Child Welfare Information Gateway

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

ISSUE BRIEF

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Child Maltreatment Prevention: Past, Present, and Future

What's Inside

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Introduction

Child abuse prevention efforts have grown exponentially over the past 30 years. Some of this expansion reflects new public policies and expanded formal services such as parent education classes, support groups, home visitation programs, and safety education for children. In other cases, individuals working on their own and in partnerships with others have found ways to strengthen local institutions and create a climate in which parents support each other.

This issue brief underscores the importance of prevention as a critical component of the nation's child protection system. It outlines programs and strategies that are proving beneficial in reducing the likelihood of child maltreatment. Looking ahead, the brief identifies key issues facing high-quality prevention programs as they seek to extend their reach and impacts.

Scope of the Problem

Recent research documenting the number of child maltreatment cases observed by professionals working with children and families across the country suggests prevention efforts are having an impact. For example, the Fourth Federal National Incidence Study on Child Maltreatment (Sedlak et al., 2010) reported a 19-percent reduction in the rate of child maltreatment as reported in a similar survey conducted in 1993. Substantial and significant drops in the rates of sexual abuse, physical abuse, and emotional abuse observed by survey respondents occurred between 1993 and 2006. Although no significant declines were observed in cases of child neglect, the NIS data mirror a similar drop in the number of physical and sexual abuse cases reported in recent years to local child welfare agencies (U.S. Department of Health and Human Services, 2010). Between 1990 and 2009, the number of substantiated cases of physical abuse dropped 55 percent, and the number of substantiated sexual abuse cases declined 61 percent (Finkelhor, Jones, & Shattuck, 2011).

Despite these promising trends, child maltreatment remains a substantial threat to a child's well-being and healthy development. In 2009, over 3 million children were reported as potential victims of maltreatment. The risk for harm is particularly high for children living in the most disadvantaged communities, including those living in extreme poverty or those living with caretakers who are unable or unwilling to care for them due to chronic problems of substance abuse, mental health disorders, or domestic violence. In 2009, an estimated 1,770 children—or over 4.8 children a day—were identified as fatal victims of maltreatment. As in the past, the majority of these children—over 80 percent—were under the age of four (U.S. Department of Health and Human Services, 2010). While child maltreatment is neither inevitable nor intractable, protecting children remains challenging.

History of Child Abuse Prevention

Modern public and political attention to the issue of child maltreatment is often pegged to Henry Kempe's 1962 article in the *Journal*

of the American Medical Association on the "battered child syndrome" (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). In contrast to those early pioneers who had used clinical case studies to explain maltreatment patterns, Kempe and his colleagues examined hospital emergency room X-rays for 1 year from 70 hospitals around the country and surveyed 77 district attorneys. These efforts painted a vivid and disturbing picture of children suffering physical and emotional trauma as a result of overburdened parents or caretakers using extreme forms of corporal punishment or depressed single mothers failing to provide for their children's basic emotional and physical needs.

Armed with these descriptions, Kempe persuaded Federal and State policymakers to support the adoption of a formal child abuse reporting system. Between 1963 and 1967, all States and the District of Columbia passed child abuse reporting laws. Federal reporting guidelines were established in 1974 with the authorization of the first Federal Child Abuse and Neglect Prevention and Treatment Act.

The 1980s represented a period of significant expansion in public awareness of child maltreatment, research on its underlying causes and consequences, and the development and dissemination of both clinical interventions and prevention strategies. As more became known of the diversity within the maltreatment population, unique subpopulations were singled out for specific programmatic options and legislative attention (Daro, 1988). On the prevention front, two distinct programmatic paths emerged (Daro, 1988):

- **Interventions targeting reductions in physical abuse and neglect** (including emotional neglect and attachment disorders), including:
  - Services to new parents
  - General parenting education classes
  - Parent support groups
  - Family resource centers
  - Crisis intervention services such as hotlines and crisis nurseries (Cohn, 1983)
- **Interventions targeting reductions in child sexual abuse**, including:
  - Universal efforts designed to teach children the distinction between good, bad, and questionable touching; the concept of body ownership; or the rights of children to control who touches their bodies and where they are touched (Wurtele & Miller-Perrin, 1992)
  - Educational programs that encouraged children and youth who had been victimized to report these incidences and seek services

The effectiveness of general parent education and support programs during this time was generally limited to parents able to access these options. Prevention efforts were far less successful in attracting and retaining families who did not know they needed assistance or, if they recognized their shortcomings, did not know how to access help (Daro, 1993).

