregiver depression, and caregiver stress (e.g., IOM & NRC, 2013). Of the 86 risk factors, only 37 were measurable using available data sources within the record keeping system. Available data sources include the information collected at enrollment or in the Program Information Report (frequently a yes/no dropdown) or via checkbox that can be easily extracted in a printed report. Most of the 86 factors were subjective or were not regularly measured by program staff and included in program records (e.g., poor hygiene; caregiver history of abuse; country of origin). For example, home visitors identified factors that would be difficult to objectively measure, such as *child appears nervous/shuts down, child is quiet, caregiver does not seek help, caregiver is guarded, caregiver is overprotective,* and *lack of love/respect in family.* Other factors that were not systematically included or readily accessible in program records include *child physical injuries, miscarriage, job loss, caregiver history of abuse, unrelated adult involvement,* and *country of origin.* Some of this information is typically included in the narrative format within the home visit documentation, which was not considered to be readily accessible and retrievable. Further, use of narrative for monitoring risk introduces considerable variability with regard to home visitor record keeping style.

All home visitors identified poverty as suggesting potential for future maltreatment. There is near universal agreement that poverty is associated with maltreatment (e.g., Belsky, 1993; Sedlak et al., 2010). While it is a strong reflection of home visitor knowledge that most participants identified poverty as a risk factor for maltreatment, EHS targets low-income families, as income contributes to enrollment eligibility in the Eligibility, Selection, Recruitment,

Enrollment, and Attendance (ERSEA) policy (U.S. DHHS, 2015a). Thus, poverty as measured by income does not help to identify families who may be at elevated risk compared to other enrolled families, since nearly all enrolled families live below the federal poverty line. It may be more beneficial to measure other indicators of community poverty rather than income itself, such as residential instability, childcare burden, and immigrant concentration, which have been associated with higher rates of maltreatment (Coulton et al., 2007; Maguire-Jack, 2014). Currently, there are not clear mechanisms through which to monitor these factors within existing record keeping systems.

Qualitative interviews also provide insight into how home visitors engage with families within the program once an area of risk has been identified. The majority of home visitors reported that they communicate their concerns about perceived risk factors to the families they work with in order to ameliorate risk before it becomes maltreatment. Participants identified strategies including providing education and connecting families to resources. However, home visitors reported that they frequently do not feel equipped to initiate these conversations about areas of concern. Home visitors identified a particular difficulty discussing concerns early in the relationship with families before they have built trust. The fear that addressing risk factors and sensitive issues with the family would cause a strain in the relationship was a barrier for many home visitors and interfered with their ability to effectively intervene. This fear persisted despite home visitor belief in the importance of sharing concerns with families (Saias et al., 2016).

4.1 Policy Recommendations

EHS was not developed to be a maltreatment prevention program, and currently does not identify prevention of maltreatment as a primary program aim (U.S. DHHS, 2016). However, reducing risk for maltreatment falls within the goals of improving healthy family functioning and

promoting school readiness. As such, these findings may provide guidance for direct engagement in maltreatment prevention within this program. Results could provide useful direction for the local EHS program in this study, the national EHS program, and other home-based interventions serving high-risk families.

One method to effectively reduce risk and prevent maltreatment is for EHS to identify a sub-population of higher-risk families within the larger population of enrolled families. Once families at higher risk for maltreatment are identified by service providers, EHS would have an opportunity to provide targeted intervention. As a universal prevention program, EHS provides the same dosage to all enrolled families, with uniform requirements in the Performance Standards (U.S. DHHS, 2016). Within this program design, home visitors could spend visit time specifically targeting identified risk factors through brief, standardized, adjunctive interventions that could be grafted on to existing services when a need is identified. These services could be provided by home visitors, mental health consultants, or referrals to community agencies. Research is needed to determine program needs related to home visitor training, educational standards, and supervisory practices given an increased focus on maltreatment.

EHS might also need to consider the feasibility of variable service provision based on level of need. Other evidence-based home visitation models that specifically target maltreatment have developed strategies through which they identify families with higher levels of need. For example, Healthy Families America assigns families conducts a risk assessment and assigns families a level of need that determines number of home visits at intake, with clearly defined criteria for increasing and decreasing frequency throughout the program (Prevent Child Abuse America, 2001). Nurse Family Partnership, a nurse home visiting program, also allows for flexible dosage whereby the frequency of visits varies over time based on family need.

