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Practice Guidelines

Integrating Prevention Into the Work of Child Maltreatment Professionals

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Statement of Purpose

Preventing maltreatment spares children pain and suffering, both physical and psychological, and improves their long-term health and developmental outcomes. The serious physical and mental harms manifested during adulthood further call us to action (Anda et al., 2002). Prevention mitigates the direct costs of child abuse and neglect as well as improving all of our lives through increased productivity and decreased crime and need for medical, mental health and social services (Alexander et al., 2003). Prevent Child Abuse America (Wang & Holton, 2008) used “conservative” estimates to calculate these direct and indirect costs at \$103.8 billion in 2007. Early prevention may be even more effective in preventing harm from abuse and neglect, saving money for society, and improving society’s health and happiness overall, with the included objective of leveraging current practices and programs to change how society values children (Greeley, 2009).

The U.S. Advisory Board on Child Abuse and Neglect (Krugman, 1991) reported that child abuse and neglect is an emergency requiring leadership through professional societies and research. Prevention is explicitly not the responsibility of any one agency, profession, or program, but is best framed as the responsibility of all to create a society less conducive to child maltreatment. In this paradigm, individual skill development, community and provider education, coalition building, organizational change, and policy innovations are all part of the prevention solution. There is increasing evidence pointing to the elements of successful interventions, the populations and programs that most benefit, and the best implementation and research to demonstrate that we have met our goals. Professionals who provide clinical or supportive services to victims of maltreatment or families facing serious challenges have a role and an obligation to be aware of and support the prevention efforts in their community and to be able to appropriately refer the families they see to these resources. The American Academy of Pediatrics has made recommendations specifically for pediatricians as well (Flaherty, Stirling & COCAN, 2010). Yet despite being mandated reporters at a minimum, professionals still continue to under-report suspected maltreatment (Sedlak et al., 2010). These guidelines are designed to assist the professional in going beyond reporting by integrating best practices for child maltreatment prevention activities into their daily work with children and families.

Definitions and Types of Activities

There are several different ways to think about and categorize prevention efforts that involve (1) when prevention occurs, (2) who is the focus of a particular prevention effort, and (3) what level of the social ecology the strategy is intended to influence. The Center for Disease Control and Prevention (CDC) has emphasized that abuse operates in a societal context and requires an entire spectrum of strategies across the social ecological model with strategies designed to influence not only behavior at the individual and relationship levels but also at the community and societal levels (Bronfenbrenner, 1977; Zielinski & Bradshaw, 2006). Different professions have differing opportunities to impact children at different levels in the ecological model. Three categories of prevention are generally described based on the focus population and occurrence before or after abuse:

1. Primary or Universal: Efforts aimed at the general population for the purpose of keeping child maltreatment from happening before it has occurred.

2. Secondary or Selected: Efforts aimed at a particular group with increased risk to keep child maltreatment from happening or intervening right after it has occurred.
3. Tertiary or Indicated: Efforts aimed at preventing child maltreatment from happening again to those who have already been victimized. This level of prevention includes treatment for the original maltreatment and works over time to change conditions in the environment.

Currently, the majority of child maltreatment (CM) efforts are focused on the secondary and tertiary levels. In addition to broadening the focus of prevention to include the context in which parents raise their children, emphasis is shifting away from risk reduction after the fact as the predominant prevention approach to promotion of protective factors and positive social change to improve the lives of families.

Elements of Successful Activities

There are several elements of successful prevention strategies that have been identified (Palusci & Haney, 2010). These include using the uniqueness of the prenatal and perinatal periods, home-visiting, approaches tied to evaluation, targeting across all levels of social ecology, and using a universal public health approach or targeting those most at risk. Some prevention efforts/advocates focus more on positive child/youth development or building protective factors than on reducing risk factors, others on education to effectively engage bystanders or to reduce risk of ever perpetrating an act of harm and others educate on challenging social norms and practices that feed the problem. Others work on parent education/supports for healthy families, community education or professional training; others build stronger and more diverse coalitions, or strengthen and engage communities, or identify and advance organizational practices and policies to more effectively challenge toxic behaviors/environments and support healthier norms/practices/decisions. Some focus more on the abuse in families, some on commercial sexual exploitation or technology facilitated acts of abuse/harm/exploitation. Some experts in the field have suggested that specific forms of CM may be better prevented using targeted strategies (Finkelhor, 2007; Daro & Dodge, 2009).

