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THE USE OF RISK ASSESSMENT IN CHILD ABUSE PREVENTION

—by Deborah Daro

The social and health problems facing parents today are most serious and for some, overwhelming. Among the consequences for children are poor nutrition, low immunization rates, lack of school readiness, and increasing rates of child abuse and neglect. Statistics suggest that one in five children are being reared in poverty, one in four children are being born to single parents, only one-quarter of infants are born to mothers who received early prenatal care, and fewer than half of children starting school in a sample of nine major cities were fully immunized (National Commission on Children, 1991). Prevention efforts are key for ensuring parents access to the supports they need to avoid the most negative of these conditions for their children and to mediate those conditions they are unable to escape.

How to ensure that prevention services reach those most in need of assistance is of growing concern to prevention advocates. Repeated evaluations of existing prevention programs suggest that most of our efforts to support families are primarily successful with parents who recognize their limitations with respect to child development knowledge, parenting skills, and the use of formal and informal supports. Far fewer resources exist for families who may not know they need assistance or, if they do know, may not know how to access it (Daro, 1993). As resources become more limited, prevention advocates are being asked to document measurable change not only in the population being served but also in aggregate indicators of child and family distress. Policy makers and the general public are looking for aggregate measures, such as reduction in child abuse rates, to indicate that early intervention can make inroads into costly social problems. In an effort to provide such measurable outcomes, prevention planners are increasingly interested in targeting their services to families most likely to engage in high-risk behavior.

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Reducing child abuse rates and other negative outcomes among the most distressed populations involves the expansion of prevention services that are intensive, comprehensive, and flexible. Such services should also provide ample opportunity for families to observe and model positive interactions (Schorr, 1985; Daro, 1993). Beyond this issue of program structure, however, is the equally critical question of appropriate participant identification. Predicting future parenting behavior is a complex, and some would argue, impossible task (Starr, 1982). Despite such dire claims, numerous theoretical models exist that suggest certain personal (Steele, 1987), familial (Straus & Kantor, 1987), and environmental factors (Garbarino, 1988) contribute to an elevated risk of maltreatment or, at a minimum, to poor parenting. While such frameworks are useful in accurately predicting which groups are at an elevated risk for negative outcomes, misclassification of specific individuals is common (Browne, Davies, & Stratton, 1988).

In assessing the failure of existing risk assessment protocols, many have argued that little empirical evidence exists that consistently ties any one variable or any combination of factors directly to poor parenting. Rather, it appears that any particular risk factor is but one dimension of a complex picture. Further, the evolving nature of human development and the changing demands of parenting as a child matures make it highly unlikely that a single-point risk assessment is reliable over time. While the key to prediction may indeed be in understanding the interplay among personal skills, stressful events, and social structure, determining a family's given status on these factors over time would require a level of personal surveillance intolerable in a free society.

The absence of perfect predictive capabilities is one of the most compelling reasons for advocating the expansion of universal primary prevention. Since it is believed that most parents will fall victim to one or more risk factors over the course of their child-rearing years, making educational and support services available to all new parents has substantial theoretical appeal. A universal type of service delivery system also avoids the issue of stigmatization, a common criticism of secondary prevention. This strategy is not without its own set of

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limitations, however. While challenges to one's parenting abilities may indeed be universal, the level of risk and the need for service are not. All families may need some assistance but some families most certainly need more intensive and long-standing support than others, as evidenced by the high service-utilization rates observed among families who do not receive early interventions (Olds & Kitzman, 1993). Any universal system that provides the same, limited number of service contacts will most likely not address the needs of multi-problem families.

One program's approach: Hawaii's Healthy Start

In grappling with this issue, the program managers of Healthy Start in Hawaii have developed a method for targeting their limited funding to families they believe are likely to need and to benefit from comprehensive home visitation services. As a first step, program managers initially focused services on a small number of geographic regions with the highest rates of negative health outcomes for children. To offer the level of service believed necessary to have a substantial and significant impact on families without exceeding budget limitations, however, service availability needed to be further limited to those identified as "high risk." At present, Healthy Start incorporates a two-tiered client identification process: a thorough review of the mother's hospital records for all new births occurring in the program's target census tracts (currently covering about 52% of all annual births) and, if necessary, an in-person interview assessment.

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The hospital record screen consists of 15 items covering demographic and socioeconomic factors (e.g., marital status, education level, husband's or partner's employment status, income, stability of current living conditions, access to a telephone); current social contacts and emotional health (e.g., extent of emergency contacts or family supports, late or limited prenatal care, an unsuccessful abortion attempt for present birth, attempts to place child up for adoption, marital or family problems); and history of distress (e.g., history of substance abuse, history of psychiatric care, history of abortions, history of depression). Healthy Start staff review hospital records for all new births to families residing in the program's catchment areas on a regular basis, scoring each item as present, not present, or unable to assess due to missing or incomplete case records. New mothers are referred for an in-person interview if they 1) are single; 2) received late or no prenatal care; 3) considered abortion for the present birth; or 4) had a positive score on any two of the fifteen items. In addition, if the case record is incomplete and the majority of items cannot be assessed through the record screen, the mother will be referred for an in-person interview. Historically, approximately 60% of all new births are screened out of the program based upon this process.