Increasing program efforts focused on higher risk families may improve outcomes within EHS. Stronger effects and increased cost-savings are seen in higher-risk families in other evidence-based home visitation models (DuMont et al., 2010; Olds, Hill, O'Brien, Racine, & Moritz, 2003), suggesting that maltreatment prevention may be better targeted towards high-risk families. Specifically, evaluations of Nurse Family Partnership found that cost-savings associated with the program were attributable to the effects seen in the highest-risk families, while services provided to lower risk families resulted in a financial loss (Olds, 2006). Additional research is needed to evaluate the potential of implementing a similar model of variable service provision within EHS.

In order to provide effective, targeted services, there is a need to improve the ability of programs and services providers to measure and track risk. Screening procedures already required by the Program Performance Standards could provide the opportunity for home visitors to monitor risk over the course of enrollment without adding substantial burden. Currently, families complete screening and assessment enrollment and other specified time points throughout program participation (e.g., 45 or 90 days after the start of each program year; U.S. DHHS, 2016). While it is not feasible for programs to assess all potential risk factors, EHS could more intentionally assess risk factors that have been strongly linked to maltreatment in the literature (e.g., caregiver history of abuse, neighborhood poverty). This process could be made more feasible by improvements to existing recordkeeping and documentation systems. While some information is provided via checkbox and yes/no dropdown boxes, the majority of information collected at home visits is presented in a narrative format. While home visitors may be including information on family strengths and vulnerabilities in this narrative, this structure does not allow for easy entry and retrieval. Improved ease of data retrieval could allow for

improved ability to track progress over time and could facilitate more effective supervision. As an example of difficulty with record keeping systems, EHS modifies the information collected and reported in the Program Information Report year to year. This is a challenge for measuring risk between and within participants across time, as variables may not always be retained.

Effective provision of targeted intervention could also be improved with increased training and supervision, a need identified by home visitors in this study. There are many existing opportunities for professional development within the EHS program model, including the annual training and ongoing trainings throughout the year. Currently, the majority of training is designed to meet the Program Performance Standards and is thus performed for compliance rather than comprehension. This is consistent with a many professional development training programs that provide general knowledge with limited opportunity for follow-up and feedback (Pianta, 2006; Sheridan, Edwards, Marvin, & Knoche, 2009; Snyder, Hemmeter, & McLaughlin, 2011). In order to improve home visitor ability to identify need and intervene appropriately, training goals should include both increased knowledge and skill development. The literature on increasing knowledge suggests that trainings are more effective when they include information along with demonstrations and opportunities for feedback (e.g., Showers, Joyce, & Bennett, 1987). For skill development, practice (i.e., role plays) and coaching are critical components of training programs (e.g., Casillas, Fauchier, Derkash, & Garrido, 2016; Joyce & Showers, 2002). Thus, it could be useful for professional development in EHS to include provision of general knowledge, role plays as opportunities to practice (e.g., initiating conversation and referring families to relevant resources) and ongoing supervisory support or coaching. Supervision has been receiving increasing attention, focused both on style (i.e., reflective) and duration (Casillas et al., 2016; McGuigan, Katzev, & Pratt, 2003). Of note, most of the professional development

literature in EHS focuses on the center-based option and little research to date has examined skill development within home visitors (Casillas et al., 2016; Korfmacher et al., 2008). Future research should evaluate professional development strategies with regard to maltreatment prevention in the home-based model.

Although the above considerations could make EHS a feasible model through which more integrated child abuse prevention and intervention could occur, there remain a number of challenges for preventing maltreatment within early childhood home visitation programs. The risk factors that make families eligible for participation in these programs, such as low income, lower educational attainment, and poor maternal and child health also lead to low engagement in services (Holland, Xia, Kitzman, Dozier, & Olds, 2014; O'Brien et al., 2012; Raikes et al., 2006). Additional risk factors faced by at-risk and maltreating families, such as parental depression, substance abuse, and domestic violence, may be particularly difficult for paraprofessional home visitors to identify and address (Duggan et al., 2004; Tandon, Parillo, Jenkins, & Duggan, 2005). This may partially be due to the minimal training and educational requirements for home visitors employed by EHS (Duggan et al., 2004; Sama-Miller et al., 2016). Low wages common to paraprofessionals may also contribute to home visitor turnover, which in turn reduces the program's ability to effectively work with at-risk families, due to less experienced workers and disrupted staff-family relationships (Gomby, 2007).

4.2. Strengths and Limitations

Results from this study contribute to the literature on the role of EHS home visitors in the identification of risk for maltreatment among young children and families. The depth of the interviews provided valuable context with which to interpret the results. Few studies have conducted qualitative interviews with home visitors related to perceptions of risk for

maltreatment. Further, this study occurred in the context of a well-established relationship with a local EHS program, which allows for immediate translation of research findings to practice and local policy. This study reflects the needs identified by that program. Results were integrated into ongoing clinical practice at the local EHS and were shared with local EHS administration.