The prenatal and perinatal periods, defined as one year before birth to one year of life, have been determined to be critical times to teach new parents skills to promote attachment and bonding, and several program models have shown promise based upon key periods within this time frame, including prepregnancy planning, early conception, late pregnancy, prelabor and labor, immediately following delivery, and at home with the child (Helfer, 1987). Opportunities for prevention in the early months of life include teaching parents and caregivers to cope with infant crying and how to provide a safe sleep environment for their infant (Dias et al., 2005). A recent meta-analysis of several early childhood interventions concluded that the evidence for their preventing child maltreatment in the first year of life is weak, but longer term studies may show reductions in child maltreatment similar to other programs such as home visiting when longer follow-up can be achieved (Reynolds, Mathieson, & Topsitzes, 2009).

Home visiting programs such as Healthy Families America and the Nurse Family Partnership aim to prevent child abuse and neglect by influencing parenting factors: (1) inadequate knowledge of child development, (2) belief in abusive parenting, (3) empathy, (4) sensitive,

responsive parenting, (5) parent stress and social support, and (6) the ability to provide a safe and stimulating home environment. Some home visiting programs have noted child maltreatment reductions of 40% (Sweet & Appelbaum, 2004; Olds, 2006; Gomby, 2007). Parenting programs delivered by health visitors have been found to have improved child mental health and behavior and less social dysfunction among parents in one randomized controlled trial (Patterson, Barlow, Mockford, Klimes, Pyper, & Stewart-Brown, 2002). Parent training includes reviewing child development, teaching and practicing specific skills, identifying and addressing maladaptive behaviors, and supporting parents in managing their own emotions and responding to stress. A meta-analysis of parent training programs has concluded that training can change childrearing strategies as well as modify parent's attitudes and perceptions (Lundahl & Harris, 2006).

Family wellness programs, including a variety of parent and family interventions, have demonstrated some positive effects. These programs range the gamut from short-term counseling to parenting classes, sometimes with home visiting and sometimes with intensive "wrap-around" services for families at high risk for maltreatment. Many of these have been "lumped" together making assessment problematic, but early meta-analyses show promising reductions in child maltreatment (MacLeod & Nelson, 2000). Intensive family preservation programs with high levels of participant involvement, an empowerment/strengths-based approach and social support were more effective.

Several parent education programs have been evaluated for their association with decreases in physical abuse and neglect. Several studies show the benefits of prevention when measured by learning and skill acquisition for children and adults as a result of policy change, education, or media campaigns (Davis & Gidycz, 2000; Rispens, Aleman, & Goudena, 1997). Regarding sexual abuse, Finkelhor (2007) has concluded that the available evidence supports providing high quality child-focused prevention education programs because children are able to acquire the concepts, the programs promote disclosure, there are lower rates of victimization, and children have less self-blame. Parent education and media campaigns have also demonstrated some positive effects (Rheingold et al., 2007). A recent review confirmed the effectiveness of school-based sexual abuse prevention (Barron & Topping, 2010).

There do remain several high-risk groups that need special, focused attention by the health care system. Addicted mothers need access to drug and alcohol treatment programs that can prevent neurologic damage to fetuses (such as fetal alcohol syndrome), and neurologic damage at birth interacts with deficient parenting to multiply the risk of criminality and maltreatment (Alexander et al., 2003). Mental health services need to be available for depressed or mentally ill parents who have greatly increased risk for physically abusing or killing their children (McCurdy & Daro, 1994). There are several barriers (time, training, culture, sensitive issues) to widespread implementation which can be addressed by identifying potential strategies, such as the use of handouts and local news stories, to begin a dialogue during routine pediatric visits (Sege et al., 2006).

