PUBLIC HEALTH *NEWS*

States Using Evidence-Based Methods to Prevent Child Abuse

Infant found strangled. Young father found guilty in the beating death of his toddler. Innocence lost. Child abuse off the charts.

News headlines from across the nation draw attention to the plight of abused and neglected children. While the media focus on the extreme cases, hundreds of thousands of children – 860,000 in 2002 alone – were victims of some form of abuse, chiefly, neglect. About 1,400 children, most of them younger than four, died at the hands of their parents or caretakers. For many children, the first day of life is the most dangerous, as unwanted infants may be abandoned or killed. The second "peak" is at eight weeks, when daily intense crying is at its highest for most normal infants.

The long-term consequences of child abuse are enormous. Abused and neglected children are at higher risk for poor health outcomes, mental health disorders, language deficits, reduced cognitive functioning, poor school performance, substance abuse in later life, criminality, teen pregnancy and of becoming abusers themselves to future generations. The financial costs are in the tens of billions of dollars. They include child welfare services (child protection, foster care and adoption), substance abuse and mental health treatment, law enforcement and medical treatment for injuries. Society also pays for costs associated with homelessness, welfare dependency and unemployment.

It's no surprise that states and localities are struggling to "fix" the child welfare system, increase penalties for perpetrators of abuse and move children more quickly out of foster care and into permanent homes. However, most experts agree that stopping child abuse before it occurs would save lives and keep children and families out of the child welfare system. The question is: how do we achieve this?

PREVENTING ABUSE: WHAT WORKS?

There are hundreds of child abuse prevention programs around the country, with the most prevalent being group-based parent education, home visitation and family resource centers. With few funds to spare, states and localities want to invest their dollars in programs that have a sound scientific base.

Research has shown that effective programs intervene with children and families very early on – prenatally or at birth; are long-term and intensive; and offer parents help with finances, health care and mental health issues, according to Dr. Deborah Daro, an expert in child abuse treatment and prevention at the Chapin Hall Center for Children at the University of Chicago. Such programs offer direct services for children and are linked to other services that support families. Effective programs also limit the caseloads for child abuse prevention program staff to no more than 15 families per worker, hire staff with strong relationship-building skills and provide ongoing training and supervision.

Programs with these elements reduce the occurrence and intensity of child abuse, improve interactions between parent and child, enhance child development and link families to much needed health-care services, Daro said.

She cautioned, however, that not all programs will work all the time for all families. One-third of families offered voluntary services refuse to participate. And even a well-designed program can make little progress with families if the health-care system is inadequate and there are few economic, educational or other resources.

Evidence continues to mount that one of the more promising strategies to prevent child abuse are home visitation programs, especially those that use nurses. The Centers for Disease Control and Prevention (CDC) Task Force on Community Preventive Services recently reviewed published studies and found that such programs reduced child abuse or neglect by about 40 percent. When delivered by professionals – nurses or mental health workers – the programs "yielded more beneficial effects than did those delivered by paraprofessionals," such as volunteers.

The report concluded, "On the basis of strong evidence of effectiveness, the task force recommends early childhood home visitation for prevention of child abuse and neglect in families at risk for maltreatment, including disadvantaged populations and families with low-birth weight infants."

One of the most effective programs reviewed by the CDC was established by Dr. David Olds at the University of Colorado. Olds' project used public health nurses to provide at-home, intensive, long-term services to low-income, at-risk pregnant women bearing their first child. In a 15-year follow-up, researchers found that participants in the Olds project experienced 79 percent fewer child abuse reports, 31 percent fewer births and 69 percent fewer maternal arrests, compared to their counterparts in a control group who did not receive project services. Their 15 year-old children experienced 56 percent fewer arrests and 56 percent fewer days of alcohol consumption, compared to controls.

Olds' project was one of the first scientifically controlled studies of this type of child abuse prevention. Based on these findings, the Center for the Study and Prevention of Violence at the University of Colorado at Boulder designated the Olds strategy of nurse-family partnerships as a model program for violence prevention. Currently, some 14,000 children are engaged in nurse-family partnership projects in 22 states.