However, there were also several limitations that should be noted. First, this study focused on the identification of risk factors with the goal of identifying areas to target in the context of an intervention. The literature has also acknowledged the important role of protective factors, noting that maltreatment risk is the result of interactions between risk and protective factors. Future research should include a strengths-based approach and evaluate protective factors, as early childhood interventions can both ameliorate risk and bolster protective factors. In addition, qualitative interviews were conducted with a small sample of EHS home visitors and supervisors in a Midwestern EHS program. Although we reached data saturation in regard to codes and themes, it is unknown how results may vary across EHS programs or with a more diverse sample. This study also included both home visitors and supervisors in the interviews. Individuals who serve as supervisors likely have different levels of training and experience and fulfill a different role within the program. Although all supervisors who participated in this study had previously been home visitors, the inclusion of their perspective could impact the results. These threats to validity should be addressed in future research. Finally, to improve trustworthiness and address concerns about social desirability given the prior relationship between the lead author and participants, all interviews were conducted by a project staff member who had not previously worked with EHS.

5. Conclusion

Overall, this study provides valuable information regarding the role of home visitors in

identifying and working with families at high risk for maltreatment in EHS. It is clear that the population of children and families served by EHS is at increased risk for maltreatment. Home visitation has been identified as an effective method for preventing child abuse and neglect, but there has been little research to date on the role of home visitors in this process. This study demonstrates how home visitors perceive characteristics that may indicate elevated risk for maltreatment. Results provided direction for improving the effectiveness of home visitors in identifying families at risk and using that information to provide targeted intervention to ameliorate risk and increase healthy family functioning. Potential future directions for EHS may be improving program supports, such as enhanced training on risk identification and communicating with families about risk, data collection and monitoring, and accessibility of targeted intervention.

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Table 1 *Home Visitor Identified Risk Factors*

Child Characteristics	Caregiver Characteristics	Family Context	Environmental Context
Academic problems	*Employment issues*	*Caregiver is not attentive/engaged*	*Dangerous neighborhoods*
Bullying	Caregiver works night shift	Father is not involved	High crime rates
Getting in trouble	Caregiver works two jobs	*Caregiver response to child behavior*	*Housing issues*
Behavior problems	Unemployment	Caregiver is overprotective	*Cheap housing*
ADHD	*Caregiver mental health problems*	Lack of knowledge about parenting	*Cultural/immigration issues*
Active/hyperactive	Depression	*Disability in other family member*	Cultural norms
Defiant	Postpartum depression	*Expectations for child behavior*	Isolation
Inappropriate language	*Caregiver stress*	*Family disorganization*	Language barrier
Tantrums	Caregiver is overwhelmed	Family inactivity	Unaware of local resources
Aggressive behaviors	*Physical appearance*	*Household size*	War/unrest in country of origin
Biting	Poor hygiene	Blended family	*Lack of social support*
Hitting	Unclean home	Unrelated adult involvement	*Limited resources*
Throwing things	*Poor coping strategies*	Close birth spacing	*Poor school systems*
Yelling	Caregiver does not seek help	*Mismatch between child and caregiver*	Lack of disability services
Behaviors	*Stressful life events*	*Missed appointments*	*Poverty/low-income*
Child appears nervous/shuts down	Bereavement	*Parental conflict*	Insurance issues
Child cries frequently	Divorce/separation	Poor family communication	Loss of food stamps
Child needs attention from caregiver	Job loss	Lack of love/respect	Overdue bills
Child is quiet	Loss of transportation	*Prior abuse*	
Challenging developmental stages	*Miscarriage*		
Teenagers	Pregnancy		
Toddlers	*Caregiver history of abuse*		
Developmental disability	*Caregiver is guarded*		
Autism	*Caregiver learning history*		
Language delay	*Caregiver physical health problems*		
Gross motor delay	*Caregiver substance use problems*		
Physical appearance	*Exposure to violence*		
Physical injuries	*First time caregiver*		
Poor hygiene	*Low educational attainment*		
Physical health problems	*Poor nutrition*		
Colic	*Short temper*		
Frequent illness	*Single parenthood*		
Poor nutrition	*Young parenthood*		
Change in			

appearance/behavior			
Mental health problems			

Highlights

- Home visitors identified a variety of risk factors for maltreatment.
- Many identified risk factors were not measurable using available data sources.
- Home visitors generally communicate concern about risk to families and supervisors.
- Home visitors feel uncomfortable initiating conversations about risk for maltreatment.