A large body of theory and empirical research suggests that intervention at the neighborhood level is likely to prevent child maltreatment within families. In addition to individual and family factors, there are also cultural risk and protective factors that may be neighborhood-specific. This represents a "fourth wave" in prevention activities, with emphasis on altering communities being

on par with efforts on the individual parenting level (Daro & Dodge, 2009). The two components of intervention that appear to be most promising are social capital development and community coordination of individualized services. Community strategies to prevent child abuse and promote child protection have focused on creating supportive residential communities whose residents share a belief in collective responsibility to protect children from harm and on expanding the range of services and instrumental supports directly available to parents. Multidisciplinary case review has also shown promise as a community approach for preventing child maltreatment fatalities. Child fatality review teams have been instituted in most U.S. states to provide a multi-agency, multi-disciplinary review of all or most child deaths. In addition to identifying misclassified deaths, child fatality review programs have found most of these deaths to be preventable to some degree, and a number of changes have been recommended (Douglas and Cunningham, 2008; Palusci, Yager & Covington, 2010).

Guidelines for Practice

Given the importance of their work with children and families and the elements of successful prevention activities, professionals need to integrate child maltreatment prevention into their daily work whenever they interact with children and families. In an age of increasing use of evidence-based practice, it is important that professionals know what is useful with their target populations and how to integrate and study their cultural adaptations and innovations. The American Professional Society on the Abuse of Children has concluded that child maltreatment prevention is an important part of all professional work related to children and strongly supports the need for institutions and agencies to provide the resources for their staff to fulfill this professional obligation. Good professional practice, staff training and agency policy addressing CM, advocating for resources for effective programs, screening, recognizing, and referring at-risk families for services, and promoting nurturing parenting and child raising styles are but some of the practices that have been suggested (AAP, 1999; Johnson, 1998; Dubowitz, 2002; Plummer & Palusci, 2010). APSAC also recognizes that other professional organizations and faith-based organizations should promulgate guidelines for specific disciplines regarding the need to integrate prevention into the daily work of a variety of professionals interacting with children and families and that the media, businesses and other industries have a role to play in preventing CM (Vieth, 2008).

General Considerations

1. Know your community
2. Be culturally appropriate
3. Design strategies that you can actually implement
4. Stay informed of research and best practices
5. Adapt your program to emerging issues, trends, and the contemporary society
6. Evaluate your program in an ongoing way

Opportunities for Primary Prevention

Parent Education: Professionals should provide parents and other caregivers with effective strategies for discipline and nurturing, by providing materials, consultation and referral. They should promote issues of media safety, supervision, selecting safe child care, and choosing quality day care and educational programs. Professionals should support early bonding and

attachment, and educate parents on normal age-appropriate behaviors for children of all ages and about parenting skills, limit setting and protective factors to be nurtured. Consistent discipline practices and body safety techniques should be emphasized. Posters in waiting rooms, take-home brochures, and lists of web addresses should be readily available for referrals for parents' use. Additional resources on child abuse prevention programs that exist in and around the community and referrals of parents to area agencies for additional information or assistance should also be available.

Community Awareness: Professionals have the credibility to promote awareness of the links between childhood trauma and future health problems. They should offer to provide radio or TV public service announcements to build awareness of child abuse as a societal and public health issue related to long-term physical and mental health.

Opportunities for Secondary Prevention

Holistic Care: Prevention begins with solid clinical practice, which includes recognizing risk factors for violence and being able to identify, treat and refer violence-related problems at all stages of child development. Professionals need to identify issues with mental illness, substance abuse, stress, inappropriate supervision, family violence and exposure to media violence, access to firearms, gang involvement and other signs of poor self-esteem, school failure and depression. Specialized programs for high-risk teen parents are needed to prevent another generation of CM.

