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The Path to Effective Child Maltreatment Prevention Strategies

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For multiple decades, the U.S. has monitored the burden of child maltreatment through the lens of Child Protective Services (CPS) reports, documenting alarming incidence rates of maltreatment each year. In 2012, 3.4 million suspected child maltreatment reports, involving 6.3 million children, resulted in 700,000 children with substantiated maltreatment.[1] Despite the enormity of this problem identified with these statistics, these data do not capture the many other cases in which a report is never generated to CPS. The public health implications are substantial as a result of our understanding of adverse childhood experiences, their neurobiological implications to lifelong health, and the disease and mortality associated with these pervasive exposures.[2,3] When one considers the limited public health approach currently applied to address this epidemic problem in the U.S., there is a slowly emerging call to action to engage and approach child maltreatment prevention as no longer a childhood issue but, with relevance to well-being throughout the life cycle.

In order to systematically tackle the prevention of child maltreatment, recognizing this as one of the most pressing public health issues is a critical first step. Some of the key mandates of public health are to: prevent epidemics; protect against environmental hazards; prevent injuries; promote healthy behaviors; respond to disasters and assist communities in recovery; and assure access to quality health services. It

seems that this conceptual framework has been more readily embraced when the health implications are more obvious to society such as the risks of smoking and cancer, or specific behaviors and HIV transmission. Not unlike these examples, addressing child maltreatment prevention in the public health model provides the ability to: provide surveillance; inform, educate and empower those affected by the problem; mobilize community collaborative partnerships; develop policies which support individual and community efforts to reduce the problem; systematically evaluate the effectiveness of efforts and modify interventions, based upon the data; and, support new research to identify innovative, feasible solutions to the problem.

While there are several encouraging interventions that are being further evaluated and disseminated, current surveillance measures are insufficient to accurately measure the burden of child maltreatment, as the measurement perspective is almost exclusively derived from state child protective service systems. Additionally, the silo effect of many health and child protection/welfare systems remains a significant barrier to greater community collaborative partnerships. The critical impact that community and adult relationships have in promoting optimal child physical and behavioral health outcomes is well recognized. Yet, despite the overwhelming literature in the last twenty years regarding the health

impacts of child maltreatment,[2,4-11] the developmental vulnerability of the brain and its regulatory mechanisms, and the social-emotional buffering that can mitigate these biological impacts to health outcomes, a public health approach has been slow in its gestation as a foundational approach to preventing child maltreatment.

The second overriding consideration for effective child maltreatment prevention is to assess where the strengths and opportunities exist with current efforts. There are some good examples of evidence-based interventions to prevent child maltreatment at the individual, and to some extent the relationship level[12-15]; however, there has been limited investigation into effective community interventions that ultimately support the relationship and individual interventions.[16] The socio-ecological framework (and variations thereof) for prevention[17-19] supports opportunities for policy interventions which could effect the magnitude of positive change at the macrosystems level, and support the microsystems of the various evidence-based interventions that are currently being implemented in many communities.[20]

Third, the CDC describes the interactive systems framework for dissemination and implementation of prevention interventions.[21] In order to facilitate the elements and relationships of research knowledge into practice, three key systems must be established: 1) prevention synthesis

and translation; 2) prevention support; and 3) prevention delivery.[21,22] In the context of child maltreatment prevention, unless the strengths and opportunities of the socio-ecological model are fully recognized, the microsystems interventions (prevention synthesis and translation) will not be effectively supported and, may subsequently fail in the prevention delivery. If the macrosystem is developed with the capacity to foster the prevention delivery in the community setting, the prevention of child maltreatment will have greater bandwidth. Unfortunately, much of our current prevention efforts are faced with the dilemma of limited dissemination, and even less diffusion of well-designed evidence-based interventions.