One of those states is Wyoming, which in 2000 allocated $2 million to create the Public Health Nursing Infant Home Visitation program. Based on the nurse-family partnership model, the program targets low-income, pregnant women and families with infants, incarcerated women, women with histories of substance abuse or mental illness, and

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HEALTHTALK

LUTZKER: PREVENTING CHILD MALTREATMENT

A Ph.D. psychologist, John R. Lutzker is one of the nation's premier experts in preventing child maltreatment. Currently, he is in charge of developing and evaluating violence prevention programs for the Centers for Disease Control and Prevention (CDC). Lutzker has published over 100 professional articles and chapters, and is the author of five books, including Reducing Child Maltreatment: A Guidebook for Parent Services. He is a recent recipient of the James M. Gaudin Outstanding Research Award from the Georgia Professional Society on the Abuse of Children.

Q: What is the CDC doing to help states implement effective child maltreatment prevention programs?

A: We are involved in many activities that will help states protect children. For example, we are currently developing uniform definitions and data elements for child maltreatment surveillance. Without uniform definitions, different terms are used to describe acts of maltreatment, and these inconsistencies contribute to confusion and a lack of consensus about the magnitude of the problem.

We also have funded 13 states to establish a National Violence Death Reporting System, which will enable them to share and link state-level data about violence, including homicide, suicide, undetermined and unintentional deaths. The reporting system will enable us to gain much more accurate and in-depth information about victims of child maltreatment and abuse-related deaths.

Separately, the health departments of California, Michigan, Minnesota, Missouri and Rhode Island are comparing alternative approaches to surveillance for fatal and nonfatal childhood maltreatment, and testing methods to survey violence at all ages.

And, we're involved in something called ICARUS, a periodic in-depth injury survey. In the next one, we'll ask the public about their willingness to pay to prevent a case of childhood maltreatment. When we have those data, we'll be able to conduct much more sophisticated cost-benefit analyses on child maltreatment prevention programs. That should help the states a great deal in finding out which programs provide the most benefit for the funding dollar.

Q: You have referred to the SafeCare project in Oklahoma as an "ecobehavioral" model. Just what do you mean by that?

A: The ecobehavioral model basically stems from the belief that families are social ecologies, they are not simply individuals in vacuums. That means, if we are going to be effective in dealing with child maltreatment, we need to deal with the entire social ecology such as the parent/child relationship, advocacy for the child, community resources and so forth.

Other models rely exclusively on assessments such as rating scales or self-reports. In the ecobehavioral model, families are observed and taught right in the home and other settings. The ecobehavioral model is designed to try to teach families skills that they have not been shown before, so that they can use those skills with new challenges in new settings. So we might teach the family in the home, or we might teach them on a car ride or in a grocery store, with the hope that they can then generalize those skills to other situations. We try to teach skills that over time become durable.

The ecobehavioral model does raise some tricky issues. There's a delicate balance between intrusiveness and help. We want to assess the families as often as possible, but we have to be careful not to become too intrusive – parents might drop out.

Q: *How did the ecobehavioral model begin? And is it catching on?*

A: The first ecobehavioral project began in 1979. I wrote a grant when I was with the University of Southern Illinois, starting something called Project 12-Ways. Project 12-Ways has been ongoing since July 12, 1979, served over 1,500 families, brought in over $12 million dollars, and trained hundreds of developing professionals. The referrals to Project 12-Ways are rather homogeneous and are exclusively through the Illinois Department of Human Services. By homogeneous, I mean that the demography of southern Illinois is largely white poor families in rural circumstances. We have data over the years to suggest that Project 12 –Ways is more effective than other services in the same region offered to families.

That led to a grant from the California Wellness Foundation to systematically replicate Project 12-Ways in California. In doing so, we labeled the program Project SafeCare. It was different from Project 12-Ways in a number of ways. First of all, we conducted it in the urban San Fernando valley of Los Angeles, and our population was far more diverse in California, with the primary recipients of the services being Latinos.

We labeled the services in Project SafeCare "bonding," which is a systematic form of parent training, parent/child behavior management training for the parent, healthcare skills for the parent for their children, and teaching home safety and home cleanliness. In neglect families, who are the majority of families seen in child maltreatment referrals, often the very poor health and safety conditions of the home are the reason for the referrals. So the goal there is to teach families the skills they need to make the environment much safer and healthier for their children.

After three years, the SafeCare families survived at a nearly 90 percent level, meaning there were no further reports of child maltreatment, whereas only 56 percent of the families who received traditional treatment only had no further incidents. Statistically, that is a highly significant rate.

Q: What recommendations do you have for state officials who are trying to prevent child neglect and abuse?