Important Roles for Educators: On a daily basis, educational professionals spend more time with children than do other professionals in society. Beyond educational needs, they usually recognize children and families with early signs of difficulty. Educators need to work with children to reduce their risk for maltreatment and strengthen their resiliency and protective factors. This requires viewing their role as more than merely educating, and it also requires school administration and government to provide support for teachers and students for this to be addressed. Educators have additional roles in advocating for community programs and resources within the school where there is often better access for children (Barron & Topping, 2010).

Bystander Involvement: In personal or professional capacities, professionals should be willing to become involved when they are concerned about a child's safety. This requires a proactive stance when being confronted with troubling parenting behaviors on the street or in public and to recognize that we all have, to some degree, a responsibility to act to prevent maltreatment and promote child safety.

Opportunities for Tertiary Prevention

Early Behavior Problem Identification: Caregivers often consult with professionals about behavior problems with their children, who may be exhibiting reactive symptoms of being abused or stress after trauma exposure. Behavioral problems are often non-specific, but professionals can guide parents while guarding against parental over-reaction to self-exploration or developmentally-appropriate behaviors.

Reporting: Despite great demands on their time, professionals must be willing to make referrals to Child Protective Services based on reasonable suspicion rather than waiting until they are certain. Professionals must understand their state child abuse mandated reporting laws, know how to make a report, and should seek supervision or consultation when necessary to make the most appropriate report.

Treatment and Referral: Professionals need to know what they can handle through office counseling and when they need to refer families for help. They must also be cognizant of the resources available in their community to address these risks. This requires knowledge of the child welfare, emergency shelter and substance abuse treatment systems and how to make referrals to appropriate therapists and mental health professionals.

Opportunities for Social and Systems Change

Keeping Up to Date With the Field: Professionals can be more effective advocates for systems change if they are knowledgeable about current prevention strategies. In CPS practice, professionals can identify prevention opportunities within the population of families and children who come to their system but who are unsubstantiated or do not require that the children be taken into protective custody. Professionals in clinical services and law enforcement can help prevention professionals and volunteers by recognizing the importance of their prevention work and participating in multidisciplinary training, thereby assisting in networking alliances between prevention and treatment fields.

Integrating Prevention Into Professional Curricula: Professionals should create, distribute and advocate for training materials and other professional curricula at the undergraduate, graduate and post-graduate levels which integrate child maltreatment prevention into training for specific professional disciplines. This includes lectures, seminars, certifications, printed learning materials as well as didactic and clinical experiences for professionals and non-professionals as well. This may also include minimum training requirements for licensing.

Policy and Organizational Efforts: Professionals should be willing to make changes in policy, hiring, supervision, and training in their own office or professional organization to put proven prevention procedures in place. This can include establishing clinical practice guidelines to address these issues in the office and clinic. This recommendation can easily be expanded to include the variety of professional disciplines caring for children.

Community Case Review: State and local Child Fatality Review Teams and Multidisciplinary Teams offer professionals the opportunity to share their experience directly with others in the public safety, public health, medical, criminal justice, child welfare, and education fields. Professionals should participate when able in these teams to inform the consideration of prevention programs within the community and to assist in improving practices concerning families and children. If these teams are not available in their community, professionals should advocate for their creation and implementation to improve child welfare systems. Where teams exist, members need ongoing training to assure current, consistent information is used to develop services and programs (Vieth, 2008).

Advocacy: Professionals should use their status in the community to advocate for the needs of individual families and for the broader needs of children in society. This includes thinking “outside of the box” and working with organizations who address the needs of children in different arenas. Professionals should endorse and support quality prevention activities, serve on advisory boards for local child abuse prevention agencies or home-visiting programs, and advocate for more scientific evaluation of existing and future prevention programs.

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Additional Resources

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