Fourth, there is some mystique to the concept of resiliency. Further study is needed to more effectively develop interventions which foster resiliency, and thus, increase the social-emotional buffering needed to prevent the sequela of child maltreatment. Resiliency may be enhanced through interventions which foster safe, stable, nurturing relationships in a child's life.[23] The evidence of: positive attachments and support from a parent figure; mentoring; school engagement; caregiver social support and education; and, a sense of hope and expectancy, have been shown to enhance resiliency.[23] Promoting resilience in the context of child maltreatment prevention requires enhancement of factors that protect an

individual from impairment as a result of maltreatment. Specifically, protective factors that contribute to resilience,[24] and interventions that facilitate resilience, are a critical aspect to achieve the goal of effective prevention strategies and can easily be integrated into a socio-ecologic framework of individual, relationship and community- level factors. Interventions that address these relationship attributes are just another piece to the prevention puzzle to promote resilience and foster well-being among at-risk children.

Finally, and critically important to address the preceding points, child maltreatment prevention investments currently being made are woefully insufficient, and poorly timed in the child's life course - "too little-too late." From an economic perspective, making greater investments in early childhood development programs which focus on at-risk (targeted prevention) families and their young children will result in greater returns (ROI range: $3-17) in that child's education, health and productivity.[25,26] More recently, this economic equation has been highlighted, and investigators demonstrated the positive health effects of high-quality early childhood programs, in addition to their benefits in reducing crime, raising wages, and promoting education.[27] Despite this recognized return on investment calculus and sound economic strategy, policies fall far short in supporting these mutually beneficial economic and human investments.

The article by Nelson in this edition of JARC[28] offers a summary of the literature (published between 2000-2013) on the prevention of child physical abuse and neglect, and which were focused on primary (universal or selective) prevention interventions for children up to age 12 years. Their findings should be considered encouraging, as they identified a cadre of effective, universal and selective programs.

Universal interventions focusing on parent education and training to address parenting skills, knowledge of childhood development, and child management techniques, with several exemplars, are described. Of those, the Safe Environment for Every Kid (SEEK) program, and Positive Parenting Program (Triple P) provide the most compelling evidence of their effectiveness in child maltreatment prevention with: lower rates of child abuse and neglect reports, less harsh punishment used, fewer incidents of child neglect (SEEK model); less substantiated child maltreatment, fewer out-of-home placements, and fewer child abuse injuries (Triple P), compared to appropriate control group conditions.

The evidence and variability of home visitation models has had spirited debate over the years; however, this approach continues to be recognized as an important model to address child maltreatment prevention. Parents as Teachers (PAT), with a predominant focus on parent education; Healthy Families America (HFA), Early Start, and the

Nurse Family Partnership (NFP), offer targeted prevention to high risk families and have demonstrated the greatest evidence of effectiveness in the literature, with NFP showing "the most promise in prevention of child abuse."[28] Additionally, blended home visitation models (Safe Care Plus) are being developed and tested, although the longitudinal effectiveness of these has not been demonstrated to date.

Finally, multi-component programs integrate a variety of community-based interventions. Parenting skills and support, preschool education, and community development are embedded into these programs; however, results have been mixed, and require more study to better understand which specific component(s) are driving the success (or failure) as an effective child maltreatment prevention intervention.

The policy implications may be the current "elephant in the room" for effective child maltreatment prevention. An overriding prevention strategy should be derived from a systems level approach, which embraces the socio-ecological, and public health frameworks (with integration of policy and practice). Otherwise, efforts will be limited by the somewhat random chance that the community is aligned and has the capacity to foster the same goal- to improve child well-being as the cornerstone of success. The prevention of child maltreatment would be an expected outcome of this broader goal, along with many other beneficial

outcomes to at-risk children. Without significant, tandem policy efforts to align these spheres to the goal, random effectiveness to child maltreatment prevention will continue to be the prevailing statistical outcome.

References

1. Children's Bureau, Administration on Children, Youth and Families, U.S. Department of Health and Human Services. Child Maltreatment. 2012. http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf. Accessed April 12, 2014.
2. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 1998;14(4):245-258.
3. Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. *JAMA.* 2009;301(21):2252-2259.
4. Dube SR, Felitti VJ, Dong M, et al. Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experience Study. *Pediatrics.* 2003;111(3):564-572.
5. Brown DW, Anda RF, Tiemeier H, et al. Adverse childhood experiences and the risk of premature mortality. *Am J Prev Med*. 2009;37(5):389-396.
6. Mills R, Alati R, Michael O'Callaghan M, et al. Child Abuse and

Neglect and Cognitive Function at 14 Years of Age: Findings From a Birth Cohort. *Pediatrics.* 2011;127(1):4-10.