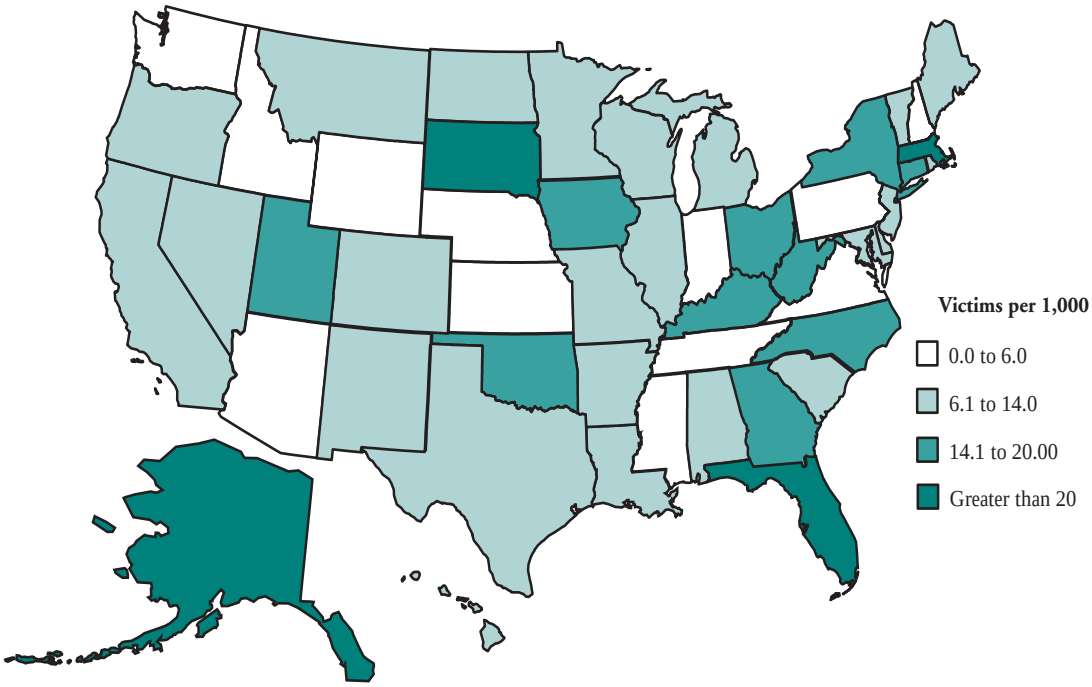
A: There are three key recommendations. First, if they are involved in evaluating a program, they should affiliate with very solid research teams. These should be teams with considerable expertise in evaluation and a record of producing publishable outcomes.

Another recommendation would be that states adopt programs that have been shown scientifically to be effective. They should evaluate and adopt only evidence-based programs – that can't be stressed enough. Many programs look good cosmetically, but if you look closely at their evaluations, those turn out to be *self*-evaluations or testimonials. Such programs should be avoided, especially if the states plan to implement them on a large scale.

Finally, I would suggest that once states choose a program, that they start small. Unless it has been proven that the program can be disseminated widely, states should test one or two regions or something very minimal, get some very good data, and make sure that the services that are delivered are the ones that were prescribed. Then, if the outcome data look good to "scale up," start expanding gradually. If you have outcomes data that show the program is cost-effective, then you've got a really robust argument for disseminating or replicating programs. *NWM*

Child Maltreatment

Rate of Child Victims by State, 2002



FAST FACTS:

In 2002, an estimated 896,000 children nationwide (12.3 per 1,000) were found to be victims of maltreatment.

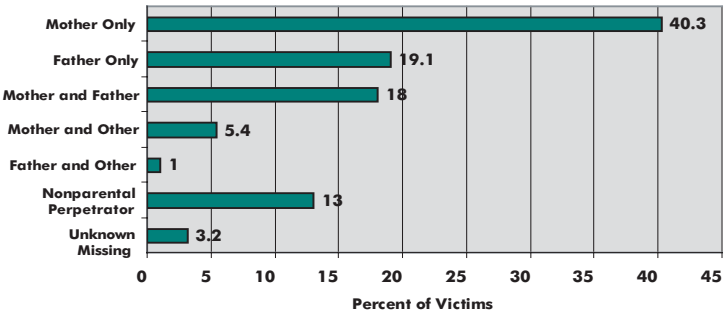
· 60% of these victims experienced neglect (including medical neglect)

·18.6 % were physically abused

· 9.9 % were sexually abused

· 6.5 % were emotionally or psychologically mistreated

Perpetrator Status, 2002



Source: *Child Maltreatment 2002*, U.S Department of Health and Human Services, Administration for Children and Families.

victims of domestic violence. Public health nurses provide "welcome home" visits, information on infant care, service referrals and a thorough assessment of the infant's circumstances. The families receive services up until the infant's 24th month.