The second risk assessment screen involves an in-person interview of the mother, and partner if possible, by Healthy Start personnel. This interview, which is preferably conducted in the hospital, is structured around the Family Stress Checklist (FSC) (Murphy, Orkow, & Nicola, 1985; Orkow, 1985). The checklist allows interviewers to summarize, in a standardized manner, a mother's response to ten risk situations: parental history of abuse as a child; parental history of criminal behavior, substance abuse, or mental illness; parental prior contact with child protective services involving charges of child maltreatment; current low self-esteem, social isolation, or depression; current multiple crises or stresses; violent outbursts between partners; rigid or unrealistic child expectations; belief in harsh punishment for a child; perception of child as provocative or difficult; and parental ambivalence about the baby. Staff are trained to follow a structured interview format and clear guidelines are provided for scoring the respondent's statements. In each area, respondents are assigned a "0" if no risk is present, a "5" if a mild risk is present, and a "10" if a severe risk is present. Those families scoring over 20 on the FSC are offered Healthy Start services. Historically, about 50% of those interviewed, or 20% of all births originally screened, are offered services.

Application of the Hawaii approach to other prevention services

The Hawaii system is an attractive approach for prevention programs for at least two reasons. First, it assures funders that scarce resources are being directed to those families most in need rather than merely to those families willing and able to seek assistance on their own. The method takes a systematic and consistent approach to identifying families facing the greatest challenges and engaging them in service. This expands the capacity of prevention services to enroll families who have been poorly served in the past. Second, by screening all births, the process normalizes prevention and explicitly recognizes the need for a universal assessment of parental capacity. While most families are screened out of service, the process itself highlights the importance of structuring social consideration of the personal, familial, and environmental factors that influence an individual's ability to care for young children.

While providing an excellent example of how risk assessment methods might be incorporated into prevention programming, the system raises questions about the overall utility of trying to improve

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the targeting of prevention services. Currently, the only evidence of the system's efficacy is an early reliability study of the FSC (Murphy, Orkow, & Nicola, 1985); a preliminary examination of the hospital screening tool's ability to identify families who would most likely be screened out after an in-person assessment (Stannard, 1988); and a comparison of reported cases of maltreatment between those classified as high risk and those classified as low risk (Hawaii DMCH, 1992). In each of these studies, the results suggest that the current system is operating as designed. Limitations in the design and scope of these studies and the pressing need to expand prevention efforts, however, demand additional research.

Child abuse prevention programs interested in supporting families facing serious economic difficulties might be wise to identify multiple points of assessment over a child's first few years of life rather than relying solely on an identification system that assesses families at the time of birth.

For example, it remains unclear how well the system retains its validity over time. A systematic analysis has not been done to determine how the level of risk for maltreatment may vary as families face new situations or challenges due to changes within the family structure or the child's developmental needs. Further, the only outcome measure assessed over time has been the rate at which the unserved population has been reported for maltreatment. Such reports are, at best, only a crude indicator of distress in a parent-child relationship. The absence of a child abuse or neglect report cannot be equated with nonabusive, or appropriate, parenting (Olds, Henderson, Kitzman, & Cole, 1995). More specific behaviors need to be monitored to determine whether a nurturing relationship exists.

New research on risk assessment in prevention

To address these and related questions, the National Center on Child Abuse and Neglect funded the National Committee to Prevent Child Abuse to conduct a comprehensive evaluation of Hawaii's Healthy Start program, including an assessment of the program's risk assessment system. The sample for the risk assessment component involves a randomly selected group of 150 families, half of whom were screened out of service based upon the hospital checklist (theoretically a "no-risk" group) and half of whom were screened out of service based upon their score on the FSC (theoretically a "low-risk" group). These families were interviewed and assessed using a variety of standardized measures at the times their infants turned six months and one year. Measures used in this study include the Child Abuse Potential Inventory (Milner, 1986); the Michigan Screening Profile of Parenting (Helfer, Hoffmeister, & Schneider, 1978); Nursing Child Assessment Satellite Training (Barnard, 1978; Barnard et al., 1989); the HOME Inventory (Caldwell & Bradley, 1984); and Maternal Social Support Index (Pascoe et al., 1988).

While data analysis is not yet complete, preliminary findings suggest some critical issues for prevention advocates to consider in better targeting their services. First, approximately one-quarter of the families in the low-risk group experienced a significant change in their status in one or more areas of parental competence over the one-year data collection period. In contrast, none of the families in the no-risk group experienced this type of shift. This pattern suggests that families with many of the demographic markers commonly associated with an elevated risk for maltreatment (e.g., single-parent status, young maternal age, low income) are more likely to experience shifts in their parental capacity over time than are families with greater personal and economic resources. Child abuse prevention programs interested in supporting families facing serious economic difficulties might be wise to identify multiple points of assessment over a child's first few years of life rather than relying solely on an identification system that assesses families at the time of birth.

Second, a full 46% of the low-risk sample presented elevated risk scores or scored more poorly on at least two of the measures used in this study than a randomly selected sample of individuals who qualified for service at the time they gave birth. Indeed, in several instances, virtually no differences in the mean or distribution pattern were observed after one year between those screened out of service and those identified as eligible for service at the time their children were born. At birth, the two groups differed, as measured by the FSC: six and twelve months later they looked very much the same. Again, the message for prevention advocates is to be cautious in how services are targeted, recognizing that poverty, single-parent status, and limited service access will take a toll on many families regardless of their initial strengths.

Finally, the elevated level of stress observed in the low-risk group during the one-year study period suggests that prevention advocates should consider focusing on identifying communities or neighborhoods at risk rather than limiting themselves to individual risk assessment protocols. Expanding comprehensive prevention services to areas with high concentrations of low-income, single-parent families might offer greater promise of measurable gains at both the individual and aggregate level. Further, the process might well encourage the development of more comprehensive prevention systems, as local agencies collectively work toward providing the diversity of support families need to best care for their children.

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