By the 1990s, emphasis was placed on establishing a strong foundation of support for every parent and child, available when a child is born or a woman is pregnant. And the way to reach new parents centered on home-based interventions (U.S. Advisory Board, 1991). The seminal work of David Olds and his colleagues showing initial and long-term

benefits from regular nurse visiting during pregnancy and a child's first 2 years of life provided the most robust evidence for this intervention (Olds, Sadler, & Kitzman, 2007). Equally important, however, were the growing number of home visitation models being developed and successfully implemented within the public and community-based service sectors. Although less rigorous in their evaluation methodologies, these models demonstrated respectable gains in parent-child attachment, access to preventive medical care, parental capacity and functioning, and early identification of developmental delays (Daro, 2000).

Prevention Today

After implementing home visitation programs for over a decade, the prevention field is facing an important challenge. Recent Federal legislation included in the Patient Protection and Affordable Care Act of 2009 will provide States $1.5 billion over the next 5 years to expand the provision of evidence-based home visitation programs to at-risk pregnant women and newborns. While research justifies an expansion of several high-quality national home visitation models, it also indicates that not all families are equally well-served by this approach; retention in long-term interventions can be difficult; and identifying, training, and retaining competent service providers is challenging. Even intensive interventions cannot fully address the needs of the most challenged populations—those struggling with serious mental illness, domestic violence, and substance abuse, as well as those rearing children in violence and chaotic neighborhoods.

Faced with the inevitable limitations of any individual program model, increased emphasis is being placed on approaches that seek change at a community or systems level (Daro & Dodge, 2009). The current prevention challenge is not simply expanding formal services but rather creating an institutional infrastructure that supports high-quality, evidence-based direct services. In addition, prevention efforts have embraced a more explicit effort to both reduce risks and enhance key protective factors, fostering strong partnerships with other local programs serving young children. Among the most salient investments in promoting protective factors are efforts to strengthen parental capacity and resilience, support a child's social and emotional development, and create more supportive relationships among community residents (Center for the Study of Social Policy, 2004). Communities where residents believe in collective responsibility for keeping children safe may achieve progress in reducing child abuse and strengthening child well-being.

Identifying and Implementing Quality Programs

All prevention services need to embrace a commitment to a set of practice principles that have been found effective across diverse disciplines and service delivery systems. A suggested list of best practice standards appears on the following page. As a group, these items represent best practice elements that lie at the core of effective interventions. To the extent that direct service providers and prevention policy advocates hope to maximize the return on their investments, supporting

service strategies that embrace the following principles will be essential:

- A strong theory of change that identifies specific outcomes and clear pathways for addressing these core outcomes, including specific strategies and curriculum content
- A recommended duration and dosage or clear guidelines for determining when to discontinue or extend services that is *systematically* applied to all those enrolled in services
- A clear, well-defined target population with identified eligibility criteria and strategy for reaching and engaging this target population
- A strategy for guiding staff in balancing the task of delivering program content while being responsive to a family's cultural beliefs and immediate circumstances
- A method to train staff on delivering the model with a supervisory system to support direct service staff and guide their ongoing practice
- Reasonable caseloads that are maintained and allow direct service staff to accomplish core program objectives
- The systematic collection of information on participant characteristics, staff characteristics, and participant service experiences to ensure services are being implemented with fidelity to the model, program intent, and structure

Promising Prevention Strategies

Several researchers suggest that the more universal or broadly targeted prevention efforts have greater success in strengthening a parent's or child's protective factors than in eliminating risk factors, particularly for parents or children at highest risk (Harrell, Cavanagh, & Sridharan, 1999; Chaffin, Bonner, & Hill, 2001; MacLeod & Nelson, 2000). Others argue that prevention strategies are most effective when they focus on a clearly defined target population with identifiable risk factors (Guterman, 2001; Olds et al., 2007). In truth, a wide range of prevention strategies has demonstrated an ability to reduce child abuse and neglect reports as well as other child safety outcomes such as reported injuries and accidents. In other cases, prevention efforts have strengthened key protective factors associated with a reduced incidence of child maltreatment such as improved parental resilience; stronger social connections; positive child development; better access to concrete supports such as housing, transportation, and nutrition; and improved parenting skills and knowledge of child development (Horton, 2003).