7. Afifi TO, Natalie P. Mota NP, et al. Physical Punishment and Mental Disorders: Results From a Nationally Representative US Sample. *Pediatrics.* 2012;130(2);184-192.
8. Cummings M, Berkowitz SJ, Scribano PV. Treatment of childhood sexual abuse: An updated review. *Curr Psychiatry Rep.* 2012;14(6):599–607.
9. Perepletchikova P, Kaufman J. Emotional and behavioral sequelae of childhood maltreatment. *Curr Opin Pediatr*. 2010;22(5):610–615.
10. Zito JM, Safer DJ, Sai D, et al. Psychotropic medication patterns among youth in foster care. *Pediatrics*. 2008;121(1):e157-e163.
11. Julie S. Steele and Karen F. Buchi. Medical and mental health of children entering the Utah foster care system. *Pediatrics*. 2008;122(3);e703-e709.
12. Olds D, Donelan-McCall N, O'Brien R, et al. Improving the Nurse-Family Partnership in community practice. *Pediatrics*. 2013;132(No.2):S110-S117.
13. Galano J, Schellenbach CJ. Healthy Families America Research Practice Network: A unique partnership to integrate prevention science and practice. *J Prev Intervent Community*. 2007;34(1-

2):39–66.

14. Duggan A, McFarlane E, Fuddy L, et al. Randomized trial of a statewide home visiting program: impact in preventing child abuse and neglect. *Child Abuse Negl*. 2004;28(6):597–622.
15. Dubowitz H, Feigelman S, Lane W, et al. Pediatric primary care to help prevent child maltreatment: The Safe Environment for Every Kid (SEEK) Model. *Pediatrics*. 2009;123(No.3):858-864.
16. Prinz RJ, Sanders MR, Shapiro CJ, et al. Population-based prevention of child maltreatment: The U.S. Triple P population trial. *Prev Sci.* 2009;10(1):1-12.
17. Belsky J. Etiology of child maltreatment: a developmental-ecological analysis. *Psychol Bull.* 1993;114(3):423-434.
18. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. Social-ecological framework. http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html Accessed April 12, 2014.
19. Garner AS, Shonkoff JP, Siegel BS, et al. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2011;129(No.1):e224-e231.

20. Children's Bureau, Administration on Children, Youth and Families. U.S. Department of Health and Human Services. Promoting Protective Factors for In-Risk Families and Youth: A Brief for Researchers. http://www.dsgonline.com/acyf/PF_Research_Brief.pdf. Accessed April 12, 2014.
21. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. Child Maltreatment Translation. http://www.cdc.gov/violenceprevention/childmaltreatment/translation.html. Accessed April 12, 2014.
22. Wandersman A, Duffy J, Flaspohler P, et al. Bridging the gap between prevention research and practice: the interactive systems framework for dissemination and implementation. *Am J Community Psychol.* 2008;41:171-181.
23. Thornberry TP, Henry KL, Smith CA, et al. Breaking the Cycle of Maltreatment: The Role of Safe, Stable, and Nurturing Relationships. *J Adolesc Health*. 2013;53:S25-S31.
24. Williams J, Nelson-Gardell D. Predicting resilience in sexually abused adolescents. *Child Abuse Negl*. 2012;36(1):53-63.
25. Heckman JJ. Skill formation and the economics of investing in

disadvantaged children. *Science*. 2006;312(No.5782):1900-1902.

26. Robert Wood Johnson Foundation. Time to Act: Investing in the Health of Our Children and Communities. Recommendations From the Robert Wood Johnson Foundation Commission to Build a Healthier America. http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf409002. Accessed April 12, 2014.
27. Campbell F, Conti G, Heckman JJ, et al. Early childhood investments substantially boost adult health. *Science*. 2014;343(No.6178):1478-1485.
28. Nelson G, Caplan R. The prevention of child physical abuse and neglect: An update. *J Appl Res Child*. 2014;5(1):1-42.