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Paraprofessional home visitors' perspectives on addressing poor mental health, substance abuse, and domestic violence: A qualitative study

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ABSTRACT

This research was conducted to understand paraprofessional home visitors' perceptions of their training in addressing poor mental health, substance abuse, and domestic violence, and their actions in working with families in addressing these issues. Five focus groups were conducted with a total of 28 paraprofessional home visitors. Three main themes emerged from qualitative analysis. Home visitors experienced tension between addressing families' more pressing needs such as housing or utilities and addressing poor mental health, substance abuse, and domestic violence. Home visitors felt that they received extensive training in these risk areas, but that this training focused heavily on knowledge acquisition rather than skill development. Home visitors also desired more guidance in addressing families' poor mental health, substance abuse, and domestic violence concerns—namely, more clarity on the extent to which they should address these issues during visits and more and varied supervision. Home visitors need more training on how to initiate conversations about mental health, substance abuse, and domestic violence, including how to transition conversations from other client needs. Home visiting programs must clarify home visitors' roles in addressing clients' poor mental health, substance abuse, and domestic violence and provide additional and varied supervision to home visitors.

In the last decade, federal and state agencies (National Commission to Prevent Infant Mortality, 1989) and private foundations (Robert Wood Johnson Foundation, 2002) have increasingly supported home visiting programs to promote maternal and child health and development. These programs focus on a range of outcomes, including improved birth outcomes (Olds et al., 1999), prevention of child abuse and neglect (Duggan et al., 1999), and promotion of school readiness (Baker, Piotrkowski, & Brooks-Gunn, 1999; Wagner & Clayton, 1999). While home visiting goals vary, programs are similar in that they aim to bring services to parents rather than expecting families to seek out services.

The American Academy of Pediatrics (AAP) has also endorsed home visiting programs as an effective intervention strategy to improve children's health and well-being (American Academy of Pediatrics Council on Child and Adolescent Health, 1998). In particular, the AAP has advocated for home visiting programs to be among the non-medical services that pediatricians and families can access to assist families in promoting their children's development. Thus, home visiting programs should be considered part of a child's medical home, as home visiting programs can provide an array of services to complement the medical care provided by a pediatric health care professional.

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As recent reviews have noted, many studies evaluating the effectiveness of home visiting programs have found no or only modest impact (Gomby, Culross, & Behrman, 1999; Olds, Hill, Robinson, Song, & Little, 2000; Sweet & Appelbaum, 2004). These reviews have also pointed out that these disappointing results are likely due, in part, to the various challenges associated with implementing home visiting services as fully, or as well as needed, to achieve desired maternal and child outcomes. One specific implementation challenge is the ability of staff to recognize and respond to the risk factors of poor mental health, substance abuse, and domestic violence (MH/SA/DV). Home visiting programs' ability to respond to MH/SA/DV is especially important since program eligibility requirements include these risk factors (Black et al., 1994; Booth, Mitchell, Barnard, & Spieker, 1989; Fraser, Armstrong, Morris, & Dadds, 2000; Marcenko & Spence, 1994). Moreover, these risk factors have been proposed as key variables related to poor birth, child abuse and neglect, and school readiness outcomes (Guterman, 2001; Peterson, Gable, & Saldana, 1996; Scott, 1992).

Failure to address MH/SA/DV among pregnant women and women with young children also has significant implications for child development. There is strong and consistent evidence that postpartum depression is associated with an array of negative child development and behavior trajectories, including emotion regulation problems, social interaction difficulties, and attachment insecurity (Cummings & Davies, 1994; Hipwell, Goossens, Melhuish, & Kumar, 2000; Murray et al., 1999; Teti, Gelfand, Messinger, & Isabella, 1995). Tarr and Pyfer's (1996) meta-analysis found a significant negative effect on the physical and motor development of infants exposed prenatally to alcohol and other drugs. Data from the National Maternal and Infant Health Survey also illustrate the negative impact of maternal substance use on child behavior, as 3-year-old children of women who used marijuana prenatally exhibited worse motor skills, shorter length of play, and increased fearfulness (Faden & Graubard, 2000). A recent meta-analysis by Kitzman, Gaylord, Holt, and Kenny (2003) found compelling evidence that exposure to domestic violence is associated with significant disruptions in young children's psychosocial functioning. Moreover, this meta-analysis suggest that witnessing domestic violence is more harmful to young children's psychosocial functioning than witnessing other forms of parental aggression (e.g., verbal aggression).

Although many home visiting programs target families with MH/SA/DV, little empirical research has examined programs' efforts to identify and address these risk factors. Korfmacher et al. found that nurse home visitors spent the largest portion of home visits discussing personal health and parenting issues while paraprofessional home visitors spent the largest portion of home visits discussing environmental health and safety, social support, and maternal life course development (Korfmacher, O'Brien, Hiatt, & Olds, 1999). A study conducted by Duggan and colleagues found that paraprofessional home visitors often failed to recognize MH/SA/DV (Duggan et al., 2004). Moreover, home visitors seldom attempted to link families with community resources to ameliorate these risk factors. These findings partially explain programs' negligible impact in reducing child abuse and neglect.

In an earlier study, we found that over half of home visited mothers participating in paraprofessional home visiting programs were screened positive by researchers for MH/SA/DV while enrolled; however, only slightly greater than one-quarter of mothers screening positive received needed services (Tandon, Parillo, Jenkins, & Duggan, 2005). Patton (1990) recommends that researchers pay attention to the purpose of inquiry in selecting methods for their research. Accordingly, given our interest in better understanding our earlier quantitative findings, we chose to conduct a qualitative study. Specifically, we carried out focus groups with home visitors in the programs that took part in the earlier study to address two objectives. First, we aimed to understand more fully how home visitors worked with families in addressing MH/SA/DV. Second, we sought to elucidate home visitors' perceptions of the adequacy of their training, and their own preparation in addressing these risk factors.

1. Method

1.1. The context for the present study: Baltimore's comprehensive family support strategy

The Safe and Sound Campaign, created in 1997, is an initiative to improve the degree to which children grow up safe, nurtured, and healthy in Baltimore City. One of the Campaign's five strategies – Baltimore's Comprehensive Family Support Strategy (BCFSS) – aims to improve the health, functioning and self-reliance of families with children birth to six. An ad hoc Strategy Team on Family Support selected six indicators to impact: (a) low birth weight, (b) preterm birth, (c) infant mortality, (d) child abuse and neglect, (e) child accidents and injuries, and (f) school readiness. It also specified four core components for the strategy model: (a) home visiting, (b) center-based services, (c) community-based activities, and (d) service linkages. In 1999, the Campaign identified 15 city neighborhoods that scored poorly on child health and well-being indicators and invited them to apply for planning grants. Seven of ten neighborhoods applying for planning grants received planning funds, and subsequently funds to implement services in the core components listed above. At the time this study was conducted, five of these seven neighborhoods were still funded to implement home visiting services.

1.2. BCFSS home visiting programs

The five BCFSS neighborhoods used two different paraprofessional home visiting models. Three neighborhoods used a Healthy Start home visiting model (National Healthy Start Association, 2004) and two neighborhoods implemented the Healthy Families America model (Daro & Harding, 1999). Paraprofessional home visitors are defined by both models as individuals who have no formal training in the helping professions. Each BCFSS home visiting program recruited pregnant