Strengthening Families and Communities: 2011 Resource Guide supports service providers in their work with parents, caregivers, and their children to strengthen families and prevent child abuse and neglect. It focuses on the five protective factors and provides tools and strategies to integrate the factors into existing programs and systems. It was developed by the U.S. Department of Health and Human Services, Children's Bureau, Office on Child Abuse and Neglect, its Child Welfare Information Gateway, the FRIENDS National Resource Center for Community-Based Child Abuse Prevention, and the Center for the Study of Social Policy, with input from numerous national organizations, Federal partners, and parents.
www.childwelfare.gov/preventing/preventionmonth/guide2011

Public Awareness Efforts: In the years immediately following Kempe's 1962 article on battered child syndrome, public awareness campaigns were developed to raise awareness about child abuse and to generate political support for legislation to address the problem. Notably, the nonprofit organization Prevent Child Abuse America (PCA America; formerly, the National Committee to Prevent Child Abuse) joined forces with the Ad Council to develop and distribute nationwide a series of public service announcements (PSAs) for television, radio, print, and billboards.

Between 1975 and 1985, repeated public opinion polls documented a sharp increase in public recognition of child abuse as an important social problem and steady declines in the use of corporal punishment and verbal forms of aggression in disciplining children (Daro & Gelles, 1992). More recently, broadly targeted prevention campaigns have been used to alter parental behavior. For example, the U.S. Public Health Service, in partnership with the American Academy of Pediatrics (AAP) and the Association of SIDS and Infant Mortality Programs, launched its "Back to Sleep" campaign in 1994 designed to educate parents and caretakers about the importance of placing infants on their backs to sleep as a strategy to reduce the rate of sudden infant death syndrome (SIDS). Notable gains also have been achieved with universal education programs to prevent shaken baby syndrome (Dias, Smith, deGuehery, Mazur, & Shaffer, 2005; Barr et al., 2009).

Child Sexual Assault Prevention Classes: In contrast to efforts designed to alter the behavior of adults who might commit maltreatment, a category of prevention programs emerged in the 1980s designed to alter the behavior of potential victims. Often referred to as child assault prevention or safety education programs, these efforts present children with information on the topic of physical abuse and sexual assault, how to avoid risky situations, and, if abused, how to respond. A key feature of these programs is their universal service delivery systems, often being integrated into school curricula or into primary support opportunities for children (e.g., Boy Scouts, youth groups, recreation programs). Although certain concerns have been raised regarding the appropriateness of these efforts (Reppucci & Haugaard, 1989), the strategy continues to be widely available.

Parent Education and Support Groups: Educational and support services delivered

to parents through center-based programs and group settings are used in a variety of ways to address risk factors associated with child abuse and neglect. Although the primary focus of these interventions is typically the parent, quite a few programs include opportunities for structured parent-child interactions, and many programs incorporate parallel interventions for children. For instance, programs may include:

- Weekly discussions for 8 to 14 weeks with parents around topics such as discipline, cognitive development, and parent-child communication
- Group-based sessions at which parents and children can discuss issues and share feelings
- Opportunities for parents to model the parenting skills they are learning
- Time for participants to share meals and important family celebrations such as birthdays and graduations

Educational and support services range from education and information sharing to general support to therapeutic interventions. Many of the programs are delivered under the direction of social workers or health-care providers.