Wyoming is not alone in its efforts to meld effective, research-based programs with strategies to prevent child abuse. In 2001, the Oklahoma Legislature passed House Bill 1143, which sets up a pilot project to identify children at high risk of abuse and to test methods of helping those children.

"When I became a legislator, I decided to request funds for a pilot project to develop a model that would work for children and families at highest risk for child abuse," explained bill sponsor Rep. Ron Peters. "I felt that if you're going to spend government money, it has to be spent on programs that work."

The legislation requires the partners to develop services for high-risk children, coordinate state and local services for these children and their families, and include both urban and rural concerns. A board, comprising representatives from the Legislature, the Governor's office, departments in the state administration, the Oklahoma Indian Affairs Commission and the CASA Association, is to evaluate the project and report back to the Legislature by May 2005.

The provider agency selected to conduct the pilot approached the CDC to identify effective prevention programs. The agency chose Project SafeCare, a home visiting program -- orginally developed in Illinois and California -- that has proven effective in reducing subsequent reports of suspected maltreatment and in preventing neglect.

Project SafeCare is different from standard child abuse prevention programs in that it provides at-risk families with comprehensive, intensive services. Most of the families in the pilot project struggle with drug and/or alcohol abuse, mental or physical disabilities, and intimate partner violence. Project SafeCare not only provides education about basic parenting, child development and safety, but it provides services for underlying issues as well, such as counseling for mental illness and substance abuse. Services that might otherwise be fragmented and difficult to obtain thus become coordinated.

The pilot project will be tested through a randomized trial. Families will either receive Project SafeCare services or a mix of standard services, such as substance abuse counseling, mental health and parenting education.

In addition to evaluating the House Bill 1143 project, the CDC and its Oklahoma partners will conduct a four-year evaluation of Project SafeCare in a larger-scale, statewide randomized trial. Three of the state's six regions will receive Project SafeCare services and the other three will receive enhanced "services as usual" in an effort to determine which route is most effective at preventing maltreatment.

WORKING WITH CHILD CARE

Another new approach to preventing child abuse is to use early care and education settings. Through a grant from the Doris Duke Foundation, the Center for the Study of Social Policy (CSSP) recently identified 21 "exemplary" early child-care programs that work with families to reduce child abuse. These programs help parents develop parenting skills, understand child development, and access community and social supports. They may also provide concrete financial and other assistance in times of need.

The rationale is that millions of children and families enroll in child-care programs, so using them to prevent maltreatment could help large numbers of children. Also, families tend to develop long-term relationships with their child-care providers, and they often share information about their family life that they would not ordinarily share with government intervention services. Child-care providers see families and children up close and can act as an early warning system for families in trouble.

Research from the University of Wisconsin appears to support the CSSP premise. Researchers there found that low-income families who participated in an intensive early childhood intervention program run by Chicago public schools had a 52 percent lower rate of maltreatment than did those who did not. Children enrolled in the program for more than four years experienced an even lower rate of maltreatment. The benefits were greatest when the children were between 10 and 17 years old.

MIAMI SAFE START

In Florida, the 11th Circuit Juvenile Court of Miami-Dade County, the state Legislature and prevention/early intervention services have joined to help court-involved families. Funded by the state Legislature in 2000, the Miami Safe Start project provides maltreated children under three with assessments and referrals to early intervention services. Mothers and children who become involved in the justice system receive services that focus on attachment and other development issues. The project videotapes mother and child interactions and uses standard assessment tools to refer families to needed services to prevent further maltreatment.

The pilot project subsequently collaborated with the local Early Head Start agency and the University of Miami's Linda Ray Intervention Center to become the nation's first juvenile court-sponsored early head start program. Funded by the Office of Juvenile Justice and Delinquency Prevention at the U.S. Department of Justice, the now-expanded program provides children and their caretakers with the services offered in the pilot.

Florida State University is evaluating the project. Baseline data collected so far documents the factors that put families at risk for maltreatment: birth complications, language delays, mental disorders, unemployment, drug/alcohol abuse and prior jail experience.

Setting out to prevent child maltreatment can be a daunting prospect, given all the factors that come into play. But working with partners in innovative ways, states are finding that there is much they can do to protect the youngest Americans. *NWM*

STATE HEALTH *NOTES*
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