A meta-analysis conducted by the Centers for Disease Control and Prevention (2009) on training programs for parents of children ages birth to 7 identified components of programs that have a positive impact on acquiring parenting skills and decreasing children's externalizing behaviors. These components included the following:

- Teaching parents emotional communication skills
- Helping parents acquire positive parent-child interaction skills
- Providing parents opportunities to demonstrate and practice these skills while observed by a service provider

Home Visitation: As noted earlier, home visitation has become a major strategy for supporting new parents. Services are one-on-one and are provided by staff with professional training (nursing, social work, child development, family support) or by paraprofessionals who receive training in the model's approach and curricula. The primary issues addressed during visits include:

- The mother's personal health and life choices
- Child health and development
- Environmental concerns such as income, housing, and community violence
- Family functioning, including adult and child relationships
- Access to services

Specific activities to address these issues may include:

- Modeling parent-child interactions and child management strategies
- Providing observation and feedback
- Offering general parenting and child development information
- Conducting formal assessments and screenings
- Providing structured counseling

In addition to working with participants around a set of parenting and child

development issues, home visitors often serve as gatekeepers to the broader array of services families may need to address various economic and personal needs. Critical reviews of the model's growing research base have reached different conclusions. In some cases, reviewers conclude that the strategy, when well implemented, does produce significant and meaningful reduction in child-abuse risk and improves child and family functioning (AAP, Council on Child and Adolescent Health, 1998; Geeraert, Van den Noortgate, Grietens, & Onghena, 2004; Guterman, 2001; Hahn, et al., 2003; Stoltzfus & Lynch, 2009). Others are more sobering in their conclusions, noting the limitations outlined earlier (Chaffin, 2004; Gomby, 2005).

In 2008, the Children's Bureau within the Administration for Children and Families at the U.S. Department of Health and Human Services funded 17 cooperative agreements to generate knowledge about the use of evidence-based home visiting programs to prevent child maltreatment. Information about the grantees, the home visiting models they are using, the cross-site evaluation, and home visiting resources is available on the Supporting Evidence Based Home Visiting website at www.supportingebhv.org/home

In 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (P.L. 111-148), legislation designed to make quality, affordable health care available to all Americans, reduce costs, improve health-care quality, enhance disease prevention, and strengthen the health-care workforce. Through a provision authorizing the creation of the Maternal, Infant, and Early Childhood Home Visiting Program, the Health Resources and Services Administration (HRSA) awarded $88 million in grants, provided under the Affordable Care Act, to support evidence-based and promising home visiting programs focused on improving the well-being of families with young children. In addition, ACF, in collaboration with HRSA, awarded 13 grants totaling $3 million for the Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program.

Community Prevention Efforts: The strategies previously outlined focus on individual parents and children. Recently, increased attention is being paid to prevention efforts designed to improve the community environment in which children are raised. Among other things, these efforts institute new services, streamline service delivery processes, and foster greater collaboration among local service providers. This emerging generation of "community child abuse prevention strategies" focuses on creating supportive residential communities where neighbors share a belief in collective responsibility to protect children from harm and where professionals work to expand services and support for parents (Chaloupka & Johnson, 2007; Doll, Bonzo, Sleet, Mercy, & Haas, 2007; Farrow, 1997; Mannes, Roehlkepartain, & Benson, 2005).

In 2009, prevention researchers Daro and Dodge examined five community child abuse prevention programs that seek to reduce child abuse and neglect. Their review concluded that the case for community prevention is promising. At least some of the models reviewed by Daro and Dodge show the ability to reduce reported rates of child abuse, reduce injury to young children, improve parent-child interactions, reduce parental stress, and improve parental efficacy. Focusing on community building, such programs can mobilize volunteers and engage diverse sectors within the community, including first responders, the faith community, local businesses, and civic groups. This mobilization exerts a synergistic impact on other desired community outcomes such as economic development and better health care.

Looking Toward the Future

Achieving stronger impacts with young children and their families will require continued efforts at developing and testing a broad array of prevention programs and systemic reforms. No one program or one approach can guarantee success. Although compelling evidence exists to support early intervention efforts, beginning at a time a woman becomes pregnant or gives birth, the absolute "best way" to provide this support is not self-evident. The most salient protective factors or risk factors will vary across populations as well as communities. Finding the correct leverage point or pathway for change for a specific family, community, or State requires careful assessment in which the final prevention plan is best suited to the needs and challenges presented by each situation.

As the prevention field moves forward, current strategies, institutional alignments and strategic partnerships need to be reevaluated and, in some cases, altered to better address current demographic and fiscal realities. Key challenges and the opportunities they present include the following:

- **Improving the ability to reach all those at risk:** The most common factors used to identify populations at risk for maltreatment include young maternal age, poverty, single parent status and severe personal challenges such as domestic violence, substance abuse, and mental health issues. Although such factors are often associated with elevated stress and reduced capacity to meet the needs of the developing child, no one of these factors is consistently

predictive of poor parenting or poor child outcomes. In addition, families that present none of these risk factors may find themselves in need of preventive services as the result of a family health emergency, job loss, or other economic uncertainties. In short, our ability to accurately identify those who will benefit from preventive services is limited and fraught with the dual problems of overidentification and underidentification. Building on a public health model of integrated services, child abuse prevention strategies may be more efficiently allocated by embedding such services within a universal system of assessment and support.

- **Determining how best to intervene with diverse ethnic and cultural groups:** Much has been written about the importance of designing parenting and early intervention programs that are respectful of the participant's culture. For the most part, program planners have responded to this concern by delivering services in a participant's primary language, matching participants and providers on the basis of race and ethnicity, and incorporating traditional child rearing practices into a program's curriculum. Far less emphasis has been placed on testing the differential effects of evidence-based prevention programs on specific racial or cultural groups or the specific ways in which the concept of prevention is viewed by various groups and supported by their existing systems of informal support. Better understanding of these diverse perspectives is key to building a prevention system that is relevant for the full range of American families.
- **Identifying ways to use technology to expand provider-participant contact and service access:** The majority of prevention programs involve face-to-face contact between a provider and program participant. Indeed, the strength and quality of the participant-provider relationship is often viewed as one of the most, if not the most, important determinant of outcomes. Although not a replacement for personal contact, the judicial use of technology can help direct service providers offer assistance to families on their caseload. For example, home visitors use cell phones to maintain regular communication with parents between intervention visits; parent education and support programs use videotaping to provide feedback to parents on the quality of their interactions with their children; and community-based initiatives use the Internet to link families with an array of resources in the community. Expanding the use of these technologies and documenting their relative costs and benefits for both providers and program participants offer both potential costs savings as well as ways to reach families living in rural and frontier communities.
- **Achieving a balance between enhancing formal services and strengthening informal supports:** Families draw on a combination of formal services (e.g., health care, education, public welfare, neighborhood associations, and primary supports) and informal support (e.g., assistance from family members, friends, and neighbors) in caring for their children. Relying too much on informal relationships and community support may be insufficient for families unable to draw on available informal supports or who

live in communities where such supports are insufficient to address their complex needs. In contrast, focusing only on formal services may ignore the limitations to public resources and the importance of creating a culture in which seeking assistance in meeting one's parenting responsibilities is the norm. Those engaged in developing and implementing comprehensive, prevention systems need to consider how they might best draw on both of these resources.

Identifying and testing a range of innovations that address all of these concerns and alternatives is important. Equally challenging, however, is how these efforts are woven together into effective prevention systems at local, State, and national levels. Just as the appropriate service focus will vary across families, the appropriate collaborative partnerships and institutional alignments will differ across communities. In some cases, public health services will provide the most fruitful foundation for crafting effective outreach to new parents. In other communities, the education system or faith community will offer the most promising approach. And once innovations are established, they will require new partnerships, systemic reforms, or continuous refinement if they are to remain viable and relevant to each subsequent cohort of new parents and their children.

Conclusion

Preventing child abuse is not simply a matter of *parents* doing a better job, but rather it is about creating a context in which "doing better" is easier. Enlightened public policy and the replication of high-quality publicly supported interventions are only part of what is needed to successfully combat child abuse. It remains important to remind the public that child abuse and neglect are serious threats to a child's healthy development and that overt violence toward children and a persistent lack of attention to their care and supervision are unacceptable. Individuals have the ability to accept personal responsibility for reducing acts of child abuse and neglect by providing support to each other and offering protection to all children within their family and their community. As sociologist Robert Wuthnow has noted, every volunteer effort or act of compassion finds its justification not in offering solutions for society's problems but in offering hope "both that the good society we envision is possible and that the very act of helping each other gives us strength and a common destiny" (Wuthnow, 1991: 304). When the problem is owned by all individuals and communities, prevention will progress, and fewer children will remain at risk.

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